PUBLIC HEARING
before
DRUG STUDY COMMISSION
at
BERGEN COUNTY COURTHOUSE
HACKENSACK, NEW JERSEY
MAY 15, 1974

A P P E A R A N C E S:

SENATOR ALEXANDER J. MENZA, CHAIRMAN

MRS. BETTY WILSON, VICE CHAIR PERSON

ASSEMBLYMAN C. GUS RYS

SENATOR WYNONA LIPMAN

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MR. MENZA: Good morning, ladies and gentlemen, we are starting late. This is a Commission of three senators and three assemblymen, whose job you might say is to study drug penalties and treatment programs, and all other aspects of our drug problem, in the State of New Jersey.

It is a reconstituted Commission, this Commission existed last year and we had three hearings, and unfortunately we were not able to finish our work. Therefore, by virtue of SCR-90, the Commission was reconstituted, again consisting of three senators and three assemblymen.

Half of the Commission is here now, myself, I am Alexander J. Menza, and I am Chairman. To my right, is Assemblywoman Betty Wilson, as Vice Chairman, and from Union County. To my left, is Assemblyman Gus Rys from Bergen County. In addition to that, we have State Senator Lipman, Essex County as part of the Commission, Senator Hagedorn from Bergen County.

I have the list of witnesses to be called. We are going to accommodate some

of the gentlemen first, I understand they have other engagements. The first witness to be called, will be Lieutenant Delaney, from the Bergen County Task Force. If any of you have other witnesses, if any of the other gentlemen would like to testify, please sign the paper and our aide, Carl Moore will arrange for you to do so.

We intend spending a good portion of the day here with you, and we will see what happens around lunchtime, and if we are getting close to completion, we will go right through lunch.

I should add, last year the Commission heard a great deal of testimony from law enforcement officers, including prosecutors, and we also heard from the Executive Director of the President's Commission to discuss marijuana. We heard the gentleman from Pennsylvania, psychiatrists from the Harvard Medical School and so forth. We are very, very interested in knowing your attitude, your ideas, with regard to drug penalties, also with regard to process in court. We are particularly interested in your approach

to marijuana, amphetamines, barbiturates, and hard drugs.

Mrs. Wilson, do you have anything to add?

MRS. WILSON: I would like to hear the witnesses.

MR. RYS: Continue, please.

MR. MENZA: First witness to be called will be Lieutenant Delaney from Bergen County Task Force. Will you give us your full name and title?

MR. DELANEY: Detective Joseph J. Delaney, Bergen County Narcotics Task Force.

As I understood your letter, it had to deal with drug penalties and then rehabilitation, and as Mr. Menza just mentioned, some of our attitudes from law enforcement regarding marijuana or other drug related penalties.

There are a few things I would like to say relative to the laws presently in New Jersey. Some of the laws that I feel need changing, some of the laws that need some new institutions. There is a law presently in our statute, 28170:77.5, this deals with hypodermic syringes. The wording of the

statutes deals with narcotic drugs, which by definition in the State of New Jersey would be heroin and cocaine. It has been our experience on the streets here in Bergen County, and throughout New Jersey, that many other substances are injected by way of hypodermic syringes, namely, speed, for example. So if we are going to change some laws, and if this is the intent of the committee, along with other things, one of the things we should change is that the hypodermic syringes, and the wording should be for any use of any control of dangerous substances. There are certain areas in the marijuana law that causes us some difficulties, by way of law enforcement, namely, species, our statutes by definition calls marijuana, Cannabistiteva. There are other various species, India, Mexicana, a number of them. For the purpose of our law, should this remain intact, it should read simply Cannabistiteva and include all species. Likewise, hashish, a production of marijuana, should be spelled out in the statutes separately, and it should be a liquid hashish with no

weight involved. Presently, again in our state, we deal in a weight factor of 25 grams being a disorderly person, and above that being a high misdemeanor. In the area of liquid hashish, again from what we see on the streets, it is a very potent drug, so it should be within our laws a separate statute dealing with liquid hashish and no weight involved.

This not only is my opinion, but that of the New Jersey Narcotics Officers Association, by the way, that is where I met the Assemblywoman.

We had within our state at one time a registry act, and although I am not going to argue the merits for that particular act, it dealt strictly with addicts, registration of addicts, and many of us, collectively speaking, felt that this particular registry act, was strictly for health purposes for registering people, and so that it was struck down by the governor in 1971, and supposedly it then subsequently was to be incorporated within our Health Department. I feel that we should have a new registry act, dealing

with those people who sell narcotics and dangerous drugs. If there should be a migration from New York City, with their new penalty structure, and we haven't seen that as of yet, I feel this act for those people who do sell drugs would be beneficial to the State of New Jersey, not only showing us who our dealers are in the state, but also from without the state. I am sure you are familiar with that registry act.

We don't intend, and we in law enforcement do not intend to have that act re-enacted in total, but dealing strictly with those people who sell drugs, is another statute on the books, 39:4-50, it talks about impaired driving. There is a case being heard in Teaneck, New Jersey, dealing with a substance called qualude , and it is argumentative as to what is and what is not.

We feel again, driving while impaired, should be charged to include all controlled dangerous substances, and then by way of proof, whatever that may be, but it should contain all controlled dangerous substances so we don't become involved in

argumentative issues.

Within the State of New Jersey we have a law dealing mainly with syringes and the like, we should at this point in dealing with those people who traffic in narcotics, have a law dealing with dilutants, those cutting agents that are used for heroin and cocaine, and there are other states, namely, Maryland and New York, that do have such laws. Should we come across a major trafficker, who at the time may not have, let's say, the heroin or cocaine, but does in fact have all of the workings for a mill, a processing mill for those two drugs, will have in his possession large bags, the whole system used for trafficking in narcotics, so we should have some law to cover us in that area.

There are certain areas dealing in monies, where narcotic officers throughout the state, and narcotic aides have to expend certain monies for narcotic cases, namely, in the area of buy money, whereby a local police department may have a limited amount of funds with which to purchase drugs from people on the street at all levels. These

particular cases, should there be an arrest, and then eventually a conviction, if that be the case, aside from any fine or incarceration, we feel through law enforcement that there should be an additional fine of those monies expended by those narcotics squads, to be returned to those narcotics squads, for large seizures of monies, as in gambling cases, and those monies should not be returned to the defendant again. I am talking about a conviction, they should be returned to the County Treasurer, or wherever somebody sees fit, that monies should not go back to the defendant.

Again, it has been our experience, that this very money is put back out on to the streets by way of purchasing drugs. In the area of sentencing, I am sure by now there has been many, many talks about sentencings, whether or not people feel, and not just law enforcement, but people at large, feel that in some cases our judicial system is falling apart at the seams. I don't really feel that is the case. I think we are dealing primarily in the lack of communication, whether

or not you know my problem versus I know yours, we just haven't sat down such as we are doing today, and I think in many cases we have seen an awful lot of people becoming involved in a merry-go-round system, whereby they are into the court and out of the court. There is no degree of certainty that I can see within our judicial system today, nobody is sure that in Bergen County he may be sentenced to X number of months or years in relation to a crime, as in maybe some other county; there doesn't seem to be any identification. Bearing that in mind, and seeing what I have seen in my 18 years as a police officer, I am somewhat half inclined to agree with some minimum mandatory sentencings, although I know it does take discretion, but I feel in these cases dealing with narcotics, that something has to be done. I am not in favor of the so called New York law, I think in many cases they are going to be hindered working under those conditions, but I do feel strongly that those people who profiteer in selling of narcotics and dangerous drugs, we should have a minimum mandatory penalty. In

the area of heroin and cocaine in particular, where we deal in large trafficking, I feel there should be a minimum mandatory sentence of three years in State Prison. This again is not only my feeling, but that of the association I mentioned previously.

Your letters alluded to rehabilitation, and, of course, dealing in law enforcement, we become deeply involved in rehabilitation. Many of us, which may be unknown to the public, deals with referrals whereby we arrest some people, and maybe we are not dealing with the type of people that you and I commonly refer to as a drug dealer, bur rather a drug abuser, for whatever reason, and we wind up referring him to a treatment center.

In my 18 years, I have been involved with an awful lot of treatment centers, both drug free and in using certain drugs, namely, Methadone. It is our feeling again, from law enforcement, that if we could work out some program by which we can have civil commitment, although there is a lot of areas of concern in that case, there is presently California, dealing with a civil commitment, and if we

cannot, then at the time of sentencing of a convicted user of heroin, or an addict, that no matter what the sentence may be, namely, six months for a disorderly person, that the court be allowed to mandate that a person should be treated, spend a minimum of one year in an in-treatment facility. We find that most drug abusers, who are faced with that option, knowing they are going to receive six months in a county jail, versus a minimum one year in-treatment program, will select the six months in the county jail.

If that be the case, I feel it should be within the court's power to have that jurisdiction, the sentence to a treatment center for in-patient and for a minimum of one year.

You asked certain opinions on marijuana. I just heard again last night from the Johnny Carson Show, his band is not there evidentally, there is some problem with a union or whatever, and his statement was, at least when the band was there, "I could walk over and inhale" alluding to the fact there was marijuana. I think our

society has glamorized this particular drug to a point, where should there be a 15 or 16 year old in our state who has not at least tried marijuana, I would be very surprised. So that we too in law enforcement have mixed emotions about that particular drug and its penalty structure.

We have talked greatly in the Association of the New Jersey Narcotic Officers, in decriminalization, and how could that work. There are many areas that have been studied dealing with decriminalization, Michigan and other places. I don't know the answer to that particular problem, but I do know that we have prodded our young people in that direction, to at least experiment with marijuana, so that I not only as a law enforcer, but as a person, feel very strongly about some young person going to jail for a violation of that particular law. As I said, I don't know the answer, Senator, but I would certainly look into the area of decriminalization. I think law enforcement feels very strongly in that area, if we somehow set

guidelines, and I can't give you the guidelines, I'm sure you will be hearing from Dr. George Gubar, who will speak at length on that particular subject. Strictly from my own opinion, marijuana definitely is here, and, as I said, we have certainly glamorized it. I have never heard Johnny Carson talk about the use of heroin, cocaine, barbiturates, amphetamines, or hallucinogenic drugs; but have in fact heard him and many other celebrities talk casually about marijuana. We are faced with a tremendous problem with our young, and not just our young, we always talk about our young, many people in the United States. Those are my particular feelings on marijuana, unless you have some questions that you might want to ask me, that is pretty much how I feel.

MR. RYS: How do you feel about legalizing marijuana?

LIEUTENANT DELANEY: I am 100 percent against legalization. I feel in our society, with the commercialism that we deal in, I could see if it was legalized, I could see billboards signs commercializing everything, I could see advertising saying get the best

high, I think we would be opening the door to a drug infested society.

MR. RYS: On the same point, do you wish to lower the commitments of these people that smoke marijuana.

LIEUTENANT DELANEY: Again, from what I see in the State of New Jersey, I don't see too many people going to jail for simple possession of marijuana. Even in the cases of first offenders, dealing with sales of marijuana, we have left open to them that option of article 27, and I don't see people going to jail.

What I am concerned about, as a person, not so much as a law officer, is the area of a young man getting involved casually, and winding up with a police record that may alter his life, that is what I am concerned about.

MR. RYS: Thank you very much.

MRS. WILSON: Lieutenant, I have a question: You referred, toward the end of your statement, about mandatory penalties of perhaps three years for the non-addict dealer?

LIEUTENANT DELANEY: Yes.

MRS. WILSON: Is it absolutely clear who the non-addict dealer is, is that an easily identifiable person?

LIEUTENANT DELANEY: Okay, as I said earlier, I personally do not draw a distinction between whether a person is an addict or not, if he is selling narcotics or any dangerous drug. As far as those people who profiteer, the people we refer to as organizational type of people, we can draw a distinction there in many cases. We know, subsequent to an arrest, he is not involved with the drug itself, but in selling of it for profit motive, so we can draw a distinction.

MRS. WILSON: Forgive me for pursuing this, how do you know a person is a profiteer, as opposed to a junkie who is dealing to support his own habit?

LIEUTENANT DELANEY: When I arrest a person who is selling three kilos of heroin, versus a person who has in his possession 20 bags of heroin, there is no question in my mind the three kilos represents a huge profit motive.

MR. MENZA: You testified last year, Lieutenant Delaney?

LIEUTENANT DELANEY: Yes.

MR. MENZA: We had some testimony from a prosecutor with regard to disposition of drugs after trial. Are you familiar with that statute?

LIEUTENANT DELANEY: You mean the destroying of certain drugs? Yes, sir.

MR. MENZA: Or lack of the statute on the subject?

LIEUTENANT DELANEY: Yes, I am familiar with it. We should have some statute dealing with that.

MR. MENZA: Is there one now?

LIEUTENTANT DELANEY: No, sir. What we do normally, in the case of Bergen County, Judge Pashman who was the assignment judge at one time, told us we should hold on to that particular evidence for a minimum of ten years and possibly forever, when we are dealing with appeals, although there are certain cases that go by where there are no appeals. At that point, Mr. Pashman indicated we should hold on to it for at least a minimum

of ten years. I have a feeling in that area. I would feel, in the case of large seizures of heroin, cocaine, whatever the drug may be, that we could bring it to a state laboratory, have it analyzed both qualitatively and quantitatively, and bring it before the judge, that lab report, and have him take judicial notice of the particular drug, its weight and potency, and then fix some sort of a certification to that particular piece of paper, indicating that that, in fact, is the drug and the weight. We can then dispose of all but a minute sampling of it to use for the court.

MR. MENZA: What about the defense counsel's right to cross examine with regard to qualifications of the chemist?

LIEUTENANT DELANEY: I think at that point, we are going to bring in the chemist to testify.

MR. MENZA: I am not trying to engage in cross examination. In the event that the defense counsel succeeds, and destroys the qualification of the chemist, you don't have any drugs to be re-examined?

LIEUTENANT DELANEY: I think at that point, in a trial, should the defense attorney succeed in either discrediting the chemist or whatever, I don't see how we are going to win that case anyway. I think the biggest part, with the drugs involved, is the shock had, when the jury sees ten pounds of heroin on the table. Again, you know from the prosecution end of it, that is where that lies. But I was dealing more in the area of after a trial, and a conviction, at that point of disposing of the particular drugs. For trial purposes, if we have to hold on to it, fine, then maybe we ought to get into the area of speedier trials and disposition of cases immediately.

MR. MENZA: Lieutenant, what is the position of the Law Enforcement Officers Association with regard to marijuana?

LIEUTENANT DELANEY: Again, we have just had a meeting two weeks ago in Union County, dealing with that very subject. At that point, the topic of discussion was decriminalization, that is pretty much their feeling, although they haven't come out with

an official position.

MR. MENZA: Was that a conclusion or a topic?

LIEUTENANT DELANEY: At that point, it was left to a committee to discuss the area of decriminalization and how it would be handled, dealing with reducing certain weights. If we are going to deal with an area of personal use for experimentation or whatever, I would feel that a person in possession of 18 grams or less of marijuana may be considered a casual user, or one gram of hashish. There are many arguments, most people want to see it decriminalized in all areas.

MR. MENZA: Is it fair to say, the association is accepting the Commission's report?

LIEUTENANT DELANEY: Not in total, but, yes, except in the area of weight.

MR. MENZA: Except in the area of weight, it is my understanding that Narcotic Law Enforcement Association would like to see --

LIEUTENANT DELANEY: There are many members on that committee who would like to

see decriminalization. What they have done now is to study the areas of decriminalization. There are going to be many questions raised.

MR. MENZA: I see that Lieutenant Kennedy is going to testify before this Commission, and --

LIEUTENANT DELANEY: I understand that this Commission is going throughout the state, Bergen County first, and when you are in South Jersey I am sure Lieutenant Kennedy will testify.

MR. MENZA: Is there an area of compromise, if you personally feel you have 28 or 29 grams, is that an ounce?

LIEUTENANT DELANEY: 28 grams is an ounce.

MR. MENZA: The point is, these young people have a criminal record which can be expunged perhaps, but is there any compromise situation? Last year a prosecutor testified, perhaps we should raise it to 50 grams or 75 or 100 grams, do you have any feelings on that?

LIEUTENANT DELANEY: Again, my feeling in the weight category is X number

of grams will roll X number of cigarettes. I don't think we can compare marijuana to Marlboro, where a guy goes into a supermarket and buys two cartons a week or in two weeks. I don't think if we raise it to 50 grams we can roll 200 joints with 50 grams, this indicates he is a casual user. Sure there is going to be areas where they have 50 grams and ultimately using it for his own personal use, I think we have to draw a line, rather than go up, I would like to go down.

MR. MENZA: How would you draw a statute with regard to marijuana?

LIEUTENANT DELANEY: In the area of decriminalization?

MR. MENZA: In the area of marijuana generally.

LIEUTENANT DELANEY: I would reduce it to 18 grams for simple possession, and one gram dealing with hashish, versus 25 grams and five grams. Again, showing the personal use, I think the interest here is to show if we have glamorized it to a point where we have prodded people to use it, or at least

experiment with it, we should be safeguarding those individuals we are concerned about. We have now presently on the statute, 25 grams, if I were going in the area of decriminalization, I would have anything under 18 grams not within the criminal justice system.

MR. MENZA: Why do you pick 18 grams?

LIEUTENANT DELANEY: Because, at that point, I can show personally that if he is in possession of 18 grams or under, and again there are going to be many devious people, but for all intent and purposes, all things being equal, that individual is using it for his own personal use. I can live comfortably with that.

MR. MENZA: You made some very good points with regard to changing in the statute, for example, hypodermic syringes, et cetera, and it is going to take us some time before we get this transcript, may I suggest you write something up as far as specific statutes are concerned and send them over to Carl Moore?

LIEUTENANT DELANEY: Surely.

MRS. WILSON: I do have two other questions: Under our present system the first offender can be conditionally discharged to a drug treatment program. Do you think this should be extended to the second offender as well, someone who is in need of rehabilitation?

LIEUTENANT DELANEY: It is a very difficult question for me to answer. When you talk about the first offender, I think nobody has any argument, you know, everybody is getting at least some sort of consideration the first time around. In the case of an addict, you know, he is going to be around maybe two, three, maybe four times. There are many areas dealing with diversion, and the addict will get the opportunity.

MRS. WILSON: Does the Narcotic Enforcement Officers Association subscribe to the diversion procedure as a more effective way of treating a drug abuser?

LIEUTENANT DELANEY: Again, initially looking at the diversion, guidelines, and some proposals that may have been made along those lines, we as an association have not taken a stand on it.

Again, from many of the members we do in fact agree with diversion.

MRS. WILSON: Do you detect or believe that there is correlation between drug use and committing of violent crimes, or is it your belief, that the connection between drug use and crime is in the area of crimes against property to support drug habits?

