INCREASED HEROIN SUPPLY AND DECREASED FEDERAL FUNDS: IMPACT ON ENFORCEMENT, PREVENTION, AND TREATMENT

HEARING

BEFORE THE

SELECT COMMITTEE ON
NARCOTICS ABUSE AND CONTROL
HOUSE OF REPRESENTATIVES

NINETY-SIXTH CONGRESS

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INCREASED HEROIN SUPPLY AND DECREASED FEDERAL FUNDS: IMPACT ON ENFORCEMENT, PREVENTION, AND TREATMENT

FRIDAY, MAY 2, 1980

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

The Select Committee met, pursuant to notice, at 9 a.m., in room 305, 26 Federal Plaza, New York, N.Y., Hon. Lester L. Wolff (chairman of the Select Committee) presiding.

Present: Representatives Wolff, Biaggi, and Gilman.

Also present: Patrick L. Carpentier, chief counsel; Jennifer A. Salisbury, assistant minority counsel; Toni Patricia Biaggi, Elliott A. Brown, Irving Soloway, and Robert Pfeifle, professional staff members.

Mr. WOLFF. The committee will come to order.

Today's hearing will consider the mounting evidence that the United States is experiencing a dramatic surge in heroin availability, precipitating a need for increased treatment services.

The 1979 opium production estimates from the "Golden Crescent"—Iran, Afghanistan, and Pakistan—is in excess of 1,500 metric tons. While a good deal of this crop will be consumed in the countries of origin, much of it will find its way into the international market and will surface in Western Europe and the United States. That will give us about 60 tons of heroin refined down. As I understand it, the estimates being made indicate in the days of the great crisis that we experienced in the 1960's and the 1970's, some 6 to 7 tons of heroin came into the United States. Now with a potential of 60 to 70 tons, this reaches even greater crisis proportions. In recent testimony before the Subcommittee on Health and the Environment, Mr. Peter Bensinger, Administrator of the Drug Enforcement Administration, testified that in a special street-level buy operation conducted in the summer of 1979 in Harlem and in the fall of 1979 in the Lower East Side of New York City, it was found that 42 percent and 60 percent of the respective exhibits were identified as being "European/Near Eastern" or "Middle Eastern" heroin.

The New York State Division of Substance Abuse Services reports that from December 1978 to December 1979, there has been an 89-percent increase in heroin-related emergency room visits, and there has been a reported increase in heroin overdose deaths. Readmissions to methadone treatment facilities for the first three quarters of 1979 show a marked increase over the same period in 1978. Heroin in the Northeastern United States is reported to be stronger, cheaper, and easier to find. There is an increased number

of admissions who report that heroin is their primary drug of abuse (45.1 percent in the fourth quarter of 1978 as compared to 54.8 percent in the fourth quarter of 1979).

In light of this threat, the proposal to cut Federal and State funding can have calamitous results.

The developing social-economic situation in this country with inflation and increasing unemployment may very well combine with the direct drug-related issues to engender increased levels of stress and frustration in many sectors of our society. This, in turn, may lead to increased levels of drug abuse, higher crime rates, and more and more drug-related casualty figures, and a very, very hot summer. In short, the eventual social costs of the proposed cutback may be enormous.

These are not scare tactics, nor are these alarmist utterings. If we look back to the early 1970's and consider the drug plague this country endured, and if we consider the secondary effects of a decreased ability to provide appropriate and necessary funding to the States, we may very well make ourselves heir to the enormous social costs such a drastic budget cut would almost inevitably cause. It is false economy to believe that we can cut back on treatment and enforcement, and expect the results to be anything else but tragic.

This drastic reduction will force addicts back into the streets, back into the grinding nightmare of addiction, back into the need to engage in crimes against property, as well as crimes of violence.

Our testimony today will surface these issues, so that the Congress may have a full understanding and appreciation of the consequences before final action is taken on the proposed cuts.

Before calling our witnesses to the stand, I would yield to the gentleman from New York, Mr. Biaggi.

Mr. BIAGGI. Thank you, Mr. Chairman.

Let me take this opportunity to congratulate you for this hearing, which has several purposes. One, to raise the consciousness of the American public to the fact that the drug problem has not gone away. Somehow a state of mind has developed, a lulled state of mind has developed, across the country. There is a belief that it has diminished and is disappearing. It does not enjoy the media attention that it received in the 1960's, that produced substantial Government response.

Another purpose of the hearing is to highlight the effect of our effort to obtain a balanced budget, which is a desirable objective. There is a balanced-budget fever in our country, and I feel the Congress will produce it. But in an effort to obtain that objective, the cuts should be more propitious. To cut in this area is extremely dangerous, especially in light of the testimony that we have received, and the evidence that we have, which points out clearly a 77-percent increase in drug-related deaths, an 89-percent increase in emergency-room visits because of drug-related incidents, and a 20-percent increase in addiction. We should not have cuts, we should have increases. To embark on this disastrous course at this point, Mr. Chairman, is to virtually abandon the fight.

Law enforcement officials throughout the country have been fighting a valiant, if not a futile effort to combat the scourge of drug addiction.

We have been in a position to provide them with some support. To tell them at this point, in the midst of a hot war, that we are taking some of the weapons from them is most discouraging and most demoralizing. In the end, society suffers from a moral point of view. In the end we all suffer from a cost point of view.

Thank you, Mr. Chairman.

Mr. WOLFF. Thank you, Mr. Biaggi.

I must say one of the inspirations for this hearing today is a series of articles that appeared in the New York Post highlighting the new problem of drug abuse that is hitting New York City. Taking cognizance of this, we actually are holding this hearing so that we can get on top of this problem in New York City, before it becomes the acute one that we forecast. I would like to yield to the gentleman from New York, Mr. Gilman.

Mr. GILMAN. Thank you, Mr. Chairman.

I, too, want to commend you for arranging this hearing. I think it comes at a very appropriate time, while we are considering budgetary cuts, and what that effect will have on the various programs. I am particularly concerned about how the budgetary cuts are affecting our law enforcement efforts here in the metropolitan area. Sunday, our New York delegation joined together just this week urging the Governor to provide an additional three-quarters of a million dollars to the special prosecutor's office so that they could help alleviate the backlog of cases that they have in their office.

Along with all of our members on our Select Committee, I am concerned about the influx of narcotics coming out of the crescent area, the Golden Crescent as it is now called—Afghanistan, Pakistan, and Iran—and what that is going to mean in the next year. For that reason I think this hearing can serve an extremely important purpose in focusing attention on the needs for the Federal effort in trying to make a more effective law enforcement effort, a more effective interdiction effort, a more effective education and rehabilitation effort in this area.

Thank you, Mr. Chairman.

Mr. WOLFF. Thank you, Mr. Gilman.

Now we should like to call our first panel.

Mr. Gordon Fink, Assistant Administrator for Intelligence, Drug Enforcement Administration; Mr. John Fallon, Regional Director, Drug Enforcement Administration; Chief Charles Kelly, deputy police chief, Narcotics Division, New York City Police Department. Will you please come forward.

Would you mind standing a moment and taking the oath, please.

Do you solemnly swear the testimony you are about to give is the truth, the whole truth, and nothing but the truth, so help you God?

TESTIMONY OF W. GORDON FINK, ASSISTANT ADMINISTRATOR FOR INTELLIGENCE, DRUG ENFORCEMENT ADMINISTRATION

Mr. FINK. I do.

Mr. FALLON. I do.

Chief KELLY. I do.

Mr. WOLFF. Mr. Fink, would you lead off, please.

I might say to the witnesses, without objection, that the full statement of each of the witnesses will be included in the record at this point. You might summarize your statements, if you can. And then we will operate under the 5-minute rule today, because we have a large number of witnesses.

Please proceed.

Mr. FINK. Thank you very much, Mr. Chairman, Mr. Biaggi, Mr. Gilman. It is a pleasure to be here today to represent the Drug Enforcement Administration.

Before focusing in specifically on Southwest Asian heroin, I would like to put the abuse problem in the United States—which we see as a bleak picture—in perspective.

The committee which I head, composed of Federal agencies, has estimated that the American public in 1978 spent between $45 and $63 billion for drug purchases at the retail level. Two-thirds of this amount is in marihuana and cocaine, principally exported from the South American countries of Colombia, Peru, and Bolivia.

As your committee well knows, the most cost-effective means of controlling that importation is crop control. We have some significant progress to report, specifically the Peruvian Government initiative to curtail new cultivation in cocaine, and their upgrading of their enforcement efforts. And let me give you a statistic that is representative to us of that progress.

In 1979 the combination of the foreign law enforcement efforts in South America, U.S. Customs, and U.S. Coast Guard seized between 5 and 6 tons of cocaine, or what we estimate to be 20 to 25 percent of the cocaine that is imported into the United States.

Mr. WOLFF. Excuse me, Mr. Fink. That represents a very substantial increase, does it not, in both the stuff coming in and the estimated amount that is available for the United States. I recall when we got our figures only about a year and a half ago or maybe 2 years ago—the estimate we were given was about 5 to 7 tons coming in. Now you say we are interdicting that amount, and that is only 25 percent, so there must be a vast increase.

Mr. FINK. The National Narcotics Intelligence Consumers Committee estimated for 1977, contained in this book, was 19 to 23 tons. We increased that for 1978, based principally on some of the NIDA information, to 25 tons. It is the 25-ton figure that I used to develop the percentage. The seizure of 5 to 6 tons by these law enforcement initiatives we think is significant progress. There is still a lot of progress to be made, but I think it is indicative that some of the governments are now sharing the concern and on their own conducting initiatives that we helped spawn, but now taking that initiative with some success.

Of concern to us is that both the cocaine and marihuana traffickers appear to become more syndicated. One of the results of that syndication is increased violence. And we of course have seen that in the Miami area, the New York City area, and other areas in the United States to a lesser extent. Most of this is due to struggle for competition, market control, but also there is a lot of money, and as a result, ripoffs occur. Violence is up. With the syndication of the marihuana and cocaine violators.

One other aspect of marihuana that I know is of concern to you and your committee is the THC content. Mexican marihuana runs

about 1 percent according to Dr. Turner, who does the research for NIDA. Colombian marihuana is averaging 4 to 5 percent. The new marihuana that we see coming from Hawaii, northern California, is averaging 7 percent, and Dr. Turner reports some samples ranging as high as 11 percent.

Mr. WOLFF. Is that not comparable to hashish?

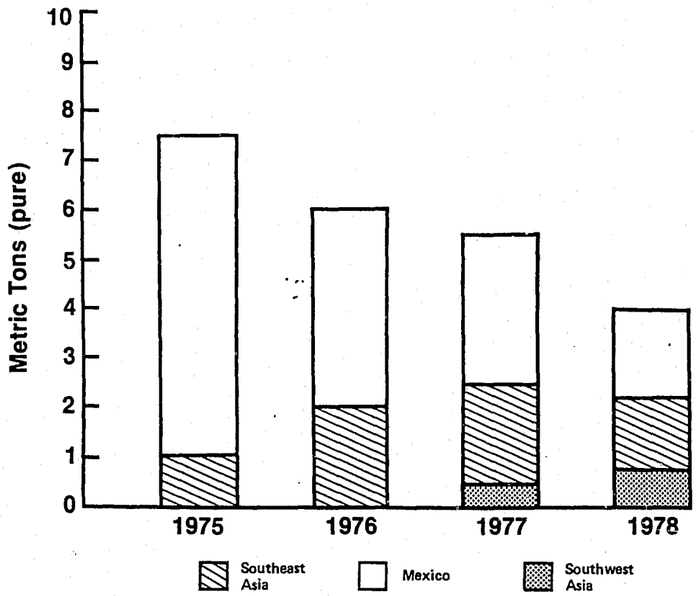
Mr. FINK. Yes, sir, it is approaching hashish. And that has the health authorities very concerned. Dr. Turner is getting much more frequent requests for data from the health treatment side, because of this increased THC content. This is a significant factor that we think is going to cause more recognition of and more attention to THC content.

Before moving into heroin, let me also mention that clandestive lab activity has increased and we are particularly concerned in the United States with the increased abuse in Quaaludes. Both the Quaaludes that are diverted from legitimate sources, and we also have some illicit operations, principally in Colombia, that are producing a large number of Quaaludes which are imported into the Miami and New York City area as two major source points, but we also see the Quaalude abuse increasing elsewhere in the United States.

I would like now to return to the focus of this hearing. The first chart that we have shows that we have made progress in reducing heroin availability through 1978, and our early statistics for 1979 which we are just about ready to come out with will show an overall reduction in heroin. We note from the reduction in the yellow portion of the chart that a lot of the reduction is due to the program of the Mexican Government to control the growth of poppies by herbicidal eradication. You see Southeast Asia on the increase, but in 1978 there was a small decrease. You see Southwest Asia, which we define as Afghanistan, Pakistan, and Iran—gum originating in those countries on the increase, and the 1979 figures will show a further increase.

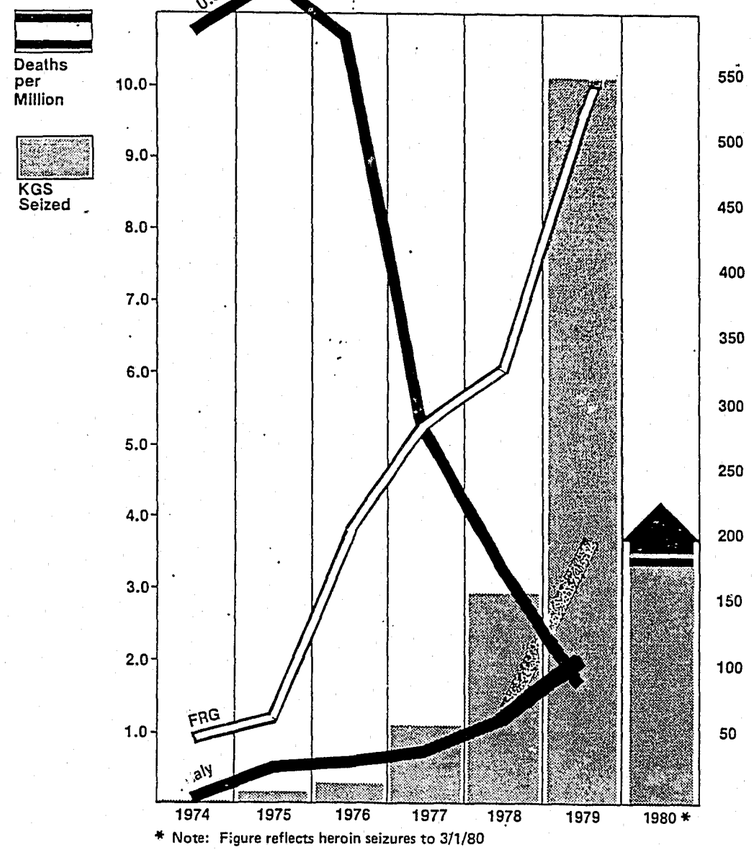
[Charts referred to follow:]

ESTIMATED SUPPLY OF HEROIN TO THE UNITED STATES, 1975-1978



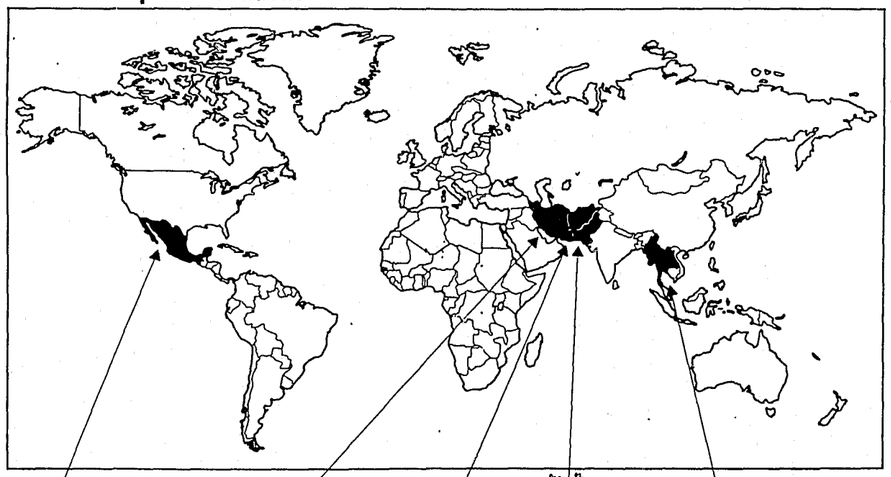
SOURCE: National Narcotics Intelligence Consumers Committee (NNICC)

Heroin-Related Deaths/Seizures of Southwest Asian Heroin in Europe

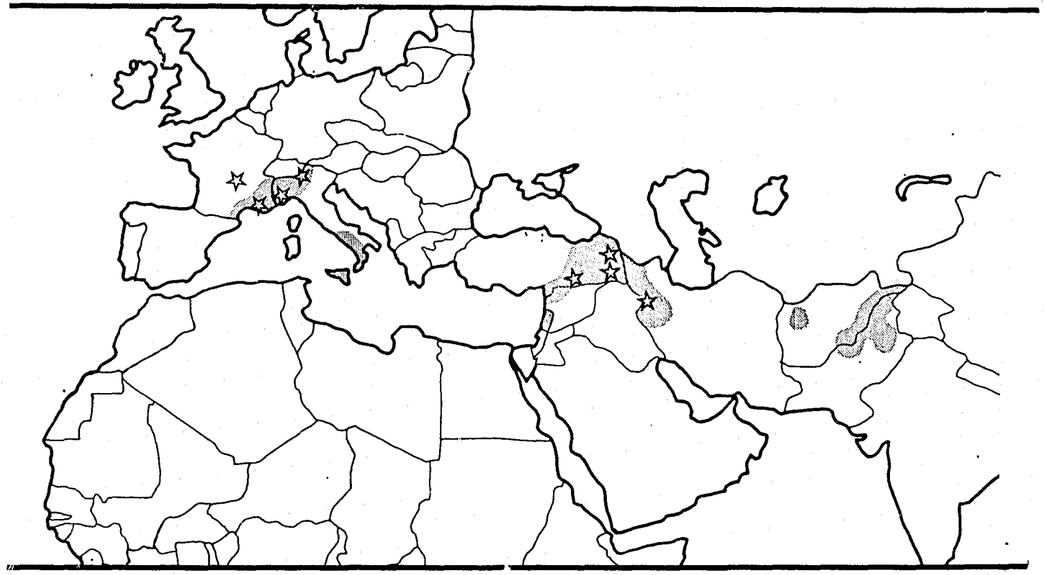


* Note: Figure reflects heroin seizures to 3/1/80

(Estimated)
1979 Illicit Opium Production



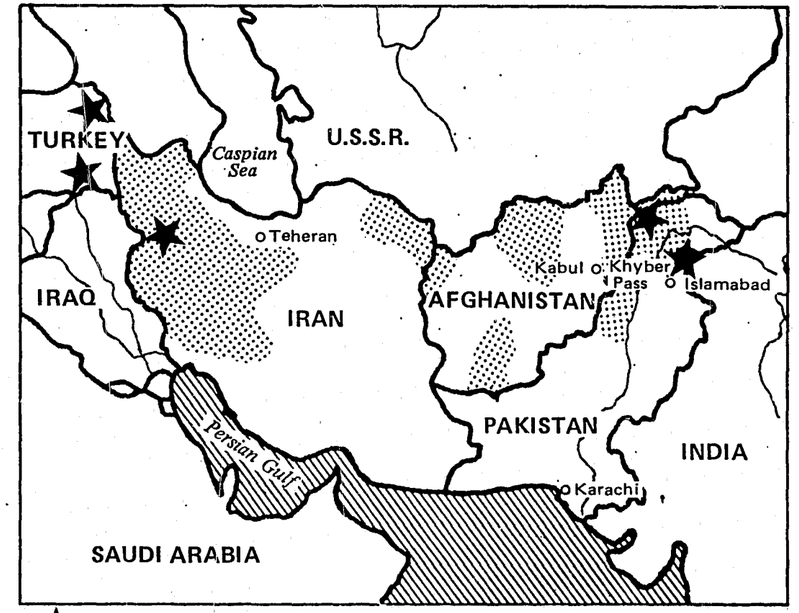
Heroin Laboratory Activity
1979-1980



☆ Laboratories Seized 1979 - 1980

Areas of Lab Activity

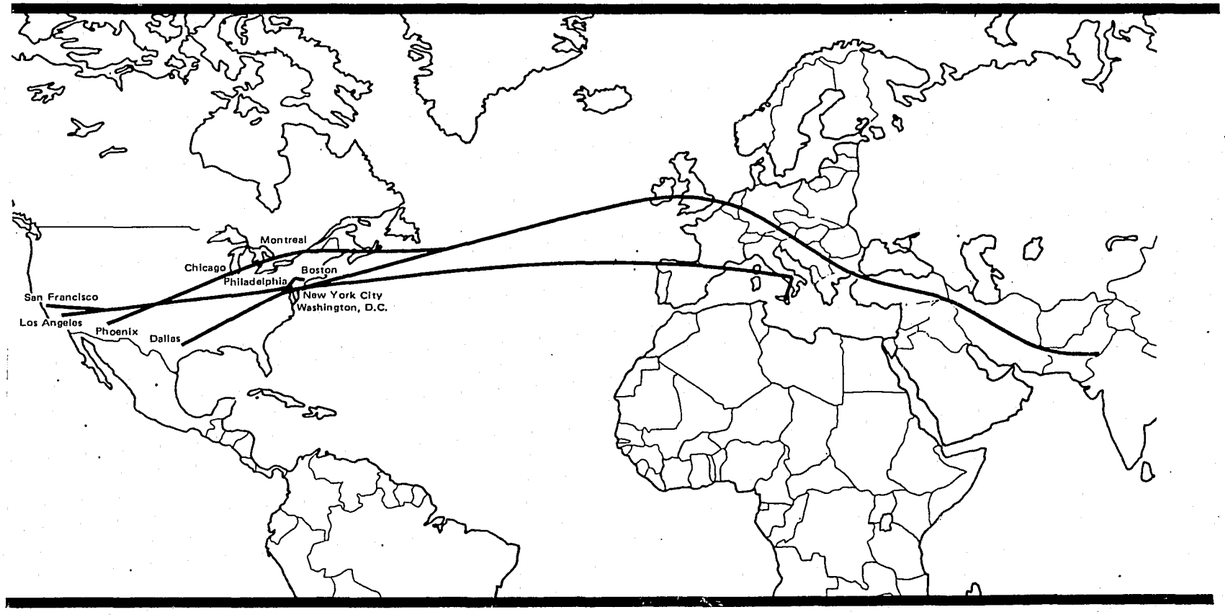
OPIUM PRODUCTION AND HEROIN LABORATORY SEIZURES



★ Heroin Laboratory Seizures

⚄ Opium Production Areas

Southwest Asian Heroin Smuggling Routes



The next chart puts the gum production, including the figure that you mentioned, in perspective. You can see now that Mexican gum production has been reduced significantly. But what has happened is that the three countries I just mentioned we estimate can produce up to 1,600 tons of gum, In the Golden Triangle, principally because of the drought, but also because of law enforcement initiatives of the Thai Government production has been reduced to 160 tons in 1979. We expect to see a slight increase in production because weather conditions have improved. Current estimates for 1980 would show approximately 250 tons produced in the Golden Triangle area. But a principal concern to this hearing today is the area represented by Iran, Afghanistan, and Pakistan. And the next chart shows the areas of cultivation in those countries. If I can spend just a brief moment on each country.

Typically, Afghanistan has produced 200 to 300 tons per year. We currently have a void in information coming out of Afghanistan, surrounding the crop that is currently being harvested. We closed our office in the spring of 1979. Because of the lack of good information after the Soviet invasion, we just really do not know what is happening as far as new cultivation. We do see some gum coming across the border into Pakistan, which is the next country of interest. Their cultivation has increased from 200 tons in 1976, to around 700 tons in 1979. I can report that there has been progress made in the crop that is being harvested right now in 1980, a significant reduction in cultivation, we believe due to two reasons. One, the fact that last year there was a surplus of gum produced, caused depressed prices, and as a result, farmers shy away from producing opium gum that they cannot derive the high profits they received the year before.

Mr. WOLFF. We have received intelligence to the effect that some of the Afghan guerrillas are paying for their weapons, bought in Pakistan, with opium.

Mr. FINK. I think that is something that has gone on historically. The tribes in those areas have smuggled gold, anything that they can derive a profit from, and a large part of their profit is derived from the opium gum trafficking. So that does track, not only with what we have seen in the last year, but historically.

I mentioned earlier a Pakistan initiative which has resulted in fines of those farmers who have been involved in the cultivation of opium, which we also believe to be significant as far as that reduction. And we welcome the trip that you are about to undertake into that area of the world so you can get a firsthand feeling for those initiatives, their effectiveness. It is the only area that we have any meaningful law enforcement liaison and relationship. In the next country, Iran, we have seen an increase of cultivation from 200 tons to now over 600 tons per year.

Mr. BIAGGI. We have no cooperation from Iran.

Mr. FINK. That is correct. And prior to 1978, we did not consider Iran an important country because that government had a program, an opium maintenance program, which provided opium to the addicts within the country. But now with controls that have been eliminated, we do see not only opium produced there, but laboratory activity in Iran. Some of our case activity involves Iranians traveling into Tehran to import heroin into the United States.

Going back to the figure that you mentioned of upward of 1,500 or 1,600 tons, we believe that two-thirds of the gum and to a lesser extent heroin hydrochloride is consumed in that area, which then leaves for export from that particular area of the world potentially 40 to 60 tons of heroin hydrochloride.

Mr. WOLFF. How does that compare with what we had coming in at the time from Turkey, for example?

Mr. FINK. Turkey, the figure was down in the order of 2 or 3 tons. But in the Mexican connection, it rose to almost 7 tons. And so that is a substantial amount.

The next chart shows some of the laboratory activity that exists.

Mr. WOLFF. Excuse me for interrupting you. Sixty tons, that would mean it was available for Europe and the United States.

Mr. FINK. That is correct.

Mr. WOLFF. And they are experiencing a tremendous increase in the number of their addict population in Europe. But try to project that—maybe some of our panel here might be able to do that—try to project that into the number of addicts that this could supply—looking at the potential that might exist. We did have at one time some 800,000 addicts that were being supplied by about 4 to 5 tons of heroin coming in. Now, if you take and try to extrapolate from those potential figures, it would give us really a horrifying potential.

Mr. FINK. Mr. Chairman, that potential exists. I will defer to those testifying this afternoon from NIDA to have them describe the current trends that they see in the increase of addiction in the United States. But there is no question, increased availability leads to increased abuse.

If I can go to the chart on the heroin-related deaths in Europe, you will see what the chairman has just made reference to. You see the decreasing death rate in the United States, down through the figures we have for 1979. But you see some 600 deaths for the Federal Republic of Germany, and you see the Italian death rate increasing. You also see the seizures of heroin in Europe increasing significantly, and that bar for 1980 reflects just the first 3 months of activity of our European counterparts in narcotics law enforcement. That picture really tells the story of what Europe is now experiencing. The laboratories, if we can go back to that chart——

Mr. GILMAN. Would the gentleman yield?

Mr. Fink, we know we have a greater influx of product coming out of Asia, a greater influx of other narcotics coming from other parts of the world. You have a higher purity rate in our own area. And yet we have a declining death rate and accident rate. How do you account for that?

Mr. FINK. Mr. Gilman, our figures for purity in the United States significantly in the last 6 months have shown the first upswing. The low that we had for purity was 3.5 percent, the system we have been tracking for the last 3 or 4 years. That figure has now gone up to 3.8 percent. There is a lag between purity on the street and abuse as it shows up on the treatment and health side, the emergency room and treatment centers. And we are just beginning to see the indicators—I think the health officials this afternoon will describe that they are now seeing an increase. The exact lag between heroin and purity, and the abuse we believe is

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roughly 6 months. But again, that depends on the type of addict that we are discussing. I think some of the addicts have moved from heroin, given the decreased availability, into PCP, into Quaaludes, and other drugs of abuse. And those addicts are the first to shift back. So we are really not sure if it is a 6-month lag or just what the lag will be. But there is a lag. Again the health officials that will be testifying can help you get an understanding.

Mr. GILMAN. Right. But there is a shift and we are beginning to incline again instead of decline in the amount of drug-related deaths.

Mr. FINK. Absolutely. I will summarize some of that information.

I think, Mr. Chairman, it is significant that we no longer have the kitchen labs that we were accustomed to in the Mexican heroin production. But I have here a book that describes a lab that the Italians seized. And you will see it was a very sophisticated operation, and it brings back to your memory I know the type of laboratory effort that existed in the days of the French connection. I would like you and the committee members to see this laboratory. And it does symbolize the seven or eight laboratories that have been seized in France and Italy in the last 6 months. It is typical of those lab seizures.

Most of the heroin that is abused in Europe has been imported by the Turkish migrant worker, coming from the laboratories that you see in Turkey, the eastern edge of Turkey, western Iran to a lesser extent, the area we call the northwest frontier, between Afghanistan and Pakistan. But if I can go now to the United States, and the trafficking routes in the picture that we see, our statistics, Mr. Gilman, pointed out, have shown an increased purity nationally, and in particular in what we call the northeast corridor. The principal importation point is the New York City area for heroin, coming into the United States.

As we began to see this heroin importation last summer, we initiated several intelligence collection activities so that we could monitor that availability. The Drug Enforcement Administration in January of 1980 initiated a new program targeted specifically at Southwest Asian heroin violators—particularly our region in Paris that is responsible for Europe and the Middle East, as well as those domestic regions that are affected by heroin availability.

In February of 1980, President Carter, Attorney General Civiletti, had a 1-day meeting of many of the senior law enforcement officials and prosecutors in the United States. Half of this day was spent briefing these senior officials on what we were seeing in Europe, and beginning to see in the United States. We felt fortunate that we had the advanced intelligence so we could alert some of the other cities in the United States as to what they might experience. The President expressed his concern at the meeting when he summarized the results of that day's activity in February, February 28.

I would like now to introduce John Fallon. But before doing that I would mention that we continue to hold in law enforcement the work that is being done here in New York City as a model of what we would like to see elsewhere in the United States. We are teamed up with the New York City Police Department. Bob McGuire has been very, very helpful, as well as the State police. I

think as you hear the testimony later on you will see some of the results of teaming up. To us, it does represent a model of true teamwork, full intelligence sharing, and one that we would like to see other cities emulate, and we are trying to do that within the Drug Enforcement Administration.

[Mr. Fink's prepared statement appears on p. 106.]

Mr. WOLFF. Thank you, Mr. Fink. The record should show that Dr. Gross, the chief medical examiner of the city of New York, has joined us. Welcome.

Mr. Fallon.

TESTIMONY OF JOHN W. FALLON, REGIONAL DIRECTOR, DRUG ENFORCEMENT ADMINISTRATION

Mr. FALLON. Yes, Mr. Chairman. I have a prepared statement. I would like to welcome the chairman and this committee back to New York. I will briefly comment from the statement.

Mr. WOLFF. Your complete statement will be put into the record.

Mr. FALLON. Very good.

Briefly, I could suggest that what Mr. Fink has addressed is all too true here in the city of New York. And I can say that the average purity of the heroin available to the retail-level buyer is on an increase, that the average purity available at the wholesale level is on the increase, that during the first quarter of 1979 there were very few exhibits of heroin with a purity in excess of 20 percent. During the first quarter of 1980, laboratory analysis has shown numerous heroin exhibits with purities between 20 and 80 percent.

Mr. WOLFF. What do you attribute that to?

Mr. FALLON. Greater availability, I think. The situation that was referred to by Mr. Fink in Southwest Asia, Iran, Afghanistan, and Pakistan. I think the fact that the assets of a lot of the Iranian people are frozen in their own country, I think people have turned to a new means of exchanging coin. It is an easier thing I guess to get heroin out of Iran than it is to get their assets out. We have had any number of incidences of arrests of Iranian nationals bringing heroin into this country. And I can assume that it is merely their way of getting money out of a country where their assets are frozen and getting it into a country where it can be negotiated back into a good currency.

It has evidenced itself in a remarkable fashion in the city of Boston, where projected heroin arrests for the first 6 months of this year were projected at a 12-percent rate. The heroin arrests in the city of Boston are at a 33-percent rate, a dramatic increase. I think it is an indication of availability, it is an indication of the fact that the marketplace in Europe, where Southeast heroin, a kilo would go for $35,000 in Amsterdam, those marketers are now withdrawing the kilos because the price is falling. That same kilo in this country will draw six times the value. A $30,000 kilo of heroin will go for $180,000 to $200,000 here.

Mr. WOLFF. When it is stepped on.

Mr. FALLON. When it is stepped on, it goes for a greater number. If you buy, in this country, an ounce of heroin at a good purity, you pay anywhere between $10,000 and $11,000. If you extrapolate that to a pound, $160,000. To a kilo, $380,000. So the stepping product

and the ability to cut pure heroin down to a level that presently exists in a well-businesslike-run organization in Harlem, where the heroin purity has remained fairly constant at the 3-percent level, they can step on their heroin and get it out in packaging, in envious retail manners. And I think it is significant that the purity there maintains constant, while the purity in an area as you referred to in Monitor-2, in the lower east side of New York, runs at an 8-percent purity. But we do see that heroin purity is on the increase. I attribute it to the fact that its availability coming in from that part of the world is more readily accessible. The inescapable conclusion is that heroin is available in higher purities than in the preceding years. The price at the retail level rarely changes. The purity may be the only change.

I will not go into comments that the medical examiner will discuss with regard to the overdose deaths from drug-related injuries. We do know from our intelligence sources that recent treatment entries to methadone programs have stated that the heroin availabile at the retail level is of a particularly good quality. We find that medical personnel at these clinics state that an average of 10 milligrams more methadone is required to stabilize these new clients. Urinalysis conducted to monitor compliance with the methadone treatment regulations show an increasing percentage of opiate positives, another large indicator.

I think the analysis of the West European situation identified by Mr. Fink was something that the Unified Intelligence Division here in New York City worked on also. As you know, the Unified Intelligence Division in our region is comprised of New York City police officers, New York State Police investigators, intelligence analysts, and statisticians. Those people projected an increase in heroin availability and purity in the New York area some while back, and it has proven itself to be somewhat accurate.

You have referred to the Monitor-1 and 2 programs that are indicators of what we might expect from retail street buys. We are doing similar-type surveys in the six target cities identified by the Drug Administration in the Southwest Asian program.

Mr. WOLFF. Have you had any indication that as a result of the Cuban situation and the influx of refugees from Cuba, that there is any relationship whatsoever of this, a spurt of new stuff, coming in?

Mr. FALLON. At this time, Mr. Chairman, I would have to say, it might be a little bit early to make a determination. But we have not really felt an impact of anything that would or could be attributed to the recent influx of Cuban refugees. It will be one of the things we will be looking for in our monitoring as we do our sampling. But right now that might well be impacting on region 2 in Miami. But I do not know as it has had a manifestation here in this city. But the Monitor-1 and 2 programs you referred to is one of the signposts of an increasing availability of heroin. And I think a more dramatic signpost has been the number of recent major seizures of heroin that have been taken at JFK airport, starting back in March of 1978, and culminating in the most recent seizure that was made in Milan, Italy, of some 41 kilograms of heroin. That particular seizure of heroin was the result of some excellent work done with the New York City police and with our task force

and our own office and resulted from seizures of heroin that have been coming into this country in August of 1979 and October of 1979 in 6- and 8-kilogram units, packed among unattended clothing or unescorted clothing arriving in in cargo on Alitalia airlines. The Alitalia airlines employees were working among themselves and were moving this heroin out. Through a seizure made by Customs, we were in a position to put together a fairly good conspiracy investigation that resulted in two individuals in Brooklyn going to Milan, Italy, to obtain 41 kilograms of heroin. The heroin was coming back to this city. I can give no better indication than the people from Brooklyn going to Milan. The original seizures of heroin were taken and put on planes from Palermo, Sicily, to Rome, to New York. This particular seizure in Milan came out of Palermo, and was seized in Milan. I think the cooperation we had with the Italian authorities now is unequaled and of the highest level, and I expect to get some very valid intelligence back from that particular seizure.

Mr. WOLFF. What was the origin of that?

Mr. FALLON. The origin of all the heroin we have referred to in the seizures made from Alitalia, are all identified as heroin grown from the opium poppies that come out of Southwest Asia, the countries of Afghanistan, Pakistan, and Iran. Recent seizures have certainly indicated that what we have seen in the seizure in Milan is an indicator of what we might expect. I think the Drug Enforcement Administration has put together a program with the SAO/SWA program, has identified the target cities. And I think the inroads made here in New York City are the result of a tremendous cooperative effort which exists as exemplified by the participating agencies in the drug enforcement task force and the Unified Intelligence Division. I feel that type of commitment and the effort and the availability of additional resources which will be made available to the SAO/SWA program will put this particular part of the country in a position to make a demonstrated effort to interdict a good deal of this heroin before it hits our shores.

That, Mr. Chairman, is my statement.

[Mr. Fallon's prepared statement appears on p. 109.]

Mr. WOLFF. Thank you, Mr. Fallon. We will go to Chief Kelly.

TESTIMONY OF CHARLES H. KELLY, DEPUTY POLICE CHIEF, NARCOTICS DIVISION, NEW YORK POLICE DEPARTMENT

Chief KELLY. Good morning, sir.

Gentlemen of the panel, I have a statement that encompasses the entire spectrum of the drug problem in the city. I do not know whether you want me to go through the whole thing, or confine it to heroin.

Mr. WOLFF. We want you to give us an overview. But we would appreciate your summarizing the statement, if you can, and we will take the whole statement and put it in the record as we have for other witnesses.

Chief KELLY. Heroin is only one problem in the city. The bigger problems of abuse in New York City is marihuana by far. Marihuana is one of the biggest problems we have, because it is visible, and it encompasses most of the complaints that we receive from the public. Cocaine is second in its popularity and in its visibility.

We do have problems with heroin, long-standing problems. We have had it for years. As you know, back in the early 1970's we had a situation in Harlem that was out of control. But the department dealt with that in an operation called Operation Drug, as you know, and we made 23,000 arrests. And I think that we impacted quite successfully on street heroin between 1975 and 1978.

But for the last 10 years the police department has made 250,000 arrests, drug arrests, in this city.

Up until the early part of 1979, we felt that heroin, street heroin traffic was at an all-time low. Ho ever, to fill the void, marihuana began to show itself in the city, in all parts of the city, as well as pills, Quaaludes, and cocaine. And this became our biggest problem.

Mr. WOLFF. I will ask the panel for unanimous consent to include in the report all of the charts that are shown by our various witnesses.

Chief KELLY. I would like to get to that in a minute. Of particular interest will be the chart illustrating the study that we made of 1,023 street bags of heroin which we purchased in the city starting with the last 6 months of 1979 and the first quarter of 1980. I will get to that in a minute.

In 1979 the police department made 18,000 drug arrests, 37 percent of which represented marihuana. And as I said before, it is obvious that marihuana represents the most flagrant visible form of drug traffic that we have at the present time.

It also demonstrates the fact that the narcotics division received 12,000 formal complaints from the public last year, most of which concerned marihuana.

So we do have a big problem there. You can see it any time of the day or night, down Wall Street, 42d Street, Bryant Park, any area of heavy pedestrian traffic. Unfortunately, there is a big market for it here. And unfortunately, a lot of our businesspeople are using it, setting a terrible example for the kids. And it is giving us a major problem in enforcement. We just cannot keep up with it.

Now, as far as heroin is concerned, we find the purity of heroin sold at the street level has increased that is talking about dime bags and Harlem quarters, a dime bag has between 2.7 and 3.0 grains in each package. The quarter package has between 20 and 30 grains.

Now, in the early 1970's we went from a high of 8 percent in purity in the dime bag and quarter bag down to a 1-percent level in the period of 1976 to 1979. During the latter part of 1979 our buy operations indicated that the purity of street heroin was definitely on the rise. In the hardcore drug areas of Harlem, 116th Street, 127th Street, 115th Street, 7th Avenue, 8th Avenue, we find the purities have gone up between 3 to 5 percent on average.

Mr. WOLFF. Are you saying it has gone up 3 to 5 percent or gone up to 3 to 5 percent?

Chief KELLY. It ranks between 3 and 5 percent. It rose from 1 percent to 3 to 5 percent. Now on the lower east side, we had a special problem. This is kind of like an aberration down there. This is nothing to do with the Harlem network. This is a Hispanic-run

heroin network. We found that the purities down there were astonishingly high.

We bought heroin down there as high as 27 percent. And I would say that this was a center of distribution for your middle-class white who came from New York and Connecticut and Westchester and Long Island. They were principally the customers on the Lower East Side.

On February 7 we conducted a large-scale raid and we eliminated that network. They are still there, but they are dispersed throughout the Lower East Side, principally through the 9th and 5th precinct.

Mr. WOLFF. One thing has always troubled us. That is the fact that we have gone into Harlem, we have gone to the various drug markets, but no matter what we seem to do on an enforcement level, those markets continue to exist. No matter how many busts you make, no matter how many people are incarcerated, these markets continue to exist in exactly the same place. We do see the law enforcement people in the area and the trafficking continuing while they are in the area. Now, how do you account for something like that?

Chief KELLY. Well, I think No. 1 is that unfortunately a market is there. The tremendous profit is there. There just does not seem to be enough deterrent to the people involved in the traffic. In fact, we have evidence now that the people who went away to jail in the 1960's and 1970's for drug trafficking are out again and they are back in the trade. So there is not sufficient deterrent and the profits are enormous.

Mr. WOLFF. But one other factor, and I think the inference might be drawn that the traffic is in the ghetto areas of our city, and that these are the people that are using the stuff. Actually, they are the marketplaces, are they not, where they are drawing people in from other areas of even the suburbs, coming into these areas to buy and then move out?

Chief KELLY. That is true. However, there is still a big market in Harlem. We also see it in the other black ghetto areas of the city. We see it in Brooklyn. And heroin is confined pretty much in Brooklyn to the black ghetto area. But you are right. Harlem traditionally, the word has gone out that this is the place you can buy heroin.

Mr. WOLFF. We saw that indicated by some very high-level people who went into Harlem to make a buy.

Chief KELLY. We hope that we have reduced that situation somewhat since those days. We have made thousands and thousands of good arrests. We have driven them off the streets and now they are behind iron doors, and all kinds of sophisticated electronic equipment. But you are right, it is still there. But we feel not to the extent it was in the 1970's, not as blatant as it was in those days, when the mayor went up there and was offered a purchase.

Mr. WOLFF. Thank you. I didn't mean to interrupt you.

Chief KELLY. That is all right.

We do say that we agree that the purity of heroin has increased. There is no question about that. However, we still find that heroin is still confined in the city of New York to the Borough of Manhattan. Lots of people think of Manhattan as New York City, but to us

it is just a borough of New York City. We have four other boroughs which I am concerned with.

Now, as far as the suburban areas of Queens and Brooklyn and Staten Island and the Bronx, we do not see the street distributions as we see it in Manhattan. There is very little of it going on out there. Out there the market is pills, marihuana and PCP.

Mr. WOLFF. As the availability grows, do you think it will reach out into those areas?

Chief KELLY. It could very well, yes, sir, of course.

Mr. WOLFF. Because I know the situation of drug abuse from what we have learned, is not one that is limited to low-income areas. In fact, people who have the funds to buy the stuff generally are into the drug scene today. One of the important aspects of this is that—I say this time and time again—when the drug problem was limited to some of those ghetto areas, nobody paid very much attention to it. It is only as a result of the fact that it has spread to the outlying areas of the city and the suburbs that people started to really pay the attention that the problem deserves.

Chief KELLY. We can go into the charts now, if you wish, just for the sake of brevity.

Mr. WOLFF. Please go ahead.

Chief KELLY. OK.

I am going to introduce my executive officer, Inspector Sibon, who will explain the purity chart for us.

Mr. SIBON. To assess the heroin purity at the street level, we studied 1,023 bags. These 1,023 bags are those analyzed by the police laboratory. They are two-thirds of the total bags purchased by the narcotics division in the last three calendar quarters. The price of these bags are 64 percent, the regular cost, $10; 19 percent cost an average of $7.50, and 17 percent cost an average of $21.

This graph depicts the purity percentages, the purity range as a percentage of the total. The weight of these bags average 2.7 grains. These red bars indicate the bags that were purchased on the Lower East Side of Manhattan what we term the Eldridge Street area, Forsythe, East 1st and 2d Streets. Half of the bags are 3 percent or less purity. The bags from 6 percent up purity, range as high in some cases as 27 percent, they were exceptionally high. They all cost, almost without exception, $10. So we have quite a good buy.

Mr. BIAGGI. Where do they sell the 3 percent bags?

Mr. SIBON. These are from other areas than the Lower East Side, primarily Manhattan and Harlem.

Chief KELLY. Primarily Harlem.

Mr. SIBON. If you average the purities from 6 percent up that we purchased on Eldridge Street, they average 13 percent. If you just took the 10 percent and above, the average purities are 17 percent. We also surmise some of these others that were purchased elsewhere, that have this high purity, because of the proximity of date and the proximity of purity, and the fact that they were double the price, were purchased at Eldridge Street and sold elsewhere. Some were sold up in the Bronx, the area we operated at yesterday, and some were sold in Brooklyn.

Mr. BIAGGI. Is that ripped?

Mr. SIBON. Those are not "rips". Those are all dime bags.

Chief KELLY. Charley, if you will, please show the other chart. This will indicate to the members of the panel how our arrests went for the last 3 years as far as type of drug in the police department, showing the number of arrests at the bottom of the bar, and the letters will show you the type of drugs involved in the arrests. And you can see 1978, 1979, there wasn't too much change there. In fact, the number of arrests for cocaine seemed to diminish a little bit. Marihuana started to go up. And the first quarter of this year, heroin has increased, the number of heroin arrests have increased, and also our marihuana arrests.

Mr. BIAGGI. What is the average quantity of narcotics in those arrests?

Chief KELLY. As far as heroin is concerned, they comprise mostly the street dime bags and quarters. So when we make arrests in Harlem, it is generally an arrest where a fellow who is a street pusher—and when we grab him he has maybe 10 bags on him. If we execute a warrant inside an apartment, we may come out with 100 to 200 quarters. So we are dealing with the low street guy, and then we are dealing with his supplier, the middle-level person.

