DRUG ABUSE TREATMENT
(Part 1)

HEARINGS
BEFORE THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL
HOUSE OF REPRESENTATIVES
NINETY-FIFTH CONGRESS
SECOND SESSION

JUNE 14, 15, AND 22, 1978

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CONTENTS

DRUG ABUSE TREATMENT
(Part 1)

WEDNESDAY, JUNE 14, 1978

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

The Select Committee met, pursuant to notice, at 10:35 a.m., in room 2337, Rayburn House Office Building, Hon. Daniel K. Akaka (acting chairman) presiding.

Present: Representatives Lester L. Wolff (chairman of the Select Committee), J. Herbert Burke, and Benjamin A. Gilman.

Staff present: Joseph L. Nellis, chief counsel; David Pickens, project officer; and Rick Carro, staff counsel.

Mr. AKAKA. The committee will please come to order.

Today's hearing will ascertain how the Federal Government is fulfilling its obligations in the treatment of drug abuse. A reduction in the supply of illicit narcotics which reaches the street is a laudable goal but must be part of a joint effort resulting in a reduced demand for these illicit drugs. The latter goal is achievable through appropriate drug abuse prevention, education, treatment, and rehabilitation. The committee has been concentrating its efforts on the prevention aspect of demand reduction and will now turn its attention to the treatment and rehabilitation side. Special population groups including women, ethnic minorities, veterans, Federal prisoners, and the elderly will be an integral part of our investigation into the treatment of drug abuse.

The magnitude of the problem is, to say the least, staggering. Although no exact figures can be given, it is estimated that there are now approximately 500,000 heroin addicts in the United States, of which 290,000 are in treatment. Two-thirds of persons in federally funded treatment programs are unemployed. First priority into treatment programs is accorded to persons who have problems with heroin, barbiturates, amphetamines, and combinations of drugs. The National Institute on Drug Abuse currently funds 102,000 drug abuse treatment slots, servicing some 161,000 persons annually. Including research and rehabilitation, NIDA's expenditures will exceed $250 million in 1978. In spite of the Federal effort in treatment, recidivism, dropout rates, and unemployment remain unsolved problems. Compounding this is the large number of agencies involved in some way with treatment. Our Congressional Resource Guide has identified as many as 17 agencies, with many more subsidiary divisions, which deal with some aspect of drug abuse treatment. The committee is concerned

that HEW is not exerting the leadership necessary to enlist, in concerted action, the support and cooperation of the other Federal agencies responsible for treatment and rehabilitation. The integrated treatment approach demands the cooperation of agencies that are capable of impacting on the problems of drug abuse. The lack of cooperation at the Federal level is the result of little or no communication between the responsible parties and from the apparent absence of effective coordination by the lead agency. The resulting fragmentation and lack of communication has led to a disorganized and often misunderstood Federal treatment policy. This is especially tragic in light of our interim report of February 1977, which estimated the cost of drug abuse to the Nation to be at least $27 billion annually.

In examining the Federal effort, the committee hopes to determine who is in charge, what forms of treatment work and for whom, and what are the Federal goals with respect to the treatment of drug abuse. It is also important that the committee look into the Federal strategy in treatment, and at what has been attempted and what should be tried in the future.

To help us understand these complex issues we have with us today leading experts in drug abuse treatment from the Federal Government:

Mr. Lee Dogoloff, Associate Director, Domestic Policy Staff, the White House; and

Dr. Gerald Klerman, Administrator, Alcohol, Drug Abuse, and Mental Health Administration, HEW.

May I extend a cordial welcome to each of you.

Before we open our hearing, I would like to swear our witnesses.

[Mr. Dogoloff and Dr. Klerman were sworn by the chairman.]

Mr. AKAKA. I want to tell you that your complete prepared statements will be included in the record, and you may paraphrase or summarize your prepared statements. Following your statements, we will ask you some questions.

We expect other members to be here shortly. In the meantime, we will continue. I thank you very much for being here.

Will you please begin, Mr. Dogoloff.

TESTIMONY OF LEE I. DOGOLOFF, ASSOCIATE DIRECTOR, DOMESTIC POLICY STAFF, THE WHITE HOUSE

Mr. DOGOLOFF. It is a pleasure to be here today to discuss our Federal policy for drug abuse treatment and rehabilitation. Early last year the Select Committee pointed out a number of deficiencies in the drug abuse treatment and rehabilitation program, many of which we agreed were justified criticisms. We felt that it was important to take a fresh look at the drug abuse treatment and rehabilitation system and the Federal response to it, and on the basis of that undertook a Government-wide study which we have called Drug Use Patterns, Consequences, and the Federal Response. This is a comprehensive policy review which sets forth a blueprint for the coming year as to programs and priorities for the Federal effort.

The major recommendations of this report fall into three areas:

First, the enhancement of treatment for drug abusers;

Second, the development of a broader base of knowledge; and

Third, the prevention of drug abuse.

Since we have already had a number of hearings and have spoken about prevention, I will not deal with that part of the report today.

In the area of treatment, we believe it is very important to enhance the planning and provision of direct services for primary clients, those that are compulsive drug abusers, and this should include both expanding the types of abusers served, to move out from a system that was primarily geared, to the inner-city heroin addict and to begin thinking of a broader range of clients, those of different economic and social classes, those who were abusing different kinds of drugs, and particularly those who were abusing multiple drugs, including the barbiturates, tranquilizers, and particularly alcohol in combination with those other drugs, which is a special kind of problem.

We also felt that it was important to expand not only who we served but the kinds of services that are available to those people who come to treatment.

For example, there are a diverse number of needs that these people have. They include employment needs, basic skills training, and the need to deal with some of the problems of criminal justice system involvement. We felt that these can be achieved through providing broad and flexible funding to States for a wide range of health, employment, education, and social services. We feel that basis exists, but that the Federal funding agencies and the State agencies need to come to some formal agreements between themselves in order to assure that these services will be provided to drug abusers, and that local agencies need to be involved in collaboration and for third-party reimbursements.

We also felt that it was important to integrate substance abuse and mental health services funded through Federal programs with each other, and to include in that service delivery system private family service agencies and other social service agencies.

We also believe it is important to sensitize a wide variety of professionals outside the drug field to serve the needs of the drug abuser and misuser. For many clients and potential clients of drug abuse services the programs that have been in place up to now are not appropriate and might not be palatable, and we need to reach out in a broader way for that diverse population.

In 1978 and 1979 we will emphasize the linkages and the need for having the traditional health-care delivery system to service drug users and abusers. We will attempt to increase sensitivity to the special needs of certain subpopulations. The committee noted, and we agree with the committee, the male orientation of existing programs. HEW has been studying the different treatment modalities and is developing models to serve the needs of special subpopulations, including Puerto Rican, youth, elderly, rural clients, and so forth.

We will emphasize vocational and employment opportunities.

We will work on the interface between drug treatment and the criminal justice system. The committee has mentioned this in its interim report, and in the past year this interface has improved, and I believe it will continue to improve.

Our second area of recommendations has to do with a broader base of knowledge. The report includes many recommendations. These include mechanisms for improving research coordination so we can

make sure we are not duplicating and are, in fact, taking advantage of research that is being done in various instances and in various Government agencies throughout the system; to upgrade our data systems and upgrade the quality and quantity of information that is available on special drug abuse populations.

There are many other recommendations in our report. In total, they form a broad and comprehensive strategy for drug abuse treatment and rehabilitation. Our domestic policy staff will monitor the implementation of these recommendations, as well as those of our other six policy reviews. The seven reviews form a blueprint for the entire Federal drug abuse prevention program, and a budget crossout is provided in my prepared testimony.

We are finally learning that treatment and rehabilitation work, and this has been particularly personally rewarding over the past year or so when we have been able to begin to answer questions from the NIDA reporting system and research into treatment outcome. We are finding that we are able to document a continued decrease in drug use during 3- and 4-year posttreatment periods.

We will continue to promote such evaluations, and have recommended that HEW develop treatment outcomes criteria as a standard for judging individual program successes, both for funding considerations as well as to establish reasonable expectations as to what might be expected from a given treatment program within a given set of circumstances.

And NIDA is working on this and we will continue to monitor their progress.

That concludes a summary of my testimony, and I will obviously be happy to discuss any of these issues with you and answer any questions that you might have.

Thank you.

[Mr. Dogoloff's prepared statement appears on p. 76.]

Mr. AKAKA. Thank you very much.

I want to acknowledge the presence of the Chairman of the Select Committee on Narcotics Abuse and Control, Mr. Wolff, and also our ranking minority member, Mr. Burke.

We will ask you questions after we receive Dr. Klerman's statement.

Will you proceed with your testimony, Dr. Klerman.

TESTIMONY OF GERALD L. KLERMAN, M.D., ADMINISTRATOR, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION, HEW, ACCOMPANIED BY KARST J. BESTEMAN, DEPUTY DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE

Dr. KLERMAN. I also want to thank you for the opportunity to appear today. I am appearing on behalf of not only the Alcohol, Drug Abuse, and Mental Health Administration, but also for the Department of Health, Education, and Welfare.

I want to take this opportunity to commend your committee and its staff for the efforts you have made to focus attention on this issue, and particularly the ways in which the interim report stressed the need for close coordination of Federal policies and programs, to avoid fragmentation or division of purpose.

Secretary Califano has asked me to reaffirm his commitment: That the HEW will play an increasingly active role in coordinating its programs and in working with other Federal agencies involved in this complex problem.

While our current drug abuse policy has resulted, as Mr. Dogoloff stated, in major improvements in the past year, it is also apparent that this policy, particularly within HEW, has been, to a certain extent, insulated from the mainstream of other health care, social, and economic programs.

For example, we can no longer regard street crime and drug addiction as intertwined and focus entirely on heroin. We no longer place heroin as the sole priority of our drug program. There are many drugs of abuse, and we are well aware there are a number of chemicals that are ingested and inhaled, such as alcohol and tobacco, which often cause us far greater economic harm and ill health than heroin. Even if we choose not to include these two in our category of "drugs of abuse," other drugs are beginning to emerge as harmful substances, including some drugs that are available readily with a physician's prescription. We are learning that some of the worst problems are caused by combinations of drugs, particularly with alcohol.

We have reaffirmed the important principle that one cannot treat the drug abuser just for the physical dependenc or for the unhealthy medical consequences of the chemical itself, that to do so will satisfy only a small measure of the needs of that individual. We must look to programs that fully rehabilitate, educate, and integrate the drug abuser, particularly that individual who has been successfully treated, into ongoing domestic programs.

And here the most difficult problem remains, as has been noted by the committee, the high unemployment rate among those individuals in the treatment program, particularly those from minority backgrounds.

We realize that to achieve these goals is a tall order, one that certainly cannot be filled by any one agency such as ADAMHA or the Department or by the Federal Government acting alone. But as this committee has indicated, HEW as a Department should review and is reviewing the full range of its programs to coordinate those aspects of its programs which directly or indirectly touch upon fulfilling the multiple needs of drug abusers.

As Mr. Dogoloff has indicated, the latest report issued by the White House in the area of demand reduction policy was published in March of 1978, HEW participated in the development of that report. We are currently involved in implementing those recommendations which apply to the Department.

Within the past 6 months Secretary Califano and Dr. Richman, the Assistant Secretary for Health and the Surgeon General, have been increasingly concerned with the need for coordination of the various program elements within HEW, and in the area of drug abuse, the Department has particularly increased its coordination.

As I reported to you in my testimony earlier this spring, the Secretary has appointed me, along with his special assistant, Daniel Meltzer, to jointly oversee the coordination of drug abuse policies within HEW. Mr. Meltzer and I have established a close working relationship. We have met with the relevant principal officials from all the various

agencies within HEW whose programs contain components which require coordination and which impinge upon the treatment and rehabilitation of individuals affected by drug abuse. We believe the results of this increased coordination will be felt within the Department over the next few months as the administration develops legislative and budget proposals for fiscal year 1980.

I am prepared to say more about prevention, and particularly in view of the emphasis being given to it by the Secretary and the Surgeon General, but that is not the focus of these hearings.

As regards the treatment programs, I think it is important to share with you today a brief summary of the extent of community-based treatment that is provided by HEW, particularly by NIDA, and how the process is evaluated. More detail will be available tomorrow when Mr. Karst Besteman testifies on the NIDA programs in detail.

The main instrumentality for the support of HEW's treatment programs is NIDA, and NIDA supports statewide treatment networks which in fiscal year 1978 totaled $181.8 million for 100,722 treatment slots. As of July 31, 1977, 36 percent of the slots were used by clients receiving methadone as part of the treatment. Sixty-one percent were used for drug-free treatment efforts, and 3 percent were for programs of detoxification. Of the total clients served, 84 percent received treatment as outpatients, and only 11 percent in residential settings, 5 percent in day care, and less than 1 percent in hospital inpatient settings. The program has shifted increasingly to ambulatory and community-based programs.

The average time spent by clients in NIDA-funded treatment ranges from 3 months in residential programs, 6 months for drug-free outpatient programs, and 10 months for outpatient methadone maintenance programs. The average cost for treating one person for 1 year is $2,200.

Now, these programs are monitored by the NIDA Division of Community Assistance through its staff of program development specialists assigned to each of the States. In addition, a contract has been given to the audit firm of Touche Ross. It requires them to evaluate drug abuse program management through a system of quarterly management reviews, reviews of the State plans, and ongoing consultation.

The NIDA staff monitors the use of drug abuse treatment funds. In addition, NIDA's treatment outcome prospective survey, known as TOPS, is to review the efficacy of the NIDA treatment effort, including a followup phase. Other outside evaluations of drug abuse treatment have been completed and will be described in greater detail in the testimony of the NIDA Deputy Director, Karst J. Besteman, at tomorrow's hearings.

In addition to those programs funded through NIDA directly, there are important drug abuse treatment resources available from federally supported community mental health centers funded by the National Institute of Mental Health. At the present time, half of the Nation's community mental health centers provide some form of drug abuse services either directly or by referral or coordination with other community agencies. NIDA funds 9,471 of its treatment slots through CMHC's at an estimated cost of $14.4 million.

I give these as examples of the range of activities in the treatment area.

I want to stress once again that Mr. Meltzer and I are responsible for the coordination of HEW's drug abuse programs, including treatment and rehabilitation, but also in prevention and in other components of the Department's programs: education, vocational rehabilitation, and research. This effort will complement ongoing Federal responsibilities. Mr. Meltzer is particularly responsible for the ongoing communication and liaison between the Department and the White House, and we are confident that the combined efforts recently undertaken will achieve positive results in the coming months. Thank you.

[Dr. Klerman's prepared statement appears on p. 83.]

Mr. AKAKA. Thank you very much, Dr. Klerman.

Dr. Klerman, are you a medical doctor?

Dr. KLERMAN. Yes; I am.

Mr. AKAKA. What is the sentiment among HEW officials regarding marihuana, cocaine, and heroin? You spoke more about heroin. My question is: How do you regard these three drugs, and in what categories?

Dr. KLERMAN. The major outline of our point of view is consistent with the White House document. Heroin remains the substance that is used that has serious consequences for health, and there are social consequences as well, particularly the high unemployment of its users and their general involvement with the criminal justice system.

Cocaine is used less frequently but has been the subject of intensive research by NIDA-supported investigators and cocaine is also the subject of treatment efforts.

With regard to marihuana, the situation is more complicated. NIDA has been mandated by the Congress to provide an annual report to the Congress on the extent and frequency of marihuana use among different aspects of the population, particularly young persons in high school. Recent studies indicate a slow but steady increase in the proportion of young people who are users of marihuana.

There is also an extensive research program underway concerning the pharmacologic and health consequences of marihuana. At this time, the consequences of chronic use are not fully documented. We do not at this time have an intensive treatment program for marihuana users, but we are involved in various educational and preventive programs particularly aimed at young persons, hopefully to determine ways in which we can influence their behavior.

Dr. DuPont, the Director of NIDA, has on a number of occasions—and I believe before this committee—indicated his concern about the growing percentage of young people who have used marihuana, especially stressing the fact that about 10 percent of high school students at any one time are using marihuana on a once-daily or once-weekly basis.

So it is a matter of some concern, but there is no consistent Federal policy with regard to a treatment program as distinct from prevention.

As you know, the President has indicated some of his own personal interest in changing some of the legal statutes, and I think Mr. Dogoloff can explain the White House position on that in more detail.

Mr. AKAKA. Will you, please.

Mr. DOGOLOFF. Surely. We are obviously concerned, as Dr. Klerman said, about the social and health consequences of heroin and its highly addictive nature.

Cocaine is a little more difficult. Although its use has been increasing, there doesn't seem to be any major health consequence, given current levels of use. Our real concern about cocaine has to do with its potential for health problems, because it is such a highly reinforcing drug and, should it become more widely available and less expensive, we are very much concerned about the negative effects that it might have.

For instance, reports from Dr. Noya, who is a psychiatrist practicing in Bolivia, have been particularly alarming. In an area where there is relatively high availability and easy access to coca paste and other forms of cocaine, the health consequences are quite serious and alarming.

So we want to do all that we can in terms of supply reduction efforts and to monitor very closely what the health impact is.

In terms of the marihuana situation, from a user perspective, we are concerned that the Government continue to give a very clear message that it stands to do all that it can to discourage the use and abuse of all drugs, including alcohol and marihuana. We do not in any way want our message to give the impression that we feel it's OK to use marihuana, or that we condone its use. And the President personally feels this way, I can assure you.

On the other hand, we felt it is inappropriate for persons possessing small amounts of marihuana for their personal use, to be incarcerated for a long period of time. We felt that this is more harmful to the individual than the drug itself. So we have talked about the propriety of decriminalizing the possession of small amounts of marihuana for personal use, under Federal statute only. This would, in effect, merely codify what is already occurring, since Federal law enforcement efforts should not be directed at people who possess small amounts of any drug, particularly marihuana.

On the other hand, we feel it is a State-by-State prerogative to make that decision based on their decisions and their considerations within their given States.

In terms of marihuana abusers, there are some instances where people get into trouble with marihuana use and require treatment. We are very much concerned, as Dr. Klerman said, about the increasing use, the fact that nearly 10 percent of high school seniors are regularly using marihuana. We don't feel that people can learn effectively while being intoxicated. We are concerned about the impact of that on their learning capability. We are particularly concerned about the impact of marihuana on driving skills. We know it impairs motor activity and coordination, and are alarmed more and more about statistics, as they begin to trickle in, about the number of traffic accidents, and sometimes fatalities, that occur when people have been using marihuana. We have asked the Department of Transportation to undertake a specific study to help us understand more about that, because given the widespread use of that drug, that could be a major sort of unknown consequence of which we need to be aware and about which we need to do something.

So that is basically where we stand on those three drugs.

Mr. AKAKA. Would I be correct in making the statement that marihuana is being commonly used in high schools? I think you said some students use it as much as once a week.

Mr. DOGOLOFF. Yes; about 10 percent of high school seniors surveyed.

Mr. AKAKA. Do you have a breakdown of the percentage of other grade levels? I am interested in the younger students.

Mr. DOGOLOFF. I think it goes down.

Dr. KLERMAN. I happen to have that information here.

According to the 1977 survey of high school students in the age group 12 to 17, 28 percent have used it at least once. And that does, as Mr. Dogoloff indicated, rise with progress through midadolescence.

In the age group 12 to 13, only 8 percent have used it.

In the age group 14 to 15, it goes up to 29 percent.

And in the 16 to 17 age group, it is up to 47 percent.

Use within the past month follows the same progression, and as indicated, about 10 percent of high school seniors are probably regular marihuana users, at least once weekly or even once daily.

Mr. AKAKA. Mr. Dogoloff mentioned marihuana treatment. Dr. Klerman, is there a program for treatment of marihuana use in that age group?

Dr. KLERMAN. There is no treatment required for the use of marihuana as such. However, marihuana, when used in high concentration, can produce a state of intoxication. Like other intoxicants, it impairs learning ability, which could be reflected in poor performance in school. It can also impair motor skills, which could be reflected in certain automobile accidents. As is also indicated it affects the ability of people who fly airplanes or use other complex apparatus.

We do not, to my knowledge, have a specific treatment program for marihuana, but are concerned with working with other groups in adolescent health programs, in taking remedial actions whether they be educational or otherwise.

Mr. AKAKA. I think Mr. Dogoloff used a good word for cocaine and for marihuana, and that is the word "potential." My questions relate to those potential problems: that is, the use of other drugs and the social consequences they might have. Therefore, we are vitally interested in what kinds of treatment programs you have.

Dr. KLERMAN. Well, in the case of cocaine, a small percentage, less than 5 percent of the 100,000 or so treatment slots supported by NIDA, are reported as cocaine users, if I am correct. Mr. Besteman can augment that.

In addition, there has been a rather extensive program of research on cocaine, including studies in countries where there is higher use, in South America, and where there is an attempt to learn about treatment methods where individuals become chronic users.

At this moment the problem is not that of chronic use; it is intermittent use by a small segment of the population.

With regard to marihuana, the situation with regard to health consequences of chronic use is not fully determined, and again we are trying to learn from the experience in other cultures, particularly those in the Mediterranean and Middle Eastern area where they have a longer experience with marihuana in its various forms such as hashish, and where their health system has had a chance to observe long-term and chronic use, and how those episodes can be treated.

Mr. AKAKA. You mentioned several methods of treatment, one of which is education. In regard to high school students and their use of marihuana, are there any pertinent drug education programs?

Dr. KLERMAN. In addition to the programs that NIDA is responsible for, there is a special program within the Office of Education on drug education for the school-age population. That program is under the leadership of Dr. Helen Nowlis, who is a very well-known psychologist with an extensive background and experience, both in education and in drugs. I believe she testified before this committee during the spring. I think the special program is currently budgeted at about $2 million to develop demonstration programs specifically geared for school-age students.

Mr. DOGOLOFF. In the past, we haven't found that programs which specifically gave information to high school kids, are effective in deterring their use. The kinds of programs that have shown more effectiveness have really been dealing with some of the underlying behavior problems that children seem to have, and dealing more effectively with some of the normal kinds of turmoil that go on in adolescent development.

In some ways society has become more complex, but kids haven't changed, the maturation process hasn't changed, and adolescence hasn't changed. What has changed is there are some other vehicles in addition to the ones we used when you and I were kids to express some of these things. And marihuana is pretty much top on the list as one of those vehicles which is available.

I think if it is understood in that context, we can go back to looking at the kids themselves and trying to deal with them, and not simply focusing on drug-using or marihuana-using behavior in and of itself.

Mr. AKAKA. Dr. Klerman, in your statement, on page 5, you talked about detoxification. I am interested in your percentages, that 84 percent received treatment as outpatients, 11 percent in residential settings, 5 percent in day care, and less than 1 percent in inpatient settings.

What are inpatient settings?

Dr. KLERMAN. They would be psychiatric units of general hopsitals, State mental hospitals, or community mental health centers. They would be in the medical health care system, where the individual is there 24 hours a day as a patient. There would be detoxification, avoidance of overdose, or, where an individual has been a heavy user of a drug like heroin, we would want to avoid the consequences of withdrawal. Also the individual may have some other health problem such as hepatitis or malnutrition that sometimes accompany heavy opiate usage.

We are pleased that since inpatient care is a very expensive part of the health care system, the most expensive part, the NIDA programs have become less reliant on inpatient care and more able to manage these problems with outpatient treatment, particularly if there is early recognition and early diagnosis.

Mr. AKAKA. Thank you very much.

May I ask the chairman if he has any questions.

Mr. WOLFF. Thank you, Mr. Chairman.

Gentlemen, one of the major responsibilities of the committee is oversight, and a recent series of reports appeared in the newspapers and also in a magazine article, relating to certain improprieties or alleged

improprieties on the part of individuals connected with the NIDA program and, if I can mention you, Mr. Dogoloff.

I have just received a copy of that report. I don't know when it was sent to us. Did we receive that this morning, Mr. Nellis?

Mr. NELLIS. Yes, sir.

Mr. WOLFF. I wonder if you would comment, then, on the report, know whether this report is for publication or not. It is?

Dr. KLERMAN. The report was issued for the public by the Secretary, I believe 10 days ago.

Mr. WOLFF. I wonder if you would comment, then, on the report, both of you gentlemen, since this is an opportunity for Mr. Dogoloff to answer any charges that have been made against you.

Dr. KLERMAN. Well, the situation is as follows, I think, Mr. Chairman:

A number of articles appeared in the column of Mr. Anderson in January of this year, which, as you say, allege certain improprieties with regard to the award of contracts by NIDA, and also about certain aspects of travel by some of the staff.

In response to those articles and concern by the public, the Secretary, Mr. Califano, directed a formal investigation by the Inspector General's Office, which is the agency within HEW responsible for such investigations, to determine impropriety or possible fraud.

The report was undertaken by the Inspector General with the full cooperation of NIDA and its staff, and the report was submitted to the Secretary on May 26 and released by the Secretary to the public on June 2.

The report goes into detail on each of the allegations made by Mr. Anderson and his staff of reporters, and makes a series of recommendations. However, no evidence of fraud or any indictable action was uncovered in the Inspector General's investigation.

The Secretary is concerned that we continue to improve the management of grants and contracts throughout the whole Department, since large amounts of Federal moneys are dispensed through either the grant mechanism or the contract mechanism, and a number of specific recommendations for improving the management of contracts were embodied in that report.

The Secretary directed that I, as the Administrator of ADAMHA, plus others in the Public Health Service, submit to him a report as to how we were taking remedial action, and that report is due to the Secretary at the end of this week.

A number of steps have been taken to prevent any possible conflict of interest and to improve the quality and management of the contract procedures. As you may know, I instituted a series of efforts to improve the management of the grant review procedures earlier this year. The Department, through the Secretary, is committed to develop preventive measures so as to insure that there is constant upgrading of the management of contracts.

But I want to once again emphasize that no evidence of fraud was found, and no evidence of impropriety on the part of any individual currently or in the past associated with NIDA's programs merits legal action. However, there is opportunity for improved management.

Mr. WOLFF. The report does say, however, "The Inspector General concludes that the articles are, in large measure, based upon facts."

Dr. KLERMAN. Well, it is a fact, for example, that some employees of NIDA have wives who work in places and firms that have in fact received contracts. Such facts do not necessarily imply automatically improprieties or an attendant conflict of interest. There is a difference between a statement of fact and an allegation of impropriety, fraud, misdemeanor.

It is true there were no major errors of fact in Mr. Anderson's columns. There are, however, differences of interpretation as to whether or not those facts represent any degree of impropriety.

Mr. WOLFF. Mr. Dogoloff.

Mr. DOGOLOFF. I see this as an internal HEW issue, and one which has received review, not only by the Inspector General, but also by the NIDA Council. You might wish to have that made available to you as well, since it is a public report.

Mr. WOLFF. I am a little bit confused as to why these public reports don't get to us.

Mr. DOGOLOFF. You would have to ask HEW. It is their report.

Mr. WOLFF. I just got this one today. The public got it—when was it?

Mr. NELLIS. It was issued June 2.

Mr. WOLFF. I would ask for a greater line of communication, perhaps. Since a member of the staff of this committee has also been mentioned in the report, I think it would be advisable that we do have this information. In the future I would hope that this is made available to us.

Mr. DOGOLOFF. As I read over those reports, it seems to be very clear to me that there is no evidence of any wrongdoing on anyone's part. The Inspector General's report is pretty clear in drawing that conclusion, as is the independent review of the Secretary's Council which advises the National Institute on Drug Abuse.

Dr. KLERMAN. I should, for a statement of complete accuracy, indicate there is one item that is still under further investigation by the Inspector General, and about which we expect a report in the near future. So in that sense there is one particular instance—I don't know the details, but I think I should say, in fairness to you and for the completeness of the record, there is one item still under investigation.

Mr. WOLFF. Perhaps we could ask counsel to join the panel here, since he is not under investigation by any means, but perhaps he would like to answer the statement that has been made here.

Mr. NELLIS. Well, may I do it from this chair, Mr. Chairman?

Mr. WOLFF. Wherever you feel comfortable.

Mr. GILMAN. What statement?

Mr. WOLFF. There was a statement in the Anderson column relative to Mr. Nellis, who is the chief counsel of this committee, and a contract awarded to Mrs. Nellis. The allegation was made by Anderson that Muriel Nellis, wife of Joseph Nellis, was awarded a $150,000 contract to study women's drug problems at the same time her husband was directing an investigation of NIDA which failed to uncover the improprieties covered in the Anderson articles.

If you like, I could perhaps read the rest of it.

Mr. GILMAN. What are you reading from?

Mr. WOLFF. This is a report of the Inspector General.

Mr. NELLIS. I'll read the conclusion first:

"We found no evidence that Mr. Nellis used his position to influence the contract award."

The fact is, my wife and I have pursued separate professional careers. A contract was awarded to my wife 2 years before this committee was formed—Mr. Chairman, I would like your attention, if I may.

A contract was awarded to my wife 2 years before this committee was formed, and the Anderson allegation was at that time I should have been investigating NIDA, in 1975, which was 2 years before the committee was formed.

Without going into all of the allegations, I can say that the Inspector General's report is extremely inartfully drawn. Even though it absolves me and my wife of any impropriety, it accuses NIDA of not having followed procurement procedures in the award of the contract, and then links that failure on the part of NIDA to the appearance of favoritism.

I reject that conclusion because I think it is totally wrong, and I think also that when an Inspector General makes a report of this kind, he should be very careful about the kind of language he uses. Because when he says that NIDA was at fault for not creating a competitive process, which its own procedures call for, in the award of the contract, and then says, "The appearance of favoritism is present," in the same sentence in which it says, "We found no evidence that Mr. Nellis used his position to influence the contract awards," it is doing a gross injustice.

The only other thing I would say is that we have reached the point in this country where the newspapers can make unfounded charges against anybody, and the opportunity for rebuttal is not available.

I debated at length—and I talked with you, Mr. Chairman—the possibility of writing Mr. Anderson or contacting Mr. Anderson, but decided it was useless because all he would do, I suspect, is use my rebuttal as some sort of further opportunity to attack me or attack the committee or to attack anybody he might have been pleased to attack.

I don't know anything about the NIDA personnel involved in this Inspector General's report. Most of the people that I have met since I have been chief counsel of this committee were not known to me prior to assuming this position. And I would say that the Inspector General has done a good job, except that he certainly could have used more artfully drawn language in absolving everyone of impropriety.

And that is really all I have to say.

Mr. WOLFF. Thank you.

I think one aspect of this is that we as a committee, in our oversight capacity, have a responsibility in this connection—and we don't pass any judgment whatsoever that the charges or the allegations that individuals have engaged in any activities are correct, incorrect, or questionable in any manner.

But I am concerned that the Department itself, as well as NIDA, conduct a review in depth of the past procedures to prevent there even being a question of any activity that would cause questions to be raised at all regarding procedures or the award of contracts. The problems that we are engaged in are very serious problems. The fact of merely a relationship of one to another does not question the professionalism or the capabilities of the individuals involved. If, how-

ever, their offices are used in any way to advance the relationship, I think that that is a serious impropriety.

And therefore we will keep a watchful eye on this and examine this situation periodically, and we ask, Dr. Klerman, that your office make available to us a continuing report as to your investigative activity, and the Office of the Inspector General as well, to see to it that we do not subject either the people involved with the contracting procedures or those to whom the contracts are awarded to the types of allegations that have been made in the past.

Mr. NELLIS. Mr. Chairman, if I may, I would like to add something.

I wish there were something this Congress or this committee or someone else could do to prevent irresponsible journalism, which I consider one of the plagues of our time.

Mr. WOLFF. Well, Mr. Nellis, let me say that according to our Constitution no journalism is irresponsible.

Mr. NELLIS. I don't agree.

Mr. WOLFF. As long as we have the question of freedom of the press—and I certainly am one who is very familiar with what you might consider to be irresponsible journalism—it is only irresponsible if the readers misinterpret the information. I do believe one of the big points we have to guard against is any infringement upon the individuals of the press who are free to write what they will.

The one point, however, that is important today is the fact that you are in a different category than I am as a public figure. At least you can sue; I cannot. As a public figure I must prove malice, which is a different position.

Mr. NELLIS. I'm afraid I'd have to do the same, Mr. Chairman, which would be very difficult.

Mr. WOLFF. But under any conditions I think this situation is a very serious one, and I would hope one of the activities your office will engage in, Dr. Klerman, is a very careful examination not only of these instances, but of whatever excesses exist in the contracting procedure.

Dr. KLERMAN. If I might comment, I would like to second one of the important points that your chief counsel made, namely that the procedures that any Government agency sets up for management of contracts or grants must protect instances such as those which occur with increasing frequency, where both the husband and the wife are involved in professional activities, and the expectation is that there be the avoidance of the appearance of conflict of interest.

And in addition to those responsibilities upon public officials, that we conduct ourselves to avoid the appearance of conflict of interest, this administration has taken a very active stance on that matter, particularly with regard to its appointees.

It is also important that the agency set up management procedures so it is not left only to the discretion of individuals, for their own protection.

I think this should be seen in context. The Secretary has engaged in a far-reaching number of activities around contracts and grants, including the establishment of the Office of the Inspector General that did not previously exist. And in some instances fraud has been found and indicated, particularly in some of the reimbursement procedures.

That has not been the case here. No instances of fraud have been uncovered. However, we had, before the issuance of the report, already undertaken some management and administrative changes. There are others.

With your permission, I would like to submit that to you. The Secretary has not seen the report yet that indicates what changes in management and contracts we are recommending, including a whole series of ones to protect individuals from the appearance of conflict of interest, independent of their own individual action. We think that the procedures recommended will go a long way toward meeting the objectives that you and the committee have identified.

I would be pleased to submit that to you in the near future.

Mr. WOLFF. Thank you.

[The information referred to is in the committee files.]

Mr. WOLFF. One aspect of this is sole-source contracting, which becomes not a questionable practice because the reasons are understood for certain sole-source contracts, but wherever possible I think these should be avoided so there can be no question raised.

Dr. KLERMAN. Our goal is to increase the percentage of contracts through competitive procurement to at least 65 percent of all contracts. That is independent of the statewide contracts which fall under different categories, since they are sole State agencies.

Mr. WOLFF. Thank you.

Mr. BURKE. Mr. Chairman.

Mr. AKAKA. Mr. Burke.

Mr. BURKE. Mr. Dogoloff, in your statement on page 5, which Mr. Akaka mentioned earlier, you talk about the comparison between rural admissions and urban admissions, and in your statement you say:

"By comparison, 30.7 percent of rural admissions report marihuana as the major problem."

Now, what is the major problem with marihuana that they are reporting that you have under discussion? Is it a dependency on marihuana, or what?

Mr. DOGOLOFF. No; it is not a dependency, because dependency doesn't go along with marihuana use.

When a person comes into a NIDA funded treatment program one of the questions that he answers upon admission is, "What is your primary drug of abuse?" And in 30 percent of the rural admissions they reported that the people who came in said their major problem was associated with the drug marihuana.

However, there are obviously lots of other behavior problems, since marihuana doesn't itself create a dependency.

Mr. BURKE. If that was the major problem, how has that anything to do with the drug problem except from an educational point of view?

Mr. DOGOLOFF. It is a problem in the view of the person presenting himself for treatment in that the use of marihuana has caused enough disruption in his or her life that he feels the need for treatment. And it is purely a perception on the part of the person who presents himself for treatment.

Mr. BURKE. What kind of treatment do you give them then?

Mr. DOGOLOFF. Provide counseling services. It might involve parents as well, but it is primarly counseling services.

Mr. BURKE. I am not so sure that that is one that should be under the jurisdiction of NIDA. I may be wrong. If you bring people on in and decide you are going to counsel them and hold their hand, that's fine if it's connected with the responsibility. But I can't see how counseling, frankly—if somebody comes in and says, "I smoked marihuana," that you would necessarily go through a long treatment program with him, particularly since this very money that is spent on this particular type of treatment may be used much better in another capacity.

There is another thing I would like to have you speak to, somewhat along the same line:

What overall Federal policy with respect to treatment and rehabilitation do we really have with the juvenile drug users?

Mr. DOGOLOFF. The juvenile drug abuser is treated pretty much like anyone else.

Mr. BURKE. May I interrupt for 1 minute? I am not talking about infants—10, 11, or 12 years old. I am talking about juveniles not in the so-called word juvenile, but the younger category, let's say from 11, 12 up to 22, 23 years old.

Mr. DOGOLOFF. In that age range again, the NIDA treatment system, combined with the State and local treatment systems, is not just one thing. It is a different thing in each community in which it locates and in each program established within a community to meet the needs of the drug-using and abusing population.

In one community you might have several programs, one geared specifically to the kind of clientele you have discussed, and others geared to another type. They provide appropriate services to meet the clientele that presents itself for treatment.

And in the case of that age group, people can be very different. You can have a junior high school person who is beginning to experiment with marihuana and having trouble with school grades and family relationships. Or you can have an 18-year-old in the inner city who has been using heroin for 3 years. Those are both within the same age group, and obviously the program and the treatment response would be very different for those individuals.

The most appropriate treatment response depends very much on who that person is and what the drug use pattern is.

Mr. BURKE. The President, in August of 1977, almost 1 year ago, said—and emphasized that fact—that it was necessary to identify the reasons why the younger generation, the younger people, turn to drugs. What things have been done to make this identification? What investigations have been made, and have there been any direct recommendations concerning it?

Mr. DOGOLOFF. In terms of better understanding why young people turn to drugs?

Mr. BURKE. Yes.

Mr. DOGOLOFF. I'm not sure I have the answer to that. That would be a research question.

Mr. BURKE. Yes; but that is the President's statement almost 1 year ago. Does anybody know whether anything is being done on it?

Mr. DOGOLOFF. I know that each of the agencies has been responding to the specific directives of the Presidential message. And we can pro-

vide for you, for the record, specific research that has been done along these lines.

Mr. BURKE. What concerns me is if this is certainly worthy of a study by statement of the President, then I think there should be more than research and each of you responding in a different way. There should be some coordination.

Has it been studied to that degree, where it is a coordinated study, or is it that each agency just writes their own report?

Mr. DOGOLOFF. Oh, no.

Dr. KLERMAN. I can tell you some of the activities within HEW, Congressman Burke.

In addition to the specific activities NIDA has, which include a survey of youth, as required for the annual report on marihuana and health to Congress, there is an annual survey which indicates the frequency of the whole range of drugs, the drugs concerned, and the extent of abuse. In addition, there are specific research projects.

Going beyond research, there is to be held this month at the National Academy of Sciences a conference sponsored by the Public Health Service on teenage health, which will look at the interrelationship between drug problems, alcohol problems, teenage pregnancy, as part of the planning for a children and youth health initiative Dr. Richman is planning, to increase the capacity of the Public Health Service to deal with children's problems.

Mr. BURKE. Well, that isn't what the President called for. The President called for an overall Federal report, as I understand, to identify the reasons why persons turn to drugs.

Now, that has nothing to do with pregnancies. It may come afterward or before. But I am talking about the President's request.

Dr. KLERMAN. I will ask Mr. Besteman, the Deputy Director of NIDA, to describe what they are doing, but I would say that one of the things we find in the teenage group, the young adult group, is that drug problems do not occur in isolation. This is the group that has an increasingly heavy use of alcohol, that has a high rate of automobile accidents, that has problems of unbalanced nutrition. One approach being taken by the Public Health Service is to upgrade the quality of health services for adolescents in general, and for better coordination of the health care system.

In addition to that comment, I would request if Mr. Besteman can contribute, in perhaps more detail than I, what the research programs are on the specific motivations and inclinations for drug use in particular.

Mr. BURKE. All right, but just before that, Mr. Besteman, may I just interject this, that if you continue to use the words "alcohol" and "marihuana" and so on with the younger generation, there are laws to be enforced, actually, with regard to the sale of alcoholic beverages to juveniles.

Now, I understand not too long ago in one State the State legislature reduced the age from 21 years to 18 years, at which age they can buy beer and wine, I guess.

But that would be part of the study also, to determine why there isn't proper enforcement of the laws which were enacted to prevent exactly what you are talking about, why they are not properly enforced.

Mr. KLERMAN. What we have found is that there is evidence that is suggestive, not yet conclusive, that in those States that have done as you mentioned, namely lowered the legal age for access to alcohol, reflect an increase in automobile accidents by young people who already have a high automobile accident rate because of alcohol and/or marihuana use. It has been suggested that there has been an increase in certain kinds of juvenile delinquency and crime, and one must consider whether it is wise that States should continue to reduce the legal age of access to alcohol.

Mr. BURKE. I agree with that. I know the alcohol business is a big business and it is a powerful group, but they are subject to various licensing requirements by the States and the counties and the cities, and I would think there should be, perhaps, some investigation. If, as you say, the teenage drinking is so heavy, then there ought to be some crackdown or determination to know why and where it is coming from.

I merely wanted to interject my own statement on that. Now, if you like you can put your statement in the record or make it public.

Mr. BESTEMAN. I would like to insert a statement in the record here in response to your question, but if I may I would like to point out three or four categories of causes—and I'll put that in quotes.

I think the first thing you have to recognize is it is a relatively normal instinct of the human animal.

Mr. AKAKA. Would you give your name for the record, please.

Mr. BESTEMAN. I am Karst Besteman, Deputy Director of the National Institute on Drug Abuse, and have been in that position since the inception of the Institute.

It is a relatively normal inclination of the human animal to change his mental state, and you can see that if you first just observe children. They like to be thrown into a state of weightlessness when they are only 6 or 8 months old. And we all, as fathers, have thrown our children up and watched them get that silly little grin as they go weightless and come back. And we encourage that kind of activity.

When they are 2 or 3 years old they will spin like tops so their perception of the world changes and they can't control themselves. That is just the enjoyment of being in a changed state.

Regrettably, some of us find out that through the use of drugs we can be in a changed state, and the drug reinforces our desire for that change, and some of that can be because the state we are in may not be too enjoyable. We may be depressed, anxious; we may be a lot of things from a personality standpoint. So there is that aspect of why people get into drugs, and some of the data supports this.

I think you had Dr. Streit here with his research on their perception of parental attitude and what this does in terms of drug behavior selection. And that is another piece of the puzzle.

I think you have the whole aspect of peer and social pressure. You know, when we were young, when and where did we have our first cigarette? Who were we with? Behind what barn or garage did we drink our first beer that we snuck out of Dad's supply, or maybe one of the other older boys got for us?

And why did we do that? Not that beer tasted that good or the fact our first cup of coffee was that enjoyable, but at some point in our life we were expected to have our first beer or start to drink coffee,

or smoke our first cigarette. Not many of us can say our first experience was enjoyable.

Drugs are very similar to that.

I think, too, you have some self-medication going on in the drug population, that people find out that they subjectively feel better or are less distressed with the use of the drug. We have found out that attitudes around risk taking or attitudes around the need to be highly stimulated or have high input in sensationalism are related to drug-taking behavior in some college populations.

These are all partial answers to the question.

And then the group that is particularly fascinating to us and that we are trying to research—we don't have data out of this group yet—is how do we explain that in the middle of a very high drug-taking population there is the individual who is absolutely immune to all the temptations, who, if you will, doesn't smoke, doesn't drink, doesn't experiment with illicit drugs, and out of a background or a social situation that we look at as rather desperate will become very successful.

And how do we identify what there is about these people who are immune to all this behavior, and what characteristics can we encourage that will spread that behavior further into the population?

That is what we are looking at.

Mr. BURKE. I hope you will look into one other thing, the ease with which it is available to young people today, which it wasn't before.

I remember the first day I had a drink. It was the day Roosevelt declared it legal. That was in 1933. And I remember where, in Berghof's Restaurant in Chicago.

I remember there was a concentrated effort when I was a kid. Cigarettes were bad for you—the churches said so and everybody said so. And I believed it. I didn't smoke a cigarette until I was 21 years old, because I had taken a pledge. They had a big thing about the dangers of smoking. Besides that, it was very difficult for anybody to walk in and get a package of cigarettes, and anybody buying cigarettes for a minor at that time was not only subject to a fine, but also subject to a possible jail sentence.

I want to thank you gentlemen. I hope there is a time when we find the solution.

The unfortunate thing is that even with your statement, we keep lagging further and further behind the answer, rather than obtaining the solution.

Mr. AKAKA. Thank you very much, Mr. Burke.

Mr. Gilman.

Mr. GILMAN. Thank you very much, Mr. Chairman.

Mr. Chairman, I would like to return to the topic we were reviewing earlier, the Inspector General's review of allegations relating to drug abuse.

I would like to ask our counsel: Did we just receive this report?

Mr. NELLIS. Yes, sir.

Mr. GILMAN. Today?

Mr. NELLIS. Yes.

Mr. GILMAN. Can you see that copies of this are distributed to members of our committee?

Mr. NELLIS. Yes, sir, I intend to.

Mr. GILMAN. Mr. Chairman, without objection, I would like to make this report part of today's record in our hearing so that we could refer to it.

Mr. AKAKA. Without objection, it is so ordered.

[The information referred to is in the committee files.]

Mr. GILMAN. Dr. Klerman, when did you first receive this report from the Secretary of Health, Education, and Welfare?

Dr. KLERMAN. Approximately 10 days ago. It was Friday. I believe it was the 2d of June—somewhere in that first part of June.

Mr. GILMAN. Does your agency intend to pursue this report any further?

Dr. KLERMAN. Oh, we have been mandated by the Secretary to respond by the 15th of June with a set of procedures and proposals whereby we will implement the recommendations for changes in various contract and management procedures.

Mr. GILMAN. Have you made some specific recommendations yourself?

Dr. KLERMAN. There has been a work group within the Department, including members of my staff, the Inspector General, and the Assistant Secretary for Management and Budget, as well as the staff of the Public Health Service, which has prepared a comprehensive set of recommendations to prevent any appearance of conflict of interest.

Mr. GILMAN. Will you submit your report to the committee?

Dr. KLERMAN. As I indicated to the chairman, I would be pleased to do so. However, that report has not yet been seen by the Secretary, and I would request I have the opportunity to discuss it with him before submitting it to this committee. I am sure he would want the committee to know of the active efforts being taken to improve the quality of the contract procedures.

Mr. GILMAN. Mr. Chairman, I would like to request that that report be made part of our record here today.

Mr. AKAKA. Without objection, it is so ordered.

[The information referred to is in the committee files.]

Mr. GILMAN. Does your agency intend to look into the allegations with regard to the appropriate aspects and the legality of any of th prior contracts where the issue of legality has been raised in th reports?

Dr. KLERMAN. There is one particular set of contracts to the Caton Associates which, if my memory is correct, is being reviewed. Is that right?

Mr. BESTEMAN. I don't know.

Dr. KLERMAN. The other matters are not currently pending. The other matters deal with episodes of contracts that occurred in the past. I think there is only one that is ongoing. I would have to check on this in detail.

Mr. GILMAN. Have these contracts that have been reviewed, then, fully expired?

Dr. KLERMAN. Yes; with the exception of one to the Caton Associates.

Mr. GILMAN. That is still pending?

Dr. KLERMAN. Yes.

Mr. GILMAN. And you intend to pursue that further, you say?

Dr. KLERMAN. That is under review.

Mr. GILMAN. I would like to address a question to Mr. Nellis and put a statement on the record.

There is one allegation, Mr. Nellis, on here that a subsequent contract had been awarded to—let's see if I can get the correct title of the firm. I believe it is called the National Research & Communications Associates.

Mr. NELLIS. That's right.

Mr. GILMAN. In 1977.

Mr. NELLIS. Yes; that was a follow-on contract to the original one that was issued in March 1975.

Mr. GILMAN. There is an allegation in here that you are an officer of that corporation. Is that correct?

Mr. NELLIS. Yes; I have been in the past and still am, although by taking the oath here I severed all connections with the corporation.

Mr. GILMAN. And you had severed your association with it after the contract had been awarded or before?

Mr. NELLIS. The original contract was awarded in 1975, which was 2 years before this committee was organized.

Mr. GILMAN. What was the date of the formation of our committee?

Mr. NELLIS. It was July 1976.

Mr. GILMAN. And when the subsequent contract was awarded, were you still an officer?

Mr. NELLIS. Yes; but I had severed all connection with the corporation. And at the time of the follow-on contract in March of 1977, that was 1 month after we issued our interim report which was highly critical of NIDA, and to which the Inspector General refers.

Mr. GILMAN. Did the Inspector General talk to you at all about this report?

Mr. NELLIS. No, sir; I had no visit from anyone representing the Inspector General.

Mr. GILMAN. Dr. Klerman, did the Inspector General meet with you or your staff prior to this report?

Dr. KLERMAN. Yes. There were a number of the members of his staff who spent 4 months at the agency interviewing members of the staff and going over documents.

Mr. GILMAN. And you had no interview?

Mr. NELLIS. None whatsoever, Mr. Gilman. And the report finds no evidence of any influence on my part, which was highly possible because the original contract was almost 2 years before I become associated with the committee.

Mr. GILMAN. Had there been, prior to this, any requirements or any regulations that restricted contracts with any person who was related to an employee or to a member of NIDA or any drug agency?

Dr. KLERMAN. There are a series of regulations with regard to conflict of interest which require, as I recall, that there be disclosure of such memberships, and that in instances where there are decisions involved, the individual relinquish his or her holdings.

For example, when I became a member of this administration, I had to resign certain memberships in certain groups, as well as disclose the sources of income of myself and my family.

Mr. GILMAN. And is there a requirement in your agency that if a member of the family is receiving some funds from someone dealing with that agency, that that be disclosed?

Dr. KLERMAN. Yes. And the proposed changes are to make that even more explicit and more direct.

I might say, sir, that there is no evidence that there has been any attempt on the part of any of the individuals in this study to withhold any knowledge from any one of their memberships or their affiliations.

Mr. GILMAN. That is what I wanted to get to now.

Was there a full disclosure of these contracts made to you with regard to the relationships?

Dr. KLERMAN. Yes. In all instances that have been alleged, the marital relationships and the affiliations were known at the time that the contracts were negotiated and reviewed, and attempts were made to separate the procurement process so as to avoid the appearance of conflict of interest.

Mr. GILMAN. Then why is it that there is an allegation here that there is an appearance of impropriety, if that was fulfilled?

Dr. KLERMAN. I don't think there is any allegation of the appearance of impropriety.

Mr. GILMAN. Let's take a look, for example, at the Nellis contract. It says: "Although no evidence was uncovered to indicate that the decisions to award the contracts were influenced by Mr. Nellis' position, it does at least lend credence to allegations of impropriety."

Mr. NELLIS. I might interject——

Mr. GILMAN. I would like to hear with respect to their regulations.

Mr. NELLIS. I was about to say that, if I may. The allegation there relates to the failure of NIDA to follow competitive procedures. And as I said earlier, before you came in, the finding was there was no influence on my part, but the allegation of impropriety is injurious and a bad use of language. It was NIDA's problem with respect to the competitive process and not ours.

Mr. GILMAN. That is why I would like to hear Dr. Klerman's comments.

Dr. KLERMAN. I would have to agree with regard to the second contract to National Research & Communications Associates, of which Mrs. Nellis was an employee, that the report of the Inspector General is critical that that was based upon what is called the sole source, and more appropriately would have been subject to better justification and establishing a technical review committee. And it is that kind of procedure that we are attempting to correct—not attempting; we will correct.

I would say that in those instances there was no attempt on the part of any of the parties involved to maintain any secrecy or any avoidance of full disclosure. There is no evidence to that effect.

Mr. GILMAN. Are you familiar with the article entitled "The Drug Abuse Hustle" by Howie Kurtz?

Dr. KLERMAN. In the New Republic?

Mr. GILMAN. Yes.

Dr. KLERMAN. Yes, sir.

Mr. GILMAN. He alleges there is quite a bit of buddy-buddy situations in the family. He says one might call NIDA's cozy circle a family.

Have you reviewed that article?

Dr. KLERMAN. That was essentially the same as the Anderson charges. I believe the author of that article was on Mr. Anderson's staff.

Mr. GILMAN. I know there are further allegations in that article with regard to Lawrence Carroll, a firm called Social Systems.

Dr. KLERMAN. I think that was one of the matters specifically reviewed in the Inspector General's report on NIDA. Allegation No. 6 on page 9 does go into their investigation of Dr. Carroll's function.

Mr. GILMAN. Page 6?

Dr. KLERMAN. Page 9.

Mr. GILMAN. Page 9, yes.

Does the investigation report, then, cover all of the allegations—I haven't had a chance to read this all yet—in "The Drug Abuse Hustle"?

Dr. KLERMAN. Yes.

Mr. GILMAN. Have you or your agency conducted an independent review of these problems?

Dr. KLERMAN There were two. One, an internal management review, was conducted by us in January when the allegations occurred; and also the National Drug Abuse Advisory Council conducted its own review and issued a report to the Secretary, independent of the report of the Inspector General.

I might say as a basis of our internal review we did, in the agency, initiate a series of changes in certain procedures in the early spring.

Mr. GILMAN. Would you be kind enough to submit the copies of those reports to our committee?

Dr. KLERMAN. Yes.

Mr. GILMAN. Mr. Chairman, I would like to request they be made part of our record at this point in the record, without objection.

Mr. AKAKA. If there is no objection, it is so ordered.

Mr. GILMAN. Thank you.

Mr. AKAKA. Thank you very much, Mr. Gilman.

[The information referred to is in the committee files.]

Mr. AKAKA. Do you have any questions, Mr. Nellis?

Mr. NELLIS. No.

Mr. AKAKA. May I ask that you would return at 2 o'clock this afternoon. We will have another panel consisting of Dr. David Lewis, Mr. Claude Reese, Mr. Ed Menken, Dr. Fred West, and Mrs. Susan M. Kirchberg, and we would like you to come back for about half an hour.

Dr. KLERMAN. Yes.

Mr. DOGOLOFF. Yes.

Mr. AKAKA. We will see you at 2 o'clock.

The committee now stands recessed.

[Whereupon, at 12 noon, the hearing was recessed, to reconvene at 2 p.m.]

AFTERNOON SESSION

Mr. WOLFF. The committee will come to order.

My apologies to our two witnesses and the witnesses to follow for being late.

I apologize. I had to attend a luncheon with Prime Minister Desai

of India. Since I chair two committees, it is hard to determine which one to give priority sometimes.

I am extremely sorry that I had to hold you up. However, let us proceed.

The Chair will recognize Chief Counsel Nellis.

Mr. NELLIS. Thank you, Mr. Chairman.

We have two basic questions to ask, and then I would like to point out that the questions that we will not be able to ask to you, with the Chairman's position, we will submit questions, and your answers will be included in the record. This question is addressed to both of you gentlemen.

The President's message which Mr. Burke mentioned this morning, last August, recommended integration of research between alcohol and drug abuse affairs.

In February 1977, this committee made a recommendation concerning the integration of the Federal agencies dealing with drug abuse and alcohol.

We all found out that approximately 25 or 50 Single-State Agencies are so integrated. Without going to much into the pros and cons, I would like to know what the policy of the administration and of HEW Dr. Klerman would be concerning that issue.

Mr. DOGOLOFF. We recognize that a number of States have chosen to link drug and alcohol abuse services into one agency, and that more States continue to do this. At this time, we do not feel it is appropriate to link the two institutes, but we do think there are a number of opportunities that exist to combine research initiatives as suggested by the President's message.

I am sure Dr. Klerman will want to talk about specific things which have been done in that regard, as well as the issue of service delivery.

Given issues like State planning guidelines, reporting requirements for individual's programs and such, it is important from the Federal prospective that we not only allow States to choose to either have separate or integrated drug and alcohol programs but also make life easier for those States who do combine these functions, by having similar reporting requirements.

By having one State plan, rather than two separate plans, joint State plannings, a number of those reporting requirements and so forth, combined data elements, standardized language for both institutes, those things have been called for and recommended in our report, and we recognize them.

And a lot of those things have been accomplished already by ADAMHA.

Mr. NELLIS. Can you tell me, Mr. Dogoloff, why it is that you have made the current decision not to attempt to integrate?

There is so much crossing between alcohol/illegal drugs, so many pieces of evidence that indicate that there is hardly any distinction in terms of abuse except that perhaps one drug is more abused than the other.

Why wouldn't that make sense to integrate the alcohol and drug abuse functions unless there is some political reason of which I am not aware.

Mr. DOGOLOFF. I think there are two things.

We want to make the linkages easiest in those community programs where it makes sense to do that and have single delivery systems. But this is not the case for all programs.

There are some programs where it really makes sense, for all kinds of reasons, to keep them separate. So, we want to have that common flexibility.

But there are considerations regarding the combination of these. At this time, it is my feeling from reading the drug and alcoholism constituency fields, outside of the Single-State Agency constituency, that there is a lack of unanimity as far as the direction that should take.

There are a lot of very strong feelings that it needs to be maintained separately. In addition to that, I think that there is a real concern in some areas of the Congress about moving them together at this point, and having combined institutes.

I think, at this point, we would be pushing a fit that people in a number of areas don't think is appropriate.

Instead of pursuing this, it seems to me there are a number of opportunities, both in terms of services, State planning, data systems, and research, where we can get that cross fertilization and meet the goals without prematurely pushing the fit.

Mr. WOLFF. Would the gentleman yield?

Mr. NELLIS. Yes.

Mr. WOLFF. On that basis, why don't you have a separate institute for marihuana?

Separate institute for hard drugs, and we could have a separate institute for alcohol.

Is it the stigma that is attached to the abuse?

What we are talking about are mind altering substances. Perhaps the same motivations are not there, but perhaps, they are.

Actually, we are attempting to achieve some coordination which seems to be lacking in all areas, not just in the health areas, but in all areas of an approach to this problem.

Mr. DOGOLOFF. The fact that Dr. Klerman sits as the Director and as the administrator of ADAMHA, and has responsibility for both the drug and alcoholism programs plus, and is one of the two people that the Secretary has designated to coordinate the drug abuse program throughout the Department facilitates that kind of coordination and cooperation.

Dr. KLERMAN. Our position is that at the Federal level there is considerable gain achieved since the creation of NIDA and NIAAA.

There are important areas of cooperation and coordination, some of which have been enumerated, but there are some very significant differences between these two substances, and the programs for them that make continued autonomy of the two institutes overrule any benefit.

For one thing, there are far, far more individuals afflicted with alcoholism. Only a small percentage of them are involved with illicit drug use.

Mr. NELLIS. On what do you base that statement, that only a small percentage of alcoholics are involved with drug abuse?

Do you have any statistics? Is that what you said?

Dr. KLERMAN. I said, involved with illicit drugs.

Mr. NELLIS. Illicit drugs, involved with alcohol?

Dr. KLERMAN. Yes.

Mr. NELLIS. And what do you base that?

Dr. KLERMAN. A study conducted by NIAAA and press studies which have been conducted by researchers.

For example, the average age of persons in alcoholism treatment is in the thirties and forties.

People come into alcoholism treatment programs at an older age; whereas, most of the persons in treatment for drug abuse programs tend to be younger.

In many communities where it has been tried, not all, there has been a reluctance of the two groups to share programs.

We are in favor of experiments where there would be sharing of programs, particularly for young people.

Mr. NELLIS. You do admit considerable cross addiction among women, among younger people, between alcohol and illicit drugs, pills, and even some illicit drugs. PCP, we see more instances of PCP used with alcohol.

Dr. KLERMAN. That is true.

We have taken a number of steps to facilitate cooperation between the two institutes.

Mr. NELLIS. In what way Dr. Klerman?

Dr. KLERMAN. One is the movement toward the creation of more common data systems.

Both the alcoholism and drug abuse institutes now require, as a condition of funding of community projects, the recording of information about the characteristics of clients, the treatments they receive, and even follow-up.

We have been under a great deal of pressure, particularly from the States and communities to develop a common system.

A great deal of progress has been made. It is also mentioned in the report of the President's Commission on Mental Health. The second area of cooperation between the institutes has to do with the level of State planning.

A number of States have consolidated agencies for drugs and alcoholism. We have developed an option for the States where they can either provide joint plans or they can provide a single plan for alcohol, drugs, and mental health.

As you know, States that receive Federal funds in these three areas must provide the Federal Government with an annual plan indicating how the Federal funds for community projects or State contracts will be used, and how they fit into an overall health plan.

Mr. NELLIS. Excuse me, Dr. Klerman.

Do you agree that the existence of separate institutes for separate types of chemical addiction does as the chairman indicated, create problems of coordination?

Dr. KLERMAN. Yes.

Mr. NELLIS. And it is that issue that this committee is most significantly interested.

And let me point out to you that the Congressional Resource Guide prepared by this committee which will be published in about a week or 10 days shows us that approximately 37 agencies within HEW alone have some jurisdiction over some aspect of drug abuse.

How in the world—maybe by now—can you possibly coordinate the activities of 37 agencies where they have never been coordinated in the past so far as we can tell.

Dr. KLERMAN. I agree with you and your chairman that the existence of two institutes plus the 36 other agencies in HEW creates a creative opportunity for coordination that has not yet been achieved.

Mr. NELLIS. Yes.

We would like to see some achievement in that area.

Dr. KLERMAN. With regard to the two institutes in question, there are benefits of separate advocacy and the independent pursuit of the special needs of those two fields.

The decision that the Congress made in 1974 was to deal with the problem by creating three autonomous institutes in mental health, alcoholism, drug abuse, and creating ADAMHA as a structure for program coordination.

I think this is the best way to proceed, and considerable progress has been made.

I have acknowledged, as you indicated, that there is a great need for coordination.

With respect to coordination between the two institutes in question, that is my responsibility by statute as well as by the special directive of the Secretary.

The Secretary has asked Mr. Meltzer and I to look into the coordination of drug abuse activities with the other 30 plus parts of the Public Health Service as well as other parts of HEW such as Human Development Services, Social Security Administration, and the other groups enumerated in your very comprehensive catalog.

Mr. NELLIS. Mr. Chairman, I hope that before I leave this committee, leave its service, that when the committee is reconstituted it will have alcohol in its jurisdiction.

The staff has the impression and the feeling, based on careful analysis, that they will come when these problems must be the responsibility of one agency and one agency that would be responsible for coordinating the activities of treatment.

Mr. WOLFF. Your aspirations may be greater than your accomplishments.

Dr. KLERMAN. I might say that other Members of the Congress have very strong opinions of a different nature with regard to the importance of the autonomy of efforts in alcoholism and drug abuse.

Mr. WOLFF. One point, however, I think is important is the fact that a great cross pollination exists in a variety of areas of mind-altering substance abuse.

It demands attention at not only top level, but at some point where we can really reach into the prevention area, to the root causes of why people are into any mind-altering substance in the first place.

I think all of the efforts that we make as a committee, the big headlines on our interdiction efforts were directed at a cut in the supply.

There is not that much general interest in the question of prevention because you don't know how many people you are going to prevent becoming dependent upon drugs.

The treatment side of it, for the most part, the public looks upon as almost parasitical on society, and yet, perhaps it is this area that is the most neglected part

When this committee talks about the idea of some sort of integration or coordination, it doesn't necessarily follow that it is looking toward the physical aspects of combining the agencies, but combining, in some fashion, the major thrusts of these agencies.

One of the greatest problems I think that exists today is the lack of information that the public has on the interaction of one drug upon another. And the dangers that exist. It was only a short time ago that people were totally unaware of the interaction between the tranquilizers and alcohol.

Now, if we have a thrust in one direction and a thrust in another direction without bringing them together in some fashion, we are going to find that we are really not solving the problem, but merely solving the problem of one area and moving the problem itself over into another area.

As we go on to the question of the drugs themselves, and the priority that is put by various agencies upon specific drugs of abuse not only this committee, but others, have directed attention to heroin.

And you have very amply stated the major thrust in the area of attempting to stop heroin abuse because of its most debilitating effects, but really, if you come down to it, PCP right at the moment is a greater danger to us than is heroin.

Why? Because of the unknown quality of PCP. The fact that it is readily available, and it is highly destructive.

Glue itself is a destructive element.

Are we going to outlaw all these substances?

We have got to go much and far beyond, reaching into, again I repeat, the root causes of addiction and depending upon these mind altering substances.

I don't think that we are making very much progress in that direction.

Perhaps you can dissuade me from that view.

Dr. KLERMAN. I can describe some small steps that have been taken.

The document in front of my colleague, Mr. Dogoloff, is entitled "Drug Use Patterns."

One of its significant features is that it does exactly what you have been urging.

Namely, at the White House level, the report has looked at the use of all drugs, including alcohol and prescription mind-altering drugs like tranquilizers and barbiturates.

And it has attempted to develop some comprehensive policy particularly in the area of prevention and research.

At our level, I can mention, for example, at NIDA and NIAAA, a Joint Committee on Substance Research which reviews research projects which involve the interaction or combination of alcoholism in certain drugs.

They are currently spending about $1 million per year on that research.

That is a cooperative effort.

They also cooperate in a program for career teachers, whereby faculties of medical schools are funded for the teaching of addiction and for the development of curricula and other material jointly on alcoholism and drug abuse.

Those mentioned are some examples of—on a program-by-program

basis—where we have attempted to meet the challenge that you identified where there is overlap in criminality and addiction.

Mr. WOLFF. What about the sociological aspects?

I repeat this time and time again—

When drug abuse was limited to the ghettos of our country, nobody gave a damn, really, about what was happening. It was not until it came out of the ghettos and into the more affluent areas of our country and affected the military that there was this now major effort waged against addiction.

What about the social pressures?

Are we examining today the social pressures? The problems of unemployment and its correlation, the problems of lack of proper housing and its correlation?

The whole gamut of social problems and where they impact upon the questions of addiction.

