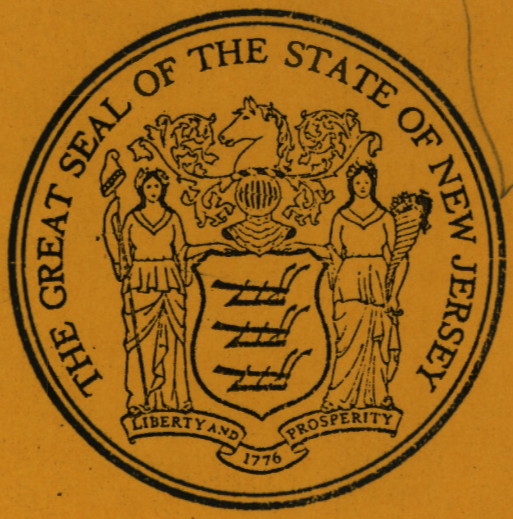
ATE OF NEW JERSEY



SECOND REPORT

TO THE

LEGISLATURE

(PURSUANT TO SCR 90 of 1974)

THE COMMISSION TO STUDY AND REVIEW THE PENALTIES IMPOSED UPON INDIVIDUALS CONVICTED OF USING CERTAIN SUBSTANCES SUBJECT TO THE PROVISIONS OF THE "NEW JERSEY CONTROLLED DANGEROUS SUBSTANCES ACT," P.L. 1970, c. 226 (C. 24:21-1 et seq.) AND TO STUDY THE NATURE AND SCOPE OF DRUG TREATMENT PROGRAMS.

JULY, 1975

LETTER OF TRANSMITTAL

JULY, 1975

The Honorable, Members of the Senate
and General Assembly

Ladies and Gentlemen:

The Commission to study and review the penalty provisions of the "New Jersey Controlled Dangerous Substances Act," P.L. 1970, c. 226 (C. 24:21-1 et seq.), and to study the nature and scope of the State's drug treatment programs, created pursuant to Senate Concurrent Resolution 90 of 1974, herewith respectfully submits its second report in compliance with the terms of the resolution and the decision of the Commission to divide its study into two reports.

(s) ALEXANDER J. MENZA
ALEXANDER J. MENZA
CHAIRMAN

(s) BETTY WILSON
BETTY WILSON
VICE-CHAIRPERSON

(s) WYNONA M. LIPMAN
WYNONA M. LIPMAN

(s)
GARRETT W. HAGEDORN

(s) C. GUS RYS
C. GUS RYS (1)

(s)
MICHAEL F. ADUBATO

(1) DISSENTING STATEMENT

(Assemblyman Rys)

I disagree with the recommendation made in Chapter II of this report that the decriminalization of marihuana in New Jersey should not be frustrated any longer. This recommendation reflects the decriminalization proposals presented in Chapter II of the Commission's First Report to the Legislature.

An update of the marihuana problem since October, 1974--the date the first report was released--does not present any conclusive medical or scientific evidence as to the non-deleterious effect, both physically and/or psychologically, of the use of marihuana. Yet those commission members who favor the decriminalization of marihuana feel that the burden of proof rests with those persons who favor the continued criminal prohibition on marihuana use to show that marihuana use is conclusively physically and/or psychologically harmful. The truth is that for every piece of medical and scientific evidence supporting the claim that marihuana is not harmful, or less harmful than thought to be, there is opposing medical and scientific evidence to show that marihuana is as harmful as alleged to be. I feel a question as momentus as this one--especially in its implications for the youth of New Jersey--should be firmly and conclusively resolved before action is taken to reform the marihuana laws.

Furthermore, the fact that many law enforcement officials oppose the decriminalization of marihuana raises doubts in my mind as to the detrimental effects such an action would have on society in general. Finally, I cannot but wonder as to the wisdom of proposing the decriminalization of marihuana in New Jersey when the majority of the citizens of this State have doubts as to its wisdom.

C. GUS RYS

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COMMISSION TO STUDY AND REVIEW THE PENALTY PROVISIONS OF THE "NEW JERSEY CONTROLLED DANGEROUS SUBSTANCES ACT," P.L. 1970, c. 226 (C. 24:21-1 et seq.), AND TO STUDY THE NATURE AND SCOPE OF THE STATE'S DRUG TREATMENT PROGRAMS

MEMBERS

Senator Alexander J. Menza, Chairman
District 20 (Part of Union County)

Assemblywoman Betty Wilson, Vice-Chairperson
District 22 (Part of Union and Morris Counties)

Senator Wynona M. Lipman
District 29 (Part of Essex County)

Senator Garrett W. Hagedorn
District 40 (Part of Bergen County)

Assemblyman C. Gus Rys
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Raymond Castro
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Richard Steen
Research Consultant

Thomas Lescault
Research Consultant

Sherry King
Research Consultant

Michael Walsh
Research Assistant

C H A P T E R I

INTRODUCTION

"The "Drug Study Commission" was originally created pursuant to Assembly Concurrent Resolution 2001 of 1973* (filed May 7, 1973), with a broad authorization to study and review the penalties imposed upon individuals convicted of using certain substances currently subject to the provisions of the "New Jersey Controlled Dangerous Substances Act," P.L. 1970, c. 226 (C. 24:21-1 et seq.).

Public hearings were held on April 24, May 11, and June 15 of 1973, and a number of Commission meetings were held prior to the expiration of the effectiveness of the concurrent resolution creating the Commission at the end of the Second Session of the 195th Legislature. The "Drug Study Commission" was reconstituted under Senate Concurrent Resolution 90 of 1974** (filed March 4, 1974), with the same broad authorization as provided for in Assembly Concurrent Resolution 2001 of 1973; in addition, the Commission was also charged to study the nature and scope of drug treatment programs. After its reconstitution, the Commission held public hearings on May 15 and July 2 of 1974, as well as a number of Commission meetings.

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* See Appendix A to this Chapter.
** See Appendix B to this Chapter.

Following approximately 18 months of research, the Commission issued its first report in October, 1974. Because of the sundry objectives falling within the Commission's mandate, a decision was made to divide the Commission's study into two reports. This allowed the Commission to issue its first three recommendations in October, 1974, as they were finalized, instead of awaiting the conclusion of all the studies being conducted by its staff.

In the Commission's first report, a study of the marihuana problem, the intervention process, and the impact of stricter drug laws was presented. The recommendations of the Commission concerning these topics--as discussed in the contexts of the findings of the Commission's first report--are contained in Appendix C to this Chapter.

As a result of the recommendations of the Commission, Senate Bill Number 1461 was introduced in the Senate on November 21, 1974, and Assembly Bill Number 2312 was introduced in the Assembly on November 25, 1974. The identical bills provide for the decriminalization of marihuana as recommended by the Commission (see Appendix C to this Chapter). Assembly Bill Number 2312 has since been released from committee and is awaiting passage in the Assembly.

Furthermore, Assembly Bill Number 3047 was introduced in the Assembly on January 23, 1975. This bill, designated the "Drug Dependence Treatment and Rehabilitation Act of 1975," would establish a State intervention program for certain drug dependent persons as recommended by the Commission (see Appendix C to this Chapter).

At the time of the writing of this report, the Assembly Institutions, Health and Welfare Committee was deliberating Assembly Bill Number 3047.

In this, the Commission's second report, the Commission has focused on the following objectives:

1. Update: An Analysis of the Marihuana Problem Since October, 1974

2. A Revision of the Schedule of Penalties and Offenses for the Illegal Possession and the Illegal Manufacturing, Distributing or Dispensing of Controlled Dangerous Substances (P.L. 1970, c. 226, §§ 19 and 20; C. 24:21-19 and 20)

3. Using or Under the Influence of a Controlled Dangerous Substance (P.L. 1970, c. 226, § 20b.; C. 24:21-20b.)

4. The Treatment of Inmates with Drug Problems

5. Miscellanea

   a. Manufacturers, Dispensers and Distributors of Controlled Dangerous Substances

   b. The Nuisance and Forfeiture of Illegal Drug Money

   c. The Storage and Disposal of Controlled Dangerous Substances

   d. Motor Vehicle Offenses and Controlled Dangerous Substances

   e. The Illegal Distribution or Possession of Hypodermic Needles, etc.

   f. The Incarceration of Persons on Methadone Maintenance

Furthermore, this report includes the results of a drug use and abuse questionnaire submitted to the County Prosecutors of New Jersey.

In arriving at its findings and recommendations the Commission was assisted by, and wishes to extend its thanks to, Peter P. Guzzo, a Research Associate in the Division of Legislative Information and Research, for directing the research and serving as secretary; William R. Thorn, who holds a Ph.D. in chemistry, for serving as science advisor; Steven Isaacson and Michael Noto, Assistant Prosecutors in Essex County, for serving as legal consultants; Raymond Castro, a graduate student at the Rutgers Graduate School of Social Work; Susan Fisher, a second-year law student at the Seton Hall Law School; Richard Steen, a third-year law student at the Seton Hall Law School; Louis Clark, a graduate student at the Woodrow Wilson School of Public and International Affairs, Princeton University; Thomas Lescault, who also worked on the first report; and Sherry King, a second-year law student at the Rutgers University Law School, for serving as Research Consultants. The Commission also appreciates the research assistance of Michael Walsh, an intern in the Division of Legislative Information and Research. All of the above people who are not members of the Division of Legislative Information and Research worked as volunteers, since the Commission had no appropriation for its second report. The Commission, on behalf of itself and the New Jersey Legislature, is deeply impressed with the concern, motivation and ability of these volunteers.

The Commission also extends its gratitude to the following people who assisted the Commission in its efforts: Robert Winter and Alfred Luciani, of the Office of the New Jersey Attorney General; Robert Lynn, Larry Longhi, Dennis Helms and Court Fisher,

of the Division of Narcotic and Drug Abuse Control, State Department of Health; Bill Scura, State Department of Institutions and Agencies; Richard Roberts, Project Director of the Essex County Bureau of Narcotics; Tony Scolpino, Assistant Director of the Bergen County Task Force; Jack Hill and Dan Dougherty, of the Hudson County Narcotics Task Force; Dr. Richard Saferstein, Dr. Robert Epstein and Dr. Jew-Ming Chao, State Police Chemists; Lieutenant Charles Croce of the State Police Narcotic Bureau; and Captain John Burke, Forensic Sciences Bureau Chief.

Background

As stated in the first report, the Commission was motivated by the feeling of the Legislature that the "New Jersey Controlled Dangerous Substances Act," P.L. 1970, c. 226 (C. 24:21-1 et seq.), enacted in 1970, should be reviewed and, when appropriate, revised, to keep pace with current scientific and medical understanding, criminal justice studies, and the community's expectations--with a primary, but not exclusive, emphasis upon the criminal law perspective. In addition, section 44 of the "New Jersey Controlled Dangerous Substances Act" (P.L. 1970, c. 226; C. 24:21-44) provides that

> within 1 year after the date the Federal Commission on Marihuana and Drug Abuse submits its report to the President and the United States Congress, the Legislature shall conduct a comprehensive study and review of the penalties established in this act concerning offenses relating to the use and possession of marihuana.

The final report of the Federal Commission on Marihuana and Drug Abuse was issued in March, 1973, while this Commission was preparing its first report.

The work of this Commission in the preparation of its first and second reports was undertaken amidst a widespread acknowledgement of the effectiveness of the "New Jersey Controlled Dangerous Substances Act" as an enlightened approach to the drug problem in this State. The Commission has premised its work on the feeling that while certain changes are needed, they can be accomplished through legislative action and within the framework of the "New Jersey Controlled Dangerous Substances Act."

Procedure

The Commission was aware of, in both the preparation of its first and second reports, the wealth of material available on the causes and cures of the drug problem; scientific and medical reports on the effects and dangers, or lack thereof, of certain controlled dangerous substances on users; and the perplexing question of whether existing maximum criminal penalties and fines are adequate to deter--or even if criminal penalties do deter--violators of the "New Jersey Controlled Dangerous Substances Act." Specifically, the Commission was oriented for this report towards determining: (1) whether information and studies released after October, 1974, provide a continued scientific and law enforcement basis for the proscription on the distribution, possession and use of marihuana and hashish; (2) an equitable and efficient means of differentiating

drug offenses, and the type of penalties to be meted out for such offense. This issue questions once again--as in the first report--the validity and equity of stricter drug laws; (3) whether using or being under the influence of a controlled dangerous substance should be treated as a criminal offense; and (4) the best means of treating inmates with drug problems in our prison complexes. In addition, the Commission examined various miscellaneous proposals, such as, how to stem, or assist in stemming, the illegal flow of drugs or drug paraphernalia.

The Commission approached this report on its previously adopted premise that while its efforts might not contribute new input to the ongoing study of the causes or cures of the drug problem in this State, it at least could propose--and, hopefully, rationalize--a redirection of State priorities with regard to coping with and alleviating the drug problem and its effect on drug users, citizens, and the court and prison systems of this State.

APPENDIX A

Filed May 7, 1973

ASSEMBLY CONCURRENT RESOLUTION No. 2001

STATE OF NEW JERSEY

PRE-FILED FOR INTRODUCTION IN THE 1973 SESSION

By Assemblymen MENZA, J. J. HORN, RUSSO and DE KORTE

A CONCURRENT RESOLUTION creating a commission to study and review the penalties currently imposed upon individuals convicted of using certain substances currently subject to the provisions of the "New Jersey Controlled Dangerous Substances Act," P. L. 1970, c. 226 (C. 24:21-1 et seq.).

WHEREAS, Serious questions are being raised about the appropriateness and effectiveness of fining and imprisoning users of certain controlled dangerous substances; and

WHEREAS, Rehabilitation of the unfortunate users of controlled dangerous substances, rather than punishment, should be New Jersey's guiding principle in her efforts to cope with the burgeoning drug crisis; and

WHEREAS, New Jersey's statutes still provide for the fining and imprisoning of users of controlled dangerous substances; now, therefore

BE IT RESOLVED *by the General Assembly of the State of New Jersey (the Senate concurring):*

1. There is hereby created a commission to consist of six members, three to be appointed from the membership of the Senate by the President thereof, no more than two of whom shall be of the same political party and three to be appointed from the membership of the General Assembly by the Speaker thereof, no more than two of whom shall be of the same political party, who shall serve without compensation. Vacancies in the membership of the commission shall be filled in the same manner as the original appointments were made.

2. The commission shall organize as soon as may be after the appointment of its members and shall select a chairman from among its members and a secretary who need not be a member of the commission.

3. It shall be the duty of said commission to study and review the penalties currently imposed upon individuals convicted of using certain substances currently subject to the provisions of the "New Jersey Controlled Dangerous Substances Act," P. L. 1970, c. 226 (C. 24:21-1 et seq.). The commission shall also study the feasibility and advisability of changing the present emphasis in New Jersey's laws from one of punishment to one of rehabilitation.

4. The commission shall be entitled to call to its assistance and avail itself of the services of any head of any department of the State of New Jersey, and of such employees of any State, county or municipal department, board, bureau, commission or agency as it may require and as may be available to it for said purpose, and to employ such stenographic and clerical assistants and incur such traveling and other miscellaneous expenses as it may deem necessary, in order to perform its duties, and as may be within the limits of funds appropriated or otherwise made available to it for said purposes.

5. The commission may meet and hold hearings at such place or places as it shall designate during the sessions or recesses of the Legislature and shall report its findings and recommendations to the Legislature, accompanying the same with any legislative bills which it may desire to recommend for adoption by the Legislature.

APPENDIX B

Filed March 4, 1974

SENATE CONCURRENT RESOLUTION No. 90

STATE OF NEW JERSEY

INTRODUCED JANUARY 28, 1974

By Senators MENZA and LIPMAN

Referred to Committee on Institutions, Health and Welfare

A SENATE CONCURRENT RESOLUTION reconstituting the commission to study and review the penalties imposed upon individuals convicted of using certain substances subject to the provisions of the "New Jersey Controlled Dangerous Substances Act," P. L. 1970, c. 226 (C. 24:21-1 et seq.) and to study the nature and scope of drug treatment programs.

BE IT RESOLVED *by the Senate of the State of New Jersey (the General Assembly concurring):*

1. The commission to study and review the penalty provisions of the "New Jersey Controlled Dangerous Substances Act," P. L. 1970, c. 226 (C. 24:21-1 et seq.) and to study the nature and scope of the State's drug treatment programs, created by Assembly Concurrent Resolution No. 2001 of 1973, is hereby reconstituted and continued with the same membership, powers and duties as heretofore provided.

2. Any vacancy in the membership of the commission shall be filled in the same manner provided for the original appointment.

STATEMENT

The six-member legislative commission authorized in 1973 to study and review the State's drug law penalties and treatment program began its work last spring. Three public hearings were conducted and the commission received substantial recommendations concerning penalty and treatment aspects of drug control from national, State and local law enforcement officers, and from public and private agencies concerned with drug treatment and with prevention of drug abuse.

Because of the range and complexity of the commission's charge, there is a need to reconstitute the commission so that it may pursue its examination of the penalty and treatment provisions in our law.

Several recent developments support this request to continue the commission, notably the major drug law revision which went into effect in New York State on September 1, 1973. The new law includes several mandatory criminal sanctions intended to deter drug use and drug sales. The commission would evaluate its recommendations in light of the developments in New York. Other recent matters for review by the commission include the Drug Abuse Treatment Information Project report released on January 16, 1974, which consists of a study of 19 methadone and therapeutic drug free treatment programs funded by the State Law Enforcement Planning Agency. Review of this study would be part of the commission's recommendations on changes in drug treatment program and policy. The commission will also examine the Comprehensive Drug Abuse Prevention Plan released recently by the Division of Narcotic and Drug Abuse Control and continue its analysis of proposals made by law enforcement and correction officials to divert more drug users from the prisons.

APPENDIX C

A. Concerning the marihuana problem:

1. RECOMMEND, that the penalties for the unlawful possession of marihuana or hashish, pursuant to P.L. 1970, c. 226, § 20 [C. 24:21-20a. (3)], should be decriminalized in the following manner. The unlawful possession of 28 grams (1 ounce) or less of marihuana--which includes any adulterants or dilutents thereof--or 6 grams or less of hashish would be considered a nuisance offense, subject to the confiscation of the marihuana or hashish, and a $50.00 fine payable without a court appearance through a procedure similar to non-moving traffic violations. The unlawful possession of less than 56 grams (2 ounces) and more than 28 grams (1 ounce) of marihuana, or the unlawful possession of less than 12 grams and more than 6 grams of hashish, would be considered a disorderly persons offense, subject to not more than 6 months imprisonment, a fine of not more than $500.00, or both. The unlawful possession of 56 grams or more of marihuana or 12 grams or more of hashish would be considered a misdemeanor, subject to not more than 3 years imprisonment, a fine of not more than $1,000.00, or both.

2. RECOMMEND, that the penalties for the unlawful manufacturing, distributing, or dispensing of marihuana or hashish, pursuant to P.L. 1970, c. 226, § 19 (C. 24:21-19), should be amended in the following manner.

Any person who violates the provisions of P.L. 1970, c. 226, § 19 (C. 24:21-19) with respect to 28 grams (1 ounce) or less of marihuana or 6 grams or less of hashish would be guilty of a misdemeanor and subject to not more than 3 years imprisonment, a fine of not more than $1,000.00, or both. Any person who violates the same provision with respect to more than 28 grams of marihuana or more than 6 grams of hashish would be guilty of a high misdemeanor and subject to not more than 5 years imprisonment, a fine of not more than $1,500.00, or both.

3. RECOMMEND, that the unlawful cultivation of any amount of marihuana or hashish would remain a disorderly persons offense pursuant to P.L. 1952, c. 106 (C. 2A:170-25.1).

4. RECOMMEND, that if the above "decriminalization" proposal is enacted and signed into law, section 20b. of P.L. 1970, c. 226 (C. 24:21-20b.) should be amended to exclude therefrom the "use" or being "under the influence" of marihuana or hashish as a disorderly persons offense.

5. RECOMMEND, that P.L. 1970, c. 226, S. 2 (C. 24:21-2) should be amended so that the term "marihuana" be defined as "Genus Cannabis L" instead of the present definition of Cannabis sativa L.

6. RECOMMEND, that the previous addition of the definition of hashish to the "New Jersey Controlled Dangerous Substances Act" (P.L. 1971, c. 367, S. 1; C. 24:21-2) necessitates the deletion of the phrase, "the resin extracted from any part of

such plant," from the definition of marihuana (P.L. 1970, c. 226, S. 2; C. 24:21-2)--which is the definition of hashish.

7. RECOMMEND, that the "New Jersey Controlled Dangerous Substances Act" shculd be amended to provide that within 3 years of the enactment of the decriminalization scheme for marihuana and hashish, the Legislature shall conduct a comprehensive study and review of the penalties established in the recommendation based on current scientific and medical understanding, criminal justice studies, and community expectations.

B. Concerning the intervention process:

1. RECOMMEND, that a supplement to the "New Jersey Controlled Dangerous Substances Act" should be enacted to implement the diversionary treatment process recommended by the National Conference of Commissioners on Uniform State Laws in its proposed "Uniform Drug Dependence Treatment and Rehabilitation Act" of 1973 to provide that:

(A) The treatment process must be substituted, formally or informally, for the criminal process if a person charged with any offense--whether previously convicted of any offense under the provisions of the "New Jersey Controlled Dangerous Substances Act" or any law of the United States, this State or of any other state, relating to controlled dangerous substances--under section 19 of P.L. 1970, c. 226 (C. 24:21-19); section 20a. and b. of

P.L. 1970, c. 226 (C. 24:21-20a. and b.); section 26 of P.L. 1970, c. 226 (C. 24:21-26); section 29 of P.L. 1970, c. 226 (C. 24:21-29); section 1 of P.L. 1966, c. 12 (C. 2A:96-5); P.L. 1952, c. 95 (C. 2A:108-9); section 1f. of P.L. 1962, c. 201 (C. 2A:119-8.1); section 1 of P.L. 1955, c. 277 (C. 2A:170-77.3); section 3 of P.L. 1955, c. 277 (C. 2A:170-77.3); section 3 of P.L. 1955, c. 277 (C. 2A:170-77.5); and section 7 of P.L. 1966, c. 314 (C. 2A:170-77.15), among other statutes, is diagnosed as drug-dependent and requests that these procedures be invoked. A defendant should not be denied treatment by being charged under a habitual criminal statute. This procedure would be initiated at the request of the defendant to the prosecutor who then must petition the court for commitment in lieu of prosecution. The court would hold a civil hearing to determine: (1) if the defendant is drug-dependent; (2) if he has cooperated with the preliminary screening and treatment program thus far; and (3) if adequate treatment is available. If the court decides in favor of treatment, criminal charges are held in abeyance until dismissed or reinstated by the court, but for no longer than the lesser of 18 months or the maximum permissible period of incarceration for the offense charged. If the defendant fails to cooperate with the treatment program, he is returned to the court for a hearing and is scheduled for trial if the court so determines. If a defendant completes treatment, charges may be dismissed by court order and the record expunged.

(B) If a drug-dependent person is charged with a non-violent crime, e.g., petty property offenses, and so requests of the prosecutor, the treatment process may be substituted for the criminal process in one of two ways: (1) by treatment in lieu of prosecution. This provides for an informal process whereby the prosecutor may withdraw or hold the charges in abeyance and so notifies the court. The charges are automatically dismissed after expiration of the lesser of 180 days or the maximum permissible period of incarceration, and expungement is mandatory; or (2) commitment in lieu of prosecution. This provides for a formal process whereby the defendant requests treatment, the prosecutor petitions the court and the court holds a civil hearing and orders commitment. The criminal charges are held in abeyance until either dismissed or reinstated by the court but for no longer than the lesser of 18 months or the maximum permissible sentence for the offense charged; expungement is mandatory.

(C) If the prosecutor elects not to use the diversionary procedure and the defendant is found guilty or pleads guilty and he is drug-dependent, the defendant may move the court to order civil commitment in lieu of an entry of judgment. Again, the time period is the lesser of 18 months or the maximum permissible period of incarceration for the offense charged. If the defendant fails in treatment, the court may enter judgment. Expungement is at the discretion of the court, except as provided for in section 28 of P.L. 1970, c. 226 (C. 24:21-28).

(D) Substitution of the treatment process for the criminal process should not be available to persons who are drug-dependent and charged with, or found guilty of, violent crimes, e.g., murder, forcible rape, kidnapping, voluntary manslaughter, etc., but participation in a treatment program may be made a condition of probation or, if the person is sentenced, treatment must be provided in the correctional institution.

(E) The defendant who has been convicted of a non-violent crime may petition the court to defer sentencing or to sentence him to a term of probation, on condition that he participate in a treatment program. Expungement would be at the discretion of the court, except as provided for in section 28 of P.L. 1970, c. 226 (C. 24:21-28).

Distinctions, therefore, should be made regarding the relationship between treatment and the criminal process, not regarding the availability of treatment.