Mr. BIAGGI. What happened to the big purchases? There was a time when the narcotics squad—I remember it well—used to effect some very, very substantial arrests, involving large quantities.

Chief KELLY. I will tell you quite frankly, in the last few years we have not come up with heavy heroin seizures, for a couple of reasons. I don't think it was that much available in heavy quantities. And I think No. 2 was that they are getting very cagey. These people all have been jailed and are out again. And they are using a lot of sophisticated equipment now. And I think they have eliminated a lot of middle people. Now they are dealing in ounce weights, although the ounces are very high quantities. The other day, as I say, we were fortunate in making a rather large seizure in one of our cases. But generally we are on the street, dealing with the street dealer, and the middle-level dealer, the ounce person.

Mr. BIAGGI. Somewhere I got the impression—and correct me if I am wrong, I am sure you will—that the thrust has been diminished as far as the larger purchase is concerned. You don't have enough money allocated or enough personnel allocated to those major buys.

Chief KELLY. I had that in my prepared statement. But I skipped over it for brevity. Since 1974, our personnel has been diminished by 30 percent. And then to compound that, the complaints that we receive for street sales of marihuana, pills, and so forth, require diverting more and more of our people to low-level traffic, and less and less to the high-level dealers. It is an unfortunate fact of life.

Mr. BIAGGI. So, you are responding to community complaints.

Chief KELLY. Absolutely.

Mr. BIAGGI. Can't have it both ways.

Chief KELLY. Nobody wants it in their neighborhood. They don't care about Nicky Barnes being arrested. They want the guy outside their schoolyard taken away.

Mr. BIAGGI. And they are impressed because the police go out there and clean up the streets.

Chief KELLY. It is a temporary solution.

Mr. BIAGGI. We are aware of it. We know the problems you are confronted with.

Chief KELLY. That concludes my statement.

[Chief Kelly's prepared statement appears on p. 111.]

Mr. BIAGGI. Dr. Gross.

TESTIMONY OF ELLIOT M. GROSS, M.D., CHIEF MEDICAL EXAMINER, CITY OF NEW YORK

[Dr. Gross' prepared statement appears on p. 115.]

Dr. GROSS. Mr. Biaggi, members of the Select Committee on Narcotics Abuse and Control, I regret very much that I am unable to provide your committee with critically analyzed data on deaths due to heroin in the city of New York. Determination of the cause of a death as due to heroin or heroin related is made following investigation into the circumstances of death including examination of the body at the scene where it is found; discovery of paraphernalia on or about the body; an autopsy including absence of injuries or natural disease sufficient to cause death; and a chemical analysis of tissues, biologic fluids removed at autopsy, and of contents of paraphernalia at the scene.

In the absence of trauma and natural disease, a preliminary determination can be made on the day of autopsy, but a final conclusion must await toxicologic analysis. Following this final determination, the original certificate of death is amended and the final cause filed with the Bureau of Health Statistics and Analysis at the Department of Health.

Statistics on heroin deaths may be compiled from those maintained in a medical examiner's office and from Registrars of Vital Statistics. Registrars, however, are dependent on data provided by the death certificates from the medical examiner's office and the extent to which such data is updated as amendments are received from the medical examiners.

For valid statistics, data collection should be initiated at the time a death is first reported to the medical examiner's office as an OD until all three aspects of death investigation (scene investigation, autopsy, and toxicological analysis) are completed.

Statistics on heroin and heroin-related deaths have not been issued by the office of chief medical examiner of the city of New York since the early 1970's. The last report was compiled by Dominic J. DiMaio, M.D., chief medical examiner, from 1976 to 1978 and acting chief medical examiner at the time of his report in 1974. This included statistics on deaths classified under the term "narcotism" for calendar year 1973 and for the first 6 months of 1974.

Mr. GILMAN. Can you tell me why statistics have not been issued by the office of medical examiner on heroin-related deaths since 1970?

Dr. GROSS. Yes. I think there are several factors. One is the shortage of the staff during that period of time. Second is the increase in the number of homicides which have occurred, which consequently required the time of the medical examiners in the investigation of those deaths. Third is that during the past decade the analysis of drugs used has become more sophisticated and more critically evaluated on a national level. The major reason is the absence of personnel, the absence of a statistician in that office.

Mr. GILMAN. I don't understand something. I think Mr. Fallon testified that DAWN received its information from the medical examiner's office. The medical examiner is now telling us they are giving nobody any information since 1970. Where is the information coming from on drug-related deaths if your office has not been able to provide that kind of information?

Dr. GROSS. Some of that information has been provided to DAWN. This was prior to my appointment in September. To the best of my knowledge, not within the past 18 months. And that data is based in part on the toxicology results, or the identification of morphine in the tissues, which is a breakdown product of heroin.

Mr. GILMAN. As far as you know, in the last 18 months there has been no drug-related death reported out of your office; is that right?

Dr. GROSS. To the best of my knowledge.

Mr. GILMAN. And that is because of a lack of personnel?

Dr. GROSS. In part because of a lack of personnel. In part because of a lack of the ability to critically analyze each of the deaths.

Mr. GILMAN. Well, I am going to ask the remainder of the panel, then, where is the information coming from on drug-related deaths, if the medical examiner cannot provide the information?

Mr. FALLON. If I may, the medical examiner's office has been very cooperative with us. And I think——

Mr. GILMAN. I am not questioning his cooperation. He is saying he hasn't been able to do it for 18 months.

Mr. FALLON. He did not have the clerks to work with them. UID on a number of occasions have sent several of our analysts down there and documents were made available that we could extrapolate from—because of the fact that he lacked the statisticians.

Mr. GILMAN. Mr. Fallon, are you saying that DEA people went down and made a finding of drug-related deaths?

Mr. FALLON. Not a finding. Gathered some intelligence from material made available.

Dr. GROSS. They would have access to our records.

Mr. GILMAN. Would your records without proper analysis be able to make a determination of a drug-related death, Dr. Gross?

Dr. GROSS. One could get—any person could walk in and based on a review of those records make determinations, based on a final certification. We have not been able to collect that data. One can have a death that is reported in which morphine is found in the tissues, and reach the conclusion that is a drug death, an overdose due to heroin.

Mr. GILMAN. Then is your problem a lack of clerical help who can just go through the records and analyze this, or is it a lack of professional help in making an analysis at the time of an autopsy?

Dr. GROSS. It is a combination of it.

Mr. GILMAN. I am not too certain. On the one hand you are telling us you are not able to provide this information because you have a lack of personnel. On the other hand Mr. Fallon says they send a clerk down, he can put it all together and get a report on drug-related deaths.

Dr. GROSS. I am not able to provide you with critically analyzed data. I can provide you with information that is raw data, information that might indicate in a certain number of cases morphine has

been found. In some cases of heroin overdoses, we might not be able to determine the presence of morphine in the tissues, and therefore there might be more deaths than provided just on the basis of the toxicology report. And I cannot——

Mr. GILMAN. Have you been requested to provide an analysis of drug-related deaths in the last year to any police agency?

Dr. GROSS. Not since I have been appointed in September.

Mr. GILMAN. And that is 18 months ago.

Dr. GROSS. No, sir. In September of this year. I did check with each of my predecessors——

Mr. GILMAN. Do you know if your office has been requested to in the last 18 months? You said in the last 18 months you haven't been able to make any reports on this.

Dr. GROSS. I checked with each of my predecessors, and asked them whether any statistics have been used from the office pertaining to these deaths. And the report that I have from each of them was that none had been.

Mr. BIAGGI. Excuse me, if the gentlemen would yield.

In your statement, on page 2, the last paragraph states that, "The last report was compiled by Dr. Dominic J. DiMaio, chief medical examiner from 1976 to 1978, and acting chief medical examiner at the time of his report in 1974. This included statistics on deaths classified under the term of "narcotism" for the calendar year 1973 and for the first 6 months of 1974."

Now, that flies in the face of what you have said, Doctor.

Dr. GROSS. No, sir. That is 1973 and 1974. I said that they had not been issued during this past period of time.

Mr. BIAGGI. Let me pursue that further. Do you make critical analysis of all other homicides?

Dr. GROSS. The only statistics that are being kept are those on the homicidal deaths in the city.

Mr. BIAGGI. Do you think there is any value in having statistical data in relation to drug-related deaths?

Dr. GROSS. There is no question about it.

Mr. BIAGGI. I will concede you have only been there a short time and it takes a while to get adjusted. I also understand you are reorganizing your office. Those of us in government know that takes a while. Do you plan to have a data collection system which would provide for the type of statistics that this committee would be interested in or any law enforcement agency?

Dr. GROSS. Yes, sir, it is needed. There is no question about it.

Mr. GILMAN. Chief Kelly and Mr. Fink, do you have any independent source of information, other than the chief medical examiner's office, for drug-related deaths?

Chief KELLY. I don't, sir.

Mr. FALLON. We have been able to get raw data and figures from UID, from the State health. State health, I think, Doctor, has its own system.

Mr. GILMAN. How would the State health department make a determination if it is within the city of New York? And you are the chief medical examiner.

Dr. GROSS. Because, Mr. Gilman, the death certificates might have on the death certificate as the cause of death acute narcotism, or acute intravenous narcotism. Those death certificates would

then be filed in the department of health, and their information obtained from those certificates.

We might have more deaths than those statistics, in all probability we do, because the cheiical analyses upon which the ultimate determination is made may not be completed until a later time, and never gets into those death certificates, and into that data. In some instances a body might be found in which the body is decomposed, and the tissues may not be analyzed or the results obtained until some time later. What I am talking about when I respond—and believe me, I do not like the fact that I cannot provide you with the data—that I cannot provide statistics unless they are as accurate as I would like them to be.

Mr. GILMAN. Are there many more drug-related deaths than have been diagnosed on the death certificates?

Dr. GROSS. Yes, there may be, because such information is not immediately entered. In other areas of the country, that information may not even be obtained.

Mr. GILMAN. Chief Kelly, do you rely on the medical examiner for your statistical information on drug-related deaths?

Chief KELLY. No, sir.

Mr. GILMAN. Where do you get your statistical information on drug-related deaths?

Chief KELLY. We don't get any.

Mr. GILMAN. How do you know how many drug-related deaths there are in your jurisdiction?

Chief KELLY. I rely on the information that I get from the UID, and that is it.

Mr. GILMAN. And UID gets it from Dr. Gross and the State.

Mr. FALLON. Congressman, I don't say we take the place of the medical examiner. But by the raw data he makes available to us, we are able to make some assessments of that as an intelligence signpost. We are not trying to take the place of the medical examiner.

Mr. GILMAN. How can you make an assessment if Dr. Gross is telling us there are some more drug-related deaths than reported to the State agency? It would seem to me this is a very fundamental aspect of trying to determine the extensiveness of overdoses of narcotics in this region, other drug-related death—certainly we all recognize in the narcotics field this is one of the more important criteria. Yet here we have the reporting agency doesn't report. I am sorry to say I cannot understand that lack of attention to a very important reporting statistic—to try to determine the extensiveness of narcotic abuse in this region. Maybe I am all wet. If I am, I wish you would tell me that.

Mr. FALLON. I wouldn't tell you that, Congressman.

Mr. GILMAN. Are we wrong? Are drug-related deaths an important criteria of the extensiveness of abuse?

Mr. FALLON. Positively.

Mr. GILMAN. Then how do we make a determination if the medical examiner cannot report to you?

Mr. FALLON. Well, I think Dr. Gross said he doesn't report and he doesn't make final analysis. But we can tell when a guy is found dead with a spike in his arm, we have a fair idea he died of an overdose of narcotics.

Mr. GILMAN. But how many do you find with a spike in his arm?
Mr. WOLFF. Maybe we ought to call Quincy.
Chief KELLY. You need at least Quincy's money and staff anyway.
Mr. WOLFF. One aspect of all of this which troubles me is the fact that are you not, Dr. Gross, required by law to state the cause of death of an individual?
Dr. GROSS. Yes, I am. And that cause of death has to be determined after a number of things have been done and a final determination made.
Mr. WOLFF. And you are not able to do that.
Dr. GROSS. I am able to do that. I am not able to collect the data from those final determinations which may take several months.
Mr. WOLFF. In other words, what you are saying, if a man has a bullet hole in his head and also a spike in his arm, as Mr. Fallon has said, you would then be able to tell he died from a combination of narcotics and bullets.
Dr. GROSS. Sometimes that does happen. There are certain number of deaths of the homicides in which morphine is identified in the tissues. And based on that one raw data——
Mr. WOLFF. What would you need in order to provide this?
Dr. GROSS. I would need a statistician, and I would need——
Mr. WOLFF. How much are we talking about?
Dr. GROSS. We are talking about perhaps $30,000.
Mr. WOLFF. And you cannot get $30,000?
Dr. GROSS. No, I am not saying that. We have placed in a request for a statistician for this office. There has not been a statistician in the office in the past 10 years, or when I was there initially. And there have been in the past questions concerning the accuracy of the data provided by the office, in the early 1970s. And I want to make certain if I do provide data that it is accurate.
Mr. WOLFF. Mr. Fink, can you tell us, do other jurisdictions throughout the United States provide this type of data?
Mr. FINK. Yes, sir. I believe there are 23 so-called SMSA's, or reporting elements in DAWN. The New York City area, there are 31 treatment units or clinics that report. In essence what the Government is paying for is some additional analysis, interview, paper filling-out to supply the system with the information. However, I would believe that these individuals are relying on this analysis, if it is going to be determined to be a drug-related death.
Mr. WOLFF. I am not talking about New York. I am talking of the SMSA's—standard metropolitan statistical areas—other areas of the county, are all of them providing this information to you?
Mr. FINK. Where it is available from the coroner's office.
Mr. WOLFF. I am not asking you where it is available. How many areas outside of New York are not providing this? Do you have any idea?
Mr. FINK. I just know the ones that we have been able to fund. It has been a financial determination as to how many cities we can afford to have reporting in the system. When I say we, it is jointly funded between NIDA, the National Institute on Drug Abuse, and DEA.
Mr. WOLFF. I would say one of the reasons why New York is not getting the type of money that it really needs is the fact that they

don't have a statistical base upon which to draw. Therefore, on that basis, you are not getting the type of funds that you need, whether it be for Sterling Johnson's office, whether it be for the police department, or for your own office, Doctor.
Dr. GROSS. There is no question about it.
Mr. BIAGGI. I think, Mr. Chairman, we can take heart, because Dr. Gross has stated that he recognizes the need, plans to implement it, and has made a request for a statistician. Given the short time he has been there, there seems to be a substantial change of policy.
Mr. WOLFF. Well, I personally think if we can spend the amount of money that we did to mount a mission to rescue 50 lives in Iran, then we certainly should be able to spend the amount of money that is necessary to rescue the lives of the people in the city of New York and throughout this country who are dying of drug abuse. The only way we are going to be able to do that is to have the information upon which to base our funding and determine the needs.
Mr. GILMAN. Mr. Chairman—if I might—Mr. Fink, I would like to make a request that the DEA provide the committee with a list of those cities who are making adequate medical examiner reports on drug-related deaths to your agency, and how you make a determination of drug-related deaths. With your permission, Mr. Chairman, I would like to include that report at this point in the record.
Mr. WOLFF. Without exception.
Mr. FINK. Mr. Gilman, we will do our best. But I believe that we will have to work with NIDA, because they are the ones that really orchestrate that system. But we will work jointly with them and provide you the best joint input we can.
Mr. GILMAN. I am directing it to you because I assume that DAWN is utilizing these drug-related death statistics.
Mr. FINK. In just the DAWN cities—we certainly can provide that.
Mr. GILMAN. And whatever other reporting areas that are available.
Mr. FINK. Yes, sir. We will give you a joint response with NIDA.
Mr. GILMAN. Thank you.
Mr. BIAGGI. I just have one or two quick questions that I would like to ask—although I am sympathetic to your position, Dr. Gross. How we have tolerated that condition for so long is beyond me. It is one of the benefits of having a hearing, I guess. It defies belief, really. Hopefully, we look forward to substantial change.
Mr. Fink, you made reference to competition for markets.
Mr. FINK. Yes, sir.
Mr. BIAGGI. Increased street violence.
Mr. FINK. Yes, sir.
Mr. BIAGGI. Would you say that is analogous to the conditions in the days of Prohibition?
Mr. FINK. From what I understand, yes, sir.
Mr. BIAGGI. I know you are too young.
Mr. FINK. I am 44. But I still have to go back to history books and knowledge, especially from some of the people from ATF. But I think very significant is the fact that we have seen the market, the trafficking syndicates change from where you had more independ-

ent entrepreneurs. Now those people are edged out by the syndicates, as they gain control of the markets, in Colombia, in Miami, in New York. And one of the related aspects of that is the increase in violence. Generally, it is one group versus another. But occasionally the innocent American public gets involved in those homicides and the injuries that are related. And that is of major concern.

Mr. BIAGGI. What is the reaction of the Colombian Government with relation to the control of marihuana growth?

Mr. FINK. Well, first, I have to express the reaction of our own Government, because we are still concerned that we are limited by law in the provision of assistance to the Colombian Government for crop control of the marihuana cultivation. So, as a result, the amendment sponsored by Congressman Rosenthal, which resulted in $16 million going to that Government, has to be used for interdiction and law enforcement initiatives. That money is just beginning to arrive in country. And we do see some positive action on behalf of the Colombian Government.

But we are in a defensive position. It is already cultivated. Now you are trying to get it as it moves toward the sources of export, whether it is a mother ship, whether it is aircraft landing in the country. You are interdicting as it is either moving on the surface or through these means of movement into the United States.

Mr. WOLFF. Mr. Fink, there has been a recent interpretation of the so-called Percy amendment, that both Senator Percy and I worked out, that does not preclude our participation in the program now with the continued use of paraquat by the Colombian Government. There is a certain restriction. But so far as the total amount that was introduced as a result of the Rosenthal amendment, that money is available now. It is just a question of how it will be used.

Mr. FINK. Yes, sir. And we certainly fully support that effort. And the Colombian Government has indicated a willingness to undertake such a program, visited Mexico, learned from the experiences they have had. So we are very appreciative of that support. We think it is very important.

Mr. BIAGGI. You made reference to the Coast Guard. I would like to address myself to that for a minute, because I am chairman of the Coast Guard Committee, and I know the work they have done. I would like to say something for the record. You may recall 4 years ago the Coast Guard was not really involved in interdiction.

There has been a change of policy as a result of my insistence. They went from 1 vessel and 40,000 pounds to 168 vessels and 3½ million pounds of marihuana, with some cocaine and some heroin. I think you stated in your earlier remarks that they had confiscated how much?

Mr. FINK. The figure I used before was cocaine, which was mostly the efforts of U.S. Customs and the foreign law enforcement organizations. But our early estimate for calendar 1979 shows 7 to 8,000 tons of marihuana removed from the importation into the United States. That, again, is a figure that combines mostly the Coast Guard, U.S. Customs efforts, together with that of the Colombian Government.

I can give you a detailed breakout of how much the Coast Guard was involved with. But we consider their effort to be extremely

important, and the program such as stop gap that was initiated in 1978, early 1979, is very, very important. And I think we are all concerned that Jack Hayes, Admiral Hayes, is short of money for fuel, and we are all suffering from that shortage, because they have a willingness, Admiral Hayes is committed to the law enforcement activities and the initiatives, to deter the importation. I think he is going as far as his budget permits.

Mr. BIAGGI. In connection with that, I know the concern, because we addressed ourselves to it, in authorizing legislation. For a little bit at least there was an attempt to reduce the missions in drug enforcement, or limit them. But that has been restored, and we have been assured by the Secretary of Transportation. I have visited in that area. It is just impossible. We could not tolerate the elimination of those missions.

Mr. FINK. Mr. Biaggi, I could just summarize by saying the problem which originally affected Florida, and that State responded by several initiatives along with the Federal Government, strong State laws were passed, new initiatives in the enforcement area. Last week I spent several days with some of the other States now beginning to be affected by the movement of the importation, the Carolinas, Georgia, Alabama, are beginning to experience some of the things that Florida went through over a year ago. And this is a major concern and the Coast Guard can be a part of helping in those areas. A lot of it is coming in by the mother ship off the coastline of those States.

Mr. WOLFF. I think the record should show at this point that the initiative taken by Mr. Biaggi has substantially helped our effort. That is one way this committee operates. The members of this committee are also members of other committees of the Congress. We are very fortunate that Mr. Biaggi is the chairman of the Coast Guard Committee, because he motivated them into some action that was not taken before.

There is also another factor in all of this—two areas particularly that I would like to talk about. One is the question of something called posse comitatus, the doctrine of restrictions that are placed upon our military services precluding their participation in civilian action. We are moving toward the introduction, the utilization of the type of sophisticated equipment that is available to the military that is not available to our people who are in the field.

I think it is shameful that we as a government make many of our law enforcement agencies depend upon confiscated equipment in order to meet the challenge of the very sophisticated drug trafficker who operates with the most sophisticated equipment available. That puts at risk your lives and your people constantly. And certainly it does not mean a maximum effort is being exerted by our Government in order to combat this traffic.

The other point that I would like to make before we release this panel is that I would like to get your ideas on either the contribution or the problems that are attendant with the moves toward decriminalization of various types of substances, particularly marihuana. Is this helping you or is this causing you some problems?

Chief KELLY. Well, in New York City it probably was one of the major factors in expanding the tremendous public use of marihua-

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na, and it probably gave impetus to the low-level dealer. So it really hurt our efforts.

Mr. WOLFF. But now the so-called Rockefeller laws themselves, which were the most stringent law we ever had, did not provide you with very much of a vehicle to accomplish your aims either. In other words——

Chief KELLY. We don't agree with that. Maybe the prosecutors might. But the police don't agree with that.

Mr. WOLFF. In other words, you felt that the Rockefeller laws provided you with the equipment necessary in order to do your job?

Chief KELLY. Yes, sir.

Mr. WOLFF. Have you noticed since we have had the change in the law any problems that you have encountered?

Chief KELLY. With the new narcotic laws?

Mr. WOLFF. Yes.

Chief KELLY. Well, the major problem is that it has forced us now to increase our budgets. We must buy a lot more narcotics to prove an A-1, an A-2 felony arrest. Where we had to buy one ounce for an A-1 felony arrest, we must get two. And with the escalation of prices, we have seen a decrease of 70 percent in our felony arrests since the new law went into effect.

Mr. WOLFF. Do you have sufficient buy money?

Chief KELLY. Well, let's say this. We could always use more. I would just like to point out in 1974 we had about $2.5 million, and now we are down to about $700,000.

Mr. WOLFF. Is that adequate for you to do the job?

Chief KELLY. We can do a better job with more money. I would say that.

Mr. WOLFF. Any other questions?

Mr. GILMAN. Thank you, Mr. Chairman.

Can you gentlemen tell me about the coordination that there exists between State, local, and Federal narcotics effort at the present time?

Mr. Kelly, I note in your testimony you say there should be a greater participation by government in improving, planning and coordination at the local level. How often do you get together with some of the State and Federal officials to do some planning on the narcotic effort and coordinating?

Chief KELLY. Well, in my statement I wasn't referring to law enforcement as far as more planning and coordination. I was referring to the departments, for example, the Health, Education, and Welfare, and those kind of people. Law enforcement coordinate their efforts in an excellent manner. We get together. Frequently we share cases. We share narcotic intelligence, UID is probably one of the best intelligence networks in the world. And we work closely together with the drug enforcement and the State police. All the local police. We have excellent relationships.

Mr. GILMAN. Who is in charge of your narcotics planning in the New York City Police Department?

Chief KELLY. Well, I work under the direction of the chief of organized crime. He represents the narcotics Division at the planning level with Mr. Fallon, and with the State police.

Mr. GILMAN. Do you work on narcotics mostly?

Chief KELLY. I work on it exclusively.

Mr. GILMAN. Are you part of that planning process with your policy people in your department?

Chief KELLY. Yes, sir, I am.

Mr. GILMAN. How often does that planning group meet with our Federal planning people to plan a strategy?

Chief KELLY. They meet regularly. Perhaps once each month.

Mr. GILMAN. Have you engaged in any long-range planning in those meetings, or are you mostly concerned with immediate major cases in those discussions?

Chief KELLY. No. There are long-range plans. One of the major factors is the use of the UID, and the intelligence that we receive from the Drug Enforcement Administration.

Mr. GILMAN. I know the tools. What I am seeking is, is there a long-range plan the city has with regard to interdicting and reducing trafficking?

Chief KELLY. Yes, sir, there is.

Mr. GILMAN. How long range is that? Is that for a year, years?

Mr. KELLY. Well, I would say it would be about a year's range, depending upon the extent of this—of the reality of this projection of heroin that is supposedly coming in from Iran.

Mr. GILMAN. So there is an overall 1-year plan for the metropolitan region with regard to narcotics effort by the city police force?

Chief KELLY. Yes, sir, there certainly is.

Mr. GILMAN. And that plan has been developed with the cooperation of Mr. Fallon's office?

Chief KELLY. That plan was developed by us, relying on their intelligence information.

Mr. GILMAN. Has there been any discussion on planning with the regional DEA?

Chief KELLY. Yes, sir.

Mr. GILMAN. They have some input in the planning?

Chief KELLY. Yes, sir.

Mr. GILMAN. And——

Mr. WOLFF. Would the gentleman yield for a moment on this? I know the gentleman is interested in the planning aspects. You indicated that you are operating under the organized crime section or bureau; am I correct?

Chief KELLY. Yes, sir, that is correct.

Mr. WOLFF. Have you noticed—for a number of years there has been a change of the trafficking patterns? And that many Americans got into the business of drug trafficking.

Chief KELLY. That is correct.

Mr. WOLFF. There have been reports recently that there has been an increase in the reintroduction of organized crime into drug trafficking. Would you subscribe to that?

Chief KELLY. I don't think they ever left it. They are involved in it today.

Mr. WOLFF. For a long time we found marihuana trafficking was not in the hands of the old organized crime groups. What I am saying is the fact that we have heard that the old organized crime groups are getting back more and more into the drug situation as a profitable operation.

Chief KELLY. That is correct.

Mr. WOLFF. Would you want to venture an opinion on that at all?

Mr. FINK. I think it does, Mr. Chairman, fit the pattern that we see. I think we can back what the chief said. It is a question of how far they are removed from actual trafficking.

But there is no question with what we see now, both in Southwest Asian heroin as well as in some areas of cocaine and marihuana. We do see traditional organized crime and the other syndicates that would fit a definition of organized crime and the other syndicates that would fit a definition of organized crime involved in the importation and the financing of the drug traffic.

Mr. BIAGGI. I have asked this question prior to the meeting, but I think it should be responded to for the record.

We have the young Turks in organized crime. We have the old bosses in organized crime. Which element is the controlling element?

Mr. FALLON. If I may, I would suggest, Congressman Biaggi, the most recent arrests in some heroin cases in South Jersey I think would fit the category of the young Turks. We took two of the Gambino nephews, sons of the brother of Carlo Gambino.

I would have to agree with Chief Kelly, though, when he said he doesn't think organized crime ever left narcotics. They may have drawn back behind, a certain element of the young Turks have been involved in Quaaludes, they are out in Brooklyn.

We see some of these guys—boats down in Bermuda bringing Quaaludes and marihuana up from Jamaica. So the young Turks have gotten into a very profitable thing.

You don't get much time for marihuana. So they have entered an area where the resistance is minimal and the profit is maximal, and anyone who comes up against them is a pushover.

The young Turk has done very well for himself.

Mr. GILMAN. Mr. Chairman.

Chief, you mentioned this planning group. What was the name of the planning group that worked on the strategy?

Chief KELLY. It is a planning coordination committee. Persons who sit on that committee, as I say, are representatives of my department, DEA and the State police.

Mr. GILMAN. Who is the chairman of that group?

Chief KELLY. I believe they change from time to time.

Mr. GILMAN. Who is the present chairman?

Chief KELLY. I believe it is——

Mr. FALLON. Could I answer, if I may. The coordinating council that you are referring to is myself, Chief Courtney, and a deputy chief of the State police. As part of the planning you have made reference to there is specific planning, targeting of major violators.

Mr. GILMAN. Besides targeting of major violators, working on critical cases, are you aware of any long-range planning in the metropolitan region?

Mr. FALLON. I am aware as Chief Kelly says he sits with Chief Courtney. Certainly——

Mr. GILMAN. They are talking about a 1-year plan. I am asking is there any long-range planning for the metropolitan region?

Mr. FALLON. I would suggest yes, it exists, by virtue of the targeting. When we target the major violators, the primary purpose of the coordinating council is to effectively take out the people having the greatest impact on the citizens of the city of New York.

Mr. GILMAN. Besides targeting, is there any other long-range strategy or plan that has been undertaken by the narcotics people in this area?

Mr. FALLON. I would suggest yes, with regard to particular problems. You may refer to it as targeting. The task force which is the primary purpose of the coordinating council meeting, has been identified almost at a 50 percentile level in responding to the cocaine problem that as occurring in Jackson Heights. I would suggest that that was targeting that has evolved into a long-range plan.

Mr. GILMAN. Is the task force devoting all its time to narcotics?

Mr. FALLON. It always has. But most specifically by direction of the coordinating council directs 50 percent of its total resources exclusively, that is the only organization I would suggest within narcotics enforcement in the State that is exclusively working 50 percent of its resources on cocaine.

Mr. GILMAN. Your coordinating council consists of yourself, Chief Courtney and the deputy State superintendent, a three-man coordinating council. Has this council evolved any plan beyond 1 or 2 years. Have they done any more planning besides focusing in on critical cases?

Mr. FALLON. I would suggest the coordinating council's primary function is to work primarily to see that the task force achieves the mission that it was brought together for, and secondly by virtue of these meetings we have been able to identify common problems. Chief Courtney has identified what would be a common problem. I am sure he goes back and discusses it with Chief Kelly and evolves a plan.

We don't attempt, and it is not the function of the coordinating council——

Mr. GILMAN. Mr. Fallon, has the national DEA office sat in with you at all and suggested any regional plan?

Mr. FALLON. No, sir. But we have a regional work plan that we are required to submit to the bureau in Washington yearly. And that identifies what percentage of our resources will be identified toward heroin, toward marihuana, toward cocaine, what percentage will be heroin arrests.

I made reference earlier that the heroin arrests in Boston are way above what we projected because of the presence of the Southwest Asian drugs.

Mr. GILMAN. Has the funding for your office been cut down in the last year as compared to prior years?

Mr. FALLON. Not demonstrably, no, sir.

Mr. GILMAN. Have you lost any personnel?

Mr. FALLON. No. Our authorized strength is as it was. It has not been cut.

Mr. GILMAN. You are not confronted with any cutbacks in the new budget?

Mr. FALLON. None that I have seen, sir.

Mr. GILMAN. Thank you. Thank you, Mr. Chairman.

Mr. WOLFF. Mr. Gilman, if you have any further questions you may submit them in writing and I am sure our witnesses will provide answers.

Mr. BIAGGI. We had recent killings, one of Angelo Bruno in Philadelphia and Phillip "Flip" Arcore in New York. Are they related to the drug supply issue?

Chief KELLY. I could not say.

Mr. WOLFF. My final question is with what we are confronted, this tremendous potential of heroin coming into this area, what are you doing in order to prepare for this? Have you adequate plans to prepare for this at the present time?

Mr. FALLON. If I may, I would like to respond to what the DEA has done in cooperation with the police department.

We have met and had seminars and briefings with every customs supervisor from the Canadian border down to Baltimore. We have had every staff officer that works for Commissioner Griffin, Commissioner Snyder, Commissioner Hurley in Philadelphia, at a briefing showing exactly what we have been faced with in the Alitalia program.

We have had senior supervisors of the Department of Immigration and Naturalization Service attend these same seminars. We have had the police department sit in with us at these briefings, the commanding officers. We have had members of the RCMP from Ottawa, Montreal, and Toronto down for the same briefing.

So I would be very pleased to say that in this instance every one of the elements of the Federal interdiction effort are at least aware of what the problem is, aware of how we have been in some instances taken by shrewd people at the New York JFK airport.

I think the enthusiasm demonstrated by those staff officers, brought down from Rouses Point and from Buffalo and from Delaware, I think the enthusiasm there is in my opinion a very good sign that these people are certainly attuned to what the threat is and are far more involved in resolving it.

Mr. WOLFF. On the question of a related situation, the projected cut of NIDA in treatment areas, do you think that this will have an effect upon the question of law enforcement? Will this cause you a greater problem if treatment slots are reduced?

Mr. FALLON. I would suggest in recent years law enforcement has become far more aware of how important a role treatment plays. I would suggest that what we have learned from treatment people is that it is a two-way street. You have to have someplace for these people to go if you start locking them up.

Mr. WOLFF. Thank you very much.

We will take a 5-minute recess.

[Whereupon a short recess was taken.]

Mr. WOLFF. The committee will come to order, please.

I must apologize to Mr. Morgenthau and Mr. Moss. There is a large demonstration taking place downstairs. Although we avoided the demonstration when we came in, we were told it would be a good idea if we went down and spoke to the people and to evidence to them the fact that the Government is listening to the people in the streets.

This was an opportunity of perhaps indicating to the people generally that the Government is responsive to their pleas. Whether or not we answered them to their satisfaction, I cannot say, but at least we tried. And my colleagues are on their way here.

We will suspend until they get back.

[Short recess.]

Mr. WOLFF. All right.

Now, Mr. Morgenthau and Mr. Moss, I know this is a committee where you have both appeared and taken the oath many times. However, we do have to administer an oath for this committee.

Do you solemnly swear to tell the truth, the whole truth and nothing but the truth, so help you God?

Mr. MORGENTHAU. I do.

Mr. Moss. I do.

Mr. WOLFF. Mr. Morgenthau, would you proceed. We are very happy to have you here. Your background in this field is well-known to our committee. We are happy you are able to devote the time you have to come over here and talk to us about this problem. I know you have been interested in it for many years.

TESTIMONY OF ROBERT M. MORGENTHAU, DISTRICT ATTORNEY OF NEW YORK COUNTY AND JAMES A. MOSS, CHIEF OF NARCOTICS UNIT, ASSISTANT U.S. ATTORNEY FOR THE SOUTHERN DISTRICT OF NEW YORK

Mr. MORGENTHAU. Mr. Chairman, Congressman Gilman, I am delighted that your committee is taking time out from your busy schedule to come here to New York to hold these hearings. I am not going to repeat what I have said in my statement.

Mr. WOLFF. The entire statement will be included in the record.

Mr. MORGENTHAU. We are terribly concerned about what is happening, about the great increase in heroin from the Middle East, from Southwest Asia.

For the last 3 years the amount coming in has doubled each year. As of last year, it was 35 percent of the supply of heroin coming into New York.

I am not only concerned about the increase in supply, but I am equally concerned by the failure of the Federal Government, State government, to provide additional resources to deal with this problem.

I think the head of the Federal Drug Enforcement Administration has done an admirable job in calling people's attention to the problem, but that the Federal Government has not come up with the resources necessary to deal with this growing problem.

The difficulty about narcotics is that the longer the problem persists, the more ingrained the distribution channels become, the more addicts that are going to be dependent on this increased supply and the more difficult the job of law enforcement is going to be to deal with it.

New York City is a great port city, so it is going to be the focal point of the importation of narcotics, no matter what local law enforcement does. It has to be dealt with I think to a substantial extent on the Federal level and treated as a national problem.

It is as though the Corps of Engineers said, "We cannot do anything about the Mississippi. It is going to overflow its banks. It is up to the townspeople to go and mop it up with mops."

It has to be dealt with to a large extent at the national level. Certainly the New York City police, the special narcotics prosecutor, the district attorney's office, are going to do everything they can to deal with the heroin here in the city. But I think the Federal Government has to take the primary responsibility of trying to interdict the importation, because that is something we cannot handle.

The cooperation between the Drug Enforcement Administration and the city police and our office, the U.S. attorney's office, I think has been excellent. But I think more resources have to be put into this fight at all levels.

I am just afraid there are an awful lot of people who think if you don't talk about drugs, it is going to go away. But the fact is it is not going to go away. We see this huge increase in availability from the Middle East, 10 times what it was in the early 1970's, late 1960's. It is coming in. It is going to come in in greater quantities, unless there is a massive law enforcement effort.

I am just delighted that your committee is raising this issue, calling it to the attention of the public, the Congress as a whole, and the States, so we can all work together to try to stop this flood before it comes in and before the distribution channels are increased, and before the number of addicts are increased.

Mr. WOLFF. Do you have adequate staffing to be able to handle the situation as it exists even today?

Mr. MORGENTHAU. I think the answer is no, we do not. We are doing the very best we can. But the State has not increased resources even to meet inflation. The special narcotics prosecutor is 50 percent financed by the State. Our so-called State felony program, which deals with narcotics has not been increased. The resources have been cut by 3 percent at a time when inflation is running 12 or 13 percent.

We need more money for buy money. We need more money for everything that you do in terms of investigating and prosecuting cases.

[Mr. Morgenthau's prepared statement appears on p. 115.]

Mr. WOLFF. Thank you, Mr. Morgenthau. We are going to go to each member of the panel first and then question later.

Mr. Moss, you are the assistant U.S. attorney in this district for narcotics matters, am I correct?

Mr. Moss. That is correct.

Mr. WOLFF. Do you have a statement?

Mr. Moss. Yes. Again, I do not wish to rehash that which I have submitted to the committee already.

Mr. WOLFF. Without objection, we will have all of these statements included in total in the record.

Mr. Moss. Thank you.

I do want to give the committee my opinion, with an overview of what we are seeing in Federal narcotics law enforcement in this district.

Within the last 4 or 5 years I think there has been a shift of focus, a necessary one, but one that does not bode well for narcotic law enforcement in the face of an impending crisis in heroin, if "crisis" is the right word.

I believe the committee has already alluded to the fact that in areas such as marihuana there has been increased evidence that organized crime is becoming reinvolved. I think that is clearly so.

There are tremendous profits in the sale and distribution of controlled substances other than heroin and cocaine—pills such as Quaaludes, LSD, hallucinogens, angel dust, which is phencycledine.

There is a tremendous market for these drugs on the streets of New York, to the point where we are bringing prosecutions against individuals who have been earning millions of dollars in the course of just a few years dealing in drugs of this sort.

It would be irresponsible for us not to devote some resources to this problem, particularly because a drug such as angel dust has a terrible effect. An increase in the death rate of drug users is in some respect a reflection of the increased availability and use of PCP.

In spite of the fact that we have an obligation to discharge our function properly, to devote resources to these areas, we are now faced with an increase in the amount of heroin that is presently coming into this area and presumably is finding its way down to the streets.

Cocaine has always been a problem. Cocaine is a problem now, perhaps even more than it has been, although the problem I should say, as a Federal prosecutor in the southern district of New York, is one which I think is greater in the eastern district.

The Colombian communities in Jackson Heights and other areas of Queens are probably the leading areas for the importation and wholesale distribution of cocaine. But certainly the cocaine problem is a substantial one.

In all of these different areas of law enforcement we have to devote as many resources as we can. So we are getting stretched in several different directions. And when I say "we" I am not specifically referring to the U.S. attorney's office, but certainly to the Drug Enforcement Administration, to the New York City Police Department and to other law enforcement agencies that are doing the investigating and the apprehension on the street.

I think the predictions that have been made to this committee, they have been made elsewhere, that there is an increase in heroin and particularly an increase in Southwest Asian heroin, are in my opinion not simply predictions, they are fact.

I think we have begun to see that. And I think anybody who is prosecuting cases in this area will realize that there is greater availability of heroin now.

The rise in the percentage of the purity of heroin that is purchased on the street is a reflection of the rise in the total amount of heroin. When heroin is not available the percentages go down. When it is readily available, the percentages go up. It is just that simple. And the percentages are going up. There is no question about that.

Mr. WOLFF. Can you give us an idea of how many cases your office handles? Is your caseload on the rise? Is it about level?

The reason I ask that is because I am really concerned, since every drug case is a violation of Federal law—I am wondering how you ascertain which cases you will handle and which cases you throw off to the special prosecutor.

Mr. Moss. Sometimes Sterling and I will go out in the hall and duke it out.

There are sometimes formal, sometimes informal ways to divide up the caseload. You are absolutely right that the jurisdiction is concurrent and that a drug offense is prosecuteable in State courts and in the Federal courts equally.

To some extent it is a reflection of which agencies are doing the investigation, whether the investigation was initiated by the New York City police, whether it was initiated by the Drug Enforcement Administration or the Drug Enforcement Task Force.

There are decisions that are made on the prosecutorial level between Mr. Johnson and myself as to which cases are more appropriately handled in Federal or State court. There are differences in the rules of evidence and various other differences which may make it more attractive to prosecute a particular case in a particular forum.

Mr. WOLFF. I don't want to interrupt your statement but I just might say that our colleague, Congressman Rangel, who is one of the ranking members of this committee—unfortunately could not be with us today. He is down trying to wrestle with the budget. He has indicated that if sufficient money is not given to the local authorities, the local authorities should dump all of that onto you.

I am just wondering whether or not if we don't have a special prosecutor's office, we don't have the district of attorney of New York able to handle this, getting inadequate funding, what is the remedy? Can you take up that caseload?

Mr. Moss. Certainly not. I think it is fair to say, and I will speak for Mr. Johnson, and I am sure he will say this as well, we are taking as many cases as we can.

Mr. WOLFF. Is that because the size of your office is limited, or is that because—let me put it in this fashion for a moment because I think this is most important.

It is said that narcotics cases are not as glamorous as some other cases that the U.S. attorneys might handle; that there is not a desire—and we have heard this in other hearings—to get into narcotics cases. Is that true here?

Mr. Moss. That is not true here. The narcotics unit in our office has been responsible for I think a very high percentage of important cases in this district. I think it is the view of people in our office that the work of the unit is important. And there is a lot of recognition given to the good work that comes out of the narcotics unit in our office.

I should say that Mr. Johnson is an alumnus of our office; that Mr. Morgenthau, during his tenure as the U.S. attorney in the district, devoted a great deal of attention and support to the work of the narcotics unit. I think that if in other districts narcotics cases are not looked upon by assistants as areas they would like to get into, that is certainly not the case here.

We have a unit that is staffed by 13 assistant U.S. attorneys. There is no unit in our office within our criminal division that is larger.

So we have devoted the resources to narcotics enforcement that I think we fairly can within the office.

Mr. WOLFF. I must say that Mr. Civiletti has been extremely active in this area. He has paid a great deal of attention to this problem. I am happy to see the attention that you are directing at this effort in New York.

[Mr. Moss' prepared statement appears on p. 116.]

Mr. WOLFF. Can we now go to Mr. Johnson, and then I think our panel would like to question the three members of the panel.

Mr. JOHNSON. First of all, Mr. Chairman, I would like to publicly acknowledge and thank you for the fact that the House Select Committee has been very, very supportive of my efforts here in New York.

I would also like to publicly thank and acknowledge the help of the entire New York delegation. They have been very, very supportive of my office and drug enforcement and rehabilitation in New York.

Mr. WOLFF. You notice, we did not swear you in for that part of the statement.

Would you rise, please. Do you solemnly swear that the testimony you are about to give is the truth, the whole truth and nothing but the truth, so help you God.

TESTIMONY OF STERLING JOHNSON, JR., SPECIAL NARCOTICS PROSECUTOR FOR NEW YORK CITY, OFFICE OF PROSECUTION, SPECIAL NARCOTICS COURTS

Mr. JOHNSON. I do.

I think the theme of the testimony from all of the witnesses this morning has been, No. 1, we all are faced with a very, very serious problem of narcotics. This has been compounded with the situation that has developed in Southwest Asia; namely, Iran, Pakistan, and Afghanistan.

Also we have been seriously hampered in the enforcement effort because of the lack of resources.

Now, in addition to this, New York State passed a drug law, modified Rockefeller drug law, and basically what the law did was to say to law enforcement officials, the police department and other agencies, in order to get that top level or middle level dealer, to convict him, you must buy twice as much drugs.

Now, the top level, according to the New York State drug law, is what they call an A-1 felony. It used to be you had to purchase 1 ounce to convict him. Now you have to buy 2 ounces.

The A-2 felon would be the middle-level drug dealer. It used to be you had to purchase an eighth of an ounce. Now you have to purchase at least a half an ounce.

Heroin 3 to 5 years ago would cost you probably $1,200 an ounce. I recently purchased an ounce of heroin for $10,000. I think as John Fallon said—I understand he said the going price is between $10,000 and $15,000 an ounce.

Now, if you have to purchase a kilo, ounce by ounce, that is $350,000.

Chief Kelly said that the number of top-level drug arrests have declined. One of the reasons it has declined is that we don't have the funds to go out into the street and to purchase the narcotics.

The other thing that is very, very important is the fact that this new drug law restricts plea bargaining. You can only plea bargain down one step.

If you are what they call a predicate, a person who has a prior felony offense within the past 10 years, then the penalty imposed upon you for conviction is much more severe than it normally would be. This is going to mean additional trials.

When the new law was passed and these provisions were put into the law, there were no funds available to hire lawyers to try these particular cases. In other words, we have a new law and we have no resources to implement the law.

As members of the New York congressional delegation, you are aware of this and you are attempting to help me persuade the Governor and members of the legislature, but particularly the Governor, to allocate some funds to remedy this particular situation.

I think it was Chief Kelly, or Mr. Fallon brought up the point—maybe Mr. Biaggi brought up the point—that what we are seeing now is a lot of the old pros who have gone to jail or maybe come out of retirement, they are back in the business again. They are utilizing that old Turkish-French connection distribution route.

Our intelligence reports tell us that we in enforcement have been tested, and I say tested. They will send through a package to see if we pick it up. If we don't pick it up, then they will utilize it. If we do pick it up, then they will try something else.

So we have been tested by these particular experts.

That is basically what I have to say.

[Mr. Johnson's prepared statement appears on p. 118.]

Mr. WOLFF. Thank you, Mr. Johnson.

Mr. Biaggi.

Mr. BIAGGI. Very briefly, I appreciate the presence of all three—Mr. Morgenthau, Mr. Johnson, and Mr. Moss.

I agree with you, Mr. Morgenthau. You made reference to the attitude of some people who say if we do not talk about it, it will go away. And frankly that is what has been happening in the last half-dozen years.

