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THE RESURGENCE OF HEROIN USE AND ITS EFFECT ON YOUTH

HEARING

BEFORE THE

SUBCOMMITTEE ON YOUTH VIOLENCE

OF THE

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

ONE HUNDRED SIXTH CONGRESS

FIRST SESSION

ON

EXAMINING THE PROBLEM OF HEROIN ABUSE AND IMPLEMENTING TREATMENT PROGRAMS

NEW CASTLE, DE

NOVEMBER 15, 1999

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THE RESURGENCE OF HEROIN USE AND ITS EFFECT ON YOUTH

MONDAY, NOVEMBER 15, 1999

U.S. SENATE,
SUBCOMMITTEE ON YOUTH VIOLENCE,
COMMITTEE ON THE JUDICIARY,
New Castle, DE.

The committee met, pursuant to notice, at 10:18 a.m., at the New Castle Police Headquarters, New Castle, DE, Hon. Arlen Specter presiding.

Also present: Senator Biden.

OPENING STATEMENT OF HON. JOSEPH R. BIDEN, JR., A U.S. SENATOR FROM THE STATE OF DELAWARE

Senator BIDEN [presiding]. Good morning, everyone. Thank you all very much for being here. I apologize for being late. I told Senator Specter that it is twice as far from route 141 as it is from Philadelphia, is the reason why.

I particularly want to thank Senator Specter on two accounts. One, for coming down to hold this hearing, and second, and technically, he should be opening this hearing. In case no one has noticed—I know former Mayor Maloney has noticed—I am in the minority. That means that I am the ranking member of a committee and it means that the majority always runs the hearing. So Senator Specter is really chairing this hearing, but he has been kind enough to allow me in my home State to do what I used to do in the bad old days when my team was in charge.

When it comes to Senator Specter and me, those who know us, and the news media know us because they are always reluctant that we never criticize one another, when it comes to us, we are a team. We are friends. I can only think of a couple things we have disagreed upon, and this is not one of them. So I want to thank Senator Specter for making the effort and being so courteous to me.

Second, I am going to make a relatively brief opening statement here and then I will turn it over to Senator Specter and then we will introduce the witnesses, and I thank them all for being here. We have two very distinguished panels this morning, and as you can tell by the turnout, there is keen interest and concern about the subject matter of our hearing today.

This is a hearing of the Senate Judiciary Youth Violence Subcommittee, a field hearing on heroin abuse, and I especially, as I said, appreciate Senator Specter being here. I also appreciate the chairman of the subcommittee, Senator Sessions of Alabama, for authorizing us being able to have this hearing.

We are here today to focus on the resurgence of heroin and to discuss steps that we can take now to prevent it from wreaking havoc on our communities like crack cocaine did in the mid-1980's and up into the mid-1990's.

There is always a drug of the moment. In the mid-1980's, it was crack. In the mid-1990's, it was methamphetamine. Today, in my view, it is heroin. Senator Specter and I join together today to hold this hearing to highlight the Delaware-Pennsylvania, more particularly the Delaware-Philadelphia deadly heroin connection.

The drug trade does not recognize State boundaries, and all of us in Delaware and Pennsylvania, and Delaware and the Wilmington-Philadelphia area, need to work together to address the problem. I would like to say publicly today that the ball is rolling to include Delaware in the Philadelphia-Camden, what we call high-intensity drug trafficking area, known as HIDTA, which allows particular resources to be able to be used, extra resources to be able to deal with the drug problem. I expect we will hear testimony today from our law enforcement folks about why this should happen.

In a 20-minute drive, teens and young people from Delaware—and, by the way, they do not have to drive 20 minutes to get heroin when they can get it right here in our own streets, but in a 20-minute drive, teens and young adults from Delaware, many of them from hard working middle-class families in the suburbs, go to the badlands and the streets in the Kensington section of Philadelphia, and for $10 a bag buy heroin that is as much as 90 percent pure. It is a death drive. It is killing our young people. It is destroying our families. We are here today to try to figure out how we can stop it.

There are an estimated two million heroin users in the United States today, and that number is growing. As our witnesses today will attest, heroin use is on the rise, especially among young people. Long-term national data showed that in 1997, we had the highest level of heroin use among high school seniors since 1975. Here in New Castle County, in the first half of this year, there were 71 heroin-related overdoses, ten of which resulted in death. Fifteen of those overdoses involved teenagers, including one 14 years of age.

It is no coincidence that the rise in heroin use among youth is happening as heroin purity levels are skyrocketing. When heroin was less potent, users had to inject it to get the same high. Now that heroin is up to 90 percent pure in some cities, including Philadelphia, users can get high by smoking, snorting, or inhaling the drug, making it much more attractive to teens and to young adults.

No matter how heroin is taken, it is addictive and it is deadly. We are going to hear some tough testimony today, the toughest from Marie Allen, whose daughter, Erin, became addicted to heroin after snorting the drug, and after three years' struggle with the addition, it finally killed her at the young age of 21.

There is no other disease that affects so many directly and indirectly as does addiction. We have 14 million drug users in this country, four million of whom are hardcore addicts. We all have family members, neighbors, colleagues, or friends who found them-

selves or their children addicted to drugs, and we are all affected by the clear connection between drug use and crime.

An overwhelming 80 percent of the 1.8 million men and women behind bars today in the United States have a history of drug and alcohol abuse or addiction or were arrested in a drug-related crime. If we decrease drug use, we decrease crime. It is simple arithmetic.

As a nation, our primary response to the drug epidemic has been punishment. Clearly, simply locking up people has not solved the problem of drug-related crime, and Senator Specter and I have been authors, and I make no apologies for it, of some of those very tough drug laws that we passed.

In the 1994 Biden crime law, we created drug courts as a cost-effective innovative way to deal with nonviolent offenders who need drug treatment to keep them from getting into the drug stream fully. Delaware's adult drug court judges Richard Gebelein and Carl Goldstein are with us today, as well as our juvenile drug court judge, Peggy Ableman, as well as Wilmington and New Castle County and Delaware State Police, all of whom are here today, and they can tell you the effectiveness of these courts.

Senator Specter and I are fighting in Congress to continue funding for drug courts. Quite frankly, as a member of the Appropriations Committee, Senator Specter has played an incredibly important role, not only in this, I might add, but in our Violence Against Women Act. He is the guy who has made sure when some in my party and his party decided not to fund fully that Act, and not to fund fully the shelters, he is the guy that bucked everyone, put it in, and forced them to vote, and after the first vote of us getting beat, we went back at it again and we won, and the very person who took the money out asked to cosponsor it when you put it back in. So I just want you to know, this is an effective advocate right here and has been a major player in making sure that these programs work, particularly fighting for the drug courts now.

As our first witness, Dr. Alan Leshner, has taught us, addiction is a chronic, relapsing disease. Ten years ago, I asked the question, if drug addiction is an epidemic, are we doing enough to deal with the medical cure? That led to the creation of the Medications Development Division at the National Institute of Drug Abuse, dedicated to unleashing the tremendous power of medical science to find medical cures for this social and human ill. I commend them for the great progress they have made thus far, and I understand there is a promising new treatment for heroin addiction that Dr. Alan Leshner, who is here today, and his team at the National Institute of Drug Abuse helped to develop. I look forward to hearing their testimony.

But before I introduce the first panel of witnesses, let me turn now to my colleague on the Senate Judiciary Committee and my friend for an opening statement.

OPENING STATEMENT OF HON. ARLEN SPECTER, A U.S. SENATOR FROM THE STATE OF PENNSYLVANIA

Senator SPECTER. Thank you very much, Senator Biden. Thank you for inviting me to this important hearing today. Senator Biden and I have collaborated on many matters in the course of the past 19 years. We ride the train from Washington to Wilmington, and

there is a tremendous amount we can accomplish in that kind of a ride.

I have been very much impressed with what Senator Biden's publications have been. I have received not too long ago this elegant treatise on the successes of the Violence Against Women Act by Senator Biden. Somehow, he left my name off as a co-author. [Laughter.]

This is in September, and on November 15, heroin. I said to Senator Biden before we began here, what happened to October? I want to make sure I have the full edition of the current treatises.

Senator BIDEN. That is on the Nuclear Test Ban Treaty. It is coming.

Senator SPECTER. Speaking of the Nuclear Test Ban Treaty, we worked on that together last month, as well, and while we have not yet been successful on that, just stay tuned. We will be.

The issue of heroin, the broader issue of drugs, the broader yet issue of violent crime, is one where we have not had an adequate societal response. I became an assistant DA many years ago. I hesitate to think of the year—1959. I was a younger lawyer then. I am still a young lawyer. I have watched our failure to respond to the drug problems and to the issue of rehabilitation generally, because there are answers.

We need to divide the criminal element into two groups, the career criminals, where we need to throw away the key, life sentences. Senator Biden and I collaborated many years ago on the armed career criminal bill, which provides for a life sentence. That is 15 years to life in the Federal courts for anyone with three or more violent offenses, including sale of drugs, anyone found in possession of a firearm.

There is another class of criminal, one who will be released, and what we need to do is to provide realistic rehabilitation. That means drug treatment, that means alcohol treatment, that means literacy training, and that means job training. We are not going to solve the problem of drugs unless we work hard on the so-called demand side, that is, to try to eliminate the demand.

For many years, I served as district attorney in Philadelphia and I think you have to have tough law enforcement. But tough law enforcement is not going to solve the problem as long as there is so much money in selling drugs, and there is a tremendous amount of money. It is long past due that we devoted at least 50 percent of the resources to the demand side.

Senator Biden refers to some of the work that I have done on the Appropriations Committee, and there, we are really placing tremendous resources into the so-called demand side. The National Institutes of Health had an increase in its budget of almost $1 billion 2 years ago. Last year, Senator Tom Harkin and I—he is the ranking Democrat, and I learned a long time ago that if you want to get anything done in Washington, you have to cross party lines, as Senator Biden and I are again today—Senator Harkin and I took the lead in adding $2 billion to the National Institutes of Health. This year, we are still working on the budget. It is $2.3 billion, and candidly, our colleagues are aghast at the kind of funds we are adding, but nobody has the audacity to try to remove them, that is, not publicly.

But speaking of the NIH Institute on Drug Abuse, that funding is up now to $690 million, an increase of $81 million from last year. The Substance Abuse and Mental Health Services Administration has a block grant to the States of $1.6 billion. That is a lot of money. And treatment programs, $214 million this year, which is an increase of $43 million over last year.

So those are some of the avenues which we need to approach, and I am delighted to look forward to the very distinguished testimony we will hear today from our very impressive panel of witnesses.

Thank you again, Senator Biden, for including me.

Senator BIDEN. Thank you, Senator, and the only reason I did not put your name on the Violence Against Women report is the reason I put that report out was I was getting criticism—questions from within my own party as to how effective was it, how was it working. So I did not want to put you in any more jeopardy than you already are about being associated with me as much as you are in your party.

Senator SPECTER. Well, goodness knows, I never get any questions from my party. [Laughter.]

Senator BIDEN. We have a truly, for the local press here, a truly distinguished panel. I want to briefly explain why we decided to ask this panel to be put together in the way it has been.

One of the things that we have found is there is an emerging consensus among law enforcement, the DEA, the treatment folks, like Tom Maloney at SODAT, and Dr. O'Brien, the University of Pennsylvania School of Medicine, as well as at the National Institute of Drug Abuse. There was a report, and poor Dr. Leshner, I am a broken record on this since the mid-1980's, another report that I wrote back in 1989 calling for spending over $1 billion on beginning the process of dealing with pharmacotherapy treatment of the drug abuse problem. There always have been promising drugs. There always have been promising alternatives.

But what has happened is, in fairness to the drug companies, it is not very much in their interest to promote them. It is not very much in their interest. If we have 1.7 million addicts, you come up with a cure for those addicts, then you have 1.7 million people to market it to, and of those folks, none of them want to buy it. So it gets difficult.

But we have with us today a genuine leader in this area, the Director of the National Institute on Drug Abuse, Dr. Alan Leshner, who we will hear from. Then on the same panel, we will also hear from one of the country's foremost experts on heroin, Dr. Charles O'Brien, who is at the University of Pennsylvania Medical Center and a professor and vice chair of psychiatry at the University of Pennsylvania, as well as the senior Drug Enforcement Administration agent from the Philadelphia-Delaware region, Bill Nelson with the DEA. He knows the territory very, very well.

Locally here, a man who runs one of the most successful programs in the country of its size and scope, Mr. Tom Maloney, the former mayor of the City of Wilmington who runs SODAT Drug Treatment Center in Wilmington and who will talk about the effectiveness from his perspective of the juvenile drug court, as well as SODAT's use of naltrexone to treat heroin addiction.

Dr. Leshner, the floor is yours. I keep saying "Lesher" because there used to be a great high school basketball player who Tom and I played with, went off to West Virginia, and his name was Lesher, from my home city of Claymont, and I apologize. But you can easily administrate as well as he could shoot, and he could shoot the lights out.

PANEL CONSISTING OF ALAN I. LESHNER, PH.D., DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE, NATIONAL INSTITUTES OF HEALTH; CHARLES O'BRIEN, M.D., PH.D., CHIEF OF PSYCHIATRY, PHILADELPHIA VETERANS MEDICAL CENTER, AND PROFESSOR OF PSYCHIATRY, UNIVERSITY OF PENNSYLVANIA SCHOOL OF MEDICINE; WILLIAM R. NELSON, ACTING SPECIAL AGENT IN CHARGE, PHILADELPHIA FIELD DIVISION, DRUG ENFORCEMENT ADMINISTRATION; AND THOMAS C. MALONEY, PRESIDENT AND EXECUTIVE DIRECTOR, SODAT DRUG TREATMENT CENTER

STATEMENT OF ALAN I. LESHNER

Mr. LESHNER. Thank you, sir. I am only sorry my basketball game is terrible.

Senator BIDEN. So is mine.

Mr. LESHNER. Good morning. I am very pleased to be here and I will discuss only briefly how science is helping us to combat the major public health problem of increased heroin use, particularly among our use.

Heroin is, of course, sold in many different forms, and it can be injected, sniffed, snorted, or smoked. Taken by any of these routes, heroin very rapidly enters the brain, where it attaches to the brain's natural opiate receptors. It is important that heroin also acts on the brain's natural rewards circuitry, where it produces pleasurable sensations.

Now, as street heroin has become cheaper and purer in the last few years, it is being used more and more by the noninjecting routes, like sniffing or smoking. This appears to have made heroin more attractive to young people, who historically have been adverse to injecting drugs, but who seem now to think that by snorting heroin, they are protected from its addictive and other harmful properties. This, of course, is simply wrong. Heroin is extremely addicting no matter how it is taken, and we know that many heroin smokers and snorters rapidly progress to injecting, as well.

A critical problem with heroin use is that, over time, prolonged use actually changes the brain's structure and function. These brain changes, then, lead to the compulsion to use drugs. That compulsion is the state that we call addiction. And this brain change-induced state of compulsion is actually the essence of addiction and is what causes family and community disruption.

The fact that addiction has this biological basis rooted in brain changes is why people cannot simply stop using heroin. The brain change is why they require treatment to get their compulsion or addiction under control. Fortunately, our strong science base has provided a number of effective treatments to help combat heroin addiction.

For example, thanks in part to Senator Biden's interest in developing antiaddiction medications and Senator Specter's strong support of NIDA's overall budget through his role as chair of NIH's Appropriations Committee, the biomedical research community has been developing new medicines to help treat addiction. Two of the most successful treatments for heroin addiction, methadone and LAMM, are helping many addicts who previously were a drain on society now to lead productive lives.

I am pleased to say that we are now very near to bringing the Nation another medication to help treat heroin addiction, this one called buprenorphine or buprenorphine naloxone. Because of this particular medicine's pharmacological properties, we expect buprenorphine will be administered in a more traditional medical environment, such as in physicians' offices, thus expanding treatment options tremendously.

In spite of this progress, less than half the Nation's four million drug addicts have received any drug addiction treatment. Thus, there is a tremendous need to make state-of-the-art science-based treatments more widely available and more widely used.

I am pleased to mention here that last month, NIDA launched its much anticipated national drug abuse treatment clinical trials network. This network will serve not only as a mechanism for testing science-based treatments in real life settings, but also as a mechanism for promoting the rapid translation of new treatments into actual community use.

I am especially pleased that one of the first nodes of this network is located in the Delaware Valley. The network is centered at the University of Pennsylvania, but it also includes ten treatment organizations as partners in Pennsylvania, New Jersey, and here in Delaware. Clinical trial network nodes have also been established in four other regions of the country, and we hope to expand this network by at least five new nodes each year.

I am going to conclude here, but I would like to state emphatically that although the data on heroin use is alarming, science does provide us with much hope for getting a better handle on this serious public health problem. I thank you for the opportunity to testify and I will be happy to respond to your questions.

Senator BIDEN. Thank you, Doctor.

[The prepared statement of Mr. Leshner follows:]

PREPARED STATEMENT OF ALAN I. LESHNER

Thank you for inviting me to participate in this important hearing. I am Dr. Alan I. Leshner, the Director of the National Institute on Drug Abuse (NIDA), one of the research institutes that comprise the National Institutes of Health. As the world's largest supporter of research on the health aspects of drug abuse and addiction, I would like to share with you today what NIDA-supported research has come to teach us about heroin abuse and addiction.

In the United States, there are over 810,000 people addicted to this illegal drug. Heroin is both the most frequently abused and the most rapidly acting of the opiates. It is processed from morphine, the naturally occurring substance extracted from the seed pod of certain varieties of poppy plants. It is usually sold as a white or brownish powder, or in some regions of the country (particularly in the Southwest) as a black sticky substance known on the street as "black tar heroin." Heroin can be injected, sniffed/snorted or smoked. It is important to point out at the outset that regardless of how heroin is taken it is extremely addictive and can lead to other detrimental consequences as well.

Heroin abuse is not a new problem. In fact opiate use dates back long in history. What is new and particularly alarming, however, is the high purity of today's heroin, its inexpensive price, and the way it is being taken, all of which appear to be recruiting new users. Heroin is now cheaper and purer than ever, making it more accessible to young people who can smoke or snort the drug rather than inject it intravenously. Until recently, the most common route for administering heroin was through intravenous injection. Today, given the purity of the drug, in many regions of the country, including the Philadelphia metropolitan area, where street-level heroin purity remains one of the highest in the Nation, people can snort heroin and achieve a high that is similar to what they can obtain from injection. Our research is showing that many of the new initiates to heroin are in fact trying the drug because they can snort it and think they would be protected by not injecting. In addition to that last fact being clearly wrong, studies also show that noninjecting heroin users are at considerable risk of becoming injection drug users (IDUs). In fact, more than 15 percent of participants in a recent study transitioned from other routes of administration to drug injection during an average period of little more than a year.

