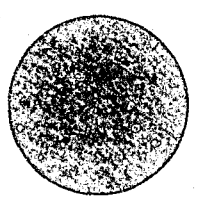


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96TH CONGRESS } HOUSE OF REPRESENTATIVES
2d Session

INCREASED HEROIN SUPPLY AND DE-
CREASED FEDERAL FUNDS: IMPACT ON
ENFORCEMENT, PREVENTION, AND
TREATMENT

A REPORT

OF THE

SELECT COMMITTEE ON NARCOTICS
ABUSE AND CONTROL

NINETY-SIXTH CONGRESS

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I. INTRODUCTION

The Drug Enforcement Administration (DEA) estimates that the 1979 opium production from the Southwest Asian nations of Iran, Afghanistan, and Pakistan totaled 1,600 metric tons. While most of this opium crop will be consumed in the countries of origin, much of the heroin produced from this crop will find its way into the international market to surface on the streets of Western Europe and the United States. In recent testimony before the Subcommittee on Health and Environment, Peter B. Bensinger, Administrator of the Drug Enforcement Administration, testified that in special street-level buy operations in 1979 in Harlem and the Lower East Side of New York City, 42 percent and 60 percent of the respective heroin exhibits were identified as "European/Near Eastern" or "Middle Eastern" heroin.

The New York State Division of Substance Abuse Services reported that from December 1978 to December 1979, heroin-related emergency room overdoses increased by 89 percent. Heroin overdose deaths also increased. Readmissions to methadone treatment facilities for the first three quarters of 1979 showed a marked increase over the same period in 1978. In many areas of the United States, heroin is reportedly easy to obtain, of high quality, and relatively inexpensive.

At the same time that Southwest Asian heroin is becoming more available in the United States, the President's revised budget proposes to eliminate the State formula grant mechanism that would amount to a \$40 million reduction for drug abuse and addiction services.

Additionally, Congress amended section 410 of the Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255, 21 U.S.C. 1177) to set aside 7 percent of Community Assistance funds for use in prevention and education activities in drug abuse (the allocation increases to 10 percent in fiscal year 1981).

The Select Committee held a hearing in New York City on May 2, 1980, to assess the extent of the influx of Southwest Asian heroin into the United States and to evaluate how the proposed funding cuts and re-allocations will affect the ability of treatment and prevention agencies to provide needed services to a growing population of drug abusers, addicts, and the at-risk population.

The Committee received testimony from representatives of Federal, State, and local law enforcement agencies, the National Institute on Drug Abuse and State and private treatment and prevention agencies.

II. LAW ENFORCEMENT

The morning session of the hearing centered on the following issues: (1) a review of the intelligence information of the Drug Enforcement Administration (DEA) and other enforcement agencies regarding the increasing availability of heroin produced from Southwest Asian opium; (2) the efforts that law enforcement agencies have implemented or will implement to combat the threat posed by Southwest Asian heroin; and (3) how the increased availability of heroin will affect the ability of both the law enforcement agencies and criminal justice system in New York City to function adequately in light of restricted Federal, State, and local resources. The Select Committee received testimony on these issues from two panels of witnesses. The first panel consisted of the following representatives of the law enforcement community: W. Gordon Fink, Assistant Administrator for Intelligence of the DEA; John W. Fallon, Regional Director of the DEA for the northeastern region; Deputy Chief Charles H. Kelly, commanding officer of the Narcotics Division of the New York City Police Department; and Dr. Elliott M. Gross, Chief Medical Examiner of the city of New York. The second panel consisted of the following representatives of the criminal justice system: Robert M. Morgenthau, District Attorney of New York City; Sterling Johnson, Jr., Special Narcotics Prosecutor for New York City; and James A. Moss, Assistant United States Attorney for the Southern District of New York.

A. BACKGROUND

Since 1976, major indicators used to track heroin availability in the United States have reflected a downward trend. According to the DEA heroin purity fell from 6.6 percent to 3.5 percent, before turning slightly upward to 3.8 percent in the last quarter of 1979. Additionally, the price of heroin per milligram rose from \$1.26 in 1976 to \$2.29 in 1979. Medical examiner and emergency room reports collected from the 24 metropolitan areas participating in the Drug Abuse Warning Network (DAWN) show approximately 35 heroin related deaths per month, compared to 150 deaths per month reported in 1976. Finally, the estimated amount of heroin imported into the United States has declined steadily in the past 3 years. The DEA attributes this decreasing availability to several factors including poppy eradication efforts of the Governments of Mexico and Southeast Asia, which currently are the major suppliers of heroin to the United States, severe droughts in both areas, and increased enforcement activities in the United States. Together these efforts have brought the United States to its lowest heroin abuse rate in the past 10 years. In 1979, the estimated addict population was less than 400,000, a decline of 300,000 from 1972 levels.

(2)

At the same time heroin availability from Mexico and Southeast Asia has decreased, opium production from Southwest Asia has risen dramatically. In 1979, the DEA estimated that Iran, Afghanistan, and Pakistan together produced 1,600 metric tons of opium. This represents a twofold increase from 1978 levels. Although Western Europe, the traditional market for heroin produced from the region, has been able to absorb most of the increased heroin production, intelligence sources indicate that Europe is quickly reaching the saturation point and traffickers have been enticed to find importation routes in the United States to sell the excess.