In the sixties, when the drug problem was given prominence in the media, and the general activity, political and otherwise, there was a greater degree of Government response as reflected in the moneys that were appropriated. And then suddenly there was a lull.

Some people believe that by being quiet, not talking about it, it had gone away. The fact is it had not, and we all know that. Perhaps there is a diminution from the peak years. But we still have substantial numbers, I think the estimates are about 550,000.

But that is one of the purposes of this hearing—to alert the people, to alert all levels of government and all of the professionals involved in this business that we must proceed with renewed vigor, especially with relation to the law enforcement aspect of it.

The other aspect which we are addressing is the reduction of the NIDA funds of some $40 million.

We know—and there was testimony here, Mr. Fallon stated it—that the prevention and counseling and the social aspect of it is inextricably interwoven with the law enforcement side of this.

I think all three of you have the same problem, with the increased costs of the contraband, the ability to buy, and to buy on the higher levels.

I am sure requests have been made to the appropriate authorities. And I know you have sufficient evidence to make your case convincing.

Do you find they turn a deaf ear or it is a question of simply different priorities?

Mr. MORGENTHAU. I am glad you raised that. We are concerned about the drug problem, not only because it destroys a lot of lives, people using the drugs, but it is also tied right up with the overall crime problem.

When the use of drugs goes up, overall crime goes up.

We have figures showing 46 percent of all of the arrests for felonies, the defendant has a prior drug conviction. Armed robberies, over 70 percent. So you are not only talking about drugs; you are talking about the overall crime picture, not only in New York City, but any other metropolitan area.

The thing that frankly disturbs me is we did rely on support from the Law Enforcement Assistance Administration and we understand that is going out of business. So that is a major source of funds not available to us.

When the grain trade with Russia was cut off, the President recommended $2.5 billion be appropriated to buy grain from farmers. I noticed in the paper the other day so far the U.S. Government has bought over $700 million worth of grain to support the farmers.

It seems to me we have to think about priorities. And the $700 million now, and the total of $2.5 billion available to buy grain from farmers—there ought to be $100 million available to put into the fight against the importation of drugs, which comes right out of the Middle Eastern problem.

Mr. WOLFF. If the gentleman would yield at that point.

I think you have laid your finger on an extremely important problem that we face. The overall effort of the Narcotics Office of the State Department now is somewhere between $30 to $40 million—that is the total effort that we are expending, throughout the world, to stop the production of narcotics from coming into our country. I am sure that you would agree that the one place to stop the narcotics is at their source, where they are being grown. And if you do not do it there, then your efforts have to be multiplied, and it becomes increasingly more difficult every step that you take away from the original growing source.

So I think that point that you make, of a complete reordering of the priorities, is a very important one. To bring it home is the fact that we can afford to give $700 million to the farmers to make up for the grain sales—what about taking some more money and putting it into this effort, this total effort—not just in law enforcement. That is the problem that we have and we have had in the past. It is just a question of the complete emphasis upon law enforcement. It has to be that in that area in our fight against drugs, there must be a priority established. And there must be as much effort given in the prevention and treatment area, as in the law enforcement area.

Mr. MORGENTHAU. Absolutely. I agree. There is no one solution to the drug problem. It is a many-sided problem. And I think that part of the frustration that people in government have is they think, OK, we have an answer now, and when that answer does not work, they want to forget about it, push it under the rug. But we have to stay with it. And we have to spend money for law enforcement, or treatment programs, for prevention.

Mr. BIAGGI. That last comment, you say you must stay with it. Some people take the position you cannot control it, it is overwhelming, hence we should abandon the effort. It is a sad commentary on the state of affairs. But it is a policy question. As a result of increased costs of heroin, and then community pressures, what is the policy with relation to the smaller arrests and the major arrests? How much and to what extent do you commit your personnel in either or both directions?

Mr. JOHNSON. I get my arrests mainly from the police department. And the police department's efforts are divided one-third top-level, one-third mid-level, and one-third low-level. And when we do get the low-level arrests, what usually happens, because of the priorities we must establish for ourselves, we frequently take pleas we normally would not take. For instance, misdemeanor pleas—or the diversion of some of the arrests from the criminal justice system. And that is because we do not have the staff to try these cases or to prosecute these cases adequately, if that answers your question.

Mr. BIAGGI. Mr. Morgenthau, how does your office as a matter of policy deal with these—where do you commit most of your personnel and effort?

Mr. MORGENTHAU. The New York County District Attorney's Narcotics Bureau is assigned to work with the special narcotics prosecutor, so it is a single unit. We have the same policies. We work together as a single unit. The head of our bureau is Mr. Johnson's deputy.

Mr. BIAGGI. Mr. Moss.

Mr. Moss. Congressman Biaggi, our office has to some extent been torn. We have to follow two different policies. What we would like to do would be to concentrate on the upper level of narcotics dealers—the wholesalers, the importers themselves. The Federal conspiracy law makes it most appropriate to prosecute that level of violator on the Federal level. We have not been able to—let us say we have been less able to deal in that level of violator, using the undercover purchase technique—that is actually the most effective law enforcement technique. Because we simply do not have the funds—I say we—the Drug Enforcement Administration, the New York City Police Department, do not have the funds to purchase the narcotics at that level. If you purchase an ounce of heroin and it costs you $10,000, and you hope that you will then be allowed to purchase a greater quantity, you have not even yet gotten into the wholesale quantity, the high-level dealer. And yet you have given $10,000 away in the sense that you cannot use it again to purchase additional narcotics.

There is a tremendous incentive, therefore, to arrest the people after purchasing an ounce. You get the money back, you can use it again in other narcotics transactions.

There is a tremendous incentive, therefore, for the agencies to specialize their efforts on the lower level, because they simply do not have the funds that are necessary to make the commitment, the investment, to spend $25,000 or $50,000 on a transaction without arresting the individual right then and there. That is what is necessary to gain the trust of higher level violators. Without gaining that trust, it is becoming increasingly more difficult for us to deal on that level through the undercover technique.

And we have to attempt to use other investigative methods. For example, an increased use in title III wiretaps, and so forth. Those are difficult. They are cumbersome. They are not always as productive. And they are certainly more difficult to try. And it requires us to devote a greater amount of resources of our assistants and time to handling and supervising those kinds of investigations. So I think the thrust of what I am trying to say is that we are finding it more difficult and more cumbersome to investigate at the higher levels of the narcotics traffic.

Mr. BIAGGI. I understand that. I expected that response. I posed the question so we would get that response for the record.

Mr. MORGENTHAU. Congressman—just for perspective. Mr. Johnson's office and our office together file about 1,400 indictments, felony cases. Another 1,400–1,500 felony cases are treated as misdemeanors. And then there are another several thousand cases that originate as misdemeanor drug cases. I think the U.S. attorney's office has somewhere around 150 indictments a year.

Mr. Moss. I think that is correct.

Mr. MORGENTHAU. I do not mean to denigrate what they are doing, because they are doing a very good job. But in terms of indictments we are doing maybe 10 times as many cases. In other words, the great bulk in terms of numbers of prosecution falls on local law enforcement.

Mr. BIAGGI. That leads me to the next question. I know the burden those numbers place on the ability of your office to process to finality. What is the status of the backlog of those cases?

Mr. MORGENTHAU. Our backlog of felony cases runs 1,300, 1,400 cases.

Mr. BIAGGI. Most of those individuals are out on bail?

Mr. JOHNSON. Right.

Mr. MORGENTHAU. And the jump rate is very high in narcotics cases. Runs about 25 percent.

Mr. JOHNSON. That is correct. The other important ingredient is the fact that once a defendent is out on bail awaiting trial, it is fruitless for law enforcement, the police department, Drug Enforcement Administration, or the task force to devote any additional enforcement energies toward this individual should he return to selling drugs again. You already have a case on him. And upon conviction he is going to go to jail. Most courts, if you are convicted again, would give him concurrent time. So it is just a waste of time to go out after a person who is out on bail.

Mr. MORGENTHAU. It raises various problems in the community when somebody is arrested, released on bail, back out on the street, a lot of allegations about corruption and so forth which are unfounded, because people cannot understand. It is a very serious problem of perception.

Mr. BIAGGI. I think that is why the police department, that and other reasons, may be dealing with a lot of the street arrests, to take them off the street. We know the complaints, and we know the process. They are operating at the same old stands. The police are not thin-skinned. I am sure you are not, either. It comes with the turf.

Thank you very much, Mr. Chairman.

Mr. WOLFF. Mr. Gilman.

Mr. GILMAN. Thank you, Mr. Chairman.

Are any of you gentlemen consulted as part of this policy planning strategy group that Chief Kelly talked about? Any of you ever been called in to take part in that planning group?

Mr. JOHNSON. You are referring to—is that the coordinating council?

Mr. GILMAN. I guess they call it the coordinating council.

Mr. JOHNSON. No.

Mr. GILMAN. Mr. Morgenthau?

Mr. MORGENTHAU. No.

Mr. GILMAN. Mr. Moss.

Mr. MOSS. I have been advised of their decisions.

Mr. GILMAN. Have they ever consulted with you to plan strategy? Have you had any input into that planning?

Mr. JOHNSON. I have never had any input or been consulted.

Mr. GILMAN. Do the three of you have input into any regional long-range planning or strategy for narcotics?

Mr. JOHNSON. I would have to say that is extremely difficult to plan.

Mr. GILMAN. Besides working on critical cases.

Mr. JOHNSON. I would have to say no.

Mr. GILMAN. Mr. Moss, are you involved in any?

Mr. MOSS. I would have to say no.

Mr. GILMAN. Mr. Morgenthau?

Mr. MORGENTHAU. Mr. Bensinger has been very good about keeping me posted about developments. He came up here for a special meeting.

Mr. GILMAN. Besides informing you, Mr. Morgenthau, have you sat in on any long-range planning sessions?

Mr. MORGENTHAU. No.

Mr. JOHNSON. I would like to correct something. I do recall on one occasion the coordinating council, a number of years ago, had devised some plan and they targeted some individuals. And I was invited to the Drug Enforcement Administration, and I was told of that particular plan.

Mr. GILMAN. That is where they related the plan to you?

Mr. JOHNSON. That is correct.

Mr. GILMAN. How long ago was that?

Mr. JOHNSON. I do not know. It is a number of years ago. To actually participate and get input into the council, I would have to say no.

Mr. GILMAN. Mr. Johnson, what is your total budget at the present time?

Mr. JOHNSON. Right now, it is about $2 million.

Mr. GILMAN. And how many assistants do you have, attorneys?

Mr. JOHNSON. Approximately 50. A little less than 50.

Mr. GILMAN. And how many investigators?

Mr. JOHNSON. Investigators——

Mr. GILMAN. To help you in preparation of cases.

Mr. JOHNSON. Two. And the investigator mainly handles finances, money to informants, relocation of witnesses. But to actually go out and do investigations, I have none.

Mr. GILMAN. Is part of that $2 million allocated to buy money?

Mr. JOHNSON. Yes, it is.

Mr. GILMAN. How much of that is buy money?

Mr. JOHNSON. I think about $130,000.

Mr. GILMAN. Of the $2 million?

Mr. JOHNSON. That is correct.

Mr. GILMAN. Was your budget cut this year by the State?

Mr. JOHNSON. The State gave me a grand total of a $66,000 raise.

Mr. GILMAN. And were you short—was there a deficit on your projected needs for the year?

Mr. JOHNSON. Yes. I informed the State with this new drug law, I am going to have to buy additional drugs, because the law mandates it. I am going to have to try many more cases. I figure, projected figure, 200-percent increase in the amount of trials I am going to have because of the restricted plea-bargaining.

Mr. GILMAN. What was the deficit in the amount that came out of the budget process?

Mr. JOHNSON. At least $750,000.

Mr. GILMAN. Short three-quarters of a million dollars?

Mr. JOHNSON. That is correct. At least.

Mr. GILMAN. Has the city given you the funds you needed?

Mr. JOHNSON. I am on a match basis. So if the State gives me $66,000, the city will give me $66,000.

Mr. GILMAN. Dependent upon the State's allocation.

Mr. JOHNSON. That is correct. If the city cuts me 66, then the State will cut me 66.

Mr. GILMAN. As a result of this deficit, are you going to have to reduce your manpower?

Mr. JOHNSON. As I said in my statement, I am faced with a Hobson's choice. What I am going to have to do is either raise the level of my indictments, so I will not be able to address the street arrests, and maybe just have them plead to misdemeanors, and divert it out of the criminal justice system, or I am going to have to continue the standard I employ right now, and because of the lack of personnel, the court is going to dismiss these cases for lack of prosecution.

Mr. GILMAN. So your enforcement effort is less effective as a result of this deficit?

Mr. JOHNSON. Much less effective.

Mr. GILMAN. Have you made a request of both the State and city for assistance?

Mr. JOHNSON. I have, Mr. Gilman.

Mr. GILMAN. Is there a backlog of cases at the present time in your office?

Mr. JOHNSON. There is a backlog of cases. It is rising. Another impact——

Mr. GILMAN. How many cases are backlogged for prosecution?

Mr. JOHNSON. About 1,500.

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Mr. GILMAN. 1,500 cases. And what is the longest period of time any of these has been awaiting trial?

Mr. JOHNSON. A year, better than a year.

Mr. GILMAN. Are you faced with a possible motion to dismiss for lack of prosecution?

Mr. JOHNSON. Yes, I am. A speedy-trial motion.

Mr. GILMAN. Mr. Moss, how many assistants do you have devoted to the task of narcotics?

Mr. MOSS. The narcotics unit has 13.

Mr. GILMAN. What is your budget for your unit?

Mr. MOSS. I do not have the figures on that. The operational budget for the Drug Enforcement Administration is what is used for purchases of narcotics.

Mr. GILMAN. Roughly how much does your unit expend each year in narcotics law enforcement?

Mr. MOSS. I have no way of assessing that, because we are 13 assistants assigned from among 117 in the office.

Mr. GILMAN. Do you have investigators assigned to your unit?

Mr. MOSS. We do not.

Mr. GILMAN. Do you use buy money in your unit?

Mr. MOSS. The buy money comes from the Drug Enforcement Administration's budget.

Mr. GILMAN. Could you provide us with the information as to the amount of funds that you expend out of your total budget of the narcotics enforcement unit, supply that to us in writing at a later date?

Mr. MOSS. I am sure that can be done.

Mr. GILMAN. Mr. Chairman, I request that information be made part of the record at this point.

Mr. WOLFF. Without objection.

Mr. GILMAN. Mr. Morgenthau, has the narcotics budget increased substantially over the past few years or sort of maintained a level here around $2 million?

Mr. MORGENTHAU. There has been no increase in the last 4 or 5 years. It has been kept at a level and, of course, you have to absorb increases in salaries, some of the increases being mandated, civil service, non-legal salaries. There has been no increase to take care of that.

Mr. GILMAN. I would assume from what you gentlemen have told me the resources available are wholly inadequate to do the kind of job that we should be doing at the present time and certainly to address the probability of increased crime resulting from the flow we anticipate of narcotics into this region.

Is that correct?

Mr. MORGENTHAU. That is absolutely correct.

Mr. JOHNSON. Mr. Gilman, I will go one step further. Not only have the funds available for prosecution of narcotics not been increased, there has been a decrease. When I came here from Washington in 1975 the budget for the Special Narcotics Prosecutor's office was $2.4 million.

The next year it was reduced to $1.3 million, then $1.1 million, and it gradually built itself back up to about $2.0 or $2.1 million. But it has never reached that point where it is $2.4 million, and it should be much more than $2.4 million.

But the resources are totally inadequate.

Mr. GILMAN. Mr. Moss, you mentioned there was a problem about IRS cooperating with you. I thought there was a new agreement that our committee had received in which IRS was supposed to be cooperating with the law enforcement agency in Justice and narcotics enforcement, to be of assistance.

Is there some problem in that?

Mr. MOSS. Well, what I outlined in my statement, I hope the impact of it was not deflected. It is not a criticism of IRS. I am not suggesting that the Internal Revenue Service is not cooperating to the extent that the law permits them to.

The statement that I made was that the law does not permit them to cooperate in a manner which permits us to effectively work together.

Mr. GILMAN. That is precisely what this committee addressed about a year ago. I thought at that time, Mr. Chairman, we had had response from IRS and Justice that they had worked out a reasonable agreement.

Mr. WOLFF. If the gentleman would yield at that point, the important element is that there is basic law. They are cooperating. Prior to the time of our intervention there was some question as to whether or not they could cooperate. We requested them to cooperate to the full extent that they could consistent with the law. But there are some basic problems that exist that require reform within the law to provide them access to the information, the tax returns and the like.

Am I correct on that?

Mr. MOSS. That is correct.

Mr. WOLFF. What changes would you suggest?

What would make your job, not easier, but would provide you with the type of material you need?

Mr. GILMAN. What specific law revisions would you like to see occur to bring about the kind of cooperation that you need?

Mr. MOSS. The thrust of the law, as I am sure the committee is aware, was to cut back; I would say it was a post-Watergate correction of abuses of the transmission of taxpayer information within the IRS, and from the IRS to other entities.

I don't think there ever was a complaint that prosecutors offices or law enforcement investigators were misusing information received from the IRS in connection with its criminal investigations. Yet included within the Tax Reform Act of 1976 are prohibitions against the dissemination of taxpayer information from the IRS to law enforcement agencies.

Those provisions are the ones which impeded the cooperation which heretofore had been very noteworthy in narcotics investigations.

Mr. WOLFF. If the gentlemen would yield further, the point being that in the days of prohibition the most successful and useful vehicle was the IRS, because in areas where you could not possibly convict or you could not possibly bring to justice some of the violators, you were able to through the IRS.

Today, because of this law they are keeping their hands off.

Mr. BIAGGI. Would the gentleman yield for an observation?

There is no question that the relationship between IRS and the law enforcement agencies have produced salutary results. The reason the law was passed is because the privilege was abused. And when you have an abuse the pendulum is going to swing, and the privilege was abused by all levels of government in many agencies.

It was an important reform that was done with the purpose of prohibiting that abuse from occurring again. The question is how do we legislatively amend that law so as to limit that privilege to important areas? Because I can tell you here from a practical point of view, you will not have that law repeated.

If you devise some language or proposal that will provide you with that important instrument, without debilitating the entire provisions of that law, then perhaps it could be entertained.

Mr. GILMAN. Mr. Moss, if you have any specific suggestions on how you think we could properly amend or revise the Tax Reform Act to be of help to our law enforcement agency, we would welcome hearing from you.

Mr. Moss. Thank you.

Mr. GILMAN. Just one last question to the panel.

What specific recommendations do you have to our committee that could make your job a lot more effective?

Mr. MORGENTHAU. The major recommendation is more resources. I think there has to be more resources on the Federal level and there has to be significant additional resources to local law enforcement in the port cities, like New York, which has been targeted as the No. 1 port for delivery of heroin.

There has to be resources for the police and for the prosecution of cases. Because that is the name of the game. If you cannot arrest and convict people you are not going to stop this traffic.

I would say that is No. 1. Can I interject one thing? Recently the police and the special narcotics prosecutor made a raid down on Eldridge Street, on the lower East Side, where there was widespread selling of heroin and cocaine in three buildings.

Virtually all of the customers there came from outside New York City. They came from New Jersey; they came from Connecticut; they came from suburban counties, and they came from upstate New York.

So we are not talking about a New York City problem. If heroin is going to be in substantial supply it will affect the entire State and the neighboring States. So it is not a New York City problem.

Mr. GILMAN. Thank you.

Mr. Johnson?

Mr. JOHNSON. One of the things that Chief Kelly did, he made a modest statement about this Eldridge Street raid. And I think that he and the members of the Narcotics Bureau did a tremendous job. Members of this particular community had written in, complained and sent letters. And there was a steady stream of traffic, people going in and out of some of these tenements to buy drugs.

They went up to this particular area and they took some photographs that subsequently led to a raid. The pictures you are about to see are some of those individuals whose cases will be disposed of or who will not be prosecuted because we cannot identify them.

There was one particular situation, and I don't know whether this will be shown, where people will be going into a club, 15 in a

hallway, 15 come out of the club, another 15 will march right in. Once inside the club, they were instructed to extend their hands, palms to the ceiling and money waiting. You get your service, heroin or cocaine. You would march out and they would march in.

This is something that happened recently, very, very recently, and a tremendous amount of the customers were middle-class whites from your bedroom communities.

Mr. WOLFF. Thank you; can we see that film now?

Mr. JOHNSON. Yes.

[Film was shown.]

Mr. WOLFF. How long was there surveillance on this?

Mr. KELLY. Four days. We had 4 days of filming.

[Back to film to end.]

Mr. GILMAN. Mr. Chairman, we were in the midst of a question. I asked for the recommendations of the panel.

Mr. Johnson, do you have any other recommendations?

Mr. JOHNSON. We need the commitment; we also need the resources. One of the things that they did when they had the problem on the border, and I don't know whether this is appropriate, but if it is or if it is not right now they took a lot of personnel from the Drug Enforcement Administration and shifted them down to the border.

Should our situation become as bad as I anticipate that it would, I hope the Federal Government does the same thing, shift people from around the country and bring them to New York. I don't know what the resources as far as the Drug Enforcement Administration are at the present moment. But if they need resources, they should get them also.

But I think the Federal Government has to step in and give a greater commitment and effort than they have been doing.

Mr. WOLFF. One point on all of this. I agree with the need for additional resources. But I do feel that there is another facet of this, another part of the equation that we are talking about in Washington, and that is the point made by Mr. Biaggi in the early part of our session here, and that is the effort to balance the budget per se.

I think that it is required that we do this, but we also have to have some balance to the budget and we have to address the various problems that face the people in this country which are contributory.

If we don't face those problems it will be contributory to adding to the number of people in the drug scene. I think, when we talk about the question of enforcement, there is lost all of those elements that are involved in creating a culture in which the drug and addict population will grow.

I am not talking in the sense of downgrading, for one moment, the enforcement elements. Where I come from, Sterling, I feel we have to develop the maximum that we possibly can to enforcement efforts.

But I don't think we should lose sight of the fact that with the direction that we are taking in some areas of the Federal Government today, the cuts that are occurring are going to create an enhancement of the problem rather than a solution to the problem.

I know we have a terrible problem of inflation. But unless we have housing in this country to provide a place for someone to live, we are going to add those persons who go on to the street and thus create further problems for you in the enforcement area.

Unless we have the jobs for people we are not going to be able to solve this problem. So the social part of the equation is a very vital one in the entire problem of addressing drug abuse in this country.

I think it has to be known. We must get involved in those areas. Some people say we can cut back on these things temporarily and hope to solve the problem, but if we are going to solve the problem of crime in the streets we have to take people out of the streets.

Mr. JOHNSON. Mr. Chairman, I couldn't agree with you more. When I say more resources, I mean more resources for the drug abuse problem. You must address the social ills, treatment, rehabilitation. You must attempt to address this problem immediately. You must put money in law enforcement, so our resources have to be put into the problem as a whole.

It is a complex problem, and it has to be solved with a complex answer.

Mr. WOLFF. What I am saying is the fact that we have to have a domestic defense budget.

Mr. JOHNSON. That is correct, and if you don't pay the dollars now, you pay the piper later.

Mr. GILMAN. Mr. Moss, do you have any specific recommendations?

Mr. Moss. I wholeheartedly agree with the statements that Mr. Johnson and Mr. Morgenthau made about the increased need for commitment of resources to the overall problem.

I think the chairman's remarks are particularly well taken about how there is a need across the board for response in a variety of different ways. I hope this morning that we have been able to give you some insights into the difficulties that we perceive from the prosecution angle.

Before you leave I did want to express to the committee what I think is an appreciation on my part as a prosecutor for the excellent work that has been done by the narcotics law enforcement establishment. The agents and officers that I have worked with in narcotics law enforcement are easily among the most dedicated and hard working that I have encountered in any area of law enforcement.

They work with extreme diligence. I can represent to the committee that to the extent that they have been entrusted with resources and the mandate to attempt to correct the problems in narcotics trafficking, that they are doing an outstanding job with what they have.

Mr. GILMAN. We thank the panel.

We thank you for your efforts.

Just one other question: Have you been able to find a close relationship between the major trafficking and organized crime in the city, and have you been able to pinpoint where the control lies?

Mr. JOHNSON. I would answer the question this way, Mr. Gilman:

The answer is yes. As Mr. Fallon said, organized crime as we know it has never gotten out of narcotics. They have been dormant for a particular period of time.

We are resurfacing now. They are using the Turkish-French connection route. This is compounded by the fact when that Turkish-French connection source was eliminated and dried up, Mexico opened up, and then you had Hispanics coming into the particular business. So you have that element in it.

When they had the war in Vietnam, you had blacks who had access to drugs or heroin from the Golden Triangle and they got into the drug business. So you have blacks, Hispanics, organized crime. Right now there is competition. There is also cooperation. So the problem that we face today is much more serious than the problem we faced when there was only one particular group who had a monopoly on the drug traffic.

Mr. GILMAN. Have you found any relationship between the trafficking and terrorist groups?

Mr. JOHNSON. I couldn't say that we have. Although we have received information that, as you said, some of the farmers in Afghanistan are trading their opium for arms. But here in New York City I cannot say that I have seen that.

Mr. Moss. With that exception I have not seen it myself.

Mr. GILMAN. Thank you.

I want to thank you both for your time and cooperation with the committee.

Mr. Moss. Thank you.

Mr. JOHNSON. Thank you.

Mr. WOLFF. We thank you very much.

We will recess until 1:30 this afternoon.

[Whereupon, at 12:45 p.m. the committee recessed, to reconvene at 1:30 p.m.]

AFTERNOON SESSION

Mr. WOLFF. The committee will come to order.

This morning the committee concentrated in the area of the supply side of narcotics, and the enforcement area particularly. This afternoon we will attempt to address the problem of treatment, prevention on the demand side—what advances, what problems we face in this area.

We are happy to welcome as the first panelist Dr. Jack Durell, Executive Assistant to the Director of the National Institute on Drug Abuse. You are accompanied by Mrs. Elaine N. Johnson, Deputy Director, Division of Community Assistance, National Institute on Drug Abuse.

Would you mind being sworn, please.

You promise the testimony you are about to give is the truth, the whole truth, and nothing but the truth, so help you God?

Dr. DURELL. I do.

Mrs. JOHNSON. I do.

TESTIMONY OF JACK DURELL, M.D., EXECUTIVE ASSISTANT TO THE DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE, ACCOMPANIED BY ELAINE JOHNSON, DEPUTY DIRECTOR, DIVISION OF COMMUNITY ASSISTANCE, NATIONAL INSTITUTE ON DRUG ABUSE

Dr. DURELL. Mr. Chairman, members of the committee, I am very pleased to be here today. I am rather new at NIDA. I came into the Office of the Director at NIDA about 6 months ago. I have

actually been quite looking forward to this first opportunity to meet with members of the Select Committee.

I am also pleased to have the opportunity to do this in New York today because I understand that New York is really the center of some of the original and some of the finest work going on in the drug abuse treatment and prevention field.

I was going to address today a number of topics. If it is all right, I will highlight the rest.

Mr. WOLFF. Your complete statement will be included in the record.

Dr. DURELL. We are very much aware of the problems testified to today concerning the possible impact of an increase in the available supply of heroin in this country, particularly as may have been reported in the cities of the northeast corridor.

Spurred by early and anecdotal reports of increases in heroin indicators, the drug policy staff of the Domestic Council has established a drug abuse trends work group comprised of representatives of all Federal drug abuse agencies, including DEA and NIDA.

In order to closely monitor these trends, the creation of a heroin strategy work group in NIDA followed. This group has monitored admissions to federally funded drug abuse treatment, reviewed hospital emergency room, and medical examiner trends available through DAWN, and updated reports from the Community Correspondents Group, a network of program officials from 20 cities convened by NIDA semiannually.

This effort, under the leadership of NIDA Director William Pollin, M.D., has been responsible for developing the data now available from which to assess the impact of a new heroin supply.

Collectively, at the national level, indicators show generally declining heroin trends for the last 3 years. However, preliminary data for 1979 indicate that some of these decreasing trends may be leveling off.

At the height of the national response to this problem in the third quarter of 1976, 67 percent of persons entering federally funded drug abuse treatment were admitted for the treatment of their addiction to heroin.

Over the last 4 years this percentage has declined nationally to a provisional total in December of 1979 of 36.9 percent. In the Northeast States, however, this trend is not in force, and 47 percent of admissions to treatment were for heroin abuse in the last quarter of 1979.

There are major limitations of the national data in that if you just look at the national picture, you tend to miss certain local phenomena.

In reviewing both our DAWN and CODAP data it does appear some heroin indicators are increasing in some east coast cities and States. Data obtained from local and State personnel tend to support this observation.

Now, it must be remembered that even though the increase in supply indicators is very clear, the impact on treatment indicators might take some time, in that there are a number of conflicting forces at work.

When the heroin supply goes up, this is not immediately represented with an increase in treatment indicators.

However, if we focus specifically in the northeast, for example, we find that in five States—New York, Connecticut, Maryland, New Jersey, Pennsylvania, and in the District of Columbia—the percentage of patients admitted for heroin addiction was higher in the fourth quarter of 1979 than in the first quarter.

In New York State, heroin admissions increased from 45.9 pecent of all admissions in the first quarter to 54.8 percent in the last quarter. In New York City the increases were even more dramatic. In addition, to the percentage of total admissions, the absolute numbers of persons admitted for heroin treatment in New York City increased during 1979.

While it is too early, based on these and other preliminary indicators, to say that this constitutes a new heroin epidemic on the order of magnitude of what was experienced in the late sixties and the early seventies, we are alert to this possibility, and in the event that the situation gets worse, every possible action will be undertaken.

In the interim, we will continue to monitor the heroin indicators on a regular basis and will provide the Congress with additional information as it becomes available.

If I can go on to talk about the national drug abuse treatment scene—the treatment effort is based on a partnership of Federal, State, and local governments. Currently the federally funded treatment system consists of a network of 3,600 clinics employing 44,000 persons with an annual investment of over $500 million in Federal, State, local, and third-party resources. Of this total, about a third is contributed by NIDA.

Public Law 96-181, the Drug Abuse Prevention Treatment and Rehabilitation Amendments of 1979, which extends authorization for NIDA programs, directs that a minimum of 7 percent of NIDA's community program funds—that is the section 410 project grants and contracts—for fiscal year 1980 and 10 percent of those funds for fiscal year 1981—be spent for primary prevention and intervention activities.

In response to this growing concern about the need for enhanced prevention activity, the Institute has developed a policy to shift a portion of its resources toward prevention programs.

We have been very pleased in the planning for this fiscal year and next fiscal year to meet the congressional mandate in this area without a reduction in the total dollar amount provided for the treatment system to each State during 1980 and 1981.

In making policy choices about the allocation of these constant resources for drug abuse treatment, it was also necessary to take into account the rising costs of providing treatment services due to inflation and the need to enhance the capability of State drug abuse agencies to administer and monitor the treatment system.

Indeed, some of the concerns about the requirements for this enhanced management capability came from a report of the General Accounting Office of the Congress.

So that we elected, in managing these constant resources, to provide a small increase in funds per slot, and a small 2-percent increase in the funds available for State administration and management, which required therefore about a 5-percent reduction in treatment slots in fiscal year 1980, and a further 5-percent decrease

in fiscal year 1981; that is, it was our election to attempt to maintain and, if possible, improve quality, and thus at the expense of 4,500 treatment slots in each of these fiscal years.

It should be emphasized that the total dollar amount provided to each State in fiscal year 1980 will not change over fiscal year 1979 levels, only the resources will be distributed differently. NIDA will continue to maintain a minimum Federal match for treatment of 60 percent.

Furthermore, I think we should emphasize that within each State we are allowing room for the State to deal with the funds in terms of their own needs. In this particular allocation we are recommending if a slight increase for inflationary needs and administrative expenses is not appropriate in any given State, that can be renegotiated with NIDA.

Now, with respect to New York State in particular, fiscal 1979, the total NIDA supported drug abuse expenditure in New York State was $37.6 million. The Federal contribution to drug abuse treatment services in New York State was $26.2 million. This supported 14,200 treatment slots currently operating at an admirable utilization rate of over 94 percent.

The estimated NIDA-funded contribution to drug abuse treatment allocated by the State to New York City has been substantial and has continued to increase since the inception of our national effort to combat drug addiction.

We estimate that approximately $19 million in NIDA funds were used to support drug abuse treatment in New York City in fiscal 1979, an amount greater than the NIDA contribution to treatment services in 48 of the 50 States.

Only the grants to the States of New York and California, which receive approximately 18.5 percent and 16 percent respectively, exceeded the NIDA treatment funding available to New York City.

As a result of this funding distribution, New York State has reduced by 782 slots the number of drug abuse treatment slots receiving Federal support.

I would like to make some final comments on the 7-percent set-aside and the use of the increased funds for prevention.

I am pleased to report, in response to a longstanding concern of this committee and a longstanding concern of NIDA, that for the first time in several years the Institute is now able to increase its activities in the prevention field.

In fiscal year 1980, over $6 million has been added to the base budget for drug abuse prevention. The largest share of the increase in this prevention funding will be made available to State drug abuse agencies. Indeed, for fiscal year 1980 it is planned that a total of $5 million will be made available through the single State agencies.

In keeping with our growing concern as to the unique needs of particular population groups, special considerations will be given to grant applications for prevention programs targeted toward women, the elderly and youth—persons under the age of 18.

Special consideration will also be given to programs located in occupational or educational settings. These priorities are in accord with those outlined in the recent extension of the Institute's authority.

The remainder of the additional funds available for drug abuse prevention nationwide will be used to strengthen NIDA's technical assistance efforts to States, local communities, and parent groups and to expand the targeted national prevention grants program administered by the Institute's prevention branch. There is also a plan for increased research in prevention, but I won't go into the details of that now.

I would like to note that I have not included in the formal statement any comment on the proposed cut for the fiscal year 1981 budget of the section 409 formula funds, which I believe were slated to amount to about $36 million.

I did not include the discussion of this because the matter is still before the Congress, and indeed will not impact upon the actual flow of funds, even if it is passed in its present form, until late in the next fiscal year, or perhaps actually early in fiscal year 1982. So that the planning for how we will deal with that coming fund has really not begun in any substantial way.

Mr. Chairman, NIDA looks forward to the continuing support of this committee as we continue our efforts to enhance our prevention activities. As you well know, a critical component of achieving long-range success in our battle against drug abuse lies in achieving an effective prevention strategy.

I am very pleased to be the person at NIDA who has been asked to coordinate all of the various efforts in prevention, and help to develop our prevention thrust.

I am glad to answer any questions.

[Dr. Durell's prepared statement appears on p. 119.]

Mr. WOLFF. Thank you very much, Dr. Durell.

I must make a few comments.

First of all, I am happy to welcome you before this committee. We have had a very good working relationship with NIDA over a long period of time. I am happy with the cooperation that NIDA has given to the community in directing attention to these prevention programs.

Someone, a long time ago, talked about ounces of prevention and pounds of ash, or whatever you want to call it. The fact is that we do feel that that money is well spent. It is very difficult to justify that money. That is one of the problems that exists because you cannot show direct, concrete results that are attributed to that work.

It is perhaps some of the most important money that is spent by the Federal agencies in alerting the public to the dangers that they face in the drug abuse prevention programs and the like. I do feel education is extremely important in the whole gamut of steps we take in trying to meet problems of drug abuse.

However, let us go to another old axiom—the Lord giveth and the Lord taketh away. The Lord, which is HEW, with about $200 billion of our budget at this time, is perhaps the largest agency that we address as Members of Congress.

One of the facets of your remarks—even with a large agency such as yours, is that there is a small agency that controls the large agency. I am talking about OMB.

I think someday there is going to be a determination, as we enacted a war powers resolution, and gave control of making war

back to the Congress, we are going to return to the Congress the ability to make determinations that are without the control of a group of accountants and the like who seem to be the all-powerful and the all-knowing.

I think it is a great tragedy for our country, to have a small agency such as this make the determinations as to how we shall meet the various serious problems that confront our Nation.

Perhaps it is just rumor, but I understand that the $40 million cut did not originate from your agency but originated outside of it. I am not going to ask you to comment, or put you in any great difficulty.

I am going to say one thing on that score; that is, you said this matter is still before the Congress. We do feel that we have to have some degree of information from your agency as to what benefit this program is and how we can compensate for it if it is cut out of the budget.

Of all that you have mentioned, I don't see the compensating factors. I am just wondering how the agency feels about the idea of a cut of this magnitude in view of the very serious overall problem that we face that is somewhat contrary to your opening statement.

You had an optimistic view of the future. Everything we heard this morning was pessimistic. We heard about a whole new surge of problems coming to our shores.

I think that one factor involved in your statement, sir, is you are dealing with somewhat old information. The new information that we have and the intelligence we have indicates a problem of much greater severity than is wished to be addressed, I guess, by the people at NIDA.

Dr. Pollin has been extremely cooperative with our committee. I am hopeful, however, that you can, from both this hearing as well as from the intelligence sources, get an indication that we are going to face an almost insurmountable problem. Consider the fact that at the height of our drug problems in this Nation there were 6 to 7 tons of heroin coming into the country, and here we are told today from other intelligence sources, that 60 to 70 tons now is the potential for our country.

This bodes very ill for us. Unless we take steps to prepare for this, we are going to be in great trouble. That is why our group is so interested in what is going to happen to this $40 million.

Can you give us any information as to why this formula grant program was started in the first place?

Dr. DURELL. Since I am new at NIDA, I could talk to how the formula money is used, but I think it might be best if Elaine Johnson comments.

Mrs. JOHNSON. As you know, back in 1972, after the passage of Public Law 92-255, section 409 called for the development of a single State agency to be responsible for the administration, planning, and development of drug abuse treatment and prevention programs on a statewide basis.

So, the formula grant was used to initiate this action—money was given to the States to begin that kind of activity. Back in 1973 there were very few single State agencies in existence. So this money was given to the development of that program.

Then we, under 410, looking at the intent of Congress, determined, in conjunction with the White House, that we should provide the States with a statewide program so they would be able to administer on a statewide basis not only the State funds, but also the Federal funds going to the particular States, because they would be in the best position to make decisions about drug programing in their respective States.

Mr. WOLFF. Well, now, what effect do you think that this cut in funds will have upon the whole area? Are we going to contribute more to the fight on drug abuse by cutting out this money or are we going to undercut some of the efforts that are being made?

Dr. DURELL. If I may, Mr. Chairman, clearly in our planning over the past few years we have recognized the importance of the 409 moneys, and indeed the drug abuse program as it is presently structured depends very heavily on the 409 moneys.

As we know how they are used, about 50 percent of them actually contribute directly to the treatment process, the treatment costs. About a quarter of those moneys have been used by the States for prevention activities.

About a quarter of those moneys have been used to support the management systems within the State, of the entire treatment and prevention efforts. Clearly those moneys were a vital part of the system that had been developed.

We are now faced with a situation in which the Nation, the President, and the Congress have said that the first priority is the balancing of the budget.

Mr. WOLFF. We ought to correct this. The first priority in this country is the people of this Nation. The budget is only reflective of what services the Government must give to the people.

Unfortunately, there is too little attention paid to this, and we are paying attention to figures rather than the persons involved. I had to say this to you. I feel you are reflective of that statement that has been made by the Government, and everybody is talking about this balanced budget.

Dr. DURELL. I understand and share those feelings, Mr. Chairman. I am certainly glad that you said that.

We are one agency within the Federal structure. It is really not possible to argue that our needs are greater than perhaps other needs without ourselves having an overview of this.

Mr. WOLFF. That is why we have asked you to come and tell us why we need formula grants, you see.

Dr. DURELL. Our sense of this at the moment is, I know that the States have been very rocked by the knowledge that even though it may be 18 months from now when they actually feel the effects of this on their financing—I know they have been rocked by the possibility of determining how they will deal with their programs in the absence of this money.

All NIDA can do is wait to see how each State proposes to cope with this problem, and then determine how NIDA can most effectively work with the States in dealing with these programs.

Where the needs seem very intense, NIDA will make every effort to request supplementary funds. Indeed, you were talking about the old figures and the new epidemic.

I think it was the thrust of what I was trying to say and what NIDA was trying to say is that that is correct, the old figures were a source of encouragement for a number of years. Now, from the data, there appears to be the real threat of an epidemic.

In places like New York City, that epidemic may actually be beginning. It may very well be in 6 or 9 months from now this epidemic will be very much more widespread.

Mr. WOLFF. Have you had any consultations with the States as yet?

Dr. DURELL. Consultations have begun, but the States themselves, I think, have to pay some attention to figuring out what they are going to do.

Mr. WOLFF. Dr. Durell, I think we ought to take a turn in that. On the Federal level, we would recommend that you initiate the requests from the States in order to make a determination.

I think that if we operate in a kind of vacuum and wait for the initiative to be taken, we are going to have confrontations which this country can well afford to miss at the present time. We have enough in the way of confrontations. We should be able to address problems before they become that acute.

Dr. DURELL. I think that is a very good suggestion.

Mr. WOLFF. We have had a number of suggestions from States that have written us, that we will pass along to you.

Mr. Gilman?

Mr. GILMAN. Thank you, Mr. Chairman.

Dr. Durell, we welcome you before our committee, along with your colleague. We are certainly interested in what you are planning to do for the next few years in this very important, very critical area.

I was concerned that you had not mentioned to any great extent the cutback. While my colleague was somewhat reluctant to place you in a position of commenting on it, I am very much concerned about your thoughts about the cutback, the $40 million cutback. It concerns the rehabilitation work in this area.

Has there been any communication between NIDA and the administration recommending that this funds be restored?

Dr. DURELL. I have not been involved directly in that communication, but I know that Dr. Pollin has been in close communication with the administration about his concerns for the integrity of the program.

Mr. GILMAN. Is there some plan to restore the funds?

Dr. DURELL. I am unaware of any such plan.

Mr. GILMAN. Will there be some effort made by your agency to restore the funds?

Dr. DURELL. I do not know that our agency has decided that that is the best alternative available, to aim at restoration of those funds, as opposed to monitoring the heroin trend and requesting supplemental funds as they are needed if special situations develop.

Mr. GILMAN. Of course, that would be extremely difficult to tackle, to try to do it by way of a supplemental fund. Have you analyzed what the impact will be of this reduction?

Dr. DURELL. As I stated, the actual flow of funds won't impact until about 18 months from now, and we have begun a process of analyzing what the impact will be, and also a process of exploring

alternatives open to our agency and the whole drug abuse treatment program, in terms of our own heroin strategy committee.

Mr. GILMAN. Will there be some recommendations made by your agency to the administration to try to overcome the impact of the loss of these funds in treatment and rehabilitation?

Dr. DURELL. I believe the agency has already made recommendations regarding its entire needs. I am not in a position to say whether they specifically relate to the restoration of those funds.

Mr. GILMAN. Who within your department would be aware of how this is being handled?

Dr. DURELL. I am sure Dr. Pollin is fully aware of what the negotiations are with the agency.

Mr. GILMAN. Could you request Dr. Pollin to provide our committee with whatever recommendation they are undertaking with regard to the restoration or the manner in which to overcome the loss of these funds?

Dr. DURELL. I certainly could.

Mr. GILMAN. I am going to ask that that be made part of the record at this point, when we get that response.

[The information follows:]

An Institute Heroin Strategy Work Group, chaired by Elaine M. Johnson, Deputy Director of the Division of Community Assistance, and consisting of staff from a variety of program areas, was established in April 1980 by NIDA Director William Pollin, M.D. This group was asked to develop a series of policy options for consideration should the demand for drug abuse treatment services related to the availability of new heroin supply and the potential decline in existing resources exceed the capacity of the Institute and the State agencies for drug abuse prevention to respond. The group discussed these issues with the National Advisory Council on Drug Abuse at its meeting May 29–30, 1980. It was agreed that the examination of the treatment system and resources will continue with the involvement and participation of the Council and others in the field.

Mr. GILMAN. You mentioned your agency was involved in a drug prevention campaign for 1980, or that you were planning one.

Dr. DURELL. We have additional funds available for 1980 and further for 1981.

Mr. GILMAN. Is there a campaign underway for 1980, drug prevention campaign?

Dr. DURELL. By campaign are you referring to a media campaign?

Mr. GILMAN. Well, is there any kind of drug prevention campaign that is being undertaken?

Dr. DURELL. There is a major initiative, as I described in the testimony; that is, of the about $6 million in new funds that will be available for prevention, about $5 million are going out to the single State agencies with guidelines as to the type of prevention programs that we would like to see them implement with those funds. That is the major new thrust.

Mr. GILMAN. Who developed those guidelines? Was that part of your drug strategy group?

Dr. DURELL. The guidelines were developed by the prevention branch at NIDA, with the participation of myself and others.

Mr. GILMAN. What are some of those guidelines that you are suggesting to the States?

Dr. DURELL. There is a great deal of emphasis on community-based programs, a great deal of emphasis on programs that are geared to working with families, supporting parent groups and

families that are concerned with drug abuse in children. There is a support of programs that are directed toward minority groups, toward the elderly and so on.

Mr. GILMAN. Are you tying it to a national campaign for drug prevention?

Dr. DURELL. Again, when you mention national campaign, I assume what you are talking about is a kind of public media campaign. We are planning a media campaign, but that is not going to be in the fiscal 1980, but in the fiscal 1981 budget that that will be developed from.

Mr. GILMAN. Is there anything being done in the 1980 fiscal year by way of drug prevention by NIDA?

Dr. DURELL. Yes, there are many things. Let's take a step back and look at the size of NIDA's prevention budget as compared to the total prevention needs. Our budget for this year is $11.2 million.

Mr. GILMAN. For 1980.

D. DURELL. For fiscal year 1980.

Mr. GILMAN. How has that been utilized?

Dr. DURELL. If one would estimate what the total prevention costs might be throughout the country if a national program were implemented, one might come to something like $1 billion.

So NIDA has not in fact seen its role as funding prevention programs. It has rather seen its role primarily as knowledge development in prevention, so a major part of NIDA's prevention funds over the past several years have been used for demonstration and research in prevention, and the distribution of information as to what works and what doesn't work.

