DRUGS—THE EFFECTS ON THE BLACK COMMUNITY

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SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL HOUSE OF REPRESENTATIVES

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DRUGS—THE EFFECTS ON THE BLACK COMMUNITY

FRIDAY, SEPTEMBER 28, 1984

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL,
Washington, DC.

The select committee met, at 9:50 a.m., in room 2237, Rayburn House Office Building, Hon. Charles B. Rangel (chairman of the select committee) presiding.

Present: Representatives Charles B. Rangel and Walter E. Fauntroy.

Staff present: John T. Cusack, chief of staff; Richard B. Lowe III, chief counsel; Elliott A. Brown, minority staff director; George R. Gilbert, counsel; Edward H. Jurith, counsel; Michael J. Kelley, counsel; Martin I. Kurke, researcher (Department of Justice detail); and James W. Lawrence, minority professional staff.

Mr. RANGEL. The Select Committee on Narcotics will come to order.

As we start this 14th annual Congressional Black Caucus weekend, we hope to be going into the question as to the impact on drug addiction and drugs in general, and its effects on the black community. As chairman of the select committee, the Congressional Black Caucus thought that if we could hold a hearing on this very important subject matter this morning, it might afford us the opportunity not only to hear from the outstanding experts that have agreed to be with us this morning, but also it would be a wonderful opportunity from those who unfortunately come from communities who are adversely affected by drug addiction to come and to share the national experience and the impact that it is having on our various communities.

Of course, to my right hand, Rev. Walter Fauntroy brings to the committee not only his deep commitment to the resolution of this problem as a reverend, but certainly as one of the outstanding legislators that we have in our Nation's Capital, and the former chairman, of course, of the Congressional Black Caucus, he has joined with us this morning.

Mr. FAUNTROY. I thank you, Mr. Chairman. I really appreciate your leadership as chairman of our Select Committee on Narcotics in calling these hearings.

As you indicate, it comes at a very appropriate time because there are literally thousands of our most alert, active, and concerned citizens in Washington today here on Capitol Hill, who will certainly want to benefit from the testimony of the panelists that we have scheduled on the one hand, and also will have much to contribute in terms of their own on-hand experience and grassroots

experience with the effects of narcotics abuse and traffic in our cities and communities across the Nation. I am pleased to join my colleague in this hearing, and look forward with great anticipation to the panel which you have structured for this purpose.

Mr. RANGEL. Thank you. Joining us is one of the Nation's outstanding public figures, a city councilperson in the District of Columbia, Councilwoman Charlene Jarvis.

Mrs. JARVIS. Thank you very much.

Mr. RANGEL. Our panel will consist of Dr. William Pollin, Director of the National Institute on Drug Abuse, that all of you are familiar with, who has worked with us; Clyde Taylor, who is the active Assistant Secretary of State from the Bureau of International Narcotics Matters; and, of course, the figure that you see on television and read so much about, the Administrator of the spearheading agency that has the responsibility of controlling not only narcotic drug traffic in our country, but certainly its international implications, Francis Mullen, who is the Administrator of the Drug Enforcement Administration. The Federal drug strategy would be the panelists that I had mentioned.

Dealing with the health aspect will be Dr. Flavia Walton, the executive director of the Black Advisory Panel on Drug Abuse Policy; Dr. Roland Dougherty, executive director of the Benjamin Rush Center in Syracuse. We then will have a panel concerning itself with the economic impact of drug abuse, where we have Dr. Dale Masi from the University of Maryland; Dr. Lonnie Mitchell, right here, from the District of Columbia. I have already mentioned the councilwoman who will be dealing with this, and Dr. James Collins from Howard University.

Because of the time factor, and because it is most important that he kicks off our hearings this morning, I once again welcome Bud Mullen, an outstanding public servant, who has the responsibility of coordinating this effort. Thank you.

We will follow the agenda here. Doctor, thank you once again for joining with us. We are anxious to hear what you have to say and how it has changed from last year.

STATEMENT OF DR. WILLIAM POLLIN, DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE, AND FRANCIS M. MULLEN, JR., ADMINISTRATOR, DRUG ENFORCEMENT ADMINISTRATION

Dr. POLLIN. Thank you very much, Mr. Chairman. First, let me repeat the message that Mr. Fauntroy communicated, the extent to which all of us are aware of the very important role you play in terms of helping to focus congressional interest and resources in dealing with this problem, and help us to cope with it.

THE FEDERAL DRUG STRATEGY

I want to concentrate on trying to summarize for my fellow panelists and for the people attending the hearing what we currently know about significant changes in trends with regard to drug use in this country, and particularly why we have been concerned for some time about the possibility that these trends will impact especially heavily on the black community in the coming decades.

With your permission, Mr. Chairman, I would like to use some charts and some overheads, and let me go down so that I can point out some of these data to the panel.

Mr. RANGEL. Thank you, Doctor.

Dr. POLLIN. If I put these over here, can you all see these reasonably well? I will assume in the absence of a nay vote that it is visible to you.

I want to start by making one point that I think got lost, and it has to do with the importance and the effectiveness of the supply reduction enforcement interdiction part of the Federal strategy. We are very much concerned, and we read most of the time some of the flaws and the failures, and of the substantial amount of drugs that continue to come into this country that constitute such a problem for the country. What we attend to much less frequently is the very, very large degree of success that is achieved by the totality of our legal and enforcement measures.

This first chart shows the number of current users of drugs in this country, people who have used once or more during the previous month. Alcohol, 100 million; cigarettes 60 million. Those are the two licit drugs against which there is no enforcement. Among the illicit drugs, 20 million marijuana smokers, all the rest, 4 million or less, 4 million being cocaine.

We have very good reason to believe that if we did not have our present enforcement and legal system in operation, that the number of cocaine users would be up in the level of users of the licit drugs, nicotine, and alcohol. And so we think that it is fair to say the totality of our local and national enforcement efforts take care of 90 percent of the potential problem that would beset this country if it weren't for those efforts.

In those countries abroad which do not have our kind of enforcement system, we find endemic use of drugs that are very similar to cocaine. This is a case where 90-percent success, though, makes the problem much, much more manageable and much less than would otherwise be the case. Nonetheless, it leaves us with the 10 percent that remains with a tremendous problem, and it is that remaining 10 percent that gets into the country that we have to deal with in terms of demand reduction.

Mr. RANGEL. That is 100 percent of what, Doctor?

Dr. POLLIN. That is 100 million.

Mr. RANGEL. What I am saying is, you are saying that we have been successful in preventing 90 percent of the potential use of cocaine.

Dr. POLLIN. Right.

Mr. RANGEL. Because of law enforcement.

Dr. POLLIN. The totality of our legal system.

Mr. RANGEL. I guess my question is, if we had no legal system, what are you using as being 100 percent? The people who use alcohol?

Dr. POLLIN. That is right. It is obviously an intelligent guess, if you wish, but we find that if we average the number of users of the two licit drugs, 60 million nicotine users, 100 million alcohol users, we say we have clearly a potential for something like 80 million people who would use any of these other drugs were they licit, and cocaine is the one where we have some evidence in certain coun-

tries in the Middle East where very, very closely related drugs, specifically called khat, are just as endemic and are used by percentages of population in south Yemen that are very analogous to percentages of Americans who use alcohol.

Mr. RANGEL. My problem with that, it is just hard to believe that you are charging to the licit system a 90-percent success rate, when we don't even know, if there was no legal system, whether people would be enjoying or be drawn to cocaine, and you are using cigarettes and alcohol as the norm. Have you tested this out in other countries?

Dr. POLLIN. As I say, the evidence, Mr. Rangel, is as follows. First, we know that most of the population of this country is aware of the fact that cigarettes cause 350,000 excess deaths per year. In terms of mortality it is a very, very dangerous drug. Despite that, we have the 60 million users.

We know that cocaine, when compared to nicotine, is a more reinforcing drug. We know that there are countries in the world that don't have anything like our system of keeping this and similar drugs illegal, and we know that in those countries, the use of cocaine-like drugs is endemic. It is used by the totality of the adult population.

Mr. RANGEL. Which countries?

Dr. POLLIN. South Yemen is one example. It is a country in which a drug very similar to cocaine, a drug called khat, has pervaded the entire society, and so, based on animal studies, human studies, and some of these anthropological studies, we think we can say conservatively, without our present system of enforcement we would have at least 10 times as much cocaine use as we currently have.

Mr. MULLEN. Dr. Pollin, you said the totality of the system. Are you saying also the education, prevention, all parts of the system, or just the legal system?

Dr. POLLIN. I think it is primarily the legal system, because we certainly have as widespread and substantial educational and prevention campaigns directed against cigarettes as we do against illicit drugs. So it seems to me that this tremendous difference—and this is a fifteenfold difference—between cigarettes and cocaine must represent primarily the consequence of the legal and supply reduction efforts.

With that as background, now let's look at what happens with the 20 percent that does get in and that constitutes this major national problem. I want to make just three major points:

First, after two decades of an explosion of use of, in this country, in terms of the country as a whole, for drugs in general, that explosive increase stopped in the late 1970's and in terms of total numbers of national users, has leveled off in the population as a whole. And we know some of the reasons for that have to do with changes in the attitudes, changes in awareness of health risk, but primarily it has to do with changes in demographics.

The final point I want to make is that those demographic changes, meaning that the percentage of the population falling into the teenage and young adult sector, the sector of the population that is highest risk for drugs and the highest using sector for illicit drug use as well as licit drug use, though that population is going

down and will continue to come down in the country as a whole, that segment of the population is increasing among the black and, more strikingly, among the Hispanic community.

As a result, as we predicted some years ago when we knew the demographic trends, our most recent analysis of actual drug use trends show that although the country as a whole is coming down in terms of the total number of users of marijuana and cocaine, the trend is in the opposite direction in the black and Hispanic communities, and that is one reason why we feel that it is especially important that priority, specialized efforts be directed at dealing with the drug problem in our ethnic minority communities.

Mr. RANGEL. Doctor, two questions. One, is there any reason, other than color and culture, that you attribute to the increased usage by minorities and Hispanics, and, two, are there any specific efforts being made by the Federal Government to target those two particular groups?

Dr. POLLIN. We think that there are a number of other factors that contribute to levels of use by different individuals and by different communities, but the three that we have thus far been able to most clearly define—and some of the data here will show what that conclusion is based on—are attitudes toward drug use, perceptions of the health risk of drug use, but most powerful, these demographic changes.

Now, in individual families or in individual communities, levels of family stability, economic issues, feelings of alienation and hopelessness, all of these play major roles. But they don't have the underlying broad social impact as other free variables thus far have clearly shown themselves to have in our national data system.

Mr. RANGEL. Thank you.

Dr. POLLIN. Let me just run through some of the figures which lead us to the conclusions I have mentioned, and in view of time, Mr. Chairman, I will rush through these and not take time to explain. By all means, if there are any questions——

Mr. RANGEL. My second question was, do you have targeted programs for those two groups?

Dr. POLLIN. Yes, we do have very especially targeted programs, and some of the speakers on the panel this morning, Dr. Flavia Walters and Mrs. Johnson, who is here in the audience, will summarize some of those special efforts.

Mr. RANGEL. Thank you.

Dr. POLLIN. This first chart, the increase in marijuana use by one segment of the population for our adolescents, from 1960 up to 1979, the peak years, there was a twentyfold increase. During those first 20 years the increase in use shown in the green line parallel precisely the increase in availability shown in this yellow line. Since 1979, although availability has continued to increase, use has decreased. The decrease has been especially dramatic in terms of daily use, whether we look at high school students, national population or here, at adults in California, we see the same trendlines precisely. This peak, which is 16 percent in terms of current use, occurred in 1979. We see the dramatic decreases since then.

In terms of total numbers of users, the same is true for most drugs. This shows cocaine. There was a tremendous increase in the number of people using cocaine between the years 1976 and 1979. It

quadrupled. Since then cocaine users in number, total number, have leveled or actually begun to come down. Problem users, people getting in serious trouble with use, have continued to increase.

We are aware of the fact that there are local exceptions to these patterns. Washington, for example, very recently has shown a tremendous explosion in the use of PCP by young people, but these local exceptions and the increase sometimes in the number of people with problem use does not undercut these national patterns.

Explanations for the peaking of use and the beginning decrease in 1979.

First, public attitudes toward drug use. This shows attitudes in California, a bellwether State, in some ways the most permissive State. The red line shows people who are in favor of stricter laws against marijuana. The yellow line shows people who were in favor of legalization of marijuana. You see that until 1979 there was a steady decrease in those who were negatively predisposed to the drug. Those who wanted stronger penalties, a steady increase in people who wanted to legalize. Since 1979 just the opposite. There is a substantial increase in people favoring strict criminal enforcement against marijuana. This is reflected throughout the country and it is true of drugs in general.

More negative attitudes, the number of people who think that marijuana—and the same is true of other drugs—constitutes a serious health risk, this number kept decreasing throughout the sixties and seventies, bottomed out in 1978, and since 1978 the people who are aware of the serious health consequences of drug use has continued to increase, and that change in awareness of health risks coincides precisely with when use peaked and then began to come down.

The most powerful factor, however, that we have been able to find, are these demographic factors, and they are drawn here. This red line traces the increase and decrease in the rate of increase or decrease of 18- to 24-year-olds as a percentage of the population, and between 1959 and 1979 we had a level of increase that had never been seen before in this country. That precisely coincides with the period when there was the increase, the explosion of drug use, increased explosion of crime rates and the like.

The demographers accurately predicted that this would peak in 1979, and this shows the predicted downturn in 1979 to the year 2000. Demographers also correctly predicted in the midseventies that drug use, crime, accident rights, divorce rates will peak at the same time in 1978–79, and that is what is happening with the country as a whole.

Now we get to the issue of particular concern this morning, what is going to happen in the black and Hispanic communities. And now we have several charts we would like to project, which will show the fact that demographics which hold true for the Nation as a whole breakdown when you separate whites and blacks. This shows essentially the same data as the data that was just on the chart we were looking at. It is spread over a different time period and isn't as steep, but you see the peak in the late seventies for the

white population and the steady decrease predicted for the rest of this century.

During the same period of time, however, for blacks we will have essentially a flat curve, for Hispanics this curve is going to look like this.

Now, if we look at what has happened to national prevalence data, and we will pick just two drugs, two different kinds of studies, cocaine use, lifetime prevalence has begun to come down for high school seniors, and at the same time has begun to increase substantially for blacks. If we look at marijuana——

Mr. RANGEL. It is my understanding, Doctor, that those figures that show reduction with high school seniors, that there is no data that would include high school dropouts; is that correct?

Dr. POLLIN. That is correct, Mr. Chairman.

Mr. RANGEL. Thank you.

Dr. POLLIN. And we have, however, had that data analyzed in terms of the impact of droputs, and we have also, as some of the other charts we have looked at, looked at other populations, total young adult populations, and the trend all go in precisely the same direction.

Mr. RANGEL. I just don't know what percentage of the dropouts would show a higher per capita ratio among black and Hispanics, but judging from my own community, it was higher, then of course that would kind of throw those statistics off a bit.

Dr. POLLIN. It changes their absolute level, but it doesn't change the direction of the trendline. This data is drawn from a different survey, not high school students but a national household survey where we picked out young adults, and here we are looking at marijuana rather than cocaine, just to make the point that these differences apply not just to one drug but apply to drugs in general, and again you see this same very, very disconcerting polarization with regard to race, that as the white population shown here has begun to show this continuing and substantial decrease in prevalence of current marijuana use among black young adults, it is continuing to edge up, although more slowly, and these two curves parallel quite sharply and consistently those demographic changes that you looked at before.

Mr. CALIFANO. What is current marijuana use? How much is that?

Dr. POLLIN. Current marijuana use means any use during the past month, from one time to daily or more.

Finally, a very different data set, Mr. Chairman, this drawn from a panel of some 750 hospital emergency rooms around the country, looking at those emergency room admissions, which had some association with the use of drugs. And again we see that since 1979, if we look at all dimensions for all drugs in the total DAWN system, this is the year 1979, and each of these is a succeeding year going up to 1983.

The total number of DAWN mentions has decreased for whites at the same time that it is increasing for blacks, and increasing for Hispanics. So from a multiplicity of data sources, we think that the predictions that were made some years ago have unfortunately been confirmed. That although for the Nation as a whole there is definite improvement with regard to the drug picture, the pros-

pects and the current state with regard to the minorities is a very different one indeed, and therefore the increased need for special attention to the drug problem.