We have had problems of addiction with us ever since, I guess, this country began, but not in the magnitude we are faced with or have been faced with since the 1960's.

We, now, are examining the whole problem of senior citizen addiction, the addiction of women within our society.

What is being done? What type of research are we doing now to attack this very basic area of the social problems attendant with drug abuse.

Dr. KLERMAN. One of the prominent studies conducted by Dr. Brenner of Johns Hopkins University, a researcher who has been funded by ADAMHA and who has studied the relationships between changes in employment and other economic indices, a study where there is some controversy, indicates that when there is a rise in unemployment, there is also an increase in alcoholism, suicide rates, and hospitalization for mental illness and drug addiction.

This does relate to one of the major problems that we face in rehabilitation of our clients, particularly those involved with heroin. About 85 percent of the clients in the NIDA programs are members of minority groups, either black or Hispanic. The unemployment rate among their populations in some communities is as high as 50 percent.

This is a very serious problem. Not only does unemployment contribute to the sense of despair and futility that leads many people in certain minority groups to get into the drug-taking cycle, it also seriously compromises and limits their rehabilitation program if there are no jobs available.

I offer that as an example to illustrate the point that you are making. There is a very intricate relationship between a social factor such as unemployment and the causation of addictive problems and our efforts at treatment and rehabilitation.

Mr. WOLFF. At the White House level, are we addressing that type of situation?

Mr. DOGOLOFF. Sure.

For the first time, in an executive level review, we have addressed issues like drug abuse in the elderly, drug abuse among women, multiple drug use. This will appear in the strategy for the first time this year. This is really new, at least in terms of things coming out of the White House. And it represents new directions. I think it is

being very well received in the field, as well as Government agencies, and new directions are emerging.

It is going to take a while to figure out the answers to the very complex questions you raise. At least the thinking has gone on. That kind of thinking and that kind of a program results in broadening our concern about the kinds of populations involved with drugs, and the kinds of drugs in which they are involved. Particularly, we are concerned about interactions between drugs, and drugs and alcohol.

We have that all set forth, and I think we have a blueprint from which to operate.

Dr. KLERMAN. The Department is underwriting a conference on teenage health problems later this month. Secretary Califano is giving the keynote address. I know that he will include in his address a concern for youth with drug and alcoholism problems.

In addition, the National Institute on Aging, which is one of the institutes at NIH, is having a conference on sedatives, hypnotic drugs, and sleeping problems of the elderly later this summer. Again, it is an attempt to deal with the problem you just identified, the hidden issue of drug abuse in the elderly, particularly around sleeping pills and sedatives.

Mr. WOLFF. Thank you.

Mr. Carro?

Mr. CARRO. Thank you, Mr. Chairman.

Mr. Dogoloff, I would like to address my first question to you, please.

In terms of policy priorities, how would you characterize the President's attitude toward drug abuse, particularly in the area of demand reduction?

Mr. DOGOLOFF. Where is his priority in terms of demand reduction?

Mr. CARRO. Yes.

Mr. DOGOLOFF. We see the President's priority regarding drug abuse as an issue that is very clear. He has been outspoken and very active in support of the program. I don't know that we think in terms of a competition in priority between demand, supply, and international aspects of the program. Each are individual efforts that are important parts of a whole program.

I don't know if there is any time when we do something in one area at the expense of something in another. It is a difficult question to answer, because we just dont think in those terms.

The demand programs are important. There is a real commitment—on the part of both the President and the First Lady—to the whole area of drug abuse, alcoholism, and mental health. Mrs. Carter has been very involved in the Mental Health Commission report. We are going to be working together with the agencies, particularly with Dr. Klerman, in implementing the recommendations. She has been very outspoken.

I think that part of her desire to remove the stigma associated with mental health problems will have spillover into alcoholism and drug abuse.

The First Family has been involved very directly in drug programming. When I was with narcotics treatment in the District of Columbia, then Governor Carter came through, looked at the program and talked to patients. In addition, some of the children have worked in drug clinics.

So this is something that is very familiar to the First Family and something that they hold as very important.

Mr. CARRO. The committee has been reviewing the NIDA budget request for treatment, prevention, and demonstration, exclusive of training, and research for fiscal years 1978–79. Between fiscal years 1977–79 NIDA increased its budget requests in these areas by $11.4 million, to a total of $176 million for fiscal 1979. During the same period the total combined treatment, prevention, demonstration budget allowed NIDA by OMB increased only $310,000. In fact, the OMB allowance in these categories actually declined by $1.2 million between fiscal 1978 and fiscal 1979.

My question is this: Has OMB's practice of straightlining the NIDA budget—in other words, holding the budget to a more or less constant figure over the fiscal years made it more difficult for NIDA to do its demand reduction job?

Mr. DOGOLOFF. That is a question better asked of NIDA, although I think it is important to put the NIDA budget into perspective.

You find that NIDA, in fact, got increases in the last year which I believe exceeded the other two institutes. If you compare what has happened with the NIDA budget in the last budget cycle, relative to NIAAA, you will see that NIDA got a very substantial increase in its research budget. I think that you were right in terms of the fact that it held steady in the demonstration area. And I think that NIDA would be better able to talk specifically about that impact.

In general, this budget has fared relatively well in view of the tight budget overall in the Government and within the three institutes.

Mr. CARRO. In 1977 OMB allowed NIDA combined for treatment, prevention, and demonstration $160 million; in fiscal 1979 it has only risen to $160,310,000. I hope the other institutes are faring a little bit better than NIDA is, in this regard.

Dr. KLERMAN. With regard to demonstration and treatment projects, the situation is the same. There were no new starts recommended or funded in the community mental health centers program.

In general, with regard to service programs, there has been a relatively level appropriation request. There have been increases in research funds, particularly as a result of the report of the President's Commission on Mental Health.

Mr. CARRO. In the area of prevention, which I think we probably all agree is one of the keys to a successful demand reduction policy, NIDA requested $8.4 million for fiscal 1979; OMB allowed $5.1 million. And between fiscal 1978 and 1979 OMB cut the NIDA prevention budget by approximately $500,000, to a point some $3.2 million below that which NIDA asked for and in which HEW concurred.

My question is: Is the NIDA effort in drug abuse prevention being hampered by lack of funds and OMB's refusal to honor the budget request in this area?

Mr. DOGOLOFF. I think the prevention issue is a much broader one than whether $3 million, $5 million, or $8 million is enough to do the job.

I don't think that any of those figures is really enough to prevent drug abuse. We talk about that in our report and lay out a philosophy that talks much more about a generic approach to prevention rather than one that is specifically aimed at drug abuse.

By continuing to make unclear differentiations between what is research and what is modelbuilding in terms of prevention and what is service delivery, I don't think NIDA has or will have the budget capability to provide effective prevention programs for all youth in our country.

On the other hand, with the resources it has it has done a very fine job of attempting to include evaluation components in all of its research.

I read just last week where there is an evaluation being done of all of the prevention programs to see what works and what doesn't work.

I think some very good things are happening. It is very difficult to say how much is enough for prevention, and whether or not prevention programs ought to be in NIDA or drug-specific, rather than generic in terms of trying to develop healthier children. To the extent that we impart decisions about drug taking we also help children make more responsible decisions about a number of things, which include drug and alcohol abuse, and vandalism and delinquency, and will impact on all of those behaviors.

I think it is very much open to question.

Mr. CARRO. If NIDA and HEW feel that there is a need to spend about $8½ million in the area of drug-abuse prevention, and OMB is coming back and cutting you, giving you only $5 million, it seems to me that you're going to have trouble doing the job that you think you ought to be doing.

That is the point I'm trying to make.

Mr. DOGOLOFF. You can't do as much of a job.

Mr. CARRO. One more question.

The figures I have been citing to this point are in terms of current dollars to the fiscal year in which they have been appropriated. What I find somewhat more striking is the fact that when you take these figures and adjust them for inflation, merely since 1977—only a 3-year-budget cycle—you find that the OMB allowances for treatment, prevention, and demonstration have actually shrunken by some $17 million.

In the area of treatment alone, when inflation is taken into account, the NIDA treatment requests have shown decreases of about $12 million, and the OMB allowance for treatment alone, again shows a decline of $10 million.

Has the decline in the buying power of the dollar, coupled with the relatively constant NIDA treatment prevention demonstration budgets allowed by OMB, hurt the total demand reduction effort?

Mr. DOGOLOFF. I think it is a strapped program. It has made it much more difficult to provide the same kinds of services. I think it calls for a rethinking on the part of the programs about what is essential and what are the most effective, efficient ways of doing it.

I think it has hurt; there is no question about that.

It is State level, and the programs are on a declining match rate down each year to 60, 40 percent, and there is no question that that has got to hurt and that it takes its toll.

Mr. CARRO. In fiscal year 1978, the NIDA budget request showed a tremendous increase. They asked for some $24 million to accommodate approximately 13,400 new treatment slots. HEW, in reviewing the NIDA budget, dropped those slots from the request and forwarded it on to OMB.

Can you fill us in on any reason—or perhaps Dr. Klerman can—as to why that cut in treatment slots took place?

Dr. KLERMAN. What fiscal year?

Mr. CARRO. 1978.

Dr. KLERMAN. I can't. I was not involved in that budget process.

I can find out by reconstructing, but I personally was not involved in those decisions.

Mr. CARRO. OK; we will ask those in writing so you can have time to put those together.

Mr. WOLFF. The gentleman's time has expired.

Mr. CARRO. Thank you, Mr. Chairman.

Mr. WOLFF. We have another panel here.

If you would submit your questions, Mr. Carro, in writing, we will be able to get answers.

Mr. Gilman?

Mr. GILMAN. Thank you, Mr. Chairman.

Dr. Klerman, in listening to the testimony about the various work that your agency does with alcohol and drug abuse, who in your agency coordinates all of this effort?

Dr. KLERMAN. It's my responsibility, as the Administrator, to provide for coordination across the three institutes.

Mr. GILMAN. And how do you do the coordination?

Dr. KLERMAN. We have a number of different mechanisms.

I meet each week with the members of the three institutes and have ongoing discussions of policy. We constitute a series of work groups on specific areas, again, that cuts across the three institutes. We have a work group going on prevention which has been ongoing for a number of years; we have a work group on data systems, epidemiology; we have a work group on the assessment of treatment.

So one mechanism is to identify the problem, share it among the directors of the three institutes, and then to develop work groups comprised of staff from the three institutes.

In addition, there is a small staff in the office of the Administrator that facilitates this coordination in areas like planning, budget analysis, personnel, and staffing some of these work groups.

Mr. GILMAN. Is there some sort of a comprehensive national strategy that your work groups, institute chairmen have worked out for treating and rehabilitating those suffering from drug abuse and drug addiction?

Dr. KLERMAN. The overall development of the national strategy comes from the White House. We participate very actively. Policy reviews were undertaken earlier this year by the White House. We participated quite actively in the one on demand reduction, which involves treatment rehabilitation.

Mr. GILMAN. Who in the White House was working on that policy?

Mr. DOGOLOFF. I was working on that, as well as other people on the staff.

Mr. GILMAN. Are you now referring, Mr. Dogoloff, to the ODAP offices?

Mr. DOGOLOFF. Yes; under the Office of Drug Abuse Policy, the study lives on even though the Office doesn't.

HEW and other agencies are in the process of responding to the specific recommendations and in fact are working on their implementation. We continue to monitor that as an ongoing activity.

Mr. GILMAN. The study that came out, "Drug Abuse Patterns, Consequences, and Federal Response," did that come out of your Office?

Mr. DOGOLOFF. Yes, sir, that's the study we are discussing.

Mr. GILMAN. Is that the national strategy for drug abuse now?

Mr. DOGOLOFF. This is the most up-to-date statement on policy regarding demand reduction programs relative to treatment, rehabilitation, and research. This is the most comprehensive statement. It will be combined with a number of other policy reviews and form the basis of the Federal strategy which is now in the process of being drafted. That will constitute the Federal strategy for the entire program in one document. It should be available fairly soon.

Mr. GILMAN. Let me understand something.

Your Office of Drug Abuse Policy then established this report?

Mr. DOGOLOFF. Yes, sir.

Mr. GILMAN. Has this been worked on by the Strategy Council at all, or reviewed by the Strategy Council?

Mr. DOGOLOFF. It has not been reviewed by the Strategy Council, per se, although the people who have worked on this paper are also represented on the Strategy Council. This includes the Secretary of HEW, and all of the Cabinet members who are also on the Strategy Council and who have some program responsibility in this area. They have been consulted and have not only participated in the formulation of the document, but also commented on it and formally responded to the recommendations.

Mr. GILMAN. In other words, then, this Strategy Council hasn't formally reviewed this or made any recommendations?

Mr. DOGOLOFF. Each of the Cabinet members of this Strategy Council has in fact, reviewed the document and formally commented on it and are now in the process of implementing the specific recommendations.

Mr. GILMAN. I don't understand something. I'm going to ask if counsel and the Chairman would bear with me for a moment.

Do you have a Strategy Council that is supposed to be making policy in the White House? Isn't that correct? And this is a policy paper, isn't it, a major policy paper on drug abuse?

Mr. DOGOLOFF. It is a policy paper for part of the drug abuse program, yes.

Mr. GILMAN. And it has not really been formally presented to the Strategy Council.

Mr. DOGOLOFF. No; policy would not normally be formally presented to that entire Strategy Council. It would be presented to those members of the Strategy Council who have specific interests or responsibility for that aspect of the program.

Mr. GILMAN. Who is making policy, then? It was my understanding, and I assume it was the understanding of the committee, that the Strategy Council was supposed to make policy with relation to narcotics addiction and drug abuse.

Mr. DOGOLOFF. At the time that this document was prepared and released, the Office of Drug Abuse Policy was charged with the responsibility of setting that policy and therefore, publishing the report under its auspices. It is not published under the auspices of the Strategy Council. It is a publication of the Office of Drug Abuse

Policy, as you can see right on the cover. It therefore reflects our responsibility to do that.

Mr. GILMAN. Mr. Dogoloff, if I'm looking at Peter Bourne's letter of submission of March 31, 1978, and it says, "The Strategy Council on Drug Abuse will monitor the implementation, receive periodic status reports from the appropriate agencies."

Mr. DOGOLOFF. And that is, in fact, going on.

Mr. GILMAN. When did ODAP go out of business?

Mr. DOGOLOFF. The end of March, I believe.

Mr. GILMAN. And ODAP submitted its March reports to the Strategy Council and the Strategy Council, then, does not act on the report?

Mr. DOGOLOFF. Not as the council itself. Individual members of the Strategy Council who have involvement in this area of the program are deeply involved in the report and in its implementation.

Mr. GILMAN. Can you sort this out a little bit more for us now?

The Strategy Council, is it supposed to make future policy on drugs and narcotics?

Mr. DOGOLOFF. As a group, the Strategy Council will review and participate in the overall strategy, which is a document that consists of this as a basis plus six other reviews. That will be the comprehensive strategy which comes out once a year, produced by our office. They will, in fact, be involved in that document.

Mr. GILMAN. That is still a little fuzzy.

Mr. WOLFF. I would say to the gentleman, again, I can understand this confusion because it is quite apparent at our hearings that you are trying to direct your thrust at this Strategy Council and the merits or workings of this Strategy Council.

Mr. GILMAN. Mr. Chairman, I'm really trying to——

Mr. WOLFF. Mr. Dogoloff, I would ask if we could get a paper from you which delineates the activities of the Strategy Council and the differential that exists between the Strategy Council and the Office, not of Drug Abuse Policy, but the Office of Domestic Policy.

Why can't we get some clarification? I think that it will help Mr. Gilman's and our understanding of just where we are going into this.

I think that the main thrust of what he has been searching for is something that we want. Who is responsible for drug policy in the United States outside of the President?

Peter Bourne? Is he the drug czar?

Mr. DOGOLOFF. Yes; he is.

Mr. WOLFF. Then let's see what he then has responsibility for. We would like to delineate his responsibilities and his relationship to the Strategy Council.

Mr. GILMAN. Mr. Chairman, If I might just pursue that a moment.

You recall our meetings in the White House when we talked about the dissolution of ODAP and our great concern with the fact that once ODAP was resolved, there would be no policymaking group.

I think our fears were well taken at that time because I don't hear any actual work by the Strategy Council to take over the work of ODAP.

Mr. DOGOLOFF. There are still individuals in the domestic policy staff dedicated to the same mission and doing the same things the

office did. But they are not statutorily set as they were with ODAP.

There is still a staff. I am still serving as Peter Bourne's deputy in that regard. We still work constantly on these drug abuse issues in the same way.

Mr. GILMAN. Without a mandate and without any title.

Mr. DOGOLOFF. We have a mandate from the President and we do have a title.

Mr. GILMAN. What is your title?

Mr. DOGOLOFF. We are the drug abuse staff of the domestic policy staff. We are a discrete unit within the domestic policy staff and work directly with Dr. Bourne. It works very much the way it did in the past.

Mr. WOLFF. I am afraid that I must cut this portion of the testimony, Mr. Gilman.

Mr. DOGOLOFF. I will be glad to submit it. If you will.

Mr. WOLFF. I want to thank both of you, Mr. Dogoloff and Dr. Klerman, for appearing here and abiding with us through this extended period of time.

Mr. GILMAN. Could I just have unanimous consent to ask one——

Mr. WOLFF. Mr. Burke?

Mr. BURKE. I have here, Mr. Chairman, a source from the National Institute, a chart on drug abuse. This is for fiscal 1977 and 1979.

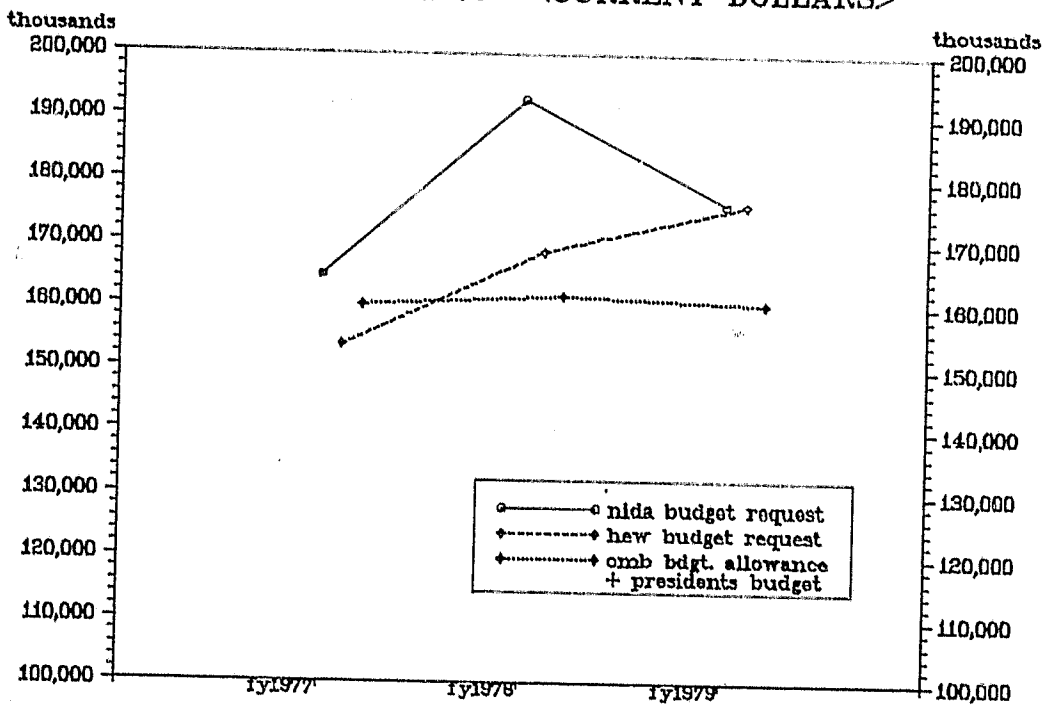
I would like unanimous consent to insert this in the record at this point.

Mr. WOLFF. All of these charts, I take it, Mr. Burke, there is a whole series of charts.

Without exception, these charts will be inserted into the record.

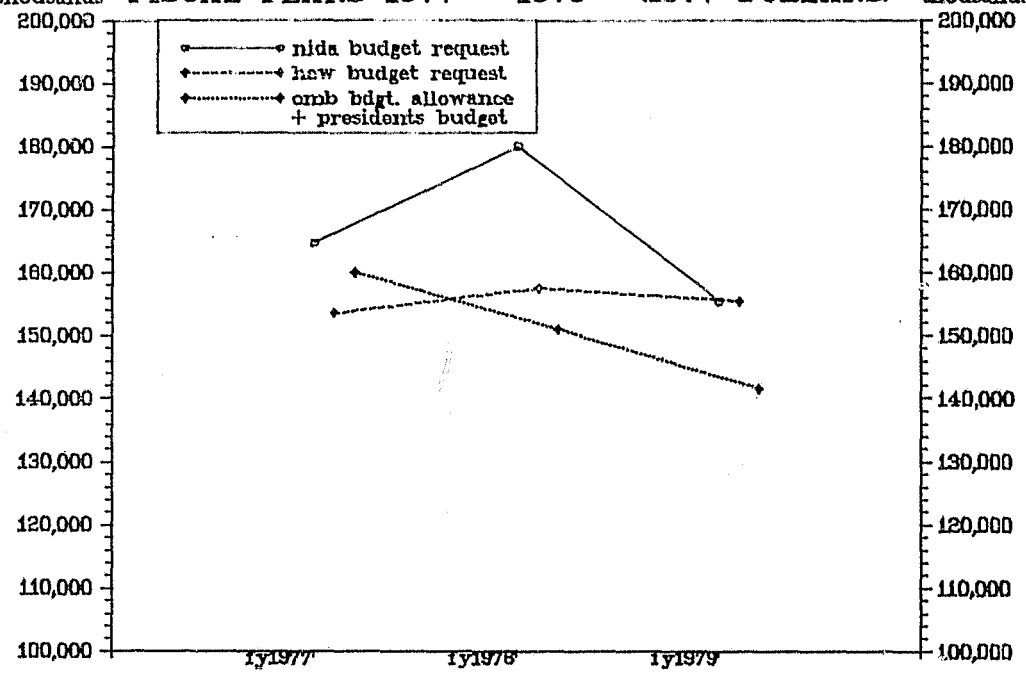
[The charts referred to follow:]

DRUG ABUSE TREATMENT – PREVENTION – DEMONSTRATION NIDA AND HEW BUDGET REQUESTS AND OMB ALLOWANCES F.Y. 1977 – 1979 <CURRENT DOLLARS>



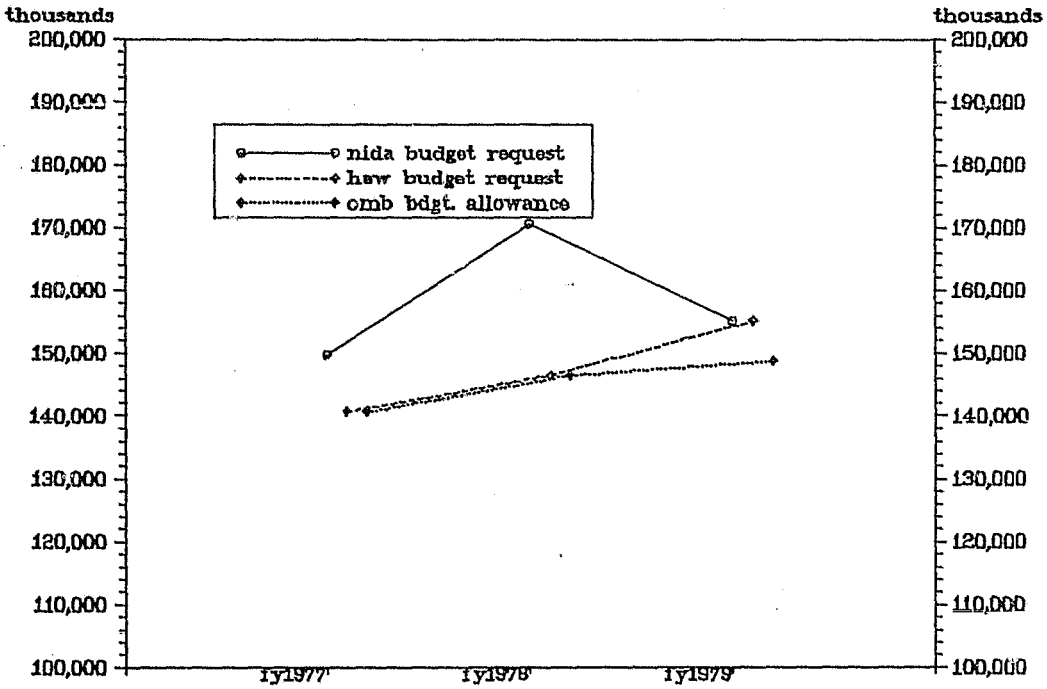
source: national institute on drug abuse.

DRUG ABUSE TREATMENT – PREVENTION – DEMONSTRATION
NIDA AND HEW BUDGET REQUESTS AND OMB ALLOWANCES
FISCAL YEARS 1977 – 1979 <1977 DOLLARS>



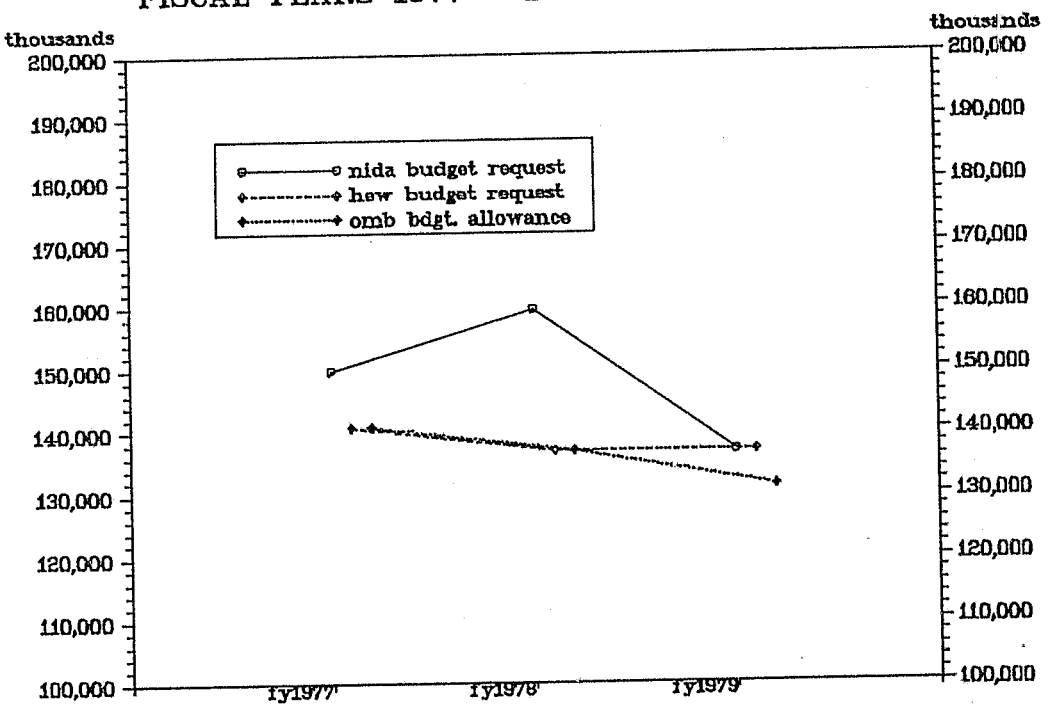
sources: nida, congressional research service.

DRUG ABUSE TREATMENT
NIDA AND HEW BUDGET REQUESTS AND OMB ALLOWANCES
FISCAL YEARS 1977 – 1979 <CURRENT DOLLARS>



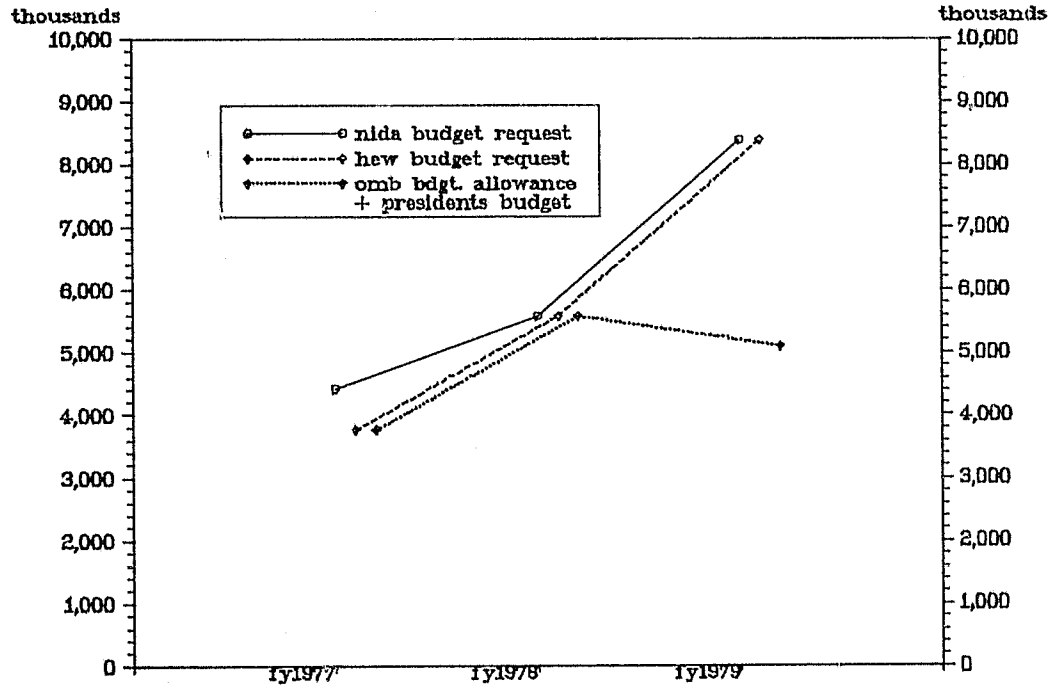
source: national institute on drug abuse.

DRUG ABUSE TREATMENT
NIDA AND HEW BUDGET REQUESTS AND OMB ALLOWANCES
FISCAL YEARS 1977 - 1979 <1977 DOLLARS>



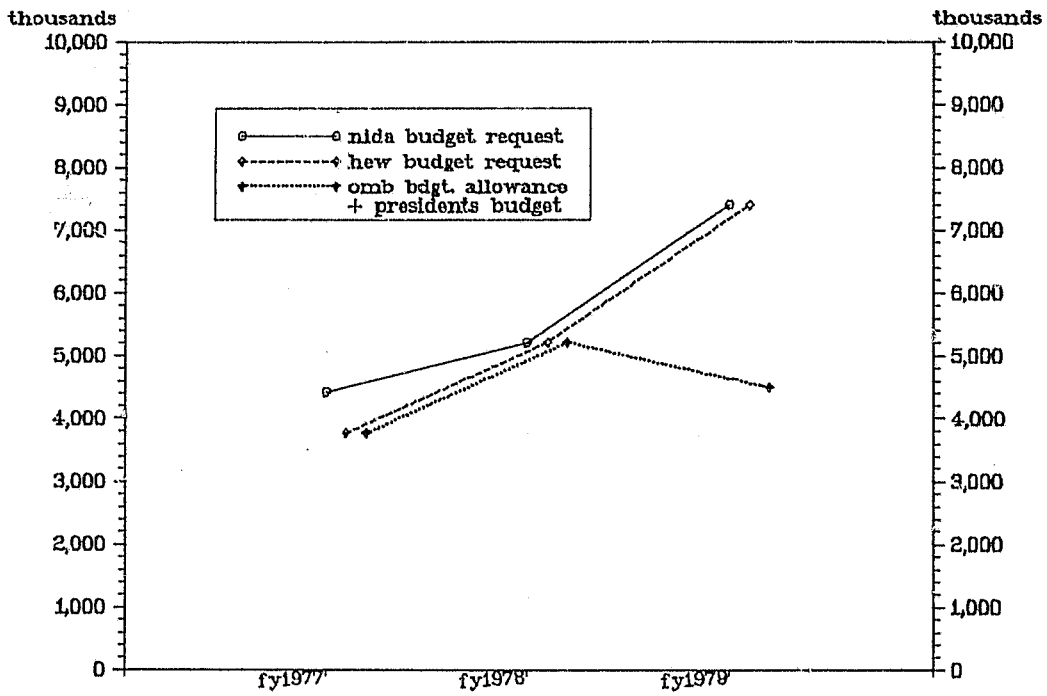
sources: nida, congressional research service.

DRUG ABUSE PREVENTION
NIDA AND HEW BUDGET REQUESTS AND OMB ALLOWANCES
FISCAL YEARS 1977 – 1979 <CURRENT DOLLARS>



source: national institute on drug abuse.

DRUG ABUSE PREVENTION
NIDA AND HEW BUDGET REQUESTS AND OMB ALLOWANCES
FISCAL YEARS 1977 – 1979 (1977 DOLLARS)



sources: nida, congressional research service.

Mr. GILMAN. Just one question.

When we were getting into the marihuana problems as I recall, there was testimony that NIDA had not undertaken a comprehensive study of the effects of the use of marihuana.

Is that correct?

Dr. KLERMAN. Marihuana has been the subject of ongoing research by NIDA. A series of annual reports have been submitted to the Congress as mandated by statute.

We provided the Congress with an annual report on marihuana in terms of levels of use——

Mr. GILMAN. I am not talking about levels of use. I am talking about the effects.

Dr. KLERMAN. Yes; including biological, psychological effects. Each year there is an updated report submitted to Congress, in January, something like $9 million a year on marihuana research.

Mr. GILMAN. On the biological and physiological effects, an extensive report?

Dr. KLERMAN. Yes.

Mr. GILMAN. Has that been submitted to our committee?

Mr. NELLIS. We got the last one. I don't know if there has been one since the last one.

Dr. KLERMAN. The 1978 report is still in progress.

Mr. GILMAN. It seems to me when Dr. de Jong was before us, we did not find any comprehensive research that had been undertaken with regard to the physiological-biological effects.

Dr. KLERMAN. We would be glad to provide you with the material.

Mr. GILMAN. I would welcome receiving a copy of it.

Mr. WOLFF. Thank you, gentlemen.

Mr. Burke, will you take over the Chair?

Mr. BURKE. Thank you very much.

This morning and early this afternoon we received the testimony of representatives from the White House on the Alcohol, Drug Abuse, and Mental Health Administration concerning the current Federal policy designed for the national treatment effort.

Now, however, for the rest of the afternoon, the committee will seek assessments of the Federal effort in promoting an integrated treatment framework from grass roots sources.

Before introducing the witnesses, I would like to explain the concept of integrated treatment services, whose development seems to be, thus far, so elusive.

Individuals requiring drug treatment services are oftentimes also in need of other services, such as vocational training, job counseling and placement, and various types of health and social assistance.

Many of these programs fall into the jurisdiction of other agencies within HEW, as well as outside HEW in the Department of Labor and the Department of Housing and Urban Development.

But it is clear to this committee that drug abuse is not an independent phenomenon separate from all other aspects of an individual's personality and problems.

Consequently, an integrated treatment approach that easily allows an ex-addict to utilize other services, through established referral mechanisms, must be promoted so that these individuals can reenter society as productive members in the most efficient manner possible.

In an attempt to facilitate the delivery of essential services to those treated under NIDA's statewide services contract, the agency recommends that contractors enter into cooperative agreements with the providers of essential services.

Services at the State and local level include: The criminal justice system; manpower and vocational rehabilitation agencies, public and mental health and alcohol abuse agencies, and the State's educational system.

The statewide services contract manual issued by NIDA specifically addresses the need for coordination of services at the State and local level.

However, these liaisons are not required for grant approval, nor are they judged by NIDA in considering program success. Recidivism rates alone cannot be the only criterion by which a program is evaluated.

This, however, reflects the Federal funding approach as being too vertical in scope and, consequently, ineffective in encouraging the establishment of integrated services.

It has been some time since the concept of the comprehensive and integrated treatment approach was first advanced. Despite the existence of the mechanisms required for such programs, the integrated framework so widely agreed upon has yet to be fully realized. Perhaps if those Federal agencies involved in its development would begin to set the good example of cooperation and coordination, counterparts on the local level could more easily actuate integrated treatment service development.

This afternoon's witnesses will address these and related issues from the local standpoint. Hopefully, from their criticism and recommendations, we can achieve a balanced view of why this wholistic approach to drug treatment has been so long in coming.

Appearing before the committee this afternoon are: Dr. David Lewis and Mr. Claude Reese, the chairperson and vice chairperson of the National Association for City Drug Coordination; Mr. Ed Menken, the vice president of Project Return in New York City; Dr. Fred R. West, Administrator, Substance Abuse Administration, Narcotics Treatment Administration; and Ms. Susan M. Kirchberg, director, Division of Substance Abuse, Department of Mental Health, Mental Retardation, and Substance Abuse, city of Alexandria, Va.

Before I begin I will ask my colleagues if they have anything to add.

Mr. WOLFF. I would like to swear in the witnesses. Then if my colleagues want to make statements, we will hear from them before hearing from the witnesses.

[Witnesses sworn.]

TESTIMONY OF DR. DAVID LEWIS, CHAIRPERSON, NATIONAL ASSOCIATION FOR CITY DRUG COORDINATION, BOSTON, MASS., ACCOMPANIED BY CLAUDE REESE, VICE CHAIRMAN, NATIONAL ASSOCIATION FOR CITY DRUG COORDINATION, NEW ORLEANS, LA.; DR. FRED R. WEST, ADMINISTRATOR, SUBSTANCE ABUSE ADMINISTRATION, NARCOTICS TREATMENT ADMINISTRATION

Mr. BURKE. I wonder if you would proceed, and what we would like to have you do, if you would, is proceed with your statements

first. We will accept your statements as if you had delivered them in the record, and then you can summarize your statements, if you wish.

After you have all concluded your statement, if we follow the policy which we intend to but don't always do, we will try not to interrupt you until you all proceed.

Dr. Lewis, will you proceed first?

Dr. LEWIS. Good afternoon, Mr. Chairman, members of the Select Committee.

I am Dr. David C. Lewis, the chairperson of the National Association for City Drug Coordination. I am accompanied today by Mr. Claude Reese, vice chairperson of our association and director of the Bureau of Drug Affairs for the city of New Orleans.

We appreciate the opportunity to appear before you today on behalf of our member cities to offer you an urban perspective on the efficacy of the Federal effort in promoting the establishment of integrated treatment services.

The National Asosciation for City Drug Coordination is a consortium of city drug coordinators representing mayors of cities with major drug-involved populations. It is, of course, at the local level of Government where drug abuse treatment and rehabilitation efforts are ultimately brought to bear.

It is, therefore, the large city drug services coordinator who is most directly aware of the success, or lack of success, of Federal and State efforts to promote a systematic, comprehensive programing effort.

The absence of large city government participation in Federal drug policymaking and State planning is an inexplicable situation inasmuch as it is in its large central cities where the Nation's most severe drug problems are concentrated. In fact, the conditions of heroin addiction and crime which initially prompted the expanded Federal response to drug abuse as embodied in Public Law 92-255, were conditions peculiar to the urban environment.

The expanded Federal response was required in part because the scope and extent of the problems associated with addictive drug use had far transcended the ability of city governments to effectively respond. And for the most part, State governments whose legislatures were frequently dominated by rural and suburban interests were generally reluctant to become extensively involved in responding to what was essentially a central city problem.

Nevertheless, State governments were designated to play a major role in the expanded Federal drug effort resulting from Public Law 92-255. The role of local government was ignored.

The imbalance between city and State government responsibilities can be directly traced to the congressional authorization of annual formula block grants to the State which was detailed in section 409 of the laws enacted. In return for awarding formula grants, Congress required that each State establish a State drug abuse coordinating agency and annually prepare a State drug abuse plan delineating treatment and prevention needs statewide.

Thus, Congress, in effect, required that nonurban States such as North Dakota, Vermont, Montana, and other States having comparatively negligible drug problems plan a drug abuse response effort while

35-070 O - 79 - 4

cities such as Newark, Detroit, Boston, Los Angeles, and others were ignored in the legislation.

The States, which are theoretically advised to take into account local needs through substate planning, have shown near unanimous reluctance to directly involve city governments in the planning process. State political realities have effectively produced a nonurban drug services orientation, often ignoring or avoiding the States' major drug problem sites—their large central cities—and there has been no effective administrative mechanism for producing greater State sensitivity.

This is not a new story. As this committee knows I was privileged to appear at the hearings recently of this committee on prevention. In the chairman's opening remarks in that hearing of May 25, 1978, he cited a report which I am going to refer to later in my testimony that was prepared by the National League of Cities and the U.S. Conference of Mayors, which is a survey of cities over 35,000 in population.

The report discusses local needs and priorities and how the planning process is proceeding.

The date on that report is September 1976.

As the chairman noted in the opening remarks of the prevention hearing, that report noted that 62 percent of member cities that were surveyed didn't participate at that time in the formation of their State plans.

So we are not talking about something that is novel information. We are talking about something that has been the status quo since the enactment of the 1972 legislation.

And while there have been some improvements over time, we feel that it is still a very substantial problem.

The problem has been further aggravated as the principal Federal drug treatment and prevention agency, the National Institute on Drug Abuse, has become increasingly reliant upon the State plans to determine Federal funding decisions.

In fact, NIDA has announced its intention to fund virtually all its treatment and prevention efforts through statewide services contracts with State governments by 1979.

The rationale offered for this decision is "administrative efficiency." In fact, this increasing substitution of State decisionmaking for Federal decisionmaking does not augur well for the large cities where social costs of drug abuse are most severe.

In my written testimony, I give examples from some of our cities that more specifically deals with this issue.

Mr. BURKE. I don't like to interrupt you, but we have a rollcall on the floor and that is the second bell. I wonder if you would excuse us while we vote, and then return, which should be within the next 10 minutes or so.

Dr. WEST. All right.

Mr. BURKE. Thank you.

[A brief recess was taken.]

Mr. BURKE. I would like to remind you that actually the rules provide that you are under oath, and that we normally have two other members. But there may be a vote pretty shortly, and rather than keep you here, since you have all been here and we are a little behind, with

your permission and your authorization to remain under oath, I will proceed with the hearing.

The PANEL [simultaneously]. Yes.

Dr. LEWIS. The National Association for City Drug Coordination is recommending that a limited number of cities directly receive block grants for planning and service delivery to permit them to more effectively utilize the funds from a number of Federal programs for drug abuse prevention and rehabilitation. Moreover, these funds could then be applied in concert with local funds from other city-sponsored efforts, such as in parks and recreation, and thus further enhance the coordination of activities.

To facilitate this improved Federal-city liaison, NIDA might find it advantageous to establish an "Office of Urban Services." Such an office could overcome the buffer zone which has developed between these two levels of government with regard to policy development. NIDA needs more aggressively to seek large city government input for its deliberations, and the cities need to develop better understanding of NIDA's activities. Such an Office of Urban Services could be involved in administering and monitoring the development and coordination of drug-related services in our major urban centers.

The NACDC further hopes that the State-city relationship could be redefined so that major cities would be directly and meaningfully involved in the preparation of the annual State drug abuse plans. The legislation currently pending which amends section 409(e) of Public Law 92-255 would, if passed, certainly help restore local government's prerogatives in this essential planning role.

The importance of a revitalized Federal and State collaboration with local government can be emphasized by noting that there are large cities, with both the need and capability, interested in committing their resources to developing comprehensive programs for their drug-involved residents. However, this local activity will never reach its full potential until we have resolved the Federal and State liaison issues. Toward this end, the NACDC makes the following proposals:

One, direct Federal planning funds should be provided selected cities with particularly severe drug problems to enhance their planning and service delivery capabilities;

Two, other Federal block grant mechanisms to cities, such as CETA, LEAA, and the community development block grants of HUD should be reviewed for their applicability as models in the substance abuse field;

Three, an urban-oriented and efficient planning and services delivery model for the drug field should be developed and implemented, utilizing appropriate Federal agencies with NIDA taking the lead as the coordinating agency.

At this point I would like to introduce five documents which I will provide the Select Committee for its records. I believe these documents will be helpful to you. I know that some are already familiar to you.

The first I have already mentioned, which is the report of the National League of Cities and the U.S. Conference of Mayors, which the chairman of the committee has referred to in previous sessions.

Mr. BURKE. That is already in our record.

Dr. LEWIS. The second is the latest edition of the city of Philadelphia's comprehensive plan, which has just been published. And I

would like to submit that, because the city of Philadelphia is a very good example of a city that has been able to put together a number of Federal programs in support of substance abuse services.

Mr. BURKE. Without objection, the Philadelphia report will be inserted.

[The information referred to is in the committee files.]

Dr. LEWIS. The next is a chapter by Mr. Peter Goldberg, of the drug abuse council which discusses rehabilitative aspects of drug dependence, and talks about the relationship of treatment programs, funding mechanisms and outcomes. I believe that is a useful document.

Mr. BURKE. Without objection, that document will be inserted in the record.

[The information referred to is in the committee files.]

Dr. LEWIS. The next is an analysis of intergovernment issues similar to those I am discussing today that was prepared by Bob Downing and Peter de Jong, of the city of Boston Coordinating Council on Drug Abuse.

Mr. BURKE. Without objection, it will be inserted into the record.

[The information referred to is in the committee files.]

Dr. LEWIS. The final report is very timely, because it is a survey the results of which we are releasing here today, which has been conducted by the National Association for City Drug Coordination. This is a survey of 15 drug abuse program coordinators representing cities across the country, and it was conducted by the National Association for City Drug Coordination under the auspices of the drug abuse council.

The survey, as I have said, is just being released today, and offers the impressions of these drug abuse professionals concerning the patterns of heroin and other drug use in their respective cities. The results of this survey indicate some positive trends mixed with new demands which cities must be prepared to meet.

On the positive side, we see that the purity of street-level heroin is lower than in recent years. At this time there appears to be a decreasing number of persons seeking treatment for heroin addiction. However, the majority of city coordinators from the reporting cities indicated that heroin treatment programs are operating at or above capacity. Also, heroin is appearing from sources other than Mexico, a few cities report, and its effect on purity levels cannot be predicted. What that means, in essence, is that we are seeing white heroin reappearing.

Mr. BURKE. That statement you are making, that is based upon the survey that you intended be put in the record, that hasn't been released yet?

Dr. LEWIS. It is being released.

Mr. BURKE. You are going to put that in the record?

Dr. LEWIS. Yes.

[The information referred to follows.]

CITY DRUG COORDINATORS SURVEY - JUNE 1978

Question 1 What is the quality of the street heroin that's available? See GRAPH, page 2.

Question 1a How has it changed in the past year?

Overall, the cities surveyed indicated that the quality of street heroin available has decreased over the past year. Four out of 15 cities reported that there had been no significant change during the past year.

Question 1b What are the current sources of heroin in your city, i.e. Mexico, Turkey, Far East?

In the questioning of 15 cities concerning the sources of heroin in their city, 14 out of 15 responded that Mexico(brown) was the main source for heroin. 7 of these 14 also claim to have white heroin in circulation to a lesser extent. One of the 15 cities stated that the predominant heroin is white, suggesting a source other than Mexico.

Question 2 What is the current utilization of treatment for heroin addicts?

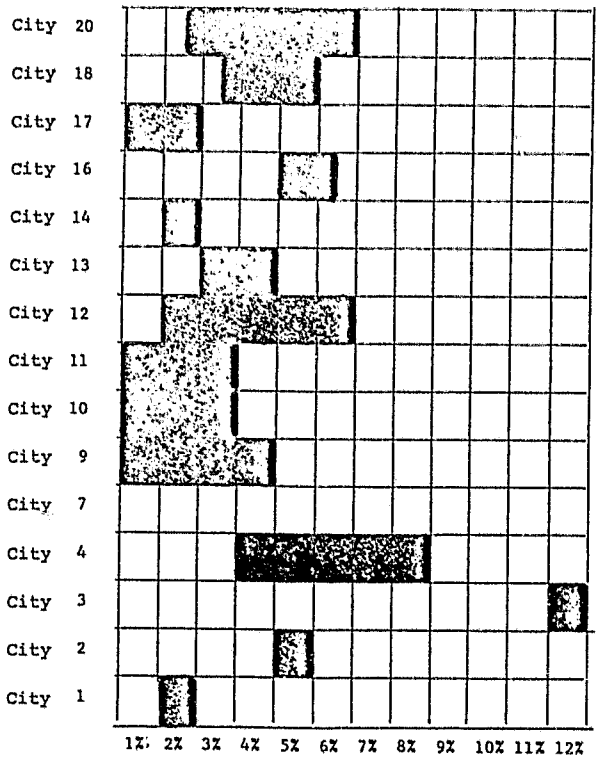
14 cities responded, 9 of which indicated that they are near(90% or above) or at, their assigned matrix. 4 cities reported lower current client levels.

Question 2a How has it changed in the past year?

10 cities noted a stable treatment services utilization rate. 3 cities advised that the utilization rate had decreased.

Question 2b Have there been any changes of note of the entry rate into treatment in the past year?

Question 1 What is the quality of the street heroin that's available?



Percentage of Purity of Street Level Heroin

Question 2b cont'd

8 cities reported that there have been no changes in their entry rates. Three respondents advised that entry rates had fallen, though one of these indicated the average age of clients had increased by almost 2 years from 27 to 29 years of age.

Two other cities noted that clientele younger than has been previously the case.

Question 3

What is the status of street-level heroin activities, as reflected in local arrests for heroin dealing?

Eight of the 15 cities responding reported that arrests related to heroin had decreased. Five of 15 cities indicated that arrests have increased. Two of 15 reported less "syndicate -related" arrests, one of these indicating that non-syndicate arrests have increased.

Question 4

Have there been any noticeable changes in patterns of drug use by high school students?

Several trends were indicated by the 15 cities responding to these questions. PCP use is generally on the increase with seven out of 15 cities citing a definite increase in use. Polydrug abuse is also showing increases, four cities mentioning their growing concern in this regard. Nine cities remarked on the rising use of both alcohol and marijuana, either separately or used together. The four trends thus identified seem to indicate an increase in the use of PCP, polydrug abuse, marijuana and alcohol among high school student populations.

Question 5

Assess the impression of heroin-related crime and associated social costs.

Ten cities discussed the relation between addiction and property crime, including breaking and entering, robbery and auto theft. One of these cities also documented a percentage of its homicide rate as "drug-related".

In describing trends, three cities indicated a decreasing drug-related arrest activity.

Question 6 — Can you give an impression of the relative importance of the drug issue for your city and predict any changes in the local drug scene for the forthcoming year?

City coordinators interpreted this question in different ways. Some looked at the priority assigned to drug abuse in the overall issues a city faces, while others looked at the problem itself.

On a scale of 1-10 with ten being "low priority" five being of "average priority", and one being "high priority", the responses might best be indicated on the following scale:

PRESENT PRIORITY

1	2	3	4	5	6	7	8	9	10
		x	x	x	x	x		x	
		x	x	x	x				
			x	x					

FORTHCOMING YEAR

1	2	3	4	5	6	7	8	9	10
		xxxx		x		x			

Cities responding to the second scale indicated that substance abuse would gain in priority during the coming year.

The majority of cities indicated that they see the "pure" heroin addict declining in numbers during the coming year. They see that the multiple (poly) drug user will increase, and are concerned that being locked into the federal matrix system will not allow them the flexibility to respond with appropriate treatment.

One city foresees an increase in overdoses during the next year, with a corresponding increase in drug-related criminal activity. The reason given for this is the weakness of the criminal justice system in encouraging plea bargaining.

Question 6 cont'd

A few cities see that adequate planning must be geared toward adolescent treatment; alcohol and pill use appear to be increasing among adolescents as does the use of PCP in a majority of cities. Only two cities indicated the recent decreased use of PCP. The majority of cities feel that greater emphasis should be made to reach students in high school, and that a wide range of services must be offered to them.

One coordinator indicated his city's concern about synthetic opiates for thebaine derivatives(e.g. naltrexone). This concern centered around the ease with which these substances are concealed, and the fact that 25 grams could supply thousands of users.

Cities in general expressed concern in their inability to evaluate and plan for the future. They feel that a mechanism must be developed to allow them to shift their resources to meet upcoming needs.

Survey conducted by the City of Boston Mayor's Office of Substance Abuse Activities, under agreement with the National Association for City Drug Coordination. (Under contract to The Drug Abuse Council, Inc.)

Mr. BURKE. The reason I ask, these are not your direct statements per se, but they are statements that appear in the study you are talking about, and you are quoting from it, is that correct?

Dr. LEWIS. I am quoting the summary of the study, which was done by the association. As chairperson of the association, I am releasing that information now.

Mr. BURKE. Thank you.

Dr. LEWIS. There are also substantial indications that users are turning to other opiates than heroin and depressants such as barbiturates. Relative to the purity of heroin in the streets—as the purity of heroin drops—there are a number of possibilities. One would be that more individuals might seek treatment, which occurred to some degree.

The other is that those users of heroin who find it more difficult to obtain the amounts they are used to will seek other drugs as substitutes, and that is what the cities are now reporting. Probably the most significant result of the study is the concern shown by every city surveyed with the changing trends in substance abuse by high school students. Most cities indicated that they are not currently equipped or funded to deal with the adolescents' growing use of PCP (phencyclidine), and various forms of sedatives, and also alcohol, which is regularly used in combination with the hypnotics and the sedatives.

In summary, in all of its activities the National Association for City Drug Coordination will be seeking a revitalized city-Federal partnership in the drug field, so that those in greatest need can be helped. I would like to offer the resources of the association to the Select Committee to form a joint effort to realize these goals.

Thank you for the opportunity to appear before you today and to discuss these issues.

Mr. BURKE. Thank you for coming.

Dr. LEWIS. I would like to introduce Mr. Claude Reese, who has come with me today. I would like him to make his comments also on behalf of the national association.

[Dr. Lewis' prepared statement appears on p. 84.]

Mr. BURKE. I want to thank you and Mr. Reese. Mr. Reese, your statements will be made by you orally, is that correct?

Mr. REESE. Yes, sir.

Mr. Burke and staff of the committee, I am Claude Reese, vice chairman of the National Association for City Drug Coordination. It is essentially important for me to clearly represent that there is organizational support for the statement made by Dr. Lewis. There is a great deal of consensus that the substance of Dr. Lewis' statement is very, very solid, and it is of critical importance that we find a way to effectively communicate that message to the committee and to a great deal of the general public which might have an interest in drug abuse prevention.

It is important also that I have the purpose to suggest that there is an urgency about us finding the ability to communicate with the committee and with others about problems cited by Dr. Lewis' statement. I can suggest that there is a study that was released about Christmas of 1972 that did not have an assessment of drug abuse, but instead sought to look at the relationship among cities, States, and the Federal Government.

That study was in part financed by HEW. The title of the study is just that: "The Cities, the States, and the HEW System." In addition to pointing out that HEW did not invent the State plan program of the State plan system, this study also suggested that many of the problems that we talk about today in having a meaningful role in the national drug program are problems that could be cited in 1972. They could probably be sooner than that, and certainly after that, and the years in between then and now.

It is the results of this study—these results suggest that mayors are drawn, willy-nilly, into the effort to understand State and Federal programs, State and Federal relationships that they have little involvement in. So I think it is important for me to reinforce Dr. Lewis' statement as vice chairman of the organization, and also to note particularly that we have a sense of urgency about finding an effective means to communicate our concerns and also our desire to provide for a more effective national program.

Mr. BURKE. Mr. Reese, we are delighted to have you here. We are delighted to have you reinforce Dr. Lewis. He did an excellent job himself. But any reinforcement is always welcome here. You expressed yourself very articulately. We are glad that you did.

Do you have anything further to say? Subsequently, some of us will ask you questions. I do want to apologize for the fact that at the present time there are not other members here, but we have other committee meetings to attend, unfortunately, and in between there is a suggestion that there may be a vote in the House on an amendment, because we are arguing amendments on the House floor. But at any rate, we will try not to hold you up any longer than we have.

I don't know who to call next, but I think it is only fair that we call on the lady. Is that Ms. or Mrs.?

Mrs. KIRCHBERG. Mrs.

Mr. BURKE. Mrs. Susan Kirchberg, Director of the Division of Substance Abuse, Department of Mental Health, Mental Retardation and Substance Abuse.

TESTIMONY OF SUSAN M. KIRCHBERG, DIRECTOR, DIVISION OF MENTAL HEALTH RETARDATION AND SUBSTANCE ABUSE, CITY OF ALEXANDRIA, VA.

Mrs. KIRCHBERG. Mr. Chairman and members of the staff, I would like to thank you for the opportunity to appear here today to outline some of my perceptions about the impact of the Federal Government on the provision of broad, comprehensive drug abuse rehabilitation programs at the local level.

In attempting to address that point, I would like to outline for you who I am and how we operate in the city of Alexandria, so that you will have some perspective on my perspective. I am the director of Alexandria's Division of Substance Abuse, one of three divisions in the city's Department of Mental Health, Mental Retardation, and Substance Abuse. I have been with Alexandria's program for 5 years, and I spent 3 years before that working in the field. This total of 8 years, as you know, makes me an oldtimer in the drug abuse treatment field.

The term "substance abuse" reflects the fact that I have responsibility for alcohol as well as drug abuse treatment, prevention, and control. In Alexandria, which has a population of 116,000, we have nine program components that provide services in the areas of alcohol and drug treatment, community and school education and prevention, and telephone crisis counseling. The number of staff members totals 60, not including police narcotics control and hospital emergency room staff. The budget for substance abuse programs in the city of Alexandria is approximately $1 million. If you look at a percentage breakdown on funding, you will see that we receive 23 percent from the Federal Government, 35 percent from the State of Virginia, 37 percent from the city of Alexandria, and 5 percent from private sources. In other words, 75 percent of our funds do not come from the Federal Government.

Alexandria's Division of Substance Abuse has its own strong advisory board, composed of private citizens as well as local agency people. The agency representatives include the city manager, the chief of police, the superintendent of schools, the director of the health department, the Commonwealth's attorney, the director of the office which operates the city's CETA program, the head of the local mental health association, the director of the recreation department, and representatives of the Alexandria Hospital and the sheriff's office.

This board is extremely important because it provides a ready framework through which our treatment programs are able to develop the kind of referral relationships and obtain the kind of program support which insure an integrated, holistic approach to treatment. Additionally, this board advises the Alexandria Community Mental Health and Mental Retardation Services Board, which is one of 38 such boards in the State of Virginia. Like the other boards, it has policy-setting and funding responsibilities to the localities and to the State's Mental Health, Mental Retardation, and Substance Abuse Department.

It is essentially at the local level that we set our program priorities, devise program goals and objectives, and establish policies and procedures for meeting those goals. We hire and supervise our own staff, including CETA employees; we decide what our basic philosophic approach to treatment will be; and we obtain the resources that are available to carry out our programs. We conduct all of these activities within what feels to me to be fairly broad, minimum standards of regulation set by State and Federal Government agencies.

When State and Federal money is involved, we present budget requests to the State. The Single-State Agency in the State of Virginia is the Division of Substance Abuse, which is part of the Virginia Department of Mental Health and Mental Retardation. The State's Division of Substance Abuse sets broad goals and objectives for the State, coordinates programs within the State, allocates resources equitably, insures that minimum standards are followed in service delivery, provides technical assistance and training, and acts as a liaison with agencies within the Federal Government.

How well does this system work from my perspective? What impact does the Federal Government have on our operation? Where do I see the strengths and weaknesses?

Given financial limitations and relative to the reality of bureaucracy, my overriding feeling is that the system works remarkably well. It

may be considered even more remarkable, given how young the field really is.

The Federal agency that I work with most often, and therefore feel most qualified to comment on, is the National Institute on Drug Abuse, or NIDA. I am affected by the policies promulgated by NIDA, so I have thoughts about Federal policies. I also have worked both directly and independently with NIDA officials, as well as in conjunction with State representatives.

Basically, I feel that the NIDA people themselves and the policies they promote are supportive to local programs. Relative to other bureaucracies, it appears to me that NIDA involvements result in far less redtape than other Federal and State agencies. The caliber of people working at NIDA is impressive, whether you work with people in the treatment division, prevention, research, grants and contracts, or women's programs, to name a few. Those I have worked with are competent people, committed people, reasonable people. They appear to me to work hard with State personnel to get as much financial and technical support for the localities as is possible, given funding limitations.

The policies and regulations set a reasonable framework of minimum standards that permit broad latitude in actual program operations, as I tried to indicate earlier. To the extent that the minimum standards have not fit our local situation, we have been able to get exemptions. NIDA also actively solicits local level input in establishing its policies, so I do feel that we can have a considerable impact on the formation of the regulations, if we choose to exercise our own power.

In working over the years at the local level, I feel strongly that Federal support of the Single-State Agency concept is commendable. The Single-State Agency in Virginia, for example, has the expertise to serve as the primary liaison with the Federal agencies working in the substance abuse field. In Virginia, the Single-State Agency model clearly provides a stability to all levels of the National drug abuse treatment network. From my experience, it appears to be an effective mechanism.

Another model promoted by the Federal Government which has had a direct and, in my opinion, a positive impact on local program operations is the merger of alcohol, drug abuse, and mental health activities under one umbrella administration, the Alcohol, Drug Abuse, and Mental Health Administration, or ADAMHA. This model, as set by the Federal Government, has already been adopted nearly statewide in Virginia. In the last 2 years, alcohol and drug abuse administrative operations have been merged at both the State and often the local levels, as in Alexandria. Furthermore, the alcohol and drug abuse administrative units have been combined at both the State and local levels, with the other mental health related units of government. This model has already increased the integration of mental health and substance abuse related activities and an improvement in service delivery has resulted.

I would also like to add, however, that as I see it from the local level, it is very important to retain strong, highly visible advocacy groups for alcohol and drug treatment and control. I am therefore very concerned about the possibility that ADAMHA might attempt to reduce the power and capabilities of the three institutes, NIDA,

NIAAA, and NIMH. It may be easier and more efficient to operate ADAMHA with one strong director, but it also appears to me that it is imperative that each of the three separate institutes have strong directors, people who have vision, high visibility, authority, and some ability to educate all of us, directors who can raise our collective consciousness and act as strong advocates for the field. What I am saying, in short, is that public information and education should not be sacrificed in order to have a more streamlined, centralized administrative structure for ADAMHA.

In summary, I would just like to say that from the local level, I feel supported and not constrained by the Federal Government. I feel that my expectations of the role NIDA should play are being met. I do not say that the system is perfect; I am a realist.

What appears to be at issue here is where the responsibility of the Federal Government starts and stops, the State's responsibility starts and stops, and that of localities starts and stops. It is my perception that the reality is that at the Federal level, you can set broad goals and funnel money through the States to the localities. However, the real control of program impact rests first at the local level where programs are operated, then at the State, and last at the Federal level. And this is how I believe it has to be.

You know as well as I do that the Federal Government cannot solve all of our problems. Program operations cannot be directed or controlled from the Federal level. What you can do, it seems to me, is to try to focus as much energy as you have toward: One, helping us educate the public about substance abuse in this culture; two, educating the other Members of Congress on the real need to appropriate more money, especially in the areas of education, prevention and research; and, three, promoting a more powerful, highly visible substance abuse prevention and treatment effort—whether at the White House, within the Department of Health, Education, and Welfare, or in your own local districts.

This concludes my statement. I would be happy to answer any questions that you might have at this time.

[Mrs. Kirchberg's prepared statement appears on p. 88.]

Mr. BURKE. Thank you for your testimony. We will have some questions after we hear you all. Mr. Menken, I think your testimony has some statements contrary to Mrs. Kirchberg's statement.

TESTIMONY OF ED MENKEN, VICE PRESIDENT, PROJECT RETURN, NEW YORK CITY

Mr. MENKEN. It seems that once again I am in a minority.

Mr. BURKE. Like the Republicans.

[Laughter.]

Mr. MENKEN. I do appreciate the opportunity once again to be invited by this body to offer my comments, experiences, and opinions regarding the national drug abuse treatment effort.

I would interject at this point that I administer one of the largest private, nonprofit drug abuse treatment programs in the United States. Our annual budget is slightly in excess of $4 million. $2.3 million comes from the Federal Government through the State of New York.

There is also city money involved and private dollars involved and

a number of hassles that we perform in order to be able to break.

On a personal note, I have been involved in this field for about 15 years, and I have worked in most of the major urban areas around the country, either on direct or consulting.

An examination of the way in which the Federal Government both finances and coordinates drug treatment and prevention activities is extremely important at this time. Some consideration has been given over the years to these matters but never in the depth nor with the level of dimensional understanding that is necessary. To begin with we must recall that period when there existed, as an extension of the White House, the Special Action Office for Drug Abuse Prevention—SAODAP. That agency was set up by Executive order during the Nixon administration and given the mandate to establish a national drug abuse prevention policy and to coordinate all efforts existing at that time, throughout the Federal bureaucracy, to bring every possible resource to bear upon the problem. SAODAP was, as I have mentioned in previous testimonies before this group, an agency born out of political motivation and "political realities." It should not therefore be surprising that much of its policy development was never formulated either with an interest or commitment to genuine problem solving or social concern. One of the best illustrations of this is the fashion in which the Federal Government, through SAODAP, developed its funding formulas for the treatment of drug abuse. SAODAP's staff sequestered themselves for a brief period of time and later emerged with the absolute conclusion that each modality of drug treatment should cost a specific amount of money. That was in 1972, and the price tags determined by SAODAP were as follows:

One thousand seven hundred dollars to treat an individual in a methadone maintenance program.