B. SUMMARY OF TESTIMONY

1. LAW ENFORCEMENT—FEDERAL AND LOCAL

The Select Committee received testimony from W. Gordon Fink, DEA's Assistant Administrator for Intelligence who explained that by the end of 1978 there was a decrease in the estimated amount of heroin smuggled into the United States. In 1975, the DEA estimated that approximately 7.5 metric tons of pure heroin had been imported. However, by the end of 1978, the estimated amount imported had fallen to 4 metric tons. The DEA attributes the declining availability of heroin to the successful efforts of Mexico and Southeast Asia, the principal sources of heroin imported into the United States, in achieving lower production levels through herbicidal eradication efforts in Mexico, to specific law enforcement initiatives in Thailand, and to adverse weather conditions in both Southeast Asia and Mexico.

The successes made in Mexico and Southeast Asia will be nullified if a significant portion of the heroin that DEA predicts is available for export from Southwest Asia reaches illicit markets in the United States. Mr. Fink described in detail how opium cultivation in three of the countries comprising Southwest Asia has increased dramatically in the past three years.

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

* * * In the next country, Iran, we have seen an increase of cultivation from 200 tons to now over 600 tons per year.

* * * And prior to 1978, we did not consider Iran an important country because that government had a program, an opium maintenance program, which provided opium to the addicts within the country. But now with controls that have been eliminated, we do see not only opium produced there, but laboratory activity in Iran * * *.

The amount of opium gum produced in the three countries totaled 1,600 metric tons. Of this amount, approximately two-thirds of the gum and heroin hydrochloride are consumed in the producing countries or surrounding regions, leaving 40 to 60 tons of heroin hydro-

chloride available for export to Europe and the United States. The estimated quantity of heroin available for export is significant because only 2 to 3 tons of heroin, smuggled annually into the United States from Turkey, produced the prodigious demand for the drug resulting in a heroin addiction population of over 700,000. Similarly, during the height of the Mexican connection, the estimated quantity of heroin reaching this country totaled only 7 tons.

Mr. Fink emphasized that the increased opium production in Southwest Asia has already created a "problem of epidemic proportions" in Europe. According to Mr. Fink, West Germany was inundated with high-quality Southwest Asian heroin by mid-1978. The problem has spread to other West European markets which previously had been outlets for Southeast Asian heroin. European governments have attempted to control the narcotics addiction problem, but the situation continues to deteriorate. Mr. Fink stated:

Throughout 1979, Western Europe absorbed the majority of the increased Southwest Asian heroin production. Heroin related overdose deaths in Italy and West Germany in 1979, for example, ran considerably ahead of those in this country. The heroin picture in Western Europe is still not good. Seizures of Southwest Asian-sourced opiates since January 1980 (including heroin and morphine base) have already surpassed comparable levels for this same time last year. Other indicators are of concern. In West Germany, street-level heroin purity is currently between 20 and 40 percent and prices in some European cities have dropped to as low as \$25,000-\$35,000 per kilogram. According to our latest figures, that same kilogram would sell for about *six times* as much in New York City.

In assessing whether Southwest Asian heroin is impacting on heroin availability in the United States, DEA relies on several national indicators, including heroin-related seizures in which the source is identified, analyses of the purity of heroin, and data reported on the number of heroin-related emergency room injuries and deaths. According to Mr. Fink the "national indicators are now showing an increase in heroin availability." For example, purity of heroin has risen from a low of 3.5 percent to 3.8 percent by December of 1979. Although not dramatic, this increase reflects the first upswing in purity levels in 3 to 4 years.

DEA attributes most of the increasing availability of heroin to the dramatic rise in opium production in Southwest Asia which is supported by recent investigations involving seizures. Mr. Fink stated:

Over the past two years there have been increasing numbers of seizures of Southwest Asian heroin investigations in the United States. During 1977 and 1978, relatively small quantities of Southwest Asian heroin were available, primarily in New York and Washington, D.C. In 1979 and 1980, purchases of Southwest Asian heroin have been made in Chicago, Detroit, San Francisco and Los Angeles.

Recently, two unrelated seizures of significant quantities were made on the same day in Washington, D.C. and in Texas. In both cases, the seizure involved three kilograms of high purity Southwest Asian heroin. Seizure of about 9 kilograms of heroin by U.S. Customs in August 1979 and a later related investigation of DEA led to the seizure of 41 kilograms of heroin in March 1980 by the Italian authorities in Milan. Yugoslavian officials recently seized 80 kilograms of heroin at their border. Seizures of heroin in this quantity and purity have not been experienced in several years.

Despite the number of heroin seizures made in various parts of the Nation, Mr. Fink stressed that the indicators suggest that heroin is much more readily available on the East Coast, especially in New York City which is the major importation center for heroin. The purity of

heroin at the retail level has risen from an average of 2.8 percent to 3.7 percent in the past year. At the same time, heroin-related injuries have risen 26 percent. Other indicators, including increasing heroin treatment admissions, retail pharmacy thefts, admissions to treatment programs for heroin substitutes, and overdose injuries and deaths related to heroin all point to a rise in heroin availability on the East Coast.