Mr. RANGEL. Thank you, Doctor, for very informative observations.

Mr. Taylor is not here. Then Bud Mullen, as I pointed out, who has the responsibility for coordinating our national, and indeed in many cases international, effort, is here with us. I thank you for taking time out again for this weekend.

STATEMENT OF FRANCIS M. MULLEN, JR., ADMINISTRATOR, DRUG ENFORCEMENT ADMINISTRATION

Mr. MULLEN. Thank you, Mr. Chairman. I always look forward, Mr. Chairman, to appearing before you and on this occasion with you on a panel. I too would like to echo the comments of Dr. Pollin with regards to your involvement in the drug enforcement, drug abuse prevention area. You and I exchange many views. Often we are not in agreement, but I never fail to recognize your sincerity, and commitment, and support of the drug enforcement effort. It was brought home to all of us in very recent past when you led the effort to prevent the legalization of heroin in some cases. I believe that was a very correct finding by our Congress and all of us in the enforcement community.

Thank you for your efforts.

Mr. RANGEL. Thank you.

Mr. MULLEN. The Federal strategy on drug abuse and the programs will be released today, the 1984 strategy, and it will cover five areas: prevention, drug law enforcement, international cooperation, treatment and rehabilitation, and research. My basic area of responsibility is that of drug law enforcement. However, DEA is involved overseas, and therefore in the area of international cooperation, and we have a number of programs in the education and prevention area.

I would like to take credit for the law enforcement community with regard to the 90-percent success, but while I agree with Dr. Pollin's approach and his theory on this, I would include the totality of the drug prevention programs, prevention education, law enforcement, rehabilitation, and others. I have often said I would hate to think where we would be today without the DEA, without the FBI, without the New York City Police Department.

There are 14 separate Federal agencies and 14,000 State and local agencies involved in the drug enforcement program. Now, DEA is your lead agency with regard to drug law enforcement. However, we are a relatively small agency, with 4,200 employees. About 2,230 of those are special agents. You can contrast that with the 2,700 members of the Transportation Authority Police in New York City.

Mr. Chairman, just a few short years ago we were down to 1,806 agents, and when our last graduating class at the DEA Training Academy completed its training, it brought us back to where we were in 1977, but we are gaining strength.

We have offices in every State and in 42 countries overseas. Just 2½ years ago the Federal Bureau of Investigation was given juris-

diction under title 21, the Federal laws covering drug trafficking, drug abuse, and now devotes 1,100 agents to drug investigations. It has resulted in some very substantial improvement in our statistical accomplishments and our ability to conduct sophisticated investigations, such as undercover activities, and court-authorized wiretaps.

Many other agencies have responsibilities at the Federal level. U.S. Customs Service for interdiction, U.S. Coast Guard for enforcing our drug laws on the high seas.

I believe we have had substantial success in the law enforcement area, but I have said, and I will continue to say, that law enforcement is not the eventual or final answer to our drug abuse problem. I believe we can perhaps stabilize it, maybe reduce it somewhat, that we have present with us. However, it is education and prevention that will eventually turn the tide.

As we are successful in some areas we see new drugs developed. We have seized, for example, 8 tons of cocaine in 1983, and that compares with only 2 tons in 1981, so a substantial improvement in the number of our seizures, but as we are successful in some areas, we see new drugs develop, as I mentioned, and I would like to just mention a few to the group. I think it will surprise some people. We have a new drug, for example, being abused called black dust. This is a combination of heroin, PCP, kerosene, and formaldehyde. It sounds more like something, Mr. Chairman, that would launch a rocket than people would use to abuse, but this is developing in the Philadelphia area, and it is a very sad development indeed.

We now find young people who do not have access to drugs such as marijuana and cocaine, who perhaps fear the use of these drugs, now sniffing typewriter correction fluid, which can be purchased for $1.39 with no questions asked, small, easily concealed, and is similar in effect to drinking a large amount of alcohol, and rather than call this a blackout, the people who use it are calling it a whiteout.

We now see more freebasing where individuals are using ether to reduce cocaine to its purest elements, and the phenomenon of speedballing, that of mixing heroin with cocaine.

Back in the enforcement area, we find that the military help has improved substantially since the posse comitatus law was amended in December 1981. As you are well aware, Mr. Congressman, this posse comitatus law is the law by which the military was prevented from being involved in civilian law enforcement, and the amendment enabled them to support our efforts in the drug enforcement area.

We are receiving help from the Air Force and Navy with regard to radar, and we are told how much time will be available to civilian law enforcement, and we then tell the military where we would like the radar located, and based on our intelligence trends we can usually pick the best locations. We are receiving helicopters, for example, for use in the Bahamas to fly police from island to island accompanied by DEA agents. We are also receiving helicopters and other aircraft for use as chase aircraft, aircraft to interdict the supply of drugs.

In addition, we are receiving intelligence observations by Navy vessels in the Caribbean, for example, on the movement of vessels

throughout the Caribbean. Many other agencies—Internal Revenue Service, are pursuing income-tax violations, are involved in the drug enforcement effort, as is the ATF, Immigration Service, the U.S. Marshals Service, and the intelligence community.

Now with regard to a national thrust and a national cohesiveness to our effort, we do not in Washington set one drug as a national priority, because in Miami, FL, for example, the major problems would be marijuana and cocaine, and the violence attendant to the shipment and abuse of those drugs.

In your area, Mr. Congressman, Mr. Chairman, New York City, heroin would be the main problem, and the priority target of our New York operation, as would be the case in Chicago and Detroit, and in the Washington, DC, area. So we let the local office, with input from local investigative agencies, determine the priorities, after which we advise Washington. We then put together a national priority, and only overrule a local division when we feel they are too far out of line with our intelligence trends, where reports on intelligence trends and local police agencies show us that a certain drug may be a problem in an area and is not being addressed.

In addition, I chair the International Association of Chiefs of Police Narcotics Committee and am a member of the National Sheriffs Association Narcotics Committee, and through these two programs local agencies have additional input into our strategy and investigative thrust, this in addition to the law enforcement coordinating committees set up by U.S. attorneys in 94 separate jurisdictions around the country.

One of our most effective tools is that of seizure and forfeiture of assets, and I am very pleased to see that our Congress, both the Senate and the House, have passed legislation in this area, which will enable us to become more effective in seizing the assets of the traffickers.

DEA has prepared model legislation which it has made available to various States, to enable State and local jurisdictions to seize and forfeit assets of the traffickers. In many areas of the country, 11 States, for example, have adopted our legislation. Some others have passed their own versions. In many areas we see local agencies supporting their drug enforcement efforts, their rehabilitation efforts, and building jails and prisons with assets seized from drug traffickers. I like this particular program because in effect you have the traffickers, those who bring the drugs to our country and cause so much misery, paying for their own demise.

We have also prepared model legislation in the area of look-alikes and some other areas of interest to the States.

There are a number of Federal initiatives underway such as the Organized Crime Drug Enforcement Task Forces, and these are designed to bring the many agencies together. In case a drug investigation becomes a task force case when it requires the efforts of more than one agency, for example, DEA obviously has the expertise with regard to the drug trafficking and the investigation of violations of our drug laws. We may need some financial expertise from the Internal Revenue Service. We may encounter some firearms violations that involve ATF agents. We may encounter organized crime elements where the FBI can be supportive, so the Or-

ganized Crime Drug Enforcement Task Forces are designed to bring the many agencies together.

In addition, DEA puts $13.3 million into a program where we have Federal, State, and local task force operations, where basically the local agencies provide the manpower and DEA provides the other resources, the communications, the vehicles, the work base, all the support that is needed, the stenographic support to conduct drug investigations, and it averages out to about one drug agent to four local offices involved in these task forces.

We have ongoing training at the DEA Academy in Georgia, and our DEA laboratories do conduct examinations for State and local agencies.

One of our major initiatives this year is the domestic eradication program where we have put $3.3 million forward, and have trained 600 officers to act as observers, and the program has grown from 7 States in 1981 to 47 States this year, and last year, we eradicated 4 million plants in the United States.

As we have become more successful at spotting these marijuana sites, the growers and traffickers have gone indoors and in last year's program, we seized many greenhouses.

I mentioned earlier prevention. DEA has involved several programs, and one that I am most excited about, and one that I believe has the most potential is the National High School Coaches Program.

There are 48,000 high school coaches in this country, and they can reach 5.6 million young people on an individual basis and encourage them to talk to their peers at the high school level.

The International Association of Chiefs of Police is supporting this program, as is the National Football League, and the National Football League Players Association. These individuals have agreed to act as role models and go out into the high schools with law enforcement officials and talk to the young people, and the athletes are people who our young athletes at our schools will listen to.

And we believe the other high school students will listen in turn to their fellow athletes.

We have been told by a number of groups, such as the National Association of Boosters Clubs, that we are not reaching far enough, and they would like us to expand those programs, intramural leagues, and others, and we will be meeting in Washington in early October to discuss an expansion of this program.

I have other programs I could discuss, such as the National Law Enforcement Explorer Scouts, and these programs are especially effective in our inner cities, and the Detroit Police Department has one of the better programs, and these young people are brought into police departments. They handle crime prevention matters, traffic control, and are put in uniform and also serve as role models to other young people in the community.

A number of our civic associations, Elks, Rotary, and others, have chosen drug abuse as one of their themes for 1984, and I hope will do so again in 1985.

In summary, I would agree with Dr. Pollin, that we are making progress. Some of the abuse has stabilized at all too high a level, so we certainly won't claim victory, but I believe we are making substantial progress, and we do have a long way to go.

Mr. RANGEL. Thanks, I am glad you emphasized the differences we do have and they are honest differences.

I regret that this is an election year, for fear some of my comments might seem political, but you would know better than a lot of people, this exchange has continued with us, and it has, regardless of who has been in the White House, Republican or Democrat, because unfortunately, there seems to be at the State Department a sense that narcotics affected drug producing countries don't receive the high priorities that it should, no matter who is the President, or at least the Secretary of State.

It wouldn't be fair to you to ask you to comment as to whether or not you think that you are getting the type of support that you would need from the Secretary of State, or from the President or Ambassador Kirkpatrick for that matter, since I have not heard her comment on this issue at all.

You had indicated that we cannot win this battle just in dealing with eliminating drugs, that we have to do it through prevention and education, and you cited the efforts being made by your Department.

Do you concur with the administration, that this education, that this prevention effort should be a private sector initiative?

Mr. MULLEN. You raise several issues, Mr. Chairman, and I will second what you say. Your views don't change during an election, after one, any time, so I certainly agree with you, but I do want to comment on whether or not we are receiving support.

We are receiving support. You mentioned the President, yes, I think you will agree, he is very interested in the drug problem and has supported us.

Mr. RANGEL. I don't believe there has been any President that has spoken about the problem of drugs more than the President has, but as we talk about the international arena, I don't believe I have ever heard the President comment on the cooperation or lack of it from any offending country, nor has he enforced any of the laws that have been passed by the Congress, the Rodino-Rangel amendment, the Gilman-Rangel-Hawkins amendment has not been spoken to.

Secretary Shultz, 2 weeks ago, gave a talk about international drug trafficking, that was not done at the United Nations or an international forum, but for a chamber of commerce in Miami, and to my knowledge, this matter has never been raised in the United Nations, so I agree with you, that the President has had many meetings, but since the Assistant Secretary of State is here, and we welcome him, I think we leave that question to him, and ask whether or not you believe that the education—you see, the problem we are having is that local law enforcement officers all over this country and in New York City specifically are saying that we are not going to deal with this problem on a local or State level; 100 percent of the cocaine, 100 percent of the heroin is coming into this country from foreign sources, and 85 percent of the marijuana, so until you fellows in Washington get your act together, we are not prepared to say that we can get a handle on this.

You come to Washington, on the other hand, and you hear, well, the answer is not in law enforcement. The answer really is in pre-

vention and education, and they would say, well, what are we doing about it?

Then, we would answer, well, that should be a private initiative, coming from the private sector.

Mr. MULLEN. For example, I mentioned the coaches' program earlier, and the Juvenile Justice Division of the Department of Justice has given us $130,000 to kick that program off.

There are many other areas where Federal funds are being made available in the education and prevention area.

If I could jump back to the international issue, and I will not take Mr. Taylor's time, he is our expert, but I do know the President of the United States has met with the President of Colombia, and the Prime Minister of Thailand, a source area for heroin.

I was with the Attorney General of the United States when he met with high-level officials of Pakistan and when comments would be made, we would like to do this or that, but certain conditions prevent us from doing so, the Attorney General pounded on the table and said: "The fact remains that drug abuse is the No. 1 problem in the United States, and we insist that you do something."

And steps are being taken, Mr. Chairman, so there are people at the highest level working on an international basis to encourage foreign governments to reduce the flow of drugs into the United States, and I have witnessed this occurring.

Mr. RANGEL. Thank you. We have with us the Assistant Secretary of State, Mr. Taylor, and we work very closely together.

I was talking with your boss, Secretary Shultz, complimenting his speech, his maiden speech 2 weeks ago, and I was a little embarrassed that it was given to a business forum rather than an international forum, or that it was so late into the administration that he had given it, but perhaps you could share with us that international effort that is being made, and that would complement what Bud Mullen talked about.

STATEMENT OF CLYDE TAYLOR, ACTING ASSISTANT SECRETARY OF STATE, BUREAU OF INTERNATIONAL NARCOTICS MATTERS, DEPARTMENT OF STATE

Mr. TAYLOR. I am sorry I missed the first part of the discussion. I heard you talking about Secretary Shultz. Perhaps it was not in a way I would agree, but it was a good introduction, and thank you.

We do enjoy the relationship with your committee and others in the Congress that have been very supportive of the international narcotics program. We all recognize that it is a complex program, and a lot of thoughtful people do not think it can be resolved.

We get many queries as to why make the effort, and I hope in a few comments that I have here that we can identify some areas in which progress is being achieved.

I want to review our program to control international narcotics and I will speak to you about the continuing problems we face, share with you our appraisal of the future, including those areas where we at State, those of you in the Congress, and you in our audience have opportunities to make progress.

My main purpose is to discuss international narcotics control. I want to interject two thoughts.

First, while reducing supplies of drugs is a vital part of our Government's total program, the effectiveness of our national effort to cope with drug abuse rests on our ability to reduce the demand for drugs in the United States, ultimately.

Dr. Pollin said 90 percent of the effort is on the source side. I won't say 90 percent is on the demand side, but we have to recognize both ends of this continuum.

Second, our efforts here at home to reduce demand and to control cultivation of cannabis have a major influence on our diplomatic efforts to persuade governments of source countries to honor their obligations under international treaties.

The President has designated National Drug Abuse Education and Prevention Week, and I urge all of you to think of the different kinds of problems associated with drug abuse and what more can be done, not just by the Federal Government, but by all Americans to overcome this national tragedy.

Our international program involves the Department of State's Bureau of International Narcotics Matters as well as our regional bureaus and embassies; the Drug Enforcement Administration and the Federal Bureau of Investigation; the Agency for International Development; the Customs Service, the Coast Guard and the Navy; and a host of other agencies.

But, narcotics control is not the sole province of these Federal agencies.

The President, the Congress and the judiciary also have commanding roles, and they play them well. As I address this caucus, I am especially aware of the outstanding leadership that Charlie Rangel has provided to the Select Committee on Narcotics Abuse and Control.

Your caucus chairman, Julian Dixon, has been a supporter for our appropriations. Congressmen Stokes, Townes and Collins have investigated narcotics production abroad and given us valuable reports.

Other members of the caucus have also been vigilant. And, thus I stand here, not as the spokesman for the international program, but as one of many representatives of our collective effort.

Let me share with you some recent achievements by the governments of source nations we have assisted.

On July 5, the Colombian campaign against narcotics, which has been progressively effective over the last 3 years, moved into a decisive new phase when the national police began the herbicidal spraying of cannabis.

By last week, some 4,940 acres had been sprayed, and the Colombians, who anticipate an even more comprehensive program in 1985, were well on their way toward achieving control of cannabis production.

The Colombians are continuing their strong effort to control cocaine production as well. In March, their police destroyed 14 laboratories in Caqueta, and seized a world record of 10 metric tons of cocaine and cocaine base, and have seized more than 17 tons thus far this year.

The Colombians have paid a tragic price for this campaign, losing Minister of Justice Rodrigo Lara to assassins. But, the killing did not deter President Betancur and his ministers.