Furthermore, the Commission is aware that such a treatment process may require additional funds; however, under the provisions of the "Uniform Drug Dependent Treatment and Rehabilitation Act" of 1973, whether treatment is available is a state-specific determination involving such factors as the extent to which the treatment program is funded and the physical availability of adequate facilities and trained personnel for treating a particular type of drug dependence. None of the judgments pertain to a specific drug-dependent person; whether adequate treatment is available for a person diagnosed as drug-

dependent is a judgment made by a court on the basis of recommendations by treatment personnel.

2. RECOMMEND, that the treatment program provided for in P.L. 1970, c. 334 (C. 26:2G-21 et seq.) should be supplemented to include all provisions of the "Uniform Drug Dependent Treatment and Rehabilitation Act" of 1973. These include:

(A) Mandating that any person, whether an adult or minor, who needs emergency services as a result of using a controlled dangerous substance, or who desires preventive services or drug dependence treatment, can apply directly to a treatment facility for either emergency or preventive services or drug dependence treatment. Minors should be included to avoid any implication that either admission, diagnosis or treatment requires parental consent. Minors who seek assistance, whether voluntarily or under commitment, are often reluctant to have their drug usage known to their parents, and the possibility of such notification may in fact deter them from seeking treatment. This is especially true of runaways. A provision for treating minors would be superceded by the Federal Regulations concerning methadone, however, which require that any person under 18 years of age must have written parental consent before methadone can be administered.

(B) The consensual nature of both the voluntary program and the commitment program requires that notice be given to an applicant that he need not submit to medical examination and diagnosis or provide a complete personal history unless he

chooses to do so; however, he should be informed that refusal to comply with the conditions of diagnosis and treatment vitiates his opportunity to participate in the program. Should the applicant consent to examination, he may be required to submit to reasonable chemical surveillance procedures, such as urinalysis or other medically reliable means of detecting the presence of controlled dangerous substances in the body. Persons who are diagnosed but not found to be drug-dependent must be referred to other public or private agencies for appropriate assistance.

Furthermore, a voluntary entrant should not become an involuntary patient. But, in recognition of the fact that the efficacy of treatment depends on patient cooperation, "reasonable conditions" for each type of treatment shall be established. Also, a voluntary patient's participation can be terminated for repeated failure to cooperate with the treatment program.

Furthermore, patients should be required to contribute toward the cost of services rendered to the extent that they are financially able to do so, but contributions are not required by the parent or legal guardian of a minor patient. For many youths, the desire for confidential treatment extends even to keeping the matter from their parents. Requiring parental contribution toward the cost of treatment would require notification and would therefore frustrate the policy encouraging voluntary entry by drug-troubled youths. At the same time, however, financial information from all patients, including minors, should be obtained as part of the treatment record.

(C) The rights and protection afforded a person in treatment should be mandated, such as: (1) the person does not lose any civil rights or liberties as a result of being treated; (2) he may not be a subject for experimental research or treatment without expressed and informed consent; (3) he may not be administered any chemical or maintenance treatment without expressed and informed consent, except in an emergency; (4) his mail may not be censored; and (5) records of private physicians shall remain confidential regarding a person's drug problem, among other rights and protections.

3. RECOMMEND, that the "New Jersey Controlled Dangerous Substances Act" should be supplemented to implement those provisions of the "Uniform Drug Dependence Treatment and Rehabilitation Act" of 1973 applicable to the following persons: (1) persons in police custody for purposes of being charged with a crime who need emergency treatment as a result of drug usage or addiction. In effect, this provision begins the formal intervention process described in Recommendation 1. It is designed to discharge the State's and municipality's obligation to treat persons in custody who need such treatment, and it is the defendant's first contact with treatment personnel; (2) persons in police custody or who have come to the attention of the police, their families, and/or others who are in need of short-term involuntary emergency treatment because they are <u>incapacitated</u> by a controlled dangerous substance. Such persons shall be civilly committed after a civil hearing, where they are represented by counsel and have a private

physician at their disposal, for no longer than 15 days after the date of commitment. This provision, in light of current drug abuse patterns, appears warranted and of value. It is expected that such a provision would not be used frequently and could be invoked only after a civil hearing in which the court must find by clear and convincing evidence that the person is incapacitated and needs such treatment (refer to proposed amendment of definition section in Recommendation 5 regarding "persons incapacitated by a controlled dangerous substance"); (3) persons in police custody, who, after screening and/or diagnosis of drug dependency, may ask the court that either in lieu of bail or as a condition of release or bail, they be referred to a treatment facility for complete diagnosis and treatment. As stated above, this procedure is designed to secure medical diagnosis and initiate treatment as soon as possible after a defendant is taken into custody for the purpose of being charged with a crime. The diversionary process outlined in Recommendation 1 is thus begun at an early stage. To operate effectively, criminal justice personnel must be reasonably certain that the defendant will appear for further proceedings; thus, a secure treatment facility is provided for, if needed, in individual cases. It also means that treatment and criminal justice personnel must cooperate.

In addition, the provision mandates that any person in police custody is entitled to receive treatment for his drug problem. In many counties this is no problem, but some counties offer no treatment or inappropriate treatment, and treatment in

State penal institutions is often not available or, again, medically inappropriate; and (4) persons in police custody who, at any time before trial, state that they are drug-dependent or appear to be so to the police. Such persons shall be screened for drug dependency and shall be referred after screening, upon their request, for diagnosis and treatment. In addition, any person who is diagnosed as drug-dependent shall be notified of his right to request treatment.

4. RECOMMEND, that a screening agency should be established as part of the network of facilities operated by the State Division of Narcotic and Drug Abuse Control. It should be independent of the individual treatment agencies operated by the Division and independent of the criminal justice system. The establishment of such an independent system might prove costly in certain counties should a new system be needed. In this case, the Division should make use of all available resources to insure adequate screening. "Screening" is to be conducted by trained medical personnel, social service staff and para-professionals to (1) determine if the defendant is drug-dependent; (2) obtain a complete social and legal history; and (3) recommend an appropriate treatment plan. It is necessary for the effectiveness of the program that the screening agency work closely with the treatment agency and the criminal justice system.

5. RECOMMEND, that if Recommendation 1 is adopted, section 2 of P.L. 1970, c. 226 (C. 24:21-2) should be amended to include

the following definitions descriptive of the diversionary treatment program described in Recommendation 1:

(a) "Commitment" means the relationship established by a court order that places a drug-dependent person or person incapacitated by a controlled dangerous substance in the custody of the Commissioner of the New Jersey State Department of Health or any person specifically designed by him to perform his functions and duties pursuant to this act for purposes of treatment under this act.

(b) "Court" means the County Court of the county in which a drug-dependent person or a person incapacitated by a controlled dangerous substance resides or is found.

(c) "Dismiss" or "dismissal" means the termination of a criminal action with prejudice to its reinstitution by the state.

(d) "Intermediate services" means treatment services for drug dependence for a part-time resident patient in a treatment facility.

(e) "Nearest relative" means, in the order or priority stated, a person's legal guardian, spouse, natural or adopted adult child, parent, adult sibling, or any other person with whom the person resides.

(f) "Outpatient services" means treatment services for drug dependence for a patient who is not a resident of a treatment facility.

(g) "Persons incapacitated by a controlled dangerous substance" means a person who, as a result of the effects of one or more controlled dangerous substances, needs treatment and

either is unconscious or his judgment is so impaired that he is incapable of making a rational decision with respect to his need for treatment.

(h) "Police" means law enforcement officers.

(i) "Private facility" means a facility providing treatment services that is not operated by the federal, State, or local government, whether or not it receives public funds or operates for profit.

(j) "Public facility" means a facility providing treatment services that is operated by the federal, State, or local government.

(k) "Residential services" means treatment services for drug dependence for a full-time resident patient in a treatment facility.

(l) "Treatment" means (1) emergency services for a drug-dependent person, a person incapacitated by a controlled dangerous substance, or a person under the influence of a controlled dangerous substance; (2) the full range of residential, intermediate, and outpatient services for drug-dependent persons designed to aid them to gain control over or eliminate their dependence on controlled dangerous substances and to become productive functioning members of the community; and (3) community-based prevention services designed to reduce the likelihood of drug dependence. Treatment includes but is not limited to diagnostic evaluation; medical, psychiatric, psychological, and social services; drug maintenance services; vocational rehabilitation,

job training, career counseling; educational and informational guidance; family counseling; and recreational services.

(m) "Treatment facility" means a narcotic and drug abuse treatment center as defined in section 2 of P.L. 1970, c. 334 (C. 26:2G-22).

6. RECOMMEND, that various other provisions of the "Uniform Drug Dependence Treatment and Rehabilitation Act" of 1973 be adopted for inclusion within the "New Jersey Controlled Dangerous Substances Act." These include appropriate services for the prevention and treatment of drug dependency among State and local employees as well as encouraging private industry to develop treatment services within the State; and non-discriminatory admission of drug users and drug-dependent persons to private and public hospitals and to private and public mental institutions. Another provision protects the drug-dependent person by providing for the termination of commitment orders upon a civil hearing and the confidentiality of records and a defendant's testimony in civil hearings.

7. RECOMMEND, that the "New Jersey Controlled Dangerous Substances Act" should be supplemented to encompass the provisions of the "Uniform Drug Dependence Treatment and Rehabilitation Act" of 1973 applicable to persons not involved formally in the criminal process but who come to the attention of families, the police or public health officials. These provide for non-criminal responses for persons under the influence of a controlled dangerous

substance who are incapacitated and need emergency treatment. This treatment may last no longer than 48 hours without the person's consent unless further commitment is authorized by the court with appropriate safeguards. The police may be informed of the person's incapacity and take him to a treatment facility--but the taking is not to be an arrest.

8. RECOMMEND, that the Conditional Discharge Statute of the "New Jersey Controlled Dangerous Substances Act," P.L. 1970, c. 226 (C. 24:21-27) should be amended so that its provisions apply to that class of defendants described as drug users who are not yet, or may never be, drug-dependent, and that second or subsequent offenders--rather than only first offenders--be eligible for treatment through conditional discharge, which should be mandated. Supervisory treatment should not exceed one year or the maximum period of confinement for the offense with which the individual is charged--if it is less than one year. It is further recommended that the term "supervisory treatment," as contained in section 27, be amended to read "appropriate supervision," which will allow the court greater flexibility in determining the proper course of action for each individual. Defendants eligible for conditional discharge should also be subject to screening by the screening agency established in Recommendation 4, so that the court will have a professional and reliable basis on which to make its decision.

9. RECOMMEND, that drug users charged with crimes other than those outlined in Recommendation 8 should be eligible for diversion

under Court Rule 3:28. In order to make this provision more widely available, it is further recommended that programs certified by the Division of Narcotic and Drug Abuse Control be approved for operation under the Court Rule 3:28.

10. RECOMMEND, that if the recommendations contained in this chapter are enacted and signed into law a provision should be contained therein to require (1) ongoing research and evaluation as to the effectiveness of the diversionary program and (2) that the Legislature review and study the program within 3 years of its creation to determine if legislative revisions are needed.

C. Concerning the impact of stricter drug laws:

1. RECOMMEND, that the "New Jersey Controlled Dangerous Substances Act" be retained as a more rational and realistic approach than the New York Drug Law (commonly referred to as the Rockefeller Drug Act) to deal with the drug problem in New Jersey, but should be revised to keep pace with current scientific and medical understanding, criminal justice studies, and the community's expectations.

CHAPTER II

UPDATE: AN ANALYSIS OF THE MARIHUANA PROBLEM SINCE OCTOBER, 1974

Introduction

In Chapter 2 of the "Drug Study Commission's First Report To The Legislature," completed in October, 1974, a study of the marihuana problem, inclusive of hashish, was presented. In reviewing the marihuana problem in the United States, and New Jersey in particular, an effort was made to keep pace with current scientific and medical understanding, criminal justice studies, and the community's expectations on the use of marihuana. Because public attitudes towards marihuana use are constantly in the news; because lawmakers and law-enforcement personnel have been seriously studying the effects of criminal penalties for marihuana offenses; and because medical and scientific studies of the effects of marihuana on the user are common occurrences at this time, the Commission decided to update its October, 1974, report on the marihuana problem by reviewing information released since that time.

In Chapter 2 of its first report, the "Drug Study Commission" concluded that:

1. Marihuana does not pose a serious threat to the user or society.

2. Marihuana has become a popular and accepted form of recreation for a large segment of the national population, including residents of New Jersey.

3. The present policy of criminalizing marihuana use in New Jersey has failed to act as an effective deterrent and has engendered various social adversities.

4. The societal costs of attempting to enforce the existing New Jersey anti-marihuana statutes, in light of medical knowledge and public expectation, far outweigh the possible benefits which may be derived from the continuation of such a policy.

5. In order to alleviate the social adversities emanating from our present marihuana policy, and to provide a rational and enlightened social policy, in light of medical knowledge and public expectation, marihuana legislation reform is needed.

The Commission recommended--based on its findings--a legislative proposal to decriminalize marihuana penalties. (See Appendix C to Chapter 1 of this report.) Decriminalization involves removing criminal sanctions from the personal use of small quantities of marihuana and imposing a nuisance offense--similar to the citation system employed for traffic offense. To implement this proposal, Senate Bill Number 1461 was introduced in the Senate on November 21, 1974, and Assembly Bill Number 2312 was introduced in the Assembly on November 25, 1974. Assembly Bill Number 2312 has since been released from committee and is awaiting action and passage in the General Assembly.

It is not the purpose of this chapter to present a restatement of why the "Drug Study Commission" recommended the decriminalization of marihuana penalties, or repeat who supports the recommendation and who does not, but rather to review what has occurred concerning the marihuana debate in this country and New Jersey since October, 1974.

Federal and State Legislative Proposals to Reform Marihuana Laws

On Thursday, April 17, the "Marihuana Control Act of 1975" was introduced in the United States Congress. The act (S. 1450/H.R. 6108), a proposal to adopt a maximum $100 civil-citation system for minor marihuana violations, was introduced for the first time in the United States Senate and in the House of Representatives. These bills were referred to the Health Subcommittee, of the House Interstate and Foreign Commerce Committee, and to the Juvenile Delinquency Subcommittee, of the Senate Judiciary Committee, respectively. Hearings on these measures are expected later this year. Another bill to completely decriminalize the use of marihuana was introduced in the House and will be introduced in the Senate shortly.

In addition, S. 1, a proposed new comprehensive criminal code, is being considered in the Subcommittee on Criminal Laws and Procedures of the Senate Judiciary Committee. It is expected that amendments to incorporate marihuana decriminalization as part of the new code will be introduced shortly.

State legislative proposals to reform marihuana laws, as of May 30, 1975, in alphabetical order and with a brief description of each proposal, appear below. While only Oregon has actually enacted a decriminalization law, many of the following bills are making their way through the respective legislatures.

1. Alaska S.S. 350, which provides for a maximum $100 civil-fine for the possession of marihuana, was recently adopted. It

establishes a civil fine of no more than $100 for possessing up to one ounce of marihuana in public, and for any amount privately possessed for personal use. The bill became law without the Governor's signature, thereby making Alaska the second state in the country to decriminalize minor marihuana offenses. The new civil-citation system takes effect on (approximately) September 1, 1975.

In addition, the Alaska Supreme Court ruled on May 27, 1975, that citizens have a constitutional right to possess marihuana for personal use in their own homes. The basis of the decision was an individual's right to privacy within his own home as long as the health and welfare of the general public is not adversely affected. The court also said that the state has a "legitimate concern" in outlawing the use of marihuana in public.

2. Arizona S.B. 1139, as originally introduced, would have established a maximum $100 civil-fine system. The bill was amended on the Senate floor, however, to reclassify the offense as a "misdemeanor," thereby making it a criminal offense rather than a civil one, and to raise the fine to a minimum $100-maximum $300. It has passed in the Senate.

3. California S.B. 950 proposes to reduce marihuana possession to a maximum $100 criminal fine, enforced with a citation rather than an arrest. It has passed in the Senate but failed in the Assembly, although another vote is expected in the middle of June.

4. Colorado H.B. 1027 proposes a maximum $100 civil-fine. The possibility of jail is retained for public use but eliminated for private use. It has passed in the House.

5. Connecticut S.B. 1151 proposes to adopt a maximum $50 civil-fine for public possession and use, eliminating all penalties for private use.

6. District of Columbia Bill #1-44 proposes to adopt a maximum $100 civil-citation system.

7. Florida. A maximum $100 civil-citation bill, introduced as H.B. 1249, is dead for the year in committee.

8. Georgia H.B. 1026, which proposes a maximum $100 civil fine for marihuana violations, and H.B. 1100, which proposes a maximum $100 criminal fine, were both defeated in committee.

9. Hawaii. A maximum $100 civil-citation bill is currently awaiting action in the Senate Judiciary Committee.

10. Illinois H.B. 1681 proposes to completely decriminalize marihuana for personal use as recommended by the President's National Commission on Marihuana and Drug Abuse.

11. Maine L.D. 314, a comprehensive new drug bill, sets a maximum $100 civil fine for minor marihuana cases.

12. Maryland S.B. 755 proposes a maximum $100 civil-citation system.

13. Massachusetts H. 2484,which proposes a maximum $50 civil-fine system in which the offender is given the choice of paying a fine or attending a drug education course directed towards realistic and responsible drug use, has been defeated by the House. Second offenders would be fined up to $100, or in the alternative they could elect to undergo a "chemical-dependence evaluation."

14. Michigan H.B. 5212 proposes to completely decriminalize the private possession and non-profit transfer of marihuana for

personal use.

15. Minnesota H.F. 749 proposes a $100 civil-citation system for marihuana offenses--offering the offender the alternative of attending a drug education course or paying the fine.

16. Nevada A.B. 285 would establish a maximum $100 civil-citation system for minor marihuana offenses for persons under 21 years of age.

17. New Hampshire H.B. 129, which proposes a maximum $100 civil-citation fine, was recently defeated in the legislature.

18. New York. Measures to legalize sale as well as to decriminalize marihuana use have been introduced in the New York Legislature. The Governor of New York has publicly indicated his preference for an Oregon-type, civil fine system. S. 4177 and A. 5487 would completely decriminalize up to four ounces of marihuana. A. 2988 and S. 1852 propose to establish a Marihuana Control Authority and to legally regulate the sale and permit legal use of marihuana.

19. Ohio H.B. 300 would maintain a maximum two month jail term for minor marihuana cases.

20. Oregon H.B. 2574 would include the private cultivation of up to ten marihuana plants within the coverage of the present civil-citation system.

21. Tennessee H.B. 1190 and S.B. 1112 propose to adopt a maximum $100 criminal fine system, enforced with a citation rather than an arrest.

22. Texas H.B. 895 would establish a maximum $100 civil-citation plan.

23. Washington H.B. 689 proposes a maximum $100 civil-fine system.

24. Wisconsin A.B. 482 would establish a state-regulated system of legal marihuana distribution.

Community Expectations

Obviously, any legislative proposal to decriminalize current marihuana laws must take into consideration how the public feels about such efforts. Unfortunately, current data is scarce.

However, as the result of an October, 1974, national survey commissioned by the independent, non-profit Drug Abuse Council in Washington, D.C., the issues have been clearly defined. According to this survey, the 13 percent of the public who want no change, plus the 8 percent undecided, will decide the issue of marihuana decriminalization. This survey shows:

16% of the public favor legalization;
an additional 13% favor decriminalization;
an additional 10% favor the civil-fine approach;
39% - (current political support for some form of decriminalization)
13% would make no change at this time;
8% are undecided;
40% would prefer stronger penalties.

The Drug Abuse Council also conducted a survey of marihuana use in the State of Oregon one year after the abolition of criminal penalties for simple possession of marihuana, which occurred on October 5, 1973. Oregon is the first state to abolish criminal penalties for this offense. On December 15, 1974, the Drug Abuse Council reported that 58 percent of the residents of the State of Oregon favor the elimination of criminal penalties for

the possession of small amounts of marihuana. Three out of every ten Oregon adults approve of their state law that makes simple possession of marihuana a civil offense--akin to a parking ticket--carrying a fine but no jail term or criminal record. An additional 26 percent favor changes making sale and/or possession of small amounts of marihuana legal.

The Oregon survey included 802 personal interviews with adults eighteen years or over, representing a balanced sample of the state's population.

On March 8, 1975, the Drug Abuse Council released the results of a marihuana survey conducted in the State of California, which show that three out of every ten California adults have tried marihuana. Of those adults who currently do not use marihuana, only 12 percent cite the possibility of legal prosecution or the lack of availability as their primary reasons for not using marihuana. Forty-six percent of those surveyed favor the elimination of criminal penalties for the possession of small amounts of marihuana and use in private.

The survey consisted of 1,004 personal in-home interviews, representing a balanced sample of the California population. Interviews were conducted between February 5 and February 11, 1975.

Only 34 percent of those polled said marihuana is no more harmful than alcohol, and 63 percent believe that people who use marihuana are likely to go on to use other illegal drugs.

The only survey conducted on the reform of the marihuana penalties in New Jersey to date is that taken by the Eagleton Institute of Rutgers University in November, 1974. Based on the

results of polling 1,005 people, 51 percent feel that penalties for the use of marihuana should not be reduced and penalties for the possession of a small amount of marihuana should not be eliminated. Only 23 percent feel that the sale and use of marihuana should be legalized--but no mention is made of whether those surveyed favor the decriminalization of marihuana.

From the above polls, it can be seen that 23 percent of the public polled in New Jersey favor the legalization of the sale and use of marihuana; 39 percent of the public polled in a national survey favor some sort of decriminalization; 58 percent of the residents of Oregon favor the elimination of criminal penalties for the possession of small amounts of marihuana; and 46 percent of those surveyed in California favor the elimination of criminal penalties for the possession of small amounts of marihuana and use in private.

Apparently, one of the misconceptions among those polled in New Jersey is that marihuana is more harmful than it actually is, and that people who use marihuana are likely to go on to use other illegal drugs. To the contrary, and as this Commission concluded in its first report after exhaustive research, marihuana does not cause physical addiction, since tolerance to its effects and symptoms of sudden withdrawals do not occur. While marihuana can produce psychological dependence, this depends mainly on the personality of the user, rather than the substance itself.

Furthermore, nothing is known in the nature of marihuana that predisposes to heroin abuse. Very few chronic users of

marihuana go on to heroin use, although many heroin users at one time used marihuana. But this should not imply a casual relationship between marihuana and narcotic drugs.

As often stated before and in many other ways, the potential harmfulness of marihuana to the user is on a much lower order of magnitude than the potential harmfulness of such other drugs as alcohol, tobacco, amphetamines, barbiturates and hallucinogens.

Another expression of public sentiment in New Jersey is that of the members of a Union County Grand Jury, January Stated Session, Panel 1, 1974 Term, "In The Matter Of An Investigation Involving Marihuana Violations," which recently recommended "that the present New Jersey Statutes pertaining to marihuana and hashish offenses be retained, at least until such time as all the medical and psychological aspects of marihuana use are fully explored and definite conclusions with respect to such matters are finalized." (Presentment No. P-1 J-74.)

Once again, the Commission can only refer to its findings and conclusions in its first report. In addition, the Commission agrees with Dr. Thomas Bryant, President of the Drug Council, that we should not permit a medical debate to frustrate the decriminalization of marihuana. The decriminalization of marihuana is not based upon an assumption of medical harmlessness alone. Rather, it is also a recognition that the costs in terms of wrecked lives and wasted law enforcement resources involved with continued criminal prohibition far outweigh any harm caused by the use of the drug to both the user and society. The notion

that arrest and imprisonment are the proper social responses to possession of a hazardous product or substance appears inconsistent with society's usual approach to such products. Alcohol and nicotine are both demonstrably harmful drugs, but society does not arrest and imprison persons found to possess them.

While the Commission feels that a medical and scientific debate should no longer frustrate the decriminalization of marihuana, it feels compelled to resummarize current medical and scientific understanding--especially findings released after October, 1974--to show that no conclusive damaging evidence as to the effects of marihuana on the user exists.

Current Medical and Scientific Understanding

With increasing use of marihuana among diverse segments of the population, concern has prompted many examinations of the effects of the material on the user. Many experiments may be cited with conflicting conclusions, but only by long term observations under controlled experimental circumstances will the necessary answers evolve. Many human volunteer studies lack proper control of marihuana sources and it is not clear whether the subjects have only employed marihuana, or may have used adulterated street samples.

This compendium of data is intended to be only a brief review of the many experiments conducted to answer the question of the effects of marihuana on health. For a more comprehensive review, it is recommended that the reader consult the various Health, Education and Welfare reports on this topic, as well as

consult the original literature cited in the footnotes.

A. Considerations in Medical Data Evaluation

When one uses test systems in the study of a compound with the intent of extrapolating the results obtained to men, many pit-falls may exist. Convenience in the choice of the test system may not afford due respect to all necessary considerations.

It has been demonstrated that many animal systems employed in the study of marihuana (Cannabis sativa L. and variants) will produce a spectrum of metabolites[1,2,3,4] somewhat different from that found in man. Since it is known in man that many of the marihuana metabolites are active physiologically, the lack of correlation between animal species and man may prove deceptive.[5,6,7,8]

All drug studies are not carried out with the entire animal. In vitro studies involve the use of isolated tissue preparations while in vivo studies utilize the entire experimental animal. Thus, in vivo studies could give different results than are found in the examination of in vitro systems. This difference could be due to enzyme availability, metabolic variances induced by various organs, alterations of distribution due to the disruption of normal transport mechanisms and more subtle considerations.