Another thing which NIDA has done is to develop a technical assistance network, so that States and communities, schools, that wish to develop prevention programs can get onsite consultation from a very experienced panel of prevention professionals.

So, that is another way in which NIDA has tried to maximize this very small number of dollars available and to have an impact on the total field.

Mr. GILMAN. Then most of the $11 million was utilized in preparing some guidelines and some consultation activity. Is that what you are saying?

Dr. DURELL. No. I would say that as in the past, about a quarter of the money is for research and evaluation of information dissemination. About a quarter of the money is for technical assistance.

It is much more than information and guidelines. It is actually onsite visiting, helping people develop their programs, teaching people how to do prevention onsite.

Now, the two quarters amount to about half, about $5.5 million, which was about the size of the budget prior to the new set-aside. Most of the rest of the budget, which came from the set-aside, is going out to the States to actually support—it is the beginning of direct funding of community efforts.

But rather than NIDA directly funding the programs that are out there, NIDA is sending the money out to the State agencies so that the directors of the State agencies and the State prevention coordinators who are funded by NIDA can then make more appropriate decisions as to how that money could best be used within each State.

Mr. GILMAN. $5 million for 50 States.

Dr. DURELL. That is correct.

Mr. GILMAN. That boils down to a very small amount, doesn't it?

Mr. WOLFF. The cost of a good congressional campaign.

Dr. DURELL. I think a conservative estimate of what could be used in this country for drug abuse prevention is somewhere between half a billion dollars and $1 billion.

Mr. GILMAN. Did NIDA make that recommendation?

Dr. DURELL. I think NIDA has spoken to the costs of a total prevention program, yes.

Mr. GILMAN. What recommendation did NIDA make by way of a national effort for funding?

Dr. DURELL. You are asking for what——

Mr. GILMAN. What was the request made by NIDA in this year's budget?

Dr. DURELL. I believe it was in the order of magnitude of the funds that have been provided.

Mr. GILMAN. Then NIDA is satisfied with the $5 million? If you made the request for 5 and got 5, I assume you were satisfied with it. I don't understand, if there is such a pressing need, how come NIDA is not saying more about that need and making a greater request. Or, is OMB running the show?

Dr. DURELL. Well, as I have described, I am rather new to this process. But as I understand it, there is much that goes on in informal conversations. But by the time the formal requests are made, they are in line with what the administration sees as in the ballpark consistent with what will be supported.

Mr. GILMAN. Are you satisfied with the $5 million?

Dr. DURELL. Am I personally satisfied with that?

Mr. GILMAN. Yes.

Dr. DURELL. I personally would like to see us have more money to work with.

Mr. GILMAN. You talked about a prevention action planning group in NIDA. Who comprises that group?

Dr. DURELL. I head the group. On it is Dr. Carl Leukefeld, the deputy, division resource development; Bernard McColgan, head of the prevention branch; Susan Lachter, head of our communications office.

Mr. GILMAN. How often do you get together?

Dr. DURELL. Once a week.

Mr. GILMAN. What is your plan for the coming year?

Dr. DURELL. The plan for the coming year, as I described, has been formulated. We are really working on plans for the fiscal year 1981. The plan for the coming year is well formulated.

Mr. GILMAN. Is that plan you discussed before, of sending a little trickle out to each State, or taking a ride out there to see how it is going?

Dr. DURELL. We have $11.2 million, not $500 million.

Mr. GILMAN. Would you be able to provide us with a copy of your plan?

Dr. DURELL. Yes.

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Mr. GILMAN. Mr. Chairman, I would like to ask it be made part of the record.

[The information follows:]

FISCAL YEAR 1980 PREVENTION PLAN

The basic goal of drug abuse prevention is to reduce or prevent drug use by promoting positive human development. This involves improving an individual's ability to cope with stress and to make reasoned decisions about daily problems. In addition, the process requires strengthening family and community ties so that people have the resources and support to deal with life situations that could precipitate drug use or other disruptive social behavior.

The federal role has been and will be increasingly to help local community groups use their own resources; to stimulate and respond to a community's awareness of its special needs; and to build a data base which clearly indicates which program strategies work best to reduce drug abuse among different target groups in varied program settings.

The Institute's activities in the prevention field are based upon the prevention objectives outlined in the "1979 Federal Strategy on Drug Abuse":

To conduct on the possible causes of drug abuse and the differing characteristics of users and non-users—particularly youth, who must be considered potentially vulnerable to the adverse consequences of abusable, mind-altering substances.

To promote healthier, more attractive alternatives to drug use and help develop the individual's ability to rely on inner resources, skills and experiences; build more constructive relationships with parents or family; and improve relationships with peers, schools, and the community.

To promote reliance on peers, parents, schools, and the community as the most effective channel for informing and guiding young people, and to assist these groups in developing prevention programs relevant and appropriate for their unique situations.

To provide clear, factual, honest, and relevant information about drugs and to disseminate this information to appropriate audiences.

To plan and develop materials for the special challenges facing women, ethnic minorities, the poor, the elderly, those in rural areas, and other special populations.

To build the capacity of States and local communities to identify prevention programs within the broad conceptual framework of providing positive alternatives and effective programs for youth.

Public Law 96-681, the 1979 amendments to the Drug Abuse Act, provides that in Fiscal Year 1980 a minimum of 7 percent of the drug abuse community program funds appropriated under Section 410 of the Act be set aside for prevention activities. The new funds made available for prevention in fiscal year 1980, as a result, will allow for the establishment of a new prevention grants program funded through the State agencies for drug abuse prevention. In addition, the State prevention coordinators program will be expanded to include all States and Territories and a family initiative will be developed.

In fiscal year 1980 at least $12 million in prevention activities supported by NIDA will include the following:

The State Prevention Coordinators Program.—To establish a prevention coordinator in each State drug abuse agency to enhance prevention programming.

Channel One.—A collaborative effort between the Prudential Insurance Company of America and single State agencies for drug abuse to assist communities to examine and create prevention programs for adolescents. This project offers an excellent opportunity to determine how the public and private sectors can work together effectively toward mutual goals. Seed money is provided to States to support community-based alternatives programs.

New Prevention Community Assistants Grants.—Funds to be provided through the State prevention coordinators to support community projects for prevention, particularly aimed at the special target population groups of women, the elderly, youth, and in occupational settings.

Pyramid.—Technical assistance and methodology transfer to State and community programming.

Center for Multicultural Awareness.—To establish a resource center and technical assistance for consultation to minority programming along with materials development.

National Prevention Evaluation Network.—A network pioneering in three States—Wisconsin, New Jersey and Pennsylvania—to provide information, technical assistance, and evaluative assistance for State and local prevention programs.

Regional Prevention Training Coordinators.—Regional resource for prevention coordiation and training.

Family Initiatives.—Assistance to parent groups organizing to prevent drug abuse, including materials, informtion and networking activities.

Prevention Grants Program.—The fiscal year 1980 prevention budget also supports the following ongoing grant projects designed to acquire new knowledge and validate prevention strategies through evaluative research:

Research on Drug Abuse Prevention Techniques.—The first year of a 3-year study of prevention strategies in 32 New York City school districts involving 5,000 students in grades 9-12. Jay Sexter, Principal Investigator.

Cost Effectiveness Evaluation: Drug Abuse Prevention.—A study by investigators at the University of Pennsylvania to determine the cost-effectiveness of four major prevention modalities: information, education, alternatives, and intervention (1st year). Teh-Wei Hu, Principal Investigator.

Seneca Center.—Family counseling for drug abuse prevention provided to black and Puerto Rican youth in the Bronx (3rd year). Lillian Camego, Principal Investigator.

Ticada, Inc.—An evaluation of the use of the performing arts in alcohol and drug abuse prevention among native Americans (3rd year). Jay Whitecrow, Principal Investigator.

Impact of a Georgia Drug Abuse Prevention Program.—An evaluation of "The Life Skills for Mental Health" program, a statewide prevention effort involving teachers and students in grades 1-2 (3rd year). Russell Dusewicz, Principal Investigator.

Project Info, Inc.—An alternatives project for 5th and 6th grade students using teachers and school-based resources. A film, curriculum, and teacher's guidebook are to be developed (3rd year). Ronald Rostan, Principal Investigator.

Issue Study: Impact Study, State Drug Usage Evaluation.—The 3rd year of a 3-year evaluation by University of Nevada of the Nevada Drug Abuse Prevention Program using a sample of 10,000 students in grades 5, 7, 8. Len Trout, Principal Investigator.

Immigration Social Service, Inc.—Family Circle.—An evaluation and service delivery counseling project to examine alternatives as drug abuse prevention services in the Chinese community in Lower Manhattan (3rd year). David Hui, Principal Investigator.

THEE Door Prevention Research Project.—Drug Abuse prevention to youth ages 8-12 at school and in the home and involving teachers, provided by the Alpha Center in the Orange County Schools, operated by THEE Door of Orange County (2nd year). George Pringle, Principal Investigator.

Shalom, Inc.—A prevention program emphasizing the use of interpersonal skills provided in 13 high schools and elementary schools in Archdiocese of Philadelphia (3rd year). Tom Klee, Principal Investigator.

Evaluation of a Prevention Support System.—An evaluation of the Minnesota Substance Abuse Prevention Program (2nd year). Richard Neuner, Principal Investigator.

The Napa Experiment: Prevention Evaluation Research.—The measurement of the effect of prevention strategies on variables such as self-esteem, decision making skills, relationship with family and peers, drug knowledge, drug use, and future intention to use drugs. The project is being carried out among elementary and junior high school students (3rd year). Eric Schaps, Principal Investigator.

In fiscal year 1981 at least 10 percent of the funds appropriated for drug abuse community programs will be expended specifically for drug abuse prevention and intervention. Current plans call for the allocation of a minimum of $16,100,000, or more than two and a half times the fiscal year 1979 level for these activities. A Prevention Action Planning Group has been established to guide planning and policy decisions for 1981 expenditures as well as future year activities. This group will develop comprehensive strategy paper to serve as a blueprint for the direction of prevention planning based upon the advice and discussion with interested persons from both within and outside of the federal government.

The prevention activities reported upon herein are those conducted by the Institute's Prevention Branch. This report does not include the work of the Office of Communications and Public Affairs, National Clearinghouse for Drug Abuse Information, or the prevention services provided in the field by the personnel of drug abuse treatment programs. Nor does it include the basic and applied research program supported by the Institute which might, by increasing knowledge and understanding of drug use itself, serve as a significant preventor.

Mr. GILMAN. You also talk about a heroin strategy work group in NIDA. Who comprises that work group?

Mrs. JOHNSON. I am the Deputy Director for the Division of Community Assistance. That is the treatment arm of the Institute. It has been our division that has been the lead group in formulating a heroin strategy.

Mr. GILMAN. Could you move the mike a little closer to you.

Mrs. JOHNSON. Yes. As I was saying, the Division of Community Assistance within NIDA has taken the lead role in this work group. What we have begun to do is look at what can be done in terms of developing resources for treatment without additional dollars.

It has nothing to do with the prevention campaign. What it deals with is, if there are no additional dollars for treatment, and there is an increase of heroin in this country, and it spreads, then what can we do in terms of developing resources for treatment?

Mr. GILMAN. It would be an interesting exercise. How do you do that without dollars?

Mrs. JOHNSON. It is very challenging. But what we have done is look at within the Department where can resources be developed to provide rehabilitation services for drug abusers.

As you know, within the Department of Health and Human Services there are other agencies that do have some linkaging responsibility in providing rehabilitation services. Those services need to be beefed up, they need to be increased.

It has taken an initiative in that area. It is also looking at other public service agencies within the department; for example, looking at public health service hospitals, looking at the National Health Service Corps, looking at manpower as well as other types of facility resources that could be used.

Mr. GILMAN. How long has your group been in existence?

Mrs. JOHNSON. It is a very new effort. We have only met within the month of April a couple of times. We are just starting.

[The following was received for the record:]

HEROIN DATA AND TREATMENT RESOURCES STRATEGY WORK GROUPS

In August 1979, NIDA Director Dr. William Pollin established a Heroin Data Work Group whose function is to monitor data from all sources concerning evidence of increased availability of heroin supply and its impact on the drug abuse treatment network. That group has met regularly during the ensuring months and has provided much of the data available to assess this problem.

A second task group was convened by the Director in April 1980. This Treatment Resources Strategy Work Group was charged, in face of mounting evidence of increased heroin supply and the possibility of declining federal resources for treatment services, with evaluating and recommending possible policy and program changes in the operation of NIDA-supported treatment programs in the event it becomes necessary to implement a reduction in the scope of NIDA treatment support. This group has provided an initial report and is now further developing an anlysis of alternative strategies.

Mr. GILMAN. And you hope to evolve a national plan for treating heroin problems without money?

Mrs. JOHNSON. As I mentioned, it is a very challenging effort.

Mr. WOLFF. Would you yield a moment, please.

One factor in the whole treatment/rehabilitation area that I find lacking is any activity of the Department of Labor in providing some sort of outlet and jobs for people while they are in a treatment program or once they are completed with the program.

Is there any effort being made in this direction at all?

Mrs. JOHNSON. Yes; we have a number of initiatives with a number of different agencies, including the Department of Labor. We do have some work groups that include them. Right now we

are trying to implement a program with the CETA program, where CETA slots are used for drug abuse clients.

It is very difficult, but as a fourth level bureaucratic agency within the Department, we are hoping an interdepartmental kind of response can then be mounted with the various Secretaries of Labor, HHS, so that the effort can be increased.

Mr. WOLFF. Thank you.

Dr. DURELL. One of the most successful joint efforts of that kind has been the supportive work program which was recently reported.

Mr. GILMAN. Dr. Durell, what has been the most effective effort by NIDA in drug prevention and drug education?

Dr. DURELL. I think the most effective effort has been the technical assistance network. You have tended to minimize its importance.

Mr. GILMAN. I don't intend to. We would like to know what it is. I don't intend to be cynical about what you are doing. We would merely like to know what your best effort has been.

Dr. DURELL. I would consider the best effort has been the technical assistance network. Given the fact that NIDA's prevention money is a drop in the bucket, what one depends upon then is local community, family, school, and then from local to statewide initiatives.

So, NIDA has seen that its most important role in this could be in teaching these people, in supporting these people, in doing the work that they want to do. So, I think we could present many examples of successful local programs that were supported by NIDA technical assistance.

So that rather than NIDA taking credit for the program itself, what we can say is we are proud that we have provided support and technical assistance to a vast number of local efforts.

Mr. GILMAN. You talked about the school program education package being designed. How long has NIDA been working on that school package?

Dr. DURELL. The design of a school package is actually tentatively planned in the fiscal year 1982 plan and is not a final plan in and of itself. NIDA has been working with school programs for a number of years. In fact, working with schools and working with youth are one of the major areas of our activity.

One of the programs within that area which has been most successful is the ombudsman program. Another program in working with youth has been Project Info. So NIDA has been working with schools for some time. But our thrust has not been the development of a prepackaged curriculum.

We still have some doubts as to whether that is the best way for us to go. But we have included that as one of the items in our fiscal year 1982 plan.

Mr. GILMAN. Then this school program education package is something you may not proceed further with.

Dr. DURELL. We may or may not do, that is correct.

Mr. GILMAN. I see.

Does NIDA presently have a program for drug awareness, a national program?

[The following was received for the record:]

NATIONAL DRUG ABUSE INFORMATION PROGRAM

In fiscal year 1981 the Institute will initiate a National Drug Abuse Information Program. This will be a five year program designed to deglamorize and discourage drug abuse by communicating current factual information about the effects of drugs on the physical, behavioral, and mental health of drug users. The program will be modeled after similar programs operated by National Heart, Lung and Blood Institute and the National Cancer Institute. This project will develop prevention messages tailored to specific groups within the populations.

Dr. DURELL. We have an evolving program. We do not at the present have a national campaign going. But we have pieces of the campaign.

Mr. WOLFF. I want to just comment a minute. I think that new marihuana film you have is very good.

Dr. DURELL. Thank you. I know the staff put a great deal of work into developing that.

Mr. GILMAN. What is NIDA's capability to respond to a national emergency, a national crisis in drugs?

Dr. DURELL. NIDA would clearly require additional funding to respond. Otherwise, at the moment, with NIDA's current resources, it can only give to one place by taking away from someone else.

Mr. WOLFF. Dr. Durell, may we make a recommendation to you, which I think the committee must. In view of the pending crisis which we see arising and the intelligence that we have been apprised of, that there be immediately set up a task force to make a determination as to what the needs will be and how you are going to meet this crisis.

If we do see, as is now very apparent, that this downturn in addict population is starting to reflect a change in the curve, then I think that we have to take steps to prevent this, as part of our own prevention program, attempting to take certain steps that would be sort of a prophylaxis to the problem.

Therefore, the committee is going to make a request of you—and I wish you would pass it to Dr. Pollin and the other people involved—that you address this overall problem and come up with some new direction, so to speak, to be able to meet head on the crisis that we see. If there is anything this committee can do in the way of attempting to sound a red alert, this is what we are doing.

We feel that your job is not going to be an easy one for the future, but unless you are prepared for this, we are going to see some very dire circumstances.

Dr. DURELL. We welcome your advice and support on this, Mr. Chairman. As we have mentioned, we have established such a committee. But with your advice, we shall clearly give it higher priority.

Mr. GILMAN. I might add that this alert, this concern is not just from this committee. It is based on an intelligence assessment that is going around to all of the narcotic agencies in the Federal Government.

So, I would assume that there would have been some planning and preparation, where you have an intelligence assessment that says we are about to have a major flow of narcotics hitting our Nation, that there should be some crisis planning.

Dr. DURELL. As we have described, we have been working on such a plan, but we will continue to give it high priority.

Mr. WOLFF. We would like to make a request of the agency that we receive a response from you as to what steps you feel we should take in order to meet this problem head on.

Dr. DURELL. Very good.

Mr. WOLFF. I would make the request of you that you be in direct communication—not you, but NIDA be in direct communication with us on this matter.

Dr. DURELL. Yes, sir.

Mr. GILMAN. I want to thank the panel.

Thank you, Mr. Chairman.

Mr. WOLFF. Thank you very much.

The next panel is Mr. Julio Martinez, director, New York State Division of Substance Abuse Services, and Mr. Robert E. Wallace, chairman, Commission on Alcohol and Substance Abuse, Prevention and Education.

Mr. MARTINEZ. Mr. Chairman, would it be possible to bring Dr. Lipton to the table?

Mr. WOLFF. Please do.

Would you take the oath.

Do you solemnly swear the testimony you will give will be the truth, the whole truth, and nothing but the truth, so help you God?

Mr. MARTINEZ. I do.

Mr. WALLACE. I do.

Dr. LIPTON. I do.

TESTIMONY OF JULIO MARTINEZ, DIRECTOR, NEW YORK STATE DIVISION OF SUBSTANCE ABUSE SERVICES

Mr. MARTINEZ. Mr. Chairman, distinguished committee members and staff, I appreciate the opportunity to speak to you about the heroin problem in New York State.

I talk to you today first as a recovered addict who knows the heroin problem from my own experience and, second, as director of the New York State Division of Substance Abuse Services, the State's drug treatment and rehabilitation agency.

I'm not here to "cry wolf" or to create a false sense of crisis. I'm here to tell you the plain facts. And the facts from the Federal Drug Enforcement Administration (DEA), Attorney General Civiletti, the New York City Police Department, hospital reports, and our agency surveys show the heroin problem is back, maybe stronger than ever.

Let me summarize the situation we face with just a few statistics. Between 1978 and 1979 drug dependent deaths in New York City rose 77 percent; heroin emergency room episodes in the city increased 46 percent; admissions to drug programs throughout the State with heroin as primary drug of abuse were up 26 percent; admissions to methadone programs increased 22 percent and detoxification program admissions increased 40 percent; opiate arrests in New York City rose 11 percent.

These increases are the result of a huge influx of high-quality heroin entering the United States and New York City in particular, from Iran, Afghanistan, and Pakistan.

The total illicit opium production in Iran, Afghanistan, and Pakistan during 1979 was about 1,500 metric tons. For comparison sake, consider that the U.S. heroin epidemic of the late 1960's and early

1970's was fueled by only 80 tons of opium from Turkey. During that epidemic there were 700,000 addicts in the United States. We are now talking about the staggering potential for nearly 20 times that number.

To compound the problem, Middle Eastern heroin being sold on city streets has tripled in purity, and thus potency, over the past year. In the summer of 1979, the average purity of street heroin was about 3 percent; it is now 9 percent. Some samples ranged as high as 19 percent.

Preliminary studies by our research staff seem to point toward greater heroin involvement by those under age 20. Between 1978 and 1979, there was a 24-percent increase in the number of youngsters under age 16 arrested for felony possession or sale of heroin, morphine, and opium. Arrests for those aged 16 to 20 years rose 20 percent.

My major concern in light of these developments is simple: How are the Division of Substance Abuse Services and the State of New York going to confront and combat the impending heroin epidemic on top of our other drug problems. The outlook is not very promising.

To meet the rise in inflation and an increase in allowable costs without spending any additional Federal funds, the National Institute on Drug Abuse cut available treatment slots in New York State in 1980. Funding these slots, to provide services to 667 substance abusers, would cost approximately $1.35 million. To make matters worse, the presidential budget request for 1981 totally eliminates Federal formula grant funds for drug treatment and rehabilitation.

The picture on the State front is not better. State appropriations for drug abuse services have been slashed from $162 million in 1975 to about $60 million in 1979; our agency's State-supported work force has dropped from 4,830 to 220. The drug problem has continued to grow steadily over that 4-year period.

The number of substance abusers in New York State is now more than 570,000; current funds available are sufficient to treat fewer than 50,000.

Despite all the indications of a heroin epidemic and actual facts of widespread drug use, funding has been reduced. I think it's important to try to understand why.

Society, and the medical and science communities, have spent a great many years and vast amounts of resources to conquer illnesses such as tuberculosis, polio, and cancer. These illnesses have stood as challenges to our knowledge and skills.

Pick up any newspaper or turn on the television and you'll see movie stars, sports figures, or statesmen campaigning for favorite causes: muscular dystrophy, multiple sclerosis, and other diseases. I'm certainly not disputing the need for that, I just want to contrast it with the number of people who stand up to let the public know about the need for treating substance abusers.

Let's face it, drug abuse isn't attractive and the people I represent don't have a constituency to fight for them.

The public needs to understand drug abuse a little better. No one chooses to become a heroin addict or a pillhead, just as no one chooses to die of cancer or suffer from polio. Drug abuse is a

matter of human condition: It's a matter of suffering, starvation, inability to cope, and hundreds of other pressures and problems that lead to drugs.

You want me to fight the war, but I can't do it without the weapons. Most of my work has been to get those who control the resources to recognize that fact. I've walked the halls; I've talked to newspapers, radio and television and the public; I've attended hearings; I've sent letters, street surveys, news clips, press releases; I've listened to what concerns you and what concerns the person on the street.

I'm not here tooting my horn. I'm here to let you know what the feelings are on the front lines of the drug battle. I can sit here and talk all day, but that won't accomplish what I want. Tell me now, will we get help? I can't go home and tell the troops that relief is on its way if it isn't coming.

It may sound dramatic, but the reality is that we deal with the casualties and tragedies of the drug war, and the future doesn't look optimistic.

We are on the verge of a heroin epidemic that has the potential to be the worst we've ever seen. We are facing rampant use of marihuana, PCP, cocaine, and other drugs by our children. Head shops now sell kits for converting heroin and cocaine so they can be smoked instead of snorted or injected. We are seeing vast numbers of adults who are misusers of prescription drugs. Some head shops in New York City are actually selling marihuana and illicit pills over the counter. We have high-profit PCP dealers, cheap available, high-quality heroin; rock and movie stars who tout drug use.

The State and Federal response to this stark reality is, reduce funding.

We can be fiscal conservatives, but let's be humane and realistic too. The fact remains that drug treatment does work; I'm a testimony to that. But it can't work unless we give it a chance and provide services to the people in need.

We know that for every $6,000 we spend for drug treatment, we save $25,000 in welfare, medicaid, law enforcement, and correctional services costs. Drug treatment is cost-effective, can save money in the long run and, above all, can save lives.

Please don't let what I've said fall on deaf ears. Tell your associates and colleagues that so far we are doing the job with what we have. We aren't losing the war, but our battle plan desperately needs a transfusion, not dope, but money.

Cuts in drug funding will only result in more casualties, more waste, and more tragedy. I'll walk the streets with you and show you who loses out when the money isn't put into treatment programs.

It is time for a renewed commitment on the part of the legislature. We are doing everything that is humanly possible to save the endangered lives of our young and others who are threatened by drugs, but we need the resources or we will be unable to hold our own in this fight any longer.

I've been waiting to hear some good news. For 14 months I've served as director of the division of substance abuse services, and I'm still waiting. I hope the good news comes soon.

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Ladies and gentlemen, permit me to quote a famous statesman. I guess he summed it up in these few words:

> It is vain, sir, to extenuate the matter. The gentlemen may cry, peace, peace! But there is no peace. The war has actually begun! The next gale that sweeps from the north will bring to our ears the clash of resounding arms. Our brethren are already in the field! Why stand we here idle? What is it that the gentlemen wish? What would they have? Is life so dear or peace so sweet as to be purchased at the price of chains and slavery? Forbid it, Almighty God. I know not what course others may take, but as for me, give me liberty or give me death!

And I bring something, because I honestly mean that. And I am committed at this point. Given the nature and scope of what is going on in the State, I am prepared to recommend to the Governor of the State of New York to collapse my agency at the expense of removing my job. And I brought a little something, because this is where we are at at this point in time, given the epidemic crisis that we have here. It is not drama; it is reality. And I wish that that would go with my testimony [displaying a noose].

The CHAIRMAN. You don't want us to hang everybody, do you?

Mr. MARTINEZ. At the rate we are going you might as well. We all hang together, or we all hang separately.

Let me show you some charts here to give you a general idea of what we are talking about. Increase in purity of straight heroin in New York City, from 2 percent in 1979, you can see that that is rising, and it will continue to go up.

Proportion of heroin in New York City from Southwest Asia, 20 percent in 1979. It has risen to 48 percent. All I can say, New York City will probably have a real hot summer.

As far as arrests—in 1979, up 24 percent—and this was under 16 years and younger, which is telling you we do not have adults selling drugs now, we have a younger population who can walk in and walk right back out, up 20 percent; 16 to 20, up 5.5 percent over 20 years, which shows the older addict, or the so-called guy dealing is no longer dealing. He is using younger people, so these figures have dropped.

If there are any statistical questions you would like to ask, a breakdown in terms of numbers, or how we came up with the numbers, I have Dr. Lipton here who will be more than willing to respond. If you have any questions for me, I guess I will answer them now, or wait until Mr. Wallace finishes his testimony.

Mr. WOLFF. I want to thank you, Mr. Martinez, for a very comprehensive and dramatic statement, and one I think that touches the heart of the problem.

I do think that it would be advisable to have Mr. Wallace talk first, and then we will question them as a panel.

Mr. MARTINEZ. Fine.

[Mr. Martinez' prepared statement appears on p. 122.]

TESTIMONY OF ROBERT E. WALLACE, CHAIRMAN, COMMISSION ON ALCOHOL AND SUBSTANCE ABUSE PREVENTION AND EDUCATION

Mr. WALLACE. Mr. Chairman, members of the committee, I too want to add my voice to that of Mr. Martinez, and thank you for being here. I am particularly glad to have you here, because I cannot get anybody to really listen to me when I talk about prevention. I am glad at least I have this opportunity.

Much of what Julio has already said is a kind of reflection of the failure of prevention in the State, not only the State but across the country as well.

The agency of which I am the chairman is just about 2 years old. It was created in April of 1978. Tragically enough, I am the second chairman it has had in that brief tenure. And our job is to essentially be responsible for the school-based prevention effort within New York State. We have some other responsibilities as well, but that is our principal function.

And we, for example, in fiscal years 1978–80, we were in a position to give away $13.6 million to school-based programs around the State. Of the 732 districts in New York State, we fund about 85 to 90 of them.

Mr. WOLFF. You are the organization that was going to get cut $10 million?

Mr. WALLACE. Ours is the organization essentially put out of business by the Governor. We were not included in his executive budget. It was restored by the legislature. It was restored to, I think, $14 million.

Mr. WOLFF. You might know that we did have some little role in that.

Mr. WALLACE. Thank you very much. That is an interesting development, because although the money was restored to provide money to the districts, there was no money for this commission to continue to operate.

Mr. GILMAN. As a result of that, are you then out of business?

Mr. WALLACE. As a result of that, the commission is out of business with the exception of myself and an executive assistant.

Mr. GILMAN. Who will be taking over that responsibility?

Mr. WALLACE. We are not sure at this point. That is an issue being considered and negotiated by the legislature and the Governor's office.

Mr. WOLFF. I do want you to know that this committee was successful in getting the entire New York delegation to send a letter to the Governor requesting a change.

Mr. WALLACE. I don't know anybody who didn't send a letter. We have gotten an awful lot of suppport as a result of that action. And the legislature in their collective wisdom decided to put us back into the budget to that extent. We do not know what the future is going to hold.

The big danger to that kind of action is, it suggested the dismantling of the entire prevention effort in New York State. We think that should not be done, obviously. We have registered those feelings with all the people we need to. But apparently the public feels essentially the same way because in the course of our efforts we reach up to 100,000 kids across the State. And we do have some very interesting and exciting things in attempts to keep them off of drugs and alcohol.

I kind of think maybe I ought to stop there and let you ask the kinds of questions you would like to ask.

[Mr. Wallace's prepared statement appears on p. 124.]

Mr. WOLFF. My concern is, as you have indicated, your talk falling on deaf ears.

Mr. MARTINEZ. That was my statement, Mr. Chairman. I swear to that, too.

Mr. WOLFF. OK. The fact that this committee is here is an indication that we are not deaf at all. We are listening long and hard. The activities of this committee are in addition to our other activities as Members of Congress. This is a select committee. But I can tell you that we meet the same frustrations that you do, because we have pledged to go out of existence by the end of this year, not that we may not come back in some other form or be reincarnated in some way. The fact is that most of the media have come to the conclusion that drug abuse, as such, and the problems of drug abuse, are over in this country. It is an unfortunate circumstance that there must be the constant repetition of the problems and how they are continuing to operate within our society.

Now, as the director in New York State, are you getting the support that you think you need? What effect do you think the question of the cut of $40 million at the Federal level will mean to New York State?

Mr. MARTINEZ. Well, let me say that in terms of 409 money it would mean the elimination—and I think you heard what type of staff I have right here—the elimination of 129 federally supported lines. And according to Federal and State guidelines, the lines that I will be using are people who are supposed to regulate these programs, whether it be methadone programs or intervention programs. So in a sense my arms are being cut off. And someone is asking me to do a function that is almost humanly impossible.

I then cannot ask the programs to be responsible and accountable if I don't have the staff and the manpower to oversee these programs, to see how they are spending their money, to see if the clients are getting equal treatment and so on and so on.

Mr. WOLFF. What percentage of your activity is directed to New York City?

Mr. MARTINEZ. When you say percentage, in terms of what?

Mr. WOLFF. Resources. What percentage of your resources are directed at New York City. You handle the entire State?

Mr. MARTINEZ. I would say that is 99 percent of the State allocation, that is Federal money, State money, and third party reimbursement money, all goes out to the community.

Mr. WOLFF. That I know. But how about to New York City?

Mr. MARTINEZ. About 75 percent.

Mr. WOLFF. Does that follow the addict population, figures on the addict population?

Dr. LIPTON. The State of New York has a responsibility beyond just the addict. About 77 percent of the addicts are in New York City. If you add in Nassau, Suffolk, Westchester, the immediate area, you are probably talking about 90 percent of the addicts. But the problems in New York also consist of PCP abuse, cocaine abuse, prescription drug misuse. These are problems which are statewide and not concentrated.

Mr. WOLFF. You quoted a figure of some 570,000 substance abusers. Can you break that down for us?

Mr. MARTINEZ. Yes, we will.

By the way, Mr. Chairman, as I give you a breakdown, let me also add New York City is probably the mecca for substance abuse.

Yet our Federal share only amounts to 17 percent. We are taking a cut at the time when we are faced with a heroin epidemic.

And I just feel, and I would say to Dr. Pollin—he is a dear man and a friend—cut someplace else, where guys don't shoot heroin, they shoot potatoes. I have junkies on the streets. I can go to some of the places—and I have been to other places. They are not heroin addicts. Yet I am asked to take the same cut that the next State is taking. And I am saying, hell, no, and I have told them that; not that he is listening.

Dr. LIPTON. I can give you a profile of the substance abusing population in New York State as of the midyear, 1979.

We had in total about 213,900 narcotic abusers. These are people who are using heroin and illicit methadone. Most are heroin users.

Mr. WOLFF. How does that compare with previous users? Do you have anything?

Dr. LIPTON. Well, that is an interesting question at this juncture, because the middle of 1979 is when we began to see the upturn. And since then, our projections are that we probably are dealing with somewhere in the neighborhood of 240,000 narcotic abusers. But the full question is also—to reiterate what I said before—we also have many heavy users of nonnarcotic substances—cocaine, hallucinogens, inhalants, the nonmedical use of tranquilizers, sedatives, stimulants; 407,600 people.

In addition to that, we have other active abusers of nonnarcotic substances, the same substances I mentioned before, consisting of 387,900 people.

Now, this is not simply someone who used it once in a lifetime. These are people who are actively involved on an almost daily basis with dependence-producing substances.

Mr. WOLFF. How do you collect your figures? How reliable are they?

Dr. LIPTON. We triangulate on these figures. We have been operating since 1972 with continuing surveys of the population, household surveys, college population surveys, school surveys of all of the secondary schools, both public and parochial.

We also continuously monitor 13 separate indicators throughout the State, which is how those figures that Mr. Martinez gave you before were derived—the arrest data, the deaths, the admissions to treatment for heroin as primary drug of abuse, serum hepatitis B+ cases, admissions to prison detoxification, new admissions and readmissions to methadone treatment, morphine positive urinalyses, quinine positive urinalyses, and others. The third leg of the epidemiological triangle consists of continuous street studies conducted by ethnographically trained ex-addicts who observe and report daily on high drug use and drug copping areas noting changes in the drug scene. These three kinds of data give us a current picture of as well as the trends in drug abuse in New York. All of our sources of data, whether from surveys, indicators or direct observation, are pointed toward an exponential increase in heroin use.

Mr. WOLFF. How do you get the death data? We heard just a few minutes ago that New York City is not furnishing any data.

Dr. LIPTON. I was not here at the time, but I understand what he said from other people who were here.

His office sends the death certificates over to the New York City Department of Health. The New York City Department of Health has a Division of Biostatistics which has a small unit headed by a woman named Frieda Nelson. She takes all of those death certificates and compiles them into the various categories of death, as stipulated in the ICDA code. The heroin deaths are recorded as 304.9. And we get an annual tally from Frieda Nelson's office, and we can also get it quarterly. We can even get it weekly.

Mr. WOLFF. But she takes the information furnished, does she not, by the medical examiner?

Dr. LIPTON. All of the medical examiners in the city. He is just one of them.

Mr. WOLFF. In the State.

Dr. LIPTON. No, in the city, sir. He is the chief. But the death certificates are stamped by the medical examiner, the Bronx medical examiner, the Brooklyn, the Queens. I saw them the day before yesterday.

Mr. WOLFF. But his statement was, there is really no accurate count of the amount of OD's that we have from narcotics since he is not adequately staffed and has not furnished any figures since 1973.

Dr. LIPTON. Well, I am not in a position to sit in his office and see what goes on. I can tell you what I know. And that is that when Ted Schramm worked for the Office of Drug Abuse Policy in the White House, he went to DiMaio who was predecessor to Gross, before Baden came in, and they offered them a position.

Nick Kozel was there with Ted Schramm. He works for NIDA. They offered him a statistician, and they got one. So I do not know precisely what they do with that person, but they do have somebody there who is supposedly in position to do so.

In addition——

Mr. WOLFF. Are you saying that they have a statistician?

Dr. LIPTON. I don't know if they still have, but they were given one at that time. The record that he maintains really consists of two kinds. One kind is those that are immediately diagnosable deaths—chronic narcotism, ingestion of heroin, whatever it might be. Then there are some pending further autopsy, pending chemical examination, or in some pending status. At the end of the year, those are reconciled and there is an addition to the total which is accumulated weekly in Frieda Nelson's office. So that when these come to Frieda Nelson, they come as death certificates, with a stamp, with a sign, the name of the condition that the person died from, the locality of residence, and all kinds of other data.

Mr. WOLFF. The point he made is the fact that in those that are definitely discernible, he can determine that they are narcotics-related deaths. But in those areas that are questionable, he cannot. Therefore, he says that he underestimates, very substantially, the number of deaths that are attributable to narcotics.

Dr. LIPTON. That may be.

Mr. WOLFF. I might say your figures, based upon their figures, maybe have conservative estimates.

Dr. LIPTON. No question about the fact that they underestimate the total, because there are always some which are suspected to be

narcotic deaths, but are listed as undeterminable within a category of the 304 series.

At the end of the year, those come as unspecified narcotics deaths.

Now, the ICDA codes list them by drug, so they have it by volume within each one of the categories.

Mr. WOLFF. Unfortunately, we came to a point where he said you had to have a spike in your arm before you had a determination there was a narcotic-related death.

Dr. LIPTON. If you saw the death certificates, you would see chronic narcotism, injection of heroin. This is not in every case, however.

Mr. WOLFF. We are talking about heroin here today and the effects of heroin. Certainly with the great amount of attention being paid to heroin, many times there is the tendency to play down the other substances, the mind-altering substances that are available in society today. We don't have a handle on that at all.

There is a very interesting development recently on the question of cocaine overdoses. Have you had any experience with that at all? Do you know whether or not there have been any cocaine overdose deaths in New York?

Dr. LIPTON. I cannot respond to that.

Mr. MARTINEZ. Let me just respond to it this way. Most of those that can afford cocaine can probably have their own physician come out and bail them out if they did have an OD. I am talking about your so-called affluent. It is not a drug of choice in the poorer areas. You have to be very bullish, and probably go to Merrill Lynch nowadays with inflation. Even the addict is suffering from inflation.

Mr. WOLFF. Mr. Wallace, you are chairman of an alcohol and substance abuse prevention?

Mr. WALLACE. That is right.

Mr. WOLFF. Now, we have not even touched on the question of alcohol here. Could you give us any insight as to what is happening in that area?

Mr. WALLACE. It is my understanding that that problem is more severe than substance abuse—if you consider other than alcohol. We find very young children—the reports we get are young children come to school intoxicated, high, they drink a lot of beer, wine. Some are drinking whisky. We are down to the sixth and seventh grades.

Mr. WOLFF. There is an interaction of alcohol abuse and drug abuse today.

Mr. MARTINEZ. Mr. Chairman, the commission is comprised of three people. I don't think that Bob and myself should try to talk on behalf of Dr. Blume, because Dr. Blume is the head of alcoholism, and I think in all fairness to both of us, to put it in the proper perspective, we can talk about drug treatment and he can talk about the prevention and education.

Mr. WOLFF. Let's talk about the question of drug treatment. Are you addressing the problem of the combined use of booze and pills or booze and drugs?

Mr. MARTINEZ. Yes, we are.

Mr. WOLFF. How are you doing that?

Mr. MARTINEZ. Well, in terms of whatever data we are collecting, we are sharing that with Dr. Blume's staff and hopefully, given the limited amount of money we have, we are trying to develop some model programs that deal with individuals who have cross-addiction, who are experimenting with marihuana, cocaine, or various other substances, including alcohol.

Mr. WOLFF. In the prevention area at the present time are you doing anything about educating people to the interaction that takes place?

Mr. WALLACE. Yes, we talk about polydrug use.

Mr. WOLFF. I am not only talking about polydrug use; I am talking now of the danger of mixing the two.

Mr. WALLACE. Specifically, no. We have not gotten into that.

Mr. WOLFF. This is something that is a great danger.

Mr. WALLACE. In treatment they do. But in prevention we are not dealing with the dangers of mixture. We are trying to keep them out of it altogether. So we do talk about alcoholism and the dangers of alcohol abuse, just as we talk about the dangers of substance abuse.

Mr. WOLFF. What troubles me is the fact that on a pack of cigarettes we have a warning that this is harmful to your health, but on a bottle of booze we don't say anything about the fact that there might be an interaction if they take some sort of tranquilizer or other drug with the booze.

I think it is about time we addressed ourselves to that type of problem. There is a very high correlation between cigarette smoking and drinking booze. I know the Office of Smoking and Health has a large sum of money to do some work in that general area, to try to show the relationship between smoking and drinking, particularly as it affects young people.

I wonder if you could tell us, Mr. Wallace, are you directing special efforts toward minority groups, since there is a high incidence within minority groups?

Mr. WALLACE. Well, if you examine the programs that we support generally around the State, and specifically in communities like New York City, there is great concentration in those communities where the minority population is very high. And so we do support all 32 districts in New York, and New York City has a large minority school population at this point. The same would be true in most of the other large urban areas where we are able to support programs.

Mr. WOLFF. Mr. Gilman.

Mr. GILMAN. Thank you, Mr. Chairman.

Mr. Martinez, your office oversees the treatment centers, is that right.

Mr. MARTINEZ. That is right.

Mr. GILMAN. How many treatment centers are there in the State?

Mr. MARTINEZ. Approximately 320 funded programs consisting of about 650 clinics.

Mr. GILMAN. Treatment centers?

Mr. MARTINEZ. Not centers. Wait a minute. There are so many to keep up with. You see, you have to break it down.

We have methadone. Then we have——

Mr. GILMAN. Is that under your program?

Mr. MARTINEZ. Yes. That treats approximately 33,000 people. I cannot break out exactly all the physical locations.

Mr. GILMAN. Are you in charge of the State institutions on narcotics?

Mr. MARTINEZ. No. We do not have any.

Dr. LIPTON. We used to have.

Mr. GILMAN. There are no longer any.

Mr. MARTINEZ. We had two but we phased them out, which were Masten Park and Manhattan. That is now under the division for youth.

Mr. GILMAN. You have the nonprofit organizations and the voluntary organizations, all come within your province.

Mr. MARTINEZ. Right.

Mr. GILMAN. What sort of a budget do you have to work with?

Mr. MARTINEZ. Right now, about $50 million in State local assistance funds.

Mr. GILMAN. You dispense that amongst these various centers?

Mr. MARTINEZ. Exactly.

Mr. GILMAN. How many people do you have working in your agency?

Mr. MARTINEZ. It is right there on the paper. 220 State-supported positions.

Mr. GILMAN. 220 people.

Mr. MARTINEZ. From a staff back in 1973 of 4,000 and change.

Mr. GILMAN. Really, you are a disbursing agent, aren't you?

Mr. MARTINEZ. Funding.

Mr. GILMAN. You are the vehicle through which funds flow from both the Federal and the State into the local treatment centers?

Mr. MARTINEZ. Right.

Mr. GILMAN. How will this cutback that NIDA is expecting, or that will be taking place, how will that affect your program?

Mr. MARTINEZ. Well, as far as the agency, what I am going to propose is like I said in the statement, is to propose to the Governor that he dismantle the agency. After those cuts it won't have any function.

Mr. GILMAN. You won't be able to exist at all without the NIDA money.

Mr. MARTINEZ. How can I lose 129 staff members, when their responsibility is to regulate methadone programs, intervention programs, where we have to be accountable to the people of the State of New York as to where and how their moneys are being spent?

Mr. GILMAN. As you address the budget for this year in the State, did you take into account the possibility you were not going to have the NIDA money?

Mr. MARTINEZ. I tell you, I don't know what NIDA is doing. I wasn't assuming or second-guessing them. My thought was that the money was forthcoming, from what we understood.

Mr. GILMAN. When did you first learn it was not forthcoming?

Mr. MARTINEZ. I found out later from Dr. Pollin when I got it in script.

Mr. GILMAN. When was that, Mr. Martinez.

Mr. MARTINEZ. We found out about it about 2 months ago, when most of our people were going up to Washington.

Mr. GILMAN. Was that time enough for you to address a State budget to make up for any loss of funds?

Mr. MARTINEZ. It is too late, because by then they were working on our cuts.

Mr. GILMAN. And you were not able to make up for the loss of Federal money in your State budget?

Mr. MARTINEZ. No. I sent a lot of telegrams, mailgrams. The only thing I did not send was candygrams, because no money was coming in. But I did everything humanly possible to tell them that New York State could not deal with this cut, there was no way in hell we could deal with this cut.

Mr. GILMAN. You made that known to NIDA?

Mr. MARTINEZ. Right.

Mr. GILMAN. When will you have to go out of business?

Mr. MARTINEZ. At the rate things are going, I still have not met with the governor to discuss it, but I would say by the end of next year, 1981, given the cuts.

Mr. GILMAN. You are going to recommend that he close shop?

Mr. MARTINEZ. And I will show you that in writing if you want to see it.

Mr. GILMAN. And you have already closed shop in Mr. Wallace's.

Mr. WALLACE. Eventually we have, yes. Our staff is dispersed all over the State.

Mr. GILMAN. Will there be any narcotics office at all if your office closes and Mr. Wallace's office is without personnel?

Mr. WALLACE. In prevention there will be roughly $15 million to be given away.

Mr. WOLFF. Who will give it away?

Mr. WALLACE. That is a decision that to my knowledge has not yet been made.

Mr. GILMAN. Without your offices there will be no responsible agency or vehicle in New York State.

Mr. MARTINEZ. They may come up with a vehicle, they may just attach the agencies to Mental Health, which would be the next step.

Mr. GILMAN. Is there a narcotics office under Mental Health in the State? Dr. Lipton is saying no.

Dr. LIPTON. No.

Mr. GILMAN. There is in the Health Department, but that is an enforcement agency, isn't it?

Mr. MARTINEZ. Right.

Mr. GILMAN. And in State police, they have a narcotics bureau. But that is the extent of narcotics in the local State of New York, is it not?

Mr. MARTINEZ. That is right. And they are being cut.

Mr. GILMAN. What is the total fund, then, that the State budget made available for narcotics education and services—education was how much?

Mr. WALLACE. The grand total would run around $15.5 million.

Mr. GILMAN. And Mr. Martinez, your total budget?