John W. Fallon, the DEA Regional Director for the northeast region, confirmed Mr. Fink's testimony regarding the increasing availability of heroin in New York City by providing the Select Committee with data on (1) the average purity and price of heroin at the retail and wholesale levels; (2) the number of heroin seizures made; and (3) emergency room injuries and deaths relating to heroin. According to Mr. Fallon:

The average purity of the heroin available to the retail-level consumer has increased during the past year in New York City. The purity of heroin encountered at the wholesale level of the traffic has also increased. DEA laboratory statistics for the New York area show not only an increase in the number of heroin exhibits analyzed, but also higher purities than the same period last year. During the first quarter of 1979, there were few exhibits with purity in excess of 20 percent. Now, during the first quarter of 1980, laboratory analyses are showing numerous heroin purities between 20 and 90 percent. According to the New York City Police Department laboratory which monitors retail purity, the street-level purity of heroin was 2.15 and 2.2 in January and February 1979, respectively. The average retail purity for the same two months in 1980 skyrocketed to 5.06 percent and 8.36 percent.

Mr. Fallon explained that the price of heroin at the retail level rarely rises during times of increasing availability. Instead, "the customer receives better quality heroin for his money." However, at the wholesale level, the price of heroin has risen dramatically. A kilogram of high grade heroin now costs as much as \$350,000.

Recent seizures of heroin in the New York City metropolitan area also support the findings of the DEA. In his prepared testimony, Mr. Fallon described "Operation Monitor" which was initiated to determine the price, purity, packaging and diluents of heroin available in certain geographic areas of New York and the place of origin of the heroin seized.

Monitor-I was conducted in the Harlem area during June and July, 1979. The average purity of the heroin was 3 percent. We believe that this was due to the tightly-knit drug distribution networks operating in the Harlem area. However, the significant finding of Monitor-I was that 42 percent of the exhibits collected originated from opium produced in the area of Southwest Asia. The remaining exhibits originated from opium produced in Southeast Asia.

Operation Monitor-II was conducted in the lower east side area of New York City in September and October, 1979. This area has a high visibility of illicit street level activity. The purity of the heroin procured here was 8.5 percent. Significantly, 60 percent of the exhibits originated from opium produced in Southwest Asia.

The third set of indicators which Mr. Fallon referred to, show that heroin is more readily available in New York City, was the rate of overdose deaths and emergency room injuries recorded by DAWN. During the last quarter of 1979, there were 225 heroin-related emergency room injuries in New York City. This compares with 96 injuries for the same period in 1978. According to Mr. Fallon, the number of heroin-related deaths has also increased. Mr. Fallon explained "The Medical Examiner's Office of the City of New York feeds data

to DAWN. Their records show an increase in drug-related deaths. In 1978, there were 248 while in 1979, the figure rose to 439."

However, the figures reported by Mr. Fallon could not be substantiated by Dr. Elliott M. Gross, Chief Medical Examiner, for New York City, who testified that to the best of his knowledge no data has been reported to DAWN regarding deaths due to heroin by the Chief Medical Examiner in the past 18 months. Additionally, Dr. Gross asserted "Statistics on heroin and heroin-related deaths have not been issued by the Office of the Chief Medical Examiner of the City of New York since the early 1970's." The last report issued by the Medical Examiner was in 1974. The Medical Examiner does provide the DEA with raw data to make its own assessment of the number of drug-related deaths.

When asked by Mr. Gilman to explain why the statistics had not been issued, despite a statutory mandate to do so, Dr. Gross responded that the primary reason was that the office does not have a statistician to critically analyze the data on drug-related deaths. The New York State Department of Health does issue reports based on death certificates filed with the Department that reflect acute narcotism or acute intravenous narcotism as the cause of death. However, Dr. Gross asserted that there are more drug-related deaths than the certificates suggest "because the chemical analyses upon which the ultimate determination is made may not be computed until a later time, and never gets into those death certificates, and into that data."

At the request of the Select Committee, DEA examined the Standard Metropolitan Statistical Areas (SMSA) Medical Examiner reporting profiles to determine how current the data on drug-related deaths reported to DAWN is (see Appendix A). The information also includes the lag time of the data which is a combination of the number of months that SMSA Medical Examiner's continue to update previous months data and the one month required to process the data and deliver it to DEA. The report shows that the data for New York City is current only through July of 1979 and that the lag time is 8 to 11 months.

Because statistics on heroin-related deaths are fundamental to establishing nationwide trends on availability and abuse, Mr. Gilman questioned the validity of all of the data of the 24 metropolitan areas reporting to DAWN. Mr. Gilman stressed the importance of New York City in providing accurate data to the Network. Dr. Gross testified that the city would have to provide the Medical Examiner with a statistician at an annual cost of \$30,000 before the information currently reported could be certified as accurate. Further, Dr. Gross asserted that he has made a formal request for a statistician, but the request has not yet been granted.

The Select Committee queried the DEA representatives on the initiatives taken to ensure that the threat posed by Southwest Asian heroin is effectively countered. Mr. Fink described the following national initiatives implemented or about to be implemented at the Federal level:

(1) In January of 1980, DEA established the Special Action Office/Southwest Asian Heroin to ensure that priority would be given to six targeted cities, including New York City, which would be critically impacted by an infusion of heroin. The program is

responsible for intensifying the awareness of State and local law enforcement officials of the threat of heroin from Southwest Asia and securing their support and resources in the Federal effort.

