STATE LAW ENFORCEMENT PROGRAM ASSISTANCE AGENCY

STAFF REPORT: A DESK-BOOK ON DRUG ABUSE

DISSEMINATION DOCUMENT NO. 5
DECEMBER 20, 1969

STATE OF NEW JERSEY

Richard J. Hughes
Governor

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STATE LAW ENFORCEMENT PROGRAM ASSISTANCE AGENCY

Editor for this issue: James A. Spady

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America's leadership must be guided by the lights of learning and reason — or else those who confuse rhetoric with reality will gain the popular ascendancy with their seemingly swift and simple solutions.

— John F. Kennedy in a speech intended for delivery in Dallas, November 22, 1963.

RICHARD J. HUGHES
GOVERNOR

JAMES A. SPADY
EXECUTIVE DIRECTOR

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STATE LAW ENFORCEMENT PROGRAM ASSISTANCE AGENCY

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December 20, 1969

Dear Colleague:

As you know, this series of Dissemination Documents includes four sub-series. One of those sub-series comprises collections of information on a topic of importance to the criminal justice system and to our society at large. This Staff Report is the first in that sub-series.

Narcotics addiction is of great importance for several reasons: (1) it is a key element in the generation of crime in the central city, (2) it is one source of the income of organized crime, and (3) it destroys lives, particularly young lives.

It is also a maddening subject: it seems to be intractable, or at least we have not yet learned how to cope with it.

Yet, we must do what we can. And we can only make headway against terrible odds if we have the facts in the hands of a broad range of New Jersey citizens and officials.

We consider this Document as a primer -- it merely summarizes in one place, what you ought to have handy on the subject. It is deliberately not elaborate, nor detailed. We call it a "desk book", because we hope that the recipients -- law enforcement officials, education officials, clergy, community leaders -- will use it.

There is no question but that a difficult battle such as that against the spread of narcotics addiction, can only be waged if a broad spectrum of citizens and officials are involved. We ask you to read these materials; to use them; to think about their implications; and to support the growth of programs against addiction, and the legislative creation of addiction control tools.

STATE LAW ENFORCEMENT PROGRAM ASSISTANCE AGENCY

It has been a common over-simplification to consider narcotics addiction, or drug abuse, to be a law enforcement problem alone. Effective control of illicit drugs requires the co-operation of many diverse agencies of the federal and local and state governments; it is beyond the province of any one of them alone.

RICHARD M. NIXON, Presidential Message to the Congress, July 14, 1969.

PREFACE

This is a Staff Report about drug abuse. There is no more important, controversial, obscure, intractable, or emotionally-charged subject at that interface between society and its government that we call law enforcement.

There are perhaps 7000 narcotic addicts in New Jersey, based upon convictions. The actual number may be higher or lower — no one knows. The Federal Bureau of Narcotics and Dangerous Drugs reports that while New York and California lead the nation in number of narcotics addicts, Illinois and New Jersey are next.

It is estimated that in one large New Jersey city, 50% of reported crimes are drug-abuse related.

It is estimated that each narcotics addict, in order to purchase his daily drugs in the street, must procure *at least* $30 that day. For 7000 addicts, this means $210,000 per day, $1,500,000 per week, $6,000,000 per month, and $78,000,000 per year. It is reasonable to assume that most of these very large sums come from the fruits of illegal acts — thefts, prostitution, muggings, and burglaries.

Narcotics addiction costs society a great deal of money — but that is also an opportunity. With perhaps $78,000,000 per year at stake, there is a clear economic justification for doing what human considerations also impel: preventing and controlling addiction.

But the narcotic drugs — the opium derivatives and their synthetic counterparts — are not the whole picture. In 1968 only 46.9% of drug law arrests in New Jersey arose from the narcotic drugs. The other 53.1% arose from marihauna (36.4%) and the barbituates and benzedrine (16.7%). These drugs, while less dangerous, can ruin reputations, prospects, careers, lives.

As if these terrible side-effects of the narcotics traffic aren't enough, there is the fact that it is perhaps the third greatest source of income for organized crime. And it is not unrelated, especially through its effect on crime, to the economic decline of the center city, and therefore the erosion of the middle class tax base. In other words, to the "Urban Crisis" — the crisis of expanding urban problems and contracting urban assets.

Any attack on crime must emphasize urban crime — Newark, for example, with only 5.7% of New Jersey's population, has 20.1% of its reported crime. Any attack on urban crime must emphasize the problem of narcotics addiction.

That is why we have made narcotics the first subject in this sub-series of documents. And that is why we have put this document in your hands — to arouse you. The hour is late, and only *you* can help.

* * *

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This present document is otherwise solely the product of SLEPA as regards concept, layout, design, and written or other content; no consultant of any kind advised or assisted in its creation.

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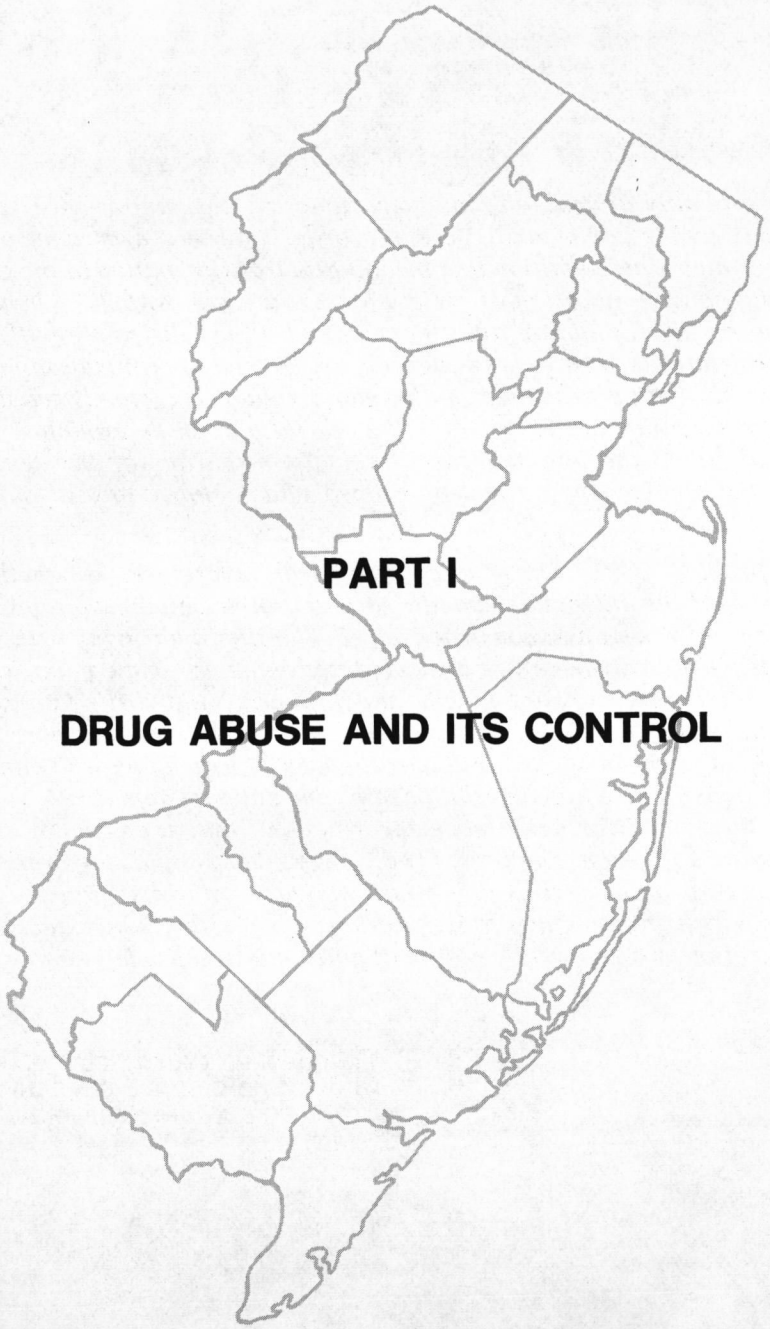
Pat calls me and says this Dominique's wife is here, and he is going to meet her. He went to meet her at some hotel, I don't know what hotel as it was downtown someplace, and when he finally came back to me, he told me he wants $8000 for a down payment. I forget if he said how much stuff would be coming. Anyway it was fifteen kilos. If you don't know what a kilo is, it's thirty-five ounces of junk.

About four weeks after that we get the word that the boat is coming in with the stuff. I'm pretty sure the boat was the United States, but don't hold me to it. Now in the meantime, Sally Sheilds has got arrested in another case and gets fifteen years, and he's out of it. I tell Tony about the shipment, and he says that he will have Patty Moccio handle everything. It will cost $1000 a kilo to pay the seaman to get the stuff off the boat, which naturally comes to $15,000.

Well, the stuff gets off okay. Now I have to explain that the deal with Tony Bender is fifty-fifty after he gets his $9000 back, and we pay the rest of what we owe to Dominique. We owe him $29,500, but who cares, as the market for the stuff here runs to $165,000?

JOE VALACHI, describing a shipment of Turkish heroin from a French processing plant, in THE VALACHI PAPERS, by Peter Maas, 1968.



PART I

DRUG ABUSE AND ITS CONTROL

It is probably impossible to overemphasize the importance of basic alterations in the social and economic order that are needed in order to combat crime. A precondition to a meaningful transformation of the ghetto is fair dealing and compassion of society for its outcasts. Antisocial behavior is produced by discrimination, indifference, and unjust distribution of wealth. Many drug addicts, drunks, and vagrants are treated as criminals not because they harm us, but because they challenge our values. It certainly is not new to say that environmental factors play the crucial part in determining whether individuals obey the law and carry the responsibilities of the democratic society, or whether they are demoralized and inclined toward antisocial, lawless behavior.

The problem with which one must deal, therefore, is whether the experiences of the individual lead him to find that he can meet his basic needs so that he can work out a constructive peaceful life in harmony with society, or whether his basic needs are neglected and violated to the point where he becomes destructive toward people and property, and drifts into a life of crime and violence. The elements which play a determining part are the stability and strength of the family, or the lack of it; contact with adults who establish constructive human relationships and support democratic values, or who by their behavior demoralize the young so that they cannot establish good person-to-person relations. And, lastly, one should not overlook the importance of contacts with other youth who have interests, motivations, and experiences which are constructive and lawful; or with young leaders, gangs, and institutions which exist by reason of antisocial and predatory activities.

ANDREW R. TYLER, Civil Court Judge, New York City, in GOVERNING THE CITY, The Academy of Political Science, 1969.

NATURE OF DRUG ABUSE

Drug abuse[1] is a controversial field. More important for present purposes, it is a confused field – particularly as to terminology, and definitions. And these things matter, because they confuse the control, treatment, and rehabilitation processes.

For purposes of this Document, a consistent terminology will be employed. Under that terminology, drugs, the abuse of which should be controlled by statute because there is a social danger in such abuse, fall into two categories.

The first category is that which comprises the "narcotic drugs" (defined and listed in a subsequent section herein). One becomes "addicted" (defined below) to a "narcotic drug" and because of this addiction, one will go to greater lengths to obtain the drug on the illicit market. The stronger, more debilitating effect of a "narcotic drug" on the person using it, plus the tendency for the person to commit crimes to enable him to purchase the "narcotic drug" create a very strong social interest in controlling the "narcotic drug" traffic, preventing "addiction", and rehabilitating the "addict."

The second category is that which comprises the "dangerous drugs." Obviously many drugs are dangerous in *some* dosage or under *some* conditions (e.g., alcohol), which drugs nevertheless are not categorically socially frowned upon, much less rendered categorically criminal. In other words, any list of "dangerous drugs" has to be somewhat arbitrary. It is the task of the Legislature to decide which drugs shall be in this lesser category. The drugs so categorized are listed and discussed in a subsequent section herein. Because "dangerous drugs" are not "addictive" (at least not in the sense of the "narcotic drugs") there is less drive in the "user" to secure the drug, and therefore less danger to society. The "dangerous drugs" are therefore generally treated separately, for all purposes, including statutory.

As will appear hereinafter, New Jersey law uses the terms "Narcotic Drugs" for one class of offenses, and "Dangerous Drugs" for another.[2] The difficulty and confusion arises because one major drug that is not like the narcotics (marihuana) is included in New Jersey's law among the "Narcotic Drugs", while a major class of drugs (barbituates and sedatives) that *are* like narcotics is included in New Jersey law among the lesser category of "Dangerous Drugs." This creates great confusion when one attempts to discuss control, treatment, and rehabilitation.

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[1] Published works pertaining to the subjects treated in this Part may be found in the first 53 titles of the Working Bibliography of Part III herein.

[2] Respectively at N.J.S.A. 24:18, and N.J.S.A. 24:6C.

ADDICTION DEFINED

"Addiction" *ought* to be the key concept in any distinction between legislative classes of drug abuse, but in any event it *is* the key distinction for purposes of social analysis, control, treatment, and rehabilitation.

Definitions of addiction are very common, but agreement of any two definitions is very uncommon. A good working definition is the 1950 World Health Organization definition[3] of addiction, as follows:

> "Drug addiction is a state of periodic or chronic intoxication detrimental to the individual and to society, produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include: (1) an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means; (2) a tendency to increase the dose; (3) a psychic (psychological and sometimes physical) dependence on the effects of the drug; and (4) a physical dependence requiring its presence for maintaining the individual's balance."

Having set out that definition, we nevertheless must refer to the other definitions, so that the reader will be able to interpret in the light of this present Document, supplementary readings that use those definitions.

In general, physicians tend to define "addiction" in terms of *physical* dependence, while psychiatrists, psychologists, and psychoanalysts tend to define it in terms of *psychological or psychic* dependence on the drug. On the other hand, sociologists, in their writings, tend to define it in terms of assimilation into a *special life style* of drug taking.

It is important to recognize that a person could be an addict under one definition and not under another. Similarly, a drug can be addictive under one definition and not under another.

It is possible to become an addict accidentally. This is so because narcotic drugs are used in medicine, and can inadvertently cause addiction as a side product of treatment. In general, however, most addiction is the result of a deliberate choice — a choice, if not to *become* an addict, then at least a choice to run a grave *risk* of becoming an addict.