LIEUTENANT DELANEY: That is an old question. I guess we will be hearing the same answer. You can take any particular individual who may have within him certain things, whether or not he is a drug abuser makes little or no difference. There are certain areas where a person becomes addicted to a hard drug which is expensive, and by nature of his addiction he will do certain things. I can't categorically say that every drug addict is a rip-off artist, where he is going to beat you over the head and commit a violent crime. I have seen many addicts who have not committed violent crimes, I have seen many who have. I can't give you a category and say, yes, in this case they

don't commit violent crimes. There are many who do commit violent crimes.

MR. RYS: Is the drug treatment center successful? Maybe I shouldn't ask that question, I know we have a doctor. I want your reaction, if you can help us.

LIEUTENANT DELANEY: I guess the only answer I can give for you, not speaking for law enforcement, but speaking for myself, any day an addict or abuser is drug free, in any kind of a center, is probably a good day for him, a good day for me, a good day for you. I think that pretty much answers the question.

MR. RYS: Thank you very much.

MR. MENZA: Captain Charles Gagabedian, please. Will you give your full name and title and place of employment?

MR. GAGABEDIAN: Charles Gagabedian, Captain of the Police Force, Rutherford Police Department.

MR. MENZA: Go ahead, Captain. This is informal, I am an attorney, but I won't cross examine or anything.

MR. GAGABEDIAN: Am I supposed to bring up statistics and so forth, or our views on this thing?

MR. MENZA: Whatever you so desire.

MR. GAGABEDIAN: I came in a little late, I was misinformed as far as the time is concerned. Well, like most of the communities in the area, Rutherford has a widespread use of marijuana. We haven't had too many cases of hard drugs recently, but we do have marijuana, as I say. It is in the schools, in the parks and so forth. It seems to be readily available. I believe at this time, we are having some of our youngsters that are selling it, however,

most of the large amounts, I believe, are being brought in from the outside, North Arlington, the Newark area, Jersey City and so forth.

MR. MENZA: How long have you been a law enforcement officer?

MR. GAGABEDIAN: I have been a law enforcement officer for 22 years.

MR. MENZA: I presume you have been dealing in the area of drugs for a period of time?

MR. GAGABEDIAN: Well, actually I haven't been involved too much with drugs. I've only been a detective for one year now, so I was mainly a patrol officer, and, of course, in a supervisory capacity. I haven't had that much expertise in the drug field.

MR. MENZA: How do you feel we should treat marijuana users?

MR. GAGABEDIAN: Again, I feel just like the gentleman who was here before, I think that we should decriminalize it, to the point where we can set a definite figure, say 18 rather than 25 grams, of course, everything over that, then we should strictly enforce it

and not give these people a pat on the back when they go to court and so forth, you know. I guess that is about the substance of it right there.

MRS. WILSON: How much time does your department spend on enforcement of narcotics, how does that break down between marijuana and other drugs?

MR. GAGABEDIAN: Well, as I said before, most of our problems are marijuana, I can't actually give you the amount of time that we spend on drugs by itself. We don't have a narcotics officer as such, we don't have anyone just working on drugs. We have a detective bureau, they are all expected to follow up investigations of complaints on drugs, our patrol officers, of course, start most of the investigations. We have an informant coming in. Of course, right now we have a close rapport with the task force, so I can't really set an amount of time that we spend on narcotics for any one officer.

MRS. WILSON: Thank you very much.

MR. RYS: No questions.

MR. MENZA: Do you have anything else

you would like to add?

MR. GAGABEDIAN: No, not really, except that the fact that I am not that expertise in the field, as I say, I am only involved indirectly with narcotics. I am in charge of the detective bureau, perhaps I should have sent one of my men that was more informed on it.

MR. MENZA: Thank you very much.

MR. MENZA: Dr. Pyle, please. Will you state your full name and address.

DR. PYLE: I am Medical Director of the Monsignor Wall Social Service Center in Hackensack. I have been associated with the center about four years, and Medical Director for about three years. I see that the mandate for this Committee is to study narcotics treatment programs, and that is precisely the area that I am addressing myself to.

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Monsignor Wall Center has been involved in various phases of drug treatment since its inception, but our focus has moved more and more to the treatment of heroin. There was a time when we were seeing many adolescents with minor drug problems, but more and more recently we are now dealing with hard core narcotic addicts. My feeling, of course, is mainly the medical treatment of heroin addicts. Now, to put this in perspective, Lieutenant Delaney was talking about the management of heroin addiction, I would tend to agree with just about everything he said. From my point of view, if

we can dry up the supply, if there were no illegal narcotics, we wouldn't have to treat addicts, but that is utopia and a dream, I guess, but in the meantime efforts can be improved.

As far as the treatment of heroin is concerned, there are two types of treatment generally. There is abstinence and there is treatment with chemotherapy or medication. As to abstinence treatment, we have voluntary abstinence where narcotics will finally tire of the habit, or whatever reason, kick the habit, and then perhaps stay clean. In our experience, this is very rare, and Lieutenant Delaney alluded to this, that there are really no -- as far as I can see, very few motivated addicts.

The successful addict will continue to use heroin as long as the money supply is there, as long as he can get away with it, until there is family pressure building up, until there is law enforcement pressure building up, until he is destitute or his health is being threatened, there has to be some kind of pressure to get the narcotic

addict into treatment; they will admit this themselves.

As far as abstinence is concerned, there is involuntary treatment by committing an addict to jail. This doesn't work very well as a treatment modality, because of the addict that we see who has served jail terms, after they come out they revert to heroin use, often the very day they get out of jail, and frequently within days or weeks.

When you ask them about their feelings about heroin, they were free from the drug, free from this habit for all these months or years, they will tell you repeatedly, they were thinking about it all the time, and they had no commitment at all to staying away from the drug when they got out.

Jail, per se, cures few addicts.

Then in the field of abstinence, there are in-patient centers, and I would say, I am sure you are going to hear this from Dr. Gubar, that other things being equal, this would be the best method of treatment for young single addicts. There are problems with drug treatment centers,

but by and large if you can get a young addict to commit himself to treatment, which would consist of psychotherapy and rehabilitation, job training, and change his life around so that he can get out of this drug seeking routine and learn how to cope with problems, and understand himself, understand his motivations, stay drug free, he wouldn't elect this kind of treatment for a person who could be successfully treated this way.

Unfortunately, this isn't always possible. Addicts characteristically are people with short term goals, they do not think ahead, they do not plan ahead, it is very difficult to convince the addict, especially the one who has no great pressure being applied on him to enter a drug treatment program.

In addition, many of them find that they will attempt it, and in a few days, in their terms, "split", they can't tolerate the discipline, the confinement, the structured life, the lack of drugs, and they just can't tolerate staying there.

So, treatment programs, the rate

at which they drop out, is really significant, it's up to about 50 percent. It also means a commitment, a long term commitment. You can't hope to take somebody who has been in drug seeking behavior, and the whole drug scene, for two, three or four years and hope to turn them around in days, and most treatment programs would expect a month, maybe a year, more than a year, and perhaps a halfway house type of return to the community. Unfortunately, even after full treatment, many relapse. I can't give you the exact figures, but I am sure there are less than half of those people successfully graduating from treatment and are back on narcotics after some period of time.

Now, the next phase of treatment is chemotherapy or medication. This is the field that I am particularly concerned with, and which I would know most about. You have heard about narcotic antagonists, cyclizine, these are new drugs that are as yet experimental, perhaps someday they will have a part in the treatment of narcotic addicts where you can give him a

long acting antagonist, and then the addict can't use the drug, because it is not activated by the antagonist, or using the drug would make him sick. That is all experimental at the present time.

Then we come to the Methadone, these are the major treatment modalities at the present time in the chemotherapy of narcotic addicts. Methadone is suitable for this type of treatment, because it is, in the first place, legal, takes the addict out of the daily breaking of the law, it is an oral medication so it can be given by mouth, it is long acting, it lasts 24 to 48 hours, so that it is possible to dispense these at a treatment center and have it last until the next day at least. It has characteristics of inducing rapid tolerance to the drug in the patient, so that after several days on the medication, he no longer feels the medication, he doesn't get high on it, it renders him a functional individual. And, finally, it has tolerance with heroin, so if a person builds up a tolerance to a large dose of Methadone, then we have a large

tolerance for heroin and they don't feel it.

Now, within Methadone treatment there are two specific types of programs, they often get confused. On the one hand, we have Methadone detoxification, on the other we have Methadone maintenance. Methadone detoxification is a necessary but rather useful treatment in some respects. Methadone maintenance is a long range treatment program, and it has in the majority of people, who are actually in Methadone maintenance, it has constructive results, at least for the time they are in the program.

Getting back to Methadone detoxification, this is simply using Methadone as a substitute drug, in a legal manner, over a short period of time, such as two or three weeks, to ease the addict off of his physical addiction, so that he doesn't get sick during the detoxification period. We start, and in two weeks we reduce the dose to zero, and the addict for the most part does not actually get physically ill. This is the thing that addicts fear so much, and that makes them so desperate about drug seeking behavior, they

are afraid of getting sick. When they get to the point that they are seriously considering stopping heroin, they have to have some way of easing the pain, the physical pain of getting off of the drug. However, the problem is, that even when you prevent them from getting physically ill, prevent the vomiting, the muscle cramps, diarrhea, sweating, the days or nights of insomnia and so on, terrible anxiety, the patient still is left with a lasting drug hunger, they still have the physical need for heroin, I guess just the way a person who stops smoking, would need cigarettes a week or two later, they would feel something is missing from their life, only I'm sure it is many times greater. In addition, it persists, not only physical craving, but the dependence exists, but they really feel and want and need the drug.

Now, why use such a treatment? Well, the results, we find, and I studied the first 400 people we treated this way, and at least 95 percent of the people so treated, reverted immediately to heroin use

again, and of the remaining five percent, there was evidence that half of them were back on heroin within a few days. At the present time, we have detoxified over 2,000 patients. You say why even bother? Well, it is an important part of treatment, because in the first place, it is the only treatment that most addicts will accept at the beginning, because they are not educated to how difficult their problem is going to be, to be cured. It brings them to the treatment center, it establishes a relationship with the patient, we get to know who they are, they get to know who we are, we are starting to get them to think about perhaps other alternatives, more difficult alternatives that may be necessary to clear them of the habit.

Now, if having tried Methadone detoxification and failing, the next thing we would try to do with an addict is refer them to an in-patient center. As I mentioned, this is very difficult for us to do, but in the course of time that Wall has been available, around 400 patients have been referred onto

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A P P E A R A N C E S:

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worthwhile, it isn't worth the money to keep shooting.

Now, the tolerance that they get from it, as the Methadone is built up to the main line level, within a few days the patient develops tolerance, within a few weeks the tolerance is complete. So complete, that you can't tell that the patient has had anything. He appears sober and functional. In fact, you can give inactive chemicals related to Methadone, but totally inactive, that is the way we dispense it, the patient can't tell he is being given anything except Methadone which only hours later, a day or two later, when the Methadone starts to wear off, the patient begins to realize he is getting sick and he needs Methadone.

Now, the goals of Methadone treatment, I suppose the eventual goal, I have to say, is getting a person rehabilitated to the point of being drug free. After two years on Methadone, the federal guidelines require we re-examine the patient and see whether they have gotten far enough in their rehabilitation program, and whether they have

gotten enough change in their character, in their behavior, they have gotten different goals in life. Perhaps they have a decent job, saving money, married, they have other responsibilities. Just so they are stable enough to withstand the withdrawal process and then stay drug free. The ultimate goal would be rehabilitation in the sense of getting a person drug free, but the more immediate goal is to try to get the patient out of drug use, and in this way we can get him into employment, or some other socially acceptable form of behavior, such as taking care of their family, if it is a woman, or someone going to school, if it is a younger person they will stop crying. Now, virtually every addict I talked to, admitted they cannot support their habit without dealing or stealing. Stealing primarily, breaking in, robbery, confidence schemes, prostitution, they all engage, I would say 90 percent of them, engage in this kind of activity to support their habit.

In addition to that, they spread the epidemic, because practically all addicts

admit to dealing, in order to support their habit, one of the ways is to buy more than you need and sell it at double the price and get more money to buy more drugs.

MR. MENZA: May I interrupt you at this point. Most of us on the Commission are familiar with the different modalities of treatment. What we are trying to do is pick brains, let me interrupt you by asking a few questions.

DR. PYLE: All right.

MR. MENZA: You talked about the Methadone program. It is my understanding that there really is no one form of treatment, that there are great modalities of treatment?

DR. PYLE: That's right.

MR. MENZA: Many modalities of treatment. How do you approach this, how do you feel involved in different modalities of treatment? We have day care centers, outpatient centers, what do you think the state's role is in rehabilitation, what rehabilitation process whould we undertake?

DR. PYLE: Well, I have to speak

from my personal experience, in terms of the individual patient. I don't know, when I see a patient, I spend a half an hour to 45 minutes taking a history, the medical history, the drug history, social history, educational history, motivation and so on, and then I decide on the basis of that, what would be best for that individual. Now, I know that there are, I would say, in-patient facilities that are certainly necessary for those people that you can get to go there. Detoxification, if that's all the patient will accept at the time. Places like Harold House, where a person who is not yet truly addicted, and we used to see people like that, we would refer them down there. Finally, Methadone maintenance, with a hard core patient, it's either back on the street with heroin or it's Methadone maintenance, because he tried other things and failed them, or he refuses other types of treatment. The patient who has a job and children to support, is not likely to give up the job and put the children on welfare to go to an in-patient treatment. Nor is a patient who is

psychotic and can't stand the confinement, or somebody who tried it twice and already failed. I would like to cite what our results are in the last quarter, to give you some idea what happens.

MR. MENZA: That is a very valid point. Many people argue Methadone is a substitution of one drug for another, and perhaps they are right to some extent. The point you make, however, is that you continue to have them functioning on a daily basis in our society. The question arises, when do they function normally without the aid of Methadone?

DR. PYLE: When?

MR. MENZA: Yes.

DR. PYLE: In the last quarter, we had 12 people who withdrew gradually from Methadone, seven of them are still drug free. That is short term. I don't think any of us can say how long these people will be able to stay drug free. While they are in Methadone treatment, we go from about 30 percent employed to about 80 percent employed. We go from practically 90 percent involved in crime, to

a record of very few arrests. At the Bernstein Institute they study an addict before and after entering Methadone, and the arrest per year fell from 50 percent to one percent in the Methadone patients, while under treatment. Patients that were simply detoxed, it stayed the same, about 50 percent, 100 were arrested per year.

MR. MENZA: How are you funded?

DR. PYLE: We are funded through S. L. E. P. P. A.

MR. MENZA: What assistance do you get from the Narcotics Abuse Office in Trenton, if any?

DR. PYLE: Are you talking about financial assistance or medical?

MR. MENZA: Any type of assistance.

DR. PYLE: The assistance that I get, is medical assistance from Dr. "Frimer" who was at one time in charge of the state program, and who acted as a consultant to the other programs.

MR. MENZA: You function then, pretty independently of that office?

DR. PYLE: Medically, yes.

MR. MENZA: Administratively?

DR. PYLE: You have to ask the administrative office.

MR. MENZA: How do you function administratively with regard to the state? In other words, what contact does your division up in Trenton have with --

DR. PYLE: I am concerned with the medical treatment of addicts.

MRS. WILSON: Doctor, you have talked a lot about the patient's choice, and the willingness, or unwillingness, of the addict to participate in one level of treatment as opposed to another. Do you have any success with the unwilling person, in a treatment program, or must it be a willing participation? I am getting around to asking you, whether we should have mandatory commitment to a program like this?

DR. PYLE: I would say, at the end of taking my history, motivation is the last thing I put down, and then prognosis. If the man isn't motivated by some kind of real pressure, you can almost foresee he is not going to be successful in any treatment.

MRS. WILSON: You can keep them there

for a year and it wouldn't do any good?

DR. PYLE: We wouldn't keep him there, he wouldn't show up.

MRS. WILSON: If the court sentenced him for a year, he has to stay, would you be able to succeed with him?

DR. PYLE: I don't know. If he was afraid of going back to jail, perhaps that would be motivation, yes.

MRS. WILSON: You referred to men, do you have women in your program?

DR. PYLE: About 20 percent.

MRS. WILSON: What is your experience in that regard, are there more treatment facilities for men than there are for women?

DR. PYLE: We see more men who are addicts than women. We take anyone who comes in to seek our help.

MRS. WILSON: Do you know whether there are more male than female addicts?

DR. PYLE: No. In our population that comes to us, we are an organization that people show up at our door, we don't go out and seek them. I have no idea. I don't think there are as many women addicts, but I have no

figures.

MRS. WILSON: Do you have any program for pregnant addicts?

DR. PYLE: Yes. We have some pregnant addicts, and our nurses do have sessions with them specifically about this. We are trying to do some conscious raising among the women addicts, because they are very passive, they don't seem to have any signs of control over their own lives.

MRS. WILSON: Thank you.

MR. MENZA: I interrupted you, sir.

DR. PYLE: I wanted to add a couple of things here. What we see are really, talking specifically about Wall, are hard cores, average age is 25, 26 years, they have been heroin addicts five to seven years. Anybody who thinks heroin is going away around here is mistaken, because the last 150 patients that we treated, there were 70 some new patients we treated, we saw for the first time, and 50 percent had never been treated anywhere before. Our addicts tell us that the average cost of their habit was about $30. It is escalated, the price of everything is going up.

Now, in the last few weeks we are hearing more about $60, but if you take $30 per day, per addict, that is $10,000 a year in heroin, and the 130 members who are on Methadone maintenance program, supposing that they are for the most part out of the heroin business, would represent, in Bergen County, a heroin use of $1,300,000.

Now, in order to get that money, they have to often steal a multiple of that. That is a lot of money in heroin.

MR. MENZA: What do the addicts tell you with regard to the drug traffic in New York, since it changed the law?

DR. PYLE: Very subjective impression, because they are usually pretty frank, most of them don't seem to have any problem getting their heroin.

MR. MENZA: Where?

DR. PYLE: Mostly in New York.

MR. MENZA: Presently, still?

DR. PYLE: Yes. I will mention some of the criticisms that you hear commonly leveled at Methadone. One is the creation of new addicts.. You see in the New York Times things

about Methadone programs. Well, the federal guidelines require that a person be addicted at least two years, and this we document, and that they be over 18 years of age. In our experience we document much longer than that. We are very cautious about letting anybody in. If we don't have physical signs of addiction, a police record, I don't think that is a real problem, it is substituting one narcotic for another and that is true, but it is legal, it gets them out of the crime business, they are not high when they are on Methadone, and it increases rehabilitation, 80 percent of our people are functioning, on socially accepted roles, it is certainly far higher than before they go.

MR. MENZA: Why not heroin maintenance?

DR. PYLE: Heroin maintenance has been tried in England. I talked to the doctors who were doing it at the International Drug Conference out in Michigan three years ago. They don't consider this a worthwhile modality of treatment. It is one way of getting people into treatment, who refuse Methadone maintenance,

and they reserve it for adolescents. They had it done under very controlled situations, with a few dozen addicts, and the hope was that they could get them on Methadone within a few months.