Since the assassination, Colombian police have staged more than 1,500 raids resulting in the arrest of 1,425 individuals, the destruction of about 50 cocaine laboratories, and the seizure of over 7.5 tons of cocaine and cocaine base.

And President Betancur has declared that Colombia will extradite traffickers sought by the United States.

By midyear, Peru has increased its eradication of coca bushes in the Upper Huallaga Valley to nearly 4,900 acres, compared to 1,100 acres eradicated in all of 1983. This program is continuing despite increased violence in the valley by terrorists as well as by narcotic traffickers.

On August 10, President Siles ordered the Bolivian military, as well as police units, into the Chapare region, the area accounting for the bulk of Bolivia's illegal coca production, to establish law and order, an absolute prerequisite to beginning U.S.-supported narcotics control programs there.

Initial goals seem to have been met, and the units are now concentrating on raids against traffickers in the Beni area.

We are collaborating with the U.N. Fund for Drug Abuse Control on projects to extend both coca control programs and rural development assistance to the other major growing areas of Peru and Bolivia.

In Pakistan, narcotics production has dropped dramatically from 800 metric tons in 1979 to an estimated 45 tons in 1984. Narcotics control programs are operating in the Malakand, Gadoon-Amazai, and Buner areas with assistance from State, AID, and the United Nations, and the government has embarked on a special development and enforcement plan to extend its ban on opium cultivation into the remaining areas of the Northwest Frontier Province. We were especially encouraged by the response of international donors to this program.

The Thai Government increased its commitment this year to controlling opium cultivation in civilian-police-military command villages in return for development assistance.

A modest, 800-acre trial effort at eradication was noteworthy in that it did not produce a political confrontation with the hill tribes and we are hopeful the Thais will pursue a much-needed opium eradication program.

The army has continued its energetic efforts to disrupt trafficking and refining activities along its border with Burma, through its military operations against the Shan United Army, the Chinese irregular forces, and other illicit drug trafficking groups.

Earlier this year, the Government of Burma conducted military operations against narcotics traffickers in the Shan and Kachin States, which resulted in the seizure of quantities of narcotics, chemicals, refining equipment, and weapons.

The Government of Mexico, whose highly effective opium and marijuana eradication programs have been among the real success stories in narcotics control, has changed tactics to cope with new diversionary schemes by growers and traffickers, and increased its

opium poppy eradication efforts to offset the increased opium cultivation recently noted.

The U.N. Fund for Drug Abuse Control is now implementing projects in support of coca control in South America, marking a long-needed involvement by the United Nations and indirectly by European donors in a problem which affects Europe as well as the United States.

Thus U.N. activity was largely made possible by a pledge of $40 million over 5 years by the Government of Italy. The U.N. fund has received pledges of $5 million each from Italy and the United States, and $1.5 million from the United Kingdom for the Special Development and Enforcement Program in Pakistan.

The Federal Republic of Germany, Saudi Arabia, and Norway have contributed to international narcotics programs in Pakistan and Thailand.

We attach real importance to a consensus which the major donors to the U.N. fund reached earlier this year, when they agreed that all U.N. drug development projects will contain drug enforcement provisions, and agreed that economic assistance should be linked to commitments by recipient governments to eliminate illicit narcotic crops by specified dates.

We believe very positive gains will emerge from the consensus of South American chiefs of state who met in August in Quito, and declared broad agreement on the need to control illicit narcotics production.

We are strongly in support of new regional enforcement initiatives in South America and have prepared a program of such initiatives which we are now discussing with the governments of the affected countries.

In sum, we are making progress in many countries and across entire regions. There are a variety of situations which we think offer new opportunities. But, lasting success will be difficult to achieve. We are challenged by numerous problems.

Some governments do not have control of the narcotics growing regions, and prospects in several countries are dampened by corruption, even government involvement in the narcotics trade.

A fact of international political life is that the United States does not, by itself, have the needed influence in all sectors of the world to achieve a lasting, substantial reduction in worldwide traffic.

Some friendly governments claim they cannot survive politically if they are seen as succumbing to the dictates of the United States. An overriding problem is the vast production of illicit drugs; worldwide production of illicit opium, coca leaf, and cannabis is many times the amount currently consumed by drug abusers.

To overcome these problems and others, we need a truly international effort. We need narcotics control programs in all the significant producer countries, and increased assistance from the international community.

Narcotics control requires a long-term effort, but our relationships with many of the Third World countries which produce illicit narcotics can fluctuate sharply, for reasons not related to narcotics control.

Moreover, too much of the effort to date has been by the United States. We need for other nations also to apply their political and

economic resources to this problem. Further internationalization will help depoliticize narcotics control efforts and establish better the idea that the drug problem is shared by all the many nations affected.

Greater participation by the international community has been the objective of broad diplomatic initiative. The President, the Vice President, the Secretary, and other State Department officials, the Attorney General, and other officials have been involved in carrying these messages to producer, transit, and donor countries.

We have told them that this is not just an American problem, that they too have an obligation, and a substantial interest in fighting the illicit drug trade.

We have also told the countries from whom we hope to see increased political and financial contributions that there are opportunities today to expand and improve narcotics control.

These new opportunities and further progress were created in part by the diplomatic efforts of the United States, and in part by the problems producing nations are experiencing.

Virtually every source country has suffered the problems of economic dislocations, institutional instability, and crime related to narcotics trafficking. Several have also been besieged by political problems, including armed insurgencies supported by profits from the drug trade.

These source countries increasingly understand that they, not we, are the first beneficiaries of successful narcotics control programs.

But, Governments in countries like Pakistan, Thailand, Colombia, Bolivia, and Peru are particularly concerned by escalating problems of drug use, especially among their youth.

Drug abuse is a problem in both industrialized and developing nations, producer and trafficking countries, as well as consumer nations. This factor works against us, in the sense that increasing demand maintains production at high levels.

But, the abuse factor also works for us, in the sense that the governments of source nations must respond to their domestic abuse epidemics.

Progress is being made in reducing demand, but let us not be mistaken about the dimensions of consumption, not about the high levels of production needed to satisfy that demand.

We must reduce demand, but no nation can cope with drug abuse by relying only on treatment, prevention, and domestic enforcement.

The demand for drugs is so widespread, and the supply of illicit drugs is so great that the best domestic enforcement efforts will not permanently reduce availability.

Illicit drugs consumed in the United States are produced in at least 14 countries and smuggled across more than two dozen national frontiers.

The networks involve thousands of profiteers, from farmers to street pushers, in what has become a veritable foreign legion of profiteers. The grower-to-user chains stretching across five continents must be broken, through a comprehensive program of international control.

We may apply pressure at all points in the chain through effective treatment and prevention; through intensified investigation and prosecution of traffickers; through increased seizures of both drug products and financial assets; and through crop control.

We need a higher level of awareness throughout the international community. We need to communicate through our embassies, through USIA, and through the world press the kind of intensive efforts that are being made to reduce demand in the United States and make these source country governments and their people aware of the problems they export to our country, and aware of the domestic problems they are creating within their own societies.

That awareness is increasing and it shows in many programs, including not just improved interdiction and eradication, but in the decisions of governments to consult with their people on solutions.

Last September, a major drug abuse treatment and prevention conference was held in Bogotá, a conference to discuss what Colombians can do about their drug abuse problem. My Department supported that conference as well as a national drug abuse awareness conference in Pakistan.

We must recognize changing market conditions. In the wake of the successful Mexican opium poppy eradication program, and the drought in Southeast Asia, heroin from Southwest Asia began to dominate in the United States.

Recently, just as market conditions and a Pakistani Government ban reduced opium production in the Northwest Frontier Province, bumper crops have been produced again in Southeast Asia.

Similarly, there has been a softening of the market for Colombian marijuana, even before eradication started this summer, but there is increased preference for higher potency cannabis, such as that produced in Jamaica.

And, while coca is being eradicated in Peru and Colombia, and there are prospects of coca eradication in Bolivia, we are already seeing new cultivation in Brazil, and new refineries in Argentina, and even in the United States.

The lesson to be learned is that reductions in availability cannot be sustained unless controls are applied to all major production sources simultaneously. Our people at State and the enforcement community are already at work in the countries which would become the next frontiers of drug production.

However, it must be understood that we cannot do what we would like when and where we would like to take action. We can sometimes stimulate opportunities, but the clear fact is that we support foreign government programs. Foreign governments must take action. We respond to opportunities.

The incentives on the part of drug exporting countries to act are not just the diplomatic urgings and economic assistance offered by the United States and other governments or agencies.

Today there is also the motivation of self-interest. These self-interest incentives include economic dislocations and undermining of legitimate business, erosion of public institutions, domestic drug abuse, international pressure, and political insurgencies linked to narcotics trafficking.

These problems apply, often in different measure, to all three growing regions, Southeast and Southwest Asia and Latin America.

At the same time, we recognize the disincentives to government action: A farm populace heavily dependent on narcotics crops for their cash income; the dependency of local economies on the drug trade; lack of government control over the growing areas; control of the narcotics trade by political insurgent groups; and pervasive corruption.

This interplay of incentives and disincentives often defines our opportunities for action.

On balance, we believe that our diplomatic and program efforts, together with an increasing awareness in producer countries of the adverse effects on them of the drug trade, are improving the prospects for narcotics control.

But these substantial successes can be severely damaged by the perceptions overseas about what is happening in the United States. To a greater degree than many people realize, our success in international narcotics control is dependent on the success of our domestic prevention and enforcement programs.

It will be almost impossible to convince other nations to eradicate their drug cultivation if they believe we are not living up to our obligation to control ours.

American marijuana growers have changed our role from that of a consumer nation to that of a producer of illegal drugs.

If we do not control drug cultivation, traffic, and demand here, we may not be able to effectively control the cultivation of drugs anywhere.

We can only be successful abroad if we are successful at home. The officials in every community across this Nation must understand that an effective foreign policy on narcotics is clearly linked to an effective domestic effort on drugs.

We need to send a message to people in other countries, and to their governments, that we in the United States intend to control our drug abuse problem.

Mr. RANGEL. Let me take time to thank you for the outstanding job you have been doing for our country and our people on the international level, and also our judge, who has left us, why would his name escape me now, after all the years we spent in New York, both as prosecutors, and members of the New York State Assembly, and the outstanding job he did with you and working with the Department of State in this sensitive area.

Again, as I told Bud Mullen, this hearing is to inform the general public and not to make a critique. Some of us truly believe that our Ambassadors and certainly our Department of State corps are guided by the statements that are made by the Secretary of State, and so I hope that you would understand that in 3½ years, we have not heard from him publicly on this issue, or in 4 years, he has not spoken about this issue in an international forum, I hope you would agree that it is reason for us to be concerned.

Again, some of us believe that those items which have a priority with the United States of America, and where we have countries that are violating international agreements, and they sit in the United Nations, some of us had thought that Ambassador Kirkpatrick spoke out against those nations when they violated international agreements, the violation of which causes suffering and pain in the United States.

And for those reasons, we had and do hope to expect to hear from these people.

We appreciate the fact that we are dealing with the integrity of nations, and that it has to be a joint effort, and that America cannot be perceived as one that is indifferent to the sovereignty of other countries, but having invaded a couple, I had assumed that in the area of drug addiction, that they could let them know that there are other areas besides just a spread of communism.

That is a very, very serious problem to us.

Nevertheless, the criticism is only meant to shore up your efforts in this area, and I do hope that it is only a perception that those diplomats and members of the State Department that involve themselves in narcotics are not eliminated from the upward mobility in the State Department, since there is a vacancy there.

And I do hope that your continued efforts with the support of the Congress are recognized, at least the last few days of this administration.

Perhaps here we might have an opportunity for the panel to ask some questions of each other, and perhaps we could take a question or two from our audience, and I am very sincere in saying that Clyde Taylor has been a very dynamic member of the team, and it is the only way that we can really impress upon people in foreign countries that we are not Republicans and Democrats, but Americans with a common concern, and we try to run the committee that way.

And we certainly get together, or get along better overseas than we do back home. It is a good working relationship that the committee has enjoyed with Secretary Taylor, and I would like to compliment the support that has always been given to us by Raymond Hess, who is sitting out there from the State Department.

Questions the panel may have as relates to the Federal drug strategy, your report which was recently produced by the President's office, that is something we have not gotten into, but the audience should know that we have a lot of people involved in one stage or the other in this effort, and some of you may think that Mrs. Reagan is in charge of it, but really she is not.

It is Carlton Turner, the White House adviser on all of these issues, and has really worked with the State Department in talking with some of these nations representing the President's efforts.

If there are no questions from the panel, we will move into the second part of this, which deals with the health aspect of drug abuse and certainly, all of you know the familiar face who has made an outstanding contribution to several Presidents, starting with President Kennedy, President Johnson, and President Carter, and that still works with Federal officials and works very closely with this committee.

His last major responsibility was as Secretary to the Department of Health, Education, and Welfare, and he has written many articles on the serious impact of drug abuse, and we are honored to have him to share his valuable time with us today and his views on this important matter.

Thank you, Joe, for being with us.

STATEMENTS OF HON. JOSEPH A. CALIFANO, JR., FORMER SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; DR. RONALD DOUGHERTY, EXECUTIVE DIRECTOR, BENJAMIN RUSH CENTER, SYRACUSE, NY; AND DR. FLAVIA WALTON, EXECUTIVE DIRECTOR, BLACK ADVISORY PANEL ON DRUG ABUSE POLICY

Mr. CALIFANO. It is a pleasure to be here, and a pleasure to be here with you who, both as chairman of this committee in the Congress, and long before then, in New York, and as a Congressman, have probably done as much to spur people to action on this problem and bring it to the attention and get funds for it as anybody in the government.

I think addiction is America's No. 1 problem in health, and probably the No. 1 cause of crime, and I think that no one who is serious about dealing with the cost of health care in the United States and no one who is serious about dealing with crime in the United States can move without putting addiction at the top of the agenda.

The deaths, disabilities, and diseases from alcohol, cigarettes, heroin, and other opiates, cocaine, marijuana, angel dust, Valium, and other tranquilizers, sedatives, and barbiturates exceed the mortality and morbidity toll of any other illness, indeed of most other illnesses combined, indeed, of all the wars we ever fought in and all of the traffic deaths we have ever had.

The economic cost of addiction, health care, days away from work, lost productivity, is over $100 billion.

The human costs can't be calculated. There is no price tag on sorrow or family tragedy or life itself. Consider the number of people involved in this country, 50 million Americans are hooked on cigarettes, 15 million of them under the age of 15; 13 million are addicted to alcohol or abuse it. One-half million are addicted to heroin. At least 1 million abuse barbiturates and other sedative hypnotic drugs every day in this country; 53 million have used marijuana at least once, and 14 to 17 million have tried cocaine and no one knows how many millions are dependent in one way or another on those drugs.

Even considering that many individuals abuse a variety of substances and therefore show up in more than one category, the number of Americans in servitude to drugs is terrifying. Combination drug abuse is up.

Virtually all heroin addicts abuse alcohol and other drugs as well. There are fewer and fewer pure alcoholics. During my tenure as Secretary of HEW, during the course of a study I did for New York State in 1981 and 1982, every alcoholic I interviewed was also involved with some other drug, usually tranquilizers or barbiturates.

Of all the drugs Americans use and abuse, heroin is the most terrifying. It holds users in a tenuous grip of physical dependence. Heroin addiction spreads through urban areas like a malignant cancer.

No other drug has demonstrated the same capacity to rip up a neighborhood and with it, the pride, and expectations, and lives of people who try to live there.

Many other drugs, legal and illegal, have a serious adverse effect on the health and productivity of our citizens. Cocaine, and pot, and pills cost our society billions of dollars each year in health care, crime, employee absenteeism, and lost productivity.

Alcoholism is now one of America's top four diseases. In the number of people it attacks and the economic toll it takes, alcoholism is gaining fast on the big three, heart and circulatory diseases, cancer, and respiratory diseases.

Indeed, if we don't deal with the alcohol problem in this country in a much more vigorous way than we have in the past, alcoholism will be America's No. 1 disease by the turn of this century.

In terms of the minority community, I would like to just briefly cite a few numbers and statistics of how much more severe the drug problem is in that community than elsewhere.

Because of poverty and unemployment: Studies of alcoholism and problem drinking among minorities in New York State, which is where most of the studies have been done, permit rough estimates of the extent of the problem.