The nature of the activity induced by a drug will also depend on the quantity used. When the social use of marihuana is considered, the dose level employed will generally be considerably lower than found in most animal studies. In the human, the social

dose of (-)-Δ^9-THC, the principal psychoactive components of marihuana, may be approximately 20-40 mg[9,10], which would be .28-.56 mg/kg for a 70 kg (154 lb.) person. This would be 1-2 gm of marihuana of 3 percent THC content. Many animal studies will use dose levels well in excess of the human dose and evaluation of these studies must also bear the recognition that toxic activity may be induced with almost any drug, if enough is used.

Careful analyses of these considerations are needed in placing the social use of marihuana, as well as potential medical benefits, in perspective.

B. Tolerance

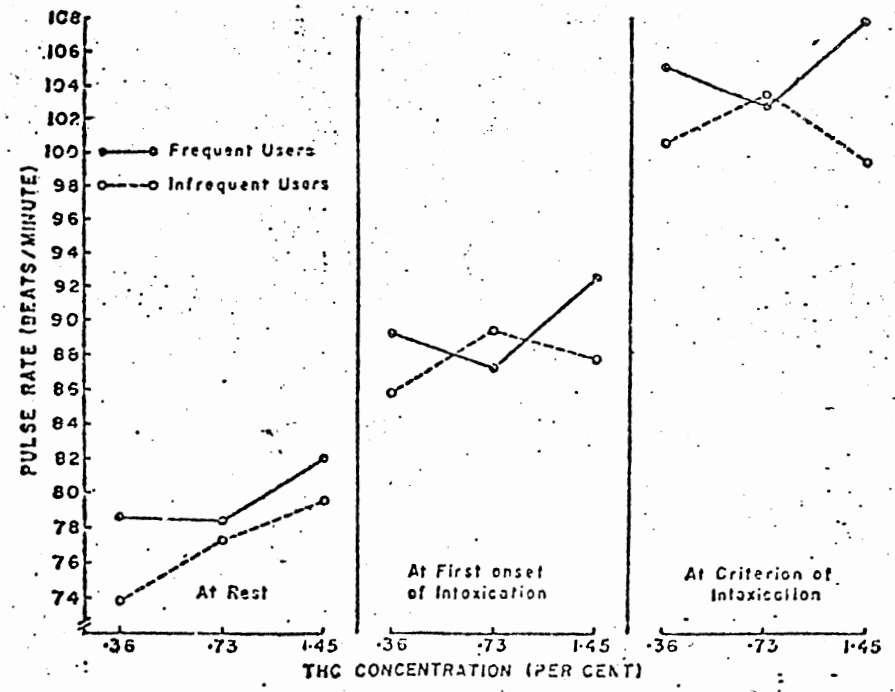
Tolerance has been found to develop with the key peck test in the pigeon with (-)-Δ^9THC.[11] In rats, however, it appeared that tolerance did not fully develop to the stimulant actions of (-)-Δ^9-THC; but some tolerance may have developed with other aspects of the drug's pharmacological spectrum. The rats were shown to be able to differentiate between a control solution and THC; this was indicated by their ability to choose the THC solution over the saline control in self administration studies.[12]

Since the purpose of studying the action of marihuana is to determine its actions in man, human volunteer studies have been performed. Experienced marihuana users and novices were allowed to accept a THC solution until a suitable "high" was obtained, and a comparison of various physiological effects was

made. The researchers drew the conclusion that marihuana as used by the young American did not produce any tolerance or increased sensitivity to its actions. Statistical data indicated that the novice used marihuana approximately nine times a year, while the experienced users smoked a mean of 290 times a year. Samples of marihuana brought to the researchers implied that the experienced users smoked a good grade of marihuana (3 to 4.5 percent (-)-Δ^9-THC content). Their data is summarized in Figures 1 and 2.[13]

In another experiment involving human volunteers, the subjects were asked to smoke until they obtained a nice "high." The authors noted no difference in the amount required by frequent and infrequent users to obtain the intoxication criterion, indicating little tolerance potential. Measurement of pulse rate was examined as the method of physiological tolerance examination. The results are shown below as a function of the content of THC of the marihuana.[14]

Regulation of the Self-Administration of Marihuana



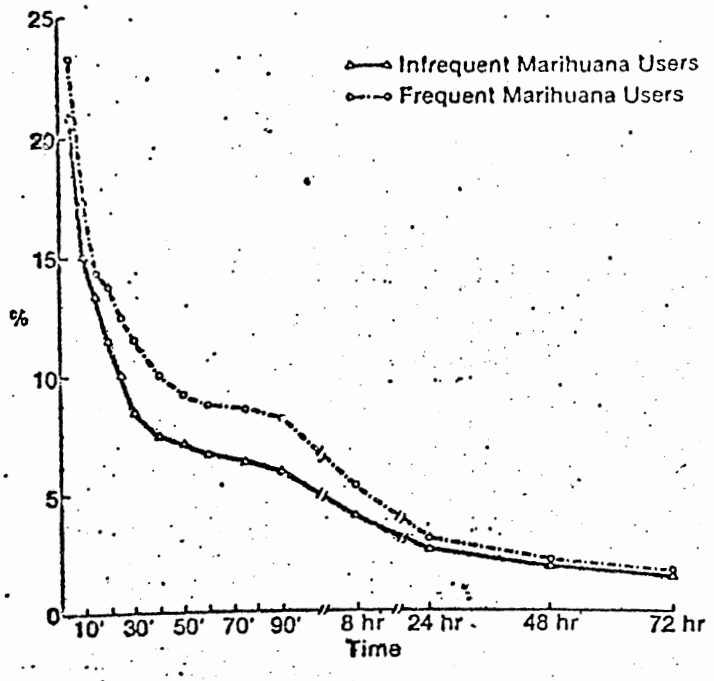


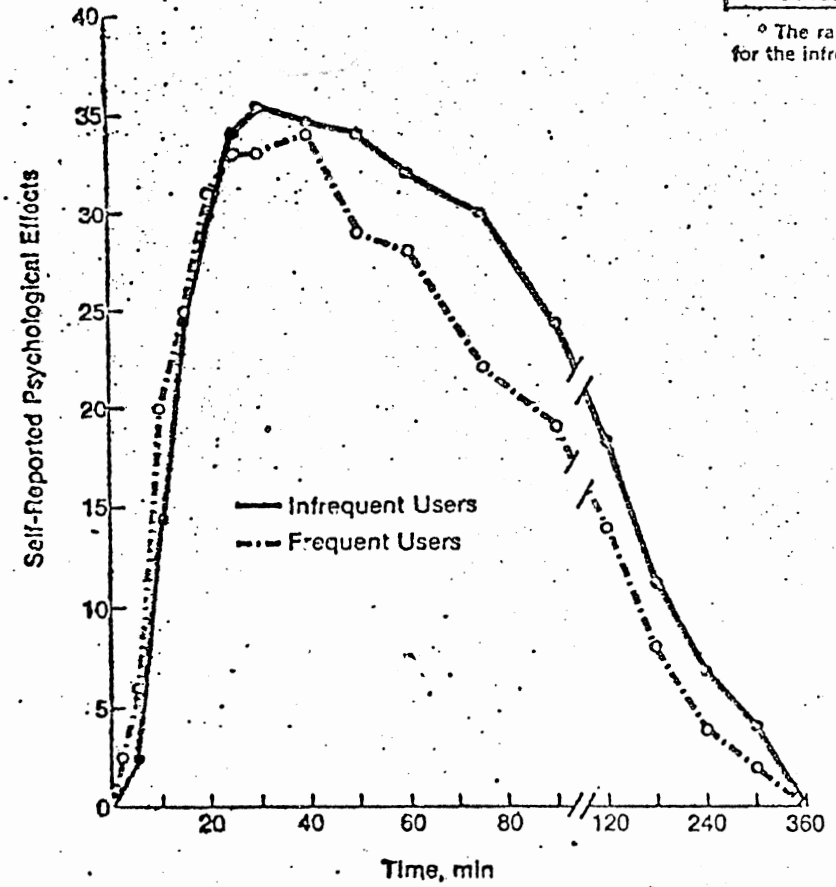
Fig 1.—Percentage of the total radioactivity administered present in the total plasma volume at the specified time intervals. The points of this graph represent the mean of the groups. The means have been obtained by multiplying the disintegrations/min/ml of plasma obtained at each point × the total plasma volume (average 45.4 ml/kg of body weight) and calculating what this figure represents in terms of the total radioactivity infused to each individual at any given moment.

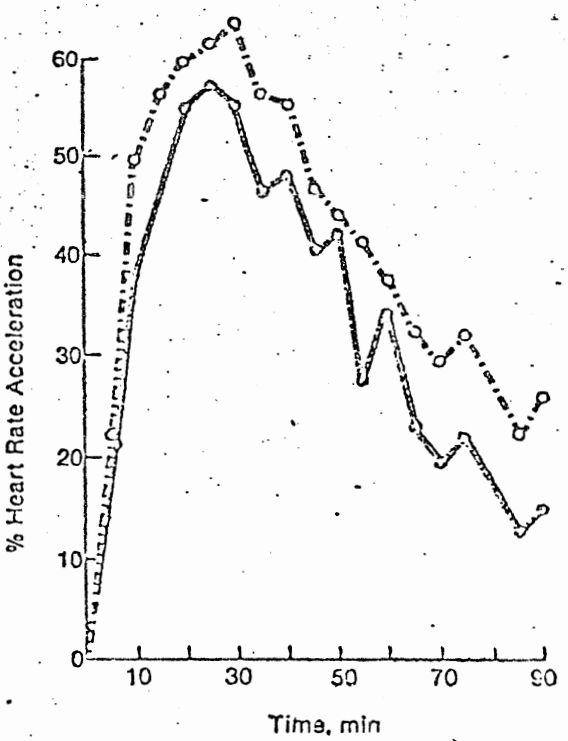
Table 1.—Comparison of the Subjects That Have Smoked Marihuana

	Total Group*		
	Infrequent, N = 15	Frequent, N = 15	P
Age	24.6 ± 1.82	22.8 ± 3.33	.10 NS
Age of onset	22.87 ± 2.12	19.73 ± 3.92	.02
Years of experience	1.87 ± 1.28	3.13 ± 1.45	.025
Marihuana use per year	9.2 ± 7.85	290.53 ± 449.89	.05
Total marihuana use	18.6 ± 18.31	914.27 ± 1,350.66	.02
Hallucinogens	0.47 ± 1.50	45.13 ± 51.39	.005
Perception of "high," μg/kg	20.04 ± 7.62	19.16 ± 8.16	.10 NS
Heart acceleration, μg/kg	22.63 ± 8.44	2[illegible].28 ± 12.68	.90 NS
Total dose, μg/kg	52.87 ± 17.70	68.10 ± 35.15	.80 NS
Maximum level of "high"	42.27 ± 14.92	42.67 ± 15.40	.90 NS
Maximum heart acceleration	74.40 ± 28.34	79.33 ± 25.34	.70 NS
Heart acceleration at 15 min	56.07 ± 35.13	55.93 ± 27.82	.90 NS

* The range of marihuana cigarettes smoked per year was 1 to 10 for the infrequent users and 104 to 1,820 for the frequent users.

Fig 2.—Left, Self-reported psychological effects to the intravenous infusion of Δ⁹-tetrahydrocannabinol. Right, Mean heart rate acceleration following the intravenous infusion of Δ⁹-tetrahydrocannabinol. The points of these graphs represent the mean values of the groups. Subjective score is measured by the number of squares in a standard graph paper that the subject indicates how "high" they felt at a given moment in time. The percentage heart rate acceleration is based in terms of increase over base line levels.





In a study concerning driving, it was noted that drivers employing marihuana had an increase in heart rate of 22 percent. The authors also noticed a similar increase in heart rate under laboratory conditions.[15] This again indicates little, if any, tolerance to the action of marihuana on the pulse rate.

Tolerance to the effects of marihuana was measured by another group using human volunteers. Time estimation was shown to develop tolerance. Although initially disrupted, the ability to estimate a specific span of time gradually improved. There was no tolerance noted in heart rate with prolonged marihuana use. The authors felt that the dose levels and schedule of administration may have been insufficient to illustrate the full development of tolerance.[16]

C. Toxicity, Embryotoxicity and Mutagenicity

Marihuana appears to have an extremely low toxicity when compared to most medicines currently used. A comparison of LD_{50}'s of marihuana components and other commonly used materials is found in the toxic substance list at footnote 26.

A report by the American Bar Association states in part:

> A large amount of research has been performed in man and animals regarding the immediate effects of marihuana on bodily processes. No conclusive evidence exists of any physical damage, disturbances of bodily processes or proven human fatalities attributable solely to even very high doses of marihuana.[17]

Embryotoxicological studies have not been conducted on pregnant women, but undoubtedly, marihuana has been smoked during this condition. It may be of interest to learn about the nature

of the offspring born to marihuana users returning from tours of duty in Vietnam. Reports of extensive use have been issued by various agencies, but to date, few, if any, birth defects appear to have occurred.

Studies have been conducted with pregnant rats, and contained dose ranges of Δ^9-THC that would be considerably higher than ever employed with human use.[18] A Mississippi group employed doses of THC during the gestation period of rats, and observed a decrease in litter size and weight of the newborn offspring. The doses were excessive; the maximum equivalent to about one pound of marihuana (3 percent THC) a day for a 154 lb. (70 kg.) person. However, at 25 mg/kg/day, (58.3 g, 2 oz of 3 percent THC marihuana for a 154 lb. person a day) there was no statistical difference from the controls in the quantity or quality of the offspring. This dose would essentially not be approached by any human user. It should also be noted that no apparent birth defects occurred, implying that the synthesis of RNA and DNA--the genetic material of chromosomes--was not significantly impaired. (See Tables 1 and 2.[19])

Earlier experiments with marihuana extract or resin showed it to be either innocuous or capable of producing birth defects in animals. It should be recognized that although a material may not exert a pronounced toxic action, long term heavy use may be detrimental. Results are often equivocal and caution must be exercised in extrapolating animal results to man. One example of controversy is the recent situation concerning the cancer causing potential of various hair dyes. A test developed

TABLE 1

REPRODUCTIVE SUCCESS FOLLOWING PRENATAL ADMINISTRATION OF Δ^9-THC

Dose Δ^9-THC (mg/kg)	N	No. delivered / No. pregnant	No. prolonged gestation / No. delivered	Pups born alive / total pups born	Litter size at birth[a]	Pup wt at birth[a]	Litter size at weaning[a]	Pup wt at weaning[a]	Percent postnatal mortality
Oil control	10	7/7	0/7	74/76	10.8 ± 1.0	5.9 ± 0.3	8.6 ± 0.8	53.5 ± 2.7	19
0.01	10	8/8	1/8	87/87	10.9 ± 1.1	6.1 ± 0.2	8.7 ± 0.4	49.3 ± 2.7	20
0.10	10	6/7	0/6	59/61	10.1 ± 1.0	6.0 ± 0.3	8.2 ± 1.3	48.4 ± 2.8	17
1.00	10	8/9	1/8	81/85	10.6 ± 0.6	5.9 ± 0.3	8.1 ± 0.5	57.2 ± 3.0	19
10.0	10	8/9	3/8[b]	86/88	11.0 ± 0.8	5.7 ± 0.2	7.6 ± 0.6	50.4 ± 1.9	29
Oil control	10	8/8	0/8	83/83	10.4 ± 0.8	5.9 ± 0.1	8.5 ± 0.7	48.4 ± 3.5	16
25	10	8/8	2/8	78/78	9.8 ± 1.0	5.6 ± 0.3	7.1 ± 0.8	49.3 ± 1.5	28
50	10	7/8	2/7	64/68	9.7 ± 0.5	6.0 ± 0.2	5.1 ± 0.5[c]	45.9 ± 1.4	47[b]
75	10	9/9	4/9[b]	77/86	9.4 ± 0.8	5.8 ± 0.2	2.5 ± 0.6[c]	42.8 ± 3.0	73[c]
100	10	9/10	6/9[c]	66/70	7.8 ± 0.6[b]	6.1 ± 0.2	3.2 ± 0.5[c]	43.8 ± 2.1	59[c]

[a] Mean ± SE.
[b] Difference from control group significant, $p < 0.05$.
[c] Difference from control group significant, $p < 0.01$.

TABLE 2

MATERNAL ORGAN WEIGHTS AND LITTER SIZE AT TERM AFTER Δ^9-THC THROUGHOUT GESTATION

Dosage Δ^9-THC (mg/kg)	N	Body wt (g)[d]	Litter size	Heart wt[a]	Liver wt[a]	Adrenal wt[a]	Thyroid wt[a]	Pituitary wt[a]	Kidney wt[a]
Oil control	15	368 ± 3	10.1 ± 0.7	227.5 ± 2.9	4814 ± 137	21.8 ± 0.9	5.2 ± 0.3	3.5 ± 0.2	597 ± 19
50	10	348 ± 9[b]	10.6 ± 0.6	229.5 ± 5.0	4223 ± 81[b]	25.8 ± 1.1[b]	6.1 ± 0.5	3.5 ± 0.2	594 ± 20
100	10	323 ± 9[c]	7.6 ± 0.9[b]	238.9 ± 5.9	3880 ± 55[c]	26.0 ± 1.3[b]	6.5 ± 0.3[b]	4.2 ± 0.5	645 ± 35
200	10	315 ± 8[c]	6.6 ± 1.2[c]	248.9 ± 5.5[b]	3802 ± 111[c]	31.8 ± 1.9[c]	7.7 ± 0.6[c]	3.9 ± 0.4	640 ± 41

[a] Mg/100 g body wt (mean ± SE).
[b] Difference from control group significant, $p < 0.05$.
[c] Difference from control group significant, $p < 0.01$.
[d] The four drug treatment groups did not differ significantly from each other in average body weight at the start of the experiment. The average weight of all the females on the first day of gestation was 276 ± 4 g (mean ± SE).

based on Salmonella bacteria has implied cancer inducing ability in many common hair dye preparations which are commonly available.[20] Studies may not be extensive enough to draw a conclusion, but at least one compound which was weakly carcinogenic by the bacteria test has illustrated no long term carcinogenicity when fed to rats and mice in a National Cancer Institute study. These bacterial tests also used some strains of Salmonella which are unable to repair genetic defects.[21] Since man has enzymes which can repair minor genetic damage, these tests may not be extrapolatable to man.[22]

In a conference concerning mutations induced by chemical agents, considerable doubt was expressed on the validity of correlating the magnitude of mutations or cancer causing ability from any known test to the human being.

At present, no mammalian test system which exists meets the toxicological requirements for routine testing of mutagenicity. Mutagenicity is not even considered by all toxicologists as a major hazard to man.[23] People with brown eyes are mutants of people with blue eyes; red heads are mutants of black haired people.

Human mutation rate may be influenced by exposure to natural and foreign compounds. If a compound induces a significant number of mutations in any given organism, it is usually declared to be a mutagenic, and is frequently regarded as a human health hazard. Unfortunately, positive or negative assay results do not correlate directly to the basic problem of determining the magnitude of influence on human beings.[24]

The state of the art in determining mutagenic or carcinogenic hazards to man of any compound does not seem to be sufficiently resolved for conclusions to be drawn. The chromosomes are important in transferring cellular data for the maintenance of life. Speculation has been raised concerning the action of marihuana on chromosomes.

One group observed an increase in the number of chromosome breaks in marihuana users over controls (3.1 breaks vs. 1.2 breaks per 100 cells). The chromosomes were observed during cell division. The number of breaks was considered significant, and could imply a degree of impairment in cell replication.[25]

Other studies have also indicated some degree of chromosome damage but the proper judgment in an area as complex as this will not readily be resolved except by observing people after long term marihuana use.

D. Possibilities of Organ Damage from Marihuana

In a study concerning immunosupression, a group of individuals used marihuana at least once a week for the previous year (average 3.4 times per week for 4.8 years). All were still smoking marihuana at the time of the study, but not taking prescribed medication. The values for complete blood counts, erythrocyte sedimentation, total serum protein and serum albumin levels were normal. All individuals in both control and subject groups had normal values for serum glutamic-oxaloacetic transaminase,

KQ6300. ETHYL ALCOHOL
CAS: 000064175 MW: 46.08 MOLFM: O-C2-H6
WLN: Q2
SYN: ABSOLUTE ETHANOL • ALCOHOL, ANHYDROUS • ALCOHOL DEHYDRATED • ALGRAIN • ANHYDROL • COLOGNE SPIRIT • ETHANOL • ETHANOL 200 PROOF • ETHYL ALCOHOL ANHYDROUS • ETHYL HYDRATE • ETHYL HYDROXIDE • FERMENTATION ALCOHOL • GRAIN ALCOHOL • JAYSOL S • METHYLCARBINOL • MOLASSES ALCOHOL • POTATO ALCOHOL • SPIRITS OF WINE • TECSOL •

alcohol

TXDS: orl-hmn LDLo:1400 mg/kg TFX:CNS	ATXKAB 17,183,58
orl-man TDLo:50 mg/kg TFX:GIT	JPETAB 56,117,36
ipr-rat LDLo:1225 mg/kg	TXAPA9 1,156,59
orl-mus LDLo:220 mg/kg	AEXPBL 135,118,28
scu-mus LDLo:4000 mg/kg	BJIMAG 1,207,44
ipr-dog LDLo:3000 mg/kg	BJIMAG 1,207,44
orl-cat LDLo:6000 mg/kg	JPETAB 56,117,36
orl-rbt LDL0:9500 mg/kg	JPETAB 56,117,36
ivn-rbt LDLo:5000 mg/kg	JPETAB 56,117,36
orl-gpg LD50:5560 mg/kg	JIHTAB 23,259,41
U.S. OCCUPATIONAL STANDARD USOS air:TWA 1000 ppm	FEREAC 37,22139,72

V007000. SALICYLIC ACID ACETATE
CAS: 000050782 MW: 168.08 MOLFM: O4-C9-H8
WLN: 1VOR BVQ
SYN: ACETICYL • ACETILUM ACIDULATUM • ACETOL • ACETOPHEN • ACETOSAL • ACETOSALIC ACID • ACETOSALIN • o-ACETOXYBENZOIC ACID • 2-ACETOXYBENZOIC ACID • ASA • ACETYLSAL • ACETYLSALICYLIC ACID • ACIDUM ACETYLSALICYLICUM • ACYLPYRIN • ASPIRIN • ASPIRINE • ASPRO • ASTERIC • EMPIRIN • A.S.A. EMPIRIN • HELICON • MEASURIN • RHODINE • SALACETIN • SALCETOGEN • SALETIN • XAXA •

aspirin

TXDS: orl-chd TDLo:81 mg/kg/16H TFX:PUL	JAMAAP 126,806,44
orl-rat LD50:558 mg/kg	TXAPA9 18,186,71
ipr-rat LDLo:420 mg/kg	TXAPA9 1,15,59
rec-rat LDLo:200 mg/kg	CJPPA3 44,909,66
orl-mus LD50:815 mg/kg	TXAPA9 23,537,72
ipr-mus LD50:495 mg/kg	AIPTAK 122,434,59
orl-dog LDLo:8400 mg/kg	TXAPA9 22,333,72
ivn-dog LD50:681 mg/kg	AIPTAK 149,571,64

XI73500. THIAMINE, MONOHYDROCHLORIDE
CAS: 000067038 MW: 337.30 MOLFM: N4-O-S-C12-H17 .Cl-H .Cl
WLN: T6N CNJ B DZ E1- AT5K CSJ D2Q E &GH &G &21/38
SYN: ANEURINE HYDROCHLORIDE • APATE DROPS • BEATINE • BEGIOLAN • BENERVA • BEQUIN • BERIN • BETABION HYDROCHLORIDE • BETALIN S • BETAXIN • BETHIAZINE • BEUION • BEVITEX • BEVITINE • BEWON • BIUNO • BIVATIN • BIVITA • CLOTIAMINA • ESKAPEN • ESKAPHEN • LIXA-BETA • METABOLIN • SLOWTEN • THD • THIADOXINE • THIAMIN HYDROCHLORIDE • THIAMINAL • THIAMINE CHLORIDE HYDROCHLORIDE • THIAMINE DICHLORIDE • THIAMINE HYDROCHLORIDE • THIAMINIUM CHLORIDE HYDROCHLORIDE • THIAMOL • THIAVIT • TIAMIDON • TIAMINAL • TROPHITE • VETALIN S • VINGTHIAM • VITAMIN B(sub 1) HYDROCHLORIDE • VITANEURON •

vit. B_1

TXDS: ivn-mus LD50:89.2 mg/kg	IZVIAK 37,82,67
ipr-rat LD50: 200 mg/kg	CURL** -,92,62

