HEROIN AND COCAINE TRAFFICKING AND T
RELATIONSHIP BETWEEN INTRAVENOUS DRUG USE AND AIDS (NEW YORK)

HEARING

BEFORE THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

FIRST SESSION

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(99th Congress)

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HEARING ON HEROIN AND COCAINE TRAFFICKING AND THE RELATIONSHIP BETWEEN INTRAVENOUS DRUG USE AND AIDS

NOVEMBER 26, 1985

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL,
New York, NY.

The committee met, pursuant to call, at 9:40 a.m., at Ceremonial Courtroom, Court of International Trade, 1 Federal Plaza, New York, NY.

Present: Chairman Charles B. Rangel, presiding; Representatives Benjamin A. Gilman, Edolphus "Ed" Towns, Michael L. Strang, James H. Scheuer, Bill Green, Thomas J. Manton, Ted Weiss, and Senator Alfonse D'Amato.

Staff present: John T. Cusack, chief of staff; Elliott A. Brown, minority staff director; and Edward Jurith, counsel.

Chairman RANGEL. The Select Committee on Narcotics Abuse and Control will come to order. I say good morning to all the distinguished witnesses and ladies and gentlemen who are here this morning that are concerned about drug trafficking and the awesome problem that faces our Nation.

Today we will be studying the problem as it affects those here in New York City in the metropolitan area, and the relationship between the intravenous drug use and AIDS [acquired immune deficiency syndrome], a complex medical condition which is spreading throughout the country and is having devastating effects on our population. We are also alarmed about the increase in heroin and cocaine that is available in our cities and the sharp increase in the purity of the amounts of drugs that have been confiscated in this area. We have found a sharp increase and the need for admission, while we have a decrease in the availability of treatment here in the city and the State of New York.

We have also seen the use of cocaine now emerging not only in our sports arenas and theatrical, but in all of the professions where we have not seen this type of abuse.

New York City has long been a major drug-marketing area with intravenous drug users and now we see there is a very close and shocking relationship with this and AIDS. There are estimated 200,000 intravenous drug users in New York City. Medical research and records indicate that they are the second at-risk group for AIDS, acceded only by the homosexual and bisexual men.

We have some sobering statistics that will be revealed today, showing that an estimated number of heterosexual IV drug users

in New York, 50 to 60 percent have been exposed to the AIDS virus and approximately 10 percent will eventually contract this deadly disease. In New York City heterosexual drug users represent 26 percent of the over 1,200 cases and 6 percent were drug users who were also homosexual or bisexual. Thus, close to 34 percent of all AIDS cases in our city involves IV drug users. I would like to state that again, that 34 percent of all of the AIDS cases in the city of New York involved intravenous drug users, by comparison to the national level of the IV drug users that represent approximately 25 percent of the AIDS cases.

New York and New Jersey account for approximately 80 percent of the drug abusing AIDS cases. More than 95 percent of the IV drug users regularly share their needles and needle sharing is the suspected cause of AIDS among IV users.

We also expect to show today the disproportionate share of minorities that have been touched by this plague in the city of New York; 50 percent of the AIDS victims in New York are black or Hispanic; 66 percent of all IV drug users with AIDS are black and Hispanic; and 66 percent of the children with AIDS in New York are children with addict parents who are 78 percent black and Hispanic. Clearly, the greater segment of our society can no longer afford to maintain this detached superior attitude toward drug users, and we have to really study this more carefully to see how deep the problem is, what are some of the solutions and what we can do in the Congress to bring about some resolution to this very serious problem.

[Mr. Rangel's opening statement appears on p. 86.]

Chairman RANGEL. I call now on the ranking minority Representative, Congressman Ben Gilman.

STATEMENT OF CONGRESSMAN BENJAMIN A. GILMAN, A REPRESENTATIVE IN CONGRESS FROM NEW YORK

Mr. GILMAN. Thank you, Mr. Chairman, and I certainly want to commend you for bringing this hearing to New York City, an area where we need to give a great deal of attention. I am pleased we are joined by our junior Senator from New York, Senator D'Amato, along with our colleague, Mr. Towns, at the hearing.

This hearing comes at a most important time. The select committee has reviewed the nature of narcotics trafficking in the metropolitan area in the past and today we are here to determine whether any progress has truly been made in our war on narcotics.

There are over a half a million people addicted to heroin in this Nation and almost half of them, 200,000, are in the New York City area. The numbers of those using cocaine continues to skyrocket and the toll has been taken in mounting deaths all across the city and across the Nation. Our concern for the very serious impacts of this scourge on our population is broad indeed, and we are hopeful that the law enforcement panel that we are bringing before our committee today will provide us with a broad overview and will provide us with some answers, answers to the questions that many of us have regarding this ever-growing menace, a menace that is doling out even a double dose of death. It was bad enough to have the serious number of deaths arising from narcotics abuse, but now

to add AIDS to the problem gives it a double dose that makes it even more critical.

The select committee is convinced that additional exposure needs to be given to the link between intravenous drug users and the acquired immune deficiency syndrome referred to as AIDS. What was first thought to be an illness confined only to a select portion of the population, originally thought mainly to come from Haitians and members of the gay community, has emerged as our No. 1 public health concern in this and many other nations throughout the world. Although I regret that the majority of concern only shifted when it became known that the populace at large could be affected, it is certainly time for us to explore in depth the manner in which the heterosexual population could be affected with this fatal disease.

It has become apparent that the most imminent threat appears to be in the drug abusing population, which is primarily composed of heterosexuals who, again, through intimate contact pass on the AIDS virus to their partners and, unfortunately, to their children.

How intravenous drug users become susceptible to AIDS and what can be done about the particular subgroup is a broad mandate that we have asked our panel of health experts to discuss with us today. The select committee is seeking to elicit viable strategies for containing the spread of AIDS any further and in identifying ways that those already affected could be properly counseled to cope as effectively as possible with their illness.

We have been told that this epidemic will get worse before it gets better. Time certainly is of the essence.

Mr. Chairman, I suspect that today's hearing will be an extremely informative and educational one for all of us. The sooner we address these two vital topics, the sooner, hopefully, we will be able to pass on some of the best methods of coordinating local, regional, and national strategies for combating narcotics abuse and the overwhelming misery that acquired immune deficiency syndrome adds to this problem.

I hope too that we can focus even more attention on the need for better education; education in our city schools; education methods to our State Department of Education, and thereby encouraging other States to undertake similar efforts.

Thank you, Mr. Chairman.

[Mr. Gilman's opening statement appears on p. 92.]

Chairman RANGEL. Thank you, Mr. Gilman.

This House select committee has been charged by the Speaker to come up with some answers to this very serious problem, but in the Senate there has been no more forceful voice and leadership than that that has been given to us by Senator Alfonse D'Amato who is joining our committee here in New York today.

Senator.

STATEMENT OF SENATOR ALFONSE D'AMATO, JUNIOR SENATOR, STATE OF NEW YORK

Senator D'AMATO. Mr. Chairman, first let me commend you for holding these hearings and for your constancy. It is not just spur of the moment; it is not just a news-gathering effort on your part, but

it has been a constant challenge and effort that you have risen to meet in this battle against drug addition and all the ills that come along with it.

There is no greater epidemic that we face in this country than the drug epidemic. It is a scourge on our society, on our young people. It is responsible for the millions of crimes that plague our people here in the New York metropolitan area. It is responsible for a loss of productivity, break-up of families, and now we have yet another cause that I believe this hearing will amply demonstrate, a vicious deterioration of the body system. The fact of the matter is that AIDS and the direct relationship between intravenous drug users has been clearly established. It is virulent. Sixty percent of the addict population have been exposed to it and 10 percent of those who now have been exposed to the virus are likely to come down with AIDS. It is virulent when we have youngsters who are born into not only addiction but who have AIDS in addition to that. Mr. Chairman, our educational efforts, because in spite of all the law enforcement efforts and the beefing up and, yes, some of the successes, if we don't take this and make a total commitment in terms of our educational community, and that's not just the school districts, that is at every level, why we are not going to begin to stem the tide.

We look at Jackson Heights, it is absolutely scandalous. It is the cocaine capital—it is battling Miami now—to become No. 1 as the cocaine capital of the world, of the world. We have to win that battle, but we can only win it if our people understand the severity of the problem and its implication and the disasterous consequences that will flow if we fail to educate and bring about prevention.

Mr. Chairman, I am looking forward to hearing the testimony of our expert witnesses. I would say initially, again, we have done a terrible job, terribly inadequate, at every single level. This is not just a Federal problem. This is a Federal, State, and local problem. This is not just one of government institutions, it is up to our private institutions as well to really educate the public as to the menace of drugs and drug abuse, what the consequences can have and will continue to be, and what we have to do to bring about real education and prevention. We are shockingly inept.

I will say this before our educators get up: If you find a decent educational program that deals with the problem of drug education as prevention, I would like to know about it, because there are shockingly few. We haven't even been able as a nation or as a great State or city to really come up with it. We haven't devoted our resources. I think it is a conspiracy of silence. Let's just make believe it is not really taking place or leave it to someone else. No one else is going to step in and all our institutions, including the private sector, are grievously guilty of this conspiracy and afraid to focus in on it and its drugs and its alcohol and the immune systems are broken down and all the sicknesses that we see in our society today come about as a result of it, so many of those sicknesses. So I challenge those people in that area to come up with something. Stop talking about rhetoric. Don't wait for a program for kids 14 years old, it is too late. It is too late, because the only thing that has gone down—this is frequently said in terms of drug addiction

and abuse—is the age of the users. All this nonsense when they say, "Oh, well, there is less use of marijuana," sure. They are using cocaine, they are using speed, they are using all other kinds of combinations of alcohol and other drugs. We are kidding ourselves in the American public if we say that youngsters and drugs, that they are beginning to have a correlation and they are moving away from them, because they are not. It is increasing, and I think we have done a shockingly inadequate job.

Thank you, Mr. Chairman.

[Senator D'Amato's opening statement appears on p. 94.]

Chairman RANGEL. Thank you, Senator.

The Chair recognizes Congressman Towns, one of the hardest working Members in the Congress, and certainly on this committee.

STATEMENT OF CONGRESSMAN EDOLPHUS "ED" TOWNS, A REPRESENTATIVE IN CONGRESS FROM NEW YORK

Mr. TOWNS. Thank you, Mr. Chairman.

Let me thank you for coming to New York, and I would like to thank my colleague, Ben Gilman, and also the junior Senator from the State of New York, Senator Alfonse D'Amato, people who have been working very hard to solve the problems.

I would like to say, Mr. Chairman, that I am really impressed with the witnesses that you have. You have a list of people that have been involved in drug addiction for many, many years; the kind of cross section I really feel that we need to be able to attack this problem.

As you know, it is a very serious problem, especially here in the metropolitan area and that young people and their lives are being destroyed and families are being destroyed, and it is the fear around the whole problem of AIDS is something that we need to begin to address. It is my hope that today we will be able to get the kind of information to be able to solve some of the problems that you have in the area. I think that in order to do that, I think that the Senator mentioned that we all have to come together in a single responsibility. I guess to sum it up and finish it up so that you can get to the witnesses, I really feel that the best way to describe it is the little boy who fell in the deep hole and was crying out for help. As he was crying out for help the first man came by with a rope, but the rope was not long enough to reach the little boy. The boy continued to cry out and a second man came by with a rope that was a little longer than the first rope, but not long enough to reach the little boy. The boy continued to cry and a third person came by with a rope that was a little longer than the first two ropes, but not long enough to reach the little boy. And finally the little boy looked up in total desperation and said to them, "Tie your ropes together." I think what the people are saying to us in New York City today is let us tie ropes together. If we can do that, I think we would be able to come up with some kind of solution to the problem we are now confronted with.

Thank you, Mr. Chairman.

Chairman RANGEL. Thank you.

Michael Strang is a very unusual Member of Congress who has dedicated himself in trying to find some answers to this serious problem. He is from Colorado and I cannot think of any meeting that we have had in Washington or anyplace else that he hasn't been in attendance. This is so even though once he even came in with a broken leg.

Thank you for joining us, Congressman. The Chair recognizes you.

STATEMENT OF CONGRESSMAN MICHAEL L. STRANG, A REPRESENTATIVE IN CONGRESS FROM COLORADO

Mr. STRANG. Thank you, Mr. Chairman. I want to congratulate you on calling this panel together and I hope that we can get at the pervasive link between AIDS and drugs because the true victims in this one are the innocent children, the hemophilacs, the unsuspecting partners, and obviously in the long run, society. And there is every evidence, as you remarked in comments, Mr. Chairman, to know that this problem is going to explode. So I hope we can get on with it and get some answers.

Chairman RANGEL. Very good.

The Chair now calls on Dr. David Axelrod, New York State Health Commissioner.

Dr. Axelrod, you certainly have developed a nationwide reputation of running one of the largest health systems that we have in the country.

The committee has your prepared statement and you could feel free to highlight that statement or testify as you feel most comfortable, but at this point, if there is no objection, your full statement will appear in the record.

TESTIMONY OF DR. DAVID AXELROD, NEW YORK STATE HEALTH COMMISSIONER

Dr. AXELROD. Thank you, Mr. Chairman.

Chairman Rangel, Senator D'Amato, distinguished members of the Select Committee on Narcotics Abuse and Control, I very much appreciate the opportunity to testify before you. I offer Governor Cuomo's regrets that he could not personally be with you today to discuss his concern for the spread of acquired immune deficiency syndrome among New York's IV drug-user population.

The statements that you have made here this morning, I think, clearly indicate the importance of the problem of drug abuse. The issue is not simply one of AIDS. AIDS is but the latest in a series of afflictions that have affected our drug abuse population.

We are talking statistics but we often forget the individual tragedies associated with IV drug use. We also have been talking about educational programs, to counsel and inform those in our population who are afflicted with IV drug use. The difficulty is far more reaching than simply dealing with the problem of education. There is an underlying root cause. There are socioeconomic forces that must be addressed if we are to be effective in dealing with the problems of IV drug abuse. Simply providing for education in the absence of major changes in the socioeconomic structure in which these kinds of festering illnesses occur, is not enough.

We have provided the committee staff with detailed, statistical portraits of the AIDS epidemic in New York State and I would like to emphasize a few key facts: nationally, persons identifying themselves as homosexual or bisexual constitute some 73 percent of the total cases cataloged by the Centers for Disease Control. This includes individuals who identify both IV drug use and at-risk sexual behavior. They are counted among the homosexual or bisexual group. Nationally, CDC identifies 17 percent of the persons with AIDS as IV drug users. In New York, the picture, as you have already indicated, is somewhat different. Some 30 percent of the total of our cases involve persons in the IV drug-user risk category. And if we change priorities and count homosexuals and bisexuals who admit to IV drug use among the IV drug-user risk group, the percentage goes to 36 percent. Which is to say, 1,956 out of 5,415 AIDS cases statewide. Isolating this year's data, that group is close to 40 percent.

Eighty-nine percent of the heterosexually transmitted AIDS cases in New York City have involved an IV drug user as the probable source of exposure to the AIDS virus. Almost 80 percent of the pediatric AIDS cases, in which complete case histories are available, have had an IV drug user as a parent. It is imperative that risk-reduction education be targeted toward this group and such an effort is going to require a new kind of educational program. Reaching this audience is a far more complex task than that needed for the homosexual community, where you had a much more homogeneous group.

We do not fully understand why New York State has a significantly higher rate of AIDS in the IV drug-user category than does California or Florida. But, as you are well aware, New York had a drug-abuse epidemic long before AIDS, and that gives us a large at-risk pool. But scientifically we do not fully understand the mechanisms of our special AIDS problems. What we do know is what I alluded to earlier: Our efforts, regardless of the extent to which we have extended ourselves, have not had a major impact on the risk behavior of drug users. Until we have a scientific means of preventing AIDS, a vaccine, we must design an aggressive, effective, educational effort, but I would again stress that an educational program will only bear fruit if it takes place within a changed socioeconomic environment that we think is essential for the educational process.

As witnesses from the New York State Division of Substance Abuse Services will tell you in greater detail later, the administration in the State of New York, under Governor Cuomo, is designing new strategies to attack the education problem. Several State-supported AIDS programs for drug abusers now exist here in New York City, at the Montefiore Medical Center, at the Beth Israel Medical Center, at Bellevue Hospital, and at the Urban Resource Institute in Brooklyn. These programs are reaching out to abusers in Methadone Programs at Rikers Island and in the street. They are a start.

A factor of particular importance when discussing AIDS among IV drug users is the increased possibility of transmission to the heterosexual community. Risks in the homosexual community are generally limited to that risk group. Self-restraint and a national

blood screening program have largely eliminated the risk of infection from transfusion of contaminated blood donated by this group. But transmission of the AIDS HTLV-III virus from an IV drug-user mother to an unborn child does occur and represents one of the very major public health problems we are going to have to face. The pregnant woman with an active AIDS case is virtually certain to pass the virus to her child. Our statistics indicate that virtually all of the pediatric AIDS cases, as I have indicated, are linked to parents who are members of the IV drug-user community. The tragedy of AIDS is profound enough when it attacks adults. The specter of hundreds of children being condemned before birth to experience the various manifestations of AIDS is a social agony. In our experience, most pediatric AIDS victims die before their second birthday. Only a very few survive their third year. The sad truth is that we have very few children who survive long enough to become the focus of the extraordinary controversy we have witnessed about AIDS children in schools.

In addition to children, spouses, or sexual partners, mainly female, of IV drug users, are at higher risk for AIDS than the HTLV-III virus. National and State statistics do not identify a significant spread from the known risk groups to the general population. As press reports and some worried public officials have alleged, if that is to happen, the IV drug users are likely to provide a major avenue of infection.

I trust that I have at least suggested the imperative of controlling AIDS among the drug community. But I would also reiterate what I said earlier, that the control of AIDS among the drug community requires the control of the drug community and new efforts, renewed efforts, to deal with the problems of drugs themselves.

I would also like to comment on a few of the well-known control proposals from the perspective of public health.

New York State has not undertaken routine screening of blood samples of inmates in the prison system simply because we do not see what assistance that would provide for the infected inmates, other inmates, guards, or the system as a whole. The HTLV-III test is not a test for AIDS; it is not a test for the virus, but a screen for antibodies to the virus. Identifying prisoners or others with antibodies to the virus does not necessarily identify persons with certainty of developing AIDS. The ELISA test, followed by confirmatory tests, such as the Western Blot, serve as an indicator of a population at risk for developing the disease. In the prison setting our experience is that those who eventually develop AIDS have all been IV drug users on the outside whose exposure predates their arrival in prison. Research on the IV drug-user population indicates that the percentage of HTLV-III positives among that population far outstrips the AIDS incidence. Indeed it is likely that the majority of the IV drug-user population, as has already been indicated by several of you here this morning, which is HTLV-III positive, is probably in excess of 50 percent. We would expect to find a high percentage of HTLV-III positives among prison inmates, particularly those with drug abuse histories. Confirming this supposition in each and every case would provide no useful information for protection or treatment. Until we have an effective treatment

we are unable to take any measures to prevent the onset of disease among HTLV-III positives. The blood test is used as a supplement to the diagnostic process in prisoners, just as it is among the population at large. We see no reason for distinguishing between the incarcerated population, with respect to the use of this test, and others who are at risk.

A number of thoughtful individuals have proposed that the State shift its policy and permit the sale of hypodermic needles without a physician's prescription or that the State permit the exchange of used needles for new ones. To date I have been reluctant to recommend either of those courses to the Governor, due to a lack of convincing evidence that they would have a significant impact on AIDS transmission, and not facilitate the expanded abuse of drugs. If the committee has any data to the contrary, we would certainly appreciate having that available to us to assist us in making our own determinations. I have been advised by the State's experts on drug abuse that the drug culture's habits include a sharing of needles as a pattern of ritual behavior. So there is an expectation that providing easier access to new or clean needles would not necessarily break that pattern. We also have been told, in those States, in those geographic constituencies that have adopted a pattern for allowing the purchase of new needles, there has also been the bartering of needles for drugs themselves. Our mandate is to find a way to persuade IV drug abusers to halt that self-abuse or at least to stop sharing needles or to clean their own needles.

AIDS is, of course, only the latest manifestation of the often ignored social crisis of drug abuse. You have all commented on it. The immune system devastated by the acquired immune deficiency syndrome is but one of the body systems assaulted by the lifestyle of the IV drug abuser in our society. We may well find a vaccine or some other treatment method for AIDS, and no doubt science will develop some ability to blunt the deadly force of this syndrome eventually, but the task in place, which the Federal Government must face aggressively, and over the long term and with a massive commitment of funds, is the greater problem of drug abuse itself. The solutions are even more remote than an answer to AIDS for they must conquer international borders, the economic and social wasteland of our inner cities, the stale failures of our primary school classrooms, and the apathy of the rich and the comfortable. If interest in the war on drugs is lacking, then let the tragedy of AIDS generate a new way to attack the basic problem. Each new recruit enlisted from our streets into the drug subculture becomes a potential new vehicle for the AIDS epidemic.

Thank you very much.

Chairman RANGEL. Let me thank you, Doctor.

Before I question, the Chair would want to welcome Jim Scheuer, an outstanding fighter against international drug trafficking, author, and legislator.

I welcome you to the committee.

Do you care to make a statement?

Mr. SCHEUER. No, thank you, Mr. Chairman. I think we all want to hear the witnesses.

[Mr. Scheuer's prepared opening statement appears on p. 99.]

Chairman RANGEL. And Bill Green, from the "silk stocking district" that has demonstrated over the years his concern about this serious national-international problem.

The Chair welcomes you to the committee.

Mr. GREEN. Thank you very much.

[Mr. Green's prepared opening statement appears on p. 105.]

Chairman RANGEL. Dr. Axelrod, you have been a person that we elected officials have found very, very easy to work with because of your candor and your understanding of our political problems and trying to get some answers to it.

Your statement today leaves us, or leaves me, wondering what we're doing about this problem. I think you made it clear in your statement, I didn't find it in there, that as far as education is concerned, you don't believe that that would have any redeeming impact unless there were some changes in the socioeconomic conditions of the environment in which this education was given. When it comes to what's happening in the prisons, you indicate that you are not screening because once you find it, there is not very much you can do about it.

You speak of needles, and indicate that you are not going to advocate giving away new needles or clean needles to the addicts. And then, of course, I think here is something about communicating with the gay leaders so that they will have a safe sex message. But quite frankly I still don't know, since it is clear from your statement that you recognize how serious the problem is, what I hope you can tell me is once you've stated that the State recognizes the problem, what the heck are we doing about it? What are you recommending that the Congress do about it?

Dr. AXELROD. We are embarking on a number of educational programs, Mr. Chairman. Mr. Whalen of the Division of Substance Abuse is going to describe in detail some of the programs that are being initiated within the drug-user population.

Chairman RANGEL. I thought you were discouraging that type of thing.

Dr. AXELROD. Oh, I didn't discourage it. What I said was that the effectiveness of educational programs, without a focus on the basic ills associated with the socioeconomic conditions of the populations that we're dealing with, is not going to be totally successful.

Chairman RANGEL. Now, there is an implication in that statement that we have tried educational programs?

Dr. AXELROD. There have been programs that have been tried.

Chairman RANGEL. Well, this is what I am very anxious to find out. Do you know of any State educational program that deals with the question of prevention?

Dr. AXELROD. The Division of Substance Abuse has had an ongoing program dealing with potential approaches to the prevention of drug abuse.

Chairman RANGEL. This is in our schools?

Dr. AXELROD. Not in our schools. This is a——

Chairman RANGEL. When I say "education," Dr. Axelrod, I want you to assume that I am talking about kids in school. Now where would this education be going on?

Dr. AXELROD. I am not aware of a major educational program firmly within the school systems.

Chairman RANGEL. So we can't really deal with socioeconomic conditions and environmental conditions because we have no fail program in education because we have never had any program in education.

Dr. AXELROD. I don't think it is entirely true that there has been no education in school systems. I don't think there has been the kind of coordinated approach that addresses the entire school system from kindergarten right on up to the high school level and prepares individuals within the school system to deal with the kinds of increasing threats that occur during the course of maturity.

I think that it is certainly true that there have been educational programs. Whether or not they have been coordinated, whether or not they have provided the continuity or the kind of program that would have its maximum effect, I don't know.

Chairman RANGEL. Well, I'm saying, Doctor, if you don't know, then I don't see what witness we can get to find out. In other words, if a parent comes to you and believes that our school system is a health hazard, that their kid is going to be exposed to AIDS; the kids are going to be exposed to intravenous drug; the kids are going to be exposed to dirty needles; and they come to me, I would like to be able to say, "Well, I have a very good friend that is in charge of the State health programs for the entire State," and I would send that mother to you. What would you respond?

Dr. AXELROD. I would respond that if I am the authority then certainly I would foster the introduction of that kind of educational program, but as I am sure you recognize, the Department of Education is independent of the Department of Health, and I do not design programs for introduction by the Department of Education.

Chairman RANGEL. Doctor, that is——

Dr. AXELROD. They are an independent authority that exists under the regents, rather than the Government.

Chairman RANGEL. Doctor, like I said, I am going to take advantage of your candor and our relationship over the years, but you have got to get more help than you asked for at this hearing.

Are you saying that you have a program and that the Education Department has refused to listen to you?

Dr. AXELROD. No, I am not saying that; no.

Chairman RANGEL. Have you recommended anything to the Governor as to what you would like to see occurring in terms of educating our kids against the danger of AIDS, the dangers of drugs, the danger of just these things that we used to have the luxury of talking about could impair your health. Now we are talking about sure death.

Dr. AXELROD. In direct response to your question, yes, it has been a matter of discussion between myself and the Governor as well as between myself and the chancellor of the regents of the State of New York. The chancellor has indicated that the regents are looking into the introduction of a program that would deal with all of the elements of the transmission of AIDS, both with respect to drugs, as well as with respect to the sexual habits that are likely to provide for transmission.

Such a program, according to my best knowledge, is in the process of development within the Department of Education. But it is

not something that we would develop unless we had been requested to do so by the Department of Education.

Chairman RANGEL. Well, it seems to be that you have got to be waiting a long time to get any requests from the Department of Education. I hope that your voice could be heard among those that are insisting that at least in the progressive State of New York that perhaps we could lead the Nation in having some effective educational program that came into being not because we were waiting for the teachers or the teachers unions to put into place, but because outstanding health specialists, such as yourself, insisted that this be a part of the curriculum and be a part of what New York State should be part of.

The Chair welcomes Congress Tom Manton to our hearing, and for the purpose of questioning, Mr. Gilman.

Mr. GILMAN. Thank you, Mr. Chairman.

Dr. Axelrod, when we travel outside of our Nation with regard to trying to find ways of reducing supply, we are continually confronted with the issue of "What are you doing about reducing demand?" And our response is that we have to do a great deal more with education.

When we visit other States and we talk about trying to enhance enforcement efforts, we are always confronted with the fact that it is a double-edged sword, that we have to attack it on two fronts, supply and demand. Then we get around once again to the educational efforts. When we visit other States we find that there is very little being done with regard to education and the dangers of avoiding drug abuse. And I am appalled to find right here in our home State, the great empire State, that very little has been undertaken with regard to educating our young people with regard to drug abuse.

I appeared before a master plan hearing on the State's division of substance abuse recently and was told, "Yes, we have developed a curriculum on drug abuse."

"Well, we regret to say that it is lingering on the shelf because we don't have the money to distribute it."

Now, I ask you, Dr. Axelrod, you mentioned in the closing portion of your Statement that the solutions are even more remote, but you talk about the "stale failures of our primary school classrooms," can you tell us what you have done to try and enhance the State's education efforts to reduce demand? What are we doing here in the State of New York to educate our young people about the dangers of drug abuse.

Dr. AXELROD. The role that I play is with respect to providing advice and recommendations to both the regents and the commissioner of education who is primarily responsible for curriculum development in the State of New York.

Mr. GILMAN. Do we have a curriculum, Doctor?

Dr. AXELROD. There is a curriculum. The extent to which it deals effectively with the problems and the degree to which it is implemented within the school system is a matter of local jurisdiction. Unless there is——

Mr. GILMAN. Well, Doctor, has that curriculum been distributed by the State education department?

Dr. AXELROD. I can't answer that, sir, I don't know.

Mr. GILMAN. Well, don't you think that it comes within your province as the State's health director to find out what we are doing about educating our young people?

Dr. AXELROD. I certainly think that it is important that every effort be made to provide as much education as we can at the primary level.

Mr. GILMAN. Well, doesn't it take more than a mere recommendation to the Governor's office or to the education commissioner? Do you just wash your hands of it once you have made the recommendation?

Dr. AXELROD. I don't wash my hands of the recommendation, I assume the responsibility for attempting to make certain that the regents are aware of the nature of the problem, the seriousness of the problem, but the implementation of a change in curriculum is solely within the province, and not within their province of the Department of Health. There are other arenas in which we have similarly sought to have——

Mr. GILMAN. Well, Dr. Axelrod, let me interrupt you for a moment——

Dr. AXELROD. Yes.

Mr. GILMAN. I regret the interruption, but our time is limited.

Isn't there a shared responsibility between the health commissioner and our education commissioner to make certain that our young people are aware of the dangers of drug abuse and that that message is given to them in a proper and effective manner by the State education system?

Dr. AXELROD. Yes, I think that that is a shared responsibility, and I think it is being extended to the point, as far as the commissioner of education himself is able to go, with respect to local jurisdictions.

Mr. GILMAN. Well, then, tell me why is there such a failure in the distribution of a proper curriculum and why don't we have a better education system for our young people?

Mr. AXELROD. I can't comment as to the failure of the distribution of the curriculum that you have identified. I am not aware of the failure; I am not aware of the rationale for not distributing the curriculum.

Mr. GILMAN. Well, Doctor, I hope you would take a look at this problem and I hope that you could make some recommendations to our committee if there is something more that the Federal Government should be doing. But it seems to me that this is a State government responsibility, and it seems to me it is a shared responsibility by both health and education to make certain that this message is being given and the program is being distributed properly to our young people.

Do you agree with that premise?

Dr. AXELROD. Yes, I do, sir.

Mr. GILMAN. I hope that you would respond to our committee at a later date to tell us what can be done or what should be done to make this a more effective program.

With regard to your suggestion, Doctor, about the prison population, and your feeling that there is no need to further explore the AIDS problem amongst prisoners, I am a bit concerned about that laxity of not trying to segregate a prison population that has been

infected with AIDS. Don't you think there is a need to segregate that kind of a population to make certain there is no further spread amongst the inmates?

Dr. AXELROD. You have, I think, identified the AIDS population; what I was addressing was the HTLV-III positive population. AIDS patients are currently segregated within our prison system. The point that I addressed was the utility or the lack thereof of random screening of all prisoners to determine whether or not they were HTLV-III positive.

Mr. GILMAN. Well, Doctor, your testimony says that New York State has not undertaken routine blood screening of inmates in the prison system simply because we don't see what assistance that would provide.

Dr. AXELROD. That's correct; HTLV-III and not AIDS. Those individuals who are symptomatic, who have AIDS, are segregated. We have a large number——

Mr. GILMAN. How do you determine whether there are any additional cases without any blood screening?

Dr. AXELROD. We have determined that if the prisoners—even those who are HTLV-III positive—are following the basic tenets that are followed by those outside the prison system, there should be no transmission of AIDS.

We are not about to segregate all of those in our society who are HTLV-III positive. If we were to do that we would have large camps with 500,000 to several million individuals isolated who are HTLV-III positive. There is no reason——

Mr. GILMAN. But, Doctor, isn't there a difference between the population that is in a controlled institution, compared to the full population of our State, to the civilian population? Here we have a controlled population that is within an institution and where it is known that there is homosexuality, and where we know that AIDS is transmitted through homosexual activity. It would seem to me that there would be some concern about segregating that population that has already been afflicted with AIDS.

Dr. AXELROD. Well, in the first instance, most of the individuals who are in prisons in the State of New York are victims of drug abuse and not members of the homosexual population. They are victims of drug abuse and we have no indication that there has been any spread of AIDS or HTLV-III transmission within our prison population.

Chairman RANGEL. Will the gentleman yield?

Mr. GILMAN. I will be pleased to yield, Mr. chairman.

Chairman RANGEL. Commissioner, I am missing something because it has been my understanding in studying the prison population that you don't have to be a homosexual to have homosexual activity conducted without consent in the prison system, but putting that aside, if you said there are no cases, how do you get your data unless you have screening? What Mr. Gilman is suggesting is that you can't think of a better control group than those who enter the New York State prison system. It's not that we put these people away and throw away the key. They are contained in prison to be released to society and we have no idea what the prison system is releasing now.

Dr. AXELROD. I think there are several different points which have to be made, if I might, Mr. Chairman.

First of all, there is a distinction between voluntary participation in a screening program within a prison system in which the prisoner provides his consent to be tested for HTLV-III as part of a study population.

Chairman RANGEL. We're not talking about consent.

Dr. AXELROD. Well, I'm saying this is a distinct entity. And certainly there is information that can be gleaned from that kind of a study.

Chairman RANGEL. Are you suggesting, Doctor, that there is a consent program, that the prisoner comes in and says, "Throw me into the consent group and I would like to be tested?"

Dr. AXELROD. What I am suggesting to you is that there is a proposed study that would provide for voluntary participation and that kind of evaluation.

Chairman RANGEL. Dr. Axelrod, I am not the least bit concerned about what is being proposed on a voluntary nature. I am talking about people who have been arrested and sentenced and you as the health commissioner telling me what the hell is it that we've got in this prison and what we are going to release from this prison as relates to AIDS. And I think you are telling me that you don't test because you don't believe that it is worth anything. Whatever is going to be voluntary, you know, we can do that outside of the prison. Mr. Gilman is suggesting that we have a control group in here that you know and I know is involved in homosexual activities and the witnesses are going to say there is a relationship between this and AIDS.

You know and I know that 60, 70, 80 percent of them are drug abusers and witnesses are going to say that there is a connection with AIDS. Now we come here, not with any expertise. We come asking health experts what is the connection, especially in jail, and what are you finding out and what does this statistic mean?

You're saying we don't have any statistics because we don't check these things out in the prison system.

Dr. AXELROD. We do not believe that the random testing of prisoners entering the prison system at the present time would provide us with any useful information that we could use.

Senator D'AMATO. Wow. Would the gentleman yield?

Chairman RANGEL. I am pleased to yield, Senator.

Senator D'AMATO. You know, Doctor, I have to tell you something, I am shocked by that. On one hand we say we don't have the statistical data that is necessary to make the correlationships and on the other hand there is not another test group, and we should do it not just for testing purposes, but we had better get ahead of this problem and find out before we see that the epidemic is far greater.

Now, I don't think there should be voluntary testing; it should be mandatory, and follow them. We will give you some research on this. You will find out that those people were carrying the antibodies 5 years ago. You will find that the percentages of them who have gone into an active case who have become AIDS victims or who have had serious cases of cancer and all the other kinds of systems which demonstrate a breakdown of the body system, and it

just seems to me, to say, "Well, we don't find any useful purpose at this point in time," given the linkage, the clear linkage, I can't accept that. I think we are just putting our heads in the sand and I don't understand why. Because it would seem to me you would give a test the following year to find out and the third year to find out and you would monitor the prison population.

Dr. AXELROD. I think that it is important that in making a determination that we are going to monitor a given population, that we recognize what it is that we are doing with respect to that population in terms of how we are going to treat them differently from the rest of the population and whether or not we have a right to treat them in ways that are different from the rest of the population.

What populations are we going to screen and for what purposes? Are we going to screen the street populations? Are we going to screen everybody who comes from central Africa because of the prevalence of the disease in central Africa?

Senator D'AMATO. Now, Doctor, no one suggested that, but we are talking to particularly people who come in who are, let's say, known drug abusers or homosexuals and you have got a potential epidemic on your hands, and I don't want to be an alarmist, but we have a heck of a problem on our hands and for you to suggest that this comes down to a matter of who we may or may not be discriminating against, in terms of stress, I would suggest to you that we have some public policy and purposes and you people haven't begun to define them. I think it is shocking. I think we darn well do have a right to make those tests there and to find out what the situation of these people are.

Mr. GILMAN. I think the good Senator has underscored the problem, Doctor, and I hope that when you go back to Albany, that you will take a good, hard look at the State's responsibility, No. 1, in education; and, No. 2, to make certain that our prison population when it is released does not further transmit AIDS out to the full population of our society.

Bear in mind that these are criminals that probably have been connected to criminal activity in drug abuse, and I think there is a responsibility of our State to make certain that once in a prison population, that that disease is not spread further amongst the prison population and amongst the total population. I hope that you would take a good, hard look at that and make some recommendations back to this committee with regard to what we could be doing nation wide to prevent this from happening throughout our State. I would like to see us be a model rather than us be lagging behind in this.

Thank you, Mr. Chairman.

Chairman RANGEL. Senator D'Amato.

Senator D'AMATO. Mr. Chairman, I just think there is an awful lot of work to be done. This is just one small aspect of it that would give us the statistical data necessary in the future. We have had some limited data, tests that were made, to those that had the antibodies, HTLV-III's. Five years later when they looked at this limited group they found that only 10 percent of them had come down with AIDS. They found that another 30 percent of them had come down with symptoms that weren't clearly connected to AIDS, but

like liver failures and cancer, et cetera. And we don't know enough about that so there are a lot of good reasons for a program to be undertaken here, Doctor, and I would commend both Congressman Gilman's attention to this and that of the chairman.

Doctor, you say that you know, in terms of dealing with education, that the basic ills of the socioeconomic conditions, et cetera, we really can't have a meaningful education program dealing with drugs until we deal with those problems——

Dr. AXELROD. I didn't say until. I think that part of the problem is that we have to deal with them at the same time.

Senator D'AMATO. We understand that. But we have some rather affluent communities that are plagued with drug epidemics, Doctor, so I would suggest to you that that almost canned approach about the socioeconomic ills that society has is not a justification for what I would suggest is almost a total failure of a comprehensive education and prevention program in our educational system. That is a fact. It is a total, colossal failure.

You say we do have a curriculum for the schools, but they don't have enough books. The curriculum spells it out, to give them out, the Education Department claims that it is revising the curriculum, and I would like to know if you could find out for us when this new curriculum would be ready. Could you do that?

Dr. AXELROD. Yes, sir, I can.

Senator D'AMATO. I would also suggest that there is no specialized training for those who are teaching the drug programs and I think there should certainly be a curriculum and a training program that should be part of the educational process; wouldn't you agree?

Dr. AXELROD. Yes, sir, I certainly think that if any program were to be introduced that there should be a training program required for those who are responsible for the curriculum.

Senator D'AMATO. Doctor, what I am saying is that given your particular position, and the great stress that those of us on this panel know that you possess within the administration, I would hope that you would loan your voice, your support, your efforts to bring about an education and prevention program that is so sadly lacking.

Dr. AXELROD. Senator, I can bring the message to the chancellor of the board of regents; I can bring the message to the Governor; but I cannot determine what the Department of Education does or does not do.

Senator D'AMATO. I understand that, but if you would loan your efforts to what has been sadly lacking to date—I call it the conspiracy of silence—and I think we have got to do something about that. I would be appreciate and I think everyone would on the panel.

Mr. GILMAN. I would just like to join with you, Senator D'Amato. I know that you so guard your reputation, Dr. Axelrod, that you would not want to be included in an administration that was indifferent to the education as relates to such a serious health matter as AIDS and drug abuse.

Chairman RANGEL. Senator.

Senator D'AMATO. Thank you, Mr. Chairman.

Chairman RANGEL. Congressman Towns.

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

Dr. Axelrod, I would like to ask, what has your department or agency recommended to the various treatment modalities since the AIDS epidemic has occurred, in terms of treatment of what they should do different than what they are doing now?

Dr. AXELROD. Are you talking specifically about the intravenous drug user population?

Mr. TOWNS. Yes, the methadone programs. Any treatment for this population?