NARCOTIC DRUGS

The word "narcotic", as used in law, has a different meaning than its other usages. In the dictionary sense, a "narcotic" is functionally something that induces sleep, dulls the senses, and relieves pain. Additionally, as we have

[3]Expert Committee on Drugs Liable to Produce Addiction; World Health Organization Technical Report Series, No. 21. Geneva, Switzerland, 1950.

seen when defining *addiction*, the abuse of a narcotic drug results in a physical *dependence*. One would think that the two last sentences would define "narcotic drug" in law. Such is generally not the case, however. In law, a "narcotic drug" is a member of a class of physical compounds that is defined by that categorization – the list always includes the opiates but often goes beyond them. Here again, every man is his own lexicographer.

The New Jersey statutes define "narcotic drugs" as including: coca leaves, amidone, opium, marihauna, isonipecaine, or any compound or substance which is chemically identical with the forgoing. There are arguments for thus classifying marihuana as a "narcotic drug", but the weight of opinion is that it cannot meet the kind of definition we have set out here.

Opium, Derivatives, and Analogs

Members of this "class" constitute the primary concern of society and law enforcement as regards drug abuse.

The class (which can of course be expanded) includes (1) opium, in all forms: *opium* itself, and extracts such as *morphine, codeine, laudanum,* and *paragoric;* (2) chemical derivatives of the opiates morphine and codeine, the most important of which, *heroin*, is the sharpest focus of the drug abuse problem in the United States[4] including in New Jersey; and (3) synthetic drugs that may or may not resemble opiates in chemical structure, but that, like *methadone* and *meperidine,* resemble opiates in narcotic effect on humans.

All of these opiates, opiate derivatives, and opiate analogs resemble in that they are *analgesics,* i.e., they give relief from pain. Also, regular dosage builds a *tolerance* to their effects, so that dosage must increase in order to hold effect constant. Finally, in addition to tolerance regular dosage produces a *physical dependence,* so that if the drug is suddenly withdrawn a *withdrawal illness* occurs. Each of the drugs is to some extent a substitute for the other, in that tolerance to one is tolerance to all, and also in that each will relieve the illness produced by withdrawal of any of the others. This last characteristic is taken advantage of when the synthetic, more physiologically tolerable *methadone* is substituted for *heroin* in an addict's treatment, and is generally called *methadone maintenance,* as will be touched on again in a later section herein.

It is interesting and informative in the sense that it give perspective, to

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[4]A.M.A. Council on Mental Health, "Report on Narcotic Addiction", in A.M.A., NARCOTIC ADDICTION – OFFICIAL ACTIONS OF THE AMERICAN MEDICAL ASSOCIATION, (1963).

review our evolving attitudes toward drug abuse — specifically of the more dangerous opiates — over the last century.

Opium has been used for medical purposes — to relive pain — throughout recorded history. It first became a social *problem* when opium smoking was introduced into China in the 18th century. The British East India Company exploited and spread the new vice among the miserable Chinese coolies. The Company also saw to it that opium use was prohibited, so that the Company could enforce its own monopoly on the traffic. This led to the Opium War of 1840.

Morphine was isolated from opium in 1812. It immediately became a blessing in an era when surgery was without anesthetics, and when heavy infection meant sure progress toward painful death.

In a sense, then, opium and its derivatives were the "wonder drugs" of the 19th century. Like our own "wonder drugs", there was a tendency to use them whenever there was any kind of medical problem. Its use in the pervasive "patent" medicines of that day made the opiates as common as aspirin is today.

The U.S. Civil War was the bloodiest war in history. Fortunately, the hypodermic syringe had been invented a few years before the war, so that the wounded and ill could be treated with morphine. However, the widespread use of morphine on the soldiers led to what was called the "soldier's disease" — morphine addiction. And the widespread use of morphine in medicine in the latter years of the 19th century after the war spread morphine addiction. In 1898 heroin was isolated from morphine.

In the early years of the 20th century heroin was widely used as a snuff. In 1914, the federal Harrison Narcotics Act was passed, as a response to the Hague Opium Convention of 1912. This was the beginning of an attempt to control the new problem, and also the initial choice of the law enforcement rather than the medical view of the problem. The law enforcement and statutory aspects of the present day situation will be treated later herein.

The Harrison Act was a tax statute. It was therefore not unambiguously a "law enforcement" approach. But it led to a law enforcement approach. And what was viewed as bathroom cabinet medicines of only 30 years before, became — with the rise of organized crime (analogous to the British East India Company?), and the appearance in the cities of suppressed, downtrodden groups (analogous to the early 19th century Chinese?) who also viewed narcotics as "outside the law" and therefore the basis of an escape sub-culture — a major social, political, economic, *and* law enforcement, problem.

COCAINE

Cocaine is included here in a separate category, because while it is categorized under the Harrison Act and under New Jersey law as a "narcotic drug", it is in fact not. It does not meet any current definition of "narcotic drug", and its legal inclusion as such has to be related to historical factors. It is really a "dangerous drug" and not a "narcotic drug."

"Narcotics" are dulling (i.e., depressants), cocaine is a powerful stimulant. "Narcotics" create, and indeed should be defined by, tolerance and physical dependence – neither of which is a characteristic of cocaine.

The statutory picture[5] evidently has its origin in the fact that, at the turn of this century, heroin and cocaine were cross-confused in the public mind. They were both used as a white snuff powder, and sometimes the names were even interchanged. The "kick" or euphoria that *is* produced by cocaine, somehow became falsely identified during that period with heroin, which is of course (as an opiate) quite the opposite: a dulling analgesic, a central nervous system depressant. On the other hand, the "narcotic" qualities of heroin – tolerance, physical dependence – became falsely identified with cocaine. This confusion led to inclusion of cocaine as a "narcotic" in the Harrison Act (which was passed during the period of popular confusion), which in turn led to imitations (the Uniform Drug Act) in State statutes, including New Jersey's.

Cocaine is derived from coca leaves (the New Jersey statute uses "coca leaves" as its categorizing term) that are grown in South America. Cocaine is generally not considered a major problem today.

MARIHUANA

Marihuana is also included here in a separate category because while under New Jersey law it is classified under "narcotic drugs", it is in fact not. It does not meet any current definition of "narcotic drug", although unlike cocaine there is controversy on that point.

Marihuana is prepared from the flowering tops of the female hemp plant, the plant from which brown rope is made. The plant grows wild, even in the

[5]Throughout this Document, analysis of statutory definition or categorization should not be taken to mean that the Legislature should not rank any drugs it may wish into a high penalty category, and any others it may wish into a lower penalty category. Still less should it be taken as an indication that a specific drug should be "legalized". Rather, what is intended is an analysis that takes the statutory phrases "narcotic drug" and "dangerous drug" at their face values, and tries to rearrange those categories so as to correspond to medical fact, so that clear differences will be apparent to the reader – differences that do not confuse categories of *treatment* modalities with the statutory categories of *penalties*.

United States, but most marihuana comes from Mexico. It is more difficult to smuggle than heroin, because of the enormous difference in bulk, but this is compensated for by its continental North American origin. It is generally used in cigarette form.[6] Hashish is a marihuana derivative.

Marihuana is not used in medicine. Undoubtedly this is one reason why it, like heroin, was *originally* treated severely by law enforcement – that is, it had no redeeming virtues. Whether or not so differentiating it originally, from say morphine and codeine that *do* have medicinal uses, *led* to its widespread abuse *because* it was more risky and would therefore appeal to deviant or rebellious personalities, is obviously outside the scope of this Document.

In any event, marihuana is an especially difficult subject because (1) pharmacologically it is more complex than nearly all other drugs subject to abuse, and because (2) it has of late become a subject of intense controversy involving essentially social questions that are engrafted onto the subject of marihuana use itself.

Pharmacologically, it is complex, producing effects that vary greatly with the personality of the user, and that include *both* elements of depression and stimulation. It will be remembered that any modern definition of "narcotic drug" must include *tolerance* and *physical dependence*. The heavy weight of opinion is that marihuana produces neither, and that it is therefore *not*[7] a "narcotic drug." That is not, of course, sufficient to decide the separate question of what methods of control should be employed over it. Those are legislative questions.

Marihuana use cuts across a much broader segment of the population than does narcotics – particulary heroin – use. The latter is more prevalent among the disaffected, especially the urban poor. The former is reputed to be prevalent among those groups, but also among the very different groups of students, artists and writers, and young professionals. Marihuana is relatively cheap, especially compared to narcotics. If heroin use costs $30 a day, marihuana use may cost no more per day than twice that of tobacco use, perhaps $1.50 (2 or 3 marihuana cigarettes). That, plus its lack of physical dependency, renders it *less* of a direct danger to society than narcotics, though obviously it nevertheless poses a serious control problem because its

[6]It was recently estimated that 12 million Americans have broken the law and smoked marihuana at least once. It is rumored that cigarette companies, under constant cancer pressure regarding tobacco, would enter the marihuana cigarette field if it were legalized.

[7]Eddy, Holbach, Isbell & Seevers, "Drug Dependence: Its Signigicance and Characteristics", 32 Bulletin of the World Health Organization, at 728, 729, (1965); A.M.A. Council on Mental Health, supra note 3, at 11 - 13.

abuse can have important implications beyond the sphere of the user himself.

BARBITUATES AND SEDATIVES

These drugs are also included in a separate category because, while they resemble "narcotic drugs", they are classified in New Jersey under the lesser category of "dangerous drugs". Like the true "narcotic drugs" (opiates), they are also central nervous system depressants, and more important from a social control point of view, they produce *physical dependence.*

Included among the barbituates and sedatives are the derivatives of barbituric acid (barbituates), and other classes of drugs like bromides, chloral hydrate ("knockout drops") and some tranquilizers such as meprobromate that have effects closely resembling the barbituates (and that may be called, by the *abuser,* "goof balls" and so on).

Because these drugs are widely used in medicine, control is not control of their mere possession or use per se, as with heroin or marihuana, but control of their *abuse.*

In normal medical use the barbituates and sedatives do not produce physical dependence. However, when taken in large doses they produce physical dependence, and therefore addiction. They could therefore be properly classified with the true narcotics — the opiates.

In ranking them against the opiates a *values* question therefore arises. For in one sense they are in fact a greater abusage problem, since they are so common. However, perhaps *because* there is a legal market for these drugs, those that *do* become addicted, do not resort to crime to support their addiction. And in *that* sense they are less of a social problem. How we view them therefore depends on our values — are we trying to protect the *user* from himself? Or *society* from the user?

DANGEROUS DRUGS

"Dangerous drugs" can be viewed medically as falling into three categories: stimulants, depressants, and hallucinogens. These have little to do with one another; some are in fact opposites in physical or psychological effect. To the extent they have a common ground, it is that (1) they are non-narcotics, and (2) they can be taken in dosages that constitute the user a danger to himself or to society.

Stimulants

It has already been mentioned that cocaine is a stimulant that has been misclassified legally with the narcotics. The other stimulants are also non-

addictive, but *are* generally classified in law with the "dangerous drugs" rather than with the "narcotic drugs."

The broadest class is the amphetamines, or "pep pills." There are many amphetamines on the legal market. Here again, it is not possession or use per se that is considered the problem, but abuse of drugs. Again, it is difficult to square this distinction with the case of marihuana — where mere possession is a crime — without taking cognizance of the fact that one has medical use and the other does not. Is it *that* accident, and not differential *effects* of the various milder drugs that accounts for the difference in control attitudes?

Also classifiable under "stimulants" are an enormous range of substances that stimulate the central nervous system, from commercial solvents (as in glue sniffing) to morning glory seeds and so on.

Depressants

These are the barbituates and the sedatives, which have already been separately discussed. Again, they are, in abusive dosages, addictive. It makes more sense, perhaps, to view them together with the "narcotic drugs" which are also addictive, rather than with the "dangerous drugs" which are not. For example, from the standpoint of treatment, "withdrawal" illness drugs should be treated in one manner, and non-withdrawal drugs should be treated in another manner. It therefore makes no sense to lump cocaine and marihuana (no withdrawal illness) together with the true-narcotic opiates. Neither does it make sense to lump barbituates and sedatives (withdrawal illness) together with the non-withdrawal "dangerous drugs." The legislatively-assigned levels of penalties, and modes of control, cannot be confused with the underlying similarities and dissimilarities — or else public understanding of the medical treatment aspects will suffer.

Hallucinogens

Hallucinogenic drugs are those that separate the user from reality; that cause him to have hallucinations.

As with stimulants, there are many hallucinogenic substances, the difference being one of degree, and one of definition as a social problem. Peyote is derived from the cactus plant, and is used legally in religious ceremonies by certain American Indian tribes. Mescaline is a hallucinogen obtained from the same cactus plant. Psilocybin is derived from a mushroom fungus.

But the main popular interest is with LSD (lysergic acid diethylamide).

This synthetic sybstance,[8] generally impregnated on a sugar cube, is capable of causing extreme hallucinations, and depending upon the personality of the user, psychosis and suicide. Its use is obviously a cause for strong social concern, partly because very harmful effects are *known* to be at least possible with LSD use, and partly because so many things about the drug's effects are *not* yet known.

CONTROL OF DRUG ABUSE

DRUG ABUSE AND CRIME

Addiction *itself* (as distinguished from possession of the drug, for example) cannot be a crime under constitutional interpretation.[9] But purchase, sale, and possession of narcotics *are* crimes, and as such *maintenance* of addiction automatically brings the addict into conflict with the law. But the really important relationship between addiction and crime is not this automatic one, but the certainty that an unknown percentage of *addicts* resort to crimes such as prostitution, thefts, and burglaries, in order to obtain the funds necessary to support their addiction by purchases in the illicit narcotics market.

Users of *non-addictive* drugs are unlikely to be driven to *such* collateral crimes in order to continue their drug abuse. With these abusers, collateral crimes, *if any,* are not likely to be crimes directed toward monetary value, but crimes of loss of self control, such as assaults, death by auto, and so on. As important as these crimes are, they pale beside the magnitude of inner city generation of crimes by narcotics addicts driven to seek the daily purchase price of their heroin needs.