HP32250. 6H-DIBENZO(b,d)PYRAN-1-OL, 6a,7,8,10a-TETRAHYDRO-6,6,9-TRIMETHYL-3-PENTYL-
CAS: 001972083 MW: 314.51 MOLFM: O2-C21-H30
WLN: T B666 HO MU&TTJ CQ E5 I I M
SYN: CANNABINOL, 1-trans-delta(sup 9)-TETRAHYDRO- • (-)-delta(sup 9)-trans-TETRAHYDROCANNABINOL • delta(sup 1)-THC • delta(sup 9)-THC • 6,6,9-TRIMETHYL-3-PENTYL-7,8,9,10-TETRAHYDRO-6H-DIBENZO(b,d)PYRAN-1-OL •

Δ^9-THC

TXDS: orl-hmn TDLo:50 ug/kg TFX:PSY	SCIEAS 168,1159,70
ihl-hmn TDLo:24 ug/kg TFX:PSY	SCIEAS 168,1159,70
orl-rat LD50:666 mg/kg	PSEBAA 136,260,71
ipr-rat LD50:373 mg/kg	PSEBAA 136,260,71
ivn-rat LD50:29 mg/kg	PSEBAA 136,260,71
orl-mus LD50:482 mg/kg	PSEBAA 136,260,71
ipr-mus LD50:168 mg/kg	AIPTAK 196,133,72
ivn-mus LD50:42 mg/kg	PSEBAA 136,260,71

HP84000. 6H-DIBENZO(b,d)PYRAN-1-OL, 6a,7,10,10a-TETRAHYDRO-6,6,9-TRIMETHYL-3-PENTYL-
MW: 314.51 MOLFM: O2-C21-H30
WLN: T B666 H) LU&TTJ CQ E5 I I M
SYN: CANNABINOL, 1-trans-delta(sup 8)-TETRAHYDRO- • (-)-delta(sup 8)-trans-TETRAHYDROCANNABINOL • delta(sup 1(6))-THC • delta(sup 6)-THC • delta(sup 8)-THC •

Δ^8-THC

TXDS: orl-rat LD50:1420 mg/kg	TXAPA9 22,321,72
ipr-rat LD50:560 mg/kg	AIPTAK 196,133,72
ivn-rat LD50:97 mg/kg	AIPTAK 196,133,72
orl-mus LD50:1500 mg/kg	AIPTAK 172,-,68
ipr-mus LD50:210 mg/kg	AIPTAK 196,133,72

GS2500. NICOTINE
CAS: 000054115 MW: 162.26 MOLFM: N2-C10-H14
WLN: T6NJ C- B15NTJ A
SYN: BLACK LEAF • 1-METHYL-2-(3-PYRIDYL)PYRROLIDINE • L-3-(1-METHYL-2-PYRROLIDYL)PYRIDINE • (-)-3-(1-METHYL-2-PYRROLIDYL)PYRIDINE • PYRIDINE, 3-(1-METHYL-2-PYRROLIDINYL)- • PYRIDINE, 3-(TETRAHYDRO-1-METHYLPYRROL-2-YL) • beta-PYRIDYL-alpha-N-METHYLPYRROLIDINE • PYRROLIDINE, 1-METHYL-2-(3-PYRIDAL)- •

TXDS: orl-hmn LDLo:1 mg/kg	AFDOAQ 13,65,49
orl-rat LD50:70 mg/kg	WRPCA2 9,119,70
orl-mus LDLo:24 mg/kg	APEPA2 188,605,38
scu-mus LDLo:16 mg/kg	APEPA2 188,605,38
ivn-mus LD50:7.1 mg/kg	JPETAB 95,506,49
orl-dog LD50:9200 ug/kg	PSEBAA 29,1177,32
ivn-dog LD50:5 mg/kg	JPETAB 95,506,49
ivn-cat LD50:2 mg/kg	JPETAB 95,506,49
skn-rat LD50:140 mg/kg	WRPCA2 9,119,70
ivn-cat LD50:2 mg/kg	JPETAB 95,506,49
skn-rbt LD50:50 mg/kg	AFDOAQ 16,3,52
ivn-rbt LD50:9400 ug/kg	JPETAB 95,506,49
scu-gpg LDLo:15 mg/kg	JPETAB 48,95,33
orl-pgn LD50:75 mg/kg	TXAPA9 21,315,72
orl-dck LD50:75 mg/kg	TXAPA9 21,315,72
U.S. OCCUPATIONAL STANDARD USOS- air:TWA 500 ug/m3(skin)	FEREAC 37,22139,72

EV64750. CAFFEINE
CAS: 000058082 MW: 194.22 MOLFM: N4-O2-C8-H10
WLN: T56 BN DN FNVNVJ B F H
SYN: CAFFEIN • GUARANINE • METHYLTHEOBROMIDE • NO-DOZ • THEIN • THEINE • THEOBROMINE, 1-METHYL- • THEOPHYLLINE, 7-METHYL • 1,3,7-TRIMETHYL-2,6-DIOXOPURINE • 1,3,7-TRIMETHYLXANTHINE • XANTHINE, 1,3,7-TRIMETHYL •

TXDS: orl-hmn LDLo:192 mg/kg	JNDRAK 5,252,65
orl-rat LD50: 192 mg/kg	JNDRAK 5,252,65
orl-rat TDLo:1650 mg/kg/(2-15D preg) TFX:TER	CRSSAF 164,1488,70
ipr-rat LDLo:280 mg/kg	TXAPA9 1,156,59
scu-rat LDLo:250 mg/kg	APEPA2 187,607,37
orl-mus LD50:620 mg/kg	JPETAB 131,115,61
orl-mus TDLo:650 mg/kg/(6-18D preg) TFX:TER	CRSSAF 159,2199,65
ipr-mus TDLo:200 mg/kg/(12D preg) TFX:TER	JJPAAZ 19,134,69
ipr-mus TDLo:200 mg/kg/(12D preg) TFX:TER	JJPAAZ 19,134,69
scu-mus TDLo:200 mg/kg/preg TFX:TER	JJPAAZ 19,134,69
scu-mus LDLo:180 mg/kg	APEPA2 166,437,32
ivn-mus LD50:68 mg/kg	TXAPA9 23,537,72
orl-rat TDLo:1500 mg/kg/(1-15D preg) TFX:TER	CRSSAF 164,1488,70
par-frg LDLo:120 mg/kg	APEPA2 166,437,32
unk-frg LDLo:4 mg/kg	TPMDAB 12,-,1691

Most of these materials are common components in everyday living. They are listed for the purpose of comparison with the two isomeric tetrahydrocannabinols (left). The term LD_{50} is the amount of the material required to kill half the animals in the test. The letters Lo indicate the lowest dose which may have been responsible for death.

alkaline phosphates and bilirubin, and were negative on testing for hepatitis B antigen. The normal liver function tests reasonably excluded the possibility of subclinical hepatitis, a condition known to depress cell-mediated responses and indirectly confirmed that the subjects were not using other drugs, or at least those that cause abnormal liver enzyme levels.[27]

In a study commissioned by the United States Department of Health, Education and Welfare and carried out in Jamaica, the results seem to obviate many common beliefs concerning the deleterious effects of marihuana. The smokers had used marihuana for a mean of 17.5 years. Abnormalities found in chromosome studies of peripheral blood cultures were slightly more frequent in nonsmoker controls. Chromatid breaks and gaps were seen in 2.36 percent of cells of marihuana smokers and in 2.90 percent of cells of controls, not statistically different. No abnormal configurations, exchanges or dicentrics were seen. There were minor heart abnormalities in 30 percent of both groups, as determined by ECG. Perhaps this indicated the prevalence of a cardiomyopathy that has been recognized in Jamaica, possibly attributable to an obliterative disease of the small coronary vessels, often associated with heavy tobacco consumption.

Hematologic studies revealed eosinophilia in eleven subjects, seven nonsmokers and four smokers, not statistically different. No significant differences were found in other hematologic tests, with the exception of hemoglobin and monocyte count values. While there were twice as many nonsmokers as

smokers in the low hemoglobin range, there were more smokers (six) in the high hemoglobin range, but only one nonsmoker was in this group. Twice as many smokers as nonsmokers had low monocyte values and twice as many smokers fell into the high category.

Elevation of the liver enzymes, serum glutamic oxalacetic transaminase and serum glutamic pyruvic transaminase was found in seven subjects, in three nonsmokers and four smokers, but this did not indicate significant liver damage.

Respiratory function was somewhat less efficient in subjects involved in heavy smoking, whether marihuana or cigarettes. Arterial blood oxygen, carbon dioxide, pH, and pulse rate appeared the same in both groups. Smokers had a higher level of bicarbonate immediately after exercise than nonsmokers.

Measurement of urinary steroids indicated no significant alteration in adrenal cortical function in smokers. No differences were found in cortisol secretion, total thyroxine and free thyroxine in either group.[28]

In a study for the treatment of insomniacs with Δ^9-THC, the authors used doses of ten, twenty and thirty mg of THC with each subject, without any untoward patient reaction. These levels would correspond to the usual social dose. The authors had the following comments, based on their observations and previous data. Physiological changes produced by Δ^9-THC are an increase in pulse and an occasional transitory lowering of blood pressure which has led some clinical investigators to consider it as a potential hypotensive agent. Other cardiac or respiratory effects have not been noted. No alterations of glucose, lipid or catecholamine

metabolism have been noted.[29]

The possibility of brain damage has been expressed with experiments involving rhesus monkeys by measurement of brain wave alterations.[30] The dose levels were excessive and may not be extrapolatable to man.

In the Jamaican study, brain wave measurements were obtained for all sixty subjects. No significant difference appeared between the two groups in definite abnormalities or equivocal cases. Further, most of the findings considered definitely abnormal or equivocal were focal in nature, unlikely to have been caused by any medication or drug effect. There was no evidence to suggest brain damage due to marihuana.[31]

E. Possible Mood Alterations from Marihuana

Subjects employing a selfcontrolled dose of marihuana and placebo controls were examined for marihuana induced anxiety. Stress was induced by having the subjects watch a film depicting dental procedures and deliver talks on various topics. The authors concluded that no significant differences existed with users and placebos.[32]

In the Jamaican study of long term marihuana use (mean 17.5 years), a psychiatric examination of subjects and controls was made without significant abnormalities emerging from mental status examinations. Only one subject, a nonsmoker, showed up as significantly depressed on the Hamilton Rating Scale. No score on either the Schizophrenic Rating Scale or the Wing Rating Scale

was indicative of any disorder. Work records were examined for evidence of "amotivational syndrome" and no differences were found between smokers and nonsmokers.[33]

In a different study, other authors stated that temporary problems such as temporal disintegration, depersonalization and psychotic-like phenomena occurred only at high doses. Within the usual dose range, open psychotic breaks, or severe extended reactions have not been reported. The authors employed doses similar to normal social doses; ten, twenty and thirty mg per subject.[34]

A clinical study was conducted with ten casual and ten heavy marihuana users in a closed hospital ward. During the period of smoking, the casual users smoked a mean of 3.28 marihuana cigarettes daily and the heavy users had a mean of 6.4 marihuana cigarettes daily containing 1.8 to 2.3 percent Δ^9-THC. The MMPI scores for subjects in both groups, administered on a pre-and post-smoking basis showed impressive shifts for several subjects in the direction of normalcy or in the direction of sickness. The mean scores for both groups of subjects fell generally within normal limits and showed no change after the test. Four casual users and three heavy users shifted from healthier to less healthy positions and four heavy users shifted to more healthy positions. There was some suggested evidence of tolerance. In preclinical tests, more heavy users than light users felt that life was worthwhile.[35]

Studies involving hostility in group settings have also been conducted. The authors found that total hostility was significantly decreased following the group session in which subjects

had been intoxicated. There was no difference between casual and chronic users. Subjects when intoxicated with marihuana were seen by their colleagues as consistently more friendly, receptive, understanding and cooperative. There was also an impression that intoxicated subjects were less irritable, disagreeable, openly antagonistic, angry or annoyed. Overall hostility did not seem changed. On the basis of these findings, the investigators felt little tendency towards increased hostility, but possibly a shift in the verbal mode of its expression.[36]

Some psychotic reactions were seen in an experiment to investigate tolerance among marihuana smokers. The smokers used marihuana cigarettes twice daily containing 435 mg of marihuana with a THC content of 2.8 percent (12.2 mg THC per joint).[37] In view of the low dose level, the nature of this behavior would seem surprising.

Another study was performed in an Indian drug addiction clinic. It was noted that the potency of the cannabis preparations, as well as the age of the subject had some bearing on the transient toxic psychosis. Of the subjects, 55 percent had a previous history of psychological disturbance. There was no direct association of the cannabis use and criminal activity.[33]

F. Immunosuppression

The question as to whether or not marihuana has a significant action on the immunity of the user has not been satisfactoril resolved.

Work by Nahas, et al. indicates that in vitro uptake of [^{3}H] thymide is reduced in marihuana users. This data was obtained by isolating lymphocytes from venous blood and measuring radioactive decay. The data results are listed below.[39]

Comparative cellular mediated immunity of normal subjects, marihuana smokers, and patients with impairment of T cell immunity. The in vitro blastogenic response of lymphocytes was studied by the MLC and the PHA tests. The incorporation rate of [^{3}H]thymidine of the T lymphocytes is given in counts per minute ± the standard error.

Subjects	MLC		PHA	
	No. tested	[^{3}H]Thymidine incorporated (count/min)	No. tested	[^{3}H]Thymidine incorporated (count/min)
Normal controls	81	26400 ± 200	81	23250 ± 210
Cancer patients				
Primary tumors	16	14894 ± 792	16	17501 ± 124
Regional spread	23	15816 ± 420	23	13345 ± 540
Distant spread	21	8968 ± 459	21	10516 ± 580
Uremic patients	26	12001 ± 272		
Transplant patients*	24	12307 ± 357		
Marihuana smokers†	34	15679 ± 499	51	13779 ± 169

* After 1 to 4 years of immunosuppressive therapy. † At least 1 year, at least once a week; no other drug taken.

Since thymidine is involved in the synthesis of DNA, the consequences of this action should be carefully examined. Nahas's experiments also indicate that caffeine will impair the incorporation of thymidine in lymphocyte cultures in vitro; caffeine is also a commonly ingested component of coffee and tea.[40]

The action of Δ^9-THC on the cellular composition of rat bone marrow was examined. The Δ^9-THC apparently accelerated the lymphocyte formation by a factor of three. Modifications of the experimental procedure led the authors to conclude that a THC metabolite, 11-hydroxy-Δ^9-THC, was responsible for the enhanced

lymphocyte formation. The doses of Δ^9-THC used in the experiment were claimed by the authors to exceed the listed intravenous LD_{50} (a dose level which should kill half the experimental animals), but no animals dies.[41]

A group of twelve individuals, ages ranging from nineteen to thirty-two years, who had smoked marihuana at least once per week for the previous year (average 3.4 times a week for 4.8 years) was studied. All had smoked marihuana at least once during the preceding forty-eight hours. Lymphocyte suspensions were prepared from fresh blood samples and incubated with [^{3}H] thymidine in vitro. No significant difference was noticed in the [^{3}H] thymidine incorporation between the marihuana smokers and controls or in mitogen responses.[42] This data is summarized below.

Mitogen-induced blastogenic responses of lymphocytes from marihuana smokers and matched control subjects; S.D., standard deviation.

Experiment	Radioactivity (dpm) per culture	
	Smokers	Controls
Phytohemagglutinin		
1	216,418	197,306
2	163,746	167,027
3	208,781	181,150
4	155,362	163,708
5	186,119	191,547
6	128,834	125,983
7	158,440	129,687
8	202,630	202,241
9	245,436	184,572
10	221,013	141,866
11	90,166	161,611
12	168,784	147,758
Mean ± S.D.	178,811 (43,486)	166,205 (25,903)
Pokeweed		
1	141,448	100,540
2	163,225	153,372
3	99,984	110,029
4	94,467	120,627
5	167,983	150,436
6	107,180	173,707
7	75,893	99,772
8	126,051	90,498
9	76,932	86,072
10	86,691	107,214
11	90,587	101,932
12	115,015	106,852
Mean ± S.D.	112,121 (31,535)	116,754 (27,585)

These authors findings differ completely from Nahas, et al. Since the Δ^9-THC plasma levels decrease rapidly after smoking, it may be that impaired lymphocyte responses can be observed only shortly after smoking. The duration of marihuana use by the subjects in this study would imply no detrimental action on immune response.

In view of the complex process by which DNA is formed in vivo, it may be premature to imply that just the reduction of thymidine uptake would impair DNA production. It is also recognized that DNA may be repaired and synthesized by the enzyme DNA ligase, from short segments of polynucleotides. DNA prepared by this mechanism can be used for the production of chromosomes.[43] Implications of possible chromosome damage by marihuana components will be discussed in another section of this report.

In human volunteer studies, marihuana smokers and controls were sensitized with 2,4-dinitrochlorobenzene (DNCB) and four common antigens. Their data for DNCB testing is summarized below.[44]

2,4-Dinitrochlorobenzene reactivity.

Groups	Subjects (No.)	DNCB-positive		DNCB-negative	
		Number	Percent	Number	Percent
Marijuana smokers	22	22	100	0	0
Normal controls*	279	267	96	12	4
Cancer patients (all ages)*	548	384	70	164	30
Cancer patients (ages 21 to 30)†	60	48	80	12	20

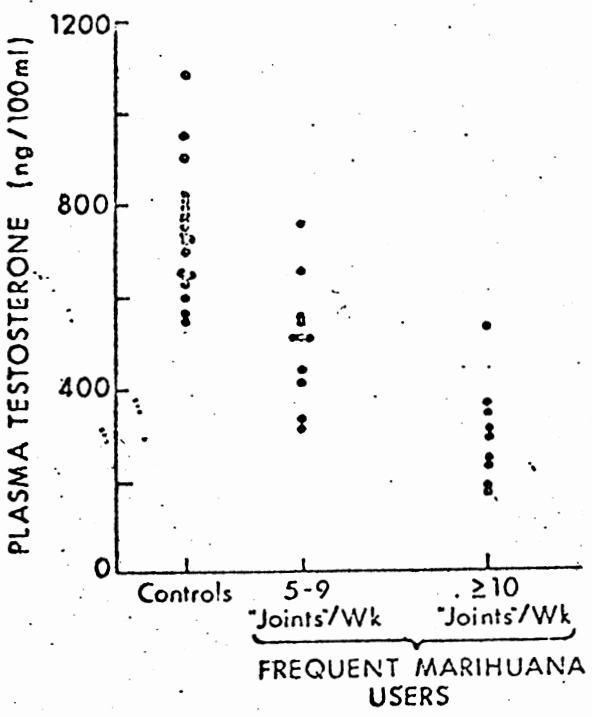
† Concurrent controls.

These in vivo studies also indicated that of the twenty-two marihuana smokers, seventeen responded to two or more of the four antigens. Two smokers showed no response to any antigen, which the authors attributed to a lack of exposure by these subjects to these diseases. These authors had no clinical or epidemiological evidence to suggest that marihuana users might be more prone to the development of neoplastic or infectious processes. The dose of marihuana was uncontrolled by the experimenters, and ranged from three times per week to several times a day.

G. The Action of Marihuana on Sexual Activity

Significantly, more marihuana users report having sexual intercourse than non-users. The incidence of sexual activity correlates linearly with the extent of marihuana use.[45] Many people consider marihuana as an aphrodisiac.[46]

In a clinical study, male human volunteers (n=20) and controls (n=20) were evaluated in regard to the measurement of various plasma hormone levels gross physical examination. The marihuana users had smoked a mean of 9.4 (SD 3.6) marihuana cigarettes a week for the previous six months. There was no mention of marihuana quality control. Anatomical examinations led the authors to believe that the marihuana users were essentially indistinguishable from the non-users.



Plasma Testosterone Levels in Men Not Using and Those Frequently Using Marihuana.

Plasma testosterone levels were decreased in marihuana users in a dose related manner. With the heaviest marihuana users, (more than ten joints a week), a mean decrease in follicle-stimulating hormone levels was found. This hormone promotes testicular growth and spermatogenesis in the male. Semen sperm count was dependent on the extent of marihuana use, with smokers of five to nine marihuana cigarettes a week having 67.9 (SD 6.3) million/ml; and those using more than ten joints a week producing 26.6 (SD 7.3) million/ml. Testosterone levels increased 57 percent to 147 percent one week after cessation of smoking.

Sexual function of all but two of the marihuana users was unimpaired, but those two had possible previous functional problems.

The authors strongly recommend that marihuana not be smoked during the period of pregnancy, since it may alter hormone levels of the fetus.[47]

A second report has been issued which found no plasma testosterone level depression in cannabis users in controlled conditions.[48] These authors questioned the lack of control of other drugs (i.e., such as tranquilizers or street drugs) in the Kolodny study (above).

Another study found a reduction in mature sperm from mice that inhaled cannabis smoke from 300 joints over three months.[49]

The role of sex hormones in behavior is still the subject of considerable debate. In many species, large doses of testosterone in castrate females initiates female mating behavior, and large doses of estrogens in castrate males will stimulate male mating behavior.[50]

In a study of homosexuality, no difference was found between the testosterone levels of controls (536 ng/100 ml) and homosexuals (537 ng/100 ml). The Kinsey rating of homosexuality failed to correlate with absolute testosterone or estradiol plasma levels. This implies that typical "male" actions are not readily predicted by plasma hormone level, but require some other factors, including social conditioning.[51] The physiological basis for sexual motivation is still the subject of considerable interest.

H. Driving Performance

Most authors consider that marihuana, like alcohol, has an impairing action on the driving of a motor vehicle. In a simulated tracking experiment, it was found that the use of marihuana had a detrimental action on the ability to follow a track pattern intended to duplicate driving conditions. The marihuana was administered in brownies to subjects with an empty stomach to facilitate absorption.[52]

In another study, it was observed that the use of marihuana had a detrimental effect on driving skills and performance in a restricted driving area, and that this effect is even greater under normal conditions of driving on city streets. The effect of marihuana on driving is not uniform for all subjects, however, but is bidirectional. The question of whether or not a significant decline occurs in driving ability is dependent on the subject's capacity to compensate and on the dose of marihuana. With those subjects who improved their performance, the authors felt the explanation may lie in overcompensation and possibly a sedative effect of the drug.[53]

The Commission feels that driving a motor vehicle while impaired by or under the influence of marihuana should be dealt with in the same manner as driving while impaired by or under the influence of alcohol.

I. Anticonvulsant Activities

Tetrahydrocannabinol (THC) derivatives have an action which may be of value in the treatment of tremor disorders. Certain isomers of THC have demonstrated the ability to eliminate the convulsions produced by maximal electroshock.[54] This action may also ultimately be of value for the treatment of epilepsy. The Δ^9-THC isomer has a demonstrated ability in reducing the susceptibility of mice to audiogenic seizure.[55] This action is not shared by LSD, amphetamine, cocaine, mescaline or morphine.[56] Nitrogen structural modifications of THC have also illustrated anticonvulsant activity.[57] These actions are not shared by a commonly used tranquilizer, chloropromazine.[58]

J. Potential Areas of General Medical Interest

If the cannabinoids have the capacity to suppress the body's immune response mechanism, potential application may exist for use in transplant operations for curtailing rejections commonly found in these operations.

Marihuana derivatives may eventually have an application in the treatment of cancer. Δ^9-THC retarded the growth of lung cancers, breast cancers and virus induced leukemia in mice and prolonged the lives of test animals by as much as 50 percent.

Folklore has implied that marihuana may be of value as a sedative and anti-tension compound. Cannabis derivatives have

been examined for use as analgesics. These materials would appear to have advantages over the morphine based materials for this purpose due to lower toxicity, less tendency to produce respiratory depression, and no physical dependence problem.

The tetrahydrocannabinols may be of value in the treatment of morphine addiction. A single administration of THC produced a dose related blockade of naloxone induced abstinence signs in morphine dependent rats. THC did not appear to be a morphine antagonist. Cannabidiol did not appear to modify abstinence.

K. Conclusion

It has not been demonstrated that the moderate use of marihuana will impair an individual's health, but some users may have an adverse reaction to marihuana which would not appear typical to the average marihuana smoker.

It is difficult to predict the long term health trends with marihuana, although the Jamaican study appears to imply that no severe problems occur from the long term use of marihuana. Unfortunately, letters to the United Nations for similar data on a broader basis did not yield any additional information.

Liver, brain and chromosome damage does not appear pronounced with extended marihuana use, although controversy still exists. The typical American marihuana user smokes a substance purchased on a clandestine basis with no aspect of quality control; and this factor may contribute to the confusion in studies involving

the indigenous marihuana user. Increased susceptibility to infections does not seem to be a difficulty, but some experiments imply that this may occur; other experiments dispel the action of marihuana on susceptibility.

Marihuana does not appear detrimental in the sexual functioning of most people. Speculation exists that in pregnant women, marihuana smoking may affect the hormone balance in the developing fetus. Data does not indicate any increased incidence of birth defects. There are some indications that fertility may be lowered for a period, but sperm levels in users remained above the limits required for fertility.

Driving under the influence of marihuana or any controlled dangerous substance generally will be detrimental to required judgment, and should be discouraged (see Chapter VI of this report).