Five thousand dollars to treat someone in a residential drug-free environment.

Two thousand dollars to provide services in an ambulatory or outpatient module.

These figures were imposed upon all programs in the United States attempting to do a credible job in treatment and rehabilitation. We were never informed of the rationale; we were never told how these formulas were arrived at, but we were ordered to live with them.

In my primary areas of experience, which is the residential treatment model, the Federal Government delivered to us an inflexible mandate to provide quality care for comprehensive services to individuals at this absurd cost ceiling. Actually, it was worse. The funding formulas that I mention were created in relation to something called "slots." We were not funded for bodies, human beings; we were rather funded for "slots" or "beds" that an undetermined number of people might occupy during the course of 1 year. It did not matter to SAODAP and the Federal Government that every time a client moved out of the treatment program and another one took his place the cost would immediately escalate. We were required, you see, to provide complete medical and psychiatric workups for each individual to develop personal treatment plans and never to add the additional costs to the allocated amount. We were also expected to provide education and vocational services, family counseling, individual and group

therapy, recreational activities, and an absurd volume of reporting, much of which was unnecessary and irrelevant.

This story is significant not merely because it describes how the Federal policies governing Federal funding formulas were developed, but also because it is the backdrop against which our current dilemmas exist. The fact is that to this day we are funded in exactly the same fashion with even greater expectations directed toward us. It is now 6 years later and while the cost of living in this country has increased probably 5 or 6 percent each year—and I think I am being a little bit benevolent there—the increase in funding allowances from the Government are negligible; for example, where in 1972 we were permitted $5,000 per year for each residential treatment slot, we are now permitted $5,400. The net increase in 6 years, gentlemen, is 8 percent. The demands upon us grow, the public feels frustrated over what this Government has done to combat drug abuse, and we in the treatment and rehabilitation sector have had to take the weight. It seems that it matters not to the U.S. Government that treatment and rehabilitation costs from 100 to 400 percent less than it does to warehouse people in prison. It appears that Government officials have no interest in saving tax dollars while at the same time conducting more sensible programs. Indeed, one might think that the way this Nation is approaching its drug treatment responsibility is entirely schizophrenic. This committee is interested in encouraging a wholistic approach toward drug abuse treatment but the policies of the National Institute on Drug Abuse serve only to discourage such approaches.

Beginning with SAODAP and now with NIDA there is no opportunity for open dialog around the issues that prohibit us in the field from providing quality care to our clients.

This committee has asked several questions of me and I will do my best to respond to them.

First, it does not appear that the Federal Government in the form of NIDA has taken any initiative whatsoever to instigate helpful and what I would consider to be necessary cooperative activities among other Government agencies both at the Federal and local levels. Our clients for the most part are people who come out of families and environments that are plagued with very serious problems. If we do a decent job with addicts' psychological and emotional conditions, our efforts must then fly in the face of a tremendous void where other services should be. The Department of Labor, for example, operates a massive CETA program and we in the drug treatment and rehabilitation sector have no direct linkage to that program. The Department of Housing and Urban Development has a variety of programs that we ought to be able to link up with. But neither NIDA nor anyone else has helped us gain entry or make that connection. Indeed, various elements of HEW provide abundant options to assist us toward successful rehabilitation, but again there is no one assuming the leadership of coordination toward this end.

We in the drug abuse treatment and prevention field but particularly our clients, become severe victims of the fragmentation of Government bureaucracy. This committee promotes the term wholistic and nowhere in this Federal system is the spirit of that term carried forward. It is as if the U.S. Government in its wisdom perceives the

problem of its people to be segmented, compartmentalized, and fragmented in the extreme. If there is a question of health services, then you must appeal to one department; if there is an educational need, you must see another agency; if there is a problem with housing or child care or legal services, then you must trip around through an ever growing maze of disconnected bureaucracies. No one does it all. Everyone wants to send you somewhere else. And the result of this is the continued waste of millions and millions of dollars, and an incalculable amount of energy. The bottom line is that if we are able to get anyone well then it is in spite of this system. The fact that we are relatively successful should be considered almost miraculous.

Second, any level of cooperation that is established locally between drugs and other health services rest entirely on the local people. The Federal Government exercises no muscle whatsoever to accomplish this objective. There is much, I believe, that could be done in this vein, but it is not.

Third, any agreements or interrelationships with State education and other authorities is again the product of individual program initiatives.

To sum up these questions, what we are able to do is very little, and it is not simply because the Federal Government has abdicated. In my opinion, Government abdication in this case goes out as a signal to all those who should otherwise be involved, but are led to believe because of the Federal neglect that the Government really doesn't care. I am finally becoming one of those believers.

I have been asked for my recommendations, and they are, in part, as follows:

1. I would urge that the Congress call forward what is, in my opinion, the only responsible and reliable investigative body that still has the confidence of the people: that is, the General Accounting Office. I would urge that the GAO be directed to examine the funding formulas for drug abuse treatment established by the Government. I would suggest that they review these formulas and determine how drug abuse treatment and rehabilitation should be financed, what should be the method of payment, and the level of reimbursement for services rendered; how the Federal bureaucracy should engage in cooperative and determined efforts; and what other corrections might be made in the national drug abuse treatment and prevention policies.

2. I would urge that the GAO be assigned the responsibility, after extensive investigation, of reporting to the appropriate congressional committees, on the progress of how drug abuse treatment and rehabilitation may be included in any possible national health program.

3. I would urge this committee to include in its hearings testimony from related Government officials with respect to long-range policy planning in this area. I would recommend that this committee not satisfy itself around this issue until it has been told what plans NIDA and HEW have for the continued funding of drug treatment and prevention; until it has learned precisely what the formulas are and will be, if they are being established; and what is the thinking behind the strategies.

4. I would urge that the Congress consider legislation that would force health insurance companies to provide coverage for drug abuse treatment and rehabilitation. This is extremely vital. The Government

has the power and the capability to make this happen and to enforce it. And unless this country takes a militant step forward in seeing to it that the primary source for financing drug abuse treatment is placed with the insurance carriers and in the private sector, we will have once again succeeded in a billion-dollar disaster.

Thank you.

That is the prepared statement. I have just a couple of quick notes, if I may. And, I think these are valid illustrations of the inequities and the disenfranchisement.

One: In the formula funding, nobody ever gave any thought, nor do they give thought today, that the same exact formula is provided to any and every agency regardless of size. That means that a small program, which chooses to remain small and still be able to provide adequate and intensive care to a small number of people, say, perhaps 30, cannot survive at that level of funding. They must deal with the same exact amount of money annually per slot that a large agency such as mine has to deal with.

If you are not large, you cannot survive. Programs by the number are being folded into larger agencies in New York. I suspect that the trend is going to occur nationally. What that means is that you are promoting institutionalization. You are promoting the development of large agencies. And, whether or not the motivation behind it is to build empires, I don't know. In some instances it may be empire development out of greed.

Hopefully, there may be a few that have an interest in empire development in humanism. There is no way to control that unless the funding formula is changed. It is simply a question of volume. If you get $5,400 a year for a residential slot, and you have a contract to provide services to several hundred people, you can make it.

But, if you have a contract to provide services to 30 or 40, you cannot make it. You cannot provide quality care.

Next, the contracts that are let from the U.S. Government through NIDA to do a variety of things like technical assistance or to exercise some authority around issues that you have concerns about here today, for example, to bring the various aspects of the system together, are often let in the form of contracts to consulting firms.

I want you to know that these consulting firms so often have a billing rate of $400 to $600 per man-day—$400 to $600 per man-day. Think about that one.

What they have to do is very simply to go out and do a quick consultation. It doesn't involve any commitment. They are interested in the profit margin; and though I am not opposed to free enterprise, the issue of how cost will influence the ability to bring various sectors together is a very serious problem. It won't be accomplished in that fashion through consultants.

You don't get consulting firms out there to do that. You get Government officials to do that. It should be a part of their responsibility to do that, and you don't let contracts out with 110 or 140 percent overhead rates, for the sake of the profit margins, to perform that task.

One more thing regarding the chairman's opening statement: I believe, Mr. Wolff, that you made some reference there to the fact that the statewide services contracts given to contractors include

wording and something to do with the effect of having cooperative agreements with a variety of agencies.

I want to tell you that even though that is a very worthwhile and sensible thing to do, we can't do it. I wish we could do it. We would like to have cooperative and supportive relationships with hospitals, other health care agencies, rehabilitation facilities, vocational training facilities.

There are two things involved that are a severe prerequisite to that: One is funding for them; two is an attitude, and no one has stepped forward with any clout to say, "You will do it." There have been no executive orders issued at the highest level in these agencies, and I mean Washington, that tells the people in the regional offices and the State funding institutions, "You will do it." It doesn't exist.

So, while you want us to do it, and we want to do it, the folks out there don't want to do it. And, if we can succeed at it, it is almost like an accident.

Mr. WOLFF. I want you to know that statement was made by Mr. Burke.

Mr. BURKE. Thank you, Mr. Chairman.

Mr. MENKEN. Mr. Burke, you are right on.

Finally, we in our agency, in attempting—this is an experience I just want to show to you to further illustrate the point—in attempting to identify the close interrelationships, and in a fashion of timeliness with these compartmentalized and fragmented agencies and service provisions, we decided about a year ago that we were going to develop a national conference on women in crises.

It was going to involve four sections: women in mental health; women in alcohol; women in drug abuse; and, women in justice. The interrelationships in terms of services and needs between the clients is phenomenal. They are almost duplicative. We developed a formula for the conference. We have a tremendous number of national organizations and advisory groups. We're hoping to have the First Lady do the keynote speech.

However, to get the thing funded is like going through a maze, because everyone says, "Well, we only do this; we don't do that." And, nobody assumes responsibility to say that there is an interrelationship, and therefore, my piece of it and my mandate and my legislation and my allocation can appropriately be invested in such a worthwhile effort.

I don't know what the alternatives are. They seem to be clouded. They seem to be misguided, but we get further and further away, and I certainly welcome the interest of this committee and the direction it seems to be going. I don't know of anybody else that is saying the things that you are saying or asking questions that you are. It is certainly long overdue.

Thank you.

[Mr. Menken's prepared statement appears on p. 90.]

Mr. BURKE. Thank you very much for your enlightening words.

As I indicated, we have some questions for each of you, I think, unless the hour gets too late, in which event, we will submit questions to you and ask you to make them a part of the record, your responses.

Dr. West, who is the Administrator of the Substance Abuse Administration—Doctor, would you proceed with your statement?

TESTIMONY OF FRED R. WEST, JR., M.D., ADMINISTRATOR, SUBSTANCE ABUSE ADMINISTRATION, NARCOTICS TREATMENT ADMINISTRATION, WASHINGTON, D.C.

Dr. WEST. Mr. Chairman and members of the Select Committee, I am Fred R. West, Jr., M.D., Administrator of the Substance Abuse Administration, Washington, D.C.

I appreciate the opportunity to appear before the committee to testify on the efficacy of the Federal effort in promoting the establishment of integrated treatment services. In the interest of time, I have cut all of the fat from my prepared statement.

The creation of the Narcotics Treatment Administration in February 1970 was a critical step in the war against drug abuse in the District of Columbia and manifested a significant departure from traditional narcotics treatment.

During the first year of operation the client population escalated to nearly 3,000; it peaked at 4,500 in 1972. Our clinics, 16 in 1972, treated both adult and youthful clients, and dealt with all District residents appearing voluntarily and other residents of the metropolitan area referred by the District of Columbia Criminal Justice System.

Along with the aforementioned changing trends, the profile of the SAA client has also changed. The typical SAA client is now 27 years old; a black male with an 11th grade education. He is unemployed and not in school or training. He is a readmission to the program, has been in treatment this time for 6 months, and is receiving approximately 24 milligrams of methadone.

What does our program have to offer this client?

Because our typical client is a readmission to our program, upon presenting himself to the central intake division, he would be referred to the reentry clinic, because one of our major problems is our dropout rate.

After the reentry clinic experiences, our typical client will be referred to one of our clinics for treatment and subsequent referrals for other ancillary services to meet his specific needs. He does not have a job, so he would be referred to one of our employment development specialists for further assessment. Our typical client has an eighth grade education, so from there he might be referred to SAA's minilearning center for GED tutoring, or a course in landscaping or a course in housekeeping.

Because he is also single, he may have a female friend with similar problems. Attempts will be made to get her into treatment at our women's services clinic, designed specifically for females of childbearing age.

Major coefforts will be made between the medical and counseling components to detoxify this client to an abstinent state.

While our client is detoxifying, should he experience unusual medical and social hardships on an outpatient basis, we have recently received Federal funds now to establish an inpatient detoxification unit. Hopefully, when his period of detoxification is over, he will be ready for our adult abstinence clinic for further rehabilitation and reinforcement for reentry to the community, this time as a useful, productive citizen who will have continuous contacts with our adult abstinence clinic whenever needed.

Should our typical client have a nonopiate problem, he would have followed this route through our polydrug clinic; should be under 19 years old, his route would have started through the youth abstinence clinic.

We at the Substance Abuse Administration, too, feel that treatment and rehabilitative services are best delivered within the community whose population the program serves. However, neighborhood pressure has forced us to create enclaves like the comprehensive services center recently opened in the PCRC Building on the grounds of the District of Columbia General Hospital. This may be a blessing in disguise, for we have under one roof our women's services clinic, Emerge House—therapeutic community—Train II—federally funded multimodality treatment clinic—adult abstinence clinic, minilearning center—federally funded educational training facility—the education/prevention division, employment development branch, and the inpatient detoxification.

I am pleased to know that the report, "Drug Use Pattern Consequences, and the Federal Response," presented to President Carter by Dr. Peter Bourne, Director of the Office of Drug Abuse Policy, emphasizes some of the same issues that the Substance Abuse Administration has accepted as challenges.

This report addresses and emphasizes the need to look at the way Americans use all drugs—tobacco, alcohol, prescribed—as well as the many illicit varieties. This same issue was the underlying rationale for our change of our name from the more specific Narcotics Treatment Administration to the Substance Abuse Administration.

Another factor equally important to the rationale of the name change is our new philosophy and thrust of abstinence as opposed to an emphasis on the treatment of narcotics abusers, methadone. This was a major policy change supported by Federal funds.

I would also like to mention three additional recommendations cited in this report in hopes that more Federal funds will be forthcoming to assist in their implementation and fill the gaps in our program.

One, drug treatment programs must provide family counseling. Because of the nature and sensitivity of this therapy, more money must be alloted for the recruitment and maintenance of professionals to provide this essential treatment tool.

Two, the use of paraprofessionals in drug abuse treatment has long been a delicate issue. Federal money should also be earmarked for the upgrading of the skills of these workers, encouraging them to be credential bona fide counselors

Three, the Department of Labor and Department of Health, Education, and Welfare must take the initiative in developing model agreements not only to support employment and training programs for drug abusers, but to provide stipends for those participants, as well.

Four, drug education should begin in the sixth grade and should be inclusive of all substances which have an impact upon the physical and mental well-being. We feel that this education should include knowledge of the effect of saccharin, food additives, pollutants, cosmetics, radiation, and so forth, besides and five, all substances that impact on everyday life should be included as a part of primary prevention and should result in a redirection of interest from treatment to prevention and early intervention.

Mr. Chairman, this concludes my statement. I hope that I have made a meaningful contribution to the Select Committee. I thank you for this opportunity and am available to answer any questions that you might have.

Mr. BURKE. I want to thank you very much, Dr. West, for your report.

I would like unanimous consent, since we have agreed to include your report as you submitted it to us in the record, that the remarks that you wish inserted also shall be included, and also that the charts appearing as appendixes and the other data as appendix to your written statement be made part of the record.

Dr. WEST. Thank you, Mr. Chairman.

[Dr. West's prepared statement appears on p. 92.]

Mr. BURKE. I would like to ask several questions.

Perhaps, Dr. Lewis, you were the one who made the statement. Or perhaps it was Mr. Menken. I don't know which one made the statement about heroin—I think it was you—that there was an increase in the amount of heroin?

The reason I want to ask, the heroin now that is coming in is on the increase, as you indicated, is not the brown or black heroin that came in from Mexico but it is a white heroin again which is similar to the type that had been cut off during the time of the breakup of the French connection.

What now is the power or whatever it might be of that? Is it 34 percent? 32 percent? 7 percent? As far as the purity is concerned?

Dr. LEWIS. I do not have that information. I do not know what the percentage analysis of the white heroin is.

Mr. BURKE. The reason I ask that question is, recently we made some investigations with regard to the military in Europe, East Berlin, West Berlin, Germany, Amsterdam, and England. We found, of course, a terrific amount not only of hashish coming in, which probably doesn't come in the area because of the Colombian marihuana, but the amount of heroin that is coming in apparently, from what we have been—from Afghanistan, Turkey, and also from the Golden Triangle area, the Chinese sectors, both the far West of our country and parts of theirs, it has increased tremendously because of the Common Market.

Have you noticed any increase in any large volume, let's say, in any of your studies recently?

Dr. LEWIS. These studies did not address that particular question, so I can't really respond specifically.

Dr. WEST. Mr. Chairman, if I might respond, in Washington, D.C., we have not noticed a significant increase in the quality or even the quantity of heroin.

However, our particular problem right now seems to be the prescription drugs, particularly Dilaudid. And there is much great abuse of another prescription drug, the amphetamines.

Mr. BURKE. We did find that a problem, also, particularly since they can go in drugstores in parts of Europe and Germany and they can get many of the things, and probably GI's can bring them on over, tourists and otherwise, if they think they wouldn't get caught.

I would like to mention the disagreement, Mr. Menken—I would rather address this to Mrs. Kirchberg.

Since there has been a strong disagreement with regard to NIDA

and their assistance insofar as New York is concerned, I presume, and some of the larger cities as distinguished from your statement with regard to the cooperation with Alexandria. Is that because of the closer proximity you might have to Washington, or is it because of an overall policy?

Mrs. KIRCHBERG. Closer proximity to Washington undoubtedly helps. But I think it may be more a function of the size of the cities.

New York City is not typical of most cities in this country. The city of Alexandria, which basically is very competently run, totals 116,000 in population. It has been fairly easy for us to establish service agreements between various agencies like the health and mental health centers, the employment and vocational rehabilitation offices and with the probation and parole units. Consequently, we have been able to establish a relatively integrated service delivery system. Furthermore, we also share staff members with certain agencies. For example, people who are on our staff are also on the staff of the Mental Health Center. There are also people who staff the psychiatric unit at the hospital who are employed by our Department of Mental Health, Mental Retardation, and Substance Abuse. These arrangements enhance the delivery of services to the clients of our substance abuse programs.

It is my understanding that there is an HEW mandate for the community mental health center program that says that the community mental health centers will provide or subcontract to insure that there are comprehensive services provided to drug abusers. That mandate has been carried out in the city of Alexandria.

It seems to me that the issue is still how much control the Federal Government can and should have. Also, perhaps a special program is needed for the larger cities, as some of you were indicating.

Mr. BURKE. We just came from some hearings in Florida—by the way, the reason I asked the question, Mr. Menken, is you are not alone, because the officials in Florida happen to agree that they don't think there is any Federal cooperation to the extent that the Federal Government should cooperate. We heard officials from the Coast Guard and Customs as well as the local people themselves—State attorneys and so on.

One other thing I would like to mention, and then I would like our official chairman, since I am the acting chairman, to make a statement if he wants and also to ask some questions.

But in your statement in paragraph 5, Mr. Menken, you suggested that the GAO be directed to examine the funding formulas for drug abuse treatment established by the Government.

That is now being done, I might explain to you, sir.

Mr. MENKEN. Congratulations.

Mr. WOLFF. First of all, you are the unsung heroes of the drug business, the drug abuse business. Nobody writes big stories about the successes you have; it is only the failures you have that merit the attention of the press. This is unfortunate, because when we do have successes and those indicate a trend, that goes totally unnoticed, because as something else breaks out somewhere else, it attracts attention to that particular program or the idea.

It is with that in mind that I—and recognition of this—that I play the role of devil's advocate here for a moment.

Many newspapers, and organizations, have criticized treatment programs as a ripoff on the public. They say that they have engendered private fiefdoms, individual turfs that people are so jealous of, they don't want to have interference or oversight from any other agency, and each one seems to have its own idea as to the methods that can be used to solve the problem.

I wonder how you would respond to that criticism—is there such a thing as self-policing? Are you doing the job which I think is most important?

There are ripoffs; we know that. Some of these things are really politically motivated. They are being used and abused, and it is really downgrading the very effective programs that we see represented here in this room today.

Mr. MENKEN. If I may, Mr. Wolff, that is a very, very serious problem. I don't know how we can totally counter it.

There are steps being taken, things happening that represent some degree of effort to attempt to turn the public view toward a more positive vein, supportive vein.

We, who are involved in the residential—primarily in the residential treatment realm of drug abuse, most of us are involved in a growing organization called the therapeutic communities of America. It involves some 150, at this time, agencies spread around the country, all the way from Alaska, Florida, Maine, to California. There are probably $60 or $70 million worth of programs, all total. God knows how many thousands of clients are involved.

I suspect that in the very near future one of our—one of this association's determined efforts, will be to establish a kind of a peer review and monitoring or, as you call it, policing body.

We do have some admissions criteria, membership criteria.

We have, in the case of New York State, been given a contract by the State of New York to recommend standards of operation which would govern quality care and residental drug treatment, and we are making them very stringent. So, basically, it is self-policing.

I would mention to you, also—and I think it is important for the record—we do it in our agency and I don't think we are the only agency around that does it, but while there are those ripoffs and there are those organizations that have succeeded in tainting the image of drug abuse treatment, there are some as we—we do a variety of things that we don't get paid to do, we don't have to do, but we do believe in. We do things like, every Thanksgiving we have a free community Thanksgiving feast. We go out to the merchants and we hustle up thousands of pounds of turkey; we go to large institutions and we get them to help cook it; we serve it in the streets to poor people, to old folks, to kids. We do that.

We do block cleanups.

We are now running a senior citizens' protection and support services project on the Upper West Side of Manhattan that has been so effective and successful that it is going to be expanded to cover the whole midtown area from east to west, probably from the 30's up to the mid-hundreds in the Borough of Manhattan.

I could go on and on.

There are people who call us—one several weeks ago, a shoestore who was going out of business and wanted to donate 500 pairs of shoes

to us. I guess we could have kept them; I guess we could have sold them. We did not. We promoted the idea, and we got people to come around, and we had a free giveaway of the shoes for old people.

It is these kinds of things that we do and get involved with. The March of Dimes chapter of the city of New York will tell you that they cannot conduct their own annual Walkathon and fundraising without our input and personnel.

We do these things in endless amount, and I think that more agencies ought to be doing that.

We as one agency have no problem when we want to go to a community to open a facility. They were against Westway on the local planning board; they were against the new Convention Center. There was debating up and down the halls that evening, and loudly. When our new facility was put before them for passage: unanimous; immediate.

Mr. WOLFF. I want you to know something; that one of the reasons why I got involved in the whole drug scene was because communities within my district didn't want to have any part of anything to do with an addict population.

Mr. MENKEN. Do something, but not in our backyard.

Mr. REESE. Mr. Chairman, we would like to respond.

I am not active at the program level. The Bureau of Drug Affairs in New Orleans is a city agency with a responsibility by ordinance to coordinate the drug abuse activities in our community, and I am an appointed city official working on the staff.

I would say that it is simply absolutely the case that there was ripoff in drug treatment programs. I think anybody who has spent any amount of time around that activity, it is clear that that happens.

But I suggest that there is a greater tragedy, a greater tragedy, which is that those agencies, governmental agencies in many cases are ineffective in responding to that ripoff, and I think that that is true for a number of reasons.

One, there is no general community support for either what drug treatment programs do or what the Government's role is.

I think another reason is that the media that publicizes or attempts to discuss ripoff activities in treatment programs can't even define it within the context of drug abuse.

For example, it would expect that it's programmatically appropriate for an outpatient to be at his treatment program center to the same extent that a methadone client might be, for example. So I think that that is a very unfortunate situation. There is a need for a greater community understanding of drug abuse prevention, and there is absolutely a need for greater community support for legitimate program efforts.

My response to you, Mr. Chairman, is that absolutely there is ripoff in drug treatments programs, but more tragically than that, there is a need for a better organization of the Government effort in program systems to be able to respond to that ripoff in those programs.

Mr. WOLFF. Thank you.

Mr. Chairman?

Mr. BURKE. I want to thank you very, very much. Our counsel, Mr. Nellis, would like to ask you some questions.

Mr. Wolff, if I may be excused.

Mr. WOLFF. Yes.

Mr. NELLIS. I would like to address this to all of you.

Dr. Lewis, you can respond first, if you want to.

The committee is aware that there are various treatment modalities available for addiction for marihuana, even for pills, cross addiction, and so on. When are we going to come to the point of deciding which of these various modalities are most effective in the treatment, Dr. Lewis?

One of the reasons for this widespread, diverse complexity, and the difficulties that you have with the Federal Government and the fact that the cities are on the tail end of the thing is that there are just too many people working in too many areas, and we don't hear about the success stories; we hear about the failures.

When are we going to decide as to which treatment is best for each of these various addictions?

Dr. LEWIS I think the tendency has always been, historically, to seek the answer for the addicted.

One of the problems that arises in this field and it pertains to Mr. Wolff's comment of how the press may view the various kinds of treatment programs and how one treatment program looks at another—is that those that do the treating are often strong-willed, committed, sometimes overcommitted, charismatic individuals who fervently believe in the kind of treatment that they are doing at the time they are doing it. That may be, in fact, a prerequisite for making each of these modalities effective.

The fact that there may be acrimony among the modalities and the one criticizes another I don't necessarily take as a negative sign, although I can understand, in reference to the chairman's question, how the press may be attracted to that kind of acrimony and controversy and play it up.

I don't think that is negative criticism, necessarily. I think that just might be a reflection of the commitment of the staff to the form of treatment they are doing.

We also know that a number of individuals can get better in different ways at different times; that is, that addiction patterns are chronic in their nature, and for some individuals no single modality may be the answer in the long term, and some people have to experience a number of different kinds of treatment programs in order to get themselves in shape. Having a variety of different treatment modalities becomes an advantage, and the seeming chaos of that variety often leads one to demand that we choose one over another. In other words, why don't we lessen this variety and thereby use the most effective programs, where in fact the variety is in itself an effective element in the approach to addiction treatment, that people can have different treatment available at different times.

Mr. NELLIS. You believe that to be true, that the variety itself creates effectiveness?

Dr. LEWIS. I believe it to be true.

Mr. NELLIS. Do you believe that overall our treatment approach in this country is effective?

Dr. LEWIS. I do, in the sense that I think that the variety that we have in our treatment programs is a very healthy sign.

My personal experience over the last 15 years as a physician with

experience setting up the various kinds of programs, has been to embrace that variety so that individuals at different points in their addiction career will have such choices, so that they might go from therapeutic community to methadone maintenance. These are not totally different treatments in the total history of the lifestyle of the addict. Although the staffs of these programs may look at them as absolutely different kinds of treatment, they are all compatible with recovery.

I think that the point is that the individual has voluntary access, and that the very choice of going for treatment, in part, determines the outcome, to a certain extent. What happens in the program is of some importance, but it may not be as important as we think.

Mr. WOLFF. I tend to agree with Dr. Lewis inasmuch as, to use a metaphorical reference, the treatment of a cold—some people believe chicken soup will do it; others feel that aspirin will, and others feel that a rest program may do it. Yet we have no common treatment of the common cold.

Mr. MENKEN. You mean chicken soup doesn't do it? [Laughter.]

Mr. WOLFF. It doesn't seem to work with me.

The fact is, however, that, the point I was making before, is not so much the methods that are used by the individual treatment modalities that are involved, but the politicizing in order to get funds.

Mr. NELLIS. That's one I was getting to.

Mr. WOLFF. We are now funneling money into certain countries ostensibly to stop the flow of narcotics coming in here, instead it is being used to stop insurgencies, the same type of ruse that was used in Vietnam. It is this that troubles me more than anything else, because it is prostituting what you are trying to do and destroying our ability to bring into focus the type of treatment programs or the magnitude of treatment programs that are really necessary.

I think, if we could in some fashion establish a unanimity in the fact that treatment is a lot better than the idea of incarceration, that it would be an economy for the people of this Nation, that with all of the moves that we are making toward economy today, that we can't economize greatly by putting people into jail instead of treatment centers—I think if we could get that across to people, we would have achieved a great goal for your treatment program. Nobody wants to fund a treatment program today.

Dr. LEWIS. The symbolism involved in the addiction field which this discussion reflects is so ingrained in our culture that when one approaches addiction treatment, it is unlike other kinds of health treatment. You are usually treating somebody to help them get better, to help them increase their human potential, and to be healthy. In addictions, treatment becomes related to a lot of other social problems. The agenda of society may be to reduce crime whether or not it is connected with addiction. All of the mythologies that surround heroin addiction and the wish of society to somehow get rid of heroin completely and get rid of the heroin addict completely, including very strict Federal laws, which have not had a very profound effect, relates to this, I think, in the way that you are pointing out. We come into that legacy in the treatment field.

Mr. WOLFF. We almost got caught up in that same type of thing when this committee started. Fortunately, through the recommenda-

tions of various of our staff counsel, discussions with the members, we did not become entrapped in that. Although we concentrated our efforts originally in the areas of supply, this entire year, if you notice, it has been in the area of demand of treatment for this year.

Mr. NELLIS. Dr. West, I would be interested in your response—and I would like to say before you respond that my question really was directed to the problem you find yourselves dealing with, namely, not so much the question of the efficacy of medical treatment or psychological treatment or methadone versus abstinence or therapeutic community versus something else, but the fact that those differences, that variety creates the very kind of politicized argument over funding, over direction, over guidelines that you complained about in your opening statement.

Dr. West?

Dr. WEST. I was asked by one of the local news commentators about the success rate of my program. I think I told him, something of about 5 percent. And he said, "You mean to tell me that the people of Washington, D.C., are funding a program that has a 95 percent failure rate?"

It took me back for a second, but I indicated to him that, after all, we are new in the treatment: we have just really started to begin to marshal our resources, and that after all, 30 years ago the cure rate for cancer of the lung was one-tenth of 1 percent, but we didn't give up sending our money to the American Cancer Society.

I believe that actually, if we look at the definition of narcotic addiction, that it is a chronic relapsing disease, because of the nature of that disease, that it in itself means that there are going to be many methods of treatment; there are going to be many types of failures.

I believe that we will not find one modality which will prove successful. I think that the magic bullet theory of one entity for one disease went out with Paul Erlich, and that we are going to have to come to grips with the fact that there will be many modalities that will work with some people and others with others, depending upon at what particular moment they enter into the treatment.

Mr. NELLIS. Thank you.

Mr. MENKEN. I just want to say, I call it the Howard Johnson's theory.

Mr. NELLIS. The Howard Johnson what?

Mr. MENKEN. Howard Johnson's theory: You have 28 flavors, and not everybody likes cherry vanilla. It is much the same, believe it or not.

Mr. NELLIS. But you see, a choice between cherry vanilla and chocolate doesn't involve you in a hassle with NIDA.

Mr. MENKEN. That's true.

Mr. WOLFF. That would be with the FDA. [Laughter.]

Mr. MENKEN. You have several problems that either people don't talk about or don't receive enough focus or whatever.

I think, for example, that where you consider methadone maintenance and that modality, it is exclusively, by definition, one which is controlled, administered, and directed by the medical profession, the health field in its most—let's say, in the clearest sense of the term. Where you look at usually the residential drug-free abstinence model, the therapeutic community, you find little of the classic health care,

professional or health model in the administrative or management realm of it. You find instead, for the most part, very vocal, very adamant, sometimes abrasive people who usually have come up out of the streets and through addiction themselves, and for whatever combination of reasons have gotten well and who are attempting to transmit a lifestyle message and a value system message to the people in their charge. Those two things don't mix. It is kind of like oil and water. They don't mix very well.

Not very much has been done on the Federal level to attempt to make that mix happen, and what you are describing as a problem is probably one of the greatest results, negative results of that absence of mix.

There are some methadone programs around where you have some ex-addicts somewhere in there doing something or another. There are abstinence models where you have some health professionals doing something or another. But that should not be mistaken to mean that there is genuine interaction or genuine interrelationship in terms of cause, purpose, interest, determination of commitment. It is not real.

I am not saying that is the way it ought to prevail. It shouldn't. But the fact of the matter is, that is what you are faced with.

In terms of successes—both you and the chairman mentioned that—one of the things that I cannot understand is that while NIDA has invested so much money in a variety of research programs over the years, one thing that it has never done, never, is to invest any money in a research project that would sample the country for identified "successes," clients who have been successful through drug treatment programs of all modalities; poll those people, develop an adequate instrument that could ask them a variety of significant questions, and determine, what it was that got them well. NIDA has never done that.

Mr. NELLIS. One of the reasons is that NIDA has concentrated its research efforts in the area of the biomedical research, and we don't see any sociological research programs at that end. Mr. Menken.

Mr. WOLFF. There is one factor that really troubled me.

Here we have an affluent society, although not all are affluent, but where we find a great availability, ready availability of drugs in their raw state, perhaps, it took us to introduce the people to the sophisticated areas of drug abuse. I'm talking about a place like Vietnam or Europe where we have introduced drug abuse into their society.

Now, why is it that this society, which has progressed as far as it has—why is it that we are the leader in the abuse area? What is the real cause?

You have dealt with an addict population for long periods of time. Why is it that we have really been a causative factor in the drug problem throughout the world?

Mr. MENKEN. I can only offer my own opinion, Mr. Chairman.

I want to say that it may sound simplistic, and I didn't invent it, but it is my opinion.

We are a twisted, pretzel-shaped society. Our values are in the wrong place very often. Our interests are misdirected. Our priorities are misshaped. And we seem to be desperate to conquer something that I don't even know if it exists or even if it does——

Mr. WOLFF. Did you ever travel in India?

Mr. MENKEN. No; Europe and some other places.

Mr. WOLFF. I have seen societies where—mere existence is a challenge. And yet when you talk about a twisted society, is that not a twisted society, where they have haves and have-nots in such great disparity?

Mr. MENKEN. I think that you have some differences that are very significant that can't be discounted. I think if there are any answers to those questions, which are very important, then I think they rest somewhere in this room.

If you look at child abuse in the United States of America, it is worthy of the same kind of consideration, perhaps more so.

We are a country that should not, by anyone's estimation, in terms of where we are sociologically, where we are in so many ways that we define as important and progressive—if you look at where we are and you look at child abuse and you look at some villages in other places around the world and you see poverty galore—it is outrageous poverty—but yet they don't have child abuse; they don't hurt themselves.

Mr. WOLFF. I really will contest that—I talked about India a few moments ago. You know, child abuse takes many forms; it doesn't mean just beating up a child.

Mr. MENKEN. That's the kind I'm talking about.

Mr. WOLFF. There is physical child abuse. I visited a village in India and I saw 6-year-olds who were in a darkened room who were making rugs, and within 2 years they must go blind from their work. That, too, is child abuse.

Mr. MENKEN. Sure.

Mr. WOLFF. I don't think that we can really make those assertions.

There is something that goes much deeper than what we are talking about. I think that this is where I am at so far as this committee is concerned I want to find out why we are breeding a culture of narcotics addiction. Why is that so?

Mrs. KIRCHBERG. I feel that we're not just breeding a culture in which narcotic addiction exists at an alarming level; we're creating a culture in which millions of people are addicted to all kinds of drugs. It seems to me that this culture is the quick-cure culture, pushing alcohol, cigarettes, caffeine, and a wide variety of other drugs. We really do push drugs in this culture. Furthermore, the excise taxes on alcohol constitute a substantial portion of the revenues for this country, following close behind personal and corporate income taxes. Approximately $6 billion of tax revenues comes into the Government annually just from alcohol alone, and cigarettes produce another $2 billion in excise taxes. The alcohol industry is really big. Pharmaceutical companies are really big. A lot of people make a lot of money off drugs. It takes money to buy drugs and we are an affluent society. So, there are a lot of people around with a lot of money who are buying a lot of drugs.

I think that our society's substance abuse problem is partially a result of the leisure we have, the money that we have, and the power that the drug industry has. Also, as our technology has advanced, the anxiety experienced in the population has also increased, which is reflected in an increase in suicide, mental illness, and dependency upon drugs as a means of coping with this anxiety.

Mr. MENKEN. "Better living through chemistry."

Mrs. KIRCHBERG. Yes.

Mr. REESE. I think the complex question of being able to know what the causal factors are in each individual case of drug abuse, I think below that or beyond that it is very simple. I believe the statement very strongly that drug abuse is frequently the result of powerlessness, of frustration, of boredom, unfocusedness, unavailability. And I think all of those are—clearly, authoritatively are suggested and worthy of acceptance of causal factors of drug abuse in this society.

I think appropriately so, the response ought to be, a wide variety of treatment opportunities for clients, just as appropriately as the total response to drug abuse is a balanced response of supply-and-demand reduction, control and reduction.

I don't think it is complex or beyond the difficulty of being able to assign one of what I consider to be the acceptable causal factors to what is the individual case of drug abuse that you encounter.

Mr. WOLFF. Coming back to that, however, again—I don't want to get into a one-on-one discussion with each one here, but it troubles me, the fact that wherever we seem to make advances, we advance one step and retrogress two.

When you indicate, as you have, the broad overall situation, I come back again—I don't want to use India as an example—the reason I say India is because I was with Mr. Desai today, so I use India as the case. We have the same unemployment, they scrounge for food—they have the same parallels that you have enumerated, and yet they don't have the same drug problem.

There are other people who have said that part of our drug problem is due to the breakup of the family relationship that has existed in this country and the fact that there is no longer a family—that the family itself has been completely disintegrated, whether it be in the affluent family or is somewhat—I recently read a paper on the fact that the affluent family today, the relationship between the parent and the child is one where the parent doesn't really have time for a family relationship because they are out doing social work; they are out enjoying their own particular life. The other end of the spectrum is the breakup of families where there is absolutely no parental guidance exercised upon the young person. Thus, a variety of factors affects this question.

The one thing that hits me more than anything else is the fact that the great influx or increase we had of drug abuse in this country came during the Vietnam war; the great impetus to drug abuse came during the Vietnam war. Why did it come about at that time?

We do know the frustrations of some of the young people in the country. Basically, they didn't want to die for an unknown cause; you know, it was just as simple as that—but perhaps that is being too simplistic. The fact is, during that period of time we experienced in the United States, a tremendous increase in the addict population on hard drugs.

I don't have the background that many of you have, or the areas of competence that you possess. I do know one thing, that unless we treat individuals and save a few from the ongoing problem of addiction, unless we get to the other end of the spectrum and learn the causative factors, your work will continue ad infinitum.

What I would like to do is work you out of a job.

Mr. REESE. Absolutely.

Mr. Chairman, I must say, I think you are correct. I think we are very effectively, in talking, the conception we have of the cause-and-effect reality in and around drug abuse, I think the problem could be that it is just impossible to structure the analogy that you want to make there.

For example, you don't begin with the same thing when you talk about our country and India. The countries, to start with, in their total context are so dramatically different, it is like talking about safety around vehicles. It is different if you want to be safe in relation to the Indy 500 racetrack as opposed to wanting to be safe on some quiet street in some residential community. Those are different things altogether, even though you are talking about automobiles and people's safety in relation to them.

I think the critical point to make now is that that analogy cannot be structured, because the two countries—there is no country like ours. There is no country that talks about and can demonstrate the standard of living that we have. There is no country that can record the history that we have, not that I know of.

I think it may be better not to look to structure that analogy and to accept that it is not as complex as——

Mr. WOLFF. I think we have to learn why in some areas of the world they have not suffered the same type of problems that we have built into our society here.

Unfortunately, I have got to go to vote.

We appreciate all of you, the time that you have given here, especially the fact that you have had to wait interminably for us to get started with your particular panel.

I would ask, if you have anything to add to this, please keep an open line of communication with the committee. We will furnish more questions to you. But most important is the fact with all of the bureaucrats—and I am not including you, Mr. Reese—all of the bureaucrats that we have who come in here, they have a pat line that they give us and that they continue to give us. We are not interested in that anymore, because what, obviously, has been done hasn't worked. We must find out from you who are out in the field what you think And you can feel that this is an area of input for you, that maybe together we can make some of the things happen.

Thank you very much.

[Whereupon, at 5:15 p.m., the committee adjourned:]

PREPARED STATEMENTS

PREPARED STATEMENT OF LEE I. DOGOLOFF, ASSOCIATE DIRECTOR, DRUG POLICY OFFICE

It is a pleasure to be here today to discuss our Federal policy for drug abuse treatment and rehabilitation. Early last year the Select Committee pointed out that there were many deficiencies in the Federal approach, and detailed the areas that needed further attention in the Interim Report. We felt that many of these criticisms were justified, and conducted a comprehensive review of our treatment and rehabilitation programs. I would like to outline the recommendations contained in the final report of our treatment and rehabilitation study for you, because they answer many of the Select Committee's specific questions and form the basis of our program and priorities for 1978 and 1979.

Our major recommendations fell under three headings—the enhancement of treatment for drug abusers, the development of a broader base of knowledge, and

the prevention of drug abuse. I will only discuss the first two since I have testified extensively on prevention before this and other Committees.

Our recommendations to enhance treatment for drug abusers have two broad thrusts:

(1) the enhancement of the planning and provision of direct services for those persons who are or should be primary clients of the federally-funded drug abuse treatment programs, i.e., the compulsive drug abuser; and

(2) the sensitizing of a wide variety of professionals who are not in the drug field to serve the needs of all persons in our society who suffer the consequences of drug abuse or misuse.

First, we want existing treatment programs to reach out and secure a broad range of social services for their clients. The majority of clients in federally-funded treatment are opiate abusers, as was intended when the Government first entered the drug treatment field with a major investment in the late 1960's. With the expansion of treatment slots since then, an increasing number of slots are being used to treat habitual abusers of barbiturates, tranquilizers, marihuana, and alcohol-in-combination with other drugs. Regardless of the drug of abuse, clients typically are unemployed, low-skilled, and have been involved with the criminal justice system.

Intensive treatment and counseling are essential because the clients have many, extremely complex needs. For a number of reasons, not the least of which is the social stigma carried by drug abusers, many treatment programs have tried—unrealistically—to respond to all their clients' needs, because abusers lack access to other service programs. Such efforts have strained the financial and personnel resources of the treatment programs.

In recent years Congress has passed legislation to remedy this situation that provides broad and flexible funding to States for a wide variety of services in health, employment, social services, and education. Treatment programs should work to ensure client access to these services, but program integration is often difficult to achieve. To aid clients in receiving a broad range of services, formal agreements should be undertaken between the State and local agencies to provide basic third party reimbursements or to collaborate in other ways which will increase services for abusers. Two programs that should be involved are Medicaid and the Social Services Program authorized by Title XX of the Social Security Act.

In addition, substance abuse and mental health services funded through the programs of NIAAA, NIDA, NIMH, and the VA should be more closely integrated with each other and with private family and social service agencies. Although the mechanisms may vary from program to program, the objective of linking services should be to ensure that persons who are substance abusers are not denied access to services to which they are otherwise entitled, and that those services reflect a sensitivity to particular needs of the client population.

Second, we hope to sensitize the broad non-drug specific service delivery systems to drug abuse problems. Many people have problems with substance abuse who are *not* appropriate clients for categorical drug programs. They must be dealt with in the service delivery system that is most appropriate for them.

Because there is a wide range in the socioeconomic, age, and ethnic background of people who get into trouble with drugs, there must be a wide range of services and settings available to those who need help. For example, one appropriate setting for services, particularly for nonchronic abusers, is the community mental health centers. In recognition of this fact, the CMHC regulations require that they provide services to drug abusers directly or by referral to drug programs. Unfortunately, CMHC's have not all been receptive to treating drug abusers. Past efforts to encourage CMHC's to provide direct services to drug abusers have often resulted in referrals of the client to the traditional drug treatment programs. However, few of the drug treatment programs are appropriate settings for the nonchronic abuser who needs help. Thus, there is a gap in appropriate services for this client group. In 1978–79 we hope to fill this gap through a variety of linkages and efforts to sensitize traditional health care delivery systems to drug problems.

Another area where we hope to improve treatment is by increasing sensitivity to the special needs of discrete sub-populations. For example, the Select Committee commented quite accurately in early 1977 that our programs are male-oriented. We are working to redress this imbalance, and recognize the needs of other special populations as well. Racial/ethnic minorities make up a disproportionate number of opiate abusers in treatment. Approximately 52 percent of

opiate abusers in treatment are Black, 12 percent are Hispanic, and 34 percent are White. HEW is currently studying whether certain treatment modalities are more successful than others with particular groups. Puerto Rican youths have been found to do somewhat better than other youths when treated in religiously-oriented therapeutic communities. A study is being conducted in Puerto Rico to determine if family therapy is particularly advantageous among cultural groups that emphasize family bonds.

Other special population studies include Native American projects designed to demonstrate innovative treatment methods of reaching and treating inhalant abuse and other drug problems. Seventeen percent of Native American youth admitted for treatment are admitted for abuse of inhalants. Other projects have provided information on the efficacy of different treatment approaches; a Spanish Family Guidance Clinic Study in Miami has provided information about social-demographic variables and the effectiveness of different treatment approaches with Cuban and Puerto Rican populations; the Latino Mental Health Task Force, Inc. is a project designed to test the hypothesis that the interaction of the Anglo and Latino cultures produces emotional stress that results in drug abuse. A treatment model has been developed which, if the hypothesis proves valid, will be tested for other ethnic groups.

Not only are special populations identified by race and ethnicity; but with drug abuse, age becomes a special population consideration. At both ends of the life span are special population needs. Youth are a target for both drug abuse prevention and treatment. Unfortunately, the age of first drug experimentation is becoming younger. Approximately 45 percent of those clients under age 18 admitted for treatment report having tried their first drug by age 13. We found that the treatment needs of youth are significantly different from those of adults. The maturation process, educational needs, learning disabilities, family problems as well as drug abuse treatment needs must be addressed by an approach both responsive and effective for this special age group. By examining the best methods by which young people can be brought into and kept in treatment, a great deal can be learned and applied to other community-based treatment programs.

We know that youth (1) do not easily trust authority figures and (2) do not define themselves as substance abusers. To reach youth, they must be provided relief for problems which are real to them, such as needing a place to sleep, car fare, a job or sexual counseling. One of NIDA's programs focuses in on these conditions as outreach and finds the common denominator of substance abuse among many of the youth. This project called "The Door" is located in New York City and is being developed to serve as a model for youth drug programs across the nation. The Door is a comprehensive multi-service facility for youth which includes drug treatment, rehabilitation and prevention services for drug abusers from the Village and Lower West Side of Manhattan. Three unique drug programs are offered by the Door: A Preventive Intervention and Treatment Program, of varying duration, for young people only tangentially or occasionally involved in drugs; an Early Intervention and Drug Treatment Program, with an average duration of three months, for young people with moderate drug involvement; and an Intensive Drug Treatment and Rehabilitation Program, a 12-month program for youth in need of a highly structured and intensive therapeutic and rehabilitative program. As part of its total person and total problem approach, The Door provides free counseling and treatment for the drug and drug-related medical, sexual, psychological, legal, family and life problems of participants.

At the other end of the life span are the elderly. It has become increasingly clear that elderly people seem disproportionately inclined to use and abuse those prescription and nonprescription drugs that are sold primarily to treat nonspecific emotional stress and its secondary effects. On our recommendation, NIDA is developing models of appropriate treatment for the elderly which emphasize education. One recently funded project has created a drug prescription card that the elderly can carry and is intended to help elderly people keep track of what they are taking and how often.

And we have made a special effort to focus on women. Studies have shown that: (1) both methadone and heroin addicted mothers tend to have lower birthweight babies; however, heroin babies are usually smaller than methadone babies; (2) both methadone and heroin addicted mothers tend to have a higher than normal rate of premature delivery but good prenatal care given in conjunction with a methadone program can dramatically reduce the incidence of prematurity; and (3) babies born to either methadone or heroin addicted mothers

are themselves addicted and most undergo some degree of withdrawal. In addition, large numbers of women have problems with prescription and over-the-counter drugs.

As a result of these findings regarding women, NIDA has developed models to meet their special needs including: (1) hospital-based programs to treat pregnant addicts and their offspring; (2) residential programs to treat women and their dependent children; (3) re-entry models for treating female addicts, including such elements as child care, vocational training, parenting, etc.; and (4) strategies to help Community Mental Health Centers, drug treatment programs, and social service organizations provide needed services to women who abuse prescription or over-the-counter drugs.

Finally, although not usually categorized as a special population, we have recommended that special attention be paid to the treatment needs of rural clients. Over the course of the past year NIDA has conducted investigations to understand the kinds of differences that exist between rural and urban drug abusers and to better understand some of the problems and concerns that face the rural drug abuse administrator. We have learned, for example, that clients admitted to rural programs (defined as those communities under 25,000) differ significantly from those admitted to drug treatment programs located in metropolitan areas (500,000 or more). Whereas 76.7 percent of urban clients report opiates as the primary drug of abuse, only 8.1 percent of clients admitted to rural settings report opiates as their primary drug of abuse. By comparison, 30.7 percent of rural admissions report marijuana as the major problem. Well over 62.2 percent of admissions to rural programs are below the age of 21 compared to 18.5 percent of admissions to urban programs. Among opiate users in the two settings, 32.1 percent of opiate users in rural communities report daily use of opiates compared to 64.9 percent of urban admissions. Rural opiate users are less likely to have methadone programs available to them and accessibility to treatment is a major problem for the rural drug abuser.

We have emphasized the importance of vocational opportunities for clients in treatment. Employment is often the key element in a client's life which determines successful outcome. We recommended that HEW pay special attention to developing promising programs for the employment of drug treatment clients.

They are developing and we will monitor the implementation of a Vocational Rehabilitation and Employment Strategy which includes: (1) improving the coordination of Federal employment and vocational programs; (2) sensitizing treatment staff with techniques for assessing clients' vocational skills and needs; and (3) expanding community resources for vocational and employment training for drug abusers.

For example, one of the most important model programs that has been developed in New York City by the Vera Institute of Justice provides supported work to ex-addicts as a transition from drug abuse treatment to regular employment. Supported work is characterized by the placement of marginally employable individuals in low stress jobs and gradually increasing both performance demands and performance-related rewards as the individuals are prepared for the regular job market. Over almost four years, the Vera Program has employed 4,000 ex-addict and ex-offender men and women. As a result of this pilot study, a national research demonstration project is underway in 16 sites across the country supported by several Federal agencies (DOL, HUD, HEW, DOJ AND DOC), private foundations and State and local sponsors to test the effectiveness of the model for other disadvantaged groups, including drug abusers, ex-offenders, youth and women on welfare. The model is characterized by the provision of low stress work in groups, with graduated performance demands and salaries for 12-15 months as a transition from drug abuse treatment or unemployment to full time regular employment. While the data are just now coming in from this project, it appears exceptionally successful. One study site in Wisconsin has shown an attendance rate of 88 percent at the end of the second year (higher than the overall program) and the jobs placement rate was 40 percent compared with the overall program average of 26 percent.

Another important area that the Select Committee touched on in its Interim Report is the interface between the drug treatment system and the criminal justice system. The interface between the drug abuse treatment system and the criminal justice system has steadily improved over the past few years. This is in dramatic contrast to the early 1960's when the drug trafficker and the drug abuser were dealt with in similar harsh fashion by the judiciary and law enforcement agencies.

In 1978 and 1979 we will seek to improve alternatives to incarceration, treatment during incarceration, and relationships between law enforcement, treatment programs, and community leaders who need to work together in creative and collaborative ways.

Finally, our report outlines many recommendations for improving our base of knowledge. These include mechanisms to improve research coordination, to continue to perfect our data collection systems, and to upgrade the quantity and quality of information that we have on special drug abuse populations.

There are many other recommendations in the report. I have only highlighted a few. Taken together, these recommendations form a broad, comprehensive strategy for drug abuse treatment and rehabilitation. The role of our office in the Domestic Policy Staff in the coming year will be to monitor the implementation of these recommendations.

In addition, we will be monitoring the progress of six other policy reviews. These seven reviews and their recommendations provide a blueprint for the entire Federal drug abuse prevention and control program. This program spans many Federal Departments and agencies. A budget crosscut for those agencies involved in treatment and rehabilitation is attached.

In closing, I would like to say that we are finally learning that treatment and rehabilitation works. The NIDA has completed follow-up studies on a number of clients recorded in the Drug Abuse Reporting Program.

The Drug Abuse Reporting Program (DARP) is a joint National Institute on Drug Abuse (NIDA) Institute of Behavioral Research (IBR), Texas Christian University (TCU) effort which commenced in 1968. Admission and in-treatment data were collected on approximately 44,000 clients entering and being treated in the newly established Federally funded drug abuse treatment network. The in-treatment assessment period lasted for four years and the data has been grouped into three cohorts: Cohort 1, the admissions during the 1969–1971 period represent primarily methadone maintenance clients; Cohort 2, the admissions during 1971–1972 represent methadone maintenance clients, as well as therapeutic community and drug-free outpatient clients; Cohort 3, the admissions during 1972–1973 period represent all principal modalities. At present, there have been follow-up studies completed on Cohorts 1 and 2. Follow ups of Cohort 1 and 2 provide a view of five years in the lives of drug abusers, an unusual perspective into their criminal, treatment and social activities from the time they came in contact with a DARP participating treatment program, to the time they were interviewed one-half decade later.

Cohort 1 had 4,449 methadone maintenance clients; Cohort 2 had 4,086 methadone maintenance clients. The following data was collected from 1,477 of these clients. Seventy-eight percent of this sample are men. Of the men, 38 percent are Black, 33 percent are White, 16 percent are Mexican-American and 13 percent are Puerto Rican. Of the women, 74 percent are Black, and 26 percent are White.

The follow up interview is approximately four years after admission to treatment. Admittedly, other life events have occurred since the client's admission to treatment. Nearly 60 percent of the clients have had at least one additional treatment experience, nearly 40 percent of the clients have spent some time incarcerated, and 48 percent of the clients have had at least one period of time during which they were using heroin on a daily basis. However, there are significant differences between pre- and post-treatment indicators.

In the pretreatment two-month period, 87 percent of the clients were using opioids on a daily basis. It should be noted that though it is required that all clients entering methadone maintenance treatment programs need to have a positive history of using opiates, there are some clients that enter methadone maintenance programs from detoxification programs, other treatment programs, (jail, hospital, or other sheltered and protected environments); 12 percent were consuming more than 8 ounces of 80 proof equivalents (half pint) daily, 62 percent were unemployed and 38 percent had illegal activities as their major source of support. This contrasts with the post-treatment period, at which time 8 percent of the clients are reporting daily opioid use; 17 percent were consuming more than 8 ounces of 80 proof liquor equivalents daily; 48 percent were unemployed and 18 percent had any illegal activity. In addition, at the time of follow up, 38 percent of the clients were receiving treatment for drug-related difficulties, and 16 percent were in jail.

In general, while other indicators vary, a continued decrease in drug use can be documented during the three-year post-treatment period.

We are encouraged by these findings and will continue to promote aggressive evaluations of our treatment and rehabilitation programs. We have recommended that HEW develop treatment outcomes criteria as standard for judging program success. We believe that we know enough about what we can reasonably expect from clinical programs to develop these criteria.

The ultimate purpose of designing and implementing such an action plan would be to assist those responsible for the various facets of the nationwide treatment system to make individual decisions regarding the continuation and/or needed improvements in programs that make up this system.

The type of criteria that HEW is assessing encompasses client outcome, client utilization, community impact, cost of treatment services, social cost of drug abuse, number and types of professionals providing the services, program management reviews, accreditation and licensing requirements, and State plans and statewide services contracts. In addition, NIDA has a number of independent and interlocking data systems which can be examined to provide a general framework within which treatment service units may be examined to determine whether or not they should continue to be funded. These data systems—Client Oriented Data Acquisition Process (CODAP), National Drug Abuse Treatment Utilization Survey (NDATUS), Drug Abuse Warning Network (DAWN), Treatment Outcome Prospective Study (TOPS), the National Surveys, Drug Abuse Reporting Program (DARP), and others—designed for developing improved management and fiscal responsibility, could yield objective criteria of treatment program performance.

Perhaps most importantly, the criteria ultimately developed could be applied across the data bank that NIDA possesses on outcome in treatment and post-treatment which spans several years. Merging the two and assessing how programs across the country have performed with different types of clients could evolve "reasonable expectations". Applying these statistical expectations to existing treatment clinics could assess how well they were doing on the criteria relative to nationwide performance.

If a program fell below that standard of "reasonable expectations," it could signal the need for a review of the program. The standards should not be taken as hard and fast gauges of a program's merit since many other factors outside of the program's control can also affect client outcome. A review board must bear in mind the importance of such external influences as unemployment, community unrest, proximity to the Mexican border, racial problems, and sudden cases of drug supply, among others. The statistical expectations, however, would provide a valuable management tool and a warning system for the need for more in-depth review.

NIDA has come up with a set of workable clinical expectations which they expect to share with the field in six months or so, and we will continue to monitor their progress.

Thank you.

Attachment.

DRUG ABUSE PREVENTION: DISCRETIONARY AND NONDISCRETIONARY PROGRAMS—TREATMENT/REHABILITATION

[In millions of dollars]

Agency	Fiscal year 1975			Fiscal year 1976			Fiscal year 1977			Fiscal year 1978			Fiscal year 1979		
	BA	OBL	OUTL	BA	OBL	OUTL	BA	OBL	OUTL	BA	OBL	OUTL	BA	OBL	OUTL
SAODAP/ODAP	6.4	6.4	6.4												
HEW:															
HCFA (medicaid/medicare)	(79.0)	(79.0)	(79.0)	88.0)	(88.0)	(88.0)	(94.0)	(94.0)	(94.0)						
NIDA	124.5	124.4	178.1	140.4	140.4	123.7	181.6	181.6	171.5	181.2	181.2	179.5	183.1	183.1	182.5
NIMH	2.1	2.1	2.1	2.5	2.5	2.5	2.8	2.8	2.8	3.4	3.4	3.4	3.8	3.8	3.8
SSA	1.34	.2	.06	6.83	.17	.11	.9	.64	.64	.38	.38	.38	.4	.4	.4
OHD	9.8	9.8	9.8	10.9	10.9	10.9	10.4	10.4	10.4	10.6	10.6	10.6	11.0	11.0	11.0
OEO/CSA															
VA	33.2	33.2	33.2	35.1	35.1	35.1	37.3	37.3	37.3	38.1	38.1	38.1	38.8	38.8	38.8
Justice:															
BOP	6.0	6.0	6.4	5.3	5.3	6.1	5.8	5.8	5.8	6.1	6.1	6.1	4.8	4.8	4.9
LEAA	20.7	20.7	16.8	10.6	10.6	14.0	7.9	7.9	16.0	10.0	10.0	13.2	8.3	8.3	10.5
DEA															
DOD	18.0	18.0	18.0	17.6	17.6	17.6	13.5	13.5	13.5	14.5	14.5	14.5	14.8	14.8	14.8
State				.1	.1	0	.3	.3	.2	.8	.8	.7	.5	.5	.4
CSC															
DOL															
DOT-FAA															
DOT-NHTSA															
DOT-Coast Guard	.2	.2	.2	.4	.4	.4	.4	.4	.4	.4	.4	.4	.4	.4	.4
USDA															
ACTION															
Total	222.2	221.0	271.1	229.7	223.1	210.4	260.9	260.6	258.5	265.5	265.5	266.9	265.9	265.9	267.5

PREPARED STATEMENT OF GERALD L. KLERMAN, M.D., ADMINISTRATOR, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. Chairman and Members of the Committee, I thank you for the opportunity to appear today on behalf of the Department of Health, Education, and Welfare. Secretary Califano has asked me to convey to you his firm commitment with respect to the role the Department will play in coordinating Federal resources and providing effective leadership for future Federal drug abuse policy.

In addition, I wish to take this opportunity to commend your Committee and its staff for the efforts you have made to focus attention on this major issue, particularly stressing the need for close coordination of Federal policies, initiatives, and activities to prevent either a division of purpose or a fragmentation of effort.

While our current Federal drug abuse policy has resulted in major improvements in the health status of many drug abusers, it is becoming increasingly apparent—and this Committee has clearly observed—that this policy has for too long been quite insulated from the mainstream of other health care, as well as other social and economic policies and programs.

Federal drug abuse programs have from their inception been fiscally healthy in this country. Throughout the years, there has rarely been any quarrel between Congress and the Administration with budget requests for drug abuse treatment programs. Moreover, we have been constantly reexamining our medical and social priorities in this area—to the benefit of both.

For example, we no longer necessarily treat street crime and drug addiction as inexorably intertwined—or assert that success in one area necessarily guarantees success in the other. Nor do we currently place heroin on our highest pedestal as the worst offender in the panoply of abusable drugs. We are now well aware that other items we inject or inhale—such as alcohol or tobacco—cause us far greater economic harm and ill health than heroin. Even if we choose not to include those two in our category of "drugs of abuse", other drugs are beginning to emerge as equally harmful substances—including drugs which are readily available with a doctor's prescription. Moreover, we are also rapidly learning that some of the worst problems can often be caused by combinations of drugs, including certain drugs with alcohol.

We are also learning that if we merely treat the drug abuser for his or her physical dependency—for the unhealthy effects of the substance itself—we are satisfying only the smallest measure of the needs of that individual. This last revelation has been—and must continue to be—the most important of all: that drug abuse is much less often the cause of an individual's or a society's problems than it is a result of those problems. As this Committee realizes, more important than our obligation simply to treat is our obligation to fully rehabilitate—to educate—to solve economic and social problems alongside the physical sickness—and thus prevent the recurrence of drug abuse as a symptom rather than a cause.

We all realize, of course, this is a tall order—taller certainly than can be filled by just one agency of HEW—by just one Department of the Federal government—or indeed, by just the Federal government acting alone. But as this Committee has clearly indicated, HEW as a Department can begin to look at the full range of its program, and to coordinate those aspects of its programs which directly or indirectly touch on filling the needs of individuals whose problems include or might one day develop into the problems of drug abuse.

Historically, the Office of Drug Abuse Policy was charged with developing government-wide drug abuse policy. Its latest report in the area of demand reduction policy entitled *Drug Abuse Patterns, Consequences and the Federal Response*, was published in March 1978. The Department is currently reviewing the most appropriate way to implement those recommendations.

Since the formal demise of ODAP this past April, HEW has been increasingly concerned with the coordination of similar program elements across agency lines. In the area of drug abuse, we have stepped up that coordination and as I indicated to you in testimony earlier this Spring, the Secretary has appointed me, together with his Special Assistant Daniel Meltzer, to jointly oversee this process. We have now begun to establish working relationships and to meet informally with relevant officials from all the various agencies whose programs contain elements which will require coordination. We believe the results of this increased coordination will be felt within the Department over the next few months as the Administration develops legislative and budget proposals for the Fiscal Year 1980.

In addition, we expect our heightened awareness of these broader elements of drug abuse treatment to have an impact in selected areas such as the Nationwide health planning process and the area of prevention, in which the Department plans increased emphasis.

With regard to the area of prevention, I would like to make a few comments.

While your Subcommittee has limited itself in this particular round of hearings to taking up separately the topic of "treatment", it is my personal belief that we can no longer afford the luxury of separating the two—either in drug abuse or in any other area of national health policy:

In particular, the field of drug abuse has long been in the forefront in defining, analyzing and endorsing the need for prevention. Drug abuse specialists have concentrated on prevention with treatment as a component for a number of years and other parts of the health world now seem to be coming around to this viewpoint. Therefore, it is essential that Federal drug abuse policy remains in step with current thinking. To the extent a national health program will demand a nationwide preventive health effort, for example, drug abuse programs must lend their own knowledge and experience. To the extent such a nationwide effort succeeds in improving the health status of Americans, we should make clear that drug abuse is one of the areas we want to be improved. In short, we can best achieve our objectives if we administer our drug abuse treatment programs so that they coordinate well with all other relevant Federal efforts.

I think it is also important to share with you the extent of community based drug treatment that is provided by the agency and how the process is evaluated. NIDA supports statewide treatment networks which in Fiscal Year 1978 totalled $145,822,000 for 94,842 treatment slots—which excludes formula shots. This number will increase to 95,716 in fiscal year 1979. As of July 31, 1977, 36% of the slots were used by clients receiving methadone as part of treatment. Sixty-one percent were used for drug-free treatment efforts and 3 percent were for detoxification. Of the total clients served, 84% received treatment as outpatients, 11% in residential settings, 5 percent in day care and less than 1 percent in inpatient settings. The average time spent by clients in NIDA funded treatment ranges from 3 months in residential programs, 6 months for drug-free outpatient programs, and 10 months for outpatient methadone maintenance programs. The average cost for treating one person for one year is $2,200.

These programs are monitored by the NIDA Division of Community Assistance through its staff of program development specialists assigned to each State. The audit firm Touche-Ross holds the contract to evaluate drug abuse program management through a system of quarterly management reviews, State plan reviews, and ongoing consultation. NIDA staff monitors the expenditures of drug abuse treatment funds. In addition, NIDA's Treatment Outcome Prospective Survey (TOPS) will review the efficacy of the NIDA treatment effort. Other outside evaluations of drug abuse treatment have been completed and will be described in greater detail in the testimony of the NIDA Deputy-Director, Karst J. Besteman, at tomorrow's hearings. Additional drug abuse treatment resources are available from federally supported community mental health centers (CMHCs), funded by the National Institute of Mental Health. Half of the Nation's community mental health centers provide drug abuse services, either directly or by referral. NIDA funds 9,471 of its treatment slots through CMHC's at an estimated cost of $14.4 million.