Another criticism is the use of Methadone creates street drugs for addicts. Well, this isn't true, if the take-home doses are strictly limited. The federal guidelines now prescribe that the Methadone be given in liquid form. We give it in orange juice, they drink it in front of the nurse. We do not permit any take-home medication, except for family emergency, or sickness, that sort of thing. The federal guidelines prescribe, it must go home in a hot locked bottle that a child can't get to. While we are much more strict at Wall than the federal guidelines prescribe, they do permit people to take them home in certain limited ways. I think this is the kind of monitoring that will prevent Methadone from getting on the street.

I think this concludes the substance of what I have to say.

MR. MENZA: If you were the medical

director of an in-patient family type theraputic center, would you then use Methadone?

DR. PYLE: Sometimes.

MR. MENZA: Why?

DR. PYLE: Well, because some people wouldn't stay there unless they had Methadone, they couldn't tolerate it. There was an article in the American Medical Association Journal, by John "Shappel", who is Director of Illinois Narcotic Treatment Program, and they have a multi-phase program, they do this: Some of the patients they have in-patient facilities, and some of the patients are drug free, some patients are on Methadone, it depends what is possible.

MR. MENZA: Thank you.

MRS. WILSON: I have no further questions.

MR. RYS: No questions.

MR. MENZA: Dr. Gubar, please.

DR. GUBAR: You want my qualifications? I am Dr. George Gubar, I am the Director of Psychological Services of the Mount Carmel Social Service Center in Paterson, which includes the Mount Carmel Hospital for Alcoholism, and the Dismas House for Drug Addiction. We are involved in in-patient, out-patient, drug free treatment, and additionally in the detoxification, and the referral and treatment of alcoholism.

I haven't heard alcoholism mentioned today, I don't know whether or not you include that under your drug laws, which I assume you might, although I imagine you're heading at the narcotic laws.

I am in the unique position, Senator and Assemblymen, because I am also, oddly enough, the consultant chief psychologist that Dr. Pyle is at, which is a Methadone center, and this is unique in that you get one person working in two kinds, drug free treatment, and then in a Methadone center, along with that you have to add my qualifications. I am Professor of Psychology at Seton

Hall University, so I deal with a lot of college population, and then I am the father of three school teachers.

Lieutenant Delaney and Dr. Pyle, both took my name in vain, and here I was going to do the usual thing of publicizing Dismas House, so rather than do that, I have given my report to the stenographer, and she will in turn incorporate that into her notes.

"Because of the varied reasons why some people become involved in active drug abuse and addiction, there is a need for varied modalities of treatment. The Theraputic Community, although not the only modality of treatment, is one of the oldest successful modalities available to us at this time.

"Dismas House for Drug Rehabilitation is one of the oldest variations on the traditional theraputic community.

"Everyone who graduates the residential phase of treatment is already employed. This is due to the uniqueness of the work-adjustment and vocational training aspects of the program. To improve this modality of treatment it would be advantageous

to develop this aspect of treatment to acquire vocational training equipment and additional vocational training instructors.

"Since the mean educational level, upon admission is eleventh (11) grade, with minimal third (3) grade level on a relatively regular basis. It would seem important to expand our already existing High School Equivalency Program so as to include more remedial work for those who have not yet reached the ninth (9) grade level of education.

"With Dismas Halfway House presently at capacity, and seeing the importance of this phase of an overall modality of treatment, we see a great (and immediate) need for more halfway houses to supplement initial residential treatment.

"From another branch of the scientific community, we see a need for the development of more accurate urine monitoring with more immediate results. Screening must be for polydrug abuse rather than simply narcotics. This is of utmost importance in the outpatient treatment process of drug abusers and addicts. Additional social

services staff are needed to assist in the supplying of necessary ancillary services since during their active addiction, most clients have neglected themselves physically, including dental care, eyes, ears, and general health.

"In regards to the "new laws" presently being presented before the legislature, concerning penalties for drug use, we would strongly endorse any bill which would allow for an option to enter residential drug treatment facilities as an alternative to jail sentence. This we would see as a civil right (for an individual to have an option to be treated) if the individual has a case history of drug abuse. If the individual, however is involved in distribution and/or sales and is not doing so "because of his addiction", harsher penalties should be imposed. These "pushers" should include not only the "street pushers" but also the "professional" and "over the counter pushers" who are involved in unprofessional and irresponsible prescribing and sales of controlled dangerous substances."

Before I can talk about what the

problems with treatment may or may not be, and because Lieutenant Delaney got me into the area of marijuana, which I am finished up with, I would first have to talk about, briefly, the particular institution that may or may not be typical of other centers. Now, Dismas House is probably one of the oldest variations on the traditional theraputic community, in that it is highly reliant on psychological evaluations and treatment. As a result of this, we feel that there is a tremendous need for the involvement of psychologists and psychiatrists in the area of in-patient treatment, more than has been evident up to this point.

We also find that we do not have a problem with employment for our graduates. The graduates of Dismas, in the residential phase, are already employed, because ours is a work therapy program where every young man who does not, and all of them do generally not have a history, the street addict, of good working habits, are immediately put to work and given some kind of vocational training. To improve then, a modality of this kind, the

state would then have to somehow assist the institution to acquire vocational training equipment, and additional vocational training instructors.

Further, since the mean educational level upon admission is 11th grade, with a minimal third grade on a relatively regular basis, and many reading and special problems, it would seem important to expand any existing High School Equivalency Program, so as to include remedial work for those people who have not yet reached the ninth grade level of education.

When I say we have no problem with employment for our graduates, this has always been a question in my mind, when I read statistics on the fact that people are getting out of halfway houses, and the in-patient facilities, and need jobs; we have not to date found that one patient who has left our facility, has not gotten a job, because we make this a condition of discharge. It is amazing what kind of motivation that is for a person to find a job.

Now, with Dismas Halfway House,

this is the second phase of the in-patient, in-patient is eight months, halfway phase is four months, and with the Dismas House presently at capacity of 22 residents, this in addition to 125 bed capacity that Dismas House itself has, we see the importance of halfway houses throughout the state. This is an adjunct to the existing residential treatment centers. This then would be a means for a young man who has, in a sense, dropped out of society, to be accustomed to getting back into society again.

From another point of view, we see a tremendous need for the development of much more accurate urine monitoring, and a tremendous need for immediate results, so that immediate action can be taken to forestall continued or increased use of drugs once it has started. Screening must be for polydrug abuse, rather than for the simple heroin, or cocaine. Additional social services are needed in institutions, because we are finding that ancillary services are much more necessary for addicts than we ever thought they were before. We find in the area of health alone,

that these people need a tremendous amount of dental care, eye care, their ears and their general health have been so neglected over a period of years, that before you can get them successfully back into society, you would have to rehabilitate them physicially. Further, we find that many, many problems have accrued socially, and we have increased our social service departments, where we have put on social workers, who are involving themselves not only in cleaning up court cases, or getting this to trial swiftly, so that they can be consummated, but also are doing a great deal of getting involved with families, getting involved with wives, children, and in other areas.

With regard to the new laws that are presently being presented before the legislature, and before this Commission, concerning penalties for drug use, we would strongly enforce any bill which would allow for an option to enter residential drug treatment facilities. Mrs. Wilson suggested, perhaps it was the Senator, I'm sorry if I don't remember who, that that be an alternative at any point

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that the judge deems would do some good. Now, whether this should be by self choice, or self commitment, this would be something that would take a great deal more consideration than could go on now. We see this, however, as a forthright individual, if he has had a case history of drug abuse, if the individual is involved in distribution or sales for profit, and is not doing so because of his addiction, and here we come to the great area again, what is an addict pusher versus a pusher or profiteer; this is something that would have to be decided, and we would then suggest that harder penalties be imposed. These pushers should not only include the street pusher, but also the professional and over the counter pushers involved in unprofessional and irresponsible prescribing in sale of dangerous substances for profit. The co-operation between the courts, the probation departments, the law enforcement agencies, institutions such as ours, I think have been at the highest level in this respect, and I would not want any change, as has been suggested to date. The

only form of motivation for an addict to seek treatment is the threat of a jail sentence. Paradoxically to that, we know that no active drug addict wants to be cured; nor can anyone cure him but himself.

Now, the question was asked, if a person is forced into treatment, will he accept it. We find that some do, and, of course, some don't. The split rate was mentioned, and we know that it is higher than we would like it to be. In getting on, we do know something happens to a percentage of these young men once they get into the institution, then for some reason many of them will go along if the institution doesn't engender this desire, or this sense of communal tie where the person wants to become involved in society again. Now, in a broader sense, let me note the following, having to do with treatment centers: One of the problems that we have traditionally encountered in the field of drug/habilitation, is the manner in which various programs have jealously and zealously guarded their autonomy and philosophy. We have grown up in the last ten years, hope-

fully, and at this point, I don't think that anybody involved in the treatment of drug abusers should be jealous of his brothers and sisters form of treatment. We should only be involved in treatment, regardless of the modality. There must be much more exchange and cooperation between the programs, if the patient is to benefit. Certainly, the state organization has attempted to rectify this situation, but presently this is not being done to any great degree.

What I would like to suggest in this area, is some form as Lieutenant Delaney brought up, in the area of drug pushers, some kind of a central registry or agency, which would be able to supply an institution with updated social, psychological information for the various programs, which would then aid them in the treatment of the addict. This, of course, should not be in violation of the civil rights of the addicts, but only to assist in his treatment. The need, as has been suggested, for integrated programs, combining the treatment of alcoholism, drug free addicts, and Methadone maintained addicts,

would assist us greatly in developing programs aimed at the cure of addiction, per se, rather than the supposedly unrelated areas of alcohol addiction, narcotic addiction, drug addiction and so on.

Some people, of course, are able to be cured in out-patient facilities, others are not. If you want me to get into Methadone, certainly I can do that, because I envision it as a modality, as long as I am connected with the Methadone center, as having validity. If it utilized, as someone suggested a long time ago, as something that would keep the addict from looking for street heroin while in fact therapy was being worked on him, but as a cure all in and of itself, Methadone will prove to be unsuccessful. The center in which I work, does provide all of the ancillary services, along with the Methadone, and it is my feeling that the Methadone is the smallest part of that particular program, but a necessary one.

So far as cure rates in the treatment centers, a study by George Nash, at the Montclair State College, where that was funded

by the State Law Enforcement Agency, covered most of the treatment programs in the State of New Jersey, it was conducted last year, and I think it possibly should be made part of the record. Briefly, it indicates that both or all types of treatment for addiction are proving effective, this specifically aimed at Methadone maintenance, and that these programs should be continued and extended. In my opinion, every legitimate form of treatment for an addict should be included. There must be also a concerted effort made in the direction of determining the causes of addiction, be they physiological, psychological, or economic. Without knowing the cause, we are only marking time in treatment, hoping that the problem will slowly fade away, and from what we have heard, we find the problem is not fading away.

The fact that it may be fading away, is wishful thinking, because the latest poll of colleges has shown that the number of college students who have tried marijuana at least once, has increased to 55 percent this year over 51 percent from

last year.

Finally, we must try to refine the categorization of drug addiction, so that treatment would be more effective. Certainly there are broad categories that we utilize, heroin user versus marijuana user, but, unfortunately, most of the addicts that we do encounter are polydrug users, and until we can discover if there are any basic differences, personality wise, character wise, then treatment will be more or less haphazard. Research in this area is already underway, one project under my direction, and I am certain that concurrent studies must be taking place throughout the country, and some interesting results, in a theoretical nature, have already caused some changes in the revision of programs such as Dismas House.

Now, Joe Delaney, somehow brought my name up when he was talking about marijuana, and I would suppose that I would have to continue on and say, that if we can set those guidelines for decriminalization, perhaps this should be the topic of conversation in the Commission, as it probably will

be. I had the fortune or misfortune of being involved with members of "Normal", and they, of course, argued not for decriminalization, but seemed to be arguing for decriminalization as the first step for legalization. If we are simply talking about decriminalization, then we have to decide on penalties, uniform codes, not only for New Jersey, but for all of our 50 states. If you begin to write a code for New Jersey, I fully believe that it will be useless, unless it conforms with the code or the laws of all the states, whether this should be subscribed to federally, or on the state level, makes no difference to me, but there should be uniformity.

If we are talking about decriminalization as a first step to legalization, just as Lieutenant Delaney had stated, I would also be against it, at this time, because of the following points: Or at least we would have to consider intimately the following points: First, the age of legal use, at what age do we do this? I was just out in the hall and when we dropped

the age limit to 18 for drinking, we find that we are now having a heck of a problem with 15 year old drinkers. We had always had a problem with youthful drinkers, but we have to somehow provide, before we drop the age, for what we are going to do when the younger people start drinking.

We find that even on the campus, where I am a professor at Seton Hall, that the problem, as stated by the college students today, is not marijuana, it is alcohol.

Secondly, you would have to consider very intimately the longitudinal effect of chronic use, physologically, and the possible implication of the psychological state of chronic and heavy users. You would have to consider the possibility of the motivational syndrome from a chronic and longitudinal use, and the last one, which is even more important, the problem of levels of intoxication. Presently, there are no ways in which we can determine levels of intoxication. I have heard talk about laws concerning possession of the physical product,

marijuana, but I have not heard anybody talking about if marijuana is an intoxicant, how do we then determine levels of intoxication.

Before we go any further, I heard alluded to, I think by Senator Menza, the suggestion, or the question, would you go along with the President's Commission Report on Marijuana. If I might, I think it very, very important that I read the last statement in this particular report, which no one ever seems to refer to. It is on page 178, under heading number four, called voluntary sector participation, it states as follows: The Commission notes the signifcant role played by the voluntary sector of the American community in influencing the social, religious, and moral attitude of our nation's citizens, and recommends that the voluntary sector be encouraged to take an active role, and this is the part that I would love to emphasize, in the support of our recommended policy of discouraging the use of marijuana.

Now, why in God's name this statement is never read, is beyond me.

Dr. Pyle and Mr. Delaney talked about the possibility of eliminating drug abuse by getting the drugs off the street, but the problem of addiction is not a problem of drugs, but is definitely a problem of people. We, as a race, have always found very, very inappropriate solutions to all of our problems, and if you are to remove all of the heroin, all of the cocaine, all of the other intoxicants from our country, people would still find means of escaping or solving their problems. The question was asked about relapse, why do addicts go back to the use of drugs. Possibly, the problem has been that we have been treating addicts as a simple disease, assuming that all the addicts have the disease. There is a basic difference amongst addicts, there are basic differences in use patterns, there are also basic differences in personality characteristics. As an example, if we were to treat every stomach pain as if it were gas, I am sure some of those stomach aches would disappear, but I am also certain that we would have many, many other relapses, if

in fact the problem was not gas pains. We will only succeed when we find out what the causes of addiction are. We find in our institutions, that we have come down to treating addicts at two different levels, one we call simple addiction, the other we call symptomatic addiction. For the simple addict, if you treat his addiction, you are curing him; if you treat the symptomatic addict by simply removing the addiction, you still have the problem, and he will most likely go back. Perhaps drug addiction can be seen as problem solving behavior or a choice, my problem is, that the public sector somehow feels that drug addiction is a self inflicted disease, therefore, should be ignored. I feel that it is a disease, as any other disease, therefore, should be treated.

MRS. WILSON: We heard a number of different modalities this morning, I love these terms, different ways of treating people who are addicts, and there is probably a lot to be said for each and for all. I am concerned, not so much with which is the best

form of treatment, I was happy to hear you say those who are treating ought to get out of the business of competing with each other and decide whose is the best. We have probably as many effective ways, as we have addicts, and maybe we need different ways of treating different people. People will respond to different forms of treatment. However, from our points of view, as far as the role of the state is concerned, and the legislature is concerned, I am concerned with, A, get into the business of providing more money at the state level for developing treatment centers. Should the state legislature set rules and regulations, and guidelines, for licensing treatment centers, how do we evaluate which centers are effective, and which centers are not, and to what extent should the state keep hands off. Can you respond to that?

DR. GUBAR: Yes, certainly. In the area of should we expand or should we finance treatment centers, the answer is, yes, because I feel that drug abuse, here I may be running into problems, is a disease and should be

treated as such, it is a public health problem. It does have overall tones and does become involved in law enforcement, but they are not going to solve the problem legally, or from a law enforcement aspect, we are only going to solve it, yes, they can dry up supplies, but we are going to have the problems. I don't care if these centers become, just as many of them do, whether they become mental health centers or not, I feel that they should continue to exist.

For instance, we are finding in the area of alcoholism, we became involved in an intervention program, so to speak, it was taking the skid row alcoholic out of the court, or the judicial system. We then brought him to a hospital, we detoxified him, tested him, gave him nutritional therapy, we referred him, we did many, many things, and we found out that a great number of the skid row alcoholics were truly not all alcoholics, but in fact, they were skid row characters, and many of them had many, many psychological problems. So we came up with impaired people, we came up with psychotic

people, we came up with a lot of other kinds of people who incidentally drank, and it is a crime that in the State of New Jersey we do not have present facilities to accommodate these people.

Now, a center such as ours, could be, or any of the other centers, could be turned into not only centers for drug addicts, whatever that is, but certainly into centers for people who have much of the same problems, who incidentally use drugs. The second question you asked is, should these centers be licensed. I fully believe that these centers should be licensed, as we license any hospital. Perhaps I am being selfish about that. The question was asked, do you get monies for treatment. I have been with Monsignor Wall, when I say Wall, I am talking about the man, Monsignor Wall. I started to work in this field ten years ago, I started a little before that, but actively in this role with Monsignor Wall in Paterson, at the Mount Carmel Hospital ten years ago. Up until we got our first contract from Bergen County, for $60,000, and then subse-

quently, a year later, a contract for $30,000, or $35,000, Passaic County, we had no outside funds and completely supported ourselves in an era where everybody else was being supported. It was very difficult, and we couldn't provide the kind of treatment that I felt, and Monsignor felt, was necessary. The state has since come in, supplying us with certain services, such as referral. We have been supplied with funds for housing, we've been supplied with a means of getting our urines done and so on, so I think, yes, they should be licensed, they should be funded.

As I say, we are presently licensed. We are unique in that we were the only licensed institution in the state. The third thing is, how do you evaluate, right? This was started in a sense on the George Nash study, this was an evaluation of programs that have been funded by state monies. Oddly enough, we at Mount Carmel volunteered when they came to us, because of the uniqueness of our facility, we volunteered to have our institution evaluated, and that the report be published, and it was. This was the first

step toward evaluation. I feel that there should be evaluation, just as there is in a hospital, we are doing that now, so that the patient, and this is a patient, I wish we could get away from, once the person becomes involved in treatment, the fact that he is a drug addict, yes, perhaps I am a cardiac patient, but I am a patient. Once a patient becomes involved in treatment, he is entitled to supervision by a state agency as a patient.

MRS. WILSON: Thank you very much.

MR. MENZA: Let me understand something: You argue basically that your facility, and similar facilities should be health centers, or part of the entire health structure in our state. Is that correct?

DR. GUBAR: With reservations, yes.