On the basis of the evidence available, mortality rates for cirrhosis of the liver, treatment rates for alcoholism, and accounts of expert observers, drinking problems and alcoholism are severe in minority communities, where there are high concentrations of poverty and unemployment.

Cirrhosis mortality rates for Hispanics exceed those for the population as a whole by a wide margin. One study showed that cirrhosis of the liver was the third biggest killer of Puerto Ricans born in New York between the ages of 15 and 54.

The top two, homicide, which is often associated with alcohol abuse and drug abuse in New York City, during 1980, 24 percent of those in criminal treatment programs, and 19 percent of those in sobering-up programs were Hispanic.

Across the State, Hispanics were 7 percent of those in clinics and 11 in sobering-up programs. Like Hispanics, blacks unfortunately have higher cirrhosis mortality rates than the population as a whole.

For black urban males between 35—25, rather, and 34 years old, the cirrhosis mortality rate is a stunning 10 times higher than the rate for white males of the same age.

Cirrhosis of the liver is one of the top three causes of death in Harlem. The cirrhosis death rate in Harlem is three to four times that of the rate in New York City as a whole.

What do we do about this problem? My own view is that in terms of the commitment of health care and other resources in this country, it is a national disgrace. We are not doing nearly enough.

If we had these numbers in a flu epidemic, you would have the President of the United States, as we once did when a flu epidemic was threatened, mounting a massive national program to innoculate every single American, woman and child.

If we had these kinds of number in any other disease, in any other problem except drug abuse, we would have massive emergency measures by the National Government, by the State governments, and by the local governments.

It is incredible to me that we have this situation. I have talked often to Chairman Rangel about it, and I know how disturbed he is about it, and we have it at every level of our health care system.

There is not nearly enough work done on prevention. The only cure for drug abuse that we know of, the only cure for alcohol abuse that we know of is not to get hooked, not to get started, and what we do in this country is woefully inadequate in prevention.

The cuts in the budget over the last several years are a national shame. We can spend $7,000 for a ladder for the Defense Department and we can't spend a few dollars to save the lives of our children, to educate them about the dangers of drug and alcohol abuse.

There should be programs in every single elementary school in this country. There should be programs by every large employer in this country directed not only at the employees, but at the family of the employees.

There should be programs targeted on groups we know are particularly vulnerable. We know now that if a child has one or two parents who are an alcoholic, that child is far more likely to be involved in alcohol or other drug abuse.

We know where the concentrations of availability of drugs are in this country. We have got to mount programs and target them at those areas.

Doctors are not properly trained in this country to recognize abuse soon enough, and they are not properly—and they are not properly confident of the nonmedical part of the health care system, whether it is Alcoholics Anonymous or some of these drug treatment programs that can be used to save their patients.

I think our research effort in this area, as Bill Pollin knows, is far too inadequate. I personally believe, with this kind of a problem, we need a National Institute of Addiction in the United States, just the way we have a National Institute for Cancer, just the way we have a National Institute for Blood, Heart Disease, Stroke and Circulatory Disorders, just the way we have a National Eye Institute.

Until we do that, and until we stop the erratic funding for research in the area of drug and alcohol abuse and addiction, we are not going to attract the kinds of minds that we need to put on a problem this difficult.

To the extent we have now begun to have breakthroughs in cancer and leukemia for children, for example, it has been because we put in place a stunning amount of funding, up to $1 billion a year for the National Cancer Institute, in a relatively short period of time.

We have guaranteed to our finest research minds that if you will devote your energies to that, we as a Nation will fund it. We are simply not serious, we are not serious as a Nation about putting in the kind of money into drug abuse and addiction research that we need.

Finally, in terms of treatment, we have nowhere near the funds. We have, unfortunately, and sadly in this country, a population of millions of people who are alcoholics or drug addicts. We have nothing remotely like what we need to treat and help those people.

My own view is that we have got to do far more, that we have not really begun to scratch the surface, that it is preposterous that

we allocate our health care funds in America in a way that provides the smallest amount of money to the largest health care problem we have, and I hope we can help change that.

Mr. RANGEL. Thank you.

Dr. Dougherty, executive director of the Benjamin Rush Center, located in upstate New York.

STATEMENT OF DR. RONALD DOUGHERTY

Dr. DOUGHERTY. In case anybody has forgotten, this conference is on drugs, effects on the black community, and I sure haven't heard much about that, and maybe we can change some of that now.

No. 1, Bill Pollin's comments were very interesting, but I would disagree with most of them. The only thing I have seen decrease in 1984 is the age of drug abusers.

Any of you folks in the treatment area, as a physician treating blacks and whites in the last 15 years, I am horrified by the escalation in the number of people being referred to us for care and treatment.

In New York State, in 1969, when I began treating substance abusers, 80 percent were black; only 20 percent white. It was amazing that it wasn't until heroin got out into the white community that anybody realized that suburbia has a problem and Federal funds started coming down for treating blacks and whites.

We see the reverse problem now. We are seeing a decrease in the age of kids, to the point that the youngest drug abuser I have treated is 6, a kid who OD'd with angel dust and had a complete stroke and was in a coma for 2 weeks. He bought it from a 10-year-old.

I have many 10-, 11-, and 12-year-olds, so I disagree that the substance abuse is decreasing. Many of my gals are prostitutes, and it is not only true, the mother who is an alcoholic, she does not drink alone.

The heroin abuser, if she is shooting heroin and pregnant, she also does not shoot alone.

This young lady, I delivered her baby, and this is this youngster in full narcotic withdrawal in 20 minutes. He has the same withdrawal symptoms an adult has, stools which are profuse, and this is a horrible thing to see.

I can tell where the kids are because I can tell by the cry that they had. Tell this baby there is a decrease of substance abuse, and he won't believe you.

This is a Hispanic gal I took care of in Syracuse who was dealt heroin cut with Dow oven cleaner. She bought it. There is no truth in packaging out there in the streets of New York.

Who are you going to complain to, the Consumer Product Safety Commission, or Betty Furness?

In 1982, we saw that 48 percent of those people requesting treatment in New York City for heroin addiction were black. We can see, in 1983, this dropped to 38 percent, and on the surface, you would say that is fantastic. It is not.

The only reason it has dropped down is because our treatment slots in New York City are operating 110-percent occupancy. We don't have the slots to treat these people.

As a result of the ADM grants coming down in 1982, we have continued to see a 30-percent decrease in funding on a national level for the treatment of substance abusers. There is no decrease in the number of blacks abusing heroin. It is simply because there is a long waiting list for these people to get on treatment programs.

We see a similar, reverse problem with cocaine. When I started treating cocaine addicts 3 years ago, this was an exclusively white men's drug and as a result of cocaine dropping in price, increasing in quality, increasing in availability, 48 percent of blacks now requesting treatment for cocaine dependence, and 3 years ago none of my patients in Syracuse were black; before they couldn't afford it.

Now, they can afford it, because the price is dropping from $3,000 an ounce down to $2,600 an ounce.

Cocaine is an equal opportunity drug. It affects all of us, black and white, across the board. This is a baby I delivered from a mother who was an alcoholic and cocaine abuser. She named this baby "Cocaine" because of her love and infatuation with this drug. He has fetal alcohol syndrome from the alcohol.

The profit in cocaine is unbelievable. We take a product like this which was, it contained pharmaceutical cocaine, 69 percent pure, one-quarter ounce, this costs a retail pharmacist $20.

This is worth $800 on the street. This cocaine is a $30 billion business in our country. We don't have to worry about the marijuana problem and eradicating that internationally.

We have the second largest hash crop in this country, marijuana. We don't need foreign countries for marijuana importation. We have a fine product of our own in this country.

The Cocaine Hotline established in Fair Oaks, NJ, pointed out to us the problem we have. In the first 12 months of the operation of the hotline, they ended up with a quarter of a million phone calls.

There are 5,000 new cocaine abusers in this country, 3 million narcotic cocaine abusers in New York State alone.

In New York State 10 percent of our population are drug dependent. The phone calls we thought would drop off—6,100 phone calls—we have not peaked on this epidemic.

Cocaine is a different drug than heroin. When I treated heroin addicts, a gal couldn't trick enough to pay for her drug, they would go off and drink alcohol or use Valium.

The cocaine user doesn't stop. This is the most reinforcing drug known to man, the only drug that we know that with animal colonies, the animal will continue to press the lever until he dies of exhaustion or seizures.

The cocaine abuser prefers cocaine over food, friends, family, recreation. I had a tough time figuring out what to put in there for sex, and they don't call it the white lady for nothing.

When patients tell me I have two women in my life, my wife who I haven't had sex with in 5 years, and the white lady, cocaine, mistress. I prefer to go to bed with the cocaine .

That is the most reinforcing drug known to man. Cocaine is a $30 billion industry. We are not going to snuff this out with education and prevention. It will require a total global effort. It is the largest industry between Du Pont and Standard Oil of Indiana.

The paraphernalia industry just to support the cocaine abuser with the pipes and the snow toker, free base kits, anybody can buy in a head shop, is a $18 billion industry.

This is big business. Are we going to stop it? It requires a supportive effort on everybody's part. We heard DEA say they got 4,200 agents, that is nothing.

If I were to make known to the Federal Government, we have plagues coming in by plane, and we would mobilize the Army, the Navy, and Marine Corps to stop it. A lot of our cocaine abusers don't bring it in by plane and by water.

There are people who are willing to take chances like this lady who brought in a packet of cocaine on our dairy; I know of an attorney who financed his last 3 years of law school by being a body packer, a young man who has swallowed 50 condoms full of cocaine.

If you fly into the United States in a plane that is not adequately pressurized, cocaine-filled balloons or condoms have a problem of exploding, and many of the people die en route.

We autopsy, the all-time winner who went into a motel, tried to remove his material with the usual method, by moving his bowels with enemas, or Ex-Lax, or Phillips Milk of Magnesia, and he did not make it.

He was the all-time winner. Every one of these condoms was double wrapped, full of cocaine, he died. Cocaine burns, no truth in packaging.

An 18-year-old black patient of mine, cocaine burns as a result of the material added to the cut, the propane, tetrocane, an Italian baby laxative for cutting dope, tell me this girl is not addicted, these are the backs of her legs. She is not even injecting that into herself.

A lot of people say you can't die from teething. This is one of our patients who had a seizure. These are how violent cocaine seizures are.

Anybody who says, "I can't die taking coke orally, vaginally, nasally," is wrong. You can die via any route. Most people who die have been doing coke for a considerable period of time, the John Belushi types.

This is a young man, a Hispanic pharmacist, who robbed them of all pharmaceutical cocaine, died from cardiac failure. He died from acute cardiac arrest, a common cause of death. You can die by any route.

We have a judge down in New York City that Congressman Rangel may recognize, we call him Turn 'Em Loose Bruce, who let 22 major Colombian drug dealers out on bail. They reached into their right-hand pocket, paid it, and took the next plane back to Colombia. We have to convince our judiciary as to a better way of stopping these people. We have had excellent relations today, put up $3 million in bail, in cash, or real property.

This will discourage some of these folks. If they split, let's put that into prevention, treatment, and rehabilitation in the black and minority community. We have nothing to treat our minorities as far as cocaine abuse is concerned. We have to get a clear message through. Cocaine is not something that grows in Marin County. Cocaine is not something that we can get in from Europe.

Cocaine is being produced in certain source countries, mainly Peru, Bolivia, and Colombia. The foreign countries have not gotten a clear message from us; if you keep sending these drugs into our country and killing our minorities Uncle Sam will no longer give you money with our left hand.

Why do we continue to do this? I know Congressman Rangel is incensed about this, why we keep on giving millions of dollars to these countries and simply turn our heads and take their cocaine with the other hand. This has to be a cooperative effort. There has to be help from all of our minorities as well as the white community, and it is going to require education, prevention, treatment, rehabilitation, help from Washington to put more money into treatment programs, not continue to cut back on AGM grants, not continue to limit the number of DEA enforcement. Otherwise, we are going to continue to have this escalation of this problem.

There is this fellow who looks up across the table, says to his son, "What is this about a serious problem in your school? Is this true?"

And the son, who hasn't seen his dad look at him cross the table in years, says, "No, dad, it's not a problem, you can get all you want!"

Thank you very much.

Mr. RANGEL. We thank you, Doctor, for a very effective presentation. I think this committee will be calling you back to see whether or not we can ask you to render your services for a larger group. It is a very impressive presentation that you have put together, and I have seen a lot of them, and this is very dramatic.

We are going to hear now from Dr. Flavia Walton, who is the executive director of the Black Advisory Panel on Drug Abuse.

STATEMENT OF DR. FLAVIA WALTON

Dr. WALTON. Mr. Chairman, fellow panelists, and those assembled, it is really a pleasure to be here today. However, I wish that the drug problem did not exist, and we didn't have to discuss such a terrible, terrible subject. Unfortunately, however, drugs are a problem, an epidemic that threatens to destroy more lives than any war we have ever experienced.

The health and social impact of drug abuse paints a bleak picture for the Nation as a whole. For blacks the picture is more dismal. Current statistics offered by the National Institute of Drug Abuse based on a survey of high school seniors, as you heard Dr. Pollin earlier, indicate a slight downward trend or a leveling in the use of marijuana and other drugs among whites, while the same survey indicates an alarming increase in drug abuse among black high school seniors.

Mind you, these are high school seniors. These are youngsters that possibly have a chance. They are close to a high school diploma. What, however, of the estimated 30 to 40 percent dropout rate from urban school districts? The few that do not reach high school senior range or inclusion in the statistics, a disproportionate number of whom, of course, are black.

Of additional significance is the overall increase in the extent of cocaine use, purported by many to be the most dangerous of illicit

drugs. Alcohol abuse continues to be a problem. Of particular note is the increase in the use of alcohol among teens. Officials of the National Institute of Drug Abuse and Alcohol Abuse and Alcoholism report the results of 1983 research that demonstrated over 45 percent of high school seniors surveyed indicated they and most of their friends got drunk at least once a week, again an upward trend demonstrated among blacks.

This abbreviated information is given as a prelude to a discussion of the vast health and social implications of drug abuse. The statistics are readily available and I encourage each of you to review all governmental and private research studies for additional information.

The glaring message throughout the statistics is that drugs and alcohol have disproportionate effects on minority populations. All the statistics mean nothing, however, unless one has seen firsthand the person who is part of the statistics, the victim of drug abuse. One need only witness the devastation, and I saw many faces as we viewed the slides we have just seen.

The following that I will share with you are excerpts from actual cases with which I had direct professional contact in several of the cities of San Antonio, TX, Tampa, FL, and Tucson, AZ.

Take, for example, the 11-year-old black female heroin addict. This child, introduced to drugs by her mother, was at the time I first met her, supporting her habits through prostitution and stealing. The case history indicated previous treatment for suspected child abuse, venereal disease, hepatitis, and malnutrition. All efforts to help this child were to no avail—lack of placement facilities, a reluctance by officials to remove her from her home, lack of alternative school settings, funding cuts that closed the door to the one program that was beginning to impact her life in a positive manner, a dysfunctional family that could not provide the physical or emotional nurturing, all factors operating in the life of this young child.

This child was found murdered in a sleazy motel room at age 14. She left behind a 6-month-old daughter that presented a myriad of problems resulting from the fact that she was born prematurely, exhibiting withdrawal symptoms. The baby was, at last contact, in the care of a maternal grandmother.

A young black man, age 24, so aged by abusive drugs and alcohol that he looked to be 50 years old. He was a high school dropout, had virtually no job history, no skills, police record, short stints in jail, one short prison term for robbery, was known by many in the emergency rooms of the hospitals serving his community, venereal disease, related injuries such as multiple stab wounds, drug shot wounds, beatings, et cetera. The prognosis, poor. Cirrhosis of the liver, impaired neurological function, and drug addiction despite repeated involvement in drug treatment centers.

Another sad story, a young, gifted, and very talented black man, from what looked to be a good family that appeared to be loving, warm, supportive, and responsive to their children. This young black man entered medical school after his junior year in college, and despite heavy involvement with many drugs, graduated near the top of his class. While practicing medicine, this young physician almost overdosed twice, one episode causing a heart attack. He

is now on probation with his license to practice medicine suspended. The charge, illegal use and possession of cocaine.

Case histories are full of stories like these, oblivion to pain, illness, disease, success, achievement, rampant because of drug abuse. Unfortunately, these episodes usually do not alter the course for the drug user.