I wish to stress that I shall facilitate the coordination of the Department's drug abuse treatment programs with other program elements—whether in education, vocational rehabilitation, social services or any other component of the Department. This effort will complement ongoing Federal activities. I am optimistic that with the efforts of Mr. Meltzer and myself the Department will effectively achieve positive results.

PREPARED STATEMENT OF DAVID C. LEWIS, M.D., CHAIRPERSON, NATIONAL ASSOCIATION FOR CITY DRUG COORDINATION

Good afternoon, Mr. Chairman and members of the Select Committee.

I am Dr. David C. Lewis, Chairperson of the National Association for City Drug Coordination. I am accompanied today by Mr. Claude Reese, Vice-Chairperson of our Association and Director of the Bureau of Drug Affairs for the City of New Orleans.

We appreciate the opportunity to appear before you today on behalf of our member cities to offer you an urban perspective on the efficacy of the Federal effort in promoting the establishment of integrated treatment services.

The National Association for City Drug Coordination (NACDC) is a consortium of city drug coordinators representing mayors of cities with major drug-involved populations. It is, of course, at the local level of government where drug abuse treatment and rehabilitation efforts are ultimately brought to bear. It is, therefore, the large city drug services coordinator who is most directly aware of the success, or lack thereof, of federal and state efforts to promote a systemic, comprehensive programming effort.

As the Select Committee well knows, 1972 marks the year that major federal legislation was enacted to respond to the growing national crises of "drug abuse". That legislation, known as the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255) established the intergovernmental system which still guides drug abuse planning and the delivery of drug abuse treatment and prevention services in this country. That system, perhaps inadvertently, has resulted in a near total absence of any sustained and systematic large city government participation in the state drug abuse planning process and in the formulation of federal drug abuse policies.

This absence of large city government participation in federal drug policy making and state planning is an inexplicable situation inasmuch as it is in its large central cities where the nation's most severe drug problems are concentrated. In fact, the conditions of heroin addiction and crime which initially prompted the expanded federal response to drug abuse as embodied in P.L. 92-255, were conditions peculiar to the urban environment. The expanded federal response was required in part because the scope and extent of the problems associated with addictive drug use had far transcended the ability of city governments to effectively respond. And for the most part, state governments whose legislatures were frequently dominated by rural and suburban interests were generally reluctant to become extensively involved responding to what was essentially a central city problem.

Nevertheless, state governments were designated to play a major role in the expanded federal drug effort resulting from P.L. 92-255. The role of local government was ignored.

The imbalance between city and state government responsibilities can be directly traced to the Congressional authorization of annual formula (block) grants to the state which was detailed in Section 409 of P.L. 92-255. In return for awarding formula grants, Congress required that each state establish a state drug abuse coordinating agency and annually prepare a state drug abuse plan delineating treatment and prevention needs statewide. Thus, Congress in effect required that non-urban states such as North Dakota, Vermont, Montana, and other states with comparatively negligible drug problems plan a drug abuse response effort while cities such as Newark, Detroit, Boston, Los Angeles and others were ignored in the legislation.

The states, which are theoretically advised to take into account local needs through substate planning, have shown near unanimous reluctance to directly involve city governments in the planning process. State political realities have effectively produced a non-urban drug services orientation, often ignoring or avoiding the states' major drug problem sites—their large central cities—and there has been no effective administrative mechanism for producing greater state sensitivity.

This resulting imbalance between large city and state determinations of problems and priorities has been further aggravated as the principal federal drug treatment and prevention agency, the National Institute on Drug Abuse (NIDA), has become increasingly reliant upon the state plans to determine federal funding decisions. In fact, NIDA has announced its intention to fund virtually all its treatment and prevention efforts through statewide service contracts with State governments by 1979. The rationale offered for this decision is "administrative efficiency". In fact, this increasing substitution of state decision-making for federal decision-making does not augur well for the large cities where social costs of drug abuse are most severe.

The issue of coordination at the State and local level in the establishment of integrated treatment services through the Statewide Services Contract funding mechanism is most pertinent. The City of Detroit has noted that its effective administrative control over its clinics has been diminished, due to the effects of the Statewide Services Contract.

The City of Gary, Indiana, offers perhaps the most distressing example of the problems which can occur under the present system. NIDA has been pressuring Gary to enter into a Statewide Services Contract with the Indiana Single State Agency (SSA), effectively turning the operation of the City's methadone program over to the State. Gary's reluctance to surrender its current direct-funded status is understandable, insofar as the State's capricious refusal to fund the program in the past was the basis for the City's assumption of operational responsibility in the first place. Rather than see the program close, depriving patients of needed services, the City contracted directly with NIDA for operational funds, and has since developed a comprehensive program with linkages to vocational and other supportive services to promote effective rehabilitation. Indeed, not only has the SSA demonstrated no commitment in the past to provide quality services to meet the City's needs, but it has consistently refused to provide the program with technical assistance while the City contracts directly with NIDA.

Against this background of local concern for the efficacy of the Statewide Services Contract mechanism, the Deputy Director of NIDA has asked the NACDC to review and comment on its "Statewide Services Contract Policy and Practice Manual". The Association is in the process of preparing a formal critique of that document, and expects to return to NIDA with its considerations shortly.

The NACDC will encourage greater federal responsiveness to urban drug issues, and suggests to the Select Committee that the activities of the various agencies could be better coordinated to provide for comprehensive drug abuse programming. The NACDC recommends that a limited number of cities directly receive block grants for planning and service delivery to permit them to more effectively utilize the funds from a number of federal programs for drug abuse prevention and rehabilitation. Moreover, these funds could then be applied in concert with local funds from other city-sponsored efforts such as in parks and recreation, and thus further enhance the coordination of activities.

The NACDC suggests that NIDA reconsider its sole reliance on the State agency mechanism and increase its flexibility to address the special urban populations through the recognition of a local city government role as a "prime sponsor".

To facilitate this improved federal-city liaison, NIDA might find it advantageous to establish an "Office of Urban Services". Such an office could overcome the buffer zone which has developed between these two levels of government with regard to policy development. NIDA needs more aggressively to seek large city government input for its deliberations, and the cities need to develop better understanding of NIDA's activities. Such an Office of Urban Services could be involved in administering and monitoring the development and coordination of drug-related services in our major urban centers.

The NACDC further hopes that the state-city relationship could be re-defined so that major cities would be directly and meaningfully involved in the preparation of the annual state drug abuse plans. The legislation currently pending which amends Section 409(e) of P.L. 92-255 would, if passed, certainly help restore local government's prerogatives in this essential planning role.

The importance of a revitalized federal and state collaboration with local government can be emphasized by noting that there are large cities, with both the need and capability, interested in committing their resources to developing comprehensive programs for their drug-involved residents. However, this local activity will never reach its full potential until we have resolved the federal and state liaison issues. Toward this end, the NACDC makes the following proposals:

1. Direct federal planning funds should be provided to selected cities with particularly severe drug problems to enhance their planning and service delivery capabilities;

2. Other federal block grant mechanisms to cities, such as CETA, LEAA and the Community Development Block Grants of HUD should be reviewed for their applicability as models in the substance abuse field;

3. An urban-oriented and efficient planning and services delivery model for the drug field should be developed and implemented, utilizing appropriate federal agencies with NIDA taking the lead as the coordinating agency.

The NACDC believes that adjustments to the existing system as established in P.L 92-255 and by administrative actions taken at NIDA are both necessary and inevitable. The NACDC, through its member cities, can bring a unique and invaluable perspective to the re-examination of the urban sensitivity of the

existing planning and service delivery mechanisms and to any possible changes to them. The recent history of the drug field is replete with examples of the difficulties encountered when representatives of city governments with the nation's major drug-involved populations are not given sufficient opportunity to fully participate in the fundamental decisions made in the drug field.

At this point I would like to introduce five documents which I will provide the Select Committee for its records.

In September 1976, the National League of Cities and the U.S. Conference of Mayors conducted a survey of cities over 30,000 in population to determine local drug abuse needs and priorities. Of particular interest is the review of "priority unmet needs", at least one of which directly responds to a specific inquiry of this Committee, adolescent services. Although the lead responsibility for this varies according to the individual state bureaucracy, it can be stated that in most states with major urban population centers, it continues to be inadequately addressed. In at least one state, Massachusetts, the state education authority has relied for critical technical assistance upon the City of Boston's coordinating agency, rather than the SSA.

I'm certain the Committee and its staff will wish to review this and the other concerns illustrated in this very helpful survey.

The second document is the City of Philadelphia "Comprehensive Plan for Drug and Alcohol Abuse Treatment and Prevention", which I offer the committee as an example of how several federal programs can be integrated into a coordinated services program at the local city government level. Philadelphia, through its innovative Coordinating Office for Drug and Alcohol Abuse Programs, has tied Prevention and Ancillary services into the Treatment and Rehabilitation services delivery mechanism, to address all aspects of the drug and alcohol-involved person's life. Key to this comprehensive approach is the reality that any such effort which does not include manpower services is inadequate. The NACDC suggests that the federal government would do well to review the Philadelphia example, and work to facilitate the integration of services through more flexible funding of vocational, prevention, referral, family, women's, and day care services. In these and other services areas, current NIDA activities are at best only a preliminary, and at worst, serve to inhibit local programming initiative through an unimaginative matrix funding concept.

I would briefly point out that the Philadelpha comprehensive services concept also encompasses "ancillary services", those services which can make an important contribution to the success of the client in treatment, but which are not classically delineated as therapy; and "prevention", which is defined as a broad-based, not subject specific, approach addressed to the entire urban population, the aged as well as the young.

The third document for the Committee's records is Mr. Goldberg's chapter, "The Role of the City in Responding to the Problems of Drug Abuse", which appears in the recently published "Rehabilitation Aspects of Drug Dependence." The Committee will find further analysis of the Office of Urban Services concept in this study, as well as additional detail rationalizing the direct funding possibilities for cities with a demonstrated need and capability.

The fourth document, "City Coordination of Addiction Services: Intergovernmental Issues," was prepared by the City of Boston Coordinating Council on Drug Abuse and endorsed by the NACDC as an accurate review of the concerns of city governments in the substance abuse field. This document, in addition to surveying the legislative history of current governmental response to drug abuse, points out the need to prepare for future integration of health services planning agencies and their developing role in this area. The NACDC plans an extensive review of the impact of the Health Planning and Resources Development Act (P.L. 93-641) on local drug abuse programming, and will be willing to share its findings with the Committee.

A final document, which I am pleased to be able to provide with this testimony, is a recently completed survey of 15 drug abuse program coordinators representing cities across the country, which was conducted by the NACDC under the auspices of The Drug Abuse Council, Inc. This survey has just been released today, and offers the impressions of these drug abuse professionals concerning the patterns of heroin, and other problem drug use, in their respective cities.

The results of the survey indicate some positive trends mixed with new demands which cities must be prepared to meet. On the positive side, we see the purity of street-level heroin is lower than in any recent years. At this time, there appears to be a decreasing number of persons seeking our treatment for heroin addiction. However, a majority of the city coordinators from the reporting

cities indicates that heroin treatment programs are operating at capacity. Heroin is appearing from sources other than Mexico, a few cities report, and its effect on purity levels cannot be predicted. There are substantial indications that users are turning to other opiates and depressants such as barbiturates.

Probably the most significant result of the study is the concern shown by every city surveyed with the changing trends in substance abuse by high school students. Most cities indicated that they are not currently equipped or funded to deal with the adolescents' growing use of PCP, pills and, especially, alcohol, which is regularly used in combination with hypnotic-depressants and marijuana.

What all of these documents indicate, is that rigid federal funding standards and an inflexible state mechanism prohibit local officials from planning and implementing treatment and prevention strategies to meet these changing patterns in urban abuse.

To address these issues, the National Association for City Drug Coordination projects the following goals for its membership for the coming year:

1. To present to the public and to the federal government the appropriate role for cities with large concentrations of drug abuse;

2. To establish more beneficial governmental relationships in the drug planning process, including the relationship of cities to federal policymaking and cities to state planning in the drug, including alcohol, abuse and health fields;

3. To initiate policy development and appropriate funding perspectives for the problem of urban drug abuse;

4. To identify those cities with the highest concentrations of drug, alcohol or similar substance abuse problems, and to support initiatives to ameliorate drug abuse in those areas;

5. To investigate, analyze and disseminate information to the public concerning the causes, effects and societal consequences of the misuse of drugs, including alcohol, in cities; and

6. To provide technical assistance, training and research support to member cities.

In all of its activities, the NACDC will be seeking a revitalized federal-state-city partnership in the drug field so that those in greatest need may be helped. I offer the resources of the Association to the Select Committee in forming a joint effort to realize these goals.

Thank you for this opportunity to appear before you again, on behalf of the National Association for City Drug Coordination. I hope we have been able to make the point that the cities are more than just another level of bureaucracy to be dealt into the intergovernmental drug abuse response. Although they represent the site of current substance abuse problems, and even the breeding ground of future problems, we are ready to offer past lessons learned, and well-tested mechanisms, to tie in positive prevention measures and to innovate treatment and rehabilitation programming for tomorrow's urban challenges.

PREPARED STATEMENT OF SUSAN M. KIRCFBERG, DIRECTOR, DIVISION OF SUBSTANCE ABUSE, DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE

Mr. Chairman and members of the committee, I would like to thank you for the opportunity to appear here today to outline some of my perceptions about the impact of the Federal Government on the provision of broad, comprehensive drug abuse rehabilitation programs at the local level.

In attempting to address that point, I would like to outline for you who I am and how we operate in the city of Alexandria so that you will have some perspective on my perspective.

I am the Director of Alexandria's Division of Substance Abuse, one of three divisions in the city's Department of Mental Health, Mental Retardation, and Substance Abuse. I have been with Alexandria's program for five years and spent three years before that working in the field. This total of eight years, as you know, makes me an "oldtimer" in the drug abuse treatment field.

The term "substance abuse" reflects the fact that I have responsibility for alcohol as well as drug abuse treatment, prevention and control. In Alexandria, which has a population of 116,000, we have nine program components that provide services in the areas of alcohol and drug treatment, community and school education and prevention, and telephone crisis counseling. The number of staff members totals 60, not including police narcotics control and hospital emer-

gency room staff. The budget for substance abuse programs in the City is approximately one million dollars. If you look at a percentage breakdown on funding, you will see that we receive 23% from the Federal Government, 35% from the State of Virginia, 37% from the City of Alexandria, and 5% from private sources.

Alexandria's Division of Substance Abuse has its own strong advisory board composed of private citizens as well as local agency people. The agency representatives include the City Manager, the Chief of Police, the Superintendent of Schools, the Director of the Health Department, the Commonwealth's Attorney, the director of the office which operates the city's CETA (Comprehensive Employment Training Act) program, the head of the local Mental Health Association, the Director of the Recreation Department, and representatives of the Alexandria Hospital and the Sheriff's Office, among others. This board is extremely important because it provides a ready framework through which our treatment programs are able to develop the kind of referral relationships and obtain the kind of program support which insure an integrated, wholistic approach to treatment. Additionally, this board advises the Alexandria Community Mental Health and Mental Retardation Services Board, which is one of thirty-eight such boards in the State of Virginia which have policy setting and funding responsibilities to the localities and to the state's mental health, mental retardation and substance abuse department.

It is essentially at the local level that we set our program priorities, devise program goals and objectives, and establish policies and procedures for meeting those goals. We hire and supervise our own staff (including CETA employees), we decide what our basic philosophic approach to treatment and rehabilitation will be, and we obtain the resources that are available to carry out our programs. We conduct all of these activities within what feels to me to be fairly broad, minimum standards of regulation set by state and federal government agencies.

When state and federal money is involved, we present budget requests to the State. The "single State agency" in the State of Virginia is the Division of Substance Abuse, which is part of the Virginia Department of Mental Health and Mental Retardation. The state's Division of Substance Abuse sets broad goals and objectives for the State, coordinates programs within the state, allocates resources equitably, insures that minimum standards are followed in service delivery, provides technical assistance and training, and acts as a liaison for Virginia with agencies within the Federal Government.

How well does this system work? What impact does the Federal Government have on our operation? Where do I see the strengths and weaknesses?

Given financial limitations and relative to the reality of bureaucracy, my overriding feeling is that the system works remarkably well. It may be considered even more remarkable given how young the field really is.

The federal agency that I work with most often, and therefore feel most qualified to comment on, is the National Institute on Drug Abuse (NIDA). I am affected by the policies promulgated by NIDA, so I have thoughts about federal policies. I also have worked both directly and independently with NIDA officials, as well as in conjunction with state representatives. Basically, I feel that the NIDA people themselves and the policies they promote are supportive to local programs. Relative to other bureaucracies, it appears to me that NIDA involvements result in far less red tape than other federal and state agencies. The caliber of people working at NIDA is impressive, whether you work with people in the treatment division, prevention, research, grants and contracts, or women's programs, to name a few. Those I have worked with are competent people, committed people, reasonable people. They appear to me to work hard with state personnel to get as much financial and technical support for the localities as is possible, given funding limitations. The policies and regulations set a reasonable framework of minimum standards that permit broad latitude in actual program operations, as I tried to indicate earlier. To the extent that the minimum standards have not fit our local situation, we have been able to get exemptions. NIDA also actively solicits local level input in establishing its policies, so I do feel that we can have a considerable impact on the formation of the regulations, if we choose to exercise our own power.

In working over the years at the local level, I feel strongly that federal support of the single state agency concept is commendable. The single state agency in Virginia, for example, has the expertise to serve as the primary liaison with the federal agencies working in the substance abuse field. The single state agency

model clearly provides a stability to all levels of the national drug abuse treatment network.

Another model promoted by the Federal Government which has had a direct and, in my opinion, a positive impact on local program operations is the merger of alcohol, drug abuse, and mental health activities under one umbrella administration, the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). This model as set by the Federal Government has already been adopted nearly statewide in Virginia. In the last two years, alcohol and drug abuse administrative operations have been merged at both the state and often the local levels, as in Alexandria. Furthermore, the alcohol and drug abuse administrative units have been combined at both the state and local levels with the other mental health related units of government. This model has already increased the integration of mental health and substance abuse related activities and a corresponding improvement in service delivery has resulted. I would also like to add, however, that as I see it from the local level, it is very important to retain strong, highly visible advocacy groups for alcohol and drug treatment and control. I am therefore very concerned about the possibility that ADAMHA might attempt to reduce the power and capabilities of the three institutes (NIDA, NIAAA, NIMH). It might be easier and more efficient to operate ADAMHA with one strong director, but it also appears to me that it is imperative that each of the three separate institutes have strong directors . . . people who have vision, high visibility, authority, and some ability to educate all of us . . . directors who can raise our collective consciousness and act as strong advocates for the field. What I am saying, in short, is that public information and education should not be sacrificed in order to have a more streamlined, centralized administrative structure for ADAMHA.

In summary, I would just like to say that from the local level, I feel supported and not constrained by the Federal Government. I feel that my expectations of the role NIDA should play are being met. I do not say that the system is perfect, but I am a realist. Where the responsibility of the Federal Government starts and stops, the state's responsibility starts and stops, and that of localities starts and stops appears to be at issue here in this whole discussion. It is my perception that the reality is that at the federal level, you set broad goals and funnel money through the states to the localities. However, the real control of program impact rests first at the local level where programs are operated, then at the state, and last at the federal level. And this is how I believe it has to be. You know as well as I do that the Federal Government cannot solve all of our problems. Program operations cannot be directed or controlled from the federal level. What you can do, it seems to me, is to try to focus as much energy as you have toward: (1) helping us educate the public about substance abuse in this culture; (2) educating the other members of Congress on the real need to appropriate more money, especially in the areas of education, prevention and research; and (3) promoting a more powerful, highly visible substance abuse prevention and treatment effort—whether at the White House, within the Department of Health, Education, and Welfare, or in your own local districts.

This concludes my statement. I would be happy to answer any questions that you might have at this time.

PREPARED STATEMENT OF EDMUND H. MENKEN, VICE PRESIDENT, PROJECT RETURN FOUNDATION, INC., NEW YORK CITY

Mr. Chairman and Members of the Committee, I appreciate the opportunity once again to be invited by this body to offer my comments, experiences and opinions regarding the national drug abuse treatment effort.

An examination of the way in which the Federal Government both finances and coordinates drug treatment and prevention activities is extremely important at this time. Some consideration has been given over the years to these matters but never in the depth nor with the level of dimensional understanding that is necessary. To begin with we must recall that period when there existed, as an extension of the White House, the Special Action Office for Drug Abuse Prevention (SAODAP). That agency was set up by Executive Order during the Nixon administration and given the mandate to establish a national drug abuse prevention policy and to coordinate all efforts existing at that time, throughout the federal bureaucracy, to bring every possible resource to bear upon the problem. SAODAP was, as I have mentioned in previous testimonies before this group, an agency born out of political motivation and "political realities." It should not therefore

be surprising that much of its policy development was never formulated either with an interest or commitment to genuine problem solving or social concern. One of the best illustrations of this is the fashion in which the federal government, through SAODAP, developed its funding formulas for the treatment of drug abuse. SAODAP's staff sequestered themselves for a brief period of time and later emerged with the absolute conclusion that each modality of drug treatment should cost a specific amount of money. That was in 1972 and the price tags determined by SAODAP were as follows:

$1,700 to treat an individual in a methadone maintenance program.

$5,000 to treat someone in a residential drug free environment.

$2,000 to provide services in an ambulatory or outpatient module. These figures were imposed upon all programs in the United States attempting to do a credible job in treatment and rehabilitation. We were never informed of the rationale; we were never told how these formulas were arrived at but we were ordered to live with them.

In my primary areas of experience, which is the residential treatment model, the federal government delivered to us an inflexible mandate to provide quality care for comprehensive services to individuals at this absurd cost ceiling. Actually, it was worse. The funding formulas that I mention were created in relation to something called "slots". We were not funded for bodies, human beings, we were rather funded for "slots" or "beds" that an undetermined number of people might occupy during the course of one year. It did not matter to SAODAP and the federal government that every time a client moved out of the treatment program and another one took his place the cost would immediately escalate. We were required, you see, to provide complete medical and psychiatric workups for each individual to develop personal treatment plans and never to add the additional costs to the allocated amount. We were also expected to provide education and vocational services, family counseling, individual and group therapy, recreational activities, and an absurd volume of reporting, much of which was unnecessary and irrelevant.

This story is significant not merely because it describes how the federal policies governing federal funding formulas were developed, but also because it is the backdrop against which our current dilemmas exist. The fact is that to this day we are funded in exactly the same fashion with even greater expectations directed toward us. It is now six years later and while the cost of living in this country has increased probably 5 or 6 percent each year, the increase in funding allowances from the government are negligible, for example, where in 1972 we were permitted $5,000 per year for each residential treatment slot, we are now permitted $5,400. The net increase in 6 years, gentlemen, is 8 percent. The demands upon us grow, the public feels frustrated over what this government has done to combat drug abuse, and we in the treatment and rehabilitation sector have had to take the weight. It seems that it matters not to the U.S. government that treatment and rehabilitation costs from 100 to 400 percent less than it does to warehouse people in prison. It appears that government officials have no interest in saving tax dollars while at the same time conducting more sensible programs. Indeed, one might think that the way this nation is approaching its drug treatment responsibility is entirely schizophrenic. This Committee is interested in encouraging a "wholistic" approach toward drug abuse treatment but the policies of the National Institute on Drug Abuse serve only to discourage such approaches.

Beginning with SAODAP and now with NIDA there is no opportunity for open dialogue around the issues that prohibit us in the field from providing quality care to our clients.

This Committee has asked several questions of me and I will do my best to respond to them.

First, it does not appear that the federal government in the form of NIDA has taken any initiative whatsoever to instigate helpful and what I would consider to be necessary cooperative activities among other government agencies both at the federal and local levels. Our clients for the most part are people who come out of families and environments that are plagued with very serious problems. If we do a decent job with addicts' psychological and emotional conditions, our efforts must then fly in the face of a tremendous void where other services should be. The Department of Labor, for example, operates a massive CETA program and we in the Drug Treatment and Rehabilitation sector have no direct linkage to that program. The Department of Housing and Urban Development has a variety of programs that we ought to be able to link up with. But neither NIDA nor anyone else has helped us gain entry or make

the connection. Indeed, various elements of HEW provide abundant options to assist us toward successful rehabilitation, but again there is no one assuming the leadership of coordination toward this end.

We in the Drug Abuse Treatment and Prevention field, but particularly our clients, become severe victims of the fragmentation of government bureaucracy. This Committee promotes the term "holistic" and nowhere in this federal system is the spirit of that term carried forward. It is as if the U.S. government in its wisdom perceives the problem of its people to be segmented, compartmentalized, and fragmented in the extreme. If there is a question of health services then you must appeal to one department; if there is an educational need you must see another agency; if there is a problem with housing or child care, or legal services then you must trip around through an ever growing maze of disconnected bureaucracies. No one does it all, everyone wants to send you somewhere else and the result of this is the continued waste of millions and millions of dollars, and an incalculable amount of energy. The bottom line is that if we are able to get anyone well then it is in spite of this system. The fact that we are relatively successful should be considered almost miraculous.

Second, any level of cooperation that is established locally between drugs and other health services rest entirely on the local people. The federal government exercises no muscle whatsoever to accomplish this objective. There is much, I believe, that could be done in this vein, but it is not.

Third, any agreements or interrelationships with state education and other authorities is again the product of individual program initiatives.

To sum up these questions, what we are able to do is very little and it is not simply because the federal government has abdicated. In my opinion government abdication in this case goes out as a signal to all those who should otherwise be involved, but are led to believe because of the federal neglect that the government really doesn't care. I am finally becoming one of those believers.

I have been asked for my recommendations and they are, in part, as follows:

1. I would urge that the Congress call forward what is, in my opinion, the only responsible and reliable investigative body that still has the confidence of the people, i.e., the General Accounting Office. I would urge that the GAO be directed to examine the funding formulas for Drug Abuse Treatment established by the government. I would suggest that they review these formulas and determine how Drug Treatment and Rehabilitation should be financed, what should be the method of payment and the level of reimbursement for services rendered, how the federal bureaucracy should engage in cooperative and determined efforts and what other corrections might be made in the National Drug Abuse Treatment and Prevention policies.

2. I would urge that the GAO be assigned the responsibility, after extensive investigation, of reporting to the appropriate Congressional Committees on the progress of how Drug Abuse Treatment and Rehabilitation may be included in any possible national health program.

3. I would urge this Committee to include in its hearings testimony from related government officials with respect to long-range policy planning in this area. I would recommend that this Committee not satisfy itself around this issue until it has been told what plans NIDA and HEW have for the continued funding of Drug Treatment and Prevention, until it has learned precisely what the formulas are and will be, if they are being established, and what is the thinking behind the strategies.

4. I would urge that the Congress consider legislation that would force health insurance companies to provide coverage for Drug Abuse Treatment and Rehabilitation. This is extremely vital. The government has the power and the capability to make this happen and to enforce it. And unless this country takes a militant step forward in seeing to it that the primary source for financing Drug Abuse Treatment is placed with the insurance carriers and in the private sector we will have once again succeeded in a billion dollar disaster. Thank you.

PREPARED STATEMENT OF FRED R. WEST, JR., M.D., ADMINISTRATOR, SUBSTANCE ABUSE ADMINISTRATION, DEPARTMENT OF HUMAN RESOURCES, GOVERNMENT OF THE DISTRICT OF COLUMBIA

Mr. Chairman and Members of the Select Committee, I am Fred R. West, Jr., M.D., Administrator of the Substance Abuse Administration, Washington, D.C.

I appreciate the opportunity to appear before this committee to testify on the efficacy of the Federal effort in promoting the establishment of integrated treatment services.

CONTINUED

1 OF 3

The drug abuse explosion of the late 1960's created such an impact that it caught the entire nation off guard. The District of Columbia was engulfed by an alarming rate of heroin addiction—2.2 percent of the total population of 765,510. While the social and personal losses due to this epidemic were tremendous, the related crime rate was appalling. There was some hope, at that time, that the creation of a public treatment program in Washington could be of great help in reducing the number of people who used the illegal drug—heroin.

The creation of the Narcotics Treatment Administration in February 1970 was a critical step in the war against drug abuse in the District of Columbia and manifested a significant departure from traditional Narcotics Treatment. Unlike earlier efforts by the Public Health Service at its hospitals at Lexington, Kentucky and Fort Worth, Texas, this program did not attempt to make all of its participants drug free. Also, unlike the therapeutic communities of the early 1960's, the Narcotics Treatment Administration did not limit itself to treating small numbers of patients. Rather, for the first time in the history of this Nation, the NTA attempted to establish a community-wide treatment program, utilizing methadone maintenance treatment to a large degree, accepting as many drug abusers into the program as could be recruited.

During its first year of operation, the client population escalated to nearly 3,000; it peaked at 4,500 in 1972, (Appendix A, "Narcotics Treatment Administration Client Population"). Our clinics (16 in 1972) treated both adult and youthful clients, and dealt with all District residents appearing voluntarily and other residents of the Metropolitan area referred by the District of Columbia Criminal Justice System.

At the same time that emphasis was being placed on the availability of drug abuse treatment for rehabilitation and crime control, law enforcement officials at all levels, put unprecedented pressure on the drug distribution network. It became much more difficult, if not impossible, for individuals to purchase drugs, and those purchased were of low purity. (Appendix B, "Purity of Street Level Heroin, Price of Street Level Heroin"). Here in Washington, D.C., both incidence and prevalence declined significantly. The decline in the number of new users was shown through dramatically reduced numbers of clients, with a recent onset of heroin use, entering treatment at NTA. (Appendix C, "Unduplicated Clients Treated"). The decline in the use of drugs was further reflected in declining narcotics overdose deaths and detection of heroin among persons arrested. (Appendix D, "Narcotics Overdose Deaths as Reported by the Office of the D.C. Medical Examiner").

Unfortunately, the decline in drug abusers seeking treatment did not signify a decline in the abuse of drugs: heroin or the non-opiate drugs (i.e., cocaine, marijuana, amphetamines, and barbiturates). In 1976 we discovered that heroin was but a small part of the drug abuse problem. (Appendix E, "Most Prevalent Illegal Drugs Abused by NTA Clients"). It is a well substantiated fact that the chronic, intensive, medically unsupervised use of amphetamines, barbiturates and prescription drugs (Valium, Librium, Dilaudid, etc.) ranks with heroin as a major social problem. Cocaine use except among certain groups, was relatively insignificant in the United States in the early 1960's. However, since 1970, there has been a steady upward trend in the amount of cocaine seized in route to the United States from South America. Marijuana is the most widely used illicit drug, with an estimated 26 percent of all District Residents 15 years and older, having smoked it once. Some 86,000 persons (or 15.1%) smoke it regularly.

The Substance Abuse Administration, has the legal implications as well as the moral obligation to treat all drug abusers within a defined jurisdiction. In addition to a treatment program, it is also necessary to provide a meaningful rehabilitative program, further providing intervention, prevention, and educational services to a segment of the population we hope never to see in treatment.

Along with the aforementioned changing trends, the profile of the SAA client has also changed. The typical SAA client is now 27 years old; a black male with an eleventh grade education. He is unemployed and not in school or training. He is a readmission to the program, has been in treatment this time for six months, and is receiving 24 milligrams of methadone. (Appendix F, SAA Condensed Data and Profile Sheet).

What does the Substance Abuse Administration have to offer this client? What impact have Federal funding agencies in this offering?

Because our typical client is a readmission to our program, upon presenting himself to the Central Intake Division, he would be referred to the Re-entry clinic. Because one of our major problems is our drop-out rate, SAA has estab-

lished this Re-entry clinic for the purpose of 1) assessing and enhancing the motivation level of recidivists; 2) ascertaining from these recidivists, problems they encountered at SAA when they were in treatment before, needs that were unmet by the program and possible solutions; and 3) providing a professional staff who can be contacted at any time the client feels his present treatment goals are not being met this time before he reaches drop-out status.

After the Re-entry clinic experiences, our typical client will be referred to one of our clinics for treatment and subsequent referrals for other ancillary services to meet his specific needs. He does not have a job so he would be referred to one of our Employment Development Specialists for further assessment. Our typical client has an eleventh grade education so from there he might be referred to SAA's "Mini Learning Center" for GED tutoring, or a course in Landscaping or a course in housekeeping (coordinated through the Department of Health, Education, and Welfare, St. Elizabeths Hospital).

Because he is also single, we can surmise that his lifestyle and living environment probably reinforce his drug abuse problem, and if his counselor discovers he has a female friend with similar problems, attempts will be made to get her into treatment at our Women's Services Clinic, designed specifically for females of child bearing age.

While all these efforts are being directed at changing lifestyles and attitudes, because he is already on a low methadone dosage, major co-efforts will be made between the medical and counseling components to detoxify this client to an abstinent state.

While our client is detoxifying, should he experience unusual medical and social hardships on an outpatient basis NTA has Federal funds now to establish an inpatient detoxification unit. Hopefully when his period of detoxification is over he will be ready for our Adult Abstinence Clinic for further rehabilitation and reinforcement for re-entry to the community, this time we hope as a useful, productive citizen who will have continuous contacts with the Adult Abstinence Clinic whenever needed.

Should our typical client have a non-opiate problem he would have followed this route through our Poly-Drug clinic; should he be under nineteen years old, his route would have started through the Youth Abstinence Clinic.

We at the Substance Abuse Administration, too, feel that treatment and rehabilitative services are best delivered within the community whose population the programs serve. However, neighborhood pressure has forced us to create enclaves like the Comprehensive Services Center recently opened in the PCRC Building on the grounds of D.C. General Hospital. The Women's Services Clinic, EMERGE House (therapeutic community), TRAIN II (Federally funded multi-Modality treatment clinic) Adult Abstinence Clinic, "Mini-Learning Center (Federally funded educational training facility), the Education/Prevention Division, Employment Development Branch, and the Inpatient Detoxification Unit are located under one roof.

I am pleased to know that the report, "Drug Use Pattern, Consequences and the Federal Response" presented to President Carter by Dr. Peter Bourne, Director of the Office of Drug Abuse Policy emphasizes some of the same issues that the Substance Abuse Administration has accepted as challenges.

This report addresses and emphasizes the need to look at the way Americans use all drugs—tobacco, alcohol, prescribed and over the counter psychoactives as well as the many illicit varieties. This same issue was the underlying rationale for our change of our name from the Narcotics Treatment Administration to the Substance Abuse Administration. Another factor equally important to the rationale of the name change is our new philosophy and thrust of abstinence as opposed to an emphasis on the treatment of narcotics abusers.

We support the thesis of this report, also as it relates to drug abuse prevention, and more specifically, the offering to young people of some real and tangible alternatives to experimental and recreational drug use.

These issues, of course, necessitate existing health and social services becoming more involved in diagnosis and treatment.

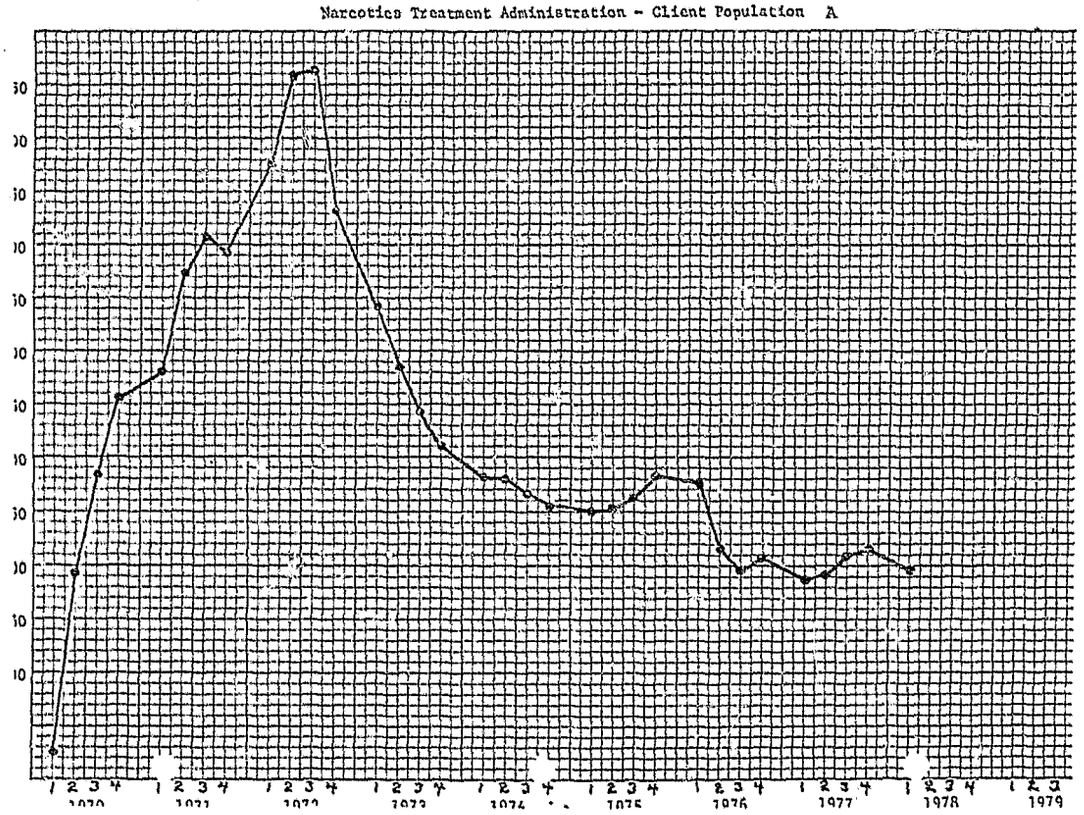
I would also like to mention three additional recommendations cited in this report in hopes that more federal funds will be forthcoming to assist in their implementation:

1. Drug treatment programs must provide family counseling. Because of the nature and sensitivity of this therapy, more money must be allotted for the recruitment and maintenance of professionals (social workers, psychologists, psychiatrists, music, recreation and dance therapists, etc.) to provide this es-

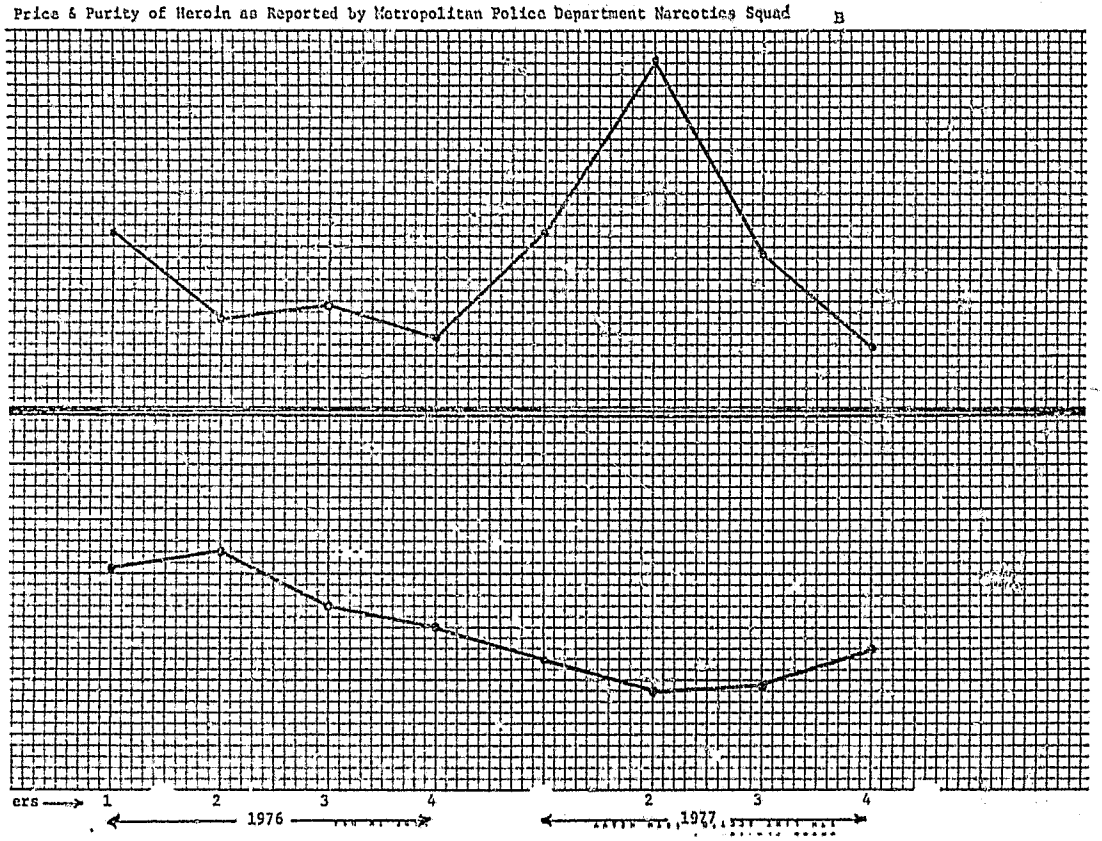
sential treatment tool. 2. The use of paraprofessionals in drug abuse treatment has long been a delicate issue. Money should also be earmarked for the upgrading of the skills of these workers, encouraging them to be credential bona fide counselors. 3. The Department of Labor and Department of Health, Education, and Welfare must take the initiative in developing model agreements not only to support employment and training programs but to provide stipends for those participants as well. Drug education should begin in elementary school and should be inclusive of all substances which have an impact upon the physical and mental well being. We feel that this education should include saccharin, food additives, pollutants, cosmetics, radiation, etc. All substances that impact on everyday life should be included as a part of primary prevention and should result in a redirection of interest from treatment to prevention and early intervention.

Mr. Chairman, this concludes my statement; I hope that I have made a meaningful contribution to the Select Committee's inquiry. I thank you for this opportunity and am available to answer any questions that you might have.

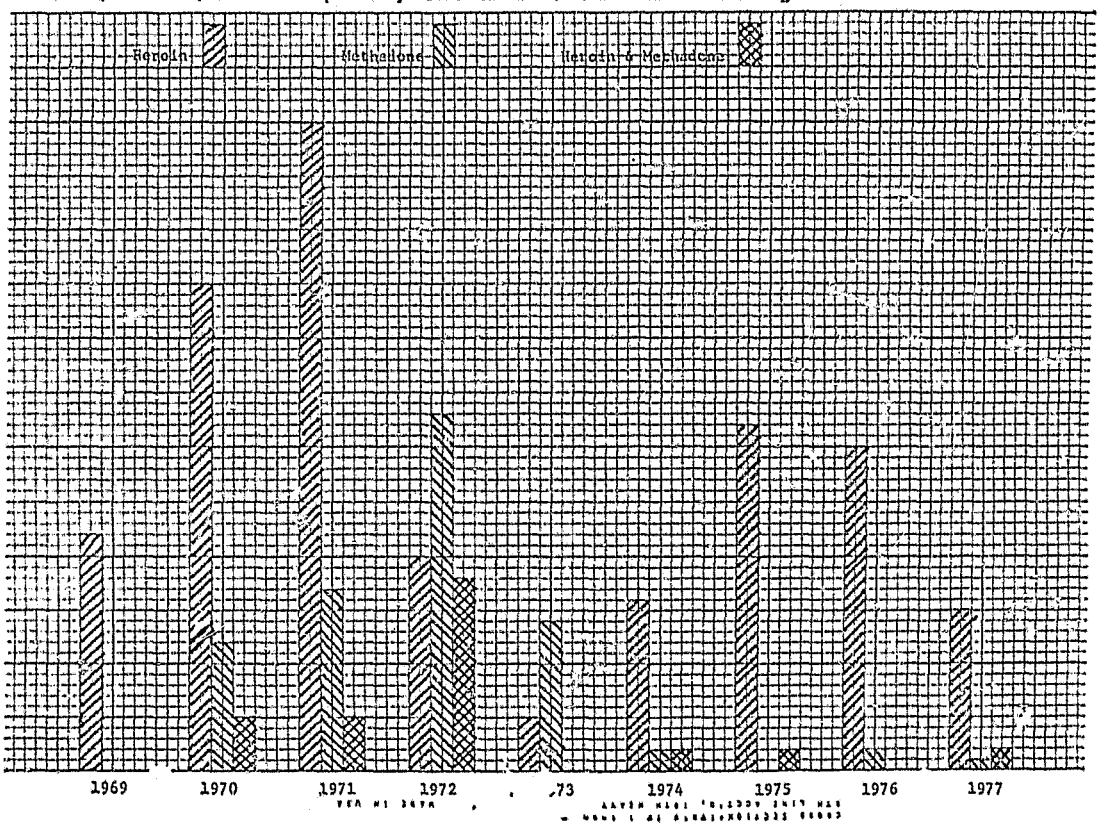
Narcotics Treatment Administration - Client Population A



Price & Purity of Heroin as Reported by Metropolitan Police Department Narcotics Squad B



Narcotic ("OVERDOSE") Deaths as Reported by Office of the D. C. Medical Examiner D



Unduplicated Clients Treated

	New admissions	Cumulative totals
Year:		
1970-71	6,149	6,149
1972	3,043	9,192
1973	921	10,113
1974	970	11,083
1975	1,129	12,212
1976	730	12,942
1977	623	13,565

MOST PREVALENT ILLEGAL DRUGS ABUSED BY NTA CLIENTS

[In percent]

	November 1976	November 1977	February 1978
Amphetamines	25.5	30.0	28.0
Heroin	18.0	17.0	21.0
Codeine	1.3	1.1	1.7
Barbiturates	.3	.4	.2
Cocaine	.2	.2	.1

NTA CONDENSED DATA AND PROFILE SHEET

	1975	1976	1977
Estimated addict population	10,000	11,000	9,000
Number of clients treated	5,275	4,339	3,765
Potency of heroin (percent)	5.5+9.4	2+5.5	1.6+3.1
Number of overdoses	34	32	18
Client population (December)	1,986	1,441	1,462
Number of youth in treatment	102	50	19
Average age	26	28	27
Average time in treatment (months)	7	7	6
Average years of education completed (grade)	11	11	11
Percentage of male	66	68	66
Percentage of black	89	90	82
Percentage of volunteer	63	61	69
Percentage of readmission	60	70	73
Percentage employed	34	34	35
Percentage in education and/or training	8	5	3
Client average methadone dosage level (milligrams)	26.5	25.4	24
Number of persons treated by NTA since 1970	12,212	12,942	13,565

DRUG ABUSE TREATMENT

(Part 1)

THURSDAY, JUNE 15, 1978

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

The Select Committee met, pursuant to notice, at 10 a.m., in room 2337, Rayburn House Office Building, Hon. Daniel K. Akaka (acting chairman) presiding.

Present: Representatives Lester L. Wolff (chairman of the Select Committee) Billy L. Evans, Daniel K. Akaka, J. Herbert Burke, and Benjamin A. Gilman.

Staff present: Joseph L. Nellis, chief counsel; David Pickens, project officer; and Michael Backenheimer, professional staff member.

Mr. AKAKA. The hearing of the Select Committee on Narcotics Abuse and Control will come to order.

This morning marks another in the continuing series of hearings on drug abuse treatment.

The focus of today's hearings is to ascertain how the National Institute on Drug Abuse is discharging its responsibilities in the area of drug abuse treatment.

The National Institute on Drug Abuse, as the "lead" Federal agency in drug abuse prevention and treatment is charged with overseeing a great deal of the Federal drug abuse prevention effort.

In 1977, the National Institute on Drug Abuse had a budget of approximately $260 million.

This budget includes funds for approximately 102,000 treatment slots which NIDA funds either completely or partially.

It is estimated that these treatment slots service in excess of 160,000 human beings suffering from some form of drug abuse.

The major issues which this committee has interest in today are the following:

1. Integrated service delivery. We are concerned that fragmentation of the Federal drug abuse treatment effort has caused drug abuse treatment to be less than optimally effective

We are interested in how NIDA is coordinating the programs of other agencies in the Federal Government.

2. Evaluation of drug abuse treatment. As in drug abuse prevention, the committee wishes to ascertain what works in drug abuse treatment and for whom and under what conditions.

Furthermore, the committee is interested in how NIDA evaluates current programs.

3. Research issues in treatment. The committee is vitally concerned is ascertaining how NIDA's research is coordinated and how the results are applied to drug abuse treatment programs.

4. Treating special populations. We of the Select Committee feel that special populations such as racial minorities, ethnic minorities, women and pregnant women need to be given their just due in drug abuse treatment.

We will seek to determine how NIDA is treating special populations.

5. Local coordination of treatment. The need to have treatment slots where and when they are needed is crucial.

The Select Committee will explore this facet of treatment utilization today.

The undertaking I have just outlined is vital to the entire public health field. Perhaps no disease exerts a more telling toll than drug abuse. With this format, let me welcome you today, Mr. Karst Besteman, Deputy Director, NIDA, and Mrs. Johnson.

We are indeed glad to have you with us today.

Before we begin let me ask my colleagues if they have any opening statements they wish to make.

Before we begin, I would like to swear you in.

[Witnesses are sworn in.]

TESTIMONY OF KARST J. BESTEMAN, DEPUTY DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE, ACCOMPANIED BY ELAINE JOHNSON, DEPUTY DIRECTOR, COMMUNITY ASSISTANCE

Mr. AKAKA. Your complete statements will be included in the record. You may summarize your prepared statement, and following that, we will have some questions for you.

[Mr. Besteman's prepared statement appears on p. 132.]

Mr. AKAKA. At this point, since we have a rollcall, I would like to call a 10-minute recess.

[Recess.]

Mr. AKAKA. The hearing will come to order.

We will continue with your statement, Mr. Besteman.

Mr. BESTEMAN. Thank you, Mr. Chairman.

I would like to just summarize my statement in just a few moments and highlight several points.

The first is that at this time the Federal Government has a substantially better capacity to estimate the nature of the drug abuse problem in the country and the trends that are occurring.

The data given yesterday by Dr. Klerman about specific age groups is an example of that ability and improvement as the result of putting several data systems in place.

Second, we are proud of the successful management of the statewide services contracts which is the major mechanism for distributing treatment money to the communities. I think it is important to highlight the fact that the amounts of money being provided for drug abuse treatment nationwide last year was distributed as follows: 43 percent of the money was provided by State government; 38 percent was by the Federal Government; and 19 percent of the money was provided by local sources, both public and private.

We are concerned with the ability of the statewide service contract mechanism to be responsive to the needs of minority communities and minority patients. The ongoing discussions that we have had with the cities regarding the ability of the mechanism to be responsive to community groups that want to influence how services are delivered and in what constellations in a given community, be they minority or just a citizen's action group, have been helpful in seeing these issues more clearly.

We have been addressing that problem by trying to encourage a greater sensitivity to the needs of minority communities. In fact, two sessions at the annual convention of the National Association of State Drug Abuse Coordinators and two seminars were devoted to their role and also to assuring that the statewide services contract mechanism is more flexible.

NIDA shares the concern of the committee and those in the field about the effectiveness of the treatment; and what should be the proper criteria for treatment outcome. Most treatment evaluation to date has centered around the behavior of the patient after treatment as regards his criminality, his continued use or reduction in illicit drug use, and his work and social productivity.

We are initiating a reevaluation effort, the so-called TOPS program, a treatment outcome prospective study, which is centering its efforts initially in four cities in order that we can get some experience with the mechanism. Some of the outcome criteria that are being used on TOPS are more broadly defined and in more detail than previous studies of this type.

The area of employment, and the relationship of the Institute with the Department of Labor and its programs has also been an area of considerable concern and effort.

The Federal funding criteria has, since 1975, required that local programs establish a relationship and have available for the patient vocational counseling and training. In formal sense, this is being met. It is our experience, however, in monitoring some of the programs that the flexibility or the access to that resource varies considerably from community to community.

One of the influences, again, that impacts on that is the local rate of unemployment. I use the city of Detroit as an example where in spite of access to these resources we find it extremely difficult to find employment for the young, black, male client in that city, since that population experiences somewhere around 50 percent unemployment in the nonaddicted population.

The relationship that the drug abuse treatment network has with the criminal justice system in having a policy and requirement of acceptance of referrals from local courts is another area of concern to the Institute. We have been working with LEAA to get coordination between the criminal justice State planning agencies and the Single-State Agencies for drug abuse prevention that we relate to at the State level. We have published handbooks in that area and we have held joint meetings between LEAA and the States around this issue and I think we have made some significant impact.

A research and treatment issue that we are highlighting that I personally think is of special interest is that of phencyclidine, or PCP, issue. PCP has come on the country over the last couple of years and its use is very widespread and especially heavy among the youth.

We do not have a lot of information on the proper treatment for PCP users. There is a considerable psychiatric component to the impact of the drug. Our clinics are reporting that there is considerable demand for treatment, but that the patients are not always readily amenable to treatment.

In addition we are continuing the development of chemical agents in treatment. The experience we have had with LAAM and naltrexone has been encouraging to us, although occasionally trying, because of the time and effort necessary to get these drugs approved.

There is another substance, butamorphine, which has come to our attention through research at NIDA's Addiction Research Center which we think also offers an even more attractive compound for treatment because the required dosing schedule is less frequent than methadone, and it appears capable of blocking the euphoric and dependence-producing effects of heroin. The drug produces only minimal dependence so that maintenance therapy termination should be considerably easier than with either methadone or LAAM. That, we feel is an important difference in these drugs.

This drug is at a much earlier stage in development than either methadone, LAAM, or naltrexone, but it is, I think, the next one that will be aggressively developed by the Institute.

With just noting those items in my formal statement, I would like to be able to respond to any questions the committee might have.

Mrs. Johnson, who is the Deputy Director of the Division of Community Assistance is with me. She will be willing to help in any way she can, too.

Mr. AKAKA. Thank you, very much, Mr. Besteman.

In my opening statement, I mentioned five issues and you have touched on these issues as you went along.

On the average, what are presently the needs of the minority population in the country?

Mr. BESTEMAN In terms of drug abuse services?

Mr. AKAKA. Yes.

Mr. BESTEMAN. Our admission statistics show very graphically that the minority populations are very disproportionately affected by drug abuse.

A paper given at the National Drug Abuse Conference in Seattle in April seemed to indicate that the minority group that is having the highest increase in heroin addiction now is the Puerto Rican community in the New York area.

Our programs are heavily used by minority groups to the point that about 50 percent of all admissions are the minorities. Many programs are located in these minority communities, and some, although not as many as are located there are run by community groups.

I think we can say that the baseline service needs of these communities are being met, however certainly not the total service needs are being met. I am speaking, now, only of the Federal effort, which represents only about 40 percent of the national effort put forth in drug treatment. Independently funded State and local programs are also somewhat disproportionately used by minorities.

There are pocket community neighborhoods, if you will, where there is a deficit of services. When you look at it in a general sense, and across a broader area, I think the service system is relatively adequate to the size of the problem in the country.

Mr. AKAKA. What about the Puerto Rican community south of New York to Florida?

Mr. BESTEMAN. As I say, in New York, they still seem to be experiencing a tremendous increase in drug use among their youth, that is even greater than the normal pattern which seems rather stable in heroin.

We are aware of this. The State of New York is aware of it. When we did put new resources into New York the last time, there were provisions made to distribute these in New York City in neighborhoods that had special needs. Within the statewide services contract of New York, as resources become available, they have the ability to move into a new neighborhood or a new treatment center. We take this kind of information and share it with the State and try to reshape the configuration and the location of service, then, within that State.

Mr. AKAKA. You mentioned a program of trying to meet the needs, in this case, of the Puerto Rican community in New York City who are addicted to heroin.

What kind of evaluation do you do on this?

Mr. BESTEMAN. Once a treatment program is in place, the evaluation consists of two kinds. One would be the actual management and running of the program, asking such questions as: Do they meet the Federal funding criteria? Do they operate as well administered service system? Do they do proper intake and evaluation of the patient, and do they see the patient as frequently as is considered necessary or usual in the treatment? Those are sort of the general management evaluations.

As far as specific outcome evaluations, we would do that only as the program would want to use a self-evaluation package that is mentioned in my testimony and which they have access to. Or if they came in with a special research project, to want to evaluate their own data, or if they became part of a larger evaluation study such as the one that Dr. Sells at Texas Christian would be running or if they would become part of the TOPS program that I referred to. Theoretically, all the above are available to them.

Our expectation is, or our assumption is, that if they are well-managed and well-run treatment programs, that the differences between—and among the programs within the federally supported system are not so great that the outcome of these large studies wouldn't be applicable to their population, also.

Mr. AKAKA. This is not really in the realm of treatment, but in your evaluation, do you try to get information that might lead to a source of, in this case, heroin?

Mr. BESTEMAN. Where the drug is coming from?

Mr. AAKA. Where you think that drug is coming from?

Mr. BESTEMAN. We do not ask those kinds of questions in evaluations.

The Drug Enforcement Administration and NIDA can answer that question, but through the use of a different mechanism without having to ask the client, simply by getting a hold of the drug on the street and testing it for—the so-called signature program that I am sure the Drug Enforcement Administration could explain in great detail.

We do know, then, where the drug originated.

Mr. AKAKA. I was interested in the statements yesterday as to the feelings of different age groups and what they called spacelessness, or——

Mr. BESTEMAN. Weightlessness.

Mr. AKAKA. Weightlessness for different age groups.

Do you, in your evaluation, try to obtain information of this kind as to why they began using the drug?

Mr. BESTEMAN. We have some evaluations that ask why the person began to use the drug. The consistent finding, going back to the 1930's when Dr. Pescor did a landmark study of 4,000 patients back in the late 1930's, and the answer we get we find totally unacceptable, is that most addicts after they are addicted who are asked why did you start, will say either curiosity or their friends were using it. Those are very surface, easy answers, and I think in many cases they avoid looking at the real reasons as to why drug abuse began.

The TOPS study, that I referred to, which will be a prospective study where we will start to study a patient as he enters treatment and continue studying him while in treatment and whether he drops out or continues, will enable us to ask many more indepth questions and know much more about it.

The way the studies have been done, previously, is to note that Mr. A went into treatment at a given time and to talk to him 3 or 4 years after he has left treatment and ask him to think back as to what was happening then.

I think we all know that very often we don't really remember the explicit circumstances that were 4 years old.

So that the quality of the evaluation, we think, in doing a prospective rather than a retrospective study will be enhanced.

Mr. AKAKA. May I break my questioning now to acknowledge the presence of my colleagues Billy Evans of Georgia, and Mr. Gilman of New York.

Further, I would like to have you expand a little more about your TOPS project.

You have it in four cities.

What cities are these, and how are you doing in these cities with this program?

Mr. BESTEMAN. I am not absolutely sure of the four cities. And I tried to check that out last night and wasn't able to get it.

I know that Seattle at one point was a candidate city. And I understand that Miami is involved, and I think, New York is also involved, and I can't think of the fourth one.

We are starting with four in order to work the early problems out of the system and hope that once we have these problems worked out, we can expand it to more cities so that it becomes more representative of the total system.

Our feeling was, since we are going through a relatively complicated and indepth evaluation, we wanted to make sure that we had those process problems solved before we went to a large effort since we estimate that this effort is going to cost somewhere between $1 million or $2 million a year ongoing, and we would rather have the design problems out of the way before we expand it and become overwhelmed with just the numbers.

The TOPS study should begin in late fall 1978 in six cities: New York, New Orleans, Houston, Portland, Chicago, and Des Moines.

Mr. AKAKA. I'm also interested in the comments you made about community groups.

Can you also explain how "interaction" is working and what you are trying to do with this method?

Mr. BESTEMAN. I think the best examples that I can give of that is if you go back to the early beginnings of community drug treatment as supported by the Federal Government, back to the OEO Act. I think it was about 1967 or 1968.

Many of the drug programs started from the community action base and perhaps the most concerned citizens ever around the drug problem are those that live in a neighborhood that is being eroded and blighted by the drug situation.

In any community, in any city or even a small town, when the community gets together and decides that drug abuse is a problem and they want to see some action, they inevitably somehow want to influence how that service is delivered.

Since the mechanisms, now, are subcontracts for the community to the State, this requires an organization sophistication that usually means that some well-established local agency becomes the vendor to the State.

We have situations where, then, communities will come to us and say, well that is a vendor that we are already dissatisfied with for a whole lot of reasons. They may also be the vendor of some other medical service or some social service.

The community may feel that the vendor is not responsive to the community's definition of its own needs. So that we get them into some negotiation as to how they should respond to the community and to what extent should a community group have direct influence on whether a purchased service is purchased from a given vendor.

There is no clear answer to the question. It is a question of having managerial stability and fiscal accountability in delivering the service and having responsiveness to defined community needs. There is always sort of a built-in tension between those two values.

Our statewide services contract has sort of highlighted that tension, because prior to that mechanism, programs could incorporate into nonprofit corporations and receive a grant directly from the Federal Government. In many situations, this was satisfying to them, but I must say on occasion it was not totally satisfying to the Federal Government in terms of the fiscal management and delivery of services.

Mr. AKAKA. You then spoke about sensitivity.

Mr. BESTEMAN. Yes.

Mr. AKAKA. You are encouraging sensitivity. Is that for the Federal Government or sensitivity in the community groups?

Mr. BESTEMAN. As I used it, I was referring to the fact that we have a management mechanism that is very efficient and effective managerially that could very easily become merely a system of numbers and budget, and so on, and forget the fact that it is there for the treatment of people who live in communities with a specific problem.

When I spoke of the sensitivity, I meant for the vendor, for the State as the contractor and for the Federal Government in managing

this, not for the community. The community stays very sensitive to its own problems.

Mr. AKAKA. I have been asking you questions for 15 minutes. I will pass it on.

However, before I do, let me ask you an important question: Do you feel that there is much fragmentation in the integration and coordination of the services in drug abuse?

Mr. BESTEMAN. Yes; if you are meaning the ability of the client or the patient to have easy access to a variety of services from different social agencies in the community. In very few communities is there one vendor, one door that the client can go in and receive his vocational, his social, his psychological, his medical, his educational services, without having to go through a series of referrals, moving to another site.

The agencies try to decide, is he my client or your client. I think that is the norm in the communities in most areas. It is not unique to drug abuse, but because drug abusers are using systems not designed for them, in which they have a low priority, the problem becomes much more visible with our clients.

But, it is there. It is in many ways the same problem that is there in the generic medical system.

Mr. AKAKA. Is there any move toward attempting to coordinate?

Mr. BESTEMAN. I think Dr. Klerman mentioned yesterday that the Secretary has set as a priority of trying to bring together and make responsive the programs within HEW. Also, my testimony refers to some of the efforts with the Department of Labor to try to make some impact on their policies and some of the programs, such as CETA, as they respond to our clients.

So, yes, there is a definite move in that direction. I think it has the backing and the power of the Secretary and the White House in trying to make this a reality.

Mr. AKAKA. Let me call on my colleague, Mr. Evans of Georgia, for questioning.

Mr. EVANS. I don't believe I have any questions at this time, Mr. Akaka.

Mr. AKAKA. You may have another chance.

Mr. EVANS. Thank you.

Mr. AKAKA. Let me call on my colleague, Mr. Gilman.

Mr. GILMAN. Thank you, Mr. Chairman.

Mr. Besteman, I note that you make some reference to how extensive the abuse is with PCP and hallucinogens and with regard to some of the barbiturates, and yet the budget of your department, apparently, gives really minor attention to those areas as compared to the amount that is expended for the other fields of abuse.

Can you tell us why that inverse proportion? Here you have one of the largest areas of abuse in PCP and with the barbiturates, and yet little money is being expended in research and treatment of that. Why do you have that?

Mr. BESTEMAN. I think there are two reasons for this apparent imbalance.

One is historical, that the priority drug that the Federal Government addressed, and you can go back if you want to take a look at the legislative history. It wasn't until 1970 that the Federal Government

permitted the concern with any drug except those defined as a narcotic, which were heroin, morphine, and then marihuana was also defined as a narcotic under the older law.

In 1970 under the Controlled Substances Act, we were finally given responsibility for substances other than narcotics. As the program got started, in its historical concern, the concentration was on narcotics. In the crisis that occurred in the early 1970's, with the establishment of the Special Action Office in the 1972 Enabling Act, heroin was the No. 1 priority, based on the judgment that heroin caused the greatest personal and physical and social disruption per victim in the community.

And, so you have the system being defined to be responsive as a priority to that drug. It isn't until about 1975 when the judgment was made that sufficient emphasis had been given on this priority where the priority was set forth by the Institute as to clinical need of the patient, without respect to what is the drug that he is presenting. Because so much of our treatment system was designed to the heroin or opiate oriented, it continues to attract that kind of client.

That is sort of the historical—how we got here.

Mr. GILMAN. That is all interesting background Mr. Besteman, but we are confronted now with some very crucial problems in these other areas.

Mr. BESTEMAN. That's right.

Mr. GILMAN. What is your agency doing to confront these problems?

Mr. BESTEMAN. We did the sedative-hypnotic study, which showed that the sedatives, in spite of the fact that there has been a vast reduction in their use in this country, were still the most lethal of the drugs abused, and if you recall, before ODAP was terminated, Dr. Bourne asked FDA to make some changes with regard to the availability of certain of the sedatives.

The Secretary and Surgeon General have taken on a Public Health Service-wide activity to do both a public and physician instruction about the use of sedatives and, there have been some efforts to inform hospital emergency rooms and so on as to the proper care.