There is no way to know accurately what the actual correlation is between narcotics addiction and crime.[10] In other words, there are no scientific, controlled studies on the subject. One can, however, estimate the order of magnitude of the impact of addiction on "fund raising" by the addicts. If there are 7000 addicts in New Jersey, and if daily heroin purchases require $30, then these addicts must obtain $210,000 every day, $1,500,000 every week, $6,000,000 every month, $78,000,000 every year. It is true that all 7000 previously convicted addicts may not still be active, or that they may not all be active all the time. It is also true that part of the needed sums may come

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[8]Blum, Richard H., and Associates, "Utopiates: The Use and Users of LSD-25", Atherton Press, New York, New York, 1968.

[9]In 1962, the U.S. Supreme Court declared unconstitutional a California statute rendering addiction per se a crime, *Robinson v. California,* 370 U.S. 660.

[10]President's Commission on Law Enforcement and Administration of Justice, "The Challenge of Crime in a Free Society", at 222 (1967).

from sources unrelated to crime. But on the other hand, the $30 per day figure is in *cash,* and the value of stolen goods needed to raise $30 per day is $60 - $90. So, balancing all these guesses, the figure of $78,000,000 per year *may* be of the right order of magnitude. If so, inner city crime — and the quality of inner city life — is obviously a function of (among other things) the state of narcotics addiction and control.

DRUG LAW ENFORCEMENT

The problems of law enforcement in the drug abuse field arise from two facts: (1) drugs are by nature compact, and it is therefore difficult to detect the *drugs* at any stage of the hierarchical distribution process, and (2) both the seller and buyer of drugs are willing parties, so that there are no *complaining witnesses* to alert the law enforcement system to the illegal transaction or act.

This twin disability forces resort to the more difficult, painstaking aspects of detective work (especially to attack the higher, main streams of distribution) involving informers, wire tapping, stake-outs, and the like. Nevertheless, the President's Crime Commission stated in 1967 that the enforcement of federal and State narcotic laws had, in the consensus of the literature and law enforcement community, reduced both the incidence of addiction and the availability of narcotics since the enactment and enforcement of the narcotic control laws.[11]

A distinction must be drawn, for enforcement purposes, among (1) narcotic drugs (opiates), (2) marihuana, and (3) most drugs classified as "dangerous drugs." That distinction relates to the methods by which they enter into illicit traffic. Basically, opiates (heroin) are imported from Europe by sea or air, marihuana is imported from Mexico by land, and most dangerous drugs are simply diverted from legal channels within the United States.

Thus all of these drugs, and especially the opiates and marihuana, involve interstate and international aspects in the early, main currents of distribution. This means that the main attack must be by federal enforcement officials against those main streams. State and local officials have access only to distribution channels several echelons below the entry or source level.

The principal source of heroin, for example, is reputed to be the Middle East, especially Turkey, where poppy harvesting is legal. Much of the legally-

[11]Id. at 219. Assertions of this consensus may be found, for example, in "Hearings on S.2113, S2114, S.2152 Before a Special Subcommittee of the Senate Judiciary Committee", 89th Congress, 2d Session, at 428, 455 (1966); also in Eldrige, "Narcotics and the Law", 80, (1962).

produced opium is diverted from the legal market into the black market in which the farmer obtains double the prevailing price.

The farmer's profit of 100% ($35 per kilogram black market compared to $18 per kilogram legal market) is small compared to the ensuing profit if the American "street" market is the ultimate destination. The $35 kilogram (2.2 pounds) of opium will produce about 0.1 kilogram of pure (i.e., 85%) heroin, which, when diluted into individual doses by the addition of an average of over 90% milk sugar, will yield at least $25,000 — a profit of over 70,000%!

Federal officials guess that about 1,500 kilograms of heroin illegally enters the United States each year. This is less than one half of one percent of the *legal* opium production of the world. In other words, the *deterrent* effect of federal entry activities is remarkably great considering how common opium is outside our borders and how expensive it is inside.

This federal deterrent efficiency is quite crucial, because all observers say that the important thing is to stop narcotics at the source; and that the next best thing is to attack the first two levels of distribution. Enforcement only against the lowest level — the so-called "pusher" and the "user" — is like attacking symptons rather than causes.

The Federal Bureau of Narcotics and Dangerous Drugs maintains twelve overseas posts in which American agents work with host countries in attempting to seize, as close to the source as possible, illegal narcotics destined for the American trade. In 1965 the efforts led to the seizure of 888 kilograms of opium, 128 kilograms of morphine, and 84 kilograms of heroin. Assuming intended conversion to heroin, this would be equilavent to about 175 kilograms of heroin, or over 10% of what is estimated to be successfully smuggled into the United States each year.

The Federal Bureau of Customs is responsible for the enormously painstaking task of border control of smuggling. In fiscal 1966, the Bureau seized 65 kilograms of heroin, or nearly 5% of what is estimated to be successfully smuggled in each year.

Internal federal enforcement is the responsibility of the Bureau of Narcotics and Dangerous Drugs. Once the border is successfully crossed, interdiction becomes extremely difficult because a process of breaking down the drug into smaller quantities in the hands of diverse wholesalers or middlemen occurs as quickly as possible. The Bureau in fiscal 1966 maintained a force of 278 agents who concentrated against the upper echelons of this traffic.

As to "dangerous drugs" — largely commercial drugs that are abused by users — the federal government took the lead in 1965 with enactment of the

Drug Abuse Control Amendments to the Federal Food, Drug, and Cosmetic Act. This Act (U.S.C. 21) prohibits, among other acts, the following:

- sale or disposition not covered by legal prescriptions.
- illegal possession for resale.
- failure to register as a manufacturer or wholesaler of controlled drugs.
- failure to keep records of receipt and distribution of controlled drugs.

In enacting this "dangerous drugs" law, Congress sought to control the diversion of legal drugs into illegal "abuse" channels by a system of registration, inspection, and record keeping. It is a sympton of the movement toward concurrent jurisdiction that Congress made the Act apply to intrastate as well as interstate transactions.

Obviously State and local law enforcement has a role in the foregoing. The role consists of cooperation or parallel jurisdiction in the middle echelon activities, and primary responsibility at the lower echelon, or "street" level. This role will be touched on in more detail when New Jersey is treated specifically in Part II herein. However, once again,as with the 1914 Harrison Act (which was the model for the Uniform Narcotic Drug Act now in force in most states), the federal government is taking the lead in this field, by formulating a Model State Drug Abuse Control Act, by increased border activities, and by forming combined "strike forces" that can attack the middle echelons of distribution with combined federal-state-local forces.[12]

TREATMENT

Treatment is of course a mode of control: from the law enforcement standpoint, addicts under treatment are removed from active "street" activites; and rehabilitated or controlled addicts reduce the addict population.

For many years, only the federal government maintained treatment facilities; now there is a wide range of programs in many states.[13] Treatment

[12]N.J.S.A. 24:6C (1966) was the first state statute to follow the Model State Drug Abuse Control Act, and enact federally-determined drug prohibitions as determined by F.D.A. under the 1965 amendments to the Federal Food, Drug and Cosmetic Act. N.J.S.A. 24:6C is discussed in the "Control" section of Part II herein. For a detailed, scholarly, and lawyerly survey and analysis of needed State legislation, see Rosenthal, Michael B., "Prosposals for Dangerous Drug Legislation", in the TASK FORCE REPORT: NARCOTICS AND DRUG ABUSE, at 83-134, of the President's Commission on Law Enforcement and Administration of Justice, 1967.

[13]A more detailed description of the various treatment programs of New Jersey, other States, and the federal government is set out in Part II herein, since it relates to programs and possible programs in New Jersey. This present section is merely intended to introduce an outline of the status of treatment today under the "control" aspect of the subject of this Part. Published items in the Working Bibliography of Part III also relate directly to this subject.

and rehabilitation programs are diverse, but in general, hospital treatment alone is not considered sufficient. Although there is now an established and accepted view that addiction is a medical, or at least partially a medical problem — as witness the growth of such programs in recent years — nevertheless the punitive or deterrent aspect of society's view of the addict continues, and it inevitably conflicts with the medical view at several points.

There is general agreement that the individual addict has an individual social or psychological disorientation that led him into narcotics, and that individual rehabilitation — or at least rehabilitation based upon the individual personality although administered in groups — is therefore necessary.

Medical researchers prefer the following steps to be followed: (1) hospitalization with treatment; (2) release under strict parole or other supervision for an extended period; and (3) provision of professional community and medical services during release.

The treatment strategies currently prevailing in the United States have been summarized[14] as follows: (1) imprisonment; (2) hospitalization with medical and psychological treatment; (3) institutional counseling; (4) community surveillance; (5) casework in the community; and (6) mutual-aid organizations of ex-addicts. To this list can be added, (7) methadone maintenance. These are, of course, not necessarily separate categories, and they are generally combined in various ways.

It is safe to say that none of these methods is the "answer" to the control of addiction through treatment. Of perhaps strategic importance is the methadone method, whereby methadone is substituted for heroin, and which is therefore very promising as an adjunct to prevent relapse to heroin after "drying out." Methadone is a narcotic, and can therefore be substituted for heroin with patient stability — the advantage is that methadone is not debilitating like heroin (for example, the patient can work) and of course the patient no longer must compete for funds to make purchases of heroin.

The fact that there is no single or group "answer" among treatment modalities, does not of course mean that treatment is not the best hope we have short of absolute blocking of the traffic, which seems impossible.

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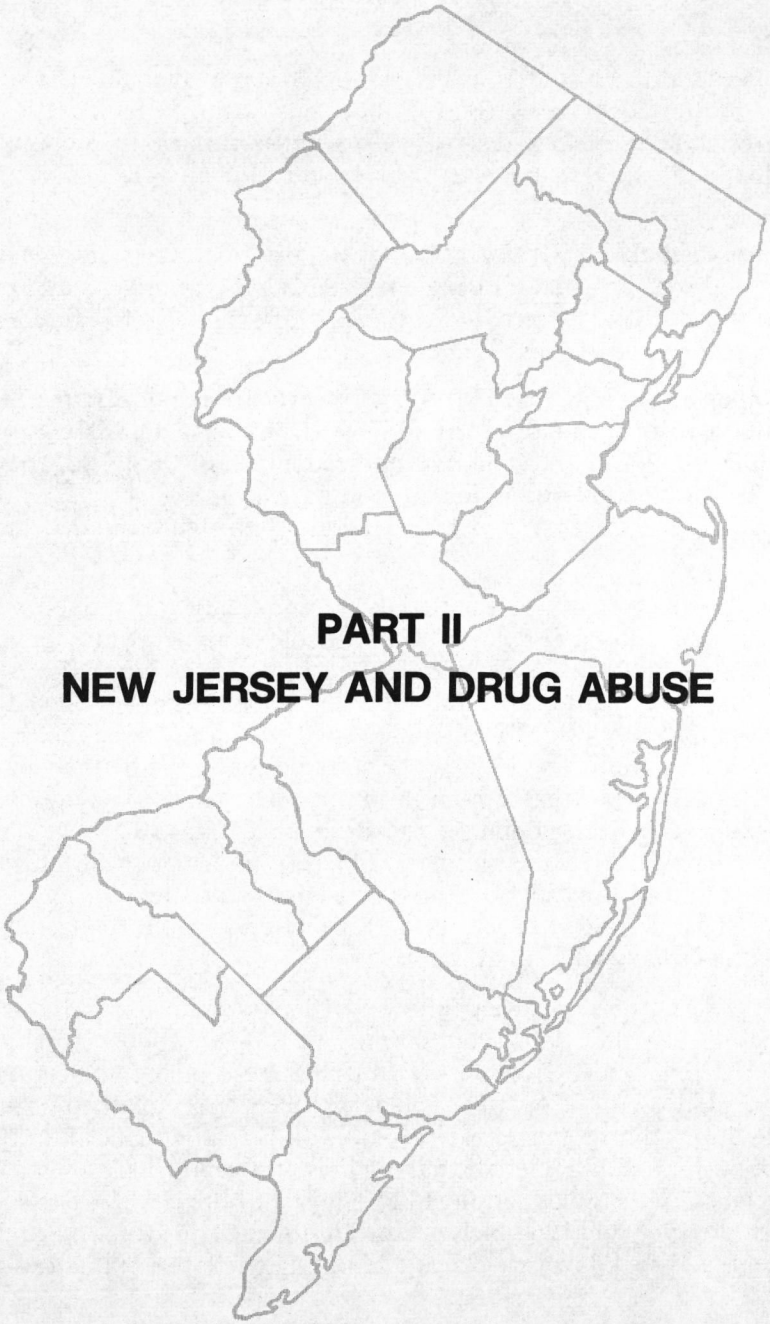
[14]Glaser, Daniel, and O'Leary, Vincent, "The Control and Treatment of Narcotics Use." Washington, D.C., H.E.W., Welfare Administration, Office of Juvenile Delinquency and Youth Development, 1966.

*There have been major innovations in legal procedures and medical techniques during the last few years. ** Careful implementation, evaluation, and coordination of new programs will be absolutely essential. These are among today's first needs. New ideas are only a first step. Unless the programs they lead to are provided with sufficient money and manpower and are competently administered, no improvement in drug abuse problems can be expected.*

From "THE CHALLENGE OF CRIME IN A FREE SOCIETY", a report of the President's Commission of Law Enforcement and the Administration of Justice, 1967.



PART II
NEW JERSEY AND DRUG ABUSE

THE PROBLEM IN NEW JERSEY

INCIDENCE

The 1968 Uniform Crime Reports[15] (which became available last summer) compiled by the New Jersey State Police show a 56.5% increase in arrests (7896 arrests versus 5045 arrests) for drug abuse violations as compared to 1967. This is the *highest* increase of arrest rate for any class of offenses in 1968.

In addition, the 1968 Uniform Crime Reports for New Jersey show that 53% of all persons arrested for drug abuse during the year were *under* the age of 21. Of that 53%, 13% were *under* 16 years of age, and 31% were *under* 20 years of age but over 16 years of age.