MR. MENZA: Therefore, you should be licensed because it is a disease or illness or whatever it may be, you should be licensed such as hospitals, mental health centers. Is that correct?

DR. GUBAR: In effect, yes. Again, with reservations.

MR. MENZA: You realize, of course, this would be state involvement, this is where your reservation is?

DR. GUBAR: No. The question was, should there be licensing, and my answer was, yes. Yes, because in fact there are patients or people being treated, and there is no other profession that treats people that are not licensed.

MR. MENZA: What other reservations?

DR. GUBAR: The reservations being that all modalities that fall under a particular modality, be licensed, and I would have to just talk off the top of my head, for instance, I don't know if this is so, if in fact treatment center X does not hire a psychologist, and gets into a purely theraputic community, then if this is the way that they are functioning, then they should be licensed to operate on that basis.

MR. MENZA: In other words, no particular criteria for all modalities?

DR. GUBAR: Which makes it much, much different, and that is why I say loosely, Methadone is a form of treatment.

MR. MENZA: What is the relationship now with the State Dismas House?

DR. GUBAR: We are presently under the supervision of, we do have a contract, it is one of these overrides, where if we fill X number of beds, the state will subsidize X number of patients beyond that.

MR. MENZA: That is funding?

DR. GUBAR: That is funding. We are in a unique position, because we are licensed, our hospital is licensed by the state. We were licensed by INA. We are now licensed by the State Department of Health, so we do get regular inspections as any hospital would.

MR. MENZA: Recently in a newspaper article, it is stated the use of heroin has declined, or use of alcohol has increased. What comment do you have?

DR. GUBAR: Well, I believe the use of alcohol, barbiturates, have increased, we have also seen an upsurge in hallucinogenics recently, which amazes me. We do not see a decrease in the use of heroin, however, it is still a little too early to determine

whether or not we are getting new users of heroin into the community. Now, what this may be, the young people are taking a breath, they are in a sense becoming involved, so you have this pause that almost refreshes, before we get another jump-off. I don't necessarily go along with Mr. "Jaffe", saying we have the second report of the Marijuana Commission that states that we may see a future drying out of marijuana use. Whether this is so or not, we do have an immediate problem, and it certainly is not going to disappear by us wishing it to be.

MR. MENZA: You think, I would presume, that the state should really structure all of these independent facilities who treat the addicts and the drug abuser, as you mentioned, with proper supervision, referral, one structure throughout the state?

DR. GUBAR: Yes. I fully believe there not be a single modality, a single structure or whatever. Certainly, there should be the state sitting up at the top. Now, whether or not I am in minority of one,

I don't know, this is personal, I feel that because of one of my early points, I need to have some kind of feedback from other institutions, I need some kind of a central referral, I need to be, in a sense, free to practice therapy as has been developed. I also need to be able to interchange and exchange ideas with other people. This has not been the case up until today. We do have some kind of get together in Timbucto, I can attend meetings in Mexico and so on, but I don't think there has been a completely healthy exchange between all of the people in the state. Perhaps what we need, is some kind of a state organization, such as the psychologists have, such as the doctors have, such as the attorneys have and so forth. Perhaps what I am saying is, I would like to make the field of drug rehabilitation and treatment more professional than it has been.

MR. RYS: Doctor, how many patients are you treating at the present time?

DR. GUBAR: Presently we have 77 in residence. We have a capacity of 125, and

I have found, in spite of what anybody says, there are no waiting lists for any residential centers in the state.

MRS. WILSON: I think we all have to agree that we have been failures in the whole area of changing the habits of the large number of drug abusers, or at least if we are changing the habits of some, we are also acquiring new addicts all the time. The drug problem, the reason we are here, is because we have failed. We had a professor last year who testified before this Commission, and some of his testimony alarmed me, to some extent, especially in view of some of the things said. You are saying we need professionalization of drug treatment personnel, institutional organizations where drug treatment personnel can be together. This gentleman referred to drug treatment industry, he cautioned us about the development of the vested interest group in perpetuating the need for drug treatment centers. Given our failure up until now, and given the number of treatment centers that we have, I wonder if this is the way

we should do it, I don't know what the alternative is, that is one of the things we are trying to find out here today. What I would like to ask you, if you see that same risk in allowing an institutionalization in vesting of interest in something that in effect has failed so far.

DR. GUBAR: Basically, what you are asking is, have we failed in the entire area of mental health? We do have the same kind of problem, we have the same kind of questions that we would have to ask about our present institutions. I recognize that this is not this Commission's problem. Yes, there is always the possibility, even today. I make my living at Seton Hall, thank God, I am also very happy to be a consultant, gave up most of my private practice, and I am a clinical psychologist and work at Mount Carmel, Monsignor Wall, with drug addicted persons, and, of course, I include the alcoholic, the soft drug user and so on. But, cure, as I define it, does not consist of an extended dependency relationship to a theraputic community, it is the restoration

of a person to be useful and productive and a well adjusted member of some society, so that he can carry on. We are not interested in establishing a dynasty. It is strange that our personnel have not stopped any other program in this country, other than one single program that asked for some people, that was in Wilmington, Delaware, the staff of our institution is for the most part professional, and we hired only about four former drug addicts, two of whom are presently in college and on their way to degrees. So that if it is a possibility, then we have to face the possibility in order to get the professional kind of treatment that we would get for any patient in need of help.

MRS. WILSON: Thank you very much.

MR. MENZA: Lieutenant Delaney, would you come back up for a second, please. In your experience, what has been the effect of the New York drug law passed in September 1973, on the State of New Jersey?

LIEUTENANT DELANEY: It has been my experience in North Jersey, and talking with my colleagues in Central and South Jersey, we have seen little, if any, migration into the State of New Jersey, as a result of the New York law. I might point out, however, that there are pending now some 300 odd cases, before that special Grand Jury that they empaneled, and depending on what happens, I would have to take maybe a different posture and look very closely should there be a migration. Some people might say we are going to go away, let's go across the bridge, but as of this date, there has been no migration that we have seen, and in some cases, which is totally contrary to popular belief, we have in fact, on large buys, namely, close to ten ounces of 100 percent heroin, they had to go to New York, the dealer would not

cross the bridge to New Jersey. The market place is still in New York.

MR. MENZA: Lieutenant Delaney, we have a series of questions which I would like to have your association answer, will you respond, can we arrange that?

LIEUTENANT DELANEY: Yes, sir.

MR. MENZA: In addition to that, we would like to hear from anybody in the association, and we would very much like to have your position on many, many questions, and if we ask them now we will be here all day long.

LIEUTENANT DELANEY: We would be happy to give them to you.

MR. RYS: Lieutenant, are you familiar with the California law?

LIEUTENANT DELANEY: Regarding civil commitment?

MR. RYS: Yes.

LIEUTENANT DELANEY: No, sir, I am not.

MR. RYS: Thank you very much.

MR. MENZA: Mayor Kugler, please.

MR. KUGLER: I don't have that much that I can give this Commission, at this time. However, as the Mayor of Saddle Brook, and I have been Mayor for the last five years, I feel that Saddle Brook has a problem, even if it has one child that is a drug addict. I am also in a professional field as a funeral director, and have had people come in with an overdose, for some reason or other, and had decided to take their lives. I would like to just say, recently I had a young boy of, a 17 year old, who had drugs, LSD, and upon his so called trip he decided to stab himself, which he did, committed suicide by stabbing. It is a shock to the town, as well as to his mother and father and all his friends. I don't know what we can do to stop this, but as the young lady said here, we are probably neglectful, we try to do the best we can, and we still have a drug problem.

Saddle Brook is a relatively small community of about 16,000 people. I don't think we have a major drug problem, however, if I have one child, it is major as far as I

am concerned.

I don't know what I can say, however, I feel there should be a strong tie between the school as well as the municipality level to try to orient our children at a very early age.

I have two boys, 11 and 12, they are not on drugs, thank God, I hope they never will be on drugs. However, I have nieces and nephews that are in our high school, and I personally cannot get drugs, I have asked around if I can get marijuana and so forth, no one will talk to me. However, my niece and nephew can get this anytime they want it. I don't know how we can get to the teachers, or to these young children to come forward to the authorities. If there are pushers in the schools, try to correct this, get them out of there. I don't have the answer, I wish I did. I don't know what I can bring forward, except my little town, as small as it is, we have a problem if it is one child. Whatever I can do, I graciously will give my time and service to this Committee, or anyone else to try to relieve the problems.

MRS. WILSON: As far as the schools are concerned, I happen to be a public teacher, who teaches in high school, and I can tell you, the drugs are being used in high schools, the availability of drugs and marijuana is coming through the students. It is not some bogey man, coming from outside, coming and pushing, it is our kids, it is our kids who are selling it. They are getting it somewhere, but it is very, very hard to detect, even when you are right in the same school house with the kids.

MR. KUGLER: I am thankful for the Bergen County Task Force that went into operation this year. This is one way we could possibly get to these pushers. I have a police department that every child in my town knows who the detectives are, but with this task force and undercover agents, they come in and we have used them in Saddle Brook, and other communities have used them, it is a tremendous thing. It is on a voluntary basis, and some communities do not participate, I feel the more money we can get into this task force, it is going to be better for the

community at large.

MR. MENZA: Bergen County for many years has had a good reputation in the area of enforcement, or understanding in regard to the drug user, as well as jail reform attitudes. Thank you very much.

MR. MENZA: Dr. Rubin, please. Dr. Rubin, what we are really looking for, we want to pick your brain and want to know what ideas and what suggestions you have, based, of course, on your experience with your facility, or without your facility. The idea is to get a report, a meaningful report, so we can hopefully come up with a brand new revision of the laws dealing with narcotics, as far as penalties are concerned, and as far as treatment is concerned.

DR. RUBIN: I am Dr. Aaron J. Rubin, I am Director of Community Affairs for the Central Bergen County Mental Health Center. First, gentlemen, I would like to read a statement, which would establish the climate about which I would like to speak about.

The abuse of drugs, and its debilitating effect on mankind has already been documented in history for centuries. We sat back comfortably for generations as we read about the Hashishians of bibilical times. We noted with interest the civilizations in some remote corner of the world that were trapped and doomed because of cocaine.

We ignored the poverty, crime, and violence of the ghetto when heroin remained within its walls. It was not until the disease, whose symptom is drug abuse spread like an insidious infection across our green lawns and tree lined streets that we reacted to this plague.

In our hysteria, in our effort to protect our young, we have made many errors. We wrote laws that did little but insure crime for profit. We punished equally the assasin and the victim. We fragmented our our approach to the problem and found those who sought to solve the problem at odds with each other instead of joined together for meaningful answers.

Some answers have come amidst the wreckage of human lives. We have learned that the victim of drug abuse, like the victim of alcohol abuse, suffers from emotional disorders such as depression, anxiety, alienation and identity problems and when we deal with these problems, the need to rely on drugs diminishes and disappears.

New legislation must sharply divide

the use of heroin and barbiturate addiction from the use of soft drugs. New legislation must seek even firmer ways to deal with the peddlers of death, and at the same time seek to help and protect the victims of these destroyers of life. As a comprehensive mental health center, with affiliate agencies long experienced in the rehabilitation and treatment of men, women, boys and girls with severe drug problems, we make the following recommendations to this legislative committee.

(1) Greater utilization by the State of N. J. of M. H. facilities for the administration and supervision of drug problems. The use of M. H. facilities for this purpose has been mandated by the federal government and has been effectively used in many states. Such Centers have demonstrated their effectiveness in dealing with this problem as they have with the problem of alcoholism. Our present fragmented approach, while successful in many areas, fail to coordinate, integrate, and provide for evaluation programs.

(2) Apply the principal of early

intervention cooperation between the courts and M. H. Centers to make more effective use of the therapeutic processes.

(3) Laws that would protect and separate the victims of drugs from the purveyor of illicit drugs.

(4) Repeal the mandate that requires centers that treat drug victims to report the names of these patients. This law inhibits many seeking help because of fear of this identification.

(5) Differentiation of "hard" and "soft" drugs.

(6) Repeal of laws that are used primarily to harrass the innocent, such as the law that prohibits carrying legal drugs outside of the original container, and also the laws which charge as a disorderly person the carrying of non-prescription non-narcotic drugs.

You asked me to talk about, in addition to these recommendations, some programs. I would like to point out, we have been treating people with drug problems long before it became the epidemic disease that

it became several years ago. We have always treated these people, we never identified ourselves as a drug treatment center, we identified ourselves as a mental health center. At one point the drug abuse was so prevalent, that we would not ask them if they took drugs, we simply say what drugs are you taking. We would approach this from a mental health point of view. We would treat the emotional disorders that led to the abuse of drugs and found ourselves successful in treating.

We weren't able to reach everyone, not everyone came to us, so what we are dealing with and talking to you about, those who do seek treatment, and we have found effective ways of dealing with them. We found other ways, a year and a half ago we started alternatives, two young people from the high school, youngsters who were very much involved with drugs, who were failing in family relationships, failing in school, failing in peer relationships, came to a crises in their lives where they felt that within a year, like many of their

friends, they would either be dead, disappear or in jail, or they had to find an answer. They came to the mental health center. They identified themselves as "having their head screwed on wrong" and wanted from us, to help them find themselves.

On a carefully established program, with a great deal of input from these youngsters, it was a program where we sat and listened very hard to what they were trying to say to us. We learned that they needed a place for themselves, we heard them saying to themselves that they had to seek a meaningful identity. They were saying to us, that they needed someone to hold their hand and guide them through some rough times. By giving them what they needed, not what we thought they needed, but what they felt they needed, we established a program which now has 250 youngsters of high school age in it. Over 100 are now completely drug free. By drug free, I mean their standard, not ours, their standard means no marijuana, no alcohol, none, period, they have established their own rules, they

have established their own criteria, which I must admit stricter criteria than Dr. Esser established for treatment, but they have been very successful.

They have another 75 youngsters who have diminished greatly their drug habit, from getting high every day, or getting high four or five times a week, to perhaps getting high once every two weeks, or every three weeks; they do not consider these kids as drug free, they are not in the inner elite circle of the 100, to be in this circle, you must be completely drug and alcohol free.

We have 50 or some who are new to the group, who are finding their way, who are trying to establish an identity with this newer peer group. We have 25 or so who come and go, walk into a room and say, heck, with 75 youngsters here I ought to be able to find a fix; they find themselves being led out of the room very abruptly, and unceremoniously, it is something that works.

As I pointed out before, other

things work. We need the kind of legislation that could coordinate the things that work, that could emphasize the things that have been meaningful, that could deemphasize the things that have been destructive and present it in a package. There are all kinds of agencies now that deal with this problem. Within the mental health field, we have agencies doing good jobs, bad jobs, different jobs, and there is no central organization that can take all of the work that all these agencies are doing at present to ladies and gentlemen like you.

MR. MENZA: You mentioned the mental health center working with drug abusers, one problem arises, we are supposed to have at this time 50 mental health centers, we have 16, that is a problem in itself.

DR. RUBIN: That is true.

MR. MENZA: You mentioned that the federal guidelines for community mental health center include treatment of drug users. Is that correct?

DR. RUBIN: That's correct.

MR. MENZA: You also mentioned,

some that would be permissible for community mental health centers to deal in this problem of drug abusers --

DR. RUBIN: Excuse me, Mr. Menza --

MR. MENZA: It would be permissible under the federal guidelines.

DR. RUBIN: Yes, it would.

MR. MENZA: Why don't mental health centers do that, other than yours?

DR. RUBIN: Well, the comprehensive centers do, because this is part of the thing that we are asked to do. Community mental health centers on the other hand, which are not necessarily part of the comprehensive center, those that are funded by the state, but not yet involved in the centers, are not mandated to do so, in fact, in some ways, frustrated by allocations of funds, especially within counties, where funds for drug abuse go to the agencies, other than mental health centers.

MR. MENZA: You also mentioned the identification of drug users --

DR. RUBIN: Yes. There is a requirement that our agency get, and each affiliated

agency gets. As a matter of fact, when you are getting input from the various affiliated agencies, each of the medical directors, the Fair Lawn Mental Health Center, Pascack, Dr. Benedict from Bergen Pines, along with Dr. Esser, each separately stated that we must deal with the law now requiring us to identify a drug user, to register this name with the state. We feel this law serves no real purpose, since the state takes a view toward these, saying we will not prosecute them, because they are coming for treatment. On the other hand, if they are not prosecuting them, while the law does act as --

MR. MENZA: Do you do this with other mentally ill people?

DR. RUBIN: No, we do not.

MR. MENZA: The requirement is that you must identify the drug user with the state?

DR. RUBIN: Yes. As a matter of fact, Dr. "Brand" pointed out, if we get a kleptomaniac in for treatment, someone who actually committed a crime for stealing various things, although he has committed a criminal act, we are not required to send

his name into an agency. We are treating him for a mental disorder.

MR. MENZA: Why is this? Why is it wrong to identify the drug user?

DR. RUBIN: Because the requiremnet, which many youngsters are aware of, they do not come in for treatment, they simply say, you know, I want help, but, you know, by having my name listed as a drug user, it is going to backfire on me. They don't understand the purpose of the law, it does maintain a threat, you know, you see no real validity to the law. If we are simply dealing with numbers for statistics, fine, we can tell how many patients we have, also who uses drugs.

MR. MENZA: It is also wrong based upon the civil rights --

DR. RUBIN: Well, you know more about the law than I do.

MRS. WILSON: I'm not quite sure I understand this registration. Is it a rule that every single drug patient who is treated throughout the state must be registered?

DR. RUBIN: Yes. We get a form each month which requires us to list those patients

by name, who are drug abusers.

MRS. WILSON: Is that sent to Odyssey House, do all of them have to do it?

DR. RUBIN: I don't know. I know that the four component agencies, Fair Lawn Mental Health Center, Pascack, Bergen Pines Hospital, the Saddle Brook Mental Health Center, each receive these forms every month.

MRS. WILSON: So far as you are concerned, you know the mental health centers have to do it?

DR. RUBIN: Yes.

MRS. WILSON: But you are not sure whether everybody else has to do it?

DR. RUBIN: No, I am not.

MR. RYS: Can you give me the age ratio of your group?

DR. RUBIN: Yes. They range from age 18 to 21, I'm sorry, 13 to 21. We deal separately with the 11, 12 and 13 year old group, that is a different age span.

MR. RYS: Are you getting funds from the State of New Jersey, what amount?

DR. RUBIN: We are getting no funds from the State of New Jersey for these programs.

We are very fortunately receiving funds from the Borough of Fair Lawn, this is separate funds to work on this problem. I might say, the youngsters came seeking help, and it is a three level process. The first help they receive is in peer relationship, they find other youngsters who are suffering, or who have suffered from the same kind of problems. Secondly, they identify with each other to help them get off the drugs and alcohol. We have worked with these groups, young professionals, who relate to them easily, who work with them four nights a weeks. They come to the center, teach them behavior modification techniques, help them in the first level, emotional problems. We also have available for these youngsters, at no cost, availability of our complete psychiatric staff, so as the need points out for these children that do need ongoing psychiatric care, we do provide this.