Marihuana does not appear to be addicting, and cessation of its use presents no major withdrawal problem. The phrse psychological addiction has been employed occasionally, but any pleasurable action may be psychologically addicting (e.g., a fine wine, sex, a good book).

Data concerning marihuana will probably remain somewhat confused, but it appears that most people can employ marihuana in moderation with little hazard, if any, to their health.

Conclusion and Recommendations

An update of the marihuana problem since the issuance of

the Commission's first report in October, 1974, has failed to uncover any new, overwhelmingly, detrimental medical and scientific conclusions regarding the effects of marihuana use on the user. The Commission feels strongly that since the initial underlying reasons for the marihuana prohibition laws in this country were unscientifically arrived at, and were the obvious results of national, if not personal, prejudices, the burden of proof rests with those persons who favor the continued criminal prohibition on marihuana use to show that marihuana use is physically and/or psychologically harmful to the user and society in general.

The Commission feels that the trend in this country is towards accepting the fact that a medical and scientific debate should no longer frustrate the decriminalization of marihuana. If, and when, conclusive and damaging medical and scientific evidence is found regarding marihuana use, the Commission will reevaluate its position. But rather than frustrate decriminalization any longer, the Commission continues to recommend the decriminalization proposals presented in Chapter II of its first report (see Appendix C to Chapter I of this report) and endorses both Senate Bill Number 1461 and Assembly Bill Number 2313--identical bills which will implement the Commission's recommendations for the decriminalization of marihuana.

FOOTNOTES

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CHAPTER III

A REVISION OF THE SCHEDULE OF PENALTIES AND OFFENSES FOR THE ILLEGAL POSSESSION AND THE ILLEGAL MANUFACTURING, DISTRIBUTING AND DISPENSING OF CONTROLLED DANGEROUS SUBSTANCES (P.L. 1970, c. 226, §§ 19 and 20; C. 24:21-19 and 20).

Introduction

As part of the "Drug Study Commission's" ongoing study of the impact of stricter drug laws upon the criminal justice system and the illicit drug system in New Jersey, the Commission has evaluated section 19 of P.L. 1970, c. 226 (C. 24:21-19), regarding the illegal manufacturing, distributing, or dispensing of controlled dangerous substances,* and section 20 of P.L. 1970, c. 226 (C. 24:21-20), regarding the illegal possession, use or being under the influence of controlled dangerous substances, in terms of their effectiveness and equity in stemming the drug abuse problem and dealing with drug offenses in New Jersey. Table I below outlines the provisions of sections 19 and 20 of P.L. 1970, c. 226 (C. 24:21-19 and 20).

An analysis of section 20b. of P.L. 1970, c. 226 (C. 24:21-20b.)--concerning the illegal use or being under the influence of any controlled dangerous substance--is presented in Chapter 4 of this report. Marihuana has been excluded from this study and any reference to controlled dangerous substances in this chapter excludes marihuana, which has been dealt with in Chapter 2 of the Commission's "First Report To The Legislature" and again in Chapter 2 of this report.

*See Appendix A to this chapter for a list of Schedules.

TABLE I

Existing Schedule of Penalties and Offenses for the Illegal Possession and the Illegal Manufacturing, Distribution, and Dispensing of Controlled Dangerous Substances * (Sections 19 and 20 of P.L. 1970, c. 226 [C. 24:21-19 and 20])

	Schedule V	Schedule I, II, III, IV	Schedule I & II Narcotics. Less than 1 oz. of which 3.5 grams is pure narcotic	Schedule I & II Narcotics, 1 oz. or more of which 3.5 gram is pur narcotic
Sentence (not more than ...)	1 Yr.	5 Yrs.	12 Yrs.	Life
UNLAWFUL SALE AND INTENT				
Fine (not more than ...)	$5,000	$15,000	$25,000	$25,000
Sentence (not more than ...)	1 Yr.	5 Yrs.	5 Yrs.	7 Yrs.
UNLAWFUL POSSESSION				
Fine (not more than ...)	$5,000	$15,000	$15,000	$15,000
Sentence (not more than ...)	6 Mths.	6 Mths.	6 Mths.	6 Mths.
UNLAWFUL USE OR UNDER INFLUENCE	Forfeit Drivers License	Forfeit Drivers License	Forfeit Drivers License	Forfeit Driver License
Fine (not more than ...)	$500	$500	$500	$500

*Marihuana excluded

Specifically, the Commission wanted to know (1) if the present statutes are a suitable deterrent to drug offenses or if a more punitive law, such as the New York Drug Law, enacted September 1, 1973,[1] and also referred to as the Rockefeller Drug Act, is needed; (2) if all or any of the controlled dangerous substances should be quantified in determining appropriate sentencing; (3) if the nature of the offense should be broken down even further than that which is presently legislated in terms of the moral culpability of the offender and an appropriate sentence; and (4) what is an effective means to lessen the sentence disparity concerning controlled dangerous substances offenses--within and between counties. These objectives were researched in terms of their feasibility, equity, deterrent effects and their relevance in dealing with the complexity of the drug system. Special consideration was given to how these approaches would interface with a diversionary program for persons who were diagnosed as drug dependent, the need for which was demonstrated in Chapter 3 of the "First Report To The Legislature." (See Appendix C to Chapter I of this report.)

Stringent Drug Laws

The best example of a stringent drug law presently in effect in this country is the Rockefeller Drug Act. This act is controversial for its harshness, its provisions of minimum mandatory sentences for most drug offenses, and its restrictions on plea bargaining. In Chapter IV of the Commission's first report, the Commission dealt with the impact of stricter drug laws upon the

criminal justice system and the illicit drug system in New York and New Jersey.

The Commission concluded that:

1. The amount of resources, in terms of money as well as manpower, to implement and enforce the Rockefeller Drug Act in New York, is a high price to pay.

2. The severity of the penalties has not, as predicted, driven drug addicts into rehabilitation facilities.

3. While the Rockefeller Drug Act mandates harsh penalties and attempts to restrict plea bargaining, this experiment now appears to be anything but successful as the dynamics of the prosceutorial and court systems have again grabbed the initiative on how a law will be enforced. In doing so, of course, they have reduced some of the law's effect, while making the law somewhat more humane and workable. The Commission believes there are certain indications that the Act will probably be amended so as to be more viable.

4. Due to changing drug use patterns, success rates under the old New York Drug laws, and drug programs which have been credited with a decline in heroin use and arrests for drug crimes in New York City since 1971, it is difficult to measure claims of the deterrent effect the Rockefeller Drug Act has had in its short life.

5. Narcotics and other dangerous drugs remain as available in New York City as before the enactment of the Rockefeller Drug Act.

6. The Rockefeller Drug Act has not had an impact on the use, availability and trafficking in drugs in New Jersey; at least it

is still too early to determine or to draw any definite conclusions.

7. Indications are that the additional fiscal expenditures necessary for the implementation of a Rockefeller Drug Act in New Jersey are tremendous.

8. The "New Jersey Controlled Dangerous Substances Act"--unlike the Rockefeller Drug Act--allows the court to determine the extent of an individual's involvement with drugs and evaluate the extenuating circumstances of the case so as to mete out a sentence beneficial to the rehabilitation of the defendant and to the protection of society.

9. Various studies reveal that in spite of the severity of penalties, drug addicts risk the threat of detection due to physical or psychological dependence, and that drug dealers continue to dispense narcotics due to the enormous pecuniary gains.

"Get tough" drug laws are not new, however. New Jersey law contained minimum mandatory sentences after 1951 in its Uniform Narcotic Drug Law (R.S. 24:18-1 to 24:18-49), which was repealed in 1970 by the "New Jersey Controlled Dangerous Substances Act" (P.L. 1970, c. 226; C. 24:21-1 et seq.). The Federal Government imposed stiff minimum mandatory sentences and even the death penalty for certain drug offenses between 1951 and 1970. The law was greatly criticized; even the Federal Bureau of Prisons called it "cumbersome and ineffective" in controlling drug abuse. And its repeal was met with widespread support. The present federal drug statutes mandate up to one year imprisonment for the simple possession of any controlled dangerous substances and up to fifteen years for the sale of and intent

to sell narcotics listed in Schedules I and II of the Federal "Controlled Substances Act" (Public Law 91-513, 91st. Congress; 84 Stat. 1236 et seq.). This is more lenient than New Jersey's present drug laws.

Mandatory minimums are usually enacted because they are seen as a deterrent to other possible drug offenders. The validity of this assumption, however, is questionable. The imposition of mandatory minimums in the previous federal statutes and New Jersey statutes had no observed deterrent effect. As the analysis of the Rockefeller Drug Act in the Commission's first report revealed, there has been no substantial effect on drug trafficking in New Jersey because of the act. Contrary to what was expected, evidence shows that drug traffickers have not moved in large scale to New Jersey to escape New York's drug law. In a survey of thirteen county prosecutors which asked if the New York Drug Law has had any substantial effect on drug trafficking in New Jersey, nine prosecutors reported that it has not, four prosecutors believe that they do not have enough information to comment, and two prosecutors reported a possibility exists that some of the New York drug traffic has moved to New Jersey.[2] At meetings held with New Jersey county prosecutors, their assistants, and narcotic enforcement officers from counties nearest to the New York City area, there were no reports of drug traffickers coming to New Jersey in any great number from New York. The New Jersey Narcotics Enforcement Association and various municipal, state, and federal officials have all said that the New York Drug Law has had no substantial effect on the drug problem in New Jersey.

The constitutionality of the Rockefeller Drug Act has also been questioned. Several New York State Appellate Division Courts ruled that certain parts of the law are unconstitutional, and the constitutionality of the law was tested before the New York State Court of Appeals. It was argued that stiff minimum mandatory sentences and restrictions on plea bargaining violate the equal protection clause of the Fourteenth Amendment to the United States Constitution, the prohibition against cruel and unusual punishment, and guarantees of due process. On June 18, 1975, the court of appeals affirmed the constitutionality of mandatory life sentences for persons convicted of felony violations of the state's drug laws. The court did not pass on the wisdom of the law, however, stating instead that "only time will tell whether the course pursued will prove effective or will fail as every similar effort---has failed."

Quantification

While the "Drug Study Commission" has rejected the Rockefeller Drug Act as a too stringent and inflexible approach to dealing with the drug problem in New Jersey, it was interested in evaluating the quantification process utilized in the Rockefeller Drug Act as a possible means to achieve an equitable and effective schedule of offenses and penalties for Schedule I and II narcotics violations.

The amount of a substance can be determined either by its aggregate weight or its pure weight. Strict quantification is the weighing only of the pure substance that is in a mixture. For example, a street ounce of heroin in aggregate form (i.e., cut with

other additives such as quinine) might be five percent pure which would mean the pure heroin would weigh only 1/20th. of an ounce. Most controlled dangerous substances are cut with other additives and dilutants. New York's is the only drug law which considers the purity of most of the controlled dangerous substances although for some drugs, such as heroin and methamphetamine, it considers only the aggregate weight. The only other states which consider the aggregate weights of controlled dangerous substances are Vermont, Illinois, Hawaii, and Connecticut--and they only do so for a few high priority drugs. The Commission feels, however, that if the amount of a drug is going to be used in sentencing a defendant, the purity of the drug rather than its aggregate weight should be used because of the tremendous variability in purity of drugs even within the same schedule.

The advantage of quantification is that it provides for a fairly simple criterion in determining the severity of the offense and appropriate sentence. It might also reduce some of the sentence disparity for drug offenses.

The disadvantage is that the quantification of most controlled dangerous substances would be too costly. It has been estimated by personnel in the New Jersey State Police Laboratory that in order to implement the quantification process for most controlled dangerous substances in New Jersey it would cost approximately $500,000. the first year for equipment, additional staff, and computerization. Although quantification is a simple way of determining sentencing, it is also very rigid. A fraction of an ounce in either direction could mean the difference between life imprisonment and a shorter sentence. Some county prosecutors

have also said that quantification would unnecessarily tie their hands. For example, in many cases other circumstances might be more important than the amount of the drug, such as the person's criminal and employment history as well as his potential for rehabilitation.

Chapter 31 of the Laws of 1975--introduced as Senate Bill Number 850 and enacted into law on March 7, 1975--amended sections 19 and 20 of P.L. 1970, c. 226 (C. 24:21-19 and 20) and introduced quantification into the "New Jersey Controlled Dangerous Substances Act" for the first time. Section 19 now provides for a sentence of up to life imprisonment for the unlawful sale of one ounce or more of a narcotic in Schedules I and II in aggregate form of which 3.5 grams is pure narcotic, and a maximum of twelve years for less than that amount. Section 20 provides that for the unlawful possession of a Schedule I and II narcotic the maximum sentence is up to seven years imprisonment for an ounce or more of a narcotic in aggregate form of which 3.5 grams is a pure narcotic, and a maximum of five years for less than that amount.

While the Commission rejects the quantification approach for other controlled dangerous substance offenses, it finds merit in quantifying Schedules I and II narcotics for the aforementioned offenses. Quantifying only these narcotics will not be as costyly as quantifying other controlled dangerous substances. And because Schedule I and II narcotics are the greatest threat to society as compared to other controlled dangerous substances, the rigidity of quantification can be justified as a greater safeguard for the public. There is also new evidence that heroin use is

once again on the increase in this country and strong measures may be necessary to discourage its use. Furthermore, because of the severity of the sentence for Schedule I and II narcotic offense, i.e., up to life imprisonment for the unlawful sale, it is important to have a quantity threshold to delineate this sentence from a less severe sentence.

There are, however, several technical deficiencies in Chapter 31 which the Commission believes must be rectified. These are:

1. Whereas the marihuana provision of the Controlled Dangerous Substances Act (section 20a. [3] of P.L. 1970, c. 226 [C. 24:21-20a. (3)]) uses grams, the proposed weight threshold in Chapter 31 refers to ounces.

2. There are two kinds of ounces: the avoirdupois (A.V.D.P.) ounce, which equals 28.3 grams; and the troy ounce, which equals 31.1 grams. Chapter 31 of the Laws of 1975 does not define which kind of ounce is referred to.

3. 3.5 grams of a pure Schedule I and II narcotic appears to be too high of an amount in determining a threshold. One aggregate ounce of heroin which contains 3.5 grams of pure heroin would be 12 percent pure. The Drug Enforcement Administration reports that from the first quarter of 1972 to the first quarter of 1975 the retail purity level for heroin in northern New Jersey and New York has fluctuated from 2.8 percent to 7.6 percent on a quarterly basis. The DEA defines heroin at the retail level when it is less than 14 percent pure, less than 14 grams, and sells for less than five dollars a milligram of pure narcotic. Above this level

heroin is considered to be at the wholesale level. The Commission recommends that the quantity threshold should be set at 2.8 grams in free base form which would be 10 percent of one aggregate ounce. Ten percent is closer to the maximum range than the 12 percent or 3.5 grams figure.

4. There is no need to include both the aggregate weight and pure weight of a controlled dangerous substance; the pure weight is sufficient. Requiring both weights can lead to iniquities in prosecution and an undermining of the intent of the law. For example, a person could distribute 27 grams (less than an ounce) of pure heroin and yet not be liable to imprisonment of up to life. Twenty seven grams of pure heroin could yield 5400 bags or decks of heroin at a narcotic purity level of 5 percent, which has an illegal market value of $54,000.00.

5. "Narcotic drugs" include cocaine--by legal definition--as well as heroin and other opiates. Chapter 31 of the Laws of 1975 makes the assumption that the street level purity of heroin is the same as for cocaine. This is not the case. The average retail level of purity for cocaine is significantly greater than for heroin. The DEA reports that the range of the purity level for cocaine at the retail level from the third quarter of 1973 to the first quarter of 1975 is 7.9 percent to 13.1 percent. The DEA defines cocaine to be at the retail level if it is less than 20 percent pure, less than 20 grams and sells for less than five dollars a milligram. Any amount above that would be considered the wholesale level. The Commission recommends, therefore, that 4.3 grams of pure cocaine in free base form, which would be 15 percent of one

ounce of aggregate cocaine, would be an appropriate threshold.

These deficiencies can be easily remedied by placing the purity threshold for a pure Schedule I and II narcotic in free base form at 2.8 grams, and at 4.3 grams for cocaine. The reference to the required aggregate weight of a narcotic or cocaine should be deleted.

Categories of Moral Culpability

New Jersey Attorney General William F. Hyland wrote in "Drug Abuse and the State Criminal Justice System: Alternatives to Existing Modes of Treatment," that New Jersey's present drug laws, with regard to sentencing, are somewhat unrealistic.[3] The large scale trafficker is oftentimes treated far too leniently, while the possessor-addict may be sentenced to an unduly lengthly prison term. He continued that it is a common mistake to classify drug offenders into "overly simplistic" categories of possessors, users and sellers, which is done in our present statutes. The Attorney General listed six categories of drug offenders which he proposes are "more pertinent." They are, in order of culpability, persons who:

1. use or are under the influence of any controlled dangerous substance;

2. possess any controlled dangerous substance;

3. sell controlled dangerous substances and are themselves drug dependent;

4. sell controlled dangerous substances as an accommodation to friends;

5. sell controlled dangerous substances for profit and are not drug dependent; and

6. engage in large scale trafficking of drugs for profit.

While the Attorney General does not recommend that these categories be enacted into law, the Commission believes there are certain benefits in doing so. Since these categories are already often used informally in determing sentences for drug offenders, mandating their use through law would provide specific guidelines and should have the effect of partially reducing sentence disparity. Yet these categories are general enough so that they would still allow for judicial discretion. Additionally, the scheme also proposes a separate category for drug dependent persons, which the Commission has already recommended in Chapter 3 of its first report to the Legislature (see Appendix C to Chapter I of this report) and which would be implemented by the enactment of Assembly Bill Number 3047 of 1975. However, the Commission now recommends that if its proposed revision of the schedule of offenses and penalties for controlled dangerous substances violations--as set forth below--is enacted into law,category IV offenders, i.e., large scale traffickers of controlled dangerous substances who are drug dependent should not be eligible for diversion. This would require amending Assembly Bill Number 3047 as it now reads.

Table II illustrates the Commission's proposed revision of the schedule of offenses, based, in part, on the Attorney General's aforementioned categories of moral culpability, and the

TABLE II

Proposed Categories of Moral Culpability and Sentencing for Controlled Dangerous Substances Offenses (Exclusive of Marihuana Offenses) and Maximum Terms of Prison and Fines

		CDS Schedule V	CDS Schedule I,II,III,IV	CDS Schedule I & II Narcotic. Less than 1 oz. of which 3.5g is pure*	CDS Schedule I & Narcotic. 1 oz. or more of which 3.5g. is pur
I	Simple Possession **	1 year ($5,000)	1 year ($5,000)	1 year ($5,000)	7 years ($15,000)
II	Possession with Intent and Sale as an Accommodation **	1 year ($5,000)	3 years ($5,000)	5 years ($15,000)	Same as Category III
III	Possession with Intent and Sale for Profit **	1 year ($5,000)	5 years ($15,000)	12 years ($25,000)	Life ($50,000)
IV	Large Scale Trafficking	3-5 yrs.*** ($15,000)	10-20 yrs.*** ($50,000)	10yrs-life *** ($200,000 or as necessary to exhause profits)	10yrs-life*** ($200,000 or as necessary to ex haust profits)

* The commission recommends that the purity threshold be changed to less than or more than 4.3 g. for cocaine and 2.8 g. for other Schedule I and II narcotics; and that reference to the required aggregate weight of a narcotic be deleted.

** A drug dependent person may be eligible for diversion regardless of the offense.

*** Mandatory minimums, with no possibility of suspension or parole prior to the expiration of the minimum term.

Commission's proposed revision of the schedule of penalties for controlled dangerous substance offenses--exclusive of marihuana offenses. It should be noted here that the Commission recommends in Chapter 4 of this report that use or being under the influence of any controlled dangerous substance should not be considered a criminal offense of any sort. Thus, the Commission's proposal contains only four category of offenders, as described below.

Category I provides for a maximum sentence of one year for any person who knowingly or intentionally obtained, or possessed, actually or constructively, a controlled dangerous substance for which there was no valid prescription or order from a practitioner. This is the same penalty provided for in the federal drug statutes for the simple possession of any controlled dangerous substances.

Simple possession is, obviously, not as great a threat to society as is the sale of a controlled dangerous substance. Even the stringent New York Drug Law mandates only a maximum of one year for the possession of specified small amounts of any controlled dangerous substances. Also, since the Commission is recommending (in Chapter 4) that use or being under the influence of a controlled dangerous substance should not be a crime, the existing sentences for simple possession of a controlled dangerous substance (exclusive of marihuana offenses) should be accordingly reduced, since a person must first possess a controlled dangerous substance before he uses it, and being caught with it may be merely fortuitous.

Possession with intent to sell is covered in categories II, III, and IV. However, simple possession of a Schedule I or II narcotic which is 2.8 grams pure, and of cocaine, which is 4.3 grams pure,

suggests intent to sell. Therefore, the Commission recommends that simple possession of such an amount carry a maximum sentence of seven years.

Category II concerns the manufacturing, distributing, or dispensing, or possessing or having under control with intent to manufacture, distribute or dispense a controlled dangerous substance as an accommodation to a friend from which there is no pecuniary gain. A person would fall in this category if, for example, he gives at no cost, or sells at cost only, a controlled dangerous substance to a friend as a favor, or to satisfy a drug dependent person's habit. Such a person would be subject to a maximum sentence of one year for Schedule V controlled dangerous substances (inclusive of some cough medicines containing codeine); three years for Schedule I, II, III, and IV controlled dangerous substances (inclusive of amphetamines, barbiturates and hallucinogens); and five years for less than an ounce of Schedule I or II narcotics (such as heroin), of which at least 3.5 grams is pure narcotic.

Category III involves the manufacturing, distributing, or dispensing or the possession or having under control with intent to distribute, manufacture, or dispense a controlled dangerous substance and is essentially the same as section 19 of P.L. 1970, c. 226 (C. 24:21-19). The difference is the amount of the fines and maximum terms of prison for the sale of a Schedule I or II narcotic and cocaine. A greater fine and prison sentence is more realistic considering the greater pecuniary gain that can be had from large amounts of narcotics and cocaine.

Category IV involves the most morally culpable offender--the large scale trafficker who makes a tremendous profit from

trafficking in controlled dangerous substances. The proposed definition of a large scale trafficker would be the same as the federal government's definition, i.e., a person engaged in a continuing criminal enterprise who is in concert with five or more persons with respect to whom that person occupies a position of organizer, a supervisory position or any other position of management, and from which such person obtains substantial income or resources.[4] In this case, a "continuing criminal enterprise" would involve a category III offense, that is, the manufacturing, distributing, or dispensing of, or the possession or having under control with intent to distribute, manufacture, or dispense a controlled dangerous substance.

A category IV offense involving any amount of a Schedule I or II narcotic should carry a mandatory minimum prison term of ten years, with no possibility of suspension or parole prior to the expiration of the minimum term, and a maximum of life imprisonment. There would also be a fine of up to $200,000. or as much as is necessary to exhaust the profits that were made from the illegal activity. While the Commission is reluctant to recommend mandatory minimum sentencing, it believes such a penalty is justified for all category IV offenses.

When the offense involves other Schedule I or II controlled dangerous substances or any Schedule III or IV controlled dangerous substances, the sentence would be a mandatory minimum of ten years, with no possibility of suspension or parole prior to the expiration of the minimum term, and a maximum of twenty years. For Schedule V controlled dangerous substances offenses, the sentence proposed is a mandatory minimum of three years, with no possibility of suspension

or parole prior to the expiration of the minimum term, and a maximum of five years.

The Commission also proposes that any legislation to implement its proposed revision of the schedule of offenses and penalties contained in sections 19 and 20 of P.L. 1970, c. 226 (C. 24:21-19 and C. 24:21-20) should amend those references to sections 19 and 20 now contained in other sections of the "New Jersey Controlled Dangerous Substances Act" so as to indicate the new schedule of offenses and penalties set forth in the commission's proposed revision.

The Commission believes that its proposed categories of moral culpability are more realistic and equitable than the present statutes which make an overly simplistic distinction between use, possession and sale of a controlled dangerous substance. This proposal is also contingent upon the enactment into law of the diversionary program recommended by the Commission in Chapter III of its first report to the Legislature and contained in Assembly Bill Number 3047--presently pending in the Assembly. The Commission feels that Assembly Bill Number 3047 must be considered as a companion proposal to, and an essential ingredient of, the proposed revision of the schedules of offenses and penalties for controlled dangerous substance violations presented in this chapter.

Sentence Disparity Concerning Controlled Dangerous Substances Offenses

The Commission has heard complaints from both incarcerated drug offenders and county prosecutors that judges vary greatly in their sentencing for similar drug offenses. Recently, empirical evidence has been presented which supports this complaint. The

Division of Correction and Parole in the State Department of Institutions and Agencies released a study on May 6, 1974, based upon sample data which compares sentencing involving prison commitments for similar offenses by individual judges, counties and regions in New Jersey. The sentence disparity was great in all areas for all categories of offenses which included gambling, property and narcotics, less serious offenses against persons, robbery, and rape or murder. For example, lengths of prison commitments in Mercer County were 24 percent above the State average for all offenses, and Ocean, Cape May, Cumberland, Salem, and Gloucester counties were 18 percent below the State average.