The high or euphoria created by the drugs becomes a priority, the high at any cost. Drug and alcohol treatment centers are finding 14-year-olds with alcohol-induced cirrhosis of the liver. The courts are perplexed with the problem of what to do with young indicted for murder, many of which are drug related. Medical and social service professionals are at a loss to formulate treatment plans for pregnant teens who are also drug abusers. Babies born to teenage drug users have presented difficult challenges to neontology and to pediatrics, and the list goes on ad infinitim.

What does this mean in terms of the social impact of drug abuse in the black community? Very simply, although very frightening, erosion and deterioration of black folks. One cannot begin to accurately estimate the extent of emotional and physical pain inflicted on black families by drugs, nor the loss of black talent attributed to drug abuse, fear of drug-related violence that erodes so many black neighborhoods, the abuse and suffering inflicted on children of drug abusers. Drugs pit child against parent, families against friends, and black survival against eradication.

Meanwhile, moneys to provide meaningful and adequate research, prevention, and treatment are cut drastically, while medical and social science professionals are pushed to the limits to treat the problem and to discover a solution.

To those for whom dollars tell the story, the cost of alcohol and drug abuse to society this year is estimated to be over $176 billion. As in the use of drugs, black folks also bear a disproportionate burden of this cost.

Concurrent with the pain and destruction is the glamor reinforced by the media. As we witness star athletes, entertainers, professionals, all the brothers and sisters that have made it, success comes to drug use and abuse, the drug pushers, the drug kings continue to be among the most prosperous and admired, both on and off the block, and more often than not, untouched by the judicial system.

Drugs, the equalizer, the least discriminating force in our Nation today. Drugs do not discriminate on the basis of race, color, creed, or age. Black folks are being equalized to the point of no return, unless dramatic efforts are taken. We must, as survivors, assume the responsibility and the challenge to rid ourselves of this menace. We must become politically aware and astute to exercise our rights to insist on stricter controls to eliminate drug traffic into our country, within our States, and into our neighborhoods.

We must be aware of how to impact the allocation of block grants in the States. We must become involved in the planning stages for relevant programs that will positively impact the problem. We must ensure the cultural relevance and sensitivity of research and research findings as they relate to the black community. Social and service organizations must include drug abuse prevention in their community agendas.

We must discourage the easy access to drugs and alochol in our neighborhoods, decrease the proximity of liquor stores to our homes, our schools, and our churches, and if one will take a look in black neighborhoods, there is a large number of liquor stores, much more so than in any other neighborhoods in our community.

Last but certainly not least, successful innovative community-based programs must be supported by governmental agencies as well as by governmental policy. Included in this is an emphasis on prevention efforts to break the cycle of drug use. It is only through concerted communication, cooperative and determined efforts that the equalizer will be minimized. Black people must maximize the wealth of potential derived from our history, our soul, and our ability to survive, rather than bankrupt our future with drugs. Thank you.

Mr. RANGEL. Thank you very much, Doctor.

That is our health panel.

Our last panel will be headed off by Dr. Dale Masi, School of Social Work, University of Maryland.

STATEMENTS OF DALE MASI, SCHOOL OF SOCIAL WORK, UNIVERSITY OF MARYLAND, BALTIMORE, MD; LONNIE MITCHELL, ADMINISTRATOR, DISTRICT OF COLUMBIA, ALCOHOL AND DRUG ABUSE SERVICES ADMINISTRATION; CHARLENE DREW JARVIS, COUNCIL MEMBER, WARD 4, COUNCIL OF THE DISTRICT OF COLUMBIA; AND DR. JAMES COLLINS, DIRECTOR OF PSYCHIATRY, HOWARD UNIVERSITY HOSPITAL, WASHINGTON, DC

Dr. MASI. Thank you very much. Congressman Rangel, fellow panel members and ladies and gentlemen, it is a honor to be invited to speak here today on this subject. I entered the field of working with companies without alcohol and drug programs, which are called employee assistance programs, in Boston 10 years ago, where I developed programs for a number of companies. Most recently I have been the Director of the Department of Health and Human Services Employee Counseling Services Program, the model for the Federal Government.

ECONOMIC IMPACT OF DRUG ABUSE

Over this time I have seen a dramatic increase in drug and alcohol programs in industry.

As I presently consult with a number of corporations, it has become evident to me that no enterprise, either public or private, can escape the impact and costs associated with drug abuse in the workplace. On any given day, 18 to 20 percent of the work population is losing 25 percent of worker productivity due to personal problems; 12 percent are drug and alcohol problems, and 8 percent have emotional difficulties.

Many of the latter include family members living with an alcohol or drug problem. This 20 percent is a conservative estimate based on such measurable items as absenteeism, sick leave, accidents, and rising health benefit claims. This does not include the hidden costs of poor decisions, corporate effects, decrease in quality

of work produced, because of adverse actions, early retirement, and workmen's compensation claims.

Problems include alcohol abuse and drug addiction, which includes both legal and illegal drugs as well as emotional stress, depression, crisis behavior. Consider the following related statistics:

Alcoholism is costing U.S. industry more than $20.6 billion a year in lost productivity. Drug addiction is costing $16.6 billion in lost productivity.

Former Secretary Joseph Califano, one of our panelists, in a report to the Governor of New York on alcohol and drug addiction, has stated that companies will pay more this year in health benefits than in dividends.

What are employee assistance programs? These programs have emerged as a method for effectively dealing with employees whose alcohol, drug and mental health problems are eroding job performance. And EAP is a combination of assessment and referral services designed to restore the employees to full productivity. They are viewed as particularly effective in combating job deterioration due to alcohol and drugs.

In fact, the highest rates of recovery from chemical dependency problems occur in EAP's, not in hospitals or other treatment facilities. The reason for this is that it lies in their philosophy. The average drug and alcohol abuser will give up their family 5 years before they will give up the job.

Job performance is the pivot of employee assistance programming. The workplace constitutes a unique setting, in that there is a contractual relationship between the employer and the employee, which allows the employer to intervene if work production deteriorates. Such deterioration must, of course, be carefully documented by supervisors or managers, and meet the standards that are established in agreements between employers and employees. These programs are growing throughout the country.

Today over 60 percent of Fortune 500 companies have programs. General Motors reports a return of $5 for every dollar invested in its program. They have had over 10,000 employees go through its program. The average employee of General Motors is supposed to work 240 days a year. The average troubled employee, drug and alcohol addicted, before going in for treatment, worked 140 days a year.

Northrop Corp. reports a saving of $19,800 a year on each employee that has gone through the program. Kelsey, Hayes, Du Pont, and Exxon, it goes on and on. But what about blacks? What about blacks and addiction, the purpose of why we are here today? There is an increasing recognition that the Nation's substance abuse problems affects every section of our society. The black community represents the largest ethnic minority in this country, and substances abuse are one of the most significant social and mental health problems in this community.

The violent consequences of these uses have been extreme for black Americans, particularly black males, in terms of homicides, accidents, criminal assaults, and other conflicts with the law. Despite this apparent need, there has been little recent activity in the research area regarding the ideology, social, and cultural factors in

substances abuse which are of particular concern to black Americans.

An analysis of all of the reviewed literature on black alcoholism for a 30-year period from 1939 to 1969 done by Harper and Dawkins revealed that only 77 of 16,000 studies dealt with blacks. Of the 77 studies, 66 compared blacks with whites. Only 11 examined blacks only. Virtually no longitudinal studies exist that measure the long-term effects of service provided to participants in treatment programs.

In order to prepare for this testimony, my staff and I did a thorough search of the literature. We conducted two computer searches and we consulted black professionals in the EAP field. Finally, we interviewed four black occupational social work students at the University of Maryland, where I teach the occupational specialization.

Having searched through the available data at NIAAA and at NIDA, only one article was found which dealt specifically with the economics of drug abuse on the black community, and I am sorry to say that was published in 1968.

Employee assistance programs have been highly successful in reaching substance abusers in the workplace early in the development of their addiction. However, black clients referred by EAP's seem to be underrepresented.

In the Employee Counseling Program at the Department of Health and Human Services, we could not collect the data according to race. Our general impression is that our services are underutilized by blacks, but there needs to be hard, fast data to support our impressions. As a result, at HHS we did, however—and I think this provides a real opportunity for blacks—develop an evening and weekend treatment program for alcoholism in the workplace.

What we did is we brought and contracted for a treatment provider to come right in in the evenings, and every evening for 6 months someone would go through the program. The status of EAP outreach to blacks parallels my experience with women, when I served on the board of directors of the Association of Labor-Management Administrators and Consultants on Alcoholism, called ALMACA; the EAP professional organization, where there were 34 white males and myself. The board members became concerned that women were not being reached by their employee counseling programs. Through my experience in consulting with the New England Telephone Co., in an effort to make their EAP's more responsive, all we had to do was hire women counselors. Black EAP administrators and black counselors are needed in the area of employee assistance programs.

As I teach this subject in the masters and doctoral program at Maryland, I have just begun to draw some black students into the field. I previously graduated 65 MSW's from Boston College and 10 from Maryland. Of these 75, only 2 were black. I am aware of only 1 black EAP administrator, and less than 12 black counselors nationally in the entire EAP field.

Because the majority of EAP's have been and continue to be administered by middle-income white males, these programs tend to be developed from that perspective with a similarly situated clientele.

Having been a member of ALMACA for 10 years, I have seen very few black persons serving on policymaking committees for EAP's, or even in attendance at meetings. In our interviewing process with black EAP workers, we talked with Gracey Johnson, one of my students, who happens to be in the audience, a social work intern with the Baltimore City EAP. Miss Johnson described the drug problem among city employees as horrendous. She asserts that the media gives the impression that hard drugs, that is, heroin, are on the decline in terms of usage.

However, 80 percent of the drug users that her agency saw in her EAP were heroin addicts, most of whom were lower-level employees. She discussed the workplace as a connection point for drug dealers and users. Miss Johnson maintains that users and dealers will take low-paying jobs in order to have a legitimate cover, in order to deal with drugs.

Dr. Muriel Gray, an EAP coordinator for United Air Lines at National Airport, asserts that blacks are generally referred to the EAP's in later stages of addiction. She believes this is due in part to ignorance concerning drug-related behavior. However, it is also attributable in a greater part to the difference in expectation on the black employee. Dr. Daniel Lanier, associate director of General Motors, suggests there are treatment issues specific to blacks which must be given attention.

In closing, I have six specific recommendations, Mr. Chairman, for you and for the caucus, that I hope consideration could be given to. From my experience, I think the following might be of some value as far as remedying the situation.

First, the Congressional Black Caucus should sponsor a national conference for black employers and other employers who employ largely black populations. The goal of the conference would be to educate them to the advantages of having an EAP available to employees. At the conference major emphasis should be given to consortium building, and a consortium is where you bring small companies together that do not have enough employees to warrant a full-time staffperson themselves, and they can incorporate and thereby you can furnish them with services that are needed.

Second, I recommend that a major evening and weekend treatment program following the HHS model that we developed be developed and implemented, in order to meet the needs of the blue-collar employees whose health insurance coverage will not absorb the cost of treatment.

Third, the caucus should support legislation making it mandatory that the Federal employee's health insurance plan provide inpatient alcohol and drug treatment. It is ironic for me to have been involved in the Federal program with an employee assistance, and then not be able to involve or refer Federal employees for treatment because Blue Cross does not cover either alcohol or drug inpatient treatment for Federal employees.

Fourth, EAP administrators and counselors need to be trained to develop EAP's that will be responsive to the needs of black employees. Counselors need to be sensitized to the cultural nuances of the black community such that cultural differences do not prohibit counseling and treatment. Having taught racism at the University of Maryland, a required course for our social work students, I have

observed unconscious socially conditioned racism operating in my students. I recommend that the Black Caucus encourage each ALMACA chapter to sponsor such a daylong workshop on racism.

Fifth, I recommend that the public and private sectors collect data along racial lines. If we collect by sex and age, we should also collect such data by race. This data would serve as an indicator of the success or failures of EAP's to serve the black population effectively. This data would also alert administrators when blacks are being fed up or might be used in a disproportionate number or referred in disproportionate numbers in programs.

Sixth, the caucus should encourage affirmative action plans be developed and executed for EAP's in the public and the private sector. These plans should outline systematic methods of including minorities and women in the EAP hierarchy from policymaker to counselor. These plans should be monitored and enforced by ALMACA.

Last, sources of funding should be cultivated to provide training grants for black students. I attempted to receive such funds by applying for a grant to train black students in EAP's from the National Institute of Mental Health. We were not successful in getting this, but to my knowledge no grant has ever been awarded by any of the institutes specifically to train black students in the EAP area. What I find is that my black social work students are turning to other areas of specialization where they can get stipends while studying.

In conclusion, I would say that the need is great. Drugs are indeed a significant problem in the black community. Drugs are costing industry great economic losses, but more importantly, they are costing the black community lives.

Mr. RANGEL. Thank you, Doctor, for a very forceful and thoughtful presentation, and I assure you that your recommendations will be taken to the Congressional Black Caucus.

From the District of Columbia, the Administrator of the Alcohol and Drug Abuse Services Administration, Dr. Lonnie Mitchell. Thank you so much, Doctor, for being with us today.

STATEMENT OF LONNIE MITCHELL

Dr. MITCHELL. Thank you, Congressman Rangel. Good morning, ladies and gentlemen. My name is Dr. Lonnie Mitchell and I am the Administrator of the Alcohol and Drug Abuse Services Administration, Commissioner of Public Health in the Department of Human Services of the District of Columbia. It is my great pleasure to be with you this morning to discuss the serious, indeed compelling question of the economic effects of drug abuse in this country, and with particular respect to the black community.

The problem is vast, yet amorphous. How big the problem is depends on where you get your statistics and what you do with them. Last week Senator Paula Hawkins released statistics that indicate that the costs to society last year in lost taxes and productivity alone amounted to $46.9 billion. Everyone knows that the economic effects of drug abuse must be considerable indeed, but few can agree on how to measure it, much less on the choice of reliable

data, to fill out the picture once the methodology has been decided on.

Indeed, experts coming out of different fields differ strongly on whether to define drug abuse in terms of health and illness or in criminal justice terms. Economists and doctors tend to define drug abuse in terms of human health and illness, while police, criminologists, and the proverbial man in the street tend to define it in terms of criminal justice violations.

If you are guessing that the experts also disagree on what should be included in making assessments of the costs of drug abuse, you would be exactly right. Let me give you a few examples of the disagreement among the experts.

You may know of someone who has spent time and many thousands of dollars in a psychiatric hospital, specializing in drug abuse treatment. All the experts would agree that the insurance costs and the family medical bills resulting from this treatment should be included in national estimates of the economic effects of drug abuse.

Or you may know someone else who was injured in an automobile accident caused by a driver high on drugs. Surely the lost income is an indirect economic cost of drug abuse, and experts would agree with you, but information on this kind of ancillary cost is sufficiently sketchy on a nationwide basis to cause these kinds of costs to be excluded from national data.

Finally, you probably know someone whose house has been robbed of valuables, like TV's and stereos. Many times the thief is a drug addict who then sells the valuables to get money to buy more drugs. The considerable replacement cost of these items, multiplied nationwide, to say nothing of increased household insurance costs, is not included at all in the economists' tabulation of the monetary costs to society of this particular problem.

Why don't they include these costs? Because economists consider that the the original goods, the TV's and the stereos that were stolen, haven't really disappeared or been consumed—they have just been transferred to new ownership.

Of course, the criminologists disagree. They want to have replacement costs, insurance costs and indeed social costs, like the fear of crime, the fear of danger, invasion of privacy, and so on, included in the national tabulations. They say that some of these costs are quantifiable, can be estimated and should be legitimately counted as economic costs of drug abuse.

This morning we shall take a look at both ways of approaching this subject, throwing in a few extra criteria that could well be added on, and then make up your own minds or our own minds as to what should be included. In any case, we will react with horror, if not with despair, to the magnitude of the problem however we define it.

These data that I will present to you do not specify specifically black economic problems. As you heard Dr. Masi indicate a while ago, there are no studies that particularly set aside information on this area, and as you heard Dr. Pollin earlier, if we just consider the demographic trends with regard to blacks and Hispanics over the next few years, I think the answer is clear.