MR. RYS: Is there a great deal of correlation between drugs and alcoholism?

DR. RUBIN: Yes, there is. We are coming to an era, where throughout the country

we are getting reports of diminished hard drug use, we know, for instance, that in Fair Lawn High School, there remains one major drug pusher, there are kids that sell to each other, they may buy two sticks of marijuana and sell one to a friend, divide it. We are not so concerned with this as the major pusher, while several years ago there were dozens of major pushers at Fair Lawn High School, and while years ago this individual that I am talking about would deal in kilos of marijuana, his business now deals in grams of marijuana, and half of his business is over high school age, young adults. But what has happened is, alcohol has replaced it. In 1972 we sold three million bottles of pop wine in the United States; in 1973 we sold 33 million bottles of pop wine. These wines were sold to youngsters, youngsters today who are using this drug, you know, an 18 year old can walk down the middle of the street with a half a gallon of whiskey, and a case of beer strapped to his back, and nobody is going to stop him. Three years ago, anyone who

looked a little strange, would be stopped and hassled and searched for a couple of grams of marijuana, or whatever. I am not saying that was wrong, you know.

I feel this is as a serious threat as any disease, and its presence must be eradicated. But we at the center deal with the user, and while others should deal with preventing the supplies from coming in, we deal with taking the user, you know. The point I want to make, among all alternatives, that we discussed the fact that hard drugs are no longer being sold, that there is very little heroin around, cocaine is going back to Spanish Harlem, heroin is going back to Harlem, LSD is not being used anymore because its effects are felt, that everything else is going away, and these kids have not indicated that their need for group-like alternatives is going away, what they see replacing this is alcohol. Even more disturbing, the same parent who became extremely upset if their sons and daughters came home with some kind of drug, are not quite as upset because they come home drunk. There

are cultural patterns, we are changing, cultures which years ago looked down on them, frowned upon the use of alcohol. The children of the people of these cultures no longer have this inhibition against the use of alcohol. 450,000 alcoholics between the ages of 12 and 18 years old in the United States, and if we can identify almost half a million, we know that there are three times as many in existence.

While we are talking about drug laws, while we are happy to discuss this with you, we must think really in terms of the illnesses that children have, the abuses of themselves that they find as answers to this. We must find meaningful ways to deal with this, whether we are dealing with marijuana, Boone's Farm Wine, or whatever the substance.

MR. RYS: Is the drug pusher, as mentioned prior, still in business in Fair Lawn? If you get in touch with me, I will see that this is completely eradicated in the Borough of Fair Lawn.

DR. RUBIN: All right.

MRS. WILSON: Do you know the gentleman's name?

DR. RUBIN: No, I don't know his name. I am put in a peculiar position, a great deal of the information that I get, that helps us make meaningful decisions about drugs and alcohol abuse, comes from kids who trust us, and what we have been able to do with the alternative, what we have been able to do with the 100 youngsters is much more meaningful to me than forcing someone to tell me a name. I see this as two separate problems, I am dealing with youngsters, I have no grief against the police and their role, I feel they should pursue their role.

MRS. WILSON: Something you said disturbed me a little bit. You said that the heroin problem is reverting to Harlem, the cocaine problem is reverting to Spanish Harlem, and I know you didn't intend it that way, but it sounded as if you were saying it has gone away. I am concerned about that, because in your opening statement you pointed out that it wasn't a problem to us until it came to our green acres out here in Bergen County?

DR. RUBIN: Yes.

MRS. WILSON: I fear that we will think it is no longer a problem once it goes back --

DR. RUBIN: I said it that way with sarcasm, you know, I meant it to prove a point, rather than to say it is not a problem anymore. Yes, it very much is a problem. If we are going to solve it, we must solve it along Amsterdam Avenue or wherever it exists.

MRS. WILSON: I really wanted to get that clarified for the record.

MR. MENZA: How do you serve, what capacity do you serve in the mental health center?

DR. RUBIN: As Director of Community Affairs. My job is the link between the clinic and the public, and the link goes both ways. I must bring to our staff, suggestions for meaningful programs as I become aware of them from the community, and, at the same time, I must make the community aware of what we are doing clinically at our center and other centers.

MR. MENZA: You speak as a layman,

what is your background?

DR. RUBIN: I have a degree in psychology, but it is not required for the particular position I hold with the center. I don't do clinical work for the center. This background helps me in interpreting some of the phraseology.

MR. MENZA: Thank you. Before I forget, referring to 26:2G-18, I see nowhere in the statute that mandates these names be furnished. We will check this out and contact the division, and ask them if they have rules by virtue of the state.

We will now take a lunch recess.

MR. MENZA: Dr. Benedict, please.

DR. BENEDICT: I am Paul K. Benedict, I direct the narcotics services at Bergen Pines Hospital for seven years.

MR. MENZA: Doctor, we suggest, I reiterate, we are picking brains here, we want to know what you have to recommend based on your experience, not so much as what you do at Bergen Pines, we know that.

DR. BENEDICT: Right. Well, in terms of priority, recommendations, I would say, we have, as you know, an in-patient unit at Bergen Pines. We have a large out-patient program. In terms of priority, my recommendations would be, we badly need a halfway house. There is a general agreement that halfway house is needed badly, and we have thought of using things like the Shelter, but we cannot use it to a very great extent under the present laws. We constantly turn out young drug addicts, no one wants them, they are unstable, they don't have money, they don't have jobs, we do not want to inflict them on their homes. One of the problems which I deal with, unless

you deal with addicts sometimes you don't realize the problem, and many average patients are 20 years old, many of these families have younger brothers and sisters, and drug addiction is very definitely a transmittal situation; it is a social condition, and to my mind a drug addict should never be in a home with younger, at least younger siblings, maybe older. Again, we see them going back into these homes, and I am concerned about the effect upon young siblings. We do have repeated cases in the same family, where there is some evidence of contact. I have treated as many as four brothers in one family. If we can establish a halfway house, get these young people out of the homes, where there is less chance of infections, it is actually an infection, and this is a priority in this country. I would say, what I know of, and everybody in the program agrees, this is a number one priority.

Number two, I would say, very strongly organized and adequately funded vocational employment service. This would operate out of the home, for example. We can put great

pressure on our patients to work. I run around 200 Methadone patients, and one of the rules of Methadone, the way we operate it, the patient must be employed, he must, I do not give him the option even when he is eligible for unemployment, I don't let him do it, which makes him very angry sometimes, and they call me un-American, but our position is, a drug addict must work to keep from using drugs, we find that they go together. So, I would say that employment, if we can operate an employment agency, and right now probation is doing something along those lines, but it should be, I think, broader than that and take in more, and so on. Those are the two obvious requests I would make. The third thing which concerns me, only three things right now, is that, in addition to overall better organization of the county referral service and so on, some kind of civil service, it can be reorganized better, I think, maybe this will be done anyway. The third specific recommendation is, that everybody, anybody in the county, I think that was brought up on a drug charge, should be examined by a

competent team, to preferably include a psychiatrist. I happen to be a psychiatrist, and to include psychological testing, this sort of thing should be done.

I understand a young offender, without previous record, can be given special treatment, and, I think, it essential he be sent at the beginning, in keeping with his legal rights, of course, and counsel, but in my experience with attorneys, usually they are very happy to have this done. As I say, I continually see cases who have already been processed by the courts. I would rather see these cases, whoever is going to see them, I don't have to, but it should be set up that they should be seen routinely. It should be done by a non-court agency, not connected with the courts, not connected with probation, it should be funded by the county, of course. I believe we would obviate a lot of problems of seeing people too late, as we have these people now. Let me remind you, we cannot use Methadone until the person has been addicted two years, and many of our cases have not been addicted two years. We prefer

a drug free approach where it can work. The important thing is, when we see the case, to make the right decision, and how this person should be treated.

MRS. WILSON: I have no questions.

MR. RYS: Are you getting any funds from the State of New Jersey?

DR. BENEDICT: We are getting matching funds since last summer.

MR. MENZA: Bergen Pines is not solely concerned with the problem of drugs?

DR. BENEDICT: You mean the whole hospital?

MR. MENZA: Well, you are part of Bergen Pines?

DR. BENEDICT: I am part of it, I am part of the psychiatric department, I am a psychiatrist.

MR. MENZA: What is Bergen Pines Hospital?

DR. BENEDICT: It is a county hospital, one of the largest hospitals in the metropolitan area, something like 1,400 beds.

MR. MENZA: Are you in charge of the drug treatment program?

DR. BENEDICT: I am in charge of both in-patient and out-patient.

MR. MENZA: You are funded by the county?

DR. BENEDICT: I don't know the amount, the state matches funds in this.

MR. MENZA: You receive how much of the funds from the state?

DR. BENEDICT: I can't tell you, the way theyoperate the Pines, I don't have too much to do with that, it is out of my hands.

MR. MENZA: How many people do you accommodate?

DR. BENEDICT: In that program? Usually about 300 patients.

MR. MENZA: How many in-patients are there?

DR. BENEDICT: In-patients? We have 16 now.

MR. MENZA: Out-patients?

DR. BENEDICT: Up to 300.

MR. MENZA: You use the Methadone approach?

DR. BENEDICT: About 200, 190, 180

Methadone patients.

MR. MENZA: You use the Methadone approach with in-patients also?

DR. BENEDICT: Well, what we have been doing with in-patients, since we had this service, our Methadone patients who are having trouble, getting positive tests, everyday we take the urine, we put them back in the hospital.

MR. MENZA: Is it fair to say, your approach is that of an in-patient, and you take a different approach with an out-patient --

DR. BENEDICT: No, not necessarily. For example, Methadone patients who are failing, if Methadone is not working, we put them back in the hospital and go over them again, give more psychotherapy, but we will keep him on Methadone, I will not take him off. We have many, many out-patients on psychotherapy.

MR. MENZA: You believe the Methadone approach does work, in fact?

DR. BENEDICT: Oh, yes, no doubt about it. This is the only approach we know that works, it has been extensively researched.

MR. MENZA: Is the approach to keep

the person on Methadone for the rest of his life?

DR. BENEDICT: No, no. When the program first started years ago, and my approach to the patient is, I demand one year on the program, and after one year, if all goes well, you are working and stable, I will try to get you off. I try to detoxify people. I don't consider a person cured, unless he is off of Methadone.

MR. MENZA: You realize that there is an awful lot of criticism in the Methadone approach, that it is an ultimate cop-out?

DR. BENEDICT: I don't know of any research person who would say that. The research is conclusive. I don't think you can say that, lay people say that.

MR. MENZA: Thank you, Doctor.

MRS. WILSON: I have one question that I have been wanting to ask all day, I don't know if you have the answer, I feel -- let me ask the question. What do you think makes someone get involved with drugs?

DR. BENEDICT: That is a difficult question. That is an area where there is, you

know, the idea about Methadone, there is a consensus, pretty much universal, our people who work in the field think that anybody can become an addict, that is the position of certain people. My own position is, depending on where you are operating, some of the slum districts in New York City, as many as one of three young people are on drugs. For example, more and more people smoke marijuana, marijuana has now been declared not a symptom by the Psychiatric Association. So many people do it, how can it be a symptom. If everybody does something, it is not a symptom. Let me talk about something I know of firsthand. Our people, I have an opportunity to backtrack and talk with these people before they became addicted. These people are obviously not just random samples. My kids tend to be, there is a popular word for it, losers, they are great losers, none of them are really criminals. We have only maybe 10 percent of my people who are criminals. More are under achievers, they are the kind that went out for the football team and the coach didn't like them,

they quit, they are quitters, cop-out artists, they drop out of school. They do not normally commit crimes, they get involved in crimes as they get involved in drugs. I would say, in answer to your question, I think in Bergen County, it is that type of person who becomes involved.

MR. MENZA: Thank you, Doctor.

MR. MENZA: Dr. John Netti, please. You heard my comments before, Doctor?

DR. NETTI: Yes. I am Co-director of the Valley Center in Ridgewood. We are finding, at Valley Center, it is not an in-patient facility, this is an out-patient facility, supported by the 16 towns, less than that actually, about 12 or 13 towns in the area of Bergen County, from Ridgewood to Oakland, in that particular area of the county. It is unique in the sense that it is run by basically the support of the individual towns, and we are an arm of the Valley Hospital, Community Hospital in Ridgewood. We see quite a few soft drug problems, in addition to heroin problems. We do not run a Methadone maintenance facility, we run a Methadone detoxification for heroin addicts.

Our experience with heroin, is as dismal as most other facilities throughout the country, we have no answers, good answers, for heroin addiction.

Dr. "Banta" who is now deceased, felt that we ought to wait, as far as Methadone maintenance was concerned; perhaps he had quite

a bit of foresight then, in that there are problems with Methadone, after all, heroin was used as a cure for morphine addiction back in the 1900's.

What we are seeing, with youngsters 12, 13, 14, 15, 16, and we are seeing the soft drug user, and we were set up in an effort to prevent drug abuse, in addition to treating it. In addition, we treat problems relating to venereal disease and pregnancy. These are the main problems of the teenager, V.D., drug abuse, pregnancy. Now, we find more and more, that marijuana, speed, barbiturates, LSD are coming down from the senior classes in high school, to the junior classes and in the junior high. Marijuana use is wide spread. Most youngsters in high school have either tried it or are on it everyday. Excuse that last statement, many have tried it. A large number are smoking marijuana everyday. We see these youngsters, they talk to us in confidence, we ask them about their useage. They will smoke it on the way to school in the morning, they will smoke it at lunch time. Marijuana,

I think you know, has an active principal which is THC. It is in hashish as well, only it is ten times more potent in hashish.

What has marijuana done to the 12 year old, 13 year old, 14 year old, let's forget the chromosomes, let's forget the other bad effects that we can measure, which is difficult, you know, in a marijuana addict. With a marijuana smoker, it is even harder to pick up, because there are few side effects.

You find the eighth grader tries marijuana, and will try anything that comes along, some of them. There are a lot of drugs out there; in all the high schools and junior high schools. When they try marijuana, it follows like the night following the day, that they will try speed and maybe trip on LSD. LSD, you know, there's no question about, if we go over to the in-patient facility at Bergen Pines, you will see many youngsters who have blown their minds, so to speak on LSD. We are talking about, in a sense, the wide spread use now of marijuana and other drugs, soft drugs, non-narcotic drugs, in our school system, getting down

to lower and lower levels, despite adequate education in the grade schools.

We feel that the problem is out of control. I could not figure how any youngster could go to class after he had had a marijuana cigarette at 8 o'clock in the morning, or at lunch time, and learn anything. What is happening, this is undermining our whole educational system, the subtle effect, there is no way that you can measure motivation. We do know, that the pothead, the chronic marijuana user, will have problems with grades. What marijuana does to the adolescent, who knows. What is the function of adolescents? Growing up, does growing up require a struggle? If you can avoid the struggle with marijuana cigarettes, does he grow up or do we produce a generation of adolescents, or many adolescents. We are primarily concerned with the issue of marijuana in the 12 year old, 13, 14 year old, and in the education of these youngsters, which many of them apparently aren't getting.

Marijuana is here, it is in the schools, it is all over, there is no control of it. Along with other soft drugs, soft being

non-heroin, we can do nothing with the heroin addict. We try, I think we have been effective where the schools cooperate with us, where our marijuana smokers have been caught red handed, and the police might have gotten him down to us on probation, we can get working with the parent, with the individual teachers, we have been successful in seeing when a youngster stops using marijuana, the grades go up. We are very concerned with the continued widespread use of this problem.

We think the underlying problem of all drug addicts is the widespread availability. I agree with Dr. Benedict, that the heroin addict often is a loser, how many heroin addicts become heroin addicts, because they start on marijuana and who knows. We know they all start on marijuana. That is about all I have.

MR. MENZA: Doctor, you stated the problem extremely well. What shall we do?

DR. NETTI: Well, you have the state legislature, you have an obligation, in the sense of education of a youngster,

that is delegated responsibility from the parent to you. My youngsters are getting exposed to all kinds of drugs in the school system. In society, they start out in kindergarten, and try to leave when they are 18, how can you educate somebody who had marijuana before you came to this hearing, or two martinis, or had two martinis, when you were going to college in the morning, how would you function? Can you drive a car, you know, teenagers, 18 years old, they are out there driving automobiles. Now, is it safe to drive an automobile after you had a marijuana cigarette? I think you know, what can you do. I think you have to give the school some authority to control this. You're teachers in a classroom, you have to teach a subject, you have to get a certain amount of that subject across, I would assume, if you want to be successful in teaching the subject. Therefore, if you have a youngster coming in stoned, but you can't prove he has been on marijuana, but everybody in that school is smoking marijuana, and you can assume he is stoned from marijuana, but what does the

teacher do? Can we put up with three kids falling asleep in school in class, should the teacher? If you bring this out, in public, the supervisor in the school, you know, maybe it is the teacher that winds up losing his job or something, but this is a matter of fact. There is no question of numbers now, if you are talking about 25 percent, 10 percent, 50 percent, 75 percent, what difference does it make? You are talking about the schools, you can't have an effective education.

MRS. WILSON: I don't know whether you heard before, I happen to be a school teacher. I think most schools in the state now have the policy where teachers are required to report any suspected cases of drug use in school, and the teacher is protected from any sort of retribution. But, I tell you, I don't know if they are using it, I can't tell. I can't tell if they stay up late at night doing many things in addition to school work, it is a very hard thing to say, because they fall asleep in class, that he or she is doing drugs. If the kids fall asleep

everyday, everyday, you begin to wonder, but I'm afraid that what you are saying makes it sound as if it is a simple job of giving the teacher more power and placing more responsibility on the teachers. I don't think that is going to solve the problem.

DR. NETTI: I'm not really saying it is simple. Certainly it is not so simple. But, can we tolerate, you know, can we tolerate the use of drugs in school all day? I can't see how we can effectively educate youngsters, if large numbers of them are under the influence of a drug while they are going to school. I am not putting the blame, per se, on the schools, but it's the juvenile society, it is part of their culture, and it seems that making it any easier for them, is not going to, you know, solve the problem. I know it is a difficult problem, I didn't mean to say that the solution is simple.

MRS. WILSON: You spoke in some length about marijuana, and I assume from what you say, that you would like to see no decriminalization of marijuana, how do you propose to control the supply? You say,

if there are --

DR. NETTI: I don't have the answer. As far as the decriminalization is conerned, my feeling on that, honestly, I don't know. I certainly think, off the top of my head, it is wrong for a youngster that is smoking marijuana cigarettes to be classified with a pusher of heroin, that is up to, you know, that is another question that I really can't answer. I haven't given it that much thought.

MR. MENZA: Or the bank robber for that matter, that is the point. The point is, we treat persons who abuse marijuana, we treat them as criminals. I don't think there is a party, at any particular block, any Saturday night, where adults aren't smoking marijuana, but that is a fact of life, we know that people smoke marijuana throughout on a steady basis, 28 million people enjoy it. You see, we know the problem, we are aware of the problem, not as directly as you, of course, but you work with it every day. But, we are in a sense, wallowing around and trying to find some type of solution. We realize

education is part of it, we also feel, some of us, should not just put our young people through the criminal process because of a sickness that they may have, marijuana or hard drugs. But a person who has two sticks, for example, for them to come through our judicial process and then jail, first of all, it doesn't work at all. Secondly, it is cruel and wrong.