Of special concern to the Commission, however, was the far greater disparity for drug related offenses which included possession, possession and sale, first offenders and multiple offenders. For all drug related cases Mercer County was 75 percent above the State average, or four years and five months above the average sentence, and Hudson was 28 percent below the State average, or one year and seven months below the average, which amounts to a disparity range of 103 percent. The disparity was even greater for individual judges across county lines. One judge in Hudson County was issuing an average maximum sentence of 2.4 years for drug offenses while a judge in Mercer County was handing out a sentence of 11.6 years for similar offenses, which amounts to a disparity range of 162 percent. When the drug offenses were broken down by particular offense the range was even greater for individual

judges. The study also compared the sentences of similar offenses with offenders who had similar backgrounds in terms of employment, previous arrests and incarceration and other important variables and also found disparity.

It should be noted that this study did not include persons sentenced to correctional facilities other than prisons or those persons who are on probation. Therefore, although the study is not conclusive, it is supportive of the widespread notion that, to a great extent, a drug offender's sentence is a result of which judge in which county and region tries the case rather than the nature of the offense tried. The division's study implies--in the Commission's opinion--that judging drug offenses may be unusually complex and multi-variable and that present statutes are probably too general and uninformative to provide adequate guidelines for sentencing, and that the judicial administrative process needs reevaluating in the area of drug offense.

Based on the aforementioned study, and after interviews with criminal justice, court, and court administrative personnel, the Commission arrived at the following conclusion. The New Jersey Supreme Court via the Administrative Office of the Supreme Court should issue a directive designating the Assignment Judge of each county or his designee or designees as a sentencing judge in all narcotic cases. In less populated counties one Superior Court Judge may act as the sentencing judge for drug and narcotic cases in several counties. The underlying rationale for this proposal is that a single judge handling the sentencing in such cases would

be more likely to treat similarly situated defendants uniformly. This would curtail the current practices which have resulted in a great disparity in sentencing and would pave the way for a much desired uniformity in drug sentencing procedures. And to further curtail the great disparity in sentencing, it should be required that sentencing judges for drug and narcotic cases should meet together at intervals to be determined by the New Jersey Supreme Court so as to compare how similarly situated defendants are being dealt with.

Conclusion and Recommendations

The Commission is of the continuing opinion that more stringent drugs will not, and cannot, deter the use of drugs or the occurrence of drug related offenses. The history of New Jersey's drug laws, the federal drug laws, and the experience of New York State's current drug law is evidence enough that there is nothing to be gained by reverting to previously tried approaches which have not worked.

In attempting to formulate an effective and equitable revision of New Jersey's schedule of offenses and penalties for controlled dangerous substance violations, the Commission has given special concern to determining the severity of the offense and the appropriate sentence, and to reducing some of the sentence disparity for drug offenses.

With this concern in mind, the Commission concludes that to better protect the public, rehabilitate the drug offender, deter

others from the same offense, and to gain retribution, a revision of sections 19 and 20 of P.L. 1970, c. 226 (C. 24:21-19 and 20) should be based on the moral culpability of the drug offender. The categories of moral culpability discussed in this chapter and outlined in Table II attempt to provide such a schedule and should be enacted into law.

Furthermore, as part of its proposed scheme of categories of moral culpability, the Commission recommends the category of drug dependent persons, which is covered in Chapter 3 of its first report and would be implemented by the enactment of Assembly Bill Number 3047 of 1975.

In addition, while the Commission rejects the quantification of drugs for purposes of determining offenses and penalties for other controlled dangerous substances, it finds merit in quantifying Schedules I and II narcotics--because of the great threat they present to society--so that there will be less discretion in determining the punishment for the unlawful sale or possession of a narcotic in Schedules I and II, as now provided for in the "New Jersey Controlled Dangerous Substances Act." The Commission endorses this limited quantification approach but recommends adoption of the amendments to the quantification provisions of sections 19 and 20 of the "New Jersey Controlled Dangerous Substances Act" as discussed in this chapter--because of the defects contained in Chapter 31 of the Laws of 1975, as pointed out in this chapter.

Finally, in an effort to achieve equity and reduce sentence disparities for controlled dangerous substances offenses, the Commission recommends that the New Jersey Supreme Court

designate single sentencing judges in all narcotic cases--either on a county or regional basis; and that the sentencing judges meet together at regular intervals--as described in this chapter.

FOOTNOTES

CHAPTER III

1. New York State Public Health Law: Article 33; Mental Hygiene Law: Article 81; Penal Law: Article 220.

2. See County Prosecutor's Questionnaire in Chapter VII of this report.

3. Hon. William F. Hyland, Attorney General of New Jersey, "Drug Abuse and The State Criminal Justice System: Alternative To Existing Modes Of Treatment," The Criminal Justice Quarterly, V. 2, No. 4 (Fall-1974), 167-177.

4. Section 408(b) of Public Law 91-513, 91st Congress; 84 Stat. 1236 et seq.)

DSR-8
Jan. 73

DIVISION OF NARCOTIC AND DRUG ABUSE CONTROL
New Jersey State
Department of Health
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Trenton, New Jersey 08625

CONTROLLED DANGEROUS SUBSTANCE SCHEDULES

New Jersey Administrative Code (Title 8 – Chapter 65 – Subchapter 10)

Effective Date: January 17, 1973

Five individual Schedules listing the Controlled Dangerous Substances within that Schedule by Generic, Established or Chemical name and the Controlled Dangerous Substances code number.

SCHEDULE I
CONTROLLED DANGEROUS SUBSTANCES

Criteria:

A. The drug or other substance has high potential for abuse.
B. The drug or other substance has no currently accepted medical use in treatment in the United States.
C. There is lack of accepted safety for use of the drug or other substance under medical supervision.

OPIATES

Unless specifically excepted or unless listed in another schedule, any of the following opiates, including its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation:

Generic/Established or Chemical Name	CDS Code
Acetylmethadol	9601
Allylprodine	9602
Alphacetylmethadol	9603
Alphameprodine	9604
Alphamethadol	9605
Benzethidine	9606
Betacetylmethadol	9607
Betameprodine	9608
Betamethadol	9609
Betaprodine	9611
Clonitazene	9612
Dextromoramide	9613
Dextrorphan	9614
Diampromide	9615
Diethylthiambutene	9616
Dimenoxadol	9617
Dimepheptanol	9618
Dimethylthiambutene	9619
Dioxaphetylbutyrate	9621
Dipipanone	9622
Ethylmethylthiambutene	9623
Etonitazene	9624
Etoxeridine	9625
Furethidine	9626
Hydroxypethidine	9627
Ketobemidone	9628
Levomoramide	9629
Levophenacylmorphan	9631
Morpheridine	9632
Noracymethadol	9633
Norlevorphanol	9634
Normethadone	9635
Norpipanone	9636
Phenadoxone	9637
Phenampromide	9638
Phenoperidine	9641
Piritramide	9642
Proheptazine	9643
Properidine	9644
Racemoramide	9645
Trimeperidine	9646
Phenomorphan	9647

Added: Program CSD#9649 eff. 4/29/73

OPIUM DERIVATIVES

Unless specifically excepted or unless listed in another schedule, any of the following opium derivatives, its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

Generic/Established or Chemical Name	CDS Code
Acetorphine	9319
Acetyldihydrocodeine	9051
Benzylmorphine	9052
Codeine methylbromide	9070
Codeine-N-Oxide	9053
Cyprenorphine	9054
Desomorphine	9055
Dihydromorphine	9145
Etorphine	9056
Heroin	9200
Hydromorphinol	9301
Methyldesorphine	9302
Methyldihydromorphine	9404
Morphine Methylbromide	9305
Morphine Methylsulfonate	9306
Morphine-N-Oxide	9307
Myrophine	9308

Generic/Established or Chemical Name	CDS Code
Nicocodeine	9309
Nicomorphine	9312
Normorphine	9313
Pholcodine	9314
Thebacon	9315

HALLUCINOGENIC SUBSTANCES

Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation, which contains any quantity of the following hallucinogenic substances, or which contains any of its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation (for purposes of this paragraph only, the term "isomer" includes the optical, position, and geometric isomers):

Generic/Established or Chemical Name	CDS Code
3,4-methylenedioxy amphetamine	7400
5 - methoxy - 3,4-methyl-enedioxy amphetamine	7401
3,4,5-trimethoxy amphetamine	7390
Bufotenine *3 - (B-Dimethylaminoethyl) - 5 - hydroxyindole; *3 - (2-dimethylaminoethyl) - 5 - indolol; *N,N - dimethylserotonin; *5-hydroxy - N - dimethyltryptamine; *Mappine	7433
Diethyltryptamine *N,N-Diethyltryptamine; *DET	7434
Dimethyltryptamine *DMT	7435
4-methyl-2, 5-dimethoxyamphetamine *4-methyl-2, 5-dimethoxy--methylphenethylamine; *"DOM"; *"STP"	7395
Ibogaine *7 - Ethyl - 6,6,7,8,9,10,12,13-octahydro - 2 - methoxy-6,9-methano-5H-pyrido (1', 2': 1,2 azepino 4,5-b) indole; *tabernanthe iboga	7260
Lysergic acid diethylamide	7315
Marihuana	7360
Mescaline	7381
Peyote	7415
N-ethyl-3-piperidyl benzilate	7482
N-methyl-3-piperidyl benzilate	7484
Psilocybin	7437
Psilocyn	7438
Tetrahydrocannabinols New synthetic equivalents of the substances contained in the plant, or in the resinous extractives of Cannabis, sp. and/or synthetic substances, derivatives, and their isomers with similar chemical structure and pharmacological activity such as the following: $\Delta 1$ cis or trans tetrahydrocannabinol, and their optical isomers. $\Delta 6$ cis or trans tetrahydrocannabinol, and their $\Delta 3,4$ cis or trans tetrahydrocannabinol, and its optical isomers. *Indicates chemical name or trade name (Since nomenclature of these substances is not internationally standardized, compounds of these structures, regardless of numerical designation of atomic positions are covered.)	7370

SCHEDULE II
CONTROLLED DANGEROUS SUBSTANCES

Criteria:

A. The drug or other substance has a high potential for abuse.
B. The drug or other substance has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions.
C. Abuse of the drug or other substance may lead to severe psychological or physical dependence.

SUBSTANCES, VEGETABLE ORIGIN OR CHEMICAL SYNTHESIS

Unless specifically excepted or unless listed in another schedule, any of the following substances whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis:

Opium and opiate, and any salt, compound, derivative, or preparation of opium or opiate, excluding naloxone hydrochloride, but including the following:

Generic/Established or Chemical Name	CDS Code
Raw opium	9600
Opium extracts	9610
Opium fluid extracts	9620
Powered opium	9639
Granulated opium	9640
Tincture of opium	9630
Apomorphine	9030
Codeine	9050
Ethylmorphine	9190
Hydrocodone	9133
Hydromorphone	9194
Metopon	9620
Morphine	9300
Oxycodone	9143
Oxymorphone	9652
Thebaine	9333

Any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of the substances referred to in subparagraph (1) of this para-

graph, except that these substances shall not include the isoquinoline alkaloids of opium.

Opium poppy and poppy straw.

Coca leaves (9040) and any salt, compound, derivative, or preparation of coca leaves, and any salt, compound derivative, or preparation thereof which is chemically equivalent or identical with any of these substances, except that the substances shall not include decocainized coca leaves or extraction of coca leaves, which extractions do not contain cocaine (9041) or ecgonine (9180).

OPIATES

Unless specifically excepted or unless in another schedule any of the following opiates, including its isomers, esters, ethers, salts and salts of isomers, esters and ethers whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation:

Generic/Established or Chemical Name	CDS Code
Alphaprodine	9010
Anileridine	9020
Bezitramide	9800
Dihydrocodeine	9120
Diphenoxylate	9170
Fentanyl	9801
Isomethadone	9226
Levomethorphan	9210
Levorphanol	9220
Metazocine	9240
Methadone	9250
Methadone-Intermediate, 4-cyano-2-dimethylamino-4,4-diphenyl butane	9254
Moramide-Intermediate, 2-methyl-3-morpholino-1, 1-diphenyl-propane-carboxylic acid	9802
Pethidine	9230
Pethidine-Intermediate-A, 4-cyano-1-methyl-4-phenylpiperidine	9232
Pethidine-Intermediate-B, ethyl-4-phenylpiperidine-4-carboxylate	9233
Pethidine-Intermediate-C, 1-methyl-4-phenylpiperidine-4-carboxylic acid	9234
Phenazocine	9715
Piminodine	9730
Racemethorphan	9732
Racemorphan	9733

STIMULANTS

Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system:

Amphetamine, its salts, optical isomers, and salts of its optical isomers	1,100
Methamphetamine, its salts, isomers, and salts of its isomers	1,105
Phenmetrazine and its salts	1,630
Methylphenidate	1,726

SCHEDULE III
CONTROLLED DANGEROUS SUBSTANCES

Criteria:

A. The drug or other substance has a potential for abuse less than the drugs or other substances in schedules I and II.

B. The drug or other substance has a currently accepted medical use in the United States.

C. Abuse of the drug or other substance may lead to moderate or low physical dependence or high psychological dependence.

STIMULANTS

Unless specifically excepted or unless listed in another schedule any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system:

(1) Those compounds, mixtures, or preparations in dosage unit form containing any stimulant substances which compounds, mixtures, or preparations were listed on August 25, 1971, in 308.32 as excepted compounds, and any other drug of the quantitative composition shown in that list for those drugs or which is the same except that it contains a lesser quantity of controlled substances.

DEPRESSANTS

Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system:

Any substance which contains any quantity of a derivative of barbituric acid, or any salt of a derivative of barbituric acid	2100
Chlorhexadol	2510
Glutethimide	2550
Lysergic acid	7300
Lysergic acid amide	7310
Methyprylon	2575
Phencyclidine	7471
Sulfondiethylmethane	2600
Sulfonethylmethane	2605
Sulfonmethane	2610

NALORPHINE 9400
NARCOTIC DRUGS

Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation containing limited quantities of any of the following narcotic drugs, or any salts thereof:

ITEM	CDS CODE
(1) Not more than 1.8 grams of codeine per 100 milliliters or not more than 90 milligrams per dosage unit, with an equal or greater quantity of an isoquinoline alkaloid of opium	9803
(2) Not more than 1.8 grams of codeine per 100 milliliters or not more than 90 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts	9804

ITEM	CDS Code
(3) Not more than 300 milligrams of dihydrocodeinone per 100 milliliters or not more than 15 milligrams per dosage unit, with a fourfold or greater quantity of an isoquinoline alkaloid of opium	9805
(4) Not more than 300 milligrams of dihydrocodeinone per 100 milliliters or not more than 15 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts	9806
(5) Not more than 1.8 grams of dihydrocodeine per 100 milliliters or not more than 90 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts	9807
(6) Not more than 300 milligrams of ethylmorphine per 100 milliliters or not more than 15 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts	9808
(7) Not more than 500 milligrams of opium per 100 milliliters or per 100 grams, or not more than 25 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts	9809
(8) Not more than 50 milligrams of morphine per 100 milliliters or per 100 grams, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts	9810

SCHEDULE IV
CONTROLLED DANGEROUS SUBSTANCES

Criteria:

A. The drug or other substance has a low potential for abuse relative to the drugs or other substances in Schedule III.
B. The drug or other substance has a currently accepted medical use in treatment in the United States.
C. Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in Schedule III.

DEPRESSANTS

Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances, including its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

Generic/Established or Chemical Name	CDS Code
Barbital	2145
Chloral Betaine	2460
Chloral Hydrate	2465
Ethchlorvynol	2540
Ethinamate	2545
Meprobamate	2820
Methohexital	2264
Methylphenobarbital	2250
Paraldehyde	2585
Petrichloral	2591
Phenobarbital	2285

SCHEDULE V
CONTROLLED DANGEROUS SUBSTANCES

Criteria:

A. The substance has a low potential for abuse relative to the substances listed in Schedule IV.
B. The substance has currently accepted medical use in treatment in the United States.
C. The substance has limited physical dependence or psychological dependence liability relative to the substances listed in Schedule IV.

NARCOTIC DRUGS CONTAINING NON-NARCOTIC ACTIVE MEDICINAL INGREDIENTS

Any compound, mixture, or preparation containing any of the following limited quantities of narcotic drugs or salts thereof, which shall include one or more nonnarcotic active medicinal ingredients in sufficient proportion to confer upon the compound, mixture, or preparation valuable medicinal qualities other than those possessed by the narcotic drug alone:

(1) Not more than 200 milligrams of codeine or any of its salts per 100 milliliters or per 100 grams.
(2) Not more than 100 milligrams of dihydrocodeine or any of its salts per 100 milliliters or per 100 grams.
(3) Not more than 100 milligrams of ethylmorphine or any of its salts per 100 milliliters or per 100 grams.
(4) Not more than 2.5 milligrams of diphenoxylate and not less than 25 micrograms of atropine sulfate per dosage unit.
(5) Not more than 100 milligrams of opium or any of its salts per 100 milliliters or per 100 grams.

CHAPTER IV

USING OR UNDER THE INFLUENCE OF A CONTROLLED DANGEROUS SUBSTANCE

Background

P.L. 1970, c. 226, § 20b. (C. 24:21-20b.) provides that:

> Any person who uses or who is under the influence of any controlled dangerous substance, as defined in this act, for a purpose other than the treatment of sickness or injury as prescribed or administered by a person duly authorized by law to treat sick and injured human beings, is a disorderly person.
>
> In a prosecution under this subsection, it shall not be necessary for the State to prove that the accused did use or was under the influence of any specific narcotic drug or drugs, but it shall be sufficient for a conviction under this subsection for the State to prove that the accused did use or was under the influence of some controlled dangerous substance or counterfeit controlled dangerous substance as defined in this act, by providing that the accused did manifest physical and physiological symptoms or reactions caused by the use of any controlled dangerous substance.

The general penalty for a disorderly persons offense, imprisonment for not more than 6 months, a fine of not more than $500.00, or both, is a relatively light offense in the scheme of penalties in New Jersey for criminal offenses. The crucial question, however, is whether the threat to society by the user or person under the influence is serious enough to warrant incarceration for up to 6 months and/or a fine of up to $500.00.

Section 20b. provides that the accused need only "manifest" symptoms or reactions caused by the use of a controlled dangerous substance; the act of administering the drug is not required. It is also not required that a person be apprehended while using the drug or that the drug was obtained or used within the State. These provisions may present a venue problem as to where the alleged offense occurred and whether or not an act occurred which was sufficient grounds for the State to claim jurisdiction.

There are several socially accepted reasons for which punishment is justified: (1) protection of the public by isolating the offender; (2) rehabilitation of the offender; (3) deterrence of others from commiting the same offense; and (4) retribution. The first two reasons can be satisfied by a civil commitment program rather than a prison sentence. The third reason is based on "free will" and does not apply to persons who are already addicted to drugs. Retribution as a justification for punishment has been seriously challenged within the criminal justice system and certainly would not apply to an offender who is charged only with a victimless crime.

Of all the classes of drug offenders, the Commission feels that those who use or are under the influence of a controlled dangerous substance pose the least risk or threat to society. Whereas every possessor of a controlled dangerous substance could become a seller, the user has already proven that the prohibited substance was for personal consumption. And since the substance is already in his body, there is no possibility of his selling it. No one has

been or can be directly injured other than the user himself--if the only act the user is guilty of is using or being under the influence of a controlled dangerous substance.

Addiction implies that there is a compulsive or repetitive desire or need to continue obtaining and using the drug due to physiological or psychological dependence on the effect of the drug. The addict, i.e., the drug dependent person, must continually violate the law since using and being under the influence of a controlled dangerous substance are necessary components of drug dependency.

It appears to the Commission to be both futile and unfair to punish a person because of a compulsive, symptomatic illness, which using or being under the influence of a controlled dangerous substance amounts to. It is futile because the traditional criminal sanctions of fines and/or jail sentences are the wrong approaches for the rehabilitation of a drug dependent person and do not deter him from further use. Drug dependency is an illness which an addict cannot easily control.

It is also possible to become addicted involuntarily or innocently. One may become addicted after prolonged medical treatment, or a baby may be born addicted due to maternal addiction. Yet because no harmful act is required under section 20b., the "accidental" addict could be charged with a disorderly persons offense.

The Eighth Amendment

The wording of the Eighth Amendment to the United States Constitution is based on the principle of the English Bill of Rights of 1688 that

> excessive bail shall not be required, nor excessive fines imposed nor cruel and unusual punishments inflicted.

This provision appeared in several state constitutions and in the Northwest Ordinance of 1787. James Madison incorporated this principle into the Constitutional Amendment he drafted in 1789; in 1791 it was incorporated into the United States Constitution as part of the Eighth Amendment.

A distinction may be made between (1) inherently cruel punishment--those methods which are considered inhumane and barbarous, such as boiling, burning alive, disemboweling, and torture--and (2) cruelly excessive punishment--such as that in which the method is considered acceptable [fines and imprisonment] but is disproportionate to the offense committeed.

The prohibition against excessive punishment--such as the lex tablonis (an eye for an eye)--dates back to the Book of Exodus of the Old Testament. Concern for equality also appeared in early Greek Philosphy. Aristotle taught that inequality--whether in favor of or against the offender--meant injustice. By the 15th Century the goal had shifted so that the punishment had to fit the crime rather than be equal to the crime. By the 16th Century the prohibition was extended to cruel methods or forms of punishment. English evidence shows that the cruel and unusual punishment clause

of the Bill of Rights of 1688 was an expression of objection to the imposition of punishments which were unauthorized by statute and outside of the jurisdiction of the sentencing court, as well as a policy statement against disproportionate penalties.

The courts in this country at first applied this clause only to cruel and unusual methods of punishment--ignoring the historical prohibition against excessive punishments--in a mistaken belief that they were following the interpretation given to this provision by the English courts. By the turn of the 20th Century, American courts finally began to expand the application of this clause to cruelly excessive punishments.

What may be "cruel and unusual" is a changing concept. Fundamentally, the Eighth Amendment prohibition rests on considerations of human decency and on the dignity of man himself. Punishment is ordinarily justified as necessary for the achievement of a long-range benefit. No matter how great the benefit or how heinous the crime, there are standards of decency that may not be violated in punishing a law-breaker. Not only the offender's human dignity, but also that of a society as a whole, is at stake. The state's power to punish must fall within the limits of civilized standards.

The Eighth Amendment's prohibition draws its meaning from the ever evolving standards of decency that mark the progress of a maturing society. The meaning of the Eighth Amendment is better understood as the public becomes more enlightened about humane justice.

The courts must look both to the severity of the offense as measured by the potential harm to individuals and to society, and the probability of such harm occurring. It is a general principle of criminal law that a logical relationship must exist between the type of behavior criminalized and the specific harm sought to be prevented. The punishment must fit the crime and cannot be excessive in length or be by its severity greatly disproportionate to the offense charged--the standard here being the potential maximum sentence and/or fine meted out. If less restrictive alternatives are available to adequately protect the individual and the public, or if punishment is being inflicted arbitrarily, then the punishment is deemed cruel and unusual. It is cruel and unusual to punish an individual not morally blameworthy. A criminal statute cannot--and should not--exist if it makes criminal an illness over which the accused has no (or little) control.

Legal Precedence

Although the United States Supreme Court determined in 1962 that punishment for "being an addict" is unconstitutional under the Eighth Amendment prohibition against cruel and unusual punishment (see Robinson v. California 370 U.S. 660), it is as yet unclear whether punishment of a person who uses or who is under the illegal influence of a prohibited controlled dangerous substance is also unconstitutional.

In Robinson, the Court attacked the power of the state to punish--not merely the form of punishment chosen. Robinson held

that punishment for the status of addiction is per se cruel and unusual because being an addict is not the type of wrongdoing subject to criminal sanction by the state.

Although the state may control drug addiction, criminal prohibition of the status itself is cruel and unusual because drug addiction is not criminal in nature. The cruel and unusual punishment results not from confinement, but from convicting the addict of a crime, especially when civil commitment would achieve the same purpose of removing the addict from society. Certain activities, traits, or weakness, although socially undesirable, are not amenable to control by criminal sanctions.

The Court also stated in the Robinson case that a statute which subjects a person to continuing liability cannot be upheld as constitutional. An offender under the California statute in question might have been prosecuted at any time before he reformed--which could also be true for a statute criminalizing use or being under the influence of a controlled dangerous substance.

Following the United States Supreme Court decision in Robinson, the Illinois Supreme Court struck down that state's use and under the influence statutes. At the present time only 15 states still provide penalties for the illegal use or for being under the influence of a controlled dangerous substance.

In 1963, however, the New Jersey Supreme Court held in State v. Margo (40 N.J. 188) that the use and under the influence provision of the "New Jersey Controlled Dangerous Substances Act" (P.L. 1970, c. 226, § 20b.; C. 24:21-20b.) was constitutional, dis-

tinguishing the status of addiction from the use or under the influence of a drug. The court stated that being under the influence was itself "anti-social behavior and a voluntarily induced active state laden with a present capacity to further injure society."