(2) On February 28, 1980, President Carter and Attorney General Civiletti hosted a meeting of 120 law enforcement officials who were apprised of the Southwest Asian heroin situation and encouraged to cooperate with the Federal Government in its interdiction efforts.

(3) Mr. Peter Bensinger, DEA Administrator, has indicated that a significant portion of the next graduating class of agents will be assigned to New York.

(4) The political instability currently existing in Iran and Afghanistan makes it impossible to interdict shipments of heroin at these opium producing centers. Thus, DEA has accelerated its interdiction efforts in Western Europe.

(5) DEA is coordinating and intensifying its exchange of intelligence information among foreign, Federal, State, and local enforcement agencies to maximize distribution of any data related to Southwest Asian heroin.

Mr. Fallon explained that at the local level, the Drug Enforcement Task Force and Unified Intelligence Division are cooperating with the New York City Police Department and the State Police to coordinate efforts to combat the heroin threat. Additionally, the Coordinating Council which consists of Mr. Fallon, a representative of the State Police, and Mr. Daniel J. Courtney, Chief of Organized Crime of the New York City Police Department, meets periodically to plan the targeting of narcotics traffickers in the metropolitan region. At the present time, the Council does not meet or coordinate its plans with representatives of the New York City Criminal Justice System.

Deputy Chief Charles H. Kelly, the commanding officer of the Narcotics Division of the New York City Police Department, explained that the primary drug of abuse in New York City is marijuana. During 1979, the Narcotics Division made 4,400 narcotics arrests, 35 percent of which involved arrests for the sale of marijuana. Further, of the 18,000 drug arrests made by the entire Police Department in 1979, 37 percent of the total represented arrests for marijuana violations.

Chief Kelly also testified that cocaine is the second most popular drug of abuse in New York City. He attributes the increasing use of cocaine to its social acceptance at all levels of society and to the media's exploitation of the glamour associated with the use of cocaine by celebrities.

In 1979, the New York Drug Enforcement Task Force initiated a special enforcement program in the Jackson Heights area that resulted in 261 arrests. A total of 178.5 pounds of cocaine and \$1.8 million were seized from traffickers investigated under this program.

Chief Kelly could not confirm DEA's findings regarding the increased availability of heroin in New York City. In his opinion, heroin is still restricted to Manhattan and Brooklyn North and has not spread to other areas of the city as would be expected if availability had markedly increased. "Now, as far as the suburban areas of Queens

and Brooklyn and Staten Island and the Bronx, we do not see the street distributions of heroin as we see it in Manhattan. There is very little of it going on out there. Out there the market is pills, marijuana and FCP." However, in his prepared testimony, Chief Kelly acknowledged that one of the indicators the DEA uses to track availability—purity of heroin, has risen at the retail level. For example, the purity of dime bag of heroin (2.7–3.0 grains of heroin per bag) rose from a low of one percent in 1976 through most of 1979 from 3 to 5 percent during the latter part of 1979. Similarly, the purity of a "Harlem quarter" (2.0 to 3.0 grains of heroin per quarter) rose from one percent to an average of 6 percent. Additionally, Chief Kelly testified that the number of arrests for heroin had increased during the first quarter of 1980.

In his prepared testimony, Chief Kelly explained how the New York City Police Department utilizes its resources to control drug trafficking. First, the Narcotics Division, which consists of 450 members including clerical personnel, handles covert investigations at all levels of the drug trade. Second, the New York Drug Enforcement Task Force operates primarily against middle- and upper-level traffickers and is currently concentrating its efforts against cocaine dealers in Jackson Heights, Queens. The Task Force is composed of city officers who work jointly with State and Federal officers. Finally, the patrol forces in the department make narcotics arrests where covert investigations are not required and generally are limited to low-level street arrests. This three-pronged drug enforcement effort has produced numerous arrests for the Department. During the past 10 years, the police have made 250,000 drug-related arrests in New York City.

Despite a policy of devoting a proportionate amount of resources to investigating and arresting all levels of traffickers, the Narcotics Division has been forced to devote more and more of its resources to arresting low-level traffickers. Chief Kelly testified that arrests for trafficking in large amounts of heroin have been declining for several reasons. First, the Narcotics Division has experienced a 27 percent reduction in personnel since the city's fiscal crisis in 1975. Second, the resources of the division are being diverted to making arrests for sales of marijuana, cocaine, and pills because of the increasing number of complaints (12,000 in 1979) to make arrests in these areas. Third, there has been a reduction of resources used to purchase narcotics during investigations. Prior to 1975, several million dollars were available for use as "buy money." For fiscal year 1980, the amount available had been reduced to \$700,000. Finally, the State of New York amended its narcotics laws by raising the amount of narcotics necessary to charge a trafficker who sells narcotics at the middle- and upper-levels.

Although the Division has made adjustments in its policy to cope with these problems, the arrest statistics for the first quarter of 1980 reflect a decrease in the number of arrests for sales of more than 2 ounces of heroin. Additionally, Chief Kelly estimated that since the narcotics amendment went into effect, felony arrests have decreased by 70 percent.