The health risks associated with both injecting and noninjecting heroin use are also substantial. For example, because of the behavioral factors (high risk sexual activity, sharing of drug paraphernalia) associated with heroin use, the chances of the individual contracting an infectious disease such as HIV, hepatitis B, and in rare cases hepatitis C, are greatly increased regardless of route of administration.

The misperceptions about the addictive properties of heroin, may account for why in 1997, an estimated 81,000 persons used heroin for the first time. We are also seeing increases in the annual number of heroin-related emergency room visits. From 1991 to 1997, the annual number of emergency room visits in major metropolitan areas increased from 36,000 to 72,000. Similar trends are being seen in the Delaware Valley. The number of emergency room visits involving heroin in Philadelphia has increased from 2,653 in 1990 to 3,817 in 1997.

We are also seeing increases in the number of individuals who are seeking treatment for heroin addiction caused by snorting or inhalation. Nationally, admissions, for heroin use by injection have dropped from 77 percent of all heroin admissions in 1992 to 68 percent in 1997, while the percentage of heroin admissions for inhalation has increased from 19 percent in 1992 to 28 percent in 1997 (National Admissions to Substance Abuse Treatment Services: The Treatment Episode Data Set (TEDS) 1992–1997). This is also a trend we are seeing at the local level. For example, last year in Philadelphia, 39 percent of the heroin treatment admissions were for snorting heroin.

Now let me explain in a bit more detail, why these data are so alarming. Because of its chemical structure heroin is able to very rapidly enter the brain where it is actually converted into morphine. In this form, the drug rapidly crosses the blood brain barrier and attaches to the natural opioid receptors. By binding to these receptors the drug initiates its multiple physiological effects, including pain reduction, depression of heart rate, and the slowing of respiration. It is heroin's effects on respiration, in particular, that can be lethal in the case of heroin overdose. Heroin also acts on the brain's natural reward circuitry to produce a surge of pleasurable sensations.

It is of course these pleasurable effects that cause people to take drugs basically, people like what drugs do to their brains. Research is showing that prolonged drug use can actually change, brains. These changes are thought to play an integral role in the development of addiction. Powerful new technologies are giving us even greater insight into these dramatic brain changes.

This poster (POSTER 1) allows you to see morphine's effects on the brain. The bottom images demonstrate the fact that when heroin addicts are given 30 mg of morphine the brain's ability to metabolize glucose is significantly reduced. Glucose is what actually fuels the brain cells. In other words, heroin reduces brain activity in some regions of the brain.

Understanding the neurobiology of addiction has led us to develop a number of effective tools to treat heroin addiction and to help manage the sometimes-severe physical withdrawal syndrome that accompanies sudden cessation of drug use. Of course we now know that withdrawal and physical dependence are only a minor part of the problem that must he addressed when treating heroin addicts. In fact, withdrawal symptoms can now be effectively managed through the use of modern medicines.

But it is the compulsive drug seeking behaviors that we have defined as the essence of addiction, which must be addressed in a comprehensive treatment program. And many behavioral and pharmacological treatments are available, although not always widely used.

For example, pharmacotherapies can be an important component of treatment for many addicts. Twenty-five years of NIDA-supported research have given us quite a number of effective medications to combat heroin addiction. For example, LAAM (levo-alpha-acetyl-methadol), a newer drug for the treatment of heroin addiction was developed and is now available as a supplement to methadone. Both methadone and LAAM block the effects of heroin and eliminate withdrawal symptoms. Treatment with methadone requires daily dosing. LAAM blocks the effects of injected heroin for up to three days. Research has demonstrated that, when methadone or LAAM are given appropriately, they have the ability to block the euphoria caused by heroin, if the individual does in fact try to take heroin. Both methadone and LAAM, especially when coupled with a behavioral treatment component, have allowed many heroin addicts to lead productive lives.

By the way, it is important to emphasize here that contrary to popular myth, methadone is not actually a substitute for heroin. Although it does bind to the same brain receptors, it acts dynamically in the brain quite differently from heroin. While heroin de-stabilizes the brain of the addict, methadone actually stabilizes the heroin addicts brain and behavior.

In an effort to give treatment providers another effective tool to combat heroin addiction. NIDA is working with the Food and Drug Administration and the pharmaceutical industry to bring to market a new medication called buprenorphine-naxloxone. This medication has the potential for administration in less traditional environments, such as in physician's offices, thus expanding treatment to populations who either do not have access to methadone programs or are unsuited to them, such as adolescents. Buprenorphine would not be a replacement for methadone or LAAM, but yet another treatment option for both physicians and patients.

Although we have some quite effective behavioral and pharmacological treatments in the clinical toolbox, many of the most recently developed science-based treatments have not found their way into normal practice settings, and we see that as a tremendous national need. This idea of bringing science-based treatments to those who are in need of treatment is fast becoming a reality, however. Recent advances in treatment research, coupled with the generous appropriations that NIDA received last fiscal year, have allowed the Institute to accelerate the launch of its much-anticipated and needed National Drug Abuse Treatment Clinical Trials Network. This Network will serve as both the infrastructure for testing science-based treatments in diverse patient populations and treatment settings, and the mechanism for promoting the rapid translation of new treatment components, into actual clinical practice in community settings throughout the nation.

I am especially pleased to announce that one of the first five research nodes we have awarded resources to is the Delaware Valley Node, which will be centered at the University of Pennsylvania. This Node is affiliated with ten community treatment programs in the region including providers in the Thomas Jefferson Health System, The Belmont Center, Fresh Start, the Northeast Treatment Centers, the Robert Wood Jobnson Medical School-Mercer Trenton Addiction Sciences Center, the Philadelphia Health Management Corporation, the University of Pennsylvania Health System, the Rehab After Work Program, the Mercy Health System, Achievement Through Counseling and Development, and the Caron Foundation. The community treatment programs are in Pennsylvania, New Jersey and Delaware. It is in these patient populations that we will be testing some of the world's most promising behavioral and pharmacological treatments. In addition to being treated, these patients will also be helping researchers determine what works best for whom and under what circumstances. We have also established Research nodes in four other regions of the country to feed into the Network.

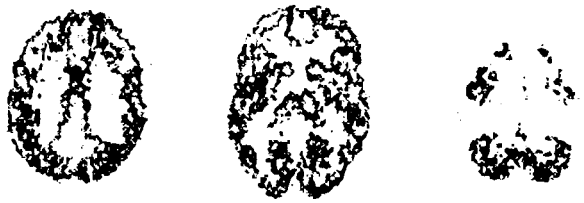
We hope to expand this Network each year. When complete, the network will consist of 20 to 30 regional research treatment centers or nodes.

Developing and bringing new medications and behavioral therapies to populations that are in need is just one aspect of a comprehensive solution we must continue to take to solve this Nation's drug problem. Because addiction is such a complex and pervasive health issue, we must include in our overall strategies a comprehensive public health approach, one that includes extensive education and prevention efforts, adequate treatment and aftercare services, and research. Twenty-five years of research has provided us with effective prevention and treatment strategies that can be used to combat heroin addiction, as well as other drug problems. Research has shown that these strategies are effective in reducing not only drug use but also in reducing the spread of infectious diseases such as HIV/AIDS, hepatitis, and in decreasing criminal behavior.

Thank you once again for the opportunity to testify at this hearing. I will be happy to answer any questions you may have.

Effect of Morphine on $rCMR_{glc}$

Saline



13.5

mg/
100g/
min

Morphine
(30 mg)

1.5

London et al., *Arch. Gen. Psych.* 1990

ALAN I. LESHNER

Director
National Institute on Drug Abuse
National Institutes of Health

Dr. Leshner was appointed Director of the National Institute on Drug Abuse (NIDA) in February 1994. One of the scientific institutes of the U.S. National Institutes of Health, NIDA supports over 85% of the world's research on the health aspects of drug abuse and addiction.

Prior to coming to NIDA, Dr. Leshner had been the Deputy Director and Acting Director of the National Institute of Mental Health. He went to NIMH from the National Science Foundation (NSF), where he held a variety of senior positions, focusing on basic research in the biological, behavioral and social sciences, and on science education.

Dr. Leshner went to NSF after 10 years at Bucknell University, where he was Professor of Psychology. While on the faculty at Bucknell, he also held long-term appointments at the Postgraduate Medical School in Budapest, Hungary, at the Wisconsin Regional Primate Research Center, and as a Fulbright Scholar at the Weizmann Institute of Science in Israel. Dr. Leshner's research has focused on the biological bases of behavior. He is the author of a major textbook on the relationship between hormones and behavior, and numerous book chapters and papers in professional journals. He also has published extensively in the areas of science and technology policy and education.

Dr. Leshner received his undergraduate degree in psychology from Franklin and Marshall College, and the M.S. and Ph.D. degrees in physiological psychology from Rutgers University. He has been elected a fellow of many professional societies, and has received numerous awards from both professional and lay groups for his national leadership in science, mental illness and mental health, and substance abuse and addiction. In 1996, President Clinton conferred the Presidential Distinguished Executive Rank Award on Dr. Leshner, the highest award in Federal service. In the fall of 1998, Dr. Leshner was elected to membership in the Institute of Medicine of the National Academy of Sciences.

(11/4/99)

Senator BIDEN. Dr. O'Brien, would you, before you begin your testimony, tell the panel a little bit about your operation up there. I was incredibly impressed, if you would be willing to speak just a moment about what you are doing.

STATEMENT OF CHARLES O'BRIEN, M.D., PH.D.

Dr. O'BRIEN. Thank you, Senator Biden and Senator Specter. I appreciate the opportunity to be able to tell you about our program because we actually began at the Philadelphia VA Medical Center in 1971, during the height of the Vietnam War. Actually, I was still in my Navy uniform when I went around the country visiting treatment programs to try to find out what was known then about addiction treatment, and then we started our program as a research program and we have done basic research on all of the major drugs of abuse, including heroin, cocaine, amphetamines, alcohol, nicotine, marijuana, and the hallucinogens.

We now treat about 10,000 veterans a year, different veterans in the Philadelphia area, including linkages with the Wilmington VA Medical Center, and we also treat nonveterans through our University of Pennsylvania Clinic, and all of this is with the idea toward building better treatments. So we come up with ideas, we test them in controlled trials, and those things that work, then we write about them and try to get other people to use them. Now with the clinical trials network that Dr. Leshner just talked about, we will be testing these new treatments in more and more programs throughout the Delaware Valley.

Senator BIDEN. I was incredibly impressed when you took me through. I advised, you probably had it done, but the press who has an interest in whether or not there is any real serious work going on in terms of treatment in the region, I do not know what your policy is, and I may be inviting chaos for you, but I really would invite you to take a look at this program at the Veterans Hospital up there and the nonveteran portion at the University of Pennsylvania. It is really impressive, truly impressive, I think. Anyway, thanks for coming down and I look forward to hearing your testimony.

Dr. O'BRIEN. Thank you for the nice words. I will try to be brief, because, as I mentioned, our work includes all of the drugs of abuse, and in order to put it in its proper perspective, I have to emphasize that the legal drugs, namely nicotine and alcohol, actually produce more problems, more deaths, and more addiction among our young people and older people than the illegal drugs. I could tell you a lot about cocaine, but there is some good news, as you implied in your opening statement, because cocaine problems have improved a great deal. But let me focus on heroin.

There is good news to report about the availability of new and effective treatments for heroin addiction, but there is also much grim news to report. Philadelphia, and presumably the surrounding areas in Delaware, has the sad distinction of having the most potent heroin in the country, according to DEA figures over the past several years, and I think that Mr. Nelson will show you some slides that support what I am telling you.

When we founded our program in 1971, and continuing until the 1990's, the average purity of a bag of heroin was around four per-

cent, and actually, we have research on testing for physical dependence. Some of the bags were zero, they were cut so much. But 4 percent was the average. Lately, it has increased to as much, as you said, as much as 85 to 90 percent, with most bags falling in the 70 percent range. In other parts of the East, the figures are only slightly lower. Thus, heroin per milligram is cheaper than ever in modern history. This increased purity is reflected in overdoses and in high levels of physical dependence in patients presenting for treatment.

Moreover, we are seeing increasing numbers of young people starting on heroin that is snorted or smoked, as Dr. Leshner said. It is so potent that they are able to get effects by smoking it or placing it in their noses rather than being obliged to inject it. This is exactly what I found in my work as a U.S. Navy physician during the Vietnam War. Our current heroin purity and use patterns are similar to the tragic situation in Vietnam.

More middle class and suburban youths are being introduced to heroin. We have been studying the Philadelphia needle exchange program, which, incidentally, has shown efficacy in reducing the spread of infection, and we were shocked to find on the first day of our study a group of students from our own university who came to get needles for their heroin injections. These were outstanding students who were hooked on heroin.

In spite of this increased severity and spread of heroin addiction, we have long waiting lists for methadone treatment and some politicians calling for reduced methadone treatment. Fortunately, we have a very effective spokesperson in General Barry McCaffrey, who has eloquently made the case for more methadone availability. He has also spearheaded the drive for making buprenorphine and other effective medication available with fewer restrictions than are now imposed on methadone.

The current situation is ironic. We have more effective treatments than ever before. In the area of medications, thanks to NIDA-supported research and introduced by this committee, as Senator Biden indicated, we have methadone, LAMM, buprenorphine, buprenorphine naloxone in combination, and naltrexone, including a long-acting depot preparation now in clinical trials. In other words——

Senator BIDEN. Explain what that means, because that is fascinating.

Dr. O'BRIEN. Naltrexone is a nonaddicting medication that sits on opiate receptors and blocks them. So a person who has been detoxified from heroin can be given this medication and they cannot get readdicted. They are absolutely blocked. It works great for motivated people. I have had some physicians who were using opiates illegally and I treated them and I put them on naltrexone and they have taken it for as long as 15 or 20 years on a daily basis, feeling normally, but they cannot relapse, even though they have to work with opiates every day in the hospital. It would be great for heroin addicts, but they tend not to take it regularly, because you have to take it every day or two.

With this new preparation, you give an injection with a needle and it lasts for 30 to 60 days. We now have, and this is perhaps news to you, Senator, we have three pharmaceutical companies

who are competing with one another to develop this depot naltrexone, and we have all three preparations in various stages of production right now. I am sure that one of them is going to win, and that will be terrific for us. That means that people who are motivated after they are detoxified, we give them this injection, and then they cannot change their mind, at least for a month or two, and during that month or two, we can work with them. So this will be a big event.

Senator BIDEN. In this report back in 1989, I suggested that maybe a way to deal with people on probation, a condition of probation is to return once a month and have this depot. The DuPont Company was developing at that time kind of like a tiny little time capsule, as they talk about on the TV. At any rate, it has phenomenal potential.

Dr. O'BRIEN. We actually did a study in probationers in Philadelphia, in the Philadelphia Federal Probation Office, randomly assigning them, one group to naltrexone orally, another group to treatment as usual. We had twice the reincarceration rate in the control group as in the group getting naltrexone. In other words, we more than cut it in half, going back into prison, because these were people who have heroin-related crimes before.

Let me just conclude. I know you are short on time. So we have strong evidence, also, for the efficacy of counseling and psychotherapy in combination with medications that can produce impressive rehabilitation of heroin users. But in the treatment area, we have an inadequate number of slots and an inadequate funding of the slots that do exist. Methadone has only minimal benefits, compared to the much greater effects of counseling and psychotherapy when given with methadone or other medical treatment.

So, in other words, we cannot get away cheaply by just giving the drug. These people have a lot of problems besides the medical ones, and so they need the counseling, as well. Unfortunately, despite the rhetoric, we really do not have enough funding for treatment.

I would like to thank you very much for giving me this opportunity to speak on these things and I would be delighted to respond to your questions.

Senator BIDEN. Thank you.

[The prepared statement of Dr. O'Brien follows:]

PREPARED STATEMENT OF CHARLES O'BRIEN, MD, PHD

1. ORIENTATION

Our clinical program treats about 10,000 veterans each year with mental disorders, about a fourth have primary substance use disorders, and another third have combined substance abuse with other mental disorders. The treatment program, one of the largest and oldest in the VA has received the Award of Excellence from VA Headquarters and is a National Center of Excellence for Substance Abuse Training. We were also recently awarded a Mental Illness Research, Education and Clinical Center (MIRECC) with a substance abuse theme. We teach medical students, residents and fellows and we host a national training program for minority medical students in treatment of substance use disorders.

2. RESEARCH

Our research program is funded by National Institute on Drug Abuse (NIDA), Dept. Veterans Affairs(DVA) and National Institute on Alcohol Abuse and Alcoholism (NIAAA). In studies dating back to the early 1970s, our group has been credited with the development of several new treatments for addiction, new understanding

of the brain mechanisms underlying addiction and for inventing the standard measuring instrument for measuring the severity of addiction used throughout the world. Our research deals with the four main addicting drugs: nicotine, alcohol, heroin and cocaine. While addiction to the two legal drugs, nicotine and alcohol, is responsible for many more deaths and economic loss than heroin and cocaine, my remarks will emphasize the current facts concerning the two illicit drugs, cocaine and heroin.

3. COCAINE

There is good news to report. New cases of cocaine abuse and dependence have fallen off dramatically. Crack cocaine dealers have been quoted as saying that they can no longer make a living selling this drug. Cocaine in both crack and powdered forms is still widely available and cheap in our area, but fewer people are buying it. This development is not surprising since previous stimulant epidemics have been self-terminated in the past, both in this country and abroad. We would like to give credit to drug prevention programs, but there are important other factors. We believe that decline of new users is related to the fact that cocaine produces destruction of lives fairly quickly and thus prospective new users can see the deterioration in their older friends and relatives and decide not to take up the drug themselves. Heroin, in contrast, is less toxic. It simply mimics the effects of normal hormones that all of us have and produces social destruction more gradually. The medical consequences of heroin use are mainly indirect based on infections such as AIDS and hepatitis.

Unfortunately, those already dependent on cocaine have generally not been able to stop permanently. Thus we see many chronic cocaine users who continue to relapse after treatment is stopped. They also have developed chronic psychiatric and medical disorders such as heart disease. We are heavily engaged in NIDA supported research to develop new medications and behavioral treatments for cocaine addiction. Currently we are testing several promising new medications including a cocaine vaccine and we have already published studies of effective psychotherapy for cocaine dependent people. Our research group has recently been awarded a special center grant for conducting clinical trials in community treatment programs. Our network involves ten treatment programs in the Delaware Valley including the Northeast Treatment Center which has clinics in the Wilmington area.