Mr. GILMAN. Mr. Besteman, if I might interrupt, do you think your agency is spending enough to combat abuse with regard to the barbiturates and the hallucinogens and PCP in those areas? You said something about 1 million abusers in those fields. There were some 8,000 deaths. I hadn't seen that figure before—between 1976 and 1977.

How many of those deaths are attributed to heroin and how many to the other types of abuse?

Mr. BESTEMAN. The largest single group was attributed to the sedatives.

Mr. GILMAN. To the sedatives?

Mr. BESTEMAN. Yes; and that was 1,700. There were fewer than——

Mr. GILMAN. Again, and I come back to my initial questions: Do you think you are spending enough funds and giving enough attention to these areas?

Mr. BESTEMAN. They think in terms of the—particularly for sedatives, since they have a very clear medical use, that we are giving enough attention to them.

When you say, are you spending enough, those of us who have been in the field can always think of more things to do in a given area. But,

the use of sedatives is heavily controlled through the Food and Drug Administration, and some of the things that are needed to be done will have to come out of that concern.

It is really not a direct function of the National Institute on Drug Abuse. We are very much committed to a consumer and physician education campaign with the rest of the PHS. If that is noted, I think that we are being sufficiently responsive to the size of that problem.

Mr. GILMAN. I want to ask Mr. Besteman if you would at this point in the record provide us with a statement of just what your programs are with regard to the barbiturates, the hallucinogens, PCP, and whatever you are doing to counter polydrug use and abuse and how much you are spending in these areas.

And, with your permission, Mr. Chairman, I would like to make that a part of the record at this point in the record.

Mr. AKAKA. With no objection, it will be so done.

[The information referred to follows:]

The National Institute on Drug Abuse has over the last year paid particular attention to the problem of barbiturates. After extensive study of the data available on the prescribing of sedative-hypnotic barbiturates, a report was issued in the spring of 1978 by the Institute's Office of Medical and Professional Affairs. This study found that a number of barbiturates commonly prescribed for sleep were ineffective if taken over a long period of time.

In the area of PCP, NIDA established an Institute Task Force on phencyclidine (PCP) in August 1977. The activities of that group were reported to the Committee at its recent hearing on PCP.

The Institute has done work in the area of polydrug abuse and recognized that the decline in availability of heroin has caused the addict population to shift to other, often multiple drug use, patterns. The Institute's services demonstration program sponsored a Polydrug Project in 1974 designed to develop effective treatment techniques for the polydrug abuser.

It is estimated that in FY 78 NIDA will spend the following amounts for *research* on substances of interest to the Committee:

Barbiturates: $4.8 million.

Hallucinogens: $1.9 million ($1.4 million of that figure will be spent for phencyclidine (PCP).)

Polydrug: $6 million.

Mr. GILMAN. One other question: Mr. Besteman, one of the big concerns on which all of us have been seeking some changes in the statewide service mechanisms has been that the cities have been somewhat shortchanged in that process. NIDA is encouraging State drug abuse planners to involve the cities in the State planning process, and it has also established its own channel of ongoing communication with city interest groups and associations.

However, yesterday Ed Menken—I believe you were here during his testimony—appeared before the committee, and he stated, and I quote, "it does not appear that the Federal Government in the form of NIDA has taken any initiative whatsoever to instigate helpful, and what I would consider to be necessary, cooperative activities among other Government agencies, both at the Federal and local levels."

He goes on to say, "we in the Drug Abuse Prevention field, particularly our clients, become severe victims in the fragmentation of the Government bureaucracy. This committee promotes the term 'holistic' and nowhere in this Federal system is the spirit of that term carried forward. It is as if the U.S. Government in its wisdom perceives the problem of its people to be segmented, compartmentalized and fragmented in the extreme."

Would you care to comment on that statement? What would be your response to his experience with NIDA?

Mr. BESTEMAN. My response would be that I cannot change his opinion or perception of it. I don't think it is wholly accurate or reflective of the efforts that we have put forth.

I think that there are others that are involved at the city level and at the local county government, and so on, who have had quite different experience, and I think our efforts have been to try to coordinate all levels of government and have all levels of government involved.

Mr. GILMAN. Here is a man working at the city level, and he sets forth his experience for us. Why is he wrong in his statement?

Mr. BESTEMAN. I am not saying that he is wrong. That may be in truth his experience in his city and with his State. That may be his personal perception. I have to respect that that is what he sees. I simply don't think that that is a characterization of the attitude or the general performance of the Federal Government.

Now, there is a lot of fragmentation. We discussed some of that yesterday, in terms of the chairman's concern about the fact these behaviors such as alcohol addiction and abuse similar to drug addition and abuse, and so forth—and we know these behaviors have great similarities, and yet we know that organizationally we have two different Institutes, and we have different mechanisms of disbursing funds and different criteria for disbursing those funds.

You get into the problem of solving things, that is to go to a wholly generic system, and yet all of our categorical institutes and all of our special programs come out of the fact that the generic system has for some reason or other not been responsive enough. It is sort of an endless tension from one need to the next.

I think that I could say that we spent about 3 years working as our chief priority on putting that management system in place. I think that over the last year to 18 months, we have been addressing the deficiencies of that management system.

I am not willing to say that this gentleman's perception of the deficiencies in his city are not correct. I don't think that they are characteristic, and I think that we are trying very hard with the States and with our regulations and with our guidelines to overcome this kind of perception.

Mr. GILMAN. We hope to take a good look at that statement. Apparently, you have a valid complaint that needs some attention.

Mr. BESTEMAN. After we left here yesterday afternoon, we met with representatives of several groups, including the half a dozen of the major cities, and we discussed the very issue that we are discussing today, which is about the third or fourth time that I have met with these people, and we have made adjustments to try to accommodate this.

We got these issues on the training agenda of the National Association of State Drug Abuse Coordinators last May in Oklahoma City. They too are concerned with it, because they feel it is partially their responsibility. It is a real issue. It varies from parts of States, and so on. But, it is not just quite as desperate, I think, as that man has expressed it.

Mr. GILMAN. My time has run out. I want to thank you.

Mr. NELLIS. Before you leave, may I add something to that, Mr. Besteman.

Unfortunately, in yesterday's testimony, this was not the only expression of that perception. We had here a representative of the city drug coordinators, Dr. David Lewis, who said to us that in fact the city's input is about at the same level as it was in September 1976 when we had the representatives of all the National League of Cities before us. And, they complained bitterly and still complain that NIDA is not responsive to the needs of the major cities of this country.

So, it is not Mr. Menken's sole perception.

Mr. GILMAN. I appreciate counsel pointing that out.

Mr. BESTEMAN. I met with Dr. Lewis and his association on three different occasions, and we are working on the problem. I hope maybe next year we can say we got it solved.

Mr. AKAKA. Thank you very much, Mr. Gilman.

May I ask, do you have any questions at this point, Mr. Evans?

Mr. EVANS. I do have a couple I would like to ask.

Mr. AKAKA. You may proceed.

Mr. EVANS. Mr. Besteman, I understand from the testimony yesterday that there is some concern about the BOP formula funding mechanism that NIDA has and that it tends to favor the larger programs, so far as giving an opportunity for more complete and better treatment.

I would like to inquire from you just what that formula is and how it is arrived at.

Mr. BESTEMAN. We have two major mechanisms by which we distribute money in the community. The first mechanism is under section 409 of our legislation and is a formula grant. The formula is derived—I almost said very simply. It is not very simply—but in the following manner. One-third of the money distributed is based on the population in each State to the total population of the United States. One-third is based on the total population weighted by financial need, as determined by the relative per capita income for each State for the 3 last consecutive years from which the data is available from the Department of Commerce. These two one-thirds are part of basic formulas that are used through HEW's health programs. These are not unique to NIDA. NIAAA uses these same weights in their formulas and so do some other health programs.

The final third of NIDA's formula is unique, in that it is based on a definition of what are the needs of that State in drug abuse as required by the law, which is an extra requirement that Congress put in our legislation.

We have chosen to take three factors as reflects need in any given State. One is the relationship of the population age from 12 to 24 years of age in each State to the total population of that age group in all States. That is based on the fact that we have some 17 surveys that show that age is one of the chief correlates to any drug use pattern, because it is basically with illicit drugs, then it is a youth phenomenon.

The second third is the relationship of the number of hepatitis type B cases to each State to the total number of all the cases in the United States. That goes back to a series of studies around the relationship of hepatitis B to heroin or other needle injection of illicit drugs.

The third third is the standing in relation to all other States of each State's per capita expenditure of State funds for drug abuse prevention. The way that third works: if your State has a high per capita expenditure of its own tax revenue, that is weighted positively, be-

cause we believe then that the State has shown through its own budget, use of its own fiscal resources, that it believes its drug problem is important.

Mr. BESTEMAN. That is for the formula grant. The other segment of our money, which comes to about $140 million a year, we distribute by the statewide services contract. That is not a formula grant; that is not a block grant. It is a cost-sharing, cost-reimbursable contract, explicit subcontracts to specific vendors designating how many patients are to be treated at any given time, by what modality, which is outpatient, therapeutic community, methadone maintenance, inpatient or outpatient day care. Very explicit proposals come from each of the States.

These are negotiated as contracts, and—when the contract is signed the State is free to execute that money over the contract year.

The State also has the authority to propose a change in the subcontract vendors and to move the treatment from one community to another if it determines that such change is in the best interest of the State. They have to come to us and get approval but they make the managerial decision that community A has a greater need than community B and we want to move some of our treatment to that community.

Mr. EVANS. Starting with 1973, can you tell me the amount per slot that was alloted?

Mr. BESTEMAN. In 1973——

Mrs. JOHNSON. $1,700 outpatient.

Mr. EVANS. This is for residential?

Mrs. JOHNSON. Residential?

Mr. EVANS. Yes.

Mr. BESTEMAN. About $4,000 back in 1973.

Mr. EVANS. Do you know what it is now?

Mr. BESTEMAN. $5,400.

Mr. EVANS. The thing that concerns me is that in an area where you have a smaller treatment program or a smaller slot allotment, you would have that on the basis of $5,400; if you had 20 or 30 slots available or needed it in an area in which you had 100 or more, it would seem that there would be more accessible money for a more complete program in the larger area than there would be in the smaller area when you are doing it on a slot basis rather than a patient basis or some other basis.

Do you see any problem with that as far as the less populated or less needy areas in terms of numbers?

Mr. BESTEMAN. When you are talking about the therapeutic community the residential slot, there is a point at which you run into a diminishing return, both for the investment and the ability to treat. It is virtually impossible to have a therapeutic community, let's say, of eight treatment slots, because the fiscal base is so small that you can't quite put all of the services together; you have to—I would have to say—it is sort of a judgment. I would say the minimum is around 20, and probably more comfortably, 30 or 40. When you get to that fiscal base then you can operate the entire matter. That is a unique characteristic of the therapeutic community situation.

Mr. EVANS. So you need to move all of your addicts to the city if you have a problem in some of the smaller areas.

Mr. BESTEMAN. If someone really needs inpatient therapeutic community, that is the kind of treatment they need, they might be better off moving to a community where that is accessible to them.

Mr. EVANS. In administering the program, don't you find a great deal of reluctance on the part of these people to participate in the program to begin with, so that anticipating a move of that nature voluntarily on the part of the needy person would be impractical?

Mr. BESTEMAN. I think the experience is nationally that around therapeutic communities it is not. For one thing, the therapeutic communities are probably appropriate to only about, roughly—I would say somewhere around 10 percent of the treatment population. Even those therapeutic communities that are not federally funded get patients from other communities that come to them because of the unique services that occur within that environment. For the population that needs that environment and that kind of treatment, since they are going to be living in what is basically a controlled and contained environment for some months anyway, it is not important to them as to where that is located.

I have known patients to travel 200 and 300 miles to join a therapeutic community.

When you are on an outpatient basis, when you are reentering your community, when you want contacts with family, employers, and so on, then—then to have that occur in a strange city where you don't know the street names could be very disruptive. But the outpatient situation is quite different from the therapeutic community.

Mr. EVANS. It would be your conclusion then that there would be no need to change the formula?

Mr. BESTEMAN. Well, I wouldn't dare say that, because we are studying that issue right now. We have, I would say, a chorus of complaints from across the field that our cost elements are too low, that they don't reflect the true cost of services, that service quality has suffered because of this. There is a litany that we hear when we go to the field.

If I said that I thought there was no need for change, I would be ignoring all of those realities.

In my testimony I refer to the fact that we have started again, for I think about the third time, another study to try and figure out if we can work some flexibility in, some different ways of costing to overcome some of the limitations of our present system. We have a very strong system, from managerial standpoint. We have a very stable system. We have a system that has fared well in relation to its sister service elements within the Public Health Service in all of the budgetary considerations, because we have a strong management element.

At the same time, when we start to talk purely clinical values from the physicians and social workers and psychologists, counselors, the exaddicts who are there who are saying, "I can't quite do everything that is needed here; why can't I be reimbursed for family therapy?"

Who is the client? We say the client is the person with the drug problem.

All of these kinds of discussions have an implication for cost and for the number of persons treated. We can't ignore them. We continue

to restudy them, but any major revision is either going to result in a request for more funds or a notification in the budgetary process that we will be treating fewer drug abusers.

That is under active review right now. It will be probably somewhere between 10 months and a year before we have the outcome of the present study.

Mr. EVANS. On one other subject, in your testimony you mentioned that NIDA is providing research demonstration and technical assistance to improve the linkages between drug abuse and the criminal justice systems. It is my understanding that approximately 25 percent of all of the Federal prisoners that we have in this country are involved in drugs in some manner.

Is NIDA participating with the prison systems in rehabilitation or any programs dealing with the drug abusers in our prison system?

Mr. BESTEMAN. The Bureau of Prisons has its own authority for its treatment systems within the Bureau of Prisons, and it has authority to purchase services for people who leave that system.

When the Bureau of Prisons was setting its program up—and this goes back to the late 1960's and early 1970's—we participated in consultation with them as to their program design and so forth. In recent years, that consultation has been less frequent because they have developed their own expertise. They have their own staff.

And if you are familiar with prison systems, they are relatively closed and feel most comfortable with their own management.

I don't know an appropriate way to say this. I have worked with State prisons and Federal prisons and so on. But the warden believes that that prison is his, and outside consultants are somewhat suspect as being nonunderstanding of his problems. That attitude does still exist within penal institutions.

We have come up with special manuals, at the request of the Bureau of Prisons, particularly one about detoxification that specifically meets a need they identify. They asked for help; we gave it.

We have made available to them our knowledge of community resources so they can contract for services on a direct vending effort of their own. There is good interaction in that area.

But in terms of the internal workings of their program, they pretty much take responsibility for that.

Mr. EVANS. Is my time up, Mr. Chairman?

Mr. AKAKA. Thank you very much, Mr. Evans.

Mr. EVANS. OK.

Mr. AKAKA. I would like to ask chief counsel for the committee, if he has questions.

Mr. NELLIS. Thank you, Mr. Chairman.

First, I would like to say for the record that the cooperation between NIDA, NIDA staff, and the staff and members of the committee has improved tremendously over the last few weeks. I wanted the record to reflect that we are grateful for your cooperation, Mr. Besteman.

Mr. BESTEMAN. I appreciate that.

Mr. NELLIS. We have had a number of Presidential messages over the last few years, haven't we, about drug abuse, the war on drugs, and changes in the drug system.

We did have a very important message from the President last August, did we not?

Mr. BESTEMAN. Yes, sir.

Mr. NELLIS. I think in that message there were several areas of concern to NIDA. I would like, if you could, for the committee, please, to review the areas that the President spoke of and what has been done since that time to conform to his direction.

For example, I remember the request that research on alcohol and drug abuse matters be combined so as to produce some results involving cross-addiction.

Could you answer that question?

Mr. BESTEMAN. There are two aspects to that issue.

The one aspect is that NIAAA and NIDA have formed a joint research pool of money where researchers in the field who want to study that issue can come in separately from other research considerations and bid against a discreet amount of money to be funded by either NIDA or NIAAA.

We both contributed to a specific program initiative and extramural research.

There was also a suggestion, as I recall it, that our Addiction Research Center at Lexington take on the issue of alcohol research. We have begun to do that in a somewhat modest way.

Part of the environment that is slowing that initiative a bit is that at the same time while they are addressing this issue, the issue of moving that facility from Lexington, Ky., to the Baltimore-Washington area, is under consideration, very active consideration. And the approval to go forward with this consideration has been given by the Secretary.

There is some reluctance to mount a major new initiative in Lexington, knowing that very shortly we might be uprooting it. Although some of the studies have begun, they are not on the scale that the message would have prompted had this other matter not come up and been under consideration.

Mr. NELLIS. And the joint studies on research prompted by the President's message, are you beginning to look at this increasing and terrible problem of cross-addiction between psychotropics and alcohol?

Mr. BESTEMAN. Yes; we are also studying that as is NIAAA independently. But this particular combined program announcement is focusing on those kinds of interactions to a considerable degree.

If you look at the DAWN data from the system that both DEA and NIDA sponsors in terms of hospital emergency room mentions, I believe the first year's total summary showed that a combination of psychotropics and alcohol was the most frequent event, and I think the last year's analysis has it as the second most frequent event in a hospital——

Mr. NELLIS. It is still up there.

Mr. BESTEMAN. Well above many of the other drugs, such as—that we—such as PCP or heroin or even sedatives.

Mr. NELLIS. And, well, I think that what you mentioned in response to Mr. Gilman's prior question indicates that we are far from having solved that problem in its entirety.

Mr. BESTEMAN. We haven't even addressed that problem to its fullest extent, let alone solve it.

Mr. NELLIS. When are we going to do it?

Mr. BESTEMAN. Part of what you have, if I may express a personal opinion, is an awkwardness of legislation.

The National Institute on Drug Abuse authorization very clearly says we are to concern ourselves with drugs under the Controlled Substances Act. That legislation very clearly excludes alcohol. So we are somewhat hesitant to get into an area where there is a special law to study alcohol by a sister Institute.

Our sister Institute has a piece of legislation that very clearly limits them to the study of alcohol.

Mr. NELLIS. Were you present yesterday when I discussed this very problem with Dr. Klerman and Mr. Dogoloff; and do you recall the answer they gave, which was that there are no present plans for merging Institutes or merging those programs?

How are we ever going to solve these problems as long as a bureaucratic roadblock remains in the way which keeps us from working together in these substances regardless of the Controlled Substances Act?

Mr. BESTEMAN. In spite of our legislation, we have initiated this program where we both contribute, and therefore get around some of the limitations of the legislation.

Mr. NELLIS. Have you asked Congress to change the legislation?

Mr. BESTEMAN. Not formally.

Mr. NELLIS. Are you in a position to say whether you can do so formally or informally? Because surely one of the things this committee could do is to make recommendations to the standing committees about roadblocks in the way of doing something about cross-addiction, which all of us conceive to be a major, major health problem in this country.

Mr. BESTEMAN. I am not a lawyer and I am not a legislative draftsman, but about 3 or 4 years ago in tinkering in the office I came up with a couple of 3- or 4-word additions to each of our pieces of legislation that seemed to me would solve the problem.

Mr. NELLIS. Do you recall them?

Mr. BESTEMAN. They went to the effect, "and other substances normally used in conjunction with the above"—something to that effect.

Psychotropic or psychoactive substances are very normally used in conjunction with alcohol, and alcohol consumption, either modestly but in some situations to excess, are relatively—is relatively consumed with psychoactive drugs classified under the Controlled Substances Act.

It is this kind of minor, technical flexibility that is necessary to fully open the opportunities for this interaction.

Mr. NELLIS. I really think it is up to the agency to make an appropriate recommendation to Congress where legislation seems to stand in the way of an all-out attack on this problem, which the President called for, Mr. Chairman, and which this committee has been increasingly involved with.

In that connection, I would like to take you to another emergency situation, if I may.

This committee has just completed hearings in Florida. Florida is a disaster area in terms of supply. There is tremendous tonnage of marihuana, of cocaine, of pills, of every kind of drug abuse coming

into the Florida area for distribution on the east coast and elsewhere. I am certain, although our hearings did not specifically focus on this, that the treatment facilities in Florida and in the State of Georgia and the other adjacent States must be overtaxed to the limit.

Does NIDA have any facilities for emergency treatment slots or emergency treatment efforts in disaster areas like Florida?

Mr. BESTEMIAN. Let me answer the last part of your question first now.

Our money is committed—you demonstrated on graphs yesterday that our budget has been level for the last 3 years. Our utilization throughout the country has been up in the 90 percentiles consistently. Some States are over 100 percent utilization. And when you have that kind of utilization of a treatment system, you do not have emergency reserves to bring into a situation.

So far as Florida is concerned, Florida is seventh in the Nation, as far as the presence of treatment dollars. Dade County, which is the largest single treatment system in that State, has about a 90-percent utilization rate, which says that they still have a little bit left to offer the community.

Their total program costs are about $6 million, of which about $3½ million come from NIDA.

Of the total State drug funds that NIDA sends into Florida, about 70 percent go to Dade County.

Mr. NELLIS. Isn't it clear that NIDA needs some methodology for treating emergencies like this? And they occur all the time at various parts of the country. The 10 percent you refer to down in Florida would not cover residential and detox facilities, which is what they need, desperately.

Mr. BESTEMIAN. Probably not.

Mr. NELLIS. Mr. Chairman, I think you have a vote.

Mr. AKAKA. The chairman declares a 10-minute recess.

[Brief recess.]

Mr. AKAKA. The meeting will resume.

We will continue with questions from our chief counsel.

Mr. NELLIS. Thank you, Mr. Chairman.

Mr. Besteman, when the recess was declared I think we were talking about the inability of NIDA to cope with emergencies.

Do you see that as a serious problem?

Mr. BESTEMIAN. It is a relatively serious problem in terms of the fact that the drug-taking patterns are changing rapidly, do change rapidly.

Every so often we do have a situation such as you described in Miami, although it is not—we are not in the 1972 situation, by any manner or means. But we have these local eruptions.

It takes some considerable time and difficulty to reprogram through our already committed funds.

Mr. NELLIS. Wouldn't it make sense then for NIDA to have a certain pool of uncommitted funds to meet emergencies like the antihistamine emergency in Chicago where there have been 39 deaths in the past 5 months, or like the PCP emergency that I saw myself in San Francisco, where they have had death after death after death and tremendous, comparatively tremendous numbers of hospital instances?

In other words, if there is no Federal response, and the local response is sometimes diminished by the absence of resources, what we are having, in effect, is a series of emergencies represented by various kinds of drug-taking that cannot be met.

Mr. BESTEMAN. The concept of having this kind of emergency or temporary capacity to respond, I think, is very attractive and would be helpful.

There are some problems involved with it.

The California one, let's take for example. It was worked out nicely in that the State responded specifically to the PCP, and I think it is appropriate that——

Mr. NELLIS. Now they have proposition 13 and can't respond to anything.

Mr. BESTEMAN. I don't wish to second-guess the California voters. I will leave that one all alone.

The problem with coming in, though, on temporary aid is that at what point then does the Federal Government withdraw?

If you have a separate emergency fund, it has to be a rotating fund, and so it has to be clearly understood that—as quite distinct from our commitment to the stable treatment system—that the Federal Government would withdraw.

Now if—I have managed Federal programs from Washington since 1967. I have had the unhappy task of going to several communities and telling them, on one of the programs, that we are leaving. The most painful task for a Federal administrator——

Mr. NELLIS. Is to declare the end of an emergency.

Mr. BESTEMAN. Even—to declare the end of an emergency, Congress even has problems with that sometimes.

We did it, and we have done it before, but that would have to be a carefully thought-out and very carefully structured concept program——

Mr. NELLIS. You agree it is worthwhile?

Mr. BESTEMAN. Yes; in order not to be caught in a constantly expanding Federal commitment. That is a reality we have to live with, too.

Mr. NELLIS. My last question, Mr. Besteman.

Our records so far indicate quite clearly that over the years NIDA has been committed to biomedical research and a good deal of money has been expended.

I have two questions.

No. 1, why is it that we can't get more of the kind of research that Chairman Wolff was referring to yesterday?

I am sure you heard his statement involving sociological matters and the reasons why people take drugs and the possibility of predicting in a group of kids which kids will take drugs and which ones will not.

That is my last question. I will let you go with that.

Mr. BESTEMAN. I want to qualify my statement by saying, I am not a researcher. I come from a clinical background. So that my chief of research, Bill Pollin, I would just like to give him the opportunity to put a disclaimer in the record here if he wants to.

But biomedical research, basic research, if you will, appears easier to design and execute, because you can control the variables and come up with a cleaner design and a more precise answer.

When we get into the psychosocial area, we get not only the factors we wish to study but we get true life and environmental things that happen that aren't in our design.

I have listened to discussions of methodologists when they try to look at the research which is presented to the Institute. We have a special panel on psychosocial research, and in our restructuring of our research committees we are going to establish this area as a separate committee which hopefully will enhance people's coming in in the area.

Mr. NELLIS. I think that would make the chairman very happy indeed.

Mr. BESTEMAN. The fact is that the design problems in the real-life arena in terms of research are—I would put somewhere between four and five times more complicated than the design problems in the basic biomedical areas where you can work in a more controlled laboratory environment.

This has had a profound impact on why the Federal Government has been criticized, not only in NIDA. The Secretary has criticized NIH. The Secretary has made the statement that he believes our agency should have more money explicitly for psychosocial research.

This all comes from the background of the various disciplines.

I trained many years ago in sociology, and this was 20 some years ago, but the bemoaning of the professors then was that our methodology was so imprecise—granted, there have been tremendous strides in methodology, but still, compared to the laboratory researcher with his white rats and his thin layer chromatography and all of his fancy machines, the human existence in an open community is more complex.

Mr. NELLIS. The last part of my final question is this. This is really a criticism that we have heard of NIDA for the past 18 months. It relates to research dissemination and research utilization in policymaking.

We have had scientists appear before this committee—I am sure that both Mr. Akaka and Mr. Evans remember this—where they have thanked the committee for the opportunity to testify because it gave them an opportunity to meet.

Why is there so much concerted criticism about the utilization and the dissemination of research that NIDA buys and pays for that apparently is not widely disseminated, is not widely replicated, is not widely utilized?

Mr. BESTEMAN. I think, partially, because it is a generic problem of all research activities that go on in any field.

Mr. NELLIS. I don't think I can accept that, Mr. Besteman.

Mr. BESTEMAN. That is part of the problem.

The lag time in terms of getting in the journals goes somewhere between 18 months and 2 years.

Mr. NELLIS. Wait a minute, Mr. Besteman. Let me say to you, I am not talking about dissemination in scientific journals, because we know that scientific journals have very limited appeal to outsiders and have very limited distribution.

I am talking about conferences at which scientists who have received NIDA grants who are working on the same or similar problems could get together and exchange views and utilize their research

and help you make drug policy that is based on scientific research rather than on some other considerations.

Mr. BESTEMAN. If you take just specifically our research division, in the past 2 years it has had approximately, I would say, somewhere between 16 and 20 meetings of specialists in that many different areas for state-of-the-art reviews, and we have produced somewhere between 15 and 17 monographs as a result of these state-of-the-art meetings.

If you wish, I can give the committee a totaled——

Mr. NELLIS. We have them. We have studied them, Mr. Besteman.

Mr. BESTEMAN. All right.

And I think they are scientifically respectable. In fact, the last two or three that we put out were reviewed in one of the professional journals that has about a 30,000-member circulation nationally.

This is one mechanism.

The Institute partially sponsors three meetings a year for the field. The one involves both alcohol and drugs. The basic sponsor is ADPA, the Alcohol and Drug Problem Association.

And finally, we sponsor a meeting which is limited to scientists which is an outgrowth of the old Drug Committee of the National Academy of Sciences. I think it is now called the Committee for Scientists Concerned With Drug Abuse or something.

Mr. NELLIS. I regret to advise you—and I'm sure you know this, because we have had private conversations about it—the scientific community that we have reached does not regard NIDA's dissemination or utilization of research as of the first order. There are many difficulties with it. Apparently the papers don't reach the people that should be reached, and the results of this type of study by scientists working in the same area do not reach NIDA so that NIDA can utilize these results in making policy.

That is just sworn testimony that we have had that makes it clear there is something wrong in your dissemination and utilization procedures.

Mr. BESTEMAN. I disagree with the last part of your statement where you say it does not reach NIDA.

Every grant and every contract we give has a reporting requirement. If the grantee does not, within the specified number of months, which I think is 6 months from the termination of his grant, submit his final report, this is done for him by the system automatically.

Mr. NELLIS. Very good. What do you do with his final report when you receive it?

Mr. BESTEMAN. His final report, depending on what category it is in, is reviewed by the staff person with responsibility in that area. It is made available through the—some technical reports system. We have periodic meetings on areas of concern where we get scientists together to talk about what the next research step should be in the area.

I am quite willing to admit that this dissemination can be improved, but I think, if I would be permitted to list the variety of mechanisms and publications and information that is presently available and being utilized by the Institute to inform people that this information is available, that partly, at least partially, that the problem is that some of the scientists do not aggressively pursue information.

[The information referred to follows:]

RESEARCH DISSEMINATION

The Executive Branch and the Congress have expressed considerable concern that results of research in the health sciences tend to remain in the scientific community and do not reach the agencies responsible for treatment or for formulation of public policy. Typically, research is funded, undertaken, and months pass before findings are published to a limited, diffused audience.

An emerging consensus concedes that underutilization and even loss of potentially valuable research findings exists. NIDA's Division of Research (DR) has initiated a program for systematic staff review and evaluation of findings and a device for transfer of results ready for utilization or demonstration. The Research Analysis and Utilization System (RAUS) is a procedure for the systematic review of research findings (progress reports and final reports) by sorting them into topic "clusters," each of which defines a specific research objective. Each cluster is then assigned to a reviewer; a review of the findings within the cluster is written and the reviewer meets with staff to evaluate, consider what action is called for, and what transfer or utilization of findings should take place; the "state-of-the-art" reviews are disseminated as appropriate to scientists, administrators, treatment professionals, and the interested public.

Several considerations support this approach: An aggregated, systematized review of methodological and substantive findings could enhance the ability of staff officers to focus program development, encourage and pinpoint new projects, and recruit new scientists, to the field. Moreover, using progress and final reports would allow this to be done sooner and less erratically than waiting for published material to accumulate.

Research dissemination may not be as efficiently served by the publication process as it once was. It is reported that scientific journals are drastically shrinking their content due to rising costs and competition from nonpeer review publications supported by industrial and business advertising. It is estimated that only three of five significant scientific papers generated by grants ever appear in established journals. Much contract work is not published at all.

Most journals are discipline, not mission oriented. Findings relevant to NIDA's particular objectives are widely scattered. NIDA/DR may have to assist both the scientific community and service/treatment people in the retrieval, inventory, and analysis of findings specific to NIDA's mission.

Dissemination is curtailed due to shrinking budgets for conferences and travel. The task of direct dissemination may in the future fall more directly to the research-granting institution. In this event systematized reviews collected by RAUS would be particularly helpful.

A second form of analysis and dissemination is accomplished by selecting individual programs for periodic "technical reviews," intensive workshops at which research progress is assessed by a body of outside scientists. Examples of review topics planned are: subjective and objective measures of withdrawal and craving; psychopathological aspects of drug abuse treatment; economics of drug abuse.

A third form of analysis and dissemination occurs through a computer system the Division of Research has developed called the Drug Abuse Research Project Information System (DARPIS) that includes a description of all Federally funded drug abuse research projects. From this, an annual publication, the *Federally Supported Drug Abuse Research Survey*, is produced. The computer system survey includes the research projects of 30 agencies concerned with drug, alcohol, and tobacco research. The Annual Survey not only provides a means for locating any duplications or overlaps in research but also allows assessing relative funding levels of different program areas.

Mr. NELLIS. Thank you, Mr. Chairman.

Mr. AKAKA. Thank you very much, chief counsel.

I would like to call on my colleague again, Mr. Evans.

Mr. EVANS. Thank you, Mr. Chairman.

Chief counsel has expressed a concern that the NIDA and other agencies dealing with drug abuse are not able to deal with emergency situations.

I have had difficulty in finding out if the U.S. Government has the ability to deal with the day-to-day situation on drug abuse.

Are we making any progress in reducing drug abuse in this country?

I know—and let me give you some observations that I have had, and people in my district in the State of Georgia and all over the United States have had. Drugs and drug abuse seems to be more prevalent now than 5 or 10 years ago. We have it in our grammar schools rather than just in high schools and on the streets. It has become a socially more acceptable situation in that it is no longer the guy in the black leather jacket making a sale behind the barn or whatever. It is a friend of a friend; it is student to student and child to child. Drugs are more accessible. More people are abusing drugs. It seems that we are having more people staying on drugs.

Are we making any progress at all in this area? Are we curing anybody? Are we getting anybody out of drugs? Are we helping anybody? Are we making any progress in reducing the use or the abuse of drugs in this country?

Mr. BESTEMAN. In several very important areas; yes. And I would like to go sort of by class of drug or at least by source of drug to make some distinctions.

Mr. EVANS. In answering it, if you would, would you tell me whether or not we are moving them from one type of drug to another rather than curing them?

I would like to know: Are we transferring the problem or are we curing them?

Mr. BESTEMAN. That is a very attractive opportunity, if I could transfer all of the heroin addicts off heroin and get them into some other drugs that have less complications. But that doesn't seem possible right now.

I think the heroin situation today is as stable or as optimistic as it has been since about the late 1960's.

We went through a tremendous increase curve out of the late 1960's and into the early 1970's. We then had a very slight respite when the Turkey supply was cut off by international agreement, and then another surge.

All of the data we have now seems to indicate that the peak years for new addicts joining the pool were actually in 1968 and 1969, that the number of new addicts joining the pool each year is either reducing or has stabilized. I would even from the data tend to say that it is reducing slightly.

Mr. EVANS. Excuse me. Is that figure somewhere around 450,000?

Mr. BESTEMAN. You are talking about the number of people in the pool, and yes; it is around that figure. If you include the people in treatment, then you get up over 500,000, which is the figure I use in my testimony. If you take the people that are not in treatment, you are in the 450,000 range. That is an improvement from a few years ago.

Now, I have a lot of concerns about that in terms of not relaxing in the fact that we have seen this slight improvement. There are still in the world ready enough supplies to supplant any improvement we have here, if somebody chooses to try to get the supply to this country, and we could experience another epidemic very readily. I think that is a fragile respite we have in that area.

To talk about sedative hypnotics as another class——

Mr. EVANS. Let me stay on heroin just a minute, if I might pursue that.

You already indicated that the lack of supply helps.

Mr. BESTEMAN. Yes.

Mr. EVANS. With the situation, as far as helping reduce heroin addicts, is there any validity at all to having heroin centers the same as you have methadone centers so as to do away with the economic benefits that are gained from bringing heroin into this country?

Mr. BESTEMAN. I believe that the management problems inherent in the dispensing of heroin are such as to make it valueless to pursue as a public strategy.

I am somewhat conservative in this particular area, but the British have essentially abandoned the free dispensing of heroin as their major strategy. They have switched to methadone for the vast majority of their patients for the same reason we went to methadone in terms of the public health implications of oral medication versus injectable solutions.

Mr. EVANS. Will heroin addicts accept methadone, generally?

Mr. BESTEMAN. Yes.

Mr. EVANS. If they have accessibility to heroin?

Mr. BESTEMAN. If they have determined that their heroin use has become a problem and they want to change. If the heroin addict does not want to change, then the availability of methadone as a treatment is not going to be attractive to him.

Mr. EVANS. What is the ultimate goal when you have somebody involved in the methadone treatment?

Mr. BESTEMAN. The ultimate goal for most programs is to either reduce the methadone dose, or enable them to become totally abstinent.

Mr. EVANS. Methadone is also habit forming?

Mr. BESTEMAN. Yes. And so is LAAM. It is just a longer acting and somewhat safer compound.

Mr. EVANS. Your conclusion is that we should continue trying to keep heroin out of the country if we can, to make it as inaccessible as possible?

Mr. BESTEMAN. I cannot find any benefit to not having a policy of prohibition on heroin.

Mr. EVANS. OK. If you want to go on to the others now.

Mr. BESTEMAN. As far as the sedative-hypnotics, and I will reflect somewhat on what Congressman Gilman was concerned about, because of changes in Federal policy, and because of changes in medical practice over the last several years: the numbers of prescriptions in toto, the numbers of persons showing up in hospital emergency rooms in toto, and the numbers of deaths have been constantly reducing over the last 5 or 6 years.

They particularly have reduced since the three short-acting barbs were switched from schedule III to schedule II, 20 months ago, something like this.

So, that the trendline on the sedative-hypnotics, the barbs, is really a most encouraging trendline, if you will, in the whole drug area. It is my personal belief, and if we follow through and have an aggressive public and physician education program, to add on to these changed policies, that it will continue and accelerate in terms of fewer and fewer deaths and distress situations around these drugs.

That is a very encouraging trendline.

The amphetamine trendline, in terms of prescription, has the same as we have used our regulatory authority in the Food and Drug Administration to inhibit accessibility. Unfortunately, the type of amphetamine can be made very readily in a local bathtub, a chemical situation.

Mr. EVANS. Haven't there been difficulties with these illegal laboratories blowing up? Is this what you were talking about, the PCP or something?

Mr. BESTEMAN. PCP, that is a hallucinogen. But, the amphetamines are on a downtrend, except for a core of people. If you wanted to say they are committed to abusing amphetamines, that core seems very low nationally, maybe in the range of 100,000 people.

In that area, the trend is also encouraging. If you take all of the hallucinogens with the exceptions of phencyclidine, PCP, the trend is either stable or slightly downward with the exception of the unfortunate use patterns coming at an earlier age.

But, if you remember the 1960's, late 1950's, early 1960's, when LSD just exploded over the country, that we have gotten relief from. We have gone to a steady state. Younger people are using the drug.

Now, one exception in the hallucinogen area is PCP. It is easily made. It is relatively available. It is being sold under a half dozen different names and reasons, and it is one of the few drugs in and of itself that I think has caused some real fear among the professionals in the field, because it has some very peculiar subjective responses.

Early in the dosing it appears to act somewhat like a stimulant, like amphetamines. The somewhat modest dose that appears to act like a hallucinogen; when you get a heavy dose, you get some purely physical complications, in terms of respiratory troubles. You get some severe psychiatric disturbances, and things get very unpredictable at the heavy dose.

Because of its ready ability to be made and because it is being marketed under so many different labels, it is very hard to know where it is going to go. We hope that we can get through to the consuming population many of its dangers.

So far we have been unsuccessful in that. That is one that I believe is a high priority, red flag problem.

Mr. EVANS. All of these classes of drugs that you are mentioning now are under the jurisdiction of NIDA?

Mr. BESTEMAN. Yes, sir. When you get beyond these, you get into a whole variety of substances where the problems are somewhat less severe. They seem to come in local epidemics and—or local fads, and then drop.

Mr. NELLIS. Excuse me, Mr. Evans, I think you should go on to the synthetics, the tranquilizers.

Mr. BESTEMAN. The tranquilizer's dangers: When you talk of tranquilizers alone, they don't show up too much in the pure form. The tranquilizers—here is where you get into the problem that chief counsel was alluding to, which is the relationship between alcohol and drug abuse.

When you get into the tranquilizers, and some of the most common, and if you will, from a medical standpoint, the safest substances, if

taken alone, become lethal when used in combination with alcohol, and subtly so to the point where patients don't appear to realize they are getting in physical distress.

The average patient that takes Valium, and that is in and of itself a very safe drug, doesn't, I think, feel the danger they are incurring as they add alcohol to that substance. Here is where when you go to—DAWN mentions in hospital emergency rooms—you find alcohol, and then you can name all of the common tranquilizers in the end, and that is a combination, the polydrug situation.

That situation is in a relatively stable state, but the stable state has a very high level. There we have to look at—this is one of the risks we incur for having developed a whole series of therapeutic elements and chemicals and medicines which when combined or used with alcohol incur substantial risks.

Mr. EVANS. What about Quāāludes?

Mr. BESTEMAN. Quāālude seems to have diminished somewhat. It went through sort of a fad epidemic, and it has diminished somewhat. We put severe restrictions on it. It is still abused but not as an emergency situation.

In other countries they are now experiencing problems with that drug in major ways.

Mr. EVANS. In connection with tranquilizers, their use with alcohol and this particular problem that was mentioned, do you think that you could obtain for us the language that would help you coordinate with other agencies that might be dealing with alcohol, so that we might make a more complete program or a more coordinated program?

Mr. BESTEMAN. I'll try to do that.

Mr. EVANS. I think that would be helpful. Maybe we can help you do the job that you are trying to do.

Mr. BESTEMAN. I would remind all of us, and come next spring, which now seems a long way away, that both the enabling legislation for the National Institute on Drug Abuse, its 3-year renewal and the 3-year renewal of the National Institute on Alcoholism, are both up for substantive review by the committees that have jurisdictions, so that any technical repair to legislation would have ample opportunity at that time.

Mr. EVANS. It has been my experience that any time an agency is created for the purpose of doing a certain job, it is somewhat zealous about maintaining its jurisdiction.

What would be the feasibility of combining the two agencies?

Mr. BESTEMAN. If I could speak to it in two different ways. I have said publicly and have been quoted in a trade paper in the drug field that if the policymakers, Congress, the Executive, would make the decision to combine the two agencies, we would need 2 fiscal years and about 22 months to managerially put them together with the only area of major problem being services.

I have been quoted publicly on that. I don't feel any restraint, although I have some friends of mine who are not going to appreciate this comment. The problem of that move is the social, political one, not a managerial one. I say that as a manager. I can tell you as someone who has been in the drug field and has been identified with the drug field now for over 20 years that there are all sorts of anxieties about

what a person from alcoholism or drug abuse had such an agency. And these kinds of discussions go on endlessly. And that these anxieties will bring out very strong reactions from many parts of both fields.

Mr. EVANS. I think we may get somebody who doesn't know anything about either one. [Laughter.]

Mr. NELLIS. That would solve the problem.

Mr. BESTEMAN. No comment.

Mr. EVANS. There is one that you have failed to mention, or at least I didn't hear it, which is one of the biggest problems I think we are developing—marihuana. This is what is involved in drug abuse in the military. I think that it is probably causing us more problems with our young people and is accepted in social circles among older people. What are we doing about that?

Mr. BESTEMAN. I would like to make two comments or three, if you are going to ask what we are doing about it, about marihuana. One is I feel personally that marihuana is joining alcohol and tobacco as the third major recreational drug in this country. And, I don't think that bodes well for us. I don't think we need another intoxicant.

I think we have sufficient in alcohol. I don't think we need another bronchial irritant. I think we have a sufficient one in tobacco. But, the country seems determined to add this drug into both——

Mr. EVANS. Your opinion is that marihuana is no more harmful than alcohol or tobacco from the standpoint of leading to more addictive drugs or from any other standpoint?

Mr. BESTEMAN. If you look at the health consequences of alcohol abuse or heavy use and the consequences of heavy tobacco use, then if marihuana were only as dangerous as either of those drugs, we have no good reason for wanting it to be part of our lives.

Marihuana does intoxicate. It does impair performance. On the short term we have ample evidence of that, and we simply don't need another recreational intoxicant in our society.

Mr. EVANS. I understand, but, for knowledge that I may communicate with my constituents, is it in your opinion more harmful, or are we talking about another that is equal to or in the same category as tobacco and alcohol?

Mr. BESTEMAN. It took 30 years of research, approximately, before we could say definitely what the health consequences of tobacco were. It took longer than that in terms of finally determining that alcohol had some very severe health consequences.

I think the only thing that keeps us from making a flat statement that you are asking for is time. I think ultimately we are going to get there. I don't think marihuana is a benign drug, but I cannot, on the basis of the scientific basis and medical basis available to me today say that it is as harmful or more harmful than heavy use of alcohol or heavy smoking.

Mr. EVANS. Let me narrow it down just a little bit. When you are dealing with marihuana, is it more likely or less likely to lead to abuse in other areas?

Mr. BESTEMAN. I think the one thing about the use of marihuana is significant is when a person uses marihuana, they have made the decision that they will use an illicit drug. That opens up the decision process to use another illicit drug.

There seems to be a decision that comes between using—the person who uses beer, say, as an introduction to alcoholic beverages has to make the decision of whether they are going to use wines or whiskeys, which are more potent.

There seems to be a progression in the natural history of someone who uses alcohol that at some later point in their life they will begin to drink mixed drinks or wines, or so on. And, some 80 or 90 million Americans do that, and many of them without any apparent ill.

When a person finally makes a decision that, yes, I am going to use marihuana, not only in terms of where they get the marihuana, but very often whom they associate with, they expose themselves to people who have PCP, amphetamines, and so forth. It doesn't mean that they are going to use it.

We know that some 45 million Americans have used marihuana. We know that the vast majority of them don't use it any more, because only about 13, 16, 18 million Americans use marihuana regularly, so that leaves you with more than half who have abandoned the drug.

The question is: Why did they abandon the drug? And, for most of them they abandoned the drug because it got in the way of their ability to do something they wanted to do that they thought more valuable, or it gave them certain risks they were not willing to take, in terms of legal complications. Those seem to be the two major reasons.

Mr. EVANS. Is cocaine use as great as marihuana use? Is it greatly on the increase as I think it is?

Mr. BESTEMAN. In a selected slice, if you will, of society that has a rather abundant availability of money, cocaine is on the increase, because it is expensive. But cocaine is rising significantly, particularly in the Eastern Corridor. It is somewhat geographic. It is not a national——

Mr. EVANS. Do you classify this as a very dangerous drug?

Mr. BESTEMAN. I personally think it is a very dangerous drug, because of its attractiveness and its ability to become habit forming, not addicting, but habit forming. Just its attraction makes it dangerous.

We had—I mean, this is not a definitive answer, but this is the kind of thing that puzzles me and makes me careful. Cocaine is the one drug that research animals will continue to take rather than eat or drink.

Now, if they are taking heroin, they will continue to eat and drink. Cocaine is so attractive and the immediate result so gratifying that they will use it instead of food.

Mr. EVANS. This is true of people too, isn't it?

Mr. BESTEMAN. We know that people who do abuse drugs——

Mr. EVANS. I mean cocaine or coca leaves, or whatever they chew in lieu of eating in South America; because they don't have the food they chew that, and it replaces or substitutes for——

Mr. BESTEMAN. This is apparently what the Dr. Noya that Mr. Dogoloff referred to yesterday is concerned about in South America. But, I don't have personal information on that issue.

Mr. EVANS. Mr. Chairman, I am finished.

Mr. AKAKA. Thank you very much, Mr. Evans.

I think you have answered the question of trend, but let me ask you to project what drug might be on the rise nationally?

Mr. BESTEMAN. Marihuana among the very young is on the rise. That is the one consistent. PCP is on the rise. That data is very well

established. We have a statistical method of following mentions, as they come out of the DAWN system. Any drug that increases a certain percentage in a given number of months automatically comes out of the computer for examination.

I shared with the committee staff the fact that about every 6 or 8 months a drug comes out of the computer, and we smile because it happens to be a mushroom that grows only at a certain time of the year that is a hallucinogen and we get mentions of it in hospital rooms, and then it disappears, because the crop disappears.

We now have a system that will monitor any drug coming on the scene, such as PCP and Quāāludes when they did, and when these two drugs initially emerged, we did not have this ability to track the early rise.

But, we don't have any drug that we are presently terribly concerned with that has a persistent rising pattern right now out of that system, except PCP. The way we produce chemicals in this society, and the way in which they are used for purposes not originally, another one could emerge tomorrow, but I have no knowledge of one today.

Mr. AKAKA. In your research activities and contracts you mentioned that there is a new chemical treatment.

Mr. BESTEMAN. Buprenorphine.

Mr. AKAKA. What was the name of that?

Mr. BESTEMAN. Buprenorphine.

Mr. AKAKA. Yes. Is this an oral medication?

Mr. BESTEMAN. Yes. Probably an oral medication.

Mr. AKAKA. Can you explain that a little more?

Mr. BESTEMAN. I am not technically capable of describing that. I could have the researcher do the work and give us an English translation for the record.

Mr. AKAKA. Please do that.

Mr. BESTEMAN. It is highly technical. It has to do with provoking some of the natural morphines that exist in the brain and not producing a strong addiction, but I'm simply not technically competent to give you that explanation.

Mr. AKAKA. Will you please submit that for the record?

Mr. BESTEMAN. I will be delighted to.

[The information referred to follows:]

BUPRENORPHINE

NIDA is examining a new drug which may have significant potential as a treatment agent. This drug, buprenorphine, is a partial agonist of the morphine type with a long duration of action. In practical therapeutic terms, these characteristics of buprenorphine indicate that this compound has subjective effects that should be acceptable to addicts in treatment. It will require a dose schedule less frequent than methadone and possibly as infrequent as with LAAM. Buprenorphine appears to have significantly fewer side effects than other treatment drugs.

Further, buprenorphine appears to be capable of blocking the toxic, euphorigenic, and physical dependence producing effects of self-administered heroin or other narcotics. It will produce cross-tolerance to heroin like methadone but will also act as a competitive antagonist like naltrexone.

Finally, buprenorphine appears to produce little if any physical dependence, and maintenance therapy could therefore easily be terminated.

Mr. AKAKA. Let me come back to the basic question where we asked for a recommendation from you. You have heard some of the charges

about NIDA. What we are trying to do in this committee is to make the system more efficient, to find a better system if there is one. A problem with Federal agencies is that legislatively they are given certain responsibilities, and they tend to do the best job that they can within that category of responsibility.

They find it very difficult therefore to get outside of their responsibilities. I know from the statements you have made that you believe in comprehensive approaches toward the whole person. The drug problem is just one of the problems of the whole person. Therefore there is a need for coordinating the activities among the several agencies.

My question is: What recomendation do you have, knowing the agencies that make efforts toward drug abuse treatment, so that we can do a better job for the people who are addicted to drugs. From our point of view, the problem is attacked legislatively, from your point of view, managerially.

Mr. BESTEMAN. I think the problem is a simple one.

You touched on part because we get a legislative mandate, and we focus on that, and we don't look at the whole scene.

We all have that tendency because life is simpler that way. When we open up to the other, then I have critics, I have to talk to 10 people instead of just 1 person to get a decision.

And it inevitably complicates the manager's life. I think that is just basic to systems.

That, second to that, is the fact that NIDA is an advocacy agency. We are concerned with drug abusers.

Many of us in the agencies have dedicated our professional lives to it.

In September, I celebrate my 21st year in this field.

So, I somehow think this is one of the most important issues around the country and in the governmental life.

Now, I approach a department like the Department of Labor, or I approach an agency, a sister agency within HEW either education or rehabilitation, and when I sit in the chair of the person who has made a career there, they look from an entirely different prospective.

And when they see my little numbers of how many dysfunctional drug abusers I have, I use the phrase with the staff that drug abuse is like a wart on a hog.

They are not interested in that wart. They don't think that wart needs to be treated.

And the priority systems between really major social concerns and someone who is in an advocacy position such as I am from a very admittedly narrow perspective around a specific social behavioral medical problem are quite different.

And then the problem of accommodation between those two is what causes this fragmentation, disunity.

Now, I am encouraged that the Secretary has not only appointed a special assistant of his, but an agency chief to do the coordination.

Because I recognize that the Institute is a bureau, and I can tell you from long experience for a bureau level to try to change a department or to go and be an advocate of another department, that is a somewhat handicapped position of power.

And so I am hopeful with the Secretary's commitment and he has placed Mr. Meltzer, who is an assistant to him in the position, and given

the Agency Director, Administrator Dr. Klerman, this charge now that we will be somewhat more succesful within the Department and without, when we have to go outside the Department knowing we have the Secretary's backing.

But I have to be truthful to say that I will watch carefully to see how that goes.

I am not exactly in a euphoria of optimism. I have been here too long, I guess, for that.

I will do everything I can. But I will also be a little suspicious of the process until I see it successful.

Mr. AKAKA. Is there a design among the other agencies to coordinate?

Mr. BESTEMAN. I think basically there is. But when they coordinate with us that they have to coordinate with NIAA. And then, there is an NIH. And then, there is the Cancer Institute and the Heart and this one, and then there are the mental health versus the mentally retarded.

And we are just 1 of 100 people that come at them for our specific client group and say, please, give us a break, even give us something special because we have special needs.

And they have heard that story day in and day out if they run a major agency.

It is just a fact of the system that when you advocate for a small, relatively small population within this large country, you need help from higher levels of the bureaucracy and from higher policy levels to make an impact.

Mr. AKAKA. Well, we are very fortunate.

I feel that way, that we do have this committee, and hopefully, we can encourage movement toward this comprehensive coordinated effort.

I hope that some day we can approach the kind of solution to this that we need.

Unfortunately, it might take a disaster treatment as in Florida, and even for our economy, it may take a depression to bring us back to our senses.

In the meantime, we should make every effort to try to improve our services.

In spite of the criticisms I have heard about NIDA, my hope is still that we can continue to improve the services for people across the country.

This committee has been looking into the supply and demand, and also, into treatment as we are doing now.

We are also looking into preventions and other facets of drug abuse.

Hopefully, this comprehensive look at narcotics abuse and control will contribute to the development of effective legislation.

If there are no further questions, I want to thank you, very much, Mr. Besteman and Mrs. Johnson, for your presence here, for your prepared statement, and your time and effort to come help us on this committee, Select Committee on Narcotics Abuse and Control.

Mr. BESTEMAN. Thank you, Mr. Chairman.

Mr. AKAKA. Thank you.

The committee stands adjourned.

[Whereupon, at 12:30 p.m., the hearing was adjourned, to reconvene at the call of the Chair.]

PREPARED STATEMENT

PREPARED STATEMENT OF KARST J. BESTEMAN, DEPUTY DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. Chairman and members of the Committee, I thank you for the opportunity to appear today to discuss the programs and policies of the National Institute on Drug Abuse (NIDA), Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), Department of Health, Education, and Welfare (HEW).

NIDA was created by the passage of Public Law 92-255, the "Drug Abuse Office and Treatment Act of 1972," to conduct and develop comprehensive health, education, training, research, and planning programs for the prevention and treatment of drug abuse and for the rehabilitation of drug abusers. The Institute has 400 employees and an annual budget of $260 million. Approximately 300 of the staff are located in Rockville, Maryland, 100 at the Addiction Research Center in Lexington, Kentucky, and a small group at the Los Angeles field office. Of NIDA's total budget, $196 million is spent on the treatment and rehabilitation of drug abusers; $34 million for research; $10 million for training treatment program staff; $4 million for prevention and education; and $16 million for data collection, management information, and other program support activities. Ninety-six percent of NIDA's funds are spent in local communities.

In preparation for these hearings, members of your Committee staff and representatives from the Institute have had several meetings to discuss issues of mutual interest. In addition, the staff shared with us a memorandum to the Committee setting forth items of specific concern. In this testimony, I will try to address many of the issues included in that paper. Before I begin my formal testimony, I would like to add how pleased we are at the productive nature and positive tone of the relationship that has developed between the staffs of this Committee and the Institute, and how much we look forward to a future of continued cooperation as we discuss important issues in the field of drug abuse. The leadership and concern provided by your Committee and its staff are a most helpful contribution to this process.

We have come a long way over the last 10 years, a period characterized in part by increasing involvement in the commitment to the problem of drug abuse by the Federal Government. As you remember, there was widespread public concern at the time of the passage of NIDA's enabling legislation regarding the acute and highly visible nature of the heroin addiction in the cities, the criminal activity directly related to this problem, the high rate of addiction to heroin among servicemen returning from the Viet Nam war, and the increasing prevalence of casual marihuana and other drug use among young people, particularly on American college campuses.

The Federal Government remains concerned about heroin addiction. Currently NIDA supports the treatment of over 126,000 heroin-addicted persons in community-based drug abuse treatment programs throughout the Nation. These persons represent 60 percent of the clients in federally funded treatment.

We have learned, however, over the last 10 years that there are no easy answers in this field. There are no fail-safe solutions or "cures" for heroin addiction or the drug problem. Drug use and addiction is a very complicated human behavior which has a serious impact on the user and his or her relationships, family, and community.

Over the last decade, we have also learned that the American drug "problem" included not only the problem of heroin addiction but also the abuse of a range of illicit drugs—PCP, cocaine, and marihuana, for example, and the misuses of legally available prescription drugs and their combination with alcohol. In a broader sense, many Americans are recognizing that their abuse of drugs, alcohol, tobacco, and even caffein is a part of the Nation's overall "drug problem."

There were many challenges to those involved in the development of an expanded Federal response to the drug abuse problem in the formative stages, and there remain many challenges to those of us in the field today. Many within the Administration and the Congress share a feeling of frustration about reaching a solution to the drug abuse problem and are questioning the effectiveness of the Federal drug abuse treatment and prevention activities. In my testimony this morning, I would like to present a few thoughts about drug abuse treatment, after which I would be pleased to answer questions and to provide any additional information the Committee might require.

THE NATURE AND EXTENT OF DRUG USE

We know much more about the drug use patterns of the American public now than we did in the early 1970's. We have developed a portfolio of sources on the problem which, when viewed together, begin to provide a rather reliable picture of the extent of drug use. Among the sources of information available to us are the Drug Abuse Warning Network (DAWN) System, jointly administered by NIDA and the Drug Enforcement Administration (DEA), the Client Oriented Data Acquisition Process (CODAP), several annual national population surveys, the National Prescription Audit, and special one-time studies and reviews.

What emerges from a very general review of these materials is the following:

1. Marihuana is a commonly used drug. The American public has had more experience with it than with any other psychoactive drug and that experience is strongly related to age. Alcohol and tobacco are still, however, more commonly used than marihuana.

2. More than 7 million Americans have used PCP, and last year the drug was associated with at least 100 deaths and over 4,000 emergency room visits. The current use of hallucinogens, except PCP, has remained unchanged since 1976, although more younger people have tried hallucinogens than have adults.

3. The use of cocaine, especially among the age group of 18–25 years, is increasing. Our last national survey (1977) reports that 19.1 percent of this age group have used cocaine.

4. The prevalence of heroin and other opiate use appears to have stabilized over the last 2 years—there are estimated to be between 522,000 and 559,000 active addicts in the United States, 126,000 of whom are receiving treatment in NIDA-supported drug abuse programs.

5. Use of sedatives, stimulants, and tranquilizers without a doctor's supervision is increasing, especially among the age group of 18–25 years.

The abuse or misuse of prescription drugs is a problem of specific concern, particularly among special population groups such as the elderly and women. A recent NIDA review of one class of these drugs—the barbiturate/sedative hypnotics—revealed that 3 million persons used these drugs outside of medical supervision and the number of deaths they caused was higher (1,700 in 1976) than for any other single class of prescribed drugs.

6. One hundred persons died from inhalant abuse in 1976, and over 2,000 more required emergency room treatment or crisis center counseling.

7. An estimated total of 8,000 deaths and 284,000 emergency room visits were related to drug abuse, based on data gathered by the DAWN System in 24 cities between May 1976 and April 1977.

DRUG ABUSE TREATMENT

Last year NIDA supported drug abuse treatment programs that gave care to over 235,000 persons. The charts included in the Appendix to this statement (Item 1) describe the characteristics of the person in federally supported drug abuse treatment. Seventy-three percent are male, although our programs have been asked this year to give special emphasis to the treatment needs of women. Seventy-one percent are currently unemployed, and 57 percent have sought treatment primarily for their heroin addiction. Only a third of these heroin-addicted persons, however, use methadone in connection with their treatment.

NIDA uses the statewide services contract as a mechanism through which to provide Federal funds to the States for drug treatment. These contracts are cost-reimbursement, cost-sharing arrangements with State governments, under which local drug treatment programs are subcontracted. The Institute currently provides funding for a minimum floor of 60 percent of the cost of services.

The use of the statewide services contract as a funding mechanism was carefully considered before it was implemented. Among the advantages to its use is its administrative simplicity. Agreements are negotiated with the 50 States, as contrasted to a direct NIDA-to-locality funding model which some have suggested. In such a system, thousands of grants would have to be directly negotiated and monitored.

The services contract mechanism also offers encouragement to State government to get involved in the drug abuse problem and to coordinate resources available at the State and local level with Federal funds. The Committee may be interested to know that in fiscal year 1978 approximately 43 percent of the expenditures for drug abuse were provided by State governments, 38 percent by the Fed-

eral Government, and 19 percent by local sources. This is certainly an indication of the importance the States attach to the drug abuse problem. The statewide services concept has been so useful, in fact, that the other Institutes within the Alcohol, Drug Abuse, and Mental Health Administration—the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute of Mental Health (NIMH)—are studying the potential for its use in their programs.

However, NIDA continues to strengthen the operation of the current finding system and has initiated the two significant efforts in that regard:

1. A feasibility study to develop units of costs and treatment episode costs for drug abuse treatment programs is currently being completed; and,

2. During this fiscal year, variations of the existing treatment slot system and other possible funding systems, including unit costing, will be examined by an independent contractor. This study will develop specific criteria with which to measure the practical implication of each funding system and its impact on the treatment system as a whole. Among the criteria certain to be used in this assessment of other systems are cost and ease of audit and monitoring of other proposed approaches. Based on the results of this review, a decision about whether a new approach to service funding is warranted will be made.

One of the basic concerns of those who have sought change in the statewide services mechanism has been that the cities were somehow being shortchanged in the process. NIDA has strongly encouraged State drug abuse planners to involve the cities in the State planning process and has also established its own channel of ongoing communication with city interest groups and associations.

As you know, the Federal Funding Criteria mandate a broad spectrum of service components be provided in drug abuse treatment, including education, vocational counseling and training, job development and placement, and legal services related to the patients' treatment. Local programs are required to use community resources to provide these services to the maximum extent possible.

Cooperation between local drug abuse programs and other social service networks often exists even without extensive coordination within the Federal bureaucracy. Admittedly, however, these efforts could be facilitated by greater cooperation at higher levels. NIDA has undertaken cooperative efforts with other Agencies and within HEW to the fullest extent possible under the current legislative authority.

The Committee staff has indicated its interest in a state of the art report on the use of the various treatment modalities. Item 2 in the Appendix to my testimony details the proportions of NIDA-funded treatment slots allocated to the various available treatment modalities. Of note is the fact that in the last year the use of inpatient detoxification has been reduced from over 600 slots nationwide to approximately 200. These slots are very expensive, costing up to $40,000 annually. In many cases this kind of hospital care is unnecessary; outpatient detoxification for most clients can be just as effective.

A new treatment modality—residential detoxification, which falls between inpatient and outpatient care—is now being tried in two States on a pilot basis. The client is placed in a residential facility staffed with two full-time nurses and a doctor on 24-hour call. The doctor visits twice daily, and the client receives continual supervision. The new detoxification slots cost between $7,000 and $13,000 per year and meet the same needs as the more expensive hospitalization.

The most important question about drug abuse treatment is what happens to those persons who receive these services. Dr. Saul Sells of the Institute for Behavioral Research has done the most extensive analysis of treatment outcome currently available. His followup study of over 3,000 admissions to drug abuse treatment found statistically significant improvements measured by reduced drug use, increased employment, and reduced criminality for those persons enrolled in methadone maintenance, therapeutic communities, and drug-free programs.

In another outside review of the results of drug treatment in Washington, D.C., and New York City, it was found that drug abusers progress from frequent use of heroin and other illicit drugs and involvement in other illegal activities, to considerably less involvement in illicit drug use and other illegal activities. (Items 3, 4, and 5 in the Appendix summarize these results.)

The Committee has indicated its concern about the evaluation criteria used to properly gauge the effectiveness of the Federal treatment effort. Treatment outcomes may be viewed either in terms of complete recovery (i.e., abstinence from drugs) or reduction in drug use patterns which allows the individual to become a more adequately functioning member of society. Because of the variety of types of outcomes observed in treatment populations, the most satisfactory

criterion is one of significant reduction in level of drug use for a given treatment modality with accompanying improvements in related measures such as criminality and employment. Other outcome measures used have been the rate of return to treatment, time unsupervised, alcohol use, and a measure of productive activity which is a composite of employment, homemaking, school attendance, and other related activities. These have been found to be related in different ways to the principal criterion measures and are perhaps more useful in analyzing patterns of treatment outcome rather than making judgments on the effectiveness of the particular modalities.

Another study which will yield a somewhat different set of criterion measures is being conducted by the College of Medicine and Dentistry of New Jersey. This study, which is developing allocation models for assignment of clients to treatment, uses a treatment outcome measure which quantifies social, economic and psychological outcomes in terms of costs and benefits. This enables expression of treatment outcomes as a single value and will, thus, permit comparison of different kinds of programs in terms of their relative efficiency.

In addition, NIDA has produced a self-evaluation handbook which is available through the National Clearinghouse on Drug Abuse Information and plans to assess the utilization of this handbook nationally during the coming year.

NIDA's Treatment Outcome Prospective Study (TOPS), beginning this fall in four cities, will differ from other evaluative work in two major ways: first, by definition it will follow clients through a treatment experience rather than look at the results of treatment after it has concluded; in addition, TOPS will evaluate treatment by including within the criteria for determining success, abstinence from drug use and lack of criminal behavior and a community readjustment measure determined by employment or other productive activities, living arrangements, family arrangements, and minimal illicit drug use or alcohol or other drug abuse.