2. CRIMINAL JUSTICE

Robert M. Morgenthau, the District Attorney for New York City; Sterling Johnson, the Special Narcotics Prosecutor for New York City; and James Moss, Assistant United States Attorney for the

Southern District of New York testified as to how their offices will be affected by the expected explosion of heroin entering New York City and how the Federal Government may better assist the prosecutors in carrying out their duties.

In 1972, the Office of the Special Narcotics Prosecutor for New York City (OSNP) was established to combine into one office the manpower, equipment, and resources of each of the five district attorney's offices that comprise the New York metropolitan area. The OSNP has citywide jurisdiction over drug-related violations, the other five district attorneys work closely with the OSNP by assigning attorneys to its staff and developing similar policies regarding prosecution of drug offenders. Sterling Johnson, as the Special Narcotics Prosecutor, is the official spokesman for the other district attorneys with respect to narcotics matters.

In 1979, more than 1,200 felony indictments were filed by the 50 attorneys on the staff of the OSNP. Additionally, 1,400 to 1,500 felony indictments were subsequently treated as misdemeanors, while another several thousand cases were filed originally as misdemeanors. Also, the OSNP employs two investigators whose duties include distributing money to informants and relocating witnesses.

For fiscal year 1980, the OSNP received approximately \$2.0 million, half of which was appropriated by the State and half by New York City, to carry out its prosecutorial duties and to provide resources (\$130,000 in fiscal year 1980 to DEA, the New York City Police Department, and the Drug Enforcement Task Force) to purchase illicit substances for their undercover investigations. This compares to \$2.4 million appropriated for fiscal year 1975.

The Office of the U.S. Attorney for the Southern District of New York employs 113 attorneys. Of the 77 Assistant U.S. Attorneys assigned fulltime to the criminal division, 13 or 17 percent work in the Narcotics Unit. In addition, other assistants are occasionally assigned to individual narcotics cases. No other unit within the Criminal Division is larger than the Narcotics Unit. Two hundred ten out of 997 indictments and informations filed in 1979 in the Southern District alleged narcotics violations. Although it was impossible for the office to compute precisely how much of the resources of the office are committed to prosecuting narcotics cases, James Moss, Chief of the Narcotics Unit, estimated that at least 20 percent of the entire budget is devoted to enforcing Federal narcotics laws.

An individual charged with a drug violation may be brought before a State or Federal court since drug-related offenses are prosecutable under either Federal or State law. Thus, the U.S. Attorney and the Special Narcotics Prosecutor are free to choose the more appropriate forum to file an information and indictment. Under normal circumstances, however, Mr. Moss and Mr. Johnson divide the caseload, depending on which enforcement agency initiated the investigation and how the differences between State and Federal law will affect the chances of securing a conviction in a particular case.

All three witnesses concurred with the intelligence reports of the DEA regarding the greater availability of heroin in New York City. According to Mr. Johnson, "The purity of the heroin on the street has increased sharply. The amount available is also up. Users are again lounging on corners, nodding and scratching like their predecessors in the late 1960's. Middle-class whites are again flooding into

Harlem and Bedford-Stuyvesant to buy drugs. These conditions forecast danger and I predict a night of the long knives similar to the late 1960's and early 1970's." Mr. Moss asserted that the predictions made by the DEA regarding heroin availability were no longer predictions; they are fact. The witness added ". . . anybody who is prosecuting cases in this area will realize that there is greater availability of heroin now."

The witnesses testified, however, that controlling an infusion of heroin into New York City will be difficult for two reasons. First, resources have been inadequate to cope with existing conditions without regard to the threat posed by Southwest Asian heroin. Second, amendments to Federal and State laws have impeded enforcement efforts in narcotics matters.

The primary concern of the witnesses was the failure of the Federal Government and the State Government to provide additional resources to deal with the heroin problem. The OSNP and the District Attorney's office for New York are both having difficulties in maintaining operations at their current levels because their budgets are being reduced by all of their funding sources. In his prepared testimony, Mr. Morgenthau stated "In the last several years we have received substantial monies from the Federal Government through LEAA (Law Enforcement Assistance Administration). If that agency is in fact cut to the extent proposed, our own ability to function as an effective law enforcement agency will be diminished. At the same time, the State has cut the State felony budget. Fifty percent of that budget is used to prosecute narcotics cases, and 50 percent is used to prosecute violent felony offenses. The fact is that we would have needed an increase in that budget just to stay even. And finally, we have been told that no additional funds will be forthcoming from the city."

Mr. Morgenthau reemphasized the deplorable situation at the hearing ". . . the State has not increased resources even to meet inflation . . . The resources have been cut by 3 percent at a time when inflation is running 12, 13 percent." Mr. Johnson predicted that unless sufficient resources are forthcoming, the OSNP will be forced into a position of "letting the Court dismiss cases for failure to prosecute on most 'street sales'."

Although the Office of the U.S. Attorney has not experienced a budget reduction, the resources of the Office are nevertheless being strained. Resources previously reserved for heroin and cocaine prosecutions have had to be diverted to prosecute cases involving hallucinogens, marijuana, and illegally dispensed prescription drugs because of increased pressure from the community to make arrests in these areas. Mr. Moss described the situation as follows:

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

I believe the Committee has already alluded to the fact that in areas such as marijuana there has been increased evidence that law enforcement is becoming reinvolved. I think that is clearly so.