DR. NETTI: Well, I am more concerned about getting to the roots of the problem, because let me tell you, Dr. Benedict can tell you, how frustrating it is to try to treat this problem. I don't really feel, if you are talking about legalizing it, are you planning to legalize it for the 12 year old and 13 year old?

MR. MENZA: Of course not.

DR. NETTI: This is the population, you see, this is the problem again, this is the area that we are worried about. You are not worried about the adult that occasionally smokes marijuana on a weekend, he might get into an auto accident, that he wouldn't have gotten into, had he not been on it, because

marijuana, depending on what you are talking about now, remember, you are talking about a drug, a drug varies with each individual that takes the drugs. How much THC is in marijuana that he is smoking? He got it illegally, you don't know what the purity is. You are talking about Vietnam, that's good, that is almost like hashish, or the stuff that comes from Mexico, that is almost as good, or the local garbage you get in the United States that might not quite be as good. You are talking about a drug, an individual substance, THC, and, you know, its proportion to the amount that is in it. You have a tough nut to crack, when you say I am going to legalize something like this. I am not saying that you are wrong in trying to not classify the marijuana smoker with the bigger heroin pusher, or something else. I still want to point out, that your biggest age group is the teenager, and the teenager, I think, is hurt in an area that is difficult to measure, as to motivation.

MR. RYS: Is there any cooperation between your hospital and the school system?

DR. NETTI: Valley Center, we actually go out to the schools on a weekly basis, talk to physical education classes, different classes in each school, talk to the P. T. A., we are talking to the P. T. A. tomorrow night from Oakland on this problem. One of our doctors will be there, we are out there, as far as education is concerned.

MRS. WILSON: I can see that every community has a drug closet full of drugs, all types, and I guess the children have this available. Should there be some legislation pertaining to the druggist and doctors, in size of the prescription, and what should be given, how it should be given?

DR. NETTI: Certainly there is a drug that you might put pressure on, Quallude, amphetamines, you know, the number you could say that this particular drug has only certain indications, you might want to limit that. Amphetamine addiction in Sweden and Japan became a great problem, shooting intravenous became a great problem. Japan was controlled by only allowing a certain number of physicians to dispense amphetamines, they controlled it,

they got tough, and they got the problem solved. There is no easy way to solve the problem.

MRS. WILSON: You feel we should bring the drug company into focus?

DR. NETTI: On some of the drugs, yes, I agree.

MR. RYS: Thank you very much.

MR. MENZA: Thank you, Dr. Netti.

MR. MENZA: Mrs. Justice, please.

MRS. JUSTICE: I am Mrs. David Justice, and I had no idea that I was going to ask to speak today. I am a private citizen, who came merely to listen to the hearing. I am compelled to say something, which nobody else has said, and which I feel is important. In fact, listening to the testimony just now, the last testimony about marijuana, is to me, perhaps, the best argument for why there should be legalization, not just decriminalization, but legalization of marijuana, with strict controls. This is the important point that has not perhaps been considered seriously enough. Starting from the testimony we have just heard, that marijuana is indeed now a part of our entire society, that it is being used by young people, I am concerned about young people, and I am also concerned about respect for the law, which has deteriorated so seriously, as a result of the drug laws and the methods used to enforce them.

This is what is damaging our country, what is really hurting our country,

is that the majority of our young people are now defined, by law, as criminals, and that in order to catch these criminals, that our law enforcement people should be putting their efforts on real criminals, and are putting too much of their time and energy on otherwise completely innocent young people.

Lieutenant Delaney testified about the idea of decriminalization, this is a step in the right direction. It seems to me, completely unrealistic, to decriminalize possession of small amounts, and it would still leave marijuana against the law, it would still be against the law to buy it, it would still be against the law to sell it. Let's face the reality of marijuana use, these young people buy from each other, because that is the easiest way to get it. If they are going to a party, they will buy enough perhaps to supply everybody at the party, so what are they under the law, felons? They are felons, possessors of large amounts, and sellers, even though all they are really interested in is recreational

use. Now, at this point, let me make one thing very clear, there should be no misunderstanding, I have no interest at all in any possible marijuana use, for myself or for my family, I have never seen marijuana. I would like to see the use of all drugs discouraged, I would like to see alcohol discouraged, tobacco discouraged, misuse of coffee discouraged, and, of course, marijuana discouraged. No reasonable person will claim that there is no risk at all to the use of marijuana, but I have studied the report of the President's Commission on Marijuana and Drug Abuse, I have studied very carefully the Consumer's Union report, a five-year study, on the legal and illegal drugs, and I am convinced that marijuana is less harmful than many of the legal drugs. So that from the point of view of the potential harm to my youngsters, and your youngsters, I would rather see that when the kids go to a party, I would rather they smoked some pot than get started on the alcohol bit, which we know is potentially extremely dangerous. Alcohol is an addictive drug, marijuana is

not.

I don't want them to smoke pot either, but it is unrealistic for us to tell these kids that this is against the law. I spoke to Lieutenant Delaney at the first break, after he first testified, and asked him about his stand on decriminalization. He said, well, of course, they are going to go on smoking pot, but they will buy it in small amounts now, in order to escape the law. Is this a realistic approach? Is this what we really want? Do we want to tell our kids, look, you can get around the law by buying an amount that won't put you in jail, nevertheless, every time a kid goes to anybody, whether it is to a friend, whether it is to a local supplier, I don't know anything about the particular technique of getting it, every time anybody buys marijuana, a joint, he is inviting somebody to commit a felony, and I really feel this is bad for our country. Can we not start being honest about the difference between marijuana and the hard drugs? Separate them completely. Legalize marijuana with strict controls, so

that we can keep track. By legalizing it, it would be possible to control the purity, the quality of the drug, it would be possible to deal with it differently than we have with alcohol and tobacco, because we can say right at the start, no advertising, it doesn't have to be advertised.

We can even say, as we are starting to do with tobacco, we could say no smoking in public, because it pollutes the atmosphere.

If we could have carefully controlled sale, controlled by government agencies, so that we knew what was being sold, this would put it in a framework where kids would not be criminals, and where above all it would separate our children from organized crime. Isn't one of the real problems of marijuana the fact that, because it is illegal, it is being sold on a large scale anyway by the big importers, it is being sold by the same organized people who import heroin. This exposes teenagers to the possibility of dealing with organized crime. I think those are my main points.

MR. RYS: I think you heard the

grim story, and considering any youngsters getting on that habit, and being a felon, that is not correct, because a youngster is a juvenile until he reaches a certain age and then comes under the criminal justice law. However, he is under the supervision until such time as the courts and/or police department are satisfied. Now, you spoke about legalizing marijuana, and we have had an expert here, Dr. Netti, and he said the only reason why children are going on marijuana, and soft drugs, are because they can't afford the hard drugs. This is the problem in each and every community. I was the former mayor of Fair Lawn, I had that problem at all times. We are looking for recommendations, I think we have to do away with the criminal element in the United States, this is one of the problems, they are making big money, but above all, what is hurting us at the present time, they are ruining the nation and the youngsters coming out from the seventh grade to the upper grades, that is the problem. I can't agree in legalizing marijuana with you whatsoever,

listening to Dr. Netti.

MRS. JUSTICE: Thank you for the opportunity of letting me speak.

MR. MENZA: Mr. Thomas, please.

MR. THOMAS: I am Willis O. Thomas, Eastern Regional Director of the National Council on Crime and Delinquency. Just a word about the National Council of Crime and Delinquency, so you will know where my remarks are coming from. We are a non-profit, non-governmental organization, that has been in business since 1970. We are governed by a Board of Citizens throughout the country, somewhere in the neighborhood of 100 on our Board of Directors. We are also staffed with about 80 professionals. We develop standards in a variety of areas in the criminal justice system. We have citizen action programs to bring about changes in criminal justice. We have an advisory committee like the Council of Judges, which is 50 of the top leading judges around the country, former Council of Judges that advise our Board and staff on a variety of matters.

Now, the official position of the National Council on Crime and Delinquency, with reference to narcotics, is set forth

in a published policy statement that was developed by our National Council of Judges for the National Council on Crime and Delinquency. I would like to make this part of my report, and I have brought ten copies of that statement which I will leave with the secretary.

Briefly, this policy statement says the addict is a sick person and should be directed to medical help rather than to be prosecuted as a criminal. It stresses that medical help for addicts should include maintenance doses of heroin or methadone or any therapy that is medically indicated.

The policy opposes civil and criminal commitment of addicts.

NCCD's policy does call for control of narcotic traffic by legislation and effective penal sanctions.

With reference to sentencing the narcotic law violator, NCCD's policy specifically opposes mandatory terms in narcotics cases and the exclusion of narcotic offenders from eligibility for probation or parole. In fact the National Council on Crime and

Delinquency opposes mandatory terms and the exclusion from eligibility for probation or parole in any kind of criminal case.

We don't have a fool-proof, handy-dandy solution to the drug problem but we do have some approaches which merit the consideration of this Commission. We have developed and promulgated model legislation governing sentencing. This is our Model Sentencing Act which in short says there are only two kind of offenders, the dangerous person and the non-dangerous. Rather than establishing dangerousness by the offense committed, NCCD's Model Act singles out these offenses which are strong indicators of dangerousness. If a person is found guilty of one of these offenses, he may then be given a separate trial based on complete examination of all factors to determine whether or not the person is indeed a dangerous person.

If so found, he may then be sentenced as a dangerous person rather than as a convicted mugger, robber or rapist. The maximum penalty for the dangerous offender would be 30 years. Even here, however, the

door is left open for judges to sentence to less than 30 years and for parole boards to release at any time the convicted person is found to be no longer dangerous.

The non-dangerous offender cannot, under NCCD's established policy, be confined in a correctional institution. Only the dangerous offender may be so delt with.

Of particular interest to this Commission is the fact that in our Model Sentencing Act we have included the racketeer - the organized crime person - among those eligible to be sentenced as a dangerous offender. This means that the non-addict drug pusher as an employee of organized crime is subject to the stiff penalities available for the dangerous offender.

We sincerely believe that the real problem facing New Jersey and the nation is not so much of what to do with the drug addict but how to remove the profits from organized crime realized through the illegal sale of narcotics. True, the addict now commits other crimes to support his drug habit. This results in astronomical losses

in property to the general public. If, on the other hand, the true addict were able to receive appropriate medical treatment, including maintenance doses of heroin or other substances the need for his criminal activities would greatly diminish. But more importantly, the growth in addiction would be curtailed because it would no longer be profitable for pushers to hook new addicts.

NCCD urges you to carefully consider the entire policy statement on narcotics law violations and to use the concepts and information contained therein in shaping New Jersey laws. I am confident that you will be convinced, as I am, that stiffer penalties, mandatory sanctions and exclusions from probation and parole for the narcotic addict will only aggrevate instead of alleviate our drug problem in New Jersey.

MR. MENZA: May I interrupt you for a moment, Mr. Thomas, most of us are familiar with the National Council on Crime and Delinquency. We are specifically mandated by virtue of SC90 to look into the area of drugs and narcotics sentencing, rehabilitation

approach. I wish you would limit your remarks, because we do have some very important information that we need, your organization's position on marijuana and so forth. We would like to hear that. We are not going to resolve any model sentencing law in this Commission. We are going to effectuate a revision.

MR. THOMAS: Well, I am very concerned, that right now there is a bill that was passed by the senate, it rests in the committee, the assembly has been put on notice, according to my understanding, that this bill may be declared on an emergency resolution as coming up for a vote tomorrow. That bill, I think, should not be considered seriously, until this particular Commission has heard from all of the witnesses and had an opportunity to feed it back to the assembly. If I am out of line in making my remarks, I apologize.

MR. MENZA: I voted against it.

MRS. WILSON: The Chairman and I both argued the same point you just stated, this Commission has a job to do, and at least

nothing should be done until we have done our work.

MR. MENZA: What is the position on narcotic addicts that are caught with a few sticks of heroin?

MR. THOMAS: In this policy statement, we definitely say that the narcotic addict, who is a pusher, should still be treated as a sick person, even though he is committing a crime as a pusher, even though he may be committing crimes to support it, we strongly feel that the criminal route, the pusher, is not solving the problem, but compounding it; organized crime is the real problem.

MR. MENZA: What about an addict charged with breaking and entering?

MR. THOMAS: There is no question, that is a crime that is subject to punishment. We would hope that if breaking and entering is occasioned by his need to support his habit, that we would try to cure the problem. We would try to make all sorts of medical treatment available, including the maintenance of heroin, if that is necessary, we would

do things which would drive the profit motive out of organized crime.

MR. MENZA: This is really an area where we really need the expertise, we cannot talk about generalities. I am telling you about specifics, I am telling you about a narcotic addict charged with entering, how do we treat the narcotic addict, what is the position of NCCD?

MR. THOMAS: There is no way that you can describe a specific penalty for a specific act, you have to have leeway, consider the individual person. This is why we oppose laws with mandatory sentences. Some of these people are truly dangerous. For the protection of society, they have to be kept out of society, we don't deny that. But we would not advocate a specific sanction or punishment for say breaking and entering, whether they be an addict or not, there has to be consideration for both of them.

MR. MENZA: What is the position of the Council on Marijuana?

MR. THOMAS: The Council has not established a specific policy on marijuana.

The staff has urged the Board to consider, strongly, well, first of all, the decriminalization of it, but consider also, the legalization of marijuana under strict controls, but this has not become an established policy of NCCD. The Board has sent it back for further work and further examination, so we cannot give you that.

I can tell you personally, I agree with some of the previous speakers, that if we don't legalize it in some fashion, we are going to create more and more disrespect for the law, and I think it ought to be given serious consideration, but that is not the official position of the NCCD.

MR. RYS: What category would you place an individual pusher?

MR. THOMAS: Who is also a user?

MR. RYS: Both.

MR. THOMAS: Well, I think you have to look at them separately. We say, and believe strongly, that a person who is pushing, and not a user, is an arm of organized crime, and should be subjected to the possible handling as a dangerous offender under our

Model Sentencing Act provisions.

The pusher is a different story, he is an addict and pushing for his own support, he would not be doing this if we could somehow give him adequate treatment, whether or not that includes maintenance. If the profit motive were taken out of organized crime for the illegal sale of narcotics, we would not only reduce the addict, among those that are now there, but you would reduce the increase of addicts, because there would be no incentive to hook somebody on drugs with the idea of making a future profit on a new market.

MRS. WILSON: Isn't it true, that we don't arrest the big time pusher now? Is there any reason to believe, by increasing penalties, we are going to have greater success in arresting the big time pushers? Isn't it really true, that those that are arrested are the small time user?

MR. THOMAS: Exactly, and that is the way it is going to continue. We have had plenty of strict laws before, we do not reach the top man, our police are apprehending

the more inept, the more visible person who is the user and who is also pushing and also committing other crimes to support his habit, without ever getting to the top.

I think it is terribly wrong to continue in a misguided notion that the stronger penalties that we place on this, the more we are going to be able to control and reduce, if not eliminate, the supply of drugs. I think our dangerous offender act has a great possibility of doing that than anything else, because it stresses the racketeer organized crime activity, as one of those things that would be dangerous, as much as a robber or anything else.

MISS LIPMAN: I don't know if I am reading something into your remarks, you seem to be saying that if an addict who is a pusher, and who has been doing crime and sentenced, there should be a strong rehabilitation program going, and he should have an indeterminate sentence?

MR. THOMAS: I did not say indeterminate sentence. In the first place, indeterminate sentence is not always the same thing

when you use it and when we use it. There should be, in all sentences, no minimum at all, only a maximum sentence, with the power to release at any time prior to completion. That may be interpreted as an indeterminate sentence, but it has a maximum.

MISS LIPMAN: We agree on that. You said that although he is a criminal, you think that he should be treated as if he is an ill person?

MR. THOMAS: I think the opportunity should be there for him to get treatment for his problem, rather than punish him for his crime, but it has to be a decision that is made by the judge, and not one mandated by the legislature.

MISS LIPMAN: All I am trying to get you to say, is this treatment inside or outside?

MR. THOMAS: Hopefully it would be outside, and hopefully the prosecution and judge will have the opportunity to give that kind of treatment, without the finding of the commission of crime on a deferred basis, or non-prosecution basis, hopefully.

MR. MENZA: We will incorporate, Mr. Thomas, your policy statement in the transcript.

MR. THOMAS: Yes.

"Narcotics Law Violations.

"A Policy Statement.

"Council of Judges, National Council on Crime and Delinquency.

"Repressing the narcotic drug traffic by criminal sanctionsis a comparatively recent innovation in the United States. Until the early 1900's, drugs, including morphine, were available at moderate prices not only from the local pharmacist but from the grocer as well. Doctors were only beginning to warn about opium addiction.

"The Harrison Act. In 1912 the United States adhered to the Hague Opium Convention, by which it undertook to control the domestic production, sale, use, and transfer of opium and coca products, and it has adhered to later international control treaties. A significant aftermath of our participation in the 1912 convention was the Harrison Act, not a criminal statute but rather a regulatory measure. The heart of the Act is an excise tax, imposed

on opium, inonipecaine, coca leaves, and other opiates and their derivatives at the rate of one cent per ounce, to be evidenced by stamps affixed to the package or container. The Act makes it unlawful for anyone to purchase, sell, dispense, or distribute any narcotic drugs unless he does so in or from the original stamped package. It is also unlawful for anyone to sell or give such drugs except pursuant to a written order for the recipient on forms supplied by the Treasury Department. Persons in any vocation involving the handling of narcotic drugs (such as importers, doctors, druggists) are required to register with the Treasury Department, pay an occupational tax of $1.00 to $24, and keep records available for inspection. In 1937 marijuana was subjected to a similar pattern of control, except that the tax rate was prohibitory -- $1.00 an ounce on any transfer to a person registered under the Act, and $100 an ounce on transfer to an unregistered person.

"Counterfeiting of stamps, failure to file returns, and other evasions are

punished by the general tax law provisions; in addition, the possession of drugs in unstamped containers is prima facie evidence of a violation, and drugs in unstamped containers are subject to seizure and forfeiture. Transporting drugs is a crime for any person not registered or protected by certain specfic exemptions -- e.g., common carriers, employees of registrants, etc.

"However, under the Act, physicians, dentists, and veterinary surgeons lawfully entitled to dispense drugs may prescribe or administer them to patients in the course of professional practice without making use of the Treasury Department order form and without conforming to the stamped-package requirement (although they must register and keep records), if the prescription is issued for 'legitimate medical uses.' Persons possessing drugs pursuant to a prescription, or received directly from a registered practitioner, are excepted from the general prohibitions against transportation and possession.