Dr. AXELROD. I believe I suggested that we expand methadone treatment. I think we have indications that the most effective means of limiting exposure is to stop intravenous drug use. The second thing is to provide treatment or medical counseling for those individuals who feel that they may in fact have AIDS or believe that they are coming down with this or a similar disease.

The other thing that we have recommended is that IV drug users recognize the impact of needle sharing and that if one is going to continue to practice intravenous drug use, that cleaning the needles is absolutely essential if you are not going to afflict yourself and your sexual partners with a variety of different infectious diseases.

Mr. TOWNS. Thank you.

Another thing is I noticed in your testimony that you've compared California and Florida in reference to IV drug use. It is my understanding that Florida does not have the kind of heroin problem that we have here in this area. Would that be the difference?

Dr. AXELROD. I am not sure that we really know the explanation.

California has a much lower prevalence of AIDS associated with intravenous drug use, and I am not sure that we can correlate this difference with heroin usage. That is a question currently under study and for which we do not have any answer.

Mr. TOWNS. Mr. Chairman, no further questions.

Chairman RANGEL. Thank you.

Congressman Strang.

Mr. STRANG. No questions.

Chairman RANGEL. Congressman Scheuer.

Mr. SCHEUER. Dr. Axelrod, I admire your cool; I admire your sense of strength, your unflappability under the kind of questioning you have been subject to in this hearing. There is a common sense on both sides of the political line here. There has been a total absence of leadership. There has been a real absence of leadership and drive and commitment and energy at top levels from the point of view of prevention, from the point of view of education. I don't think it would come as any secret to you if I blew the cover on the fact that education is an integral part of health care. Preventive education is an integral part of any health delivery service system and if you are not up to date on what is happening in preventive health care and in health education, then you are not up to date on an essential element in the health care system. And I can't help feeling very disturbed about that.

We are talking about what are we approaching in drug addiction, interdiction? Truthfully, when you connect your drug addiction to AIDS there is no treatment. Interdiction has been a total failure for the last 20 years. There have been all kinds of Federal, State and local efforts to stop this stuff from coming into our country; to

identify it when it's raised in our country. We have never had a point where the Federal Bureau of Narcotics and Dangerous Drugs or its successor agency, the DEA, has told us that more than 5 or 10 percent of the stuff coming in is being picked up. That was the situation a decade ago when this committee first started, and I served on it then and it is the situation today. So 80 to 90 percent of the stuff that is put in the pipeline gets through and what is picked up is simply handled by the drug processors and the organized drug distribution systems. It is part of the cost of doing business, so they shove another 15 or 20 percent in to build the market. The market is being built. Drugs are available in all of our streets, our main streets and our side streets, at our schools, at the places where people work. So interdiction is not an apparent solution.

As far as treatment is concerned for AIDS, we know it is fatal. It is compassionate to spend $120,000 or $30,000 or $40,000 or $50,000 for an AIDS patient, but it doesn't seem to change the likelihood for mortality. It makes people more comfortable; it may extend their lives a few months. So we are left with education as the only answer and what we want to do is cut this cycle. So for you to say that you don't know what is happening in drug education in the schools is entirely unacceptable to us, Dr. Axelrod.

I don't want to add to your burdens, but I should hope that in the future that you will look upon drug education in our school system and AIDS education as an integral part of your responsibility. And I hereby authorize you on behalf of this committee, Democrats and Republicans alike, to storm into the Governor's office, to bang the table and to say you got hell from a bunch of unruly Congressmen and Senators, they really lost all restraint in blaming me—that's you, Dr. Axelrod—for the delivery of health education, and they said that is my mission. If I look at my mission as a totality, the health of the citizens in New York State, health education in the schools is an integral, central, vitally important part of your mission. And if you have not understood that up until today, I hope that there is no doubt in your mind as of 10:40 this morning, because we are going to come back to you.

Mr. Chairman, I hope that we will have hearings of this committee up here in another 6 months to find out where we are then and what remedies have been created, and I hope we will do it in conjunction with a health committee, on which I serve as the ranking majority member. It could easily be a joint session up here. I think it is absolutely pitiful that the chief health officer of this State could tell us that he knows nothing about the health education efforts, the preventive education efforts that are going on in the schools when it is an essentially important part of your job, Dr. Axelrod.

Dr. AXELROD. I think you are overstating what I have said with respect to the health education curriculum in the school system. No one asked me whether or not I have reviewed or seen the school health education curriculum.

Mr. SCHEUER. You told the Senator that you didn't know anything about what was going on at the schools.

Dr. AXELROD. That isn't quite what I said.

The Health Department has been requested by the Department of Education to review an entirely new health curriculum which is in development and has not yet been implemented.

Mr. SCHEUER. Well, Doctor, you can talk about the old one then, you know. If you could share with us the old one, that's good enough.

Dr. AXELROD. Mr. Chairman, what I said was——

Senator D'AMATO. Doctor, you know, I want to tell you, I hope you are not playing a game with me.

Dr. AXELROD. No, I am not playing a game, and I was responding to——

Senator D'AMATO. Well, let me just suggest, and Congressman Scheuer, let me tell you, I share with you 110 percent your feelings, your statement, your sentiments, you are absolutely right on.

Doctor, I asked you about the curriculum, you didn't say, you didn't volunteer that yes, you are part of that process. I have said to you that I have been told that they are studying this curriculum, can you find out what it is? You didn't come forth and say, "Well, yes, Senator, we are part of that study and it is going to be done such and such a time and this is what we are looking at, et cetera." You know, be a little forthcoming with us.

Dr. AXELROD. Well, I am sorry if I gave you the wrong impression.

We have been given the new health curriculum that has been devised. It is a health curriculum, not a drug curriculum, in which there is a portion relating to drugs.

Senator D'AMATO. What about a drug curriculum? We have got an epidemic in our schools, in the classrooms. I want to tell you, if you have a teenager you live with fear in your heart. The peer pressure, in terms of drug and alcohol abuse in this State, in affluent communities, affluent not just poor communities, is something that borders on epidemic. Now, I am telling you as a parent. I know it. I see it. And when you start to tell me that we are looking at it as part of an overall health curriculum, I want to tell you that we are doing literally nothing as it relates to drug and alcohol abuse in our schools, precious little. When you don't have curriculum books that are sent out because they say "We don't have enough money," and when you ask the State education department what are they doing and then they say, "Well, we are working on a new curriculum."

I would suggest to you that is taking too long, and there is not enough effort and there is not enough dedication to it, and there is a total conspiracy of silence. Let's pass the buck on to someone else.

Now we will fight to get Federal dollars. We will fight to increase the law enforcement efforts, but as Congressman Scheuer said, the best of interdiction, the best is not going to win the battle.

Mr. GILMAN. Will the gentleman yield?

Doctor, you are talking about a new curriculum, but where is the old curriculum? It is sitting on a shelf and that is the responsibility we are talking about, about implementation of these well-intentioned programs. If they are not getting out to the youngsters then they are meaningless, just gathering dust up on a shelf someplace.

Dr. AXELROD. I can't dispute that, Mr. Gilman, I think that you are absolutely correct, that if there is a health curriculum that is not being implemented, then obviously it is of no use to the students.

Chairman RANGEL. Mr. Scheuer.

Mr. SCHEUER. One last question, Mr. Chairman.

Dr. Axelrod, I would like to know whether you think we ought to institute a program of providing sanitary, new unused needles at no charge to IV drug users? Now, I know there have been some reservations expressed because the feeling is that these IV drug users won't use these needles, they will continue to share. I suggest that is a simple education job—not a simple education job, a very tough one, but that it can be done. I detect from what I have read and from what I have heard that there is panic in the IV community, in the homosexual IV users community over this problem of AIDS. That community may be much more amenable to education and much more amenable to stopping the sharing process than is commonly regarded, even than they may have been as little as a year ago. There have been some powerful concentration of minds out there from the recent publicity on the whole question of AIDS just in the last few months, and I would suggest that the education problem of getting IV drug users to use free needles, if they could be distributed, might at least reduce the incidence of geometric increase in this population.

I would like to have your opinion on that.

Dr. AXELROD. Mr. Congressman, I did indicate in the course of my testimony that it is something we are continuing to evaluate.

There are two aspects to it: One is that the ideal needle would be a single-use needle which could not be reused. If we could assure ourselves that by virtue of the mechanics of the needle itself, it could not be used again, then that has major advantages over the current needles which can be reused. The second aspect is that if it is going to be done, it should be done in a very controlled environment in which we can, in fact, evaluate the success of a pilot program. The difficulty has been in evaluating the information, and it is not conclusive information, from other states and other constituencies, that such measures have not had a significant affect on other kinds of infections that have been transmitted during the course of IV drug use. The States which have had freer availability of sterile needles have not experienced a significant decline in hepatitis B, for example, which is similarly transmitted by IV drug use. Another difficulty, as you have identified, is that there is a ritual associated with passing the spike, and there have been reports of needles being used as items of barter for drugs.

So that before one provides needles, one has to carefully confront the problems that can accompany their increased availability. The pilot program may, in fact, be the most effective way of evaluating the efficacy of such a proposal.

Chairman RANGEL. Mr. Green.

Mr. GREEN. Let's do some educating right now.

I gather the first message you would give to current IV drug users is stop; because they are addicted they won't stop. And the second message I heard you give was "Don't share needles." But

you also indicated the sharing of needles is a pattern of social behavior and that's going to be tough to stop.

So your third advice was "Clean your needles." What do you clean them with? Do we know what current antiseptics will clean needles with the AIDS virus?

Dr. AXELROD. One of things that we have suggested is that bourbon flushed in and out of a needles will effectively kill—or similar alcohol concentrations—will effectively——

Chairman RANGEL. Did you say "bourbon"?

Dr. AXELROD. Bourbon or similar alcohol concentrations. [Laughter.]

Mr. GREEN. Can you use rubbing alcohol?

Dr. AXELROD. Yes.

Chairman RANGEL. Mr. Manton.

Mr. MANTON. Dr. Axelrod, it is my understanding that for about 20 years the State of New York has required education programs on narcotics and alcohol abuse and that school districts are mandated by the law to carry out this program.

Does your office get involved with the education people in formulating and I might add updating this curriculum?

Dr. AXELROD. No.

As I indicated in response to Congressman Scheuer's question, only in the past month did we receive the new, updated curriculum and we are in the process of reviewing it, to offer our comments to the Education Department. It is a health curriculum that we are reviewing, within which are components that relate to the drug abuse and alcohol problem that you have alluded to.

Mr. MANTON. Who prepares this for the educational authorities? What health people are involved?

Dr. AXELROD. The Department of Education contracts out or has its own persons who are responsible for the preparation of the initial material that is provided to us. We do not initiate the materials.

Mr. MANTON. Is it not part of your overall mandate, as the chief health officer of the State, to be more involved in this type of preparation of curriculum?

Dr. AXELROD. There is a mandate with respect to the responsibility of the Commissioner of Health, which extends to the public health of the entire State of New York, and certainly in that general sense, yes. On the other hand, it is the prerogative of the Department of Education to prepare curriculum content in a way that it deems most appropriate and as well as to carry out an appropriate review process. In the course of our review, we can certainly assure that our concerns are adequately met or make recommendations for revision and through our critiques achieve the outcome that I think we would like to see.

Mr. MANTON. In light of the almost epidemic trend of AIDS, among other diseases, do you not think that it would be important for statutes to be changed to mandate you and your department, as the chief health agency, to be more involved than you have been in the past?

Dr. AXELROD. I think that changed mandates sometimes are effective. On the other hand, I think that the level of cooperation and coordination that has been evident with respect to revision of

the current curriculum, provides for the same kind of input. I believe that there is a recognition on the part of the regents and the Department of Education that there are health issues which require close collaboration and coordination with the health department and that has occurred. So I am not sure that a mandate is necessary. There has clearly been an effort to involve the department of health in the revision of the curriculum, to insure the changes that we feel are appropriate are incorporated.

Mr. MANTON. Dr. Axelrod, you don't think that you ought to be stepping in with a mandate and directive to be involved, but rather continued cooperation?

Dr. AXELROD. I would have to think about that. Certainly a mandate requires a review. A review has taken place in the absence of a mandate. I don't know what additional impact would occur as a result of a mandate.

Mr. MANTON. Well, I am a little concerned that leaving this to the educational authorities may not be the route, particularly when we have the geometric spread of AIDS in the community. I think that it ought to be a health issue, rather than leaving it simply to the educators.

Dr. AXELROD. I don't think it is fair to say that it has been left simply to the educators, but I certainly understand your perspective, and it is something that I would be prepared to discuss with the chancellor and the commissioner of education.

Chairman RANGEL. Mr. Weiss, I don't think there is anyone in the Congress who has provided more leadership in trying to get to bottom of this serious epidemic of AIDS, and we welcome you joining us and lending your expertise to this panel.

Mr. WEISS. Thank you very much,Mr. Chairman. I appreciate your inviting to participate with you for some portion of today's hearing.

Dr. Axelrod, I am going to just go through one aspect of your testimony. I heard one of your responses and I have just read the portion of your testimony which relates to the utilization of needles and the problems that the needles themselves create.

Your testimony suggests, and you correct me if I am wrong, that the greatest rate of increase in the spread of AIDS is in fact among the intravenous drug users. Is that correct?

Dr. AXELROD. That is correct.

Mr. WEISS. And that for the current year your records are that about 40 percent of the newly diagnosed cases come as a result of IV drug users.

Dr. AXELROD. Yes.

Mr. WEISS. Given that, would you tell us—I know that you have said that that information is still sufficiently uncertain for you to have come to any conclusions, but tell us what you are doing to try and cope with the problem of the spread of the disease among the IV drug users and what kind of pilot program you are going to be embarking on. I heard you mention something about a pilot program, is that in form at this point? Are you planning it? Tell us a little more about it.

Dr. AXELROD. There is no formal plan at this point. We are developing a proposal that would jointly be evaluated by the department of health and the division of substance abuse that would

enable us to come up with the kind of information to indicate whether or not providing needles or syringes would have any impact on the spread of the disease.

As I have indicated also, one of the things that we would like to do, is if there is a way of assuring that a needle is limited to a single use, that there is a collapsible needle in effect. So that once there is a positive pressure on the needle, that it closes over at the end, once you stop exerting pressure on that needle, so it cannot be used again. That would certainly enhance the likelihood that one could design a program to test the efficacy of providing sterile needles and syringes.

Mr. WEISS. But there are needles of that kind being utilized, aren't there?

Dr. AXELROD. There are single uses—the question of whether or not how single use they are is something that is also a problem that we have found that some of these needles can by manipulation be used over again, and we are trying to——

Mr. WEISS. That would be no worse than the problem that exists currently, would it? You are saying a user could use one of those needles over again and at least that is in question as to whether you could. Even assuming that you could, it would be no worse than the situation that occurs today where drug users are sharing users as a regular pattern of conduct.

Dr. AXELROD. But it would be no better either and I think that is the——

Mr. WEISS. But the prospect of it being better is there; isn't that correct?

Dr. AXELROD. The potential being there, there is also the potential of eliminating one of the deterrents to drug abuse, which is the knowledge that using a needle over again also provides you with the potential of contracting a number of infectious diseases such as hepatitis, AIDS, and transmitting to others some of those diseases. And once you remove that, then you will have removed one of the inhibitions that presumably would limit the use of the drug.

Mr. WEISS. Dr. Axelrod, wait a minute, stop right there. I am not sure that I heard you correctly.

Are you suggesting that you are reluctant to embark on this program because in some fashion you think that drug addicts would be more likely to continue their addiction if they had clean needles; is that what you are saying?

Dr. AXELROD. I think that that is one aspect of it. That is not the aspect which I have identified as being the critical one.

Mr. WEISS. Then what is critical?

Dr. AXELROD. The two areas that I have identified as being critical are: One, making the needles available, given the nature of the ritualistic behavior, does not necessarily provide you with an outcome that is going to——

Mr. WEISS. Not necessarily; what harm would it do to try it?

Dr. AXELROD. Well, the other aspect of it is that we have information from other areas where the needles have been used to barter for drugs themselves. There are groups who have used the advantage of obtaining needles and others who need to obtain needles, who are then placed in a position where they are actually bartering drugs to obtain the needles.

Mr. WEISS. And you think that if they don't—if you were to put the fresh needles on the market that in fact more people would become addicted or that there would be more drug addicts who would be using drugs. Is that what you are suggesting?

Dr. AXELROD. I am not suggesting that there would be more drug addicts. I think that we would be making it easier to safely administer addictive drugs, which is not the intention of a public health policy.

Mr. WEISS. Dr. Axelrod, there are people who are by the hundreds and by the thousands killing themselves and spreading the disease to other people who are also consigned to death. Now, it seems to me, given that circumstance, that you would be concerned about that prospect more than the vague possibility that in some fashion you would be demonstrating less than 1,000 percent opposition to drug addiction.

I don't think anybody would draw the conclusion that you are favoring drug addiction by trying to cut down on the spread of the disease.

Dr. AXELROD. Congressman, what I think I indicated was the need to carefully evaluate the impact of distributing syringes and needles if we were to pursue that kind of a policy. And I also indicated that we are in the process of developing a protocol which would allow us to evaluate the efficacy of a pilot program.

Mr. WEISS. But you just told us you had no such plan in formation.

Dr. AXELROD. No. I didn't say we didn't have it in formation. I said we are in the process of putting together a plan.

Mr. WEISS. When do you think it would be ready?

Dr. AXELROD. I don't know. I can't give you a date. Obviously, it is going to take some time for us to develop a program that would have to be jointly administered by the division of substance abuse and would lend itself to the evaluative process I have outlined.

Mr. WEISS. Well, Dr. Axelrod, I have no further questions. I am distressed now. We are really talking about life and death in this instance. Dr. Axelrod, I know that you are committed to preventing the spread of disease, and I am afraid that in this particular instance, with regard to this disease, there is less than the kind of urgency that you would want to see take place in order to get some kind of a handle on this problem. Now, I wish that you would go back and decide that, well, within 2 weeks we will have a plan in place. At least we will try on a sample basis, on a pilot basis. But everything is so vague. It is like nothing is really in focus.

Dr. AXELROD. I think that there are problems associated with the distribution of needles. There are problems with the distribution of syringes that have been identified in other constituencies, Congressman, and I think that we don't want to repeat some of the same mistakes that have been——

Mr. WEISS. What are you talking about? What problems where?

Dr. AXELROD. We have contact with a number of States, all of which have varying ways in which they deal with the problems of the availability of syringes.

Mr. WEISS. Where? Which?

Dr. AXELROD. Texas is one State which has a different policy. I think we identified some 30 States, all of which have——

Mr. WEISS. And what do they tell you? Do you have that study available? Can you give us a copy of it?

Dr. AXELROD. I can give you the information that we have gleaned from those States as to the efficacy of the availability of—

Mr. WEISS. Do you have a report that is compiled on the basis of the experience of 30 other States; is that what you are saying?

Dr. AXELROD. Yes, we have that information.

Mr. WEISS. Do you have a report to that effect? Do you have a summary drawn up?

Dr. AXELROD. Yes, we do.

Mr. WEISS. Would you make that available to the committee, please.

Thank you, Mr. Chairman.

Chairman RANGEL. Dr. Axelrod, it is the consensus of this committee that we are going to contact our colleagues in the New York State Legislature and to ask them to give you some assistance in making certain that health care as relates to AIDS and drug addiction is incorporated in our educational system as a part of your mandate, and as Congressman Scheuer indicated, we feel compelled to ask this committee to revisit this issue no later than spring.

The reason why we have to emphasize it is that you are really our last threshold. If we talk to the State Department or the people overseas in the drug-producing countries, one thing this committee hears more than anything else is to reduce demand. If you listen to this next panel you are going to hear law enforcement say that it is either a question of drying it up at its source or educating our youngsters. And when we go to our top chief honcho in charge of health care and find that you are only recommending to education, but that there is no partnership going on, then we are going to have to see what assistance we can be to you and the Governor to make certain that we may be failing throughout the country, but we are not going to fail in the Empire State in providing basic information to our youngsters, and the question as to what you are doing or not doing in our prison system, we don't have enough expertise to give you any direction, but it just appears to us that if you know that the contact group that has the greatest problems in this country are minorities that are drug addicts that are involved in homosexuality and then target that to our prison system and see that that is a mirror of the target group that they have told us about, and we are not doing any screening or testing in the prison system with this control group, we are going to do some homework and come back to you.

I want to thank you for your patience with us and I thank the members for their restraint in this area. You are going to need a lot of help and we are going to be prepared to give it to you.

Dr. AXELROD. Thank you.

[Dr. Axelrod's prepared statement appears on p. 106.]

Chairman RANGEL. The Chair apologizes to our next panel of witnesses, but those of you who came on time could see why we had to spend a little more time with Dr. Axelrod than we had planned. But we do have Benjamin Ward who is an outstanding police commissioner of the State of New York, Sterling Johnson, who is a special narcotic prosecutor for the city, who this committee relies on, as well as Senator D'Amato on the other side, to give us the type of

expert advice that is so necessary. Certainly, our U.S. attorney, Rudolph Giuliani, who has developed a national reputation in striking out against organized crime, and as we said earlier, the Drug Enforcement Administration has been able to bring one of its outstanding members, special agent in charge, Robert Stutman, who has recently taken charge of the New York Division.

Again, on behalf of the entire committee, we were trying to make it easier for you, without us saying it, as to what is lacking in education. I have heard each one of you individually and most of you collectively say that law enforcement would be made a lot easier if our youngsters were taught early on about the dangers of drugs, but I think that you see what we are up against and, therefore, we can't even do anything in our prisons.

Anyway, we thank you for your patience. I will advise the members that we are running behind schedule, which we ought to keep in mind with our questions, and I will ask Commissioner Ward to lead off.

TESTIMONY OF BENJAMIN WARD, POLICE COMMISSIONER, CITY OF NEW YORK

Commissioner WARD. I am pleased to be with you this morning to testify about the New York City Police Department's response to the drug problems in this city.

Mr. Chairman, Senator D'Amato and other members of the committee, I am particularly pleased to be participating in this panel with such distinguished individuals as Sterling Johnson and Rudolph Giuliani and Robert Stutman. I believe that our presence here together is significant: We need the cooperation of police and prosecutors working together at the local and Federal level to combat the drug problem. In New York City this type of cooperation exists and is making a real difference.

As your committee is well aware, drugs are not grown in New York City, yet they plague the city. Drugs cause human suffering for addicts and their families, and they contribute significantly to the crime problems in our community. We cannot and should not tolerate this plague.

I urge this committee to use its influence to stop the flow of drugs into this country and to stop the production of drugs by other countries. I particularly support and applaud your efforts, Mr. Chairman, and Senator D'Amato, in this regard. Short of stopping at the border, I believe we have a responsibility for breaking up drug smuggling and drug trafficking operations. We also have an equal responsibility to rehabilitate addicts and to prevent our young people from becoming drug users in the first place.

In New York City we are meeting our responsibility by undertaking several major police operations to interrupt the flow of drugs. The committee is familiar with Operation Pressure Point that began on the Lower East Side, and since that operation began in January 1984, we have made over 16,000 arrests and have seized over 2.2 million dollars' worth of drugs.

On March 1, 1984, we started Operation Pressure Point II in Harlem and since that time we have made over 16,000 arrests, over 9,000 of them for narcotics violations. It is important for this com-

mittee to realize that the success of Pressure Point strategy can only be measured by a reduction in crime. In Harlem, for example, the rate of robbery in the Pressure Point II area has decreased by 13 percent in the first 10 months of 1985, compared to the first 10 months of 1984. Burglary has declined by 17 percent. Grand larceny has declined by 27 percent. These reductions in crime mean that the neighborhood is safer and the citizens of Harlem can begin to regain control of their streets.

Building on its experience with Operation Pressure Point, the police department has undertaken several initiatives against local drug dealing, each one tailored to the unique needs of the community. Examples include the project in the Bronx called BAND [Bronx Anti-Narcotics Drive]; an initiative in the 73 precinct; a special effort in the Washington Square Park and Bryant Park; a most recent operation in South Jamaica, Queens, we called it Operation Cleanup, where we recently took out 15 houses with $60,000 in cash and about 24 pounds of cocaine, in addition to cleaning up a notorious long-term street condition around Wouth Road, Suphten Boulevard and 150th Street; a program targeting smokeshops in East Brooklyn; and another special effort in the 34th precinct. Since their inception, these programs have resulted in over 10,000 arrests.

We have also started an organized effort to close the storefronts known as "smokeshops" throughout the city. We have targeted identified locations for triggering arrests. We have notified landlords of violations in their premises, and we are using our local padlock law as a final weapon for shutting down these illegal operations.

I am not satisfied with making thousands of arrests. While this type of enforcement activity is both needed and effective, I firmly believe that we must also try to cut down the demand for the drugs. In keeping with this belief, the police department and the board of education have launched an educational program in the fifth and sixth grade to say "no" to drugs. This project also includes other early childhood grades, but not with the intensity in which it is put into the fifth and sixth grades and it also involves parents and teachers as well. This project is called SPECDA [School Program To Educate and Control Drug Abuse]. SPECDA has been enormously successful and has been expanded from two board of education school districts to seven board of education school districts, and one, I might point out, Congressman Rangel, is in your area.

Before closing my statement, I want to call the committee's attention to the fact that in New York City we have developed an excellent spirit of cooperation between Federal and local law enforcement officials and between police and prosecutors. As you may know the U.S. attorney for southern district has agreed to prosecute drug offenses where the Federal courts have concurrent jurisdiction. Since March 22, 1984, the New York City Police Department has effected 722 drug arrests, which have been prosecuted in the Federal systems; 320 of those Federal prosecutions have been based on arrests made under Operation Pressure Point II in the Harlem area. And while this is a small part of the total drug prosecutions that go on in this city, we are grateful for this type of co-

operation, and I might add that the street drug users refer to it as Federal day. They fear Rudy Giuliani, perhaps more than they fear the police.

The committee should also be aware that 91 of these arrests were made under title 21, United States Code, section 845A, which provides enhanced penalties for drug sale arrests made within 1,000 feet of an elementary or secondary school. This is another example of Federal clout being brought to bear on a local government. We have a similar program that we started before the passage of this statute in which we target drugs sales within two blocks of any school. We continue with that program and prosecute thousands of cases in the State and county courts and through Sterling Johnson's office as well.

Finally, I want the committee to be aware of the excellent level of cooperation between the police department in this city and the Federal Bureau of Investigation and the DEA, the Drug Enforcement Agency, as well as the State police. We cooperate in a variety in a variety of task forces and have formed a truly productive partnership in the fight against the drug trade.

The Federal Government should do more to stop drugs from entering the country. The Federal Government should do more to provide financial support for local law enforcement as it spends taxpayer's money to fight against the drugs that make their way into our city. The Federal Government should actively support educational programs, like the SPECDA, that keep students from becoming addicts. Quite frankly I believe that if this battle is ever to be won, it is to be won on the educational front and not on the law enforcement front, although we must continue with the law enforcement effort. And finally the Federal Government should continue to support the cooperative efforts and task force approach that is working so well here in New York.

Thank you very much.

[Commissioner Wards' testimony appears on p. 114.]

Chairman RANGEL. Thank you, Commissioner Ward.

The Chair would like to hear now from special prosecutor, Sterling Johnson.

TESTIMONY OF STERLING JOHNSON, JR., SPECIAL NARCOTICS PROSECUTOR, CITY OF NEW YORK

Mr. JOHNSON. Senator D'Amato, Mr. Chairman, members of the committee, it is a privilege to be back here again. It is kind of sad that we have to be here under these conditions to discuss such a serious matter. Since the last time we have met, not only have things remained the same, they have gotten a little worse.

I concur with the statement of Commissioner Ward that things have never been better as far as law enforcement is concerned, as far as cooperation. We here at the table cooperate and speak; we pool resources; we pool intelligence and we pool everything humanly possible to address a very, very serious problem, not only for the citizens of New York State, but New York City and of the Nation. We also are in contact with members of your staff, both sides of the House and we see a lot of cooperative effort and for that I would like to publicly thank all of you.

As I said, I will not read my statement. It is here for the record.

[Mr. Johnsons prepared statement appears on p. 119.]

Mr. JOHNSON. Things are worse than they ever were before. There was a time that when we went out to purchase narcotics the bad guys would dictate a price and we would have to buy it. It has gotten so now that if they dictate a price, I can negotiate or I will walk away and they will come down on the price. For example, not too long ago, I think, one defendant had wanted to sell a kilo of cocaine for $40,000. That price, not too long ago was as high as $60,000, but I refused to buy at $40,000 because he was trying to rip us off. You can get that same kilo for 30, 31, 33 tops. Over in Brooklyn, we conducted a major investigation where the bad guys had wanted to sell a half kilo of heroine for $125,000. After some skillful negotiation we reduced that price to $123,000, which we purchased narcotics. Several people were arrested. They are awaiting trial right now.

I have attended many community meetings, all over the city, and no matter where I went passions are so deep you can swim in it. And no matter what you tell the citizens what you are doing and what we are doing collectively, it is still not enough. In essence, what the citizens of New York are telling us, it is circle the wagon time, and wherever you put out a fire, prosecute, there is another fire to put out. We will continue to do what we can individually and collectively, but we desparately need additional help, help in the sense that we have to stop the drugs from coming into this country, and the further away the raw product gets from its source, the more difficult it is. I endorsed the Rangel-Gilman bill in the House in which you state that you would like local and State governments to receive moneys from the Federal Government over a period of years for police, for prosecutors, and other things, jails. I totally support that and I hope that it will pass. I understand, Senator D'Amato, that there is a similar bill in the Senate and I stand forth to support that, notwithstanding, of course, that we are in a deep fiscal crises and there is an effort to balance the budget. But I think that this problem is so serious, serious enough to be at the top of our national priority, like national defense and balancing the budget, because if we don't pay the pennies today, we are going to pay the dollars tomorrow. It is very, very serious out there.

There is not a day that goes by that I don't receive calls from mothers, from schools, and we really have to address these problems, and no matter how good we are doing, it is still not good enough.

I would like to conclude. Like I say, we are cooperating. We have new programs going on. We are welcoming Mr. Bob Stutman, who I have known for 15 or 20 years, and he is a very capable and able administrator and narcotics agent and I look forward to working with him.

We have programs that we are going to proceed with the FBI. They are not here, but we are working very, very closely with them. And we hope to get some very meaningfully, visible, and positive results, but notwithstanding that fact, unless we get some help from the top, from Washington, DC, we will be digging a hole

in the ocean, and we will be back here the next time the committee has hearings and we will be saying the same things.

Chairman RANGEL. Thank you, Mr. Johnson. You should know, if we can't get a handle on it with this outstanding team, you can imagine the problem we are having throughout the Nation.

Mr. Giuliani, the U.S. district attorney for the Southern District of New York.

TESTIMONY OF RUDOLPH W. GIULIANI, U.S. ATTORNEY, SOUTHERN DISTRIST OF NEW YORK

Mr. GIULIANI. Mr. Chairman and Senator D'Amato, distinguished members of the committee, it is a privilege to be here both with this group and for your committee. Your committee has made such helpful and useful efforts in the fight against drugs, that as one who is part of the law enforcement effort, I want to say that we are very appreciative of all the things you have done to focus attention on this problem, the legislation that you have sponsored and focusing national attention on the drug problem.

This morning when I came into work I walked past a group of people, as I do approximately one morning a week, who had been arrested last night in Operation Pressure Point, in the Federal day aspect of Operation Pressure Point, and four of Commissioner Ward's detectives and nine defendants were sitting there. Obviously, street level drug dealers last night were arrested for selling $40 or $50 or $60 or $70 or $100 worth of heroine or cocaine to undercover agents. The cases number 730, 731, 732, 733. Then when I walked past the bridge where they are held as they come into court for arraignment, I noticed the Federal marshals bringing the witness to the trial of United States against Badalamenti, a witness who would offer testimony against people who were allegedly at the other end of the drug trade, people who allegedly were involved in bringing in billions and billions of dollars worth of heroin and cocaine over a period of time, laundering it through some of our most distinguished financial institutions and through Swiss bank accounts. I was struck by one very, very stark fact and that is that law enforcement, Commissioner Ward, the Drug Enforcement Administration, the FBI, the Customs Service, all of these people who have to make these cases at the street level, at the middle level, at the upper level, are frankly doing everything that they can do with the resources that they have. Believe me, probably a thousand times more than their resources really allow. I see the Commissioner's police officers as he does, working beyond what any human being should be asked to work. My assistants do, Sterling Johnson's assistants do, because they are dedicated to doing something about this problem, and you get the feeling that you are holding your finger in the dike at best.

Obviously, what we do is important. I am not trying to minimize it and I am not trying to take responsibility off ourselves because we bear a very heavy responsibility for deterring and controlling the drug problem. I am not trying to say that this is too frustrating a problem for us to deal with, because I think that is nonsense and we say that too often to ourselves.

Your committee in this morning's hearing has focused on what I think is the crucial problem, and that is lack of leadership. Lack of leadership on this issue, and refusing to take responsibility for it. There are five areas that have been mentioned, and there are five areas in which if we made this a national, State, and local priority—not by one level of government pointing a finger at the other or trying to get responsibility off itself. But taking responsibility for what it can do. We could dramatically turn around this problem.

You, Mr. Chairman, and Senator D'Amato, and Mr. Gilman, I know have said all of this at one time or another. But let me just see if I can just summarize the five areas very briefly.

First, foreign policy. It has to become a major issue for us and the way we deal with foreign nations, that we convince foreign countries that drug production and acting as intermediary countries for the distribution of drugs in this country will be dealt with very harshly by the United States with whatever means are necessary to convince them of that. That issue, the drug issue, is as important to our survival as a nation as the question of East-West alignment. It has to become a matter of grave priority. I know that all of you have done a great deal to focus attention on that. It is of crucial importance, but indeed the only thing that can be done. Because if we are more successful than we have been in the past, if in fact there is a tremendous market in this country of $70 billion, or $80 billion, or $100 billion, or whatever the market is, someone is going to satisfy that market. Some country, some group of people, if there are $70 billion available in the United States for any product, will satisfy that market. So, we have to work in other areas as well.

The second area in which we have to give a tremendous amount of attention is doing a better job of controlling our borders. We can't seal our borders, that is an impossible task and it is inconsistent with our values and it is inconsistent with us as a commercial nation. But we can do a more effective job through the use of the military and through the use of technology and through enhancing our border patrol in cutting down the amount of drugs that come across the borders.

Third, we have to continue to do an effective job of interior law enforcement; the FBI, DEA, the U.S. attorneys office, the Department of Justice, the police departments, Sterling Johnson's offices. We have to continue to do what I think has been in the last several years a very effective job. We have to continue to do that job, do it more effectively. I think there is one thing that we can add to it. It really has to become a rule in this country at the Federal level, at the State level, and at the local level, that if you are caught and you are convicted for selling heroin or cocaine, whatever the amount, you go to prison. No excuses, no explanation for some other purpose, no diversion. If you get caught selling drugs, you go to prison. If you get caught selling drugs in large amounts, you go to prison for large periods of time. In medium amounts, maybe a lesser period of time. If it is a small first sale, and a young person, maybe you get a taste of prison, but you go to prison. That message has to be delivered to the street. Not the message that we presently deliver as a society, which is, if you get caught selling drugs, and it

is tough to catch people, and if you get convicted for it, and it is difficult to convict people, now by and large the message is you do not go to prison. You get away with it, and that is what the drug users, the drug sellers, and the people in the drug culture from the people that I saw sitting there this morning who were arrested in Operation Pressure Point, right up to the very top level—Mafia, Colombian, or whatever other drug dealers you are talking about. The lesson they know is you probably won't get caught, and if you do get caught, you probably will not go to prison.

We have to change that, and we can change that. It is very, very important as a matter of interior law enforcement and delivering messages to people who are in this business for profit. This is a white-collar crime. Not a crime of passion, and not a crime of violence. Even for many of the drug users this is a white-collar crime. A crime of profit.

Four, we have to put resources into treatment of drug addicts, and not have a self-defeating attitude that because the programs are maybe only 30 or 40 percent successful that they are not worthwhile. A 30 or 40 percent reduction in the number of drug users is a contribution. It is not perfect, it is not ideal. But it is a contribution.

Finally, and of most importance, as you have outlined this morning more effectively than I can, and as I know others on this panel have already mentioned, education is the crucial area. It is the crucial area for us to be able to bring down the demand for drugs. If we can bring down that $70 billion market to a $50 billion, to a $30 billion market, to a $20 billion market. At those reduced levels, law enforcement could have a much more dramatic effect than it has now with this problem that is a runaway problem.

Education at all levels: school education; education using the media; education using all of the methods of communication that are available to us. There is absolutely no doubt that you are correct when you say that all of the four other efforts that we are talking about, although of crucial importance, will not work unless we have an effective educational effort at all levels to teach people the dangers of using drugs.

It is really appropriate, I think, that I turn to Mr. Stutman, who has come to New York as the new head of DEA in New York. Mr. Stutman, while he was in Boston, spearheaded what was in fact, one of the most effective governmental efforts to educate people to the dangers of using drugs in Massachusetts. Because he didn't look at this problem as a bureaucrat, he didn't look at this problem as I don't know what I can do, or somebody else maybe really has the responsibility for this, as easily could have as a law enforcement officer. Instead, he got involved in the educational aspects of this problem and was, in fact, as I have heard the story, and I think it is quite reliable, the major reason why the State of Massachusetts now has an educational effort that involves all of the schools, many of the private aspects of society in Massachusetts, and is by far, one of the most effective efforts in the United States.

Thank you, Mr. Chairman.

Chairman RANGEL. Thank you.

Bob Stutman is no stranger to this committee. We have worked with him very closely in Washington, and followed his career in Boston. We welcome your testimony in front of this panel.

TESTIMONY OF ROBERT STUTMAN, SPECIAL AGENT-IN-CHARGE, DRUG ENFORCEMENT ADMINISTRATION, NEW YORK DIVISION

Mr. STUTMAN. Thank you, Mr. Chairman.

It is truly a personal honor for me to appear before this committee. As you have said, I have worked with you and Mr. Gilman, Mr. Scheuer, Mr. D'Amato, some of you since 1976. It is truly a personal honor. I know that all of you gentlemen are not in the drug abuse drug trafficking investigation game for the short run. I personally appreciate that, as I know members of this panel do.

I might add, as a personal note, it is an honor for me to appear before your chief of staff, a gentleman who 21 years ago taught me an awful lot about the drug law enforcement business. It is truly an honor to appear before him.

Second, it is an honor to be in New York City as the agent-in-charge of DEA. Mostly because it is a pleasure to work with what I honestly believe to be the finest police department in the country, and to work with prosecutors at the Federal and State level who are the most aggressive and most capable in the country. People look at Rudy Giuliani, Ray Deahry and Sterling Johnson, throughout the country to see how can we best go after the tough cases. So that makes my job easy.

I would like to take just a few minutes to point out what DEA sees as the problem in New York, and tell you very quickly what our response is and going to be. Then, I want to speak about the issue that Mr. Giuliani raised.

Clearly, as far as heroin goes in New York, things are not any better. They are not perceptively worse, they are not perceptively better. That is not good news. The heroin availability on the streets of the lower east side is still running somewhere between 16 and 20 percent, whereas in the Harlem area, as it has for the past 3 or 4 years, it is remaining at a fairly constant 3 percent.

What is changing, however, in New York is who is controlling heroin. We are beginning to see less and less Southwest Asian heroin and more Southeast Asian heroin. We are beginning to see more heroin being controlled by oriental groups. It is my personal belief that because of the prosecutions of the major members of L.C.N. families in New York, we may begin to see less and less traditional organized crime involvement in heroin trafficking here in New York City. That certainly will be a change.

The second drug that I think we should talk about for just a minute, that has not frankly been mentioned at this table, is a drug that is called PCP or Angel Dust. Harlem has now become known as the Dust Bowl, and that is because there is such a tremendous amount of PCP available in that particular area. Interestingly, New York is only one of two or three cities in the country that still has a major PCP problem. That is one of the issues that DEA is certainly going to address.