I would also like to point out that the legislation for the NIDA medications development program was introduced by Senator Biden and it resulted in funding for one of the most successful drug research programs in our history. The report on development of medications for addictive disorders by the Institute of Medicine of the National Academy of Sciences cited the remarkable benefits of this legislation.

4. HEROIN

While there is good news to report about the availability of new and effective treatments for heroin addiction, there is also much grim news to report. Philadelphia and presumably the surrounding areas in Delaware has the sad distinction of having the most potent heroin in the country according to DEA figures over the past two years. When we founded our treatment program in 1971 and continuing until the 1990s, the average purity of a bag of heroin was 4 percent. Lately it has increased to as much as 85 percent with most bags tested falling into the 70 percent range. In other parts of the East, the figures are only slightly lower. Thus heroin per mg. is cheaper than ever in modern history. This increased purity is reflected in overdoses and in high levels of physical dependence in patients presenting for treatment. Moreover, we are seeing increasing numbers of young people starting on heroin as smokers or snorters. It is so potent that they are able to get effects by smoking it or placing it in their noses rather than being obliged to inject it. This is exactly what I found in my work as a navy physician during the Vietnam war. Our current heroin purity and use patterns are similar to the tragic situation in Vietnam.

More middle class and suburban youths are being introduced to heroin. We have been studying the Philadelphia needle exchange program, which incidentally has shown efficacy in reducing the spread of infections, we were shocked to find on the first day a group of students from our own university who were coming to get needles for their heroin injections.

In spite of this increased severity and spread of heroin addiction, we have long waiting lists for methadone treatment and some politicians calling for reduced methadone treatment. Fortunately, we have a very effective spokesperson in General Barry McCaffery who has eloquently made the case for more methadone availability. He has also spearheaded the drive for making buprenorphine, another effec-

tive medication, available with fewer restrictions than are now imposed on methadone.

The current situation is ironic. We have more effective treatments than ever before. In the area of medications, thanks to NIDA-supported research, we have methadone, LAAM, buprenorphine, buprenorphine/naloxone combination and naltrexone including a long acting depot preparation now in clinical trials. We have strong evidence for the efficacy of counseling and psychotherapy in combination with medications that can produce impressive rehabilitation of heroin users. But in the treatment area, we have inadequate number of slots and inadequate funding of the slots that do exist. Methadone alone has only minimal benefits compared to the much greater effects of counseling and psychotherapy for patients in methadone or other medical treatment.

5. OTHER DRUGS

There are, of course, other drug problems that I don't have time to discuss. Marijuana is a problem for some young people although research shows that compared to the drugs cited earlier, the rate of dependence is low. Ecstasy or MDMA is a problem, less so in this country than in Europe, but still worthy of attention. Solvent abuse receives little publicity in this part of the country, but those of us in the Delaware Valley were saddened last spring to read of five young girls from the same high school killed in an auto accident attributed to solvent use. Benzodiazepines, sleeping pills and other prescription drugs can be associated with abuse and we also have some patients with such problems. In terms of national policy, however, it would appear that our prevention and treatment efforts should be directed to the four major drugs that I cited earlier: nicotine, alcohol, cocaine and heroin. Among high school and college students, I must remind you one more time, that the overall negative impact of nicotine and alcohol from binge drinking far outweighs the impacts of the illegal drugs.

Senator BIDEN. Mr. Nelson, welcome.

STATEMENT OF WILLIAM R. NELSON

Mr. NELSON. Thank you, sir. Good morning. Good morning, Senator Specter. Thank you for the opportunity to participate in this important hearing and to speak to you today about the heroin situation in Pennsylvania and Delaware and particularly DEA's efforts to combat the influx of heroin in this area.

DEA's Philadelphia Field Division is responsible for enforcing the Federal laws in the States of Pennsylvania and Delaware. DEA staffs seven offices in Pennsylvania and Delaware, with more than 250 special agents, task force officers, intelligence analysts, and support personnel. This morning, we would like to outline production trends and the international trafficking routes of heroin to the United States and specifically to this region; and to also discuss the national, local, and regional trends in the heroin situation in terms of heroin trafficking, availability, use of heroin, prices and purities of heroin that have been observed to this date; also to describe DEA's current efforts to combat heroin traffic and abuse in this region, which are often conducted in cooperation with Federal, State, and local law enforcement agencies.

The supply of heroin to the United States originates from four distinct production areas around the world. The United States may be the only country in the world that is supplied by each of these four source areas, Southeast and Southwest Asia, Mexico, and most importantly in this region, South America, and in particular, Colombia.

Most, if not all, of the heroin seized in Pennsylvania and Delaware originates in South America. I have a chart that will display the highlights of the typical routes used to transport heroin from Colombia to the Caribbean and Mexico to the East Coast of the

United States. The next figure highlights the regional trafficking routes from what we believe to be a source city for Delaware, which would be Philadelphia.

Colombian heroin is typically transported to the United States via couriers who smuggle one or two kilograms at a time aboard commercial aircraft flights directly to cities such as Miami and New York. Couriers employ a variety of means to smuggle heroin into the United States, which include the use of false-sided suitcases, body packs, and internal body carries.

Due to the increased law enforcement efforts at Eastern ports of entry, South American heroin traffickers are smuggling heroin across the U.S. Southwest border into Texas. New York, Miami, New Jersey, and Puerto Rico have been identified as primary source areas for the South American heroin found in the Pennsylvania-Delaware region.

New York-based Colombian groups are primarily responsible for wholesale distribution of heroin to the Philadelphia and Delaware area. The Colombians saturated the market with high-purity heroin, using strategic marketing techniques such as providing free samples of heroin with shipments of cocaine, allowing customers to take heroin on consignment, and lowering prices. Regional investigations have shown that distributors purchase retail quantities of heroin in Philadelphia and then sell them on the streets of smaller cities and towns throughout Pennsylvania and Delaware. Philadelphia-based Hispanic, primarily Dominican, led organizations are active in this particular type of distribution.

There are two distinct heroin markets in the United States, one on the Eastern side of the Mississippi. In the East, high-purity white heroin from South America is predominately available, while in the West, lower-purity Mexican black tar and brown heroin are predominately available.

Heroin users, both in this region and throughout the Northeastern United States generally represent all socio-economic classes and age groups. The combination of heroin's readily available low prices and high purity has made it attractive to many new, nontraditional users. For example, many young middle-class users are now able to snort and smoke heroin because of the high purity instead of injecting it. Many of these users are lulled into a false sense of security, believing that because they inhale heroin, they are less likely to become addicted.

According to the DAWN information, the annual number of heroin-related emergency room visits was slightly over 10,000 in 1978, as we see on the chart. In 1990, the number of heroin-related emergency room visits was roughly in the 33,000 range. By 1997, that number had more than doubled, to approximately 70,000.

Nationally, the number of heroin-related emergency room visits by young people aged 12 to 17 increased significantly since 1989. As we see in this particular chart, it is up significantly from 1989 to 1997 with the age group of 12- to 17-year-olds.

During 1998, the price of heroin emanating from South America ranged from $50,000 to $200,000 per kilogram. In this region, gram quantities of high purity South American heroin sells for up to $100 in Philadelphia and between $100 and $300 in Delaware and other regions of Pennsylvania.

Studies indicate that heroin purity has increased tenfold since 1979. In the 1980's, heroin purity levels averaged between 1 and 10 percent. Today, in some cities, average purity levels exceed 70 percent. This significant rise in purity corresponds to the increased availability of higher-purity South American heroin, especially in the Northeastern part of the United States.

In this particular figure, Figure 5 on the easel shows a 20-year trend to where heroin prices have decreased while purities have increased. Inexpensive and highly pure South American heroin has flooded the Pennsylvania and Delaware market. In 1999, retail heroin purities ranged from 54 percent in Boston to 60 percent in Newark and 63 percent in New York City. Yet, in Philadelphia, the average retail heroin purity was 71.7 percent. The chart on the easel will reflect the national average compared to the Philadelphia-Delaware area. In fact, Philadelphia has reported higher heroin purities than anywhere else in the nation in 4 of the last 5 years.

Heroin brand names are used by dealers as a marketing tool to increase their share of the market. Brand names change frequently, and the popular ones are sometimes imitated by competing trafficking organizations. Brand names help identify the product of a particular organization and are sought after by users to ensure they are buying high purity, high quality heroin.

Senator BIDEN. Mr. Nelson.

Mr. NELSON. Yes, sir.

Senator BIDEN. Is the heroin I have on this table here, "Bad Boy," "Boss," "Pac Man," "White Bear"——

Mr. NELSON. "Turbo Dead Com"?

Senator BIDEN. "Murder One," yes.

Mr. NELSON. They are brand names.

Senator BIDEN. And they are brand named particularly to target to teenagers and younger people, is that the reason?

Mr. NELSON. In my opinion, yes, sir. The brand name is a trademark, as I stated, and that is a typical example of a trademark. I cannot see it from here, but——

Senator BIDEN. Let me pick one up and read. "Land Rover."

Mr. NELSON. Yes.

Senator BIDEN. Now, this is actually heroin?

Mr. NELSON. I would suspect it is, sir. I think one of the officers had it there.

Senator BIDEN. What would the consumption of what is in this bag, what would the consumption of this amount of heroin do in terms of giving a person the affected high that they want, or however you characterize it?

Mr. NELSON. The injection method, with that particular brand name, if it is the high-purity heroin we have in Philadelphia, the injection method is the fastest, intravenous method. If it is snorted, the effects take 15 to 20 minutes and will last for 4 to 5 hours.

Senator BIDEN. Four to five hours?

Mr. NELSON. Yes.

Senator BIDEN. Thank you. And how much did this cost?

Mr. NELSON. Ten dollars. As I was saying, typically, stamp bags of user amounts of heroin sell from between $10 and $20. DEA Philadelphia intelligence and the Philadelphia Police Department

maintain databases containing thousands of brand names, such as "Turbo," "Dead Com," "Ready to Die," and "One Half Dead."

It is not just adults who are selling heroin. In August of 1999, a Delaware newspaper reported that a 14-year-old young man from Wilmington was arrested after he was found with 35 packets of heroin.

Senator BIDEN. By packets, you mean something this size?

Mr. NELSON. Yes, sir, individual packets, and, of course, the larger amounts are bundles or bindles.

Over the last decade, DEA has arrested numerous heroin distributors and immobilized scores of large trafficking organizations. In fiscal year 1998, the last full year in which statistics are available, DEA arrested 32 percent more individuals nationwide in heroin investigations than in 1995.

To address the threat posed by Colombian and Dominican trafficking groups, the DEA and the Philadelphia Field Division has focused its resources against the communication networks of the Colombian sell managers. Simultaneously, DEA has targeted surrogate groups from the Dominican Republic and Puerto Rico who comprise the ever-growing conglomerate of distribution networks in our area. Hopefully, these areas will help us with an increased ability to build prosecutable cases against the leadership of the Colombian and Dominican syndicates.

A cornerstone of DEA's mission has been working closely with other Federal, State, and local enforcement agencies. We believe it is a win-win situation to pool our resources, expertise, and intelligence to attack a common enemy. We benefit from local investigators' knowledge of the methods of known drug dealers within their communities.

One way DEA and other law enforcement agencies work together is through our DEA State and local task force program. Another way in which DEA assists State and local enforcement is through its newly formed mobile enforcement teams. DEA field divisions deploy mobile enforcement teams at the request of local enforcement officials who are confronting serious drug-related crime and violence in their areas. Since the program's inception within our division in 1995, we have worked with the cities of Wilmington, DE, as well as in Philadelphia as part of Operating Sunrise, Reading, Allentown, Clairton, Easton, Norriston, and Bristol, PA. Our MET Program has posted impressive results both in terms of drug seizures and the arrests of violent drug traffickers.

DEA Philadelphia has recently placed more emphasis and attention to heroin cases and trafficking organizations and has recently formed an enforcement group specifically designed and dedicated to investigate drug trafficking organizations whose members are of Caribbean nationals. As a result, there has been more than a fourfold increase in arrests in heroin cases since 1994 through 1999. We have also removed more heroin for that fiscal year period of 1994 through 1999, and the number of new heroin investigations has also increased almost 300 percent.

One recent investigation stands as a prime example of DEA's emphasis on heroin trafficking organizations. On November 3, 1999, a Federal grand jury in the Eastern District of Pennsylvania returned a 61-count indictment charging 29 individuals with partici-

pating in a heroin, cocaine, and crack cocaine distribution organization.

This indictment and the recent arrest of several of the indicted individuals were results of more than a 2-year-long investigation into the Darien Street organization, as it is known in the parlance in Philadelphia, that organization, which allegedly used an entire Philadelphia city block to conduct illicit operations for more than 15 years. This organization operated around the clock, selling multikilogram quantities of heroin, cocaine, and crack cocaine on a weekly basis, generating over that particularly period of time more than $20 million in proceeds. The street on which this organization operated was also within 1,000 feet of a Philadelphia middle school.

DEA stresses the need for all segments of the community, law enforcement, schools, government, churches, the media, business, and industry, to work together in mounting a well-orchestrated response to local drug-related issues. The Philadelphia Field Division has a very active demand reduction program, reaching out to schools, civic groups, and community coalitions in cities and towns throughout our area of responsibility.

Senator BIDEN. Mr. Nelson.

Mr. NELSON. Yes, sir.

Senator BIDEN. I want to hear everything you have to say. Senator Specter is going to have to leave to go to Washington shortly because his appropriations bill is part of this final negotiation which we are going to figure out by Wednesday, hopefully, and I want to give him a chance to ask questions first. So if you could summarize the remainder of your statement, then I will pick up on, when he leaves, on some of the detail of it, if I may.

Mr. NELSON. I think we could conclude. Thank you.

Senator BIDEN. Thank you.

[The prepared statement of Mr. Nelson follows:]

PREPARED STATEMENT OF WILLIAM R. NELSON

SENATORS BIDEN AND SPECTER: I thank you for the opportunity to participate in this important hearing and speak to you today about the heroin situation in Pennsylvania and Delaware and DEA's efforts to combat the influx of heroin to this area. I am accompanied today by Resident Agent-in-Charge Paul Maloney of our Wilmington office.

DEA's Philadelphia Field Division is responsible for enforcing the federal narcotics laws in the states of Pennsylvania and Delaware. In Delaware, we have offices in Wilmington and Dover, while in Pennsylvania, the cities of Philadelphia, Harrisburg, Pittsburgh, Allentown, and Scranton house DEA offices. DEA staffs these offices with more than 100 special agents and another hundred support personnel. Additionally, we have 69 Task Force Officers working in various cooperative enforcement efforts and a number of contracted personnel assisting with computer support and administrative functions.

Besides using our own resources, I believe that it is vital to DEA's mission to work in concert with other federal, state and local law enforcement agencies. I will describe our cooperative efforts in greater detail when I outline our response to the growing heroin threat.

This morning I would like to:

- Outline production trends and the international trafficking routes of heroin to the United States and, specifically, to this region,
- Discuss the national and local (or regional) heroin situations in terms of heroin trafficking, availability and abuse of heroin, and prices and purities of heroin observed to date, and

- Describe current DEA efforts to combat heroin trafficking and abuse in this region, which are often conducted in cooperation with other federal, state, and local law enforcement agencies.

TRAFFICKING TRENDS

The supply of heroin to the United States originates from four distinct production areas around the world. The United States may be the only country in the world that is supplied by each of these four source areas: Southeast Asia (principally Burma), South America (Colombia), Mexico, and Southwest Asia-Middle East (Afghanistan, Turkey, Pakistan, and Lebanon).

Most, if not all, of the heroin seized in Pennsylvania and Delaware originated in South America. Figure one (1) highlights typical routes used to transport heroin from Colombia, through the Caribbean and Mexico, to the East Coast of the United States. Figure two (2) highlights regional trafficking routes.

The most common method of transporting Colombian heroine to the United States is via couriers, who typically carry one to two kilograms aboard commercial air flights directly to cities such as Miami and New York. Couriers employ a variety of means to smuggle heroin into the U.S., which include the use of false-sided suitcases, body packs, and internal body carriers. However, increased law enforcement efforts at eastern ports-of-entry forced South American heroin traffickers to find alternative routes. Recent investigations have shown that Colombian and other Latin American couriers are smuggling heroin across the US southwest border into Texas.

DEA uses what is known as the Heroin Signature Program to combine scientific, chemical profiting of heroin samples with investigative data and intelligence to determine what amounts of heroin are entering the U.S. from what source areas. In the early 1990s, the Heroin Signature Program reported that Southeast Asian heroin dominated the national heroin market. Since 1993, South American heroin has been increasingly reported, to the point where, in 1998, 65 percent of the heroin seized nationally originated in South America.

Cheaper, higher purity, South American heroin is mainly available in the east. It is for this reason that the DEA Philadelphia Field Division consistently reports the availability of inexpensive, high-purity heroin.

New York and Miami, along with New Jersey and Puerto Rico, have been identified as primary source areas for the South American heroin found in the Pennsylvania/Delaware region. New York-based Colombian groups are primarily responsible for wholesale distribution of heroin to the Philadelphia area.

Colombians saturate the market with new, high-purity heroin. using strategic marketing techniques. For example, to increase their market share, Colombians allowed heroin customers to take whole quantities on consignment and also forced cocaine wholesale customers to accept quantities of heroin along with their shipments as a condition of doing business. Also, they build clientele by dropping the price so low, that the heroin can be purchased for less.

Regional investigations have shown that distributors purchase retail quantities of heroin in Philadelphia and then sell it in on the streets of smaller cities and towns throughout Pennsylvania and Delaware. Philadelphia-based Hispanic, primarily Dominican-led, organizations are active in this type of distribution activity. In fact, the Philadelphia Field Division recently created a dedicated enforcement group to address the trafficking activities of these organizations.

The high availability of heroin in Philadelphia allow traffickers to supply users in the urban areas of Harrisburg, Lancaster, Lebanon, and York, as well as the Scranton/Wilkes Barre metropolitan region. Northern Delaware, including the cities of Wilmington and Newark, is the primary region of heroin abuse and distribution in Delaware.

AVAILABILITY/ABUSE

There are two distinct heroin markets in the U.S., demarcated along the Mississippi River. In the east, high-purity white powdered heroin from South America is predominantly available, while in the west, lower purity Mexican "black tar" and brown heroin are predominantly available.[1]

As previously mentioned, national trends indicate that smaller urban and rural areas are no longer isolated from the heroin problem. These areas are supplied by traffickers who travel to larger metropolitan areas to purchase retail quantities of heroin for street sales.

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[1] Source: National Narcotics Intelligence Consumers Committee. The NNICC Report 1997 page 63.