EMPLOYMENT SERVICES

NIDA has collaborated with the Department of Labor (DOL) on the issuance of notices to the field to encourage cooperation between the drug abuse treatment community and the DOL employment and training programs funded through the local Prime Sponsors. Letters were sent to all drug abuse single State agencies and Prime Sponsors.

Recently preliminary discussions have been held within the Rehabilitation Services Administration (RSA) to determine whether it would be feasible and appropriate to attempt to develop a cooperative agreement between RSA and NIDA, or ADAMHA and NIDA, similar to the agreement developed between RSA and NIMH. The RSA–NIMH agreement sets forth general principles of cooperation and identifies areas such as training, research, and delivery of services for which detailed agreements will be developed later. The cooperative agreement has been endorsed by the appropriate mental health and vocational rehabilitation State agency organizations since they will be responsible for much of the implementation and stand to benefit from any collaboration.

Recently, in response to the President's Drug Abuse Message of August 1977, NIDA has worked with DOL and the Office of Drug Abuse Policy (ODAP) in the planning and preparation of a program of model dissemination, training and technical assistance for Prime Sponsors and the drug abuse treatment community on techniques for establishing linkages between the treatment and skills training systems and for providing skills training and employment to ex-addicts. This initiative is being modeled after the DOL ongoing technical assistance campaign for improving employment opportunities for ex-offenders.

Since 1975, NIDA has participated with DOL in the national supported work research demonstration program. A consortium of five Federal departments and agencies (DOL, Law Enforcement Assistance Administration, Department of Housing and Urban Development, Department of Commerce, Department of Health, Education, and Welfare) and the Ford Foundation have sponsored employment demonstration projects in 15 sites across the country to test whether the model of supported work is effective in assisting hard-to-employ individuals make the transition from long-term unemployment to regular full-time work. The target groups include ex-addicts, ex-offenders, youth, and welfare mothers.

In addition, in the summer of 1977, NIDA/HEW recommended to DOL that the regulations for the implementation of the Youth Employment and Demonstration Projects Act of 1977 reflect that eligible young drug abusers be included as a special target group for services. ODAP made similar recommendations. Unfortunately, these recommendations were not adopted.

The 1975 Federal Funding Criteria require that vocational training and job counseling be provided the client in drug abuse treatment. While the value of vocational rehabilitation is incontrovertible, many addicts continue to use drugs even though they have job skills. It is important to keep the importance of vocational rehabilitation in perspective—as one of the many important parts of a total rehabilitation program.

COORDINATION WITH THE CRIMINAL JUSTICE SYSTEM

NIDA is providing research, demonstration, and technical assistance activities to improve the linkages between the drug abuse and criminal justice systems and to provide methods for early identification and treatment of the drug-abusing criminal offender. As part of NIDA's commitment, a study of the California Civil Addicts Program was carried out under NIDA sponsorship and published as a monograph by William H. McGlothlin, and represents the most definitive study to date on the effectiveness of civil commitment.

Currently the State of Wisconsin under a NIDA grant is testing the effectiveness of different arrangements for pre-release therapy, a residential reentry facility, and aftercare in the community for drug-dependent inmates of the Wisconsin State prison system. Another study which is just being completed examines the feasibility of procedures for early detection and identification of drug abuse in arrestee populations, so that candidates for treatment may be identified as they enter the criminal justice system. Studies of treatment provision in the criminal justice system are valuable because they identify treatment needs and provide information on the various kinds of arrangements which can be used for providing such treatment to inmates and those being released into society at large. NIDA also funded a study on drug abuse treatment in the Nation's jails, and is undertaking a study of drug treatment in prisons.

NIDA-funded treatment programs continue to cooperate with efforts by the State drug abuse agencies to make slots available to persons referred through the criminal justice system, including those referred through the Treatment Alternatives to Street Crime (TASC), and the Treatment and Rehabilitation for Addicted Parolees (TRAP), which are sponsored by the Law Enforcement Assistance Administration.

TRAINING AND CREDENTIALING OF DRUG ABUSE WORKERS

The NIDA program for training professionals has addressed itself principally to physicians and social workers. The amount of money, time, and the number of persons trained under this program are significant. We have only recently begun to address the continuing education needs of some of the other health professions (for example, psychologists, pharmacists, nurses, physician assistants, and nurse practitioners). It is not true, however, that there is a shortage of qualified personnel to staff and administer drug treatment programs.

The majority of drug treatment personnel are paraprofessionals. NIDA has established a national manpower and training system to provide these workers with the skills, knowledge, and attitudes necessary to deliver quality service to drug abuse clients. This training system has been cited as an exemplary model by the National Association of State Drug Abuse Program Directors and recommended to the National Institute on Alcohol Abuse and Alcoholism and the National Institute of Mental Health as a model training strategy.

The issue of credentialing of drug abuse workers is one of increasing importance. The development of credentialing standards is a matter of State legislation. NIDA has assisted the States to develop credentialing standards which provide for reciprocity between States. In this regard, we have developed model credentialing standards in several States that are now being used by other States in formulating their policies.

THE USE OF SELF-HELP GROUPS IN DRUG ABUSE TREATMENT

The use of self-help groups as a treatment technique is quite widespread in a variety of fields concerned with modifying individual behavior; however, by comparison, it has been relatively unexplored in the drug abuse field. NIDA has investigated the potential role of the self-help approach as a treatment modality for drug abusers, and in this regard the Institute held a self-help conference on March 8-9, 1978.

For the purposes of this conference, self-help organizations were defined as those groups of persons organized to support and aid each other in their efforts to control and eradicate undesirable behavior patterns. Self-help groups for drug abusers were viewed as enhancing the first line of treatment for the drug abuser, as support for ongoing treatment, and for use in providing aftercare services.

The conference was attended by representatives of self-help groups, drug abuse treatment programs, and/or academicians who had written and researched in the field. In addition, there were representatives from NIDA, NIAAA, and NIMH, and the National Center on Child Abuse and Neglect.

The objective of the conference was to explore the potential role of non-residential self-help organizations in the drug abuse field. Various non-residential self-help models were examined, and questions involving the special needs of drug abusers were considered. In addition, the conference generated discussion on resources and roles for government agencies and private groups for further development of non-residential self-help organizations in the drug abuse field. Recommendations for future NIDA self-help activities were also discussed.

The conferees were reluctant to suggest direct financial support because of regulatory and financial reporting requirements which could hinder anonymity and group functioning. If funds are awarded to self-help groups, they should be cautiously administered to avoid excessive intrusion into the groups' operations. The conferees suggested that demonstration studies be encouraged in self-help programs (with special attention to minority involvement) to examine the group process, membership, organizational management, methods of establishing self-help groups, and pathways into the group, and emphasized that NIDA should avoid "effectiveness" studies which could hamper movement in the development stages of a group.

NIDA is currently encouraging the submission of research demonstration grants in the area of self-help.

MULTIPLE DRUG ABUSE

NIDA has sought to learn more about the nature of nonopiate, or what has been termed polydrug abuse, and has conducted a number of epidemiological studies in general population groups.

One study examined interviews with 30,000 people over a 4-year period in 30 States. The data collected suggest that approximately 35 percent of the users of prescription psychotherapeutic drugs are regular drinkers, and about 10 percent exhibit a drinking pattern which would place them into the "heavy drinking" category.

Another study (O'Donnell 1976) reported on the use of combinations of different drugs, including alcohol. The data indicate the extensiveness of combined drug usage. The study examined the prevalence of multiple drug use within a large (N = 2,510) representative sample of American men, ages 20 to 30. Thirty-three percent of the respondents stated that they had used only alcohol and tobacco. An additional 22 percent reported use of alcohol, tobacco, and marihuana. Fourteen percent of this non-patient sample reported using other drugs in addition to these three.

The Drug Abuse Warning Network reports Alcohol-in-Combination as the number two leading mention in 1974–75 at approximately 8 percent. The data indicate that more than one-fourth of all problems cited involve three drugs: diazepam, alcohol-in-combination, and heroin.

A summary performed on Client Oriented Data Acquisition Process data for January–September 1975, showed that those primary barbiturate/sedative problems (N=9,023) had the greatest alcohol involvement, with 1,064, or 11.8 percent, and 730, or 8.1 percent, respectively, reporting secondary and tertiary problems with alcohol. The CODAP data are based on all clients treated in federally funded treatment programs.

The Polydrug Project was organized in 1973 in response to the reported increase in prevalence of nonopiate drug use in this country.

The goals of the Polydrug Project were:

1. To provide a focus for the development of data, particularly demographic data, on the problem of polydrug abuse;
2. To develop a cadre of professionals with knowledge about polydrug abuse;
3. To develop technology for the treatment of patients with this problem; and
4. To provide pilot demonstrations so that State and local agencies can develop similar programs on their own initiative.

To achieve these goals, the Federal Government funded 12 polydrug programs. While the projects were designed to provide service to the communities, their primary function was to serve as a research effort in providing important sources of data concerning the nature of the polydrug problem and the population involved, as well as allowing the testing of the efficacy of various treatment approaches.

A book called Polydrug Use and Abuse, presenting the findings of the Polydrug Project, is being published by Academic Press and will be released in September 1978. In addition, the following two manuals resulting from the Polydrug Project have been published by the Federal Government and were widely disseminated in the drug abuse treatment field.

Medical Treatment for Complications of Polydrug Abuse, and

Referral Strategies for Polydrug Abusers.

Two additional manuals are currently being prepared for publication.

DRUG ABUSE RESEARCH

Each year NIDA supports over 600 research projects spanning a wide area of concern. Such studies led to the discovery of endorphins, a totally unexpected category of substances manufactured by the brain that have powerful analgesic and learning functions and may contribute to various disorders, including drug abuse.

Other NIDA research among college students has shown that those who have low activity levels of an enzyme (MAO-monoamine oxidase) affecting specific neurotransmitters, score high on personality measures such as the sensation-seeking scale. High scores on this scale have been associated with increased marihuana, hashish, amphetamine, and LSD use. Individual preferences for stimulants or polydrug abuse have also been associated with high sensation-seeking scale. During the past year, NIDA researchers have shown that platelet MAO in male marihuana smokers was significantly lower than in a comparable group of non-marihuana smokers, and that the level of current marihuana use was inversely correlated with MAO activity. Although several explanations for this finding are possible, it would appear that MAO activity levels may provide a reliable index of an individual's proclivity to abuse drugs given access to the drugs. We plan to further investigate this problem in the coming year and to include tests for MAO activity levels in our ongoing longitudinal marihuana study so that we can determine how many individuals with low MAO levels went on to abuse drugs as compared to those with normal MAO activity who avoided drug abuse.

Another line of research which has significance for drug abuse treatment is concerned with the relationship between depression and opiate addiction. Recent studies have shown that between 20–33 percent of patients in methadone maintenance programs are clinically depressed. NIDA-supported research in the past year has demonstrated that treatment of this group of patients with antidepressants has a beneficial effect as measured by time in treatment and positive change in social functioning.

Recent results from a variety of studies on the role that personality plays in drug abust have led to the conclusion that there appear to be similarities in traits within various groups of users. For example, among college students, drug users tend to be more unconventional, individualistic, and independent, while high school student users tend to be more rebellious and deviance prone and more alienated from their parents. The question of whether these personality traits lead to drug abuse or are caused by drug abuse still remains unanswered.

A recently completed analysis of the history of epidemics of drug and substance abuse concluded that advances in communication, medical discoveries, and adverse social conditions are highly correlated with drug abuse episodes, that drug abuse frequently begins with the elite in a society, and that governments generally try to control abused substances through control of price and supply by passing tax acts. This information should be useful in planning our response to the drug abuse problem.

NIDA's research program over the next few years will continue to develop knowledge concerning the mechanisms underlying drug abuse. Among the many areas to be addressed are the following:

1. We are interested in developing a comprehensive and practical approach to the treatment of heroin-dependent persons and drug abusers that is based on theoretically sound knowledge of the psychiatric state of such individuals. NIDA-

supported research will seek to assess the psychiatric status of addicts in and out of treatment and will attempt to assess the impact of various types of pychotherapies on treatment outcome.

2. NIDA will investigate the possible clinical significance of a new drug—buprenorphine—for the treatment of heroin dependence. This compound seems to have effects that should be acceptable to addicts in treatment; it would require dosing schedules less frequent than methadone; it appears capable of blocking the euphoric and dependence-producing effects of heroin; and it produces minimal dependence, and hence maintenance therapy should be easily terminated.

3. NIDA has launched a major program aimed at understanding factors involved in cigarette-smoking behavior.

4. NIDA research in the next few years will be increased in the area of studies involved with phencyclidine (PCP) abuse.

5. Another area of interest involves the natural history of drug use. We need to understand more about the various stages of initiation, practice, and final outcomes of drug abuse careers. We need additional information concerned with the factors associated with the onset and cessation of drug abuse behavior—in other words, what variables are common to those individuals who become drug abusers and what variables are common to those individuals who successfully stop their drug abuse.

6. NIDA will increase research on the prevention of drug abuse. Studies will be initiated which are aimed at (a) a better understanding of the dynamics of peer pressure, (b) how media campaigns can be effectively implemented, (c) understanding the factors of gateway drug use, and (d) identifying those factors that make some individuals "immune" to drug abuse while they live in the midst of a drug abuse epidemic.

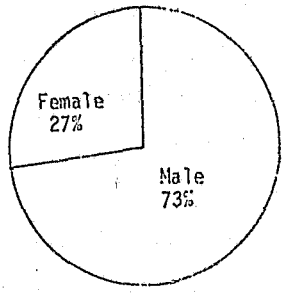
Finally, the feasibility of making NIDA's Addiction Research Center responsible for coordinated research on a variety of drugs including opiates, alcohol, and tobacco, and relocating it from Lexington, Kentucky, to within the Washington/Baltimore area is now being reviewed by HEW.

We share the Committee's concern that the findings of the drug abuse research program be widely disseminated not only to the professional audience but also to the public at large. In addition to making results more widely available, the recently initiated RAUS (Research Analysis Utilization System) effort has been designed to review research findings, analyze groups of studies in the same subject area, and plan and coordinate future research inquiry.

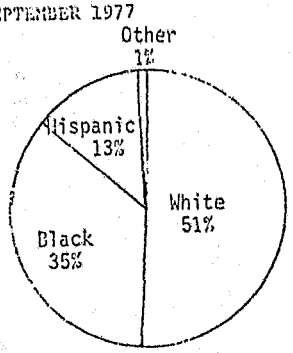
Mr. Chairman, I thank you for the opportunity to appear this morning and would be pleased to answer any questions you or the members of the Committee might have.

Item 1

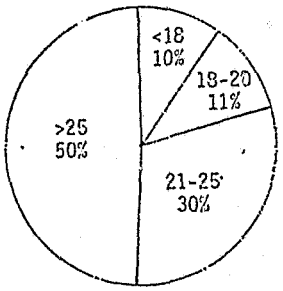
CHARACTERISTICS OF CLIENTS ADMITTED TO TREATMENT IN FEDERALLY-FUNDED CLINICS: JANUARY - SEPTEMBER 1977



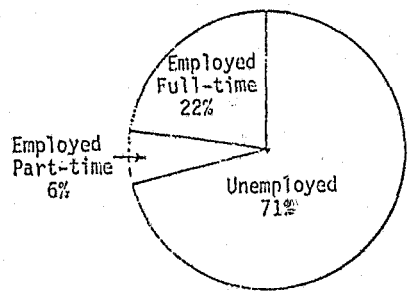
SEX



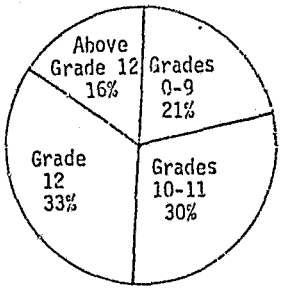
RACE/ETHNICITY



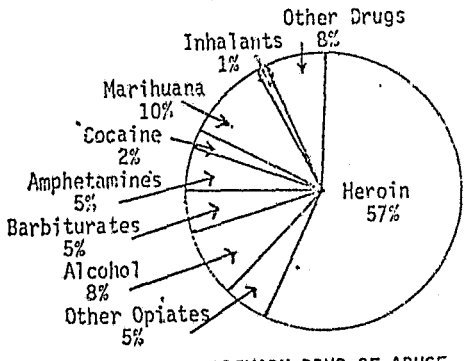
AGE



EMPLOYMENT STATUS



EDUCATION



PRIMARY DRUG OF ABUSE

Source: Client Oriented Data Acquisition Process: # Clients - 150,516

DIVISION OF COMMUNITY ASSISTANCE, NIDA SLOTS AND UTILIZATION, MARCH 1978

State	Inpatient	Day care	Residential			Outpatient			Total	Utilization	
			Detoxification	M.M.	D.F.	Detoxification	M.M.	D.F.		January 1978	Percent
Alabama	9	20	3		57	18	274	425	806	695	86
Alaska					11	2	20	20	53	43	81
Arizona	3	29	1		184	38	726	666	1,647	1,629	99
Arkansas			6		52	20		448	526	431	82
California	42	139	34		1,667	673	3,775	7,817	14,147	13,121	93
Colorado					49	5	462	467	983	918	93
Connecticut	19	98		8	443	35	790	801	2,194	1,890	86
Delaware	3				50		185	114	352	242	69
District of Columbia						25	545	30	600	287	48
Florida	11	341			666	126	1,222	2,295	4,661	4,284	92
Georgia					191	56	568	545	1,360	1,157	85
Hawaii		18			98	10	75	175	376	378	101
Idaho								97	97	85	88
Illinois		27		41	170		1,429	753	2,420	2,093	87
Indiana	1				36	20	735	313	1,105	843	76
Iowa	2		1		101	7	46	707	864	716	83
Kansas		8			8		72	47	135	110	82
Kentucky	4				24	13	99	510	650	584	90
Louisiana		161	18		137		787	458	1,561	1,394	89
Maine					8			135	143	152	106
Maryland					44	25	644	323	1,036	988	95
Massachusetts	7	158	10		297	70	873	1,810	3,225	2,850	88
Michigan		2			170	106	4,063	1,988	6,329	5,302	84
Minnesota		64			68	20	198	476	826	784	95
Mississippi	1				20			152	173	87	50
Missouri			5		94	8	686	539	1,332	1,167	88
Montana					10			321	331	323	93
Nebraska					26	10	90	125	251	230	92
Nevada		25			126	15	110	157	433	362	84
New Hampshire					73			230	303	279	92
New Jersey	14	137	10	34	700	277	1,874	2,493	5,539	5,290	96
New Mexico	2				45	48	562	341	998	870	87
New York	52	2,997	21	183	2,562	451	2,226	5,863	14,355	11,950	83
North Carolina	1	56			42	20	148	430	697	584	84
North Dakota								20	20	27	135
Ohio	7	20	15		218	47	1,886	1,362	3,555	3,124	88
Oklahoma	3	10			10	18	166	157	364	325	89
Oregon					55		434	591	1,080	966	89

35-070—79—10

DIVISION OF COMMUNITY ASSISTANCE, NIDA SLOTS AND UTILIZATION, MARCH 1978—Continued

State	Inpatient	Day care	Residential			Outpatient			Total	Utilization	
			Detoxification	M.M.	D.F.	Detoxification	M.M.	D.F.		January 1978	Percent
Pennsylvania	5	104	10		456	232	2,811	2,587	6,205	5,354	86
Rhode Island	15	30			85	7	120	540	797	741	93
South Carolina		62			62	10	95	394	623	518	83
South Dakota		17						9	26	23	89
Tennessee	7				65	11	200	424	707	557	78
Texas		16	12		378	19	2,217	2,825	5,467	4,974	91
Utah		4	6	16	59	5	207	504	801	732	91
Vermont					25			360	385	332	86
Virginia					322	19	447	703	1,491	1,297	87
Washington			6	6	176	80	395	705	1,368	1,203	88
West Virginia								223	223	344	154
Wisconsin		10			110		252	559	931	656	71
Wyoming			5				5	20	30	16	53
Guam						10	10		20	31	155
Puerto Rico		150			200	55	607	103	1,115	1,155	104
Virgin Islands											
American Samoa											
Pacific Trust Territory											
National	208	4,703	163	288	10,450	2,611	33,136	44,157	95,716	84,493	88
DR funded projects									344	344	100
National									96,060	84,837	88

DRUG USE

[In percent]

Frequency of use	NTA			ASA		
	2 mo before	2 mo after	Last 2 mo	2 mo before	2 mo after	Last 2 mo
Heroin:						
Not at all	2	55	65	20	73	86
Occasionally	26	33	30	13	15	11
Daily	72	12	5	67	12	3
Total	100	100	100	100	100	100
Number	189	189	189	373	369	370
Illegal methadone:						
Not at all	65	83	92	83	91	92
Occasionally	32	15	7	15	8	7
Daily	3	2	1	2	1	1
Total	100	100	100	100	100	100
Number	189	189	189	373	369	369
Cocaine:						
Not at all	42	72	78	61	85	86
Occasionally	52	27	20	29	14	13
Daily	6	1	2	10	1	1
Total	100	100	100	100	100	100
Number	189	189	189	373	369	371
Amphetamines:						
Not at all	75	80	86	86	97	97
Occasionally	18	16	13	12	3	3
Daily	7	4	1	2	0	0
Total	100	100	100	100	100	100
Number	189	189	189	373	369	369

Source: Drug Treatment in New York City and Washington, D.C. Followup studies DHEW, ADAMHA, NIDA, Services Research Branch Monograph, March 1977.

EMPLOYMENT

[In percent]

Program and status	2 mo before	2 mo after	Last 2 mo
NTA:			
Paid job	33	37	48
Keeping house, student, job training	5	4	6
Illegal activities	46	38	24
All other activities	16	21	22
Total	100	100	100
Number	189	189	189
ASA:			
Employed	21	43	57
Not employed	79	57	43
Total	100	100	100
Number	368	352	374

ARRESTS

[In percent]

Status	NTA			ASA		
	2 mo before	2 mo after	Last 2 mo	2 mo before	2 mo after	Last 2 mo
Arrests:						
Arrested	25	11	9	30	9	4
Not arrested	75	89	91	70	91	96
Total	100	100	100	100	100	100
Number	188	188	188	361	347	358
Incarcerations:						
Incarcerated	12	9	12	21	7	4
Not incarcerated	88	91	88	79	93	96
Total	100	100	100	100	100	100
Number	188	188	188	358	352	339

DRUG ABUSE TREATMENT

(Part 1)

THURSDAY, JUNE 22, 1978

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

The Select Committee met, pursuant to notice, at 2:07 p.m., in room 2337, Rayburn House Office Building, Washington, D.C., Hon. Lester L. Wolff (chairman of the Select Committee) presiding.

Present: Representatives Glenn English, J. Herbert Burke, and Benjamin A. Gilman.

Staff present: Joseph L. Nellis, chief counsel, and David Pickens, project officer.

Mr. WOLFF. The committee will come to order.

Today we are holding the seventh hearing on demand reduction issues and we will focus on the important subject of international programs.

The majority of U.S. Government international demand reduction programs are under the control of NIDA and the senior adviser in the State Department. The Department of Defense carries out an extensive program overseas but this Select Committee has been evaluating their work in a separate series of hearings.

In August 1977, President Carter stated in his message to the Congress on drug abuse, "I will, in addition, promote the international sharing of knowledge and expertise in the treatment of drug abuse." This afternoon we will examine how this initiative is being implemented.

I have found during my travels around the world that the United States generally gets good cooperation on international narcotics control from foreign governments only after they recognize that they have a serious domestic drug abuse problem themselves. Our international demand reduction programs often sharpen the awareness of foreign governments of the seriousness of their own problem.

This afternoon the Select Committee will seek to determine what the State Department and NIDA hope to accomplish with their spending of approximately $42 million per year, how the programs are coordinated and how they are evaluated.

I am pleased to welcome this afternoon two distinguished witnesses who possess excellent credentials in this field: Ms. Mathea Falco, Senior Adviser to the Secretary of State and Coordinator for International Narcotics Matters; and Dr. Robert DuPont, Director of the National Institute on Drug Abuse.

Mr. Burke, do you have anything to add?

Mr. BURKE. The only remarks I have to make, I would like to welcome you here as the chairman has done, and to certainly state that we look forward to any input you can give to us in connection with this problem.

Then, I would like one other thing, Dr. DuPont. I never did get a copy of the report that you have made concerning marihuana, and whatnot. I wonder if I could get a copy of that from you?

Dr. DUPONT. I will be happy to provide a copy of our most recent annual marihuana and health report for you.

Mr. WOLFF. Can we swear the witnesses?

[The witnesses were sworn by the chairman.]

Mr. WOLFF. Ms. Falco, would you please proceed?

TESTIMONY OF HON. MATHEA FALCO, SENIOR ADVISER TO THE SECRETARY OF STATE AND DIRECTOR FOR INTERNATIONAL NARCOTICS MATTERS

Ms. FALCO. Yes, Mr. Chairman. I have a prepared statement which we have submitted to the committee.

Mr. WOLFF. Without exceptions, that prepared statement will be included in the record at this point.

[Ms. Falco's prepared statement appears on p. 191.]

Ms. FALCO. Would you like me to read it? How would you like me to proceed?

Mr. WOLFF. I would prefer you——

Ms. FALCO. To sum up?

Mr. WOLFF. Give us a summary of it, if you could.

Ms. FALCO. Fine. I understand.

When I assumed this position a year ago February, one of the first areas that I looked into with Dr. DuPont, Dr. Bourne, Mr. Bensinger—our Principals Group—was the area of demand reduction in our international effort. For a number of reasons, which I can go into more deeply if you wish, at that time the proportion of our program devoted to demand reduction internationally was very, very small.

Since that time, we have worked very closely together, Dr. DuPont, his agency, and my agency, to develop a comprehensive plan for demand reduction activities in the international arena. And we have begun this to implement portions of that plan.

Key to our progress together in this area was Dr. DuPont's generous offer to detail to my staff Mr. Robert Retka, one of his very fine officers. Mr. Retka has been working extremely hard within our office in the Department of State to put together a viable demand reduction plan.

As you know, the State Department does not have in-house expertise in this area. Narcotics control is relatively out of the mainstream of traditional foreign policy training and demand reduction activities are really technical.

It became essential to have somebody with real expertise, which we have had now since last October 1. That has been invaluable.

We believe that demand reduction activities abroad are very important, primarily because they tend to increase the awareness—as you

pointed out—of other countries to their own problems, as well as fulfilling our humanitarian goals of decreasing the worldwide suffering arising from drug-abuse problems.

In Southeast Asian countries, the heroin addiction problem has become much more severe during the last few years, and that has contributed to their increasing commitment to taking the kinds of measures needed to control illicit production and traffic of narcotics.

We have received representations from governments like Malaysia which, until recently, have not been terribly active in narcotics control. They begin to see their children, particularly of the affluent classes, the future leaders of the country, affected by this terrible problem. And they are concerned, and they come to us for help.

We have developed with the government of Thailand, several treatment programs, all of which are discussed at length in the prepared statement.

We have a program with Ecuador, and are working with a number of other countries.

I would say that now I come to you for help. The single greatest limitation on our ability to do anything in this field is manpower, person power. As I said, there is no resident expertise in the Department of State in this area. NIDA's resources in the international area are also limited.

One of the issues that we have been exploring together during the last few months has been the question of whether NIDA or HEW, the parent agency, could find some slots to give NIDA, to detail specifically to international narcotics program funded demand reduction activities.

I would like to put more money into this area. But we cannot do that unless we have viable programs to support.

Many of these governments would like, I think, to develop some programs, but they don't have the expertise to put the program plan together themselves.

We have dealt with this need in some cases by short-term consultative help.

Through NIDA, we find somebody who is an expert in an area, and we send them out for a short period of time. In other cases, it really takes a long time.

For example, the Bangkok addict detoxification centers had been in the works before my tenure. It is not just a planning problem; it is also, as with any kind of program, sometimes a bureaucracy problem getting all the right people in the host government to sign the same piece of paper. The program has finally begun in Bangkok, and we are very pleased about that.

I have been having discussions with Dr. DuPont, Dr. Klerman, Dan Meltzer, at HEW, about finding some more slots. We have a number of people, both in customs and DEA, who implement various aspects of our international narcotics program, whose salaries we pay, but who sit on slots that belong to the parent agency.

NIDA is the only agency with which we do not have this arrangement. The 1-year liaison that we have had, where Mr. Retka has been physically present almost every day in our office, and then goes back and forth to NIDA, has been very, very helpful.

That is our single greatest need. That is our single greatest limiting factor. I would like to do more.

We have worked through the Colombo plan and the International Council on Alcohol and Addiction, too, because both of those organizations work primarily in the demand reduction area, preventive education, treatment seminars, rehabilitation. Because of their international nature, they are able often to reach officials in other countries it would be more difficult for us to reach directly.

Their activities are laudable. I would like to do more, particularly in the area of bilateral demonstration projects. But that takes planning, and I come here today in the hopes that we will be able to find a solution.

HEW has indicated to me that they are very willing to help. Dr. Klerman is strongly supportive.

Every agency has its own problems. Apparently, NIDA is already over its congressional and OMB slot ceilings. We are going to try to work it out somehow.

Thank you, Mr. Chairman.

Mr. WOLFF. Dr. DuPont?

TESTIMONY OF ROBERT L. DuPONT, M.D., DIRECTOR, NATIONAL INSTITUTE ON DRUG AEUSE

Dr. DUPONT. Yes, Mr. Chairman. I am delighted to be here. As always, it is a pleasure to appear before this committee. I am particularly delighted to appear on this subject. As you know, the international aspects of demand reduction is one area that I have been most especially committed to for the last several years.

Ms. Falco is too modest in emphasizing her own role in bringing about a change of direction in this area. She has promoted a tremendous upgrading of the activities in the Department of State in the demand reduction area.

She also didn't tell quite the whole story about how Mr. Retka got down to the State Department. Let me fill in the details: Dr. Peter Bourne, the President's adviser on human needs, was the person who really put the finger on me and said, "You have got to send somebody down there to the State Department to help out." This directive was given at one of the principals meetings we have every 2 weeks at the White House. At first I was a little skeptical because Mr. Retka is one of NIDA's most talented and productive employees. A sensible manager doesn't willingly give up his best employee to some other agency! But I have been converted to Dr. Bourne's point of view. Bob Retka has done a superb job working as a liaison between NIDA and the State Department. He has really upgraded the collaborative program in a dramatic way.

I must also emphasize the indebtedness we all have in this area—as in many others to you and Mr. Gilman for your persistent support for international demand reduction activities.

Recognizing how far we have come in the last year, we must also recognize that we are still at the very early stage of developing an international demand reduction program. It is with pride, satisfaction, and pleasure that I can point to the achievements that have been

made, particularly in the last year. But also as Mathea has pointed out, we are aware of how small our international demand reduction program really is, and how much greater the opportunity is for future development.

I have spent some time at a very popular game in Washington: Finding devils. Whenever there is a problem, we try to figure out who the culprit is, who to blame. And I have considered several candidates over the last several years for why our international demand reduction has not grown faster and stronger. In reflecting on this problem, I have become convinced that the problems aren't "people," so much as they are reflections of structural and programmatic realities that are very difficult to overcome.

Let me point out just a few of these problems.

One is the relatively low placement of NIDA within the HEW bureaucracy in contrast to the situation at DEA, Customs, and Mathea's office in the State Department. Those offices each have immediate access to their Cabinet officers, and have a much better capacity to respond to major changes, and particularly to international activities.

This is compounded for us by the fact that HEW traditionally has had a relatively low international profile and a fairly low investment in international activities, except for a very modest, but important, relationship with the World Health Organization in some research activities.

Mathea also referred to the issue of staff. Let me point out that NIDA is a very different kind of organization from DEA and Customs. Although NIDA has a budget that is on a par with theirs—a very large budget—we have a very small staff. We have just under 400 people to carry out all the activities of NIDA. One hundred of our NIDA staff are devoted to intramural research. So all of our extramural activities and all of our studies, grants, contracts, and all the rest, are carried out by 300 people. This contrasts with Customs' 14,000; and DEA's 4,000.

To find slots to divert to international programs in an organization of many thousands is relatively easy; whereas, in an organization with a relatively large budget, and a small staff, it is remarkably difficult.

In addition—and this is something Mr. Retka has helped me see—the international demand reduction programs we are developing are labor intensive. They are very different from programs we have in the supply reduction area which tend to consume larger blocks of money. They are typically relatively easily negotiated in hundreds of thousands, or even millions of dollars. By contrast, it takes an enormous amount of energy—perhaps half a man-year—to spend $100,000 in a demand reduction program.

It is a lot more difficult to buy human power, the activities that are involved in demand reduction, than it is to buy helicopters.

All four of these factors have been underestimated. At least they were underestimated by me in the past as sources of the frustration that we have felt.

Now in terms of what can be done about this, this committee can be enormously helpful. It can reemphasize the urgency of balancing our international drug abuse prevention by bringing a greater emphasis to the demand reduction side of the program.

I know it may sound a little strange, but I think you will appreciate this. I really think that legislative action, making this point, is probably going to be essential to getting the bureaucratic wheels turning. That will probably involve, or require, a change in the mandate for HEW, if not for NIDA, and some impact on the budgetary process.

Now we must be clear that this is not a big problem in that we don't need hundreds of new employees, and millions of new dollars. But we do need a clear signal that will have to emanate from the legislative branch. Although there is always a possibility the executive branch could do it. I am a little skeptical about that, but possibly it could occur.

We need from either the legislative or the executive branch a signal which says there will be, let's say, a 10-person staff at NIDA devoted to international demand reduction activities with a substantial budget of $2 million, or $3 million, devoted to these activities.

If we had that, we at NIDA would be in a position to be much more supportive of what Mathea and the State Department are doing.

The real problem is not in the State Department; I think it is with us. But NIDA cannot make those changes without that clear signal.

It is through their own demand reduction efforts that other countries are going to make the commitment of their own resources and their own energies in dealing with the drug problem. That is essential to America's international efforts in the general drug-abuse prevention field.

Many countries—and you know this was also true in this country—can go for years, and years, and years with a serious drug abuse problem, and simply ignore it, deny the problem. This is the case in many countries around the world today.

It is not the case in Thailand or Burma or Hong Kong or Iran. There are a number of countries in which this is no longer the case. But the general pattern is one, still, of denying the problem and not committing one's own national resources to solving it.

Through training programs—the kind that DEA and Customs have had for years, and which we are now starting—through technical assistance programs, through very-modest-in-terms-of-cost demonstration programs, I think we can stimulate these activities on a global basis.

This policy goal has been clearly articulated by Ms. Falco and Dr. Bourne, among others. It is now a matter of putting the muscle behind it. Mathea, again, has understated her own important role in terms of forming relationships between her office and HEW, principally with Mr. Meltzer and Dr. Klerman, that will help bring about these changes.

In conclusion, let me say that this has been one of literally a handful of my top priorities in the last 3 years. It is with very mixed feelings that I come to you and describe where we are. We have made progress, but we still have a very, very small effort. Our current efforts in this area of international demand reduction fall far short of the potential in this area.

Thank you, Mr. Chairman.

[Dr. DuPont's prepared statement appears on p. 194.]

Mr. WOLFF. Thank you very much, Dr. DuPont and Ms. Falco. I want you both to know that I am very much aware and appreciative of

both your efforts in the area of demand reduction. I think it is important to understand that there has been close cooperation between your offices and ourselves, and it is appreciated by this committee.

You know, we have been working now for almost 2 years on a "Congressional Resource Guide" which has just been completed. And it has been a monumental task. Our staff is to be congratulated on the work that it has done, because it is the first time that all of the various agencies of Government have been put together into one—it is a small volume. I thought it was going to be much more voluminous than this, but it gives us an idea of magnitude and those agencies that are involved in the various processes and programs of Government, their history, and the funds that they have authorized and their allocation.

Now, I asked—and I was able to get for the first time very quickly, within a period of minutes from counsel a list of those agencies that are involved in international demand reduction. And I have before me State, NIDA, Public Health Service, ADAMHA, Agriculture, Army, Air Force, DOD, Justice, LEAA, DEA, and the Center for Disease Control, all involved in the question of international demand reduction.

Ms. FALCO. Agriculture?

Mr. WOLFF. Yes.

Ms. FALCO. What do they do? That is interesting.

Mr. NELLIS. The book will tell you.

Mr. WOLFF. Let me have my staff look and read it to you from this reference book the committee has prepared, because I think it is important.

Ms. FALCO. Crop substitution?

Mr. WOLFF. Crop substitution is not demand reduction. But under any circumstances, let's just come down to one element. I do know that you have help from DEA and State. You have help now from Dr. DuPont's organization. What other agencies?

Ms. FALCO. Customs.

Mr. WOLFF. There are other agencies that do not interface with you, obviously.

Ms. FALCO. We interface in a different context. The three primary agencies have assigned full-time liaison officers who are physically present in our office every day.

Mr. WOLFF. The point I make is: I would like to know whether NIDA itself is engaged in any overseas demand reduction programs.

Dr. DUPONT. Oh, yes; we are.

Mr. WOLFF. You are?

Dr. DUPONT. We have an office which is devoted to international activities. Dr. Jean Paul Smith, who is sitting right behind me today, is in charge of these activities at NIDA. We have three professionals in his office who are devoted full time to this area. NIDA spent $1.3 million in international demand reduction programs last year.

Mr. WOLFF. What is it that your office does in this connection?

Ms. FALCO. Under the foreign assistance legislation which provides our appropriation, we are empowered to give assistance to foreign governments and international organizations, only. The projects which I have described in my testimony and which, in this fiscal year, we hope will reach $1.1 million, are not the projects to which Dr. DuPont is——

Mr. WOLFF. Well, why? Why does it need two agencies to accomplish this?

Dr. DUPONT. There is a different emphasis in the two areas, although there are areas where we do share an interest.

We, for example, do research, and the State Department does not fund research activities. Research constitutes about half of our international program.

Mr. WOLFF. Overseas?

Dr. DUPONT. Yes; so that is one area where there is not an overlap but a complement.

There are other areas where there is much more of a sharing. For example, we have a project that we have funded through the World Health Organization to study the treatment of rural opium addicts in Southeast Asia.

Mr. WOLFF. You are primarily a domestic agency.

Dr. DUPONT. Yes; this area involves $1.3 million out of our $260 million annual budget.

Mr. WOLFF. Why wouldn't that be coming through the service office? How do you delineate which office handles the project?

Ms. FALCO. Usually, it is not a problem. The problem is developing viable programs.

Mr. WOLFF. The problem, though, Ms. Falco, for a moment, is that we do not find this unusual. We find that there is generally—I am happy to see that you have somebody in your office, for example, from NIDA, because this indicates a degree of coordination. But the biggest problem that we have had in the entire drug effort is a lack of coordination between departments.

In other words, I don't see why there is this fragmentation.

Ms. FALCO. There is no need for it; I think it is historical.

I was willing and indeed eager to spend some of my appropriation on demand reduction.

Mr. WOLFF. Why would you need the appropriation? Why wouldn't the appropriation be over there?

Ms. FALCO. They don't have it. You don't have the money, do you?

Dr. DUPONT. No.

Mr. WOLFF. Why isn't it requested, then?

Ms. FALCO. I don't know, Mr. Chairman.

Dr. DUPONT. First of all, in terms of coordination, our staffs are in very close collaboration. There is no activity that NIDA is doing internationally that the State Department is not aware of, and vice versa.

So, in terms of the programmatic content and the operation of these programs, unlike many programs you will find around the Government where there is simply no knowledge of what is going on, our programs are well coordinated.

Mr. WOLFF. But you require two staffs in order to do this.

Dr. DUPONT. We have three people, and they have one.

Ms. FALCO. Who was yours?

Dr. DUPONT. Who was really ours? It is such a tiny amount of staff, we just don't——

Mr. WOLFF. I don't see why two agencies have to do this. That is all I am saying.

Dr. DUPONT. Because there is a different emphasis in the two.

Mr. WOLFF. You now have all of the AID functions under your jurisdictions; do you not?

Ms. FALCO. Yes. sir.

Mr. WOLFF. With all due respect, I don't know whether it is a step forward, or a step backward. I think it is a step forward, because it does represent some coordination. But if we are going to have this continuing fragmentation in other agencies, what we are going to do is continue to have duplication and added costs.

Dr. DUPONT. Mr. Chairman, would you seriously propose that either the State Department or DEA get out of the international supply reduction activities? Do you feel there is a duplication there?

Mr. WOLFF. I don't see why two agencies are running programs. I would prefer to see as, for example, with DEA's operation with the State Department, they do the entire program overseas, but it is coordinated through the State Department.

Dr. DUPONT. That is the same. We have the same relationship. There is no difference.

Mr. WOLFF. Do you have to go through the State Department in order to——

Dr. DUPONT. Anything that happens overseas must be handled by the State Department in one way or another.

Mr. WOLFF. Work out your program——

Dr. DUPONT. Sure.

Mr. WOLFF. With multilateral international agencies?

Dr. DUPONT. Our NIDA situation is the same as DEA's. The only difference is that DEA actually has people overseas; we don't. DEA has a much larger and older program overseas. While it might be attractive on a theoretical level to have only one agency in the Government doing one thing, from a practical point of view we would have an enormous loss if we were to say that NIDA should not do any international activities at all, or if we at NIDA said that the State Department should be out of this area.

I think either of those would be less attractive or effective than what we have. We need both agencies. As long as their programs are complementary and coordinated, I can see no virtue and much risk in consolidation.

Mr. WOLFF. Well, I think the State Department should be out of some of the activity and the agencies that are particularly qualified to engage in those operations be permitted to engage in their own operation.

Dr. DUPONT. We would be dead without the State Department in the international community. DEA is a different matter. That might be a viable possibility for DEA.

Mr. WOLFF. You are not interfering with international relations at all.

Dr. DUPONT. We don't have a substantial, experienced, international staff. We don't have the expertise. We would be just lost in trying to cope overseas without the State Department as an active partner.

For example, the Bangkok treatment program Mathea talked about earlier in the hearing. To negotiate that and work that out in Bangkok absolutely required the State Department to be involved. Even with

that help, it took 2 years to fund that project. We have no prospects of having overseas agents of NIDA to negotiate such arrangements. We are dependent on the State Department to do that.

Mr. WOLFF. But getting back to this point—and I will yield after this—on demand reduction, I do know that, Mathea, you have had great experience in the area yourself.

Ms. FALCO. Yes.

Mr. WOLFF. And the treatment area, particularly.

The big point, however, is that you indicate you don't have anyone on the staff. They are loaning you someone now——

Ms. FALCO. That's right.

Mr. WOLFF [continuing]. In order to help.

I might see, in all of this, an attempt—and this is not your office—the State Department itself having a desire to increase their authority, again. This committee has found that the greatest difficulty it has had over the years has been the question of the State Department's international relations getting in the way of the actual facilitating of various programs.

You have done a yeoman's job of stripping away some of that, but the important element is the fact that it is still present. And I think if we are going to talk, now, about something that is as humanitarian as treatment and demand reduction, I don't see where the State Department has to intervene.

Ms. FALCO. Let me just clarify, Mr. Chairman, that the reason we got involved in demand reduction when I came on is that I thought it was very important to allocate some of my own appropriation to that activity.

To my knowledge, the State Department and its embassies abroad have never in any way intervened against the demand reduction program.

What I was trying to stress earlier was that the limiting factor is developing programs. And since the State Department does not have that expertise either in Washington or in the embassies abroad, and since many of the countries in which these programs would be useful do not themselves have the expertise, it is very, very tough and labor-intensive to get programs going.

I think Bob and I agree completely. I have no objection at all to having NIDA or HEW do the job. I do stress, however, that if you are going to do that, if you are going to take part of my foreign assistance appropriation and put it over in NIDA, it is important, then, to make sure that NIDA is itself elevated to a viable level within a very, very large bureaucracy.

Mr. WOLFF. One final question of both of you. We have found that where there is an increase of an availability and increase of local addiction, there is a greater opportunity for us to work with these governments who are experiencing this problem than if they are not infected with this problem themselves.

On that basis, I take it you agree—or don't you?

Dr. DUPONT. Absolutely.

Ms. FALCO. Yes, we both do.

Mr. WOLFF. What is the situation today that you have found, so far as Europe, so far as Asia, so far as a place like Mexico where we have

the big problems of supply? What is the situation? Is there a much greater—or is there a great increase today taking place in those areas in the way of local addiction?

Ms. FALCO. I mentioned earlier, Mr. Chairman, that is definitely true of Southeast Asian countries. And I think that is one of the major reasons that we have seen improved control efforts in that region of the world in the last few years.

Mr. WOLFF. How is it, "only recently"? Opium has been around for years.

Ms. FALCO. Epidemiology. Intravenous heroin.

Mr. WOLFF. What do you say, Bob?

Dr. DUPONT. One of the most fascinating questions right now in the entire drug abuse prevention field is the question of this global drug abuse epidemic. It is fascinating, for example, to see that the Bangkok heroin addiction incidence and the relative incidence in Los Angeles and Atlanta and New York City and Tokyo, and perhaps all show a similar epidemic peak in the last decade.

You could say, as some have, that the Southeast Asian peak relates to the Vietnam war and the American troops who were stationed over there. But that war cannot explain the similarity that exists because it has occurred in nations unrelated to the war, too.

In a country like Iran, which had absolutely nothing to do with the American activities in Southeast Asia, you see the same relative epidemic curve of illegal drug use over the last decade as you see in Paris or Naples or South America. There has been a global epidemic that has taken place in the last decade, and it is, in most of the world, continuing.

Today it is an absolute certainty that this is happening in countries all over the world, regardless of their political and economic structure.

Mr. WOLFF. How do you account for it?

Dr. DUPONT. I don't know. There are some hypotheses but new research will be needed to answer the question—the question which I consider to be the most important unsolved mystery in our field. One characteristic of the modern world is increased personal choice including increased travel, increased communications, and increased "consumption." Whatever the politics of a modern nation, this revolution of personal choice is going on. And it is going on just as traditional controls on individual behavior are losing their grip—traditional politics, cultural, and religious cultures.

We are also much more involved with each other around the world now than we ever were before. These changes have fostered, along with much goods, the drug abuse epidemic.

Most of the drugs that are being used—not all—have been around for a long time. It is as if there were possibilities of use of these drugs which have been in existence for generations, and in some cases, millenia, but people have only now traveled outside of those old constraints of geography and culture to try drugs.

The typical pattern is for first use to occur among the better educated, urban youth. In the United States, and I know you held a hearing about minorities, some drug use has spread through the poor and through the unemployed. But, globally, this pattern has not been for the poor to first adopt a new drug, but the most mobile youth.

The initial spread of the "infection," if you will, is often through the students, the affluent young people who are involved in international travel and the spread of new ideas and new behavior. So today you see this spread, whether it is marihuana use, or heroin use, or cocaine use occurring globally.

Cocaine, you know, has been used in the United States for several generations—but on a small scale by isolated, unconventional groups. Today its use is far more widespread. Europe, too, is now experiencing a big increase in cocaine use. And, of course, Latin America is, as well.

The United States has made a major investment in drug abuse prevention during the last decade that far exceeds that made by any other country in the world. Because of that, I think we are in a much better position to deal with this problem in our country than are these other countries—particularly the less developed countries. We are going to see, over the next decade, very big increases in those countries, too.

Now you may ask, "Why don't they react?" Why doesn't a country like Mexico, for example, react more strongly to their domestic drug abuse problems?

Here, you have to realize that even when drug abuse is a big problem, it still involves a relatively small percentage of the total population. Particularly in the less developed countries, the capacity to identify any problems within their populations is very low. Even with this country, the heroin epidemic was well underway before there was any definitive indication of it.

I myself worked in the District of Columbia Department of Corrections, for example, in 1968. And we had an executive staff meeting at which nobody in that executive staff perceived there was a serious problem with hereoin addiction in the city.

Well, a year later, we finally couldn't overlook the problem anymore. It wasn't that there was a conscious effort to deny it; it just wasn't noticed in the midst of all the other, more familiar problems.

In our international demand activities we have to help these other countries develop their own technology to identify their illicit drug abuse problems as they are happening so they have the capacity to do the trend analysis necessary to know that they have twice as many users of "drug x" this year as last year. Once they have that capacity, they will be far more likely to respond appropriately.

Right now one vital area which you mentioned, Mr. Chairman, is Europe. And I am convinced that Europe is experiencing a major illicit drug abuse epidemic, particularly with intravenous heroin use, but not limited to that, and that the European nations are not responding adequately. Their resistance has to do with politics and history and culture. But we should stimulate them to start doing something more. I note that Germany is holding a major conference on drug abuse in August to look at this. That is a hopeful sign.

We, jointly, with State Department funds and one of our experts, went over to Berlin to help them deal more effectively with their problem.

But to return to your initial question of why this drug abuse epidemic happened in this last decade, we are left with hypotheses. One of them which I think is important relates to the effect of the Second World War and its effect on fertility rates in the developed countries, particularly Europe and the United States. Improved health in the

less developed countries over the postwar decades, like the postwar fertility boom, has made a worldwide bulge in the most vulnerable age populations. We've had an unusually large crop of teenagers globally during the last decade. This increase in the vulnerable population has surely contributed to the epidemic. These increases in the youthful population in the last decade have provided the "tinder," if you will, which has been ignited in this global drug epidemic.

Mr. WOLFF. Thank you.

Mr. Burke?

Mr. BURKE. Thank you, Mr. Chairman.

Dr. DuPont, just let me make a few statements. A year ago, Mr. Gilman and I and several other Members of Congress who were members at the time of the Mexican-American Parliamentary Group, talked to the parliamentarians in Mexico. They had agreed to a document which we would like to call the Hermosillo document, whichever it might be, in which they agreed that they had a problem.

For years, they didn't recognize it; but they would immediately take some action and try to halt, at its inception, the growth of the poppies. Yet, you said now, just a minute ago when you made your statement, that they didn't recognize it.

You mean, in the last year? Or——

Dr. DUPONT. There has been a big improvement in the Mexican recognition of the drug abuse problem and in their response to it. This committee, and particularly the chairman and Mr. Gilman, deserve much credit for this change. I had the pleasure, in one of my first experiences with the two of them, in Mexico of watching them do their magic. Mexico has changed, but there is still a ways to go, especially in terms of their recognition of their domestic heroin problems.

For example, in Culiacan the mayor petitioned the Central Government to stop the heroin traffic, even though it was enormously lucrative. This happened during their last presidential campaign, a year and a half ago. The Culiacan mayor made his plea based not only on the criminal violence which had characterized the city, but because so many local youths were becoming addicted to heroin.

But there is still a way to go—and Mathea can correct me on this. Mexico's official position in terms of heroin addiction is still that it is an American problem. They recognize their heroin trafficking problem but not their problem with heroin addiction. They are denying they have this problem except along the U.S. border. That is unfortunate because they do have a heroin addiction problem, and it is serious.

Mr. BURKE. Doctor, at the time we had those hearings at the time of the Hermosillo declaration, they admitted they had a problem. And the problem was getting more acute.

In addition, they admitted to the fact that, as a humanitarian operation alone, they should participate in the world attempt to stamp out drugs becausee of the damage it does throughout the world.

So I am a little disappointed because the statements that you made about them, saying it "was not their problem" was what they said 2 or 3 years ago, but not following on the Hermosillo declaration when they admitted they not only had the problem, but they wanted to participate because of the world problems created by drug export.

35-070 O - 79 - 11

One other thing. You know what the Mexican Government does with those that have been named as international drug exporters, heroin exporters?

Dr. DuPont. No.

Mr. Burke. Have they taken any action, do you know—criminal action—against them?

Dr. DuPont. They have done a good job. Mathea, do you want to talk about that?

Ms. Falco. Are you talking about prosecution of traffickers?

Mr. Burke. Yes.

Ms. Falco. The record has been mixed. The Government has proceeded against some, but not as many or as rapidly as we would have liked. The DEA has a program called JANUS, a cooperative judicial program, with the Government of Mexico. And they have presented a number of cases to them for prosecution this last year.

As I said, they have taken action on some, and for a variety of reasons, have not taken such action on others. Mr. Burke, just for my own clarification, in the Hermosillo declaration, you were indicating they did recognize they had a problem?

Mr. Burke. Yes.

Ms. Falco. They have indicated to me that they recognize that opium cultivation and heroin trafficking are very severe problems for them for all kinds of reasons—internal, as well as external reasons. And they have been very good in their eradication efforts against the poppy.

Dr. DuPont knows much more about drug use patterns in Mexico than I do. But my conversations with Mexican officials have indicated to me that they feel that marihuana abuse is a primary drug problem among their own citizens.

I have not heard them talk about heroin addiction problems that their own citizens have.

Mr. Burke. Well, they talked to us about it. And there are Mexicans over there that are addicted to heroin.

Ms. Falco. I believe you. I am sure there must be.

Mr. Burke. Let me ask, on a different subject: What criteria, Ms. Falco, do you use to select countries for international demand reduction programs? And why specifically did you take Ecuador instead of areas like Peru, or Paraguay, or some of the other ones where it is actually grown in those areas? Ecuador is only a corridor, more or less.

Ms. Falco. I asked that myself, Mr. Burke, when I came into this job. Why Ecuador? Because at that time, it was the only demand reduction program we had funded anywhere in the world.

And the explanation was historical. That is, the Embassy staff several years before had been particularly interested in the demand reduction area, as had various officials in the Ecuadorean Government. And they had submitted a proposal for a drug-awareness program in Ecuador, and that had been funded. That is the only program I inherited.

I think it is great.

Mr. Wolff. Would the gentleman yield?

Mr. Burke. I will be glad to yield.

Mr. Wolff. Coming back to that, I don't think that is really the entire history.

Ms. FALCO. I am sorry. That is what I learned. I suspect you were there.

Mr. WOLFF. Wasn't there a situation that developed between a promise that was made?

Ms. FALCO. In Ecuador?

Mr. WOLFF. In Bolivia.

Dr. DUPONT. Bolivia.

Ms. FALCO. Bolivia's $45 million for crop substitution, but that is Bolivia.

Dr. DUPONT. Mr. Kissinger talked about $45 million for crop substitution in Bolivia, whereas we are talking today about a demand reduction program in Ecuador which costs $50,000. Note this contrast in scale: $45 million versus $50,000. That captures the contrast between international supply reduction and international demand reduction.

I had a chance to visit Ecuador, Peru, and Bolivia 2 years ago. I can confirm what Mathea just said. The Ecuador demand reduction program is a single U.S. Government employee in Ecuador literally turning this country to its drug abuse problem. This small project is but one manifestation of his good work.

One person got the whole blooming Government turned on down there. They have done a beautiful job with the small amount of money. We have gotten people all over that country turned on to demand reduction activities. It is one of our absolutely best activities. It will pay us dividends in terms of the potential for Ecuador as a supplier, too. They really have got the message down there that drug abuse is not only an American problem—it is also an Ecuadorian problem and this helps us in many ways.

Mr. BURKE. I just wondered if it wasn't partly because of the oil that Ecuador moved in a certain way.

Dr. DUPONT. In this case it was one fellow who got an idea and turned it into a reality.

Mr. BURKE. At any rate, we have people in Peru where certainly they chew the coca loaf, and they have done it for years. And they export the coca leaves, or even the final product, down through Ecuador to Colombia. So I would think the problem would be more the movement throughout Ecuador, rather than the problem of use.

And if you talk about "use," the use certainly is in Peru. I don't know what it is, but I wonder if you could, for the record, give us the amount, if you have them, or there is a way of getting them, of addiction, for instance, in Colombia, Mexico, Peru, Chile. Those particularly, I would like to know.

And if possible, maybe those in Thailand, also.

Dr. DUPONT. We have some of those through the U.N. Commission on Narcotic Drugs from which there is an annual report, and we would be happy to supply those.

The others, we may have to make some very crude estimates but we will be happy to do that, Mr. Burke.

Mr. BURKE. With your permission, Mr. Chairman.

Mr. WOLFF. OK.

Mr. BURKE. Also, Dr. DuPont, you mentioned NIDA's part in research.

Specifically, who determines what the research is to be and what it is, and where it is done?

Dr. DuPont. Most of our international research is funded through the grant mechanism. It participates in the general HEW research grant program which, as you may know, Mr. Burke, is an investigator-initiated program.

So the Government does not decide that it wants to do research on question X in country Y. Some investigator, some scientist, proposes to do a specific research project and submits that for funding. His proposal is reviewed by a group of scientific experts for scientific merit, and is given a priority score. And if it is high enough, it will be funded.

Now for international research activities, however, there is an additional test that is applied. The proposed project not only has to meet the requirements for research excellence and for relevance, but the investigation must be able to show that the research can be carried out only in the international setting and that it cannot be done in the United States.

If the research proposal meets all those tests, we fund it. Virtually all of the research that we are talking about has gone through that tough process.

An example of NIDA's international research is our study of chewing in both Bolivia and Peru. We have very small but important research projects studying the impact of coca chewing on the Andes Indians.

Mr. Burke. But if I might interrupt, that seems to me to be a waste of money, because there has been research done on the chewing of coca leaves in the Andes from the time of the Incas and all the rest of them.

Dr. DuPont. Very little research has ever been done. Even an issue of knowing what the dose is that the people are exposed to has not been well studied.

Mr. Burke. What has the chewing of coca to do with cocaine, really, of the final product which takes refinement through the chemical end of it with some real intelligence, rather than just chewing coca leaves because the Government doesn't want to feed them?

Dr. DuPont. First of all, the investment is small. I would agree, such a question would not merit a major investment. The two projects together probably don't total $100,000 a year. It is not a big investment, but it is important, from our point of view.

We are talking about populations that are exposed to cocaine. The major psychoactive substance in the coca leaf is cocaine. The difference between U.S. cocaine use and Bolivian coca leaf is that the leaf delivers a lower dose level of cocaine over a long period of time.

It is important for us to know, given the use patterns in the United States, if there are any serious consequences from lower level, chronic exposure. It also is important for us to know what the cultural controls are which limit the use of the coca leaf in the Andes.

For example, what is the pattern of socialization into coca-leaf chewing? It appears that coca-leaf chewing is almost a rite of adolescence in these Andes families. They begin chewing it a little bit like our youth in the United States begin use of coffee and, also like coffee, coca-leaf chewing is associated with work and not with relaxation or recreation.

In any event, it is important for us to know some of the rudiments about that. It seems to me possible that we may see coca-leaf chewing in

the United States before long. There are a number of people who have talked about this, and I think it is important to know what there is to know about it.

One other point—and Mathea could speak on this as well—there is at least one American researcher who is interested in learning more about the potential therapeutic uses of coca-leaf chewing in the United States. This is similar to our interest in the potential therapeutic uses of marihuana and heroin in the United States.

It is easy, I think, to mock these research activities, but we do have a real and important interest in knowing more about patterns of drug use around the world for purely selfish reasons, in addition to our commitment to contributing to the general fund of knowledge and encouraging those countries to know more about it as well.

Mr. BURKE. I can appreciate that, but I sometimes wonder.

By the way, who gets these reports?

Dr. DUPONT. They are made public as is general research, in addition to which we get formal reports for use in our official publications.

Mr. BURKE. It has been of interest to us.

Dr. DUPONT. In addition, of course, the results of this research are published in the scientific literature so that everybody has access to it.

Mr. BURKE. Are any of these funded through the United Nations?

Dr. DUPONT. Some are and some are not. For example, I mentioned the conference on the treatment of rural opium addicts which NIDA has funded through the World Health Organization.

Mr. BURKE. Mr. Chairman, we have a vote on the floor.

Mr. WOLFF. Yes; we will have to go into recess for the vote, and then we will resume.

[Whereupon, a recess was taken.]

Mr. WOLFF. The committee will come to order.

Before we recessed, we indicated something about the Agriculture Department. And I don't know whether or not during the recess you have had an opportunity to look at our Congressional Resource Guide, but I might tell you, or inform you, that according to the information we have here, through the Extension Service of the Department, education programs and the like, the Extension Service has developed drug-abuse programs in order to educate acceptable young people in the incidence of abuse. And it includes overseas activities, as well as the 4–H Youth Development program, which includes activities overseas.

Counsel keeps pointing to "crop substitution." Although I can see a fairly obtuse relationship, I do believe that this is more toward supply reduction than demand reduction, but he does have a point. When you reduce the supply, you reduce the demand. So there is something to that.

The Chair recognizes Mr. English.

Mr. ENGLISH. Thank you very much, Mr. Chairman.

Ms. Falco, we have had some hearings with regard to drug abuse in the military, and the question of Western Europe—particularly Germany—has arisen. The committee has received information from DEA to the effect that there was a great deal of the heroin that went into West Berlin and West Germany—in fact, in excess of two-

thirds—came through Communist countries—at least, were routed through there. And evidently, it was provided safe passage since, as far as we know, there are no risks.

You may have some information on that. If you do, I hope you will present it to us.

But the question that has arisen with regard to that is that the route seems to be through West Berlin, and then, as I understand it, there is pretty much safe access. In other words, from those sources made into West Germany and, in fact, all Common Market countries.

Could you go into it to some degree and explain to us exactly what the process is from, say, one of these Turkish laborers—which I think is at least credited with being with the group of individuals who use this route—how the Turkish worker comes from East Germany, East Berlin, and then on into West Germany, and what the safeguards are as far as attempting to intercept any individual who may be a courier?

Ms. FALCO. Yes, Mr. English.

After hearings of this committee—I think that General Fitts from the Defense Department was here testifying—we received a number of press inquiries on this subject. I had been aware, of course, because we work very closely with DEA, of this increasing problem of couriers, particularly Turkish nationals, although all kinds of foreign laborers——

Mr. ENGLISH. Yes, laborers.

Ms. FALCO [continuing]. Coming from other countries.

There are very cheap charter flights which make flying to West Berlin through Schoenfeld Airport in East Germany much cheaper apparently than other modes of transportation.

The afternoon after your hearings were finished, I talked to the European Bureau Deputy Assistant Secretary, who was then acting as Assistant Secretary, about this.

And I said, "It seems to me that this is a very sensitive area that you have really got to get involved in." And they did. The response that we have gotten back from our Embassy in Germany is that this is an issue, as Bob mentioned earlier, which is of increasing concern to the West German Government. The sensitivity of Berlin. I am sure you have heard a great deal about.

Part of the problem is the particular status of Berlin. The wall between West Berlin and East Berlin is not recognized as an international border by the Western Powers where regular customs searches, for example, would be appropriate.

However, our officers over there are apprised of your very real interest in this problem. Most of this action is handled by the European Bureau, and I think that is really where they have got to work it out.

Mr. ENGLISH. The thing I am most interested in is: Can you—you say these guest laborers fly in with charter flights?

Ms. FALCO. To Schoenfeld Airport in East Germany, just outside Berlin, then they come across to the West.

Mr. ENGLISH. Once they cross that border, is there any type of check made—anything similar to our customs check?

Ms. FALCO. No; the reason for that is because the wall is not recognized as legitimate. It is not a "border."

Mr. ENGLISH. You are talking about their wall? Or the border?

Ms. FALCO. The wall between East Berlin and West Berlin which separates the eastern sectors of Berlin from the western sectors.

Mr. ENGLISH. The so-called Berlin Wall. What about it? That, of course, is not on the side of jurisdiction of the Western Powers. Is that not correct?

Ms. FALCO. This is all, for me, secondhand knowledge—the Western Powers do not recognize that as an international border. They have never recognized the wall. I mean, they see it, Mr. English, but they don't recognize it.

Mr. ENGLISH. I know, but it seems to me——

Mr. WOLFF. If they had recognized it as a wall at the start, maybe it wouldn't be there, now.

Mr. ENGLISH. It seems to me that I have heard, over the years, about "Checkpoint Charlie," and all kinds of checkpoints in there.

Ms. FALCO. Checkpoint Charlie is the Allied installation on the western side of Friedrichstrasse crossing point between the eastern and western sectors of Berlin which is one of a number of places where persons enter West Berlin. There are no regular customs searches, Mr. English. That is correct.

Mr. ENGLISH. What happens at, say, Checkpoint Charlie, and some of these other checkpoints along the border?

Dr. DUPONT. I believe Checkpoint Charlie governs access from West Germany through East Germany into Berlin.

Mr. ENGLISH. You are saying the only checks that are made are whenever they are going into East Berlin, and not when they are coming from East Berlin, or East Germany into the West? Is that correct?

Ms. FALCO. Allied personnel entering or leaving the eastern sector are briefed at Checkpoint Charlie as are civilian travelers who request assistance. No regular controls are imposed by the Western authorities on civilians.

Mr. ENGLISH. And I would assume—is the same true on the Communist side?

Ms. FALCO. The "Communist side"? You mean, East Berlin?

Mr. ENGLISH. Yes. Do they check? Do they make checks of people who are coming from the West into the East?

Ms. FALCO. Yes; they make sure they have the right kinds of papers, but——

Mr. WOLFF. If the gentleman would yield, there are no customs checks at the border. There are personal checks of the individuals going through.

Mr. ENGLISH. Check your papers.

Mr. WOLFF. But no customs check, because there is supposed to be free access to both areas of Berlin. We do not recognize a divided city.

Mr. ENGLISH. So in effect, what you are saying is: The Communists have the Berlin Wall, and they make their checks of people that are leaving East Berlin, going into West Germany. And the United States has their Checkpoint Charlie to check papers of people who are going from West Berlin into East Berlin, and nobody really checks who is coming into their country. They are only concerned about who is going out. Is that correct?

Ms. FALCO. I would reiterate the chairman's point: There are no regular customs checks, in terms of contraband goods made by the Allies or West Berlin customs officials.