Clearly, the third drug, which I think is the subject of the largest change, and in fact may represent the most significant problem in

the near future for New York City is cocaine. Let me share one single number, if I may, with you gentlemen. In the last 23 days in the greater New York area, we—the Federal, State, and local police departments—have seized 2,100 pounds of pure cocaine. In the last 23 days. That is an almost unbelievable figure, and frankly, in the immediate future, we do not see that situation improving.

Two years ago in New York City seven people died from overdoses of cocaine. Last year in New York City, 91 people died from overdoses of cocaine. Three years ago in New York City, cocaine purity at the retail level—that is what the user actually uses, inhales, snorts, sticks up his nose—was about 20 to 25 percent. So far, this year according to police department and our figures, the retail purity of cocaine on the streets of New York is running somewhere between 50 and 60 percent. Those figures are clearly alarming, and one that has forced me and DEA to say we may take a look at our priorities. In fact, I believe that we may be changing our priorities and spend a great deal more time looking at the availability of cocaine and the organizations trafficking in cocaine.

In addition to that, we have had some preliminary indication that the traditional organizations that control cocaine, which are Colombian organizations in New York, may in fact be moving into other drugs such as heroin. All of these are issues that we in DEA, the police department, and the prosecutors intend to look at and work at very closely.

What are we going to do about it? I pledge to this committee that clearly as both Commissioner Ward, Mr. Johnson, and Mr. Giuliani pointed out, the cooperation that has already grown up over the years in New York is going to be enhanced. DEA over the past 4 weeks has entered into some new initiatives with the Federal Bureau of Investigation, and I would look for that relationship to grow. The ongoing relationship with the police department that has been here for 15 years, I know will continue to grow. Clearly, as more and more complex cases are taken up, not only with traditional organized crime, but in the Colombian community and the various other ethnic communities that have now become heavily involved with heroin trafficking—such as Pakistanis, Nigerians, et cetera—the relationships with the U.S. attorney's office will grow.

I wish to add in conclusion, as my three predecessors at the table added, we are clearly not operating at 100 percent today in law enforcement. We can be better. I would also suggest to this committee that if we sat before you and said we are operating at 150 percent, we would still not solve the drug problem. Because anybody in this audience who thinks that the four of us can solve the drug problem in New York, is not familiar with what is really happening.

We have to make it better. We have to make drugs less available, and that we will do. But the bottom line is we have to give our kids a reason to say no to drugs. Three years ago, as Rudy pointed out I worked in Massachusetts, and I was in a very affluent high school in a community—a suburb of Boston. As Senator D'Amato pointed out, I had a young lady walk into the room who was 14 years of age. She was wearing the uniform of the day for that particular town, which was a Sasson top, Calvin Klein jeans, and Frye boots. One o'clock in the afternoon, whacked out of her tree, at age 14 on qualudes. She didn't walk in, she floated in.

And after talking for a while, I asked her a very simple question. I said, "Stacey, why do you do drugs?" And she gave me such an honest, simple answer, that as Senator D'Amato said it was scary. She said, "Because nobody has ever told me why not." And I would suggest to this committee that that is where we as a society have failed. We have to give our kids a reason why they shouldn't do drugs.

I would also suggest to this committee that the three most dangerous words, when we talk about kids and drugs, aren't AIDS, aren't cocaine, aren't heroin, aren't LSD. The three most dangerous words that any of us have to deal with are, "Not my kid." I'm too Catholic, I'm too Jewish, I'm too rich, I'm too strong a family, it can't happen to my family.

So, in addition to the five very important points that Rudy Giuliani pointed out, I would like to add a sixth point. That is, that we have an obligation as legislators, as law enforcement officials, and as leaders, to turn around the attitude of toleration. We must teach our citizens that by saying it is OK, it's only coke, it's only grass, that the next generation of citizens of this State are going to be the ones to suffer. And I would certainly pledge to this committee, that DEA is going to do all that it can in the State of New York to do that.

Thank you, gentlemen.

[Mr. Stutman's prepared statement appears on p. 126.]

Chairman RANGEL. I want to thank this entire panel for excellent statements. Before I inquire, the Chair would like to recognize the presence of an outstanding State legislator, Danny Farrell, who is here with us and will be working with us in trying to see if we can get some legislative support which is so sorely needed in the health department and also Commissioner Daniels, who is here from the liquor authority, in view of the fact that the health commissioner is advocating bourbon to cleanse needles, maybe there is some significance to his presence here. They may have better coordination than I thought.

I am going to be brief to set an example for the panel members because all of you are expert, and I can't think of a better team, and we have been throughout the country, than what is before this congressional panel. But I am going to pick on Commissioner Ward because he is the biggest, and I think the most outspoken, and a person that has never had a problem in expressing what he thinks we should be doing.

In U.S. Attorney Giuliani's summary of what the problem is—and I don't think any of us deny it—when citizens are hitting on us, we all find an inclination to point to each other. I am going to take care of this overseas business, so you can take it off of your list. Because you can forget it if you think we have any handle at all on what is being produced overseas. Even when we were successful in the Congress to get sanctions against the countries, they are not even cooperating. And cooperating doesn't mean eradication, it means just having a plan. The U.S. Attorney General said that he didn't believe in sanctions, and that was hurriedly followed by the Assistant Secretary of State John Thomas, who did not believe in sanctions either. This wouldn't be so bad if any of you could record any statement that was made by our Secretary of

State in this area, which you cannot. And if it wasn't for Mrs. Reagan, I don't know what we would have coming out of the White House.

Having said that, the United Nations has said that we should expect bumper crops, and when the United Nations starts criticizing each other instead of the United States, you know there has to be some credibility to their statement. The State Department in a variety of different ways they see light at the end of the tunnel, there is a turnaround, the answer is within our grasp, we have turned the corner. They don't dispute that we are going to get bumper crops in heroin and cocaine in this country. So, I think that we can say that that is not going to happen, even though we must continue to fight to make certain that we get it included in our foreign policy because I don't believe it is a part of a priority in our foreign policy.

We talk about our borders, but staff has just shown me where some 60 to 70 percent of the drugs that are coming in are coming in by commercial airlines. And we have had hearings on the Mexican-United States borders. And we go back again in January, and the requirement to cross the border is to say that you are a citizen. We went back and forth on the border. And tens of thousands of people cross that border every day, allegedly going to work, no green cards, no identification, just a hand wave.

Then, of course, when we get down to education—I hope some of you heard what happened here this morning where the Chief of all of the Health Services for the most progressive State in the Union, in my opinion, and with the exception of Mr. Stutman, you know that I believe this is it. If it is not done here, take my word as to what we found in other States where law enforcement have talked about what we should do and demand an education. And we asked what is the system, and they don't know about the system. And, of course, no one has been more responsive then you, Commissioner Ward, to communities that have been hit hard. But some of your people have told me that there is a limit to what we can expect in terms of arrest. There is a limit to what we can expect in terms of conviction. There is a limit to what we can expect in terms of prosecution. There is a limit to what we can expect, Mr. Giuliani, in terms of how many people can do time. The judges have to make decisions as to who would do the time, and sometimes the drug pusher is not given the priority because of the limitation of the warehouse where you put these people.

And so, because law enforcement traditionally has not really been an outspoken part of our society, there is just something conservative about law enforcement that they don't speak out and say, listen, I can't do my job unless certain things are done. We don't hear from the National Organizations of Police Chiefs, of local prosecutors. Certainly, we don't expect to hear from the U.S. attorneys because that is the Attorney General Department of Justice, and depending on who is President, and I am not talking about this President I am talking all the Presidents that preceded him. That there is something about not speaking out for resources in this area.

Now, when we leave here, the citizens are going to be pointing at all of us and asking what are you doing about it. And they don't

care whether you are a Member of Congress, whether you are a Federal prosecutor, local or Federal law enforcement. And I am saying that is almost like having a firing squad in a circle. We all know the answer, but somehow we haven't gotten together and spoken with one voice. And I have to admit that DEA is getting more eloquent every time I hear them in the areas of education. But when I go back to Washington, and I ask from the Secretary of Education, he will tell you there is no Federal program in the education area that deals with drug prevention. So more and more law enforcement are finding out more and more the need to stopping it at its source, and educating our youngsters. But somehow, Ben, we haven't come together and spoken with one voice.

And with all due respect to the panelists that are not from the city of New York, I believe that if we can't come together here with some guidelines for a national program, then it can't be done anywhere.

Would you care to respond, Commissioner Ward?

Commissioner WARD. Well, I certainly can't respond to all of that because I can't remember all of it, but I think you are on the right track when you talk about education. We speak about education here, the Federal prosecutors, State prosecutors, Federal law enforcement agencies, city law enforcement agencies, because we are somewhat frustrated at the enforcement level. I think we have increased our enforcement over the years, and we do not see evidence that the amount of drugs is radically decreasing.

I believe we have to continue that effort. I believe that the Federal Government is somewhat lax in not having provided the resources for Operation Blockade so that we could keep more of the drugs out. I suggested that if the Coast Guard could not beef up its patrols to stop more of the ships on navigable waters, that they designate police departments to do so. I forget how many boats we have, but we have over seven and maybe a dozen boats. Designate those boats as U.S. Coast Guard vessels. We have six or seven helicopters. Designate them as U.S. Coast Guard vessels. And if that could not be done for some legal impediment, then why not place a Coast Guard person on those vessels, to carry out the Coast Guard operations which I believe gives them the right to stop and board any boat on the navigable waters in the country, while the police department even when it is on the water and in the air, has to be guided by U.S. Supreme Court mandates as to probable cause before we can stop and conduct any searches.

But on the educational level, we started this program here in New York. Chancellor Quinnones and myself out of our own budgets. It cost us $70 thousand in the first year, out of each budget to start a pilot program in two school districts. We have now expanded that to 7 additional school districts, to involve 154 schools. Drug sales and peer pressure can be expected anyplace in New York where we have over 950 schools. So there are 900 public schools that we are not touching; untold numbers of private and parochial schools and it does not include any of the community colleges and universities. For the U.S. Department of Education, not to be providing funds in that area, seems to me to be terribly shortsighted.

Chairman RANGEL. Ben, I meant to congratulate you on that effort, because I did know about it and you are really attempting to

fill the gap with law enforcement resources. But I guess, you know, you are familiar with the legislation that all of us have in to bring some assistance. This legislation is not going to be considered unless it has some type of political support behind it, and I guess my question is there a National Organization of Police Chiefs that we can talk with and to let them know that you expect more from your government and you expect more in terms of education, that this is not just a law enforcement problem.

Now, you're here, but we are going to have to—and when I say "we" I include this panel—to find some way to get our message across.

Commissioner WARD. It is the International Association of Chiefs of Police. The National Association of Sheriffs is another organization; and there are several more.

Chairman RANGEL. If this isn't on the agenda we are going to have to find some way to try and get it on the agenda.

Commissioner WARD. Unfortunately, gun control dominated the last conference in Houston of the International Chiefs, and I think it was a very important effort that was being mounted there.

Drugs—there is more danger with these drugs around the country than perhaps is happening in New York City, because the little effort that the Federal Government made to close off Florida forced drugs, first, north in Florida, then along the gulf and out through Texas and further west; but perhaps more importantly, north in the southern part of this country, where you can take a caterpillar tractor and scoop out a dirt runway in less than a day and those low flying twin engine jet planes scooping in over the gulf can land, and even if stopped by local police, you have the problem of someone offering you substantial hundreds of thousands of dollars tax free if you just not see, not be in this location on a particular day, or if you happen to be here, take it and turn around and be gone in a minute. And that was a major conversation among the chiefs of the Major Cities Committee of the IACP, because we know that these small police forces are subject to great corruption because of the increased drug traffic in those areas. That stuff is rapidly put on to other means of transportation and brought into this area.

I don't believe that the Federal Government has funded ways to stop that stuff. The Customs effort has been increased since Senator D'Amato spoke about a year ago, I believe, and got us about 100 new agents in this area, but as far as I know there is no one looking at the trains and we know that some of those drugs are coming from the west coast of Florida to New York by train since the clamp down on the east coast. And no one looks at the thousands and thousands of trucks that comes into this city everyday. No one searches those trucks and many of them are allegedly sealed and they just flow right in and go back empty.

Chairman RANGEL. What I am hoping is—and we will follow up outside this committee—if this panel will find out how we can agitate and get national groups to be more supportive in terms of congressional initiatives, even in this administration—I think clearly what all of us is saying is that notwithstanding what we do, it is not the answer unless we follow what Rudy has mentioned, and we can't do it without resources.

The Chair would like to recognize the presence of Judge Dominick DePallo (ph.), some of you remember him as Assistant Secretary of State for Narcotic Matters. I would like to think of him as an outstanding legislator from Brooklyn to the New York State Assembly. We welcome your presence.

Mr. Gilman.

Mr. GILMAN. Thank you, Mr. Chairman.

Again, I just want to thank this distinguished panel. I just wish we had more panels of this nature of law enforcement officials throughout our country, I would have less of a problem with the suggestions that you have made.

Let me ask the panelists, do you come together to work out an overall strategy for the region periodically? I address this to any members of the panel who care to answer that.

Commissioner WARD. Let me just start with one piece of it. In this city we have the example for the country in terms of cooperation between State, Federal and city law enforcement agencies. So that with Bob Stutman we have a task force that is a tripartite task force.

Mr. GILMAN. Commissioner Ward, how often do you get together in that task force?

Commissioner WARD. Our people work together in the FBI units that are controlling drugs and organized crime and a variety of other things. In the drug enforcement task force there are State troopers and New York City policemen assigned daily.

Mr. GILMAN. How often do your top level people meet?

Commissioner WARD. Daily. Chief Raymond Jones, who is sitting on my right, who is Chief of Organized Crime Control Division and his subordinate, Deputy Paul, are in daily contact with the drug enforcement——

Mr. GILMAN. I realize there is that kind of interaction. But how often do the four of you, or five of you with our district attorney, get together and just take a look at overall strategy? Does that happen very often?

Mr. STUTMAN. I have been here 1 month, Mr. Gilman, and I have already met formally with Chief Jones and the head of the New York State Police. We have met informally, I think, three times. I have met with Mr. Giuliani at least four times in the past month.

Mr. GILMAN. Those are individuals. What I am asking, Bob, is how many times did the four or five of you sit down and say, "Let's take a look at the overall region and what can we do on a strategy technique?"

Mr. STUTMAN. I have been here one month and it has happened one time already.

Mr. GILMAN. Where all of you sat down——

Mr. STUTMAN. Representatives of all the offices.

Mr. GILMAN. Now, you've heard our problems with regard to education this morning, that there is very little of it apparently being done at the State level. Any suggestions? The Commissioner has a good program going, but it is only in a very small portion of the city.

What are your thoughts about how can we devise a more effective educational program? What should we be doing? What can you as chief law enforcement officials be doing to bring about a better

education system right here in our own region? And I address that to the entire panel.

Commissioner WARD. Well, I can tell you what I am going to do. I am going to go out and lobby for my budget this year, and one of the items in my budget is going to be for a tax levy support for the expansion of this special education program that we have. I am going to get the community groups that deal with the police department, and they are by the hundreds, and we are going to personally lobby that budget and lobby for those funds.

And then Congressman Towns is going to hear about it, and Tom Manton is going to hear about it, because I am going to be talking to their constituents. Charlie Rangel is going to hear about it and Senator D'Amato because we are going to be saying to those people we need this money, and we need Federal and State aid.

Mr. GILMAN. Commissioner, have you asked the mayor for funds for that program?

Commissioner WARD. We have not asked him for funds to this date because we did it on a pilot basis, and Quiniones, the Chancellor, shifted some of his resources, I shifted some of my resources. And we thought the best strategy since it started in between budgets was to go forward with a demonstration project which we could show would work. And then present that, both by lobbying the community and the budget committees. And I expect to pack that Board of Estimate room this year with people that will be demanding that kind of support.

Chairman RANGEL. If the gentlemen will yield.

If you could get the U.S. attorney's office and the Drug Enforcement Administration just to sign off on this as to the type of thing that they are talking about, we hope that you would give us a crack at it too in Washington. Not because it is a national thing, but perhaps this could be just a pilot type of thing we are talking about.

Commissioner WARD. Well, General Reese has been very receptive. I met with him on several occasions, the last time just a couple of weeks ago up at Harvard University. I have met people from the White House, and a staff person from the White House and a staff person from the U.S. attorney's office who came down and went to Harlem, visited the schools in Harlem and seemed to be terribly impressed by these kids. After these kid's exposure to police officers, he asked two little girls, "What do you want to be?", and the one said, "I want to be a cop.", and the other one said, "I want to be a policewoman." It was a Texas fellow. I've forgotten his name. But he thought that these young black kids would never want to ordinarily be associated with law enforcement.

Chairman RANGEL. They know the right answers if the man is there.

Commissioner WARD. Yes, well, I have to tell you that a very important part of this program, and everybody that comes to see it recognizes immediately that because we pick police officers who come from the very areas and sometimes the very schools in which they are taking part in this program, they represent role models for these kids. And our police officers are so innovative, I saw one young black police officer early on in this program slipping in reading lessons to the kids. It is a team teaching approach with the

teacher. He asked these children, "What do you do when you go home?" And he got WLIB, and the records, and all of that stuff. And he quietly started talking about do you read, and finally down to do you read comic books. And when they said, yes, he handed them our comic books which are addressed to suppressing drug trade.

So, they act as a role model. They say to this kid for the first time, "You can get out of this, He did it." And especially when we have one of the young police officers who is a female. And they look up and see this diminutive looking police officer with the big gun on her side. And they think I can do that. And I think it helps.

But in the final analysis, I think you are right. We have to somehow or other involve that Federal Government. I think the Federal Government being a political organization will react to political pressure that will come from a successful program. And that was my strategy to move in that direction.

Mr. GILMAN. Commissioner, I hope you won't be reluctant to involve our State government as well at the same time, and try to encourage our Governor and the State education department to take a look at your program.

Do any of the other panelists have any suggestions on education that they would like to see us develop?

Mr. STUTMAN. Mr. Gilman, I would just like to advocate that there be a meaningful, truthful, positive, K through 12 Drug Alcohol-Education Program. The average first age for drug use in this country is 12½ years. Most school systems that have any drug education at all start at age 14. I am not an educator, but I know it doesn't do a lot of good to teach a kid 2 years after he has made his decision about drugs.

Second, I would strongly advocate that school systems say, "We are not going to tolerate drug use in this school as the norm." My kid, your kid, Senator D'Amato's kid, and Mr. Rangel's kid, have a right to go to school without seeing kids smoking bones, snorting coke, et cetera. I think that is a very unhealthy atmosphere in which for them to go to school.

Third, while the school says we are not going to tolerate you using drugs, the school system also has an obligation to say, however, if you want help, this school system will make that help available in a nonconfrontational, nondisciplinary manner. Most of those things cost very little money. When I was in Massachusetts it was costed out that probably the best drug education in the country, K thru 12, could be instituted in every school in the country for under 1 percent of the entire school budget. That is not a lot of money, and I think as Senator D'Amato rightly said, if we care about our kids dying, that 1 percent should not be a major impediment.

Chairman RANGEL. If the gentleman would yield, I just hate to see this type of talent and these recommendations just go into the transcript and to the air.

Don't you think it might make some kind of sense if we got together in an informal way and allow Commissioner Ward to head up this body. To pick perhaps the members of this committee to join with you and to pick some State legislators to sit around the table with the mayor's and the Governor's people. And certainly

from what we heard this morning, we need someone from the State health department and the State education department, and try to see whether in a nonpolitical way we can be not only supportive of each other's efforts but to come out with some statement as to what we expect from our city, our State, and our Federal Government.

If we can't get the resources, I think if nothing else with the type of talent that is here we would be able to create a program that perhaps more progressive cities and States could adopt. And I will get back in touch with you, Commissioner, since I started picking on you.

Commissioner WARD. That's all right, everybody does.

Chairman RANGEL. That's all right.

And see whether we can get this type of team together with staff, with these recommendations, and we'll use it in Washington and in Albany and in city hall.

Commissioner WARD. Can I just take 5 seconds on that, Congressman?

In your district, we are showing Harlem kids drug scenes with palm trees and rolling lawns that we got from California because we could not even find films depicting the innercity. So, I have to explain to these kids that drugs do the same thing whether you're under a palm tree or a lamp light in Harlem. But we don't even have the film, and no money to produce our own. So, we are going around begging foundations now to put the money together and pay for it.

Mr. GILMAN. Mr. Johnson and Mr. Giuliani, in the past we have heard many reports about backlogged prosecution due to lack of resources.

How are we today on any backlog with regard to drug prosecutions? Are we current, do we need more resources, how do we stand with regard to drug prosecutions?

Mr. JOHNSON. I really need more resources. I am going over 3,000 indictments this year which is double the amount that I have had in the last 4 years.

Mr. GILMAN. Have you increased staff in that period of time?

Mr. JOHNSON. In the last couple of years, I would have to say, no.

The amount of cases that I process that I don't handle directly are in the neighborhood of 12,000 to 15,000. And those that I don't handle, I handle the felony cases, but the nonfelony cases are referred to Bob Morgenthau's office. So, I am handling 15,000 cases. I am indicting about 3,000 cases because of the lack of resources.

Mr. GILMAN. I will be pleased to hear from the gentleman from Colorado.

Mr. STRANG. Can you hear me all right?

Mr. GILMAN. Yes, I can.

Mr. STRANG. I would like to compliment you on the most spectacularly good panel I have heard yet on this committee. All of you are very good.

Would it help your work to be done if laws could be changed a little bit to provide that when somebody is caught at Kennedy or wherever, you could just send him back instead of turning him into the system, and maybe send the junk back with him?

Mr. JOHNSON. That is somewhat a problem because if they come into this country as John Doe and we send them back, they come back tomorrow as Jack Doe. We take these people, we convict them, they do their time, they are deported and they come right back in. So, that is part of the problem.

Mr. STRANG. I was just curious if there were any tools which would just take those people—those you could capture bringing it in—and take them out of the system. Send them back where they were from along with their goodies, which are presumably illegal in the country they came from, and let somebody else do the work for you just to ease the backlog.

Mr. JOHNSON. I think one of the most effective Federal tools that we have is the Federal forfeiture statutes, and particularly that statute which permits local law enforcement to share in the proceeds. And we have several cases in the pipeline where we hope to be sharing in the proceeds of major narcotic investigations that have been successfully concluded.

Mr. STRANG. Let me, if I may just express one more view, isn't it true that a number of these couriers, which is really what they are, are sick and they have AIDS and are in this problem when they come in here and they become a public health responsibility?

Do you run into that?

Mr. JOHNSON. Most of these couriers that do come in are not the users per se. They are the entrepreneurs, and they supply those people who are sick and who have AIDS. These are just business men who are just in it to make the dollar. And our problem is that pool of addicts that adhere to feed upon the drugs that are brought in by those couriers.

Mr. GILMAN. Mr. Giuliani, on the question of resources, could you tell us if there is any need in your office?

Mr. GIULIANI. Mr. Gilman, I would say that my office is prosecuting, as in many cases, probably a lot more cases than it really can prosecute given the resources that it has. But on the whole question of resources, I think that one of the things that this committee can do, particularly in the spirit that the chairman mentioned about looking at the whole overall problem, you really have to look at law enforcement resources comprehensively. And to say that I need 10 more prosecutors, or Sterling Johnson needs 50 more prosecutors, frankly right now, will create more of a problem than we are presently undergoing. Because all we will do is create more cases that we are not handling.

You have to look at the whole system and say if we are going to increase the number of police officers and we are going to increase the number of agents and if we are going to increase the number of prosecutors—all of which I think is necessary—we also have to increase the amount of prison space available, State and Federal. That is a very important part of it.

Mr. GILMAN. And rehab centers.

Mr. GIULIANI. And we have to increase the number of probation officers and parole officers that are available. We have to look at the whole system. It doesn't become an impossible bill in terms of dollars because the dollars we are talking about in comparison to the State or Federal budget are not tremendous amounts of money. And the thing that Sterling mentioned before is very, very impor-

tant. The forfeiture laws, the Federal laws now have the ability to share those forfeitures with the State. It makes it possible to do drug enforcement in a way that doesn't really cost the taxpayers any money.

We seize approximately about as much money as it costs the Federal Government to operate my office, the Drug Enforcement Administration——

Mr. GILMAN. Does it go into a revolving fund?

Mr. GIULIANI. The legislation in 1984 provides for a certain percentage of that money to come back for law enforcement. And most importantly, for a certain percentage of that money to be shared with State and local law enforcement if they participate in the effort.

Mr. GILMAN. Who doles that fund out?

Mr. GIULIANI. Well, it is done now by the Justice Department.

Mr. GILMAN. Is that picking up a substantial portion of your costs?

Mr. GIULIANI. The Federal law enforcement does not get the money directly back. But if we seize let's say $1 million in a drug case that we do with Sterling Johnson's office, a certain percentage of that—25 percent normally, but it can go as high as 50 percent—can be turned over to Sterling Johnson for use in his office.

Chairman RANGEL. How does the city get their share?

Mr. STUTMAN. Commissioner Ward mentioned the task force. Every dollar that is seized by the task force, and I believe so far this year it is somewhere around $10 to $12 million, one-third automatically goes to the New York City Police Department.

Mr. GILMAN. You see the money? I mean, do you see it in your budget?

Commissioner WARD. We are waiting for the first check, and we expect it to be about $300,000. Frankly, my greatest fear is that we will get the $300,000 at the top, and somebody in budget will arrange to cut it out at the bottom.

Chairman RANGEL. You just have to make certain that you don't let that happen. We didn't enact these laws in order for this money to be subsidized in some other part of city and State government. And it doesn't always have to be your voice alone.

Commissioner WARD. I fight even harder with the budget people than I do with my friend, the mayor.

Chairman RANGEL. I am always extremely reluctant to be critical of the mayor, but in this case I might make an exception.

Commissioner WARD. The mayor has been tremendously supportive. It is other people, the budget directors, they have a lot of demands.

One thing that Congressman Strang said that I think you might want to pay some attention to, when I was correction commissioner in the State for about 4 years, I got this bright idea to get rid of the illegal aliens—particularly those who were dealing in drugs. Get them out of the State system to make more room in the State prisons. Well, I got the best conversations, and trips to Burlington, VT, and all over the place. And we talked for a couple of years. And I finally left in 1978, and I tried it again in the city. We got the same kind of beautiful conversation. We never got rid of one illegal alien out of the State or local jail. And that would certainly spring up a

lot of State space if you sent those people who have been convicted back to the countries that they came from.

Mr. GILMAN. One last question, I have overextended my time.

Mr. Stutman, has there been any evidence of an area link with Asian organized crime? The Yakuza, for example, and any other organized crime group in the Asian area to the New York metropolitan Asians?

Mr. STUTMAN. There is certainly some preliminary evidence that Asian organized crime is involved in heroin trafficking. I will tell you very candidly that this is one of the areas where the Drug Enforcement Administration needs to improve. I am looking toward setting up a specialized group for Asian traffickers.

Mr. GILMAN. You mean specialized people such as those fluent in the languages, Chinese, et cetera. Do you have that kind of competency?

Mr. STUTMAN. I either have that now or have Chinese, Mandarin, and Cantonese speaking agents being transferred in here in the very near future.

Mr. GILMAN. Have you found any direct link with the Yakuza group?

Mr. STUTMAN. The Japanese group, I can't tell you at this point. I haven't documented any yet.

Chairman RANGEL. Thank you.

Senator D'Amato.

Senator D'AMATO. Chairman, I am simply going to say to you I think this is probably one of the best, if not the best, hearing in this area that I have had the privilege to participate in.

On a second, your call to attempt to bring about by using the very panelists who testified today a program that will deal in real substance with the prevention aspect. And when we talk about education, let's understand that if we were to have the most successful education program, and I say for the record now we have none. We have had a failure. We have a political system that is magnificent. We have an Office of Drug Prevention and Abuse, and we have Mental Health and a Health Commissioner, and we have an Education Department, and we have no preventative meaningful program to deal with drug and alcohol addiction—none.

And they can come in, and they are spending millions of dollars in salaries to get rid of them. The superstructure, and there is a fantastic political superstructure, but when it comes to doing the job they are a disgrace. And if it weren't for some individual citizen groups, and if it weren't for the efforts of Commissioner Ward, and some of the local school districts—and by the way, they shouldn't be off the hook either. Just because a curriculum has not been designed, doesn't countenance the conspiracy of denial, the conspiracy of silence to continue. Because any educator worth his salt understands what is taking place. And it is not just in the high schools. It is in the junior high schools, and it is in the grade schools. And it is after school hours. And it is on weekends where these kids are becoming addicted and partying with drugs and alcohol.

And so, we better develop a prevention program, educationally. Not only in our school systems, but throughout our private sector, if we are going to win the battle. And if we win that battle, we are

still going to take time. There are a lot of addicts out there. We need that rehabilitation as well as the efforts of these gentlemen who are fighting a tough battle. And there are enormous odds, and they are doing a darn good job. And sometimes the public doesn't realize it because they are out there and they are getting victimized, and they say, "What has happened?"

We can't blame these gentlemen and the people that they represent. So, I look forward to, Mr. Chairman, your suggestion in bringing these gentlemen together, bringing our State legislators together, and getting our private sector involved, and, yes, stop this business of just passing the buck. We've got areas that can and should be utilized including the Federal resources as well. But there have been too many people looking for others to do it.

So, Mr. Chairman, let me thank you. And, Mr. Stutman, I am looking forward to your active participation as you participated in the Boston area in bringing in that new dimension to this Federal law enforcement problem. And really it is the problem of providing leadership so that we can have domestic tranquility in our homes and in our streets and in our communities once again.

Thank you, Mr. Chairman.

Chairman RANGEL. Thank you.

Congressman Towns.

Mr. TOWNS. Thank you, Mr. Chairman.

I would just like to pass along that this is probably the most respected panel I have ever heard. Not only have they done a magnificent job, but it has been brought out to us that we all have a lot of work to do. And I feel very strongly that if we work together that we can begin to do something about this drug problem that we see, especially in this area.

And, Mr. Stutman, I would like to welcome you to this area. I have heard about your outstanding work in Boston, and we look forward to working with you as we have with the other gentlemen here in this area.

Thank you very much, Mr. Chairman.

Chairman RANGEL. Congressman Scheuer.

Mr. SCHEUER. Thank you, Mr. Chairman.

I do wish to congratulate this panel for the exceptional quality of the testimony that we have heard. It is ironic to me that we heard from a law enforcement panel more commitment to the importance of education, and more commitment to the indispensable quality of health education and preventive education, from this panel than we did from the State official who is in charge of health. If that isn't the greatest irony of all time, I haven't heard it. And I want to congratulate this panel for its absolutely outstanding testimony. I know many of you for years, and you have met your finest hour this morning.

I have just two questions. First of all, I would like to ask Mr. Stutman to elaborate a little when he says we have to teach the kids how to say no, we have to teach them why they should say, no.

What should that message be?

Mr. STUTMAN. The message should clearly be that drugs are harmful. But we should give them that message in a factual manner that is nonpreaching, noncondescending. One of the things that is perhaps the scariest of all, is when I talk to kids I say,

"Who do you talk to about drugs?" It is a very simple question, and they will tell you that the only ones they feel comfortable talking to are each other. They have become their own experts. So frankly, Congressman Scheuer, they believe such garbage to be true that it is scary. If it weren't so scary it would be funny.

They can't talk to parents, they can't talk to teachers, and we have to break down that wall so that we can honestly talk to them about the subject.

Mr. SCHEUER. You used the expression, "We have to give them a reason to say, no, to drugs." Any magical element that seems to have worked in the past?

Mr. STUTMAN. The magic is that (a) kids trust you and feel you are being honest with them; (b) perceive you know more than they do; and (c) you don't preach to them. Most kids will listen to you. Maybe I am an optomist, but I will tell you that I honestly believe that if most kids truly believe it is harmful for them, they won't do it. Some will. But, the majority of kids we are talking about, won't. And that is where I think we have failed. We haven't given them a reason to say, no.

Mr. SCHEUER. OK.

Mr. Chairman, I would like to make one recommendation. It comes from my being so absolutely, marvelously impressed with the commitment of this law enforcement group to the importance of education. And that is that they be enabled and empowered to review the educational curriculum that is now being designed. They seem to have a level of not only commitment and professionalism, but street smarts that maybe just possibly perhaps the curriculum developers at the department of education and the other professionals at the department health, may not have. And I feel that they are so knowledgeable, and they have been out there on the streets so sensitive, that they all be enabled to give whatever input they have to make into the drug education materials as they are being developed, I hope jointly by the department of education and the department of health.

Chairman RANGEL. Well, Mr. Scheuer, you are far more optimistic than I because I would not ask this panel to wait for the State to get its curriculum together, but we see whatever they have. That curriculum, you know, just came up in the middle of the questioning that Senator D'Amato had. Five minutes earlier, there was none.

Mr. SCHEUER. There was nothing.

Chairman RANGEL. In any event, I think in view of what the city has done that when we do bring ourselves together that it would be inescapable that this issue would be a part of that exchange.

Mr. SCHEUER. I have a second question. All of you mentioned the importance of more arrests, more convictions. On the pusher level, it seems to me from our experience that you can make the case that you can make arrests of pushers in Harlem, Bed Stuy, South Bronx, in suburban Queens, from now till hell freezes over, and for every pusher that you take off the streets there are 20 new would-be pushers ready to take their place. The financial rewards—that magnet is so high—and these kids, I guess, kid themselves that they aren't going to be picked up. That there is almost a limitless

supply of veritable Hall of Mirrors behind each pusher of young people who would be happy, and are happy, to take their places.

Looking at law system, what do we achieve by more and more and more arrests and convictions beyond the certain minimum that I suppose you have to have for law enforcement to be credible. And aren't there other ways that we can direct those funds, such as drug education, that really will have more effect on demand than the deterrent effect of arresting more and more pushers when they are going to be replaced instantaneously and the pusher system is going to remain intact?

Mr. GIULIANI. Mr. Scheuer, you are addressing two separate problems. Drug education is not going to do very much about the professional drug pusher. You are not going to educate the professional drug pusher through the State, department of education, or any video cassette or television advertisement not to sell heroin or not to sell cocaine or not to sell PCP. He is going to continue to do that, and he is probably also a career criminal at the same time.

The frustration that we feel is that the problem is so large and we haven't really adequately addressed the problem. Either of crime or the problem of drug use. We have decided that there is a limit in this State and other States on the side of the governmental systems who are dealing with crime problems and drug problems. And the side we decided on is this large (indicating), and the size of the problem is this large (indicating). And what we do is we leave it on the streets to victimize innocent people.

I mean, when you hear the prison population numbers they sound like they are magic numbers that have been written by some deity. And that is the size of the problem, the prison population is 34,000. Well, I mean, that is fine if in fact there are approximately 34,000 people who are mugging, killing, selling drugs, and committing dangerous acts against other individuals. The simple fact is that the problem is far larger than the resources that we are provided to deal with the problem as an emergency law enforcement problem. That is one segment of it.

Now, education and all of the other things that we have talked about can help, even in the short term and certainly in the long term, to start making that problem a more manageable problem. But some of the solutions that we are talking about aren't going to work next month and next year, even if we started on the right course today, we are talking about effects that we are going to feel 3, 4, 5, 10 years from now. And until then, we've got to do something about the emergency problem.

And I also think there is a circular effect to all this. If you are going to start turning things around, you have to start somewhere. And the simple statement that it is illegal to deal drugs, I believe is an important teaching device when you are talking about education. And the simple statement that we can effectively enforce those laws, I think helps to bring the problem down under somewhat greater control. And there is no doubt—you said very nice things about us, and we have all flattered each other—but in the work that we are doing, we could be more effective than we are. We are not in any off the hook for this problem. And in fact, we could all use additional resources, particularly in the prison area,

the parole area, the probation area, so that we deal with this problem in a more effective way than we have in the past.

Mr. JOHNSON. Congressman Scheuer, I think that arrests and prosecutions are just some of the things that just must be done. It is inescapable. If we don't do that, then we just throw up our hands, and I don't think that any of us are suggesting that.

The other solution that some governments have tried and it has proven to be a total failure is a demonstration where they want to legitimatize or give out free drugs. And that has absolutely not worked.

Mr. JOHNSON. I have spoken to people from Harlem, from the People's Republic of China, from Australia—everyone has a problem all over the world. And although we all agree that enforcement in and of itself is not the answer, we must continue strong strict enforcement and prosecution.

Mr. SCHEUER. I agree. And I think the importance of going after, especially the career criminals that you talked about, Mr. Giuliani, cannot be overestimated.

I read a report coming up in the plane of a study in Philadelphia, 27,000 kids who were born in 1958. And it traced their criminal history, and it indicated that 7 percent of those kids caused 75 percent of all violent crime in Philadelphia. So, especially in terms of drug-related violent crime, I think the career criminal has to be a target of opportunity. And I think that this committee ought to do everything within its power to focus law enforcement efforts and arrest and conviction resources on the career criminal.

Thank you, Mr. Chairman.

Chairman RANGEL. Thank you, Mr. Scheuer.

Mr. Weiss.

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

First of all let me say that the high praise which you all have received for being the professionals that you are in your field, and the experts that you are, it is absolutely warranted. And I know that the regard and respect with which you are held extends far beyond this panel and goes across the country certainly as far as Congress is concerned.

I must say that as one who 25 or 30 years ago was part of the law enforcement officials in the justice system, I know you all have an impossible job. You are being asked in essence that classic simile to empty the oceans with a teaspoon. And, Mr. Giuliani, I think that the last two points that you made of resources and for treatment facilities and education, probably are the best way to approach the problem. And although I appreciate all the problems of legitimizing and so on, it seems to me that until I am sure in some fashion the profit motive is taken out of the whole legal narcotics area, your job is going to be almost impossible.

When I was in the DA's office here in Manhattan in the late fifties, I think the percentages were roughly 50 percent of the case load that we had. People who were arrested it was either drugs or a drug-related crimes. And I assume that that percentage has not gone down with all the resources that have gone into it. So, I appreciate the concern that you all have for the lack of resources. And I wonder whether the resources, no matter what they are,

without focus on treatment, education, and elimination of profit motive, will really give you a chance to deal with it.

I have one question only, and it is sort of a transition because I am not really on the panel, so anything else I say really doesn't count officially. As a transition from what Dr. Axelrod was addressing and the next panel will be addressing, you all deal at least independently with the AIDS problem. It has become part of the focus of your activities too whether you will it or not. And there has been a discussion about the problem of needles. And Dr. Axelrod's comments sort of indicated that there is a school of thought they ought to use these people to use dirty and contaminated needles because maybe that will keep them from continuing on as drug addicts. I tend to think that that is a hell of a way of punishing people or trying to force them off addiction.

And I would like your thoughts as to what you see pro or con in the approach of at least not censoring addicts to this kind of unofficial execution by providing them with sanitary needles.

Mr. JOHNSON. I was asked this question by Mayor Koch, and I responded in a letter to him and if the panel does not have a copy I can leave a copy of this particular letter. I do not think that providing free needles is the answer. Drug addicts do not take the time out when they are shooting up to take a separate distinct uncontaminated to shoot up——

Chairman RANGEL. How do you know that—have you tried it?

Mr. JOHNSON. We know it from observation on the streets——

Mr. WEISS. Have we tested this. Have we said to addicts, here are some clean needles, and here are some dirty needles, you take your choice?

Mr. JOHNSON. We have made arrests in a room where there are several addicts and you have what they call packs of sterilized needles laying on the floor, and these groups of addicts are using one particular needle. And their idea of sterilizing the needle is for one addict to shoot up and when he passes it over, the other addict will spit on it, wipe it off, and then will shoot up again.

Mr. WEISS. Do you think education could work to improve their knowledge about what proper sterilization really is all about?