Pennsylvania and Delaware are not exempt from this trend. Heroin has been and remains readily available in metropolitan, suburban, and rural areas of Pennsylvania and Delaware. Local distributors from northern Delaware, and the Pittsburgh, Harrisburg, Allentown, and Scranton areas of Pennsylvania purchase heroin in Philadelphia and transport it back to their own areas to be sold on the street.

Heroin users, both in this region and throughout the northeastern U.S., generally represent all socioeconomic classes and age groups. The combination of heroin's ready availability, low prices and high purity has made it attractive to many new non-traditional users. For example, many young middle-class users are now able to snort and smoke heroin because of the high purity instead of injecting it, which is the traditional, yet higher-risk method of administration. Reports indicate that 50 percent of users inject, while the other 50 percent snort heroin.

According to the Drug Abuse Warning Network (DAWN) and as shown on figure three (3), the annual number of heroin-related emergency room visits was slightly over 10,000 in 1978. In 1990, the number of heroin-related emergency room visits was roughly 33,000. By 1997, that number had more than doubled, to about 70,000. Nationally, the number of heroin-related emergency room visits by young people (age 12 to 17) also increased significantly since 1989. Figure four (4) shows this dramatic increase.

The ability to snort or smoke, rather than inject, undoubtedly played a role in the increase of heroin abuse by teenagers. Many of these users are lulled into a false sense of security believing that because they inhale heroin, they are less likely to become addicted to it. The teenagers also believe that they are safe from, acquiring diseases, such as AIDS or hepatitis, which are associated with the use of needles. As a result we are seeing a rise in first-time heroin users.

PRICES AND PURITIES

During 1998, the price for a kilogram of South American heroin ranged from $50,000 to $200,000 nationally. In this region, gram quantities of high-purity, South American heroin sold for a price up to $100 in Philadelphia and between $100 and $300 in Delaware and other regions in Pennsylvania. This pricing reflects the trend where retail quantities of heroin are purchased in Philadelphia for sale in smaller urban and rural areas throughout Delaware and Pennsylvania.

The DEA's Domestic Monitor Program (DMP), a program where retail quantities of heroin are regularly purchased in major U.S. cities to collect data on the price, purity, and origin of the heroin, indicated that heroin purity has increased tenfold since the program was initiated in New York City in 1979. In the 1980s, heroin purity levels averaged between one and ten percent; today, in some cities, average purity levels exceed 70 percent. This significant rise in purity corresponds to the increased availability of higher-purity South American heroin, especially in the northeastern United States.

Figure five (5) shows a 20-year trend where heroin prices have decreased while purities have increased.

Inexpensive and highly pure South American heroin has flooded the Pennsylvania/Delaware market. In 1999, the DMP found that retail heroin purities ranged from 58.4 in Boston to 60.6 percent in Newark and 63.1 percent in New York City. Yet, in Philadelphia, the average retail heroin purity was 71.7 percent, the highest of all DMP markets. Philadelphia has reported higher heroin purities than anywhere else in the nation in four of the last five years (see figure six). Again, the trends indicate that the high-purity heroin used in Delaware and Pennsylvania comes from Philadelphia.

Heroin brand names are used by dealers as a marketing tool to increase their share of the market. Brand names change frequently and the popular ones are sometimes imitated by competing trafficking organizations. Brand names help identify the product of a particular organization and are sought after by users to ensure they are buying high purity, high quality heroin. Typically, stamped bags of user amounts of heroin sell for between $10 and $20. DEA Philadelphia intelligence and the Philadelphia Police Department maintain databases containing thousands of heroin brand names, such as "TURBO", "DEAD CALM", "READY TO DIE", and "½ DEAD."

It is not just hardened criminals who are selling heroin with brand names. In August 1999, a Delaware newspaper reported that a 14-year old young man from Wilmington was arrested after he was found with 35 packets of heroin, marked with the brand name "LANDROVER." The young man was charged with distribution, among other charges.

ENFORCEMENT/IMPACT

Over the last decade, DEA has arrested numerous heroin distributors and immobilized scores of large trafficking organizations. In fiscal year 1998, the last full year in which statistics are available, DEA arrested 32 percent more individuals nationwide in heroin cases than fiscal year 1995.

To address the threat posed by Colombian and Dominican trafficker groups, the DEA and the Philadelphia Field Division has focused its resources against the communications network of the Colombian cell managers. Simultaneously, DEA has targeted Surrogate groups from the Dominican Republic and Puerto Rico who comprise the ever-growing labyrinth of distribution network in our area. Hopefully, these efforts will provide us with an increased ability to build prosecutable cases against the leadership of the Colombian and Dominican, syndicates.

A cornerstone of DEA's mission has been to work closely with other federal, state and local enforcement agencies. We believe it is a win-win situation to pool our resources expertise, and intelligence to attack a common enemy. We benefit from local investigators' knowledge of the methods of known drug dealers within their communities.

One way DEA and other law enforcement agencies work together is through state and local task forces. Within our division we have formalized joint task forces in Philadelphia and Pittsburgh. Also, a provisional task force operates both in Wilmington and Dover, Delaware.

Another way in which DEA assists state and local law enforcement is through its Mobile Enforcement Team (MET) program. DEA field divisions deploy Mobile Enforcement Teams at the request of local law enforcement officials who are confronting serious drug-related crime and violence in their areas. Since the program's inception within our division in 1995, we have worked with the cities of Wilmington, Delaware as well as Philadelphia (as part of Operation Sunrise), Reading, Allentown, Clairton, Easton, Norristown, and Bristol, Pennsylvania. Our MET program has posted impressive results, both in terms of drug seizures and in arrests of violent drug criminals.

DEA Philadelphia has recently placed more emphasis on and attention to heroin cases and trafficking organizations. As a result, there has been more than a fourfold increase in arrests in heroin cases between fiscal year-1994 and fiscal year-1999. We also have removed nearly double the amount of heroin from the street in fiscal year-1999 than in fiscal year-1994. The emphasis on heroin investigations is also shown in the number of heroin cases opened. The number of new heroin investigations has increased more than 300 percent from 1995–1999.

One recent investigation stands as a prime example of DEA Philadelphia's emphasis on heroin trafficking organizations. On November 3, 1999, a federal grand jury returned a sixty-one count indictment, charging twenty-nine individuals with participating in a heroin, cocaine, and crack cocaine distribution organization. This indictment and the recent arrest of several of the indicted individuals were the result of a more than two-year long investigation into the Darien Street Drug Organization, which allegedly used an entire Philadelphia city block to conduct illicit operations for more than fifteen years. This organization operated around the clock, selling multi-kilogram quantities of heroin, cocaine, and crack cocaine on a weekly basis, generating more than twenty million dollars in proceeds. The street on which this organization operated was also within 1000 feet of a Philadelphia middle school.

DEA stresses the need for all segments of the community—law enforcement, schools, government, churches, the media, business, and industry—to work together in mounting a well-orchestrated response to local drug-related issues. The Philadelphia Field Division has a very active demand reduction program, reaching out to schools, civic groups, and community coalitions in cities and towns throughout the region.

It should be noted that other local agencies have taken proactive steps to counter the growing heroin abuse problems in their areas. The "Heroin Alert Program," sponsored by the New Castle County Community Services Unit is regionally, if not already nationally, recognized for its effective program to educate teenagers and the community at large.

CLOSING

In conclusion, heroin dependence is a chronic, relapsing disorder that exacts an enormous cost on individuals, families, businesses, communities, and nations. Along with prevention, education, and treatment, law enforcement is essential to reducing drug use in the United States.

Law enforcement is our first line of defense. I believe that law enforcement efforts alone are not the only answers to the heroin problem. There is no magic formula

for success and the problem will not disappear overnight. However, DEA, with our other federal, state and local partners, are prepared to fight this problem aggressively. With the concerted, cooperative efforts of the law enforcement community working together with our prevention, education and treatment professionals, we can take tremendous strides toward limiting the destructive effects of this scourge.

I thank you again for the opportunity to speak to you today and have prepared copies of my prepared statement for you and for the record. I will be happy to answer any questions you may have.

BIOGRAPHY OF WILLIAM R. NELSON ACTING SPECIAL AGENT-IN-CHARGE PHILADELPHIA FIELD DIVISION DRUG ENFORCEMENT ADMINISTRATION

William R. Nelson began his career in 1968 as a criminal investigator with the Drug Enforcement Administration's (DEA) predecessor agency, the Bureau of Narcotics and Dangerous Drugs (BNDD), in Baltimore, Maryland. Special Agent Nelson participated in the first federal drug telephone wiretap investigation in the country in 1968, authorized under the 1968 Omnibus Crime Bill. Special Agent Nelson was then assigned as the Regional Training Officer responsible for the training of over three thousand state and local police officers.

In 1972, Special Agent Nelson was assigned to the Dallas Office of Internal Security, conducting internal security investigations in the southwest and south central regions of the US.

In 1977, Special Agent Nelson was assigned to DEA Headquarters in Washington, DC where he coordinated all internal security investigations and office inspections.

In 1979, Special Agent Nelson was appointed as chief of the DEA Headquarters State and Local Section's Office of Compliance, directing criminal investigators who investigated the illegal distribution of legally produced drugs. This program involved the administration of twenty-six programs in twenty-five states.

From 1981 to 1988, Special Agent Nelson was assigned to the DEA Baltimore District Office as a supervisory special agent for a number of different enforcement groups, including state and local task forces.

In 1988, Special Agent Nelson returned to DEA Headquarters as chief of the Contracting and Transportation Section, managing the procurement and transportation needs of DEA.

In 1990, Special Agent Nelson was appointed chief of the State and Local Section at DEA Headquarters, where he supervised the administration of the DEA Organized Crime Drug Enforcement Task Force (OCDETF) program, the DEA task force program, the High Intensity Drug Trafficking Area (HIDTA) program, and the Weed and Seed Task Force program.

In 1995, Special Agent Nelson was assigned as an assistant special agent-in-charge of the Philadelphia Field Division, where he supervises the administration of the division and a number of enforcement group operations.

Since July 1999, Special Agent Nelson has served as the Acting Special Agent-in-Charge of the Philadelphia Field Division, pending the arrival of the newly appointed Special Agent-in-Charge in December 1999.

Special Agent Nelson is a graduate of the University of Baltimore and holds a Bachelor of Science degree in psychology.

Senator BIDEN. Mr. Maloney.

STATEMENT OF THOMAS C. MALONEY

Mr. MALONEY. Senator Biden and Senator Specter, I am happy to be here and I am present here before you today representing SODAT-Delaware, Inc. Incorporated in 1971, SODAT is the oldest continuously operating outpatient substance abuse treatment center in the State of Delaware.

During our most recent years of operation, SODAT has piloted several innovative approaches for working with substance abuse problems in our State. In anticipation of the increase in heroin abuse, resulting addictions in our community, SODAT launched a program in October 1993 that utilized opiate antagonist medication naltrexone. In fact, the person who headed that program, Lisa D'Angelo, is here today and is now working for Doctor O'Brien.

During this program, we had many people attempt to stabilize in the program, but of the 12 clients that did, they were placed in an intensive outpatient treatment setting, monitored in their naltrexone dosage, and remain completely off all illicit substances, as evidenced by urine screen results and clinical consultations. Had these continued to use heroin at an average cost of $1,800 per month for heroin for each client, these clients would have consumed $21,600 worth of heroin, or a total of $259,200 in illegal drug purchases for any 12-month period.

Criminal justice statistics indicate that fencing of stolen goods yields approximately 10 percent on the dollar. In other words, these 12 clients would have had to steal or deal over $2.5 million in property or drugs to support their addiction.

In Delaware, the approximate annual cost for incarceration of an adult is $25,000. These figures stand in stark contrast to the $23.20 per diem per client costs for SODAT to operate the intensive treatment program. The annual per client cost is $8,468.

Eighty-two percent of these clients completed the program with no new criminal charges. The program clearly demonstrates that the combination of intensive substance abuse treatment and case management services with the use of effective medications produces good outcomes.

We at SODAT are very hopeful that the depot long-term naltrexone caplet or caplet implant or injection can be approved in the near future. This will allow for greater concentration on direct treatment services. Groups who can immediately benefit from this innovation include offenders released from incarceration by significantly reducing the likelihood of recidivism that results from drug use.

In 1995, SODAT partnered with Delaware's family court under a grant through the City of Wilmington to implement a diversion and treatment program for illegal drug offending juveniles with no or minor prior criminal records. We expanded this program's geographic reach under a grant from the Department of Justice and funding from the State of Delaware to become Statewide. I believe we are the only Statewide juvenile drug program in the country.

There are currently 188 clients in this program. Each client is provided with the option of participating in counseling and case management services or taking his or her case to trial. If the client succeeds in the program, the referring charges are dropped and there is no loss of the privilege to hold a driver's license.

We have studied the participants in this program and their progress for over 3 years. Our most recent evaluation demonstrates a 21 percent less likelihood of recidivism among program graduates as compared to a control group. Those that do commit new crimes are far less likely to commit serious misdemeanors and felony offenses to the degree that we see in the control group.

Program expenses range from $3,600 to $4,800 per year, as compared to the $70,000 to $77,000 it costs to incarcerate a juvenile in Delaware for a year. The hallmark is that prevention and early intervention works and works well.

In conclusion, I cannot emphasize enough the innovation of directly partnering treatment and case management agencies with a judge to improve outcomes and reduce recidivism. This concept of

therapeutic jurisprudence is mirrored in Attorney General Janet Reno's recent call for reentry courts for the recently released offenders.

Senator BIDEN. Thank you very much.

One brief introduction before you begin your questioning, Senator. I want you to know that this audience that is assembled here are the activists and the leaders in our community, including some of the mothers.

I looked over here and I showed you a bag that was empty and I wondered, I said, oh, my Lord, I hope the bag wasn't full when it was here. My staff pointed out that some of the empty bags were provided by the mothers in the audience who found them in such places as washing machines and around the home.

We have the Speaker of the Delaware House, Terry Spence, here, and I appreciate his presence here.

We have Senator Margaret Rose Henry, one of the leaders in this community. Stand up, Margaret Rose, so everybody can see you.

We also have former State Representative Herman Holloway, who, unlike many when we decide to leave office or we are defeated, fade away, he did not fade away. He was active in the community before and since. Herman, stand up and welcome. I want people to know you are here.

We also have leaders here from the schools who run programs within the schools, like Mrs. Aiken, who is here and has been very involved with school counselors across the State and, actually, from my alma mater.

And we have community leaders in the union movement here, like the president of the GM local, which is a very large local, Joe Brennan, who is here, along with others I will introduce later.

I just want you to know that this is an audience of concerned and informed people here and I thank you all for coming.

Senator.

Senator SPECTER. Thank you very much, Senator Biden. That is a very impressive group, both on the podium and in the audience.

Mr. Maloney, beginning with you, the statistics you cite are very impressive in terms of the costs of incarceration and the costs of prosecution compared to the costs of rehabilitation. We have never been able to put together a really comprehensive statistical set on how the rehabilitation works. I think it would be very useful if you could put all those figures together for us to show the economy on therapy and treatment contrasted with the prosecution and incarceration. You are well on your way there. But I think if you could put those together, I know I would be interested and I think our full Judiciary Committee would be interested.

Mr. Nelson, you have gone through the sources of supply, Latin America being the principal for this area, and there have been massive efforts made to try to substitute crops in Colombia, Bolivia, all over Latin America, for more than a decade since we have authorized the use of military intervention, and we are still struggling in the Judiciary Committee and in the full Senate and the Congress for a 50/50 split for so-called supply side, to try to eliminate sources and prosecute dealers, contrasted with 50 percent for the demand side.

What is your view as to what the spilt ought to be? Do you think a 50/50 split would give enough emphasis to law enforcement on supply, to bring more emphasis to the demand side?

Mr. NELSON. Senator, that is a difficult question for me to answer. Certainly, I advocate that the law enforcement component of the three-legged stool, if you will, is the first line of defense. The demand side certainly, I think by the testimony you have heard here today, needs support. We often said that if you have a three-legged stool, the enforcement portion of it is one leg, the educational leg, and, of course, the rehabilitation leg. Take one leg away and the stool will fall over.

But to answer your question directly, I would not be in a position to——

Senator SPECTER. Well, if you have a three-legged stool and education and rehabilitation are two legs, I think I just upped the percentage to two-thirds.

Mr. NELSON. That is a good way to look at it.

Senator SPECTER. Dr. Leshner, on the research, we have been very expansive and expensive in what we have allocated to the National Institutes of Health, mental health, drug abuse. Are you adequately funded? Would it be useful—the statement goes that there are ten doors and we open three or four of them to look behind on the grants. With a budget of $1.8 trillion, when we are allocating this year $15.6 billion and next year, if our allocation goes through, $17.9 billion, it is still a relatively small amount. My view is that the NIH is the crown jewel of the Federal Government, perhaps the only jewel. Could additional funding open some more of those doors and perhaps give us greater insight into drug abuse?

Mr. LESHNER. Absolutely, Senator, and we do very much appreciate the gracious largess that the Congress has given us. I should point out that the National Institute on Drug Abuse supports 85 percent of the world's research on drug abuse and addiction, and although the increase that is now proposed will be extremely useful, it still will only allow us to open some 2.8 out of 10 of those doors and only allow us to expand our clinical trial network by four or five nodes.

Senator SPECTER. Only 2.8 out of 10 doors?

Mr. LESHNER. That is right, Senator.

Senator SPECTER. One of the reasons the closed doors remain so numerous, I understand that the more the grants go up, the more doors there are to open, more applications.

Mr. LESHNER. Well, actually, the number of applications——

Senator SPECTER. Can we get ahead of this curve, or more funding will just produce more applications, which is fine in and of itself?

Mr. LESHNER. We are in a situation where the science of drug abuse and addiction has really expanded exponentially in the course of the last decade. When I came to NIDA 5 years ago, at the Society for Neuroscience meeting, there might be four posters on the neurobiology of addiction, and now there are 40 posters, so that the opportunities are expanding at a tremendous rate. I would argue the accomplishments have also expanded.

Senator SPECTER. The Genome Project is supposed to reach 90 percent completion by next spring, that is, to identify the genes and

have a road map of the human body. Does NIH's work on drug abuse or mental health offer any realistic likelihood that the gene can be identified for drug addiction to deal directly and target that specific cause of drug addiction?

Mr. LESHNER. There is no question that the individual differences to the vulnerability to becoming addicted has a very large genetic component to it, and in response to that, last year, actually, my institute mounted a major initiative focused on determining precisely what genes. It is unlikely it will be one gene, more likely to be an interaction among multiple genes, but we have mounted a major effort to go after that genetic determinant of vulnerability to being addicted.