The health oriented economists first consider core costs when they talk about the economic costs of drug abuse, and of course core costs involve the Nation's health care system as it relates to drug abuse, hospitals, inpatient and outpatient facilities devoted to drug abuse treatment, rehabilitation and services from doctors and other sources. They also include losses in productivity resulting from the poor health and early deaths of drug abusers.

In 1980, treatment and support costs for those known drug abusers who came in contact with drug treatment programs came to $1.5 billion. Of course, many substance abusers don't come in contact with treatment programs at all, so this figure substantially, as long ago as 1980, underestimates the potential expenditures if all users were to seek treatment. The indirect costs, including mortality, reduced productivity and lost employment, amounted to $28 billion in 1980, and you might note that premature mortality results from drug overdoses, as you heard earlier, liver disease, suicide, homicide, motor vehicle crashes, and the like. Accidental overdose alone accounted for $2 billion in loss to the economy in that particular year.

Economists consider the category of other related costs in totaling up the loss to the country brought about by drug abuse, and we have already noted that there aren't enough good statistics available to show what the property costs of motor vehicle accidents involving drugs might be, although we know it is surely high.

Police accidents across the country do not always have the necessary equipment to be able to pinpoint alcohol as the cause of accidents, and they certainly have less equipment available to measure drug usage. Nevertheless, scientific studies have shown clearly that the use of drugs impairs drivers' alertness, reaction time, skillfulness, and ability to draw swift and logical inferences. Drugs certainly cause and abet accidents, and therefore cause considerable economic loss to the country, even if the extent of this loss cannot be estimated at this time.

Other economic costs directly and indirectly related to crime have been estimated for the year, again, as late as 1980 and amounting to $17.5 billion, and of this, $5.9 billion resulted directly from public and private criminal justice expenses toward system and lawyer costs primarily, and $111 million directly from property loss or damage, and in crime careers, such as drug trafficking, property crime, and various victimless offenses motivated by drug addiction were estimated to cost society $8.7 billion.

Because addicts pursue, and often do pursue, socially nonproductive careers, the cost of jailing addicts for drug related crimes amounted to nearly $1.6 billion, and is rapidly rising, and, of course, the lost employment of crime victims resulting from nondrug related attacks came to $845 million in 1982. The true costs probably were much greater as much crime goes unreported.

On the question of the crime costs of drug abuse, there are some statistics available that cover the loss of property, and, of course, we all know that many robberies, burglaries, are never reported to the police, and therefore never enter into national crime statistics.

A national crime survey has gathered information on personal victimization by property crimes. The most frequent type of crime was personal larceny, with 2.6 million reported drug-related cases.

The average value of property and cash stolen was $110 million, with a total value of $302 million. There were 1.5 million drug-related burglaries that same year, with an average loss of $490 million and a property cost of $715 million.

Drug-related household larcenies took place 1.8 million times during that same year, with the total cost of $212 million, and, of course, there were 239,000 drug-related car thefts, with an average loss of $938 per week, and a total loss of $225 million.

The statistics go on, but altogether these are serious economic consequences and altogether the total value of drug-related thefts from all types of personal offenses was $1.5 billion, and, of course, the cost of crime prevention, such as alarm systems, guards, and so on, has been again estimated by Senator Paula Hawkins at $1.3 billion.

Governmental resources dedicated to the detection and eradication of drugs and drug trafficking have increased dramatically in the past several years. This is one of the few areas of the Government aside from the military which has expanded rather than decreased since the onset of the Reagan administration. According to the Tuesday edition of the Washington Times of Washington, DC, your taxpayer dollars dedicated to drug enforcement by the Justice, Treasury, State, and Agriculture Departments, plus the Coast Guard, have climbed from $719 million in 1981 to $1.2 billion in 1984.

The Washington Times estimates that Federal and local police will spend an estimated $3.8 billion by the end of this year, which is just 2 days away, chasing drug dealers and users, and for the first time in its history, the FBI has begun working on drug cases devoting, as you heard earlier, 1,100 agents in this area. There are many economic costs to society brought about by drug usage which may never be known.

How many children drop out of school or college as a result of drug usage? We know that nationally one quarter or 25 percent of all high school students drop out of school before they graduate. A significant percentage of these drop out because of drug problems being the precipitating factor, and what kind of economic loss does that cause given that a young man or young woman who does not complete high school earns $260,000 less over his or her lifetime than one who does graduate, and that a young man or woman who drops out of college earns $233,000 less over a lifetime than one who finishes college.

What about the effects on lifetime earnings of those children who have not dropped out of school, but who would have shown much more potential than they now have were it not for the depressing effects on their grades due to the drugs they are taking.

We have reliable national figures on the numbers of high school kids who have experimented with or are currently using drugs. You heard that from Dr. Pollin earlier, so I won't go through that piece here.

The value of illegal drugs consumed in the United States is so large that it is a major factor in the national economy. The respected National Narcotics Intelligence Consumers Committee, NNICC, estimates that consumer expenditures for cocaine as long ago as 1979 was $21.7 billion; for marijuana, $18.7 billion; and for heroin,

$21.7 billion; and for other drugs, $16 billion. And when you look at the street value and add that up, you have a grand total, an incredible grand total of $64.9 billion on 1 year alone.

Today the economic impact of these drug sales is even higher, because consumption has gone up. The volume of heroin estimated to be consumed in the United States in 1983 has gone up from somewhere between 3.4 to 4 tons, to 4.1 ton. The New York City wholesale price for a kilogram of heroin ranged from between $165,000 to $200,000. The volume of marijuana has increased from somewhere between 10,000 and 13,000 metric tons to between 13 and 14 tons, and the wholesale price for 1 pound of domestic sinsemilla is and does range anywhere between $1,000 and $3,000.

The volume of cocaine consumed here has doubled, while the wholesale price of cocaine has declined; the retail price has not been greatly affected, and given a retail gram cost of between $75 and $100, the economic costs of this drug are considerable and growing rapidly.

According to a recent New York Times article:

> The problem with cocaine is so serious that a wide range of Federal officials are saying that it has become the most serious drug problem this Nation has ever faced. More than 20 million people in the United States are now estimated to have tried the drug. Five thousand people use it for the first time every day and at least 1 million people are addicted.

Another way of looking at the amount of money that is involved in illegal drug sales is to consider bank deposits in Miami and Jacksonville, FL, the main collection points for heroin and cocaine sales coming into the United States. During 1983, the Miami and Jacksonville branches of the Federal Reserve Bank of Atlanta reported the largest yearly surpluses of U.S. currency in the Nation, $4.4 and $1.3 billion, respectively.

These surpluses are 550 percent and 91 percent higher, respectively, than the next highest surplus of $678 million reported by the Philadelphia Federal Reserve Bank, which receives moneys generated by legal gambling activity at Atlantic City, NJ. A major part of these unusual surpluses can certainly be attributed to the drug trafficking activities.

Much of this multibillion-dollar illegal profit leaves the country for laundering or for distribution to foreign dealers, according to the National Narcotics Intelligence Consumers Committee, and the Drug Enforcement Adminstration. Intelligence gathered in 1983 indicates that a significant portion of the profits exits the United States headed for foreign banking havens, some of it coming back for reinvestment in the safe investment climate of the United States, and, of course, some drug money never leaves the United States.

Drug moneys are commonly disguised as loans, profits from successful businesses, stock or real estate transactions, and salaries paid by foreign corporations and banks.

For the drug trafficker, it is important that both the repatriated moneys and those moneys which remain in the United States appear to have been earned legitimately. The IRS takes a lively interest in this vast underground economy, and is expanding its use of legislation in this area to nail traffickers.

It is evident, then, that the economic costs to this country of drug abuse are enormous. So where do we go from here, and what can we do about it?

As a professional in the field, I see the miseries every day caused by drug abuse. As a black professional, I particularly deplore the loss of productive life among our young men and women, and I am deeply afraid for the well-being of our children who are constantly being urged to turn on and tune out.

Drug messages are rampant in the music our children listen to and the TV shows they watch. There are almost no children who will have gone through high school without being offered the opportunity to use drugs, and only a relative few who turn down the offer every time it is offered.

The PCP crisis, for example, in Washington, DC, has reached truly epidemic proportions. Our system here and the St. Elizabeths Hospital emergency room are stretched to the breaking point dealing with PCP abuses and violent psychotic states. The number of PCP-related arrests going to trial has jumped sixfold in the last 4 years here in Washington, DC.

Can we afford not to get involved? I say to you that if you want to face your family in the morning secure in the knowledge that your children are not experimenting with drugs, you had better get to work individually and collectively to insure that your family, your schools, your neighborhoods, your State, and your country are not going to succumb to this tidal wave of human misery and degradation. You are going to have to initiate the work yourself, no matter how much help law enforcement officials and health officials can offer. In the last analysis, you will have to supply the effort, the energy, the dedication, and the vision to prevent a holocaust of drugs from destroying your and our future.

The figures I have presented here today indicate that the costs to society are enormous, and so are the profits to the drug suppliers. The costs affect everyone, you and me and every taxpayer in the country, while the profits aid only the traffickers and those who supply these luxuries. Make no mistake—I think there are entrenched and powerful economic interests at stake that will fight you every step of the way, and not necessarily by the World Boxing Association rules.

Can you afford any longer to be removed from entering the fray? Can you affront and afford any longer to let someone else bear the burden or the fight because it has nothing to do with you? Given what is at stake, I think not, and never before have we needed as much to help break the tyranny of drug abusers over our young people and over our economy and over ourselves than ever before, and it is my advice to let us all begin now. Thank you.

Mr. RANGEL. Thank you, Doctor.

My dear friend and councilwoman from the District of Columbia, indeed a national figure in her own right, Charlene Drew Jarvis.

STATEMENT OF CHARLENE DREW JARVIS

Mrs. JARVIS. Thank you, Congressman. I have been asked to participate in this discussion here this morning, but more importantly, the opportunity to learn from some of the experts in their own

fields about the problems of drugs and drug abuse in the country and how we can address it. Before I became a member of the city council, I did basic research on the brain at the National Institute of Mental Health in Bethesda, and as I was leaving to enter the field of politics there was a whole new field being discussed, which was in the area of the indigenous opiates.

There are areas in the brain apparently that produce opiates themselves, and if we can begin to understand that, we can begin to understand something about the problems of addiction and the reasons for addiction, and that is why continued funding, as Joe Califano was mentioning, is so critical, if we are to begin to understand something about the physiological mechanisms of addiction.

Without the addiction, perhaps we could reduce, not eliminate, because it is the salutory effects of the drugs that are attracting people to their use, but we could at least reduce the need for the dependency that occurs.

Now, I chair the Committee on Housing and Economic Development for the District of Columbia City Council, and so it is economics of the city that I am looking at most closely. I am concerned with the flow of dollars into the District's economy. The sale of drugs is an untaxed large source of cash that does not flow into our economy at all. It is in fact a very separate economy which we have no way of capturing, but unfortunately the effects of the use of drugs do fall into our economy, and we who are public policymakers, and who have to control the expenditure of dollars for the cities, feel the pinch tremendously, the least, of course, being the pinch in terms of the life of the user of drugs.

We must then look at the cost to our prisons and our prison system, and know that it costs almost $20,000 a year for incarceration in prison, and that probably 70 to 75 percent of those who are incarcerated have a history of drug use, or have a history of being sellers of drugs. That is an enormous figure. It shows you the problem that exist here in the District of Columbia, where we have a related unemployment rate of 50 percent among black teenagers, and an unemployment rate generally of 12.2 percent, which is higher than probably in many other jurisdictions.

Drug use is associated with unemployment, and it is particularly associated with those who are chronically unemployed, and frankly unemployable, and we begin to get more and more in the District of Columbia of those who can be characterized as unemployable as they are unemployed for longer periods of time, so the cost to our prison system is enormous, and it is pushing us to build more prisons rather than to spend the dollars in ways that would be more productive in decreasing actual drug use.

When we combine that with legislation—which I have opposed but which is now law—that requires mandatory penalties for some types of drug activities, then there is going to be even more of an impact on our prison system, and even higher costs of incarcerating those who are drug users and drug sellers.

The impact on our hospital system is also enormous. If we just look at the numbers of people who are going now to St. Elizabeths Hospital as the result of the epidemic, the true epidemic in the use of PCP, we see that 35 to 45 percent of people admitted to St. Eliza-

beths Hospital on an emergency basis have been diagnosed recently as having PCP in their systems.

The PCP problem creates an enormous problem, because the PCP user has an extraordinarily high threshold of pain. The normal police procedures that are used to control the behavior of violent persons are not effective with PCP users because they don't have the sensation of pain. The usual police techniques that are used to subdue those who are violent are not working, and so the whole law enforcement system has to crank up and look at the control of those who are PCP users in an entirely different way, and has got to train its police force in an entirely different way with respect to control.

The choke-hold procedure, for example, which is usually very successful in subduing violent people who are being detained by the police is not effective, because the PCP user does not feel the pain of the choke hold, and as a result there are a number of deaths that result from that, and police truly do not know how to approach the PCP-violent person. It takes four or five very strong and very big men to subdue the PCP user, so for us in the District it has become an extraordinary problem.

When you combine the cost of treating drug abusers with the tendency of urban jurisdictions to try themselves to get out of the delivery of health care because it has become such an enormous cost, you see that at one and the same time the drug use is increasing, that governments are trying to make the problem of help a really private sector problem. It is very much a Reagan administration Republican notion, but it is beginning to find itself in urban environments, which are predominantly democratic kinds of enviroments.

When I first became a member of the city council only 4 or 5 years ago now, one of the things that I fought most strenuously was the closing of one of our major health facilities in the District of Columbia. If the Government is not going to accept its responsibility to absorb the costs of health care at a time when minority populations are being impacted more and more, then we will have even a more serious problem than we ever imagined, as it takes life and health of our young people in our city.

We are now considering, and I think one of the panelists mentioned, the recommendations of mandatory coverage for drug and alcohol abuse and mental illness in insurance policies. The city council just on Tuesday had a piece of legislation which came to the dais that did just that, that would make the third-party payers, that would require third-party payers to have drug and alcohol costs as a part of a mandatory coverage, and also mental illness.

The bill went back to committee. The issues that were raised, some of them raised by people whom we would not have expected to be raised. For example, the labor unions have said to us: If you make insurance for drug and alcohol abuse and mental illness mandatory, what you do is raise enormously the costs of the health care benefits, and that leaves you, the labor unions, unable to negotiate with respect to all the other fringe benefits, and for that reason we would not like to see mandatory health insurance for drug and alcohol abuse and mental illness.

The health care coalitions came in to us and said that they were very concerned about the cost of mandatory insurance coverage, and that we ought to rethink and relook at the whole issue of that mandatory coverage, and they were more concerned about mental health care treatment than drug and alcohol abuse, without, I think, understanding that drug and alcohol abuse very often is mental illness, and it requires that kind of address of the problem.

We have not come as far as we ought to have in our thinking about the substrate for alcohol and drug abuse, and that it is in fact the problems of living that produce the necessity for that kind of relief. People are self-medicating themselves, and that is one of the basic reasons for alcohol and drug abuse, and it has to be addressed in a mental health perspective.

It will be costly indeed to do that kind of thing. It will be costly for the person who has to buy the policy, but far more costly to the individual lives and health of people and to the society, if we do not make a real attack on the problem and regard it as one of the most serious social and economic problems that we have in the District of Columbia.

Besides the prisons and hospitals, I think we have heard from Dr. Mitchell, the other kinds of costs that we incur as a result of this huge drug industry. If you just look at businesses, for example, that are suffering the result of shoplifting, we are finding that it costs probably between $200 and $300 for a family of four to essentially allow for shoplifting that occurs in businesses. They understand that that is going to be millions of dollars lost to their businesses every year as a result of the shoplifting, and we are the ones who pay for that as prices increase in the stores.

I think one of the panelists has said that the drug industry is probably the second or third major industry in the United States that has an enormous impact upon our economy, and I think that when we talk about stopping drugs from coming into the country, we have got to look at the fact that for some of those countries, the production of the drugs is a major part of their economies, and the question is whether or not they can prevent the flow of drugs, or wish to prevent the flow of drugs into this country, when it does provide the whole substrate for their entire economies, and for them I am sure drug abuse is a problem, but at least the drugs are available in a way that they are not available to us, where they are not indigenously grown.

I have some concern about whether or not we will ever be successful in working with foreign countries where the drug manufacture is a part of their basic economy. We do have the leverage to stop it, when we give dollars, but we seem not to be effective in doing that.