"For the first ten years of the Harrison Act's operation physicians were

unhampered in their prescription of narcotics to patients, and a number of clinics for addicts were operating. Indeed, 'the Treasury Department's 1919 report encouraged local health departments to set up clinics where addicts could receive carefully regulated amounts of drugs and be encouraged at the same time to overcome their habits. Such clinics were established in forty-odd cities. Some of them appeared to be fairly successful, although many took insufficient precautions to assure that addicts would not obtain drugs from more than one source or failed to ascertain that they were treating actual addicts, so that sometimes peddlers came and sold the drugs they received from the clinics.'

"In 1920 the Narcotics Division of the Treasury Department was merged into the new Prohibition Unit, then launching its crusade against liquor drinkers and bootleggers. It also launched a campaign against doctors who administered narcotics to addicts. The drive, destined to achieve the practical outlawing of medical administration of drugs

to addicts, is reflected in a series of cases that reached the United States Supreme Court.

"The Cases. In 1919, Dr. John Webb was prosecuted for a flagrant abuse -- selling thousands of prescriptions at fifty cents apiece, to any person indiscriminately. He was found guilty and appealed to the Supreme Court, which affirmed in a five-four decision. The Court said that 'to call such an order for the use of morphine a physician's prescription would be so plain a perversion of meaning that no discussion is required.' Subsequently, a second case of outrageous abuse was appealed to the Court and again the conviction was upheld.

"In the next case, United States v. Behrman, decided March 27, 1922, the abuse was also flagrant. Dr. Behrman had given a known addict, at one time and for use as the addict saw fit, prescriptions for 150 grains of heroin, 360 grams of morphine, and 210 grams of cocaine. The indictment, drawn so as to omit any accusation of bad faith, charged, in effect, that the purpose of Dr. Behrman's treatment was cure of the addict.

Thus its validity depended on a holding that prescribing drugs for an addict was a crime, regardless of the physician's intent in the matter. The District Court sustained a demurrer, and the Government invoked its right to appeal directly to the Supreme Court. A majority of the justices, no doubt moved by the flagrant facts, which they set forth fully in the opinion, ruled that the indictment was good. Three justices dissented. 'It seems to me wrong,' said Justice Holmes, who wrote the dissent, 'to construe the statute as creating a crime in this way without a word of warning. Of course the facts alleged suggest an indictment in a different form, but the Government preferred to trust to a strained interpretation of the law rather than to the finding of a jury upon the facts.'

"Armed with what came to be known as the Behrman indictment, the Narcotics Division launched its campaign. As described by Dr. Marie Nyswander, a former staff member of the Federal Narcotics Hospital at Lexington, Ky.: 'Prosecution of a number of physicians had made others doubly wary. Of the 8,100

physicians practicing in New York City, less than forty continued to prescribe narcotics for addicts. And the Bureau seized upon this fact further to discredit the physician's role. These physicians, besieged by addicts, were of necessity giving out a large number of prescriptions. Accused of 'trafficking in drugs,' they were indicted. The term 'trafficking physicians' carried such opprobrium that practitioners who valued their reputation could not afford to administer drugs no matter how ill the addict. The Bureau had won the day in New York, and the private physician's right to treat the ill had been abrogated.'

"The New York Academy of Medicine reports: 'From the year of the Harrison Act to 1938 it is estimated that 25,000 physicians were arraigned and 3,000 served penitentiary sentences on narcotics charges. About 20,000 were said to have made a financial settlement.'

"Any doctor prescribing for an addict who did not have some other ailment that called for narcotization was likely to be in trouble with the Treasury agents. Addict-patients

became addict-criminals dealing with illegal peddlers and committing crimes to sustain their habit, even though many of those who were caught had once been respected members of their communities. Instead of policing a small domain of petty stamp-tax violators, the Narcotics Division expanded its activities until it was swelling the prison population with thousands of felony convictions each year.

"The Behrman ruling was soon challenged. Dr. Charles O. Linder, after a lifetime of honorable practice in Spokane, Washington, was induced by one of the Division's female informers to give her a prescription for three tablets of cocaine and one of morphine. He was indicted in the Behrman form, convicted, and sentenced. He lost on his appeal to the Circuit Court of Appeals. But he carried the fight on to the Supreme Court, where he was completely vindicated.

"The unanimous opinion, written by Justice McReynolds, set forth what is still the Supreme Court's interpretation of the Harrison Act.

"As the Court said, the doctor

"knew she was addicted to habitual use of these drugs and did not require administration of (the drugs) because of any disease other than such addiction; and he did not dispense them for any other disease or condition; they were not administered by him or by any nurse or other person acting under his direction, nor were they consumed or intended for consumption in his presence; the amount was more than sufficient to satisfy the recipient's cravings if wholly consumed at one time; petitioner put the drugs into her possession expecting that she would administer them to herself in divided doses over a period of time; they were in the form in which addicts usually consume them to satisfy their craving; the recipient was in no way prevented or restrained from disposing of them.' But the doctor's act here was, in all the circumstances, bona fide and within the course of proper medical practice and was upheld.

"The Court warned that its opinions in the Webb and Jin Fuey Moy cases should be narrowly limited to the facts there involved,

and it condemned the indictment in the Behrman case in this strong disclaimer.

"But it was too late to change the pattern. The doctors had withdrawn. The addict could not reapproach them. The peddler had taken over, and his profits soared as enforcement efforts reduced his competition and drove his customers deeper into the underworld.

"This situation has continued, sustained by Narcotics Bureau regulations advising doctors of their rights in dealing with addicts, and ignoring what the Supreme Court said in the Linder case -- regulations which paraphrase the discredited language of Webb v. United States.

"In direct conflict with the Supreme Court ruling, the Narcotics Bureau regulations still provided as follows:

'An order purporting to be a prescription issued to an addict or habitual user of narcotics, not in the course of professional treatment but for the purpose of providing the user of narcotics sufficient to keep him comfortable by maintaining

his customary use, is not a prescription within the meaning or intent of section 4705(c)(2), and the person filling such an order, as well as the person issuing it, shall be subject to the penalties provided for violations of the provisions of law relating to narcotic drug.'

"This regulation, as well as the administration of the Bureau of Narcotics enforcing it, clearly violates the rulings of the courts. As the U. S. Court of Appeals said in interpreting the Linder case.

"In England a doctor is free to precribe for an addict (a) under gradual withdrawal treatment, (b) when it has been demonstrated that the drugs cannot be safely discontinued, and (c) when it has been demonstrated that the patient is capable of leading a relatively normal life under a minimum dose of morphine or heroin but not when the drug is entirely discontinued. Although some believe that the British experience is not applicable here, the weight of medical opinion supports the view that the British program has been successful in avoiding a rise in addiction, in keeping the addict from

turning to crime, and in preventing racketeering in narcotics.

"The Council of Judges adopts the following policy position: Medical Care:

1. The narcotic drug addict is a sick person, physically and psychologically, and as such is entitled to qualified medical attention just as are other sick people.

"As a sick person, the addict should receive whatever medical care he may need, as an out-patient of a clinic or private physician or, when necessary, in a hospital. Sick persons do not need criminal or civil process for medical care to be available to them, although some are subject to civil commitment. The mentally ill, for example, are committable under the principle of parens patriae (when they are unable to care for themselves), or the police power (when they are a danger to others, as in quarantine cases), but the vast majority of them, like other persons who are ill, go to doctors and hospitals without any court process. A drug addict should, therefore, have access to medical care, in or out of the hospital, without

so-called civil commitment, unless he is, in fact, unable to take care of himself despite medication. Whenever necessary, treatment facilities should be provided by communities.

" The cure of addiction seems to be extremely difficult and doubtful. More research and experimentation are needed.

"As the Supreme Court pointed out in Linder v. United States, the present law is interpreted -- and should be so interpreted and enforced by the Narcotics Bureau or any other government agency -- as allowing prescription of medicine, including narcotic drugs, 'for relief of conditions incident to addiction.' Despite this interpretation, the nature of administrative enforcement of the Harrison Act deters physicians from performing their ethical duties. Accordingly, the NCCD Council of Judges recommends that necessary action be taken, either by statute or by the appropriate bureaus and departments, to have the interpretation of the Harrison Act, as set forth in Linder v. United States, carried out administratively and the regulations of the Bureau of Narcotics amended to

to conform thereto.

"Law Enforcement. 2. The traffic in narcotic drugs is properly controlled by legislation and effective penal sanctions. Since the illegal handling of narcotic drugs today is a big business of organized crime, state and federal law enforcement efforts should concentrate on reaching the criminals at the upper level.

"The addict should be directed to medical help and should not be criminally prosecuted.

"While the Council of Judges recommends freedom of medical treatment for addicts, it recognizes the evil of the existing narcotics traffic and the need to prohibit it by penal laws. The problem is primarily one of law enforcement. Our experience coincides with that of other state and federal judges: The 'higher-ups' in the rackets are rarely brought before us for sentence. Rather, the great majority of narcotics law violators before us are addicts. Although a number of narcotics pushers are also convicted, the majority of them are

primary users also, whose addiction leads them to sell drugs in order to continue their own supply. These persons are more victims than criminals.

"To cope with the real trafficker in narcotics, state and federal law enforcement efforts should be concentrated against all aspects of organized crime. Meanwhile, extending medical care to addicts and administering drugs as necessary would deprive organized crime of a constantly increasing percentage of its customers and would weaken the foundation of narcotics syndicates, which came into existence after the drug addict was 'criminalized'.

"Sentencing. 3. In recent years the penalties for narcotics crimes have become more and more severe, the theory of the legislation evidentally being that the greater the penalty, the greater the deterrence. The result in practice is to glut the penal institutions with smallfry pushers and addicts serving long terms, without any deterrent effect on the racket but with deteriorating effect on the prisoners

and the correctional institutions. We oppose mandatory terms in narcotics cases and the exclusion of narcotics offenders from eligibility for probation or parole.

"As already described, the policy adopted by the Narcotics Division during the 1920's led at an early date to a packing of prisons. A 1928 census of prisoners in federal institutions revealed that during the heyday of Prohibition there were two prisoners serving sentences for narcotic drug law offenses for every one incarcerated for liquor law violation. Prisoners committed for violation of drug laws constituted one-third of the total prison population, 2,529 out of 7,138.

"In 1951 the Senate Committee on Organized Crime turned its attention to narcotics and marijuana, receiving testimony that drug addiction was on the increase and had captured school children and teen-agers. The Narcotics Bureau urged harsher penal measures. Congress enacted a bill, submitted by Hale Boggs, of Louisiana, providing for mandatory minimum penalties and prohibiting suspended sentence and probation for second

offenders. A number of state legislatures have enacted comparable legislation and some jurisdictions enacted new legislation providing for compulsory treatment of addicts in confinement. Addiction was made a crime in acts passed by several states, acts subsequently condemned by the Supreme Court. In 1955 a Senate subcommittee of the Judiciary Committee was authorized to make a study of the Harrison Act. This committee, under the chairmanship of Senator Price Daniel, rendered a report calling for even more severe legislation. This resulted in the enactment of new legislation which included the death penalty and raised mandatory minimum penalties.

"The state laws follow the style of the federal acts as interpreted by the U. S. Bureau of Narcotics. The Uniform Narcotic Drug Act is law in forty-six states, Puerto Rico, and the District of Columbia; the remaining four states are more or less similar in their punitive approach.

"The Uniform Act, like the federal narcotics laws, makes possession generally

unlawful. A physician is allowed to administer drugs 'within the scope of his employment or official duty, and then only for scientific or medicinal purposes' and may prescribe drugs 'in good faith and in the course of his professional practice only.' One study reports that 'though very few cases have arisen which interpret these phrases, it seems clear that the Uniform State Narcotic Acts will be so interpreted as to make unlawful prescriptions to addicts for the purpose of treating his addiction.' In the Uniform Act the penalty section is left blank, but typically the states provide for stated mandatory minimum terms, increasing in severity for repeated offenses, and some include life imprisonment or death in offenses involving minors. Some of the acts are similar to the federal law in barring probation or parole; a number of state laws make addiction a crime.

"In 1960 15 percent of the federal prison population was made up of narcotics violators, compared with 4.3 percent in 1946. James V. Bennett, director of the U. S. Bureau of Prisons, pointed out that longer sentences

and mandatory minimum sentences, with no parole, accounted for the increase. The federal laws designed to be 'tough' on narcotics offenders are proving tough on the federal prison system, producing an increasingly difficult administrative problem. 'Prisoners become problems when they have no hope of relief from confinement, regardless of how well they respond to treatment programs. . . . You can well imagine the effect on prison treatment programs for more than 3,000 prisoners who have been sentenced for a purely punitive purpose when parole cannot be extended to those who have rehabilitated themselves.

"The Council of Judges will cooperate with judicial, bar, and medical groups whose programs are substantially in accord with its policy. It supports studies of the methods used here and abroad in the treatment of drug addicts in correctional institutions, in hospitals, and in the community."

I would urge very strongly, that the members of the Committee, and any other legislatures interested, read thoroughly and make

the best possible use of the material that is in this printed policy statement on narcotics. If you do, I am sure you would not vote in higher penalties and stiffer sentences for drug laws.

MR. MENZA: We would appreciate you sending any literature that you have in addition.

MR. THOMAS: I will send you whatever we have. I will be glad to appear before any committee or assist any legislature in this.

MR. MENZA: Thank you very much.

MR. MENZA: Mr. George Gagel, please.

MR. GAGEL: I am the Narcotics Program Co-ordinator for the County of Bergen County. I have been a police officer for 17 years, I was in the Bergen County Prosecutor's Office, Narcotics Squad, for the past five years. I have been a department head for the drug programs throughout the county.

This department was created by the Bergen County Board of Freeholders in 1968, to deal with prevention and rehabilitation, as to the problem of drug abuse. I have volunteered to answer questions for the Committee, and I heard some questions go unanswered that the Committee posed to Dr. Pyle and Dr. Benedict.

Insofar as funding, I am familiar with some of those answers; where some of the money comes from to support these programs. However, I have heard testimony given here relative to legalization of marijuana, I have heard most recently, Mrs. Justice, who testified, Lieutenant Delaney, who has somewhat different points

of view on the subject. I have heard words like decriminalization, which is a new word in the past two or three years, and it would almost seem as if it were created to deal with marijuana.

In my own personal opinion, it would seem that perhaps society at this point has to make a decision as to whether or not we want a third drug of pleasure; we have at the moment, tobacco, alcohol, both legally, socially accepted drugs of pleasure. We are just beginning, recently, to become more familiar with the consequences of both. The World Health Organization states that we have 13 million alcoholics in the United States, and that alcoholism is the number one drug of abuse.

Mrs. Justice said that, and the gentleman that spoke immediately prior to me, I think, stated that perhaps we could take it out of the realm of criminal activity and legalize it, and they propose this be done in order to take the profit motive out of it by profiteers. We know that we had the Volstead Act repealed in

prohibition, that alcohol was once a controlled dangerous substance, against the law. Society saw fit to vote on that, and changed that; as a result we have 13 million alcoholics in the United States. At the time that happened, the people who were asking for the change in the law, didn't happen to be 14, 12, 15 years old, they weren't the ones carrying placards or crusading for it. People that voted on it were 21, they were the voters. Some people can handle alcohol, and obviously we have 13 million who can't.

The Surgeon General believes that smoking is dangerous, and the American Medical Association and other people are now strictly against smoking cigarettes. I don't think, my own personal opinion, I don't think that all of the facts are anywhere near in on marijuana, and my personal opinion, again based on what I know about the use of marijuana, hundreds of arrests that I have participated in as a police officer, that it would have to be kept in the realm of criminal activity. I don't think you can enact legislation,

or pass legislation that is going to please all people by putting a number on the amount of grams, 18, 25, and hope for a minute that you can control something like this. We are finding out now, we have changed the law with alcohol in New Jersey to make it 18 years old, and we know now we have a problem, we know it. We have a problem with 14, 15 year old drinkers, many of whom are buying alcohol in legitimate places and passing as 18. Add to this, the fact that we have the treaties with some 60 other nations that prohibit the import export or cultivation of marijuana for import or export, to those countries or from those countries. Where marijuana was once a way of life in some countries, India in particular, they have made it, I don't know what they call it there, it is strictly against the law.

Those are my views, insofar as based on what I have seen both as a police officer and a director of the narcotic programs in this county. I think we should have learned something, we have statistics

available in this county, the county with a population of one million people, 70 municipalities, that point out from 1952 to 1966, only 70 arrests were made within this county for violation of the drug laws, which means too many people for so long a period of time were paying too little attention.

In about 1967, people began to push the panic button, the laws began to be enforced. It would seem as if perhaps certain people are reacting to minority groups, by minority groups, I think they are in the minority, certainly the majority of that minority hadn't reached the majority, they are not 18. These are the people that are crusading with placards to make marijuana legal. We know that out of some 60,000 people treated at the Monsignor Wall Center in Hackensack, that only four percent of those people have only had a problem with marijuana; its been multiple drug use, which we suspect and can document to some degree, marijuana in the majority of cases has been the substance that introduced many youngsters

into the drug culture.

I heard Mrs. Justice say that she would rather, I think she said she would rather her daughter or son smoke a joint of marijuana cigarette than would have them get involved with martinis. Dr."Goddard", the head of the Food and Drug Administration once said that same thing, and probably it turned thousands or millions onto marijuana; so did, I think, Timothy Leary, with his LSD cult, and who just lost an appeal recently based on his willingness to retract everything he had ever said about LSD and asked for parole.

Those are my views on marijuana. I think that it is much too early to just reach a decision, based on whether or not marijuana is less or more harmful than the other two legally and socially acceptable drugs of pleasure, and because some people have contempt for this law. One other thing I would like to point out, not too long ago the state law was changed, it had to do with education, making it mandatory for the school district to exceed any

public monies to teach so many hours on the dangerous drugs of alcohol, that was fine, and neglected before that. I have talked in public schools, I certainly have had the opportunity to talk with dozens or hundreds or youngsters in public schools who receive little or no education or information on drugs or alcohol. However, as long as they have gone that far, it would seem that it might be in line to include A through 8 classes in education, because it would seem that by the time a youngster reaches the age of 13 or 14, and is entering high school, many of today's youngsters have made their own decisions, based on peer pressure, and very little factual information. That is all I have to say.

MISS LIPMAN: You say you are head of the drug program for Bergen County?

MR. GAGEL: Yes.

MISS LIPMAN: That means preventing, not rehabilitation center?

MR. GAGEL: Both.

MISS LIPMAN: How many centers do you have under your direction?

MR. GAGEL: Well, we have a Methadone maintenance center in Hackensack with the Monsignor Wall Center, that is maintenance and out patient counseling. The County of Bergen has a contract through my office for in-patient services with Dismas Center, Dr. Gubar who testified earlier, he happens to be part of that. We also have another intervention program, which is in-patient, residential program, for youngsters who are not addicted to heroin, youngsters who have begun to experiment with this and have become involved, have had problems in school or involved with the law, and that happens to be a full time secondary school where the youngsters live and attend school seven days a week. Then we have an out-patient counseling service that provides counseling upon request from the 70 municipalities at Bergen County, at no charge to the municipality.