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

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

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

The problems of inflation combined with budget constraints experienced by the law enforcement agencies generally have already affected the number of highlevel undercover narcotics investigations initiated by the DEA and the New York City Police Department and subsequently prosecuted. According to Mr. Johnson, heroin cost \$1,200 an ounce in 1977. By 1980, the cost of an ounce had risen to \$10,000. Although each of the prosecutors adheres to a policy of preferring to prosecute the importers and wholesalers of heroin, Mr. Moss explained how the high cost of narcotics makes it exceedingly difficult to do so.

What we would like to do would be to concentrate on the upper-level of narcotics dealers—the wholesalers, the importers themselves. The Federal conspiracy law makes it most appropriate to prosecute that level of violator on the Federal level. We have not been able to—let us say we have been less able to deal in that level of violator, using the U.S. cover purchase technique—that is actually the most effective law enforcement technique.

Because we simply do not have the funds—I say we—the Drug Enforcement Administration, the New York City Police Department, do not have the funds to purchase the narcotics at that level. If you purchase an ounce of heroin and it cost you \$10,000, and you hope that you will then be allowed to purchase a greater quantity, you have not even yet gotten into the wholesale quantity, the high-level dealer. And yet you have given \$10,000 away in the sense that you cannot use it again to purchase additional narcotics.

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

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

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

When asked by Mr. Biaggi how the increased cost of heroin coupled with community pressure to make "arrests for street sales" affected the OSNP's ability to prosecute narcotics violations involving small amounts of drugs, Mr. Johnson responded:

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

If the number of arrests for "street sales" of heroin rises as a result of the increased availability of Southwest Asian heroin, the prosecutors predicted that their backlog of cases will also rise because budget restraints will prevent the hiring of additional attorneys. Currently, the backlog of felony cases at the OSNP is 1,500. Some defendants involved in these cases have been awaiting trial for more than a year. Ultimately, the cases may be subject to a speedy trial motion and dismissed.

The backlog of cases poses another problem for the prosecutors because most offenders charged with a drug-related violation remain out of jail on bail while the case is pending. According to Mr. Morgenthau, the "jump rate" for narcotics cases is about 25 percent. Mr. Johnson explained that once the offender is out on bail "it is fruitless for law enforcement, the Police Department, Drug Enforcement Administration, or the Task Force to devote any additional enforcement energies toward this individual should he return to selling drugs again. You already have a case on him. And upon conviction he is going to go to jail. Most courts, if you are convicted again, would give him concurrent time. So it is just a waste of time to go out after a person who is out on bail."

The witnesses also testified about how recent amendments to State and Federal laws have affected their ability to prosecute drug offenders. In 1979, the New York State legislature enacted amendments to the State drug laws which raised "the quantity of drugs necessary to charge a dealer at the middle- and top-levels."

As indicated by Chief Kelly, these amendments have further reduced the number of arrests made of importers and wholesalers of heroin and other narcotics because of the lack of "buy money" necessary to make such arrests.

Additionally, recent amendments to State statutes restrict plea bargaining and increase mandatory minimum sentences for predicates (an individual who has been convicted of a felony within 10 years). Although Mr. Johnson supports these amendments, he stressed that ". . . the State has failed to realize that if a defendant is restricted to the 'deal' he can get, he is forced to go to trial. More trials mean more attorneys. In my office alone, based on the cases we have received since September 1979, I estimate that there will be an increase of 200 percent in the number of trials required. There are simply no resources to implement the new law."

Prior to the enactment of the Tax Reform Act of 1976, the Office of the U.S. Attorney and the Internal Revenue Service (IRS) worked closely in investigating and prosecuting major narcotics distribution networks that involved substantial and sophisticated money-laundering operations. However, certain provisions of the Act (26 U.S.C. 6103) now restricts the information that may be exchanged between law enforcement agencies and the IRS. The effect of the law has been to impede the successful prosecution of some violators of the Federal narcotics laws.

At the hearing, Mr. Biaggi asserted "The reason the law was passed is because the privilege (to exchange information) was abused." Mr. Biaggi added "It was an important reform that was done with the purpose of prohibiting that abuse from occurring again. The question is how do we legislatively amend that law so as to limit that

privilege to important areas? Because I can tell you from a practical point of view, you will not have that law repealed." Mr. Biaggi and Mr. Gilman then urged Mr. Moss to recommend and submit to Congress specific language to amend the affected provisions of the statute.*

When asked by Mr. Gilman what recommendations the witnesses had of the Select Committee that would better assist them in carrying out their prosecutorial duties, the witnesses each replied that more resources were urgently needed. Mr. Morgenthau stated:

I think there has to be more resources on the Federal level and there has to be significant additional resources for local law enforcement in the port cities, like New York, which has been targeted as the number one port for delivery of heroin.

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

Mr. Johnson stressed that additional resources must be available to address the entire drug abuse problem, including funds for treatment and rehabilitation, as well as for law enforcement. Mr. Johnson added, "it is a complex problem and it has to be solved with a complex answer." Mr. Moss concurred with the statements made by the other witnesses regarding "the increased need for commitment of resources to the overall problem."