The cost to maintain the drug habit in the District is anywhere from $25 a day to some several hundreds of dollars a day, and you have to do a lot of burglarizing and stealing in order to accommodate a habit like that.

What we are seeing in the District is there are sophisticated rings that have become an outgrowth of this whole drug industry, and there are areas of the city that are targeted.

They are hit in a large number of ways and the gang moves on to another area, and they move from one area of the city, trying to stop the thefts clearly associated with drug abuse.

As a council member and somebody who is always concerned about the kind of constituent complaints that we get from those who live in our communities, we see the effects of the drug usage from people who call to complain about drug users in their neighborhoods, who sell and buy in their neighborhoods, and what the police do, because they cannot stop the flow into their section, they move the drug users from one corner to another.

There has been no effective way of stopping the importation or the use of drugs that can be manufactured by simply going to the store in some cases, with the more modern uses, and buying the drugs.

So what the police do is simply monitor the use. We move the drugs two blocks over and they move back again, and for law enforcement officials, it is simply a circle of chasing the drug user and the drug pusher, and we never solve the problem.

The problem must be solved at a very national level, and I am glad to listen to the law enforcement people, but clearly, I understand now why it is not working.

The effort is simply not large enough. The effort, and I will bring this back again, because I feel very strongly that it has a great deal to do with racism, that if the white community and the young white community was affected to the extent that the black community is affected, there would be a much greater drive to eliminate the problem than there is.

As soon as problems become problems of white American families, the Government pays much more attention to them, and considers them to be of a much higher priority.

That there is now declining drug use among the white middle class will also mean that there will be a declining attention to the problem.

The problem which exists in the black community, it is an expectation of many, that that is a kind of social disorder that will always exist in the black community, so the efforts will be reduced, because it is considered to be a part of a culture that already has endemic to it this kind of social problem that drug use produces.

As a local official, I would welcome a greater presence of the National Government in stopping the flow of drug trafficking, and a greater effort to make sure that the kind of treatment facilities that are necessary are a part of the agendas of the National Government.

Mr. RANGEL. Thank you, Councilwoman, and it makes us feel a lot more comfortable in the Congress knowing of your strong partnership in the city council in the District.

We are privileged to have the director of psychiatry, Dr. James Collins.

STATEMENT OF DR. JAMES COLLINS

Dr. COLLINS. Thank you, Mr. Chairman, and fellow panel members, batting cleanup it is kind of difficult to not repeat much of

what you have already heard, so I am going to try to vary my formal remarks, which I will submit as a part of the record.

First, I would like to say that we in the black community are accustomed to being catered to, and solicited around election time, and our votes certainly are important for the politics of this country, but quite often, we overlook the fact that so are our dollars, that as the largest minority in this country, approximately 20 million, and of course, all of us don't get counted, we do, or we are, in fact, a significant economic bloc.

We constitute as many people as in the entire country of Canada. You also heard earlier today that several people have grown up during the drug age, Timothy Leary is ancient history to some of you, there are drug-using lawyers, doctors, business majors, drug-using Congress people very much involved in economic have, in my opinion, have targeted our community because of its economic resources.

We heard somewhere between $100 and $200 billion a year go into the underground economy of our country, and we are talking about cash.

Dr. Dougherty told you how much $20 worth of cocaine can bring on the streets, but we are talking about $100 to $200 billion annually in cash, no checks, no receipts, no nothing.

This is the underground economy. Dr. Mitchell has mentioned that the drug dealers, and perhaps even the drug users, benefit somewhat from this economy, but I would submit to you that all of us perhaps benefit more than we think, and this is why it is very difficult to eliminate this problem.

As a professional, and as a person who treats substance abusers, certainly one could say that I profit from this disease. Many of you represent organizations and entities that send you here to talk about this at one conference after another, and perhaps you also profit in some way, but aside from that, think about the rest of the $200 billion economy.

It was mentioned earlier that the largest drug producers of cocaine, certain types of marijuana, and hash, and heroin, come from abroad. He touched on Colombia, and he mentioned one minister was killed recently in trying to eliminate the drug problem.

And he also touched on Bolivia, which is a high producer of cocaine, in fact, 100,000 people are employed in the country of Bolivia. One-third of the economies of both of these countries are dependent upon drug use.

We are talking about an agribusiness, perhaps the most profitable cash crops that we know of.

Much of the money goes abroad and comes back, as was said, in terms of laundered money in offshore banks, in terms of buying our products. In a drug user in the ghetto, common junkie, he may buy a Cadillac. He is going to have to pay taxes on that Cadillac, so some of the money does come back to the economy, along with the sale for the Cadillac dealer, but talk about a big-time user, a user that needs a fleet of new boats to introduce his products into this country.

If you can imagine the kinds of moneys that turn around and support not just the user, the junkie, or the dealer, but come back to our larger economy. The underground economy is a cash econo-

my that does in many ways prop up the rest of our entire economy, that the people in Bolivia, from public releases said:

> We will not submit to growing coffee instead of cocaine, Mr. Secretary, because cocaine is too profitable, and if you desire not to do that, we will simply cut back on our sale of tin to you.

Of course, Bolivia also produces quite a bit of tin which is needed in our country and the rest of the world. We have not been able to convince that they should shift from cocaine, the coca leaf, to coffee.

This impacts the black community. Most of us can't deal with million dollar figures because we have never seen that much money. One of my colleagues gave me the recent figures on the weekly cost of some commonly used drugs in the District of Columbia: PCP averaged $10 to $15 per bag, and you can make three to five joints per bag, and most people who use average doses spend about $45 per day.

Heroin, about $30 per bag, $120 per day, average users, people not necessarily getting into big trouble. Cocaine is a lot more expensive, the average daily cost would be $300 to $400 per day.

Marijuana, $5 a bag, you get about five joints per bag, that is a bargain, and as mentioned earlier, we have our own variety of marijuana, in the State of California now, and in New York.

Preludin, diet pill, $15 per tablet, another part of the underground economy. These drugs are purchased and manufactured, some in this country. There are taxes paid on them, and they do employ people, but when they go out to the street, the turnaround value then begins to increase, and it depends on how much you want to pay.

Dilaudid, $30 and $35 per tablet, so in dollars, we are losing a tremendous amount of money to the offshore interest, but some of this money comes back into our own country, and many of us profit directly and indirectly from this underground economy.

Some of you are familiar with the co-op type purchases for groceries and other consumer products, but throughout the country, there is now being adopted in the drug industry co-op purchases, groups of users may in fact purchase a larger amount of marijuana or cocaine to reduce the unit cost.

Why shouldn't it be used in the drug community? It is particularly prevalent in high schools and colleges for students purchasing large quantities of marijuana and other social drugs.

The drug industry is flourishing in our country, and nothing short of a major national effort will contain its growth and continued destruction of our society.

Thank you, Mr. Chairman.

Mr. RANGEL. Thank you, Doctor.

Before we open this up to questions, I want to thank the staff of the committee, Jack Cusack, our chief of staff, and Dick Lowe, our chief counsel, who pulled all of this together and contacted new witnesses and Ed Jurith, who is still with us here, and of course, our old faithful, Lou Williams, for the work that they have done.

Now, it is the time for you. You have been patient with us.

We have had an outstanding array of panelists that brought this expertise to you, and they have agreed to try to answer questions that you may have.

Do I see any New York City staff out there? I see my city councilman there.

Mr. LOGAN. My name is Fred Logan. My comment is addressed to you. My name is Fred Logan, and I am from Pittsburgh and represent a community-based organization, and our work is not from the professional end, even though there are professionals in the coalition, we are trying to organize and politicize the community around the problem of drugs.

Specifically, several members of the coalition who are—they asked me to ask you this question, and that request is that they feel that there is a dire need at this time for a national conference on this whole issue of specifically drug abuse in the black community.

And there are several suggestions, and what they are talking about, in general, the mass mobilization, educational-political aspect, and how the black community could go about doing that, because we feel this thing about national pressure will have to come from the people themselves, and the other is this whole professional aspect and treatment in, and what they had offered was perhaps in the summer of 1985, in the city of Pittsburgh, PA, the fact that this conference could be held.

And we were just hoping, if we would address a letter to your office, since you are now identified nationally around this issue of drugs, and the black community in particular, that you could help us in terms of pulling this conference together, in terms of people who we could contact nationally to involve themselves in the planning of this conference?

Mr. RANGEL. It certainly is worth an effort. It is a very difficult job, and of course, if it is not done properly, and with the proper staff work, it can fall flat on its face.

Mobilizing people to get involved in this issue is difficult because so many people disassociate themselves with those that are afflicted, and of course, since the answer to the problems rely on international intervention as well as Federal funds you are talking about a political mobilization as well.

I have responded to groups that have tried to mobilize interested groups in their communities, rather than providing the leadership in bringing everyone together at one place.

I do a lot of that in law enforcement. I do a lot of that on the national level with those that are providing treatment. I have not done any of it in bringing together the black community, and I would welcome the ideas that your group would have to see one, whether I think it is feasible; two, to be able to ask some questions so we can at least establish a dialog.

It does sound like an exciting idea. It does sound like it is really going to take some organizations that have the expertise in putting those types of things together.

Mr. LOGAN. We were not asking for your leadership, but your logistical help in helping us identify people nationally.

Mr. RANGEL. That is no problem at all. What timeframe are you talking about?

Mr. LOGAN. It was just said generally the summer of 1985. None of this stuff is down.

Mr. RANGEL. I welcome the opportunity to work with you.

Mr. LOGAN. Might I have your office number?

Mr. RANGEL. 225-4365, area code 202. You can address your mail just to me, U.S. Capitol, Washington, DC, the ZIP here is 20515.

Mr. LOGAN. Thank you very much.

Mr. RANGEL. Councilman Archie Spignor.

Mr. SPIGNOR. Thank you very much, Congressman.

Let me make plain that I am not an advocate of any particular point that I may raise in my question. Sitting and listening to the panelists, I must tell you that I probably was as disturbed and depressed as anyone here at the overwhelming magnitude of the problem.

I didn't hear any of the panelists express any view toward the possibility of legalizing and controlling. It seemed to me, from Mr. Taylor and others, that we are overwhelmed by our inability to control the international foreign countries, and we can't even control it on a national basis, and the last speaker, Mrs. Jarvis, she talked about the inability to control it on a street corner basis.

We learned we couldn't control alcohol consumption, manufacture, and do any of the members of the panel have any thought on legalizing, and thereby, education and regulations try to control the problem with the resources that would be freed up from all the other aspects?

Mr. RANGEL. Before the panel responds, maybe you could refine your question as to legalization. Through prescription?

Mr. SPIGNOR. I want to leave it as vague as it is.

Mr. RANGEL. Are you restricting it to adults?

Mr. SPIGNOR. I would look at it in the same way.

Mr. RANGEL. Go ahead.

Mr. SPIGNOR. We know cigarettes and alcohol are certainly addictive and abusive, and if we would be healthy and productive, we would not indulge ourselves, but yet we subsidize the growth of tobacco and profit in a great way from taxes on alcohol consumption and sale.

And I know if I drink, I can't function. I try to teach my children and grandchildren not to use alcohol. I learned that smoking was bad for me, and I stopped smoking. I never was addicted to drugs for a lot of reasons.

Wondering that these other elements, alcohol and tobacco are bad, but they are legal, and we try to control them, some discussion might be given to cocaine and the others.

Dr. DOUGHERTY. The problem with heroin and cocaine is not addiction. It simply means if you stop a drug, you have withdrawal. The problems we see with those drugs is tolerance, that the more you take, the more the brain says you must take more and more and more and more.

One out of ten people who abuse cocaine know if you put a pile of cocaine the entire length of this dais, stacked to the ceiling, they would not stop until it was all gone, and that is what any of us know who work with addiction.

You give a person a continuous supply, they will continue to use it until they are dead. I asked one of my colleagues from London, I

said, what happens if this fellow comes in and takes 25 milligrams of heroin today and I dispense it to him, 60 milligrams, 6 months, a year from now, if he needs 200 milligrams of heroin and you dispense it, his response is he dies, and that is exactly what would happen.

Heroin maintenance in London was a failure. They now have a heroin epidemic over there that they thought they would never get because they thought it was a peculiar art of the United States.

You cannot maintain people on a drug to which they develop a tolerance, that 1 year from now, they will need 5 to 10 times what they are taking now.

Dr. COLLINS. Mr. Chairman, it is a complex issue. We heard Dr. Pollin mention earlier that it was felt in the era of prohibition, if we legalized it, things would go better, and it wouldn't necessarily lead to the problem it is today.

By the year 2000, that might be our No. 1 medical problem. I agree with Dr. Dougherty, in addition to the fact that we still have a big profit business in the use of legally prescribed drugs to people who shouldn't have them, people like children, so if we legalized cocaine or marijuana, there would still be a sale in that business to children or other people who would not ordinarily have access to it, so legalization in itself probably would not contain the problem, based upon what we know about alcohol and cigarettes.

And I also agree that education will probably not make a difference. We like to say in our community that because of deprivation, we tend to use drugs more.

On the other hand, looking at the animals, primates and monkeys that live pretty well as things, when given the opportunity to take the drugs, will take them in preference to food, to sex, to anything else.

So perhaps it is not just the deprivation that is a factor. I submit that it is the marketing question, but I don't think legalization would solve it. If we do, more people would become than they are right now.

Mr. RANGEL. Dr. Pollin, Director of the National Institute on Drug Abuse, he testified this morning, and he gave data which I have not studied, but I questioned him on it. I will share this with you, and he indicated that given the number of people who use alcohol, because it is legal and given the number of people who smoke, because it is legal, that there would be a 90-percent increase in the people that use cocaine is that were legalized, and that figure would come between the number of people who smoked and the number of people who use alcohol, and he attributed just the legal system for the reason that 90 percent were deterred from using cocaine.

I don't know what it is worth, but I will share it with you, and perhaps we can look into it further.

Dr. SMALLWOOD. I am Dr. Katherine Smallwood from San Francisco, CA. No. 1, to supplement what I have heard presented today, I would like to introduce a new concept. This concept is called quasi mort si, and what it does, it deals with the whole.

Now, we have talked about drug abuse, alcohol abuse, and we are concerned with this high rate of suicide among the black com-

munity. We commit more suicide, drug abuse, alcohol abuse, and self-precipitated homicide than our white counterparts.

In fact, the rate is highest among the ages of 15 to 44, which is our future. We, of course, originated this name, quasi mort si; quasi, same as; mort meaning death; and si meaning kill.

To put an emphasis on the nature of this problem. It is at crisis proportions. What we would like to propose, and I would like to ask your assistance, is the allocation of funds on the Federal level to, one, educate the population to the problem of quasi mort si; to set up a national committee to deal with this problem; to do research and to explore target QM areas, and to hire professional staff to set up quasi mort si centers in the various target areas; and, of course, basically, the first area, of course, is education and prevention.

Mr. RANGEL. Thank you, Doctor. Is this the subject matter that you covered in the paper that you left with me?

Dr. SMALLWOOD. Yes.

Mr. RANGEL. Yes, ma'am?

Ms. GRACIE JOHNSON. Gracie Johnson. While the insight provided by the panelists has been very poignant and the problems of drug abuse and its repercussions in the black community certainly are not new, what can we expect in terms of outcomes and solutions for the problems of drug abuse in the black community?

Mr. RANGEL. This administration looks upon the problem as a local problem, No. 1, they put out a report just yesterday which if you leave your name and address, I will share with you, where they believe the answer to the problem that we are facing is one of education and prevention, which wouldn't be too bad, if they thought that the Federal Government would be involved in preparing programs or the resources in order to show our youngsters how dangerous it was to abuse.

But they believe that this should be a local and State initiative with private sector people, comic books or whatever they do, to assist in this, in having the First Lady from time to time appear on situation comedies and then when it gets to our international effort.

And certainly, I am not trying to single out Jamaica, because we have many friends and constituents from Jamaica, but if we can't deal with a small island country that is so dependent on us in terms of economic exchanges in trade to deal with their crop, because of the political relationship between Jamaica and the United States, then it seems to me, as other panelists have said, that we are not even showing the heads of these foreign countries that we mean business.

Now, Councilwoman Jarvis has pointed out, as you find more white Americans being afflicted with this disease, you see changes in the attitude in terms of the Federal Government, but we do have a pretty hard-hitting community.