Senator SPECTER. We had the scientists in on Parkinson's, Alzheimer's, other diseases. The Parkinson's expert said that they were within 5 years of a cure, 10 years at the outside. If you scientists can give us something very tangible, Senator Biden and I have a better chance of working on our colleagues to appropriate. What would a realistic estimate be of identifying the genome for drug addiction in terms of a target date for solving that problem? We listened to Mayor Maloney on the costs. If we have a cost efficient target, perhaps we can get you some more money. Can you give me an encouraging time table?

Mr. LESHNER. One of the problems with addiction, of course, is that it is a multigenetic determinant and it is not going to be a single gene and, therefore, it will be more difficult to find. I am reluctant to give you a specific date, but I can tell you that in another domain, we have made tremendous advances in developing new medicines for the treatment of addiction and we are about to bring one out for opiate addiction, hopefully within the next 2 months, assuming it is approved by FDA, and then we are well on our way to the development of anticocaine medications.

Senator SPECTER. I understand the success that you are finding with treatment modalities. I would urge you to take a look at the genome prospect. If you can realistically work on the issue of cure, it is a little different than the therapy or the medicine.

Dr. O'Brien, your statement, many of your statements were profound. Many statements have been profound. But when you say that there are more problems from nicotine and alcohol than from all of the illegal drugs, we have been tackling the tobacco issue and trying to put the tobacco companies on a penalty line for teenage addiction. What suggestions would you have if you want to focus on nicotine and alcohol, contrasted with illegal drugs, as to what ought to be done by the medical profession, or more specifically, by the Congress?

Dr. O'BRIEN. Of course, I do not want to diminish the importance of the illegal drugs, and we spend a lot of our effort, including genetics, which I could tell you about another time——

Senator SPECTER. You have not diminished their importance. You have just elevated nicotine and alcohol.

Dr. O'BRIEN. But I have to tell you that if you just look at the gross numbers, there are far more young people engaged in binge drinking and getting into serious problems with that, and also getting hooked on nicotine, and when you get hooked on nicotine at age 14 or 15, it is very, very hard to get off, and as we know, about

450,000 Americans die prematurely each year, which is, you know, about 10 or 20 times the amount of people who die from illegal drugs. So it is a huge disparity.

I think the answer is prevention, and in prevention—for example, I just saw what they are doing in Florida, which I think is wonderful, because they are taking some of the tobacco money, the tobacco settlement money, and they are putting it in the hands of teenagers who are designing programs to get to teenagers on smoking directly themselves. I think that kids are really terrific at figuring out what works with kids.

Senator SPECTER. Prevention education?

Dr. O'BRIEN. Yes, sir.

Senator SPECTER. Thank you very much. As Senator Biden stated, we are in the final stages of trying to conclude the budget in Washington and my bill on Labor, Health, Human Services, and Education is at its final stage and I am due there in the early afternoon, and perhaps I can do more good there on trying to get increased funding for some of these programs than I can do here by the next round of questions. And besides that, you have a very good questioner on tap. Thank you, Senator Biden.

Senator BIDEN. Thank you very much, Senator Specter. I appreciate it. [Applause.]

Gentlemen, I am going to ask you some questions that are pretty basic for professionals like yourselves and those who have been advocates, like myself, for the last 27 years, and some of the questions I clearly know the answer to, but I think it is very important that the folks understand what we are talking about here.

Dr. Leshner, would you explain to the committee the difference between an antagonist and an antigen? What are we talking about here? What do we mean? What do we know about how the brain functions relative to the stimulation it receives from these various drugs? In this case, we are talking about opiates.

I might make it clear. The reason I focused on heroin is not because heroin is the worst thing that is happening to America. If God came down and sat here and said, I promise you I can eliminate one form of addiction and only one, just eliminate one, I would pick alcoholism as the thing that affects the most malformed babies, affects the most accidents, affects the most cost, affects the most everything.

But the difference here is that on the controlled substances like heroin, unlike alcohol and others, which cause more deaths, it spawns a culture of crime. It spawns a subculture that has the wave of infecting much more than the users. It affects, with the accumulation of billions of dollars, it affects our economy. It affects our workplace. It affects us in ways that are malignant, not that the others are not, not that the others are not, but it literally spawns, which is, I might add, one of the reasons why some folks like Kurt Schmoke and Mr. Buckley and others have called for the legalization of these drugs, which I think is a very bad idea, but I will not bore you with that now.

So I do not mean to imply by the reports that I have written and keep pounding at this, is that one of the reasons—I am the guy that wrote the legislation, as you know, to set up the drug director's office. I fought 7 years to get that done. Nobody wanted it

done, and particularly Presidents, Democratic and Republican, because it requires accountability. And one of the reasons was to try to be able to get ahead of the curve on the drug of choice at the moment and to spare some of our children and spare our society if we could get ahead.

Right now, we are finally just beginning to deal with what I talked to you and your colleagues about over a decade ago, pharmacotherapy. There is nothing new today that we did not know then except we did not have the money then to spend the time—there is maybe some new, but not much. All these drugs, I listed the drugs, LAMM, buprenorphine, all the drugs that are used, I listed them in this report in 1989. They were out there. The scientific community, you guys told us about them and we just did not spend any money on dealing with it.

So what I want to focus on here for the people of my State to understand is, one, and let me explain my prejudice and then I will ask my question. I believe if mothers and fathers of this State understand how readily available this stuff is, how appealing it is to young kids, how I view it very much like the crack epidemic. Remember, that started in the Bahamas. You had guys like Moynihan waving a flag, saying, it is coming, it is coming, it is coming, and no one would pay attention.

If I am not mistaken, it used to be for every one female cocaine addict back in the early 1980's, we had four men. The ultimate equalizer was crack cocaine. Now, it is one to one, because women could smoke it instead of snort it and distort their nostrils or do things that they thought at the front end would, in fact, affect them cosmetically. You could just smoke it, no problem.

That is what I am worried about with heroin. I am worried about, and the New Castle County Police here can tell you, I had a little seminar with all of them 4 years ago saying, this is what you are going to see. This is what is coming.

So I want to establish how dangerous it is and available, so people know. There used to be a commercial on television—they have taken it off—for a long time, 6 or 8 years ago, a man on a wintry day standing in a graveyard looking at a tombstone, and all you saw was his topcoat and his pants and his shoes and you heard his voice and he would say, "Johnny, I am sorry. I did not know. I knew drugs killed, but I did not know. I did not know it happened. I did not know when you were 12 this could happen."

We are talking about 12-, 13-, 14-, 15-year-olds. Granted, the average age is down to 17 from 18, thereabouts. But I want parents to understand this is real. It can happen anywhere.

The other reason for this is that if we do some smart things, we can affect, we can affect those who are out there, because I get calls from mothers and fathers saying, my child is addicted to heroin. There is nothing I can do. They truly view that once that occurs, life is over. It is not over, if we make the right investment, if we do the right things.

So they are, very selfishly, the two purposes, the reason why I wrote the report and the reason I asked you all here. But in order for the very people that are paying the taxes to understand why I want to spend more of their money on this effort, it is important to me, I think, to be able to explain to them what we are talking

about here. So explain how some of these drugs work, some of these medicines work on the brain.

Mr. LESHNER. OK; I will try to be brief on this subject. I have been known to go on for hours.

Senator BIDEN. I could listen to you for hours.

Mr. LESHNER. Let me start out by saying the essence of addiction is the changes that drug use produces in brain function, and one needs to understand that, at its core, both drug abuse and addiction are about brains. That is to say, people like drugs because they like what drugs do to their brains. The problem is that, over time, prolonged drug use changes the brain in fundamental and long-lasting ways that produce the compulsion that is the essence of addiction.

Having said that, that tells us that an addicted individual is actually in a different brain state than a nonaddicted individual, and that is why they cannot just cut that out, why they cannot just stop it and why you have to have treatment.

Now, the fact that addiction is a brain disease, actually, that has embedded behavioral and social context pieces to it, is why you have to use medicines as a part of the total treatment modality that you will use to deal with the problem, and what we have been trying to do, stimulated, I must say, by your tremendous leadership, why we have been putting so much focused effort into the development of new and improved medicines and why we are taking advantage of what we have learned about the brain and how it interacts with drug abuse interdiction to develop new biology-based approaches to dealing with the problem.

Senator BIDEN. Are the same parts of the brain—I know the answer to this, but it is important to say—are the same parts of the brain affected by the consumption of heroin, an opiate, as they are by the consumption of coca, cocaine, which is a stimulant?

Mr. LESHNER. Every drug of abuse has its own individual or idiosyncratic way of affecting the brain, but what we have learned in the last 5 years, I would say, is that there also are common effects on the brain that are common to all drugs of abuse. For example, they all modify the functioning of the brain's reward system of pleasure centers in a particular way, and we believe that those common effects are actually a part of the common essence of addiction, that is, the common essence of what produces that compulsion to use drugs. So our efforts are directed not only at specific drugs, but at addiction per se, addiction itself.

Senator BIDEN. With regard to heroin, it was explained to me by one of your colleagues at Yale years ago that there are several receptors in the base of the brain, and indicated to me that if we could find a way to effectively block those receptors, like, and the analogy used was, like when you have an infant child, you put those little plastic things in each of the receptacles on the floor. You stick them in so that the kid cannot stick his fingers in it. If the kid cannot stick his fingers in a receptacle, he does not get electrocuted.

The way it was suggested to me was, there is a possibility, then, based on adhering to molecules—well, without going into all that, either, that you could literally block the receptor, theoretically, block the receptor in the brain that makes you get the good feeling

from the consumption of an opiate, in this case, heroin. Is that essentially true?

Mr. LESHNER. That is what, if I may speak for him, that is what Dr. O'Brien was speaking about with naltrexone. That is, naltrexone is what is called an antagonist. It blocks the action of heroin or other opiates at the opiate receptors in the brain and, therefore, when a heroin addict who has been detoxified is put on naltrexone, if they were to use heroin, they would not get the high from it. So it is actually doing exactly what you suggest.

Senator BIDEN. Doctor?

Dr. O'BRIEN. There is a risk here, though, that we have to tell you about, and that is that the drugs actually hijack normal brain functions. So the same pathways that Dr. Leshner talks about are also called into play during pleasure, watching a good movie, having sex, eating a good meal, or whatever, and so we do not want to block all pleasures, but we would really like to block the linkage, the abnormal memories, really, that link the drug use stimuli and the pleasure, and that is tricky, but that is what we are working on.

Naltrexone, fortunately, does block the very, very specific effects of heroin and other opiates, but most of our patients—not all, some of them actually cannot take it because they get unhappiness, really, with it, but that is a relatively small number, but most of them can still have normal pleasures even though we block the opiate-rewarding pleasures.

Senator BIDEN. What are some of the other drugs, medicines, that you are looking at, or are there others that have the potential to block only the pleasure that comes from opiates but would not block other pathways of pleasure, in other words, would not block the pleasure of tasting, I guess, good food, sex, whatever else? Are there any other vehicles you are looking at?

Dr. O'BRIEN. In the antagonist category, the best one that we have available right now is naltrexone. There is another drug called nalmethine that is being studied. Buprenorphine that Dr. Leshner talked about is another special category of drug. We call it a partial agonist, because——

Senator BIDEN. Spell agonist.

Dr. O'BRIEN. A-g-o-n-i-s-t—a partial agonist, whereas heroin, morphine, methadone, these are full agonists, and buprenorphine is a partial agonist, so it gives some opiate effect, but it has a ceiling. It has a limit on it and it cannot give a full opiate effect. So it is almost impossible to overdose on it and it prevents the excessive effects from other opiates. It also, unlike naltrexone, which you have to have good motivation to take it every day, you need a lot of support, because you do not get any good feeling from it. Methadone, you get good feeling from, but you can still use it excessively. It has mostly benefits, but you have to know how to use each one of these.

Buprenorphine has other benefits in that it is something like naltrexone in its blocking ability, but it is also something like methadone in that you feel a little bit better. So there are more addicts who are willing to take buprenorphine on a regular basis than they are willing to take naltrexone.

Senator BIDEN. I have one last question in this area. The way it has been explained to me by you gentlemen and others in your field is that the antagonist, the things that block any impact of the drug, like naltrexone, that they are thought of as most useful in the context of a holistic treatment of the person. Once they are off, it keeps them off for a time in order for you to be able to—it is not thought of as the vehicle to keep them on the rest of their lives, although some, I guess, it is possible. That in order to be able to live a normal life and have normal pleasures that do not relate to opiate consumption, in this case, that it is part of a psychotherapy regime that it goes on with and other initiatives that are nonprescriptive, nonpharmacotherapy in nature. Is that right? Is that how you think of the best use of these antagonists, as opposed to agonists?

Dr. O'BRIEN. Right. Exactly. I think all of the medications, whether we are talking about agonists, partial agonists, or antagonists, they all require counseling, psychotherapy, something to help people with the transition from heroin use to a drug-free state.

If I could just add one point that I think is responsible for a lot of trouble in this field, there is a lot more than just taking people off the heroin, which is what is generally paid for in our public assistance programs for Medicare and Medicaid and in our insurance and HMO programs. They are willing to pay for detoxification, but in most programs, they do not pay for the long-term treatment.

So what happens is you have a revolving door. You get people to stop the heroin, they are clean for a while, and then they relapse. It is because there is a change in the brain that Dr. Leshner talked about that you need the chronic treatment, and I, personally—I am in charge of a large treatment program. I have a budget. I have to spend my money in the most efficient way. I think it is much more efficient to pay for long-term outpatient care, like the SODAT Program, rather than investing a lot in inpatient care without paying for the chronic long term to prevent the relapse, with medication and psychotherapy.

Senator BIDEN. Now, one or both of you, and I would like to hear what you have to say about that, Dr. Leshner, we are going to add another piece to it and you can speak to both, if you would. One or both of you referenced that methadone, for example, has become a bit of a political football. There have always been its critics in terms of the way it is distributed, gets to readdiction to a "less dangerous" drug, et cetera.

One of the things we have worked with you on, my office has, Dr. Leshner, is this notion. I introduced a piece of legislation called the Drug Addiction Treatment Act which would establish a new way for drugs like buprenorphine to get to patients, not in the clinic system like methadone, but in doctors' offices. It is also very controversial. One of my colleagues in the Florida Senate made a very tough speech saying this is just the liberals gone astray again. I had to remind him, every * * * criminal law written since 1978, I have authored, literally, not figuratively, but literally, that is the new battleground.

The new battleground is when it is appropriate to prescribe buprenorphine or methadone or what may come along. What is the best way to do that to diminish the possibility of abuse and, none-

theless, help make it safer for my mother to walk out of the PathMark at dusk and not get mugged in the parking lot putting her groceries in by somebody who needs another $500 to maintain a habit for the remainder of the next 2 weeks. Can you talk to both those issues for a moment?

Mr. LESHNER. Sure.

Senator BIDEN. Then I will yield and I will let you respond.

Mr. LESHNER. Just quickly, to reiterate, addiction is a bio-behavioral disorder, and just like any other brain disease, Parkinson's, Huntington's, whatever, having a stroke, not only do you have to deal with the biological consequences but the fact that it takes over your life, as a stroke does. You need rehabilitation. You need rehabilitation from addiction.

Having said that, let me turn to methadone. One of the problems with methadone is there is tremendous ideology out there that is rooted in a fundamental misunderstanding about methadone.

Senator BIDEN. Yes.

Mr. LESHNER. It is not true in the technical sense that methadone is literally a substitute for heroin. Whoever said that many years ago did a terrible disservice to drug treatment in this country. Methadone does, in fact, bind to the same receptors. However, it has a slow onset, a slow offset, and it actually stabilizes the brain of the heroin addict rather than destabilizing the brain.

Having said that, the Institute of Medicine and the National Academy of Sciences and a specially convened consensus panel of the National Institutes of Health both advocated that methadone, and now buprenorphine, buprenorphine naloxone, be brought into the mainstream of medical care in this country. There is no question that, over time, we are going to need to see these medicines, better understood, and then well delivered in clinical practice by physicians.

Senator BIDEN. Explain what you mean by the mainstream of medical practice. Give me an example of what you mean. Do you mean, John Doe is a heroin addict. John Doe has gone through the process where he or she has been detoxified, if that is the phrase—I know, in alcohol, it is detoxified. Now, they are looking for a maintenance, an ability to stay off the stuff, whether they choose the naltrexone route or not, and they go to the local doctor. Do you mean the local doctor should be able to write a prescription?

Mr. LESHNER. I do not anticipate that just any GP is going to be giving any addiction medications. Addiction medicine is a specialty and you need some substantial training to understand how to do it, to understand when you have to refer to treatment, to understand when you have to do clinical practice.

But having said that, there is no reason why an appropriately trained physician could not prescribe methadone, or particularly buprenorphine combined with naloxone, this new medication, that actually will be virtually nonabusable by a heroin addict on the street.

So what we are hoping for is that appropriately trained physicians will be able to, through hospital clinics, through private practices with a limited number of patients, will, in fact, be able to prescribe these medicines in an appropriate way to those people who so desperately need it.

Senator BIDEN. The last question I have on this, because the press, understandably, will want to ask more about this, about what are you proposing, Biden? Is there within the medical community, the governing boards, the accreditation community, is there discussion about the accreditation—assume we go this route, because that is what medical science and the practice is saying, we should move that direction—is there discussion about what credentials would be required, particularly requiring a particular, not just having an M.D. behind your name? Is there any discussion of narrowing the circumstance under which medical doctors could prescribe these kinds of agonists or partial agonists?

Mr. LESHNER. Absolutely, and Dr. O'Brien has been involved in some of these activities. Let me just quickly say that the American Society of Addiction Medicine certifies physicians to be addiction physicians. The American Academy of Addiction Psychiatry also certifies physicians in addiction psychiatry, and both of those organizations have agreed to be working on guidelines for the administration. So this will not be a haphazard activity.

Dr. O'BRIEN. If I could just add, there are two opposing issues here because nowhere else in medicine do we have people required to get special accreditation. I am a physician——

Senator BIDEN. I agree. That is why I am raising the question.

Dr. O'BRIEN. I could prescribe all sorts—legally prescribe all sorts of very dangerous immunotherapies and hormones and cardiac drugs and things that I know very little about, but I could legally do it. I could not ethically do it, but I could legally do it. And, actually, buprenorphine is a very safe drug and there are probably a lot of physicians who could benefit from some information about it so that they could prescribe it. But if we put legal restrictions, I think that that is going to really limit it more, and if you compare it to other drugs, it is actually a lot easier to use.

Senator BIDEN. That is why I raised the question, because I think there is going to be a political dynamic here, that if we move in this direction with the ability to so easily demagogue this issue from the right, I mean, it is a great thing. I can make a speech. It is an easy one to make. I think, absent some way in which to do something that I think is probably not from a professional standpoint particularly enlightened or wise, but nonetheless may be politically necessary in order to get the kind of support that is going to be needed to deal with this pharmacotherapy aspect of treatment. We are just beginning that fight.