C. FINDINGS

1. The combined opium production in the Southwest Asian countries of Iran, Afghanistan, and Pakistan increased from an estimated 700 metric tons in 1978 to 1,600 metric tons in 1979.

2. Approximately 40 to 60 tons of heroin hydrochloride produced from the opium cultivated in Southwest Asia are available for export to Europe and the United States.

3. Intelligence reports of the Drug Enforcement Administration (DEA) reveal that Europe is inundated with Southwest Asian heroin and is currently experiencing problems of epidemic proportions.

4. For the first time in more than 3 years, the average purity of heroin in the United States is higher, up from 3.5 percent to 3.8 percent. Other indicators including the quantity of heroin seizures, data on emergency room injuries and deaths related to heroin, heroin treatment admissions, and retail pharmacy thefts point to a gradual increase in heroin availability in the United States.

5. Determinations made of the source of heroin seized in various metropolitan areas around the Nation show that a steadily increasing percentage of the heroin currently entering the United States was produced from Southwest Asian opium.

6. Heroin is more readily available on the East Coast than elsewhere in the Nation. New York City is the gateway of heroin entering the United States and that metropolitan community has the largest heroin population in the Nation.

7. The witnesses confirmed that heroin availability in New York City has increased during the first quarter of 1980. Numerous laboratory analyses of heroin at the wholesale level are showing purities between 20 and 90 percent. Few exhibits of heroin showed purity levels of greater than 20 percent during the first quarter of 1979.

*Several bills were introduced in the 96th Congress, which if enacted, would enable the IRS to cooperate more readily with law enforcement agencies investigating organized crime cases after established procedures are adhered to. See S. 2402, S. 2403, S. 2404, S. 2405, H.R. 6826, H.R. 6827, and H.R. 6828.

Additionally, the purity of heroin at the street level increased from an average of 2.1 percent in February of 1979 to 8.36 percent in February of 1980.

8. During the last quarter of 1979, there were 225 heroin-related injuries reported to the Drug Abuse Warning Network (DAWN) by emergency rooms in New York City, compared to 96 heroin-related injuries reported during the same period in 1978.

9. The Chief Medical Examiner for the city of New York has not issued reports on the number of heroin or heroin-related deaths since 1974. The Medical Examiner lacks the ability to critically analyze each drug-related death but he does provide DEA with raw data which that agency analyzes to determine the number of heroin-related deaths occurring in New York City.

10. DEA has initiated several programs to counter the threat of Southwest Asian heroin including establishing the Special Action Office on Southwest Asian Heroin, apprising law enforcement officials of the Southwest Asian heroin situation; assigning additional agents to New York, exchanging information with foreign, Federal, State, and local law enforcement officials, and accelerating interdiction efforts in Europe. DEA coordinates narcotics enforcement efforts made in the New York Metropolitan area with the State and New York City police. Additionally, the Coordinating Council, which consists of representatives from Federal, State and local law enforcement agencies, meets periodically to plan law enforcement initiatives regarding major narcotics traffickers.

11. Marihuana and cocaine are the primary drugs of abuse in New York City. During 1979, the New York City Police Department made 18,000 drug-related arrests, 37 percent of which were for marihuana violations. Because of pressure from the public, the police department is devoting more of its resources to making arrests for street sales of marihuana and cocaine.

12. The staff of the Narcotics Division of the New York City Police Department has been reduced by 27 percent since 1975.

13. The cost of an ounce of heroin has increased from \$1,200 in 1977 to \$10,000 in 1980. Also, the amount of money appropriated to the Narcotics Division of the New York City Police Department and the Office of the Special Narcotics Prosecutor for New York City to purchase narcotics for undercover investigations has been reduced. The high costs of heroin coupled with less money to purchase narcotics have resulted in fewer arrests and prosecutions of wholesalers and importers of heroin.

14. Recent amendments to New York State drug laws that raise the quantity of drugs required to charge high-level traffickers have also affected the number of arrests and prosecutions of wholesalers and importers of heroin.

15. The Office of the Special Narcotics Prosecutor (OSNP) for New York City employs 50 attorneys and has city-wide jurisdiction to prosecute any drug-related violation. In 1979, the office filed more than 1,200 felony indictments, but, because of inadequate funding resources, OSNP has a backlog of approximately 1,500 cases.

16. For fiscal year 1980, the Office of the Special Narcotics Prosecutor was appropriated \$2.0 million, compared to the \$2.4 million appropriated in 1975. During the intervening years OSNP's budget

was slashed to \$1.1 million and gradually has been increased to \$2.0 million.

17. The Office of the U.S. Attorney for the Southern District of New York employs 113 attorneys; 13 attorneys are assigned to the Narcotics Division. In 1979, the office filed 210 indictments alleging narcotics violations.

18. The Offices of the Special Narcotics Prosecutor and the District Attorney for New York City are operating under severe budgetary restraints to carry out their prosecutorial duties. The increasing availability of heroin in New York City will result in more arrests, but without additional resources to hire attorneys, there will be a larger backlog of cases, more offenders remaining out of jail on bail pending trial, and fewer prosecutions for "street sales" of heroin. The District Attorney's Office has a backlog of between 1,300 and 1,400 felony cases; the bail bond jump rate is about 25 percent.