Mr. ENGLISH. I recognize that. But the point the State Department is making—or that you just got through making—is: First of all, we don't want to recognize the Berlin Wall, which is on their side, which is on the side of where there is Communist authority, let me put it that way.

The second point is that the United States does have checks.

Ms. FALCO. The Allied authorities monitor travel by Allied personnel and some random customs checks are made by the West Berlin customs authorities on civilian travelers.

Mr. ENGLISH. And they do check people who are leaving West Berlin going into East Berlin.

Ms. FALCO. They do not impose any controls on civilian travelers going to East Berlin.

Mr. ENGLISH. And they check the papers. What is the difference between doing a customs check and checking an individual's papers?

Mr. WOLFF. If the gentleman would yield again, the United States does not maintain any check there. It is maintained by the German police. The United States is part of a tripartite administration of West Berlin, and actually the United States has no role in the checking of people coming back, except as a part of the Allied group that is responsible for the administration of the area involved.

Mr. ENGLISH. OK; does the State Department, then, have any objection to the West German Government, or whoever is running those checks, to doing a customs-type search of individuals coming in?

Ms. FALCO. Because of the very important position of the western allies that Berlin is one city under four-power control we have been careful to avoid imposing controls on persons crossing the sector boundary between East and West Berlin. We would not wish to institute any kind of regular controls which would resemble international border controls.

Mr. ENGLISH. It would appear to me this is a source—and an increasing source—of supply coming through into this country. From what we can determine from what you have told me here today, there is absolutely no check made in an attempt to intercept those drugs coming into West Berlin and into West Germany. And under those circumstances, you are also telling me that the West German Government is the one who is, in effect, running the checks of papers. Is that correct?

Ms. FALCO. West Berlin, not the West German Government, officials perform the usual customs and immigration controls on persons arriving in West Berlin directly from places outside of Germany. Only random customs checks which include examining travel documents, are made on persons entering West Berlin from East Berlin, however.

Mr. ENGLISH. But as far as the State Department is concerned, they would have no objection, and there would be no difficulty from a diplomatic standpoint, for the West Germans to also do a customs-type check at the same time they are checking papers. Is that correct?

Ms. FALCO. Neither we nor the West Berlin officials regularly check the papers of persons entering West Berlin from East Berlin. We and

the other western allies do not wish to do anything which would give the appearance of creating an international border between West and East Berlin.

Mr. ENGLISH. There is one other point I would like for you also to check while you are doing it.

Would you see if anyone within the State Department, this Government, has encouraged the West Germans to carry out such a program? Has there been any discussion about that program? Has there been any inquiry from the Department of Defense, or U.S. commanders in Germany for such a search being made?

I think these are extremely important issues.

Ms. FALCO. I can say, Mr. English, that I have met personally with the West Berlin chief of police when he was here. We have worked very closely with West Berlin officials on their developing concerns. Even in the year and a half that I have been in Government, they have been coming to grips with the facts that they have a very serious problem.

As to the DOD inquiry, I don't know.

Mr. WOLFF. We will stand in recess, unless—are you going to pursue your questioning when you come back?

Mr. ENGLISH. I would like to, sir.

Mr. WOLFF. If you don't mind, we will stand in recess.

[Whereupon, a recess was taken.]

Mr. ENGLISH. Ms. Falco, if you would, could you elaborate with regard to the situation as far as the knowledge that you have with regard to the situation in West Berlin and West Germany, and exactly what the status is there?

Ms. FALCO. Thank you, Mr. Chairman.

As we were discussing before the brief recess, West Berlin, under the quadripartite agreement, does not exercise any direct legal authority. The United Kingdom, the French, and the United States jointly administer the area.

Earlier, I indicated that there was a reluctance on the part of the governments who administer the quadripartite agreement to create any appearance of accepting an international border in Berlin. And therefore, they have had a reluctance to treat the Berlin Wall as a border for customs search purposes.

However, there are periodic random customs checks in West Berlin by West Berlin customs officials, which is one way, of course, that we have become apprised of this increasing trafficking problem.

Mr. ENGLISH. Did you say customs-type checks by West Berlin officials? Or did you mean West German officials in West Germany? West German in West Berlin?

Ms. FALCO. I am sorry. I meant "West Berlin in West Berlin," random customs checks.

Mr. ENGLISH. Is there any reason why, if they can do random-type customs checks, it couldn't be done, say, 5 feet away from any of these checkpoints where an individual comes through?

Ms. FALCO. Mr. English, I am sorry, I don't know the answer to that. Perhaps I could supply that for the record.

Mr. ENGLISH. I would be most appreciative.

[The information referred to follows:]

Random custom checks are performed near checkpoints or crossing points between the eastern and western sectors of Berlin. Since there are more than 150 points at which a traveler coming from East Berlin by subway or elevated train may disembark in West Berlin, however, in addition to the crossing points at the wall, the problems of real controls are great. We would not, as I stated earlier, wish to institute the regular, stationary customs controls which are characteristic of an international border.

Mr. ENGLISH. The point I am trying to get at is—if we are going to be successful in cutting off this route—is this issue of some type of customs check. I recognize the diplomatic problems that are involved, but certainly there must be a way that this could be worked out. Whether it is West Berlin police officials who conduct it, or whoever it is, there should be some manner in which it could be worked out without getting involved in all this international difficulty.

And I would certainly think that it could be done, say, at the airport in Berlin, or those people who are leaving particularly going to the West, would be another point.

What I would like, if you could supply it for the record, is to go indepth not to the reason why it has not been done in the past, but the question of: Can it be done for the future? And if so, what is it going to take for it to be done?

[The information referred to follows:]

Regular international customs controls are currently being exercised on persons arriving at West Berlin airports from outside Germany. We have been and will continue to study the problem of controlling the transportation of drugs from East Berlin and the GDR to West Berlin. Because of the very important legal questions involved and the practical difficulties which would have to be surmounted, however, we do not now see how this can be accomplished. In the meantime, we and the West Berlin Government are taking steps in other areas which are practical and politically realizable. One of these is our discussions with officials of the GDR on the problem of narcotics control. Although we are just beginning this process, our initial impression has been positive and we hope that we can develop some meaningful cooperation with the GDR in dealing with the narcotics problem in Berlin.

I am not particularly interested in hearing why it can't be done in the future; I just want to know how it can, and what is going to be required to do it in the future—and even to the point of whether or not this country can provide any assistance in that area. Because I think it does impact tremendously upon this area, and certainly the national defense and defense of Europe because of that particular issue.

I believe you also indicated there have been, in the last few days at least, some discussions between the Department of Defense officials and the State Department officials about this problem. Can you elaborate on that?

Ms. FALCO. Initial talks have been held with the East German Government regarding ways in which better cooperation might be achieved.

I would like very much, if it is possible, Mr. English, to supply all this either to you personally tomorrow or for the record, or both, since I do not have firsthand knowledge today of the fine details. I think that you might be better answered if I have a chance to go back and get something in writing from the responsible officials.

Mr. ENGLISH. Well, I certainly have no problem with that, and I hope that you will do that.

I would like, as much as you feel like you can, to get as much out today, simply because of the fact, of course, that brings on additional questions.

But you state that discussions have taken place with East German officials. Can you tell us who was involved?

Ms. FALCO. I am sorry, Mr. English, I did not come prepared on that in detail today. I thought these hearings were on demand reduction. I am sorry to be unprepared.

Mr. ENGLISH. They are, but you are the first representative of the State Department we have had an opportunity to discuss this with.

Ms. FALCO. I hope that you will allow, perhaps, the Assistant Secretary for Europe to meet with you, because I think it would be very good for us to discuss these issues.

Mr. ENGLISH. I would say, also, I am concerned there are discussions taking place now, and I think that is positive. And from what I understand, the Department of Defense is also involved in these discussions. And in view of that, I think that is commendable.

Can you zero in on Germany, West Germany, West Berlin?

Dr. DuPont, perhaps you can help us somewhat in this area, as well. Can you give us something of a picture as to what the drug situation is in that country?

Dr. DUPONT. Yes; the Germans have experienced a continuing rise in their heroin problem, as well as problems with other drugs. The problem is particularly severe in West Berlin. Their government is increasingly concerned about this problem. They are holding an international meeting of policymakers in August at their expense to promote more response in Germany to their drug abuse problem. There are signs that Germany is addressing the problem more forthrightly.

I had an ironic experience at the meeting of the United Nations Commission on Narcotic Drugs a year and a half ago. I listened to the German representative say that there had been a doubling of the number of heroin overdose deaths in 1 year, but this was not to be interpreted as an increase in the size of the heroin problem. That was a kind of logic I had never heard before. But he did not repeat that again this year, I am pleased to say. So maybe we are making some progress there.

Mr. ENGLISH. I realize this is probably walking on thin ice, and probably rather dangerous, but I think from a layman's standpoint, it is helpful.

Can you give us some feeling about the supply of hard drugs—mainly with heroin, as well as other hard drugs—the availability of those drugs, and the amount of abuse among the civilian community in those countries? Can you categorize——

Dr. DUPONT. Yes, sure.

Mr. ENGLISH [continuing]. That for us?

Dr. DUPONT. Sure. I would be happy to, for the record.

Mr. ENGLISH. For the record?

Dr. DUPONT. Yes.

Mr. ENGLISH. OK.

But there is no question as to the fact that the supply is increasing, the abuse is increasing, and availability is increasing?

Dr. DUPONT. Right. Absolutely.

Mr. ENGLISH. Does this also mean that the price of those drugs is also decreasing?

Dr. DUPONT. I don't know about that. We could provide some data for the record on that subject.

I think the other thing that is increasing, Mr. English—and I am pleased about this—is that the European governments' concern about their drug abuse problem is also increasing, albeit from a very low level, and grudgingly, but it is increasing. Ms. Falco has played an important role in encouraging that increased attention.

Mr. ENGLISH. Also, would you agree with the assessment that, particularly American personnel, military personnel—I know I am getting you all out of your field here, but this has been a subject of great interest at least to me—that before we can really expect to see an improvement in the problem in Europe among military personnel—U.S. military personnel—it is going to take a good deal of cooperation from the leaders of those countries in which these people are stationed? Namely, West Germany.

Dr. DUPONT. Absolutely.

Mr. ENGLISH. The situation in West Germany, West Berlin, you wouldn't disagree with me?

Dr. DUPONT. Yes; and also, of course, the difficulty of the dollar in relation to the mark has made it very difficult for U.S. servicemen in Germany. So there are many stresses, including the high availability of drugs in Germany, that are aggravating the problem of drug use among American personnel in Germany and elsewhere in Europe.

Mr. ENGLISH. You would say, to your knowledge of the subject, that the overall conditions that American servicemen find themselves in—particularly in Germany—is one that is basically adding kindling to the fire?

Dr. DUPONT. That's right; it is a very difficult situation for all concerned.

Mr. ENGLISH. Bringing that type of situation home.

Dr. DUPONT. It is hard for the Americans who served in Germany in the years after the Second World War to imagine the circumstances now. American servicemen can no longer have the military maneuvers they used to be able to conduct. And, of course, rather than being relatively rich, they are now downright poor. So it is much more difficult to keep the military personnel active and happy in Germany than it used to be.

Mr. ENGLISH. It is my understanding there is also a situation existing as far as segregation; that Europeans, particularly those in Germany, no longer care to associate; that American servicemen are no longer accepted even at public facilities. Is that correct?

Dr. DUPONT. I don't know about that point.

Mr. ENGLISH. Is there anything additional that you would care to add, as far as this subject, particularly as far as Germany is concerned, anything additional that you could give us that would be of assistance to us in looking at this situation in the military?

Dr. DUPONT. You in particular, and this committee in general, have done as outstanding job in the last few months of bringing vitally needed attention to this area. The military, as you know, has a long history of ignoring the drug problem. But then when they are finally dragged into an awareness of it they have a tradition of doing a heck

of a fine job of responding to it. I hope that that is what is going to happen in Europe now with the military. To the extent that it does, it is clear that the change can be traced to the good work of this committee.

Mr. ENGLISH. I would also like to state for the record: I think that both the chairman and myself are very encouraged by the President's reception on Tuesday morning that we presented him with the knowledge that we had on the subject; and that the President indicated that he would be talking to the NATO leaders, and particularly with the idea of securing their cooperation.

So that was the reason I was addressing that particular issue and the importance of that issue in dealing with this problem. So I am also hopeful that we will see some improvement.

I think counsel has some questions.

Mr. NELLIS. Yes. Thank you, Mr. Chairman.

I can address this to both our witnesses.

Can you and will you please state, succinctly, what are the goals of our international demand reduction program?

Dr. DUPONT. I am delighted you asked the question. Our goals in international demand reduction are frequently misunderstood. And let me outline five reasons why it is important for us to support an international demand reduction program in drug abuse prevention.

The first and foremost is that these programs help to raise the awareness of the officials and the public in the other countries about the extent of their own drug abuse problem. This, in turn, leads to an increase in their cooperation globally and in their own country in terms of reducing the supply of drugs. So the first justification for these programs is "raising the awareness."

The second substantial reason is to establish a quid pro quo. To the extent that we are helpful to them in terms of dealing with their domestic drug abuse problems we promote their cooperation with us in a variety of areas, including supply reduction.

The third reason to support our international demand reduction program is to increase the knowledge we have about drug abuse and its control in local contexts. We can learn a great deal from working with other countries. One of the clearest examples of this, though it doesn't involve any funding, is the use of heroin maintenance. This is an idea which was proposed here a couple of years ago for the umpteenth time. I don't hear as much about it now, thank heavens, but our knowledge of what has happened in England with that approach has helped us deal with that issue as it came up in the United States. Similarly, we have learned about acupuncture from our colleagues in Hong Kong.

The fourth reason is a purely humanitarian desire to assist people who have problems. And that, I wouldn't dismiss. It is very important also.

The fifth reason, and one of the most subtle but I think most important, is that by reducing the demand for drugs in another country—Thailand is a good example of this—we reduce one of the major stimuli to the supply of that drug in that same country. To the extent that we have a continuing, major local demand for heroin in Thailand, we have a persistent stimulus to supply in that country which we in the United States are ultimately vulnerable to. Thus, by reduc-

ing the demand for heroin in Thailand, we can reduce the local stimulation for supply, which will reduce the overall stimulus to production in that country. Thus, literally, we are all in this world menaced by demand for illicit drugs in any country.

I have found it important, in dealing with people from other nations, to be extremely explicit about these reasons for our support of the international demand reduction program. There is nothing in this we need to be shy about. All of these reasons have self-interest at their heart. But there is nothing wrong with that, if it is made explicit.

And I have found people from other countries, both developing countries and developed countries, to be quite empathetic with our reasoning. In fact, they are generally eager to have our support in the demand reduction area.

As it happened in this country, there is generally some small nuclei of demand reduction experts in other countries. By getting in touch with us, they are able to do things and have status in their own country that they wouldn't have had otherwise. They are thus able to stimulate a lot of activity in their own countries all on their own once we help them a little.

I met yesterday with the head of demand reduction for Argentina. And it was clear—he is now their government's major drug abuse expert—that without support from the United States—support provided from Ms. Falco's office and the Drug Enforcement Administration—he simply would not have been able to do what he has done.

These five reasons are the major bases for our programs in international demand reduction. It is extremely important that we support these efforts and not be reticent about them.

Mr. NELLIS. Thank you, Dr. DuPont.

Ms. Falco, do you have anything to add?

Ms. FALCO. I think Dr. DuPont said it all beautifully.

Mr. NELLIS. I think so, too. Let me ask this question about our response to those five criteria.

If in fact it is an important consideration, and one that we should really be attending to, why is it these charts which I showed you during the recess seemed to indicate a reduction in the amount of expenditure in this area? Is it because we can't find the people? Is it because the slots are not available? Is it a bureaucratic response?

Ms. FALCO. I would say 90 percent of it, unfortunately, is a direct result of the bureaucratic limitations that I outlined earlier for Chairman Wolff.

As Dr. DuPont pointed out, to develop these programs and to implement them effectively is very labor intensive. In fact, in order for us to have planned even this level of expenditure is a tribute to the very hard work that our NIDA detail officer, Mr. Retka, has put in this last year.

As I said earlier, if we could have three or four people devoted to this kind of programing and development, we could allocate more money.

Mr. GILMAN. Would the gentleman yield?

Mr. NELLIS. Surely.

Mr. GILMAN. I don't understand why you are having difficulty in borrowing personnel from other agencies. It was my understanding

that there was a great deal of flexibility in the executive branch for doing just that in emergency situations.

Who has restricted you from doing this?

Ms. FALCO. Unfortunately, although it is true that we are able to draw on the personnel resources of other agencies—primarily Customs and DEA—because of NIDA's very severe personnel shortage of its own, and the fact that it has exceeded its statutory and its OMB slot ceiling, at least right now it looks unlikely as though we will be able to have qualified people detailed to developing these programs. We are trying.

Mr. GILMAN. Then it is not a matter of an unwillingness by the agencies? It is a matter of their not having qualified personnel in the agency?

Ms. FALCO. The State Department does not have available within the Foreign Service personnel system, the kind of expertise that is required to develop demand reduction programs.

Mr. GILMAN. I think that is ridiculous. And what I am trying to find out is why you are in that situation.

Ms. FALCO. The way we have dealt with it this past year is that Bob DuPont's office has detailed to my office Bob Retka, and he has developed a viable plan which we are slowly beginning to implement.

Our greatest lack is personnel. Right now, I am in discussions with people in Secretary Califano's office, and Dr. Klerman, the Administrator of ADAMHA, to try to find two or three slots on which NIDA people could be detailed down to our office. We would be willing to pay their salaries.

Ironically, for once, it is not a money problem; it is a slot problem.

Mr. GILMAN. How long has this been going on?

Ms. FALCO. We have been exploring the possibilities for the last several months together. Mr. Retka's detail terminates September 30. If we do not receive another liaison from NIDA, much less the extra two or three people who should be devoted to this activity wherever they are located—they don't have to sit in my office—I don't think it would be possible for us to move forward on the demand reduction program because we don't have the expertise, Mr. Gilman.

I know a good deal about it, but I cannot, unfortunately, spend my time developing demand reduction programs. I am the only person on the whole staff who has any background at all, and that is because I am an outsider. The State Department doesn't develop this kind of expertise as part of its foreign policy initiative.

Mr. GILMAN. How many experts do you have in narcotics in your office?

Ms. FALCO. I would say, for the most part, they learn as they go along. We rely primarily on the Foreign Service system to provide us with officers, and on our embassies abroad to implement the programs.

Now this is the interesting difference that Dr. DuPont brought out earlier. When it comes to supply reduction programs, a lot of which involve various kinds of equipment—helicopters, radios—that kind of program is much less labor intensive. We do have those experts on my staff. They are technicians.

But that is very different from developing a human program—a human resources program. And this is a very new undertaking in the international program.

When I came into this office, there was only one program, in Ecuador. That was a historical kind of accident—a very happy accident—and we have been working very hard together over this last year—Bob and I—to try to move it along faster.

But you have three people at NIDA devoted to international activities out of a budget of, what?

Dr. DUPONT. $260 million.

Mr. GILMAN. Three people devoted——

Ms. FALCO. In NIDA.

Dr. DUPONT. Mr. Gilman, one of our limitations is the authority within NIDA for these programs. We need a commitment which says that international activities are a major priority for us. We operate within the Department of Health, Education, and Welfare; we need it from them.

Mr. GILMAN. Hasn't this ever been stressed as a priority?

Dr. DUPONT. We don't have any legislative authority for international activities at all except in the narrow context of research. Our authority strictly relates to research to promote the health of Americans.

Mr. GILMAN. You have three people in your office. Ms. Falco has one assigned from your office to her office. I note in the budget book that I have before me, you have a total of 14, Ms. Falco, in your office—a total of 17, rather, in the Domestic Office.

How many of those do just secretarial work?

Ms. FALCO. Five.

Mr. GILMAN. How many are people who have expertise knowledge in narcotics?

Ms. FALCO. A number of them have expertise in supply reduction.

Mr. GILMAN. Of the 10 remaining, how many have expertise? You have six or seven secretaries——

Ms. FALCO. Most of them have developed expertise along the way. Something I am trying very hard to get the State Department to focus on is the need to bring first-rate career officers into nontraditional areas such as narcotics control, which is a very important one; human rights, environment, oceans. It is a problem in the State Department.

Mr. GILMAN. Of your remaining 10 people who are nonsecretarial, how many of these are professional narcotics people?

Ms. FALCO. A lot of th[illegible] have some kind of narcotic related backgrounds. Some of the Foreig[illegible] officers obviously have come in from graduate degrees in something else.

I can give you information on our personnel. They all have some expertise; otherwise, we wouldn't be able to operate the program.

[The information referred to follows:]

The six advisors transferred from AID to the Department of State as part of the reorganization are technicians with background in procurement, telecommunications, aviation, program management and fiscal administration.

Our 10 field personnel, including 2 assigned in Washington, are primarily Program and Project managers who have had an average 12.5 years of experience in the field working with foreign police agencies in staff and advisory positions. These men were, before coming with the Federal Government, in administrative and supervisory police positions averaging 17 years of service, and include one police chief, 2 police captains, 3 police lieutenants and 4 detective sergeants or equivalent rank. Without exception they have had experience in the field of narcotics during some phase of their police careers, including at least

three who headed narcotics enforcement units with up to 15 years exclusively in narcotics enforcement; additionally six have had five or more years with AID as narcotics advisors. All have had a minimum of three years exclusively as narcotics advisors in the field.

Four additional program specialists, bring to the program managerial and administrative expertise gained through diversified experience in Federal and foreign service including consular matters, such as narcotics liaison with foreign police and health officials; coordination of the development of Federal drug policy; review of Federal drug enforcement operating programs; and personnel and training activities.

Mr. GILMAN. That's what I would like to explore with you. There are only 10 people besides secretarial. Can you tell us what they do in your office?

Ms. FALCO. Yes, sir, for the most part, they administer the bilateral country programs which we have, which you are very familiar with, with Mexico, Burma, Thailand, Pakistan.

The point I was trying to make is that demand reduction—prevention, treatment, and rehabilitation of drug-addicted people—is not an expertise that we have in the Department. That is something that we have turned to NIDA for help with.

NIDA itself faces terrible limitations, as Bob DuPont has just pointed out. And right now, we are trying to get HEW—which has 150,000 slots—to find one or two slots.

Mr. GILMAN. Have you presented this problem to the executive?

Ms. FALCO. Yes, sir, I have, repeatedly.

Mr. GILMAN. To whom?

Ms. FALCO. To Dr. Klerman, who is head of ADAMHA, to Dan Meltzer, who is a personal assistant to Secretary Califano.

Bob knows all about it.

Mr. GILMAN. Is Secretary Vance familiar with the problem you are having?

Ms. FALCO. He is not specifically familiar with these aspects of the problem, because I haven't given up, yet. They are all expressing very great support for finding these people, and it is possible they will find a solution. They haven't said "no" yet.

Mr. GILMAN. Mr. Chairman, with your permission, I would like to ask for an opportunity to ask one or two questions, and then I have to return to another committee that is functioning, if I could.

Mr. ENGLISH. Without objections.

Mr. GILMAN. Thank you.

Could you tell us what is happening with regard to the Mexican situation? We were getting all sorts of conflicting reports. Has it been improving? Has there been a reduction in the amount of drug abuse and drug addiction in Mexico?

Ms. FALCO. With regard to the actual amount of drug abuse by Mexicans within Mexico, I am not informed.

The Government of Mexico, as I said earlier, does not believe that it has a serious heroin abuse problem. It does recognize, obviously, that it has a very serious illicit opium production and heroin trafficking problem on the supply side.

The Mexican Government has indicated to me on several occasions they believe marihuana abuse is their primary drug problem, particularly among their youth and their unemployed.

Mr. GILMAN. Do we have any statistics from Mexico at all?

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Ms. FALCO. I do not have any hard statistics. There are various estimates.

There is a conference going on this next month down in Mexico which is going to examine the marihuana problem. And perhaps I could supply statistics for you. I will make the request, specifically.

Mr. GILMAN. Can you tell us, Ms. Falco, what the situation is with the subgroup of the United States-Mexican consultative mechanism? We have appointed our people. What has happened in Mexico?

Ms. FALCO. We were hoping to have a meeting the weekend of June 17 and 18. On our end, that was all right with three of the four subcommission members. Unfortunately, it was not a suitable time for the Mexican officials.

They have proposed the end of July. I understand from your staff that is not an acceptable time for you and for Chairman Wolff. So we are now seeking another mutually acceptable date.

Mr. GILMAN. Are they prepared to go ahead, now?

Ms. FALCO. Yes.

Mr. GILMAN. Do they have their appointees?

Ms. FALCO. They were ready to go the end of July, but I just learned this week that is not a good time for you and Mr. Wolff, and perhaps later in the year would be better.

It is very difficult to get all of you very busy people together in the same spot with the Mexicans.

Mr. GILMAN. Do either you or Dr. DuPont have any input with regard to assisting the formulation of policy in the United Nations Fund for Drug Abuse Control?

Ms. FALCO. Yes, sir.

Mr. GILMAN. What sort of input?

Ms. FALCO. Because we remain a major donor, we have frequent discussions with the new director, Dr. Rexed of Sweden, and with the staff, through our mission in Geneva, which has a full-time officer assigned to narcotics. He meets with United Nations officials almost on a daily basis to convey our interest and concerns.

Mr. GILMAN. And we are actually helping to formulate policy in that group?

Ms. FALCO. Yes, sir, we are. More importantly, we are trying to help them move toward defining their program goals more precisely and develop viable programs which will be suitable for funding by other countries as well as ours.

Mr. GILMAN. Are you satisfied with the United Nations' drug effort?

Ms. FALCO. I think that they have made a great deal of progress, Mr. Gilman. I think there is still an awfully long way to go.

Mr. GILMAN. Is there some way that this committee can be of help to you or the Congress can be of help to you in making certain you have adequate personnel to do the job?

Ms. FALCO. Yes; Dr. DuPont was saying earlier that he thinks it will take a legislative prod to get HEW, for example, to focus on the need to allocate some more personnel resources to the international area.

One of the problems—and we talked about it earlier—is that NIDA is so far down in such a huge bureaucracy. That is one reason why we

thought it might be more useful in the short term to try to run the international demand reduction program through our office with NIDA people, because there is less bureaucracy.

Mr. GILMAN. Could you send us a memo to our committee indicating what your problem has been, so maybe the committee could be of some help?

Ms. FALCO. Yes, sir, thank you.

Mr. GILMAN. Ms. Falco, could you tell us what your comprehensive plan for comprehensive demand reduction is?

Ms. FALCO. Yes, sir, it is outlined in my prepared statement. We decided initially to focus on priority countries, where we have major supply problems already existing, on the theory that it would help increase the commitment of those governments to strengthen their own supply control efforts.

It is partly, as Bob said earlier, a quid pro quo.

Mr. GILMAN. What is the plan?

Ms. FALCO. Initially, as I said, we would want to develop global approaches to demand reduction.

Unfortunately, we are severely limited because we have only had one person working on this. We thought, by beginning in major supply areas, that that would have also a catalytic effect on other areas.

Mr. GILMAN. How do you propose to reduce?

Ms. FALCO. For instance we have already started in Bangkok where we have finally gotten the addict detoxification centers project moving. They have several hundred thousand addicts in Thailand.

Mr. GILMAN. That is "rehabilitation." I am talking about how you are proposing to reduce demand.

Ms. FALCO. Rehabilitation is one very important part of reducing demand because the addicts, if cured, will not be creating a continuing demand for the substance.

In Ecuador, we have programs with the Ministries of Health and Education to create public awareness of the drug problem.

In Malaysia, we are working with their Ministry of Health to develop preventive education programs.

These, of course, have to be specifically tailored to each country because our experience is not entirely applicable to other cultures. And it is something that, as Bob said earlier, a lot of countries come to very slowly.

Mr. GILMAN. Then, primarily, is it an education program?

Ms. FALCO. In some countries, we are doing that. We are also now providing training, as we have done for a number of years, with customs officials and drug enforcement officials from other countries. We are now, for the first time, beginning to provide extensive training for drug treatment and prevention personnel from other countries.

For example, the head of drug abuse treatment for Argentina, Dr. Cagliotti, who just visited, chaired a regional drug abuse conference. It was the first of its kind, and a very good manual came out of it. They are going to have a followup conference and manual. We supported these efforts.

I believe if we can encourage each country that we work with to develop its own response, and then work regionally, that that is one of the most effective means of creating awareness. So that they don't feel we are imposing our version of the problem on them.

This worked very effectively in South America this last year.

Mr. GILMAN. I would hope that the drug education program you are embarking on is a lot more successful than our own domestic drug education program.

Ms. FALCO. That's one reason we deferred to other countries' perceptions of their problem, because we haven't been entirely successful. But I also think we have much to learn from them.

Mr. GILMAN. I believe my time has run.

Mr. ENGLISH. Thank you, Mr. Gilman.

I believe chief counsel has some additional questions.

Mr. NELLIS. First, Mr. Chairman, with your permission, I would like to put into the record the charts we have prepared, and the witnesses have seen, concerning these.

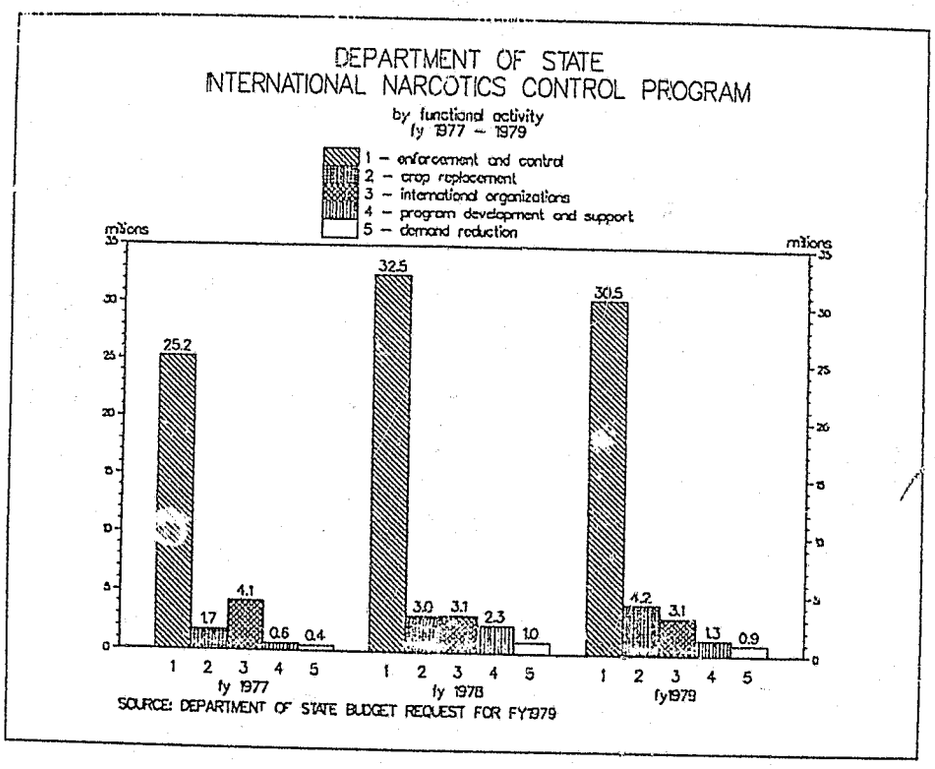
Mr. ENGLISH. Without objection, so ordered.

[The charts referred to follow:]

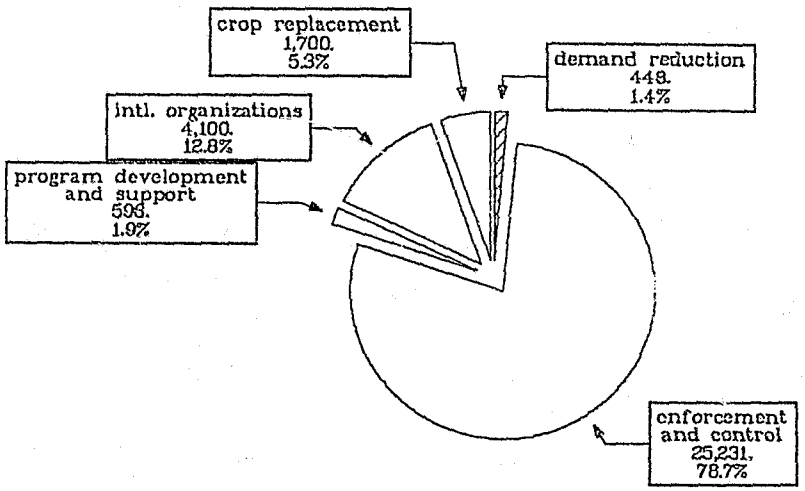
DEPARTMENT of STATE

INTERNATIONAL NARCOTICS CONTROL PROGRAM
BY FUNCTIONAL ACTIVITY
(In thousands)

	FY 1977 Actual	% of Total	FY 1978 Planned	% of Total	FY 1979 Proposed	% of Total
ENFORCEMENT AND CONTROL	25,231	78.7	32,459	77.4	30,518	76.3
CROP REPLACEMENT	1,700	5.3	3,045	7.3	4,153	10.4
INTERNATIONAL ORGANIZATIONS	4,100	12.8	3,125	7.5	3,125	7.8
DEMAND REDUCTION	448	1.4	981	2.3	904	2.3
PROGRAM DEVELOPMENT AND SUPPORT	596	1.8	2,300	5.5	1,300	3.2
TOTAL PROGRAM	32,075		41,910		40,000	

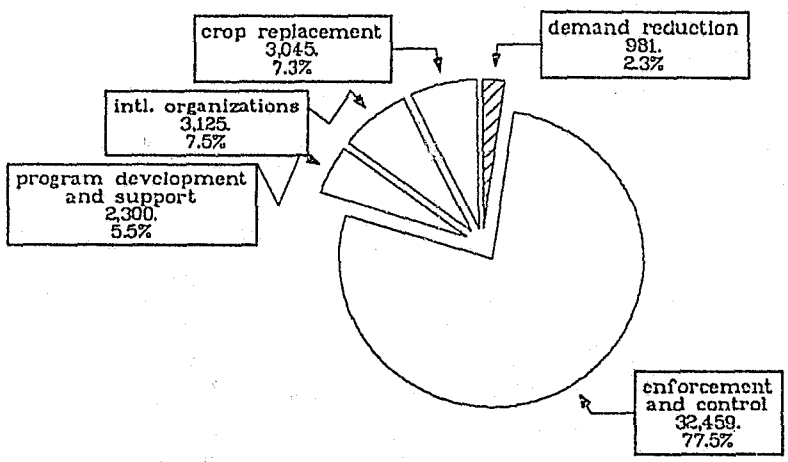

DEPARTMENT OF STATE
INTERNATIONAL NARCOTICS CONTROL PROGRAM
by functional activity
fy 1977 – 1979
1 – enforcement and control
2 – crop replacement
3 – international organizations
4 – program development and support
5 – demand reduction
millions
millions
25.2
1.7
4.1
0.6
0.4
32.5
3.0
3.1
2.3
1.0
30.5
4.2
3.1
1.3
0.9
1 2 3 4 5
fy 1977
1 2 3 4 5
fy 1978
1 2 3 4 5
fy1979
SOURCE: DEPARTMENT OF STATE BUDGET REQUEST FOR FY1979

DEPARTMENT OF STATE
INTERNATIONAL NARCOTICS CONTROL PROGRAM - FY 1977
by functional activity
in thousands of dollars



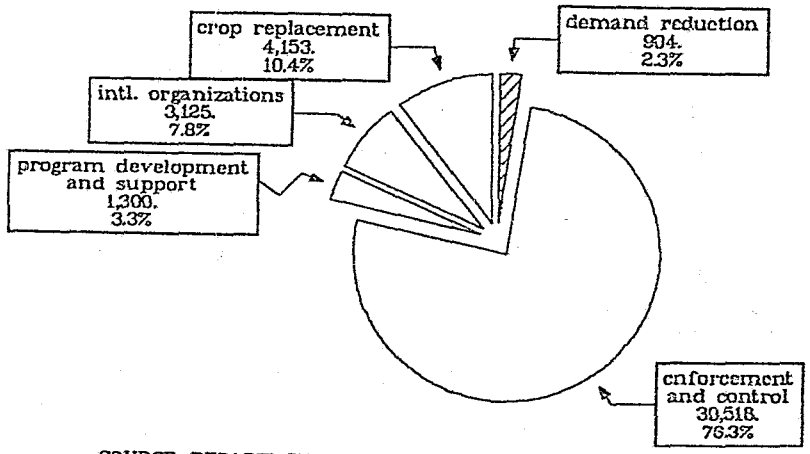
SOURCE: DEPARTMENT OF STATE FY 1979 BUDGET REQUEST.

DEPARTMENT OF STATE
INTERNATIONAL NARCOTICS CONTROL PROGRAM - FY 1978
by functional activity
in thousands of dollars



SOURCE: DEPARTMENT OF STATE FY 1979 BUDGET REQUEST.

DEPARTMENT OF STATE
INTERNATIONAL NARCOTICS CONTROL PROGRAM – FY 1979
by functional activity
in thousands of dollars



SOURCE: DEPARTMENT OF STATE FY 1979 BUDGET REQUEST.

Mr. NELLIS. I want to ask a question about U.N. Resolution 32/124, which is the famous OLF Resolution. And in the absence of the chairman, I think we at least ought to put on the record what its status is.

What is its status?

Ms. FALCO. It is thriving. I hope very much to have the input of the chairman and members of the committee in the working paper that is now being prepared.

Mr. NELLIS. May I say, we are preparing something along that line at the staff level, and you should be getting that very shortly.

Ms. FALCO. Good.

Mr. NELLIS. What is the present progress of the resolution?

Ms. FALCO. The Commission on Narcotic Drugs discussed it at some length in the February meetings. It was very well received by all parties, which was very encouraging.

Mr. NELLIS. I was present the day it was introduced and listened to some of the seconding speeches, especially the one by the Ambassador from Thailand, which I thought indicated great enthusiasm for the idea of international treatment facilities.

Ms. FALCO. The Commission essentially decided to develop a working paper on implementation of the resolution for later consideration by the whole body. It is that part of the process that we are now in.

We are preparing our Government's input into the working paper which is being headed up by Dr. Smith, the Canadian delegate, to the Commission, who will be president of the Commission next year.

They are having special meetings in Geneva of the officers of the Commission to work through the various documents that they are getting from all governments this summer. That is why I urge you to give us your ideas, so that we can have our paper in at the right time.

It might be very good for me to submit, at this point into the record, the decision of the Commission——

Mr. NELLIS. I think that would be very useful.

Ms. FALCO [continuing]. Regarding this resolution.

Mr. ENGLISH. Without objection, so ordered.

[The information referred to follows:]

ANNEX—DECISION ADOPTED BY THE COMMISSION ON NARCOTIC DRUGS AT ITS FIFTH SPECIAL SESSION

Decision 7 (S–V). *The procedure followed by the Commission on Narcotic Drugs in connexion with its response to General Assembly resolution 32/124.*

At its 853rd meeting on 22 February 1978, the Commission on Narcotic Drugs took the following decision:

(a) The Commission welcomes the General Assembly's request, contained in its resolution 32/124, as presenting an opportunity for it to undertake a timely review of developments since the United Nations concerted action programme against drug abuse was launched six years ago, with a view to assessing the results achieved and identifying future strategy and new directions;

(b) The Commission decides to request its Officers, in consultation with its Steering Committee, with the assistance of the Division of Narcotic Drugs and the support of the United Nations Fund for Drug Abuse Control, the International Narcotics Control Board and the appropriate specialized agencies of the United Nations, to prepare a working paper to serve as the basis for an in-depth discussion by the Commission at its twenty-eighth session in 1979;

(c) The Commission also decides to invite all Governments wishing to do so to communicate to the Secretary-General in writing, at the latest by 30 June 1978, any views they wish to be taken into account in the preparation of the working paper. It is furthermore understood that the paper will also take into account

such views as may be expressed by delegations at the first regular session of the Economic and Social Council in 1978 during the Council's discussion pursuant to paragraph 6 of General Assembly resolution 32/124;

(d) Expenditure in the implementation of this decision would be appropriate for financing by the United Nations Fund for Drug Abuse Control;

(e) The Commission's decision to the foregoing effect should be included in its report to the Economic and Social Council at its first regular session in 1978.

Drug Abuse in Europe

The following information on the drug abuse problems in Europe is from the Report of the February, 1978 Meeting of the United Nations Commission on Narcotic Drugs:

Europe

13. Of major concern in Europe was the rise in heroin seizures. As in 1975, the total quantity seized during the period under review more than doubled in relation to the previous year; 717 kg were seized compared with 311 kg in 1975. The volume of the illicit traffic in cannabis products continued to be high, nearly 46 tons being seized, of which over 26 tons were of cannabis resin.

14. Total seizures of opium, 243 kg for the region, remained at a low level. There was a reduction in the total quantity of morphine intercepted (61 kg compared with 210 kg in 1975). Seizures of cocaine continued their steady yearly increase, 62 kg being seized compared with 51 kg in 1975. Of the psychotropic substances reported seized, the amount of depressants intercepted remained very low. Seizures of stimulants, however, rose, a total of 224 kg being seized.

Europe

39. The observer for *Austria* stated that traffickers from the Near and Middle East were increasingly passing through that country with cannabis and heroin for the Federal Republic of Germany and elsewhere in Western Europe. While the number of seizures of drugs had declined in 1977, 855 kg of cannabis resin and 6.432 kg of heroin were confiscated: that was more than double the amount of resin and nearly six times the amount of heroin seized in 1976.

40. The Representative of *Belgium* expressed concern at the increased international illicit traffic in narcotic drugs and psychotropic substances. Belgium was involved because of its geographical position, which made it essentially a transit country, and the simplifying of customs controls with five neighbouring States. The traffic in cannabis and its derivatives appeared to have stabilized, but seizures of heroin continued to be considerable. The number of persons involved in the traffic increased annually, with a 64 percent rise between 1973 and 1977. 85 to 90 per cent of those involved were themselves users of drugs.

41. The representative of *France* said that, with the exception of products stolen from pharmacies or fraudulently diverted from the licit trade, all drugs abused in France came from abroad. There was, however, a possibility that the line of supply of morphine base, which appeared to originate from opium produced in the Near and Middle East, might be established once more in France. It was a matter of high priority to determine the precise locations of manufacture of that morphine base and of heroin which had, during the last few years, caused an increase in the number of seizures, in several countries in Europe and in the United States, of heroin manufactured in the Near and Middle East.

42. Despite that new threat, the traffic in heroin from South-East Asia remained the primary problem in France. Some slowing down of the traffic had occurred in the second half of 1977, but it had revived again at the end of the year when, during one month, three seizures had taken place involving 25 kg of No. 3 heroin. A direct trafficking route had been established by minor traffickers between Bangkok and Paris. Attempts were also being made to utilize persons formerly involved in the "French Connection" to re-establish a heroin trafficking route from Thailand to the United States via France.

43. The traffic in cannabis and its derivatives continued to escalate inexorably. So far as cocaine was concerned, although there was some tendency towards the increased use of that drug within France, the traffic was essentially in transit, particularly towards the United Kingdom and the Federal Republic of Germany.

44. The representative of France emphasized the interdependence of countries and regions and the need for even more international co-operation in the work against traffickers.

45. The representative of the *Federal Republic of Germany* reported that the most important trend was the change in the source of supply of heroin. In 1976, about 80 percent of this drug seized in the Federal Republic was of South-East Asian origin, whereas in 1977 the figure was only 25 per cent. The Netherlands and Amsterdam in particular, were no longer the focal source of heroin for the illicit market in the Federal Republic, and distribution centres in 1977 were increasingly urban centres within the country and West Berlin. The precise source of the heroin now appearing in the traffic had not been identified. There were no indications of the diversion of supplies of raw material from legal opium poppy cultivation in Turkey, but it had to be assumed that most of the raw opium required to produce the heroin now appearing came from illicit or uncontrolled cultivation in the Near and Middle East. There had been an increased involvement by traffickers of Turkish nationality.

46. Cannabis was still the drug most trafficked in the Federal Republic. Of more than 9 tons seized in 1977, 6 emanated from Lebanon and a flood of that drug appeared to be approaching Western Europe, with internationally organized groups of traffickers increasingly involved.

47. The illicit drug traffic had been accompanied by a rise in thefts from pharmacies, forgeries of prescriptions, and other attempts at diversion from the licit trade.

48. The representative of the *German Democratic Republic* stated that the minor seizures of cannabis resin, heroin, morphine and pethidine which had taken place in 1976 had been even further reduced during 1977. Illicit traffic was not a problem and that which did occur was predominantly in transit.

49. The observer for *Greece* stated that in 1976 and 1977 large quantities of cannabis and heroin had been seized, but that the seizures were of drugs in transit, since Greece, because of its geographical position, was naturally vulnerable to that type of activity.

50. The representative of *Italy* reported that illicit traffic trends in 1977 continued to show a consistent increase. The total amount of heroin seized in 1977 was indeed 12 per cent lower than the quantity seized in 1976, but the total amount of seizures of illicit drugs over-all had increased by 78 per cent.

51. The majority of seizures of heroin took place at three airports, the drug having been found to be in transit from Far Eastern countries to the Netherlands. The heroin trafficking pattern showed that some traditional South-East Asian sources of heroin were still active, but that new sources in the Near and Middle East were now being developed.

52. Seizures of cannabis and its derivatives continued to escalate, the total amount seized in 1977 being 105 per cent more than 1976, and nearly 300 per cent more than in 1975. The total of 259 kg of liquid cannabis seized in Italy in 1977 was believed to be the highest amount ever seized in any European country in one year. There was a slight increase in 1977 in seizures of cocaine, and there were continued seizures of psychotropic substances, partly from the international traffic and partly following thefts from pharmacies.

53. The observer for *Portugal* said that the drug most frequently seized from the illicit traffic in his country was cannabis. In addition, diversion by theft or fraud from licit sources accounted for a considerable amount of the internal illicit drug traffic. The greatest volume of seizures took place at frontiers and customs posts.

54. The observer for *Spain* stated that there had been growth in the illicit traffic in 1977, especially in that of cannabis, which had shown a 100 per cent increase. More than 10 tons of cannabis resin had been seized, including two major individual seizures, destined in one case for France and in another for the United States.

55. Prosecutions for illegal possession of drugs increased by 51 per cent, and there had been a wave of thefts of opiates from pharmacies. There had also been an increase of seizures of cocaine, which amounted to a total of 23 kg in 1977 compared with 14 kg in 1976. This drug was in transit from the Americas through Spain to other parts of Western Europe. The traffic in amphetamines from Spain to the Netherlands and Switzerland, however, had virtually ceased.

56. The representative of *Sweden* reported that, as was the case in many other European countries, cannabis was the drug most prevalent in seizures, and there was seldom any shortage of supply. Heroin seizures had levelled off during 1977, following closer co-operation with the authorities of the Netherlands and with other Scandinavian countries. The source of supply of the heroin was now shifting from South-East Asia to the Middle East although, so far as Sweden

was concerned, there had been no sign of any leakage from the licit cultivation of the opium poppy in Turkey. Seizures of cocaine showed a worrying increase during 1977. Traffic in that drug appeared to emanate from South America and to enter Western Europe through Spain and possibly Portugal. Increased co-operation with those two countries was desirable to counter the new trend.

57. The representative of *Turkey* emphasized the importance of timely and comprehensive reports on the illicit traffic from Governments to ensure a realistic assessment of world trends. The trends for 1977, as reflected in figures already available, were alarming.

58. The Government of Turkey continued to reinforce and modernize control and enforcement agencies to ensure that there was no diversion from unlanced-opium-poppy cultivation licensed in Turkey. The Turkish representative emphasized categorically that there had been no leakage into illicit channels of any opium or heroin in Turkey from unlanced-poppy cultivation in 1976 or 1977, and that allusions to that effect were unfounded.

59. Turkey faced a new problem of transit traffic by reason of its geographical position as a bridge between Europe and Asia. The Government shared the general concern to trace the sources of heroin of apparent Middle East origin entering the illicit traffic in Western Europe and urged even closer co-operation and collaboration, bilaterally and multilaterally, to that end. The involvement of Turkish nationals in such traffic was deplored by the Government, which wished to end the use of Turkish citizens by trafficking organizations for that purpose.

60. Increased control measures had ensured a fivefold increase in seizures of cannabis in 1977 as compared with 1976.

61. The representative of the *United Kingdom* reported little change in the over-all pattern of illicit traffic in 1977, apart from some specific increases. There had been a 25 per cent increase in the total amount of heroin seized in 1977 as compared with 1976, and the amount of cocaine seized had increased by the same percentage over the same period. There had also been considerable increases in the total seizures of amphetamines and methylamphetamine powder.

62. Cannabis and its derivatives remained the drug most frequently found in the illicit traffic, although amounts seized in 1977 were 18 per cent below the total for 1976.

63. Sources for the heroin traffic were both South-East Asia and the Middle East and there were indications that London was being used as a transit point for heroin intended for the rest of Western Europe. The United Kingdom might also be a transit point for morphine tablets which had been seized in a new development in 1977, and which possibly originated in Pakistan.

64. Opiate-type drug abusers in the United Kingdom showed a tendency to try to obtain their supplies by theft or fraud from licit channels when other sources were not available.

142. *Europe.* In the majority of countries, the drug abuse situation had either remained static or deteriorated. A decrease in the abuse of drugs had, however, been reported in a few countries. Abuse of opiates, especially heroin and synthetic narcotics, had increased in several countries. Increasingly heroin abuse and deaths due to heroin overdose had been observed in a number of countries. It appeared that opiates were frequently abused by young people, mostly males. The large amounts of heroin and other opiates which had been seized in a number of Western European countries were consistent with an increase in the demand for those drugs. Abuse of pentazocine and tilidin had been indicated by several countries. Abuse of cannabis was widespread in most countries and this drug was generally taken by young people. Abuse of sedative-hypnotics seemed to have increased and as in the case of opiates, a number of sedative-hypnotics were diverted from legal sources. A number of countries pointed out that those drugs were frequently abused by adolescents. Some countries, however, noted that those drugs were taken by older persons. In some instances, sedative-hypnotics were the preferred drugs of "hard-core" addicts. Abuse of methaqualone, methaqualone in combination with diphenhydramine (Mandrax) diazepam and chlordiazepoxide was indicated by a number of countries. Amphetamine abuse was becoming more widespread and serious in several countries, and was sometimes associated with the criminal underworld. There was continued abuse of hallucinogens, particularly LSD, in a certain number of countries. Abuse of substances related to atropine and scopolamine had been indicated by two countries. Sporadic cocaine abuse was reported by a number

of countries. One country, however, had shown concern about the possible widespread abuse of that drug. Multiple drug abuse was a common pattern, practically all kinds of drugs being combined.

158. *Europe.* Preventive measures included increased penalties for illicit drug-related activities and a greater tendency to distinguish between an offense for illicit drug trafficking and the use or possession of a drug for personal consumption; also, increased control over the prescribing of drugs. In an attempt to prevent abuse, some countries carried out drug monitoring surveys on the legal consumption of drugs. There was a greater tendency to be prudent in communicating drug information through the mass media and to avoid sensationalism. Some countries organized special campaigns. In general, attention was focused on the appropriate selection of publications for general distribution. In that connexion, information to doctors, pharmacists and other professionals was provided. Drug education for young people was often aimed at reinforcing positive values and preparing them to face daily life with a sense of responsibility. In some countries, attention was given to providing alternatives to drug abuse, such as educational opportunities, participation in youth clubs, and to the early identification of behavioural disturbances through schools and "street-corner" work. Drug education in many countries was incorporated in the school curricula. It was indicated that education on drugs could best form part of a wider discussion on health issues and problems in personal relationships. To increase the understanding of drug abuse and its related problems, discussion groups or meetings were often held by young people and/or parents and teachers, and other concerned. Educational programmes were most often directed to target groups, such as schoolchildren, parents, teachers, etc. The need for the improved training of professionals dealing with drug-related problems was strongly emphasized.

159. Approaches to treatment and rehabilitation ranged from detoxification, through various forms of psychotherapy, psychosocial approaches, maintenance, counseling, work therapy, vocational and/or social rehabilitation, to the organization of therapeutic communities and other community-oriented activities. In one country, methadone was too widely prescribed and a decision was recently reached to restrict the prescription of methadone. Treatment was provided mostly on a voluntary basis and was less often compulsory. There appeared to be a consensus that the motivation for treatment was of the highest importance for a successful outcome of treatment.

160. Treatment, rehabilitation and social integration were usually seen as a long-term process requiring continuity and flexibility. It was considered that the method of treatment should be tailored to the individual needs of each person. Treatment and rehabilitation were provided in different facilities, which most often included psychiatric (out-patient and in-patient) and other health, welfare and social institutions; in some countries, treatment was also provided in psychopedagogical institutions and, in others, in residential facilities or prisons, etc. In a number of countries, there was a shift from in-patient to out-patient treatment and to community-based programmes. However, treatment in hospital was viewed generally as indispensable in certain situations. In one country, a comprehensive national programme aimed at reducing drug abuse had recently been formulated and it was likely that the programme would be launched in 1978.

161. In the United Kingdom, a "White Paper" entitled "Prevention and Health", concerning government policy on health topics, had been presented to Parliament: a section of the document dealt with the misuse of drugs. Also two reports dealing with reduction of demand had been issued by the Advisory Council on the Misuse of Drugs.

Mr. NELLIS. If you will supply it to the reporter, very good.

My final question, Mr. Chairman, relates to a different subject. I have just had an opportunity to visit with a public member of that Strategy Council. I won't name him, for reasons that will become obvious in a minute. He is very dissatisfied and unhappy.

No. 1, the Strategy Council, as I understand it, has not met since its initial meeting in November 1977. Is that a correct statement?

Ms. FALCO. That's correct.

Mr. NELLIS. I do understand the subgroups, the working groups have been at work in this sort of ad hoc basis every couple of weeks. Is that also correct?

Ms. FALCO. That is true for my group, Mr. Nellis. I don't know about the other parts of the Strategy Council.

Mr. NELLIS. Special, only for your group, Ms. Falco. Is there a likelihood you will be presenting some policy recommendations to the Strategy Council in fairly short order?

Ms. FALCO. Yes; I feel very strongly that the Strategy Council is a very useful vehicle——

Mr. NELLIS. If used.

Ms. FALCO [continuing]. For developing policy.

Two public members were assigned to the international area—Dr. David Musto, from Yale, and Dr. Harvey Sloane, of Kentucky. Dr. Musto came as a member of the U.S. Delegation to the Commission on Narcotic Drugs, and made a very fine contribution there.

After the Strategy Council had its meeting, I called a meeting of the international working group, which was essentially high-level representatives from all the agencies, even those tangentially involved in the international narcotics area.

Warren Christopher, Deputy Secretary of State, opened that meeting. Peter Bourne was also there.

Subsequently, we formed a number of subworking groups which now are producing reports of their activities. A number of these groups have been very active, for example, the one chaired by Richard Davis, Assistant Secretary of the Treasury, on the role of the international financial institutions, which is a critical area that hasn't been looked at enough.

They will all be preparing very short papers, and we are going to put them together into an overall paper and give it to the White House office that is responsible for the Strategy Council.

Mr. NELLIS. Is it very likely the Strategy Council will meet soon and act upon some of the policies enunciated by the President last August?

Ms. FALCO. I don't know that, Mr. Nellis. I have not been informed of such a meeting in the near future.

Mr. NELLIS. That is too bad. The only comment I can make is: This committee is very concerned about the dissolution of ODAP and the fact that there are ODAP papers floating around—very good ones, too, I might say—which just seem to be sitting there without much happening.

We were hopeful that the Strategy Council would take up each of the seven subjects addressed by ODAP but—if not in the same vein, at least to discuss them in terms of policy and come forward with something the Congress can look at.

Do you think there is much chance of that happening soon?

Ms. FALCO. Mr. Nellis, I think so.

Mr. NELLIS. I have no other questions, Mr. Chairman, at this time.

Mr. ENGLISH. I do.

I have thought of another question or two I would like to get into, if you don't mind.

Dr. DuPont, I suppose you would be the one to answer this: Given the obvious, for want of a better word, I suppose, captive type of condi-

tion to latch onto in a certain degree we have in the military, it would seem to me the military would be a good place to really get a feel for many of the more innovative and perhaps—I don't want to use the word "experimental" because I think that would be incorrect—but you would have a controlled situation, to a certain extent, to work out and see how various drug prevention type programs, drug rehabilitation type programs, and so on and so forth, that could probably fit into our civilian life and treating this problem nationwide.

It would also seem to me that the military is the one place in which we would have the most ideal conditions, as far as trying to develop such things as the extent of drug abuse. That is where we should have the best idea of the amount of drug abuse that exists.

It also seems the ideal place for determining the effects of drug abuse on such things as attitude and discipline and that sort of thing, from a national defense standpoint, combat readiness.

Do you have any observations that you would care to make about that, and about how we could have something, I suppose, of a tradeoff from the standpoint of having a more drug-free populace within our defense system and, at the same time, be acquiring new techniques for dealing with drug abuse in our civilian community?

Dr. DuPont. Yes; I agree with you. The military has never achieved its potential in these areas. There are now two major inhibitions to the achievement of this potential.

One is a congressionally imposed mandate about drug abuse research in the military.

Mr. English. I will say one thing, for the record. This committee, last October—in fact, all through last year—heard a great deal about this. And I think what you are speaking of is the directive by the Appropriations Committee in its report. And I believe that was 1976.

Dr. DuPont. Yes, sir.

Mr. English. To the effect that research—and I think what they were talking about is more of a universal-type research—should be done not by DOD, but go over to HEW; that this committee wrote the Appropriations Committee back in October.

And interestingly enough, less than 30 days later, DOD finally decided to request a clarification of this particular issue. And low and behold, we found that far from objecting, the Appropriations Committee certainly had no intention in cutting off any research funding or prohibiting any research which dealt with combat readiness or affected the military primarily.

In other words, "military-oriented research." There was absolutely no intention that that be done.

What the Appropriations Committee was getting at—as they clarified and pointed out—was simply they didn't want duplication taking place. And what they had hoped would happen would be that the civilian agencies would cooperate with the military and would share its information and its findings, and it could be carried out in that way. Certainly, military-oriented research would be done by the military. They are the only ones that really have the idea of what needs to be done.

Dr. DuPont. I am delighted to hear that. I admit that I didn't know about that development until you told me just now.

Mr. ENGLISH. I might state: We were quite concerned that it took DOD so long to request any type of clarification.

Dr. DUPONT. Some folks in DOD rather liked the idea of having this barrier to their doing drug abuse research.

Mr. ENGLISH. I am glad you said that and I didn't.

Dr. DUPONT. Whatever their motivation was, at least this inhibition to action is now removed.

The other barrier, in addition to all the general problems with any bureaucracy in developing new activities, is that the DOD has had a difficult time dealing with the drug-abuse problem because it is so unpleasant and so visible. To deal with an issue like the impact of drug use on troop readiness has been something they have been slow to get involved with.

This committee, again, can be very helpful in encouraging them to overcome this inhibition, as you have already been in removing the first inhibition I mentioned. At the same time you were meeting with the President last Tuesday, I was meeting with Rich MacDonald, the doctor who is in charge of the drug and alcohol problems for the Army in Europe. He is a wonderful fellow. I was tremendously impressed with him personally, but he also seemed generally interested in pursuing some of these questions.

For example, there was a survey a year or so ago that pointed out that 10 percent of the military personnel in Europe used hashish every day.

Now the obvious question is what is the impact of that on troop readiness. Perhaps the answer is that this hashish use has no impact. If that is the case, we ought to know it. But to have that survey figure sitting there with no assessment of its meaning, is awful, Dr. MacDonald agreed, maybe that's why I liked him so much!

He may be pursuing some of these questions right now. I offered to help him develop a plan to answer these questions and to direct him to the civilian expertise we have in these areas so that he can answer these vitally important questions.

As you say, answering those questions in the military where we have a relatively captive population and clearly defined work tasks, which they have very good capacities to measure, is vital to both the military and the American public. The military has done an outstanding job of thinking through the issue of the tasks associated with all the various functions in the military, and measuring the performance of those tasks. In general, they have done much better than civilian employers have ever done.

I have great hopes something useful and important will come from this. I agree with you completely. It is, however, going to take some very persistent encouragement. One of your questions—about the levels of use—would require the military to be much more aggressive with these problems.

Another question has to do with responding to the drug problem once we recognize it. And another issue is knowledge development—not in the sense of pure research knowledge, but in the sense of very practical knowledge about the impact on various specific military related functions of various kinds of drug use, including alcohol use. But that is all very, very important.

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Mr. ENGLISH. What you are saying, and what you are telling me, in effect, is that you believe that those who are involved in drug-abuse research in the civilian sector, as far as the Federal Government is concerned, would be most interested——

Dr. DUPONT. Absolutely.

Mr. ENGLISH. In associating and joining with the military in carrying out this type of an effort.

Dr. DUPONT. And we at NIDA will be happy to facilitate that interaction, absolutely.

Mr. ENGLISH. Would you be willing, at this point, to state for the record that you would so notify DOD?

Dr. DUPONT. I will do that, yes, sir.

Mr. ENGLISH. Would you please submit, for the record, the response of DOD?

Dr. DUPONT. Yes.

First, I will submit my——

Mr. ENGLISH. Without question.

Dr. DUPONT. I will.

Mr. ENGLISH. I hope you won't send that by mail, but call me personally.

Dr. DUPONT. When I get the response, yes.

Mr. ENGLISH. I think that is a very important matter, and I think it is one that could be most helpful—certainly as far as the military is concerned. And if, in fact, we are about to launch upon an effort with DOD to get at the bottom of the problem, not to learn just the nature of the business, so to speak, but to turn this situation around and begin dealing with the problem. And I think you are right. I think this spin-off it would have in dealing with civilian problems and to better acquaint American people as to the impact that drug abuse can have would be enormous.

Dr. DUPONT. Let me cite one small example. In the area of drug abuse prevention, the military has a tremendous capacity to do studies of alternative approaches, and to measure the consequences of those alternative prevention approaches. That would be tremendously helpful in terms of our overall prevention technology.

Mr. ENGLISH. I assume, from what you are saying, that to your knowledge there has been no request by the military to the civilian sector for such cooperation?

Dr. DUPONT. No, but Dr. MacDonald was quite interested, and I gave him a couple of names of civilian research scientists. And he was going to see those people, or talk to them, before he went back to Heidelberg.

Mr. ENGLISH. But there has been no high-level——

Dr. DUPONT. No; that's right. And he made very clear he has a staff function, not a command function. And the critical question is where the command line is on this problem of the impact of drug use on military functioning.

Mr. ENGLISH. I think, first of all, there has to be a policy decision made at high levels within DOD, and perhaps even by the White House, with regard to this matter before we can pursue it any further.

Very good. I think that that does it. I have no further questions.

Before I recess this meeting, I would like to make an introduction. After July 1, joining my staff will be Dr. James E. MacDonald.

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2 OF 3

Dr. MacDonald, if you will stand up.

He will be assisting in the new oversight committee, or at least assisting me in my efforts as chairman of the oversight committee with regard to the Department of Defense and Veterans' Administration, and will be primarily looking into the drug rehabilitation area. And it is certainly one that has tremendous importance.

We have no further comments. The committee is adjourned subject to the call of the Chair.

[Whereupon, at 5:05 p.m., the Select Committee adjourned to reconvene subject to the call of the Chair.]

PREPARED STATEMENTS

Prepared Statement of Hon. Mathea Falco, Senior Adviser to the Secretary of State and Director for International Narcotics Matters

Mr. Chairman, members of the House Select Committee on Narcotics Abuse and Control, I am pleased to be with you today to discuss our international efforts to reduce the demand for dangerous drugs.

The primary objective of our international narcotics control program is to stem the flow of illegal drugs into the United States; that is, to reduce their availability in this country. An important, although smaller, part of this effort is directed at demand reduction. These activities increase awareness of other countries of the threat that drug abuse represents to the health and welfare of their own people. Recognition of this threat helps motivate other governments to improve their internal narcotics control capabilities and to assist in international drug control efforts. Our assistance in improving drug treatment and prevention capabilities abroad also provides tangible evidence that our Government is concerned about the worldwide social impact of drug abuse, and is committed, as President Carter said in his drug abuse message last year, to "sharing our knowledge and resources to help treat addiction wherever it occurs."

During 1978 we are, for the first time, focusing major attention on international drug demand reduction activities. As you are aware, a NIDA staff member, Mr. Robert Retka, was detailed to my office at the beginning of the fiscal year to develop a comprehensive plan for demand reduction as part of the International Narcotics Control Program. We are now beginning to implement the plan that has been developed.

Before describing that plan, I would like to explain how INC program priorities are defined. As noted earlier, our chief international objective is to reduce, as close to the source as possible, the supply of illegal drugs reaching the United States. As a result, the bulk of INC program activity is focused on those countries in Asia and Latin America where the bulk of illegal drugs are produced, processed, or transshipped. Since our demand reduction efforts are intended to complement this supply reduction focus, they are developed within the same priority framework. Although demand activities are not limited to the priority countries, these countries do receive first attention.

Our long-range strategy for demand reduction is to build regional capabilities to meet regional needs. We do this by providing training and technical assistance, by conducting ongoing information exchange and executive observation programs, and by supporting targeted demonstration projects.