I apologize to the other folks in here. One of the senses of relief my colleagues got when I gave up the Judiciary Committee and we lost control of it is, I find this so interesting and so fascinating, I hold hearings for hours on this subject. It makes me, as my mother would say, a little bit of knowledge is a dangerous thing. I have a hell of a lot more knowledge than anybody in the Congress, but only a little bit of knowledge, which is worrisome, I guess, to people. I could keep you here all day, but you both have incredibly busy schedules, as does the second panel.

So I have no more questions for you two. You are welcome to stay. I do have questions for the remaining two members of the panel, but I know, Doctor, you have got to get back to Philadelphia, and I know you have to get down to Washington, and I appreciate

it very, very much and look forward to being able to call on you again, as well, privately, to pursue some of these specific issues.

Mr. LESHNER. Thank you, Senator.

Dr. O'BRIEN. Thank you.

Senator BIDEN. Thank you so much for coming. I appreciate it.

Mr. Nelson, I want to focus on two items. One is, as I understand it, to cut to the chase here, one of the reasons why I started 6 years ago saying heroin is coming and it is coming from South America, it is not going to come from Turkey, it is not going to come from the Golden Triangle in Southeast Asia, it is going to come from the South, is because our boys in the South had basically saturated the market on cocaine and it was predictable there was going to be a new deal coming.

It does not take a whole lot of hectares to provide enough poppy for opium. These guys already had the network set up and they already were in business and they, * * *, they could bring in oil by their pipeline that they have, almost, although that is more cumbersome and bulky. But they are very, very efficient distributors.

So as I understand it, there has been a shift not away from cocaine, but an added product, a new service offered by our friends from Colombia and the Wahila Valley and other areas between Peru, Bolivia, Colombia. But now, the route is either through Mexico or up through the Caribbean, the traditional route that used to be the way until we got relatively effective and it found its way through Mexico.

The interesting thing to me is, though, the Colombians and Dominicans seem to be in control, whereas cocaine, the Mexicans have taken over a major chunk of the distribution because they have seized not only—they not only have the old tollbooth method, if you are going to come through my country, you give me a piece of the action, they have essentially taken over networks and cocaine.

Mr. NELSON. Right.

Senator BIDEN. Can you explain to me why the Colombians still seem to be the wholesalers and the Dominicans on the East Coast are the retailers?

Mr. NELSON. Senator, I believe that, as you put it, the Colombians have the network. They utilize the transportation routes for airports into Miami and New York. They had the retailers right at their beck and call. They were giving the product of cocaine to the Dominicans for distribution and they simply told them, we have a new product, and for you to continue to have access to this cocaine and the lucrative money making, you must take the heroin. That is one of the rationales that we believe that the Dominicans have control of the cocaine and most of, if not all of, the heroin distribution in Philadelphia, which impacts, obviously, here into Wilmington.

Senator BIDEN. One other question about the distribution piece. When cocaine was introduced, crack cocaine was introduced, it was essentially given away like candy to get people addicted. I mean, these guys could sell soap well. They go out into a market, they saturate the market, they have a low price, they have given it away in the past to teenagers, they have given it away at a very low price, not unlike, and I am going to get in real trouble for say-

ing this, the tobacco companies promoting, early on, at least, additional addictive nicotine content in cigarettes, based on the records that are being made available, in order to get people hooked early. You get them early, you have got them for life. You get them early, you have got them to the average life expectancy of heroin users, 29, or 28 it used to be. It may be a little lower on average. I do not know, Tommy, what it is now, today.

But is there a relationship between the purity and the introduction? When I say introduction, I mean this new wave of heroin is relatively new in terms of purity and price. What do you anticipate happening? I mean, as the market expands, as the clientele expands, if it does, do you expect the purity and price to stay where it is?

Mr. NELSON. Yes; years ago, when heroin was being used in Washington, DC, where I first began, it was at a 4 and 5 percent usage level, and as you can see now, we are talking about 80, 90, and even higher. Ninety-five percent, I think, is our highest. That is a quicker introduction to the product. The addiction process begins quickly. It is not a short-term event. So we believe that, yes, that the purity is going to stay there, currently at the percentage we show in Philadelphia, and the price is going to possibly go up. Of course, in the business end of this, if you have something that someone desperately needs and you have it sold to them for $10 yesterday and they desperately need it and you can up the ante, the profitability certainly is there.

Senator BIDEN. The irony of all of this to me is, as a student of this subject, we are well into our second drug epidemic. The first one, particularly with opiates, began in the 1870's, culminated with the passage of the Harrison Act in the late teens and early 1920's, and our first drug czar was actually a guy named Anslinger, like gunslinger, back in the 1920's.

It used to be, by the way, that we had mandatory drug education in about 32 States, K through 12, back then to break the drug addiction, and we do not have that anywhere today. I mean, I do not know why the heck we do not learn from the past, but apparently, it is not a route we want to go, but it leads me to this question.

This idea of dealing with the ability to interdict drugs, which we all support, the question is not—I am not going to ask you the percentage, but the irony is, you are seizing incredibly larger amounts of controlled substances, cocaine and heroin, and yet we are still maintaining usage and/or the total amount being consumed is higher, which would lead one to believe that, notwithstanding how, and this is no criticism, I mean, the effectiveness is amazing. You are picking up incredible amounts of seizures, but there are also incredible amounts getting through. What does that tell you? I guess in your business, it is seize more.

Mr. NELSON. Yes, sir. That would be—like I said, the more we do in law enforcement, it seems like we end up having more to do. This is one of the issues that has faced us in the law enforcement business over the years.

To answer your question, I do not have the figures of the production of the heroin and the cocaine throughout the world. Yes, our statistics show that we are making seizures every day and increasing those seizures, yet the problem still exists.

Senator BIDEN. I have one last question for you. Given the fact that people in both my State and the State of Pennsylvania are getting heroin—and New Jersey, I might add, the Camden area—are getting heroin from the same place, downtown Philadelphia——

Mr. NELSON. Correct.

Senator BIDEN [continuing]. Are local, State, and Federal law enforcement agencies in all three jurisdictions working together to deal with this, along with the Feds?

Mr. NELSON. Yes, sir. That is one of the classic efforts that DEA prides itself in, working with States and locals and their Federal counterparts. We have a major task force operation in Philadelphia, well over 30 years old. As you know, we instituted an office in Dover with your help as a part of our program to establish the communication between the State and local folks and our efforts. We are a national agency. We work worldwide, so our communications are good.

But to answer your question, the communication is there. The support is there between the agencies, and it is one of DEA's primary missions, is to work with our State and local counterparts.

Senator BIDEN. I do not want to get you in trouble, and I am occasionally accused, because of my having, in a sense, founded the office and my relationship with General McCaffrey, but do you have an opinion on whether or not Delaware should be included in the Philadelphia-Camden HIDTA efforts?

Mr. NELSON. Yes, sir, I think that Delaware could certainly benefit from the resources of the Drug Czar's office. The coordination aspect of that certainly can be handled between the DEA offices, as well as the committees that are formed to oversee the HIDTA's, which are basically the State and local entities, the Federal entities. Inclusion into the Camden-Philadelphia HIDTA is one method. Creating its own HIDTA here may serve better. But the resources that could be applied here, an approach could be to identify the needs of that three-legged stool, law enforcement, treatment, and education, and have that as the backbone for requests for support from ONDCP in terms of funding and other resources.

Senator BIDEN. I am, as should come as no surprise to you, I am working on that and I am hopeful that we can get that done.

Tom, I have a couple questions for you, because the three people who have spoken are national and regional in their scope and they have worked in this issue for a long time. But to use that old expression, you are right where the rubber meets the road. I mean, you have Delawareans walking in off the street, being sent by the courts. You work with the courts, the drug courts, closely.

You have cited the success you have had with naltrexone and why and the relative savings versus enforcement. If—if—a depot is developed, and as I said, as long ago as 10 years ago, 11 years ago, we wrote about that as a possibility, then it was talked about literally injecting, in effect, a capsule into your arm so that you would be in a position that for up to 30 days, and I heard today they may be able to go up to 60 days, that you would have this blocker in place. And, I might add, there is very promising research on cocaine, carzomezapine and other medicines, and there is a particularly promising one that I will not bore you with that you know about, but this is about heroin.

Assume, for a moment, that there is developed a depot—by depot, again, you and I know what I mean, that is whether it is through injection or insertion into the bloodstream an ability to have one injection or one orally-taken pill that would block the receptors, the opiate receptors in the brain, for up to 30 to 60 days—what is the practical impact on the person who receives that blocker, heroin addict who receives that blocker? Does it enable them—assume, for a moment, based on your experience, they were in that state for 30 to 60 days at a shot. Can you extrapolate from your experience how that affects their motivation, how that affects their ability to hold a job, how that affects their life?

I know with lithium, with those who are bipolar and alcoholic, the consumption of lithium tends to work, but they do not take it because they lose the ability to have that manic high and they miss it and so they do not take it.

What is the practical effect, if you can talk about it, how someone would be able to function?

Mr. MALONEY. Well, Senator, the problem we had with the naltrexone with those who we administered it was that it was in 50 milligrams, which meant we would have to give it to them every 2 days. Obviously, if someone did not show up on a Friday, you had a pretty clear indication we probably would not see them on Monday.

So part of the treatment side of it was administering the medication, and if you could have something that would have a 30- to 60-day lasting effect, then full concentration could be given to treatment as well as some of the horizontal integration of getting jobs for people, job skills training so they could get decent jobs. And so you could focus on those kinds of alternative things in their life that would make——

Senator BIDEN. If you had a long enough period for them to be off of it?

Mr. MALONEY. Yes. And in addition, if you stop in Delaware and look at the largest increased population in our prisons, it is for people who are violating probation. Now, we all know that many people come out of prison and no one wants to hire them. They cannot get a job, so they obviously do not feel very good about themselves. They usually revert back to drugs, if that is what their background was, and they end up that they want to get more drugs and the only way they are going to get them is to commit a crime. So, eventually, this cycle goes back.

So the enormous cost to us by having a population coming out of prison that is going to get rearrested in a 2-month period, that is an enormous cost to us. Therefore, if we could have medications that would last for 30 or 60 days and incorporate them into a probation program, I think we would see a radical change in the crime rates in our State.

Senator BIDEN. When I suggested that 10 years ago, I was met with the following, and I think legitimate, criticism. They said that the moral component of this is not there. To force someone on probation, which I proposed, into a circumstance where the condition of probation was that they take, assuming it were developed and we are on the eve of that happening, a medicine that, by injection or otherwise, would block the effects of the addiction that they had,

in this case, opiates, for 30 to 60 days, was immoral, that the State had no right to do that.

I realize you are not an ethicist, although you are one of the most ethical people I have ever known in my life, and I have known you since high school. Do you have an opinion as a treatment provider what the social/ethical dynamic, if that were written into the law, assuming we arrive at this capability, to deal with probation or parole as a condition to have to show up with you or whomever once every 30 days or 120 days?

Mr. MALONEY. Well, I would think the easiest example to use would be those who we think we might be able to release earlier than we normally would under the condition that they would accept taking the medication, and there, it would be a voluntary choice on the part of the participant that, yes, I would like to be released earlier.

If it is someone who has completed the sentence, whether or not the court could impose after they have fulfilled the sentence a condition of probation that they take the medication, I suspect there may be legal issues of due process on that.

Senator BIDEN. I think there——

Mr. MALONEY. But I certainly would think that it would be something that many people would opt to do, because I do not think that the people that I have dealt with want to do drugs. They would like not to have to do drugs. And many of them would love to have an opportunity to find something that would work for them.

Senator BIDEN. The way, I think, from a constitutional standpoint, the way to do it, and I will raise this with my next panel and my staff is telling me to move on here, is that it could be a condition of the sentencing at the front end. If the sentencing was, you are sentenced to *x*-number of months or years and then, I assume that could be met constitutionally.

I thank you both for being here. I may submit a couple questions in writing for you, if I could, for the record.

It has been extremely helpful and I thank you very, very much.

Mr. MALONEY. Thank you, Senator.

Mr. NELSON. Thank you.

Senator BIDEN. Now I am going to call our next panel. Our next panel is made up of Sergeant Tony Hernandez, New Castle County police officer assigned to the heroin alert unit.

Next is Lt. Karl Hitchens, New Castle County paramedics supervisor. He has the unfortunate job far too frequently of responding to heroin overdose calls and help coordinate the New Castle County Police heroin alert video slide presentation.

We also have Marie Allen of Heroin H.U.R.T.S., H-U-R-T-S. Heroin H.U.R.T.S. is a support group of parents whose children are either heroin addicts or have died from overdoses. Her daughter, Erin, died earlier this year of a heroin overdose.

Next is Maria Matos, executive director of the Latin America Community Center.

And we have Sally Allshouse, Brandywine Counseling and Treatment, which is a methadone treatment facility in Delaware with some 600 clients.

Why do we not start with you, Sergeant Hernandez, and tell us a little—if you can keep your statements to about 5 minutes, I would appreciate it, because I do have questions for you. Tell us a little bit about the heroin alert unit, please.

PANEL CONSISTING OF SGT. TONY HERNANDEZ, NEW CASTLE COUNTY POLICE OFFICER, HEROIN ALERT UNIT; LT. KARL HITCHENS, NEW CASTLE COUNTY PARAMEDICS SUPERVISOR; MARIE ALLEN, HEROIN H.U.R.T.S; MARIA MATOS, EXECUTIVE DIRECTOR, LATIN AMERICA COMMUNITY CENTER; AND SALLY ALLSHOUSE, BRANDYWINE COUNSELING AND TREATMENT

STATEMENT OF SGT. TONY HERNANDEZ

Sergeant HERNANDEZ. Good afternoon, Senator. The Heroin Alert Team was developed last year, April. It came into existence at the direction of our colonel. He saw a national trend with heroin and decided, let us look to see what is going on at home. A team was formed to research the extent of the problem. We did that, determined that we had a serious problem that was really sneaking up on us, and then developed a program, initially directed to parents to heighten their level of awareness. Once they started to see the program, they asked us to take it into the schools, communities, churches, youth groups.

We have had some successes that we would never have guessed we would have experienced, successes such as a student who approached us at a local high school after seeing the program and was very, very gracious and kind and thanked us for having the presentation. His school, we thought it was no big deal. He later indicated that it was a big deal because he had plans of using heroin, trying it for the first time that weekend, and he was so moved by the program that he decided that is not where he wanted to go, and he was being misled. He was being deceived by those around him that were using. So that is just one example, and we have had other successes.

Senator BIDEN. What do the kids say in high school these days? I can remember back early on, if you said to kids, you know, you can inject this heroin in your arm and they go, oh, man, that is bad stuff. But then, on the other hand, if you said, by the way, you can smoke a joint here and it is not addictive, it is no big deal, in what end of the spectrum is—I mean, how does this get sold, figuratively speaking? How do high school kids talk to each other, because a lot of "good kids" are trying this stuff. How is it sold? I do not mean physically sold, I mean, what is the deal? What do people say to one another?

Sergeant HERNANDEZ. A lot of people, I think, consider peer pressure as one of the main factors, and it is true. Peer pressure does contribute to the problem. However, curiosity plays just as big a factor, and a lot of the young people we talk to try it because they are curious, because they want to——

Senator BIDEN. Do they think it is addictive? I mean, what do they think? What are you hearing in the high schools? Do kids say, well, I can try this and it is no big deal, I mean, or they think it is a big deal.

Sergeant HERNANDEZ. Sure. We have had cases or incidences where young people have been drinking alcohol, smoking marijuana, thinking, well, I beat those addictions. I could try heroin and it is not going to affect me. Again, they are being misled, though, by their own friends, or so-called friends, and persuaded into doing something that is obviously deadly.

Senator BIDEN. Lieutenant Hitchens.

STATEMENT OF LT. KARL HITCHENS

Lt. HITCHENS. Yes.

Senator BIDEN. Do you have an opening statement you would like to make? Can you tell us a little bit about the work you are doing?

Lt. HITCHENS. With the Heroin Alert Team, I was put on it because the paramedics are dealing with these addicts on a day-to-day basis. I can tell you, we have a slide presentation, if you would like to start that, to give you an idea what is going on with this drug.

Senator BIDEN. OK.

Lt. HITCHENS. You hear a lot of statistics and figures and numbers, and a lot of people do not realize that these are our kids that are dying in our homes and the streets. When I started in EMS 12 years ago, responding to a heroin overdose was an event and they were few and far between. Most of them tend to occur in the city, and your victims were your older, hardcore addicts.

But over the past few years, with heroin becoming popular, cheap, pure, heroin overdoses are commonplace. They are common occurrences in our county. I can tell you that, last year, in New Castle County, we had 136 heroin overdoses that the New Castle County paramedics canceled, and that shows you where they are at all over the county. It does not matter where you live. We also had 24 deaths. They occurred all over the county. Right now, in 1999, we respond to an average of 12 heroin incidents a month, and those numbers are rising.

The victims of the overdoses are getting younger and younger and they come from the very communities that we all live in. They do not come from somewhere else. Heroin has become the drug choice of mainstream America. It has moved from the opium den into the family den. And, yes, Senator, I can tell you, heroin is in your community just as well as it is in mine. It is in everyone in this room's community.

No walk of life is immune to this epidemic. During my tenure with the Heroin Alert Team, I have met police officers, nurses, doctors, lawyers, elected officials, you name it. We have met a profession who is living through the * * * of having a loved one addicted to heroin. Something has got to be done.

We need more funding for treatment, prevention programs, before another little brother has got to find his big brother like this, or a mother finds her son like this, or another boyfriend is found like this, or a single mom finds her only son like this.

Now, words alone cannot express the frustration of families that are dealing with this heroin problem. As a paramedic handling heroin overdoses, I not only have to deal with the sights of another dead young person, I have to deal with the family emotions. Each

and every scene is the same, the young victim, the paraphernalia, the family wondering out loud, why? Where did we go wrong?

One, in particular, heroin death sticks out. It was a 19-year-old young man dead from heroin. As the paramedics were declaring him dead, his family was downstairs asking out loud what went wrong. His sister was screaming, "I only left him for a little while." She had been keeping an eye on him on a 24-hour watch after he asked her for help for his heroin addiction because there were no beds in detox for him to go to. His healthcare insurance would not cover the treatment he needed. So his sister tried to watch him and tried to accomplish the near impossible. She tried to keep him away from the heroin. She did her best. She was with him day and night as he fought the cravings. But she took some time to take care of herself, and when she came home, she found him like this, dead from a heroin overdose. From his bedroom, he went here, to the cold, hard slab.