It is important to note that marihuana arrests are rising very fast. In 1967 marihuana arrests accounted for 28.9% of drug abuse arrests (1458 out of 5045) while in 1968 marihuana arrests accounted for 36.4% of drug abuse arrests (2874 out of 7896). When we compare 1968 (2874 arrests) to 1967 (1458 arrests) we see that marihuana arrests, considered alone, increased 97%!

In 1967, the Narcotic Drug Study Commission of the New Jersey Legislature issued its final report. That valuable document summarized drug abuse statistics gathered in the period 1952-1966 by the Narcotics Squad of the Criminal Investigation Section, New Jersey State Police. The data were presented graphically, which is of course very helpful in seeing the trend over that period. It is interesting to view the statistics gathered by the New Jersey Uniform Crime Reporting System in its first two years of operation (1967, 1968) against the background of the drug abuse statistics that had been collected, since 1952, from the clerk of every court in the State under a separate statutory authority. Those baseline statistics for the present Uniform Crime Reports are set out in this section in the format prepared by the Narcotic Drug Study Commission.

The first seven of the eleven following Charts relate to "narcotic drug" violations during the 1952-1966 period mentioned above. It should be remembered that under New Jersey Statutes these include marihuana and cocaine in addition to the opiates. The next three Charts relate to "dangerous drug" violations during the period (prohibition here commenced in 1962). In New Jersey this would include barbituates, tranquilizers, amphetamines, commercial solvents (glue) and the like. The last of the eleven Charts is taken from both the 1967 and 1968 New Jersey Uniform Crime Reports, and shows the percentage breakdown by drugs underlying the latest statistics set forth above.

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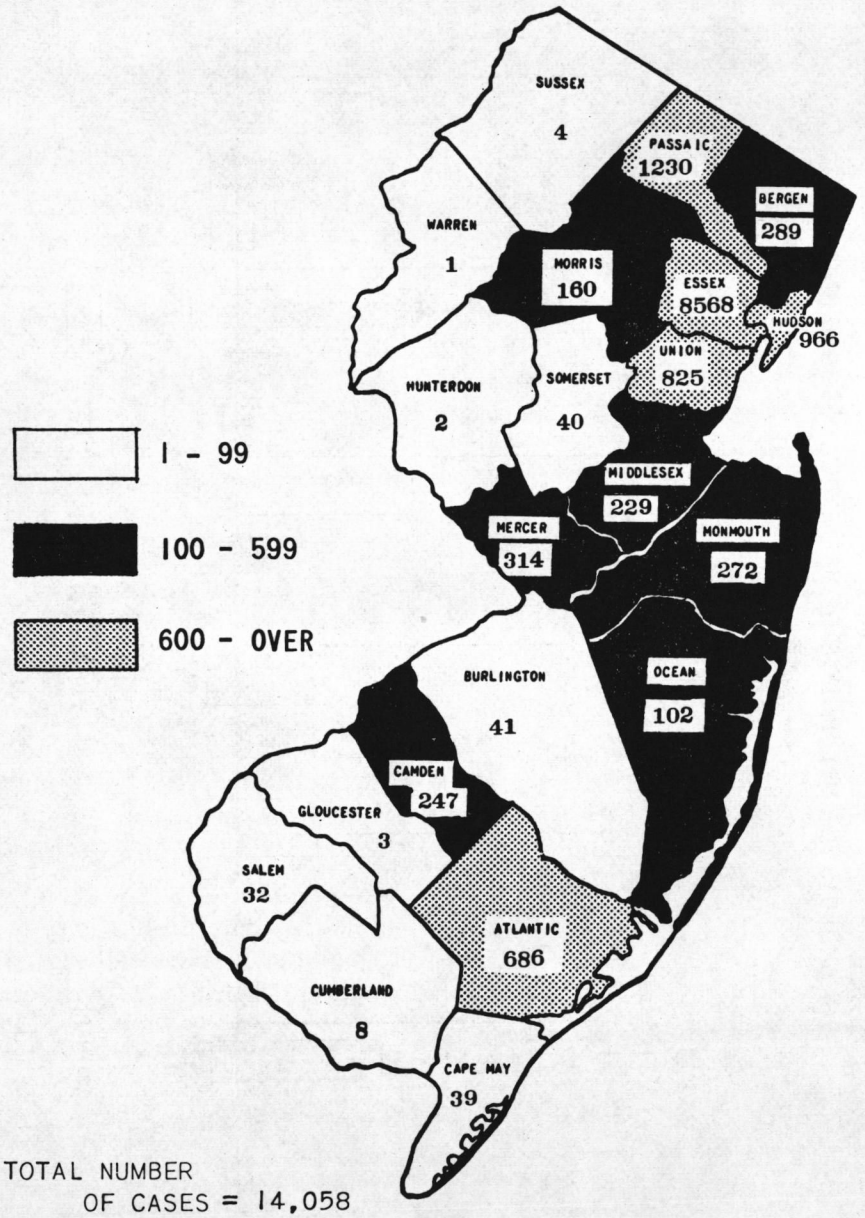
[15]State of New Jersey, Department of Law and Public Safety, Division of State Police, "Crime in New Jersey – 1968 Uniform Crime Reports", Trenton (1968)

CHART 1
DISTRIBUTION OF NARCOTIC ARRESTS BY COUNTY*
1952-1966 (INCL.)*



TOTAL NUMBER
OF CASES = 14,058

*Excludes juvenile and Federal Bureau of Narcotics arrests.

CHART 2

ARRESTS FOR USE BY TYPE OF NARCOTIC 1960-1966 (INCL.)

Excludes Federal Bureau of Narcotic Arrests

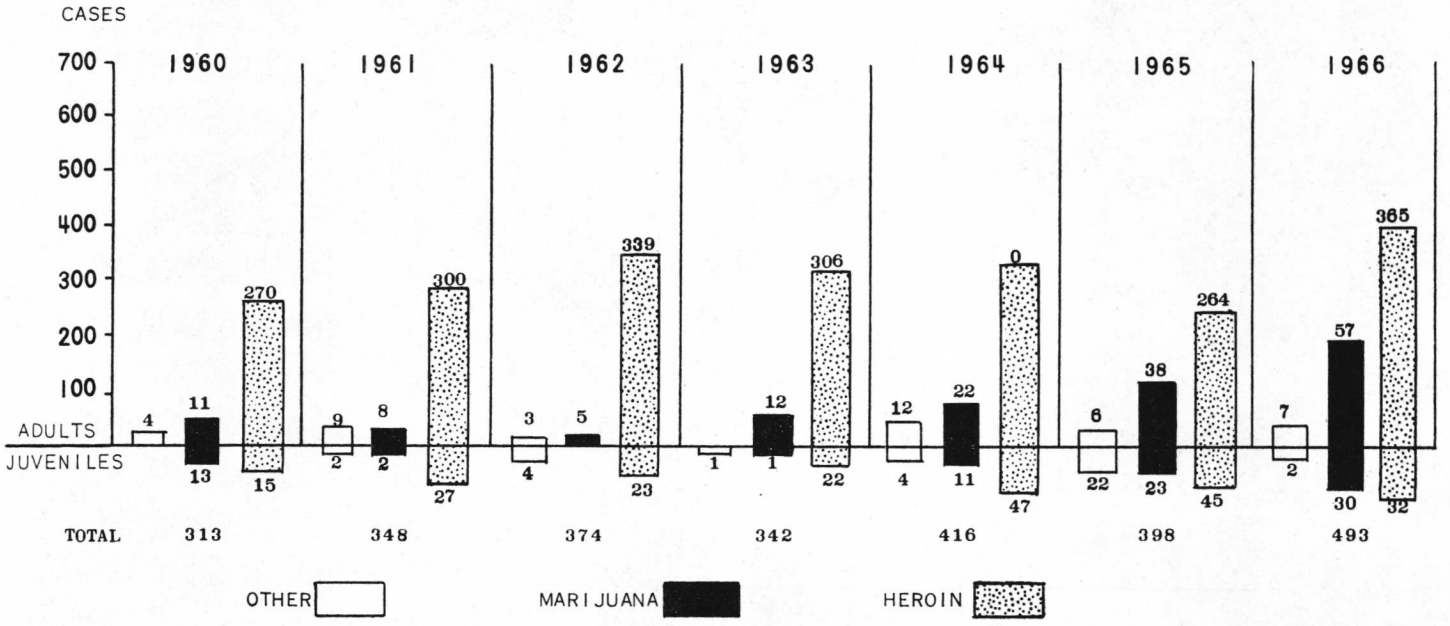


CHART 3

TRENDS IN NARCOTIC ARRESTS BY TYPE OF OFFENDER 1952-1966 (INCL.)*

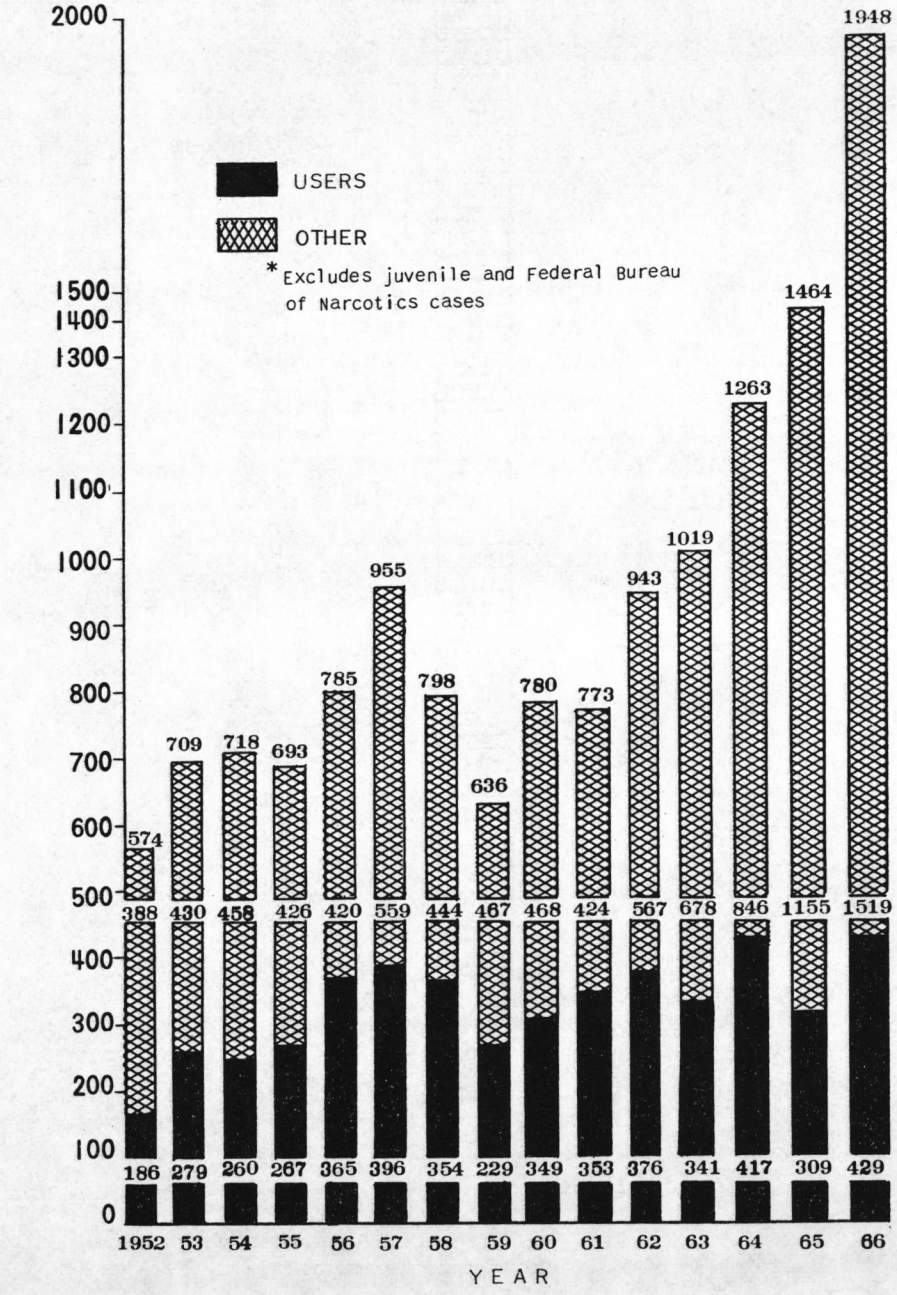
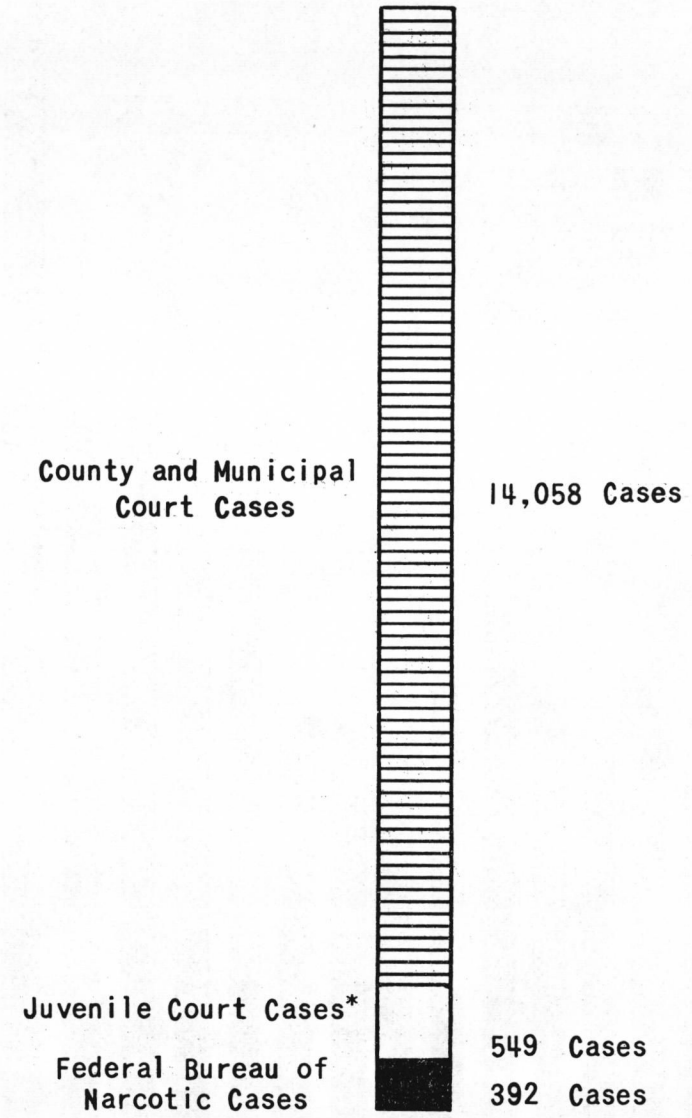


CHART 4

TOTAL NARCOTIC ARRESTS
1952-1966 (INCL.)