Mr. JOHNSON. Addicts do two things every waking moment of their life, every time they suck God's air, they live for that particular moment to get a fix. And in between they are saying to themselves and to the world, "I am going to kick the habit." Anything else beyond that means nothing. The only education you can give them right now while they are in this terrible state is where can I get another fix. So, I don't think education is the problem as far as addicts. They are educated. They know the risk that using a needle, an intravenous fix, will have. They know about AIDS. But it is like the marines hitting a beachhead, they say, "Yes, we can get AIDS if we use this needle, but it will happen to the next guy. It won't happen to me."

Mr. WEISS. What harm would it do then to provide them with free needles?

Mr. JOHNSON. What harm will it do?

As I said in my letter, then you are going to have to manufacture and provide a half a billion needles a year just to supply the

300,000 addicts that we have here in the city. And that's still no guarantee that these addicts will use these needles.

Mr. WEISS. OK, but what harm is done?

Commissioner WARD. The harm that is done is that it is going to go out as Government sanction and approval because we are supplying these needles——

Mr. WEISS. But he is not going to use them anyhow?

Commissioner WARD. I don't believe in doing foolish things and wasting time, but more importantly what you have to do here is not send out any message that this kind of killer is OK and that if you just use the free needle, it is OK for you to go forward and commit suicide and contaminate the neighborhood.

Mr. WEISS. They contaminate people who are not drug users themselves—there are children being born of mothers who have been contaminated by IV drug use. Those are innocent people. Maybe you could save some lives. That is really the purpose of my asking these questions.

Commissioner WARD. The reason you are getting into this line of thinking, Congressman, in my opinion is you are applying a rational process as a rational man to what is essentially an irrational behavior by irrational people.

Mr. WEISS. I am thinking of babies who are born.

Commissioner WARD. You can think of babies, but you might as well propose that for every drug addict who is arrested and convicted of being a drug addict, you take the child away from the family. Or some other way of protecting that child.

Mr. WEISS. I want to give them some needles so that they won't create new AIDS patients.

Commissioner WARD. You won't find a prosecutor or law enforcement authority in this country that will support what you are proposing. It sounds like a good idea, but in reality we know from experience that you can go in any shooting gallery in this city and see sterilized needles in containers and the drug addicts will be doing exactly what Sterling Johnson says.

Mr. JOHNSON. the other thing is that we have examples of drug pushers who will sell drugs with a sterilized needle as part of the deal, as a come on. Still the addicts use the first needle available, which is the contaminated needle. They are just not going to take the time out.

Mr. WEISS. Well, I asked about education before, and obviously education doesn't count as far as drug addicts are concerned. But let me just close by saying that it seems to me that with all due respect for your capacities, which are accomplished as far as law enforcement is concerned, maybe—just maybe—you ought to pay some heed to some of the health people. I don't know what their answers would be, but don't make this kind of judgment. Don't sentence innocent people, nondrug users, to AIDS because you think they are not going to use them, or because you are legitimizing. I really think you ought to think a little bit harder as to the broad societal problem that is involved in the spread of AIDS and how it is spread.

Mr. JOHNSON. Well, if we are going to give free needles to addicts, we should give field glasses to Peeping Tom under the same rationale.

Mr. WEISS. Well, I appreciate what you are saying, but I must tell you that that kind of comment itself perhaps tends to underscore exactly how serious a problem we have in educating the broad public as to this disease that is devastating our society and has no limits. The testimony we have had is that the past year, 40 percent of the new AIDS cases were among IV drug users or those who it through IV drug users. And I just think that facile remarks may not be the way of dealing with this problem.

Mr. JOHNSON. I apologize if you think it is facile. I didn't mean to be facile, but the addicts know that you get AIDS by using contaminated needles and they still use these contaminated needles.

Mr. WEISS. Try teaching them not to.

Chairman RANGEL. The Chair would like to end on this note. It is abundantly clear that this problem is being approached from two different directions. I would be glad to work with my distinguished colleague through a different committee to see whether or not tests could be set up in order to explore this thing.

And also, we will share with you the letter which this committee has from Mr. Johnson, which does give us the benefit of the research which has already been done by law enforcement in this area.

Let me again thank this panel, and take this opportunity to say that we will be in touch with you. I will assume the responsibility of contacting Commissioner Ward to see whether or not we can spend a half of day or less time than that together, and come up with some comprehensive plan. If nobody is going to listen to me, the President or the Governors, than perhaps we can at least say that those of us that are involved in the city and State of New York have come up with something that we've all touched to see whether we can sell it as a pilot project. But if it can't be done here, than it is worse that we can expect for the rest of the Nation.

I want to thank you for your expertise and your dedication.

The Chair would like to recognize the presence in this courtroom of the judge who the Federal courtroom belongs to, and that is Judge Wachtler. And we also recognize the presence of the deputy speaker of the New York State Assembly through his daughter, Missy. I also see from the district attorney's office a fighter that has been involved for decades, Mario Kozzy, formerly with Customs and now with Bob Morgenthau's office.

The Chair will call the next panel on IV drug use and AIDS led by Dr. Jerome Jaffe, the Acting Director of the National Institute on Drug Abuse; Dr. Harold Jaffe, the AIDS Task Force, Centers for Disease Control; Dennis Whalen, Division of Substance Abuse Services, State of New York; Dr. Beny Primm, who more than any other has encouraged the Chair and this committee, to explore the relationship between drug addiction and AIDS, who is the executive director of the Addiction Research and Treatment Corp.; and Dr. David Sencer—who supports the idea I believe that was advocated by my colleague from New York, Mr. Weiss—Dr. David Sencer, the Commissioner of the New York City Health Department.

Let me say that the Chair will enter into the record, if there is no objection, the entire statements that have been prepared by the witnesses. We thank you for your patience because we are running

behind time. And you may proceed not by just your written statement, but by highlighting it or whatever means you find comfortable.

TESTIMONY OF DR. JEROME JAFFE, ACTING DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE

[The statement of Dr. Jerome Jaffe appears on p. 141.]

Dr. JAFFE. Mr. Chairman, members of the committee, thanks for inviting me to come here today to discuss the relationship between AIDS and drug abuse.

The issue is of great concern to us at NIDA, and I know it is to you as well. I am accompanied by Dr. Harold Jaffe from the CDC, and by Dr. Harold Ginzburg, my special assistant for matters pertaining to AIDS. The bulk of my remarks this morning will be about the role of intravenous drug use in spreading both the AIDS virus and the diseases related to the AIDS virus. I will try to foreshorten my remarks. Feel free to interrupt me, if you wish.

The relationship of drug use to the complex problem of AIDS now facing us involves more than our concerns with the cases of AIDS already reported. The widely cited numbers of 14,500 cases of AIDS reported to CDC represent only the visible tip of the iceberg. We are concerned also about those individuals who have been infected by the AIDS virus but are still asymptomatic. It is estimated that there may be 1 million such people in the United States.

The categories of people who are at risk for AIDS as categorized by the CDC are: sexually active homosexual or bisexual men, present or past abusers of IV drugs, patients with hemophilia, transfusion recipients, and the sexual partners of individuals at increased risk for AIDS. The last group is of particular concern when we address the issue of heterosexual transmission.

You have heard from others today that these are not mutually exclusive risk groups. In particular, the individuals at risk because of sexual behavior may also be at risk because they are IV drug users. If we combine the number of homosexuals with a history of IV drug use and the number of heterosexual IV drug users, we see that in the United States as a whole, individuals with a history of IV drug use make up slightly more than 25 percent of the total number of reported AIDS cases. Based on national data, approximately 8½ percent of reported AIDS cases are among homosexual IV drug users, and about 17 percent of AIDS cases are among heterosexual IV drug users.

However, there is considerable variation from region to region. Five States: New York, California, Florida, New Jersey, and Texas, have the bulk of the AIDS cases; three-quarters of all the cases so far diagnosed. And in the New York area, 38 percent of reported AIDS cases are among those with a history of IV drug use, while in California, 17 percent of AIDS cases have a history of IV drug use. Pediatric cases represent less than 1½ percent of the total AIDS cases. However, 52 percent of these children are the offspring of IV drug users.

When we talk about patient risk groups, we tend to talk about homosexual and bisexual men and heterosexual IV drug users. What some people fail to appreciate is there are significant num-

bers of women who are developing AIDS or who are infected with the AIDS virus. The majority of AIDS cases among women are those who have a history of using IV drugs or who have had a heterosexual contact with an individual who is in a high-risk group for AIDS or who has AIDS.

Approximately 60 percent of the AIDS cases are white, non-Hispanics. Blacks represent approximately 25 percent, Hispanics approximately 14 percent. A majority of the cases of AIDS among homosexual users are white, while blacks compose one-half of the heterosexual IV drug users group.

A study that is being conducted in New Jersey by NIDA, the National Cancer Institute and the State of New Jersey, shows that more than one-half of the AIDS cases in New Jersey are found among IV drug users. And within that group, about half are women. This particular study involves more than 1,000 clients in 10 drug abuse treatment programs throughout the State.

Approximately 44 percent of the individuals entering detoxification programs—most of these are northern New Jersey—tested positive for antibodies for the AIDS virus. One-third of those in methadone maintenance programs tested positive independent of the time spent in treatment. It should be noted that about 95 percent of the IV drug users in this study, whether using heroin, cocaine, or amphetamines, reported sharing their needles.

In other areas of the country, such as New Orleans, where intravenous drug use rates are high but where large scale needle sharing such as we see in shooting galleries is not common practice, we have much lower numbers of AIDS cases and of individuals testing positive to the AIDS virus. Clearly, change must be effected in needle-sharing behavior in order to make progress in reducing the spread of this virus.

Mr. GILMAN. Dr. Jaffe, if I might interrupt you, since we have such a distinguished panel and since there are a number of panelists, we have made your testimony a part of the record, and we would welcome if you could summarize the highlights.

Dr. JAFFE. Let me just look through it. I have already gone through it and gotten it down to half of what was typed up for the record.

Mr. GILMAN. We would welcome that since we would like to be able to have a discussion with the panelists after you all touch on your highlights. And I'd like to encourage our other panelists to do the same.

Dr. JAFFE. Let me summarize in about 2 minutes what ought to be in.

I was asked to take on the role as Acting Director of NIDA sometime in May. Since that day, AIDS has been on the front burner as the highest priority issue at the National Institute on Drug Abuse. We have developed plans and put those plans through the budgeting process to the Public Health Service. It now looks as if we will be having additional resources to significantly expand our efforts in developing the information needed to prevent the further spread of AIDS.

We have a fairly comprehensive plan that will involve research in a number of drug-using populations to determine if we can identify those procedures and those interventions that will be effective

in getting drug abusers to change their habits with respect to needle sharing and with respect to needle use.

We also are interested in finding ways to see if we can persuade them to alter their habits with respect to their heterosexual activity. And we will not limit ourselves to those who are opiate users, but will look at cocaine users as well since it doesn't really make much difference what drug you use. If you use a needle and you share it, you are at risk.

We are also cognizant of the problems in the criminal justice system, and are trying to communicate with a number of prisons around the country to find those whose administrations are flexible enough to look at alternative ways to manage the AIDS issue—to see what happens, for example, when you identify AIDS virus carriers—what methods can change their behavior so that we can reduce the rate of spread within the prison system. We obviously need to intensify our efforts to get people into treatment, but we also recognize that getting them into treatment is itself a problem, not necessarily related exclusively to the availability of treatment resources. There are studies from New Haven that indicate some people are just not interested in coming in for treatment even though it is available. Sometimes this is because they are doing too well on the streets, for example, they are not doing badly enough yet; or alternatively, they don't like the kinds of treatment available. Therapeutic communities are too demanding for them in terms of the time commitment, and methadone maintenance has developed a bad reputation among some IV drug users.

We feel we have to renew our efforts to develop alternative treatment approaches that may be more acceptable. So, in short, the National Institute on Drug Abuse recognizes that we have a major responsibility to learn ways to change the behavior of drug users, to discourage drug use, and to work with all of those who are now involved in the treatment process to improve education about AIDS, to share with them the information we have developed from our research so that they can implement programs that will bring the problem of AIDS under some degree of control.

With that, I will be happy to answer your questions.

Chairman RANGEL. Thank you, Dr. Jaffe. We will proceed with the additional panelists, and we will hold our questions until the entire panel is completed.

Dr. Harold Jaffe.

TESTIMONY OF DR. HAROLD JAFFE, CHIEF, EPIDEMIOLOGY BRANCH, AIDS PROGRAM, CENTERS FOR DISEASE CONTROL

Dr. H. JAFFE. The CDC has not submitted separate testimony, so the NIDA testimony will stand for us.

Chairman RANGEL. Thank you.

And Dennis Whalen of the division of substance abuse services.

TESTIMONY OF DENNIS WHALEN, DIVISION OF SUBSTANCE ABUSE SERVICES, STATE OF NEW YORK

Mr. WHALEN. Yes, I am testifying on behalf of Commissioner Martinez of the division of substance abuse services who is unable to be with us this morning. And he is troubled by that fact because

he wanted to indicate personally his deepest concerns about the problem of AIDS and IV drug use, which he considers to be the division's top priority and the most critical and pressing health issue that we have faced.

Our testimony has been submitted to the panel, and I would like to touch on some highlights as you have suggested. In the United States the AIDS epidemic among IV drug users is centered in the New York City metropolitan area, and clearly the AIDS epidemic is most advanced among IV drug users in this area where we estimate that about 50 percent of the IV drug users population has been exposed to the virus.

It is clear from other testimony that you have heard this morning that the sharing of paraphernalia for injecting drugs is the primary method of transmitting the HTLV-III virus among this group. I want to stress that this paraphernalia can not only include needles, which have been a subject of discussion, but syringes, cookers, and even rinse water that may be reused in cleaning needles. All of these implements that permit the exchange of blood between persons injecting drugs are implicated in the spread of AIDS.

As you can well imagine, shooting galleries are places where this virus can be widely spread and it is important to emphasis that the particular drug injected does not appear to play an important part in the spread of virus. So if you share the needle, it doesn't matter if you are injecting heroine, cocaine, amphetamines or other drugs.

To touch on a subject which I am sure Dr. Primm will mention, IV drug use has traditionally had a disproportionate impact on ethnic minority groups in the United States. As a disease among IV drug users, AIDS similarly will have a major impact upon minority groups. And one particularly important aspect of this impact will be on the heterosexual partners who do not inject drugs themselves, and children of IV drug users. The majority of IV drug users have their primary sexual relationship with a person who does not inject drugs. The potential for heterosexual transmission and in utero transmission will increase the strain on couples where one partner injects drugs. Such couples and their children already experience high levels of health and social economic problems. IV drug users and their heterosexual partners are typically at the ages of high rates of childbearing and our current studies indicate that approximately one-quarter of the IV drug users in New York expect to have additional children, and another quarter are not certain as to whether they will have additional children or not.

In collaboration with the New York City Department of Health, we are presently intensively studying relationships among IV drug use, ethnicity, exposure to the virus and development of clinical AIDS. From our preliminary analyses it appears that ethnic minority IV drug users are developing AIDS at a slightly higher percentage than the percentage among all IV drug users in New York City. Dr. Freidman, who has accompanied me is working with the department of health on this study, and we are currently investigating whether it is as a result of different rates of exposure to the virus, measurement error or a product of as yet unidentified cofactors that influence disease progression after viral exposure. We will certainly be pleased to keep the committee informed as this study progresses.

Needed efforts for the immediate future: In the absence of a vaccine or treatment for AIDS, education and prevention, as was stressed here this morning, are currently our best vaccines. It would be a major mistake, I think, to think that intravenous drug users cannot change behavior. We have consistent evidence from a variety of studies that a great many IV drug users do change transmission related behavior in response to the threat of AIDS. Dr. Freidman can expand on this a little later on during questioning; and prevention efforts, we have found, can be successful in this regard. As Sterling Johnson and others have indicated, IV drug users are certainly aware of AIDS; they are aware that AIDS is spread by a sharing of needles and there is evidence from some of our studies that they are indeed making behavior changes already to deal with this knowledge.

There are basically five subgroups that we feel are most important for targeting of prevention efforts. These include current intravenous drug users, program staff in our treatment programs, sexual partners of IV drug users, clients presently in treatment and those who we consider at risk for beginning IV drug use.

We know who we want to send the message to and we know what we want to say. Those at risk should stop IV drug use; they should stay out of shooting galleries and not share needles; if they are not so inclined, they should clean needles and adopt safer sex practices. The problem lies in determining how to pass along this information in the most effective manner. The IV drug-user population exists as a subculture fraught with literacy and jargon problems. It is difficult to ensure that messages to this population are understood. We find that there is a clear need for interaction and for question and answer, with IV drug users if we are to guarantee that our messages are understood. To deal with all these things we are currently developing a plan which focuses, certainly, on traditionally information sharing strategies such as pamphlets, but also include a strong analysis on face-to-face education.

We have a research group within the Division which we call our "Street Studies Team." This is a group of individuals who are ex-addicts or ex-substance abusers, who go out into the community, primarily in New York City, to survey the major drug-copping areas. It was through some of their efforts that we found out about drug dealers enticing buyers by including sterile needles as a part of their selling tactics. We feel that use of such a street studies team that is relatively mobile or that uses storefronts is probably the most effective way of interacting with the IV drug-user population to promote behavior change.

Also, just to touch on Congressman Weiss' discussion with previous witnesses regarding the needle question: As you know, this proposal was made by the New York City Department of Health, and the department, as I am sure Dr. Sencer will mention, has just raised the question of possibility reducing the restrictions on availability of sterile needles. Certainly, as Mr. Johnson indicated, there are instances where you can go into a shooting gallery and see new unused needles on the floor, but we have some indications, as I previously noted, that IV drug users will make behavior changes. So that we expect that as the increase in AIDS cases occurs among IV drug users, that this will certainly become a topic for more discus-

sion. We feel also that we ought not to have a knee jerk reaction which rejects this proposal outright, but that we ought to develop some carefully defined study where we could actually measure what the effects of such a proposal would be.

Chairman RANGEL. Thank you, Mr. Whalen.

[Mr. Whalen's prepared statement appears on p. 155.]

TESTIMONY OF DR. BENY PRIMM, EXECUTIVE DIRECTOR, ADDICTION RESEARCH AND TREATMENT CORPORATION, NEW YORK CITY

Chairman RANGEL. The Chair would like to especially thank Dr. Primm for his insistence that Congress look into this very serious area, and I look forward to your testimony.

Dr. PRIMM. Thank you very much, Mr. Chairman.

Mr. Chairman and members of the select committee, as you may recall I have discussed this problem and the impact of AIDS on the American public and particularly on minorities. As you are aware, New York City has the infamous distinction of being the home of the greatest number of AIDS patients, 4,827, as of October 30, and the estimated highest number of estimated intravenous drug users, 177,000. A more distressing fact, Mr. Chairman, is that your congressional district has the greatest number of at-risk persons, cases per population, of any other in the United States. There are at minimum in your district 10,000 registered intravenous drug users in treatment. It has been reported that at least 60 percent of that number would test positive for the presence of the HTLV-III antibody. That population is in constant contact, intimate contact with spouses, lovers, and significant others, and almost all are infected, despite being asymptomatic themselves.

My purpose here today, Mr. Chairman, is not to sound the alarm and cry "fire," but to call to the attention of those responsible that our minority communities are very fertile grounds for the spread of this retro virus.

We have in Harlem the highest incidents of new active cases of tuberculosis in the United States; that's 109 cases per 100,000, and the second highest, only exceded by Haiti, 134 per 100,000 population, in the whole free world. We also have reported and unreported cases of pneumonia that are numerous. As you know, Mr. Chairman, tuberculosis is a disease of those who are stressed, living generally under deplorable conditions with poor nutrition, housing and health care. Many of the AIDS cases at Harlem Hospital present with the diagnosis of tuberculosis, and their average AID caseload at Harlem Hospital is 30 patients at any given time. Alcoholism, smoking and the use of marijuana and cocaine is rampant among minority youth in the Harlem community. Drug dependence, homocide and cirrhosis of the liver, secondary to alcoholism, are the first, second and third leading killers of blacks and Hispanics between the ages of 15 and 44 in Harlem and in east Harlem, your district.

More often than not homocides in these areas are either directly or indirectly associated with alcohol or other substances of abuse. All research reports indicate that drug abuse of any kind impairs the body's immune response, resulting in greater vulnerability for

such persons for all diseases, but more so for those in the risk group for AIDS, for the minority population represent 50 to 54 percent of that population in the New York City area.

Mr. Chairman, I would like to recommend that this committee advocate for an all-out educational approach to this problem in the minority communities. This must include stressing a change of lifestyle and behavior, using street workers and mobile units to reach that population not in treatment and also to reach the so-called street people.

I would like to further suggest that this committee recommend strongly that there will be a better mechanism for detection and screening for tuberculosis in minority communities, a better mechanism for treatment, control and followup of diagnosed cases of tuberculosis. The establishment of an advisory committee to the New York City Department of Health and to the New York State AIDS Institute, to ensure an inclusion of a minority and cultural prospective in all of their health policies. The establishment of an enforcement group to make immediate sweeps and the closing of all shooting galleries in New York City and elsewhere, with emphasis on Harlem and other minority communities. To establish a mechanism to ensure that medical school curriculums include lectures on signs, symptoms and diagnosis of acquired immune deficiency syndrome and the AIDS-related complex.

Some people are going to use drugs and I think that some thought and effort on the part of the Federal Government should be made to investigate how to teach people who use drugs to do so in a manner that is not at risk to their health. Prevention and education efforts have been effective in decreasing morbidity and mortality among the homosexual and bisexual communities and despite the difficulty that has been reported in using the same strategy among intravenous drug users, I feel that all efforts must be exhausted to accomplish the same results as has been accomplished in other high-risk groups.

Mr. Chairman, that sort of finishes my testimony and I am willing to answer any questions that you might pose, concerning this problem particularly in the minority communities of New York City.

[Dr. Primm's prepared statement appears on p. 163.]

Chairman RANGEL. Thank you, Dr. Primm.

Dr. Sencer.

TESTIMONY OF DR. DAVID SENCER, COMMISSIONER, NEW YORK CITY HEALTH DEPARTMENT

Dr. SENCER. Thank you, Mr. Chairman.

I have a very short statement. I will try to make it even shorter by condensing as many of the other witnesses have already covered much of what I was going to do.

I have a little bit more recent information.

Dr. Primm, this morning we did our count for this month and we now, unfortunately, have over 5,000 cases of AIDS in New York City and about 36 percent of these are related to substance abuse.

The State Substance Abuse Service estimates that we have about 200,000 active heroine users in the city and at least 60 percent of

these are infected with the virus that is the underlying cause of AIDS. I just recently looked at the deaths in New York City: 6 percent of all deaths in the age groups between 25 and 65 are related to substance abuse. This is, I am sure, a gross understatement of the true magnitude of it. This is up from 3 percent in 1980 to 6 percent in 1984.

As Dr. Primm mentioned, we do have this increase in pneumonia as a cause of death in substance abuse patients. We recognized this about 3 years ago. We have investigated this. This is not due to any normal causes of pneumonia. It is not due to the usual cause of pneumonia in AIDS patients, something that we have under investigation. Tuberculosis has also increased in the last 4 years in direct proportion to the increase in AIDS. It is in the same area of town where we have drug abusers; the same area of town where we have AIDS. So that we have studies under way at the present time that would indicate that the immune deficiency seen in AIDS is really the cause of people activating old infections with tuberculosis. This is not new disease. This is disease that these individuals caught 20 years ago. Now that their immune system is being stressed, they are developing the symptoms of the disease.

I was not going to talk about education, but hearing some of the comments that were made before, I would just like to make a couple of comments: Mr. Stutman, I think, referred to the young girl who said nobody had ever told her why she should not use drugs. I think AIDS is a very good reason to tell people they shouldn't use drugs. It kills. There is no doubt about it.

I think another thing I would like to see is recreational drugs be outlawed. I don't think there is such a thing as a recreational drug, yet you hear this all the time. "It is something we do for a little recreation," and it is the first sniff and the first snort that leads to the use of the needle that will kill eventually.

What are we doing about AIDS and substance abuse in the city? We're doing more than we were a year ago, but we are still not doing very much. Just what can we do? We can tell people not to use drugs. We can tell people that if they use drugs, they should use clean needles. We can tell people if they had used drugs or continue to use drugs, they should realize that they may spread the disease by sexual intercourse. We can train workers to counsel people who seek help.

We are doing these things, but will they help? Not too much. What will help? I think sessions such as this are an important first step. Too many people in this country think that AIDS is a gay disease and don't realize the magnitude of the drug problem. In the early days of the epidemic the gay community rightfully felt that society is not sympathetic to their problem. Today the attitude exists as it relates to substance abuse, "It's their problem, it's not mine. It serves them right." These are the unstated attitudes of many people that we hear speaking today.

What more can we do? We do know that many users will benefit permanently from treatment. Methadone or drug-free therapeutic communities, whatever it will be. We know, unfortunately, also that many people will not stay on substitution or drug-free programs permanently. We also know that there are not enough resources to provide the needed treatment that is desired in this city.

What can we do? Let me speak not as much as an epidemiologist as the Commissioner of Health. I am speaking now about my concern about stopping the transmission of HTLV-III virus. I am not speaking of the best way to solve the whole drug abuse problem.

I think there are two ways in which we can prevent infection and transmission of HTLV-III virus, hepatitis and the other infections that are transmitted in this population: One is don't inject; and, two, if you do inject, use clean needles. I am already on record as having offered the suggestion, the spirited discussion about earlier. I will be glad to give you a copy of my memo to the mayor that started the discussions here in the city.

I think having the discussion is important. Whether people agree or not, we have got this up on top of the table with something we can talk about. I was most pleased to hear the State say that they look at this as something that we need to try. We need to find ways to see whether it is effective. I don't think any of us know, but it is certainly worth trying.

Now, how do we keep people from not injecting? I think we have to find ways of making treatment modality much more available to anyone who wants help. Dr. Jaffe mentioned the fact that people are rejecting treatment because it doesn't suit their needs; it doesn't suit the other problems that they may have at the present time. There are thousands of people on the street now that we know want treatment. Let's provide it to them in the best way we can. It may not be under the ideal circumstances, but at least a form of treatment that is humane and desired.

What can the Federal Government do about it? I think one thing that the Federal Government's Food and Drug Administration can do is to eliminate their arbitrary restraints upon capacity to provide treatment. The Federal Government has cut back on funds, but continues to mandate that certain services be provided that may be considered ideal, but this deprived many needy users from the benefits of bare bone treatment. If we can't afford a luxury car, let's at least use a compact. To continue that analogy, there are safety standards for all cars, whether they be a luxury or a compact. Standards are needed also for treatment programs, but these standards should be for 1985, not 1965 or 1975. Totally unsupervised treatment is medically and socially unacceptable, just as provision of heroine is unacceptable, but we have to come up with emergency measures.

I am not sure that more money is needed as much as new ideas, because we need to bring new people into searching for community solutions. I am not a drug abuse expert, I can envision approaches which others will find completely distasteful, but it is only through dialog that these solutions will be found. You are to be congratulated, I think, for opening that dialog. You made an offer earlier to join in discussions with all of us. The city health department wants in.

Thank you, sir.

[Dr. Sencer's prepared statement appears on p. 167.]

Chairman RANGEL. Well, thank you, Dr. Sencer, because you ended on the note that I had hoped that you would, and that is to see what recommendations this panel of experts would have, because if you were here earlier, the State director of health had in-

dicated that he did not have any input in what was being done by the Education Department, and we know that the Education Department isn't doing anything. Dr. Jaffe worked with the Congressional Black Caucus at congressional hearings in September, and before you arrived the Commissioner of Education indicated that there is no Federal program, no model program, that could be suggested to State and local governments. And so—I am talking about Commissioner Davenport of Education had indicated that there was not even a program that they could recommend to the Governors, and I think if I recall your testimony, it is that you have regional meetings where educators can voluntarily come in and check out what is going on.

Now, Dr. Sencer, it seems to me, and I am not expert, that we are sitting on a time bomb, and that this isn't a question for politicians or lawmakers, it is a question of what do you do if you find that you are on the brink of an epidemic of a disease where there is no cure, but you have been able to identify the carriers? Now, Dr. Axelrod testified that they weren't checking out the prisoners. They were not screening and blood testing the prisoners, and I am no penal expert, but if you can find the people that Dr. Primm has described as being black and Hispanic, addicted to drugs and involved with homosexual activity, it just seems to me, if you really wanted to find that population you would go straight to the jails and they would be there. And yet, they are just allowed to exist and not even be studied, much less treated.

Dr. SENCER. Well, we estimate in New York City, Mr. Chairman, that there probably are a half a million people who are infected. These estimates are based on the facts that we have a population of close to a half a million gay men and about half of them are affected. We have 200,000 heroine users and about 60 or 70 percent of those are infected. So this adds up to close to a half a million people who are infected; most of those people are not in jail. So that by looking at the Rikers Island population or the penal institution, we are only getting at a small group.

Chairman RANGEL. I didn't mean that. What I meant was this was a control group where you didn't need to send out a whole lot of questionnaires.

Dr. SENCER. No; we know, we can say that they are infected and if they continue to use drugs once they get out of the penal institution they are going to——

Chairman RANGEL. What are you recommending? What should we be doing? Have you discussed this problem with the State officials?

Dr. SENCER. We talk a lot with the State officials. I am not sure that any of us know the answer. Do you put people in separate penal institutions? Lock them up? I don't think that seems to be the answer.

Chairman RANGEL. Don't a group of doctors get together and say, "This is the problem that we have and it is a national problem and New York has more of it than anybody else?"

Dr. SENCER. Dr. Jaffe might be in a better situation to answer this, but there is a group at the present time who are trying to develop policies for dealing with infections within the penal institutions of this country. We hope to see guidelines. There will be a

meeting in 2 weeks of the leaders of the correction system of the country with their physicians and their lawyers, all getting together to talk about how you can best solve and work with these problems in the correctional institutions of the country. So there is a lot of dialog going on. The State health department, the State corrections department was involved in the discussions at CDC on the problems of AIDS in correctional institutions and Commissioner McNivens, director of corrections, I think, will be going to the Phoenix meeting. So we are getting together and we are talking. I think this is the important thing. We have to talk; we have to find out how other people are solving it; what ideas we have for it.

Chairman RANGEL. I can't help but believe that if we weren't talking about gay's or addicts or minorities that this would have a higher local, State and national priority, and there seems to be some question as to whether or not people think morally we should be addressing this problem. And as Senator D'Amato was saying, it seems like almost a conspiracy of silence that we are much better off if we just ignore this problem.

Dr. SENCER. I think that this——

Chairman RANGEL. I mean, you have been outspoken and we have heard from you——

Dr. SENCER. Yes.

Chairman RANGEL [continuing]. But it just seems to me that the mayor, the Governor should be making some special appeal to the Congress or to the administration. It is not just New York City's problem.

Dr. SENCER. I know that. I have been down to testify before Mr. Weiss on several occasions. We did support getting demonstration money for provision of services. One of the big problems that this committee is only peripheral to this committee is how we begin to provide the health care services to these thousands and thousands of people who are going to need treatment. This is not going to bankrupt the city again, but it is going to put a severe strain upon the fiscal ability to meet the hospital requirements of the people. And that is why it is so important to find ways to stop transmission of the virus, so we don't have this 10 years from now.

Chairman RANGEL. Well, that is way down the line, but it just seems to me that with all of the costs associated with just taking care of the victims, that we could do a lot more if we could put in some up front money and determine the depth of the problem.

Mr. Gilman.

Mr. GILMAN. I think, Mr. Chairman, in hearing all of our witnesses in this distinguished panel, the common thread that runs through all of your testimony is that public education is an important aspect of what we should be doing at the present time.

I have a release from Governor Cuomo, dated October 24, in which he states that "until the scientists find a cure for AIDS," the Governor said, "education is our only vaccine." And here you are, a group of specialists in this area, experts in the important responsible positions, what educational programs have you suggested to our State and local governments, not only for AIDS, but for drug abuse, which is involved with the AIDS Program? What educational program have you suggested or tried to recommend or tried to implement at either State or local governmental levels?

I address that to the entire panel, don't be shy.

Mr. WHALEN. I was here this morning when the committee spoke with Dr. Axelrod concerning the implementation of a drug and alcohol curriculum, and I know that——

Mr. GILMAN. Is that the new or the old curriculum?

Mr. WHALEN. I am speaking of the old curriculum.

Mr. GILMAN. The dusty one?

Mr. WHALEN. Yes.

As Dr. Axelrod, I think indicated, he was speaking in terms of two curriculum, one being a general health curriculum in which he had some oversight responsibilities to review and so on, and a separate and distinct drug and alcohol curriculum which has been formally adopted by the State education department, and which for all intents and purposes is supposed to be operable throughout the school districts of New York State.

Mr. GILMAN. Well, Mr. Whalen, when I appeared before your agency just a few months ago on the master plan——

Mr. WHALEN. Yes.

Mr. GILMAN [continuing]. It was your agency that told me, "Yes, it is a great curriculum, but it is not being distributed because of lack of funds."

Mr. WHALEN. Yes; there is a problem apparently in distribution through the State education department. We have been working with them not only on this new curriculum that is now being developed, but also to attempt to help them aggressively implement the old curriculum by training teachers. In other words, we have offered the services of our training bureau to help teachers and others who are responsible for relaying this information to students.

Mr. GILMAN. Mr. Whalen, your agency has done an outstanding job in helping to promote community endeavors and community projects. You have worked with groups in my own congressional district. What, though, have you done with regard to the State education department, to work hand in hand with them to get their program implemented?

Mr. WHALEN. We have offered the resources, not only of our experts, to help them develop the appropriate information, but also to help train their teachers in the implementation of this curriculum, and I am speaking now of the old curriculum.

Mr. GILMAN. Have they accepted that offer? Have you become involved?

Mr. WHALEN. Yes; we have over the past 4 months or so been working closely with them to develop what we call a turnkey training project whereby a selected group of teachers is trained; they in turn train other teachers; a sort of a "training of trainers" type program.

Mr. GILMAN. What happened to the curriculum in this period, is it still sitting on a shelf?

Mr. WHALEN. As far as I understand; yes.

Mr. GILMAN. Is there anything your division can do to put that into a distribution system?

Mr. WHALEN. I know that there has been concern and a request for aggressive and immediate action on the implementation of such a curriculum. That was expressed at a subcabinet meeting where

the Governor's staff indicated to the State education department that they wanted the implementation of the curriculum made a priority.

Mr. GILMAN. Well, is the Governor aware of this problem, when he talks about education being the only vaccine for AIDS, that we have a program on there on drug abuse that is just sitting on the shelf. Is he aware of that?

Mr. WHALEN. I can't say whether he is personally aware of it or not, but I know his staff has been quite concerned about that and the Governor himself has taken a front-line role in attempting to educate the general public about the AIDS problem, which is particularly important and even has implications for the IV drug abuse community, because when we meet with AIDS victims that are IV drug users, we hear a host of problems such as housing problems and getting public assistance, problems in getting medical care, where they face a whole range of problems separate and distinct from AIDS, but caused by the fact that they are victims of that disease.

Mr. GILMAN. When the Governor talks about the "high priority" that remains for prevention through education, what is the cost of this program that makes it so inaccessible to the public?

Mr. WHALEN. I can't provide you——

Mr. GILMAN. Is it an expensive proposition to distribute this kind of curriculum throughout our school system?

Mr. WHALEN. I don't know, Congressman, but what I can do is speak to someone at the Education Department and get that information for you.

Chairman RANGEL. If the gentleman would yield, we have Dr. Michael Willie, the director of division——

Mr. WHALEN. Dr. Willie, I think, is familiar with the curriculum.

Chairman RANGEL. Dr. Willie is here, isn't he? Maybe if Dr. Willie would join this panel, it might help us out here.

Dr. PRIMM. Mr. Chairman, after he joins I would like to take a crack at just the AIDS education piece also, particularly for minorities.

Chairman RANGEL. Doctor, we apologize for the late request in inviting you here and we thank you for joining with us, but, again, you can see that the general thrust of our questions has been what have we been doing in the State educational system to better educate our kids about the dangers of drug abuse and associated problems of AIDS. Can you enlighten us as to is there a State educational program?

TESTIMONY OF DR. MICHAEL WILLIE, DIRECTOR, DIVISION OF PUPIL HEALTH AND SICKNESS, NEW YORK STATE DEPARTMENT OF EDUCATION

Dr. WILLIE. Well, it's a pleasure to be here and have a chance to share some ideas.

I think there are two issues, one is the actual issue of substance, of drug-abuse prevention; and the second issue is that of what we are doing in terms of AIDS. We have been working very closely with Dr. Axelrod and have prepared several documents which have been distributed to schools, concerning AIDS and education about

AIDS. There has been much concern, especially here in New York City, where there were youngsters seeking admission to schools who were suspected at that particular point of perhaps having AIDS. So there were several policy statements; I did not bring those along with me, but I will be pleased to make those available to you.

All public schools, nonpublic schools, universities, and libraries have received the informational package which was developed in concert with the department of health. So that addresses the AIDS in terms of education and trying to provide educational programs for in-servicing education of professionals relative to the AIDS issue.

Mr. GILMAN. Would the gentleman yield?

Chairman RANGEL. It's your time.

Mr. GILMAN. Dr. Willie, has there been a curriculum established and mandated to the school system, local school systems, with regard to substance abuse and its relationship to AIDS?

Dr. WILLIE. Not particularly in relation to AIDS. I have made available to you copies of our K through 12 drug education curriculum. Currently that is being updated. We are doing that in concert with the Department of Health, the Division of Substance Abuse Services, and the Division of Alcoholism and Alcohol Abuse.

Mr. GILMAN. Dr. Willie, we had been informed that this curriculum that had been developed—and I guess Mr. DiBenidetto had some involvement in helping to formulate that curriculum——

Dr. WILLIE. Yes.

Mr. GILMAN. And that while it was a good curriculum, there had not been any distribution of the curriculum.

Dr. WILLIE. There had been approximately 72,000 copies of it distributed across the State. In terms of the distribution pattern, it was at one point at least, one copy for every grade level in every school building. That was the distribution itself.

At this particular point we are revising, but at the same time are reprinting certain issues of that and it is available upon request by individual teachers.

Mr. GILMAN. Dr. Willie, are you telling us then that every teacher has a copy of this in the New York State School System?

Dr. WILLIE. No, every teacher has not had a copy of it. We don't distribute in that way. But we do—for example, it does come in individual grade levels. There is one booklet for grade K, one booklet for grade 1, and so on up. We have tried to make available at least one copy in every school building at every grade level.

Mr. GILMAN. Did every school building in the State of New York have at least one copy of this curriculum?

Dr. WILLIE. They have had, and whether or not when teachers are informed they take the materials or not, we can't judge that.

Mr. GILMAN. What was the date of that distribution then, Dr. Willie?

Dr. WILLIE. The date of the distribution was 1979 and then there was another one in 1981, and then we have been making copies available on a singular basis since 1981.

Mr. GILMAN. Only if requested?

Dr. WILLIE. Only if requested, yes.

Mr. GILMAN. Has there been any implementation of mandating this program or have an oversight of the program?

Dr. WILLIE. There are several ways in which we have attempted to do that. Number one, we have offered workshops and made it available to those teachers who attend the workshops. We feel that curriculum in and of itself without in-service training is not effective. It sits on the shelf. So one of the things we try and do, and we work with the Division of Substance Abuse and the Division of Alcoholism, is to try and in-service teachers so that they would know how to use the materials.

Mr. GILMAN. And how long has that in-service training program been in effect?

Dr. WILLIE. Since the implementation of the document; I would say 1979, 1980. The heaviest in-servicing was during that particular period.

Mr. GILMAN. What proportion of the teachers in the State of New York had been trained in that type of program?