I could go on and on with story after story, but they are all the same, about families fighting to get help for their loved ones' addictions.

In particular, the State of Delaware needs to wake up. I cannot put it any plainer. I will give you an example. Delaware has no juvenile detox center. They detox on the cell floors. A 14-year-old in the State of Delaware can sign themselves out of treatment without their parents' consent. That is State law. There are no long-term residential treatment centers in the State of Delaware, and we have a serious heroin problem. We need to wake up before another mother has to identify her daughter in the morgue like this. Thank you.

Senator BIDEN. Thank you. [Applause.]

Ms. Allen, are you OK?

Ms. ALLEN. Yes.

Senator BIDEN. I must say to you that I have, having lost a child by other circumstances, not addiction, a young baby, almost 2 years old, I am not sure I could sit through that—it happened to be an automobile accident, the statistics about automobiles—and still testify. You are a better person than I am. We truly appreciate you being here and we welcome your testimony. Take whatever time you need. If you want to stop and we will come back, we will do it any way you want.

Ms. ALLEN. I am all right.

Senator BIDEN. OK.

STATEMENT OF MARIE ALLEN

Ms. ALLEN. Thank you for letting me be here. When I found out that Erin was addicted to heroin, I really did not have a clue. I was uneducated about heroin and its deadly grip. I thought that she could kick this addiction. Little did I know that she had been lured into a deadly trap that would eventually take her life.

Erin was becoming someone I did not recognize. Her arms and legs were scarred with needle marks. Her eyes were sunken and dark. She was dying before our eyes and we did not know how to help her. Our entire family was being controlled by Erin's heroin addiction. Getting heroin had become Erin's full-time job. She traveled to Kensington and to Philadelphia every day to feed her addic-

tion, going in the places that you and I would never dream of going. Erin did not want to be a junkie, a slave to heroin. She tried many times to detox and rehab. She would stay clean for maybe a week or so, then she would give in to her cravings for heroin.

After being clean for 9 months and residing at the CREST Program in Wilmington because of a felony charge directly related to Erin's heroin addiction, she had gotten out on work release. A simple blood test had made Erin's cravings for heroin return stronger than ever. She left work that day and went to Kensington. I did not see Erin again until we were called to the coroner's office in Philadelphia. Erin had died and heroin was her killer, and it is still loose in our neighborhood.

Since April of last year, I have been working with the New Castle County Police Heroin Alert Team in an effort to raise the level of awareness about this problem. I have been telling Erin's story because I know how she suffered and I know that she would want me to warn other people about heroin. She would want me to tell them how this drug took her life and changed our family's life forever.

A little over a year ago, after seeing a Heroin Alert program, three moms who all have children who are addicted to heroin formed the Heroin H.U.R.T.S. support group. I joined that group, and we now have over 150 families in Delaware and Maryland who come to share their pain, their horror stories, their hope that their children will someday be able to live a life without heroin.

Heroin H.U.R.T.S.'s mission is to provide support, education, and advocacy to parents, family members, and friends of persons with addictions, and to promote research and development for more and better treatment programs and facilities specifically for heroin addiction. Heroin H.U.R.T.S. is in the process of getting transitional housing so that when a person is released from detox, they will have a safe haven while waiting to be placed in treatment, instead of being sent back into the streets to use again.

Over the past 1½ years, I have met too many young people addicted to heroin and fighting to get their lives back. Some of those young people have come here today with their parents. They are involved with each other's lives through a peer counseling group that was started by Heroin H.U.R.T.S. This group is giving these young people a chance that my daughter, Erin, did not have.

If the devil is out to destroy lives, then I would have to say that the devil is heroin. I have never seen anything so destructive, and I do not know how, but it must be stopped.

Senator BIDEN. Thank you very much, Ms. Allen. Let me ask you one question. What did you mean by a simple blood test caused her to relapse?

Ms. ALLEN. She went to get a blood test, and when the nurse put the needle in her arm, she came out of the office like she was going through withdrawal. She told me it made her start craving it.

Senator BIDEN. That is what I thought you meant.

Maria, welcome. Thank you for being here.

STATEMENT OF MARIA MATOS

Ms. MATOS. Thank you.

Senator BIDEN. You seem to be involved in every good thing we try to do.

Ms. MATOS. We try to be there. We have to all get involved. I thank you for having me.

This very second, there is a teenager in our community trying heroin for the first time, not knowing where in the long run he is going to end. Here in Delaware, heroin use is skyrocketing. Heroin in our community is not only affecting the older generation, but now, more than ever, it is affecting our youth. The number of adolescents and young adults using heroin is growing rapidly every day. Heroin affects the whole community. It is not just a problem in the inner city. Heroin has found its way into suburban families all around Delaware.

Today, heroin users range from the homeless to the straight-A honor students. One important factor that we have learned is that heroin does not discriminate. One of the main reasons heroin is so appealing to our youth is because of the way it is packaged. The majority of youth use heroin in powder form, which is much more attractive than the dirty old syringe. The sad part is that whether they inhale or inject, it still pulls them into the dark, horrible world of addiction.

In an informal survey conducted at the LACC——

Senator BIDEN. Explain what you mean by the LACC.

Ms. MATOS. The Latin American Community Center. Young people, ages 11 to 22, were asked three questions. One was, do you know what heroin is? If so, have you ever seen anyone doing heroin, and how difficult or easy is it to get or to buy? We talked to 56 kids. Out of those, 16 did not know what heroin was. Forty knew exactly what it was. And out of the 40, 45 percent, or 18, had actually witnessed someone using. Pretty disturbing.

When asked about the assessability, the answers were very alarming. Answers were, like buying candy from the store, extremely easy to get. They come up to you and ask you. You do not have to ask.

This is where the question of treatment comes in, Senator. Delaware at this moment cannot meet the demands for the treatment programs, especially treatment for our young people. Many of the drug treatment programs that we have in Delaware requires a person to be at least 18 years or older. We are dealing with a drug addiction which is a very, very cunning disease and requires long-term intensive treatment, 24 hours a day.

We need longer-term care programs, programs like Hogar Crea. Hogar Crea is a nonprofit, 2½- to 3-year drug and alcohol treatment program with a 5-year followup. Maybe you are asking yourself, what makes Hogar Crea different from all other types of treatment programs? What makes Hogar Crea different from all the other treatments in the world is Crea believes in reeducating rather than rehabilitating. Any addict can go away to a program and get healthy and rehabilitated, and rehabilitate his body and leave. But when he leaves, he will still have all those negative behaviors and characteristics of an addict, which will soon head them back to addiction, whereas in Crea, we focus on breaking down everything about a negative character and rebuilding a healthy, positive character and instilling moral values into their lives. The theme of

Hogar Crea is responsibility, because our main focus is to restructure the lives of addicts so they become responsible, respectful, mature, and productive members of society.

This State and the country need to fund programs that work. Programs like Hogar Crea that has a success rate like no other drug and alcohol treatment in the world. Ninety-two percent of all residents who finish the entire program, including the 5-year followup, have not returned to drug addiction. Hogar Crea's success rate speaks for itself. Many will agree that Hogar Crea is the most effective drug treatment in the world.

At this moment, Hogar Crea only has one facility in the entire State of Delaware that is opening and functioning. We also own another property, which will be developed into a women's center, and we have plans to go as far away as Georgetown. Of course, the only obstacle Hogar Crea has is the funding to open up the centers, which are desperately needed in the State.

In our community, we have seen the trend locally go from crack cocaine to heroin, and this is obvious based on bags that area residents are finding and police have identified as heroin paraphernalia. There is a large number of young people that have been introduced to heroin and now need help. We find that the resources are not in place to meet the growing need, very few detoxification beds and no long-term treatment programs. Heroin is very addictive and in order to break that addiction, one needs long-term care and intensive aftercare.

Parents who have addicted youth are told either by the courts, the parole officers, or others that they have to watch their youths 24 hours a day. How is this possible if they have to work to support their families?

Non-English-speaking inmates with heroin addiction are left out in the cold because programs like CREST and KEY are not accessible to them.

I thank you for allowing me to speak on behalf of the many families that have lost their children to this dreadful disease, including myself—I lost a stepson to heroin—and many that are still looking for help and their children but cannot find it. Thank you.

Senator BIDEN. Thank you very much.

Ms. Allshouse.

STATEMENT OF SALLY ALLSHOUSE

Ms. ALLSHOUSE. Yes. My name is Sally Taylor Allshouse and I would like to thank you for the opportunity to speak before this public hearing. I have worked in the drug and alcohol field for over 26 years in the State of Delaware. We are at a crisis point and all resources, both State and Federal, must respond to the heroin epidemic in Delaware.

I have brought a chart for you today that I think shows the problem that treatment programs are experiencing in Delaware. This chart presents the increasing census that Brandywine Counseling has experienced over just the past several years. These numbers just reflect our heroin missions. We have over 1,000 people in treatment, and these are just our heroin.

As you can see, Brandywine Counseling has shown an increase of over 300 percent in our heroin admissions, and for the first time

in several years, waiting lists will now occur for both methadone programs in Delaware. This will occur since dollars are no longer available to meet the demand. The Division of Alcoholism, Drug Abuse, and Mental Health funds the majority of treatment programs in Delaware, and even though the State continues to experience surplus in revenues, the alcohol and drug treatment dollars have actually decreased over the past several years, thus not allowing providers inflationary increases or addicts increased access to treatment.

This chart also shows you the breakdown of people who are actually in treatment at this point, 66 percent male, the race, 47 African-American, 46 percent Caucasian, seven percent Hispanic, and as you see, over 39 percent of our clients are really between the ages of 18 and 34, and again, that is for just our heroin admissions.

Senator BIDEN. Are you able to treat legally someone under 18?

Ms. ALLSHOUSE. With parental consent, yes.

Senator BIDEN. But you do not have any?

Ms. ALLSHOUSE. None. These numbers just reflect individuals being admitted to Brandywine Counseling methadone maintenance program. Heroin addiction hurts not only the addict, but also hurts the parents, the children, other family members, and our communities. These numbers do not show the crimes committed, the neglected children, and the medical complications associated with this drug.

Delaware ranked seventh in the nation for AIDS cases, up from 13th in 1992. Intravenous drug use is the number one reason for that ranking. This alone should be a reason to fund programs that fund heroin addiction.

These charts are people who are waiting outside at midnight to be admitted into my program. Since they know that there is a demand for slots, if they show up and sleep outside, they might get a number to get in early into treatment.

Brandywine Counseling is not the only alcohol and drug treatment program in Delaware being stretched to its limit. Programs Statewide are seeing admissions soar. In fact, New Castle County detox, for the first time since records have been kept, saw heroin become the primary drug of admission, outranking alcohol for the first time.

Delaware has hit a crisis point, and if increased dollars for treatment and law enforcement are not provided, then still another generation will be lost. The changing face of heroin addiction has brought younger addicts to our programs, overwhelming our resources.

What can be done? One, provide additional dollars to treatment programs so that waiting lists are eliminated. This will allow treatment for heroin addiction on demand. It costs less than $3,500 a year to keep one heroin addict in treatment at Brandywine Counseling, a small price to pay for the hurt heroin afflicts both financially and emotionally in our community.

Two, investigate adding to the drug courts in Delaware crimes of shoplifting and prostitution. These crimes are not included at this time and are associated with heroin use. This will allow earlier intervention into the addiction process, and other drug courts have

found this very successful. Delaware has a very successful drug court and adding these crimes would further enhance the program.

Establish a needle exchange program in New Castle County. All revenues for prevention of HIV and AIDS must be brought to the table. The City of Wilmington and many legislators do support this effort, and with dollars and a commitment by the legislature in Delaware, this could occur.

Four, increase law enforcement efforts between Delaware and Pennsylvania. Delaware needs their cooperation, since the majority of users buy their drugs in Pennsylvania. Both States have to have a mutual commitment if law enforcement can begin to combat this problem.

I would like to thank you and also say that Renatta Henry, the Division Director of Alcohol, Drug Use, and Mental Health, is here today, and I would be glad to answer any questions and I know she would, also. Thank you, Senator.

Senator BIDEN. Thank you very much.

Let me begin with you. What does it take for a treatment center to be qualified to distribute methadone?

Ms. ALLSHOUSE. They have to be approved by the single State agency, which is Renatta, Ms. Henry's division, at this point. We have to be approved by the FDA and the DEA to also provide the drug, since it needs to be stored and distributed appropriately.

Senator BIDEN. And how many such distribution sites are there in Delaware?

Ms. ALLSHOUSE. There are only two in Delaware, Brandywine Counseling in New Castle County, and as you can see, we have over 700 addicts in treatment just in that particular program, and also there is one in Kent County run by Peg McMullen, Kent County Counseling, which I know has over 60 individuals.

Senator BIDEN. Have you noticed any change in the profile of those seeking help from you, not court assigned, but just spontaneously seeking help?

Ms. ALLSHOUSE. Yes, sir. Most of the people who come for admission are younger now. Methadone programs, they used to say they were aging out. People were 35, 40, 50 years old. Now, we are getting people younger, a lot of younger white young ladies, which brings another whole problem into drug treatment, which is pregnancy. We also have a pregnancy program, and that is being stretched to its limits, also, because when you deal with a younger population, you are also dealing with other problems associated with that.

Senator BIDEN. In the report that I have updated here, this heroin report, and it is the second one, I mean, I did this 6 years ago and I think you are familiar with that——

Ms. ALLSHOUSE. I am.

Senator BIDEN [continuing]. One of the things that I call for is for drug addiction, generally, for adults, is that there either be treatment or prison, and then treatment in prison if there is prison. What I hear from my critics is that—I mean, personally, my critics, those who criticize that position, is the following. Without enforcement, without the threat of a sentence over the head of an individual, no one seeks treatment. Is that true in your experience?

Ms. ALLSHOUSE. No. That is why I brought these slides. Those people waiting outside, camping outside our doors, are not sent by the law. In fact, that is a real misconception about heroin addiction. Most of the people in my program, heroin addicts, do not really have long criminal records. Most of the crimes they commit early on in their addiction have to do with against their families, stealing checks, taking credit cards, also shoplifting, also prostitution, and those crimes really do not end you up in jail, and a lot of times, heroin addicts have to go way down in their addiction in order to end up in the prison setting.

I think there should be treatment in prison, but we need to intervene early in these lives, and so by including things like shoplifting and prostitution in the drug courts, we would be able to intervene earlier on in the addiction process. Those people had no courts over them to get admitted. They were waiting. They want to come to the programs.

Senator BIDEN. Now, my experience nationally has been, regardless of which jurisdiction I am in, that there are always a heck of a lot fewer treatment slots than people who literally are raising their hand and saying, I am not arrested yet, I am not being sent anywhere, I need help, and literally knocking on somebody's door. I thought it was a pretty graphic slide, two young kids, they look like they were high school, college-age kids, sleeping outside the door to get inside.

What we have to do across the Nation is we turn these folks out, and I do not know what the hell we expect them to do. I mean, we are going to turn them away and they are going to say, oh, well, no problem. I am going to just say no today. I am not going to rob anybody. I am not going to burglarize anything. I am not going to steal Dad's credit card. I am not going to hock the family jewels. I am not going to do any of that. It is beyond me. I do not quite get it, except I think I really do get it.

Ms. ALLSHOUSE. Senator, if you had a disease and you had to sit outside your doctor's office at 5:30 in the morning in order to get an appointment, you would think something is wrong, and that is just what we are doing.

Senator BIDEN. Well, the difference here is, that I have found, since I have worked in this not as intensely as you, but for 2 years longer than you have been doing it, is that I, and I get in trouble—I get in trouble a lot, but I get in trouble for saying this, as well. As part of our sort of puritan ethic, which is not a bad thing, this idea that if you are ill, if you get cancer, you did not do anything to get the cancer, so society rallies around and says, we will try, we will try to help, although we are not doing a very good job of that in terms of access to medical care and insured medical care.

But my experience has been, and I would like you to comment on this, that there is this piece that this is a self-inflicted wound. Somebody by their own volition at some point picked up the first bag of this and used it. Therefore, there is this reaction, I find, across the social spectrum, white, black, Hispanic, Asian, rich, poor, men, women, liberal, conservative. It is, hey, look, do not make me pay to get them well when they did this to themselves. I have no obligation to deal with that. What is your response to that?

Ms. ALLSHOUSE. Well, you know, we pour a lot of money into cancer research and a lot of people pick up cigarettes and we still pay for that. We treat people for cancer and they might relapse. We continue treating them. We have heart disease in this country and people do not do the exercise, they do not eat correctly, but we still treat them. Relapse in all other diseases is acceptable.

For some reason, we have chosen this disease to have some sort of stigma associated and it needs to stop because we are losing too many children.

Senator BIDEN. One last question I have for you. I believe that people would be more inclined to support my initiatives in the Congress and other places if they believed that "treatment works." In other words, we hear the phrase, "treatment works," but I think the average person, based on some experience, some observation—Ms. Allen, your daughter was in treatment a number of times, and——

Ms. ALLEN. But she was never there long enough.

Senator BIDEN. Right. Well, that is what I want to get at. There is the notion abroad that treatment does not work and the most often criticized aspect of my—I mean, the good and bad news is that I am most associated with the drug problem and drug strategies of anyone in the Congress because I have been doing it so long. It does not make me right, I have just been doing it so long.

The letters, the comments, whether it is from the community, from the press, from anyone, is that, Biden, you keep pushing this notion of treatment, but it does not work. How do you define a success at Brandywine Counseling and Treatment? What constitutes a success?

Ms. ALLSHOUSE. I would say the majority of my staff that works for me are recovering staff and they are a success. But every day an addict is not out committing a crime, hurting themselves, hurting their family, is a success.

I would say again to you that we would not, because someone relapsed from another disease, deny them access to treatment, and this, again, is a chronic relapsing disease. Every research has shown, the longer you stay in treatment, the more successful you are going to be in staying off drugs. So the longer we keep addicts into treatment by any means, whether it is residential, outpatient, drug-free, drug detox, whatever, the longer we can hold onto them, the more they are going to be successful, and yes, they are going to relapse.

Senator BIDEN. That is the key. I think one of the things that sometimes I also get criticized for is I say that we have to redefine what we mean by success.

Ms. ALLSHOUSE. Right.

Senator BIDEN. For example, if we shut down every high school in America that had a graduation rate less than 100 percent, we would shut down almost every high school in America, literally. If we shut down every high school in certain minority communities in major cities that had a graduation rate less than 60 percent, we would shut down a majority of the high schools in all of those areas, in minority areas. We would shut them all down.