TOTAL NUMBER OF CASES 14,999

*Data for juvenile arrests collected from January 1, 1956

CHART 5

TOTAL NARCOTIC PROCESSED CRIMINAL CASES REFERRED TO PROSECUTORS 1952-1966 (INCL.)

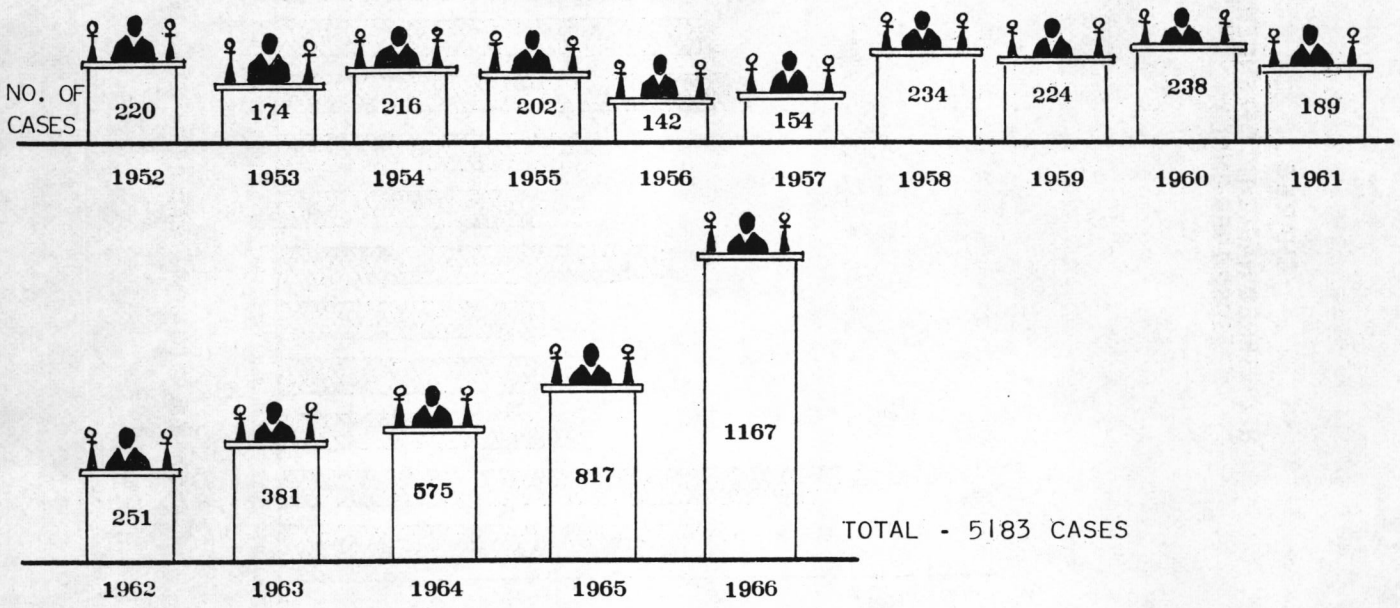
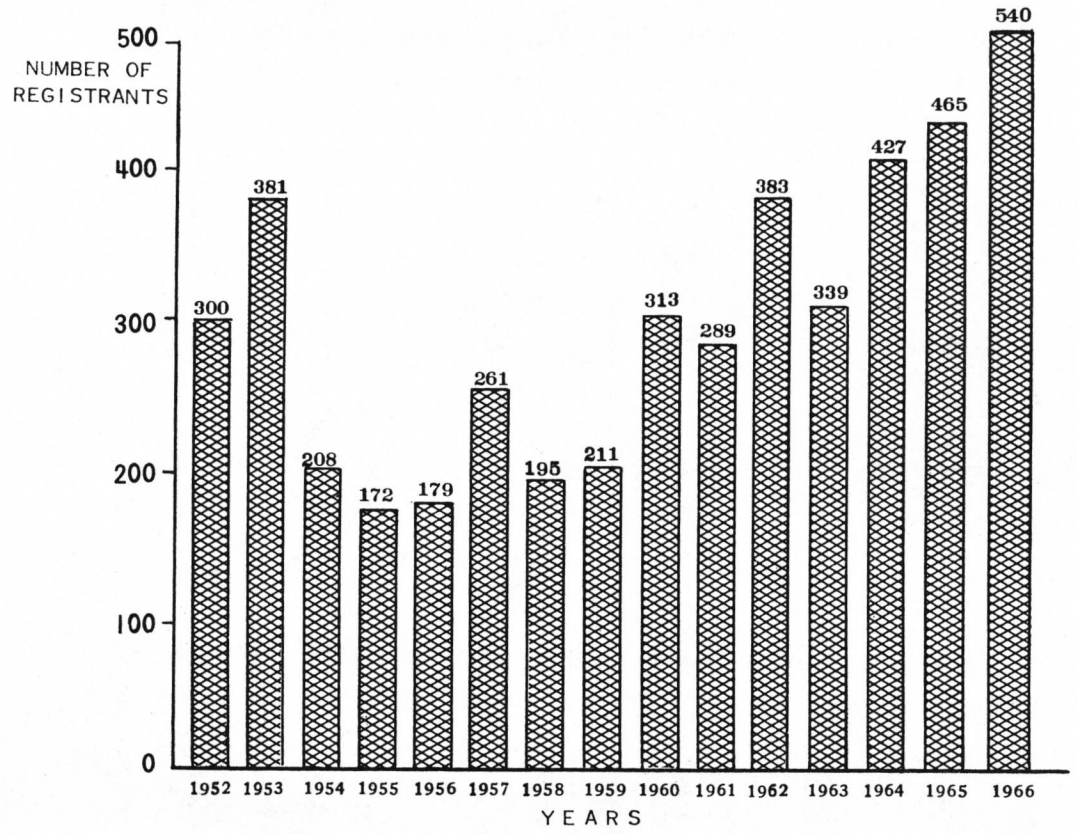


CHART 6
REGISTERED NARCOTIC OFFENDERS
1952-1966 (INCL.)



4660 NARCOTIC OFFENDERS REGISTERED DURING THIS PERIOD

CHART 7

NARCOTIC ARRESTS BY TYPE OF LAW ENFORCEMENT
1952-1966 (INCL.)

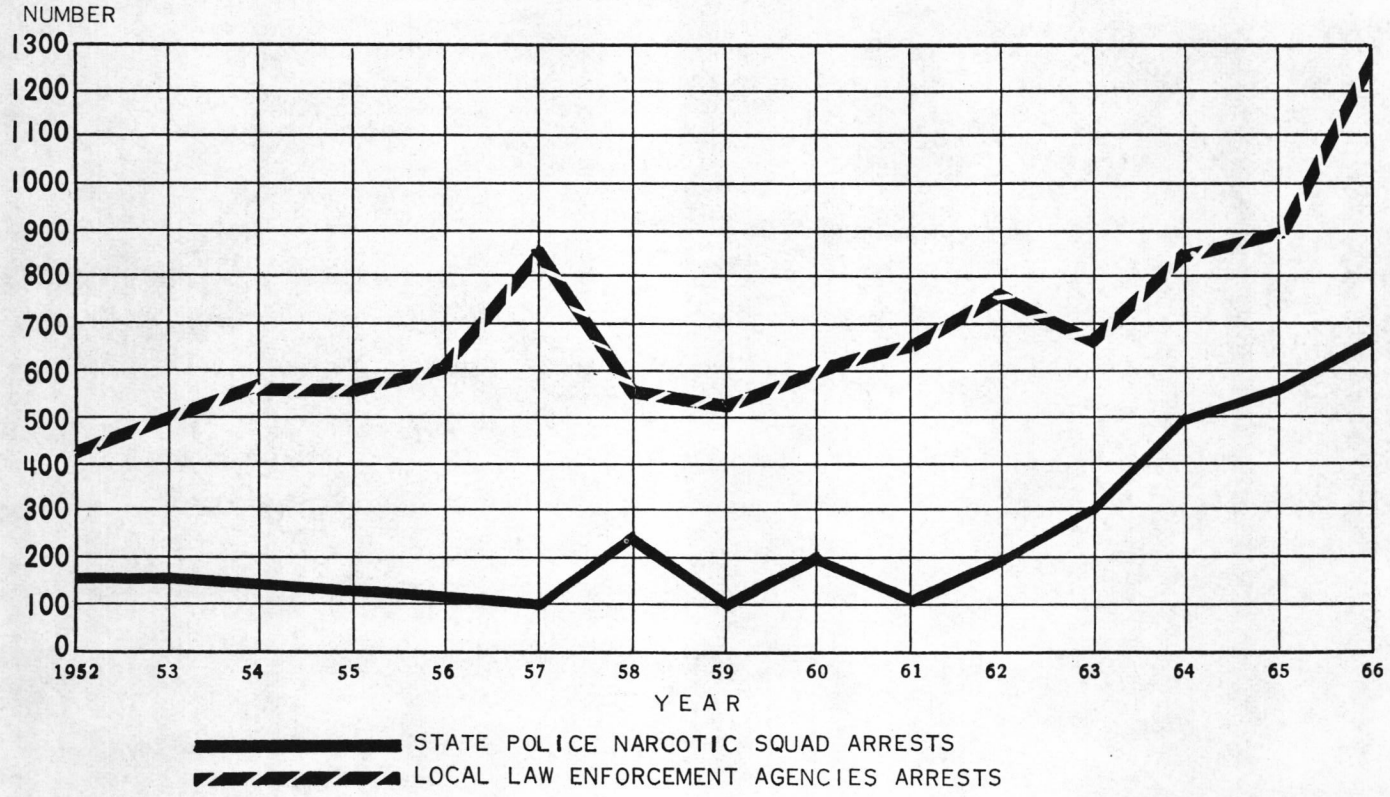
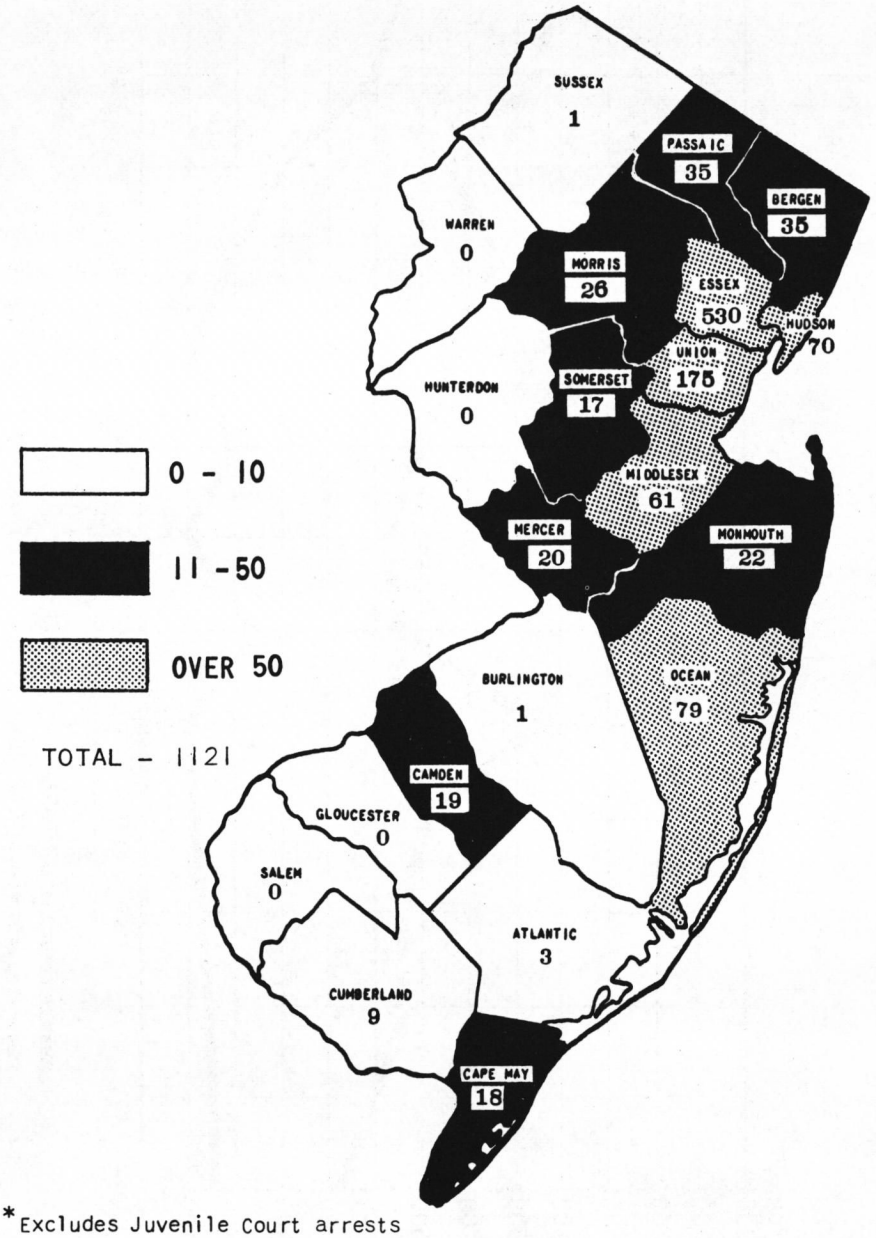