Dr. WILLIE. To be honest with you, I really don't know. I would say at this point the proportion, because of the large turnover in the number of teachers, we are seeing declining numbers in terms of people who have been trained for this curriculum.

Chairman RANGEL. If the gentleman would yield——

Mr. GILMAN. I will be pleased to yield, Mr. Chairman.

Chairman RANGEL. I guess you can see the thrust of our questions. We have been informed that we have the largest per capita drug abuse population in the country, which necessarily means, I guess, that we have the largest age-related population in the country—before you arrived or before you testified—State, city, and Federal officials had indicated that we can't control our borders or the trafficking and so, therefore, we have to rely heavily on education and prevention.

I was sharing with Dr. Jaffe that the Federal education officials have said that they from time to time have regional conferences where they share the best information they have on the question of drug and alcohol abuse. And what we have been trying to find out is, in the State of New York, just how qualified are our teachers to educate our kids, as it relates to alcohol education prevention abuse and related AIDS. And then we had, of course, Dr. Axelrod, who made it clear that he was working on some proposals to do something with the Education Department, which maybe my colleagues can improve on what his testimony was because I think that he agreed that whatever we had in the Department of Education, we have not been able to find the resources to distribute that information.

Now, you are saying that pamphlets such as these have been distributed to at least a teacher on that grade level throughout the years, but you don't know whether or not in any given school this material is available now and that you do have a supply of this material if a teacher or principal or superintendent would request it, but that your agency or department really has no way of knowing whether in fact this information is used at all?

Dr. WILLIE. We do at the high school level, where we have a process called "reregistration of high schools." One of the issues there, as they go around on a 5-year cycle, they do look at the vari-

ous programs and do look at the curriculum in terms of what is contained in the curriculum. Health education and substance abuse is one of those items which is reviewed.

Chairman RANGEL. How do you review it?

Dr. WILLIE. There are actually review teams that do go into the schools. There are materials that are sent in terms of check lists where certain items are required to be checked. In terms of the review team, they then go into the schools and take a look at the curriculums that are being used, and what's being imparted at that level.

Chairman RANGEL. Can you then tell me, Dr. Willie, if a question is asked of a layman, and I am, to what degree are our high school kids being exposed to education as relates to drug abuse and drug prevention, what would your professional response be?

Dr. WILLIE. My professional response would be there is very little in terms of the total child's education, and I say that because, number one, if you would look at a youngster, and all of the time that is 1 year, that youngster is only in school about one-ninth of his time. That means that there is some eight-ninths or somewhere in that vicinity where the youngster is not in school. So then we look at the courses that are required of that youngster, and in terms of health education in the secondary schools, only one-half unit is required.

Chairman RANGEL. How many units are there?

Dr. WILLIE. Approximately 20, 20½.

Chairman RANGEL. What would that be a semester?

Dr. WILLIE. Yeah, that would be about a semester. Then, within that semester, not only is substance abuse and other topical areas of consumer health, dental health and other things taught—so, we are looking at a very, very small percentage of time where that youngster actually receives instructional education in terms of health education or anything surrounding or peripheral topics.

Chairman RANGEL. You mean that this subject would just come under the broader topic of health education?

Dr. WILLIE. Yes, probably.

Chairman RANGEL. The Health Commissioner could not identify any input into that educational system.

Dr. WILLIE. Only insomuch as he or his staff, at least, has reviewed the curriculum and the requirements of the health curriculum under development.

Chairman RANGEL. So, judging from what you are telling us as a parent, we could not say with any degree of accuracy that we have any program at all designed for drug abuse in education. What we do have is a very limited time assigned to health and that this would be just a part of that?

Dr. WILLIE. Yes. And I think that part of our strategies, we have been meeting this year with the Division of Substance Abuse and the Division of Alcoholism and the Department of Health, to look at just that issue. How can we leverage the time that we do have in school, make it crisp and then get the same message in terms of community and parent education and involvement? So part of what we have been doing, we have been working on the Prevention '86 Program, which is a drug abuse prevention program and we have been working now to provide additional in-service education, espe-

cially at the elementary school. We are hoping to make available those documents with some updates and then some in-service, heavy in-servicing of elementary school teachers, because we feel that that is really one of the places we really need to get started. The idea that the teachers, in terms of their limited experience, educational experience, in the areas of drug abuse and alcoholism, we see that they have their own feelings and sensitivities and fear, really, about teaching it, oftentimes because of what their experience has been and they have not had that kind of training which would enable to deal with the subject area comfortably.

Chairman RANGEL. Dr. Willie, it is some comfort to know that you are looking at it, but for the last couple of decades there had been an assumption that educators thought that this was essential in the sense that they could not control the trafficking or the home situation or the international drug situation, and we had hoped that in our progressive State that there was, really, an ongoing educational program, since many of our school systems really hold the teachers and the school in hostage because of the drug traffickers in and outside of the school building.

Dr. WILLIE. After meeting, I guess, with my colleagues across the country, I feel that we do have some good documents. The feedback that I have gotten from other States and persons in other States who hold similar chairs, is that the material is good. I think in terms of in-servicing, we are perhaps doing more than many other States in trying to make sure——

Chairman RANGEL. Dr. Willie, how long have you been with the State in your capacity?

Dr. WILLIE. About 5 years.

Chairman RANGEL. Because I have just never heard an educator particularly proud of the documents where available who did not know whether those documents were actually being used. And in this very sensitive area that we are dealing with, it really hurts me as a parent to believe that I have to rely on the school teacher to request this information, and I guess there is some question as to whether or not, even in our local schools, that this material is actually there.

Mr. Gilman.

Mr. GILMAN. Thank you, Mr. Chairman——

Mr. WEISS. I wonder if you would allow me, I have to go on to some other things?

Mr. GILMAN. Of course.

Mr. WEISS. Thank you.

Before I leave let me just express my appreciation to you and to Mr. Gilman and the committee for tying in these two aspects of the current problems of AIDS through substance abuse and the problem of AIDS. I would have felt happier if the law enforcement people had stayed around long enough or had left some of their representatives here so that they could benefit from the health information that is coming forward because of this panel's testimony. I don't know, and I put the question rhetorically at this point, as to whether or not there is any interaction at all between the health people and the law enforcement people.

I think, Mr. Chairman, you were right when you suggested that there seems to be less of a sense of urgency in dealing with the

AIDS problem because of the people who are being affected. I don't think that has to do with race, by the way. I think it has to do with an attitude that drug addicts are not really people. I mean, when you listen to some of that distinguished panel that was on before us suggesting that the only thing that a drug addict cares about is when he is getting his next fix and that he is going to knock the habit and suggest that they are beyond education, I mean, you are really talking about less than animals. You are talking about pieces of stone. And I think that that is really the basic problem that we have to overcome and I want to commend all of you for the effort that you are trying to make, Dr. Sencer, in generating the debate as to whether in fact the evil of letting people kill themselves and contaminate other people who then also become fatal victims, whether that is worse or better than letting people have needles to use on themselves.

I just think this is an important discussion and I would like to think that somewhere along the line there would be some sense of humility on the part of the law enforcement people and they would recognize that we have great enforcement and I think the panel we have before us is outstanding, but they know next to nothing about health, and that is your responsibility, all of you here, and education. And I wonder whether in fact you have any interaction with them at all?

Dr. Sencer, I remember after you came up with your proposals, three district attorneys of this city and the police commissioner and God knows who else, perhaps Mr. Johnson said, in essence, "Pillory that man. How dare he come up with that kind of suggestion." Have you had any kind of rational discussion with those folks as to how to deal with this problem as a health and education problem?

Dr. WILLIE. Unfortunately, we deal more with how to deal with health problems among the law enforcement agents than we do the relationships in the community.

Mr. WEISS. Very sad.

Thank you very much, Mr. Chairman.

Chairman RANGEL. Thank you. Let me thank you again for the work and for the leadership that you provided for the Nation and the Congress in this very important area, and as you pointed out, very unpopular area. There is no constituency for this. So it's not that it takes a lot of political courage, but it certainly shows your dedication in trying to find some answers to this serious problem. This committee appreciates your contribution.

Mr. Gilman.

Mr. GILMAN. Excuse me, Mr. Chairman.

Dr. Willie, there is something on which I am not clear: This whole set of documents that is before the chairman, one set goes to each school; is that correct?

Dr. WILLIE. At least.

Mr. GILMAN. And went out in 1981, in general distribution?

Dr. WILLIE. Yes.

Mr. GILMAN. To every school in the State of New York?

Dr. WILLIE. Yes.

Mr. GILMAN. Now, I know in the forward or in the introductory part, it was revised in 1982——

Dr. WILLIE. Yes.

Mr. GILMAN. Was there any general distribution after revision?

Dr. WILLIE. I'm not aware of that. As I understood it, we ran out of certain copies and where we ran out of them we did a reprint and revision of that particular item.

Mr. GILMAN. And they're available only on request?

Dr. WILLIE. Well, there are two ways in which we do it: No. 1 is by request; No. 2, we have a system in terms of our BOCE's [boards of cooperative education], and one thing that does happen there is that school districts get together and request certain kinds of in-service workshops. Substance abuse has been one of the most popular; we make them available at that kind of an affair.

Mr. GILMAN. If there is a request from those boards of education?

Dr. WILLIE. Right.

Mr. GILMAN. What is the requirement, curriculum requirement, under the State education law for providing this curriculum and implementing it? I note that it says that the curriculum provides school administrators, health and drug coordinators and teachers with direct assistance in meeting the requirements of New York State's statute, chapter 982, 1977 education law, section 804, and insuring compliance with the regulations of the Commissioner of Education, particular in sections 135.1 and 135.3. That is a mandatory program for State education; is it not?

Dr. WILLIE. Health education is required by law and by Commissioner's regulations. The amount of time——

Mr. GILMAN. And that includes education for drug and substance abuse?

Dr. WILLIE. Yes, it does. It includes education for drugs, alcohol and tobacco.

Mr. GILMAN. How much time is mandated?

Dr. WILLIE. There is no time mandated at the elementary level; it is left in terms of that local school's curriculum.

Mr. GILMAN. So if they gave 1 hour for the whole year that is, as far as you are concerned, they are meeting the requirement?

Dr. WILLIE. Right. There is no time mandated at the elementary level.

Mr. GILMAN. Where is time mandated?

Dr. WILLIE. Half a unit for one semester at grades 7 and 8, and ½ unit at grades 9 through 12.

Mr. GILMAN. Now, what does that mean, a half unit, in our language?

Dr. WILLIE. A half a year, usually; ½ a year in terms of a course of study.

Mr. GILMAN. Tell me what that means by way of hours, for example in 1 week how much time would be provided?

Dr. WILLIE. It is approximately 180 minutes of seat time with mastery a week.

Mr. GILMAN. 180 minutes a week?

Dr. WILLIE. Yes.

Mr. GILMAN. Just on health?

Dr. WILLIE. Yes, for ½ year; yes.

Mr. GILMAN. And how much of that is devoted to drugs?

Dr. WILLIE. That depends on the school district. That is minimum time. Many schools go far and above that; and many schools

do have programs that are comprehensive K through 12 and across the board in terms of——

Mr. GILMAN. You are saying 3 hours a week is devoted to health when you get up into which grades?

Dr. WILLIE. It can be offered either at grades 7 and 8 or grades 9 through 12.

Mr. GILMAN. 9 through 12, ½ unit for that whole period of time?

Dr. WILLIE. Yes.

Mr. GILMAN. So for the 4-year high school period, if they do 3 hours a week for 1 semester, that covers the whole program?

Dr. WILLIE. Yes.

Mr. GILMAN. And how much of that would you estimate would be devoted to substance abuse?

Dr. WILLIE. Probably about a third.

Mr. GILMAN. So we are talking about 1 hour a week for one semester?

Dr. WILLIE. Yes.

Mr. GILMAN. On substance abuse for the whole 4-year period?

Dr. WILLIE. Yes.

Chairman RANGEL. If the gentleman would yield, we have a panel of experts here and here we have the person in charge of our whole New York State educational program dealing with this subject. Now, you know, it shouldn't take a congressional committee to say that something is wrong.

First we had the Commissioner of Health who has no input into this, except looking it over generally. Then the Commissioner of Education is saying that they give 3 hours in a semester dealing with health matters, one semester, but what you other gentlemen are saying is that we are on the brink of an epidemic, that you don't have confidence, or we don't, that we have got to stop this stuff from coming into the United States, that you have heard law enforcement saying that they can't deal with it through arrest, so everyone agrees that where you hold the line is in education.

Commissioner.

Dr. SENCER. I feel called upon to say something.

Chairman RANGEL. I am sure you all feel called upon to say something.

Dr. SENCER. I am sure that the 1982 material doesn't mention AIDS, no.

Mr. GILMAN. So we have no material on AIDS being distributed by way of a curriculum?

Dr. SENCER. From that standpoint.

In New York City the Academy of Medicine developed a brand new curriculum on health education for the school system in New York City, but we can't get certain local school districts to adopt it because it talks about sex. So that it is fine to have a curriculum, but until we can get the school districts to accept it, we are going to have a hard time in getting this through.

Now, in terms of AIDS and education, on the October 28, we let all the kids in New York City out of school for ½ day, and we had an 1½ almost 2 hours on television aimed at all the school teachers. 68,000 school teachers got an 1½ education on AIDS, with a distinguished panel, and then a question and answer period with 15 or 20 teachers asking the questions of this panel.

This is the way we are trying to get information out. I think the State mentioned the pamphlets and cards aren't the way to do it. We have to find better ways of communicating with the kids to get this information to them. Two years ago in New York City we did a survey, a stratified sample of all of the schools, to get some active information on what the health problems of the kids really were. In the 7th grade—this is on a self-administered questionnaire, what the kids want to say about themselves—in the 7th grade 3 percent of the kids said they had been using drugs. We didn't try and get into how much or which drugs, but by the 10th grade 10 percent. Now, that's, you know, everybody knows it's going to go up, but we have figures. The important thing is that 40 percent of the kids in the 7th grade said they wanted counseling, they wanted more education, they wanted more classroom on drugs and tobacco and alcohol.

Chairman RANGEL. So what did you do with this information? You turned it over to the State or——

Dr. SENCER. As Mr. Ward said, we went to the budget people and we got money, and we now have what we call a Health Resource Coordinator at the junior high school—not all of them yet—this year we are aiming to have a health resource coordinator at each of the junior high schools in this city who is there as a Health Department person, not a Board of Education, not a teacher, somebody that the kids can come to and talk to and it doesn't get into the school records. I think this is very important. Kids are reluctant to bring——

Chairman RANGEL. Well, let me ask this: Are you satisfied with our State education system——

Dr. SENCER. I really am not qualified to say. I am dissatisfied as——

Chairman RANGEL. I am not talking as an educator. This is what we have got.

Dr. SENCER. I just don't know because our dealings are——

Chairman RANGEL. You don't know. You heard Dr. Willie explain to you what comes out of Albany for the school districts.

Dr. SENCER. As I said, I really don't know. This is the first I have seen of their pamphlets.

Chairman RANGEL. I am assuming the pamphlets are the best that we have in the Nation.

Dr. SENCER. There are positions funded, working in the schools as counselors——

Chairman RANGEL. But as a professional health expert you are satisfied that having these things——

Dr. SENCER. I haven't seen them——

Chairman RANGEL. No, I am not talking about the quality. Are you a parent?

Dr. SENCER. I hope to be a grandparent before too many years.

Chairman RANGEL. All right, then, as a parent, are you satisfied that these pamphlets are available upon request and that your State is doing the best they can?

Dr. SENCER. I am not satisfied with curriculum material as the best way to approach——

Chairman RANGEL. Well, "curriculum" is kind of stretching the word.

Dr. SENCER. I think we have to find ways of getting at the kids after school. We have got to find ways of getting at their parents.

Chairman RANGEL. I am not talking about before school or after school or before birth. I mean, I am talking about——

Dr. SENCER. I mean after hours.

Chairman RANGEL. OK. thank you. I understand. I understand your position.

Mr. GILMAN. Will the gentleman yield?

Chairman RANGEL. Yes.

Mr. GILMAN. Doctor, as we have said to Dr. Axelrod, isn't there a need to share responsibility between the Health Department and the Education Department? Commissioner Ward sat here and said he had a great program, but he is having trouble getting that program through the system, and he is only touching a very small portion of the schools. What is the administration doing about broadening out this program and taking a look at what we are doing in education?

The Governor says that "education is our only vaccine in this program, until we come up with a scientific solution," and we are trying to find out how can we get that education out to the people, to our young people?

Dr. SENCER. I can't speak for the State, I can speak for the city. I mentioned our educational efforts with the teachers. We have provided educational materials, pamphlets if you will, to the teachers for their education, so they can do a better job of educating the kids. We are meeting with school districts. Our staff is meeting almost two or three times a week with the school districts, with parent groups and so on. Not talking about substance abuse per se, but talking about AIDS, how it is transmitted and what can be done to prevent it in the future.

Mr. GILMAN. But today we learn how AIDS is tied into intravenous injection of substance and that substance abuse is one of the underlying causes of our AIDS problem.

Dr. SENCER. Absolutely.

Mr. GILMAN. Then, again, it all comes back to how do we educate our young people about the dangers of all of this.

Dr. PRIMM. I would like to make a statement, Mr. Chairman, excuse me Mr. Gilman, and that statement is that to educate the intravenous drug abuse community is a most important thing also. To educate the intravenous drug abusing community is most important also, and those people that this intravenous drug abusing community touch, OK? And particularly in areas where incidents and prevalence of AIDS is very high, and I am talking about Brooklyn and Harlem. Now, my program has only $58,000 for the Borough of Brooklyn, where we have the highest number of minorities and we are to educate with that $58,000 the minority population, black and Hispanic and intravenous drug users are our target.

I only mention this because in Harlem, where the incidence and prevalence is triple that amount that is in the Brooklyn community, we have no money for education—and I want you to hear that—and particularly in the 19th District, Mr. Chairman.

Furthermore, the city of New York, so I hear, and correct me if I am wrong, Dr. Sencer, only has now about $180,000 that you have to, you know, give an RFP out and so forth, to write for education

and prevention efforts in AIDS; is that right, Dr. Sencer? I don't want to put you on the spot, but——

Dr. SENCER. No, that is the amount that is in our budget this year for special contracts for education about substance abuse and AIDS, not substance abuse.

Dr. PRIMM. We have 177,000 intravenous drug users in New York City. I can see how Dr. Sencer can have an adequate education program with that kind of money, and I am really putting the city on the spot and myself on the spot, I guess, because I am going to be applying for some of those dollars to expand some prevention and education treatment in the Harlem community. I think it is incredible that only that amount of money is being spent at this time when this disease entity is at epidemic proportions and we have all discussed it here today.

Mr. GILMAN. Well, Dr. Primm, why——

Dr. PRIMM. Let me go further, Mr. Gilman.

Mr. GILMAN. Permit me to interrupt a moment.

Dr. PRIMM. Yes, sir.

Mr. GILMAN. Why can't all of this education for our young people be accomplished in the existing public education system?

Dr. PRIMM. Well, I see no reason why it can't. I met on Saturday with the New York City Council of Churches and a number of teachers came to that particular meeting where people from the institute and the city health department talked to ministers to expand the whole network of people who can understand about AIDS and do something at the churches and elsewhere. Just like someone earlier had said, Dr. Willie said, that not only does it have to be in the home, it has to be in the church, it has to be in the community centers, it has to be everywhere, but we don't have enough money to put it everywhere. Somehow this congressional committee is going to have to mandate that money be spent in these areas. I mean, Dr. Sencer can't do a job with $180,000. I wouldn't be able to, I don't know how he could do it.

Mr. GILMAN. Then I ask you a question, how many recommendations have been made and have you been refused funding based on these recommendations? That is what we are here to find out, where we can be of help and where we can be supportive. We are looking for the constructive suggestions and not the fact that we have a program that is sitting up there waiting an invitation for distribution.

Dr. SENCER. We have at least three applications awaiting funding at the present time from the Federal Government that has made funds available for education. One of our proposals is an after school——

Mr. GILMAN. These applications are to educate who?

Dr. SENCER. Community education, particularly for substance abuse individuals. However, these funds have been held up and have not been allowed to be spent because of congressional concern that there will be some bad words used in them, that we will get into explicit sexual matters which is essential if we are going to begin to educate the people about the problems of AIDS.

Mr. GILMAN. Dr. Sencer, you are saying that your application has been withheld because of congressional objection to sex education?

Dr. SENCER. There was congressional objection to funding applications that got into explicit sexual activities, which is one of the problems in AIDS. So we are sitting waiting.

Chairman RANGEL. Dr. Sencer, you don't submit those applications to the Congress, where is your proposal now?

Dr. SENCER. With the public health service.

Chairman RANGEL. And have you made any special appeal to your congressional delegation to support you?

Dr. SENCER. We just got the letter about a week ago saying that these were all put on abeyance until it was figured what was acceptable to talk about.

Chairman RANGEL. Well, you have a New York City lobbying office in Washington, are they familiar with this problem?

Dr. SENCER. Not yet, they will be.

Chairman RANGEL. You know, what I am suggesting is, your problem, you should share it with us so we could see what we could do with it.

Mr. GILMAN. And they haven't said that it is due to specific congressional objection that it is being withheld, they are telling you that it is subject to some interpretation. Is that what they are saying to you, Doctor?

Dr. SENCER. The intent was rather clear in the appropriation language. The legislative history was rather clear.

Mr. GILMAN. Have they spelled out their objection to your education——

Dr. SENCER. I would be glad to send you a copy of the letter.

Mr. GILMAN. I would welcome if you could send me a copy.

Gentlemen, our time is running, just one general question with regard to the prison population.

Today we heard some testimony that our prisoners in New York State were not being bloodtested to determine whether they were subject or had been afflicted with AIDS, and there was some testimony that it wasn't really important to do that at this point. And I raise a question, isn't this an important responsibility of the State, with regard to our prison population, sometimes referred to as 50 percent drug related, to make a determination as to whether or not they are infected with AIDS and whether or not it might be important to segregate that population so that we can try to do something about curing or helping them before we send them back out into the public, possibly to further contaminate the civilian population out there?

Dr. H. JAFFE. I may be able to comment in part.

CDC has had a series of discussions with corrections officials representing a number of States, the American Corrections Association and other groups of professionals in this area. I think at this point there is still not consensus on the issue that you raise. People see the possible benefits of doing such screening, but they also see the problems it will create within the prison system.

My feeling is that there may not be a consensus and it may ultimately be that different correctional facilities adopt different policies, but I would say that this kind of discussion is going on actively right now.

Mr. GILMAN. Well, does anyone on the panel have any thinking on this? I see that the Governor is talking about regulations on

bath houses, Dr. Axelrod is even talking about closing down hotels, and yet we have a prison population that may be 50-percent affected and we are not concerned. Dr. Axelrod said New York State has not undertaken routine screening of blood of inmates in the prison system simply because we do not see what assistance that would provide.

Mr. WHALEH. I wonder if I can comment for one second. I just want to make the comment, and that concerns the way you phrased your question: "Shouldn't we test them to find out if they had AIDS?" I think if we had a test that would tell us that, the answer to your question would be a lot easier. Unfortunately, the test that now exists merely indicates the presence of antibodies to the HTLV-III virus; it does not necessarily mean that the individual has AIDS.

Mr. GILMAN. You mean there is no way of knowing whether a person has AIDS from any test that is available?

Mr. WHALEN. Not solely from the test, no.

Chairman RANGEL. Not solely, but if you've got AIDS and you're tested, you would know it, you would know you've got it.

Mr. WHALEN. The diagnosis of AIDS requires the appearance of symptoms, some special blood studies to look at the cells, and also possibly use of the screening test for the antibodies.

Mr. FREIDMAN. On the questions, as it was raised before, there was some discussion of the question of research screening versus mass prison screening.

We have discussed the possibility of doing research in prisons. It is difficult research to do in various ways. The only reasons we haven't gone ahead with it are essentially resource problems.

On the question of mass prison screening, there are several complications that should be considered. On the one hand it's tempting to say "Of course we should do it." But as we have been screening drug users in various drug programs, we have run into certain difficulties about what do you do after you do the tests. That is a person who is told he or she is positive on having antibodies for the AIDS virus is put into a position of extreme stress. For the rest of his or her life he will not know, until we get further information, and then the information may be negative, whether he or she can have sex without endangering a partner, for example, just one element, and that can break up families.

You are talking in a prison situation about potential suicides; you are talking in a prison situation about potential murders, where perhaps somebody says somebody positive raped him or her or shared needles; you are talking about a serious question about the relationships between the prisoners on the one hand and the guards on the other. What do the guards start saying when they start having to deal with people who are tested positive, given the hysteria?

In addition to that, we have had the experience possibly of some of the best people who have been doing this feedback in the New York City area. We have had a procedure develop where you do not merely tell them the results from the antibody test, but you also feed back to them information about their general health stance, test their immune system, and in general give them the information they may need in order to survive this information they have

just got. This is expensive screening. It takes equipment that is not widely available. So that on the one hand it may be tempting to say "Of course we should go ahead and do this kind of policy," I just want to bring to your attention that there are some serious negative aspects.

Chairman RANGEL. Well, listen, perhaps we were too ambitious in trying to get answers to this question in one afternoon and with one panel, but I assure you that this committee is going to revisit this.

What I may ask you to do is to ask you to write a paper to this committee and to share with me individually what you believe should be done, feeling comfortable in believing what you believe is a city, State, and Federal function. I did not intend, Dr. Sencer, to have you critical of the State system, but it is clear to me that the Commissioner can only do with what resources he has, and with limited resources the priority has to be established, if not legislatively then politically. And I am saying this, that this is really the last threshold, I mean, and no one can contradict it, that his situation is not going to get better waiting for law enforcement and waiting for us to get these drug producing countries to stop. And if we don't have some program that we can be proud of, whether it works or it doesn't work, but at least that we have done something, then I think that all of us, including the Congress, have been less than fair to the younger generation and those afflicted with drug abuse and potentially afflicted with AIDS.

This has been a pretty rough day for all of us to find out how little is being done in our own hometown, and we hope that whatever knowledge we find from here would be to share with our colleagues and, therefore, the rest of the Nation.

But, Dr. Willie, I hope that you understand that we didn't expect that there was any program with the State at all. And these pamphlets are a good beginning perhaps for something to get started.

If we have got to send our kids to the school, I agree with Dr. Primm that it is not—we know the problem before they get to the class, we know the problem after they get to class, and it is going to take a whole lot to change that environment. But if we are not doing anything while they are in class, this is where politically, you know, we can't deal with the parents or the churches or the synagogues, then my God politically we should be able to say that the curriculum is there. Whether they can consume it or not, that is something else for the rabbis and the ministers, but we should be able to say that politically we have got it out there. We are trying our best to train the teachers to see that it has been consumed.

Look at us as people that are part of the problem too because if I had my way the Federal Government would be involved of taking care of this and we would just ask you to be supportive, but since we need each other, I hope you will be very candid in your approach. There is nothing that we will be taking to the Governor or taking to the mayor. It is something that we will be taking to ourselves to see whether or not it makes some sense, because if you people with your expertise can't come up with something that should be done, then we might as well forget the whole darn thing. You represent the best brains we have in the Nation on this specif-

ic subject and we just want to see whether we can do something to come up with some type of program that we all can be proud of.

Mr. Gilman.

Mr. GILMAN. Mr. Chairman, just one closing remark: Your panel of experts represents city, State, and Federal Government. It would seem to me there ought to be some way of their getting together to work out a much more effective program, bringing these problems home to our young people. And I hope that you would undertake that voluntarily without any mandate from any direction, to sit around a table and try to come up with the better education——

Chairman RANGEL. We will share the papers that you send to us with each other, and maybe we will come back and—by the way, I agree with Mr. Gilman, you don't really need a gang of politicians in there, but we will be glad to call you together and to see what we can do to implement what ideas you have.

And, again, another thank you to Dr. Primm, because it was hard for me to understand over the phone what you were talking about, but your statistics tragically proved to be true and we have a big job in front of us.

Thank you very much.

Let's hear from the community. We have two community members here that would like to share their observations, Ms. Leola Hagerman from Exodus House Prevention Program in East Harlem, and Mr. David Harris from Community Planning Board No. 9.

TESTIMONY OF LEOLA HAGEMAN, EXODUS HOUSE, NEW YORK CITY; DAVID HARRIS, COMMUNITY PLANNING BOARD NO. 9

Chairman RANGEL. Well, you are the professionals. You heard the testimony today and you won't need any prepared statement. We have got our work cut out for us and I would just appreciate hearing your observations as to what we should be doing.

Ms. Hageman.

Ms. HAGEMAN. Good afternoon, Mr. Chairman, and members who are left of the committee.

My name is Leola Hageman. I come before you to share the pain of some children in a corner of the city of New York. I apologize for having nothing to say of the seismic disruption or mass starvation or the advent of a Halley's Comet. It seems that we set our eyes on the heavens and our ears to the radio when things get bad in our midst. We get comfort and joy from sending things to people who are needy, but far away. I suggest that this giving spirit is the noble twist of the human soul. This compulsion to help those who are suffering in our television sets, I suggest that those who have should give, but who will help some children in the corner of the city of New York?

My children are not bony, mud covered celebrities, who momentarily evoke sympathy and crack our wallets only to fade in that day-to-day off camera suffering can be ignored? No. The children of East Harlem live in your midst. You bump into them in trains. You drive by them when you head north to some well deserved bucalic ease in your country home. They might waive at your child's Big Mac, large coke, french fries, please, at nearby fastfood restau-

rant. They are adequately clothed; they may have running water; and during the winter often have heat in their apartments. They can attend school. They can eat enough to maintain biological functions. They won't suffer from earthquakes, mudslides, or volcanic eruptions.

Then what is the problem, you may ask? Let me call the problem legend, for there are many. However, so often these problems that beset my children take one insidious form, drug abuse. My qualifications for coming before you is the same as yours, I am a concerned citizen. However we live in an age where concern is dwarfed by credentials. So I will give you an account of my life to give me further right to speak before you.

I am the executive director of Exodus House, a drug prevention program for children of East Harlem. Exodus House was established as a drug rehabilitation program in 1965 in a storefront of East 103d Street. My husband, the Reverend Doctor Lynn L. Hageman, a pioneer in the field, was the director. Three years later Exodus House moved to its current location on 103d Street, in a building that was renovated by some churches, individuals and various foundations. At this time my husband, I, and our three young children moved into the building to share our residence, lives, and our commitment with men and women we were treating.

From 1968 until 1984 my family lived with and helped hundreds of drug abusers. I am proud to say that in this time Exodus House freed hundreds from the trammels of drug addiction. Not only did these men and women, many with violent criminal records, no longer prey on the innocent citizenry, they contributed to our city and our Nation in the fields of business, social services, academia. At the same time our three children, raised among drug addicts in the East Harlem Rehabilitation Center, graduated from Ivy League schools.

In 1981 my husband suffered a near fatal stroke. Not long thereafter I became director. Since the mid-1970's Exodus House confronted painful changes: mounting budget cuts for social service programs; a change in drug abuse patterns; and an increasing incidence of drug abuse among the very young population. These realities and the near loss of my husband convinced me to change priorities to prevention.

In September 1984, the New York State Division of Substance Abuse Services recertified Exodus House as a prevention outpatient program for youngsters from 6 to 14 years of age. This change came none too soon as the following anecdotes will reveal:

A mother called out the window to her pre-schooler for the child to purchase "bambu" (wrapper used for rolling marijuana joint) the child could not hear or understand her, so after yelling to the child three times she called the child a dirty name, as she threw the money wrapped in paper with the word "bambu" written on the paper for the child to make the purchase at the corner store.

A second pre-schooler (female) reported having smoked "pot" a "joint," marijuana. The drug was given to the child by an adult family friend. This child comes from a family of drug dealers and drug abusers.

Be sure that drug abuse is a deep problem. Be aware that drugs do not offer empty promises. Know that drugs often, too often, fulfill needs and opportunities that otherwise seem closed to the citizens of places like East Harlem:

First, drugs offer a sense of achievement for those who can't achieve in an inadequate school system and a racist work place.

Second, drugs provide a production role for those who can't get a job.

Third, drugs provide involvement with and excitement for those who can't afford tickets to the Nicks game, see America in a Winnebago, or thrill with the launching of another space shuttle as they scuffle for train fare.

Fourth, drugs provide a sense of belonging for those who have no shot at the Kiwanis Club or feel they don't belong browsing in Bloomingdales or the Museum of Modern Art.

Drugs provide recreation for those who will never see the inside of the New York City Athletic Health Club or Club Med.

These truths the Reverend Dr. Lynn L. Hageman pointed out years ago. However, they have not become self-evident until our chains are snatched from our neck or until drug abuse rears its ugly head on Wall Street and some of the better boarding schools. Meanwhile, some children, in a little corner of the city of New York suffer.

Drug-related violence in East Harlem explodes and despair runs rampant. Now, there is the threat of AIDS. Several of our children have parents who are intravenous drug abusers and it is alleged that one of them died from drug abuse and/or AIDS. A whole generation is at risk, not only from chemical thralldown, but also for a painful and inexorable death. Exodus House and several other prevention and rehabilitation agencies stand as a poorly funded maginot line against the threat to our city. We cannot do it alone, and I told you so, will bring us little comfort in the dark times ahead. Gentlemen, we need money.

Chairman RANGEL. Thank you, Ms. Hageman, for a very eloquent and substantive statement.

Ms. HAGEMAN. Thank you.

[Ms. Hageman's prepared statement appears on p. 171.]

Chairman RANGEL. Mr. Harris.

TESTIMONY OF DAVID HARRIS, COMMUNITY BOARD, MANHATTAN

Mr. HARRIS. Good afternoon, Congressman Rangel, other distinguished members of the committee.

My name is David Harris and I am speaking to you on behalf of Robert Van Lira, chairperson of Community Board, Manhattan, in New York City. I bring my chairperson's apologies for his absence. However, he lost his father this weekend and he gives his respects and he is unable to attend.

Chairman RANGEL. Please send him the committee's deepest sympathy.

Mr. HARRIS. Thank you.

I appear before you wearing two hats: One is the vice chairmanship of Community Board Nine, and I am also executive director of Jobs for Youth, a citywide program geared toward addressing the problems of youth unemployment. Therefore, my remarks will address two distinct yet related areas of concern: The impact of drugs on the Harlem community and black youth.

Harlem is a community presently under siege. A battle exists between concerned community residents and drug traffickers over who will control our community. Drugs are today more than ever before a serious threat to the stability of our community. The economic, political, and social threads which hold Harlem together are constantly being torn apart and tested by the drug subeconomy. This subeconomy siphons millions of dollars from the community and creates a fear of fear, both of which hinder any real economic and social long-term development in Harlem.

The recent New York City Police crackdown over the past 2 years has not had any visible effect on drug dealing from the viewpoint of community residents, as pushers have just packed up shop in areas which were under surveillance and have moved just a few blocks away to other areas of safety. Then there are blocks where no action over the past 2 years has been done at all, and I will give you examples. One is 158th Street between Broadway and Amsterdam Avenue, where the Dominican controlled cocaine and heroine trafficking has flourished over the past 4 years, in spite of Commissioner Ward's crackdown. Everyone in the neighborhood in which I live, a few blocks from 158th Street, knows that that is one block you do not go down. Everyone also believes that, for example, Mr. Wilson, the famed Harlem restauranteur who was assassinated a number of weeks ago, whose bakery is on the corner of 158th Street and Amsterdam, was murdered by individuals who were threatened by his strong antidrug dealing stance. Though I can't confirm this figure, I have been told once that that one block, 158th Street between Broadway and Amsterdam, had more drug-related deaths in 1984 than any other block in the country. That is one block.

Let us go down eight more blocks to St. Nicholas Avenue, between 149th Street and 150th Street, where the Jamaican controlled marijuana trafficking has also ruled that block for the past few years. This is a street, Mr. Chairman, which is two blocks away from the local precinct.

Chairman RANGEL. This is on Amsterdam?

Mr. HARRIS. This is on St. Nicholas between 149th and 150th Streets, two blocks around the corner from the local precinct.

Everyone in the community knows that there is drug dealing going on on that block. Why aren't the police, which are located two blocks away, doing anything about it? We believe that the police are either afraid, they are either being paid off, they don't have enough support, or they just don't care. We don't know what it is, but the community needs an answer. If the community does not get an answer, I would warn the members of this committee that if responsible officials don't take charge, that the situation in the community will become so much out of hand that community residents themselves will have to take this into their own hands, as far as determining their own history in our battle for survival of our community. This has to happen because drugs are affecting the youth. And when you say "drugs" that is synonymous with youth. I am referring to Harlem or any other underprivileged community in this country.

I would like to share with you a few general statistics relating to black youth: One out of every six black youngsters are arrested by

the age of 19—that is black male. Six million violent crimes were committed in this country last year; 51 percent of the arrests for those crimes were black youths between 16 and 19; and 46 percent of the U.S. prison population are blacks, and as stated in the Daily News last week, Yale is "cheaper than jail," but yet we see that many of the black youth are in jails and any knowledgeable community resident would know that a large part of that comes from drug-related activities.

From an economic point of view, 42 percent of black youth are estimated to be unemployed. Even in light of our recent economic recovery, of 22 million new jobs created since the present recovery began, black youth only received 0.1 percent of those 22 million jobs or 22,000 jobs.

It is estimated that 25 percent of black teenagers' income come from crime. Now, when you look at 50 percent of black, single mothers earn $6,000 or less, you can understand why that comes to shape.

Basically, we in the community are afraid for the fact that we are losing our youth and we are losing our future when we talk about losing our youth. Drugs have a big influence on our youth. I run an agency that tries to deal with the problems of youth unemployment, and my competition are not the other programs, whether they're JTPA or private programs, but my competition are the drug dealers who provide employment for the young people who I have to figure out developing a viable alternative to that employment. Basically, we are making an impassioned plea, on behalf of Community Board No. 9, for your committee to dig into this further, to help increase public awareness and education around this issue. We feel strongly that while public education has very positively been geared toward the issue of drug abuse, little has been done around the issue of drug trafficking, and that is a very sensitive issue. And we feel that someone has to take a strong stance on it.

We know that it is also—there is a safety issue concerned, because when you begin taking a strong stand against trafficking versus abuse, you put your life in jeopardy. But someone has to take that stand. We feel that not only must the city and State do that more, but it also must come from the Federal level.

As far as legislation, we strongly support stronger national legislation that addresses the area of trafficking, and any pressure that the Federal Government can give on the local and State levels to increase the law enforcement capabilities to battle this problem, and to also deal with more stringent measures, even dealing with drugs such as marijuana. Many youngsters begin smoking marijuana before they are 10 years old. They look at it not as a drug, and they will more than likely continue to smoke marijuana throughout their whole life, and now, with the new incidences of polyaddiction, will do that along with drinking or using any other drugs, and they don't think they are doing anything wrong. We call for strong steps to tackle that.

Lastly, jobs: Jobs are necessary prerequisites to solving these problems, particularly as it pertains to the youth. Unless we can provide viable economic alternatives for these young people to go after what they see on TV, known as the American dream, they

will try to get it other ways, and you can be rest assured that those other ways will primarily include drug trafficking, which is providing right now the most lucrative financial opportunities in areas such as Harlem around the counter.

Thank you.

Chairman RANGEL. Thank you, Mr. Harris, for a very well thought out statement. The Chair agrees with everything that you have said. We believe that we have a mandate to go beyond just to Congress, but to the President, to the Governor, and certainly to the city. We have had the experts here. We are going to regroup with them to see whether we can come out with a well-coordinated plan of attack on this issue, and I can only say don't give up in your dedication toward the resolution of this problem. You are indeed our last hope, that is, a community that is concerned with protecting our youth and we just have to hang tough and stick in there together. It has been a very disappointing hearing, but I am glad that we ended on the high note of hope that you two have brought to it.

Thank you very much.

The committee stands adjourned, subject to the call of the Chair.

[Whereupon, at 2:30 p.m., the hearing was adjourned.]