To date, most of our training activity has been directed at individual country needs and has been coordinated with demonstration projects in key countries. For the past few years, for example, we have been working with the Ministries of Health and Education in Ecuador to create an increased awareness of drug abuse among the general population and especially among school-age youth. In late 1977, we collaborated with NIDA on a special training project for sixteen Ecuadorean health and education specialists. This Spanish-language program was conducted in Puerto Rico and Florida, and was tailored to the specific needs of the Ecuadorean trainees. Within the next several weeks, a training consultant will be sent to Quito to design an in-country follow-up to this earlier training effort. The objective will be to adapt the training provided in the United States to the Ecuadorean environment.

In Thailand, a similar approach is being followed. We recently agreed to assist the Bangkok Metropolitan Health Department in setting up a network of out-

patient detoxification clinics for heroin addicts. These clinics, which will be established within existing Public Health Centers, will provide an opportunity for relatively large numbers of heroin addicts to be detoxified. As the first phase of this project, NIDA conducted a training program for ten drug treatment officials. These officials have now returned to Thailand where they are preparing to train personnel from other drug programs. We expect that the first three detoxification clinics will begin seeing patients later this summer.

Next month we will send two NIDA staff members to Bangkok to help build an information base for evaluating the Addict Treatment Project. One of these consultants will make recommendations regarding the use of urinalysis data; the other will help develop a patient reporting system.

Thailand is a particularly appropriate country to receive demand reduction assistance. As you know, the Government of Thailand has been active in international narcotics control efforts. However, as international enforcement efforts become more successful, the domestic Thai market becomes more and more attractive to drug traffickers. The result is a burgeoning addict population, estimated by some Thai authorities to number half a million.

A similar fate has befallen Burma and Malaysia. Estimates of the addict populations in these countries run into the hundreds of thousands. Although we currently have no bilateral demand reduction projects in Burma, we are working closely with the Government of Malaysia in this area. The Malaysian Government's response to an exploding heroin problem has been hampered by a shortage of trained personnel. Public Welfare Officers are being trained as addict rehabilitation counselors; but the challenge remains immense.

The Government has requested our assistance in meeting this challenge. In response, we will be sending a training team to Malaysia for six months. The team will work with Ministry of Welfare Services counterparts to train 125 Public Welfare Officers in rehabilitative counseling techniques. They will develop a model training curriculum that will enable the Malaysian Government to continue a large-scale training effort after the team departs.

We are also discussing the possibility of sending an adviser to Malaysia to work with PEMADAM, the National Organization Against Drug Abuse, in organizing demand reduction projects. A wide variety of community-based volunteer services are available in Malaysia; it will be the adviser's job to mold these resources into an effective demand reduction program.

Several months ago, the Government of Bolivia asked us for assistance in training several high-level personnel with key management responsibilities in Bolivia's domestic drug abuse treatment programs. Later this summer NIDA will provide this training through a combination of intensive instruction here in Washington, followed by field placements at appropriate drug abuse treatment agencies.

All of the training projects I have mentioned share a common theme—they are tailored to individual country needs. Not all training in demand reduction need be this specific to individual country needs. Our most important initiative in the training area this fiscal year will be to expand our training effort to include courses focusing on generic skills needed in many countries. We hope to provide three such courses this year, two of them through NIDA. The two NIDA courses will provide technical training in drug problem assessment techniques and in training methods. Both courses are still under development, but we hope to begin implementation of each this fiscal year.

A third multinational training project is already underway in collaboration with the International Communications Agency. Each year, ICA funds an extended training effort conducted by the Council of International Programs. The program provides a five-week orientation for social service workers from other countries, followed by a ten-week field placement in an American social service agency. During most of their field placement, the participants live with volunteer host families. This year, eleven of the participants are drug abuse workers. Our agreement with ICA provides for a training module designed specifically for these drug abuse participants. This training involves intensive seminars in Washington before and after the trainee's field placements.

Our international training and demonstration projects are complemented by technical assistance, executive observation, and information exchange programs. In addition to the technical assistance to Thailand mentioned above, we are also assisting the Government of Hong Kong to complete implementation of a Central Registry of Drug Addicts. The costs of operating the system are borne by the Hong Kong Government; we provided technical input in determining the

feasibility of such a system and in preparing a detailed design for it. Now that implementation of the system is nearly complete, we will work with Hong Kong authorities to ensure that it is used to its full potential.

Our executive observation program in demand reduction is proceeding somewhat more slowly. This year we will support observational visits by officials from Thailand, Ecuador, and Mexico. The purpose of these visits is to expose key demand reduction officials to the range of programs implemented in this country. Through visits to working programs, foreign officials can often find ways of adapting the core concepts of these programs to their own environments.

Our information exchange program helps disseminate the information we have developed in drug abuse research, treatment, and prevention over the past decade. We do this by sending technical resource persons to international meetings on drug abuse, and by translating or publishing appropriate research papers. This year we will send technical resource persons to international meetings in India, Malaysia, Venezuela, Thailand, Switzerland, and Mexico. We are also funding the translation of NIDA's recent reports on Cocaine and Marihuana as well as the proceedings of an upcoming International Symposium on Marihuana to be hosted by the Government of Mexico.

Of course, not all of our demand reduction activities are funded through bilateral country agreements or our Interregional Drug Demand Reduction Program. Many of the multinational organizations to which the United States contributes annually conduct programs to strengthen drug abuse control measures and to reduce drug abuse in developing nations. The United Nations Fund for Drug Abuse Control, for example, is involved in many drug demand reduction projects. The largest UNFDAC undertaking is the multisectoral project in Burma. UNFDAC is supporting Burmese drug control activities in various fields, including treatment and rehabilitation, education, social welfare, and crop substitution. Additionally, Bolivia, Egypt, Pakistan, and Peru are receiving UNFDAC assistance for treatment and rehabilitation, and preventive education in drug abuse. As part of its program, Peru is also conducting an epidemiological study of drug consumption.

As you noted, so forcefully, Mr. Chairman, as a member of the U.N. General Assembly U.S. Delegation last year, the United Nations must grant drug abuse a higher priority and greater resources. Your Resolution, which the UNGA adopted, addresses itself to the questions of international drug abuse prevention, treatment, and rehabilitation and stresses collaborative support for Government projects to promote economic alternatives to those dependent on illicit cultivation and production of narcotic substances. As you stated, "Drug abuse, once only a serious problem in America, now is spreading through Europe, Asia, Latin America and even into the developing countries of Africa, as more and more nations are falling victim to the pandemic condition that we have faced in the U.S. for years." The U.N. Commission on Narcotic Drugs is presently preparing a paper for the U.N. General Assembly on the implementation of your Resolution and I am certain that as a result the U.N. will give higher priority in the future to drug control efforts.

We also provide support to the Colombo Plan Regional Drug Program for the purpose of assisting member countries in developing programs for drug abuse control. The Colombo Plan Drug Advisory Program has been one of the most active and useful regional cooperative efforts devoted to the problems of drug abuse in Asia.

The Drug Advisory Program features three major types of activities: fellowships, seminars and workshops and multinational conferences.

In 1977, the Drug Advisory Program assisted in school programs and three drug abuse seminars in Sri Lanka; co-sponsored the National Workshop on Drug Abuse Prevention in Indonesia, the National Workshop on Drug Abuse Prevention Education in Pakistan, the Second Asia/European Meeting of Heads of Drug Enforcement Services in Belgium, and sponsored some of the participants in the Regional Workshop on Drug Abuse Preventive Education organized by UNESCO in Kuala Lumpur. Each seminar and workshop co-sponsored by the Drug Advisory Program deals with a single aspect of the drug problem.

In all our demand reduction activities, however, the role of the United States is secondary. The American experience with drugs can be generalized only to a certain degree, since the effects of drug abuse are influenced by the culture and setting in which drugs are used. Similarly, drug abuse treatment and prevention efforts in other countries are affected by a host of cultural, legal,

and drug availability factors. In short, our intent is to help other countries develop their own demand reduction resources. We cannot do the job for them; but we can help them to do it themselves.

Thank you, Mr. Chairman. I will be happy to answer any questions you may have.

PREPARED STATEMENT OF ROBERT L. DUPONT, M.D., DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

INTRODUCTION

Chairman Wolff—Members of the Select Committee on Narcotics Abuse and Control: Thank you for the invitation to appear before you to discuss international demand reduction. It is a particular pleasure for me to discuss NIDA's involvement in international aspects of drug abuse. This area has been, for me as well as for you, a long-standing interest and one that I have personally been very active in. With me today is Dr. Jean Paul Smith, NIDA's Assistant Director for International Activities.

Over the last five years, U.S. participation in international demand reduction has significantly increased as greater emphasis has been placed on preventing and controlling the illicit consumption of drugs. The reason for this is the recognition that real progress must be made both at home and abroad, both in the control of supply and demand, for real long-term improvement in this field to take place. We have learned that the production and supply of illicit narcotics and psychotropic drugs are, to a significant degree, a function of the illicit demand and consumption of these drugs. Without their consumption, there would be no incentive to produce them and little profit in the illicit traffic. This increased emphasis on demand is found not only in the United States but also in many other countries and in major international organizations. With your permission, I would like to discuss some of the world trends in drug abuse, the U.S. response and our goals, some past and current NIDA programs, collaboration with the Department of State, efforts to expand our programs, our statutory authorities, and collaboration with international organizations.

1. World picture of drug abuse

Early this year, the United Nations summarized the main patterns and principal trends of drug abuse as follows: (a) a continuing spread of heroin abuse; (b) increased deaths due to drug overdose, primarily of heroin and barbiturates; (c) an increasing abuse of psychotropic substances, particularly amphetamines, sedative-hypnotics and, to a lesser extent, tranquilizers; (d) expanded cocaine, LSD, phencyclidine, and cannabis abuse in some regions; (e) a general tendency toward multiple drug abuse and persistence of traditional opium consumption which is a severe problem in a number of countries; (f) a tendency toward a change in the mode of drug taking, such as from oral administration to injection. This summary of an increasingly serious problem is consistent with my observations.

2. U.S. response: Department of HEW

The U.S. response to drug abuse has been to develop a prevention and control strategy for both supply and demand aspects. On the demand side, the Department of HEW has four agencies involved in international demand reduction. These agencies are the National Institute on Drug Abuse, the Food and Drug Administration, the Office of Education and the Rehabilitation Services Administration. From a survey of the activities of these agencies, carried out late last year, I believe it is accurate to say that of the four, NIDA is the most actively involved in international efforts. For this reason, my statement will concern only NIDA.

3. Goals of international demand reduction

Overseas demand reduction programs are initiated either as complementary to diplomatic and enforcement efforts or as separate, direct projects standing on their own in general support of overall U.S. efforts. We have found that demand efforts are the most effective way to help a country develop an awareness of their own problems and the shared responsibilities and opportunities that all countries have in this area. As the Committee knows, our primary goals in this area are two:

To encourage other countries with drug abuse problems to more systematically assess and respond to their own drug problems; and

To develop and make available practical models of response in the prevention, treatment, and rehabilitation area, and to promote the exchange of information which would stimulate the development of such models.

4. Priorities of NIDA in international demand reduction

Priorities are found in two primary areas: Public Health Service programs and assistance to the Department of State. In our PHS programs, priorities for international demand reduction are the same as for any international health research in the PHS, namely, scientific merit, special contribution to U.S. health sciences and unavailability in the U.S. of the particular approach to be studied. In NIDA's efforts to carry out information exchange and to build better models and approaches to reduce illicit demand, we have collaborated with the major international organizations and interested countries. Here we follow several different concepts. One of these is organizational interest—such as WHO's interest in developing countries—and another is whether the country has a demand problem, is willing to work with us and can influence other countries in that region and around the world. Thus, European countries, Iran and Hong Kong, to mention only a few—have been of significant interest to us. Our aim is not to treat the addict population of other countries but to collaborate with them to make sure that they know about various means to reduce illicit demand.

Second, in our support of the Department of State, we follow the priorities of their International Narcotics Program. We understand that they fund programs primarily in countries that produce illicit drugs.

5. NIDA's international program

A. *Background.*—NIDA's international activities involve information exchange, briefing international visitors, technical assistance, training, research, treatment demonstration projects, and international meetings and conferences. Technical assistance is provided to foreign governments and international organizations which request U.S. assistance in developing demand reduction plans and programs. Qualified experts are sent to foreign countries to assist in the assessment of the nature and extent of the drug problems, and the necessary treatment, rehabilitation and prevention required to cope with them.

During the period of 1973–76, NIDA spent approximately $125,000 for on-site technical assistance to 13 different countries, primarily in S.E. Asia and South America. During FY 1977, NIDA expended the following:

Research grants and contract	$780,073
Contract for training and technical assistance	400,000
Treatment demonstration project	99,500
Staff travel	36,000
	1,315,573

During FY 1978, we anticipate spending the following:

Research grants and contracts	$543,415
Contracts for technical assistance, prevention, and training	616,571
Other international contracts	132,325
Staff travel	32,485
	1,324,796

In late 1977, NIDA expanded its international activities and support program with the addition of two full time staff positions to this area. We now have three full time professionals working in this field plus a substantial amount of time contributed by other staff persons from our operating offices and divisions. Although we have only slightly more total dollars in FY '78 the areas involved in technical assistance are increasing more rapidly than the others.

B. *Current NIDA Activities.*—This year our international activities program has expanded to assist the State Department's Office of International Narcotics Control in carrying out demand reduction projects. These initiatives were undertaken as official efforts of the U.S. Government and the Department of Health, Education, and Welfare. For purposes of this testimony, they will be referred to as NIDA activities. Most of the expansion has been in the area of international training. Two examples deserve mention:

1. This past November, NIDA and the Department of State cosponsored the training of seventeen Ecuadorian health and education professionals in two specific areas:

(a) planning for the delivery of health services to drug addicted individuals, and

(b) prevention techniques, both educational and informational, for youths and adolescents.

The training program lasted six weeks, with field observations in Orlando, Florida and Puerto Rico. It culminated in an action plan designed to help the Ecuadorian Government develop and implement prevention and treatment programs.

2. This spring NIDA planned and conducted a specialized 37-day training program in the United States for 10 physicians and social workers from Bangkok, Thailand. Supported by the Office of The Senior Adviser to the Secretary of State, this program included structured classroom training in drug abuse treatment methods and techniques, planning, management and evaluation of treatment programs, and training of trainers as well as observation visits to various treatment facilities in the United States. Two physicians remained for an additional 6-week on-the-job placement at Beth Israel Medical Center's Methadone Treatment Center and at Eagleville Hospital outside of Philadelphia. On their return to Bangkok, these professionals will be responsible for the planning, management, supervision and training of additional personnel to operate new addict treatment facilities in the Bangkok Metropolitan area. To assist them in starting up their new treatment programs, an action plan was prepared during their program in Washington. Also, an assessment of this entire program was carried out by the ten participants, staff, and trainers to evaluate the accomplishments of this program. All of these areas are described in the draft report on this program.

Plans are currently underway for specialized training programs for groups of professionals from Malaysia, Bolivia and Ecuador, which are expected to take place in this fiscal year.

NIDA is also continuing to provide technical assistance and information to other countries in the demand reduction area. Through our controlled Substances Supply Program, we have supplied for many years controlled substances (Schedule 1 and 2) and noncontrolled substances to researchers in the United States as well as to many foreign countries. When important compounds are not available in the pharmaceutical market place, NIDA has made them available on a selected basis. Prior to 1974, few foreign exports were made. However, in the past five years the interest has increased both from foreign governments and from individual foreign researchers. The types of compound requested include, cannabinoids, hallucinogens, amphetamines, narcotic antagonists, phencyclidine and its analogs. Requests are received from all over the free world but mainly Canada, Australia, and Switzerland. However, Japan, Israel, West Germany, Argentina, Malaysia, Brazil and other countries have received compounds from this program. Over the last five years, we have made more than 130 shipments to foreign governments to assist them in their research and forensic standards programs.

Other examples of technical assistance are: a NIDA staff expert in the assessment area has been working with health officials of the Government of West Berlin to help them begin to respond to their rapidly increasing heroin problem. This summer, NIDA will provide advice and assistance to Thailand on the feasibility of the development of a patient management information system in Bangkok similar to the CODAP system now used in the U.S. In the prevention area, NIDA is preparing a resource package on prevention which will be useful for other countries, including papers and annotated bibliographies developed for three special groups—planners, teachers, and health personnel. Other publications for international audiences to be produced this year include: Spanish translations of the *Marihuana and Health Report* and *Cocaine: 1977*, for dissemination to interested Spanish speaking persons and professionals in Latin America.

6. Collaboration with the Department of State

Many of the projects described above have been funded by the Office of the Senior Adviser for Narcotic Matters in the Department of State. This office is the primary focal point for all international drug abuse activities by the U.S. Government. Overall policy direction and major funding for technical assistance programs abroad have been and continue to be funded by this office.

Over the last two years, NIDA and the International Narcotics Program at the Department of State have developed a close working partnership in the inter-

national demand reduction area. Under the very capable leadership of Ms. Mathea Falco, the International Narcotics Program at the Department of State has expanded their support of demand reduction. It is our understanding that her office has the authority to fund demand reduction projects within the congressional limits of a foreign assistance program designed to curb the flow of illicit drugs into the U.S. With this existing authority, the Department of State is now funding more projects in priority countries through NIDA and through other agencies. To assist her office in the demand reduction field, NIDA has provided a full time liaison officer this last year. We hope this effective collaboration will continue in the future.

7. Expansion of technical assistance to foreign countries

Earlier this year, the Office of Drug Abuse Policy issued a Report entitled International Narcotics Control Policy, March, 1978. This report, which I am sure the Committee has seen, recommends that several steps be taken in this field. The major steps to be taken are:

(a) that more technical assistance be provided to other governments and,

(b) that we seek to use, to a greater extent, the international organizations in reducing illicit demand.

The Department is reviewing the appropriate implementation of the report and is engaged in consultations with Ms. Falco at State.

8. Statutory authority for international demand reduction

To determine our legal basis for conducting and supporting demand reduction activities in foreign countries, our Office of General Counsel examined Public Health Service statutes. The conclusion drawn was that HEW may conduct and support demand reduction activities in foreign countries only to the extent that those activities are:

(1) for the benefit of American citizens and will reduce the incidence of drug abuse in the United States; or,

(2) may be considered research or may involve the collection, processing or tabulation of health statistics and data which would enure to the benefit of the citizens of the United States.

In short, two kinds of activities are authorized: first, biomedical and health services research and statistical activities to improve the health of Americans; and second, limited treatment for Americans with health problems abroad. Although HEW lacks the authority to conduct operational, non-experimental demand reduction activities in foreign countries, it can and has carried out such activities on agreement with the State Department.

Perhaps more serious than our lack of statutory authorities are the limitations on our personnel and resources. We are, however, looking into this question very actively.

9. Collaboration with international organizations

NIDA's collaboration with and support of international organizations is longstanding. In addition to participating in expert and advisory groups, NIDA has sponsored projects with WHO, sent experts to ICAA meetings to describe U.S. trends and treatment, prevention and assessment approaches, and regularly participated in the U.N. Commission on Narcotic Drugs meetings in Geneva.

In regard to the U.N., let me first say that it has been a pleasure for me to give the U.S. Statement on demand reduction at the U.N. Commission on Narcotic Drugs these last several years. Last February, it was particularly important because we had the opportunity to support an initiative of the General Assembly, the result of your effort, Mr. Chairman. I quote the statement I made before the Fifth Special Session of the Commission:

"The U.S. Delegation strongly supports the action taken by the General Assembly in Resolution 32/124 to bring about greater international cooperation in prevention, treatment, rehabilitation, and training. In order to implement the Assembly's initiative, we propose a consensus be developed in the Commission and be considered and approved later in this sesssion."

As you know, the Commission did approve that measure and we particularly appreciate your leadership Chairman Wolff. NIDA has also supported an important project carried out by the U.N. Division of Narcotic Drugs. This project is designed to make available information on the measures to reduce demand in the form of a resource book which could be used in all countries. Both I and Dr. Smith have worked very closely with Dr. Rexed and Dr. George Ling at

the U.N. in Geneva preparing this practical guide to assessment, treatment, prevention and training. We look forward to presentation of this resource book at the next meeting of the Commission in February, 1979.

At the last Commission meeting, and in the same statement on demand reduction, I reported on the U.S. Drug Abuse situation, highlighting the recent upsurge in abuse of phencyclidine. After an extended statement, we said: "We bring phencyclidine to the Commissions' attention because it is probable that its use will become more widespread in the world and, in addition, it represents an example of the kind of drug problem we all will face increasingly in the next decade: the easily synthesized, highly potent, psychotropic drug. The dangers of this trend are clear." Such warnings will we hope help other countries to protect themselves against phencyclidine and other new patterns of abuse.

In addition to the Division of Narcotic Drugs, we are also working closely with the WHO. Two funded projects are worth mentioning. The first is to use the regional office structure of WHO to stimulate greater involvement by the health and social welfare arms of governments in two regions: the Middle East and South East Asia. Through a careful review of the abuse of drugs in each country, we expect more involvement and more results in preventing and treating drug abuse problems. The second funded project with WHO concerns rural opium producing regions in South East Asia. This project will review and synthesize the measures we now have in the epidemiology and intervention strategies to reduce the unauthorized consumption of opium. It will help us to move more effectively in assessing and understanding opium dependence in isolated areas. Not much research has been done here so we will use the collective experience of the consultants and staff to find out what our best approaches are.

That concludes my statement. I will be happy to answer any questions you may have.

DEPARTMENT OF STATE,
Washington, D.C., July 26, 1978.

HON. LESTER L. WOLFF,
Chairman, House Select Committee on Narcotics Abuse and Control,
House of Representatives,
Washington, D.C.

DEAR MR. CHAIRMAN: In response to your letter of July 17 regarding my June 22, 1978 appearance before the Select Committee on Narcotics Abuse and Control, I am submitting the following information.

1. Are there any restrictions to instituting a formal customs check near the entrance to West Berlin to accompany the "papers" examination which currently takes place?

The Wall between East and West Berlin is not recognized as an international border by the Western Powers. Because of the very important position of the Western Allies that Berlin is one city under Four-Power control, we have been careful to avoid imposing controls on persons crossing the sector boundary between East and West Berlin. We would not wish to institute any kind of regular controls which would resemble international border controls. The German Democratic Republic (GDR) border authorities check the travel documents and luggage of all civilian travellers entering or leaving East Berlin. There are not, however, regular customs checks, in terms of contraband goods, made by the Allies or West Berlin customs officials.

Random customs checks are performed near checkpoints or crossing points between the Eastern and Western Sectors of Berlin. Since there are more than 150 points at which a traveller coming from East Berlin by subway or elevated train may disembark in West Berlin, however, in addition to the crossing points at the Wall, the problems of real controls are great. We would not wish to institute the regular stationary customs controls which are characteristic of an international border.

2. Please explain how greater control could be maintained over the borders in West Berlin.

Regular international customs controls are currently being exercised on persons arriving at West Berlin airports from outside Germany. We have been and will continue to study the problem of controlling the transportation of drugs from East Berlin and the GDR to West Berlin. Because of the very important legal questions involved and the practical difficulties which would have to be surmounted, however we do not now see how this can be accomplished. In the

meantime, we and the West Berlin Government are taking steps in other areas which are practical and politically realizable. One of these is our discussions with officials of the GDR on the problem of narcotics control. Although we are just beginning this process, our initial impression has been positive, and we hope that we can develop some meaningful cooperation with the GDR in dealing with the narcotics problem in Berlin.

3. Could you please provide any statistics which you have on the level of drug abuse in Mexico.

See attached cable Mexico No. 10293.

4. You refer to a conference on drug abuse which was to take place in Mexico. Please describe the scope of the conference and provide the Committee with any reports which are issued at the close of the Conference.

The conference, sponsored by the Government of Mexico, is to be held in Mexico late in August 1978. The purpose is to examine from an international perspective, recent studies on marijuana related health questions and to examine levels of marijuana abuse throughout the world.

The United States Government will fund the publication of reports which are forthcoming as a result of the conference. I shall forward copies from the conference to the Select Committee.

5. Please explain the problem which your office is having in obtaining qualified staff to plan or implement the international demand reduction program. Please include any initiatives which could be undertaken by the Select Committee to resolve the problem.

See memorandum attached, dated 19 July 1978, from Mathea Falco to the Select Committee on Narcotics Abuse and Control.

I hope this information is helpful. If I can be of further assistance, please let me know.

Sincerely,

MATHEA FALCO,
Senior Adviser and Director for International Narcotics Control Matters.

Enclosures: (1) Mexico cable 10293; (2) Memo from Ms. Falco to committee dated 19 July 1978.

[Telegram]

DEPARTMENT OF STATE,
AMERICAN EMBASSY,
Mexico.

Subject: Narcotics—Drug abuse patterns in Mexico.
Reference: Alexander/Bernal Telecon, June 7, 1978.

1. Following Embassy inquiries based on Reftelcon, Centro Mexicano de Estudios en Farmacodependencia (CEMEF), the approximate GOM equivalent of U.S. National Institute on Drug Abuse, delivered to Embassy June 19 copy of as yet unpublished report entitled "Prevalence of Drug Use in Selected Mexican Cities—Household Interviews".

2. Study is based on random or stratified random samples in Mexico City (1974), La Paz, Baja California (1974), San Louis Potosi (1975), Monterrey (1975) and Puebla (1976). Study involved interviews with sample of 4,715 selected to represent a fixed-residence population age 14 or higher of both sexes estimated at 6.5 million.

3. According to the study, the percentage of the population involved in the nonmedical use of drugs is as follows in each of the studied cities:

(A) Mexico City: Marijuana, 1.3; inhalants, 0.4; halucinogens, 0.3; heroin-morphine, 0.1.

(B) San Luis Potosi: Marijuana, 2.1; inhalants, 0.5; halucinogens, 0.9; heroin-morphine, zero.

(C) Puebla: Marijuana, 0.3; inhalants, 0.01; halucinogens and heroin-morphine, zero.

(D) Monterrey: Marijuana, 1.6; inhalants, 1.2; halucinogens and heroin-morphine, zero.

(E) La Paz: Marijuana, 4.9; inhalants, 0.7; halucinogens, 1.1; heroin-morphine, 0.4.

4. For purposes of this study, drug use was defined as use of the specified drug during the 30 days preceding the interview.

5. While this study reports drug use in the entire population over 14, three 1972 studies cited in this study report:

(A) Approximately 12 percent of Mexico City students in grades seven through nine used marijuana at least once and 1.5 percent used amphetamines at least once. Heroin-morphine use was not detected.

(B) Approximately 10 percent of Mexico City students in grades 10 through 12 used marijuana at least once. This population also reported use of inhalants (10 percent), amphetamines (10 percent), barbiturates (9 percent) and LSD (1.2 percent).

(C) In one private university in Mexico City 20 percent of the students reported "Experimentation" with marijuana.

DEPARTMENT OF STATE,
Washington, D.C., July 19, 1978.

MEMORANDUM

To: Select Committee on Narcotics Abuse and Control.
From: K. Mathea Falco.
Subject: International demand reduction—personnel issues.

Recent testimony before the House Select Committee on Narcotics Abuse and Control highlighted the acute shortage of qualified personnel to plan and implement international drug demand reduction programs. As you know, demand reduction activities serve to increase the awareness of other countries of the threat posed by drug abuse to the health and welfare of the citizens of other countries and thus motivate other governments to improve their international narcotics control capabilities. Additionally, U.S. assistance in drug treatment and rehabilitation provides tangible evidence that our Government is concerned and willing to share its knowledge and resources to combat drug addiction wherever it occurs.

In order to plan and implement effectively demand reduction programs in key countries, it is essential that such activities be supported with technically qualified personnel. The importance of this is underscored when one recognizes the labor intensive nature of these projects. Personnel qualifications dictate that individuals be prevention-oriented and specialized in the fields of drug treatment, rehabilitation and research. The Department of State relies on the Department of Health, Education, and Welfare (DHEW) and its National Institute on Drug Abuse (NIDA) to support this most important effort.

Presently, the international narcotics demand reduction programs are supported by a total of seven personnel located in the Washington area. Of this seven, three professionals are located at NIDA and one professional works with the Department of State's International Narcotics Control (S/NM) staff in developing various demonstration projects. The current staffing resource pool is a significant constraint on the overall level of demand reduction programs which we can productively undertake in the international arena. Out of the approximately $40 million annually appropriated for international narcotics control under the Foreign Assistance Act, personnel support by NIDA permits us to undertake less than $750,000 per annum in various programs involving demand reduction.

To ensure that demand reduction becomes an integral part of our overall international effort, additional qualified personnel must be made available both in Washington and in the field to develop and implement a responsible, comprehensive, and well-integrated program. In addition to the staff which NIDA currently assigns to the international area, I believe that a minimum of three additional professionals must be dedicated to demand reduction tasks abroad. I believe that through S/NM's foreign assistance resources, these positions could significantly enhance the U.S. Government's ability to develop a comprehensively planned program which would have important impacts in the future. While S/NM certainly supports the proposal to provide three additional slots with the necessary reimbursable funding from the International Narcotics Control Program, it is uncertain whether the DHEW and NIDA will be able to meet this requirement due to other pressing priorities.

STATEMENT BY THE REPRESENTATIVE OF THE FEDERAL REPUBLIC OF GERMANY

Mr. Chairman, since 1970 there is being carried out in the Federal Republic of Germany the action programme for the control of drug and narcotic drug abuse.

This programme has been followed-up in the course of time according to the changes in the drug situation. At present, there is being considered on the basis of a loop-hole analysis to subsequent the programme.

Since the last Session drug situation in the Federal Republic of Germany has hardly changed. Those being affected for four years are about 40,000 young people between 14 and 25 years of age. 338 juveniles died from drugs, either directly or indirectly, in 1976; 380 in 1977.

The drug most frequently used in our country is cannabis. Heroin has become a particular risk due to the fact that it is being offered for sale in very different degrees of purity. Thus, in the case of temporary heroin abstinence the resort to the former dose can be absolutely fatal. To improve the effect as it is said, heroin is sometimes being added dangerous substances such as the highly toxic strychnine increasing the risk even more. Despite the considerable success by both the police and the customs there can be found on the drug market heroin of an unusual degree of purity at a relatively low price and almost everywhere in smallest quantities. As to the "hard core" of those consuming opium, morphine, heroin and nowadays also cocaine that has apparently not increased very much in number, we know that here people are concerned who try these drugs, in part out of curiosity, on pressure of friends or in conflict situations and have then been addicted thereto.

Since drug scene has shifted towards the private sector it has become hard to recognize and to influence the same. Often, the change-over to heroin is still supported by the criminal drug trade availing itself of tricky methods. In the whirl of this development the interest in the pretended "harmless" illicit drugs flickers up again, at least regionally. Via the Standing Working Party of the Drug Commissioners of the Federal Government and of the Laender ("Stiindiger Arbeitskreis der Drogenbeauftragten des Bundes und der Länder") the Federal Government has observed this development with growing concern. The victims of heroin and other drugs have in large numbers escaped the direct assistance of the advisory centres provided by public authorities and voluntary carriers and can therefore hardly be reached in the usual way. All those directly involved in drug problems, either as affected ones or as helpers, find valuable assistance in a list titled "Drogenberatung, wo?" (Drug advice, where?) enumerating altogether 655 addresses. Said list is published by the Federal Minister for Youth, Family Affairs and Health in its third edition meanwhile. Here, the institutions for the consultation, treatment and rehabilitation of persons sensitive to and dependant on drugs, alcohol and medicaments are being listed. The relevant addresses are grouped under the following aspects:

psychosocial advisory and treatment centres,
sanatoria for drug addicts,
rehabilitation and therapy centres,
therapeutical communities,
central coordination and control centres.

This list is being distributed free by the Federal Minister for Youth, Family Affairs and Health.

People with whom we met:

1. Dr. Schroeder, FRG representative to the INCB.
2. Herr Heiligental, who has some responsibility for control of licit drugs.
3. Frau Schreiber.
4. Dr. Heinz Hedrich whose position in the Chancellery would be akin to our Executive Office of the President staff support.
5. Dr. Klaus Kersten.
6. Gerhardt Buhringer, Max Plank Institute, responsible for demonstration and applied research/information gathering programs.
7. Herbert Schramm of the Federal Anti-Narcotics Squad.
8. Karl Heinz Lehmann, Office of Policy and Procedural Questions, Ministry of Economic Cooperation.
9. Various people in the U.S. Mission, including DCM Francis Meehan; Narcotics Coordinator Bob Gallagher; DEA Special Agent in Charge Tom Cash.

NATURE AND EXTENT OF PROBLEM

Given the nature of the German Governments—the very limited central government and strong individual states—it is difficult to have any significant data collection in any rigorous way. For example, not only is it impossible for the Federal Government to require any statistical reporting, there is the strong

belief among some of the Germans that such a request would be ignored by some of the individual states. However, a few things are apparent. One is that over the last couple of years, there has been a steady increase in the number of overdose deaths. While only 20 in 1970, there were 334 reported heroin overdose deaths throughout the FRG last year. However, given that identification of heroin overdose is unlikely and that there is no routine requirement even for autopsy on unexplained deaths, this is likely to be a gross underestimate and the actual number is probably at least twice that. The general consensus was that the only time a death is determined to be a heroin overdose is when the person is actually found dead with the needle in his arm. There are no other indicators of the problem since five percent or less of the people have actualy come to treatment in the FRG (excluding Berlin). No one even knows how many of the heroin addicts have come to treatment.

SUPPLY RESPONSE

In contrast to the health officials, the police are very much concerned about the problem and their ability to deal with it. They have 25,000 addicts actually registered in the FRG and estimate that there are probably 40,000 addicts in total. There is general agreement that the supply of narcotics in the past came from Southeast Asia through the Netherlands to the FRG. However, since the Netherlands has taken a strong stance and deported a large number of persons in the Chinese community who were involved in the trafficking networks, distribution and sources have changed. The common wisdom now says that Mid-East heroin is being trafficked, primarily in small amounts, by Turks who come as guest workers on cheap charter flights from Istanbul to the Schoenefeld Airport in East Germany. There they are under the control of the East Germans who have virtually no interest in close customs inspection for narcotics. Once into Schoenefeld they essentially have access to West Berlin and then to the FRG. Given the unique international problems, there is little that can be done in terms of border surveillance to intercept the drugs. Once they are into Germany, of course, it is much more difficult and basic training is both needed and occurring in developing intelligence and good police methodology for narcotics control. There seem to be excellent relationships between the FRG police and our DEA and the cooperation is good. There is great skepticism on the part of police on the value of treatment as a response, even though they volunteer that reducing the demand is critical to solving the problem.

DEMAND

The health official, Mrs. Schreiber, with whom we spoke, feels that the problem is decreasing rather than increasing in the FRG. She is very clear that their system of long term, very expensive, and primarily inpatient care is appropriate. This system is a revised Synanon/Daytop model with increased restrictions and harshness. Our impression is that relatively few people come in and many do not stay. There is no use of chemotherapy for detoxification in any of the official programs and an unbelievable resistance to even the thought of methadone for detoxification, to say nothing of maintenance. There is some modest concern about the fact that although ⅓ of the people are cured in this program, there is another ⅓ that they do not know very much about and another ⅓ that they do not seem to be able to do anything with. However, there is no realization that some other kinds of treatment might need to be provided. As a further illustration of how determined the health people are to underestimate the problem, she gave us a figure of 20,000 addicts in the FRG in face of the fact that the police have actually registered 25,000 by name.

In our discussions with Gerhardt Buhringer of the Max Plank Institute, he noted that some progress had been made in developing an information system similar to CODAP (a copy of which was given to us) and that there are some 30 outpatient treatment programs that are going to be opened on an experimental basis in the next year. These programs are designed for secondary prevention as the most likely target for success, and so they are still looking at straight counselling/psychotherapy as an approach.

INTERNATIONAL

Everyone with whom we spoke seemed to have good feelings toward the U.S. and the prospects of international cooperation. Dr. Schroeder was committed to

the helpful role that the INCB could and should play in international affairs and specifically expressed concern about the control of licit opium production. He felt this posed a great potential problem and asked for our support for a resolution that he had prepared for the CND meeting in Geneva the following week, calling for restraint on licit production of opium. We were able to have some discussion about our failure to ratify the Psychotropic Convention. I said this was very embarrassing to us but relayed how optimistic we were for passage in the present session of the Congress.

In an offhand and almost joking manner, he referred to the fact that the illicit producing and trafficking countries always pointed to us saying that we *flood* the market with licit drugs and do not have appropriate controls. I related that I felt it was an important issue and that we have a serious responsibility to have appropriate controls over exports to assure that we are not contributing to the drug abuse problem. (An interesting footnote to Dr. Schroeder's perception of the problem came in an informal conversation I had with him at a cocktail party where he stated that he did not believe in the 20,000 figure offered by the Health Ministry at the meeting at all. Nor did he believe that the group of addicts was a contained group which just seemed to get older—in fact, the contrary was probably true.)

The issue of the use of bilateral assistance and the directed use of funding through UNFDAC was discussed at the Economic Ministry. The person with whom we spoke (Karl Lehmann) had no jurisdiction over U.N. fund contributions but seemed to be intrigued with the idea of bilateral aid directed toward basic rural and agricultural development in major producing countries. We talked about the involvement of Germany in Afghanistan, and the idea seemed new to him in terms of incorporating the interests of one's own country and not only the priorities of the recipient country in terms of bilateral assistance. He admitted that it represented an area which he was interested in pursuing. In addition, he was very receptive to the whole issue of the role of the IFI's and would be willing to support the U.S. position at a future meeting of the Consortium on Pakistan.

COORDINATION

There is no federal coordination currently existing between supply and demand areas. Initially in our meeting with Dr. Hedrich, he was rather resistant to the idea and basically reiterated the Health Ministry's position, saying that the problem was not serious, under control, and not in need of federal coordination. He explained that they had done a plan in 1970 or so and that, for Germany, hashish is the major problem and that other drug use and abuse is decreasing. Research is the key and finding the solution will come once research is completed. However, he became more and more interested in the concept of a role for the Chancellery for providing the kind of coordination that's done now by ODAP and seemed particularly intrigued by the need to establish and improve the criminal justice/treatment interface. He admitted that he was somewhat displeased with the lack of action on the part of the Health Ministry and said that he had recently gone to them and said that they must solve this problem now, and that it is an important problem. He also intends to share that message at a colloquium of state and local officials involved with the problem. He was very much concerned with the cost and relative ineffectiveness of their current treatment systems, feeling that they could not go on much longer for the cost would become absolutely prohibitive. At the end of the meeting he specified four issues on which he would like to continue to work with us for follow-up information and activities:

Research data.

Treatment outcome, research methodology and findings.

Criminal justice/treatment interface.

Opportunities for international cooperation.

He said that these issues should be on our agenda for continued cooperation, and we promised to send him follow-up information.

SUMMARY AND RECOMMENDATIONS

The FRG is probably undergoing a major heroin epidemic. For the most part, they are experiencing the first phase of reactions to such an epidemic, i.e., denial. There is little federal organization—the Health Ministry is looking for rigid solutions and cures to the problem and the law enforcement officials are neither trained in narcotics enforcement, nor well versed in drug investigative techniques. In general, I believe that we can do little more than to wait

for the next phase of their response which, if it mirrors the experience of our own country, will be panic. There will then be many opportunities for real cooperation.

In the meantime, there are a number of things that can and should be done on the positive side:

We need to concentrate on understanding the situation relative to supply. Most of the understanding is based on anecdotal information and there does not seem to be any hard evidence as to where the trafficking is coming from and what the origin of the heroin is. There is some preliminary work being done in cooperation with DEA on a signature-type program, and this will be helpful. In addition, the training that is going on will provide assistance. Once we feel more confident in understanding the trafficking patterns, etc., we can begin to deal with the Turkish Government, if the major source of trafficking is by Turkish nationals coming on the inexpensive charter flights into Germany as is suggested, as well as the Afghan and Pak governments if that region seems to be the major source of the opium.

In the FRG the demand side is currently quite discouraging. We need to delicately and diplomatically chip away at their denial syndrome and, if and when it changes to panic, we need to be ready to offer assistance in terms of some real health planning and executive observation programs for people to come to the U.S.

Internationally, there are some real opportunities for cooperation and I believe that the FRG is very willing to join with us in any initiatives that we might consider regarding the use of the IFI's for basic agriculture and rural development in producing areas and possibly to direct some of their own bilateral assistance once we can clearly show that that could have an impact on supply.

In terms of Federal coordination, I believe there is some encouragement in that we have identified the counterpart at the Executive Office level in the Chancellery. This should probably get a great deal of attention over the next year in nurturing and developing such a relationship. We will begin by sending him the specific information he requested and by exploring opportunities for further discussions and consultation in terms of encouraging him to take a more active and aggressive role in national planning and coordination.

FEDERAL REPUBLIC OF GERMANY—RECOMMENDATIONS

Develop better intelligence on origin and transit of illicit drugs into Berlin and FRG.

When source of illicit drugs is determined, work with the German Government to influence growers, manufacturers and transmitters, including the possibility of encouraging pre-departure inspections in Turkey.

Urge signing of U.S.-German Agreement and call for early meeting of central working group.

German health sector—develop workshops as first step in implementing U.S.-German Agreement.

Hedrich (a) send the information he requested, (b) establish basis for further dialogue, (c) invite him to visit U.S.

Lehmann—follow-up on bilateral assistance, IFI's, Commission on Pakistan.

BERLIN (FEBRUARY 1–2, 1978)

Persons with whom we met:

1. Professor Gerhard Heinmann, Chief of the Senate Chancellery.
2. Senator Ilse Reichel, Senator for Family and Sports Matters (responsible for civil narcotics matters) and her two assistants: Dr. Wolfgang Heckmann and Ms. Marie Schmajkel.
3. Otto Boettcher, Chief of Criminal Police for Western Sector of Berlin and members of the Western Police Narcotics Division.
4. Various members of the U.S. team, including Mr. George Humphrey, Public Safety Advisor; Mr. Stephen Rabourn, Assistant Public Safety Advisor; Brigadier General Walter Adams, Commander of the Berlin Brigade; and Minister Scott George.

The situation in Berlin is somewhat different from that of the Federal Republic of Germany, given both the unique status of the City as well as its relative independence from the rest of Germany. Eighty-four heroin overdose deaths in the last year puts them ahead of cities like New York and Chicago in terms of

overdose death rate. When compared with the rest of the FRG, Berlin is grossly over-represented in terms of overdose deaths, but this may indeed be a function of better reporting and more likely identification of narcotics as a cause of death. In terms of Executive Office coordination, there seems to be virtually no interest on the part of Professor Heinmann, under whose aegis such coordination would fall. He claimed that he "had no competence" for these matters and that they should be dealt with by the various supply and demand personnel. On the Berlin law enforcement side, there needs to be continued training and cooperation with U.S. DEA officials. The relationships seem good and they are excited about the permanent assignment of a DEA agent to Berlin. This should help to develop the information that we need and to provide the training capability needed by the Berlin police.

The shining light here comes on the health side. They have traditionally accepted a very rigid Synanon/Daytop model. However, they have recently recognized that this more likely leads to "cure" for the small number of people who are able to tolerate such treatment and that it is not attracting people into treatment at significant levels. They claim that 5 percent or less of the people are coming to treatment and that although there are thirty beds set aside for detoxification, these beds are not always used. The situation is further complicated by the fact that, for some unexplained reason, the heroin that is found on the streets is very pure (about 35 percent) and street level captures at 80 to 90 percent purity are not unusual. This may partially explain the high overdose death rate in Berlin. The health people were very interested in establishing liaison. They seemed ready to move away from the cure concept and to concentrate on reducing the number of heroin overdose deaths as a major focus. They recognized the importance of getting large numbers of people in treatment in order to achieve that goal and were not adverse to the concept of methadone, at least for detoxification and possibly even maintenance. They were very interested in follow-up and receiving information and seemed very receptive to the invitation for them to come to the U.S. (at their expense) for sort of an executive observation program to look at the various treatment techniques that we are using. The importance of their flexibility, etc., is not only in terms of what it might do for the City of Berlin, but also that it might well prove possible to establish a treatment system in Berlin that could be a model for the rest of FRG, and indeed for other countries in Europe as well.

MILITARY

General Adams was both aware and very much concerned about the problem of narcotics use among the military. There were four military overdose deaths in the Berlin Brigade last year, and in a confidential survey conducted within the brigade, six to eight percent reported having currently used (but were not necessarily addicted to) heroin. General Adams is a strong advocate of unit sweeps and has requested permission from his superiors to accomplish this. Right now, it takes from two to three weeks to get urinalysis results, and he is not able to do the command sweeps that he thinks are critical to both identify and prevent heroin use. This should be a priority for our follow-up. I feel in General Adams we have a very dedicated, energetic and responsive leader who, given the appropriate tools (including an EMIT machine, which we discussed, or similar technology) would put them to good use and we could probably see a real reduction in both the overdose deaths and overall use of drugs among soldiers in the Berlin Brigade.

BERLIN—RECOMMENDATIONS

Hasten assignment of permanent DEA agent to Berlin or provide full-time temporary agent until permanent agent is assigned.

Utilize NIDA assessment review to obtain information about the drug situation in Berlin, for training, and as a model for other European cities.

Invite Senator Reichel (at her own expense) to visit the U.S. (Her visit should follow the April visit of her assistant, Ms. Schmajkel.)

Follow-up with information exchange with health sector.

32/124. Narcotic drugs: international co-operation in treatment and rehabilitation

Date: 16 December 1977, Meeting: 105.
Vote: 125–0–11 (recorded) Report: A/32/458.

The general assembly

Recalling Economic and Social Council resolutions 2064 (LXII), 2065 (LXII) and 2066 (LXII) of 13 May 1977, and other resolutions on the dangers of drug abuse,

Acknowledging articles 38 and 38 bis of the Single Convention on Narcotic Drugs, 1961,[1] as amended,

Recognizing the growing threat caused by the spread of drug abuse in many parts of the world, the impact of this situation on social and economic development, agriculture and many other areas, and the resultant increase in crime and corruption.

Aware that drug abuse has serious adverse effects on the quality of life of individuals and upon the societies in which they live,

Concerned by the fact that trafficking exploits every individual with which it comes in contact,

Realizing that the concerted effort of States is required in dealing with this problem, and that international effort, in this respect, should be strengthened.

Noting that agencies of the United Nations system are addressing attention through various programmes to reduction of drug supply and demand.

Bearing in mind that the initial purpose of the introduction of drugs into society was to improve the health and well-being of individuals.

Recognizing the urgent need to make individuals and Governments more aware of the dangers of drug abuse and the need for increased attention to the field of prevention, treatment and rehabilitation,

1. Invites the United Nations Fund for Drug Abuse Control to initiate, in collaboration with the World Health Organization and other appropriate agencies and bodies of the United Nations, actions to design models for prevention, treatment and rehabilitation, taking into account the diversity of cultures in which drug abuse exists, for the purpose of identifying and demonstrating the best techniques for assisting drug abusers in order to facilitate the work of national authorities in reducing drug abuse;

2. Further invites the above-mentioned organizations to study the feasibility of establishing treatment and rehabilitation centres to care for individuals suffering from addiction and abuse and to train persons to apply the best methodologies in this field;

3. Invites the United Nations Development Programme and other appropriate agencies and bodies of the United Nations, as well as international or multilateral financial institutions engaged in development assistance, to cooperate with and assist the United Nations Fund for Drug Abuse Control, in accordance with requests by Governments, in the commissioning of pilot projects aimed at providing farmers who had relied on growing narcotics raw material as their principal source of income with other ways and means of income in areas where the illicit cultivation and production of narcotics raw material shall gradually be eradicated in accordance with the decisions of the Governments concerned;

4. Invites Governments to consider including projects designed to promote economic alternatives for farmers and others who are dependent on illicit production of narcotic substances, as additional and integrated components in their economic development programmes when applying for technical and financial assistance from multilateral institutions;

5. Requests the Commission on Narcotic Drugs to study at its next session the possibility of launching a meaningful programme of international drug abuse control strategy and policies, including the possibility of integrating therein existing policies or envisaged development assistance programmes;

6. Suggests that the Economic and Social Council at its sixty-fourth session give special consideration to all problems related to drug abuse.

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[1] United Nations, Treaty Series, vol. 520, No. 7515, p. 151.

RECORDED VOTE ON RESOLUTION 32/124

	YES	ABSTAIN	NO
Afghanistan	●		
Albania			
Algeria	●		
Angola	●		
Argentina	●		
Australia	●		
Austria	●		
Bahamas	●		
Bahrain	●		
Bangladesh	●		
Barbados	●		
Belgium	●		
Benin	●		
Bhutan	●		
Bolivia	●		
Botswana	●		
Brazil	●		
Bulgaria		●	
Burma		●	
Burundi	●		
Byelorussia SSR		●	
Canada	●		
Cape Verde			
Central African Emp	●		
Chad	●		
Chile	●		
China			
Colombia	●		
Comoros			
Congo	●		
Costa Rica	●		
Cuba	●		
Cyprus	●		
Czechoslovakia		●	
Democratic Kampuchea			
Democratic Yemen	●		
Denmark	●		
Djibouti	●		
Dominican Republic	●		
Ecuador	●		
Egypt	●		
El Salvador	●		
Equatorial Guinea			
Ethiopia	●		
Fiji	●		
Finland	●		
France	●		
Gabon	●		
Gambia			
German Rem. Rep		●	
Germany, Fed. Rep	●		
Ghana	●		
Greece	●		
Grenada			
Guatemala	●		
Guinea	●		
Guinea-Bissau	●		
Guyana	●		
Haiti	●		
Honduras	●		
Hungary		●	
Iceland	●		
India	●		
Indonesia	●		
Iran	●		
Iraq	●		
Ireland	●		
Israel	●		
Italy	●		
Ivory Coast	●		
Jamaica	●		
Japan	●		
Jordan	●		
Kenya	●		
Kuwait	●		
Lao Peoples Dem. Rep	●		
Lebanon	●		
Lesotho	●		
Liberia	●		
Libyan Arab Jamahiriya	●		
Luxembourg	●		
Madagascar	●		
Malawi			
Malaysia	●		
Maldives	●		
Mali	●		
Malta	●		
Mauritania	●		
Mauritius	●		
Mexico	●		
Mongolia		●	
Morocco	●		
Mozambique	●		
Nepal	●		
Netherlands	●		
New Zealand	●		
Nicaragua	●		
Niger	●		
Nigeria	●		
Norway	●		
Oman	●		
Pakistan	●		
Panama	●		
Papua New Guinea	●		
Paraguay	●		
Peru	●		
Philippines	●		
Poland		●	
Portugal	●		
Qatar	●		
Romania	●		
Rwanda	●		
Samoa			
Sao Tome and Principe	●		
Saudi Arabia	●		
Senegal	●		
Seychelles			
Sierra Leone	●		
Singapore	●		
Somalia	●		
South Africa			
Spain	●		
Sri Lanka	●		
Sudan	●		
Surinam	●		
Swaziland	●		
Sweden	●		
Syrian Arab Republic	●		

RECORDED VOTE ON RESOLUTION 32/124—Continued

YES	ABSTAIN	NO	YES	ABSTAIN	NO
Thailand			Un. Rep. of Tanzania		
Togo			United States		
Trinidad and Tobago			Upper Volta *		
Tunisia			Uruguay		
Turkey			Venezuela		
Uganda			Viet Nam		
Ukranian SSR			Yemen		
USSR			Yugoslavia		
United Arab Emirates			Zaire		
United Kingdom			Zambia		
Un. Rep. of Cameroon					

*Later advised the Secretariat it had intended to vote in favour.

32/125: United Nations Fund for Drug Abuse Control and its programmes related to economic and social development

Date: 16 December 1977, Meeting: 105.
Vote: 125–0–11 (recorded) Report: A/32/458.

The general assembly

Recalling its earlier appeals for voluntary contributions to the United Nations Fund for Drug Abuse Control in resolutions 3012 (XXVII) and 3014 (XXVII) of 18 December 1972, 3146 (XXVIII) of 14 December 1973, 3278 (XXIX) of 10 December 1974 and 3446 (XXX) of 9 December 1975 as well as similar appeals by the Economic and Social Council in resolutions 1664 (LII) of 1 June 1972, 1937 (LVIII) of 5 May 1975 and 2004 (LX) of 12 May 1976.

Noting with interest Economic and Social Council resolutions 2066 (LXII) of 13 May 1977 on the co-ordination of technical and financial assistance in areas of illicit production of narcotic raw materials and 2067 (LXII) of 13 May 1977 on restriction of cultivation of the poppy.

Realizing that many programmes of the United Nations Fund for Drug Abuse Control aiming at the reduction of illicit cultivation (production) of narcotic raw materials require, to a large extent, socio-economic development action as a condition for and a complement of their primary drug control aspects, and help Governments assisted by such programmes, in particular by multisectoral country programmes, in the economic and social development of the geographical areas concerned,

Convinced that such drug control-related programmes, which contribute to the general economic and social development of the areas covered by them, merit support from Governments and international or multilateral organizations and institutions concerned with providing economic and social development aid,

1. Endorses Economic and Social Council resolution 2066 (LXII) on the co-ordination of technical and financial assistance in areas of illicit production of narcotic raw materials;

2. Reiterates its appeal to Governments for sustained contributions to the United Nations Fund for Drug Abuse Control by giving due consideration to the economic and social development provided in drug control programmes financed by the Fund;

3. Urges all international or multilateral organizations and institutions concerned with providing economic and social development aid to co-operate with the United Nations by supporting financially the implementation of such drug control programmes which include sectors dealing with the economic and social development of the areas covered by those programmes;

4. Requests the Secretary-General to bring the present resolution to the attention of all Governments and of international or multilateral organizations and institutions concerned with providing economic and social development aid and to invite them to co-operate in its best possible implementation.

RECORDED VOTE ON RESOLUTION 32/125

YES	ABSTAIN	NO
Afghanistan		
Albania		
Algeria		
Angola		
Argentina		
Australia		
Austria		
Bahamas		
Bahrain		
Bangladesh		
Barbados		
Belgium		
Benin		
Bhutan		
Bolivia		
Botswana		
Brazil		
	Bulgaria	
	Burma	
Burundi		
	Byelorussia SSR	
Canada		
	Cape Verde	
Central African Emp		
Chad		
Chile		
	China	
Colombia		
	Comoros	
Congo		
Costa Rica		
	Cuba	
Cyprus		
	Czechoslovakia	
	Democratic Kampuchea	
Democratic Yemen		
Denmark		
Djibouti		
Dominican Republic		
Ecuador		
Egypt		
El Salvador		
	Equatorial Guinea	
Ethiopia		
Fiji		
Finland		
France		
Gabon		
	Gambia	
	German Dem. Rep.	
Germany, Fed. Rep		
Ghana		
Greece		
	Grenada	
Guatemala		
Guinea		
Guinea-Bissau		
Guyana		
Haiti		
Honduras		
	Hungary	
Iceland		
India		
Indonesia		
Iran		
Iraq		
Ireland		
Israel		
Italy		
Ivory Coast		
Jamaica		
Japan		
Jordan		
Kenya		
Kuwait		
Lao Peoples Dem. Rep		
Lebanon		
Lesotho		
Liberia		
Libyan Arab Jamahiriya		
Luxembourg		
Madagascar		
	Malawi	
Malaysia		
Maldives		
Mali		
Malta		
Mauritania		
Mauritius		
Mexico		
	Mongolia	
Morocco		
Mozambique		
Nepal		
Netherlands		
New Zealand		
Nicaragua		
Niger		
Nigeria		
Norway		
Oman		
Pakistan		
Panama		
Papua New Guinea		
Paraguay		
Peru		
Philippines		
	Poland	
Portugal		
Qatar		
Romania		
Rwanda		
	Samoa	
Sao Tome and Principe		
Saudi Arabia		
Senegal		
	Seychelles	
Sierra Leone		
Singapore		
Somalia		
	South Africa	
Spain		
Sri Lanka		
Sudan		
Surinam		
Swaziland		

RECORDED VOTE ON RESOLUTION 32/125—Continued

Sweden	●	Un. Rep. of Cameroon	●
Syrian Arab Republic	●	Un. Rep. of Tanzania	●
Thailand	●	United States	●
Togo	●	Upper Volta *	●
Trinidad and Tobago	●	Uruguay	●
Tunisia	●	Venezuela	●
Turkey	●	Viet Nam	●
Uganda	●	Yemen	●
Ukrainian SSR	●	Yugoslavia	●
USSR	●	Zaire	●
United Arab Emirates	●	Zambia	●
United Kingdom	●		

*Later advised the Secretariat it had intended to vote in favour.

32/126. Intensified and co-ordinated efforts to fight the illicit traffic in and illicit demand for narcotic drugs and psychotropic substances

Date: 16 December 1977, Meeting: 105.
Vote: 125-0-11 (recorded) Report: A/32/458.

The general assembly

Recalling relevant articles of the Single Convention on Narcotic Drugs, 1961,[2] as amended by the 1972 Protocol,[3] as well as of the 1971 Convention on Psychotropic Substances,[4]

Bearing in mind Economic and Social Council resolutions 1932 (LVIII) and 1934 (LVIII) of 6 May 1975, 2002 (LX) of 12 May 1976, 2064, 2067 and 2081 (LXII) of 13 May 1977, as well as the relevant recommendations of the Fifth United Nations Congress on the Prevention of Crime and the Treatment of Offenders,[5]

Recognizing the serious health, social and economic problems caused by drug abuse,

Noting with satisfaction the considerable results achieved by national law enforcement agencies, by increasing regional and interregional collaboration and in co-operation with the competent international organizations and bodies, in intercepting more and more the actual movement of drug contraband,

Noting with great concern that the continuing international illicit traffic in both narcotic drugs and psychotropic substances causes the death of many human beings or severely infringes upon their health and thus is detrimental to many societies,

Convinced that measure to reduce illicit demand for narcotic drugs and psychotropic substances, including prevention, treatment and rehabilitation, must be taken concurrently with measures to reduce illicit supply of, and illicit traffic in, drugs,

Convinced also that intensified and co-ordinated efforts by all competent agencies and organizations concerned with the fight against illicit drug traffic, at the national, regional and international levels could bring about better results in the interception of such traffic,

1. Urges every Government to intensify its efforts in that respect by strengthening and co-ordinating its law enforcement agencies responsible for intercepting the illicit traffic in narcotic drugs and psychotropic substances, by providing them with the best and most expeditious ways and means of the exchange of relevant operational information with the respective authorities of other countries, and by co-operating to the fullest extent possible with the international organizations working in his field, in order to achieve the best possible results and to avoid waste of time and manpower;

2. Calls upon those international organizations and bodies, such as the International Criminal Police Organization (INTERPOL) and the Customs Co-operation Council, to assist in all possible ways, and in the most co-ordinated manner

[2] United Nations, Treaty Series, vol. 520, No. 7515, p. 151.
[3] United Nations publication, Sales No.: E.77.XI.3.
[4] See Official Records of the United Nations Conference for the adoption of a Protocol on Psychotropic Substances, vol. I (United Nations publication, Sales No.: E.73.XI.3), part four.
[5] United Nations publication, Sales No.: E.76.IV.2.

avoiding duplication, the respective law enforcement agencies of all Governments, in particular by providing them with all available operational information related to the illicit traffic in narcotic drugs and psychotropic substances;

3. Invites Governments to take all appropriate measures against drug abuse, including in particular the early prevention of drug addiction and health education programmes, as well as to provide facilities for treatment and rehabilitation of persons addicted to drugs;

4. Invites Governments to carry out evaluation of their drug prevention programmes in order to assess their efficiency as well as to expand and intensify research in the fields of epidemiology and knowledge of causes and motives of drug abuse with regard to both pharmacological and sociological aspects;

5. Calls for more extensive and effective co-operation of Governments and competent bodies of the United Nations and specialized agencies, in order to facilitate appropriate designing and implementation of programmes aimed at reducing illicit demand for drugs and at furthering exchange of experience and information among scientists and experts actively engaged from various nations.

6. Reiterates its appeal to all States not yet parties to the 1971 Convention on Psychotropic Substances to take steps to accede to it and requests the Secretary-General to transmit this appeal to all Governments concerned;

7. Urges Governments to provide, in addition to the data already furnished in their annual reports to the Secretary-General, other relevant information on the extent, patterns and any new trends in the abuse of narcotic drugs and psychotropic substances, as well as information on programmes undertaken to reduce illicit demand for drugs;

8. Requests the Secretary-General to strengthen and expand, to the extent possible, and in co-operation with specialized agencies, the facilities available to assist Governments which request it in their work to reduce illicit demand for drugs.

RECORDED VOTE ON RESOLUTION 32/126

YES	ABSTAIN	NO
● Afghanistan		
Albania		
● Algeria		
● Angola		
● Argentina		
● Australia		
● Austria		
● Bahamas		
● Bahrain		
● Bangladesh		
● Barbados		
● Belgium		
● Benin		
● Bhutan		
● Bolivia		
● Botswana		
● Brazil		
Bulgaria		●
Burma		●
● Burundi		
Byelorussia SSR		●
● Canada		
Cape Verde		
● Central African Emp		
● Chad		
● Chile		
China		
● Colombia		
Comoros		
● Congo		
● Costa Rica		
Cuba		●
● Cyprus		
Czechoslovakia		●
Democratic Kampuchea		
● Democratic Yemen		
● Denmark		
● Djibouti		
● Dominican Republic		
● Ecuador		
● Egypt		
● El Salvador		
Equatorial Guinea		
● Ethiopia		
● Fiji		
● Finland		
● France		
● Gabon		
Gambia		
German Dem. Rep		●
● Germany, Fed. Rep		
● Ghana		
● Greece		
Grenada		
● Guatemala		
● Guinea		
● Guinea-Bissau		
● Guyana		
● Haiti		
● Honduras		
Hungary		●
● Iceland		
● India		
● Indonesia		

RECORDED VOTE ON RESOLUTION 32/126—Continued

Iran	●	Poland	●
Iraq	●	Portugal	●
Ireland	●	Qatar	●
Israel	●	Romania	●
Italy	●	Rwanda	●
Ivory Coast	●	Samoa	
Jamaica	●	Sao Tome and Principe	●
Japan	●	Saudi Arabia	●
Jordan	●	Senegal	●
Kenya	●	Seychelles	●
Kuwait	●	Sierra Leone	●
Lao Peoples Dem. Rep	●	Singapore	●
Lebanon	●	Somalia	●
Lesotho	●	South Africa	●
Liberia	●	Spain	●
Libyan Arab Jamahiriya	●	Sri Lanka	●
Luxembourg	●	Sudan	●
Madagascar	●	Surinam	●
Malawi		Swaziland	●
Malaysia	●	Sweden	●
Maldives	●	Syrian Arab Republic	●
Mali	●	Thailand	●
Malta	●	Togo	●
Mauritania	●	Trinidad and Tobago	●
Mauritius	●	Tunisia	●
Mexico	●	Turkey	●
Mongolia	●	Uganda	●
Morocco	●	Ukrainian SSR	●
Mozambique	●	USSR	●
Nepal	●	United Arab Emirates	●
Netherlands	●	United Kingdom	●
New Zealand	●	Un. Rep. of Cameroon	●
Nicaragua	●	Un. Rep. of Tanzania	●
Niger	●	United States	●
Nigeria	●	Upper Volta*	●
Norway	●	Uruguay	●
Oman	●	Venezuela	●
Pakistan	●	Viet Nam	●
Panama	●	Yemen	●
Papua New Guinea	●	Yugoslavia	●
Paraguay	●	Zaire	●
Peru	●	Zambia	●
Philippines	●		

*Later advised the Secretariat it had intended to vote in favour.

Hon. ROBERT N. SMITH,
Assistant Secretary of Defense (Health Affairs),
The Pentagon, Washington, D.C.

JULY 27, 1978.

DEAR MR. SMITH: The National Institute on Drug Abuse (NIDA) shares your concern and that of others who have studied the nature of the drug abuse problem in the military services, and we are prepared and willing to help you launch a program of studies to assess the extent and consequences of illicit drug abuse among the military.

The epidemiological research supported by NIDA over the past four years (and earlier by the National Institute of Mental Health and the Special Action Office for Drug Abuse Prevention) has helped develop a sizable group of competent, active scientists specializing in such studies of substance use and abuse. The names and affiliations of these researchers are available along with descriptions of their projects and in many cases publications resulting from their work. One whom you may know about is Dr. Lee Robins of Washington University in St. Louis, who conducted the followup study of Vietnam veterans. Others include: Dr. John O'Donnell, University of Kentucky; Dr. Ira Cisin, George Washington University; Dr. William McGlothlin, University of California at Los Angeles; and Dr. Lloyd Johnston, University of Michigan.

You should be aware also that the National Institute on Drug Abuse has undertaken research on the effects of drugs on complex human performance which may have relevance to military tasks, such as driving and other psychomotor tasks. The individuals performing this research are:

Dr. Herbert Moskowitz, Southern California Research Institute, Los Angeles, Calif.

Dr. Everett Ellinwood, Duke University, Department of Psychiatry, Durham, N.C.

It would be helpful if you would let us know when you can meet with us to discuss your needs for this kind of information. You or your designated representatives may wish to meet with members of NIDA's research staff to begin to establish a working relationship. Please let me or Dr. William Pollin, Director of the Division of Research, know when you would like to hold such a meeting. The telephone numbers are, respectively: 443–6480 and 443–1887.

Sincerely yours,

KARST J. BESTEMAN,
Acting Director.

○

END