MISS LIPMAN: Do you oversee all the programs, private agencies as well as public agencies?

MR. GAGEL: The county programs, with the exception of Bergen Pines Hospital, that is managed by the Board of Managers at the hospital, but the other programs, yes. The other programs that are public monies, either county programs or SLEPA money provided, we receive somewhat over $300,000 from SLEPA, with the majority provided by the Board of Freeholders. We also receive money in the case of Harold House, because of the school from the "Bedelson Act".

MISS LIPMAN: Do you know how many other counties are organized in this way?

MR. GAGEL: I suspect there are none. Union County has a program somewhat similar to ours, on a smaller scale. I know that that particular facility that I described, Harold House, which is a residential center, and a full time secondary school, is the only kind of place within the state, there isn't another one.

MRS. WILSON: Do you arrest many big profiteers?

MR. GAGEL: Well, at this moment I am no longer a police officer, I was for

17 years. I know something about figures, arrest figures, and I know there were less than 20 people arrested in this county during the past 15 or 18 years, who could be called big time profiteers, who were not drug users. The majority of the arrests made in this county, were persons arrested for sale, who were also addicts themselves, very rarely the instance where a person is not a user. Nine out of ten of them usually sell to help sustain their habit, or as an accommodation for a friend.

MRS. WILSON: What do you think can be done to increase the rate of arrests of the big profiteers?

MR. GAGEL: To increase the rate of arrests?

MRS. WILSON: What can we do, we have to cut off the supply --

MR. GAGEL: I think that is a problem for our federal government. The things we are talking about, heroin, cocaine, not native to this country, the federal authorities, you know, the people who exert in the field, they know where it

comes from, they know the routes, and it has been a difficult thing over the years for them to enforce catching someone, someone leaving a plane at Kennedy Airport with a kilo of heroin. The profit in this is terrific, probably for a $3,500 investment, if they can get that one package in, that little package, they will make at least $10,000 profit handling it once, if they just sell the package once. If they want to chance it on handling and cutting that, the profit can go to a quarter of a million dollars for that kilo.

MRS. WILSON: Is there any likelihood that increased penalties would increase our ability to arrest these persons?

MR. GAGEL: No. I don't think its been proven or demonstrated, by increasing the penalties it would help to get the major traffickers in the drug business. I think what we need is, a stepped up effort on the part of the federal government, with customs people in particular, to see that it doesn't enter the country.

MR. MENZA: In light of that statement, I would imagine that you feel there is no point whatsoever in increasing the penalty for sale, we can't catch them in the first place, that is not the approach. You prefaced your remarks by saying it is an enormous profit, if it is such a profit why not take the gamble, you are free to gamble. Is that correct?

MR. GAGEL: Well, yes, that is pretty near correct.

MR. MENZA: A big seller is someone who attempts to make these enormous profits, and is really not going to be influenced by the fact that in New York you get life imprisonment and in New Jersey you get some 20 years.

MR. GAGEL: I would say that is true for that kind of profit. I think we are not talking about organization, organized crime, nowadays we are talking about adventurers, two or three people that are willing to put up $800 or $900 a piece, legitimate people who have no past record in that field, and take a chance on bringing a package back

for an investment of $1,000 apiece, and they get a return three or four times that, by getting off the plane with it, that's all, handling it once. I think we are finding more and more of these kind of people who are mixed up in it. I don't know whether you have ever seen the commercial on television, I think they are endorsed by our State Department, paid for by the public, for the youngsters that travel abroad, it is almost as if they are saying, fine, if you use marijuana you are all right, if you go to Greece or Italy, don't take a chance on it, because they take a dim view of it; it is kind of a left handed thing, you know. We are warning them not to do it in other countries, what they have been doing here in this country.

MR. RYS: What do you think is coming into our State of New Jersey, coming from New York or Pennsylvania, or any other city?

MR. GAGEL: Well, New York City is known as the drug capital of the United

States, the drug capital of the world. Our proximity to New York, at various points, the major portion of it would have to come from New York City. It can come from other areas, it can come from Philadelphia into South Jersey, but we know, from experience, people in the law enforcement field, federal agents, State Police, people in our prosecutor's office, have records on people who have connections in New Jersey, or based in New York; the major portion of it would come, I think, I'm sure, from New York City.

MR. MENZA: Mr. Gagel, is it my understanding you are the head of administrative handling in all of the programs in Bergen County?

MR. GAGEL: All of the county programs with the exception of Bergen Pines Hospital, which is run by the Board of Managers.

MR. MENZA: Thank you very much, Mr. Gagel.

MR. MENZA: Dr. LaBera, please.

DR. LaBERA: I am Rosario LaBera, I am Committee Chairman of the Drug Abuse Action Committee of the City of Garfield. I hold a degree in sociology from Marquette University. Officially, my title is Doctor of Podiatria, as opposed to psychologist or doctor of medicine.

The Drug Abuse Action Committee of the City of Garfield, for approximately a year, has been asking the state, and state senators, including the governor, we have also forwarded letters to the State Department of Police, Colonel Kelly in particular, that there is a definite necessity for strict laws with absolute enforcement in the State of New Jersey. We feel this for a number of reasons: I am not going to rehash our cause, which all of you have already received. I will submit copies of this to you, to your committee, for your consideration. We have been on top of this for several months over a year already, and we were quite upset that something had not been done prior to this

time, but, finally realize that this takes time. In any event, what we are currently working on, are petitions on which we are providing to all the people in our area, in Bergen County, since Bergen County from the statistics that we have received, is second for drug related problems in the state.

Now, we can't really realize how much of a problem we have in the State of New Jersey, before we finally sit down and say that we have a problem, do we wait for everybody in New York to come over to New Jersey, because in New York they are getting too strict. We do not expect to see this big movement into New Jersey, because the laws have not been prosecuted, the drug pushers have not been prosecuted yet. But the main crux of our chance is, the definite need for the drug pushers, in particular, the non-addict drug pushers, to have a mandatory life sentence, with a minimum sentence being -- if you are going to talk about minimum, 30 years. Now, we also talked about the addict drug pusher having

a lesser offense, because they are "sick people", how sick is he? Does a 16, 17 or 18 year old person, who gives a nine or ten year old child, is he any better than the person who is a non-addict pusher? The big problem, and I think the problem that all of us are missing, both here and in other states, is that the crux of the problem is not after the fact, you don't start rehabilitating people after they have already been subjected to the problem, you have to treat them, it's true, you have to have the rehabilitation programs, but you have to get at the reason, the psychological reasons as to why these people are going on drugs to begin with. I feel this Commission should devote its attention to psychological programs, and educational programs. For example, centers, prior to these people getting involved in the drug scene, there are many delinquency problems in the lesser grades and in the junior high school level, where you really need communication with these kids before they get involved into the drug picture. The other program you

have, with respect to your rehabilitation programs afterward, your rehabilitation program must emphasize psychological treatment prior to medical treatment. The medical treatment should be used only in conjunction with controlling the individual, so that you can keep him under control within the psychological realm, because this really is where he needs the help. All too frequently we miss the whole point, we miss the fact, you have to find out why they got hooked on this stuff to begin with.

As far as monies to be spent, I feel that the monies should be devoted to these ends. I feel that your Commission should work directly with doctors of medicine, doctors of psychology, so that you can best find out what these particular problems are. Your rehabilitation programs should also have the same individuals keep reinvolved in this area. The other monies that should be spent, and you asked Mr. Gagel if any big pushers have been caught recently. He said that within 20 years, or within the last number of years, only 20 that he could think of, and, I'm sorry, I missed how

those ultimately ended up.

But one of the big problems from the people I have talked to, within the law enforcement area, has been that there are insufficient monies to be spent to make significant buys, and it is up to the Commission to perhaps work some way to provide these monies so that these big buys can be made; that is why there is only the smaller individuals that are being prosecuted and acted upon.

As far as the State Commission, it should act or it should serve as a coordinating body for all programs within the state area. Medicine today is studying everything as an approach, it is up to the legislators, the medical area, the people who are getting involved with this program to also approach this with respect to a team approach.

We feel that strict laws are definitely a necessity, because only by strict laws, with strict enforcement in the courts have to be made to enforce these laws, because people who are repeated

offenders, they get three months suspended sentence, $50 fine, probation. Most of these people are committing crimes while they are on probation, it is no deterrent factor at all.

You promulgate laws, it is up to the Justice Department to see that these laws are in force, and only by enforcing our laws, both in this state and the nation, will we get anywhere. There are too many people dying, suffering, too many families that are destroyed, too many innocent people which are hurt because of this wishy-washy type of attitude on the part of our justice people. It is time that they are instructed to enforce the laws, you have gone through the trouble to have them. We feel strict laws, we feel a necessity for psychological programs and education, or problem centers, prior to these people getting involved with the drug program. We feel rehabilitation programs must emphasize psychological treatments, and use medical treatment only in conjunction with these programs.

MR. MENZA: Thank you very much,

Dr. LaBera.

MR. MENZA: Dr. Rohrs, please.

DR. ROHRS: We came today to deal with one particular problem, but as we sit here and listen, there are other things that I feel should be said, and I will speak just briefly.

MR. MENZA: I presume that you are going to speak about the problem on funding of Odyssey House?

DR. ROHRS: That's right.

MR. MENZA: I understand you met with the Governor and --

DR. ROHRS: That's correct. There are just two or three things that I want to say: One of the things was very interesting, Mr. Gagel mentioned the fact that we have treaties with foreign countries, I think one of the things that the legislature should be aware of, that without having a treaty with New York, and without things being done on a regional basis, the very fact that New York has passed laws, which are very much more restrictive and severe than exist anywhere else, we are already feeling on the streets in Newark, we know

definitely that there is an increase in drug abuse that is occurring in this state. As soon as the laws begin to be enforced, there is no doubt that the drug problem will XX7 increase in this state. I don't know what the role of the legislature is, in terms of promulgating laws for certain jurisdictions and things like that. But, I think, the only way this could be meaningful, is for your legislature, your Commission to be able to take the position and say only when we form laws on a country-wide or at least a region-wide basis, when these laws are passed, is there going to be anything effective that really occurs in this problem.

Now, I am saying this because of the fact that the State of New Jersey presumably has a state directed system, which helps to deal with drug problems in terms of rehabilitation, in terms of courts referring, in terms of diversion from the criminal justice system, in terms of dealing with the heroin problem amongst adults. In terms of dealing with multiple drug abuse and everything else, I hope you have not gone

under the assumption that such a system truly exists. We have been dealing, for a period of five years, with exactly the same people in Trenton who have overall responsibility for problem solving in terms of creating and sustaining meaningful rehabilitation efforts, meaningful court criminal diversion efforts, meaningful re-entry programs in the state. I think when Mr. Gagel said, to his knowledge, only Bergen County has the system of the type that exists in Bergen County, that really tells you an awful lot about the state. There is no meaningful system in Essex County, particularly in Newark, it has the worst drug program of any city in the western hemisphere, and on a per capita basis, this makes Essex the problem. There is no doubt that the problem will get worse in New Jersey.

What I am calling for, the reason I am here, is because of the lack of co-operation, interest, creativity, ability to think, and plan and utilize their own resources, the State of New Jersey is willing to let

my program fold. We have deluged the governor with telegrams, we have met with other people, all of these apparently to no avail. I am prevailing upon you, your Committee, what you can do at the very least is exercise what power you have to see whether or not it is possible for emergency appropriation. But, moreover, I am asking that if a watchdog committee for the State Division of Drug and Narcotic Abuse does not exist, one should be created, that the legislature should hold these people responsible to the people of the State of New Jersey.

MR. MENZA: We do have an office, they get a pretty big salary and --

DR. ROHRS: Yes. The only thing I did say, sir, I dealt with that office since 1969, I likewise don't know what they do. I am suggesting any number of things. This is the first thing that comes to mind. There should be an organization which is mandated to be in some way responsible for this aspect of the drug problem in the State of New Jersey, should be held accountable.

As far as I know, there is no way they can be held accountable. What we need right now is the way to survive.

MR. MENZA: To put your problem aside, you are saying, in effect, there is no structure within the counties for rehabilitation of narcotic --

DR. ROHRS: I am not an expert on county systems, outside of Essex County. Essex County has the situation with Newark, and outside of Newark, within the City of Newark, there has been an attempt in the last three or four years to develop a system. Now, as you know, Newark is quite dependent upon Trenton for funding as far as we know, there has been no state coordination, no meaningful state supervision, or direction, and when people get out of line, there is no provisions that this state organization uses to bring people back. They are willing to let us go out of existence. This incredible set of circumstances, such that we receive more than enough money to function, to operate, but the monies are so restricted, that we cannot utilize them in a way to meet

operating expenses.

MR. MENZA: Off the record.

(Whereupon there is a discussion off the record.)

MR. MENZA: You have had $401,000--

DR. ROHRS: That is not for one fiscal year. This must be over several years.

MR. MENZA: Allocated, to June 30th, 1973, and I can give you the breakdown. I would suggest this, for the purpose of saving time, if you get in touch with Carl Moore, our legislative aide, he will forward the reports in writing and we will discuss your problem and see what we can do. I understand you are on the last leg and you have how much time left?

DR. ROHRS: I should only like to state for the record, that Senators Williams and Case, Congressman Rodino, numerous county freeholders and mayors, including Mayor Gibson of Newark, and all of the drug programs that exist in Newark, including traditional programs, all support the position that we find ourselves in terms of what we have to do to survive.

We told the state six months ago, that unless we hear by tomorrow, May 17, we would have to close our doors. We had a meeting on Monday, in which they told us that this was the first time they ever heard of such a thing. We have documentation going back, not only months, but years, that speak to the contrary. We are appealing to you, like we appealed to everyone else, this seems incredible, there was even an editorial in the Newark Star Ledger this morning.

MR. MENZA: If you get in touch with Mr. Moore with the information, I will contact the Division of Narcotics Control, we will have a meeting on this, Thursday, 12 o'clock, and we will see what the administration is going to do about it. My office is in Elizabeth, if you would like to call me.

DR. ROHRS: Thank you. I want to say one other thing: We are one program, but from our point of view, in terms of what goes on in the entire state, since I have been involved in at least eight states, and also worked for the federal government on occasion and the State Department,

consulting with foreign countries, this to my way of thinking is absolutely the poorest organized most unresponsive state agency that we have ever been involved with.

MISS LIPMAN: What is now the role of the New Jersey College of Medicine and Dentistry, as far as you are concerned?

DR. ROHRS: We are under the understanding that the New Jersey College of Medicine is trying to get out of its present responsibility by September of 1974, because they find that the contract that has been arranged for them, through the state, is so inadequate, it cannot begin to meet the needs, and the college cannot afford to administer this contract. The money is given under federal legislation, and the Health Service Act stipulates it can only be used for one purpose. That represents the entire sum total of monies available to the City of Newark to run programs, so that the college is trying to get out.

MR. MENZA: Thank you very much.

MR. MENZA: Mr. Reynolds, please.

MR. REYNOLDS: I am Grover Reynolds, and am here, more or less, to take issue to what I have heard. I will run through this briefly, and if there are any questions I will try to answer them. Number one: I think any drug program, or any other program that is financed in this area should be designed to phase itself out, or else it is not doing its job.

Number two: I think that the adjudication, especially where juveniles are concerned, the judges sitting in juvenile court should be trained to deal with the problem. Here in Bergen County, where the Children's Shelter is concerned, there was a case in the Children's Shelter wherein Bergen Pines psychiatric people took about 20 minutes to review a case, made a decision. Dr. "Chapman" who was the psychiatrist, reviewed the case and presented it. There was a conflict. It was further reviewed by a state agency, wherein Dr. "Chapman" with his diligence in pursuing the case, proved that something was wrong with the child, and

a decision came back that Dr. "Chapman" was right. The special interest group, which I will classify Bergen Pines as, was very unhappy about it, and there were people serving in the special interest groups, who demanded and got Dr. "Chapman" dismissed from the service. Now, 20 minutes of psychiatric treatment, or observation, cannot determine the sickness of an individual. It must be a prolonged observation, in my book. I feel, any juvenile judge in the State of New Jersey should be capable of dealing with the problem of a juvenile, not someone that is a political appointee. If he is appointed politically, he might not even know how to present the case to the court. I think the adjudication, in all due respect, I think the cop-out is to the adjudication, the arrest, the psychiatric treatment. 20 minutes of psychiatric observation cannot determine the sickness of a child. That is where you have to start, with the juvenile, to prevent turning him into a criminal.

I take issue to referring to the

poverty stricken, as the addict of the country. There are many affluent drug addicts, as there are poverty drug addicts, more so probably, because it is a fact. I will preface this by saying, it is a possibility, that some law enforcement office becomes judge and jury, depending on the affluent neighborhood or the lack of affluence in the neighborhood. The judiciary in many cases become the tool of the affluent. Therefore, you get no rehabilitation here at all, you get a criminal. I will run down a few of the things that I have heard, that I think could be thought of as something that you can work at. Halfway House, I feel that Halfway House is just another, you know, it is another cop-out, because there is nothing being done there really, for what I have observed, over a period of years. Probation can't deal with them, because it is too hasty, they go in and interview the person once a week, or once a month. 300 out-patients and 1,600 in-patients at $476,000 is a waste of money. The Methadone doesn't work, it is another act. One thing that has been

forgotten, is the human aspect, you are dealing with somebody that needs help.

I feel, on a social worker's level is where this should be done, a social worker can sit down and develop a relationship with the individual to find out what his true problem is. A psychiatrist will not spend the time when he is on a salary, he will not spend the time. If it was a private patient, for two and a half hours, two and a half hours is far different than 20 minutes. Jersey City alone is spending $600,000 of SLEPA money for the Methadone program, what good is that, when the same addict keeps returning day after day after day; you are just supplying his habit.

As far as new laws, I feel there are enough laws on the books, if they were enforced properly. I think what is needed, is that the individual should be treated, you should first find out what is wrong with him and then proceed to treat him. Let him tell you what his hang ups are, and then you deal with his hang ups instead

of telling him what is wrong with him. You will never find out if you are going to tell him, but if you allow him to tell you, you can get to the root of the problem.

I will give you an example and then I will be finished: At Christmastime, at the Shelter, there were boys, some drug addicts, they didn't want to go home for Christmas, because they enjoyed being with the youth workers of the Children's Shelter. I will state that now there is a concrete effort by Bergen Pines' staff, to phase out the Children's Shelter, which was built with public funds, with tax money for the children. They are trying to make it an outhouse. I feel that this is totally wrong, I think that is part of the problem, serving special interests of the people, the special interest groups of the whole system.

MR. MENZA: Thank you very much.

Thank you, ladies and gentlemen, for coming here today, we appreciate it.

I, DORRIS BAVONESE, a Certified Shorthand Reporter and Notary Public of the State of New Jersey, hereby certify that the foregoing is a true and accurate transcript of my stenographic notes.

Dorris Bavonese

A Notary Public of the State of New Jersey