Dr. LIPTON. The total budget, including medicaid reimbursement, all possible third-party funds, tax levy funds from localities, private donations, the total Federal contribution, all of our local assistance

money, and the 409 money, every bit of the dollars amounts to $133.6 million.

Mr. GILMAN. And of that $133 million, how much is Federal?

Dr. LIPTON. The Federal portion is $28.7 million.

Mr. GILMAN. That is last year's?

Dr. LIPTON. That is 1979–1980.

Mr. WOLFF. That includes medicaid?

Dr. LIPTON. No. That is $22.8 million.

Mr. WOLFF. You are talking Federal reimbursement?

Dr. LIPTON. Federal reimbursement for medicaid.

Mr. WOLFF. Then you have to add the $28 million and $22 million?

Dr. LIPTON. I separated the two.

Mr. MARTINEZ. You have to understand. When we count our money, we are talking about hard cash—State appropriations, Federal appropriations. That other money, the programs have to pretty much get it, if they can get somebody on their program that is eligible for welfare or medicaid.

Mr. GILMAN. How many hard dollars did the State put into your budget?

Mr. MARTINEZ. $52.3 million in local assistance funds and in State purposes, $9.3. We have these figures.

Mr. GILMAN. You have about $60 million there and $15 million there.

Mr. WALLACE. We don't in the traditional sense get Federal funds. Our money is all State money. We recover about $8 million under social security, and we have been able to recover an additional $700,000 under a title 20 training contract. But we in the traditional sense don't get those funds.

Mr. GILMAN. The State put $15 million into your budget?

Mr. WALLACE. Yes.

Mr. GILMAN. $15 million and $60 million—about $75 million is what New York State spent last year to narcotics.

It would seem to me our good State of New York is not doing its fair share of trying to help in this severe problem. I would assume that we have a great deal more to do in addressing that problem with the State administration.

Mr. MARTINEZ. I will second that.

Can I add something else, which I don't think was taken into account?

On top of the 409 money, we at the treatment end have to shave off 7 percent. Given the epidemic—and I have to give it to my good friend here—to be candid I won't be interested in giving him my 7 percent if I can help it. I would like to get that back.

Mr. GILMAN. Just one last question.

Mr. Martinez, how many people are in your programs?

Mr. MARTINEZ. That is Doug's department.

Dr. LIPTON. At the end of January 1980, we had in funded programs, that is funded through the State, 44,574 people. In addition, in nonfunded programs, that are receiving some direct Federal moneys and so forth, another 7,676 people. We are talking about over 51,000 people in treatment in New York State.

Mr. GILMAN. Most of these are hardcore addicts, aren't they?

Dr. LIPTON. No. I would say that is roughly 50 percent.

Mr. GILMAN. All right. Thank you.

Mr. MARTINEZ. We would be more than willing to leave this information with you.

Mr. WOLFF. We see our Federal authorities standing by. We wonder if our State authorities could stand by while we have some of the other people here.

Mr. MARTINEZ. That is what I am here for. We represent the people of the State of New York. We are here to hear their gripes and beefs, not that we can do much to help, but I will listen.

Mr. WOLFF. I understand next week there is going to be a State hearing. I am communicating with Senator Padavan the fact that we would be very much interested in getting the results of his hearing as well, so we can be acquainted fully with the State problem.

Mr. GILMAN. Which of your agencies did the drug awareness day program in the State of New York?

Mr. MARTINEZ. We did.

Mr. GILMAN. I want to commend you. I think it was a great program. I wish you had publicized it statewide. We didn't know it was a State program. We took part in the program. We thought it was excellent. We see a lot of the clips coming in around the State from various seminars held. I want to commend you for it.

Mr. WOLFF. Just before you leave, how do you feel about the Federal materials that you get?

Mr. WALLACE. In prevention we have made great use of them. They have been very, very helpful. He is no longer there either, but we had for a time the gentleman who develops a whole public information approach. And he made great, great use of your materials. And you may recall, you and I corresponded with respect to the whole marihuana issue. Mr. Pawlak, the gentleman, was very, very resourceful in tapping into all of the NIDA materials, and getting it out to the communities where people can use it best.

Mr. WOLFF. I want to let you know that this committee was over in Rome recently and spoke to his Holiness, and we had enlisted the church into our efforts. I think it is going to be very helpful. In fact, we are going back at the end of May. We are hopeful that his Holiness is going to do a film for us, which I think would be very useful.

Mr. MARTINEZ. Mr. Chairman, I would just like to say one thing on behalf of Dr. Pollin, I think his hands are pretty tied, just as my hands are tied as a State official, because a lot of times we have to go with the party line. And I must admit not that we are always pleased with the party line. And I think that people at the State level and people at the Federal level are going to have to be told what we are facing.

I do it every day, but it only helps when assemblymen, State legislators, Congressmen, also echo the concerns of the community groups and what we are saying here.

Mr. WOLFF. We share your concerns. Otherwise, we would not be here.

Thank you very much.

Our next panel is Edmund Menken, president, Project Return; Kevin McEneaney, director of public information for Phoenix House; Beny Primm, director, Addiction Research and Treatment Corp.; James Allen, director of Addicts' Rehabilitation Center, and Mr. Ronald Coster, senior vice president, Phoenix House.

I will ask you gentlemen to stand and raise your right hand, please.

Dr. PRIMM. Mr. Chairman, may two of my staff join us here?

Mr. WOLFF. Do you solemnly swear the testimony you will give will be the truth, the whole truth and nothing but the truth, so help you God?

Mr. MENKEN. Yes.

Mr. MCENEANEY. Yes.

Dr. PRIMM. Yes.

Mr. ALLEN. Yes.

Mr. COSTER. Yes.

Mr. WOLFF. We would like to have all of you submit your total statements, and, if you can, to summarize your statements. Your entire statement will be included in the record. If there are any charts we can include them in the record.

Mr. Menken, why don't you lead off.

TESTIMONY OF EDMUND H. MENKEN, PRESIDENT, PROJECT RETURN

Mr. MENKEN. Thank you, Mr. Chairman. I do have portions of my prepared testimony that I would like to read. I have condensed it.

Mr. WOLFF. Please proceed.

Mr. MENKEN. What I would like to do is begin with some prefacing thoughts.

I am very angry and highly frustrated, particularly over some of the comments that I have heard from the representatives of NIDA. I am also angry about the perception that I have just recently developed and want to shape in the form of recommendations. This is a bit of a twist I imagine, because most often we are asked to give recommendations subsequent to testimony. I want to do it before the testimony. And these things are a bit unusual.

I would like to recommend two things that this committee, in the interests of its task here today, consider promulgating in some form or manner. They are as follows: One, I would like to see the Congress of the United States somehow be able to put forward in writing some kind of document that describes the Nuremberg law. I would like to see that every civil servant, and particularly appointed executives, those people who are at the highest rungs of the ladder of the GS-series, are given a sense and an understanding of what the Nuremberg trials produced in the way of concepts of law; that there is unquestionably and inevitably and invariably a moral responsibility that is left to the individual in the face of orders or directives to the contrary from superiors.

It seems to me that in much the spirit that Julio Martinez brings to this room, being one of a kind in my opinion, and I think that opinion is shared by most of my colleagues in the field, you have a demonstration of an individual, and I think many other individuals around him, of what a public official can and ought to do when in fact in Government, and faced with a situation wherein that public official's superiors, say to him:

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Go out there and lie to the public, go out there and represent our biased politically expedient purpose. Do not say to us that you cannot do the job. Don't tell us that there has to be another way. Go out there and work for us, and our message and our rhetoric.

It seems to me that civil servants, people who work for Government, should begin to understand that there has to be a moral boundary to that; that they must be able to respond to questions from congressional people, when you, Mr. Gilman, would say for example, "and what has NIDA done, what preparation has NIDA made for this coming onslaught—" NIDA's posture of course is to support the administration, or with the administration's recommended cuts in budget.

It seems to me that that comes out of a kind of a psychology that runs rampant in this country and does not permit the subordinates who have to have the tools to get the job done, as well-stated by Julio, must be able to go and respectfully and clearly state to their superiors, to the people in the White House, "We cannot do the job with what you are giving us." That is item 1 for recommendation.

Mr. WOLFF. May I just comment on that?

A very high figure in the administration just did that.

Mr. MENKEN. Yes, he certainly did. And I would venture to guess that those who read newspapers and watch television and listen to radio news have a great deal of respect for Cyrus Vance.

The second recommendation which is made in the spirit of cooperation and friendship and support for this committee and its purpose here today is that someone should think about and perhaps enact legislation calling for a school for legislators.

Now I do know that there is some kind of orientation that occurs when a new legislator is elected and arrives in Washington.

Mr. WOLFF. If you can find that place, let me know, because when I came there no one gave me any information. I didn't have a scrap of paper on my desk.

Mr. MENKEN. I could be wrong, Mr. Chairman. I was under the impression there was some sort of orientation made available to junior legislators.

Mr. WOLFF. As our counsel has said—to the pages.

Mr. MENKEN. Well, then, my comment, my suggestion, my recommendation I think is even more profound and should be considered in that light.

It seems to me that every individual, every person who is elected to office, whether it be the Presidency, to the Senate, or to the House, ought to have a required series of briefings, an understanding about what the issues and problems are in the inner cities, in urban and rural America, what farming problems are, what drug problems are, what the health issues are, and it seems that they should not be able to raise their hand in yea or nay fashion to a vote, to pass laws that affect the lives and welfare of the people of this country until they have a substantial orientation for that purpose.

Mr. WOLFF. You see in this country we do not have the orientation, but we have some sort of after-the-fact education. That comes at the next election, because if elected officials do not reflect the community from where they come, then they don't find themselves back in that position in the legislature again. And it is up to the

community to be able to have their voices heard, or to see to it that they have that type of representation.

That is one of the things we are fortunate in this country that we do have. There are other countries of the world who have people that are appointed to legislatures, or who have to abide by the dictates of an individual. We fortunately are one of the few remaining countries that have something like a Congress, and the various elected legislatures that we do have in the State of New York, for instance. But your point is well taken.

I do think that it is very difficult to be thrust into a legislative role without a full appreciation of all the problems that are involved. But that is where the ability of an individual comes in, to be able to hire the staff that is necessary to provide them with the information and the disciplines that the individual does not have for his own. But the point that you make is well taken.

In your reference to the Nuremberg laws and the like—I know what you are pointing at. I know the fact that you would like to see a greater amount of independence displayed by those people who are in the various bureaus of Government. But that independence should be shown before a decision is made rather than after the decision is made.

Mr. MENKEN. Absolutely.

Mr. WOLFF. However, the executive departments are charged with the responsibility of carrying out those decisions that are made by the legislature in affecting the lives and the welfare of the people of this country. The executive department must, by law, execute those directions that are given them in fulfilling the laws that are enacted by the legislature.

I think that there is a midpoint where you and the people in these positions are now. Suppose they do not do that, and are not there to fight another day itself, though they may be of the highest intention.

I have been one of the great critics of bureaucrats in the country, sitting in the spot that I do, because I work with them every day. But I do think you have to defend their position in the way that they are required to not state an administration position, but to fulfill the responsibilities they are given by their own departments.

Mr. MENKEN. I think that is best characterized, Mr. Chairman, in the words that you put forward before having to do with the first responsibility of this Government, and that is to its people, and not to its budget.

But forgive me for the diversion. I will get to what I consider to be the salient points of the testimony.

Mr. GILMAN. If the gentleman would yield, Mr. Chairman.

Mr. Menken, I would just like to comment a moment. I think your points are well taken about the responsibilities of some of our administrators. More could become advocates that should be advocates of their jurisdictional problems. Unfortunately, many are not.

But we do have in the executive branch a policy group that is supposed to be the advocate of drug problems, and that is in the Domestic Council, in the Office of Drug Abuse Policy. I would hope that where you find you are not finding a resolution of your problems amongst the agencies, that you direct some attention to that office that coordinates policy as well as strategy.

Mr. MENKEN. I have. I have been there, and I include them in the same comment.

Mr. GILMAN. All right. I am pleased that you are.

One other comment I would like to make. As part of the education process for legislators, and new legislators particularly, too often groups, agencies, people who are working on problems, fail to reach out to their legislators and make them part of the problem and get them involved and try to orient them. And I would hope that some of you might make certain that you get your legislators, State and Federal, to come in and take a look at some of your problems, and wander them through your program and spend some time with them. That is part of the educating process.

Mr. MENKEN. Mr. Gilman, that is absolutely true. And I think that onus certainly is upon us. I had more in mind, quite frankly, not the exceptions to the rule, which the gentlemen that have been here today representing the Congress certainly are. You are the exceptions. There are many more, however, who sit, as we all know, in very important places, on very, very significant committees, be it Finance, Appropriations, who when we have recently come to the awareness that politicking is so important to the survival of the issue of treating drug abuse, we just recently discovered how little they knew about anything at all. So that onus certainly is in part on us.

I am wondering whether or not the Government can do a little bit more in that direction also.

Mr. GILMAN. Both should be.

Mr. WOLFF. Mr. Gilman and Mr. Menken—we have a large panel. We are going to have to stick to time constraints.

Mr. MENKEN. I did not intend that my preliminary comments would create such a response.

There is a time bomb ticking away in our midst that is about to explode, causing misery and human destruction through America. Hard evidence, from both public and private sources, clearly points to the fact that we are confronting another heroin epidemic, the likes of which have never been seen before in this country.

Prior to the recent crises in Iran and Afghanistan, our Government was able to estimate, with reasonable accuracy, that that sector was producing about 200 tons of raw opium annually.

Since the crises, however, the conservative guesstimate is that a minimum of 1,600 metric tons are being produced, but it could, in fact, be closer to 2,000 tons. To make matters worse, the crops from the Golden Crescent are not the only problem. Now, the Golden Triangle area of Burma, Thailand, and Laos must also be reconsidered.

Production from this area has leveled off in recent years, not as a result of law enforcement efforts or international diplomacy initiatives, but rather as a result of an act of nature.

The Golden Triangle has suffered 3 consecutive years of drought. Unfortunately, these conditions have changed and a bumper crop is anticipated this year.

As this occurs, we can look forward to a situation of global heroin manufacture and distribution which is unprecedented in human history. These vast quantities of raw opium must find a

market and it is necessary to assume that the United States is the likely victim.

For nearly 2 years, there have been reports of a major heroin epidemic developing in Europe. Countries which never before experienced a drug problem of any serious magnitude are beset by an influx of white heroin of excellent quality and increased availability.

Among the nations most seriously threatened is West Germany where, not incidentally, the majority of American troops in Europe are stationed.

According to Erich Rebscher, Chief of Intelligence for the Narcotics Division of the Federal German Police, "Heroin in Germany is so plentiful and so potent that (they've) had 595 overdose deaths, almost twice the American total in 1979, although (they) have only one-fourth the population."

What has been occurring in that part of the world should have received greater attention in this country, for it wasn't just happening in Germany. All over Europe reports of a flood of high-grade heroin should have signaled the inevitable for us here at home.

Some of our own enforcement officials predicted what was to come, but our legislators and elected executives apparently took little heed.

John Warner, the U.S. Drug Enforcement Administration Regional Director for Europe and the Middle East, warned that:

> Since Europe is clearly saturated, all the new laboratories being set up and the tremendous increases in the flow of heroin to Europe demonstrates that a major drive is being prepared for Middle East heroin to take over the American market.

And Peter Bensinger, head of the DEA, added to the prophesy by stating:

> All of Western Europe is overflowing with Middle East heroin and our intelligence strongly indicates that we can expect larger amounts to hit the United States in the new year.

Well, the prophesy was more than a prophesy. Look at the facts.

In a recent 4-week period, five individuals who were in treatment at my agency dropped out of the program and died of heroin overdoses within days of their departure.

Since history shows that most of the people who drop out of therapeutic communities eventually return, you can understand the frustration around this indicator.

I will pass some of the statistics. You have heard them over and over again. I would only change one word there, that the deaths due to drug overdoses are what is appropriate rather than heroin overdoses. That was a mistake in my office.

Data available through the New York City Police Department that identifies, by age groupings, the people arrested for felony drug offenses—opium and derivatives, which in fact means heroin—indicates the following: The largest increase in this category, 24 percent, occurs in the under 16 age group; the second largest increase is shown in the 16 to 21 age group.

As confirmed by law enforcement authorities, the purity levels of street heroin is way up, the price has come way down and the availability on the streets of New York is far greater than at any time in the past 25 years.

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1 OF 2

But our lawmakers were reading or weren't hearing or weren't listening.

We are indeed seeing the first wave of a new and worse epidemic than ever before. It is spreading far and it is spreading rapidly. The U.S. Journal of Drug and Alcohol Dependence reports that Persian heroin appears to be heralding significant increases in west coast drug use.

What is uniquely frightening about the California situation is that the Persian heroin being seen out there is not only of a higher concentration, but it appears to have been basified so that it can be smoked rather than injected.

This means that tens of thousands of young people who reject the idea of an intravenous high, but indulge quite comfortably with smoking marihuana, may be very susceptible to a new but devastating euphoria.

Smoking heroin is, in fact, the preferred method of ingestion in places like Hong Kong, and while a great many folks may believe that this method is less dangerous than injection, nothing could be further from the truth.

According to Dr. Daryl Inabe of the Haight-Ashbury free clinic in San Francisco, there is indeed widespread use of Persian heroin in the bay area. Approximately 80 percent of the clients at the free clinic are heroin addicts.

About one-third of the heroin addicts, or 24 percent of their entire client population, are involved with some form of Persian heroin. It appears that 50 percent of this group are smoking the heroin, with the other half injecting it. Similar reports are now coming out of Florida and Texas.

DEA also reports that a new form of heroin, originating in Bangkok, known as "paper dope" or "soaks" consists of 1½- to ¾-inch squares of artists paper in which heroin has been absorbed.

The heroin is administered to each square, which is then cut and sold individually on the street for $25. The addict puts the paper in the "cooker" and adds water. There is no need for boiling or straining through a "cotton."

Each square is about three-quarters of a gram of street heroin at 1- to 3-percent purity. The heroin is undetectable unless held up to a strong light, at which time a brown stain is evident if heroin is present.

If the west coast continues to be the trendsetter for youth as it has in the past, then, with respect to these matters, the cost in human life could be incalculable.

If I sound like the prophet of doom, it is because I have come from the front lines, from the trenches. Here in New York and all along the east coast drug treatment facilities are at or over their capacities.

I am hearing from my colleagues throughout this part of the country and the story is the same everywhere. We have an epidemic on our hands. How can we make our leaders understand this? What must we do to have your help and support?

We in the substance abuse treatment field have had to contend, in recent years, with curious circumstances. While we have gone about the business of trying to treat the misguided, psychologically debilitated, abused and addicted youth of this country—the children of the rich and the poor alike—we have had to wrestle with social apathy, a contagious permissiveness toward drug taking behavior, and a governmental posture which, at best, has been unresponsive and, at worst, negligent.

As a result of the NIDA reauthorization legislation, Public Law 96-181, signed into law on January 2, 1980, in fiscal year 1980, the treatment sector loses a minimum of $11 million, or 7 percent of its allocation.

For fiscal year 1981, the forecast is even dimmer. With the administration's most recent request to completely wipe out the formula 409 funds, a total of nearly $40 million, the treatment sector stands to lose approximately $28 million.

The capability of the States to deal with their respective drug abuse problems will be virtually destroyed by this move since they rely so heavily upon 409 money for the administration of their State drug abuse efforts.

For 3 successive years, funding for the National Institute on Drug Abuse has remained virtually the same. No regard for spiraling costs. No sense of concern for the needs of the service providers. No appreciation of the conditions created by the burgeoning drug problem. And now, the prospect of having to cut back even further, crippling any capability to respond to this epidemic that will surely claim thousands of young lives.

What we are clearly facing here is an intentional and deliberate disintegration of what, on the one hand, is a very meager Government investment in the interest of public health but, on the other hand, one of the most vital systems to the well-being of America's youth.

When the simple economics involved are examined, the posture taken by our Government makes even less sense.

In a recently released GAO report it is stated:

> Another major consequence of the drug problem is the heavy financial burden to society. According to HEW, the annual social cost of drug abuse is $10.3 billion. The cost includes absenteeism, unemployment, and death; law enforcement (including the judicial system); drug traffic control and prevention efforts; medical treatment, and about $518 million for providing drug abuse treatment services.
>
> The estimate does not include the range of intangibles that cannot be priced, but represent the pain of mental and physical debilitation, the destruction of families, the disruption of neighborhoods, and other human suffering associated with drug abuse.

A recent informal study of the eight New York Regional Therapeutic Community of America programs revealed some startling information.

In 1979 there were approximately 355 graduates of these affiliated programs. We took this group to try to get a handle on a group we could look at pretreatment, during treatment and post-treatment and see what the dollars mean.

People seem to be more concerned about dollars than life these days in Washington, so we figured we would take that tact.

Using HEW's figures, these former addicts accounted for roughly $47.5 million in costs to society related to their untreated addiction in the streets. The total governmental cost to treat and rehabilitate these young men and women was barely $2 million.

They came off the welfare rolls, out of the public dependency syndrome and away from the drug scene. They currently return,

through their combined income, over $3.2 million a year to the economy of this Nation and their tax contribution is in excess of $500,000.

Clearly, the Government investment in drug abuse treatment is miniscule when compared to the benefits gained by society for each person who is rehabilitated. Our Federal Government is truly guilty of being pennywise and pound foolish.

What is happening in this country? Where are we going? What will it take to get the powers that be to stop for a moment and realize that for the want of a dollar we are going to lose our children?

If that is to be our destiny, history will record that these were the years when our Nation's leaders could not demonstrate the courage and creativity to deal with one of our most insidious enemies.

We have been shortsighted, ignorant, neglectful, and irresponsible.

I would urge every member of this committee to use his best influence and good offices to reject the administration's recommendation for funding reductions in the 1981 budget and to consider appropriate increases to all geographic areas of this Nation identified as being stricken by this new heroin scourge, not to wait until after the people are dead and gone.

Additionally, I urge this esteemed body to recommend that the Congress amend Public Law 96-181 to allow for the moneys therein set aside for prevention to return to the treatment sector.

Prevention is certainly important but it cannot be supported at the expense of vitally needed treatment resources. We have already heard this.

I hope and pray that our leaders will take a new and deeper look at the drug abuse tragedy in this country and give to that problem all the help and support that it desperately needs. Quite simply, the future of America depends upon it.

Thank you.

[Mr. Menken's prepared statement appears on p. 126.]

Mr. WOLFF. Thank you very much, Mr. Menken. We will proceed with other members of the panel and then question.

Dr. Primm?

TESTIMONY OF BENY J. PRIMM, M.D., DIRECTOR, ADDICTION RESEARCH AND TREATMENT CORP., NEW YORK, N.Y.

Dr. PRIMM. I had a somewhat, I wouldn't say lengthy, presentation but certainly there were some slides I wanted to present, to give you some idea about some of the sociological factors that I feel greatly influence the problem of drug abuse. In view of time, I won't go through the whole prepared statement.

I don't know how many of you can see the slide. If you come over a little closer, you can see this is the number of total felonies in New York City in central Harlem in 1969 until 1979.

What we have tried to do is show the impact of drug treatment funding—there are many other variables that affect this—and to give you an idea what has happened in that community secondary to the amount of moneys that went into the community.

The solid line, of course, is New York City's felony crime rate for that period of time, from 1969 to 1979. The broken line indicates that of central Harlem, central Harlem being the 110th Street South to 155th Street North, and let's say from East River over to Amsterdam Avenue.

At that time, in 1969 and 1970-71, we had a very, very high incidence of felonious crime. This is when the infusion of funds began to flow into New York, in terms of drug abuse treatment.

Suddenly there was in New York City a precipitous drop in crime, a precipitous drop in felonious arrests and crime in Harlem. That continued throughout the period.

We are seeing now, over here, an increase in felonious crime in Harlem. We were not able to add that statistical data on this slide, but if we showed it, we would show it going up also. This is at the point where funds begin to decrease.

The next slide is on grand larcenies, a crime that addicts unquestionably are generally the greatest number of participants in that crime. In central Harlem, I want you to look at the precipitous drop in crime secondary to drug infusion money. It could also be maybe there was greater law enforcement.

One could argue that. One could say maybe there wasn't anything to steal in Harlem because of the blight in Harlem. But whatever the case, we feel that because of the proliferation of substance abuse treatment programs, the infusion of funds from the Federal and State government in the Harlem community, that it was responsible for most of this reduction.

The next slide shows burglaries, ones that addicts constantly participate in. If you look at the broken line, as compared to New York City, you will see a great reduction in crime.

By the way, Dr. Pollin was in New York City last week and he visited some of my programs up in the Harlem area. He was appalled to see the situation that he did. So not only is the Select Narcotics Committee now coming to New York to talk to us, but certainly people from NIDA are coming down to be right on the front line to see what is happening.

He saw some of these charts and he saw the relationship of what we had done in ARTC in relationship to crime and other sociological factors, in relationship to addiction, became extremely interested, and has requested this data so he can begin to prepare also a substantive argument for whatever, to restore these funds.

The next slide shows drug dependency. This one I think is one of the most important that I can show. The broken line indicates the death rates in drug dependence in New York City and central Harlem.

This line is New York City rate over a 10-year period. This is central Harlem's death rate. In 1969 the census of central Harlem was about 159,000 people. Of course, we know the census of New York was about 8 million.

If you look at the number of deaths that occur in central Harlem secondary to overdose of narcotic addiction, it is just absolutely tremendous.

One item that you will miss on this slide, if you don't look carefully, this amplitude is also included in this total number of

deaths for New York City. So if we took out Harlem's deaths in this particular rating down here, this slide would almost be flat.

In other words, the bulk of the deaths that occur in narcotic overdose in New York City occur in the Harlem community, secondary to that would probably be Fort Green and Brooklyn, which is another program in which my program serves, and Bedford-Stuyvesant in Brooklyn.

I think this is alarming. I think any reduction in drug treatment money will increase the amplitude of this particular line, certainly increase the amplitude of New York City.

I could go home with that one.

For homicides, you heard this morning the district attorney say that homicides, certainly felonious crimes, are all very closely related to that of narcotic addiction. In central Harlem the homicide rate is incredible in relationship to New York City.

By the way, this figure is already in this one down here, and you must take that into account. Not only that. If a youngster is living in Harlem, he has a seven times greater chance of being killed than any other part of the city.

It is closely associated with narcotic addiction. The biggest killer of young black men in Harlem, from 15 to 35 years of age, is homicide.

The biggest killer among Puerto Rican youth in New York City, the first is cirrhosis of the liver, secondary to alcohol. The second biggest killer is that of homicide. The third biggest killer is that of substance abuse. Very closely related.

Another reason why treatment programs unquestionably must have money for alcoholism, must have moneys to also do some studies and some prevention area in terms of crime.

The next slide.

This one shows cirrhosis of the liver. Harlem has a population of 159,000, as I indicated before. New York City has a population of 7-plus million. Here we have an incidence of cirrhosis of the liver that far surpasses that of the city of New York.

Despite the fact that cirrhosis of the liver is the fourth largest killer of everybody in New York, secondary to alcoholism, in Harlem it ranks No. 2 or 3, depending upon the time of year that you take the death rate.

Remember that we only have 159,000 people and remember that this amplitude is already included in there. It is incredible. Any stopping of any money in any way, shape or form or fashion will so cripple that neighborhood that I would expect this to go over the scale.

Could I have the next slide.

I show the one for tuberculosis to give you some idea of what is happening in that community. These diagonally sort of striped columns represent blacks in the Harlem community. In New York City—the white ones represent the male population.

I am trying to show the relationship between the number of blacks that fall prey to tuberculosis, and new cases in males in the city of New York. I want you to look from zero to 4 years of age, the incidence of new cases of tuberculosis among black males.

Right on up to 65, we are dying as fast as hell with tuberculosis, a disease that is preventable, one that is closely associated with

narcotic addiction, and the bad conditions that you talked about, the sociological conditions in Harlem that predispose to disease entities like TB—poor housing, no jobs, et cetera, et cetera, et cetera.

I think not only that. We just had a closing in Harlem of 9 of 22 clinics for TB; 45 percent of all the people admitted to Harlem Hospital with the diagnosis of TB do have a diagnosis of narcotic addiction.

The thing here is that this problem so impacts upon the health conditions of both the minority groups in New York City, that anything done to decrease funding in those areas will further doom us to a demise, I feel.

That is the last slide, Mr. Chairman.

I think no community more clearly shows the relationship that I just talked about than that of Harlem. It is a homogenous community; 97 percent is black. We can look at it from a very socio-medical perspective and come up with some very strong implications.

Harlem is in a climate of fiscal austerity, steadily shrinking employment opportunities and a sharp decrease in human services resources.

There is no single city in America more greatly affected by drugs than is New York, specifically those communities with high minority populations.

It almost seems as if there is an institutionalized and governmentally contrived conspiratorial effort to insure that these chronically stressful conditions endure until complete deterioration is irreversible.

Any diminishing of rehabilitative efforts, particularly the 7 and 10 percent setasides of federally allocated funds under Public Law 92-255, section 410, and its effect on section 409 State discretionary funds will inevitably exacerbate and accelerate these intolerable consequences.

Treatment dollars were overwhelmingly responsible for the reduction of the drug abuse epidemic and associated social costs of the late sixties and early seventies. That experience and much research has indicated that treatment drastically reduces the contagion factor and prevents many new cases of narcotic addiction.

The charts have shown that scanty treatment dollars dispro portionate to the incidence and severity of the problem have caused downward trends in addict-related crime in the Harlem community.

A needs assessment for treatment services in Harlem that pinpointed underfunding to minority programs as compared to those in the greater New York area—that is, Nassau, Suffolk, and Westchester Counties—was commissioned and ignored by the State of New York.

Reimbursement formulas for comprehensive minority-run methadone maintenance programs were found to be significantly lower than all programs in New York State. Yet the mortality rate of narcotic addiction in Harlem is seven times the rate for the city of New York.

While the New York City mortality rates are steadily falling, in Harlem there is a precipitous increase especially in those associ-

ated with substance abuse; that is, tuberculosis, cirrhosis, cardiovascular-renal, and homicides.

The sociological and health indices presented are overwhelming evidence that citizens of Harlem, as those of Fort Greene, Bedford-Stuyvesant and the South Bronx, attempt to survive in a milieu of inordinate stress.

The response for some is the use of readily available licit and illicit psychotropic substances to alter their perception of and reaction to a hostile and psychically painful environment.

Harlem has a paucity of health and mental health services, an anticipated reduction in those that presently exist, a density of liquor stores that exceeds that of all other New York City communities, and is the hub and supermarket of east coast licit and illicit narcotic traffic.

It is plagued with insufficient funding for substance abuse treatment resources and now faces State and Federal reduction in support.

You have already heard from previous speakers mounting evidence of increased importation of illicit high quality Middle Eastern heroin. The alarming statistics presented here reflect malignant neglect and racism. Unrest, anxiety and depression pervade our communities rendering them fertile for epidemic implosion.

If you look at the very last thing down on the chart, where we talk about liquor stores in Harlem, we have 1 for every 2,870 people. In Brooklyn at the Bronx it is 1 for every 4,500. In Queens and Richmond, 1 for every 5,000.

I am wondering why the State liquor authority doesn't talk to the State health department. The State health department, knowing cirrhosis of the liver is the biggest killer among black and brown youth in this town, fourth largest killer in New York City among all people, and still issuing liquor licenses in the Harlem community, making alcoholic beverages available, with that kind of indices in terms of cirrhosis of the liver.

I am wondering why they don't talk. I think this committee could play an important role to ask them to speak to one another, to exchange information that would certainly help the citizenry not end up with cirrhosis of the liver because of the availability of the substance in their community.

With that, I close, Mr. Chairman. I want to thank your committee for your long-standing efforts in trying to do something about substance abuse. Not many people do that. I want to thank your staff. You can call on me anytime to provide you with whatever my office can assist you with.

[Dr. Primm's prepared statement appears on p. 129.]

Mr. WOLFF. Thank you very much, Dr. Primm.

I would instruct counsel to pose this question to the state liquor authority. In addition, I think it should be posed as well to the panel.

May I say one of the reasons why I have such great interest in the Harlem area is the fact that I was born at 25 Convent Avenue.

Mr. McEneaney?

Mr. MCENEANEY. Mr. Coster will present our statement. He is the vice president of Phoenix House.

TESTIMONY OF RONALD COSTER, SENIOR VICE PRESIDENT, PHOENIX HOUSE, NEW YORK, N.Y.

Mr. COSTER. Mr. Chairman, members, my name is Ronald Coster and I am senior vice president of Phoenix House. I am here to present the testimony of Dr. Mitchell S. Rosenthal, president of Phoenix House, who unfortunately cannot be with us today.

With me is Kevin McEneaney, who heads our drug education and intervention unit and may be able to respond to any questions the committee has about the prevention efforts of Phoenix House.

From what you have already heard today, it would be very difficult to dismiss evidence of an incipient heroin crisis in the United States as alarmist conjecture. All the indicators are there.

You are aware of how an increasing amount of potent, white heroin is now reaching the United States and the devastating impact this drug flow has already had in Western Europe, particularly in West Germany.

I won't go into the purity of the heroin hitting the streets because other people have already talked to that. But it is quite pure heroin.

Treatment programs have already felt the impact of more and more potent heroin on the street. The number of clients entering treatment in New York with heroin as their primary drug of abuse increased 42 percent between January 1978 and the third quarter of 1979.

There is no question but that we are going to have another heroin crisis. What we should be asking ourselves is what kind of a crisis we are going to have. If we imagine we will be seeing a replay of the late 1960's or 1970's, then we are in for a considerable shock.

Addiction in the coming decade, however, will be a truly egalitarian phenomenon. It will run throughout all of our society and throughout every community, and its primary victims will be the young.

To see this coming, one need only look at the presently rising tide of youthful drug abuse. I am sure you have heard many of these figures before. But the numbers appear even more grim when considered in the context of widely available, potent, and low cost heroin.

Between 1975 and 1978, regular marihuana use among high school seniors increased by more than one-third to 37 percent, while the number of daily users doubled. Recent studies in Maine and Maryland showed one high school student in six using marihuana on a nearly daily basis.

Increasing use of marihuana by adolescents and preadolescents is itself a significant problem, a problem that becomes more alarming as additional evidence of harmful physical and psychological effects becomes available.

But what should concern us now is the growing number of youngsters who are not content to stop at pot. The 1978 New York study that found a quarter of a million new marihuana smokers also found 118,000 school-age children who had their first snort of cocaine and 125,000 who had tried PCP for the first time.

The NIDA survey of high school seniors in 1979 found that marihuana use seemed to be leveling off after its rapid rise be-

tween 1975 and 1978, but other, more powerful drugs were gaining ground. The number of seniors who reported regular cocaine use had increased by more than 100 percent between 1975 and 1978 and rose another 47 percent by 1979.

Now, after 20 years of studying and treating drug abuse, there are certain aspects that we understand very well. We may not yet know all we should or as much as we should, but there are a number of basic relationships that we do understand.

We know, for example, that the probability of disability is related to a stepping-stone process, a progression from less potent to more potent drugs. And we know that increased availability of a drug invariably increases the number of users.

So we are facing today a tragic constellation—a growing number of younger users each year, a movement by younger users from marihuana to more potent drugs, and the availability of more and more lethal heroin.

The outcome of this situation is frighteningly predictable. The heroin crisis of the 1980's will strike hardest and most devastatingly at the young. How, then, are we preparing for this crisis?

The answer is that we are not. Local treatment programs in New York are now at 96 percent of capacity, and funds for local treatment have been cut. Not only must programs like Phoenix House find some way to swallow cost increases for fuel and food and rent—increases that are running well ahead of the national inflation rate—but they must also live with a 2 percent reduction in State funds, a cut that was restored by the legislature and vetoed by the Governor.

Now I find it hard to fault the effort New York State has made. New York has built and sustained the Nation's largest and most effective drug treatment and prevention network. The costs have been heavy and New York State has borne the bulk of them alone.

The State's drug program now gets only $26 million from NIDA. Let's look at that $26 million from NIDA; $3 million of it, more than 11 percent, is 409 money, money that may be cut by Congress. Since 409 funds are allocated by formula rather than need, New York State doesn't get as much as it should to begin with. Nevertheless, 409 funds make up more than 11 percent of the State's total NIDA allocation.

The bulk of this 409 money goes to support statewide services, many of which have been mandated by the Federal Government. Funds for statistical studies required for funding and for the preparation of a comprehensive State plan all come out of the State agency's 409 pocket.

Now, clearly, these services won't be eliminated should the money to pay for them disappear; $3 million will have to come from somewhere else, and the somewhere else will most likely be local treatment.

That means treatment programs—facing what amounts to an incipient client population explosion—will get no help meeting inflationary cost increases, will lose 2 percent of present State funds plus the NIDA 410 dollars that will have to go to cover the loss of 409 dollars.

This makes very little sense. It is not the final folly we are dealing with this legislative year. There is also the setaside for prevention—7 percent of the NIDA dollars now going to treatment.

Now, clearly more and better prevention programs are needed. We cannot look at the rising rate of youthful drug abuse and deny that. But the notion that funds for this purpose should come from the treatment budget is simply ludicrous.

It is like preparing for an epidemic of typhoid or cholera by adding squads of new sanitation workers and paying for them by dismantling some hospitals.

Let us consider for a moment what is to be done with the setaside. The bulk of it is to be spent on new prevention programs. About $3.2 million from the setaside will go to prevention program development by State agencies.

This money—most of it or all of it from 410 funds—will be allocated to States by formula, a formula similar to the one for 409 funds. In other words, States like New York, where the need is greatest, will get the short end.

I would like to suggest to the committee that what has developed here is the direct result of arbitrary division within the drug abuse field between prevention and treatment. We, in the field, made that division and, I suspect, we have lived to regret it.

The reality we have come to recognize is that prevention and treatment are parts of a continuum. They are rather distinct parts of that continuum, but it is almost impossible to say where one leaves off and the other begins.

What is more, there are direct relationships between treatment and prevention, and they have a powerful impact on each other.

For example, we at Phoenix House have found the natural outreach and community involvement of our facilities produce a kind of community conciousness-raising that is essential to successful prevention.

Let me also point out that as the approach to prevention changes—and it is changing rapidly today—many treatment programs are taking a more direct role in prevention. Across the country, schools, parent groups and community groups are reaching out for help. They are turning to treatment programs. Phoenix House now gets at least 200 requests each month from all over the country—for information and help.

Part of our response to this demand has been to create our own drug education and intervention unit, which is now working with more than 250 schools and community groups throughout the New York metropolitan area.

While our program in the public schools is supported by the State, there are no public funds for our program in New York's private and parochial schools or for the work we are doing with schools and parent groups elsewhere in the Nation.

I see the role of drug-free treatment programs in the area of prevention continuing to grow. This is consistent with the recent realization that an essential ingredient in the prevention of drug abuse is parental involvement.

Indeed, a family strategy seems our last best hope to stem the flood of youthful abuse. And drug-free treatment programs have

had years of experience working with parents and with parent groups.

This means that reducing the funds available to treatment programs will most likely inhibit the very kind of activity you hope to encourage with those funds.

The setaside will produce little initial movement on the prevention scene, but denying those funds to treatment programs will limit their growing involvement in prevention activities. Indeed, I suspect that the net result can only be a setback for prevention.

It will also be a disaster for treatment. That disaster can only be worsened should the need to field new prevention players raise community awareness of drug dangers without providing solid local resources.

Let me explain. When a new prevention effort is mounted, public and parental awareness of drug abuse is heightened. Schools acquire a capacity to identify present abusers. Thus, the first product of a prevention program is invariably a sizable number of hitherto undiscovered candidates for treatment.

We at Phoenix House have seen this happen over and over again. We have seen it in communities where we have become involved—in New Jersey, Maryland, Georgia, and Idaho. Every group we have helped has made the same discovery. To get the kind of prevention program they want, they mus first have a local treatment capacity.

Let me put it all together. We now have a heroin crisis in the making, a crisis that will primarily affect young people. We see a need for more drug prevention and we must recognize that treatment programs are becoming increasingly involved in community-based prevention. What's more, the first result of prevention is to escalate the demand for treatment.

Our treatment facilities are now operating at close to capacity, at least in New York. They will be unable to accommodate the number of youngsters whom we can unerringly predict will require treatment in the next few years. Furthermore, they will be unable to sustain even their present level of activity.

In New York, they will be receiving no funds to meet their increased costs. In fact, State funds will actually be reduced. So will the support they receive through NIDA.

The loss of 409 money used for statewide services will inevitably be balanced by a reduction in local treatment funds, while the prevention setaside will cut further into the treatment budget.

I am sure the committee can recognize the obvious absurdity of this situation. I hope that the members will call it to the attention of their colleagues in the Congress.

Thank you very much.

[Mr. Coster's prepared statement appears on p. 137.]

The CHAIRMAN. Thank you very much, Mr. Coster.

Now we will turn to Mr. Allen.

TESTIMONY OF JAMES ALLEN, DIRECTOR, ADDICTS' REHABILITATION CENTER, NEW YORK, N.Y.

Mr. ALLEN. My name is James Allen. I am the Executive Director of the Addicts' Rehabilitation Center, which has been located in Harlem for some 22 years. Most of what I have to say here—I am

glad I have a chance to appear—I believe it was 2 years ago you invited me.

Very carefully I prepared my speech, I worked all night, and the next morning I did not appear. I couldn't make it.

Altogether we should receive $1,250,000. Subtract from that about $139,000, which we have not figured out how to get yet through the third-party funds.

Last year we provided incidental treatment, mostly referrals, for 2,500 victims; 951 of those lived in our residential or drug-free treatment program; 364 of those 951 victims worked while they were living there and earned $2.2 million, which they saved one-fourth of. So that when they left the program they didn't have to go on welfare.

When we talk about success, we like to think in terms of dollars and cents, too.

Those 364 people working meant that we produced 364 taxpaying citizens, contrasted to what they would have been doing. They probably would have been stealing approximately $64 a day, which would have amounted to over $21 million. We feel that we have saved the taxpayer that much money by providing treatment.

In addition to the treatment that we provide, we also have what we call a preventive education program, which is unfunded.

One of the things we have recognized in providing prevention in these 22 years is that the bulk of preventive education must be aimed at persons other than the potential victims of drugs.

The reason why I say this is because those people who provide preventive education for the kids don't say what is relative to the kids' needs. They usually say what the parents want to hear, and when the parents feel good with us saying this, the parents think we have done a good prevention job. The kids laugh at it.

The objectives of the ARC preventive program are as follows:

One, certainly to discourage the kids from being suckered into drug abuse by their peers, but also to discourage innocent, naive, ill-suspecting people from financing the drug problem.

We believe this is why we have a drug problem. Housewives and people in barber shops buy stolen merchandise. If they didn't do this, the addict would have no incentive to steal, he would not have any money to buy drugs. Maybe he would hit somebody over the head, but then the whole country would become aroused and do away with the drug problem.

We also feel that preventive education ought to portray the cured drug victim, and his talents, his skills and his achievements in a positive way to contrast the sort of degrading concept that most citizens have of the addict; namely, that once an addict always an addict.

Now, we do this by participating in speaking engagements like most people do from the level of counseling a mot r to speaking before this committee.

But we have also developed a film strip portrayal, which I took the pictures for myself, of addicts stealing, of housewives buying the merchandise, of addicts buying drugs from pushers, and some overdose deaths.

I took this so that people could really see graphically what role they had played in perpetuating this problem.

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Also for the past 5 years, even though I am the director of the program, I have also directed a 25-voice a cappella choir that sings gospel and spiritual songs in churches throughout the metropolitan area.

This group is good. They have one album that is out, and they are planning to do another soon.

The reason I think this is innovative in prevention is because these people standing in churches, singing gospel songs, making people feel good, is a testament of the fact that drug victims who have been written off as being hopelessly dead and left abandoned to the street, if they were given adequate support, could be resurrected and brought back to the community to contribute significantly to its development.

When I think of Harlem and the drug problem, I rename it Harlem money versus morality because that is what it is. It is money versus morality. Or, as another legislator put it once, benign neglect.

In fact, our community doesn't need prevention nearly as bad as it needs treatment. Some time ago I was invited to show our film and another film called Angel Death, and to have our choir sing at a local intermediary school in Harlem.

The person in charge of that program told me that he would be receiving some Federal funds to provide a preventive education program, and if we wanted to make some consultant money, he would keep us in mind.

I couldn't help but feel sorry for him and all of the other teachers in that school. They were going to establish a preventive program and teach the kids not to use drugs. They could not even teach the kids to read and write.

The only way I could get the kids to stay quiet was by threatening not to let the choir sing for them. I wondered whether or not this was going to be part of the 7-percent set-aside money.

I asked myself how in the world could they provide preventive education when they could not even make the kids sit down and be quiet. It was almost like a joke. Then they were going to prevent these kids from using drugs. Most of the kids I talked to had already been using drugs for 2 or 3 years, although they were still in an intermediary school.

I am also wondering whether or not preventive education programs are really going to gear themselves toward discouraging housewives from financing the drug problem and whether prevention is going to enlighten local welfare centers to the fact that while they provide food, clothing, and shelter, the basic needs for the addict, that this only leaves him free to hustle fix money all day.

On my way home that day along Madison Avenue I was looking around me at an area where thousands of people used to live and now it is almost deserted. I was thinking to myself that area is dead, it is like a cemetery. Then when I looked out of my car window right in the middle of that graveyard I saw a bunch of young people laughing, happy, dancing, their radios turned up loud, smoking reefers, nodded out.

I was mad. It was so odd, the whole damned neighborhood dying, and there they were happy, dancing, laughing, singing the blues,

opiated by drugs and music, and they didn't even realize they were standing right in the middle of filth and death.

They were happy because they had plenty of music and plenty of dope and plenty of liquor and plenty of sex, which left them immune to any desire to improve the dead, dying community.

The only people that they were harming was themselves. They were permitted to do this as long as they kept it in their own neighborhood. Nobody was going to stop them.

I was mad because our society permits these people to destroy themselves.

The strong people in our society are making millions of dollars destroying these young people, all over the country. I am not just talking about dope dealers or organized crime. I am talking about all of us.