The problem with this proposition is that a person's "state" is not necessarily "active" since many users and persons under the influence of a controlled dangerous substance are addicts who physicially require the substance. Even the initial use of the drug need not have been voluntary as a person can become an addict after first having been medically treated with a certain drug or as the result of having been born addicted because of an addicted mother.

Furthermore, a user, or a person under the influence, of a controlled dangerous substance is more likely than not to "act" passive and lethargic. If there is any "capacity" to injure society it is in the harm caused to the user or person under the influence and in society's possible loss of a productive citizen--neither of which is cured by imprisoning or fining the person.

In September, 1963, the Appellate Division of the Superior Court of New Jersey relied on Margo to affirm a similar conviction in State v. Dennis (80 N.J. Super. 411). However, the Dennis court noted twice in its opinion that it was bound by Margo and it could not question Margo's logic or reasoning, as that was the role of the Legislature.

The Superior Court held that the fact of being an addict does not make a person immune from liability for being under the

influence as section 20b. punishes only for the latter condition and not the former. The difference is one of semantics as every addict uses or is under the influence of a controlled dangerous substance. Once the person stops using the drug or being under its influence by choice, that person is slowly becoming nonaddicted.

The state has the power to prevent drug addiction and to provide diagnosis, treatment, care, and rehabilitation for drug addicts. The addict-user or addict-under-the-influence needs treatment as much as one convicted of addiction. However, it appears to the Commission to be an overreaching of the proper limitation of the state's police power to make use or being under the influence a crime.

Law enforcement efforts should be directed toward the detection, prosecution, and punishment of the most morally culpable drug offender--the large scale trafficker--not the user who has the lowest degree of moral culpability and may be an addict. And while it has been argued that making use or being under the influence a disorderly persons offense serves as a means for removing users from public places and directing them to treatment, there is another means to achieve this end.

Non-Criminal Alternatives

In Assembly Bill Number 3047--which, as previously mentioned, resulted from the Commission's first report to the Legislature--section 10 provides for the voluntary treatment of drug-dependent persons and other persons. It authorizes any person

to apply directly to a treatment facility for either emergency or prevention treatment or drug dependence treatment. Minors are specifically mentioned to avoid any implication that either admission, diagnosis or treatment requires parental consent. Minors who seek assistance are often reluctant to have their drug usage known to their parents, and the possibility of such notification may in fact deter them from seeking treatment. This is especially true of runaways. Drug users who seek emergency treatment or other assistance constitute an ideal target group for drug dependence prevention efforts, and early contact with treatment personnel is a sound preventive policy which should be encouraged. Efforts should be made to encourage voluntary treatment--without the stigma of an arrest. Finally, it should be noted that the "Federal Drug Abuse Office and Treatment Act of 1972" (21 U.S.C. § 1175) requires that emergency facilities receiving federal assistance offer treatment to all "drug abusers."

Furthermore, section 31 of Assembly Bill Number 3047 authorizes emergency treatment for persons under the influence of controlled dangerous substances. This section applies to a person who appears to be under the influence of controlled dangerous substances in a public place and to be in need of emergency treatment. The police are authorized to take such a person, with his consent, to the nearest hospital or emergency medical facility or his home. If the physician in charge of emergency treatment confirms the need for continued treatment, the person, with his consent, shall be referred to a screening agency (as defined and provided for in the bill) which shall recommend an appropriate treatment plan and

a program of adequate services and facilities.

Identification and referral of persons under this section do not, in themselves, constitute probable cause to arrest the person or search him for contraband. Once admitted to an appropriate treatment facility, the person may be detained until treatment is complete, but for no longer than 24 hours. Only a handful of states currently authorize non-criminal police referrals for emergency treatment.

Conclusion and Recommendations

For both reasons of (1) redirecting law enforcement efforts toward the detection, prosecution, and punishment of more morally culpable drug offenders, and (2) removing a criminal stigma from persons who are guilty of only using or being under the influence of a controlled dangerous substance, subsection 20b. of P.L. 1970, c. 226, as amended (C. 24:21-20b.), should be repealed. The Commission endorses the non-criminal procedures authorized by sections 10 and 31 of Assembly Bill Number 3047 for directing users or persons under the influence of a controlled dangerous substance to treatment facilities and again recommends the enactment of this bill into law.

CHAPTER V

DIVERSION OF DRUG DEPENDENT PERSONS FROM THE STATE CORRECTIONAL COMPLEX INTO COMMUNITY BASED TREATMENT

Introduction

The focus of this chapter is on inmates in the State correctional complex who are drug dependent and are seeking diversion into community based treatment. The question looked into by the "Drug Study Commission" is whether the existing diversionary system is adequate or if legislation or administrative changes are needed to implement an effective inmate release process in New Jersey.

Background

In the past 50 years, public opinion in America has reflected the two following hardfast views regarding the personal consumption of many chemical substances that alter a person's mood, perception or behavior: (1) use is a problem in that it creates negative consequences to both the user and society; and (2) the best way to deal with this problem is to use the police power of the State to prohibit consumption. Thus, the use of many drugs was made a crime. While the precise definition of the acts required to constitute criminal use of a particular drug varied from one jurisdiction to another, as did the criminal sanctions which were

imposed, the results were usually the same, i.e., an individual who was publicly identified as a drug user became involved in the criminal justice system.

Designation of the criminal justice system as the mechanism to deal with the drug problem has had serious consequences for the system itself. In most of our legal jurisdictions, a considerable proportion of available law enforcement resources is expended to arrest drug users. And arrested users overcrowd county detention facilities while they are waiting for trials or other dispositions of the charges lodged against them. Thus, the dockets of the criminal courts, already backlogged, are further burdened by the influx of these drug cases, and the prisons become more and more crowded with drug offenders who are sentenced to these facilities.

Drug Rehabilitation in a Prison Setting

This overcrowding is dramatically illustrated in New Jersey. During fiscal 1974, 2,360 offenders or 45 percent of the 5,226 admissions to the State's prison, youth correctional institutions, and training schools had a history of drug use. It is estimated that 902 offenders or 17 percent of all admissions were actually committed for controlled dangerous substance violations alone.

Correctional facilities are designed both to protect society by isolating individuals defined as dangerous and to

provide for their health and rehabilitation. Overcrowding makes the achievement of these goals difficult, as it results in a constant state of tension within prisons and a constant focus of attention on short-range security matters rather than long-range rehabilitation programs. As a result, correctional officers are used, and see themselves, only as guards and are infrequently used in any constructive rehabilitation efforts.

Overcrowding also means that space available for any rehabilitative programs within prison walls is extremely limited. Ideally, inmates should be segregated into units depending on their rehabilitative needs, such as drug therapy, but because space is so limited inmates are assigned rather on the basis of available space. This reduces the possibility of any concentrated group rehabilitation programs over an extended time period.

Overcrowding also results in too few treatment personnel--psychiatrists, social workers, psychologists--for inmates seeking their services. Inmates, therefore, receive only minimal, if any, therapy from these professionals. Furthermore, because of the demands placed on them, the professionals usually do not have time to participate in the establishment of programs and priorities for the facilities and, therefore, have a limited impact on improving rehabilitative efforts.

The treatment needs of drug users vary widely, as do the individual's interest and motivation in seeking treatment. The specific treatment desired depends, of course, on emotional, physical and motivational characteristics, as well as the individual's living environment. In the community, a wide range of treatment modalities

exists. These include outpatient counseling or intensive inpatient therapy in a therapeutic community or hospital setting. Detoxification may also be part of a particular treatment program.

In correctional institutions, however, treatment choices are limited. Neither chemotherapy nor detoxification are used, since an inmate has involuntarily withdrawn during a preceding period of temporary detention and generally does not have access to illegal chemical substances while in prison. Because of this externally imposed control of drug use, there is little reason to use a drug such as methadone to control drug craving.

The primary rehabilitative programs in prisons--where they are available--are designed to help the inmate to return to society when released, and if addicted, not relapse into his former state of drug use. These include psychotherapy, counseling, therapeutic, community, vocational and educational programs. Such programs, particularly the psychotherapeutic ones, are severely limited, however, both by their number and, more importantly, by their environmental setting. Indeed, only 10 percent of those persons requiring drug treatment services are currently receiving them in the New Jersey correctional system.

Psychotherapeutic and counseling programs depend on an individual's desire to examine and change himself. This is a difficult task, particularly in the coercive environment of a prison. The process of personal growth and change through such treatment requires the development of trust between the client and professional. In a correctional setting, an inmate may be in treatment primarily

as a means to impress paroling authorities in releasing him from prison. In addition, such treatment depends on freedom of both parties to continue or end a relationship and determine how the client should change. Such freedom may not be available in the prison setting.

Successful treatment, then, normally develops in a context where (1) a client's motivation to participate in treatment is not mainly to remove himself from the setting in which it takes place; (2) the client and professional have mutual control over goals of treatment; and (3) the client and professional have mutual control over the time limits of the relationship, which are determined primarily by the internal dynamics of the treatment relationship. Treatment, in other words, most successfully operates in a voluntary or noncoercive framework.

The Commission feels that treatment efforts are seriously compromised in a prison system, where the client, by reason of being an "offender," is told to accept treatment and change his behavior by criteria defined and imposed by an authority responsible for determining the length of punishment by confinement.

This is not to say that certain forms of personal counseling or therapy are not possible in a correctional setting or that it should not be attempted. New Jersey has made serious attempts in its correctional system, ranging from the establishment of five therapeutic types of communities with a total treatment capacity of 245 beds to various group and individual counseling and therapy programs offered by the professional staffs of the different institutions.

Success of any such efforts, however, depends on the extent to which paroling authorities and prison rehabilitation and security staff can work together in providing a healthy and safe environment where all participants, including the inmate-client, can participate in the treatment discussions. Since the goal of any prison rehabilitation effort is to integrate the client back into the community, treatment success must also depend on the extent to which community rehabilitation resources can be brought to meet the inmates treatment needs.

An Alternative

The Commission believes that, based on the above facts, the development of a systematic means of utilizing existing community drug treatment programs to aid in the reintegration of addicted inmates into society is an alternative to the treatment of addicted inmates. Drug Addicts currently in prisons should be prereleased or paroled to State-certified drug treatment programs available in the community. The programs and modalities used would vary, depending on the inmate's particular needs. For example, an inpatient community based program providing traditional therapeutic services might be used for inmates who desired and were permitted access to those programs.

Other drug programs might offer living accommodations and minimal supportive services similar to those offered by a halfway house, with residence at the program a requirement of parole. And still other programs could administer naltrexone, one of the better

service addicted inmates living elsewhere in the community. Finally, some of these programs could administer methadone in conjuction with outpatient therapy in support of an outside living and work experience.

The services presently offered by community programs vary, as discussed above. Clearly many of them, particularly the inpatient programs, are not designed to cope with individuals who have been incarcerated, sometimes extensively, immediately prior to entry into the program. As a result, some programs may have to alter their approach to provide some of the services described above.

Whatever treatment modality is provided, however, the critical element in this approach is the linkage between the prison and the community drug programs, i.e. the use, for the first time, of existing drug programs as part of the correctional process.

The Candidates

One important aspect of this approach would be the selection of those inmates to participate in this program in such a way as to minimize the risk to the community. The releasing authority, the custodial authority and the drug treatment authority would be responsible for developing eligibility criteria. The selection of participants should be based primarily on whether an addict would benefit from participation in this approach rather than on the severity of his crime. Despite popular impressions to the contrary, it has not been established that addicts who have committed violent crimes are less amenable to treatment than those committing nonviolent crimes. Thus, while the nature of the crime may determine how long the releasing

authority (parole board) wishes to keep an addict incarcerated to satisfy the punitive aspects of his sentence, it should not be a significant measure of his acceptablility for this approach to treatment. Rather, acceptability should be determined by the releasing or custodial authority on the basis of such factors as institutional behavior and effective participation in existing treatment programs within the prisons. In addition, the opinions of prison staff, both treatment and custodial, as to an individual's motivation for participating in community-based programs should be carefully weighed.

The releasing or custodial authority must also determine whether an addict can participate in community treatment while legally an inmate or whether the addict must wait until he or she is eligible for, and has been granted, parole. In arriving at this decision, the nature of the crime would assume greater importance.

The Central Intake Unit and Referral System

Another critical aspect of this approach is the linking of the custodial authority or releasing authority and the drug treatment programs in a central intake unit and referral system. This would facilitate placing the addict in a particular program and allow for monitoring the service delivery and supervising the addict's progress and behavior while in treatment. The authority responsible for linking the custodial or releasing authority and the drug treatment programs would be assigned the task of knowing how each program under its aegis functions, and would be in a position to better align the

needs of a particular addict with the services of a particular program than could the releasing authority.

A central intake unit and referral system should also be responsible for finding another placement should the first be ineffective or inappropriate. Should it be necessary, the unit could place the addict in various programs until it becomes clear that none would succeed. Then and only then would the unit refer the addict back to the releasing or custodial authority for processing without reference to his addiction.

Responsibilities of the Custodial Authority

In addition to selecting carefully the addicts who would participate in this approach the custodial authority would be responsible for providing the addict with rehabilitative services which do not relate specifically to his addiction, since freedom from addiciton is only one aspect, albeit an important one, of successful reintegration into society. The custodial authorities must also make available basic educational and, in some cases, vocational rehabilitation. The development of these skills, in turn, must be accompanied by job development and placement services. While these aspects of an addict's overall rehabilitation are not elaborated upon here, they are noted because of the importance of recognizing that without them the likelihood of an addict's ultimate success will be seriously diminished.

Advantages and Obstacles to the Approach

There are numerous advantages to this approach. First, the addicted inmate in a community program could maintain closer ties with his family, have better access to jobs and receive real assistance and therapy at a most critical time. Instead of being thrown back suddenly into a no longer familiar world, he is allowed to reenter slowly at a pace to which he can better adjust. His chances of ultimate success must certainly be heightened as additional resources are brought to bear on his problem.

Second, the prisons, with fewer inmates, could devote more time and staff energy to internal rehabilitation programs. Correctional officers might be better utilized in providing a resource for supportive work.

Third, the community as a whole would benefit as addicted inmates, who traditionally have a high rate of recidivism, would be receiving far more extensive treatment and supervision than ever before. Since the community currently receives a steady stream of released inmates whose supervision, if any, is the sole responsibility of an overburdened parole officer, it cannot help but benefit from the additional involvement of its facilities in the reintegration of these inmates.

The major obstacle in implementing this approach is the current lack of coordination in the criminal justice system. At present, there is at best a loose working relationship between the custodial authorities and the releasing authority. There are even weaker ties between the releasing authority and its parole supervisors in the community and the community treatment programs. If co-ordination at all these levels is not measurably improved, the trust

and cooperation necessary to implement this approach will never be achieved. And the releasing authority may have to alter its attitudes toward granting parole to incarcerated inmates in light of expanded use of community programs.

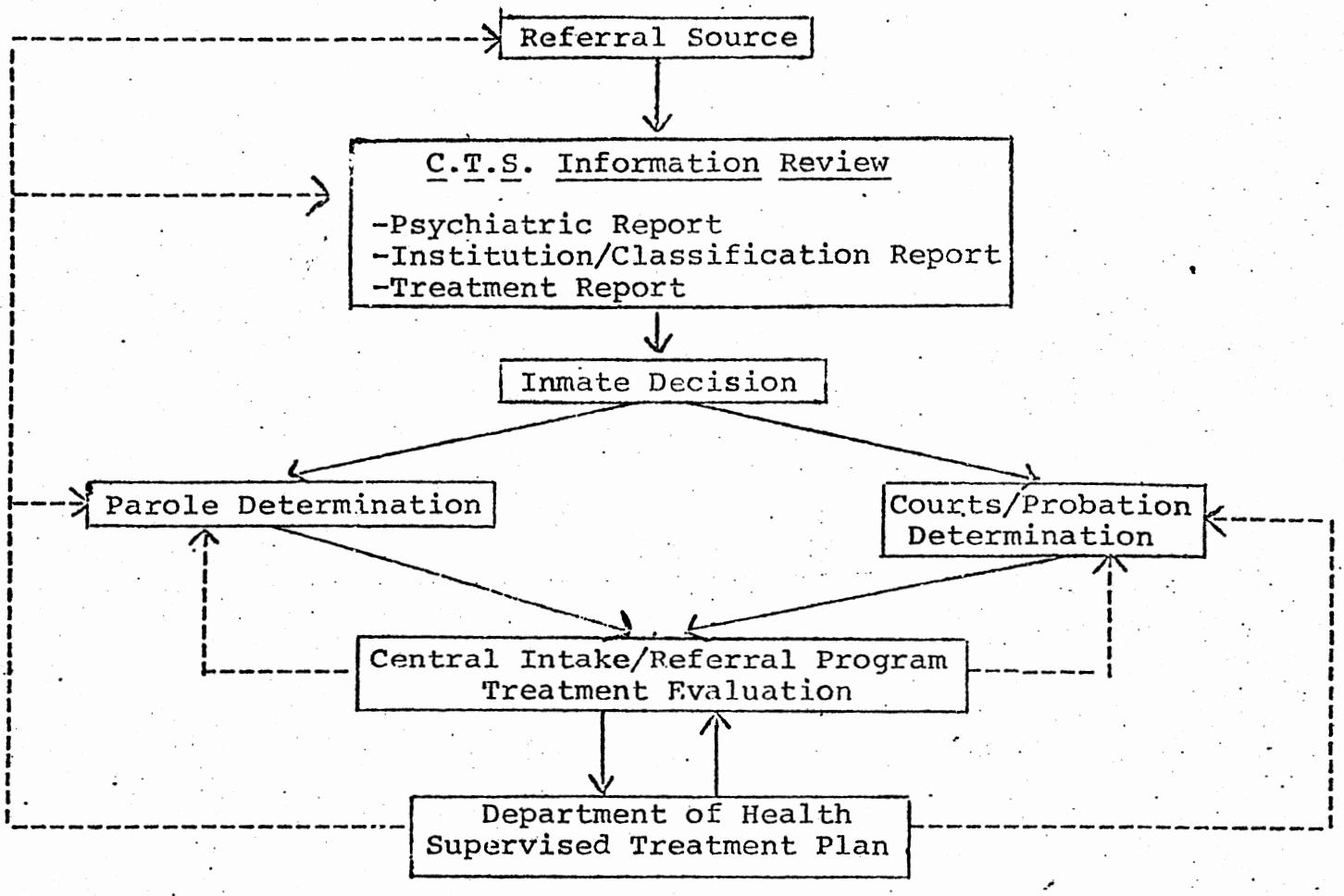
Only the need to restructure is new. Lack of coordination at all levels of the criminal justice system and local hostility to community-based correctional programs have long existed. None of these difficulties is insurmountable, however, and solutions to them are not found in greater expenditures of money alone. Rather, the Commission believes that what is needed is a better working relationship between the custodial authorities and the communties to achieve the mutual goal of a more successful transition of the addicted inmate from the prison to the community. The alternative program suggested below is one approach to achieve that goal.

Administrative Structure Implemented for Processing Inmates into Community Based Treatment

In May, 1973, the combined staffs of the Division of Correction and Parole in the Department of Institutions and Agencies, and the Division of Narcotic and Drug Abuse Control in the Department of Health, established the Interdivisional Policy Committee (I.P.C.) for purposes of addressing common problems within the areas of correction and treatment that overlapped the traditional divisional boundaries and authorities.

In April, 1975, as an out growth of the I.P.C. meetings and recommendations, the Community Treatment Services Program (C.T.S.)

COMMUNITY TREATMENT SERVICES PROGRAM FLOW CHART



was created under the administration of the Division of Narcotic and Drug Abuse Control. A unique quality of this program is that it utilizes a combined staff from both divisions for purposes of processing inmates from the State correctional complex into community based treatment (See the C.T.S. Program flow chart on the opposite page).

The C.T.S. Program has been effective in blending the rational authoritative concepts of both probation and parole and the necessary expertise from the Departments of Institutions and Agencies and Health to identify, screen and evaluate drug dependent inmates for placement into community based treatment facilities. The following explains the various steps in the C.T.S. Program:

1. Referral Sources

Inmate referrals to C.T.S. are accepted from the institution's parole officer, professional services, and institutional drug programs.

2. C.T.S. Information Review

After an inmate completes the C.T.S. application requirements, a report and recommendation is submitted from the referral source. The C.T.S. Program, upon receipt of this report, compiles an information folder which includes a psychiatric report, an institution and classification report, and a treatment report with a recommendation.

3. Inmate Decision

The inmate is advised of the conclusions contained in the C.T.S. information folder and decides if he should proceed further for parole or court determination.

In those cases when an affirmative decision is made by the inmate to proceed for a court or parole determination, C.T.S. will forward the information folder to the releasing authority with a recommendation as to the inmate's suitability to treatment.

4. Determination by the Releasing Authority

The specific information contained in the C.T.S. folder will assist the releasing authority in deciding if an inmate should be considered for release. If, after a review of the information, a determination to release an inmate is made, a condition of the release will specify that treatment be entered into with the Division of Narcotic and Drug Abuse Control of the State Department of Health where the individual shall remain until discharged by the releasing authority.

Agreements have been reached with the individual superintendents in the State prison complex for C.T.S. staff to enter the institutions and review and have access to Classification and Bureau of Parole files. Arrangements were also made with the Directors of Professional Services within the prison complex to identify C.T.S. as the coordinating agency to process inmates into community treatment.

The Department of Health's Central Intake Unit (C.I.U.) assumes with this procedure the responsibility of scheduling the diagnostic evaluation and selecting the type of treatment an inmate should enter as a condition of the release. It should be noted, however, that the Department of Health's selection of treatment only occurs after the releasing authority so determines an inmate is ready for release. If, with cause, the treatment type requires

modification, the C.I.U. will re-evaluate and make the necessary treatment changes.

Recommended Administrative Changes for Processing Inmates Through the Department of Health into Community Based Treatment

In addition to the abovementioned program for processing inmates out of the State correctional complex and into community based treatment programs, the Commission concluded that various existing administrative programs could become more effective in accomplishing this same objective if certain changes were accomplished. The Commission has identified five of these programs and recommends changes therein accordingly.

1. Bureau of Parole

The bureau should identify a staff person to coordinate all parolees referred for diagnostic evaluation prior to treatment. The Bureau of Parole should consider having a Specialized Narcotic Treatment Caseload with trained parole officers identified to work closely with the client while he is in treatment.

2. Institutional Parole Officers

As a referral source to the Department of Health, the I.P.O. should have a close working relationship with Health staff in the development of a parole plan or proposed parole contract.

3. Administrative Office of the Court, Probation

Through the Department of the Public Advocate's Office of Inmate Advocacy, an amendment was drafted to New Jersey Court Rule 3:21-2 for the purpose of identifying the Division of Narcotic and Drug Abuse Control in the State Department of Health as the agency to evaluate and diagnose convicted drug dependent persons prior to sentencing (see Appendix A to this Chapter). It is recommended that this change be approved.

4. Department of the Public Advocate, Office of Inmate Advocacy

Community Treatment Services staff has met with the staff from the Department of the Public Advocate to develop or revise procedures for processing inmates from the state correctional complex into community based treatment under New Jersey Court Rule 3:21-10(A).

The Office of Inmate Advocacy, at the request of the Department of Health, has submitted a draft copy amendment to New Jersey Court Rule 3:21-10(A) which identified the Division of Narcotic and Drug Abuse Control in the State Department of Health as the agency to examine, diagnose and select the type of treatment for inmates being processed for release (see Appendix B to this Chapter). Again, it is recommended that these changes be adopted.

5. State Parole Board

It has been recommended to the administrative staff of the State Parole Board that the Community Treatment Services Program be given responsibility for compiling the necessary

information to assist the Board in making a determination for releasing drug dependent inmates on parole.

If a determination of release is decided on by the Parole Board, it is recommended that the State Department of Health conduct the diagnostic evaluation and select the type of treatment parolee must enter as a condition of release.

Conclusion

The Commission strongly believes that these recommended administrative changes, if implemented, would help in developing a better working relationship between the custodial authority, releasing authority, and treatment programs, and would achieve the goal of a more successful transition from the prison to the community for the drug dependent inmate. These changes alone are not sufficient, however, as they depend on the good will of all concerned and on the assumption that all authorities have an adequate knowledge about drug treatment. In order to achieve an effective inmate release process, therefore, the Commission also recommends necessary legislation in addition to the above recommended administrative changes. Through legislation the Department of Health could be designated as the responsible authority for providing the diagnostic evaluation and selecting the type of treatment as a condition of the release order.