We have tried to give this administration an opportunity to deal diplomatically with these countries, and I am afraid we are just going to have to, in the Congress, take these countries to the max, let the chips fall where they may.

We have enacted legislation to cut off economic and military assistance, but it has not taken hold, and the great problem has been that there has been a lot of talk, and it is true, about the increases

in arrests, seizures, and they have not said there has been an increase in production, manufacturing, increases in the amounts coming into the United States.

And so, there has to be an outrage felt, and I do not sense that outrage. It bothered me that with all of the candidates that were running for President, how difficult it was to get any of the candidates to focus on this issue, any of them.

It just seems as though narcotics and the narcotic addiction is not a sophisticated thing for people to talk about, and especially not diplomats, and so, it is not a question of leaving depressed—as someone has said—we got a committee that has been exposed to the effects of the addiction.

We have a Republican, Ben Gilman from New York, who is one of the leaders in this struggle, and we also do have changes in the attitude for the first time from local officials.

They are so used to asking for guns and so used to not challenging the political system, that you would never hear a local police officer criticizing the Federal Government.

Now, they have reached the breaking point, and people are asking, what are you doing about the open sales of drugs on our streets, and now in New York, Chicago, Cleveland, and elsewhere, they are saying that the Federal Government has to step in, because we can't deal with it, and they have never been able to say that before.

They have always said what you heard before, we are doing a good job, we got a handle on it, and you should be seeing results soon.

They are not saying that anymore. It is not a good answer, but it means in the sixties, we were able to bring together all of these forces, the churches, the community forces, and the politicians and work together.

Something did happen. It was an increase in giving help and assistance to people who need it. I hope we will be moving toward that.

Ms. GRACIE JOHNSON. I have a second comment.

In terms of the Federal initiatives toward the problems of drug abuse, it is my sense that it is long overdue that we black representatives and professionals begin to address the problems of drug abuse in the black community ourselves, and begin to provide our own solutions, to not wait for someone else to trickle down some funds or whatever.

Mr. RANGEL. Maybe I have to ask Dr. Collins to respond, because in my community, people complain so much about the ill-effect of drugs, and in many cases, I know that they are the direct recipient of the profit of drug dealing and everybody on the block knows that they are, and once you arrest their son for dealing, then the person who has been raising the most hell talks about how much their son just got hooked up with the wrong company.

The hypocrisy that exists because of the high profit involved in drugs just defies understanding.

Dr. COLLINS. Our country was founded on the growth, and manufacture, and sale of tobacco. This is still an issue in the State of North Carolina for the senatorial races that are there, do we subsi-

dize the growth of this product or spend millions of dollars for treatment of emphysema and all the problems associated with that.

People who grew sugar cane in the West Indies, and that was sold as rum in this country and Europe, and slaves came back on the other route and this is an integral part of our economy.

Imagine having a $200 billion a year business, would you do everything you could to keep the legitimatization of that product, but also to create the kind of furor that we have here, so you don't have enough inspection officers, enough other things?

We have to look at that, that many people benefit from drug usage in this country. It is not simply a question of helping or treating the addict. Education is probably valueless in terms of totality.

Can we bite the bullet and say what will happen, $200 million, in our underground economy, if it were taken out, how many people would lose their jobs?

Mr. RANGEL. Doctor, talking about the black community, you see, we don't have people from Peru, or Mexico, or Thailand in our community selling the drugs. We find agents from our family selling the drugs to members of the family.

And so, the question is, and the gentleman from Philadelphia talked about it, how can we just get together and say, notwithstanding the profits that others are getting, and whatever indirect profit the community is getting has to be minimal compared to what leaves the community, how can we survive with the poison that is being distributed by ourselves to each other?

Dr. Walton.

Dr. WALTON. There are some national efforts being made right now to mobilize the black community. I think it is incumbent upon us as black people, whether professional, wherever, I mean, this is a black problem, as I mentioned earlier, drugs do not discriminate.

It is going to take all of us to become involved. I don't think that we can sit back and wait for the Feds to come in and do our work for us. We have learned a lesson or at least we should have learned a lesson from that, because at any time that carrot can be taken away.

Certainly, I think we ought to make demands, because we do have rights, and we ought to exercise those rights and demand that war be declared on drugs in the black community, but at the same time, we have to fight that battle ourselves.

If it means taking baseball bats out and running the pushers out of our neighborhood, maybe that is what that will take. They did it in Ireland. It was on a news segment, and it worked.

I think that we as black people are going to have to return to many of the basics that we have lost, and teach our children that you don't have to do this to be accepted. This is not acceptable behavior.

This is not part of a black code of ethics. There is acceptable behavior for black people and that certainly is not it.

Also a beautiful program, Oakland Parents in Action, basically started by a black woman living in her neighborhood who got tired of seeing the drug addicts run through her yard, so she has mobilized her neighborhood.

She has gotten the whole city involved, from the police chief, the superintendent of schools. I mean, everybody knows who she is, and everybody is mobilizing with her. She has made a difference.

The dream that all of us have is that, I don't think we will ever stop all the drugs coming in, although it would seem simple if you or I went into a store and pocketed a comb, we would get caught, all these tons and tons of drugs coming in, and the people never get caught.

Our dream, a whole truckload of cocaine can be put into any black neighborhood and black people walk by and not touch it.

Mr. RANGEL. Thank you for your contribution.

Dr. Masi has indicated your interest in this, and I hope you can continue to work with us, and maybe hook up with the gentleman from Philadelphia.

We see a fighting sitting councilman from the Bronx, Reverend, and I know you provide leadership in that area in South Bronx.

Ms. HILL. I am Edna Hill, fourth-year medical student at Howard. When I rotated through pediatrics, we saw numerous admissions for PCP intoxication, and on many of the occasions when these kids would be in more lucid moments, or by the time their friends would start coming into the hospital to visit them, they would tell me that, how many times they are admitted into the hospital for PCP intoxication, was a status symbol amongst their crowd, much as getting a driver's license was for me when I was in that age group.

Mrs. Jarvis addressed the PCP problem to some extent in her comments. What kind of efforts were being made to coordinate health care providers, law enforcers, educators, and legislators to deal with this issue specifically in the District of Columbia, but in other major urban centers as well?

Ms. JARVIS. I will defer to Dr. Mitchell for the specific coordination, but clearly, not enough is being done to address the problem of PCP use. It is a law enforcement and hospital admission problem, and I don't think the coordination that is necessary is in place, so I am sure that it is something that Dr. Mitchell's administration is struggling with.

One of the things I wanted to say in response to the last question, which is germane to you also, the judicial system has a tremendous responsibility not to incarcerate, but to get people into treatment programs and it must see PCP users, heroin users, and marijuana users in the system repeatedly, and it has very few alternatives.

Alternative sentencing is not an option in many areas. It is not used, so that you could get at the root cause of the drug use which has a lot to do with self-esteem and has a lot to do with peer acceptance.

That is what you were saying, that drug use has a lot to do with the fact that people are admired for frequent uses, and that has a lot to do with simply the tremendous absence of self-esteem among black youth and we begin to address that problem.

We begin to take away the prior support for the use of drugs. It becomes a mental health, education problem.

Mr. RANGEL. Dr. Mitchell.

Dr. MITCHELL. Let me say just a word.

The Administration for Alcohol and Drug Abuse is at this moment in the process of developing a comprehensive interagency network of leaders, and we have been in the process of meeting with police, church leadership and the major institutions, private and public sector, to create what we are going to be doing in the city, termed a comprehensive community initiative, which says everyone has to be involved in this, from top to bottom.

We will be shifting our major focus of treatment away from the traditional methadone maintenance to health and prevention activities.

Mr. SNYDER. I am Deron Snyder, a student at Howard University. I want to bring to light an idea that is sometimes prevalent in the minds of some of my peers, people my age group, I am from Brooklyn, NY; I used to look up and down Ocean Avenue and you can find a liquor store every three or five blocks, and also you could find storefronts that sell marijuana about the same frequency, and I used to talk with many of my friends, we were not into it as much as some other people, and we could look at it and say, this is detrimental to our community.

I talked to them, and we came to the conclusion that the liquor stores were in such exasperation, we figured it didn't just happen. They were put there so they could be used.

Mr. RANGEL. You put stores where people think they can sell and buy things, whether you talk about fried fish or fruit. People believe that somebody wants to buy it.

Mr. SNYDER. The oversaturation of them in black communities.

Mr. RANGEL. That was said by the panelists, talking about bars or liquor stores, everyone agrees with you. You said they were placed there.

Mr. SNYDER. A bad choice of words. Marijuana shops also with such great frequency. I am trying to say that a lot of people feel it is not just there because it is there. It also has been argued that the explosion of drugs in the black community that occurred in the sixties—no, it didn't just occur——

Mr. RANGEL. You are saying that it is a white racist plot to put the liquor stores and marijuana stores in the black community?

Mr. SNYDER. No; people feel that there could be a lot more done to decrease it, if people really wanted to. That is all I am saying, so what I want from you is like a reassurance, well, we know that it is a problem, and the members of my peer group, we know it is a problem, and we feel that there could be a lot more done.

The reason why we feel, frankly, that a lot more is not being done is because if you want to, certain bosses don't want to see more get done. I want your reassurance that you have no doubt, nothing like what I am thinking, if you can just tell me I am wrong, or far off track.

Mr. RANGEL. Come on now, if you are implying that there is collusion sometimes between law enforcement and the criminal activity that takes place in your community or in New York or here in the District of Columbia, there is no question that it exists, there is no question that there is collusion.

Where you have any number of liquor stores, where some of them could be in violation of the State law, there is no question

that many times dollars have been paid to corrupt State officials and county officials to get those stores there.

It is safe to say, however, if people were not buying that liquor and wine, marijuana, it wouldn't make any difference how many stores, they would not be able to cut a profit, so it means that we have to stamp out the corruption, but we also have to find people as strong as you and your peers were, and not succumbing to the temptation, and the more you see it, there is no question that the temptation is there.

Because of the great job that has been done by our city council people in New York, Archie Spigner, and others, it has been signed into law which allows the New York City Police to come in and to close and padlock any storefront where a number of convictions have been had where the people have broken the law.

This has been a source of embarrassment to the police. This is the type of thing you are talking about, this is one of the most effective tools that has come out of our city council.

I don't see those smoke shops in the District.

Ms. JARVIS. We outlawed them.

Mr. RANGEL. We still have to keep working on it. Thanks for your contribution.

Yes, ma'am?

Dr. COLE. I am Dr. Lorraine Cole and my question is really for Dr. Pollin, and I wondered if a member of his staff is here?

Ms. ELLEN JOHNSON. I am here.

Dr. COLE. He stated that the strongest evidence for the basis of the projected increase in drug use among Hispanics and blacks is demographic information and specifically fertility information, that there will be an increase in the number of Hispanic and black teenagers, and his percentages of the number of blacks and Hispanics who will be or are using drugs was based on the total number of blacks and Hispanics, according to the census, I believe, and since it is widely recognized that blacks and Hispanics are undercounted in the census, that would tend to inflate those percentage figures.

I was wondering if that information or that potential bias was considered in his data that he presented.

The second part to my question had to do with the DAWN survey that he used to support his projections, which is based on emergency room records, and some would argue that emergency room information is more indicative of who is hurt by the drug, such as bad drugs, or contaminated needles, or something like that rather than an actual indicator or cross-rational incidence of drug abuse, and I was wondering, it would appear then to use DAWN survey information could be misleading to substantiate projections of drug abuse.

Ms. ELLEN JOHNSON. In terms of the census data, you are correct in saying it is potential that it is biased in terms of all of the figures not being home or identified, that figure could be inflated. The figure does come out, the figures are basically coming out of census data.

That factor is not built into the presentation that was made. DAWN data, we recognize that DAWN data shows how consequences, not incidence of prevalence, and his presentation in terms of the national surveys, high school, and household surveys, inci-

dence and prevalence, he was not looking at that in terms of health impact.

And I might add, you are correct in terms of us not having sufficient data, what we plan to do is sample black and Hispanics to get more information, and I will be happy to share with you where we pull that data from.

Mr. RANGEL. Didn't NIAAA lose its ability when you went to a block grant system?

Ms. ELLEN JOHNSON. We were unable to collect treatment data.

Mr. RANGEL. As opposed——

Ms. ELLEN JOHNSON. Particularly related to minorities. We had very good data when we collected treatment data.

Mr. RANGEL. Share with Dr. Pollin, many of the panelists would like to have a conference as professionals with him, because the more this administration makes this a local and State problem, letting them do what they have to do, the less they have the direction as to what should be done, if we don't have the statistical data to see how it should be used, you might share with Dr. Pollin that there is a concern that we get together, and I think we can do it before the year is out.

Ms. WOMBLE. I am Maxine Womble. With the changeover of the Institutes and NIAAA from treatment, prevention to more research-oriented institutes, black people don't have an entry into funding. We have very few black researchers who can qualify to get those research dollars.

Those dollars are going to the traditional institutions. I am not sure what we can do about it except to—what we are trying to do as a national organization is surface this as a problem in trying to interest more black people into going into research.

We would be very interested in having people to submit résumés, whatever, to the institutes so this will become a national problem, so we can get some people into research and get those dollars.

I would also like to, Dr. Walton, since you are on the National Policy Committee for Drug and Alcohol, if you are addressing this issue in terms of getting more black people into research.

Dr. WALTON. Absolutely. To use a term, we have just kind of put a "double whammy" on the Institute, we have requested some gaps in research, that information be supplied, not only for our information, but for information for NIAAA as well.

There are some definite gaps in the information going out and we are also supplying some names of some credible black researchers, and also research announcements, grant announcements, so that it will be hard to say no.

Ms. WOMBLE. We have not heard anything about the rate of alcoholism among blacks. Do you have a number anybody is using?

Dr. WALTON. I just have the 45 percent for teenagers.

MR. RANGEL. Chairman. I know Joe Califano mentioned it.

Ms. WOMBLE. He talked about 15 million. No one knows in terms of black people. The national black alcoholism is 2.8 million. We don't have the data.

Mr. RANGEL. We have an outstanding expert, Dr. Lorraine Hale.

Dr. HALE. Thank you, Congressman. I wanted to speak about the plight of very young children who are born addicted to drugs. There has been some research and that is very spotty, and certain-

ly done in a rather haphazard way, about the development of these children and somehow, one gets the impression that by the time these youngsters are 1-year-old, it is finished, and they are fine.

Well, at Hale House, we certainly know that is not true, that the children continue to have problems, and I would like to kind of repeat what has been said here, and that is to call for more research, but research to be done by the people who are involved, and I don't necessarily mean minorities, but I do mean minorities, because certainly, we are the ones involved.

About 4 or 5 years ago, I came to you and we went to NIAAA to see if we could do research on the youngsters. We were told that children born of addict parents were not addicted and we said certainly, we have been working with these children 6 months later, Bellevue in New York City was given a huge research grant, and those are the kinds of things that occur very, very often. Right now, we are talking about a group of youngsters, many who have achieved the age of 15.

We don't know anything about them, their development. We know that very many of them are doing poorly in school, but that is a rather haphazard way of finding information. There needs to be money allocated for the research of these children, but to be done by, of course, the larger institutions, but also those of us who work with youngsters on a daily basis; and I would like to urge you in your office, if you can help us to do that.

And let me just say to the audience here, boys are born to the drug addict. An average of one boy to every four girls. Those boys are going to marry somebody. We need to know who it is that those girls are going to marry.

If we get the same kind of statistics out of the drug child that we do the alcohol youngster, we then know that 50 percent of all children born of alcoholic parents become alcoholics by the time they are 18.

Can we say that that is the same kind of satistics we are going to get about the child born addicted to drugs, and if it is, let us know it now rather than 20 years from now.

Thank you very much.

Mr. RANGEL. Thank you, Doctor, and I hope that you redraft that proposal we were talking about, and with the people here from NIDA, they would reinforce the need for it, which is the general consensus here.

Let me really thank the panelists. Out of this, I think we got a general consensus that we are going to have to regroup and see whether or not we can give some direction to this administration or another administration, and I really want to thank the audience for their direct participation in being here, and again, I want to thank the staff of the select committee that have put this together.

And so, on behalf of the congressional Black Caucus, we thank you for participating in our 14th annual weekend, hope that you have had a chance to join in with the other workshops, and I look forward to meeting with you at other activities that are scheduled.

This hearing will stand adjourned.

[Whereupon, at 1:32 p.m., the select committee was adjourned.]

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