Our schools, our universities all over the country have reduced their human service departments and expanded their criminal justice departments. But in all these years crime has not been curbed or even reduced. And nobody—and everybody will admit it—seems to be able to stop the flow of drugs into our country.

When I look at the kids in Harlem and the way that they get caught up in the criminal justice system, it reminds me of the old English fox hunt.

The fox is the young, gifted black American who is trapped in the ghetto struggle, and he is hunted down like a fox. When he is caught, he is usually turned loose again to be hunted down again. The people who hunt him get paid to hunt him. It doesn't do him any good. The whole hunt is done without any feelings, as if he was not even a human being.

For our society, this represents a tremendous drain of talent. Thousands of people who have the imagination, the daring and the creativity, ingenuity to make tomorrow better than we have made today are caught up in this fox hunt.

It seems like society has decided it is more sporting to chase them than it is to correct their behavior. I say this alluding to the reduction of funds to provide for human services.

But then I can understand why really, because there are no children in Harlem. We all who live in Harlem, young and old, see and feel and smell and taste the same things. Nobody stops anybody from doing anything as long as you got the money to do it with.

Now I realize that I should be professional because this is a professional hearing. And I should keep my emotions out. That is what we are trained in this day and age.

I believe that that is what is wrong with our society. It is difficult to make any kind of strong emotional appeal to any segment of our society and get them to really do anything because everybody wants to be cool.

An example of some of the things that have been permitted in our neighborhood that I know about, I know a lady that runs the cleaners that told me she was robbed one day while she had her pistol in her pocket, but she was afraid to shoot the robber because she knew she would be arrested and go out of business.

I asked her if she called the police. Yes; they came by half an hour later but didn't even stop.

A client in our program told me a story of how she received a suspended sentence because she had been caught with a large quantity of drugs and a pistol, and then afterwards she reverted to the use of drugs and a dope dealer sold her some bad drugs so she decided to cut him with a knife.

She is now doing 4½ to 7 years for assault and robbery upon a dope dealer.

Our Government finds it hard to arrest dope dealers but easy to close treatment programs. Also, in some instances, and I think we should look at this, and I am not blaming those people who operate these programs, but we have to look at the cold hard facts that our Government itself is competing with the dope dealer in providing methadone for drug victims who are incapable of making the decision for themselves, in spite of the fact that we know that in those areas most of those areas where methadone programs are, the total neighborhoods have been destroyed.

I will cite for you one example.

At 125th Street and Park Avenue, under the train station, there used to be a thriving business. Now it is nothing but a methadone clinic, a fish and chip joint, a snack stand, a liquor store, a railroad station, and a whore stroll.

Back in the 1960's when the drug problem blossomed all over the United States everybody got scared and tried to do something about it. But now it is almost again completely decentralized where it belongs, in our Harlems, among the poor. And because of this I believe that funds are shrinking.

In the old days if you wanted to buy heroin you eased around a corner and you had to know the guy you were buying it from. And the same thing was true of reefers. It was almost impossible to get cocaine unless you snuffed it in the guy's house.

Now whether you use drugs or not, if you drive down a street in Harlem, some streets you have to slow down to about 5 or 10 miles an hour to keep from running over the guy who is trying to sell you some dope. And he will sell you anything you want and he tells you in detail as you drive by exactly what he has.

You can buy drugs on almost any corner, and you don't have to ask who has it. They will come up to you. Anywhere you see a group of people congregating, whether they are addicts or not, somebody there has a bag of drugs to sell.

If you are scared to go to the corner you can walk boldly into certain stores on some of the avenues, along 125th Street, and put your money down on the counter, and there ain't nothing there, where nobody cares who don't see who.

You just put your money on the counter and you tell him whether you want heroin, marihuana, cocaine, PCP or any other drug, and you get it right there.

These places are commonly known in the community as drug supermarkets. They sell drugs around the clock, and the people who work for them are salaried workers who sometimes even punch clocks and they work 8-hour shifts and then they go home.

The degree to which our Government has permitted all of this, the increased supply of drugs, the degree to which it has boldly cut back on funds made available to fight against drugs and the resulting chaos which I have just described, is a disgrace.

When I think of how we have, our society has afforded itself the luxury of harnessing human suffering and using this suffering only to make the strong stronger, I am appalled. Because it is done under the disguise of helping.

We have allowed ourselves to become almost animalistically barbaric in making money, except we are not as honest as the animals. When they consume their weak and dying, animals just simply do it. They don't pretend they are trying to help. But humans pretend we are trying to help.

If we really want to decide the problem we have unlimited power. We can make laws. We have human beings sworn to uphold these laws and enforce and protect the innocent.

We have a news media that is so powerful it can convince me to buy a new suit twice a year and a new car every other year. I don't understand why all of these forces cannot be coordinated and eliminate this problem that we have of money versus morality, or benign neglect in Harlem.

Thank you.

[Mr. Allen's prepared statement appears on p. 139.]

Mr. WOLFF. Thank you very much, Mr. Allen.

That is really a magnificant statement. I am reminded of the fact that I am also on the Foreign Affairs Committee, and the State Department tends to treat us like we are from the Kremlin, as though we are from some other government. We, those of us in the legislature, find that we are in the middle.

People look to us and say, well, "the Government is not doing this." The Government itself looks to us and says, "you fellows are not entitled, you are representatives of the people."

What it reminds me of is that cartoon strip which says, "We have met the enemy and they is us."

The fact is that when we talk about Government, that Government is only as responsive and is only as representative as you want to make it. And if the Government is not responsive, then I think we have to do something to see to it that the Government is responsive. That is where the vote comes in.

I think there is a responsibility of people in all communities to make their voices heard. The best way, and there is no better way that you can do the job of making your voice heard than at the ballot box.

I find a great problem throughout this country of people who are very wont to criticize and yet not willing to participate, and I am not talking about this panel because you have taken an active role in trying to do something about the problems as you see them.

I think that is part of the whole problem. When you do the work that you are doing it is quite obvious that each and every one of you who are in this field could do very well in some other field and make the money that you are talking about, much more than you are probably getting out of this, because something like the life blood goes into this work as well.

I think that all of us have a responsibility to involve ourselves, not only in this problem but in the other problems that are involved in the entire gamut of situations that impact upon drugs.

This is why I spoke as I did before. Our talk now in the Congress, is reflective of people throughout the country. Those who don't reflect that position will be voted out. The election is not far off.

But I can get up on the floor of Congress and I can talk about the fact that I want to put all these criminals in jail. I get the money for that. When I talk about the fact that I want to do something to get some better housing in this country or to see to it that we have better educational facilities, it is very, very difficult to get that money, very difficult.

Yet the money that goes into the agency as part of the prevention money that we are talking about, would alleviate the problem before it really exists, it helps you supplement the treatment activities by providing the opportunities for people on the outside to become a useful part of society.

So I think we are all actually involved in this thing together.

I went down the street before. I took the committee down the street to let people know that there is a Government that is responsive to them. I think this is most important. What happens in other countries when the Government does not respond to the needs of the people then the people make certain changes that maybe our society does not want to have.

I think that it is important that Government respond to the needs and that is why we are here. We are going to see to it that something is done.

I might take exception to some of the things that have been said here on the question of prevention. I think that your point has been that you don't want to see the money for prevention taken out of treatment.

By the same token, I think we do need money for prevention in this country. I think it is most important we try to find some method of prophylaxis to act before people get into the drug scene. Intervention programs I think are important.

You have a combination of both in your treatment program. But the overall objectives that we have, I think, are to prevent a degradation of society that is occurring, that is dragging our country down.

People see a short-range solution in stopping inflation by balancing the budget. Now, I have voted against the idea of increasing our public debt every year. But that doesn't mean that we should not pay attention and fund those things that are necessary in this country to provide for a life style to which the people are entitled.

That is where we come to grips really with the important problems that face us.

Mr. ALLEN. Congressman, excuse me.

I had not meant to imply that we did not need prevention. I simply wanted to indicate two things: One is that prevention ought to be put in the hands of people who have the experience and knowledge.

Second, that it ought not be taken away from treatment. Certainly we need it. I apologize if I created that impression.

Mr. WOLFF. I understand. I am going to yield to our chief counsel.

Mr. CARPENTIER. I might just address the panel on this.

Has NIDA provided any guidance as to how your organizations would implement the 7 percent set-aside, or is that somewhat discretionary or do you believe that you do have some latitude where some of your programs could legitimately qualify in the definition of prevention?

Mr. COSTER. Well, I think the guidelines or the lack of guidelines that are coming out since the 7 percent set-aside was implemented, there are just very few guidelines.

Mr. CARPENTIER. You mean there are none?

Mr. COSTER. Very few. I think what is going to happen is $25,000 are going to go to each State for a drug prevention coordinator. There is going to be some continued funding of channel sites, and then about $3.2 million going out to the States for which programs can submit proposals and they will be competitively reviewed.

The congressional intent was to try to do something in this area. By the time you get to the end of the fiscal year you will find that there will be very little time and there will be a lot of time spent for consultants and other things trying to get a prevention effort going.

We at Phoenix House believe there has to be a prevention effort. But I think the way it might have been handled is to utilize not just residential programs but the drug networks that you already have in existence and get some guidelines to those programs of what you want us to do to increase our prevention activities while at the same time we are continuing our treatment activities.

I think you would get a major bang for the dollar, which is very precious today.

Mr. MENKEN. I would like to tell you what my experience was with that question.

As you know, several of you know, the Congressman knows, I have been in and out of Washington quite a bit lately. I ought to get a little closet to stay in town there.

My visits to NIDA, to the White House and on Capitol Hill, which go back several months and began at a stage when just prior to the passage of 96-181, gave me and many of my colleagues who had been deeply concerned about the proposed legislation, we were given assurances, assurances that adjustments were to be made in the language of that legislation in consideration of the fact that therapeutic communities in particular had been doing such a prominent job in this fight, and since Washington had recognized in each of those areas that therapeutic communities did perform in the community a variety of preventive and interventive services, that we would not be affected by it with the change in language.

We therefore would be able to continue to receive those funds simply by couching whatever kinds of other language or additional language was necessary within the structure of the State plans. That never came to pass. We were lied to, and I am not going to make it any softer.

We were misled. And now everyone is pointing the finger at everyone else.

You have the two legislative committees in the House and the Senate. Unfortunately, it is not this committee that has the legislative power but those two. NIDA and the White House, the Office of Domestic Policy, and in each instance, as of late, our situation has

been as we have gone down there and tried to find something out and learn something and get some help, is the buck gets continuously passed somewhere else.

The White House tells us it is the Congress, that they never wanted at the White House the set-aside, that they never had an opportunity to make the input into a conference committee, which was never held prior to the passage of the legislation.

It was negotiated around for other reasons. NIDA tells us they have to deal with the congressional mandate. The Congress tells us they are committed to prevention, and they think NIDA had been eating away at prevention dollars. So everyone pushes the ball around, and we have not only no guidelines we don't even know which way to walk.

Mr. ALLEN. I would suggest, and certainly my suggestion should go I guess to NIDA, I think before they even think about developing guidelines for prevention what they should do is convene those people who have experience and take a look at their experience and subtract from what they are already doing that is effective, and then draw their guidelines up for prevention.

Dr. PRIMM. I would like to comment that this money is going to be sought after by so many people and the competition is going to be so great that many, many programs are going to spend time preparing the great and perfect proposal in order to insure themselves to get the money and it will be an exercise in futility.

The money will go, as it usually does, to a minor university who has two or three hot-shot Ph. D's just finding something in behavioral science, and they will head up the program with great evaluative studies and measuring tools and analyses, and very little prevention will be done.

So I think that there should be great prudence, that this committee should oversee some of these. Just pull out a few of the awards and look at them. Despite the fact that they go before a review committee, et cetera, they are composed of people much like myself, highly credentialed, from the major ivy-covered towers that make the decision on who gets the money.

So I think it would do you well if you had somebody to look at these.

Mr. WOLFF. We have one man here now whose specific job is to do that.

Dr. Soloway?

Dr. SOLOWAY. To that point, Dr. Primm, I would like to ask you a direct question.

Do you believe that NIDA's prevention effort in the recent past, and as you are beginning to understand their current initiatives, is responsive to the needs of black Americans and Hispanic Americans?

Dr. PRIMM. Let me start by saying I have never seen to this day NIDA or any other agency responsible for prevention or whatever, or education, from the Department of Education, produce anything that was particularly effective in the black and Hispanic communities.

They have made an attempt, but they have not done what they are supposed to do.

I hear about a new movie that has just been made and acclaimed to be a great prevention too. With us being 68 percent of the problem, I don't think there was a black person in the whole movie. It is incredible. It was shown at the White House, et cetera; Angel Death.

Mr. MCENEANEY. You are talking about "For Parents Only"?

Dr. PRIMM. It is incredible to me. Here we are 68 percent of the problem, and there is not a black or Spanish person in the movie. Nor does it have Spanish subtitles. There was no thought. Just clear institutional racism; whether intentional or unintentional. That is what it is, because there was no thought of the black or brown people or American Indians or others who abuse drugs that they even existed.

I am kind of tired of that, Congressman.

Mr. ALLEN. I would agree. Also the concept that I heard mentioned this morning of preventive education for the family and the school, like I said before, I don't want to harp to the schools, but I just happen to have two teenage daughters now who are trying their best to drop out of school, not drop out of school but drop out of class. They go to school every day. They just don't go to classes because nobody else goes.

And the concept of the family that exists in the Harlem community is uniquely different, distinct and apart from the family as it is known across the United States.

Therefore, any prevention or education that is addressed to the family in Harlem has to be addressed to a mother perhaps who aspires to get a raise by having more children.

Mr. WOLFF. You know, one of the things that I have been trying to work on, a little aside from the narcotics program, is the fact that we have a number of laws on our books today that are directed to a breakup of the family rather than bringing the family together.

We have got to find ways and means of revising those laws to accommodate society; also, to see to it that they are not in some sense counterproductive rather than being productive of a life style that we want to pervade our society.

The situation is not just peculiar to the black community or the question of aid to dependent children and things of that sort. But you have it also today in a fantastic phenomena that has occurred.

The older people in our country are shacked up just like the young people are today. Why? Because you have a situation whereby the laws, social security laws and everything else, are such that our aged benefit by being separated rather than remarrying.

Many of the laws that we have on our books today, the income tax laws in particular, are of benefit to people who are apart. I heard a story the other day that there is a couple that gets divorced every year in December and they get remarried again in January so they pay less taxes. It is an incredible situation.

I think we have to address this.

That is why when we talk about the question of putting money into prevention, and I know people take exception to something like that, I think that we have to address this problem. You cannot address what has happened in the past, this is something that our committee has tried to cover. People have tried to address the

problems of drug abuse from an isolated circumstance, and you cannot do that, because drug abuse is part of a total problem that exists in the country.

Unless you address it in its overall aspects, you are not going to get anyplace. That is why this committee has always directed attention not only to the law enforcement part but to the other areas as well.

I am sorry; we were supposed to be out of here at 5 o'clock. We started our hearing this morning at 9:30. We were supposed to start at 9 o'clock; we have been going for 8 hours now. We have to vacate the premises, otherwise they will charge us overtime.

Mr. MARTINEZ. What can we do at the State end to help give a little more teeth to this shark here? What can my agency do, aside from what we are trying to do already, because we have just about done everything else. We have sent telegrams.

Mr. WOLFF. Just let me say one thing which I think is most important. Here we have a whole group of agencies together, organizations that are dedicated to the treatment side of our problem. There is strength in this.

I am a Representative from New York. I find great difficulty in the Congress because everybody comes down on New York. No matter what we do or propose, everybody really gangs up on us because they say, "You guys are getting more than you deserve," and all the problems that are attendant to that.

One of the important things would be to get the State agencies together. You have an association of State agencies. Bring them together to put pressure on their legislators who may not be of the same opinion that we are.

I think that you can take the leadership in something like that, which would be extremely helpful to us, because we have got to get the votes in Congress. We have to establish a constituency in the Congress. One way we can is through the constituents that live in the various areas of those States that have State agencies.

I am afraid that we have got to bring this hearing to a close. I want to thank you for your participation.

I want to thank you for bringing a real depth to some of the, I won't say superfluous information that we get from time to time in the way of facts and figures. You have put some meat on the bones. This we appreciate.

We will attempt to do whatever we possibly can in order to see to it that the problem is addressed in the proper fashion, and see that these funds are returned to the budget so that you can do the job that is necessary to be done.

Thank you very much.

[Whereupon, at 5 p.m. the committee adjourned.]

PREPARED STATEMENT OF W. GORDON FINK, ASSISTANT ADMINISTRATOR FOR INTELLIGENCE, DRUG ENFORCEMENT ADMINISTRATION, U.S. DEPARTMENT OF JUSTICE

Chairman Wolff, Members of the Select Committee on Narcotics Abuse and Control: Good morning. I am pleased to appear before you once again on the occasion of these hearings.

Mr. Chairman, many of our foreign counterparts have intensified their efforts against drug trafficking. But in some areas of the world, the lack of a government commitment to narcotics control has resulted in a significant expansion of opium production. From our perspective, we are particularly concerned about three countries in Southwest Asia—Iran, Afghanistan and Pakistan—because this area is

capable of producing many times the amount of opium needed to satisfy world demand.

In order to appreciate more fully the implications of this Southwest Asian opium production capability, it is important to reflect on the background of the current heroin situation.

Since 1976, the major indicators we use to track heroin availability have consistently reflected a downward trend. The purity methodically fell from 6.6 percent, and stabilized at 3.5 percent, before beginning a slight upward turn during the third and fourth quarters of 1979, when it rose to 3.7 and 3.8 percent, respectively. The price per milligram of pure heroin has risen consistently from $1.26 in 1976 to $2.29 at the end of 1979.

Medical examiner and emergency room reports are collected from 24 metropolitan areas participating in the Drug Abuse Warning Network (DAWN). Significantly, at the present time, DAWN is recording approximately 35 heroin-related deaths per month in contrast to the 150 per month in 1976. According to DAWN, the number of heroin-related injuries has been declining steadily and, since 1978, has returned to the low levels of 1973. The average number of heroin-related injuries per quarter for 1979 is consistent with the average per quarter in the preceding year.

However, from the data we have accumulated thus far, the national indicators are now showing an increase in heroin availability. The situation is clearer on a regional level. For example, the East Coast cities in particular are reporting purities well above average for their area. During the same 12-month period in which average retail purity on the East Coast rose from 2.8 to 3.7 percent, heroin-related injuries rose 26 percent. Other indicators, such as heroin treatment admissions, retail pharmacy thefts, treatment admission for heroin substitutes, and overdose injuries and deaths related to heroin analogs, all suggest a gradual increase in heroin availability and abuse on the East Coast. An extended period of increased availability in more than one geographic area would have a more profound impact on national indicators.

Indicators, such as the estimated quantity of heroin coming into the United States from foreign sources of supply, have posted consistent declines between 1975–78. These declines can be attributed to a number of factors, mostly related to opium production.

Significantly as a result of the continued eradication efforts of the Government of Mexico, joint U.S./Mexican operations, law enforcement initiatives in the United States, and to some extent as a consequence of an unusually severe drought in late 1977/early 1978 in the northwestern part of the country, Mexico's opium production (and consequently its share of the U.S. heroin market) has diminished significantly. The Government of Mexico is to be commended for its dedication to the opium poppy eradication effort.

Drought conditions also directly affected opium production in the Southeast Asian/Golden Triangle area. In a typical growing season, the Golden Triangle can produce between 450–500 tons of opium. As a result of a drought, we estimated the 1978–79 growing season yielded only between 160–170 tons of opium. Consequently, estimated shipments of Southeast Asian heroin to the United States dropped about 15–30 percent from 1978 to 1979. The climatic conditions have not improved considerably and intelligence indicates a continued short-term reduced availability of Southeast Asian heroin.

The dynamics of the heroin market, however, have been threatened by the increased availability of opium from Southwest Asian sources over this same time frame.

It is estimated that in 1978 Afghanistan produced 300 metric tons of opium and Pakistan produced approximately 400 metric tons, for a regional total of about 700 metric tons. Iran cannot be included in this total because, at that time, opium cultivation in Iran was legal and controlled. In 1979, opium production in all three of these countries in Southwest Asia is believed to have increased to maximum of 1,600 metric tons.

This increased opium production has already been translated into a heroin production and consumption problem of epidemic proportions in Europe. As you can well imagine, intelligence gathering in that part of the world is, at best, very difficult. Our agents stationed abroad are a major intelligence source. However, DEA has closed its offices in Iran and Afghanistan. Our efforts in Pakistan were disrupted, albeit temporarily, and still have not returned to the level of previous years.

The high quality and availability of Southwest Asian heroin make it a very marketable commodity. By mid-1978, West Germany was inundated with this high-quality Southwest Asian heroin. The problem has since spread to other West European markets which were traditionally outlets for Southeast Asian heroin. Despite

sincere attempts by European governments to control the narcotics addiction problem, the situation has continued to worsen.

Throughout 1979, Western Europe absorbed the majority of the increased Southwest Asian heroin production. Heroin-related overdose deaths in Italy and West Germany in 1979, for example, ran considerably ahead of those in this country. The heroin picture in Western Europe is still not good. Seizures of Southwest Asian-sourced opiates since January 1980 (including heroin and morphine base) have already surpassed comparable levels for this same time last year. Other indicators are of concern. In West Germany, street-level heroin purity is currently between 20 and 40 percent and prices in some European cities have dropped to as low as $25,000-35,000 per kilogram. According to our latest figures, that same kilogram would sell for about six times as much in New York City.

This profit motive has enticed numerous Black, Hispanic, Italian, Iranian and other traffickers to enter the Southwest Asian heroin trade in the United States. At present, this trade is becoming organized. There are indications that in the future it will be dominated increasingly by cohesive criminal groups

Over the past two years, there have been an increasing number of seizures of Southwest Asian heroin investigations in the United States. During 1977 and 1978, relatively small quantities of Southwest Asian heroin were available, primarily in New York and Washington, D.C. In 1979 and 1980, purchases of Southwest Asian heroin have been made in Chicago, Detroit, San Fransciso and Los Angeles.

Recently, two unrelated seizures of significant quantities were made on the same day in Washington, D.C., and in Texas. In both cases, the seizure involved three kilograms of high purity Southwest Asian heroin. Seizure of about 9 kilograms of heroin by U.S. Customs in August 1979 and a later related investigation of DEA led to the seizure of 41 kilograms of heroin in March 1980 by the Italian authorities in Milan. Yugoslavian officials recently seized 80 kilograms of heroin at their border. Seizures of heroin in this quantity and purity have not been experienced in several years.

Based on increased Southwest Asian heroin availability in United States, DEA in January of 1980 established a special emphasis program—the Special Action Office/Southwest Asian Heroin. This initiative insures priority attention overseas as well as the affected areas in the United States.

On February 28, 1980, President Carter and Attorney General Civiletti hosted a meeting of approximately 120 law enforcement officials, including State Attorneys General and several police chiefs and prosecutors. At this meeting, the threat of Southwest Asian heroin and the five point program were discussed with these officials, and their cooperation and participation with the program were encouraged. To follow up this meeting in a manner reflecting the Administration's concern for this problem, DEA's SAO/SWA program was specifically tasked with responsibility for intensifying the state and local law enforcement officials' awareness of the potential and existing threat of Southwest Asian heroin in the major cities and the enlistment of their intelligence, scientific and enforcement resources to be used in conjunction with the Federal effort.

The Administration is coordinating efforts of the Departments of Justice, State, Treasury, Defense, and Health, Education and Welfare, specifically the development of cooperative international efforts; a coordinated Federal program; identification of target cities and increased involvement of state and local enforcement agencies. Steps taken to date to implement the program include, but are not limited to, the following.

The Department of State is seeking international cooperation, not only through contacts with individual nations, but also by raising the issue in international forums, such as NATO.

Our preference is to work as close to the source as possible, but this is very difficult in the case of Southwest Asia. Consequently, we have accelerated the effort of our agents and country attaches stationed along the transshipment corridor in Western Europe. Additionally, the State Department has approved additional overseas positions—a Special Agent position and an Intelligence Analysts position in Frankfurt, Germany, and an additional Special Agent position in Turkey.

Attorney General Civiletti and Administrator Bensinger have met with the Italian Prime Minister and Minister of the Interior of the Federal Republic of Germany to discuss mutual concerns regarding the Southwest Asian heroin problem. We intend to continue to assist foreign law enforcement agencies with support services directed at identifying and immobilizing major drug trafficking networks.

Also, DEA is intensifying its intelligence exchange among the various foreign, Federal, state and local participants to ensure that there is maximum development and distribution of available information regarding Southwest Asian heroin organizations and traffickers. New York, Philadelphia, Boston, Newark, Baltimore and

Washington have been designated as target cities where special emphasis will be directed at Southwest Asian heroin traffickers. Furthermore, in cooperation with the U. S. Customs Service, we will redirect and intensify the airport/port of entry program to provide better support to the U. S. Customs Service interdiction program. For example, we are developing specific trafficker/cargo profiles for each of the primary Southwest Asian heroin arrival ports of entry.

As you can see, the Drug Enforcement Administration is fully committed to the Administration's program to counter the threat posed by the availability of Southwest Asian heroin.

Chairman Wolff, I appreciate the opportunity you have afforded me to testify before you today. I appreciate the interest and support of this Committee. Thank you.

PREPARED STATEMENT OF JOHN W. FALLON, REGIONAL DIRECTOR, DRUG ENFORCEMENT ADMINISTRATION, U.S. DEPARTMENT OF JUSTICE

Chairman Wolff, Members of the Select Committee on Narcotics Abuse and Control. Welcome back to New York. It is always an honor to appear before this Committee. Your inquiry into the drug abuse situation here is most timely. After a fairly stable period, the indicators are now reflecting changes in the heroin situation.

The average purity of the heroin available to the retail-level consumer has increased during the past year in New York City. The purity of heroin encountered at the wholesale level of the traffic has also increased. DEA laboratory statistics for the New York area show not only an increase in the number of heroin exhibits analyzed, but also higher purities than the same period last year. During the first quarter of 1979, there were few exhibits with purity in excess of 20 percent. Now, during the first quarter of 1980, laboratory analyses are showing numerous heroin purities between 20 and 90 percent.

According to the New York City Police Department laboratory which monitors retail purity, the street-level purity of heroin was 2.15 and 2.1 in January and February 1979, respectively. The average retail purity for the same two months in 1980 skyrocketed to 5.06 percent and 8.36 percent.

Even though the average purity by month may fluctuate depending on the level of enforcement activity, the geographical area of enforcement concentration, and special situations such as strikes, this is a significant change. Taking both laboratories analyses into account, the inescapable conclusion is that heroin is more readily available in higher purities than it had been in the preceding year.

The price of heroin at the retail level rarely changes to any great extent. The customer usually pays the same price; the element which changes is the purity. In times of more availability, the customer receives better quality heroin for his money than in times of limited availability.

Price and purity are one set of indicators to be considered among others. As you are aware, the overdose death and injury rates as recorded by the Drug Abuse Warning Network (DAWN) are also used to monitor trends in drug abuse and availability.

The Medical Examiner's Office of the City of New York feeds data to DAWN. Their records show an increase in drug related deaths. In 1978, there were 248 while in 1979, the figure rose to 439.

According to the statistics obtained from emergency rooms reporting drug-related injuries to the DAWN, heroin injuries are also on the increase. The data below clearly demonstrates this:

October to December, 1978	96
January to March, 1979	133
April to June, 1979	163
July to September, 1979	181
October to December, 1979	225

Recent treatment admittees to methadone programs state that heroin available at the retail level is of particularly good quality. Medical personnel at these clinics state that an average of 10 milligrams more methadone is required to stabilize the new clients. Urinalyses conducted to monitor compliance with methadone treatment regulations show an increasing percentage of opiate-positives.

Analysis of the West European situation led us to expect arrival of Southwest Asian heroin in New York. Approximately a year ago, our Unified Intelligence Division, which is staffed with DEA Agents, New York City Police Department officers, New York State Police Investigators, Intelligence Analysts and Statisticians, projected an increase in heroin availability and purity in the New York area.

To get a fix on the then current situation, the U.I.D. embarked on Operation Monitor, an intelligence probe of certain geographical areas within New York City, in order to determine specifically the price, purity, packaging and dilutents of the heroin available to the retail consumer and the area of origin of that heroin.

Monitor I was conducted in the Harlem area during June and July, 1979. The average purity of the heroin was 3 percent. We believe that this was due to the tightly-knit drug distribution networks operating in the Harlem area. However, the significant finding of Monitor I was that 42 percent of the exhibits collected originated from opium produced in the area of Southwest Asia. The remaining exhibits originated from opium produced in Southeast Asia.

Operation Monitor II was conducted in the lower east side area of New York City in September and October, 1979. This area has a high visibility of illicit street level activity. The average purity of the heroin procured here was 8.5 percent. Significantly, 60 percent of the exhibits originated from opium produced in Southwest Asia.

A number of recent major seizures also support our findings of increased heroin activity. These cases involved heroin being shipped from Italy to New York City. Most of the opium, from which the heroin was produced, originated in Southwest Asia. Some of these significant seizures are listed below.

MAJOR HEROIN SEIZURES

	Weight (kilograms)	Purity (percent)
March 1978	4.3	82.5
June 1978	6.0	87.5
July 1978	.25	68
August 1979	6.0	85
October 1979	5.0	83.5
January 1980	24.0	49.9–99.7
March 1980	41.0	Unknown

The following two examples demonstrate the magnitude of the problems we are facing in New York:

On March 18, 1980 the Italian Police in Milan, Italy, with the assistance from DEA Officer's in Milan and the John F. Kennedy Airport Detail, arrested three Italian nationals and seized 86.9 pounds of heroin. The heroin was secreted in three metal cans packed in cardboard containers containing stero records, tapes and styrofoam and was destined for delivery to New York's John F. Kennedy Airport.

On January 16, 1980 twenty-four kilograms of heroin was confiscated at John F. Kennedy Airport. The heroin was secreted in unaccompanied baggage and arrived on a flight from Rome, Italy.

I know that you have all been briefed in Washington regarding the full scope of the Southwest Asian heroin problem and the Administration's initiatives to combat this significant situation. Mr. Gordon Fink, our Assistant Administrator for Intelligence, will address those issues in detail. DEA's Special Action Office/Southwest Asian heroin (SAO/SWA) is in full swing; and as New York is one of the six target cities, I expect that we will be in the thick of things.

We have made significant inroads here in New York City. The tremendous cooperative effort which exists, as exemplified by the participating agencies in our New York Drug Enforcement Task Force and Unified Intelligence Division, is a major factor in our success. Because of the current Southwest Asian heroin situation, Administrator Bensinger has determined that a significant portion of the next basic agent class will report to New York.

I expect that our reinforced commitment will have an impact on this burgeoning Southwest Asian heroin problem. DEA stands ready to do what we can. Chairman Wolff, the concern and attention the House Select Committee on Narcotics Abuse and Control has given this problem is gratifying.

Thank you.

PREPARED STATEMENT OF CHARLES H. KELLY, DEPUTY CHIEF, COMMANDING OFFICER, NARCOTICS DIVISION, NEW YORK CITY POLICE DEPARTMENT

The enforcement policy of the Narcotics Division is to provide a proportionate degree of pressure to all levels of illegal drug trafficking within the City of New York. During the past year, up to 50% of our manpower resources were, and are, responding to low-level street conditions due to two factors:

1. The increase of street traffic in marijuana, cocaine and pills, throughout the city.

2. The public awareness of these conditions has increased and this awareness was transmitted to the Police Department via 12,000 formal complaints received at our complaint desk during 1979.

The remaining resources of the Narcotics Division are utilized in developing major investigations.

The New York City Police Department's effort to control the drug problem takes three forms:

(a) The Narcotics Division consisting of 450 members including clerical personnel.

(b) The New York Drug Enforcement Task Force, consisting of 80 City officers working jointly with State and Federal officers.

(c) All uniformed patrol and special field forces.

The Narcotics Division handles covert investigations at all levels of the drug trade. The New York Drug Enforcement Task Force operates primarily against middle and high-level traffickers, currently concentrating against cocaine dealers in Jackson Heights, Queens. The patrol forces in the department make narcotics arrests where covert investigations are not required, generally consisting of low-level street activity.

This tri-modal enforcement has produced a sizable number of arrests.

During the past ten years, the New York City Police made 250,000 drug arrests in the City of New York.

In 1976, the department initiated a program titled "Operation Drug" in the hard-core heroin locations of Harlem, specifically the 28th and 32nd police precincts. This enforcement effort involved both uniformed patrol forces and Narcotics Division officers. Its prime mission was to reduce the heavy street then in full swing on many streets and avenues. The program was successful in sharply reducing the level of street traffic, and forced the dealers to adopt new, more sophisticated methods of delivering their goods. During the period of 1976 to 1979, 23,667 arrests were made in these two precincts. The following are some interesting statistics relative to the operation.

Total arrests—23,667

Narcotics arrests:	
Felony	6,422
Misdemeanors	6,754
Other Arrests:	
Felony	4,604
Misdemeanors	5,078
Violations	809

Illegal firearms recovered

Shotguns	113
Revolvers	799
Automatic pistols	285
Rifles	62
Starter pistols	51
Zip Gun	1
Total guns	1,311
Hand grenades	4

Drugs recovered

Envelopes of heroin	50,548
Envelopes of cocaine	20,449
Bottles of methadone	7,478
Angel dust	24,927
Envelopes of cannabis	31,124
Assorted pills	25,992
Hypo-syringes	26,037

The street value of the drugs seized was in excess of $4,820,000, and it cost the department almost 100,000 man days, but was well worth the expenditure of our resources. Most drug transactions now take place behind fortified apartment doors, where the drug dealers employ steerers to direct the customer to a "peephole" in the door where money is exchanged for drugs.

Peephole operations make arrests for drug sales much more difficult.

As a result of "Operation Drug," a specialized "Street Enforcement Unit" composed of 75 experienced Narcotic Division personnel was assigned specifically to monitor street conditions in this area.

In addition, the Manhattan North Narcotic Unit also covers the Harlem community. Both units combined represent 35% of the Division's total strength. During 1979, 1,900 arrests were made by both units.

Over 200 major violator cases have been prosecuted in the federal courts. With such a high level of arrest activity, it is reasonable to ask why the problem persists.

The answer is that the impact of local law enforcement has not been sufficient to offset the tremendous demand, the tremendous profits, and the seemingly inexhaustible supply of drugs.

An arrest made at the street level of the distribution system, assuming there is a subsequent jail term, simply removes the individual arrested from the scene. Our experience indicates such an arrest has little deterrent effect on the subject or his associates. In some cases, the subject resumes his drug activities while awaiting trial. To simply stay even, one person must be removed from the drug population for each new entrant. When we arrest at the mid-level, one who deals in ounce weight, we find no shortage of replacements who take the defendant's place in the supply structure. The size of the profits outweigh all perceived risks. Even in those situations where we have been successful in investigations of high level dealers, no protracted shortage of drugs has ensued following "Mr. Big's" removal from the trade. There are a plentiful number of "entrepreneurs" around to fill the void, especially in the traffic of marijuana and cocaine.

It is a fact of urban life learned at an early stage of a police commander's career, that community leaders are not concerned about whether a "Nicky Barnes" was arrested as much as the local drug pusher dealing in their neighborhood.

During 1979, a total of 4,400 narcotics arrests were made by the Narcotic Division, 35 percent of which involved the sale of marijuana on the streets of this City.

The entire Police Department effected 18,000 drug arrests during 1979, 37 percent of which represents marijuana arrests. It is obvious then that marijuana represents the most flagrant, visible form of drug traffic at the present time.

Cocaine has also emerged as a popular drug, even among the poor who can purchase it for as little as $10 per "blow" in many stores and street corners.

HEROIN ASSESSMENT

The purity of heroin sold at the street level, that is "dime" bags and "Harlem quarters", decreased in the early 1970's, from a high of 8 percent to the 1 percent level in the period from 1976 to 1979.

During the latter part of 1979, buy operations indicated that the purity of street heroin was on the rise. In the hardcore drug areas of Harlem, street purities rose to an average of 3- to 5-percent per $10 bag. Harlem quarters rose to about 6 percent. At the same time, wholesalers began to offer a higher quality product, although in smaller quantities.

In the Lower East Side of Manhattan, heroin street bags were being distributed containing purities as high as 27 percent.

The network responsible for controlling this operation was located on Eldridge Street between West Houston Street and Stanton Streets.

Covert video tape films taken by my office during several days in January, 1980, revealed an unprecedented amount of daily street traffic involving hundreds of customers per day, seven days a week.

On February 7th, a massive raid was conducted by the Narcotic Division, composed of 130 uniformed and plainclothes investigators. Fifteen search warrants were executed in four tenement buildings and social clubs, resulting in 58 arrests and the suppression of a major heroin supply outlet.

It can be said with some degree of certainty, that the general quality of street heroin has increased. As of yet, there is no marked increase in heroin availability in the City. Evidence of this fact is the absence of heroin in areas outside Manhattan, specifically the suburban neighborhoods of Queens, Bronx, Brooklyn South and Staten Island. Street heroin found in Manhattan in Harlem and Brooklyn North. It is true that some heroin is purchased in Harlem or the Lower East Side of Manhattan and transported back to these areas. However, it is generally sold in the poorer neighborhoods and has been "cut" several times to a rather low quality.

During the first quarter of 1980, samples of street heroin purchased by the Narcotic Division, indicate purities have averaged between 5 and 6 percent.

Constant pressure at the street level has driven the hard-core location dealers indoors. They have moved into vacant apartments and set up "peephole" operations. Steerers and hawkers remain outside directing customers to these locations. Customers are required to pass their money through the peephole of fortified doors and then receive their purchases from under the door. This technique prevents positive identification by undercover officers and necessitates that multiple purchases be made before a search warrant can be obtained. It also affords protection from rip-offs and also effectively prevents arrests from the more severe sale charges. The dealers have employed counter measures to our efforts to overcome these obstacles. Police radio scanners, transmitter detectors, fluorescent powder detectors and other measures are commonly employed by the drug merchants.

Multi ounce dealers are tending to sell better quality heroin in amounts which will not incur the higher A-I Felony charge, (2 ounces or more). Instead, dealers now offer to sell an ounce at 60 percent purity rather than 4 ounces at 15 percent purity. Of course, the ounce price has been greatly inflated up to $10,000 per ounce.

With current street level purities, strung out addicts are not observed as they were in the early 70's. A possible explanation for this is the decline in heroin availability or the fact that older, former heroin addicts have switched to other drugs.

The effects on New York City of an increase in heroin supplies from abroad is an obvious one. It has been stated that New York City has approximately ⅓ of the estimated 450,000 United States heroin addicts. This means that at least ⅓ of the heroin entering the United States could remain in New York City. It could re-infect old addicts and cause a new generation of heroin addicts as in the early 70's, repeating the cycle.

FISCAL PROBLEMS

Since the 1975 lay-offs of police officers, the Narcotics Division has suffered a 27 percent decrease in personnel. Other effects of the City's fiscal crisis have been a steady reduction in operational funds normally used to purchase narcotics, referred to as "buy money."

Prior to 1975, several million dollars per year was available for investigative expenses. Today, that figure has been reduced to approximately $700,000 per fiscal year.

In September of 1979, the narcotics laws of the State of New York were amended sharply, increasing the amount of narcotics required to establish an A-I and A-II Felony arrest. Under the new law, the Division must purchase double the weight of heroin or cocaine as previous, from 1 ounce to 2 ounces for sale and from 2 ounces to 4 ounces for possession.

Since the wholesale purities of drugs has increased, a kilo of good grade cocaine (over 50 percent) costs $65,000 and up. A kilo of high grade heroin could cost up to $350,000.

To cope with this problem, we have made adjustments in our investigative strategy to make the greatest use of our resources. However, the first quarter arrest activity for 1980, indicates a decrease in the number of "A" Felony arrests vs. the same period for 1979. The bulk of our felony arrests are falling into the lower class "B" Felony category. In effect, we are making more felony arrests but of a lower penalty classification. Additional "buy money" could help improve this situation.

COCAINE

The recreational use and social acceptance of cocaine is increasing throughout the City. The glamour associated with the use of cocaine has been exploited in the mass media. Movies and newspaper headlines are replete with coverage of public celebrities involved with cocaine. The huge profits and lack of deterrent has attracted

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many free-lance individuals into the traffic. All levels of society have access to cocaine. The disco scene has also contributed to the popularity of cocaine. Ten dollar ($10.00) "blows" or tins and $100 gram quantities are the vogue.

Cocaine abuse is fueled by a large number of Colombian Nationals residing in the Jackson Heights Area of Queens. This area has the largest concentration of Colombians in the United States. Many are hard working industrious persons who have come to the United States looking for a new life. However, there are many who illegally enter this country for the sole purpose of financing and receiving large shipments of cocaine.

A special enforcement program in the Jackson Heights Area has been undertaken by the New York Joint Task Force. This effort has been highly successful. Results for 1979 include 261 arrests. Of these, 209 were illegal aliens. 178.5 pounds of cocaine and over 1.8 million dollars has been seized from these traffickers. Additionally, huge caches of firearms have been seized from these individuals. 96 guns and 34 cars were seized. A New York Joint Task Force investigation resulted in a 286 pound seizure of 92 percent pure cocaine in Florida, in March of this year, indications were that it was destined for delivery to New York. Most of the current major cases closed during 1979 involved large quantities of high grade cocaine.

PCP (ANGEL DUST)

Phencyclidine is a chemical depressant which may be in powder, pill or liquid form. The liquid is sprayed on mint or parsley leaves. When evaporated, it leaves a "dust" film on the leaves which are then rolled into cigarettes. A recent New York State Division of Substance Abuse Services Survey, concerning the use of drugs and alcohol among 27,000 students in Grades 7 through 12, indicates that PCP has been used at least once by approximately 18 percent of those students. Bear in mind that these figures include our Grammar Schools and indicate not only the extent of abuse but also the age level. Harlem and Jamaica Hospitals average six cases a month of emergency room treatment for overdoses of PCP. Joints of PCP sell for $2.00 and from $5.00 to $7.00 per envelope of dust treated parsley leaves. It is sold both in ghetto neighborhoods and middle class areas.

The PCP phenomenon has spread in the New York Metropolitan Area. For awhile it challenged marijuana in popularity. Mass media coverage of the hazards of PCP use, plus an upgrading in crime classification, has had little positive effect.

MARIJUANA

A recent survey conducted by the New York State Division of Substance Abuse Services indicate that 54 percent of children in secondary schools have used marijuana. This is double the percent in a similar survey taken in 1971. Due to the increasing social acceptance of marijuana, illicit transactions and public use is visible throughout the City. Street peddlers are attracted to areas with high pedestrain volume, i.e., Bryant Park, Times Square, Wall Street, office building plazas, etc. In residential areas of the City, marijuana traffickers establish smoke shops/head shops. These enterprises deal in youth oriented items, i.e., pop posters, disco clothes and the highly profitable marijuana paraphernalia (pipes, rolling paper, bongs, etc.). Plexiglass partitions are installed to afford protection from rip-offs and also deter quick apprehension by law enforcement personnel. The plexiglass permits the destruction of evidence and enhances escape. The high profits in the marijuana trade attracts many persons not previously associated with criminal groups. Many "smoke shops" or store fronts have appeared in the older sections of the City, where it is sold freely over the counter to children and adults. These shops are heavily fortified with steel doors and thick plexiglass screens to prevent arrests and "rip-offs". The Division is heavily involved in suppressing these troublesome locations. Since the 1977 Marijuana Reform Act, there is greater public use outdoors. In New York City, it is our most visible form of drug traffic and the object of most protests by neighborhood community groups. The Marijuana Reform Act of 1977, reduced the criminal penalties for possession and modified the penalties for sale of marijuana, which led to wide-spread use in many public areas, including sports events.

The Marijuana Reform Act of 1977 created Article 221, which made a violation of private possession of less than 7/8 of an ounce or 25 grams. The possessor is now given a summons and is required to appear before a magistrate. Our experience indicates that fines meted out are very conservative, even to those arrested for selling large quantities of marijuana. This drug has gained such wide acceptance by the public, that the courts are reluctant to impose penalties available in the new law.

Under the old law, sale of any amount of marijuana or the possession of over an ounce was punishable by a jail term of up to 15 years. Today, the sale charge may

be punishable by up to 1 year in jail. Currently, the most severe charge is the sale of 10 pounds or more and this is classified as a "C" Felony with a penalty of 0 to 15 years.

The Narcotics Division maintains constant pressure against drug traffickers. This is evidenced by the thousands of arrests effected each year. We do not labor under any illusions that the police can successfully solve the drug problem on its own. Society must unite against this insidious threat to our existence.

The record of the law enforcement effort is one of total commitment. We have adopted innovative and unified strategies. In the face of a common challenge, we have overcome jurisdictional and inter-agency problems and have joined together in a spirit of mutual cooperation. Law enforcement alone cannot hope to achieve lasting success. There must be a greater participation by government to improve planning and coordination at the local level, to alert community groups on methods available to them to deal with narcotic abuse in their neighborhoods.

Recently, a booklet titled "Parents, Peers and Pot" was published by the Department of Health, Education, and Welfare, describing the success achieved by local community groups in suppressing drug abuse among their children. It is this type of government support that should be expanded to every state in the country. More leadership must be given to the communities if we are ever to achieve success in halting the tide of drug abuse among our young.

Prepared Statement of Elliot M. Gross, M.D., Chief Medical Examiner, City of New York

Determination of the cause of a death as due to heroin or heroin related is made following investigation into the circumstances of death including examination of the body at the scene where it is found and discovery of "paraphernalia" on or about the body; an autopsy including absence of injuries or natural disease sufficient to cause death; and a chemical analysis of tissues, biologic fluids removed at autopsy, and of contents of "paraphernalia" at the scene.

In the absence of trauma and natural disease, a preliminary determination can be made on the day of autopsy, but a final conclusion must await toxicology analysis. Following this final determination, the original certificate of death is amended and the final cause filed with the Bureau of Health Statistics and Analysis at the Department of Health.