CHART 8
DISTRIBUTION OF DANGEROUS DRUG ARRESTS BY COUNTY* 1962-1966



*Excludes Juvenile Court arrests

CHART 9

TYPE OF DANGEROUS DRUG ARRESTS MUNICIPAL COURTS

1966

TOTAL - 292

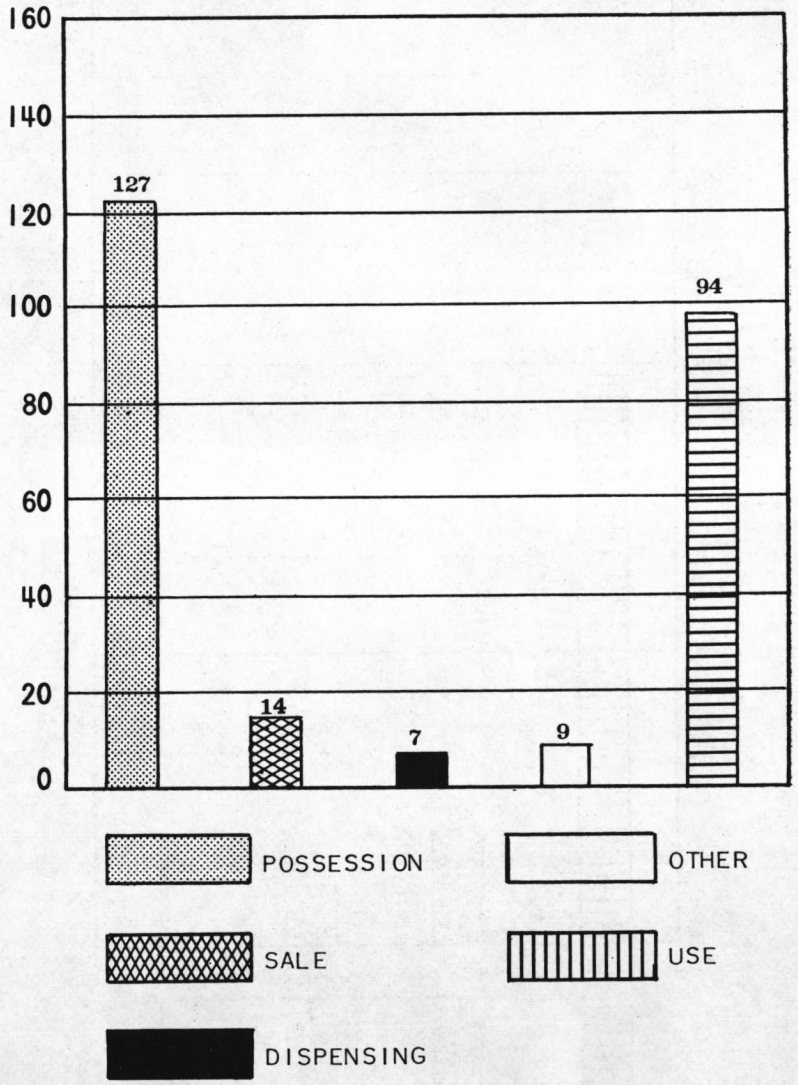


CHART 10

TYPE OF DANGEROUS DRUG ARRESTS
JUVENILE COURTS

1966

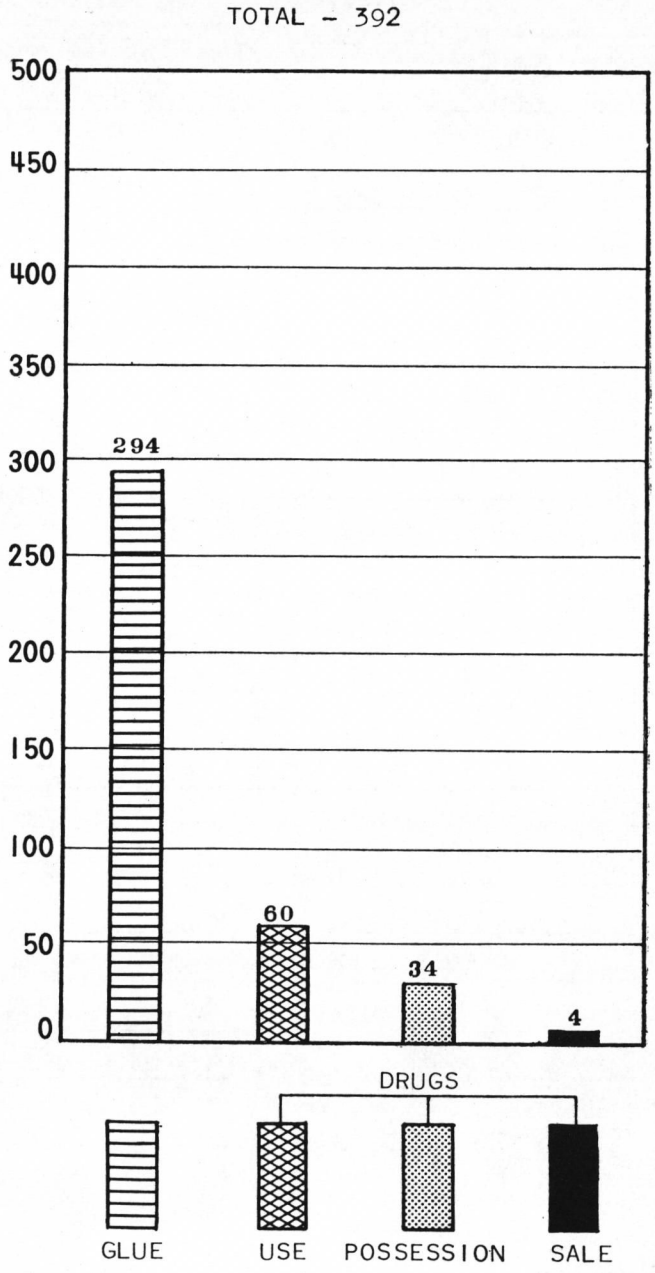
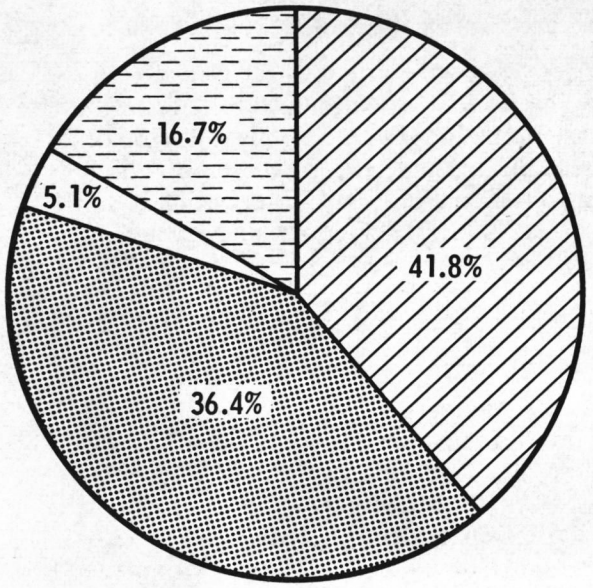


CHART 11

ANALYSIS OF NARCOTIC DRUG LAW ARRESTS 1968



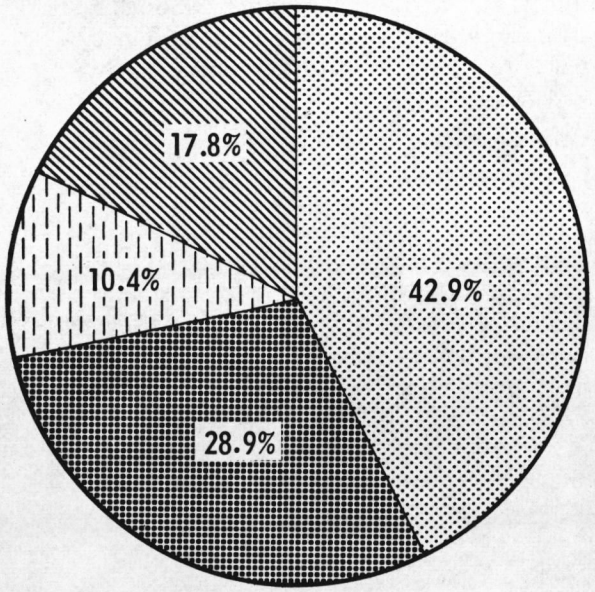
Opium or Cocaine & their derivatives (Morphine, Heroin, Codeine)

Marijuana

Synthetic Narcotics (Demerol, Methadones)

Other Dangerous, Non-Narcotic Drugs (Barbiturates, Benzedrine)

1967



Opium or Cocaine and their derivatives

Marijuana

Synthetic Narcotics

Other Dangerous Non-Narcotic Drugs

CONTROL

New Jersey has a very extensive statutory framework for the control of drug abuse, through each of (1) criminal law sanctions, (2) prevention measures, (3) administrative controls such as registration and recordskeeping, and (4) medical and other treatment means.

A complete collection of all New Jersey laws in any way relating to drug abuse, has recently been published.[16] The reader's attention is directed to that public service publication, for reference to the State's entire body of law on or in any way relating to the subject. In addition, under the next section in this Part, the main elements of the statutory scheme of control are set out in the context of programmatic responsibilities of various agencies of New Jersey government.

Accordingly, only selected statutory features deemed central to control will be reviewed here.

N.J.S.A. 24:18-1 to 48 covers, in nine Articles, the Uniform Narcotic Drug Law. Chapter 18 defines and proscribes the sale, dispensing, or possession of "narcotic drugs" (basically, opium and opium derivatives, cocaine, isonipecaine, and marihuana, 24:18-2). Enforcement of the chapter's provisions is "made the duty of the State Department of Health, its officers, agents, inspectors and representatives, and of all peace officers within the State, and of all county prosecutors", 24:18-10. The chapter includes numerous controls over "narcotic drugs" ranging from individuals through the responsibilities of hospitals, manufacturers and wholesalers, pharmacists, and physicians. 24:18-47 prescribes penalties that are, with one exception, high misdemeanors bearing a minimum sentence of 2 years at hard labor for a first offense, 5 years for a second offense, and 10 years for a third offense. Maximum sentences vary from 15 years to life (selling to one under 18, by one over 21).

N.J.S.A. 2A:170-8 renders an unauthorized user of any narcotic drug defined in N.J.S.A. 24:18-1, a disorderly person.

N.J.S.A. 24:6C-1 to 3 defines depressant and stimulant "dangerous drugs". Barbituates and amphetamines are specifically included. Other stimulants, depressants, and hallucinogens are included by reference to administrative classification under the chapter, including federal administrative classification. A person who manufactures, sells, dispenses, or possesses such a drug without authorization, is a disorderly person.

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[16]"New Jersey Narcotic Laws", New Jersey State Library, Department of Education, Bureau of Law and Legislative Reference, Trenton, 1969, 71pp.

N.J.S.A. 2A:170-77.8 renders an unauthorized user or possessor of a "dangerous drug" defined in N.J.S.A. 24:6C-1 *or* any other prescription legend drug (other than a narcotic drug under N.J.S.A. 24:18-2), a disorderly person.

N.J.S.A. 30:6C-6 permits a person adjudged a disorderly person under N.J.S.A. 2A:170-8 (unauthorized use of "narcotic drug") or N.J.S.A. 170-77.8 (unauthorized use or possession of "dangerous drug" or "other prescription legend drug"), to be placed on probation "on condition that such individual immediately voluntarily admit himself to a State or county mental hospital or other similar facility designated by the Commissioner of Institutions and Agencies, there to receive medical and other care and treatment designed to effect a cure for his condition and his rehabilitation, and on condition that such individual upon release or discharge from such hospital or similar facility receive specialized medically oriented after-care treatment for the balance of the time that the individual shall remain on probation". N.J.S.A. 30:6C-5 allows voluntary commitment for others who believe themselves addicted. N.J.S.A. 30:4-123.43 allows parole of incarcerated narcotics violators for voluntary commitment to such hospital treatment.

N.J.S.A. 2A:170-25.9 et seq., controls "glue sniffing". Users, possessors, dispensers, and sellers are, under certain conditions, disorderly persons.

N.J.S.A. 2A:169A requires persons who have been convicted of a "narcotic drug" offense in New Jersey, any other state, or federal court, to submit to a registration and identification card system.

PROGRAMS AGAINST DRUG ABUSE

CURRENT IN NEW JERSEY

If, as the federal Bureau of Narcotics and Dangerous Drugs claims, New Jersey is fourth, after New York, California, and Illinois, in number of addicts, then it can be said that New Jersey has taken steps commensurate with the problem. While New Jersey has perhaps not innovated on the scale of New York or California, nevertheless it has in the past five years and especially in the last three years, taken a great number of steps on several fronts.

This section will enumerate the programs current in New Jersey, and the next section will enumerate federal and out-of-state programs of merit. This first section on New Jersey programs will cover the SLEPA State Plan (as it pertains to drug abuse), then the on-going public programs in New Jersey, and finally the State's on-going private programs.

SLEPA State Crime Control Plan

On May 29, 1969, SLEPA filed in the U.S. Justice Department "A Plan for Law Enforcement and the Administration of Justice in New Jersey," under the Crime Control Act of 1968 (P.L. 90-351). The plan was approved on June 23, 1969. There were 73 broad "program approaches" included in the plan and ten of these were selected for 1969 funding. The Plan is contained in SLEPA Dissemination Document No. 1.

The ten 1969 "program approaches" include three that cover prevention and rehabilitation activities that can, if the applicant so desires, apply specifically to drug abuse. In fact, several applicants for fiscal 1969 funding did apply to SLEPA, under one or the other of these three program approaches, for anti-drug abuse program assistance.

But before setting forth these three, or the other SLEPA State Plan "program approaches" applicable to drug abuse, it is helpful to review the broad principles underlying SLEPA's grant-in-aid program approaches in the drug abuse area. These are as follows:

1. *Knowledge.* Pilot and development programs must be conducted that experiment with prevention, treatment, and rehabilitation methods that are now used in New Jersey, or that could be used in New Jersey based on out-of-state experience.

2. *Prevention.* The public, and especially the youthful public, must be prevented from drug abuse by a broad range of innovative educational and prevention techniques.

3. *Control.* The supply of illegal drugs, and the distribution system, must be more efficiently controlled through more precise statutory mechanisms, and better staffed and trained law enforcement personnel of all kinds.