STATEMENT OF THE

HONORABLE CHARLES B. RANGEL
CHAIRMAN

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

NEW YORK CITY HEARING

ON

HEROIN AND COCAINE ABUSE, INTRAVENOUS (IV)
DRUG USE, AND AIDS

TUESDAY, NOVEMBER 26, 1985

GOOD MORNING COLLEAGUES, LADIES AND GENTLEMEN, DISTINGUISHED WITNESSES AND ALL OF YOU CONCERNED ABOUT THE AWESOME PROBLEMS OF DRUG TRAFFICKING AND DRUG ABUSE THAT FACE OUR NATION.

TODAY THE HOUSE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL WILL HOLD HEARINGS ON THE PROBLEMS OF DRUG TRAFFICKING AND ABUSE IN THE METROPOLITAN NEW YORK CITY AREA, AND THE RELATIONSHIP OF INTRAVENOUS DRUG USE TO AIDS. ACQUIRED IMMUNE DEFICIENCY SYNDROME IS A COMPLEX MEDICAL CONDITION WHICH IS SPREADING ACROSS THIS COUNTRY AND AROUND THE WORLD, INFLICTING TREMENDOUS DEVASTATION.

I AM PARTICULARLY ALARMED BY THE INCREASING AVAILABILITY OF HEROIN AND COCAINE IN NEW YORK CITY. THE NEW YORK CITY POLICE DEPARTMENT LABORATORY REPORTS THAT IT IS ANALYZING AN INCREASING NUMBER OF HEROIN EVIDENCE. 5,469 EXHIBITS OF HEROIN WERE ANALYZED IN 1983; IN 1984, THE NUMBER OF EXHIBITS ANALYZED INCREASED 23% TO 6,725. THE PURITY OF "STREET" HEROIN IS ALSO RISING. IN 1981, THE AVERAGE "STREET" PURITY WAS BETWEEN 2 AND 14%; BY THE END OF 1984 THE "STREET" PURITY WAS BETWEEN 4 AND 27%. THE PURITY DURING THE FIRST QUARTER OF 1985 WAS EVEN HIGHER - 4 TO 39%. THE AVAILABILITY AND "STREET" PURITY FIGURES FOR COCAINE ARE ALSO HIGH AND INCREASING STEADILY.

THE NEW YORK FIELD OFFICE OF THE FEDERAL DRUG ENFORCEMENT ADMINISTRATION REPORTS INCREASED SEIZURES OF BOTH HEROIN AND COCAINE. DEA SEIZED 96 KILOS OF HEROIN IN FY 1981, 131 IN FY 1982, 122 IN FY 1983 AND 127 IN FY 1984. FEDERAL COCAINE SEIZURES ARE SIMPLY THROUGH THE ROOF. DEA'S NEW YORK FIELD OFFICE SEIZED 984 KILOS OF COCAINE IN FY 1984, COMPARED TO 148 KILOS IN FY 1981.

THE ABUSE OF BOTH HEROIN AND COCAINE IS HIGH. WHILE THE NUMBER OF HEROIN TREATMENT ADMISSIONS SEEMS TO HAVE DECLINED, IT IS STILL MUCH TOO HIGH. HEROIN CONTINUES TO BE THE PRIMARY DRUG OF ABUSE AMONG ADMISSIONS TO TREATMENT PROGRAMS IN NEW YORK CITY. THE NUMBER OF COCAINE ADMISSIONS TO TREATMENT PROGRAMS HAS INCREASED STEADILY IN THE NEW YORK AREA OVER THE PAST FEW YEARS. AS AN INDICATION OF THIS, WE NEED ONLY COMPARE THE NUMBER OF COCAINE ADMISSIONS IN THE THIRD QUARTER OF 1981 - 116 - TO THE NUMBER OF ADMISSIONS DURING THE FIRST QUARTER OF 1985 - 604.

VIEWING THESE KINDS OF STATISTICS, IT IS CLEAR THAT WE ARE LOSING THE WAR AGAINST DRUG TRAFFICKING AND ABUSE IN OUR NATION. DRUGS ARE BEING PRODUCED, TRAFFICKED AND IMPORTED AT UNPRECEDENTED RATES. THIS COMMITTEE HAS HEARD REPORTS OF DRUG ABUSE AT THE HIGHEST LEVEL OF SOME OF OUR MOST RESPECTED PROFESSIONS. WE HAVE HEARD REPORTS OF INCIDENTS OF VIOLENCE

OCCURRING HERE IN NEW YORK CITY. TO MAKE THINGS EVEN WORSE, INNOCENT PEOPLE -- PEOPLE NOT INVOLVED IN THIS DIRTY BUSINESS -- HAVE BEEN SERIOUSLY INJURED, AND EVEN KILLED BY DRUG TRAFFICKERS. TODAY WE WILL EXAMINE THE EFFORTS BY CITY AND FEDERAL LAW ENFORCEMENT AGENCIES TO CONTROL AND EVEN CURTAIL DRUG TRAFFICKING.

NEW YORK CITY HAS LONG BEEN A MAJOR ILLICIT DRUG MARKET WITH A HIGH PERCENTAGE OF IV DRUG USERS. NONE OF THESE IV USERS, NONE OF US, EVER ANTICIPATED THE POSSIBILITY OF EVEN GREATER SUFFERING THAN IS COMMONLY ASSOCIATED WITH DRUG ABUSE AND DEPENDENCY BECAUSE NO ONE EVER ANTICIPATED AIDS.

AS MANY OF YOU ARE AWARE, HARDLY A DAY GOES BY THAT THERE ARE NOT SEVERAL ARTICLES IN OUR NEWSPAPERS ABOUT AIDS. I AM ALARMED BY THE REPORTS THAT I HAVE RECEIVED ABOUT THIS DEVASTATING ILLNESS. AT A TIME WHEN I WONDERED WHAT POSSIBLY GREATER TRAGEDY COULD BEFALL IV DRUG USERS, THE SPECTRE OF AIDS REARED ITS HEAD.

THESE ARE AN ESTIMATED 200,000 INTRAVENOUS DRUG USERS IN NEW YORK CITY. MEDICAL RESEARCH AND RECORDS INDICATE THAT IV DRUG USERS ARE THE SECOND LARGEST AT-RISK GROUP FOR AIDS, EXCEEDED ONLY BY HOMOSEXUAL AND BISEXUAL MEN. IT IS WITH GREAT SADNESS THAT I SHARE WITH YOU THESE SOBERING STATISTICS:

1. OF THE ESTIMATED NUMBERS OF HETEROSEXUAL IV DRUG USERS IN NEW YORK CITY, APPROXIMATELY 50 TO 60% HAVE BEEN EXPOSED TO THE AIDS VIRUS. APPROXIMATELY 10% WILL EVENTUALLY CONTRACT THE AIDS "DISEASE."

2. IN NEW YORK CITY HETEROSEXUAL IV DRUG USERS REPRESENT 26% OR 1,261 OF THE CASES. AN ADDITIONAL 6%, OR 285, WERE DRUG USERS WHO WERE ALSO HOMOSEXUAL OR BISEXUAL. ANOTHER 1.7%, OR 82, ARE IV DRUG USERS WHOSE SEXUAL ORIENTATION IS UNKNOWN.

THUS CLOSE TO 34% OF ALL AIDS CASES IN OUR CITY INVOLVE IV DRUG USERS.

3. BY COMPARISON ON THE NATIONAL LEVEL INTRAVENOUS DRUG USERS REPRESENT APPROXIMATELY 25% OF AIDS CASES.

4. NEW YORK AND NEW JERSEY ACCOUNT FOR APPROXIMATELY 80% OF DRUG ABUSING AIDS CASES. MORE THAN 95% OF IV DRUG USERS (INCLUDING THOSE WHO INJECT NARCOTICS, COCAINE, OR AMPHETAMINES) REGULARLY SHARE THEIR NEEDLES. NEEDLE SHARING IS A SUSPECTED CAUSE OF AIDS AMONG IV DRUG USERS.

5. MINORITIES HAVE BEEN DISPROPORTIONATELY TOUCHED BY THIS PLAGUE IN NEW YORK.

- 51% OF THE AIDS VICTIMS IN NEW YORK ARE BLACK OR HISPANIC,

- 66% OF ALL IV DRUG USERS WITH AIDS ARE BLACK OR HISPANIC,

- HOWEVER, BLACKS AND HISPANICS COMPRISE 80% OF HETEROSEXUAL IV DRUG USERS WITH AIDS,

- 66% OF THE CHILDREN WITH AIDS IN NEW YORK ARE CHILDREN WITH ADDICT PARENTS; 78% ARE BLACK AND HISPANIC.

CLEARLY THE GREATER SEGMENT OF OUR SOCIETY CAN NO LONGER AFFORD TO MAINTAIN THE DETACHED SUPERIOR ATTITUDE TOWARD IV DRUG USERS. WE WILL LEARN TODAY THAT AIDS CAN BE AND HAS BEEN TRANSMITTED TO PEOPLE WHO ARE NEITHER HOMOSEXUAL, BISEXUAL, OR IV DRUG USERS. WE WILL FURTHER LEARN TODAY OF ALARMING STATISTICS OF PEDIATRIC AIDS CASES.

DURING THE NEXT SEVERAL HOURS WE WILL FOCUS OUR INQUIRY UPON THESE ISSUES. WE WANT TO EXAMINE FEDERAL, STATE, LOCAL AND COMMUNITY RESPONSES TO THE CURRENT DRUG SITUATION IN THE METROPOLITAN NEW YORK CITY AREA, ASSESS THE NEEDS THAT EXIST AND ATTEMPT TO DETERMINE HOW THESE NEED CAN BEST BE MET.

I CALL ON MY COLLEAGUES TO MAKE ANY OPENING REMARKS THEY WISH.

OPENING STATEMENT - HONORABLE BENJAMIN A. GILMAN
RANKING MINORITY MEMBER, SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL
NOVEMBER 26, 1985
HEARING ON HEROIN AND COCAINE TRAFFICKING IN THE NEW YORK AREA AND THE RELATIONSHIP BETWEEN INTRAVENOUS DRUG USE AND AIDS

MR. CHAIRMAN, I AGREE WITH YOU THAT THE HEARING WE ARE ABOUT TO CONDUCT TODAY COMES AT NO MORE IMPORTANT TIME. THE SELECT COMMITTEE HAS REVIEWED THE NATURE OF NARCOTICS TRAFFICKING IN THE NEW YORK CITY AREA IN THE PAST, AND TODAY WE ARE HERE TO DETERMINE WHETHER ANY PROGRESS HAS BEEN MADE IN OUR 'WAR' ON DRUGS. OVER HALF A MILLION PEOPLE ARE ADDICTED TO HEROIN IN THIS NATION; ALMOST 200,000 OF THEM IN NEW YORK CITY. THE NUMBERS OF THOSE ABUSING COCAINE CONTINUES TO SKYROCKET, AND THE TOLL IS TAKEN IN MOUNTING DEATHS ALL ACROSS THE CITY. OUR CONCERN FOR THE SERIOUS EFFECTS OF THIS SCOURGE ON OUR POPULATION IS BROAD INDEED, AND WE ARE HOPEFUL THAT THE LAW ENFORCEMENT PANEL WE HAVE ASSEMBLED HERE TODAY WILL PROVIDE US WITH ANSWERS TO THE QUESTIONS THAT MANY OF US HAVE REGARDING THIS EVER-GROWING MENACE.

THE SELECT COMMITTEE HAS ALSO BECOME CONVINCED THAT ADDITIONAL EXPOSURE NEEDS TO BE GIVEN TO THE LINK BETWEEN INTRAVENOUS DRUG USERS AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). WHAT WAS FIRST THOUGHT TO BE AN ILLNESS CONFINED TO HAITIANS AND MEMBERS OF THE GAY COMMUNITY HAS EMERGED AS THE NUMBER ONE PUBLIC HEALTH CONCERN OF THE NATION. ALTHOUGH I REGRET THAT THE MAJORITY OF CONCERN ONLY SHIFTED WHEN IT BECAME KNOWN THAT THE POPULACE AT LARGE COULD BE AFFECTED, IT IS INDEED TIME FOR US TO EXPLORE IN DEPTH THE MANNER IN WHICH THE HETEROSEXUAL POPULATION CAN ACQUIRE THIS FATAL DISEASE. THE MOST IMMINENT THREAT APPEARS TO US TO BE FROM THE DRUG ABUSING POPULATION, WHICH IS PRIMARILY COMPOSED OF HETEROSEXUALS, WHO CAN, THROUGH INTIMATE CONTACT, PASS ON THE AIDS VIRUS TO THEIR PARTNERS AND THEIR CHILDREN.

HOW INTRAVENOUS DRUG USERS BECOME SUSCEPTIBLE TO AIDS, AND WHAT CAN BE DONE ABOUT THIS PARTICULAR SUBGROUP, IS THE BROAD MANDATE WE HAVE ASKED OUR PANEL OF HEALTH EXPERTS TO DISCUSS. THE SELECT COMMITTEE HOPES TO ELICIT VIABLE STRATEGIES FOR CONTAINING THE SPREAD OF AIDS ANY FURTHER, AND IN IDENTIFYING WAYS THAT THOSE ALREADY INFECTED MAY BE COUNSELED TO COPE AS EFFECTIVELY AS POSSIBLE WITH THEIR ILLNESS. WE HAVE BEEN TOLD THAT THIS EPIDEMIC WILL GET WORSE BEFORE IT GETS BETTER. TIME IS OF THE ESSENCE.

MR. CHAIRMAN, I EXPECT THAT TODAY'S HEARING WILL BE AN EXTREMELY INFORMATIVE AND EDUCATIONAL ONE FOR US ALL. THE SOONER WE ADDRESS THESE TWO VITAL TOPICS THE SOONER WE WILL BE ABLE TO COME TO SOME AGREEMENT AS TO HOW WE CAN BEST COORDINATE LOCAL, REGIONAL, AND NATIONAL STRATEGIES FOR COMBATTING NARCOTICS ABUSE AND THE OVERWHELMING MISERY THAT IS ACQUIRED IMMUNE DEFICIENCY SYNDROME.

STATEMENT BY SENATOR ALFONSE D'AMATO
HEARING ON HEROIN AND COCAINE TRAFFICKING,
IV-DRUG USE, AND AIDS
NOVEMBER 26, 1985

MR. CHAIRMAN, I THANK YOU FOR ALLOWING ME THIS OPPORTUNITY TO TESTIFY BEFORE THE HOUSE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL.

DRUG ADDICTION IS THE GREATEST DOMESTIC THREAT FACING OUR NATION TODAY. DRUG ABUSE IS RESPONSIBLE FOR MILLIONS OF CRIMES EACH YEAR IN THIS CITY ALONE. IT INCREASES THE SCHOOL DROP-OUT RATE, REDUCES PRODUCTIVITY IN THE WORK PLACE, AND COSTS OUR ECONOMY $200 BILLION EACH AND EVERY YEAR.

MR. CHAIRMAN, TODAY'S HEARING COMES AT A MOST IMPORTANT TIME. IN THE LAST TWO YEARS, THE FEDERAL LAW ENFORCEMENT BUDGET IN NEW YORK HAS GROWN BY $50 MILLION. WE HAVE 32 MORE FEDERAL PROSECUTORS AND 73 MORE DEA AGENTS THAN WE DID JUST 5 YEARS AGO. THE CUSTOMS SERVICE IS GROWING AGAIN, AND THE FBI HAS ENTERED THE BATTLE AGAINST NARCOTICS.

WE HAVE INCREASED OUR FEDERAL LAW ENFORCEMENT RESOURCES AND HAVE HAD SOME INCREASED SUCCESS IN COMBATTING THE DRUG MENANCE, MR. CHAIRMAN, BUT THE THREAT REMAINS.

WE STILL HAVE NOT ASSIGNED SUFFICIENT RESOURCES TO THE WAR ON COCAINE, FOR EXAMPLE. THERE IS NOT A NEIGHBORHOOD IN THIS CITY THAT IS IMMUNE FROM THE COCAINE EPIDEMIC. THE JACKSON HEIGHTS AREA OF QUEENS HAS BEEN COMPLETELY INUNDATED. IT IS SECOND ONLY TO MIAMI AS THE MAJOR COCAINE DISTRIBUTION CENTER FOR THE ENTIRE UNITED STATES.

TO BREAK THIS STRANGLEHOLD, WE MUST:

1. STRENGTHEN THE NEW YORK DRUG TASK FORCE;

2. BRING BACK TO NEW YORK THE MOST ABLE AND EXPERIENCED DRUG ENFORCEMENT AGENTS THAT HAVE BEEN ASSIGNED TO OTHER PARTS OF THE COUNTRY;

3. GIVE THE FEDERAL IMMIGRATION SERVICE ENOUGH CRIMINAL INVESTIGATORS TO TRACK DOWN AND DEPORT ILLEGAL ALIENS WHO ARE INVOLVED IN DRUG TRAFFICKING;

4. REDUCE THE DEMAND FOR DRUGS, AS WELL AS THE SUPPLY. THIS MEANS A STRENGTHENING OF OUR DRUG PREVENTION AND TREATMENT PROGRAMS.

TO PROVE THAT THERE IS NO INCOMPATIBITY BETWEEN DRUG LAW ENFORCEMENT AND DRUG DEMAND REDUCTION, I HAVE ASKED THE NEW HEAD OF THE DEA IN NEW YORK TO INITIATE A DRUG PREVENTION AND EDUCATION EFFORT. I AM VERY PLEASED THAT HE HAS ACCEPTED THIS INVITATION.

MR. CHAIRMAN, I ALSO COMMEND YOU FOR CALLING ATTENTION TO THE DIRECT LINK BETWEEN DRUG ABUSE AND AIDS. INTRAVENOUS DRUG USERS ARE THE SECOND LARGEST GROUP OF PERSONS WITH AIDS IN THE UNITED STATES. 60 PERCENT OF THE INTRAVENOUS DRUG USERS IN NEW YORK CITY ALREADY HAVE BEEN EXPOSED TO THE AIDS VIRUS.

THE LINK BETWEEN DRUG USE AND AIDS IS GETTING STRONGER BY THE DAY. IN THE LAST HALF OF 1981, IV-DRUG USERS REPRESENTED ONLY 18% OF AIDS PATIENTS. THIS YEAR, THE NUMBER HAS GROWN TO 33%.

THIS INCREASE INDICATES A FRIGHTENING TREND, ONE THAT IMPLIES THAT PREVENTATIVE AND EDUCATIONAL EFFORTS MUST BE ENACTED TO CONTROL IV-DRUG USE AND THE SPREAD OF AIDS.

IN NEW YORK CITY, 4,531 AIDS CASES HAVE BEEN REPORTED SINCE RECORDKEEPING BEGAN IN 1981. 2,354 (52%) OF THESE INDIVIDUALS HAVE DIED. 1,235 OF THESE CASES (28%) WERE NON-HOMO/BISEXUAL IV-DRUG USERS. AN ADDITIONAL 277 (6%) WERE HOMO/BISEXUAL IV-DRUG USERS. THESE FIGURES CLEARLY POINT OUT

THE SEVERITY OF THE IV-DRUG CONNECTION TO ACQUIRED IMMUNE DEFICIENCY SYNDROME.

THE NEW YORK CITY STATISTICS ARE STAGGERING: 50-60% OF THE IV-DRUG USERS IN NEW YORK CITY ALREADY HAVE BEEN EXPOSED TO THE AIDS VIRUS. ABOUT 10% OF THESE INDIVIDUALS WILL EVENTUALLY CONTRACT THE DISEASE.

CHILDREN ALSO ARE AFFECTED BY THE RELATIONSHIP BETEEN IV-DRUG USE AND AIDS. APPROXIMATELY 85 CHILDREN IN THE NYC AREA NOW HAVE AIDS, AND AN ADDITIONAL 300-500 CHILDREN NATIONALLY HAVE AIDS-RELATED COMPLEX. IN MOST CASES, THESE ARE THE CHILDREN OF IV-DRUG USERS.

THE CASE MORTALITY RATE FOR CHILDREN WITH AIDS IS HIGHER THAN 70%. IV-DRUG USE BY ONE OR BOTH PARENTS IS PRESENT IN 74% OF THE PEDIATRIC AIDS CASES.

THE AIDS-DRUGS LINK IS NOT LIMITED TO INTRAVENOUS DRUG USE. MANY NON-INTRAVENOUS DRUGS SUCH AS PCP, COCAINE, BUTYL NITRATE, MARIJUANA, AND ALCOHOL ALSO WEAKEN THE IMMUNE SYSTEM, AND MAKE THE BODY VULNERABLE TO VIRUS AND INFECTION.

AT A RECENT SENATE APPROPRIATIONS COMMITTEE HEARING, SENATOR WEICKER AND I SPENT SEVERAL HOURS LISTENING TO DOCTORS AND FEDERAL OFFICIALS WHO ARE DEEPLY INVOLVED IN AIDS RESEARCH, EDUCATION, AND TREATMENT. THE TESTIMONY THEY GAVE

WITH RESPECT TO THE RAMPANT SPREAD OF THE AIDS VIRUS IN THE DRUG-ABUSING COMMUNITY IS HORRIFYING.

MR. CHAIRMAN, WE HAVE NOT ONLY LEARNED. WE HAVE ACTED. THE FISCAL YEAR 1986 LABOR/HHS APPROPRIATIONS BILL, WHICH HAS NOW GONE TO THE PRESIDENT FOR SIGNATURE INTO LAW, INCLUDES $2 MILLION WHICH I ADDED TO THE BILL FOR A 24-HOUR INFORMATION CENTER TO PROVIDE INFORMATION ABOUT AIDS, THE MEDICAL CARE AND TREATMENT AVAILABLE, AND THE HOUSING FACILITIES THAT WILL ACCOMMODATE AIDS VICTIMS; AND $16 MILLION FOR AIDS TREATMENT DEMONSTRATION PROJECTS WITHIN A TOTAL OF $234 MILLION FOR RESEARCH AND EDUCATIONAL EFFORTS TO COMBAT AIDS. THIS IS MORE THAN TWICE THE AMOUNT PROVIDED LAST YEAR.

MR. CHAIRMAN, THIS IS ONLY THE BEGINNING, HOWEVER. I LOOK FORWARD TO WORKING WITH YOU TO EXPAND THE BATTLE AGAINST BOTH AIDS AND THE DRUG EPIDEMIC.

THANK YOU, MR. CHAIRMAN.

STATEMENT OF THE HONORABLE JAMES H. SCHEUER
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL
NOVEMBER 26, 1985

MR. CHAIRMAN, I COMMEND YOU AND MR. GILMAN FOR SCHEDULING TODAY'S HEARING ON THE CONNECTION BETWEEN INTRAVENEOUS DRUG USE AND ACQUIRED IMMUNE DEFICIENCY SYNDROME.

IT IS NO COINCIDENCE THAT THIS HEARING IS BEING HELD IN NEW YORK CITY SINCE MORE THAN ONE-THIRD OF ALL REPORTED AIDS CASES NATIONWIDE ARE FOUND HERE.

IN NEW YORK CITY, AIDS IS THE LEADING CAUSE OF DEATH AMONG ALL MEN IN THEIR TWENTIES AND THIRTIES, AND THE SECOND LEADING CAUSE OF DEATH AMONG WOMEN BETWEEN THE AGES OF THIRTY AND THIRTY-FOUR.

WE CAN NO LONGER DISMISS AIDS AS A DISEASE AFFECTING ONLY THE GAY COMMUNITY.

HERE IN NEW YORK, OUR EXPERIENCE HAS PROVED OTHERWISE:

* 26 % OF AIDS VICTIMS IN NEW YORK CITY ARE HETEROSEXUAL INTRAVENEOUS DRUG USERS.

* IN THE LAST SIX MONTHS OF 1981, HOMOSEXUAL AND BISEXUAL MEN ACCOUNTED FOR 76 PERCENT OF NEWLY REPORTED AIDS CASES IN THE CITY AND IV DRUG USERS ACCOUNTED FOR ONLY 18 PERCENT OF THE CASES. BY THE FIRST HALF OF THIS YEAR, THE NEW AIDS CASES AMONG GAY AND BISEXUALS DROPPED TO 58 PERCENT, AND THE PROPORTION OF IV DRUG USERS NEARLY DOUBLED TO 33 PERCENT.

MANY OF NEW YORK CITY'S HETEROSEXUAL AIDS VICTIMS ARE WOMEN, OFTEN IV DRUG USERS -- AND CHILDREN, MANY OF WHOM WERE BORN TO WOMEN WHO ARE IV DRUG USERS OR PARTNERS OF IV DRUG USERS.

THE AIDS PROBLEM AMONG INTRAVENEOUS DRUG USERS IS REACHING EPIC PROPORTIONS IN NEW YORK CITY.

OF THE ESTIMATED 200,000 IV DRUG USERS IN NEW YORK CITY, ABOUT 50 TO 60 PERCENT COULD HAVE BEEN EXPOSED TO THE AIDS VIRUS -- AND 10 PERCENT PROBABLY WILL CONTRACT AIDS.

HOW DO WE SOLVE THIS MULTI-FACETED PROBLEM?

THE SHARING OF NEEDLES, OR "WORKS" AS THEY ARE CALLED, AMONG DRUG USERS IS A MAJOR FACTOR IN THE TRANSMISSION OF AIDS.

HOPEFULLY, ADDICTS AND OTHER USERS ARE AWARE OF THIS FACT -- AND I EMPHASIZE THE WORD "HOPEFULLY" BECAUSE I'M NOT SURE THEY ARE.

(MORE)

AT THE SAME TIME, I WONDER WHETHER THESE DRUG ABUSERS REALIZE THAT THEY CAN CONTRACT THE DISEASE THROUGH THE USE OF A COMMON "COOKER" TO HEAT HEROIN, OR BY SHARING THE COTTON USED TO STRAIN THE SUBSTANCE.

ARE THEY AWARE, IN THEIR DRUGGED STATE, THAT THEY CAN PASS THE AIDS VIRUS TO ANOTHER THROUGH HETEROSEXUAL ACTIVITY?

AIDS IS A BAFFLING AND PRESENTLY INCURABLE DISEASE THAT ALREADY HAS BEEN RESPONSIBLE FOR MORE THAN 7,000 DEATHS NATIONWIDE.

MORE THAN 14,000 AMERICANS HAVE BEEN DIAGNOSED AS AIDS VICTIMS AND THE CENTERS FOR DISEASE CONTROL REPORTS THAT THE INCIDENCE OF AIDS IS DOUBLING EVERY YEAR.

WE WILL HEAR FROM A NUMBER OF EXPERTS TODAY ON PROPOSALS TO REDUCE THE TRANSMISSION OF AIDS AMONG IV DRUG USERS.

ONE PROPOSAL WOULD BE TO PROVIDE DRUG USERS WITH STERILE SYRINGES IN AN ATTEMPT TO HALT THE PRACTICE OF SHARING NEEDLES.

BUT MANY EXPERTS ARGUE THAT MANY DRUG USERS WOULD NOT AVAIL THEMSELVES OF SUCH A SERVICE AND THAT THE NUMBER OF NEEDLES THAT WOULD BE NEEDED WOULD REACH A HALF-BILLION ANNUALLY IF DRUG USERS DID PARTICIPATE IN SUCH A PROGRAM.

IN ADDITION, SOME EXPERTS SAY SUCH A PROGRAM WOULD SPUR OTHERS INTO DRUG ABUSE AND DEMORALIZE THOSE WHO ATTEND OR WORK AT DRUG REHABILITATION CENTERS.

AT THE SAME TIME, THOUGH, THE COST OF PROVIDING CLEAN SYRINGES TO DRUG USERS WOULD BE FAR LESS THAN THE COST OF TREATING AIDS VICTIMS -- A COST THAT IS 60 TO 70 PERCENT HIGHER THAN THE AVERAGE COST OF CARING FOR OTHER HOSPITAL PATIENTS.

I LOOK FORWARD TO HEARING FROM OUR DISTINGUISHED WITNESSES ABOUT THIS PROPOSAL AND OTHER PROPOSALS DEALING WITH EDUCATION AND RESEARCH.

I ALSO LOOK FORWARD TO HEARING ABOUT THE SCOPE OF THE HEROIN AND COCAINE ABUSE PROBLEMS IN NEW YORK CITY.

WE HAVE A GREAT DEAL TO LEARN ABOUT THE AIDS PROBLEM AND THE LINK BETWEEN IV DRUG ABUSE AND AIDS.

THIS HEARING IS A STEP FORWARD IN ACCUMULATING THE INFORMATION WE NEED TO ADDRESS THIS GRAVE AND GROWING PROBLEM.

# # #

BILL GREEN
15TH DISTRICT, NEW YORK

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STATEMENT BY CONGRESSMAN BILL GREEN

TO THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

NEW YORK CITY - NOVEMBER 26, 1985

Mr. Chairman, I should like to thank you for your leadership in holding this hearing today to examine New York's narcotics problems in general, with particular emphasis on IV drug abuse and acquired immune deficiency syndrome (AIDS).

The impact narcotics abuse has had on New York City over the years is no secret to anyone. It is responsible for a large portion of the crime our city faces. I have long supported federal, state and local efforts to address these problems, both from the supply side, with added resources for interdiction efforts, and the demand side, by supporting programs to help those who abuse drugs.

New York City has always had a disproportionate share of the country's drug problem. It also has an exceptionally large share of the country's AIDS cases -- 33 percent of the total. This compares to San Francisco, which follows at 11% and Los Angeles, with 8%. One reason for New York City's unusually large number of AIDS cases (4,795 of the nationwide total of 14,862 as of 11/18/85) is that we have so many IV drug abusers. These people represent the second highest risk group for AIDS. While IV drug abusers account for 17% of all AIDS cases in the U.S., they represent 28% of New York City's cases.

Clearly, AIDS transmission by IV drug abuse, particularly by sharing needles, has exacerbated the entire narcotics use problem in New York. There is a demonstrated need to improve both AIDS and narcotics education among this particular risk group. I am pleased to see that so many federal, state and local officials, from the health and law enforcement fields, have joined us today, and I look forward to hearing from these witnesses.

TESTIMONY BY NEW YORK STATE HEALTH COMMISSIONER DAVID AXELROD, M.D.
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL
REP. CHARLES RANGEL OF MANHATTAN, CHAIRMAN
NOVEMBER 26, 1985. NEW YORK CITY

CHAIRMAN RANGEL AND OTHER DISTINGUISHED MEMBERS, I APPRECIATE THE OPPORTUNITY TO TESTIFY TODAY AND REGRET THAT GOVERNOR CUOMO COULD NOT BE HERE TO DISCUSS PERSONALLY WITH YOU HIS CONCERN ABOUT THE SPREAD OF ACQUIRED IMMUNE DEFICIENCY SYNDROME AMONG NEW YORK'S IV DRUG USER POPULATION. LET THERE BE NO MISTAKE. THOUGH THERE HAS BEEN RATHER LESS ATTENTION GIVEN TO THE IV DRUG USERS THAN TO OTHER GROUPS AT RISK FOR AIDS, IT IS THIS GROUP THAT MAY NOW HARBOR THE GREATEST AIDS POTENTIAL IN NEW YORK STATE -- BOTH TO ITS OWN MEMBERS AND OTHERS. AND WHILE WE HAVE HAD SUCCESS ENCOURAGING THE MALE HOMOSEXUAL COMMUNITY, FOR INSTANCE, TO TAKE SELF-PROTECTIVE STEPS, THERE HAS BEEN PRECIOUS LITTLE SUCCESS IN EDUCATING AT-RISK DRUG ABUSERS TO MODIFY THEIR BEHAVIOR. THIS CHALLENGE IS ONE THE GOVERNOR HAS NAMED AS TOP PRIORITY IN THE NEW YORK STATE WAR ON AIDS.

NUMBERS

WE HAVE PROVIDED COMMITTEE STAFF WITH DETAILED STATISTICAL PORTRAITS OF THE AIDS EPIDEMIC IN NEW YORK STATE, AND I WOULD LIKE TO POINT OUT A FEW KEY FACTS IN MY TESTIMONY. NATIONALLY, PERSONS IDENTIFYING THEMSELVES AS HOMOSEXUAL OR BI-SEXUAL CONSTITUTE 73% OF THE TOTAL CASES CATALOGED BY THE CENTERS FOR DISEASE CONTROL (CDC). THIS INCLUDES INDIVIDUALS WHO IDENTIFY BOTH IV DRUG USE AND AT-RISK SEXUAL BEHAVIOR; THEY ARE COUNTED AMONG THE HOMOSEXUAL OR BISEXUAL GROUP.

NATIONALLY, CDC IDENTIFIES 17% OF THE PERSONS WITH AIDS AS IV DRUG USERS. IN NEW YORK THE PICTURE IS SOMEWHAT DIFFERENT: 30% OF OUR CASES ARE AMONG PERSONS IN THE IV DRUG USER RISK GROUP. AND IF WE CHANGE PRIORITIES, AND COUNT HOMOSEXUALS AND BISEXUALS WHO ADMIT TO IV DRUG USE AMONG THE IV DRUG USER RISK GROUP, THE PERCENTAGE GROWS TO 36%, 1956 OUT OF 5415 CASES STATEWIDE. ISOLATING THIS YEAR'S CASES, THAT GROUP IS CLOSE TO 40%.

WE DO NOT KNOW OR FULLY UNDERSTAND WHY NEW YORK STATE HAS A SIGNIFICANTLY HIGHER RATE OF AIDS IN THE IV DRUG USER CATEGORY THAN, CALIFORNIA OR FLORIDA. AS YOU ARE WELL AWARE, NEW YORK HAS A DRUG ABUSE EPIDEMIC, LONG PRECEDING AIDS, AND THAT GIVES US A LARGE AT-RISK POOL. BUT SCIENTIFICALLY, WE DO NOT FULLY UNDERSTAND THE MECHANISMS OF OUR SPECIAL AIDS PROBLEM.

WHAT WE DO KNOW IS WHAT I ALLUDED TO EARLIER -- OUR EFFORTS HAVE NOT HAD A MAJOR IMPACT ON THE RISK BEHAVIOR AMONG DRUG USERS. UNTIL WE HAVE A SCIENTIFIC PREVENTION (VACCINE), WE MUST DESIGN AN AGGRESSIVE, EFFECTIVE EDUCATIONAL ONE. AS WITNESSES FROM THE DIVISION OF SUBSTANCE ABUSE SERVICES WILL TELL YOU IN GREATER DETAIL LATER IN THIS HEARING, THE ADMINISTRATION IS RIGHT NOW DESIGNING NEW STRATEGIES TO ATTACK THIS EDUCATION PROBLEM. SEVERAL STATE-SUPPORTED AIDS PROGRAMS FOR DRUG ABUSERS NOW EXIST HERE IN NEW YORK CITY -- AT MONTEFIORE MEDICAL CENTER, AT BETH ISRAEL MEDICAL CENTER, AT BELLEVUE HOSPITAL CENTER AND AT THE URBAN RESOURCE INSTITUTE IN BROOKLYN. THESE PROGRAMS ARE REACHING OUT TO ABUSERS IN METHADONE PROGRAMS, AT RIKERS ISLAND, AND IN THE STREET. THEY ARE A START.

TRANSMISSION

ONE FACTOR OF PARTICULAR IMPORTANCE WHEN DISCUSSING AIDS AMONG IV DRUG USERS IS THE POSSIBILITY OF EXPANDED TRANSMISSION TO OTHERS. THE HOMOSEXUAL COMMUNITY IS LARGELY LIMITED IN TERMS OF TRANSMISSION OUTSIDE THAT RISK GROUP. SELF-RESTRAINT AND THE NATIONAL BLOOD SCREENING PROGRAM HAS LARGELY ELIMINATED THE RISK OF INFECTION FROM TRANSFUSION OF CONTAMINATED BLOOD DONATED BY THIS RISK GROUP.

BUT TRANSMISSION OF THE HTLV-III VIRUS, OR AIDS ITSELF, FROM AN IV DRUG USER MOTHER TO HER UNBORN CHILD DOES OCCUR. SPEAKING MEDICALLY, THE PREGNANT WOMAN WITH AN ACTIVE AIDS CASE IS VIRTUALLY CERTAIN TO PASS THE DISEASE TO HER CHILD IN UTERO OR DURING BIRTH. DATA ARE NOT SO CERTAIN AS TO TRANSMISSION OF THE VIRUS. OUR STATISTICS INDICATE THAT VIRTUALLY ALL OF THE PEDIATRIC AIDS CASES REPORTED IN NEW YORK STATE ARE LINKED TO PARENTS WHO ARE MEMBERS OF THE IV DRUG USER COMMUNITY.

THE TRAGEDY OF AIDS IS PROFOUND ENOUGH WHEN IT STRIKES ADULTS. THE SPECTRE OF HUNDREDS OF CHILDREN BEING CONDEMNED BEFORE THEIR BIRTH TO EXPERIENCE THE VARIOUS MANIFESTATIONS OF AIDS IS A SOCIAL AGONY. IN OUR EXPERIENCE, MOST PEDIATRIC AIDS VICTIMS DIE BEFORE THEIR SECOND BIRTHDAY, ONLY A VERY FEW SURVIVE THEIR THIRD YEAR. THE SAD TRUTH IS THAT WE HAVE VERY FEW CHILDREN WHO ARE ELIGIBLE TO BECOME THE FOCUS OF THE TREMENDOUS CONTROVERSY WE HAVE WITNESSED ABOUT AIDS CHILDREN IN SCHOOL.

IN ADDITION TO CHILDREN, SPOUSES OR SEXUAL PARTNERS (MAINLY FEMALE) OF IV DRUG USERS ARE AT HIGHER RISK FOR AIDS AND THE HTLV-III VIRUS. NATIONAL AND STATE STATISTICS DO NOT IDENTIFY A SIGNIFICANT SPREAD FROM THE KNOWN RISK GROUPS TO THE GENERAL POPULATION -- AS PRESS REPORTS AND SOME WORRIED PUBLIC OFFICIALS HAVE ALLEGED. BUT IF THAT IS TO HAPPEN, THE IV DRUG USERS ARE LIKELY TO PROVIDE A MAJOR AVENUE OF INFECTION.

I TRUST I HAVE AT LEAST SUGGESTED THE IMPERATIVE OF CONTROLLING AIDS AMONG THE DRUG COMMUNITY.

CONTROL

CONTROL ISSUES ARE COMPLEX AND CONTROVERSIAL. I EXPECT DEMANDS TO ARISE IN THE STATE LEGISLATURE EARLY NEXT YEAR FOR MANDATORY HTLV-III BLOOD SCREENING OF A NUMBER OF POPULATION GROUPS.

AS COMMISSIONER OF HEALTH, I AM RESPONSIBLE TO ADVISE THE LEGISLATURE AND THE GOVERNOR OF THE FULL SCIENTIFIC EVIDENCE AVAILABLE, AND MAKE RECOMMENDATIONS THAT WILL HAVE A BENEFICIAL IMPACT ON THE PUBLIC HEALTH.

I WOULD LIKE TO DISCUSS A FEW OF THE WELL-KNOWN CONTROL PROPOSALS FROM THOSE PERSPECTIVES AND THOSE PERSPECTIVES ALONE -- SCIENCE AND THE PUBLIC HEALTH.

SCREENING

NEW YORK STATE HAS NOT UNDERTAKEN ROUTINE SCREENING BLOOD OF INMATES IN THE PRISON SYSTEM SIMPLY BECAUSE WE DO NOT SEE WHAT ASSISTANCE THAT WILL PROVIDE, FOR THE INFECTED INMATES, OTHER INMATES, GUARDS OR THE SYSTEM AS A WHOLE.