Statistics on heroin deaths may be compiled from those maintained in a Medical Examiner's office and from Registrars of Vital Statistics. Registrars, however, are dependent on data provided by the death certificates from the Medical Examiner's office and the extent to which such data is updated as amendments are received from the medical examiners.

For valid statistics, data collection should be initiated at the time a death is first reported to the Medical Examiner's office as an "O.D." until all three aspects of death investigation (scene investigation, autopsy, and toxicological analysis) are completed.

Statistics on heroin and heroin-related deaths have not been issued by the Office of Chief Medical Examiner of the City of New York since the early 1970's. The last report was compiled by Dominic J. DiMaio, M.D., Chief Medical Examiner, from 1976 to 1978 and acting Chief Medical Examiner at the time of his report in 1974. This included statistics on deaths classified under the term "narcotism" for calendar year 1973 and for the first six months of 1974.

The collection of data on heroin and heroin-related deaths is an important function of the Office of Chief Medical Examiner. I regret that I cannot present the Committee with critically analyzed data.

I have recently been appointed to the position of Chief Medical Examiner. I am currently reorganizing the Office and plan to establish a data collection system.

I very much hope that, in the future, I shall be able to report to the Committee on heroin and heroin-related deaths in New York City.

Prepared Statement of District Attorney Robert M. Morgenthau, New York County

Recent assessments by the Drug Enforcement Agency show that unless there are dramatically expanded law enforcement efforts, we face an explosion of heroin importation and use and, with that explosion, a likely increase in other crimes.

Because of political instability and anti-American sentiment in Iran, Afghanistan, and Pakistan, American officials cannot work effectively with officials in these countries to eradicate the production of illegal heroin. Each year since 1977, this part of the world has increased its share of the American heroin market. In 1977,

the share was 8 percent; in 1978 it was 17 percent; and in 1979 it was 35 percent. In 1979, these three countries produced an estimated 1600 metric tons of illegal opium, twenty times more than the 80 metric tons of illegal Turkish opium that fed 700,000 addicts in the United States in the 1960's and early 1970's.

The dramatic increase in heroin production in Iran, Afghanistan, and Pakistan has not yet had its full impact on the United States. However, the countries of Europe, and especially West Germany, are being seriously affected. In West Germany, the number of heroin related deaths increased ten times from 1974 to 1979. In 1974 .9 kilos of heroin were seized. In 1979, 90.1 kilos were seized. Heroin has become so freely available in West Germany that one kilo sells for $25,000. Heroin of similar quality sells in the United States for $200,000 a kilo.

The costs of simply waiting for the expected explosion of heroin importation in this country will be high. If we wait too long the channels of importation will become firmly entrenched. The free availability of heroin will increase the number of addicts. The increased number of addicts will, in turn, increase the demand for heroin. Increased heroin addiction will not only cause misery to the addicts, it will also, in all likelihood, cause an increase in other kinds of crime. We have taken a sample of cases prosecuted in Supreme Court and have found that, of the defendants in the sample who used weapons in the course of the crimes, 46 percent have at least one prior drug arrest. Seventy-one percent of the defendants who were charged with robbery in the first degree had at least one prior drug arrest.

Since we can no longer effectively limit the heroin production at its sources, we must redouble our efforts at home. Unfortunately, in the face of the coming crisis, our budgets are being cut by every one of our funding sources. In the last several years we have received substantial monies from the federal government through LEAA. If that agency is in fact cut to the extent proposed, our own ability to function as an effective law enforcement agency will be diminished. At the same time, the State has cut the State felony budget. Fifty percent of that budget is used to prosecute narcotics cases, and 50 percent is used to prosecute violent felony offenses. The fact is that we would have needed an increase in that budget just to stay even. And finally, we have been told that no additional funds will be forthcoming from the City.

All of this budget cutting, in my view, will make it much more difficult for us to fight the coming growth in narcotics importation and use as well as crime in general. The time to spend money for law enforcement efforts is now, before there is a dramatic increase in narcotics usage and in crime. Waiting until after we see that increase is, in my view, a bad policy as well as bad economics.

Prepared Statement of James A. Moss, Assistant U.S. Attorney, Chief, Narcotics Unit, Southern District of New York

THE NARCOTICS UNIT

The United States Attorney's Office in the Southern District of New York was the first federal prosecutor's office to set up a separate unit charged with the responsibility for investigating and prosecuting drug violations. This unit has been in existence for over twenty years and has been responsible for many of the most important and successful prosecutions of major narcotics traffickers and their organizations over that period of time. Many of our noteworthy successes which have attracted nationwide attention involve criminals at the highest levels of organized crime. The list includes names such as Vito Genovese, Joseph Vilachi, Carmine Galante, Carmine Tramunti, Vincent Pacelli, Leroy "Nicky" Barnes, as well as high-level members of what has become known as the "French Connection."

Throughout its existence, the Narcotics Unit has worked closely with the agents and officers of the Drug Enforcement Administration, the New York Drug Enforcement Task Force, the New York City Police Department, as well as with the Assistant District Attorneys in the Office of the Special Narcotics Prosecutor for New York City (Mr. Sterling Johnson). From time to time we have had occasion to collaborate with the New York State Police, with other federal and state prosecutors' offices, and with other Federal agencies, including Customs, the Coast Guard, the Immigration and Naturalization Service and the Federal Bureau of Investigation.

Regrettably, the close association our Unit once had with the Internal Revenue Service has been impeded as a result of the passage of the Tax Reform Act of 1976. The restrictions which the Act imposes upon the exchange of tax information between the I.R.S. and law enforcement agencies has all but ended an era in which major narcotics operations were dismantled by prosecutions brought jointly under the drug and tax laws. It is now extremely difficult and cumbersome to bring such

prosecutions and there are very few of them. This is particularly distressing since the paintaking work of scrutinizing complicated financial records to uncover sophisticated money-laundering operations (done so well by revenue agents) has traditionally been an important element in the successful investigation of major narcotics-distribution networks. Moreover, the financial evidence uncovered is often the most persuasive to a jury at trial, and to a judge at the time of sentencing.

PRIORITIES

The reputation of our Narcotics Unit has been built upon the successful prosecution of major heroin traffickers, as well as significant cocaine importers and distributors. While it remains true that the first priority of the Unit is, and has always been, to combat the heroin and cocaine problems in the New York metropolitan area, within the last two years our prosecutive resources have been stretched by the need to branch out beyond heroin and cocaine prosecutions to include an increasingly larger number of cases involving hallucinogens, illegally-dispensed prescriptions drugs and marijuana.

Our efforts in prosecuting distributors of hallucinogens—principally phencycledine ("PCP" or "Angel Dust") and to a lesser degree LSD—were prompted by a near epidemic rise in the number of deaths and physical disorders resulting from the use of Angel Dust. We are continuing to devote whatever resources we can to this problem for obvious reasons, although it appears that the abuse of hallucinogens may have peaked within the last six months.

The alarming abuse of prescription drugs has forced us further to divert resources away from the prosecution of "hard drug" violators. There is a massive black-market demand for what may be called the "lesser drugs"' depressants—*e.g.* methaqualone ("Quaaludes") and barbiturates (including Tuinal)—and stimulants—*e.g.* amphetamines ("speed") and Preludin. This demand has been met on the one hand by the formation of well-financed organizations that illicitly manufacture and distribute these drugs, and on the other hand by the collaboration of corrupt doctors and pharmacists. These doctors will knowingly sell prescriptions to pharmacists who are willing to fill them in violation of federal law. The profits so derived are enormous. In one case alone, agents of the Drug Enforcement Administration seized $1,200,000 which a single pharmacist had earned by filling prescriptions illegally.

Yet another drain on our heroin-prosecution resources is the effort we must devote to prosecuting large-scale seizures of marijuana. In spite of the fact that more marijuana is sold and used in this country than any other controlled substance, including either heroin or cocaine, the prosecution of marijuana offenses has never been a priority of drug enforcement in the Southern District of New York. Nor have we made it one recently. However, it has become clear that the profits available from the wholesale importation of marijuana have attracted the attention of organized crime. Therefore, we have pursued investigations and prosecutions where a sufficiently massive seizure of marijuana suggests the likelihood of organized crime involvement. As an example, there is a case now pending in our Office arising from the seizure in March by the Coast Guard of 30-tons of marijuana from a South American vessel loitering off the coast of Long Island.

BUDGET RESTRAINTS

Over the past two decades, each United States Attorney in the Southern District of New York has affirmatively supported this effort to prosecute drug violators. At present, the Narcotics Unit has more Assistant United States Attorneys assigned to it (13) than does any other unit within our Criminal Division. Yet despite this concentration of manpower, it is fair to say that a unit twice this size would still be kept busy by the cases generated in the Southern District of New York. Regrettably, many drug dealers who should be prosecuted are not.

Even more regrettably, fewer high-level undercover narcotics investigations are being initiated by the Drug Enforcement Administration (and the New York City Police Department) because of the rising cost of conducting such operations. This problem has become particularly acute within the last few years because of a dramatic increase in the price of heroin, an ounce of which now costs over $12,000 (as compared to $2,000 in 1977). Thus, an undercover expenditure of $25,000 will now develop only a marginal case against a low-level drug dealer, whereas that same investment several years ago would enable undercover agents to penetrate a heroin organization at a significantly higher level.

Obviously the increases in the operational budget for the Drug Enforcement Administration have not matched this six-fold rise in the cost of heroin. While the expenditure of money is not the only way to make significant narcotics cases, it

remains true that the distinctly higher prices of narcotic drugs has frustrated many attempts to infiltrate major drug rings at the highest levels.

SOUTHWEST ASIAN HEROIN

I believe it is a fair prediction from all of the above that if in the near future we encounter a mass infusion of heroin from Iran, Pakistan and Afghanistan, law enforcement will find it increasingly more difficult to respond effectively.

There is evidence to support predictions that the flow of heroin emanating from southwest Asia may soon increase substantially. These predictions are based at least in part upon intelligence information about the immense capability of the region to produce poppies. Corroboration of this intelligence has already come from Western Europe (and particularly the Federal Republic of Germany) where there has been a sharp increase in the volume of traffic in southwest Asian heroin, and an accompanying rise in the number of heroin overdose deaths.

The price of this heroin in Europe is substantially less than the price of heroin in this country; the incentive to exploit the difference in the two markets is tremendous. It is apparent that within the last six months heroin traffickers have intensified their efforts to set up smuggling networks to bring more and more southwest Asian heroin into this country. In the first four months of 1980 the Drug Enforcement Administration seized almost as much southwest Asian heroin as it had seized in all of 1979. The average purity of the heroin seized was 79 percent.

Although most of this heroin was smuggled through New York City, the traffickers are beginning to look for importation routes throughout the United States. Within the last month, Customs and the Drug Enforcement Administration have twice intercepted wholesale quantities of Iranian heroin at Chicago's O'Hare International Airport that was being smuggled into the country in shipments of canned food.

The effects of the increase in heroin are already being felt at the street distribution level. It is not uncommon to find retail heroin (purchased in ounce or even subounce quantities) to have purities ranging from 60 percent up to 100 percent—purities that were virtually unheard of a few years ago.

While all of the evidence is not in, all preliminary indications suggest that we may indeed be in the early stages of an influx of southwest Asian heroin, the magnitude of which we are not yet capable of measuring. The future for narcotics law enforcement during this period is also unclear. Suffice it to say that with restricted resources being stretched in several directions, the new challenges imposed by the infusion of southwest Asian heroin will be, to say the least, formidable.

PREPARED STATEMENT OF STERLING JOHNSON, JR., SPECIAL NARCOTICS PROSECUTOR, NEW YORK CITY POLICE DEPARTMENT

The spectre of drug abuse hangs over the head of every citizen in New York City like a dark cloud. Whether it is a family member who has become addicted; a son or daughter who is being offered drugs in school; or the victim of an addict's burglary or mugging, everyone is exposed to the drug problem. Heroin is a household word in many homes outside of Harlem. This problem however, has recently been compounded by the lack of fiscal support.

The number of addicts in this country varies according to the experts you talk to. Some estimates are as low as 450,000 and others quote a figure of 600,000. Many believe that 40–50 percent of this population is in New York.

Whatever the number, if you estimate the average daily dosage a heroin addict requires to sustain himself, it comes to 6–8 tons annually.

Looking at the other side of the coin, the further away the raw material moves from its source, the more difficult it is to interdict.

Law Enforcement, given the lack of resources, has done a remarkable job over the years. Significant seizures have been made. The number and quality of arrests have improved greatly. The New York State Division of Criminal Statistics disclose that felony arrests for New York State rose 7.4 percent during the first six months of 1979. In this same period, felony drug arrests rose 23.9 percent.

Despite these arrests, the prognosis for the future is bleak. Street sellers, or "scramblers" as they are called still "hawk" heroin by brand names. Because of enforcement efforts, the scene of the old market place has changed. Vendors still service their addicts, but now they do it in dark hallways, damp cellars and cold alleys.

The purity of the heroin on the street has increased sharply. The amount available is also up. Users are again lounging on corners, nodding and scratching like their predecessors in the late 1960's. Middle class whites are again flooding into

Harlem and Bed-Stuy to "buy" drugs. These conditions forecast danger and I predict "a night of the long knives" similar to the late 1960's and early 1970's.

My reasons for this forecast are several: First, as I said before, there is more heroin available today than there has been in a number of years. Not only are we concerned with Mexico and the Golden Triangle (Burma, Laos and Thailand) but we are now being invaded with high quality heroin from Southwest Asia, (Iran, Pakistan and Afghanistan). In 1975, these countries produced 300 tons of opium (capable of making 30 tons of heroin). In 1979, this same region produced 1,600 tons of opium capable of producing 160 tons of heroin). Because of the political instability in that part of the world the drug faucet is not likely to be turned off anytime in the near future. Second, the fuel that fans the flames of frustration is the lack of resources available to enforcement. Here are some examples: In the classic buy operation undercover officers purchase narcotics from sellers at all levels. These cases take less police time to investigate and less court time to try than any other type of narcotics case. However, there is so little "buy" money available that the police find it difficult to buy mid and upper level sellers with any regularity. Recent amendments to the New York State Drug Law also raised the quantity of drugs necessary to charge a dealer at the middle and top levels.

Inflation has also raised the cost of drugs. In 1977 you could buy heroin for as little as $1,200 an ounce. My office recently purchased an ounce of heroin for $10,000 and the package was almost 80 percent pure.

Third, mandatory minimum drug sentences have been increased for predicates (one convicted of a felony within the past 10 years) and plea-bargaining is much more restrictive under the new law. I support this move. However, the State failed to realize that if a defendant is restricted to any "deal" he can get, he is forced to go to trial. More trials mean more attorneys. In my office alone, based on the cases we have received since September 1979, I estimate that there will be an increase of 200 percent in the number of trials required. There are simply no resources to implement the new law.

The Hobsons choice I face will be that of letting the Court dismiss cases for failure to prosecute, or raise the standard of indictments to the point where I must decline to prosecute on most street sales. Neither solution is correct or acceptable.

If asked what is required to attack the problem, I must say many things. Interdicting the raw produce at its source, medical treatment, education and rehabilitation. All of these are needed working together with a strong law enforcement effort. To sustain such a program requires more resources and less rhetoric.

PREPARED STATEMENT OF JACK DURELL, M.D., EXECUTIVE ASSISTANT TO THE DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION, PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Chairman Wolff and Members of the Select Committee, I thank you for your invitation to appear before the Committee to discuss the treatment and prevention funding policies of the National Institute on Drug Abuse (NIDA) for Fiscal Years 1980 and 1981 as they apply to the delivery of Drug abuse services in New York State and New York City.

Many would say that community-based drug abuse treatment was born here in New York City through the efforts of such programs as Phoenix House, Project Return, Daytop Village, Beth Israel Hospital, The Addiction Research and Treatment Corporation, The Door, and many others. The commitment and dedication to excellence of these programs have provided stimulus of the drug abuse field across the Nation.

HEROIN INDICATOR TRENDS

We are very much aware of the problems testified to today concerning the possible impact of an increase in the available supply of heroin in this country, particularly as may have been reported in the cities of the northeast corridor. Spurred by early anecdotal reports of increases in heroin indicators, the Drug Policy Staff of the Domestic Council has established a Drug Abuse Trends Work Group, comprised of representatives of all federal drug abuse agencies, including the Drug Enforcement Administration and NIDA. In order to closely monitor trends from the drug abuse treatment community, the creation of a Heroin Strategy Work Group in NIDA followed. This group has monitored admissions to federally-funded drug abuse treatment, reviewed hospital emergency room, medical examiner, and crisis center trends available through the Drug Abuse Warning Network (DAWN); and updated reports from the Community Correspondents Group, a network of program officials from 20 cities convened by NIDA semiannually. This effort, under the leadership of

NIDA Director, William Pollin, M.D., has been responsible for developing the data now available from which to assess the impact of a new heroin supply. Each of the sources of data and information available to the Institute is limited in its ability to precisely describe heroin use patterns; however, they represent the best information available and together provide a useful indicator of emerging heroin trends.

Collectively, at the national level indicators show generally declining heroin trends for the last 3 years; however, preliminary data for 1979 indicate that some of these decreasing trends may be stabilizing or leveling off. At the height of the national response to this problem in the third quarter of 1976, 67 percent of persons entering federally funded drug abuse treatment were admitted for the treatment of their addiction to heroin. Over the last 4 years this percentage has declined nationally to a provisional total in December 1979 of 36.9 percent. In the northeast States, however, 47 percent of admissions to treatment were for heroin abuse in the last quarter of 1979. Similarly, heroin admissions accounted for less than 30 percent in the north central states, 23 percent in the south, and 40 percent of those in treatment in the west.

In the drug abuse field, a major limitation of national data is that many drug abuse phenomena tend to be localized. Thus, if a change were occurring in drug abuse patterns, it most likely would first become apparent in smaller area data. In reviewing both our DAWN and CODAP data, it does appear that some heroin indicators are increasing in some East Coast cities and States. Data obtained from local and State personnel tend to support this observation.

If we focus specifically in the northeast, for example, we find that in five States—New York, Connecticut, Maryland, New Jersey, Pennsylvania, and the District of Columbia—the percentage of patients admitted for heroin addiction was higher in the fourth quarter of 1979 than the first quarter. In New York State, heroin admissions increased from 45.9 percent in the first quarter of 1979, to 54.8 percent of all clients in the fourth quarter. Both the percentage of admissions and number of persons admitted for heroin treatment in New York City increased during 1979. Indicator data from several other cities in the northeast corridor are showing similar upswings.

While it is too early, based on these and other preliminary indicators, to say that this constitutes a new heroin epidemic, on the order of magnitude of what was experienced in the late 1960's and early 1970's, we are alert to the possibility and will take every conceivable action in the event such a situation becomes evident. We will continue to monitor the heroin indicator information on a regular basis during the coming months and will provide the Congress with additional information as it becomes available.

NATIONAL DRUG ABUSE TREATMENT

The national drug abuse treatment response is based on a partnership of Federal, State and local government. Currently, the federally funded treatment system consists of a network of 3,600 clinics employing 44,000 persons with an annual investment of $511,000,000 in Federal, State, local, and third party resources. Of that total, the contributions of all State governments and NIDA were nearly equal.[1] NIDA's current Fiscal Year 1980 budget for community drug abuse programs, including that portion of the Section 409 formula grants expended for treatment, is $159,200,000.

NIDA's contribution supports a variety of treatment approaches in different settings to substance abusers. Last year our provisional figures indicate that NIDA funds provided treatment for approximately 281,000 persons.

The vast majority of federal funds for drug abuse treatment are administered through statewide services grants to State governments. NIDA funds support approximately one-third of the total national treatment slot capacity—or currently 95,000 slots. The Institute has established the maximum dollar amount or ceiling it will support for each treatment slot, of which the Federal government will pay a 60 percent match to support the various modalities of treatment. State drug abuse agencies then subcontract to counties and other local units of government and treatment programs themselves for the delivery of treatment services.

Public Law 96–181, the Drug Abuse Prevention, Treatment, and Rehabilitation Act of 1979, which extends authorization for NIDA programs, directs that a minimum of 7 percent of NIDA's community program funds (Section 410 project grants and contracts) for Fiscal Year 1980, and 10 percent of those funds for Fiscal Year 1981, be spent for primary prevention and intervention activities.

In response to this growing concern about the need for enhanced prevention activity, the Institute has developed a policy to shift a portion of its resources

[1] Source: 1979 National Drug Abuse Treatment Utilization Survey (NDATUS). Staffing figure includes those employed in drug abuse only and drug and alcohol combined treatment units.

toward prevention programs. We have been able to meet the Congressional mandate in this area without a reduction in the total dollar amount provided to each State last year.

In making policy choices about the allocation of constant resources for drug abuse treatment, it was also necessary to take into account the rising costs of providing treatment services due to inflation, and the need to enhance the capability of State drug abuse agencies to administer and monitor the treatment system. Therefore, the Institute opted to enhance the quality of treatment provided and grant some relief to States on the inflationary front through reducing the number of treatment slots supported nationally, and using these resources to meet these goals.

The treatment funding policy being implemented for fiscal years 1980 and 1981, therefore, will provide the States with a modest ability to maintain quality in treatment services in the face of inflation, by raising slightly the Federal base of support for each treatment slot. In addition, the policy also provides a modest increase in funds available to the States for management of the drug abuse treatment system. Those States that currently have available less than 10 percent of their funds for administrative costs may elect to reallocate NIDA funding in this way. This would enhance the management capability of the States, enabling them to begin to address those concerns raised by NIDA and the General Accounting Office in its recent study of NIDA-funded treatment services. Those States not wishing these additional management resources are able to negotiate with the Institute to retain those funds in support of treatment services.

It should be emphasized that the total dollar amount provided to each State in fiscal year 1980 will not change over fiscal year 1979 levels, only the resources will be distributed differently. NIDA will continue to maintain a minimum Federal match for treatment of 60 percent and our policy to reduce those program grants whose current Federal share is above 60 percent, 5 percent annually until the 60 percent rate is met. We have worked closely with individual States to ensure that any necessary slot reductions would be directed at underutilized programs and are based upon an analysis of the unique needs, priorities, and performances of each individual State. This process has included discussions and negotiations between NIDA staff and State personnel.

NEW YORK STATE

Last year—fiscal year 1979—the total NIDA-supported drug abuse expenditure in New York State was $37,602,000. This is the largest expenditure in any one of the 50 States. In addition to funding for drug abuse treatment, in fiscal year 1979 NIDA obligated $388,000 for prevention activities; $498,000 for training activities; $842,000 for services research demonstration projects; $6,272,000 for research projects; $349,000 for a contract in support of the National Drug Abuse Treatment Utilization Survey, and $3,012,000 in formula grant funds.[2]

The Federal contribution to drug abuse treatment services in New York State was $26,240,000 in fiscal year 1979. This supported 14,220 treatment slots, currently operating at an overall 94 percent utilization rate. The estimated NIDA-funded contribution to drug abuse treatment allocated by the State to New York City has been substantial and has continued to increase since the inception of our national effort to combat drug addiction. We estimate that approximately $19,000,000 in NIDA funds were used to support drug abuse treatment in New York City in fiscal year 1979, an amount greater than the NIDA contribution to treatment services in 48 of the 50 States. Only the grants to the States of New York and California, which receive approximately 18.5 percent and 16 percent of our treatment dollars respectively, exceeded the NIDA treatment funding available to New York City.[3]

As a result of the funding redistribution which I have described, New York State has reduced by 782 the number of drug abuse treatment slots receiving Federal support. The 1980 funding level for the State includes a 3 percent increase in the State's fiscal year 1979 slot costs and a 2 percent increase for administrative costs. This same formula was applied consistently and fairly in all States and does not result in a reduction in the total dollar availability to any one State.

PREVENTION FUNDING

I am pleased to report, in response to a long standing concern of this Committee and of our own, that for the first time in several years the Institute is now able to

[2] Not all funds were expended through the State Drug Abuse Agency.

[3] These fiscal year 1979 figures do not include Section 409 Formula Grant funds expended for treatment.

increase its activities in the prevention field. In fiscal year 1981, over $6 million has been added to the base budget for drug abuse prevention.

The largest share of the increase in prevention funding in fiscal year 1980 and fiscal year 1981 will be made available to State drug abuse agencies. This will include a base of about $35,000 to $40,000 for each State to continue support of State Prevention Coordinators, and about $3,250,000 nationally for all States to support community-based prevention programs. These grants will be distributed equitably with no State to receive less than $25,000.

In keeping with growing concern as to the unique needs of particular population groups, special consideration will be given to grant applications for prevention programs targeted toward women, the elderly, and youth—persons under the age of 18. Special consideration will also be given to programs located in occupational or educational settings. These priorities are in accord with those outlined in the recent extension of the Institute's authorities.

The remainder of the additional funds available for drug abuse prevention nationwide will be used to strengthen NIDA's technical assistance efforts to States, local communities, and parent groups, and to expand the targeted national prevention grants program administered by the Institute's Prevention Branch.

Among the national program initiatives currently being planned are Prevention Research Evaluation Multidisciplinary Centers to analyze and share new prevention knowledge as it is developed; a special grants program for minorities, women, and other special populations to validate drug abuse prevention strategies for these target groups. A pilot effort to provide technical assistance to parent groups involved in preventing drug abuse is being initiated and a national family initiative is being planned. An effort to increase our activities with schools is being planned and, in addition, a 5-year National Drug Abuse Information Program to deglamorize and discourage drug abuse by communicating factual information about the effects of drugs on the physical, behavioral, and mental health of drug users will begin in fiscal year 1981. A Prevention Action Planning Group has been established within the Institute to facilitate these initiatives.

New research in the prevention field will also begin, including studies on the long-term effect of attitude change on drug-taking, the sequence of drug-taking patterns, evaluation of the efficacy of various examples of school-based prevention programs, and parental involvement on the attitudes of youth towards drugs and the role of the community in drug abuse prevention efforts.

Studies on the interdependence of addictive disorders considered as a general class of dysfunctional behaviors will commence, including a review of the dynamics and impact of public information efforts in controlling the development of such disorders.

Mr. Chairman, NIDA looks forward to the continuing support of this Committee as we continue our efforts to enhance our prevention activities. As you well know, a critical component of achieving long range success in our battle against drug abuse lies in achieving an effective prevention strategy. Mr. Chairman and Members of the Committee, this concludes my formal statement. I would be pleased to answer any questions you might have.

PREPARED STATEMENT OF JULIO MARTINEZ, DIRECTOR, NEW YORK STATE DIVISION OF SUBSTANCE ABUSE SERVICES

Mr. Chairman, distinguished committee members, and staff, I appreciate the opportunity to speak to you about the heroin problem in New York State.

I talk to you today first as a recovered addict who knows the heroin problem from my own experience and secondly, as Director of the New York State Division of Substance Abuse Services—the state's drug treatment and rehabilitation agency.

I'm not here to "cry wolf" or to create a false sense of crisis, I'm here to tell you the plan facts. And the facts from the Federal Drug Enforcement Administration (DEA), Attorney General Civiletti, the New York City Police Department, hospital reports, and our agency surveys show the herion problem is back, maybe stronger than ever.

Let me summarize the situation we face with just a few statistics. Between 1978 and 1979:

Drug dependent deaths in New York City rose 77 percent;

Heroin emergency room episodes in the City increased 46 percent;

Admissions to drug programs throughout the State with heroin as primary drug of abuse were up 26 percent;

Admissions to methadone programs increased 22 percent and detoxification program admissions increased 40 percent; and

Opiate arrests in New York City rose 11 percent.

These increases are the result of a huge influx of high-quality heroin entering the U.S.—and New York City in particular—from Iran, Afghanistan, and Pakistan.

The total illicit opium production in Iran, Afghanistan, and Pakistan during 1979 was about 1,500 metric tons. For comparison sake, consider that the U.S. heroin epidemic of the late 1960s and early 1970s was fueled by only 80 tons of opium from Turkey. During that epidemic there were 700,000 addicts in the U.S. We are now talking about the staggering potential for nearly 20 times that number.

To compound the problem, Middle Eastern heroin being sold on City streets has tripled in purity, and thus potency, over the past year. In the summer of 1979, the average purity of street heroin was about three percent; it is now nine percent. Some samples ranged as high as 19 percent.

Preliminary studies by our research staff seem to point toward greater heroin involvement by those under age 20. Between 1978 and 1979, there was a 24 percent increase in the number of youngsters under age 16 arrested for felony possession or sale of heroin, morphine and opium. Arrests for those aged 16 to 20 years rose 20 percent.

My major concern in light of these developments is simple: how are the Division of Substance Abuse Services and the State of New York going to confront and combat the impending heroin epidemic on top of our other drug problems? The outlook is not very promising.

To meet the rise in inflation and an increase in allowable costs without spending any additional federal funds, the National Institute on Drug Abuse cut available treatment slots in New York State in 1980. Funding these slots—to provide services to 667 substance abusers—would cost approximately $1.35 million. To make matters worse, the presidential budget request for 1981 *totally eliminates* federal formula grant funds for drug treatment and rehabilitation.

The picture on the state front is not better. State appropriations for drug abuse services have been slashed from $137 million in 1975 to about $50 million in 1979; our agency's workforce has dropped from 4,830 to 220. The drug problem has continued to grow steadily over that four year period.

The number of substance abusers in New York State is now more than 570,000; current funds available are sufficient to treat fewer than 50,000.

Despite all the indications of a heroin epidemic and actual facts of widespread drug use, funding has been reduced. I think it's important to try to understand why.

Society, and the medical and science communities, have spent a great many years and vast amounts of resources to conquer illnesses such as tuberculosis, polio, and cancer. These illnesses have stood as challenges to our knowledge and skills.

Pick up any newspaper or turn on the television and you'll see movie stars, sports figures, or statesmen campaigning for favorite causes: muscular dystrophy, multiple sclerosis, and other diseases. I'm certainly not disputing the need for that, I just want to contrast it with the number of people who stand up to let the public know about the need for treating substance abusers.

Let's face it, drug abuse isn't attractive and the people I represent don't have a constituency to fight for them.

The public needs to understand drug abuse a little better. No one chooses to become a heroin addict or a pill head, just as no one chooses to die of cancer or suffer from polio. Drug abuse is a matter of human condition: it's a matter of suffering, starvation, inability to cope, and hundreds of other pressures and problems that lead to drugs.

You want me to fight the war, but I can't do it without the weapons. Most of my work has been to get those who control the resources to recognize that fact. I've walked the halls; I've talked to newspapers, radio and television, and the public; I've attended hearings; I've sent letters, street surveys, news clips, press releases; I've listened to what concerns you and what concerns the person on the street.

I'm not here tooting my horn. I'm here to let you know what the feelings are on the front lines of the drug battle. I can sit here and talk all day, but that won't accomplish what I want. Tell me now: will we get help? I can't go home and tell the troops that relief is on its way if it isn't coming.

It may sound dramatic, but the reality is that we deal with the casualties and tragedies of the drug war. And the future doesn't look optimistic.

We are on the verge of a heroin epidemic that has the potential to be the worst we've ever seen. We are facing rampant use of marijuana PCP, cocaine and other drugs by our children; head shops now sell kits for converting heroin and cocaine so they can be smoked instead of snorted or injected; we are seeing vast numbers of adults who are misusers of prescription drugs; some head shops in New York City are actually selling marijuana and illicit pills over the counter; we have high-profit PCP dealers, cheap, available, high-quality heroin, rock and movie stars who tout drug use.

The state and federal response to this stark reality is: reduce funding.

We can be fiscal conservatives, but let's be humane and realistic too. The fact remains that drug treatment does work; I'm a testament to that. But it can't work unless we give it a chance and provide services to the people in need.

We know that for every $6,000 we spend for drug treatment, we save $25,000 in welfare, medicaid, law enforcement, and correctional services costs. Drug treatment is cost-effective, can save money in the long run, and—above all can save lives.

Please don't let what I've said fall on deaf ears. Tell your associates and colleagues that so far we are doing the job with what we have. We aren't losing the war, but our battleplan desperately needs a transfusion—not dope, but money.

Cuts in drug funding will only result in more casualties, more waste, and more tragedy. I'll walk the streets with you and show you who loses out when the money isn't put into treatment programs.

It is time for a renewed commitment on the part of the Legislature. We are doing everything that is humanly possible to save the endangered lives of our young and others who are threatened by drugs, but we need the resources or we will be unable to hold our own in this fight any longer.

I've been waiting to hear some good news. For 14 months I've served as Director of the Division of Substance Abuse Services, and I'm still waiting. I hope the good news comes soon.

Ladies and gentleman, permit me to quote a famous statesman. I guess he summed it up in these few words:

"It is vain, sir, to extenuate the matter. The gentlemen may cry, peace, peace! But there is no peace. The war has actually begun! The next gale that sweeps from the north will bring to our ears the clash of resounding arms! Our brethren are already in the field! Why stand we here idle? What is it that the gentlemen wish? What would they have? Is life so dear or peace so sweet as to be purchased at the price of chains and slavery? Forbid it, almightly God. I know not what course others may take, but as for me, give me liberty or give me death!"

PREPARED STATEMENT OF ROBERT E. WALLACE, CHAIRMAN, NEW YORK STATE COMMISSION ON ALCOHOL AND SUBSTANCE ABUSE PREVENTION AND EDUCATION

Chairman Wolff and Members of the Committee, my name is Robert E. Wallace. As the present Chairman of the New York State Commission on Alcohol and Substance Abuse Prevention and Education, I welcome the opportunity to submit this testimony to the House Select Committee on Narcotics Abuse and Control. Your Committee has done an outstanding job in focusing governmental and public attention on the continuing problems we face in addiction control and I congratulate you and your Chairman, Congressman Lester Wolff, for giving leadership to this aspect of American life.

I would also like to thank the Committee for holding hearings of this kind in communities across the country. These hearings provide communities the chance to be heard on this very vital issue and can only strengthen the hands of elected and appointed public officials as we seek for the shrinking public dollars for necessary school-community programs. As you travel from State to State and hear what the problems and needs are, I hope you will not only identify what each level of Government must do if we are to stem the tide of alcohol and substance abuse, but will add your voice to those of us who toil for their solution.

As the Chairman of an agency that is primarily responsible for the administration of school-based prevention and education programs in New York State, I would like to specifically address my remarks to the tenuous and unstable nature of that effort today.

The Commission of which I serve as Chairman was created by an act of the New York State Legislature on April 1, 1978 as one of three (3) agencies in the Office of Alcoholism and Substance Abuse. Although the Division of Alcoholism and the Division of Substance Abuse Services remain as independent operating agencies, the Directors of those two (2) Divisions and I meet as equals as members of the Commission. In addition to its responsibilities for school-based prevention and education programs, the Commission has also been given the responsibility—shared with a number of other agencies—of promoting an awareness of the problem of alcohol and substance abuse among the general population through education and information.

The Commission inherited many of the prevention and education responsibilities of the former Division of Prevention and Education which at one time was a part of the Office of Drug Abuse Services—a precursor to the present Division of Substance Abuse Services. Under that agency and several others that preceded it, Local Assistance (State) funds have been provided for school-based prevention programs

for the past nine (9) years. In each of these years funding has been steadily and substantially decreased to the point where the 1979–80 funding level ($14.9 million) represents a decrease of approximately 50 percent over the past nine (9) years. Of the $14.9 million allocated for fiscal year 1979–80, 87 percent was targeted for the operation of prevention and education programs in New York City, 5 percent was allocated for Region No. 8 (Nassau/Suffolk) and 8 percent was allocated for the remainder of the State. The Commission inherited these approximate allocations. It has been hard pressed to fulfill its financial responsibilities, in light of the increased costs due to inflation and mandated increases in salaries and fringe benefits, much less to expand its efforts to additional school districts in need of State funds. As a consequence, new programs have not been funded, established programs have suffered and in many instances have had to reduce staff and programming. Everyone at the Federal, State or local level with access to information in drug and alcohol readily agrees that the problems in those areas are on the increase, particularly as they affect our young people. Data provided through the Division of Substance Abuse Services, the Division of Alcoholism and Alcohol Abuse and the National Institute on Drug Abuse support that contention.

Almost 3.3 million teenagers (14–17) are considered problem drinkers.

Almost a million New York State high school students have used marijuana.

220,000 of these students have used hashish, glue or solvents, PCP and tranquilizers non-medically.

More than half of the students in New York State have used at least one such substance.

Every fourth person in this State, 14 years and older, has taken an illegal drug or used a legal drug without a prescription.

Alcohol and substance abusers become so in a number of different ways. While not everyone would agree what works best, many knowledgeable persons would insist the programs which include informational services, humanistic education, individual and group counseling, values clarification, peer leadership training, family-oriented services and educational alternatives within the school setting, usually in one or another combination, seem to be most effective in reaching and helping young people at greatest risk. The data generated through these programs clearly indicate that prevention-early intervention programs are effective and should be expanded.

The Governor's Executive Budget for the current year (1980–81) did not include the funds for the continuation of the school-based prevention and education programs beyond June 30, 1980. The Legislature, however, restored funding for school-based programs at the 1979–80 level. Although funds have been restored for school-based programs for the current year, funding has been provided for only two (2) staff persons to the Commission on Alcohol and Substance Abuse Prevention and Education for its operations for one-half of the 1980–81 fiscal year. No provisions have been made for the continuation of operations, training, evaluation or program monitoring. The situation remains unclear at present, but, hopefully, clarity will come when the negotiations are completed.

Fears have been expressed that failure to adequately support a prevention effort in alcohol and substance abuse will eventually lead to the dismantling of the entire prevention effort in New York State. Rather than a reduction or a denial of funds to this significant prevention effort, New York State has been urged to expand the effort and to increase its financial commitment. Although New York remains in the forefront in its support of alcohol and substance abuse prevention and education it must do more, so must every other jurisdiction of government.

The commitment of a mere $7 million at the national level for prevention is an embarrassment. That allocation represents an even greater embarrassment when one considers that those monies were "diverted" from treatment programs to prevention. A strategy that pits one deserving program against another, denies the validity and soundness of both needs.

Because treatment modalities—however sound their justification—cannot solve the problems of alcohol and substance abuse, prevention offers the most reasonable alternative.

It is our opinion that the time has come for all levels of Government to cooperate fully in the creation and development of a meaningful nation-wide prevention effort. In spite of the still limited funds available, and short-term setbacks, the national trend is toward increased funding of prevention efforts in the areas of health, mental health, substance abuse, alcoholism, child abuse, etc. That trend must be supported. This Nation needs and deserves an independent prevention mechanism designed to incorporate the presently fragmented prevention activities of its State governments and their various agencies into a comprehensive, coordinated effort.

n effort that recognizes the soundness of prevention strategies and provides funds for their initiation, their testing and validation.

PREPARED STATEMENT OF EDMUND H. MENKEN, PRESIDENT, PROJECT RETURN FOUNDATION, INC., NEW YORK, N.Y.

Mr. Chairman, members of this prestigious body, I am grateful for the opportunity to appear before you today.

My name is Ed Menken, and I am President of the Project Return Foundation, a voluntary, non-profit, New York City based human services agency providing a wide range of comprehensive health and social services to substance abusers, battered women, senior citizens and foster children. Project Return operates with a $5 million a year budget under various Federal, State and City contracts, and among our many activities is one of the largest publicly funded drug free treatment and rehabilitation programs in the United States. I am also a member of Therapeutic Communities of America, a national organization representing 302 drug abuse treatment centers throughout the country, caring for over 12 thousand clients, with a combined funding base of nearly $62 million.

I have come here today to discuss a matter of grave concern to me, to thousands of my colleagues in the field of substance abuse and to millions of parents throughout this nation.

I think it is urgent that recent developments be brought to your attention which are vital to understanding the crisis facing this country.

There is a time bomb ticking away in our midst that is about to explode, causing misery and human destruction throughout America. Hard evidence, from both public and private sources, clearly points to the fact that we are confronting another heroin epidemic, the likes of which have never been seen before in this country. Let me acquaint you with some facts.

After the disappearance of the French Connection in the early 1970's, the relative impact of crop subsidy programs and joint international enforcement efforts resulted in a temporary leveling off of the heroin supply to the United States. The "Golden Triangle" (Burma, Thailand and Laos) continued to produce significant quantities of raw opium, but the primary source of heroin smuggling into this country became Mexico. The purity of the heroin decreased while the price increased, but the problem continued to escalate. Then the phenomena of polydrug abuse emerged and the age of the typical drug abuser dropped significantly. The ravages of drug abuse spread from the ghettos of America and struck the suburban middle class.

It was then the mid-seventies and public attention was focused on the problem. The federal government responded for a time, but the interest turned out to be short-lived. Eventually, media coverage moved away from the issue and other matters captured our concern. As a nation, we began to act as though the problem had gone away and the consequence to that complacency is that we are now on the threshold of a new national disaster. Like a huge deadly monster rearing up out of the sea, the "Golden Crescent" has emerged—that volatile part of the world emcompassing Pakistan, Afghanistan and Iran. The fact is that the largest opium crops ever known are now being cultivated in that area.

Prior to the recent crises in Iran and Afghanistan, our government was able to estimate, with reasonable accuracy, that that sector was producing about 200 tons of raw opium annually. Since the crisis, however, the conservative guesstimate is that a minimum of 1,600 metric tons are being produced,[1] but it could, in fact, be closer to 2,000 tons. To make matters worse, the crops from the "Golden Crescent" are not the only problem. Now, the "Golden Triangle" area of Burma, Thailand and Laos must also be reconsidered. Production from this area has leveled off in recent years, not as a result of law enforcement efforts or international diplomacy initiatives, but rather as a result of an act of nature. The "Golden Triangle" has suffered three consecutive years of drought. Unfortunately, these conditions have changed and a bumper crop is anticipated this year. As this occurs, we can look forward to a situation of global heroin manufacture and distribution which is unprecedented in human history. These vast quantities of raw opium must find a market and it is necessary to assume that the United States is the likely victim.

For nearly two years, there have been reports of a major heroin epidemic developing in Europe. Countries which never before experienced a drug problem of any serious magnitude are beset by an influx of white herion of excellent quality and increased availability. Among the nations most seriously threatened is West Germany, where, not incidentally, the majority of American troops in Europe are stationed. According to Erich Rebscher, Chief of Intelligence for the Narcotics Division of the Federal German Police, "Herion in Germany is so plentiful and so potent that (they've) had 595 overdose deaths, almost twice the American total in 1979, although (they) have only one-fourth the population." [2]

Mathea Falco, United States Assistant Secretary of State for International Narcotics Matters, recently told this very committee that a "sudden increase in availability of mid-east heroin over the last few years has brought a heroin epidemic to Europe in greater proportions than exists in the United States." She then said that, "The exposure of our military forces in Europe to this new supply is an indicator of the threat faced at home." [3]

David Anderson, the highest ranking American diplomat in West Berlin, further underscored the dilemma by noting that "the drug epidemic was posing a threat not only to young Europeans and United States troops stationed in Europe, but to Western society as a whole." [4]

What has been occuring in that part of the world should have received greater attention in this country, for it wasn't just happening in Germany. All over Europe reports of a flood of high-grade heroin should have signaled the inevitable for us here at home. Several of our own enforcement officials predicted what was to come, but our legislators and elected executives apparently took little heed. John Warner, the United States Drug Enforcement Administration Regional Director for Europe and the Middle East, warned that, "Since Europe is clearly saturated, all the new laboratories being set up and the tremendous increases in the flow of heroin to Europe demonstrates that a major drive is being prepared for Middle East heroin to take over the American market." [5] And Peter Bensigner, head of the DEA, added to the prophesy by stating, "All of Western Europe is overflowing with Middle East heroin and our intelligence strongly indicates that we can expect larger amounts to hit the United States in the new year." [5]

Well, the prophesy was more than a prophesy. Look at the facts!

In a recent four week period, five individuals who were in treatment at my agency dropped out of the program, and died of heroin overdoses within days of their departure.

Since history shows that most of the people who drop out of therapeutic communities eventually return, you can understand our frustration around this indicator.

The number of heroin addicts admitted to treatment in New York during 1979 increased 42 percent over the previous year.

Heroin related emergency room episodes in the New York metropolitan area during 1979 have increased 89 percent over 1978.

Deaths due to heroin overdoses in 1979 show an increase of 77 percent over the previous year.

Data available through the New York City Police Department that identifies, by age groupings, the people arrested for felony drug offenses (opium and derivatives, which in fact, means heroin) indicates the following:

(a) The largest increase in this category (24 percent) occurs in the under 16 age group.

(b) The second largest increase is shown in the 16 to 21 age group.

As confirmed by law enforcement authorities, the purity levels of street heroin is way up, the price has come way down and the availability on the streets of New York is far greater than at any time in the past 25 years.

But our lawmakers weren't reading, or weren't hearing or weren't listening.

We are indeed seeing the first wave of a new and worse epidemic than ever before. It is spreading far and it is spreading rapidly. The U.S. Journal of Drug and Alcohol Dependence reports that "Persian Heroin" appears to be heralding significant increases in West Coast drug use [6] What is uniquely frightening about the California situation is that the "Persian" heroin being seen out there is not only of a higher concentration, but it appears to have been basified so that it can be smoked rather than injected.[6] This means that tens of thousands of young people who reject the ideal of an intravenous high, but indulge quite comfortably with smoking marijuana, may be very susceptible to a new but devastating euphoria. Smoking heroin is, in fact, the preferred method of ingestion in places like Hong Kong, and while a great many folks may believe that this method is less dangerous than injection, nothing could be further from the truth.

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[1] National Office on Drug Abuse Policy, White House.

[2] New York Times, Jan. 11, 1980.
[3] New York Times, Nov. 11, 1979.
[4] New York Times, Oct. 21, 1979.
[5] New York Times, Jan. 11, 1980.
[6] U.S. Journal of Drug and Alcohol Dependence, January 1980.

According to Dr. Daryl Inabe of the Haight-Ashbury Free Clinic in San Francisco, there is indeed wide spread use of Persian heroin in the Bay Area. Approximately 80 percent of the clients at the Free Clinic are heroin addicts. About one-third of the heroin addicts or 24 percent of their entire client population are involved with some form of Persian heroin. It appears that 50 percent of this group are smoking the heroin, with the other half injecting it. Similar reports are now coming out of Florida and Texas.