APPENDIX A

Draft Copy of Amendment to New Jersey Court Rule 3:21-2 as Prepared by the Department of Public Advocate

3:21-2. Presentence Investigation

Before the imposition of a sentence or the granting of probation the probation service of the court shall make a presentence investigation and report to the court. The report shall be first examined by the sentencing judge so that matters not to be considered by him in sentencing may be excluded. The report, thus edited, shall contain all presentence material having any bearing whatever on the sentence and shall be furnished to the defendant. If a custodial sentence is imposed, the probation service of the court shall, within 10 days thereafter, transmit a copy of the presentence report to the person in charge of the institution to which the defendant is committed. In all cases in which the defendant is convicted of a violation of the Controlled Dangerous Substances Act (N.J.S. 24:21-1 et seq.) involving a narcotic, depressant or stimulant drug as defined in the Act, or in which the court determines there is reasonable cause to believe the defendant is a drug dependent person as defined in N.J. 24:21-2, the court, before imposing sentence, shall refer the defendant to the Division of Narcotic and Drug Abuse Control of the Department of Health for examination and diagnosis. The Division shall prepare a report based on such examination which shall be made a part of the presentence report.

Rationale for Proposed Amendment to 3:21-2

A recent survey revealed that 22,000 persons or approximately one-half of the total 46,000 persons under probation supervision have had some form of drug abuse involvement.

Of the 22,000 persons in this category, only 2,393 drug abuse probationers were registered in treatment in 1972 with the Department of Health. This statistic clearly illustrates that probation is underutilized as a referral source for the identification and treatment of drug abusers.

There are currently no uniform sentencing guidelines for registering, screening, evaluating, placing and treating drug abusers committed to probation jurisdiction. The manner of treatment often is "prescribed" by the sentencing judge, who reviews and relies on the recommendations of the probation presentence investigator.

The manipulative drug abuser, in addition, usually is successful in selection of his own treatment during this sentencing period. In effect, we have a situation where medically oriented treatment may be decided by the sentencing judge, the probation investigator, the drug abuser, or a combination of all three. This is not to say that any of the above treatment decisions may not be effective, but more importantly that there are no uniform drug abuse treatment procedures at time of sentencing in the 21 county courts.

The fragmented uncoordinated attempts to treat drug abusers may vary from one area of the State to another with a bias for or against a type of treatment. This bias or disparity

may range from favoring methadone maintenance to total disapproval.

Frequently, staff from treatment programs will prevail upon the court to send drug abusers to their respective program without the benefit of proper evaluation and screening. The motive on many occasions may be only financial. Program funding is available from Federal sources for drug abusers referred into treatment. As a result of a program's need to recruit, it does not take the newly enrolled drug abuser long to realize he is a commodity upon whom a program's financial success may depend. This type of behavior is inimical to the entire treatment process. Actually, the treatment process may never begin.

A manipulating drug abuser may continue to use drugs and also continue in a treatment program to avoid further court involvement as a probation violator. The treatment staff also may be hesitant in calling this person to task. To reveal that a person is not responding to treatment may result in the court suspending sentence and violating probation. This action would further jeopardize the program's funding.

The failure of treatment programs to submit information requests and accurate progress reports on a regular basis results in the court's having less confidence in the drug abuse treatment process. This lack of program confidence consequently places limits on the court's sentencing options.

If no specific treatment is indicated at the time of sentencing, the probation officer who supervises the case may

select the type of treatment or he may decide to "treat" the drug abuser with the Probation Department. This treatment supervision, in reality, may be nothing more than a once per week required visit and urine monitor. Probation officers, due to their heavy unspecialized case loads, have difficulty devoting their time exclusively to drug abusers who require more supervision than routine once a week reporting.

APPENDIX B

Draft Copy of Amendment to New Jersey Court Rule 3:21-10 as Prepared by the Department of Public Advocate

3:21-10 Reducation or Change of Sentence

(a) Time. A motion to reduce or change a sentence shall be filed not later than 60 days after the date of the judgment of conviction, or, if an appeal is taken within the 60 days, not later than 20 days after the date of the judgment of the appellate court. The court may reduce or change a sentence either on motion or on its own initiative, by order entered within 75 days from the date of the judgment of conviction or, if an appeal was taken within 60 days, within 35 days of issuance of the judgment of the appellate court, and not thereafter; provided, however, that an order changing a custodial sentence to permit transfer of a defendant to a narcotics treatment center may be made at any time. Whenever any defendant moves for transfer to a narcotics treatment center, the court, before hearing the motion, shall refer the defendant to the Division of Narcotic and Drug Abuse Control of the Department of Health for examination and diagnosis. The Division shall prepare a report based on such examination for the consideration of the court on the motion. Such report shall be made available to the defendant and shall be confidential unless otherwise provided by rule or court order.

CHAPTER VI

Miscellaneous Recommendations

The "Drug Study Commission" also looked into a number of suggested revisions of New Jersey laws concerning controlled dangerous substances or controlled dangerous substance offenses. The revisions--suggested to the Commission by persons interested in correcting certain inequities, ambiguities and omissions which exist in our laws--involve existing laws concerning (1) the manufactures, dispensers and distributors of controlled dangerous substances; (2) the nuisance and forfeiture of "drug money"; (3) motor vehicle offenses involving controlled dangerous substances; (4) the illegal distribuion or possession of hypodermic needles; (5) and the incarceration of persons on methadone maintenance. They are discussed below with Commission recommendations.

Manufacturers, Dispensers and Distributors of Controlled Dangerous Substances

Section 10 of P.L. 1970, c. 226 (C. 24:21-10) requires that every person who manufactures, distributes, or dispenses any controlled dangerous substance shall obtain annually a registration issued by the State Department of Health in accordance with all the rules and regulations promulgated by it. The Commission recommends that instead of requiring a registration the law should be amended to require a <u>license</u> and allow for the inspection and search of premises for which the license is sought. A license is

generally considered a privilege rather than a right and would facilitate the investigation of possible illegal activities by manufacturers, distributors, or dispensers of controlled dangerous substances.

Current opinion holds that an administrative warrant issued pursuant to the present statute (C. 24:21-10) requiring anything less than probable cause in the traditional or criminal sense is violative of the Fourth Amendment's protection from unreasonable search and seizures. The courts have already ruled, however, that such a position cannot be taken when a license to operate is involved.

The background to this proposed revision is the illicit diversion of controlled dangerous substances by pharmacists and physicians. While this is a little known problem in New Jersey, it has been estimated by the State Attorney General's Office that over 200 cases are currently pending which involve the illicit diversion of controlled dangerous substances by physicians and pharmacists. The requirement for a license and the correction of the following problems in reference to registrants would facilitate the prosecution of these cases.

Subsection 24:21-15a. (P.L. 1971, c. 226 § 15a.) provides that except when dispensed directly in good faith by a practitioner in the course of his professional practice to an ultimate user, no Schedule II controlled dangerous substance which is a prescription drug as defined in R.S. 45:14-14 may be dispensed without a written prescription of a practitioner. The intent of this statute is to prevent a practitioner (physician) from prescribing or directly

giving a Schedule II substance without doing so in good faith and in the course of his professional practice. However, if the statute is read closely, it seems to say that no Schedule II substance may be prescribed (dispensed) without a written prescription. This, needless to say, makes no sense. The Commission recommends that the wording should be changed to simply say that no practitioner may dispense or distribute a Schedule II substance unless it is done so in good faith in the course of his professional practice.

Subsection 24:21-15c. (P.L. 1971, c. 226, § 15c.) states that no controlled dangerous substances included in Schedule V may be distributed or dispensed other than for valid and accepted medical purposes. Most Schedule V substances are distributed or dispensed by pharmacists, and there is a question as to whether or not a pharmacist can be held to make a medical judgment as required in subsection 15c. For this reason, the Commission recommends that the statute should include the phrase in the "professional judgment" of the pharmacist.

Subsection 24:21-22a(2) (P.L. 1970, c. 226 § 22a(2)) states that it shall be unlawful for any person knowingly or intentionally to use in the course of the manufacture or distribution of a controlled dangerous substance a registration number which is ficticious, revoked, suspended or issued to another person. The word "dispensing" is held to be (by definition in the act) synonymous with prescribing. However, it is not included in this subsection. And there are cases where physicians who have had their dispensing registration number revoked because of prior bad acts are now using fictitious registration numbers on prescriptions.

A literal reading of this subsection would seem to exempt them from any penalty. For this reason the Commission recommends that the word "dispensing" should be added to subsection 24:21-22a(2).

Subsection 24:21-24b. (P.L. 1970, c. 226, § 24b.) states that information communicated to a practitioner in an effort to unlawfully obtain or procure the administration of a controlled dangerous substance shall not be a privileged communication. The word "administration" is defined in the act as injecting or the direct administering of a drug to a patient. This does not include the sale of packaged drugs or the act of prescribing. The Commission therefore recommends that this subsection should be amended to include "the administration, distribution, or dispensing," rather than solely isolating it to the "administration," of a drug.

Nuisances and Forfeitures

Section 35 of P.L. 1970, c. 226 (C. 24:21-35) concerns the forfeiture to the State of property found on the premises which was employed for the unlawful manufacture, distribution, dispensing, administration or use of a controlled dangerous substance. The Commission feels that the statute is incomplete in two areas. It does not list as subject to forfeiture money that is seized or captured by the police in connection with a controlled dangerous substance related arrest--as is the case with gambling money. Although money is presently confiscated in controlled dangerous substance related arrests, there is no statutory provision for doing so. Furthermore, the question remains of what the

authorities are to do with the confiscated money. At the present time, such money is usually placed in the general treasury of the county in which the money is seized and is not designated for any particular purpose.

The Commission believes that money seized and forfeited in connection with a controlled dangerous substance violation should be designated for the further investigations of controlled dangerous substance violations. In effect, let the drug offender's money be used to apprehend and deter other drug offenders. This can be accomplished by the designation of a special fund, in which money seized or captured in a controlled dangerous substance arrest would be deposited, and which would be used only for the enforcement of controlled dangerous substance laws in the county in which the money was seized.

The Commission therefore recommends that P.L. 1970, c. 226, § 35 (C. 24:21-35) should include a subsection b.(6) to provide that all money, currency, or cash seized or captured by the police or officers in connection with any arrests for violation of or conspiracy to violate the controlled dangerous substance act of this State shall be subject to forfeiture and no property right shall exist in them. Section 35 should be further amended to add a new provision--as follows:

> All money, currency or cash seized or captured under b(6) of this section shall be deposited with the County Treasurer in the county in which said money, currency or cash were seized or captured within 7 days after seizure. In those counties which do not operate a county narcotics strike force, or county narcotics squad, the said funds shall be deposited in the

> general revenue fund of that county. In those counties that do operate a county narcotics strike force, or county narcotics squad, said seized funds shall be deposited in a special Narcotics Purchase Money Fund to be used for the purchase of controlled dangerous substances and the investigation of violations of this act. Said fund shall consist of, but not be limited to, all money, currency or cash seized or captured and lawfully retained in connection with this act.

Section 35 does not explain what the State is to do with controlled dangerous substances once they are confiscated. These substances must be preserved long enough to effectively prosecute the defendant but not so long that a danger or unnecessary expense for storage is incurred. The Commission recommends that the following procedures which are now followed in Essex County should be added--by way of amendment--to section 35 of P.L. 1970, c. 226 (C. 24:21-35):

> Upon the seizure or capture of those substances subject to forfeiture under this act, the prosecutor of the county where such seizure is made shall have the same destroyed or rendered useless for the uses and purposes aforesaid and it shall be unlawful to return them to the person or persons owning the same or to any other person; provided it shall be lawful for the prosecutor, in his discretion and subject to an order from a court of competent jurisdiction, to donate and deliver such of them as may be used for lawful purposes to any institution located within the county where such seizure is made and which is under the control and operation of the federal government, the State of New Jersey or any political subdivision thereof, or which is under the control and operation of any public, semi-public, or private, charitable, religious or philanthropic institution or organization.
>
> (1) Any substance which has not been donated in accordance with subsection (a) shall be destroyed or rendered useless upon obtaining a

court order from a court of competent jurisdiction as follows:

(a) Upon the rendering of a final decision in his favor; or

(b) Upon the expiration of 3 years after all appellate review has been exhausted or the time has elapsed for the filing of any appeal; or

(c) The expiration of any custodial sentence to which the defendant has been subjected; or

(d) Where no custodial sentence has been imposed upon the expiration of a 90 day period after the entry of judgment of conviction.

(2) In those cases where the substances have been seized or captured from more than one person, such substances shall not be destroyed or rendered useless until the steps in (a), (b), (c) and (d) have been applied and affectuated as to each and every such person.

Motor Vehicle Offenses Involving Controlled Dangerous Substances

Section 20c. of P.L. 1970, c. 226 (C. 24:21-20c.) authorizes a sentencing judge to determine whether to forfeit the right of a person to operate a motor vehicle for a period of not more than 2 years from the date of conviction for violating those provisions of section 20 which involve disorderly person's offenses, i.e., use or under the influence of any controlled dangerous substance, or possession of 25 grams or less of marihuana, or 5 grams or less of hashish. According to this provision, the mere fact that a person is adjudged a disorderly person for the aforementioned offenses is sufficient grounds for loss of his right to operate a motor vehicle. He need not have been operating a motor vehicle at the time. New Jersey is one of only four states in the

country which has such a provision in its laws.

The appropriateness of this provision is questionable. Because a person used a controlled dangerous substance does not necessarily mean that he is a dangerous driver or that he even drives while possessing or using the controlled dangerous substance in question. The enforcement of this provision has also interfered with treatment efforts to rehabilitate drug offenders, since a driver's license is often needed to commute to a treatment center. And while a person in a drug treatment program may apply to have his driver's license restored, such a procedure is lengthly and frustrating. The Commission therefore recommends that section 20c. of P.L. 1970, c. 226 (C. 24:21-20c.) should be repealed.

This is not to say drugs and motor vehicles are compatible. Rather, the Commission believes an individual who operates a motor vehicle while under the influence of a controlled dangerous substance should be prosecuted. In this regard, the language of subsection a. of R.S. 39:4-50--operating under the influence of liquor or drugs--is inadequate. The phrase "narcotic, hallucinogenic or habit-producing drug" should therefore be deleted and the words "any controlled dangerous substance" inserted therein.

Subsection b. of R.S. 39:4-50 provides for a fine of not less than $50. nor more than $100., and the forfeiture of the right to operate a motor vehicle for a period of six months from the date of conviction for a person who operates a motor vehicle while his ability to operate is impaired by the consumption of alcohol. The Commission recommends the amending of this subsection to include operating a motor vehicle while one's ability to operate is impaired by the use of any controlled dan-

gerous substance.

The State Division of Narcotic and Drug Abuse Control has reported that several of their clients who were observed recklessly driving a motor vehicle were charged and prosecuted under R.S. 39:4-50a. simply because they were enrolled in a methadone maintenance program. Although methadone is legally defined as a "narcotic," the division reports studies have shown that once a person is stabilized on methadone, his coordination is normal and he is perfectly capable of operating a motor vehicle. The division further asserts that if a methadone maintained person is arrested for improper driving, the explanation for his conduct can almost invariably be traced to the presence in his system of a chemical substance other than methadone. That is, a methadone maintained person can thwart--if he is not immune to--the effects of more methadone.

Another difficulty with R.S. 39:4-50a. as drafted, therefore, is that it does not attempt to make exceptions for the aforementioned situations. From the criminal justice perspective this is not a problem; incapacitated drivers should not be permitted to operate a motor vehicle. From a treatment perspective, however, the failure to adequately identify the incapacitating substance leads to the conviction of drivers on methadone when the only evidence of this is the driver's participation in a methadone program. This in turn leads to a weakening of the credibility of the methadone maintenance effort--an effort in which the State has invested millions of dollars and from which the State has derived numerous benefits. It should be further noted that for the several thousand methadone

maintained persons in this State, employment is an essential part of their rehabilitation, and an inability to drive would be fatal to their employment in most cases.

The Commission therefore recommends that R.S. 39:4-50a. should be amended to read that any person prosecuted under this subsection who has been verified by a licensed methadone maintenance treatment center as a regular patient thereof and has been stabilized on a daily dosage of methadone shall not be regarded as being under the influence of a controlled dangerous substance for that reason alone unless expert medical testimony has been adduced to that effect. Any such methadone maintained person who is arrested hereunder must be given an opportunity within six hours of the arrest to produce a specimen for urinalysis, to give a blood sample, and to undergo a breathalizer test.

Illegal Distribution or Possession of Hypodermic Needles, Syringes and Other Instruments

The Commission recommends that those sections of New Jersey's statutes dealing with the illegal distribution or possession of hypodermic needles, syringes or any instrument adapted for the use of narcotic drugs by subcutaneous injections without a written prescription of a duly licensed physician, dentist or veteranarian (section 1 of P.L. 1955, c. 277, C. 2A:170-77.3; section 2 of P.L. 1955, c. 277, C. 2A:170-77.4; and section 3 of P.L. 1955, c. 277, C. 2A:170-77.5) should be amended to omit narcotic drugs and insert in its place controlled dangerous substances as defined in section 2 of P.L. 1970, c. 226 (C. 24:21-2). Since many sub-

stances other than narcotic drugs, i.e., amphetamines and cocaine, are injected by means of hypodermic needles, syringes or any instrument adapted for the use of controlled dangerous substances by subcutaneous injections, the aforementioned laws prohibiting the illegal distribution or possession of said instruments should be for any controlled dangerous substance--rather than solely narcotic drugs.

Incarceration of Persons on Methadone Maintenance

The Division of Narcotics and Drug Abuse Control has reported that persons legitimately on methadone maintenance have been incarcerated in certain county jails in New Jersey and have been denied continued methadone maintenance or detoxification from methadone even if the clinic offers to provide and dispense the methadone. This results in the person suffering from withdrawal symptoms which are painful and debilitating. Such a practice in some of our county facilities appears to be cruel and inhumane treatment. The Commission believes legislation should be enacted that would remedy this situation.

CHAPTER VII

County Prosecutor's Questionnaire

The New Jersey "Drug Study Commission" sent a questionnaire to all of the twenty-one county prosecutors in New Jersey. The questionnaire asked the county prosecutors to express their views on certain provisions of the "New Jersey Controlled Dangerous Substances Act"; possible changes needed in the act; and the effects of New York State's recently enacted stringent drug laws on the drug problem in New Jersey. Thirteen of the twenty-one county prosecutors responded; this chapter reports summarily and without comment on the findings of the questionnaire while respecting the confidentiality of each county prosecutor who responded.

The respondents represent experience in the field of criminal justice ranging from sisteen months to nineteen years. The time spent by their offices on the prosecution of drug offenses varies from 5 to 50 percent--with the dismissal of drug cases ranging from none to 30 percent. The respondents reported a current court backlog of from none to 1400 cases and are divided six for to seven against the idea of a special court to handle drug related cases.

The prosecutors feel almost three to one that marihuana leads to harder drugs and they all beleive that heroin is related to "urban crime," e.g., mugging and robbery.

Seven of the thirteen prosecutors responded that they favor a new classification or scheduling of drugs in New Jersey.

The new classification or schedule should be scaled by the nature of the drug, addictiveness of the drug, and the quantity of the drug.

Eleven prosecutors believe that possession of drug paraphernalia should be illegal, on the grounds that such a law would clarify the distinction between a dealer and a user of hard drugs.

A majority of the prosecutors recommended increased penalties for possession of controlled dangerous substances with intent to sell; mandatory sentences for hard drug sales; weight guidelines to define sales dealing in actual weights, not cut weights; improved rehabilitation programs; and conditional discharge for subsequent offenses for users and addicts.

Eleven prosecutors believe that it would be useful for New Jersey to employ a system of medical certification of addiction. In order of importance they feel that the narcotic used, the date of last use, the length of use, the frequency and cost of use, the history of treatment, the specific program recommended, and the type of program recommended should be listed in such a report. Nine of the prosecutors favor civil commitment for addicted (1) possessor-users; (2) small time sellers supporting a habit; and (3) defendants--certified as addicts--arrested for non-violent crimes. A civil commitment program would involve: active hospitalization with therapy; "walk-away" prevention; initiatives for offering admission would rest with the discretion of the prosecutor; availability to first offenders only; and the exclusion of large scale sellers from the program.

In the past year (1974), the thirteen prosecutors have individually used the conditional discharge provision of the "New Jersey Controlled Dangerous Substances Act" as many as 200 times. Seven prosecutors agree to its valid use for heroin/opiate possession violations, while eleven prosecutors stated they had never used it for heroin/opiate sales violations. All of the respondents are unwilling to extend this provision to any second or subsequent offenders except for one county prosecutor who is in favor of extending conditional discharge to a user who is certified to be drug dependent.

All but one county prosecutor prefers that a plea be taken before a conditional discharge is agreed to. Eleven prosecutors replied that they would be more willing to agree to a diversionary program before a finding of guilt if the program was required to report the defendant's progress twice a month during the first three months. If the progress were not satisfactory, then the case could be reopened at the end of three months to prevent the state's evidence from becoming too "stale."

Eight prosecutors prefer an in-residence drug-free diversionary program for first time offenders while one prosecutor prefers methadone maintenance. Some prosecutors favor the availability of all programs so that the client has the best chance possible to be rehabilitated. Nine prosecutors believe that a law making absconding from a rehabilitation program punishable by imprisonment for one year would make them more favorable to diverting a defendant to a treatment program before a finding of guilt. Of the nine prosecutors, six of them believe that if a defendant who violates

such a charge is arrested for a subsequent offense, their general reaction might be to run the absconding sentence concurrently with the sentence for the subsequent charge. These prosecutors feel that their reaction will be to prosecute both charges as independent crimes, while 3 other prosecutors believe their reaction will be to dismiss the absconding charge for the purpose of a plea.

Two prosecutors replied that the provision for expunging a defendant's record has been used extensively; six said it has been used moderately; and five stated that it has rarely been used.

Eight prosecutors stated that they had never recommended the use of the double time/double fine provision of the "New Jersey Controlled Dangerous Substances Act"; two said that they seldom had used it; and one replied that he had used it twice.

Nine prosecutors feel that the recently enacted stringent New York State Drug Law has had no impact on the drug problem in New Jersey. Four prosecutors believe that they do not have enough information to comment. Only two county prosecutors cite an increase in hard drug cases which might indicate that some of the New York drug traffic has moved to New Jersey. One prosecutor feels that once current New York drug offenders start receiving the jail terms mandated by the New York State Drug Law, New Jersey will see an influx of drug traffickers from across the Hudson River.

Three county prosecutors reported that there has been an increase in heroin/opiate cases in their counties in the past year; one county prosecutor feels the number has levelled off in his county; and one county prosecutor feels the number has decreased in his county.

Seven county prosecutors are against a New York State type drug law in New Jersy, while four prosecutors favor such a drug law for this state. Comments on such a drug law ranged from, it would be helpful, with particular emphasis on habitual offenders and dealers, to, New Jersey's drug laws present sentences are sufficient, but maximum penalties are not being meted out.

Eleven of the prosecutors think mandatory minimums will increase the number of trial requests, although one prosecutor thinks discretion can still be maintained with mandatory minimum sentences. It is estimated by the prosecutors that trial request will increase from 10 percent to 75 percent; eight of the eleven prosecutors also think that mandatory minimums will increase the use of plea bargaining to fit the punishment to the individual.

Six prosecutors favor mandatory minimum sentences for the possession of large amounts of drugs; five prosecutors feel that the seller of any drug should receive a mandatory minimum sentence; three prosecutors would impose such a sentence only for second offenses concerning hard drug violations; one prosecutor favors the same for second offenses concerning the sale of marihuana; two prosecutors would impose mandatory minimums for the sale of hard drugs; and two prosecutors would impose the same for big time manufacturers and distributors of drugs.

All thirteen of the county prosecutors replied that there is no reluctance on the part of juries to convict for heroin, methadone or barbiturate violations, whether for the sale or possession of such drugs. Seven prosecutors cited a reluctance on the part of juries to convict in cases of sales of marihuana and

nine said there was jury reluctance in cases of marihuana possession. Eight prosecutors said that they had plea bargaining guidelines, both formal and informal, such as no-noncustodial recommendation for any seller and never dropping sales cases to lesser offenses.

Nine prosecutors reported that they had guidelines for handling marihuana cases where the weight of the drug is just over 25 grams. Examples given by the prosecutors are: conditional discharge; downgrading to a lesser offense; and follow the intent of the statutes. Five prosecutors were in favor of increasing from 25 grams to 50 grams the threshold for a disorderly persons offense regarding the possession of marihuana. Six were in favor of a simple fine, to be increased depending on the weight involved, for all cases of marihuana possession. Twelve prosecutors were against a fine for marihuana sales, and two were in favor of disposing of all marihuana penalties for possession of under 50 grams. Eight said that they would be in favor of a statute setting up an adjournment for six months in contemplation of dismissal for first time offenses of marihuana possession. At the end of this period the case would be dismissed and the defendant's record automatically sealed, if there has been no subsequent violation.

In response to why they thought arrests had dropped for heroin offenses but remained the same for marihuana offense, the prosecutors cited the difference in the availability of the two drugs, world wide enforcement of drug laws, school drug education programs, and Turkey's boycott of poppy growers. None of the prosecutors could give evidence, other than the decline of heroin

arrests on police records, that showed there is a decline in heroin use while the use of alcohol and barbiturates has increased among youths. Five county prosecutors believe that there has been an increase in the illicit use of methadone; one county prosecutor cited ten deaths from methadone over-doses to support this contention.

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