THE HTLV-III TEST IS NOT A TEST FOR AIDS OR THE VIRUS, BUT A SCREEN FOR ANTI-BODIES TO THE VIRUS. IDENTIFYING PRISONERS WITH ANTIBODIES TO THE VIRUS DOES NOT NECESSARILY IDENTIFY PERSONS WITH THE VIRUS OR WITH THE CERTAINTY OF DEVELOPING AIDS. THE ELISHA TEST, FOLLOWED BY CONFIRMATORY TESTS SUCH AS THE WESTERN BLOT, DOES SERVE AS AN INDICATOR OF A POPULATION AT VERY RISK FOR DEVELOPING THE VIRUS. OF COURSE IN THE PRISON SETTING, OUR EXPERIENCE IS THAT THOSE WHO EVENTUALLY DO DEVELOP AIDS HAVE ALL BEEN IV DRUG USERS ON THE OUTSIDE WHOSE EXPOSURE PRE-DATES THEIR ARRIVAL IN PRISON. RESEARCH ON THE IV DRUG USER POPULATION, INDICATES THAT THE PRECENTAGE OF HTLV-III POSITIVES AMONG THAT POPULATION FAR OUTSTRIPS THE AIDS INCIDENCE; INDEED IT IS LIKELY THAT THE MAJORITY OF THE IV DRUG USER POPULATION IS HTLV-III POSITIVE, SO WE ARE DEALING LOGISTICALLY WITH A CLOSED CIRCLE OF CIRCUMSTANCE. WE WOULD EXPECT TO FIND A HIGH PERCENTAGE OF HTLV-III POSITIVES AMONG INCOMING PRISON INMATES, PARTICULARLY AMONG THOSE WITH DRUG ABUSE HISTORIES. YET CONFIRMING THIS SUPOSITION ON EACH AND EVERY CASE WOULD NOT PROVIDE USEFUL INFORMATION FOR PROTECTION OR TREATMENT.

UNTIL WE HAVE AN EFFECTIVE COURSE OF TREATMENT, WE ARE UNABLE TO TAKE ANY MEASURES TO PREVENT THE ONSET OF DISEASE AMONG HTLV-III POSITIVES. THE BLOOD TEST IS USED AS A SUPPLEMENT TO THE DIAGNOSTIC PROCESS FOR PRISONERS, JUST AS IT IS AMONG THE POPULATION AT LARGE.

AS FOR PROTECTION OF THE OTHER INMATES AND THE PRISON STAFF, IT IS WELL ESTABLISHED THAT INTIMATE SEXUAL CONTACT INVOLVING SEMEN-TO-BLOOD CONTACT AND BLOOD-TO-BLOOD CONTACT THROUGH TRANSFUSIONS OR SHARED NEEDLES ARE THE PRIMARY ROUTES OF TRANSMISSION. SINCE THE PRISON SYSTEM ALREADY FORBIDS AND REGULARLY INTERDICTS CONDUCT WHICH COULD LEAD TO SUCH CONTACT, HEALTH DIRECTIVES WILL HAVE LITTLE ADDED IMPACT IN STEMMING TRANSMISSION. I WOULD SUBMIT THAT NEW YORK'S PRISON SYSTEM HAS BY FAR THE LARGEST INCARCERATED AIDS POPULATION IN THE COUNTRY, YET WE HAVE NOT HAD REPORTED TO US A SINGLE CASE OF AIDS TRANSMISSED BEHIND BARS.

THERE MAY BE A NUMBER OF RESEARCH PROGRAMS POSSIBLE INVOLVING THE IV DRUG ABUSER/AIDS POPULATION IN PRISON, BUT AT THIS POINT WE SEE NO POSITIVE BENEFIT FROM MASS MANDATORY SCREENING. OBVIOUSLY, WE ARE CONSTANTLY IN SEARCH OF NEW INFORMATION ABOUT THIS DISEASE AND ITS TRANSMISSION. WHEN EVIDENCE DEMONSTRATES OTHER CONTROL MEASURES CAN BE HELPFUL IN TERMS OF TREATMENT OR STEMMING TRANSMISSION, WE WILL BE PREPARED TO MODIFY OUR POLICY.

FOR THE SAME REASONS, WE SEE NO COMPELLING REASON TO BEGIN MANDATORY HTLV-III TESTING OF ALL PARTICIPANTS IN METHADONE TREATMENT PROGRAMS. INDIVIDUALS ENROLLED IN THESE PROGRAMS CAN BE, AND ARE BEING, MADE AWARE THAT THEY ARE LIKELY TO BE CARRYING THE HTLV-III VIRUS. THEY MAY SEEK TESTING THROUGH THE ALTERNATE SITES PROGRAM ESTABLISHED BY THE STATE. HOWEVER, THE RESULTS OF THAT TEST WILL NOT TELL THEM ANYTHING THEY DO NOT ALREADY KNOW -- THEY ARE HIGH RISK FOR AIDS, AS ARE THEIR WIVES AND CHILDREN.

NEEDLES

A NUMBER OF THOUGHTFUL INDIVIDUALS HAVE PROPOSED THAT THE STATE SHIFT ITS POLICY AND PERMIT THE SALE OF HYPODERMIC NEEDLES WITHOUT A PHYSICIAN'S PRESCRIPTION OR THAT THE STATE PERMIT THE EXCHANGE OF USED NEEDLES FOR NEW ONES. TO DATE, I HAVE BEEN RELUCTANT TO RECOMMEND EITHER OF THESE COURSES TO THE GOVERNOR, ESSENTIALLY DUE TO A LACK OF EVIDENCE THAT THEY WOULD HAVE A SIGNFICANT IMPACT ON AIDS TRANSMISSION AND AT THE SAME TIME NOT FACILITATE THE ABUSE OF DRUGS. (WE WOULD APPRECIATE ANY DATA YOUR COMMITTEE MAY HAVE ACCESS TO, WHICH COULD ASSIST IN OUR CONTINUING EVALUATION OF THIS ISSUE.)

I AM ADVISED BY THE STATE'S EXPERTS ON DRUG ABUSE THAT THE DRUG CULTURE'S HABITS INCLUDE A SHARING OF NEEDLES AS A PATTERN OF SOCIAL BEHAVIOR. SO THERE IS AN EXPECTATION THAT PROVIDING EASIER ACCESS TO NEW, OR CLEAN NEEDLES WOULD NOT NECESSARILY BREAK THAT PATTERN. RATHER, WE MUST FIND A WAY TO PERSUADE IV DRUG ABUSERS TO HALT THAT SELF-ABUSE OR, AT LEAST, TO STOP SHARING NEEDLES OR TO CLEAN THEIR OWN NEEDLES.

BECAUSE OF THE OBVIOUS NEED TO WORK WITHIN THE DRUG ABUSER COMMUNITY, COMMUNICATING AS EFFECTIVELY AS THE GAY LEADERS HAVE COMMUNICATED THE "SAFE SEX" MESSAGE, WE WILL SHORTLY BE CREATING A SUBSTANCE ABUSE POLICY PANEL TO WORK WITH THE GOVERNOR'S AIDS ADVISORY COUNCIL.

DRUG ABUSE

AIDS IS OF COURSE ONLY THE LATEST MANIFESTATION OF THE OFTEN IGNORED SOCIAL CRISIS OF DRUG ABUSE. THE IMMUNE SYSTEM DEVASTED BY THE ACQUIRED IMMUNE DEFICIENCY SYNDROME IS BUT ONE OF THE BODILY SYSTEMS ASSAULTED BY THE LIFESTYLE OF THE IV DRUG ABUSER IN OUR SOCIETY.

WE MAY WELL FIND A VACCINE, OR SOME OTHER TREATMENT METHOD FOR AIDS, AND NO DOUBT SCIENCE WILL DEVELOP SOME ABILITY TO BLUNT THE DEADLY FORCE OF THIS SYNDROME EVENTUALLY. BUT THE TASK YOU FACE ... WHICH THE FEDERAL GOVERNMENT MUST FACE AGGRESSIVELY AND OVER THE LONG TERM AND WITH A MASSIVE COMMITMENT OF FUNDS ... IS THE GREATER PROBLEM OF DRUG ABUSE. THE SOLUTIONS ARE EVEN MORE REMOTE THAN IS AN ANSWER TO AIDS, FOR THEY MUST CONQUER INTERNATIONAL BORDERS, THE ECONOMIC AND SOCIAL WASTELAND OF OUR INNER CITIES, THE STALE FAILURES OF OUR PRIMARY SCHOOL CLASSROOMS, AND THE APATHY OF THE RICH AND COMFORTABLE.

IF INTEREST IN THE WAR ON DRUGS IS LAGGING, THEN LET THE TRAGEDY OF AIDS GENERATE A NEW WILL TO ATTACK. REMEMBER THAT EACH NEW "RECRUIT" ENLISTED FROM OUR STREETS INTO THE DRUG SUBCULTURE BECOMES A POTENTIAL NEW VEHICLE FOR THE AIDS EPIDEMIC.

THANK YOU.

Testimony of Benjamin Ward

Police Commissioner

City of New York

Before

Select Committee on Narcotics Abuse and Control

November 26, 1985

Mr. Chairman, Members of the Committee:

I am pleased to be with you this morning to testify about the New York City Police Department's response to the drug problem in this City.

I am particularly pleased to be participating in this panel with such distinguished individuals as Robert Morgenthau, Sterling Johnson, Rudolph Guiliani, and Robert Stutman. I believe that our presence here together is significant: we need the cooperation of police and prosecutors working together at the local and federal level to combat the drug problem. In New York City this type of cooperation exists and is making a real difference.

I have a short statement to make before taking your questions.

As your Committee is well aware, drugs are not grown in New York City -- yet they plague this City. Drugs cause human suffering for addicts and their families. They contribute significantly to the crime problems of our communities. We cannot and should not tolerate this plague.

I urge this Committee to use its influence to stop the flow of drugs into our country and to stop the production of drugs by other countries. I particularly support and applaud your efforts, Mr. Chairman, in this regard.

Short of stopping drugs at the border, I believe we all have a responsibility for breaking up the drug smuggling and drug trafficking operations. We also have an equal responsibility to rehabilitate addicts and to prevent our young people from becoming drug users in the first place.

In New York City we are meeting our responsibilities by undertaking several major police operations to interrupt the flow of drugs. The Committee is familiar with Operation Pressure Point that began on the Lower East Side. Since that operation began in January 1984, we have made over 16,000 arrests and have seized over $2.2 million worth of drugs.

On March 1, 1984, we started Operation Pressure Point II in Harlem. Since that time we have made over 16,000 arrests, over 9,000 of them for narcotics violations. It is important for this committee to realize that the success of the Pressure Point strategy can also be measured by a real reduction in crime. In Harlem for example, the rate of robbery in the Pressure Point II area has decreased by 13% in the first ten months of 1985 compared to the first ten months of 1984. Burglary has declined by 17%. Grand larceny has declined by 27%. These reductions in crime mean that the neighborhood is safer and the citizens of Harlem can begin to regain control of their streets.

Building on its experience with Operation Pressure Point, the Police Department has undertaken several initiatives against local drug dealing, each one tailored to the unique needs of

the community. Examples include the project in the Bronx called BAND (Bronx Anti-Narcotics Drive): an initiative in the 73 Precinct; a special effort in Washington Square Park and Bryant Park; Operation Clean-up in Jamaica, Queens; a program targeting smokeshops in East Brooklyn; another special effort in the 34 Precinct. Since their inception, these programs have resulted in over ten thousand arrests.

We have also started an organized effort to close the storefronts known as smokeshops throughout the City. We have targeted identified locations for triggering arrests, notifying landlords of violations in their premises, and using the Padlock Law as a final weapon for shutting the illegal operations down.

I am not satisfied with making thousands of arrests. While this type of enforcement activity is both needed and effective, I firmly believe that we must also try to cut down the demand for drugs. In keeping with this belief, the Police Department and the Board of Education have launched an educational program in the fifth and sixth grades to teach students to say no to drugs. This project, called SPECDA (School Program to Educate and Control Drug Abuse) has been enormously successful and has been expanded from two to seven school districts.

Before closing my statement, I want to call the Committee's attention to the fact that in New York City we have developed an excellent spirit of cooperation between local and federal law enforcement officials and between police and prosecutors.

As you may know, the United States Attorney for the Southern District has agreed to prosecute drug offenses where the federal courts have concurrent jurisdiction. Since March 22, 1984, the New York City Police Department has effected 722 drug arrests which have been prosecuted in the federal system. Three hundred and twenty (320) of these federal prosecutions are based on arrests made under Operation Pressure Point II in Harlem. We are grateful for this type of cooperation.

The Committee should also be aware that 91 of these arrests were made under 21 U.S.C. Section 845A which provides enhanced penalties for drug sale arrests made within 1,000 feet of an elementary or secondary school. This is another example of the federal clout being brought to bear on a local problem.

Finally, I want the Committee to be aware of the excellent level of cooperation between the Police Department in this City and the Federal Bureau of Investigation and the Drug Enforcement Agency. We cooperate in a variety of Task Forces and have formed a truly productive partnership in the fight against the drug trade.

There is much more that can and should be done in this battle against the drug trade. The federal government should do more to stop drugs from entering this country. The federal government should do more to provide financial support for local law enforcement as it spends taxpayers money to fight against the drugs that make their way into our City. The federal government should actively support educational programs like our SPECDA program that keep students from becoming addicts. And finally the federal government should continue to support the cooperative efforts and task force approach that is working so well here in New York.

Thank you.

STATEMENT TO THE HOUSE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

STERLING JOHNSON, JR.
Special Narcotics Prosecutor
80 Centre Street - 6th Floor
New York, New York 10013

November 26, 1985

The war against narcotics is the most serious challenge facing American law enforcement officials today. The illegal drug trade has grown dramatically in recent years, at the rate of $10 billion per year since 1978 and grossed an estimated $110 billion in 1984. It is further estimated that 85 tons of cocaine entered this country in 1984 as compared to 25 tons in 1980. More than 100 tons is anticipated for 1985 and this figure could rise to 200 tons in 1986.

Law enforcement, on both the national and local levels, have made significant efforts to combat the drug problem. In recent years many major drug traffickers have been arrested and large shipments of heroin and cocaine have been seized both here and abroad. In 1984 for example, federal authorities seized more than 340 kilograms of heroin. In June, 1985, 95 kilos were seized in Seattle, Washington. In October, 1985 another 60 kilos, destined for New York was seized in Vienna, Austria.

Federal officials in Florida have seized more than 22,000 kilograms of cocaine during the first nine months of this year, a figure which exceeds the total amount confiscated nationwide in 1984 (11,000 kilograms). The "Pizza Connection" case, also illustrates the intensity in which law enforcement authorities have investigated and prosecuted organized crime figures involved in the importation and distribution of narcotics.

In New York, local, state and federal law enforcement authorities have joined together in an effort to free our streets from the crime and violence associated with drugs. Together we have employed new and innovative approaches to combat the drug problem. In addition, a number of important projects have also been undertaken to deal with specific problem areas. Operation Pressure Point, for example, was created by the New York City Police Department to deal with the massive drug problem which swept through the streets of Harlem and the Lower East Side. Although Pressure Point did not solve the drug problem entirely, it did have an immediate impact in the community. It helped to

clean up the streets and drive drug dealers out of the area. Thousands of dealers were arrested and many of these individuals were sent to state prison. Additional projects in other areas of the city have also been employed in an attempt to eradicate the drug problems that exist there.

As a result of these efforts more drug offenders are being prosecuted than ever before. In the past four years the number of defendants indicted for serious drug offenses by my office has almost doubled. This year alone my office will indict over 3000 individuals, many of whom will receive substantial prison sentences. Furthermore, we are handling more investigations and executing more eavesdropping and search warrants than ever before. In essence we are straining our resources to the limit to deal with the ever increasing drug problem in this city.

However, with all our efforts and all our successes, we are not any closer to winning the war on drugs. The more dealers we arrest, the more there are to arrest. The more drugs we confiscate, the more there is to confiscate. Despite all our programs

and all our efforts there is still drug dealing taking place on the streets of New York. Every day we hear new complaints about drugs in our neighborhoods, our streets, our parks and even our schools. Drugs are no longer the scourge of the poor and the weak. Drugs are everywhere, from Washington Square Park to Washington Heights in Manhattan, from Williamsburgh to Crown Heights in Brooklyn, from South Jamaica to Rockaway in Queens, and from the South Bronx to Riverdale in the Bronx. Every community has seen and felt the horror of the drug epidemic in this city. Without question narcotics is the main reason for the decline in the quality of life in our neighborhoods.

Unfortunately, the problem that confronts us today is not drugs alone, but the violence and crime associated with drugs. Recent studies dealing with criminal behavior have confirmed the widespread belief that drugs breed violence. A 1982 Rand Corporation study entitled "Varieties of Criminal Behavior", revealed that heroin addicted criminals commit more crimes at a higher rate than other criminal. A 1985 study conducted by Dr. Martin

Wish, in conjunction with the National Institute of Justice, examined over 6,400 men arrested on felony charges in Manhattan. The results revealed that a majority of these serious offenders (56%) had used drugs within 24 to 48 hours of their arrest. This data becomes even more alarming when one considers that a 1984 report of the New York State Division of Substance Abuse Services revealed that heroin activity in this state was at peak levels.

Drugs have also played a central role in the Aids crisis which is presently sweeping through the nation. Intravenous drug users injecting themselves with unsanitary needles have been a major reason for spread of this dreaded disease. By the third quarter of 1984 an average of 42 new cases a month were reported nationwide involving intravenous drug users. Furthermore, of the 2,542 Aids cases reported in New York City through October 1984, 32% (812 cases) involved intravenous drug users.

Today, we must recognize the danger that illegal drugs pose to our nation and take the steps necessary to eradicate this plague. We must first educate our young and teach them about the

dangers of drugs. We must also devote our time and energy to drug abuse treatment and prevention activities. We must make sure that these programs are adequately funded and staffed to ensure their success. The federal government must also provide the states and cities of this nation with the resources needed to effectively combat narcotics on the local level. Most importantly, however, the federal government must employ diplomatic measures and make greater use of the military to ensure that illegal drugs do not reach our shores. No program or effort, regardless of how strong it is, can succeed in the war against narcotics, unless drugs are interdicted before they cross our borders.

Presently, we are fighting a holding action in the war against drugs. We make inroads whenever we can, and preserve our neighborhoods from the evils and violence of drugs wherever we can. Only, however, when these measures are taken seriously can we begin to think about winning this war.

62-973 O - 86 - 5

STATEMENT

ROBERT M. STUTMAN

SPECIAL AGENT IN CHARGE

NEW YORK DIVISION

ON

DRUG TRAFFICKING TRENDS

IN

NEW YORK STATE

BEFORE THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

UNITED STATES HOUSE OF REPRESENTATIVES

CHARLES B. RANGEL, CHAIRMAN

November 26, 1985

NEW YORK CITY

Mr. Chairman and Members of the Committee,

I am pleased to represent the Drug Enforcement Administration before this Committee to discuss the current drug situation in New York and our response to it. As you know, my current assignment here in New York as Special Agent in Charge commenced September 30, 1985. I look forward to working with you, Mr. Chairman, and the finest law enforcement agencies in the United States in order to make an impact on drug trafficking within the State of New York and consequently throughout the United States.

The heroin and cocaine trafficking and abuse situations continue at serious levels. Heroin continues to be available in the metropolitan New York City area at both the wholesale and retail levels. Despite impressive seizures overseas and in New York, the price of a kilogram of heroin has stabilized at approximately $185,000 depending upon the quantity ordered and the method of delivery. The purity of this heroin is often in excess of 70 percent. This same kilogram will gross approximately $1 million a pound at the street-level.

Organized crime, both the traditional and non-traditional groups, are responsible for the importation of heroin to this area. The last estimate from the National Institute of Drug Abuse is that there are 492,000 heroin addicts in this country. The New York State Division of Substance Abuse Services estimates that as of this year there may be in excess of 198,000 heroin addicts in New York City.

New York is at the end of a long supply route closely guided by various criminal groups. Historically, Italy, with its Sicilian organized crime families, has played a major role in supplying the dealers on our streets. As an example, in one case heroin from Southwest Asia was smuggled to Italy. In Italy it was concealed in the pallets of a shipment of ceramic tile and placed in a shipping container destined for the Port of Newark. An alert U.S. Customs inspector discovered 18 kilograms of heroin. The tile was destined for Buffalo, New York and then eventual distribution in New York City. Investigation led to the seizure of an additional 10 kilograms of heroin, a kilogram of cocaine and $280,000 cash. This case was investigated in full cooperation with the U.S. Customs Service and the Federal Bureau of Investigation. Additionally, we received outstanding cooperation from the Italian government.

Non-traditional organized crime involvement in drug trafficking and distribution has also increased significantly. Ethnic groups such as Nigerians, Lebanese, Jordanian, Pakistanis, Iranian, Syrian, Israelis, Thais, Chinese and Hispanics have now entered the arena of heroin smuggling and distribution. In some of the source countries torn by civil strife or governmental problems, law enforcement and customs control is sporadic or non-existent. It is difficult for law enforcement to infiltrate these non-traditional organized groups because they tend to interact only with each other, making undercover penetration difficult. Since New York City is a "melting pot," these diverse ethnic groups gravitate here with illicit drugs.

Nigerian violators, for example, are indicative of this trend. Many arrive at JFK Airport directly from Lagos. According to U.S. Customs, in 1982 two seizures totaling 4.3 pounds of heroin were made. By way of contrast, during the first 10 months of this year, over 53 seizures have been made totaling over 32 pounds of heroin. The heroin is usually high purity Southwest Asian and is distributed to Nigerian enclaves in East Coast Cities, including New York. Once their routes have become known to law enforcement, violators are quick to utilize alternative methods of operations and even, as in this example, use non-Nigerian couriers who enter the U.S. via the West Coast.

Heroin is also readily available at the retail level. Harlem and the Lower East Side and Manhattan are historic street sale areas. The New York City Police Department has made a significant impact with its Operation Pressure Point programs. Neighborhoods have been cleaned up, street corners that once were jammed with addicts and dealers have, to an extent, been returned to residents. The enforcement effort is the catalyst that forces dealers into other adjacent neighborhoods.

The constant pressure being exerted contributes to the disruption of violator groups and their sources. DEA's Intelligence Division, working with the New York City Police Department, has documented major violators and their locations, which include gutted buildings to homes in affluent areas. We have also identified the brand names of the heroin they sell and have traced them to Connecticut and New Jersey towns.

As a result of this type of intelligence, DEA has developed at least

three Continuing Criminal Enterprise cases. One case involved traditional organized crime and is a classic example of organized crime control. Using the intelligence gathered by street surveillance, DEA undercover agents developed what appeared to be several low-level cases. After extensive debriefings, electronic surveillance and analysis, an Italian/American organized crime figure was identified and arrested as a main supplier to an Hispanic group which supplied the Lower East Side with kilogram quantities of heroin. Over $3 million in cash was seized from this organized crime violator's home.

Retail heroin purity on the Lower East Side remains high, approximately 18 percent. Purity in this section historically has been high and generally ranges from 18 to 22 percent. Several distributors may share a "cutting mill," a place where heroin is diluted by the addition of quinine, mannite, or other diluent prior to street distribution. Profits are high; the controlling distributor may realize in excess of $7,000 to $10,000 daily.

In Harlem, continuing intelligence probes during 1981 - 1984 revealed that the purity has varied between 2.1 and 3.5 percent. This is attributable to the tight control exercised by high-level distributors. Prices have remained fairly stable at the retail level, indicating few fluctuations in availability. The "New York Quarter" costs approximately $35 to $50 and remains the most popular package to the street abuser. "Speedballs," a combination of heroin and cocaine, are also popular. Dilaudid, a popular pharmaceutical substitute for heroin, is also available at $14 per capsule. Dilaudid is popular because the 4mg. capsule gives a guaranteed euphoric effect.

Overall, since 1981 Southwest Asian Heroin (SWA) has dominated the New York market and is now decreasing. However, Southeast Asian (SEA) heroin is increasing, and Mexican heroin maintains a small share.

NEW YORK

CY	SWA	SEA	MEX
1981	92%	7%	17%
1982	96%	3%	1%
1983	84%	16%	-
1984	72%	25%	2.5%
1985 (6 mos.)	67%	33%	3%

Controlled substance analogs, sometimes called designer drugs, have made their appearance in the New York area. Recently, after several abusers purchased what was later identified as MPTP, they evidenced symptoms similar to Parkinson's Disease.

Statistics indicate that heroin remains the primary drug of abuse of those admitted to treatment centers. The New York State Division of Substance Abuse Services shows that 30,796 individuals in New York City were in State funded treatment programs at the end of May 1985. At that same time, methadone programs, alone, were operating at a capacity of over 100 percent with 24,130 clients.

Drug dependent mortality, i.e., deaths due to chronic acute

intravenous narcotics use has shown a 27 percent decrease. The following statistics, prepared by the New York City Department of Health, indicate the scope of the problem:

YEAR	1978	1979	1980	1981	1982	1983	1984
DEATHS	246	472	534	510	528	582	427

Based on an analysis completed by the New York City Department of Health for the year 1984, AIDS was listed as a cause of death in 26 percent of the narcotic related deaths.

When hypodermic needles are shared, AIDS (Acquired Immune Deficiency Syndrome) is a major risk to a drug abuser. According to the New York State Division of Substance Abuse Services, there have been 3,926 AIDS cases reported in New York City as of June 1985, and one-third have been intravenous drug users. Overall, reported cases are up 72 percent this year over 1984 and more than half of the AIDS patients in New York City have succumbed to the disease. Drug users have reacted to this problem. According to the New York Division of Substance Abuse Services, several street distributors sell a combined package of a bag of heroin and a hypodermic needle for $25. Other dealers sell extra needles.

I would like to briefly address another drug abuse situation which is causing problems for our youth. There has been a dramatic increase in treatment admission for abuse of phencyclidine (PCP), also called "Angel Dust." There was a 73 percent increase in 1984 compared to 1983,

according to the New York State Division of Substances Abuse Services, and additional increases will be shown once the 1985 data is compiled. The State of New York reacted by enacting legislation effective November 1, 1985 which makes the sale and possession of PCP a felony.

PCP, an illicit hallucinogen, is sold as a powder in "bags" similar to heroin, or as a liquid. The cost of the drug is minimal at the street level; one dosage unit costs $2-$6; a "bag" costs $5-$10. Ounce and higher prices vary according to purity. Like heroin, "bags" are sold with brand names: OMEN, B-BOMBER-Z, HE-MAN, ROXANN, and ROCKET FUEL. Liquid PCP is usually sprinkled on a marijuana cigarette for a fast acting "trip." At times, it is sprinkled on any vegetable-type matter, even tea leaves.

PCP abusers, or "dusters", are prone to violence. Last year, in the Bushwich section of Brooklyn, a naked "duster" ran down a street and spontaneously snatched a child from a father's arms and threw the child to the ground causing serious injury. Harlem Hospital, which sees many "dusters" in emotional turmoil, has initiated special measures to protect both patient and staff.

The Harlem area is sometimes referred to as the "DUST BOWL" because sales take place openly on street corners and in abandoned buildings. But PCP sales are not restricted to economically depressed neighborhoods. It is also sold in: Westchester Square, Bronx, and parks such as Alley Pond, Cunningham and Forest Park.

The New York City Police Department Laboratory records reflect the increasing problem. In 1983, there were 1,225 exhibits submitted. In 1984, there were over 2,100 and in the first six months of this year, over 1,400 exhibits have been submitted.

Historically, the PCP abused in New York is made in clandestine laboratories on the West Coast and brought to this area, usually as a liquid. DEA, with the New York City Police Department, is making a concerted effort to reduce the impact of PCP on our city by conducting investigations at the highest levels. We are pursing violators to their laboratories, monitoring the shipment of essential precursor chemicals, and otherwise conducting complex investigations.

COCAINE

Colombia maintains its position as the hub of cocaine distribution to the United States. The method most often utilized to smuggle cocaine into the U. S. is private or commercial aircraft. The Narcotics Intelligence Estimate for 1984 shows that approximately 80 percent of the cocaine smuggled into the U. S. arrived by air. These aircraft penetrated the U. S. airspace along the East Coast, generally between North Carolina and Florida, but at times further north along the coast. A variation of this route is called the "New York Express," where a plane leaves the coast of Colombia and follows the 74 degree west meridian directly to the coastline of New York State.

Cocaine is also brought to New York overland from Florida. Cocaine

is shipped via parcel post or commercial package delivery, by train, in trucks with cocaine secreted within household furniture, or by private car. Commercial flights from Florida to New York or upstate New York cities are often utilized. Vessels from South America also play a role in smuggling cocaine to this area. Secret compartments on commercial vessels, container freight and other cargo, plus kilogram quantities under the control of a crew member are all used to smuggle cocaine. These are but a few of the smuggling routes or methods. The list and variations are much too long to enumerate.

Once the cocaine arrives in our metropolitan area it is usually distributed by Colombian groups. Traditional organized crime has also financed and imported cocaine. Cocaine prices have generally declined at the kilogram level during the last several years. In New York today , a kilogram sells for approximately $35,000 to $40,000. The purity of cocaine at the kilogram level is high, usually 85 percent or more. Lesser amounts cost approximately $1,500 and the abuser may expect a purity closer to 45-50 percent.

I would like to describe a recent case which exemplifies the cocaine traffic. An aircraft left the northern coast of Colombia proceeding north, towards Long Island. One refueling stop was made at an island country. A large cash bribe was given to officials for the "landing rights" and then the aircraft was refueled, at a premium price for the aviation fuel. The aircraft then continued north, eventually mixed in with local traffic patterns and landed on Long Island. Surveillance teams observed the suspect aircraft and arrested the occupants. A search

of the aircraft revealed over 1,500 pounds of high quality cocaine. Several days later, after the defendants posted bail and were released, we learned that one defendant told the intended recipient, "Don't worry, I'll have another load for you next week." This seized cocaine was destined for New York City distribution.

The center of cocaine activity is the Colombian community, especially in Jackson Heights, Queens. It is estimated that there are approximately 500,000 persons of Colombian background residing within a few square miles. While the majority are law-abiding, industrious people, one element -- highly organized and quick to violence -- exists within this community. Drug-related homicides and assaults are common. Hard working people, who have saved to buy homes, now find "stash houses" or "safe houses" in their neighborhoods. "Social clubs" proliferate and are the boardrooms of the cocaine traffickers.

These Colombian traffickers exemplify the new organized crime, complete with their own enforcers. Many utilize false passports and identities and travel frequently to Florida and Colombia. Traditional organized crime has also become more involved in the financing and importation of multi-kilogram quantities of cocaine. They are working with Colombian violators, as well as with violators in other source countries.

Over the last decade, the purity of cocaine delivered to New York has more than doubled. During 1975, an analysis of cocaine exhibits received by the New York City Police Department Laboratory found an

average purity of approximately 20 percent; in the third quarter of 1985, the average purity was 55 percent.

With higher purity we have seen a corresponding increase in cocaine-related deaths and injuries. According to the New York State Division of Substance Abuse, there were seven cocaine-related deaths in the State in 1983, as compared to 91 such deaths last year when the purity was around 48 percent. There has also been a dramatic increase, 63 percent, in treatment admissions for cocaine abusers. In 1983, there were approximately 1,900 persons admitted for treatment. Last year there were over 3,100.

Those of us in law enforcement are very concerned about the new directions we are seeing in cocaine trafficking and abuse. The advent of clandestine cocaine manufacturing laboratories within our communities brings with it the potential to cause explosive damage and/or personal injury to innocent law abiding citizens. Colombian violators are coming to the United States where there is greater availability of essential chemicals. This has come about because of the initiatives taken by the Colombian Government to supress the importation of ether, acetone, and other chemicals utilized in the manufacture of illicit drugs. Since January 1, 1983, the Colombian Government has required that a special permit be obtained to bring these essential chemicals into Colombia. No permits have been issued.

During 1983, 11 clandestine cocaine laboratories were seized within the United States. This number rose to 21 in 1984 and now, during the

first 10 months of 1985, has risen to 29.

There have been several cocaine conversion laboratories located in this general area. Several weeks ago in a residential community on Long Island a cocaine laboratory was seized. Many 55 gallon drums of ether were stored in the garage. Ether is highly combustible and could have destroyed the neighborhood. During April and July 1985, two large laboratories were located in rural, upstate New York. Another laboratory, near Riverhead, Long Island was located as a result of the upstate seizure. These laboratories, operated by Colombian violators, utilized a roving chemist who may have charged as much as $5,000 for every kilogram he produced from the violators' cocaine base.

Of particular concern to the law enforcement community is the appearance of "crack," which is freebase ready prepared for the abuser. The hydrocloride, as well as any diluents, are removed from the cocaine to make the cocaine more potent for instant stimulus. The DEA laboratory has analyzed some exhibits and has found purity extremely high -- 93 percent. The "crack" is sold in vials, about one inch in length with a waterproof cap, weighing about 150 milligrams. Sold for only $10 to $20, "crack" is more affordable than heroin and has the potential for becoming a major abuse problem.

We have already seen an increase in availability of "crack" and have also noted the establishment of "Crack Houses." Abusers become psychologically addicted to this powerful form of cocaine and when they have lacked the funds to buy this drug they have attacked the sellers of

"crack." There is a great potential here for an increase in violent robberies, assaults, and homicide as "crack" users seek money to support their addiction.

Bazuco, a cocaine base or coca paste commonly mixed with tobacco or marijuana, has created a serious addiction problem among Colombian youth. In New York, the abuse of paste has not spread to a great extent due to the availability of processed cocaine. However "street talk" continues to indicate its desirability by some abusers.

DEA is currently in the process of reassessing the staffing situation in the New York Field Division. Presently, we have five groups, staffed with experienced Federal Agents, State Police Investigators and New York City Police Department personnel specifically assigned to investigate high-level cocaine traffickers and distributors. I believe that in light of the increasing cocaine problem, several more groups may be required to realize a reduction in trafficking operations.

Increasing interagency cooperation is also on my agenda. Already, special operations involving active participation by the FBI and U. S. Customs are being formed to carry out new initiatives and to utilize their expertise. IRS agents are presently assigned to DEA and actively participate in asset seizures and forfeitures, as well as guiding our agents in complex financial cases.

I feel that we must continue to emphasize the dangers of drug abuse to our young people, particularly through our education systems. It is vital that the education departments of our states and our local school

boards be cognizant of the ever increasing social problems associated with drug abuse and reach out to children at a formulative stage.

In this regard, New York City is extremely fortunate to have the SPECDA program - the School Program to Educate and Control Drug Abuse. This is a two prong approach that recognizes that both law enforcement and education are necessary and that each works best in an environment where the other is present. The New York City Police Department makes arrests for drug sales within a certain radius of the targeted schools in order to, as Commissioner Ward says, recapture the streets of New York from the drug dealers. At the same time, uniform officers team up with Board of Education drug counselors to teach drug abuse resistance education to the school children. The community - especially the parents - are also involved in the program. I commend Commissioner Ward and School Chancellor Nathan Quinones for their efforts and hope to be able to assist them in this outstanding program.

In conclusion, the trends and situations created by drug trafficking organizations have challenged law enforcement. We must continue to enhance cooperative efforts, to coordinate our targeting programs and work with a common goal to realize a meaningful reduction in supply. We need continued emphasis on these situations to raise public awareness and commitment to reduce drug abuse and drug trafficking.

I appreciate this opportunity to appear before the Select Committee and I look forward to providing whatever assistance you may require.

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Alcohol, Drug Abuse, and
Mental Health Administration
Rockville MD 20857

To Be Released Upon Delivery

Statement of

Jerome H. Jaffe, M.D.
Acting Director
National Institute on Drug Abuse

before the

Select Committee on Narcotics Abuse and Control
U.S. House of Representatives

on

Intravenous Drug Use and AIDS

Tuesday, November 26, 1985

9:30 A.M.

New York City, New York

62-973 O - 86 - 6

Mr. Chairman and Members of the Select Committee:

I am pleased to be here today to discuss the relationship between AIDS and drug abuse, an issue which is of great concern to us, as I know it is to you. I am accompanied by Dr. Harold Jaffe, AIDS Activity, Centers for Disease Control and by Dr. Harold Ginzburg, my special assistant on matters pertaining to AIDS.

I will not discuss at length what the Acquired Immunodeficiency Syndrome or AIDS is, but I would like to reiterate some of the basic facts. We know that AIDS is an infectious viral illness. The causative agent of AIDS is the human T-lymphotrophic virus or HTLV-III. The virus is transmitted principally by sexual contact with infected individuals and by the shared use of intravenous needles and/or other drug-related paraphernalia. It can also be spread from mother to child before, during, or shortly after birth and through the direct transfusion of contaminated blood or blood products, although these modes of transmission account for far fewer cases. AIDS is not transmitted by casual contact. The incubation period for this illness, from the time of viral infection to the manifestation of the disease, is up to five years or more. We do not presently have effective treatment for, or vaccination against, AIDS.

The bulk of my remarks this morning will be about the role of intravenous (IV) drug abuse in spreading both the AIDS virus and its diseases; these

include both AIDS and the so-called AIDS Related Complex (ARC). The relationship of drug use to the complex problem facing us involves more than our concerns with the cases of AIDS.

WHO IS AT RISK?

The widely cited number of 14,500 cases of AIDS reported to CDC represents only the visible tip of the iceberg. We are concerned also about those individuals who have been infected with the AIDS virus, but are asymptomatic. It is estimated that there may be one million such people in the United States.

The categories of individuals who are classified at risk for AIDS by the CDC are: sexually active homosexual or bisexual men; present or past abusers of intravenous drugs; patients with hemophilia; transfusion recipients; and sexual partners of individuals at increased risk for AIDS. The last group is of particular concern when we address the issue of heterosexual transmission.

It is important to realize that these are not mutually exclusive risk groups. In particular, individuals at risk because of their sexual behavior may also be at risk because they are IV drug users. If we combine the number of homosexuals with a history of IV drug use and the number of heterosexual IV drug users, we see that, in the United States as a whole,

Individuals with a history of intravenous drug use make up slightly more than 25 percent of the total number of reported AIDS cases.

Based on national data, approximately 63 percent of the cases of AIDS are among non-IV using homosexual men, 8.5 percent are among homosexual IV drug users, and approximately 17 percent are among heterosexual intravenous drug users. However, there is considerable variation from one region to another. Five states--New York, California, Florida, New Jersey, and Texas--have the bulk of the AIDS cases, three-quarters of all the cases so far diagnosed. In the New York area, 38 percent of reported AIDS cases are among those with a history of IV drug use, while in California, 17 percent of AIDS cases have a history of IV drug use. Pediatric cases represent less than 1 1/2 percent of the total AIDS cases; however, 52 percent of these children are the offspring of IV drug users.

When we look at patient risk groups, we predominantly talk about homosexual and bisexual men and heterosexual IV drug users. What many people fail to appreciate is that there are significant numbers of women who are developing AIDS or are infected with the AIDS virus. The majority of cases of AIDS among women are either those who have a history of using intravenous drugs or who have had a heterosexual contact with an individual who is in a high risk group for AIDS or who has AIDS.

In terms of age distribution, one of the factors that makes this disease so

devastating is that it affects young individuals. More than half of the cases occur in individuals in the age range 30 to 39, with a significant number in under 30 age categories.

Approximately 60 percent of the AIDS cases are white non-Hispanics. Blacks represent approximately 25 percent; Hispanics approximately 14 percent. A majority of the cases of AIDS among homosexual drug users are white, while Blacks compose half of the heterosexual IV drug user group.

WHAT IS THE RELATIONSHIP BETWEEN IV DRUG USE AND AIDS?

I would like now to talk about a specific study which is being conducted by NIDA, the National Cancer Institute, and the State of New Jersey. I should begin by saying that more than half of the AIDS cases in New Jersey are found among intravenous drug users, and, within that group, more than half are women. This particular study involves more than 1,000 clients in ten drug abuse treatment programs throughout the State. For this analysis, we excluded those individuals who denied ever using intravenous drugs, those men who had any male sexual partners, whether voluntarily or involuntarily, those who had received blood transfusions, and those who had reported a history of either pneumonia or Kaposi's sarcoma.