4. *Treatment and Rehabilitation.* New knowledge of treatment and rehabilitation options should be put into actual practice after proving-out in pilot projects; sentencing laws should be revised to allow use of such wider options in dealing with drug abusers; and judges should be kept abreast of development of new knowledge in this field.

The three SLEPA 1969 "program approaches" (deadline for applications expired on October 15) that can apply to drug abuse will be refunded and re-offered in 1970. These three programs (the number in parentheses after each indicates which of the above four principles it will tend to implement, in SLEPA's judgment, if applied to a drug abuse problem) are as follows:

1. "Public Education on How to 'Harden' Crime 'Targets' " (Approach No. 1969-b-6). The "target" can be youth, and the "hardening" can be

making them, through education, resistant to inception of drug abuse. (2)

2. "Community Involvement in Delinquency Prevention" (Approach No. 1969-c-1). This is a counseling, or a group support and guidance program, that can apply to drug abuse prone youth. (2)

3. "Community-Based Corrections" (Approach No. 1969-f-2). This program relates to any of a broad range of community-based corrections, e.g., halfway houses, work-release, job placement, remedial education, specialized probation and parole, and so on. Drug offenders, even more than most offenders, need such support after release. (1) (4)

The 1970 plan is due in the U.S. Justice Department on April 15, and will probably be approved and funded to SLEPA by May 15. SLEPA will then solicit sub-grant applications under the 1970 "program approaches." The Congress has (just this week) approved enough money nationally so that New Jersey's population share, in a "block" to SLEPA for subsequent sub-grants to SLEPA's awardees, will be $6.47 million.

At this writing, SLEPA is in the midst of the process of revising the 1969 Plan to 1970 funding. As aforesaid, the ten 1969 "program approaches" will be refunded, including the three drug abuse construable ones just listed. Which of the remaining 63 "program approaches" in the 1969 Plan will be funded for the first time in 1970 is not known at this time. However, probably between ten and thirty will be funded in addition to the 1969 ten.

Since it is not known at this time which will be funded of the 63, we list below all the "program approaches" found among the 63 that apply to subjects that can cover anti-drug abuse program assistance. We continue the total list by starting with numeral "4", since there are already three listed above. Again, the numeral indicating the principal or principles set out above that, in SLEPA's judgment, the program approach can tend to implement, is included in parentheses after the program approach description. The drug-abuse construable "program approaches" are:

4. "Special Offenders Rehabilitation" (Approach No. f-6). This approach applies directly to drug abusers, especially narcotics addicts. It is directed specifically toward development of new rehabilitation methods and programs. (1) (4)

5. "Decentralized Police Training Facilities" (Approach No. a-6). Provides for improvements in curricula or regional and mobile facilities. Drug abuse training can be the subject of such improvement. (3)

6. "Centralized Academies for Pre-Service, In-Service, Vocational and Technical Training for Criminal Justice Personnel" (Approach No. a-4). Such technical training can include drug abuse. (3) (4)

7. "Criminal Adjudication Officers Training Program and Reference Materials" (Approach No. a-5). Training and published materials for judges, prosecutors, defenders. (4)

8. "Criminal Justice School" (Approach No. a-9). (1) (3) (4) (2)

9. "Criminal Justice Institute" (Approach No. j-3). In conjunction with the School. (1) (3) (4) (2)

10. "Reducing Street Crimes by Increasing the Police Presence" (Approach No. b-2). Increase by better allocations, by police aides, etc. Could affect "street" traffic in drugs. (3)

11. "Prevention of Crime Through 'Hardening' of Crime 'Targets'" (Approach No. b-5). Non-education counterpart of No. 1 above. "Target" can be drug abuse prone youth. (2)

12. "Diagnostic Services to Juvenile Delinquents" (Approach No. c-3). Diagnosis of juvenile detainees, that can factor out drug abusers or drug abuse prone, for special treatment. (2) (4)

13. "Emergency Shelters for Children" (Approach No. c-5). Would prevent non-delinquents mixing with delinquents, and thus reduce all mixing of habits, including drug abuse. (2)

14. "Extension of the Uniform Crime Reporting System" (Approach No. b-8). U.C.R. should be extended to offender data of more detail, and other data. This could help unravel the facts about drug abuse prevention, control, and rehabilitation. (1) (2) (3) (4)

15. "Criminal Judicial Information Reporting System" (Approach No. e-4). Furnish detailed individual case data to Administrative Office of the Courts. Allows correlations and recommendations. (1) (4)

16. "Experimental and Demonstration Projects" (Approach No. j-5). For new methods and programs, including in drug abuse (1) (2) (3) (4)

17. "Criminal Law Reform" (Approach No. e-8). Law Reform support; also staff support to Senate and Assembly Committees on Law and Public Safety. (3)

On-Going Public Programs

There have been three very significant events in New Jersey in recent years that are precipitating a rapid and far reaching advance in drug abuse prevention, control, treatment, and rehabilitation in the State. Each had its genesis in statutory enactment by the New Jersey Legislature. Before discussing on-going public programs in the State, these three milestones must be recounted.

The first major step was the enactment in 1964 of Senate Bill 210, which[17] offered hospitalization as a voluntary alternative to incarceration for noncriminal addicts convicted as disorderly persons. This bill reflects the socio-medical view of drug abuse. It called for a pattern of *in-patient residential treatment centers* for withdrawal and treatment, and regional *aftercare clinics* sponsored by counties for medical aftercare services. Precisely because the bill was ahead of its times, it sparked interest in the subject of treatment and rehabilitation in New Jersey to new levels, because experience under the new bill quickly showed that after withdrawal there were few available skills and facilities to reorient and stabilize the addict. With this bill, New Jersey plunged into the cold water, with the usual salutory effects such boldness brings.

The second major step was placement by the Legislature on the November, 1968 ballot, and approval by the people in referendum, of a $6 million bond issue for the construction of a Narcotic Drug Treatment Center. Architectural studies are currently under way. This facility is the key to redemption of the State's commitment to the socio-medical approach.

The third major step was the enactment in 1969 of Assembly Bill 271, which[18] creates a Division of Narcotic and Drug Abuse Control in the State Department of Health, and draws together a wide range of State prevention, control, treatment, and rehabilitation activities presently scattered in several Departments. These include education programs, registration programs, institutional and community-based treatment and rehabilitation programs — a potentially synergistic combination that may, with the first two tools set out above, vault New Jersey into the forefront in integrated State programs against drug abuse.

The new Division is even now in process of formation. Many of the public programs listed herein will be part of the new Division's armory within a matter of months. A likely synergism will result from their combination and coordination. The public programs are as follows:

- *Department of Institutions and Agencies.* This Department presently has prime responsibility for carrying out a wide range of education, diagnosis, treatment, and rehabilitation activities in accordance with the aforesaid N.J.S.A. 30:6C.

Of particular interest in this regard is the Department's discharge of the in-patient and aftercare aspects, already mentioned above, of that statute.

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[17]N.J.S.A. 30:6C, discussed briefly already under the section on "Control", in this Part.

[18]Signed by Governor Hughes on August 11, 1969, as N.J.S.A. 26:2G.

A Drug Substance Section (the statute's in-patient facility) is maintained at the New Jersey Neuro-Psychiatric Institute, Skillman, New Jersey.

Most of the patients admitted for treatment have been sentenced as disorderly persons based upon N.J.S.A. 24:18, or N.J.S.A. 24:6C. The magistrate on sentencing is required to give the offender the option of serving time or of volunteering for treatment. If the offender volunteers for treatment, sentence is suspended and the person is placed on probation up to three years, providing that he remains under an effective treatment program. The maximum length of sentence upon conviction as a disorderly person is six months. The law also provides for the admission of patients not under duress. As a private citizen age 21 or over or as a married person under age 21, a patient may voluntarily admit himself. He must agree to remain a minimum of 45 days. If he is under 21 years of age and unmarried, he can be admitted if his parent or legal guardian will sign the admission papers.

Those convicted on the charge of use of narcotics or dangerous drugs, who are serving sentence, may apply for resentencing. As a condition of resentence they may ask for admission to in-patient treatment centers. People on bail or bond who await grand jury action or trial for the use of drugs or other charges not involving acts of violence that constitute high misdemeanors may seek treatment in a residential in-patient center. They must be considered acceptable to the program by the professional staff, and they must be recommended by professional custodial persons. In-patient facilities comprise seventy-six beds, with ancillary services and treatment including screening, diagnosis, detoxification, and methadone maintenance preparation. Under a 51 month N.I.M.H. grant, a second in-patient facility is maintained at Marlboro State Hospital, with thirty-two beds.

An out-patient facility for subsequent methadone maintenance is maintained at 1100 Raymond Boulevard, Newark. Also, nine County-State aftercare clinics are maintained in Union County (Rahway), Bergen County (Bergen Pines Hospital, Paramus), Middlesex County (Roosevelt Hospital, Metuchen), Morris County (All Souls' Hospital, Morristown), Passaic County (Paterson), Essex County (State offices, with two sub-stations), Mercer County (Trenton), and Camden County (Camden).

• *Department of Health.* This Department has responsibility for the control[19] of manufacturing and distribution of "narcotic drugs" through licensure and inspection. It engages in similar control[20] of "dangerous drugs", but here the tools are registration and records keeping. In addition,

[19]N.J.S.A. 24:18-10

[20]N.J.S.A. 24:6C-2

the Department is responsible[21] for examining (after notice to the Department) and certifying the identity of wild marihuana, and for the supervision of destruction by the County Prosecutor.

• *Department of Community Affairs.* This Department is fiscal intermediary for, and supplies additional in-kind services to, the New Jersey Regional Drug Abuse Agency (Burma Road, P.O. Box 4099, Jersey City, N.J. 07305) at "Liberty Park" in Jersey City. This is a community-based facility, in the form of a non-profit corporation financed through the Department from federal funds under the 1966 amendments to the O.E.O. Act of 1964. The facility includes 225 beds. It is a voluntary program, and includes detoxification, interaction group therapies, job training and placement, and attitudinal training. There are six community out-reach centers in four counties: Union City, Jersey City, Newark (2), New Brunswick, and Asbury Park.

• *Department of Education.* This Department has prime responsibility[22] for mounting educational programs against drug abuse. This is discharged through a Summer Workshop for school teachers on drugs and drug abuse; regional seminars for teachers and administrators on drugs and drug abuse; and State (Teachers) College conferences on drug abuse for students (future teachers), school nurses, counselors, and other personnel.

• *Department of Labor and Industry.* This Department conducts rehabilitation efforts toward employment counseling and placement of detoxified addicts. The Department works with the Neuro-Psychiatric Institute and the County aftercare facilities. Hudson, Middlesex, Essex, Bergen, and Union Counties are served.

• *New Jersey College of Medicine and Dentistry.* This State Medical College, situated as it is in Newark, and actively entering into a comprehensive narcotics program, holds great hope for impact in the Newark area. As of September 1, 1969, an N.I.M.H. grant has enabled establishment of a narcotic addiction treatment and rehabilitation program for the Newark Model City catchment area. Relationship as co-sponsor is extended to six private and public agencies. In-patient care, out-patient care, halfway houses, emergency services, consultation and education will be provided. In addition, the College is mounting a Narcotics Registry Project, a Narcotics Laboratory, preventive education courses, an out-reach clinic, and an evaluation unit.

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[21]N.J.S.A. 26:2-81 to 82

[22]N.J.S.A. 18A:4-28.2

On-Going Private Programs

There are seven principal *institutional* (non-profit corporation) private drug abuse programs conducted in New Jersey. Frequently these are community-based operations, and there is frequent religious organization involvement. Presently there are no State standards, and hence little State-aid. The private programs do, however, perform a State service, since they provide 37% of the State's in-patient beds. There are also a number of non-incorporated associations (citizens or community) against drug abuse, one of which (S.L.A.N.T.) is included below as an example.

- *New Well.* This is a day center self-help program in Newark with a satellite unit in Passaic. The program is privately financed with supplementary staffing funds from the National Institute of Mental Health. The program offers detoxification, urine analysis, case finding, self-help therapies and vocational guidance and placement. Address: New Well, 163 Belmont Avenue, Newark, New Jersey, (201) 242-0715; New Well of Passaic, 35½ Bergen Avenue, Passaic, New Jersey.

- *D.A.R.E.* (Drug Addiction Rehabilitation Enterprise, Inc.). This is an addict and ex-addict self-help program with a central office and an out-reach unit and residential center in Newark, a residential hotel operation in Island Heights, and a rural residential treatment farm in Carlisle, Pennsylvania. The program is funded by private N.I.M.H. support. The program offers medical care, urine analysis, modified Daytop Village approach of induction, treatment and after-care services in the community. Address: D.A.R.E., 211 Littleton Avenue, Newark, New Jersey 07103, (201) 642-7411; Edgewater Hotel, 2 Central Avenue, Island Heights, New Jersey, (201) 244-5600.

- *Mt. Carmel Guild Narcotic Rehabilitation Center.* The program is located in Newark, and consists of individual and group therapy and counseling in all areas of addict rehabilitation. The program is planned to be included in the Mt. Carmel Guild Community Mental Health Center now being constructed. This agency is funded by diocese and federal support. Address: Mt. Carmel Guild, 9 South Street, Newark, New Jersey (201) 625-5313.

- *St. Dismas Hospital for Drug Addicts.* This is a residential treatment, privately operated hospital in Paterson. Residential program offers a religious, authoritative and directive treatment regimen. Families of addict residents are directed to attend group therapies. Privately and contractually funded. Address: St. Dismas Guild, 396 Straight Street, Paterson, New Jersey 07501, (201) 525-1858.

- *Integrity, Inc.*This is a residential self-help house with cost sharing and interaction supportive program. Staff is partially funded by N.I.M.H. grant.

Address: Integrity, Inc., 45 Lincoln Park, Newark, New Jersey, (201) 642-9287.

• *N.A.R.C.O.* (Narcotic Addicts Rehabilitation Center Organization). This organization provides narcotic casefinding services, urine monitoring and ex-addict and professional services. It is a privately funded self-help group. At present it is seeking further funds through the County and State. Address: N.A.R.C.O., 1705 Artic Avenue, Atlantic City, New Jersey, (609) 345-4035.