We do not have the same standard of what constitutes success for baseball teams, football teams, high schools, military spending,

about anything you can think of, as we do on the treatment side. But I think part of the reason is, we tend—not you—we tend to oversell treatment as what we mean by success.

If my numbers are correct, and I have been doing more foreign policy these days in my responsibility than I have been the author of these initiatives, but if my recollection is correct, the average addict in America addicted to whatever substance, it could be cocaine, it could be heroin, it could be any number of hallucinogenics, any number of drugs, they commit, on average, 171 felonies a year, because most are not born millionaires. Most are not born owning a bank. Yet if you have that same person in treatment for 6 months, what you have done is you have cut the number of crimes they have committed in half.

Ms. ALLSHOUSE. Right.

Senator BIDEN. So there is a social value, and it is cheaper. It is cheaper.

Ms. ALLSHOUSE. Much cheaper.

Senator BIDEN. I think we have got to—or I have got to figure out a way to be more articulate in terms of communicating to people what the genuine benefit, the immediate benefit of treating someone who they believe it is their fault that the reason they got there, and more explicitly, immediately and clearly their fault in the minds of the vast majority of Americans, and I think they think that with good reason.

Maria, you and I have known each other a long time. I am a big fan of yours, as you well know. One of the things I like about what, as you pointed out so nicely in an occasion not so long ago, although I am not a co-founder, I am basically a co-founder of the Latin American Community Center. We go back a long way. I can remember when you only had a little row house and not much else. You have expanded greatly.

I think one of the reasons for your success is, you are also street smart. You understand what people mean and what they are saying. What are kids saying? This is what I was trying to get at, and maybe Sergeant Hernandez can get into this again. What is the deal in the school yard, in the parked car at 11:30 at night, in the locker, in the places where kids congregate? What do they talk about when they talk about heroin? How do they talk about it? Do they talk about it like they talk about marijuana?

I go to high schools all up and down this State. One of the disturbing things, and I have talked about this with Mrs. Aiken, whether it is a fine private school, an expensive private school like Tower Hill or Archmere, Catholic or nonsectarian, or whether it is a local public school, a small one like Del Mar, or a big one like any number of the large high schools in the State, I ask them about marijuana. One of the disturbing things that has happened in the last 15 years, and I have been doing this a long time, I asked them if it is dangerous. Most of them do not think it is dangerous.

Now, 15 years ago, you asked that question, we went through a period where they raised their hand and said, yes, it is dangerous. It was accepted that it is a dangerous thing. Today, it is not.

What do kids say when you say heroin? In our generation, and I was still on a college campus in 1968 when the drug epidemic was real there, and you say heroin, they go, oh, man, heroin, man,

that is bad stuff. But if you said marijuana, if you said doing a line of coke, if you said, with these same people who were in a drug culture, they would say, I can handle that. But today, what are they saying about heroin? How are they talking about it?

Ms. MATOS. It is da bomb.

Senator BIDEN. It is da bomb. I know the phrase, but explain what you mean by they say it is da bomb.

Ms. MATOS. It makes you higher faster. I mean, it is faster.

Senator BIDEN. But do they look at it in terms of—do they have a sense of the gravity of it? I am sure—I should not say I am sure.

Sergeant HERNANDEZ. Senator.

Senator BIDEN. Yes.

Sergeant HERNANDEZ. If I may, it all depends on their knowledge base. If they have not been equipped with that knowledge of how dangerous this drug is, they are likely to be drawn to it, again, by their friends, in a context that you should try this. This is the greatest stuff. If they are not equipped with that knowledge, what we have found, once they have seen the Heroin Alert Program, they walk away from it saying, I did not know.

Senator BIDEN. What I am trying to get at is, I am trying to make your case for you. What do they say before they see the program? If you said to kids in high school today, if you walked up—if I were a 16-year-old kid and I walked into any of the high schools that I went to, any one, and I said, man, I tell you what, I got the greatest high last night. I got this hypodermic right here. All I have got to do is give you a shot, man.

Ninety percent—99 percent of the kids, unless they are already addicted to something else, would go, whoa, wait, keep that thing in your pocket, man. I do not want any part of that. I do not know anyplace anyone has ever testified that kids do not understand that when you stick a needle in your vein, that is something bad. That is worse.

Sergeant HERNANDEZ. That is not the process, though.

Senator BIDEN. No, I know it is not. That is what I am trying to get at.

Ms. MATOS. Senator, here is what I am going to do for you.

Senator BIDEN. Talk to me like it is a street.

Ms. MATOS. Here is what I am going to do. I am going to go back and I am going to ask the kids and then I am going to send it to you in writing. I am going to go back and ask the kids, just like I asked them how available it is.

Senator BIDEN. Let me tell you what they tell me, because I go around and I ask, and I would like your response. Let me tell you what they tell me. They tell me that doing this is not a big deal. I can handle this. There is nothing to this. It is like back in the 1920's, they used to have a phrase called "chasing the dragon." Do you know what "chasing the dragon" means? We are only about 60 years behind. It was they would smoke, these rings of smoke, and they would follow the smoke, and it was heroin they were smoking because it used to be real pure. It is no problem, man. This is not like that crack crap.

Ms. MATOS. Exactly. That is——

Senator BIDEN. This crack stuff, man, I have got that figured out. You use that, you never get back. That is all this stuff. But this,

this is no big deal. I wish some of the students out there who experienced it would tell me how they talked about it before they used it—before they used it—because somehow, that is the reason why I think your program is so important.

The only problem I have with the program, and I am going to yield to Ms. Allen here because she wants to say something, I think—the only problem I have with some of the education programs, and I have none with yours, is whether or not they are real, whether or not they get to these kids. I mean, you can get up there and all the adults can get up and talk all they want about drugs and drug use, and there are certain things like seeing that video, Lieutenant. That would get their attention, in my view.

I am an old man now, I am not a kid anymore, but part of the problem is that when we do all these education programs that keep kids away from bad things, whether it is drugs or other things, it is like, get a life, will you? You are adults. You are not talking—I mean, we have to figure out what they are saying, what they think, before we can figure out how to deal with it.

I have not been very convinced, and maybe because I am getting hoarse hollering about this issue. I have been hollering about this issue for 5 years. By the way, when I first brought this up, none of the police agencies in the State—I had a meeting with you all; you all yawned. We met down at Buena Vista. It was, like, OK. Joe has got another warning. Here we go. This is it.

I talked to the school administrators. Heroin? Oh, come on, heroin. Marijuana, cocaine, yes; heroin, no. So these guys have figured out a way to package, man. They give it a name. It is cheap—cheap to start with, and it is real easy. You either snort it or you smoke it, but you do not have to stick it in your vein. Now, they all want to stick it in their vein once they get addicted because that is quicker, that is higher, it is faster.

But you all are talking like adults to me. Maybe that is because you are adults. Maybe I should have young kids here.

Sergeant HERNANDEZ. We do have some youths that I have been asked to recognize. If I may, we have a peer group of these young folks who are here.

Senator BIDEN. Why do you not introduce them?

Sergeant HERNANDEZ. There are here to change the world. That is what they are here to do.

Senator BIDEN. Why do you not stand up. [Applause.]

Let me ask you a question, and you do not even have to identify yourself. Let me ask you a question. The first time you were around somebody—first of all, is heroin the first drug you used?

Male FLOOR SPEAKER. No.

Senator BIDEN. How many people do you know, their first introduction to a drug is heroin?

Male FLOOR SPEAKER. Nobody.

Female FLOOR SPEAKER. None.

Senator BIDEN. Nobody? So you think that, or your experience is that the heroin users that you are associated with all came with a bit of sophistication to the process. They had either used coke or methamphetamines or something. What is the experience of the drug most often used before heroin in your circles?

Male FLOOR SPEAKER. Marijuana.

Female FLOOR SPEAKER. Marijuana.

Senator BIDEN. Marijuana? Now, why marijuana to heroin? Why not marijuana to coke?

Male FLOOR SPEAKER. From my experience, it goes both ways.

Female FLOOR SPEAKER. Right. Yes. If they go from marijuana to cocaine, then usually, like in my experience, they need the heroin to come down from the high of cocaine.

Senator BIDEN. Is that the old parachute? The way crack cocaine was being marketed, it got real sophisticated. You get that immediate high, but you lace it with heroin so that you come down slower.

Female FLOOR SPEAKER. Right.

Senator BIDEN. How many totally brand new, in any of your experience, the two young people or any of you at the table, how many of you experienced the circumstance and could tell me about it where a kid just flat out, first time out, after being drunk or whatever or just straight, and tries heroin for the first time? Any experience with that? Mom, what was your experience with your daughter? How did she talk to you about how she got introduced?

Ms. ALLEN. She told me that the first time she was attending an AA meeting.

Senator BIDEN. Attending an AA meeting?

Ms. ALLEN. Someone offered it to her and she did it, and she snorted it.

Senator BIDEN. All right. How long, kids, and I am calling you kids because I do not want to identify you, young people, how long after snorting—I assume you started by snorting heroin as opposed to injection, right?

Female FLOOR SPEAKER. Right.

Senator BIDEN. What is your experience of watching your friends and acquaintances? How long before they start to mainline it?

Male FLOOR SPEAKER. For me personally, it was about 1½ years after I smoked it.

Senator BIDEN. About 1½ years after?

Male FLOOR SPEAKER. About 1½ years after smoking, I started injecting, because I found out—I mean, it would have started me off cheaper to go back and start shooting, for the quicker high and the immediate high, instead of spending the $130 a day, where the sniffing just to feel normal again, I decided I am just going to start shooting and pay $10 and $20 a day and get that same effect.

Senator BIDEN. So it was the economics of it that sent you that way?

Female FLOOR SPEAKER. Yes.

Ms. ALLSHOUSE. They are not stupid.

Senator BIDEN. No. By the way, I asked one of the leading experts in drug addiction in 1981, I asked one of the leading guys in the world on drug addiction, what makes somebody use drugs in the first instance? Is there any common denominator? Do you know what they said? They said, they tend to be the kids who are the brightest. They tend to be the kids who are most inclined to take risk. They tend to be the kids who, when they were 4 years old, you said, do not cross the street, and they said, OK, fine, and get out there and decided they are going to cross the street. It is an amazing phenomenon. So I have no doubt they are not dumb.

Ms. ALLSHOUSE. But, you know, Senator, what they said, I think, is also true, that a lot of people who were using cocaine have switched to heroin, and when the DEA was here and talked about combining the markets, that is when I think our program really saw an increase, because you could do one-stop shopping then. It was not someone else selling heroin and someone else selling cocaine. They learned to market that to younger kids, then.

Sergeant HERNANDEZ. Senator, some of the cocaine users have indicated to us that the programs that they have been introduced to heroin, as you heard already, to soften the crash of crack cocaine, and as a result, now they are heroin addicts. One young lady, in particular, I recall, she said, it kicked me in the rear end. It is not what I wanted.

Senator BIDEN. One of the things we have known for a long time is that there is a market for—and the reason why I predicted 10 years ago they would double market this stuff—is that there is a market for, just if you look how they started to lace crack, so that the down would not be so devastating, the paranoia would be impacted on, and so on.

The reason I ask this question, my last question, because I promised I would get everybody out of here by 1 o'clock, if, in fact, this little bag, if we knew, 90 percent or 95 percent or 100 percent of the time were used by someone only after they had already been consuming a dangerous and controlled substance, then with all due respect, the program is not very effective.

Let me get right to it, cut to the chase here. I do not mean to be critical of any program. I do not know enough about the program to tell you whether it is effective or not, because if you sit with somebody who is already hooked on coke and you tell them, this is going to be a very bad thing for you, and you tell them all the dangers of heroin, they are going to, the way the mind works, anyone's mind, say, hey, man. I am already strung out on coke. Do not give me a lecture on this is bad for me. I have already figured out what is bad. I am strung out on coke. At least this way, it can give me the kind of lasting effect that I want, does not bring me down with such a crash.

On the other hand, if, in fact, kids are using this stuff for the first time, if this becomes, you do not need a gateway beyond marijuana, it is just here, marijuana to here, then you have got a different deal. Then you have got a different deal in terms of what you sell.

One of the things that I cannot afford, to be honest with you, as being the guy most out front in this for so long, is I have got to make sure what I am supporting works or I lose my constituency. That is, taxpayers are willing to come up and pay for a Biden crime bill that provides, or a drug program that provides billions of dollars. And so that is why I want to know, I want to know how you get here the first time. If the first time you get here is after you are already addicted, then it is a different kind of program.

You wanted to say something?

Female FLOOR SPEAKER. Back to when you were saying how they treat cancer and all of those diseases, well, addiction starts before anybody even picks up the drug. Most heroin addicts do not know

when their addiction started until they are in recovery. Addiction starts long before you actually pick up the drug.

Senator BIDEN. Unfortunately, the medical science does not sustain that. That is part of the problem. So that is the assumption addicts make and that is the assumption many in the field make, but there is not hard data to sustain that.

Female FLOOR SPEAKER. That is why you need us up on this table, rather than them.

Senator BIDEN. Yes.

Male FLOOR SPEAKER. Like she was just saying, the chances of that happening, about you telling somebody else about that, the reason they are not going to listen to you is because, 99 percent of the time, you have not been there, unlike us, who have been there and who have experienced this, because they would rather hear it coming from somebody our age, which is their age, telling them, I have been there. I know what is going to happen to you. It is different from somebody given your age who has never been there, with only textbook knowledge.

Senator BIDEN. I do not disagree with that assumption. I do not disagree with that assumption.

Ms. MATOS. Senator.

Senator BIDEN. Yes.

Ms. MATOS. Sobert Silagy, who is the subdirector of Hogar Crea, is here. Maybe you can ask him.

Senator BIDEN. Where is he?

Ms. MATOS. Is he still here?

Mr. SILAGY. Yes. How are you doing? My name is Robert Silagy.

Senator BIDEN. Robert, how many folks come to you after having been just introduced with this little bag and end up being addicted? They say, look, the first drug other than marijuana I tried was heroin.

Mr. SILAGY. I think, realistically, everybody starts with the least effective drugs and works their way up to harder drugs, except maybe in Puerto Rico, because where our program is founded from in Puerto Rico, it seems that heroin usage down there starts at such a young age, I would think that there are people there that jumped right into heroin without trying anything else.

But for the most part, in the United States, I think that most of the people grew up with the knowledge that they just do things for experimentation, but it goes a little further than they want it to and they find themselves stuck somewhere that they cannot get out of.

Senator BIDEN. One of the things, again, medical science has indicated, based on all the reports I have read and, like I said, a little bit of knowledge with a legal background, not a medical background—it is dangerous, but I have been doing this for so long—one of the things I have found is that a significant number of people who try heroin for the first time, it does not work on them. They get sick. So that is why, up to now, particularly before it became so pure, it was not something as many people stuck with.

I will not tell you the analogy that Dr. Klieber and others who are leaders in the field have used, but it is a little like trying something for the first time in the back seat of a car in some lousy cir-

cumstance and not getting much pleasure from it and doing it and getting much pleasure from it.

One thing that brings you back is peer pressure. The other thing that brings you back is the pure joy of it, and there is not a lot of, for the first time, pure joy, especially when folks were mainlining heroin, especially when purities were way down.

So what we have got to figure out is what the dynamic has changed in terms of the purity being up, the impact upon use, and whether or not this is a case of first instance, because if these folks are right, Marie, and I think they are, the students, the young people as well as all of you, that it is not a gateway drug, it is the drug that you work your way up to, then there are a whole lot of signs that come before we get to this and we have got a chance of getting a lot of people off of this beforehand, as opposed to what I have been hearing up until now.

I have been hearing, and students tell me, literally in the high schools when I go around, that they have seen people who have never used drugs after getting drunk and hanging out trying this. It is no big thing, a little bit like the first time somebody tries a hallucinogenic drug. You do not have to already be addicted to anything to try a hallucinogenic. That is not the experience. It is not automatic. You do not have to be strung out on anything. It is the dare. It is the time. It is the moment. It is told you can control it. It is told it is a one-time effect, and so on and so forth.

So one of the things that is important for parents to know is whether or not the first thing they are going to find is one of these little blue bags, these plastic bags, or the first thing they are going to find is paraphernalia for smoking marijuana, to give some guidance to parents. If, in fact, this is in the vast majority of time only after being a habitual user of marijuana, or only after being on some other drug, then what you have got to do, with all due respect, is spend your time in the schools talking about those other drugs and what it leads to, as opposed to talking about what this effect is alone.

Yes.

Mr. PRICKETT. Senator, I am William Prickett.

Senator BIDEN. I know who you are, Bill. I used to work for you.

Mr. PRICKETT. Your memory is wrong. Let me say briefly, thank you for these hearings today. They are very meaningful. You have the cream of the enforcement group, Federal and State, here, and you have the cream of the treatment people. What you do not have is what Senator Specter referred to, that is, the leadership of this community. Where are the church leaders? Where are the industry leaders?

Sergeant HERNANDEZ. They are here. They are here.

Mr. PRICKETT. Some, but not all. And your message, Senator, should be much wider, because, as Senator Specter said, the societal response has not been adequate to the peril that we face from drugs. There is not one family in Delaware that does not have a member or a friend who has not either been devastated or threatened by drugs.

So I appreciate what you have done and told all of us. What I suggest, the most important thing is to get the forces of the com-

munity as well-educated and as dedicated to the problem as is warranted. Thank you.

Senator BIDEN. Thank you.

Would any of you like to make a closing comment? It is now 1 o'clock.

Ms. MATOS. I would like to say something, Senator, that while you have treatment on your mind and treatment works, we also have to remember not to give up on prevention, because we want to prevent it. We want to prevent the alcohol and then the drugs and the tobacco before it starts. So remember prevention, because prevention also works.

Senator BIDEN. As you well know, and I will just state the obvious, the purpose of this hearing was to focus on one drug, one time. I am the author of that prevention bill that calls for spending $10 billion on prevention, as well as the treatment side of it, as well as the medical side of it, because unless we can figure out how to treat these diseases of the brain better than we are now and prevent them as well as treat them, this is a problem that is just going to be the drug of the week, the drug of choice. We will be back in 5 years and we will be rediscovering crack cocaine, or 10 years.

Ms. Allen, do you have any comment you would like to make?

Ms. ALLEN. Yes; I just wanted to say one thing. For the young people, the parents know this, that they should never give up on their young people that are addicted, but another thing is, I do not want them to give up on us for our efforts.

Senator BIDEN. Thank you.

Gentlemen, any comment?

Again, I thank you all very much. I can hang here a little bit for those who want to talk to me, but I thank you all very, very much for your time and your effort and we are adjourned.

[Whereupon, at 1:06 p.m., the subcommittee was adjourned.]

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