Approximately 44 percent of the individuals entering detoxification programs (most of these were in northern New Jersey) tested positive for antibodies

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to the AIDS virus. One-third of those in methadone maintenance programs tested positive, independent of the time spent in treatment. The relatively high rates of exposure among Blacks in this population is due to the larger number of Blacks in detoxification rather than methadone maintenance or residential treatment programs.

It should also be noted that about 95 percent of the drug users in this study, whether using heroin or cocaine or amphetamines, reported sharing their needles. In other areas of the country, such as New Orleans, where intravenous drug use rates are high, but where large-scale needle sharing (such as we see in shooting galleries) is not common practice, we have much lower numbers of AIDS cases and of individuals testing positive for antibodies to the AIDS virus. Clearly, change must be effected in needle sharing behavior in order to make progress in reducing the spread of the virus.

WHAT IS NIDA DOING?

What can we at NIDA do about the AIDS problem? Until a cure and/or vaccine is developed, the major goal of the Department of Health and Human Services is to keep the number of new AIDS cases as low as possible by reducing the number of individuals exposed to the AIDS virus. This will require fundamental changes in lifestyle for people at risk of exposure. We are pursuing a vigorous effort towards this end with regard to users of

intravenous drugs, but there are complex issues involved.

One of the major tasks facing us is to assess more accurately the spread of the AIDS virus among the drug using population. Because the incubation period for AIDS is prolonged and most individuals with the virus are asymptomatic, many people are unaware that they are carrying the virus until they become ill. Who should be tested for the virus, what the implications of those test results are, and what should be done in the nature of follow up, have become pressing questions for all of us, but the issues involved--both ethical and practical--are not easy ones to resolve.

The major laboratory test that is used for screening for HTLV-III, such as our blood banks are doing, is the ELISA test. If the initial results are positive, the test is repeated. If the individual again tests positive, a confirmatory test is conducted by some research facilities using the so-called Western Blot.

It is important to understand precisely what it means to have a positive result on these tests. It means that you have been infected with the virus. It does not mean that you will necessarily develop either AIDS or the other clinical manifestations of the virus that we know as AIDS Related Complex or ARC. <u>But it does mean that you must assume that you are able to transmit the virus to others</u> by the routes previously mentioned. The significance of this cannot be overemphasized.

Although the test was developed for the screening of blood, large scale testing of individuals at high risk either for contracting the disease or for carrying it--such as IV drug users--is an idea which has been given serious consideration. We are conducting research which will determine whether such large scale testing and subsequent case finding can be useful in changing behavior. We are also involved in discussing with people at the State and local levels the actual implementation of testing programs at those levels.

Ongoing activities of NIDA have already begun to assess the extent that HTLV-III has spread among the drug using population; the New Jersey study I described earlier is one example. In addition, there are several populations for which widespread case finding can identify individuals either with, or at-risk for developing, AIDS as a result of drug use. The purpose of case findings and maintenance of records is to monitor the incidence and prevalence of the disease so that appropriate prevention and intervention measures may be developed. Further, if infected individuals are identified they may take the steps necessary to protect themselves, their families, and society. Among the populations for which large scale testing is being considered are admissions to drug abuse treatment programs and pregnant drug users and their offspring.

Right now we have no way of predicting which individuals carrying the virus will develop AIDS. At present, it appears that over a 5 year period

approximately 5 to 10 percent of those infected with the virus will go on to develop AIDS, and about 25 percent will probably develop some of the symptoms associated with AIDS. We have reason to believe that the IV drug user who uses frequently is at greater risk than one who uses infrequently. Nevertheless, even the occasional user of IV drugs, whether heroin, cocaine, amphetamines, or some other substance, is at risk for contracting the virus and subsequently AIDS itself. This point must be stressed and should be the cornerstone of our efforts in prevention and education regarding AIDS and IV drug use.

NIDA's activities in the area of AIDS have focused on three principal populations: drug users currently infected with the AIDS virus; other drug users at high risk of and concerned about the disease; and drug abuse treatment and service providers. While these high risk groups will continue to be major foci of the Institute's efforts in this area, NIDA is now formulating a long-term strategy which takes a broader look at the problem.

For example, we are refocusing many of our ongoing activities in research and education. In the past several years, a number of research investigations supported by NIDA have sought to determine the relationship between the effects of various drugs of abuse on the function of the immune system. We intend to continue support for these studies and will stimulate research into the way that the immune system is altered by various drugs of abuse. We are also encouraging studies to develop and expand our

understanding of the epidemiology of AIDS. These will focus on the etiology, risk-factors, and natural history of AIDS among populations at risk for developing the disease due to drug abuse or contact with drug abusers.

Education and prevention programs targeted at several audiences are another major element of our strategy. Clearly, drug users, particularly IV drug users, need to know about the risks to themselves, their sex partners, and families when they use IV drugs. We are also developing and disseminating information to specific high risk subgroups and the general public about the relationship between drug abuse, the spread of the AIDS virus, and the risks for subsequently developing AIDS. A "NIDA Capsule" or fact sheet on the subject of AIDS and drug abuse has been developed and has been distributed both to the press and to State drug abuse agencies. It describes AIDS, the methods by which the disease is transmitted, and specific ways to reduce risk of infection with the virus. Other publications are being planned, including flyers, booklets, and posters to be printed in both English and Spanish. We are also encouraging the press to present stories on the transmission of AIDS through drug abuse, especially in those publications directed to drug users.

We are undertaking a number of other activities aimed at better informing treatment and service providers about suitable procedures for serving drug abuse clients infected with, or at-risk for becoming infected with the AIDS

virus. We have developed a repository of findings and materials about AIDS and IV drug use and have initiated monthly mailings to State agency directors of recent findings and new materials that may be useful in planning service delivery and prevention activities. The first of these mailings included flyers, brochures, information sheets, and other materials developed by Federal and State Governments and directed at the drug abuse client in order to encourage changes in drug using and sexual behaviors.

It is important to address staff fears about contagion by communicating facts and to recommend procedures for handling clients' body fluids, etc. NIDA is planning to circulate to drug abuse treatment programs guidelines recently published by the Public Health Service on AIDS in the workplace which contain recommendations for preventing the transmission of infection with the AIDS virus. Additional efforts are needed to help staff deal effectively with client fears about AIDS, to address issues surrounding the presence in the clinic of AIDS patients or individuals carrying the AIDS virus, and to counsel patients about the dangers posed to themselves and others. Training materials and programs are being developed for State drug abuse agencies, drug treatment programs, criminal justice detention systems, and other relevant health care agencies which encounter IV drug users and/or their families. NIDA will provide on-site technical assistance on AIDS and drug abuse to drug abuse treatment programs.

We have gathered information from drug abuse program directors to determine

what they are doing in the area of AIDS prevention, risk reduction, and counseling. A series of workshops will be held during the next several months to discuss such topics as: AIDS and the drug abuse treatment environment; counseling clients exposed to the AIDS virus, whether or not they are symptomatic; and treatment of these clients in residential programs. Though specific procedures and policies will of course have to vary from State to State, we hope to establish consensus around a number of issues.

We believe that all of these efforts can be effective in helping to halt the spread of AIDS. We are also aware that other measures have been suggested. It does seem clear that we need to intensify our efforts to prevent the onset of drug use entirely and to persuade current drug users to enter treatment. In the United States, addicts entering drug abuse treatment programs show sharp decreases in the rate of illicit drug use, especially the use of IV narcotics and cocaine. The drug abuse treatment system can play an important role in keeping drug users already infected with the virus from spreading it to others and in preventing uninfected drug users from contracting the virus. As more patients enter treatment programs, the practice of using and sharing needles may be reduced, thus reducing the spread of the AIDS virus. Furthermore, private practitioners should be encouraged to include counseling and treatment of drug abuse patients in their practices. The use of the narcotic antagonist naltrexone by such practitioners might prove useful .

However, recent research from New Haven suggests that the mere availability of treatment is not the only determinant of whether drug users enter treatment. Often, such factors as the price and availability of drugs and the kind of treatment available are also determinants. Some addicts are now as reluctant to enter methadone programs as they once were to enter therapeutic communities. We need to find additional acceptable treatment modalities that are effective; this is one of the goals of NIDA's treatment research program.

In attempting to prevent the further spread of AIDS and the AIDS virus via the IV drug use route, our major objectives are to clearly articulate the message, "do not use IV drugs; if you do, don't share needles," and to encourage drug users to enter treatment. Secondarily, we need to provide information to those who continue, despite our warnings, to share needles and other drug paraphernalia that these items can be disinfected of the AIDS virus through inexpensive and readily available methods. Some of the publications which we have released or are planning to release describe these methods in precise detail.

Still, despite all these steps aimed at the drug using behavior of current drug users, it will not be easy to halt the spread of this disease. Many IV drug users have non-drug using heterosexual partners. Reducing the number of those infected with the AIDS virus in the IV drug using population is an important step in protecting the community. However, even totally

eliminating needle use would do little to reduce the further spread of the AIDS virus via the sexual route by drug users already exposed to the virus. Unless there is also a modification of their sexual practices, these exposed individuals can spread the virus to their sexual contacts and future children. We need to find the best ways to motivate those infected with the virus to change their behavior in order to protect those close to them.

We hope that by increasing public awareness of AIDS as a significant health consequence of drug use, we may well be able both to increase the effectiveness of our current drug abuse prevention and education efforts and to encourage large numbers of current drug users, especially IV drug users, to enter treatment. Success in these two areas are capable of providing us with not one, but two, major long term public health dividends--reduced numbers of drug users and reduced numbers of AIDS carriers and AIDS victims.

We will be happy to answer any questions you may have.

Testimony Prepared for the Select Committee on
Narcotics Abuse and Control

Hearings on AIDS in Intravenous Drug Users
Nov. 26, 1985

testimony of
Julio A. Martinez
Director
New York State Division of Substance Abuse Services

I would first like to thank the Select Committee for this opportunity to testify on the very serious problem of acquired immunodeficiency syndrome (AIDS) among intravenous (IV) drug users.

I would like to acknowledge the Division's work in this area, particularly the research conducted by Drs. Don C. Des Jarlais and Samuel R. Friedman. This research has been conducted with colleagues from the New York University Medical Center, the Beth Israel Medical Center, the Manhattan Veternans Administration Medical Center, the New York City Department of Health, and the Centers for Disease Control. Major financial support was provived by the National Institute on Drug Abuse.

IV drug users are a critical group in the AIDS epidemic because of the large numbe of AIDS cases in this group and because of transmission of HTLV-III/LAV, the virus that causes AIDS, from IV drug users to their sexual partners and children.

Intravenous (IV) drug users form the second largest group of persons who have developed AIDS in the U.S. Of the 14,519 adult cases of AIDS reported to the Centers for Disease Control through Nov. 4, 1985, 3643 (25.1%) have occurred in IV drug users, including 1195 (8.2%) IV drug users who also have a history of male homosexual activity.

The present hierarchical risk classification method used by the CDC does not distinguish male homosexual IV drug users from other male homosexuals, and thus tends to underestimate the numbers of IV drug users with AIDS.

IV drug users are important not only because of the number of them who have developed AIDS, but also because they form the primary linkage to two other groups at increased risk for the disease. Of the 206 children who have developed AIDS, 107 (52%) have had an IV drug user as a parent. Of the 148 persons who appear to have developed AIDS through heterosexual transmission, 100 (68%) have involved transmission from an IV drug user. Most heterosexual transmission AIDS cases have involved male-to-female transmission. (Data from the Centers for Disease Control, through Nov. 4, 1985.) Thus control of the epidemic within the IV drug user group will also lead to great reductions in the number of children and heterosexual partners who are likely to develop the disease.

Epidemiology of HTLV-III/LAV among IV Drug Users

It is clear that the sharing of paraphernalia for injecting drugs is the primary method of transmitting HTLV-III/LAV virus among IV drug users. In terms of viral transmission, "needle sharing" should also include the sharing of the syringes used for injection, and possibly even the "cookers" used for preparation of the drugs prior to injection and any rinse water that is re-used in cleaning needles. The sharing of syringes, cookers, and rinse water as well as the needles themselves permits exchange of blood between persons injecting drugs. Much of the sharing of needles occurs within friendship groups of drug users, who may have pooled resources to obtain the drugs. "Shooting galleries," places where IV drug users can rent or purchase needles that have been previously used by others, appear to be important locations where HTLV-III/LAV can be spread across friendship groups. Heroin and cocaine are by far the most commonly injected drugs among IV drug users who have been exposed to the HTLV-III/LAV virus, but the particular drug being injected does not appear to play an important part in the spread of the virus. Persons sharing needles to inject

amphetamines or other drugs must also be considered at risk for viral exposure.

In the United States, the AIDS epidemic in IV drug users is centered in the New York City metropolitan area. Our 1984 studies of HTLV-III/LAV seropositivity among IV drug users in New York City show approximately half of the IV drug users had been exposed to HTLV-III/LAV. Studies with our colleagues in San Francisco and in Chicago found approximately 10% positive in these cities. Clearly the AIDS epidemic among IV drug users is most advanced in the New York City area, but it has also begun in other cities with large numbers of IV drug users. Prevention efforts are needed throughout the country. It should be emphasized that this includes areas like San Francisco and Chicago, and many smaller cities, where the great majority of IV drug users have not yet been exposed to the virus and where few IV AIDS cases have yet appeared.

We have also conducted historical studies of the epidemic in New York City, using serum samples that were originally collected for other purposes. We have samples of serum from IV drug users that go back to the middle 1960's. The first indication of HTLV-III/LAV antibody presence was found in a sample from 1978. Seroprevalence increased steadily in later samples--29% of the 1979 samples were positive, 44% of the 1980 samples, and 52% of 1982 samples. These sera were not collected from random samples of IV drug users, and caution is needed in interpreting the results. The HTLV-III/LAV virus appears to have been introduced to IV drug users in the late 1970's in New York City and the seroprevalence rate has increased steadily since then. From our large seroprevalence studies conducted in 1984, we estimate that about half of the estimated 200,000 IV drug users in New York City had already been exposed to HTLV-III/LAV. From viral isolation studies, we must assume that almost all of these HTLV-III/LAV exposed IV drug users are capable of transmitting the virus to other drug users, to sexual partners and to potential children. However, this transmission does not occur through casual contact, a fact that is underscored by the lack of AIDS cases among drug program personnel (and corrections officers) in spite of their many years of contact with exposed drug users before they even knew AIDS existed.

Large increases in the injection of heroin and cocaine were also occurring during the late 1970's and early 1980's in New York. These apparently were the result of increased supplies of heroin to the northeastern United States and a general increase in the popularity of cocaine use in the nation. There also have been epidemic level increases in tuberculosis and pneumonia deaths among IV drug users since the late 1970's, though parallel increases have not been seen in other AIDS risk groups. The extent to which the increase in tuberculosis and pneumonia deaths are attributable to co-infection with the AIDS virus is under current investigation. If half of the increased deaths from these diseases can be attributed to HTLV-III/LAV, then the estimates of the number of HTLV-III/LAV related deaths among IV drug users in New York would increase by fifty per cent.

Impact on Minority Communities

Intravenous drug use has traditionally had a disproportionate impact on ethnic minority groups in the United States. As a disease among IV drug users, AIDS similarly will have major impact upon minority groups. One particularly important aspect of this impact will be on the heterosexual partners (who do not inject drugs themselves) and children of IV drug users. The majority of IV drug users have their primarily sexual relationship with a person who does not inject drugs. The potential for heterosexual transmission and in utero transmission will increase the strain on couples where one partner injects drugs. Such couples and their children already experience high levels of health and social/economic problems. IV drug users and their heterosexual partners are typically at the ages of high rates of child bearing. Our current studies indicate that approximately one quarter of IV drug users in New York expect to have additional children and another quarter are not certain as to whether they will have additional children. The HTLV-III/LAV antibody test has the potential for providing needed information in some of these circumstances, but would require voluntary testing and substantial skilled counseling in addition to the laboratory work if the test is to be

utilized constructively.

In collaboration with the New York City Department of Health, we are presently intensively studying the relationships among IV drug use, ethnicity, exposure to HTLV-III/LAV, and development of clinical AIDS. These studies involve complex analyses of very large data sets. From our preliminary analyses, it appears that ethnic minority IV drug users are developing AIDS at a slightly higher percentage than their percentage among all IV drug users in New York City. We are currently investigating whether this is a result of different rates of exposure to HTLV-III/LAV, measurement error, or a product of as yet unidentified co-factors that influence disease progression after viral exposure. We will be pleased to keep the Committee informed as our analyses progress.

Needed Efforts for the Immediate Future

Work on developing effective treatment and vaccines for AIDS must be continued. There are formidable problems in developing both treatment and vaccines, however, and we cannot ignore the current epidemic increases in AIDS among IV drug users until treatment or vaccines are developed.

The current increases in cases of AIDS among IV drug users, their sexual partners and children are probably the results of viral transmission that occurred three to five years ago. We must expect that these increases will continue for at least the next several years. We will have to provide treatment for these expected increases in cases. In order to utilize scarce treatment resources effectively, we will also have to develop new residential arrangements for IV drug users with AIDS. Many IV drug users with AIDS or AIDS related complex spend unnecessary time in expensive hospital beds simply because we have not yet developed alternative sites where they could receive the needed levels of nursing/medical care.

It is essential that we intensify our prevention efforts for AIDS among IV drug users. To date there has been comparatively little prevention effort focussed on IV drug users because of a lack of public attention to this risk group, and little realization of the transmission of HTLV-III/LAV from this group to heterosexual partners and children.

The false stereotype that IV drug users are incapable of changing health related behavior has also contributed to the relative lack of prevention efforts directed towards IV drug users. We have consistent evidence from a variety of studies that a great many IV drug users do change HTLV-III/LAV transmission related behavior in response to the threat of AIDS. Prevention efforts can be successful in this regard.

There are three subgroups where efforts at preventing AIDS among IV drug users can be targetted. First would be persons who are not yet injecting drugs, but are at high risk for doing so. This would include youth who have experimented with intranasal use of heroin and cocaine. Second would be current IV drug users who wish to enter treatment to stop their drug use. At present in many parts of the country the treatment system simply does not have sufficient capacity to enroll all those who want to enter.

We also need to consider reduction of HTLV-III/LAV transmission among IV drug users for whom our present forms of drug abuse treatment are not likely to eliminate drug injecting. The size of this group and its potential for transmitting the virus to sexual partners and children require that HTLV-III/LAV transmission be reduced within the group. Our present studies show that many of them respond to information about AIDS by seeking to reduce transmission related behavior. Clearly we need to fully inform them about AIDS, the varieties of HTLV-III/LAV transmission, and the various steps that they can take to reduce viral transmission. The steps must emphasize that ceasing to inject drugs would be the only certain method of stopping transmission, but that ceasing to share works for injecting drugs and sterilizing works may also be important in preventing AIDS.

The question of reducing the legal restrictions on availability of sterile needles as a way of preventing AIDS has been proposed by New York City Department of Health. No action has yet been taken in this area. If the AIDS epidemic among IV drug users, their sexual partners and children continues on its present course--AIDS cases are increasing most rapidly in these risk groups in New York--we expect that additional serious consideration will be given to reducing legal restrictions on sterile needles. Any actions

regarding legal availability would have to be carefully designed and coordinated with prevention efforts so as to reduce initiation into drug injecting and not to reduce recruitment into treatment so that any increased legal availability did not increase drug injecting. Research is needed on this problem; such research should include both study of the effects of present differences among states and experimental designs.

Much of the prevention effort to date for all risk groups has consisted of pamphlets and posters. There are clear limits on the effectiveness of these methods, including language and literacy problems among IV drug users. Sexual and/or drug use patterns are quite resistant to change, and such change is very difficult without interpersonal support. Our prevention efforts for IV drug users and their sexual partners need to include opportunities for the types of questions and answers and modulation of the emotional content of the messages that are possible in personal contact situations. The social organization of the IV drug use subculture in the United States limits the extent to which self-help and risk reduction efforts will originate from within the group, particularly for current IV drug users. Thus the personal communication and interpersonal support for risk reduction efforts will probably have to originate from public health and drug abuse treatment sources and perhaps from ex-users.

The types of prevention efforts that are needed to control the AIDS epidemic among IV drug users, their sexual partners and potential children will not be easy or inexpensive. They do, however, offer the likelihood of greatly reducing HTLV-III/LAV transmission, the human suffering associated with HTLV-III/LAV caused disease and the fear of AIDS. Given the cost of medical treatment for AIDS cases, estimated to be approximately $150,000 per case in New York, prevention efforts begun now would almost undoubtedly be highly cost effective.

Education of the General Public

In addition to education and prevention efforts aimed at IV drug users, there is a clear need for education of the general public about AIDS and AIDS among IV drug users. The public needs to be better informed about the the public health need for control of the

epidemic in this group and the potentials for heterosexual and in utero transmission of HTLV-III/LAV.

At the same time there is a need for continued education of the public regarding the lack of evidence for casual contact transmission of HTLV-III/LAV. Inflated concern over casual contact transmission threatens to increase discrimination against members of the present risk groups and to undermine the cooperation between risk group members and public health officials that will be needed actually to reduce HTLV-III/LAV transmission. Unreasonable fears of AIDS are spreading faster than the virus itself, and are adding extra dimensions of social costs to the epidemic. Methods for reducing these unreasonable fears, while promoting actual risk reduction, are a final area of needed research and public health action.

SELECT COMMITTEE'S NEW YORK HEARING ON HEROIN AND COCAINE TRAFFICKING, INTRAVENOUS DRUG USE AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

Appellate Courtroom of the Court of International Trade

1 Federal Plaza

New York, New York

Testimony of: Beny J. Primm, M.D.
Executive Director of the Addiction
Research and Treatment Corporation
22 Chapel Street
Brooklyn, New York 11201

Mr. Chairman and Members of the Select Committee, as you may recall we have discussed the seriousness of the impact of the Acquired Immune Deficiency Syndrome on the American public and particularly on the minorities. As you are aware New York City has the infamous distinction of being the home of the greatest number of AIDS patients (4,827) and the estimated highest number of intravenous drug abusers (177,000). A more distressing fact is that your 19th congressional district has the greatest number of at risk persons cases for AIDS per population than any other in the U.S.A. There are at minimum, 10,000 registered intravenous drug abusers in treatment in the 19th congressional district. It has been reported that at least 60% of that number would test positive for the presence of the HTLV III antibody by the ELISA test. That population is in constant intimate contact with spouses, lovers and significant others and almost all are infective despite being asymptomatic themselves.

My purpose here today is not to sound the alarm and cry fire but to call to the attention of those responsible that our minority communities are very fertile grounds for the spread of this retrovirus. We have the highest incidence of new active cases of tuberculosis in the U.S., 109 per 100,000, and the second highest, only exceeded by Haiti, 134 per 100,000 population, in the free world. As you know Mr. Chairman tuberculosis is a disease of

of those who are stressed, living generally under deplorable conditions with poor nutrition, housing and health care. Many of the AIDS cases at Harlem Hospital present with the diagnosis of turberculosis, and their average AIDS caseload is 30 patients. Alcoholism, smoking and the use of marijuana and cocaine is rampant among minority youth. Drug dependence, homicide and cirrhosis of the liver secondary to alcoholism are the first, second and third leading killers of Black and Hispanics between the ages of 15-44 in Harlem and East Harlem. More often than not homicides in these areas are either directly or indirectly associated with alcohol or other substances of abuse. All research reports indicate that drug abuse of any kind impairs the body's immune response resulting in greater vulnerability for such persons to all diseases, but more so for those in the risk group for AIDS.

Mr. Chairman I would like to recommend that this committee advocate for an all out educational approach to this problem in minority communities. This must include stressing a change of lifestyle and behavior, using street workers and mobile units to reach that population not in treatment, and the so called street people.

Suggestions for improvement of health care and thus the reduction of susceptibility to AIDS in the minority community.

FOR TUBERCULOSIS

1. Better mechanism of detection and screening for tuberculosis.
2. Better mechanism for treatment, control and followup of diagnosed cases of tuberculosis.
3. Establishment of an advisory committee to the New York City Department of Health and the New York State AIDS Institute to ensure an inclusion of their cultural perspective in their policies.
4. The establishment of an enforcement group to make immediate sweeps, and the closing of all "shooting galleries" in New York City and elsewhere, with emphasis on Harlem and other minority communities.
5. Establish a mechanism to ensure that medical schools curriculum includes lectures on signs, symptoms, and diagnosis of Acquired Immune Deficiency Syndrome Related Complex (ARC) and Acquired Immune Deficiency Syndrome (AIDS).

Since some people are going to use drugs, some thought and effort on the part of the Federal government should be made to investigate how to teach people who use drugs to do so in a manner that is not at risk to their health.

Prevention and education efforts have been effective in decreasing morbidity and mortality among the homo and bisexual risk groups. Despite the difficulty reported in using the same strategy among intravenous drug users, all efforts must be exhausted to accomplish the same results as in other high risk groups.

Mr. Chairman and Members of the Committee:

I am David Sencer, Commisioner of Health, the City of New York, and I welcome the opportunity to discuss AIDS and substance abuse with you.

Unfortunately, NYC has more AIDS than any place in the country and in contrast to the rest of the country, drug abuse is a major and growing risk for the spread of AIDS. Let me first give some indication of the magnitude of the problem.

There have been 4827 cases of AIDS reported in NYC since the beginning of the epidemic.

1343 of these are directly associated with the use of drugs intravenously.

An additional 285 are men who are both gay and users of drugs.

65 are sexual partners of drug abusers.

87 children have been born with AIDS and for the most part their mothers are either substance abusers or the sexual partner of a man who is a user.

The State SAS estimates that there are 200,000 active heroin users in the city, and studies have indicated that at least 60% are infected with the virus that is the underlying cause of AIDS. While these people may not develop AIDS they are probably capable of spreading the virus, both through contaminated needles and through sexual intercourse.

AIDS has become the leading cause of death in young men in NYC and the second leading cause of death in young women. However, if all of the mortality that is associated with substance abuse were lumped together, it would be the leading cause in both men and women. 6% of all deaths in NYC between the ages of 25-65 have substance abuse as a cause of death, up from 2% only 5 years ago

It is not only mortality that has changed as a result of AIDS and substance abuse. As a result of our investigations at the City DOH we have identified new outcomes of infection with the virus associated with AIDS. For the past four years there has been a rise in pneumonia cases and deaths that is now linked to HTLV-III infection. A similar rise in tuberculosis has been seen. This is not as a result of the spread of tuberculosis, but is a reactivation of infection that was acquired many years ago. Now, with the HTLV-III infection damaging the immune system, the body can not contain the bacteria of the disease and it becomes a serious infection for the individual.

If you put all of the above together you can see why I think that substance abuse is the main health problem that the City faces today.

What are we doing about AIDS and substance abuse? More than we were a year ago, but not very much. What can we do? We can tell people not to use drugs. We can tell people that if they use drugs they should use clean needles. We can tell people that if they have used drugs or continue to use drugs, they should realize that they may spread the disease by sexual intercourse. We can train workers to counsel people who seek help. We are doing these things but will they help? Not much.

What will help? Sessions such as this are an important first step. Too much of the country thinks that AIDS is a gay disease, and doesn't realize the magnitude of the drug problem. In the early days of the epidemic the gay community rightfully felt that society was not sympathetic to their problem. Today the same attitude exists as it relates to substance abuse. "It is their problem, not mine. It serves them right." These are the unstated attitudes of many.

What more can we do? We do know that many users will benefit permanently from treatment--methadone or drug free. We know unfortunately that many people will not stay on substitution or drug free programs permanently. We also know that there are not enough resources to provide the needed services for treatment. What can we do?

I speak more as anepidemiologist than as the Commissioner of Health. I speak as one who is concerned about interupting the spread of the HTLV-III virus through the sharing of blood and sexual experiences among drug abusers. I am not speaking of the best way to solve the drug abuse problem.

There are two ways to prevent infection and transmission of HTLV, hepatitis and other infectionsin this population. One, don't inject. Two, if you inject, don't share-use clean works. I am already on record as offering a suggestion on the second. As to the first, lets find ways to make methadone and other treatment modalities more available to any one who want help. There are thousands of people on the street who want treatment. Let us provide it to them as best we can--maybe not under the most ideal circumstances but at least a form of treatment that is humane and desired. What can the Federal government do? The Federal government can eliminate its arbitrary restraints upon capacity to provide treament. The Federal government has cut back on funds, but continues to mandate certain services that may be considered ideal, but deprive many needy users even the benefits of bare bones treatment. If we can't afford a luxury car, allow us to use compacts.

To continue the analogy, there are safety standards for all cars, luxury and compact. Standards are needed for treatment programs, but these standards should be for 1985, not 1965. Totally unsupervised treatment is medically and socially unacceptable, just as provision of heroin is unacceptable. But we have to come up with emergency measures. I am not sure that more money is needed as much as new ideas. We need to bring new people into searching for community solutions. I am not a drug abuse expert. I can envisage approaches with which others will find fault. But it is only through dialogue that solutions will be found. You are to be congratulated for opening that dialogue.

I shall be glad to answer questions if I can.

Nov. 26, 1985

NEW YORK HEARING

THE HOUSE SELECT COMMITTEE ON NARCOTIC ABUSE AND CONTROL

LEOLA HAGEMAN

EXECUTIVE DIRECTOR

EXODUS HOUSE, INC.
309 EAST 103RD STREET
NEW YORK, NEW YORK 10029

NOVEMBER 26, 1985

NEW YORK HEARING

THE HOUSE SELECT COMMITTEE ON NARCOTIC ABUSE AND CONTROL

GOOD AFTERNOON. MY NAME IS LEOLA HAGEMAN. I COME BEFORE YOU TO SHARE THE PAIN OF SOME CHILDREN IN A LITTLE CORNER OF THE CITY OF NEW YORK. I APOLOGIZE FOR HAVING NOTHING TO SAY OF SEISMIC DISRUPTION, MASS STARVATION, OR THE ADVENT OF HALLEY'S COMET. IT SEEMS THAT WE SET OUR EYES TO THE HEAVENS OR OUR EARS TO THE RADIO WHEN THINGS GET BAD IN OUR MIDST. WE GET COMFORT AND JOY FROM SENDING THINGS TO PEOPLE WHO ARE NEEDY BUT FAR AWAY. I SUGGEST THAT GIVING SPIRIT IS A NOBLE TWIST OF THE HUMAN SOUL, THIS COMPULSION TO HELP THOSE WHO ARE SUFFERING IN OUR TELEVISION SETS. I SUGGEST THAT THOSE WHO HAVE SHOULD GIVE. BUT WHO WILL HELP SOME CHILDREN IN A LITTLE CORNER OF NEW YORK CITY? MY CHILDREN ARE NOT BONY, MUD-COVERED CELEBRITIES WHO MOMENTARILY EVOKE OUR SYMPATHY AND CRACK OUR WALLETS, ONLY TO FADE INTO THAT DAY-TO-DAY-OFF CAMERA SUFFERING WE CAN IGNORE.

NO, MY CHILDREN, THE CHILDREN OF EAST HARLEM, LIVE IN YOUR MIDST. YOU BUMP INTO THEM IN TRAINS. YOU DRIVE BY THEM WHEN YOU HEAD NORTH FOR SOME WELL-DESERVED BUCOLIC EASE AT THE COUNTRY HOME. THEY MIGHT RING UP YOUR CHILD'S BIG MAC, LARGE COKE AND FRIES, PLEASE- AT A NEARBY FAST FOOD RESTURANT. THEY ARE ADEQUATELY CLOTHED. THEY MAY HAVE RUNNING WATER AND DURING THE WINTER OFTEN HAVE HEAT IN THEIR APARTMENTS. THEY CAN ATTEND SCHOOL. THEY EAT ENOUGH TO MAINTAIN BIOLOGICAL FUNCTIONS. THEY WON'T SUFFER FROM EARTHQUAKES, MUDSLIDES OR VOLCANIC ER'JPTIONS.

NEW YORK HEARING

THE HOUSE SELECT COMMITTEE ON NARCOTIC ABUSE AND CONTROL

" THEN WHAT IS THE PROBLEM?" YOU MAY ASK. LET ME CALL THE PROBLEM LEGION, FOR THEY ARE MANY. HOWEVER, SO OFTEN, THESE PROBLEMS THAT BESET MY CHILDREN TAKE INSIDIOUS FORM: DRUG ABUSE.

MY QUALIFICATION FOR COMING BEFORE YOU IS THE SAME AS YOURS- I AM A CONCERN CITIZEN. HOWEVER, WE LIVE IN AN AGE WHERE CONCERN IS DWARFED BY CREDENTIAL. SO, I WILL GIVE YOU AN ACCOUNT OF MY LIFE THAT GIVES ME FURTHER RIGHT TO SPEAK BEFORE YOU.

I AM THE EXECUTIVE DIRECTOR OF EXODUS HOUSE,INC. A DRUG PREVENTION PROGRAM FOR CHILDREN OF EAST HARLEM. EXODUS HOUSE,INC. WAS ESTABLISHED AS A DRUG REHABILITATION PROGRAM IN 1965 IN A STOREFRONT ON EAST 103RD STREET. MY HUSBAND THE REVEREND DR. LYNN L. HAGEMAN, A PIONEER IN THE FIELD, WAS THE DIRECTOR. THREE YEARS LATER, EXODUS HOUSE,INC. MOVED TO ITS CURRENT LOCATION ON EAST 103RD STREET, IN A BUILDING THAT WAS RENOVATED WITH FUNDS FROM CHURCHES, INDIVIDUALS, AND VARIOUS FOUNDATIONS. AT THIS TIME MY HUSBAND, I, AND OUR THREE YOUNG CHILDREN MOVED INTO THE BUILDING TO SHARE OUR RESIDENCE, LIVES, AND COMMITMENT WITH MEN AND WOMEN WE WERE TREATING. FROM 1968 UNTIL 1984, MY FAMILY AND I LIVED WITH AND HELPED HUNDREDS OF DRUG ABUSERS. I AM PROUD TO SAY THAT IN THIS TIME EXODUS HOUSE,INC. FREED HUNDREDS FROM THE TRAMMELS OF DRUG ADDICTION. NOT ONLY DO THESE MEN AND WOMEN, MANY WITH VIOLENT CRIMINAL RECORDS, NO LONGER PREY ON THE INNOCENT CITIZENRY-THEY CONTRIBUTE TO OUR CITY AND NATION IN THE FIELDS OF BUSINESS, SOCIAL SERVICES, ACADEMIA. AT THE SAME TIME, OUR THREE CHILDREN, RAISED AMONG DRUG ADDICTS IN THIS EAST HARLEM REHABILITATION CENTER, GRADUATED FROM IVY LEAGUE COLLEGES.

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NEW YORK HEARING

THE HOUSE SELECT COMMITTEE ON NARCOTIC ABUSE AND CONTROL

IN 1981 MY HUSBAND SUFFERED A NEAR-FATAL STROKE. NOT LONG THEREAFTER, I BECAME EXECUTIVE DIRECTOR. SINCE THE MID-70'S EXODUS HOUSE,INC. CONFRONTED PAINFUL CHANGES: MOUNTING BUDGET CUTS FOR SOCIAL SERVICE PROGRAMS. A CHANGE IN DRUG ABUSE PATTERNS, AND AN INCREASING INCIDENCE OF DRUG ABUSE AMONG A VERY YOUNG POPULATION. THESE REALITIES AND THE NEAR LOSS OF MY HUSBAND, CONVINCED ME TO CHANGE PRIORITIES TO PREVENTION.

IN SEPTEMBER OF 1984, THE NEW YORK STATE DIVISION OF SUBSTANCE ABUSE SERVICES RECERTIFIED EXODUS HOUSE,INC. AS A PREVENTION/OUTPATIENT PROGRAM FOR YOUNGSTERS AGED 6 TO 14 YEARS. THIS CHANGE CAME NONE TOO SOON AS THESE FOLLOWING ANECDOTES REVEAL:

A MOTHER CALLED OUT THE WINDOW TO HER PRE-SCHOOLER FOR THE CHILD TO PURCHASE "BAMBU" (WRAPPER USED FOR ROLLING MARIJUANA JOINT) THE CHILD COULD NOT HEAR OR UNDERSTAND HER, SO AFTER YELLING TO THE CHILD THREE TIMES SHE CALLED THE CHILD A DIRTY NAME, AS SHE THREW THE MONEY WRAPPED IN PAPER WITH THE WORD "BAMBU" WRITTEN ON THE PAPER FOR THE CHILD TO MAKE THE PURCHASE AT THE CORNER STORE.

A SECOND PRE-SCHOOLER (FEMALE) REPORTED HAVING SMOKED "POT" A "JOINT", MARIJUANA. THE DRUG WAS GIVEN TO THE CHILD BY AN ADULT FAMILY FRIEND. THIS CHILD COMES FROM A FAMILY OF DRUG DEALERS AND DRUG ABUSERS.

BE SURE THAT DRUG ABUSE IS A DEEP PROBLEM. BE AWARE THAT DRUGS DO NOT OFFER EMPTY PROMISES. KNOW THAT DRUGS OFTEN FULFILL NEEDS AND OPPORTUNITIES THAT OTHER WISE SEEM FORECLOSED TO THE DENIZENS OF PLACES LIKE EAST HARLEM:

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NEW YORK HEARING

THE HOUSE SELECT COMMITTEE ON NARCOTIC ABUSE AND CONTROL

1) DRUGS OFFER A SENSE OF ACHIEVEMENT FOR THOSE WH CAN'T ACHIEVE IN AN INADEQUATE SCHOOL SYSTEM AND A RACIST WORKPLACE. 2) DRUGS PROVIDE A PRODUCTION ROLE FOR THOSE WHO CAN'T GET A JOB. 3) DRUGS PROVIDE INVOLVEMENT IN SOCIETAL EXCITMENT FOR THOSE WHO CAN'T AFFORD A TICKET TO A KNICK GAME, SEE AMERICA IN A WINNEBAGO, OR THRILL IN THE LAUNCHING OF ANOTHER SPACE SHUTTLE AS THEY SCUFFLE FOR TRAIN FARE. 4) DRUGS PROVIDE A SENSE OF BELONGING FOR THOSE WHO HAVE NO SHOT AT THE KIWANIS CLUB OR FEEL THEY DON'T BELONG WHEN BROWSING IN BLOOM-INGDALES OR THE MUSEUM OF MODERN ART. 5) DRUGS PROVIDE RECREATION FOR THOSE WHO'LL NEVER SEE THE INSIDE OF THE NEW YORK ATHELETIC CLUB OR A CLUB MED.

THESE TRUTHS THE REVEREND DR. LYNN L. HAGEMAN POINTED OUT YEARS AGO. HOWEVER THEY HAVE NOT BECOME SELF-EVIDENT UNTIL OUR CHAINS ARE SNATCHED OFF OUR NECKS OR UNTIL DRUG ABUSE REARS ITS UGLY HEAD ON WALL STREET AND IN SOME OF OUR BETTER BOARDING SCHOOLS.

MEANWHILE SOME CHILDREN IN A LITTLE CORNER OF THE CITY OF NEW YORK SUFFER. DRUG RELATED VIOLENCE IN EAST HARLEM EXPLODES AND DISPAIR RUNS RAMPANT. AND NOW THERE IS THE THREAT OF AIDS. SEVERAL OF OUR CHILDREN HAVE PARENTS WHO ARE INTRAVENOUS DRUG ABUSERS. A WHOLE GENERATION IS AT RISK NOT ONLY FOR CHEMICAL THRALLDOM, BUT ALSO FOR A PAINFUL, INEXORABLE DEATF. EXODUS HOUSE,INC. AND SEVERAL OTHER PREVENTION AND REHABILITATION AGENCIES STAND AS A POORLY FUNDED MAGINOT LINE AGAINST A THREAT TO OUR CITY. WE CAN NOT DO IT ALONE AND " I-TOLD-YOU-SO'S WILL BRING US LITTLE COMFORT IN THE DARK TIMES AHEAD.

THANK YOU.

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