• *Odyssey House.* This is a residential house, affiliated with Narcotic Project of the New Jersey College of Medicine and Dentistry. Operational as of November of 1969, its treatment includes a psychiatrically supervised therapeutic community moving 30 beds with "storefront" outreach centers in the neighborhood. Address: Odyssey House, 61 Lincoln Park, Newark, New Jersey, (201) 642-6550.

• *S.L.A.N.T.* (Student League Against Narcotic Temptation). This is a unique student movement against drugs. Primarily active in Hudson County, but nationally reported-on. Address: S.L.A.N.T., c/o Professor Silvio Lacetti, Stevens Institute of Technology, Castle Point Station, Hoboken, New Jersey 07030.

OUT-OF-STATE EXAMPLES

Statutory Prohibition Systems

As has already been mentioned, the basic federal narcotics law is the 1914 Harrison Act,[23] a tax statute. The basic federal marihuana law, the 1937 Marihuana Tax Act,[24] is also a tax statute. The basic federal "dangerous drugs" law is the 1965 Drug Abuse Control Amendments to the Federal Food, Drug, and Cosmetic Act. [25]

The Harrison Act led to the Uniform Narcotics Drug Act, which was adopted in 46 states, including New Jersey.[26] The 1965 federal Drug Abuse Control Amendments led to the Model State Drug Abuse Control Act, which New Jersey was the second state[27] to adopt, with its administrative controls over dangerous drugs and its administrative determination by the Secretary of HEW or the Commissioner of Health as to what (aside from barbituates

[23]Int. Rev. Code of 1954, Sec. 4701-36

[24]Int. Rev. Code of 1954, Sec. 4741-76

[25]79 Stat. 226 (1965)

[26]N.J.S.A. 24:18-1 to 48

[27]N.J.S.A. 24:6C (1966)

and amphetamines) constitutes depressant and stimulant (including hallucinogenic) "dangerous drugs."

New Jersey can then be considered to be a typical State as regard statutory prohibition of "narcotic drugs", and in the forefront as regards statutory prohibition of "dangerous drugs." However, even being typical may not necessarily be good. The original difficulties of classification introduced by the 1914 Harrison Act are with us all still. In that regard, James V. Bennett, formerly Director of the Federal Bureau of Prisons, has asserted that "the American narcotics statutes . . . in their savagely indiscriminate treatment of violators, will someday be equated with the Salem witch trials of colonial America."[28]

Hospitalization

In regard to treatment in in-patient residential facilities with aftercare, New Jersey is[29] a *statutory* leader in development of a socio-medical approach to addiction.

The federal government pioneered the hospital treatment approach, with the Public Health Service hospitals at Lexington (Ky.) and Fort Worth (Tex.) respectively established in 1935 and 1938. The capacity of Lexington is 1,042 beds and of Fort Worth 777 beds. Since 1935 there have been more than 80,000 admissions of addicts to the two hospitals. Voluntary patients, who make up almost one-half the hospital population at any given time, are admitted on a space available basis after federal narcotics prisoners have been accommodated. Recently, there has been mounted a federal effort to provide space in each State as an alternative to Lexington and Fort Worth, by means of grants to State facilities. New Jersey is beginning participation in that program.

The Lexington and Fort Worth programs provide withdrawal, and medical and psychiatric services during hospitalization, but there are two drawbacks. One, the voluntary patients can leave at any time. Two, except for a paroled prisoner-patient, there are no aftercare services. Relapse rate, perhaps because of these last factors, is somewhere between 54% and 94% — probably closer to the former figure.

The California Rehabilitation Center,[30] operated by the California Youth and Adult Corrections Agency, was established in 1961. Most admissions are

[28]American Journal of Correction, Vol. 22, No. 5 (Sept.-Oct. 1960) pp. 38-39

[29]N.J.S.A. 30:6C

[30]Out-of-State examples are reflected in the Working Bibliography of Part III herein at titles 54 through 67.

by order of the court — California misdeamants and felons.

Addicts are required[31] to remain on in-patient status for at least six months — the average is about 15 months. Work therapy, vocational courses, and a full academic course through high school are offered. The capacity of the Center is 2,300 patients.

Upon release to out-patient status, the patients are supervised by caseworkers with special training and small caseloads. Patients are chemically tested for the presence of drugs five times a month, both on a regular and a surprise basis, for at least the first six months. Failure of the test or other indications of relapse to drugs results in return to the Center. A halfway house provides guidance for those making a marginal adjustment to the community. The patient becomes eligible for final discharge after 3 drug-free years as an out-patient.

Institutional Group Counseling

A number of States, notably California, have special counseling programs for drug addicts in penal institutions. Under legislation in California, parolees with a history of narcotics use who are found to be relapsing to drugs but are not yet known to have committed serious offenses, may be returned to prison for a 90 day counseling program. They then resume parole, without formally being declared violators. This program is operated at Chino and San Quentin prisons, with the involved inmates separated from the rest of the prison population. It is conducted in conjunction with a community surveillance and testing program, to be described in the next section.

In the Chino program, all returnees participate in a single counseling session for over an hour each morning, and they have small group sessions of similar duration in the afternoon. Clinical psychologists and social workers, as well as custodial staff and visiting parole officers, sit with the groups which are operated under non-directive techniques.

At Rikers Island Penitentiary and at Riverside Hospital in New York, counseling through "psychodrama" is employed. In this procedure, after semi-directed discussion brings out the addicts' problems in various social relationships, special manipulations are introduced to make him more aware of the viewpoints of others in these relationships.

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[31]Civil commitment is not discussed as such in this Document. For a complete discussion, see Appendix D of TASK FORCE REPORT: NARCOTICS AND DRUG ABUSE, the President's Commission on Law Enforcement and Administration of Justice, 1967, at 148-158.

Group counseling programs in an institution *alone,* are subject to the same difficulty as hospitalization *alone:* the addict may do all right in the protected environment, but without aftercare, is likely to relapse after release under the pressures of his environment.

Community Surveillance

Control of once-convicted addicts should be a matter of surveillance after release. Although urine analysis is very accurate, it is a lengthy (6 hours) procedure.[32] In recent years, a very quick surveillance adjunct has been devised — the Nalline tests.

Nalline is an antinarcotic. It is related to opiates in such a way that, if a suspect has opiates in his system, and Nalline is introduced in a small dose, his pupils will *dilate* within 20 to 30 minutes. The amount of dilation is a very rough indication of the amount of opiates in his body. If he is "clean", his pupils will *contract* due to the Nalline, thereby giving a clear contrast.

Obviously, the use of Nalline is almost necessary if surprise tests are to be made, and the results known soon enough to still have the suspect in hand. Nalline has been used on both scheduled and surprise bases in California for some years now.

Apparently Nalline testing has a very salutory effect on preventing relapse. Since it has been instituted in California, the positive results have been reduced from 20% of testees to less than 1% for each testing.

In other areas of antisocial mentality it has been shown that the *swiftness* and *certainty* of detection are powerful deterrents to the somewhat childish ("It won't happen to me; I won't get caught") mentality of the delinquent personality. Perhaps Nalline is an aspect of this principle.

It can be objected, validly, that Nalline should not be used on arrestees, that to do so would violate their civil rights (self incrimination). However, this present discussion is directed to probationers and parolees, not arrestees. With the former, there is a sufficient special status to render testing appropriate.

In California, surveillance with Nalline is combined with the institutional counseling described in the previous section. Civil commitment in California has altered these procedures slightly.

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[32]It is the method employed in New Jersey.

Casework Community Programs

Programs of counseling for addicts in the community are of two major types: one consists of government-sponsored programs in which some element of compulsion is employed to insure participation; the other consists of voluntary programs, often organized by ex-addicts, in which the only compulsion consists of expelling those persons who do not conform to prescribed standards of behaviour. The first is dealt with in this section, the second is dealt with in the next section.

Special counseling and assistance programs for parolees and probationers with histories of narcotic addiction have been established in Philadelphia, New York, California and other localities. The New York program involved the creation of special narcotic caseloads, of small size, assigned to specially selected parole officers. This provided closer attention to the addicts' needs than would be possible under ordinary parole supervision conditions. The program was very successful in reducing parole violations, but was not especially successful in reducing relapse rate to drug use.

The Philadelphia program provides a narcotic testing program in conjunction with a series of carefully defined supervision methods. Four types of supervision are provided varying in caseload size, intensity of counseling, and frequency of contact. Both the testing and the supervision have proven to be positively related to reducing relapse to drug use.

Ex-Addicts Organizations

Synanon is the best known ex-addicts self-help organization. It was founded in Santa Monica in 1958. It now has "branches" in Reno, Nevada; Westport, Connecticut; and San Diego, California. Synanon is a self-governing corporation, made up of and managed by ex-addicts. It is supported by contributions. Membership is voluntary, and present members screen potential members. New arrivals are not allowed to leave (except permanently) for several months, and for additional months they can only leave in the company of a senior member. The organization is a community, and uses group pressures and the opportunity for status in the community, as incentives to stay abstinent. Members who relapse can be expelled. Daytop Lodge is a similar organization serving addict-probationers in Brooklyn, New York under court supervision.

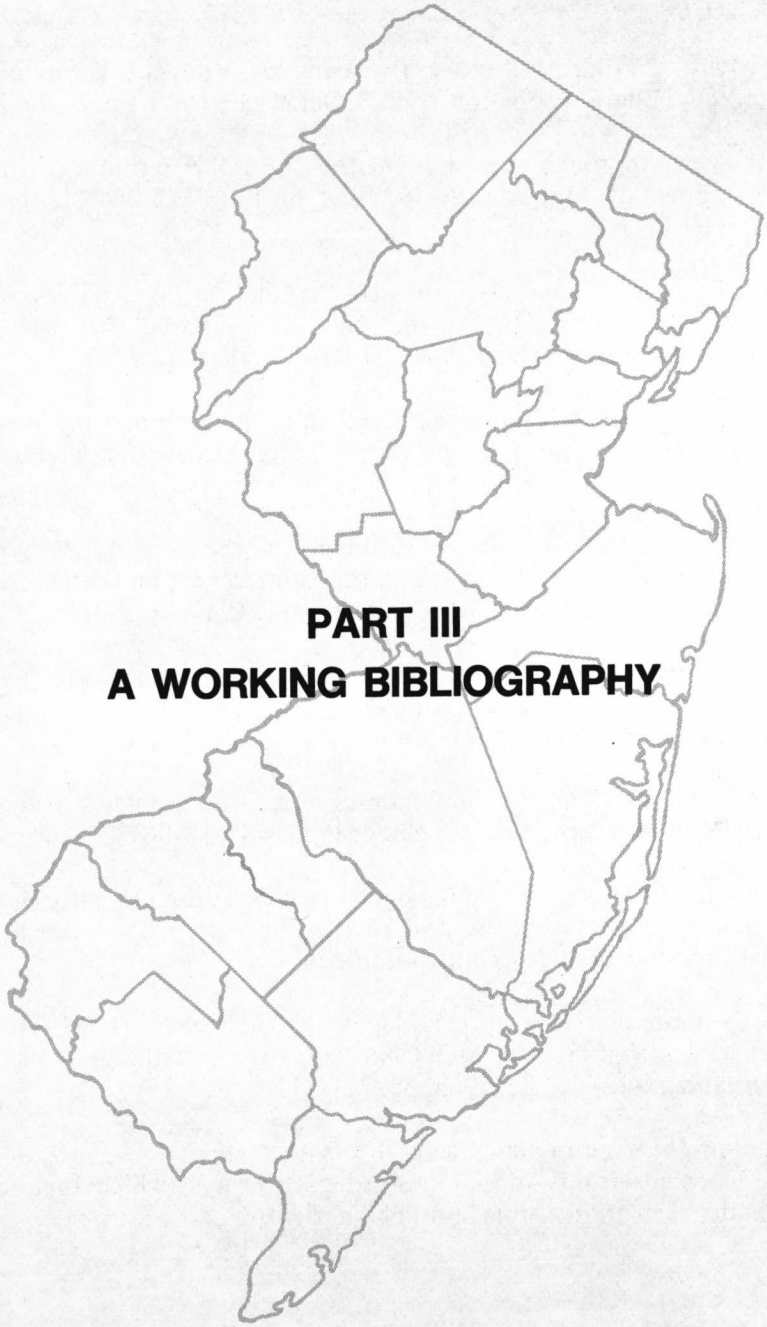
Methadone Maintenance

As has previously been mentioned, all opiates are cross-tolerant, and each will relieve the withdrawal sickness of any of the others. Methadone, a synthetic opiate analog, will thus substitute for heroin. The *methadone*

maintenance program was invented by Drs. Vincent P. Dole and Marie Nyswander at the Rockefeller Institute Hospital in 1964. As was also previously noted, methadone is employed in New Jersey under N.J.S.A. 30:6C-6 practice.

In the Dole-Nyswander program, the heroin addict is hospitalized and withdrawn from heroin. Methadone is then substituted, for about 5 weeks, until a stable dose is attained. The patient then goes into an out-patient phase, still under daily doses of methadone. Since methadone can be a full substitute for heroin, the addict has been removed from the heroin society and no longer has a need for $30 a day to support a heroin habit in the illicit market. Just as important perhaps, methadone does not produce euphoria, sedation, or distortion of behaviour as do true opiates including heroin. The addict can therefore work or go to school, and many do. Methadone maintenance is therefore a highly promising adjunct to other after-care methods for dealing with addicts after withdrawal, treatment and release.

Further developmental work with methadone in New Jersey should be a high priority item in any comprehensive narcotics control program.



PART III
A WORKING BIBLIOGRAPHY

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*The answer is not more penalties, the answer is information. All of us can go back to our communities and ** wage a campaign ** of education and information that will reach all the people.*

RICHARD M. NIXON, to an audience including 39 Governors and two Governors-elect, at the White House Conference on Drug Abuse, December 3, 1969.

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STATE LAW ENFORCEMENT PROGRAM ASSISTANCE AGENCY

STAFF REPORT:
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ON DRUG ABUSE

DISSEMINATION DOCUMENT NO. 5
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