DEA also reports that a new form of heroin, originating in Bangkok, known as "paper dope" or "soaks" consists of one and one-half to three-quarter inch squares of artists paper in which heroin has been absorbed. The heroin is administered to each square which is then cut and sold individually on the street for $25. The addict puts the paper in the "cooker" and adds water. There is no need for boiling or straining through a "cotton". Each square is about three-quarter grams of street heroin at 1 to 3 percent purity. The heroin is undetectable unless held up to a strong light, at which time a brown stain is evident if heroin is present.

If the West Coast continues to be the trendsetter for youth as it has in the past, then, with respect to these matters, the cost in human life could be incalculable.

If I sound like the prophet of doom, it's because I have come from the front lines, from the trenches. Here in New York and all along the East Coast, drug treatment facilities are at or over their capacities. I am hearing from my colleagues throughout this part of the country and the story is the same everywhere. We have an epidemic on our hands! How can we make our leaders understand this? What must we do to have your help and support?

We in the substance abuse treatment field have had to contend, in recent years, with curious circumstances. While we have gone about the business of trying to treat the misguided, psychologically debilitated, abused and addicted youth of this country—the children of the rich and poor alike—we have had to wrestle with social apathy, a contagious permissiveness toward drug taking behavior, and a governmental posture which, at best, has been unresponsive and, at worst, negligent.

As a result of the NIDA reauthorization legislation, Public Law 96-181, signed into law on January 2, 1980, in Fiscal Year 1980, the treatment sector loses a minimum of $11 million, or 7 percent of its allocation. For Fiscal Year 1981, the forecast is even dimmer. With the Administration's most recent request to completely wipe out the Formula 409 funds, a total of nearly $40 million, the treatment sector stands to lose approximately $28 million. The capability of the states to deal with their respective drug abuse problems will be virtually distroyed by this move, since they rely so heavily upon 409 money for the administration of their state drug abuse efforts.

For three successive years, funding for the National Institute on Drug Abuse has remained nearly the same. No regard for spiraling costs. No sense of concern for the needs of the service providers. No appreciation of the conditions created by the burgeoning drug problem. And now, the prospect of having to cut back even further, crippling any capability to respond to this epidemic that will surely claim thousands of young lives.

Organizations such as mine, which operate residential drug free treatment facilities, have been hit by 100 percent increases in fuel costs and 50 percent increases in food expenses. Our situation is so critical that in many instances we were not even able to purchase winter clothing or desperately needed shoes for our clients. But the fracturing effect of inflation was never even considered. What are we to do? The states cannot make up the difference. And the cities are certainly not able to.

What we are clearly facing here is an intentional and deliberate disintegration of what, on the one hand, is a very meager government investment in the interest of public health, but, on the other hand, one of the most vital systems to the well being of America's youth.

And when the simple economics involved are examined, the posture taken by our government makes even less sense.

In a recently released GAO Report, it is stated—

"Another major consequence of the drug problem is the heavy financial burden to society. According to HEW, the annual social cost of drug abuse is $10.3 billion. The cost incudes absenteeism, unemployment, and death; law enforcement (including the judicial system); drug traffic control and prevention efforts; medical treatment, and about $518 million for providing drug abuse treatment services. The estimate does not include the range of intangibles that cannot be priced, but represent the pain of mental and physical debilitation, the destruction of families, the disruption of neighborhoods, and other human suffering associated with drug abuse."

NIDA's breakdown of $10.3 billion cost of drug abuse is as follows:

	Billion
Treatment, prevention and premature mortality	$1.6
Foregone productivity	5.5
Law enforcement and other criminal justice costs	3.2
	10.3

A recent informal study of the 8 New York Regional Therapeutic Community of America programs revealed some startling information:

In 1979 there were approximately 355 graduates of these affiliated programs. Using HEW's figures, these former addicts accounted for roughly $47.5 million in costs to society related to their untreated addiction in the streets. The total governmental cost to treat and rehabilitate these young men and women was barely $2 million. They came off the welfare rolls, out of the public dependency syndrome and away from the drug scene. They currently return, through their combined income, over $3.2 million a year to the economy of this nation and their tax contribution is in excess of $500,000. Clearly, the government investment in drug abuse treatment is miniscule when compared to the benefits gained by society for each person who is rehabilitated. Our federal government is truly guilty of being penny wise and pound foolish.

What is happening in this country? Where are we going? What will it take to get the powers that be to stop for a moment and realize that for the want of a dollar we're going to lose our children. If that is to be our destiny, history will record that these were the years when our Nation's leaders could not demonstrate the courage and creativity to deal with one of our most insidious enemies.

We have been shortsighted, ignorant, neglectful and irresponsible.

I would urge every member of this committee to use his best influence and good offices to reject the Administration's recommendation for funding reductions in the 1981 budget and to consider appropriate increases to all geographic areas of this Nation identified as being striken by this new heroin scourge.

Additionally, I urge this esteemed body to recommend that the Congress amend Public Law 96-181 to follow for the monies therein set aside for "prevention" to return to the treatment sector. Prevention is certainly important but it cannot be supported at the expense of vitally needed treatment resources.

I hope and pray that our leaders will take a new and deeper look at the drug abuse tragedy in this country and give to that problem all the help and support that it desperately needs. Quite simply, the future of America depends upon it!

Thank you.

PREPARED STATEMENT OF BENY J. PRIMM, M.D., DIRECTOR, ADDICTION RESEARCH AND TREATMENT CORP., NEW YORK, N.Y.

Congressman Wolff and members of the committee staff, we in the treatment community are extremely grateful for your past and present concentrated efforts to highlight the perplexing problem of substance abuse to your colleagues and the Nation. Your hearing, in our once great but steadily declining city, is welcomed by the entire treatment community and those unfortunate members of addictdom. (Kingdom of addicts.)

What we have chosen to do in our presentation is to show rates of death, crimes, homicides and to compare them through charting (and showing trends) from 1969 to 1978/79. What we are trying to show is a direct relationship between these sociological variables and the impact of funding and treatment slots.

This pictorial and mathematical approach provides evidence to indicate correlation between these socio-pathic events. There is a remarkable similarity in shape and amplitude of these graphically depicted diverse, sociologically related phenomena.

No community more clearly shows this relationship than does central Harlem of New York City.

Harlem is in a climate of fiscal austerity, steadily shrinking employment opportunities, and a sharp decrease in human services resources.

There is no single city in America more greatly affected by drugs than is New York, specifically those communities with high minority populations. It almost seems as if there is an institutionalized and governmentally contrived conspiratorial effort to ensure that these chronically stressful conditions endure until complete deterioration is irreversible.

Any diminishing of rehabilitative efforts, particularly the 7 and 10 percent set asides of federally allocated funds under Public Law 92-255 sec. 410, and its effect

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on section 409 state discretionary funds will inevitably exacerbate and accelerate these intolerable consequences.

Treatment dollars were overwhelmingly responsible for the reduction of the drug abuse epidemic and associated social costs of the late Sixties and early Seventies. That experience and much research has indicated that treatment drastically reduces the contagion factor and prevents many new cases of narcotic addiction.[1]

The charts have shown that scanty treatment dollars disproportionate to the incidence and severity of the problem have caused downward trends in addict related crime in the Harlem community.

A needs assessment for treatment services in Harlem that pinpointed underfunding to minority programs as compared to those in the greater New York area (i.e., Nassau, Suffolk and Westchester Counties) was commissioned and ignored by the State of New York. Reimbursement formulas for comprehensive minority-run methadone maintenance programs were found to be significantly lower than all programs in New York State. Yet the mortality rate of narcotic addiction in Harlem is seven times the rate for the city of New York.[2]

While the New York City mortality rates are steadily falling, in Harlem there is a precipitous increase especially in those associated with substance abuse, i.e., tuberculosis, cirrhosis, cardiovascular-renal and homicides.

The sociological and health indicies presented are overwhelming evidence that citizens of Harlem, as those of Ft. Greene, Bedford-Stuyvesant and the South Bronx, attempt to survive in a milieu of inordinate stress. The response for some is the use of readily available licit and illicit psychotrophic substances to alter their perception of and reaction to a hostile and psychically painful environment.

Harlem has a paucity of health and mental health services, an anticipated reduction in those that presently exist, a density of liquor stores that exceeds that of all other New York City communities,[3] and is the hub and supermarket of east coast licit and illicit narcotic traffic. It is plagued with insufficient funding for substance abuse treatment resources and now faces State and Federal reduction in support.

You have already heard from previous speakers mounting evidence of increased importation of illicit high quality Middle Eastern heroin. The alarming statistics presented here reflect malignant neglect and racism. Unrest, anxiety, and depression pervade our communities rendering them fertile for epidemic implosion.

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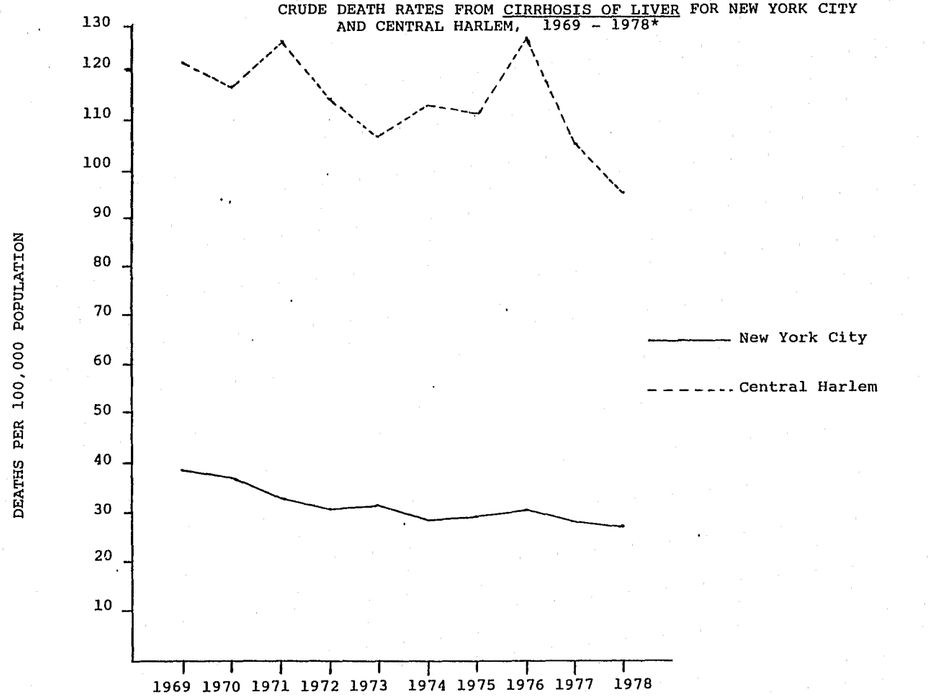
[1] Mark Moore, 1973 Presented to the National Advisory Committee for Drug Abuse Prevention.

[2] 23.9:3.3; Black:White—Bureau of Health Statistics and Analysis, Dept. of Health, the City of New York.

[3] Queens & Richmond, 1:5,000 population; Brooklyn & Bronx, 1:4,500 population; Harlem, 1:2,870 population. New York State Liquor Authority Computer Printout.

CRUDE DEATH RATES FROM CIRRHOSIS OF LIVER FOR NEW YORK CITY AND CENTRAL HARLEM, 1969 - 1978*



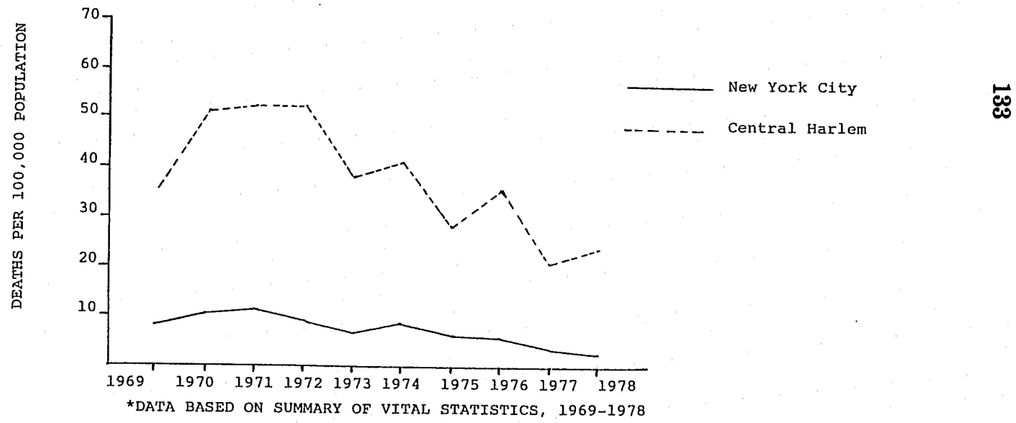
*DATA BASED ON SUMMARY OF VITAL STATISTICS, 1969 - 1978

M.Usman - Addiction Research & Treatment Corporation

CRUDE DEATH RATES FROM DRUG DEPENDENCE FOR NEW YORK

CITY AND CENTRAL HARLEM

1969 - 1978*



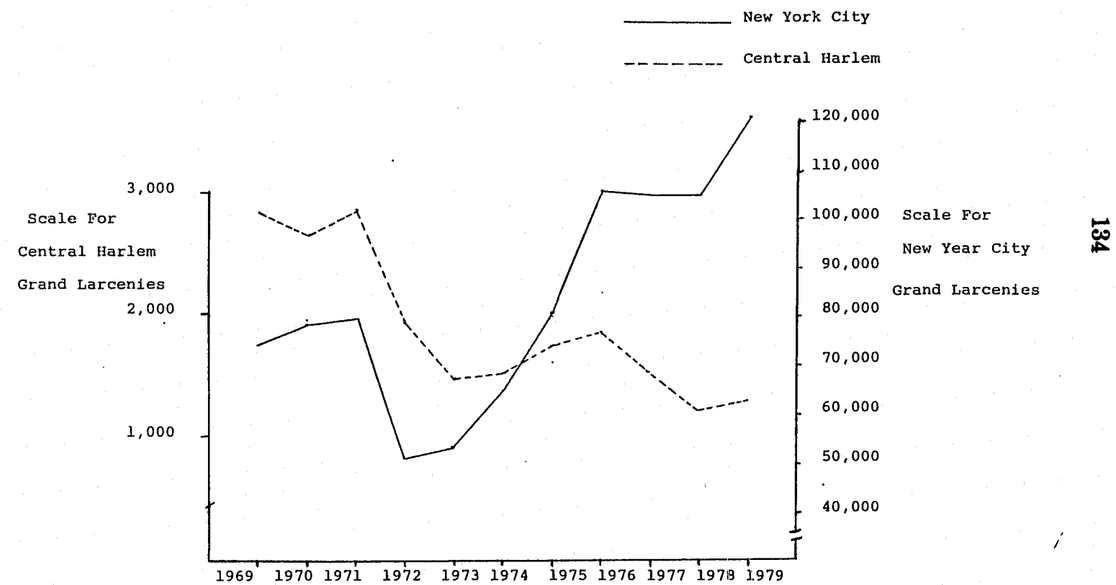
*DATA BASED ON SUMMARY OF VITAL STATISTICS, 1969-1978

M.Usman - Addiction Research & Treatment Corporation

Figure 3.

Number of Grand Larcenies in New York City and

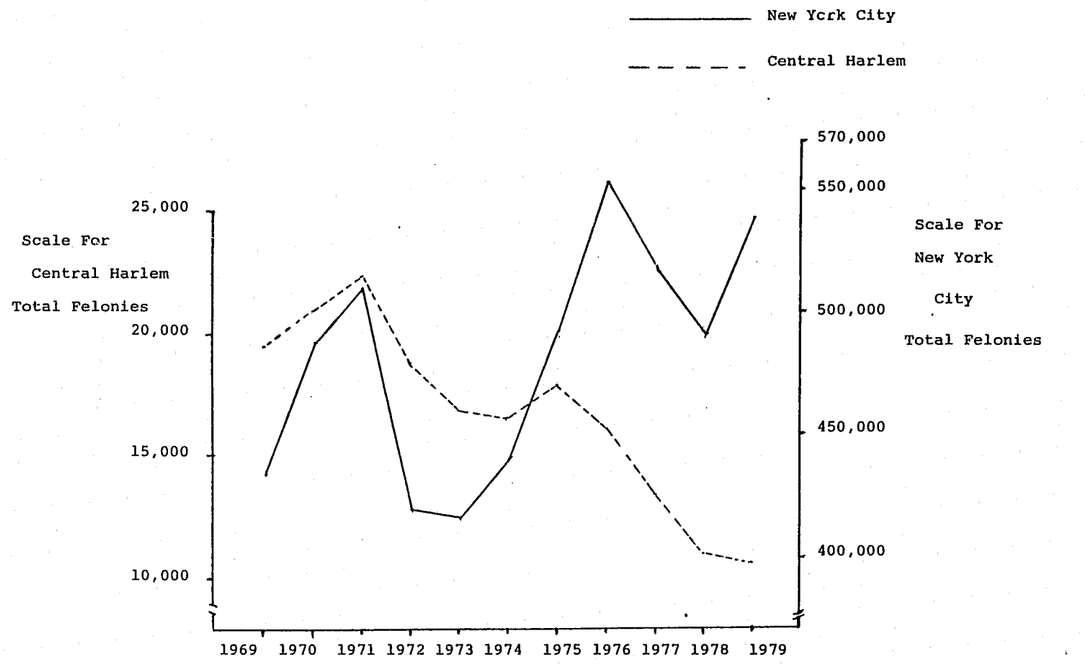
Central Harlem 1969 - 1979



M. Usman - Addiction Research & Treatment Corporation

Figure 4

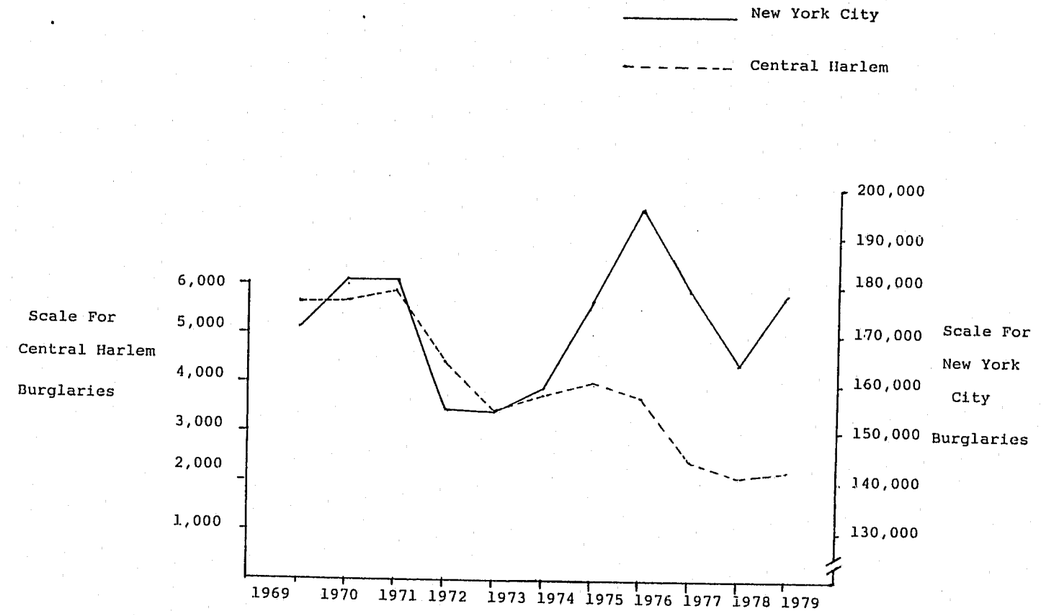
Number of Total Felonies in New York City and Central Harlem, 1969 - 1979



M. Usman - Addiction Research & Treatment Corporation

Figure 2.

Number of Burglaries in New York City and Central Harlem, 1969 - 1979



PREPARED STATEMENT OF RONALD L. COSTER, SENIOR VICE PRESIDENT, PHOENIX HOUSE FOUNDATION, INC., NEW YORK, N.Y.

My name is Ronald Coster, and I am Senior Vice President of Phoenix House. I am here to present the testimony of Dr. Mitchell S. Rosenthal, President of Phoenix House, who unfortunately cannot be with us today. With me is Kevin McEneaney, who heads our drug education and intervention unit and may be able to respond to any questions the Committee has about the prevention efforts of Phoenix House.

From what you have already heard today, it would be very difficult to dismiss evidence of an incipient heroin crisis in the United States as alarmist conjecture. All the indicators are there. You are aware of how an increasing amount of potent, white heroin is now reaching the United States and the devastating impact this drug flow has already had in Western Europe, particularly in West Germany.

Today, in New York, you can find ten-dollar bags of heroin on the street that are 19 percent pure. Yet, as recently as last summer, five percent pure street heroin was a statistical rarity. Now, anything less than four percent is rare, 15 percent is not uncommon and the average is close to nine percent.

Treatment programs have already felt the impact of more and more potent heroin on the street. The number of clients entering treatment in New York with heroin as their primary drug of abuse increased 42 percent between January 1978 and the third quarter of 1979.

There is no question but that we are going to have another heroin crisis. And what we should be asking ourselves is what kind of a crisis we are going to have. If we imagine we will be seeing a replay of the late 1960's or 1970's, then we are in for a considerable shock.

Now, there were great fears a decade ago that heroin addiction would spread beyond the inner city. Middle class communities prepared for an onslaught that never really came. Not that all heroin victims were poor or black or Hispanic. But the minority communities bore the brunt of that crisis.

Addiction in the coming decade, however, will be a truly egalitarian phenomenon. It will run throughout all of our society and throughout every community, and it's primary victims will be the young.

To see this coming, one need only look at the presently rising tide of youthful drug abuse. I am sure you have heard many of these figures before. But the numbers appear even more grim when considered in the context of widely available, potent and low cost heroin.

Between 1975 and 1978, regular marijuana use among high school seniors increased by more than one-third to 37 percent, while the number of daily users doubled.

Recent studies in Maine and Maryland showed one high school student in six using marijuana on nearly a daily basis.

In New York State, one quarter of a million school children began using marijuana in 1978, and that same study showed that one-third of all seventh and eighth graders in the state had used the drug.

Increasing use of marijuana by adolescents and preadolescents in itself a significant problem, a problem that becomes more alarming as additional evidence of harmful physical and psychological effects becomes available.

But what should concern us now is the growing number of youngsters who are not content to stop at pot. The 1978 New York study that found a quarter of a million new marijuana smokers also found 118,000 school-age children who had had their first snort of cocaine and 125,000 who had tried PCP for the first time.

In 1979, New York State researchers found PCP becoming even more popular and other hallucinogens, like LSD, making a comeback. They learned that girls were now using drugs as often as boys, and that treatment programs were seeing a growing number of children between nine and eleven.

The NIDA survey of high school seniors in 1979 found that marijuana use seemed to be leveling off after its rapid rise between 1975 and 1978. But other, more powerful drugs were gaining ground. The number of seniors who reported regular cocaine use had increased by more than 100 percent between 1975 and 1978 and rose another 47 percent by 1979.

Now, after twenty years of studying and treating drug abuse, there are certain aspects that we understand very well. We may not yet know all we should or as much as we should, but there are a number of basic relationships we do understand. We know, for example, that the probability of disability is related to a stepping-stone process, a progression from less potent to more potent drugs. And we know that increased availability of a drug invariably increases the number of users.

So we are facing today a tragic constellation: a growing number of younger users each year . . . a movement by younger users from marijuana to more potent drugs . . . and the availability of more and more lethal heroin. The outcome of this

situation is frighteningly predictable. The heroin crisis of the 1980's will strike hardest and most devastatingly at the young. How then are we preparing for this crisis?

The answer is that we are not. Local treatment programs in New York are now at 96 percent of capacity, and funds for local treatment have been cut. Not only must programs like Phoenix House find some way to swallow cost increases for fuel and food and rent—increases that are running well ahead of the national inflation rate—but they must also live with a two percent reduction in state funds . . . a cut that was restored by the Legislature and vetoed by the Governor.

Now, I find it hard to fault the effort New York State has made. New York has built and sustained the nation's largest and most effective drug treatment and prevention network. The costs have been heavy, and New York State has borne the bulk of them alone. The state's drug program now costs 150 million dollars, and New York gets only 26 million from NIDA. That is 17 percent—while other states get as much as 60 percent of their drug program costs paid by the federal government.

Let's look at that $26 million dollars from NIDA. Three million of it, more than eleven percent, is 409 money—money that may be cut by Congress. Since 409 funds are allocated by formula rather than need, New York State doesn't get as much as it should to begin with. Nevertheless, 409 funds make up more than 11 percent of the state's total NIDA allocation.

The bulk of this 409 money goes to support state-wide services, many of which have been mandated by the Federal government. Funds for statistical studies required for funding and for the preparation of a comprehensive state plan all come out of the state agency's 409 pocket. Now, clearly, these services won't be eliminated should the money to pay for them disappear. Three million will have to come from somewhere else . . . and that somewhere else will most likely be local treatment.

That means treatment programs—facing what amounts to an incipient client population explosion—will get no help meeting inflationary cost increases, will lose two percent of present state funds plus the NIDA 410 dollars that will have to go to cover the loss of 409 dollars.

This makes very little sense. And it is not the final folly we are dealing with this legislative year. There is also the set-aside for prevention—seven percent of the NIDA dollars now going to treatment.

Now, clearly more and better prevention programs are needed. We cannot look at the rising rate of youthful abuse and deny that. But the notion that funds for this purpose should come from the treatment budget is simply ludicrous. It is like preparing for an epidemic of typhoid or cholera by adding squads of new sanitation workers and paying for them by dismantling some hospitals.

Let us consider for a moment what is to be done with the windfall of 11 or 12 million dollars that the set-aside will produce for prevention. The bulk of it is to be spent on new prevention programs. While this is indeed a worthwhile undertaking, it will not put a lot of troops in the field initially. Most of this money—now paying for treatment slots and treatment personnel—will go to consultants. It will be spent on development, on planning and on proposal writing—all of it necessary and none of it immediately useful.

About 3.2 million dollars from the set-aside will go to prevention program development by State agencies. And this money—most of it or all of it from 410 funds—will be allocated to States by formula—a formula similar to the one for 409 funds. In other words, States like New York, where the need is greatest, will get the short end.

I would like to suggest to the committee that what has developed here is the direct result of an arbitrary division within the drug abuse field between prevention and treatment. We, in the field, made that division. And, I suspect, we have lived to regret it. The reality we have come to recognize is that prevention and treatment are parts of a continuum. They are rather distinct parts of that continuum, but it is almost impossible to say where one leaves off and the other begins.

What's more, there are direct relationships between treatment and prevention, and they have a powerful impact on each other. For example, we at Phoenix House have found the natural outreach and community involvement of our facilities produce a kind of community consciousness-raising that is essential to successful prevention.

There is also the role of young, former drug abusers in the prevention process. Graduates or senior residents of drug-free treatment programs are among the most effective players in the prevention field. They have a unique capacity to reach and influence other young people. Indeed, each year Phoenix residents make several hundred appearances at schools and community centers to support the efforts of prevention workers.

Let me also point out that as the approach to prevention changes—and it is changing rapidly today—many treatment programs are taking a more direct role in prevention. Across the country, schools, parent groups and community groups are reaching out for help. And they are turning to treatment programs. Phoenix House now gets at least 20 requests each month from all over the country—for information and help.

Part of our response to this demand has been to create our own drug education and intervention unit, which is now working with more than 250 schools and community groups throughout the New York metropolitan area. While our program in the public schools is supported by the State, there are no public funds for our program in New York's private and parochial schools or for the work we are doing with schools and parent groups elsewhere in the Nation.

I see the role of drug-free treatment programs in the area of prevention continuing to grow. This is consistent with the recent realization that an essential ingredient in the prevention of drug abuse is parental involvement. Indeed, a family strategy seems our last best hope to stem the flood of youthful abuse. And drug-free treatment programs have had years of experience working with parents and with parent groups.

This means that reducing the funds available to treatment programs will most likely inhibit the very kind of activity you hope to encourage with those funds. The set-aside will produce little initial movement on the prevention scene. But denying those funds to treatment programs will limit their growing involvement in prevention activities. Indeed, I suspect that the net result can only be a set back for prevention.

It will also be a disaster for treatment. And that disaster can only be worsened should the need to field new prevention players raise community awareness of drug dangers without providing solid local resources.

Let me explain. When a new prevention effort is mounted, public and parental awareness of drug abuse is heightened. Schools require a capacity to identify present abusers. Thus, the first product of a prevention program is invariably a sizable number of hitherto undiscovered candidates for treatment.

We at Phoenix House have seen this happen over and over again. We have seen it in communities where we have become involved—in New Jersey, Maryland, Georgia and Idaho. Every group we have helped has made the same discovery. To get the kind of prevention program they want, they must first have a local treatment capacity.

Let me put it all together. We now have a heroin crisis in the making—a crisis that will primarily affect young people. We see a need for more drug prevention, and we must recognize that treatment programs are becoming increasingly involved in community-based prevention. What's more, the first result of prevention is to escalate the demand for treatment. Our treatment facilities are now operating at close to capacity—at least in New York. They will be unable to accommodate the number of youngsters whom we can unerringly predict will require treatment in the next few years. Furthermore, they will be unable to sustain even their present level of activity. In New York, they will be receiving no funds to meet their increased costs. In fact, State funds will actually be reduced. So will the support they receive through NIDA. The loss of 409 money used for Statewide services will inevitably be balanced by a reduction in local treatment funds, while the prevention set-aside will cut further into the treatment budget.

I am sure the committee can recognize the obvious absurdity of this situation. And I hope the members will call it to the attention of their colleagues in the Congress.

Thank you.

PREPARED STATEMENT OF JAMES ALLEN, EXECUTIVE DIRECTOR, ADDICTS REHABILITATION CENTER, NEW YORK, N.Y.

Harlem does not need prevention nearly as bad as it needs treatment. Recently we were invited to show a film we had rented called "Angel Death" at a local intermediary school. Our choir was also invited there to sing for the young people after the film. The person coordinating the program informed me that he would be receiving some funds from the federal government to provide a drug prevention program in the school. I couldn't help but feel sorry for this person and all of the teachers in that school that were going to establish a drug prevention program and teach the kids not to use drugs, they can't even teach kids to read and write.

I made the kids stay quiet by threatening not to allow the choir to sing for them. I couldn't help but wonder whether or not that prevention program was going to be part of the 7 percent set aside. I also asked myself how in the world were they going

to provide preventive education for kids whom they couldn't even get to sit down and listen? Almost like a joke. They were going to get funds to prevent these kids from becoming drug abusers. These kids had been abusing drugs for the past 2 years.

I also wondered whether or not preventive education was going to be geared towards discouraging housewives from financing the drug problem, or whether prevention would be aimed at local welfare centers who pay for food, clothing and shelter for active addicts leaving them free with plenty of time to hustle "fix" money.

On my way home along Madison Avenue, near 117th Street, I looked around me at an area that used to house thousands of people. It now is almost deserted. It looks like a cemetery. As I looked out of my car window I saw a group of young people right in the middle of that grave yard laughing, happy, dancing, their radio turned up loud, smoking reefer, nodded out, and I was angry. It was so odd. The whole damn neighborhood dying and they were happy, dancing, laughing, singing the blues, so opiated by drugs and music that they didn't realize that they were standing in the middle of rats, roaches, decayed buildings and garbage.

They were happy because they had plenty of music, plenty of dope, plenty of liquor, plenty of sex and no desire to leave a dead community. The only person they could harm is themselves and as long as they kept it in the neighborhood, nobody would stop them from doing it to themselves. I was also angry because someone made it so easy for these young people to destroy themselves.

The strong people in our society make millions of dollars as a result of the fact that these young blacks are so weak. All over the country our schools are cutting back on their human service departments and expanding their criminal justice departments. But in all of these years, crime has not been curbed and absolutely no one can seem to stop the flow of drugs into the country.

I am reminded of the old English fox hunt. In this instance, the fox is the young, gifted, black American who is trapped in the ghetto jungle. He will be hunted like a fox and when he is caught and maybe he will be turned loose again and he will be hunted again. The people who hunt him will get paid to hunt him and it is done without any feelings as if he was not human.

Our society suffers tremendously because of the drain of talent resulting from this fox hunt. Thousands of young people who possess the imagination, daring, creativity and ingenuity to make tomorrow better than we have made today, are permitted to use drugs, engage in crime, and exploit all of the other illegal vices in their own neighborhoods. Then they are hunted down like the fox. It seems that our society has decided that it's more sporting to hunt these down than it is to correct their behavior.

There are no children in Harlem. We are all adults. We all young and old see, hear, feel, smell and taste the same things. Nobody stops anybody from getting whatever anybody in Harlem has the money to buy.

I realize in addressing the committee that I, as a professional, should have learned to keep my emotions out of it, but maybe that's what's wrong with our society, we have no emotions. We have disciplined ourselves against emotions. So there is no way that anyone can make a strong enough emotional appeal to any level of our society to encourage us to respond to our major emergencies, particularly this one of drug abuse. Everyone wants to be cool.

Those young people that we force into the fox hunt are conspicuously absent from our educational institutions and you don't see them in church and you can't even encourage them to either work or get an education because they can make more money selling drugs.

A lady who runs a cleaners in my neighborhood told me that she was robbed while she had a pistol in her pocket but that she was afraid to shoot the guy who robbed her because the pistol was illegal and she would go to jail. She had called the police she said and that they didn't even appear until a half hour later, when they rode by without even stopping.

A client in our program related a story about how she received a suspended sentence after being caught with a large quantity of drugs and a pistol . . . and how after reverting to the use of drugs she assaulted a dope dealer who tried to cheat her out of her money and got slapped with an assault/robbery charge for which she received 4½ to 7 years.

Our Government finds it very difficult to arrest dope dealers but will close drug treatment programs who violate minimal operational standards. We expect our funds to be cut any day now because some people don't feel that we've enthusiastically tried to get the people in our program on welfare. Our Government has established itself as a dope dealer and competes with the illegal dope dealer in providing the addict with the methadone instead of the heroin that he needs to

destroy himself. In spite of the fact that we all know that methadone has not reduced crime and has demoralized and destroyed entire neighborhoods. I know specifically of one area, at 125th Street and Park Avenue, that used to be a thriving business area but now it's little more then a methadone clinic, a Fish & Chip joint, a snack stand, a liquor store, a railroad station and a whore stroll.

There are more then 570,000 drug abusers in the State of New York. In 1978, 42 percent of the people abusing drugs, were heroin abusers. In 1979, 57 percent of persons abusing drugs, were heroin abusers. In 1978 there wee 248 drug related deaths. In 1979 there were 439 drug related deaths. There was a 42 percent increase in the number of people seeking treatment for drug abuse in 1979.

Funds made available to New York State for treatment of drug victims had dwindled from 137 million dollars in 1975 to the current figure of approximately $27,930,000, for 1979, approximately 30 percent of all funds are supposed to be allocated to Harlem to fight against drug abuse. We were told that last year Harlem received 5.5 million dollars and that this year, Harlem will receive 5 million dollars to fight drugs. Through the years there has been a steady, constant cut back on funding the Harlem community. This cut back is done by closing out services that were made available to addicts in Harlem, with no return of those funds to the community. I will name a few—United Harlem Drug Fighters, Narco II, Carve, Harlem Confrontation House.

The New York State Department of Substance Abuse Services supplied the above listed statistics and concludes the following:

(1) Heroin is now more plentiful than ever.
(2) Law enforcement is now more lenient than ever.
(3) Treatment for drug victims is now more scarce than ever.
(4) There are now more overdoses from drugs than ever.
(5) There are more addicts than ever.
(6) There is less money available for combatting the problem than ever before.

Back in the 60's when the drug problem blossomed all over the United States, everybody got scared and the Government started to spend money to do something about it.

But now that it has again been re-centralized where it belongs, in our Harlems, among the poor, funds are shrinking. In the old days if you wanted to buy heroin you had to ease clandestinely around a corner, contact someone whom you knew in order to make the buy. The same thing with reefer, and unless you knew someone, you would have a hard time buying drugs in quantity. Buying cocaine was virtually impossible.

Now in Harlem, whether you buy drugs or not, sometimes in certain streets you have to slow down to about 10 miles an hour to keep from running over some guy who is trying to sell you a bag of drugs or some reefer or some angel dust, you can buy drugs on almost any corner where people, any people, congregate. And you don't have to ask "whose got it?" There will be people there telling you that "they got it" and explaining in detail exactly what they have.

If you are afraid to go to that corner and buy drugs, you can walk boldly into certain stores on 125th Street or along most of our avenues and plunk your money down on the counter and tell the clerk exactly what you want, whether it be heroin, marijuana, cocaine, PCP or any other drugs, and it is available to you right there, across the counter, in any quantity you care to buy. These places are called "drug supermarkets," and for the young, very young, it's easier to buy these drugs than it is to buy alcohol because there is no age limit on who can buy it. All you need is money.

The people who work in these stores do not own them. They are salaried workers as are the people who sell the drugs on the street. They work regular days and weeks and hours, sometimes they even punch a clock.

The degree to which our Government has permitted this increasing supply of drugs to come into the country and to permeate certain communities; and the degree to which it has boldly cut back resources made available to fight against drugs in these communities; and the resulting chaos that is visible for all to see, is a horrible disgrace.

When I think how society has afforded itself the luxury of harnessing human suffering and used this human suffering to make the strong stronger, I am appalled, because it was done under the guise of providing help. We have allowed ourselves to become almost animalistically barbaric except when animals destroy and consume their weak and dying, the animals are more honest about it than we humans are. They don't pretend that they are trying to help the weaker ones, they just simply destroy them.

If we wanted to we could have almost unlimited power in establishing policy to institute a massive war against drugs, by enacting laws and statutes to cope with

the apprehension, conviction and disposal of those people who make drugs available, at all levels, from the importers through the retailers to the consumers.

I believe that if human suffering was considered high enough a priority, these same elected officials could make money available to finance the treatment, supervision and evaluation of the treatment necessary for the delivery of services to the addicted victim and his family and his community and our society.

We also have law enforcement people, human beings sworn under oath to God, to uphold and enforce these laws. And we have the most powerful and persuasive news media force of all times. Through their advertisement they make us all buy new suits every year and new cars every other year.

I don't understand why they cannot convince the general public and the church and the Government to make the fight against drugs a higher priority in its concern for humanity.

When we begin to accept the fact that the drug problem could not exist if we all did not support it, either directly or through "benign neglect," then and only then will we be able to make a significant impact on curbing this flow of drugs into our country.

BACKGROUND INFORMATION

I am James Allen.

I am the executive director of the addicts rehabilitation center.

In late December of 1957, weighing exactly 119 pounds and with ten wasted years of heroin addiction behind me, I checked into the United States public health service hospital at Lexington, Kentucky for treatment. My treatment consisted of seven days of methadone support for withdrawal, and 18 days of living in what was then called the regular "population."

Those were probably the most important 25 days of my life because it was my "turning point." God helped me find myself and what I should be doing with my life. After those 25 days, I signed myself out of Lexington and came back to New York City. I was "scared stiff" but I was determined to become a supportive part of the church and our society in general. I am a member of the church and I have served both as a deacon and as an elder, respectively. I am a registered voter and a home owner, and in 1976 I graduated with a bachelor of science degree from John Jay College of Criminal Justice.

ARC FACILITIES

I feel my greatest contribution to my community has been the development of the addicts rehabilitation center, which has provided 22 years of multi-services, specifically designed for those victimized by drugs in Harlem.

And during these 22 years I have been consistently blessed to be able to recruit and direct some 65 dedicated people of varying degrees of education ranging from PhD, down to high school dropout in the operation of our programs to provide services.

Our main facility is located at 1881 Park Avenue. It was formerly a factory warehouse and is valued at $350,000. It was given to us in 1972 on the condition that we be able to pay off a $130,000 mortgage by 1981.

The facility is a 60,000 square foot brick and mason structure which we ourselves converted into the following renovated components:

The first floor contains a reception area, a storage room, a laundry room, a dining room and a maintenance office.

The second floor contains the administrative offices, treatment, counseling and lounge areas.

The third floor contains sleeping quarters for females.

The fourth and fifth floors contain sleeping quarters for males, a recreation and theater area.

Our facility is fully licensed by New York state to be operated as a residential drug free treatment program and is certified for occupancy by the New York city department of buildings.

ARC COMMUNITY OUTREACH

We also operate an ambulatory component for outreach and street recruitment. This space located at 130 West 116 Street is donated to us by the Caanan Baptist Church.

Our recruitment counselors operate from this location around the clock in 8 hour shifts, going out into the jungle by ways of Harlem to stand around the fire barrels and wander through the abandoned buildings . . . and whenever they find congregations of addicts they recruit them by convincing them that being in treatment and learning to become self sufficient is better in the long run than sleeping in the streets just to receive a welfare check. Although our outreach component is responsible for 70 percent of the people recruited into our residential program there are no funds available and there has been none the past 5 years for the operation of this program.

Addicts recruited into the ARC residential program go through four stages of treatment during a six to nine month period. During the 3rd stage of this treatment, which occurs after the 1st month, they begin working or attending school or training in some skill. All those who work must save one-fourth of their salaries so that when they graduate they won't have to apply for welfare. By this time most of them will have secured and furnished an apartment.

ARC's sources of funding from July 1, 1979 through March 31, 1980 were as follows:

(1) New York State Department of Substance Abuse Services	$443,496
(2) NIDA	665,245
(3) Anticipated SSI income maintenance	[1] 140,090
Total	1,248,831

[1] Due to complications beyond our control we have only received $3,000 of the third party, S.S.I. income maintenance funds.

With these monies received we were able to provide direct services to a total of 2.578 victims from April 1, 1979 to March 31, 1980; 1.627 or 63% were provided with detoxification and/or supportive counselling services on a short term basis; 37% or 951 of these were recruited directly into the residential program.

Of the 951 drug victims recruited into the residential program, 803 were males and 148 were females; 88% of these residents were black, 8% of them were Puerto Rican and 3% of them were white, with 1% comprising all others; 94% of them were unemployed, leaving only 6% employed at time of entrance into the program. During the program year 38% of the total resident body was employed and earned collectively two million, two hundred thousand on which they paid taxes and saved one-fourth of, so that when they left they didn't have to go on welfare or depend on society for a living. They had a nest egg.

We like to think of the success of our program in terms of dollars and cents saved for society. 38% or 364 of our total resident population was employed and earned collectively two million, two thousand dollars, which means that we produced three hundred and sixty-four tax paying citizens who would have otherwise been parasites upon society. In addition to this we have discovered that the average cost of drugs used by addicts who came to us was about $64.00 a day per addict. This would make the street cost of heroin for our 951 residents around $21,891,240. It cost us one million dollars to run the program. When one looks at the nineteen million dollars saved and projects it against the alternates of custodial care and adds to it the human sufferings and all of the other complexities included in the terminal illness of drug abuse that these people would have suffered, we offer this evidence of the need to increase support to the Harlem community to fight against dope.

Finally, while our contractual capacity limits us to the provision of services to only 207 residents, the needs of our community forces us to operate consistently at over capacity through the years. An evaluative report prepared by the New York State D.S.A.S. task force submitted April of 1980, documents this by noting that our average daily capacity during the 1979-80 fiscal year was 227.9 or 20 people over the number we were contracted to handle and our end of March 1980 census has swollen to a record total of 275 men, women and children who, were they not at ARC, would be sleeping in the streets. We cite these figures as further evidence of the need for an increase, not decrease, of funding support to the Harlem community to fight drug addiction.

ARC'S PREVENTION PROGRAM—ITS OBJECTIVES

The objectives of the ARC preventative educational programs are as follows:

(1) To discourage kids from allowing their peers to sucker them into using drugs.

(2) To discourage innocent, naive, ill suspecting people from financing the addict's habit and encouraging him to steal by buying his ill gotten merchandise.

(3) To arouse public concern and gain support for drug victims involved in successful treatment and to discourage handicapping the drug victims back into society with negative labels and myths and beliefs, i.e. "once a junkie always. . . ."

(4) To portray the cured drug victims and his talents, skills and achievements in a positive contrast to the degrading portrayals of him at his miserable worst . . . we do this by utilizing, publicizing and demonstrating the skills and talents of those recovered victims so that society can see how it has short changed itself by not reclaiming more of those whom we have lost to drugs.

The methods we employ to achieve these objectives are as follows:

(1) We participate in all levels of community speaking, ranging from the quiet counselling of a mother who may suspect a child of using drugs to participation in meetings and hearings such as this one, conducted by the Select Committee on Narcotic Abuse and Control.

(2) A few years ago I developed a visual aid filmstrip portrayal of addicts stealing and selling their wares to non-suspecting housewives . . . buying drugs from pushers . . . and some deaths from overdoses. I made this 25 minute filmstrip with sound of addicts, pushers and non-addicts in order to graphically prove that we are all working together to perpetuate not prevent the spread of drugs.

For the past five years I have personally directed a twenty-five voice Acapella choir that sings gospel and spiritual songs for churches and sororities throughout the metropolitan area. They are in concert approximately two or three times weekly and they have travelled to perform concerts as far away as Boston.

Outstanding among these performances were an April 1979 appearance with the Dixie Hummingbirds at Avery Fisher Hall. Again in late 1979 we appeared with the Harmonizing Four and the Brooklyn All-Stars, and on April 18, 1980 solo concert for 2 hours at Town Hall. The choir has also produced one album and is in the process of producing a second album. In three short years our choir has raised $62,000, of funds needed to pay off the mortgage on our facility.

But in addition to being a fund raising entity to pay off the mortgage, the choir has a much more important purpose for singing. It sings as a public testament of the fact that those people who have been written off as hopelessly dead in the street are very much alive and if they had adequate help and support to find their way back through the maze of confusion they have allowed themselves to fall into, they would contribute significantly to the development and survival of society.

I believe the ARC gospel chorus is the most innovative, preventative instrument that has yet come along and its impact upon its audiences is most profound. These drug victims, dope fiends as you please, whom everybody including the church, has written off as being hopelessly dead standing in such sacred places singing such sacred songs so beautifully. Our choir is public testament of the fact that drug victims who have been written off as being hopelessly dead and left abandoned in the streets, if given adequate help and support, can be resurrected. Brought back into society to contribute significantly to our total survival. This is preventative education at its best and it needs to be funded for expansion.

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