19. The Office of the United States Attorney for the Southern District of New York has been forced to divert resources previously reserved for prosecuting traffickers in heroin and cocaine to prosecuting traffickers in marihuana, hallucinogens, and illegally dispensed prescription drugs because of the tremendous profit in the sale of these drugs and increased public pressure to make arrests in these areas.

D. RECOMMENDATIONS

1. With the rapidly increasing influx of Southwest Asian heroin threatening to create enormous problems for both the law enforcement and drug treatment communities in the United States, it is imperative that every effort be made to counter the threat. The Select Committee commends the Drug Enforcement Administration (DEA) for the initiatives implemented and encourages the DEA to commit more resources to interdicting Southwest Asian heroin before it reaches the United States. Further, the Select Committee urges the DEA to assign additional agents to those metropolitan areas currently experiencing an increase in heroin availability.

2. To ensure that narcotics enforcement in New York City is more effective, the Select Committee urges the Coordinating Council, now consisting of Federal, State and local law enforcement officials, to also include representatives of the Offices of the U.S. Attorney for the Southern District of New York and the Special Narcotics Prosecutor in any strategy sessions regarding targeting of major narcotics traffickers. The Select Committee also urges the Coordinating Council to develop and implement plans for coping with the increased availability of heroin in New York City.

3. Statistics on heroin and heroin-related deaths collected and analyzed by medical examiners in the 24 metropolitan areas reporting to the Drug Abuse Warning Network (DAWN) are critical for predicting local and national trends on heroin availability and abuse. Since there are more drug-related deaths than have been diagnosed on the death certificates, the Select Committee urges the city of New York to provide the Chief Medical Examiner with sufficient resources to employ a statistician to prepare valid statistics on all drug-related deaths. Until such time as a statistician is employed, the data reported by DAWN for New York City is subject to question.

4. The Office of the Special Narcotics Prosecutor (OSNP) has been severely restricted by inadequate resources to effectively carry out its task of prosecuting drug violators. OSNP's budget has been reduced from \$2.4 million in 1975 to nearly \$2.0 million in fiscal year 1981. OSNP needs additional funds to carry out its increased responsibilities mandated under the State's new drug law, to hire additional attorneys and to meet rising operational costs including additional "buy money" to purchase sufficient amounts of drugs to obtain successful drug prosecutions. Accordingly, the Select Committee urges that the City/State matching funds to underwrite OSNP's operations reach at least the 1975 appropriated level of \$2.4 million.

III. DRUG PREVENTION AND TREATMENT

During the afternoon session, the Select Committee sought to assess the effectiveness of drug treatment and prevention programs at a time when increased shipments of Southwest heroin are entering the United States and when the Administration has proposed a \$40 million budget cut in drug treatment programs.

Testimony was provided by drug treatment and prevention administrators, researchers and clinicians. The witnesses included:

Jack Durell, M.D., Executive Assistant to the Director, National Institute on Drug Abuse.

Elaine Johnson, Deputy Director, Division of Community Assistance, National Institute on Drug Abuse.

Julio Martinez, Director, New York State Division of Substance Abuse Services.

Dr. Douglas Lipton, Assistant Commissioner, New York State Division of Substance Abuse Services.

Robert E. Wallace, Chairman, New York State Commission on Alcohol and Substance Abuse Prevention and Education.

Edmund H. Menken, President, Project Return Foundation, Inc.

Ronald L. Coster, Senior Vice President, Phoenix House, Inc.

Kevin McEneaney, Director of Public Information, Phoenix House, Inc.

Beny J. Primm, M.D., Director, Addiction Research and Treatment Corporation.

James Allen, Director, Addict's Rehabilitation Center.

The witnesses discussed the potential impact of the Administration's revised budget proposal to eliminate section 409, Public Law 92-255 Formula Grant funds to the States. This proposed revision amounts to \$40 million. They also testified regarding the implementation and the possible effects of Public Law 96-181 requiring that 7 percent of Federal monies allocated under section 410 of Public Law 92-255 be set aside for primary prevention and intervention purposes.

A. BACKGROUND

Prompted by concerns that prevention activities were inadequate due to insufficient funding and based upon the findings of the Subcommittee on Health and the Environment, chaired by Congressman Henry Waxman, the Congress amended section 410 of Public Law 92-255, requiring that for fiscal year 1980 at least 7 percent of the funds allocated under section 410 "be obligated for grants and contracts for primary prevention and intervention programs designed to discourage individuals, particularly those in high risk populations, from abusing drugs" (Public Law 96-181). Public Law 96-181 reduces the amount of Federal funds under section 410 of Public Law 92-255 (The Drug Abuse Office and Treatment Act of 1972) mandated for

drug abuse treatment while increasing the allocation of funds for prevention and education activities.

In addition to the prevention/education 7 percent set aside, the President's proposed revised budget for drug abuse services administered by the National Institute on Drug Abuse (NIDA), would eliminate all State Formula Grants under section 409 of Public Law 92-255. This proposed budget revision amounts to a \$40 million loss nationwide for the drug abuse treatment, rehabilitation, prevention, education, research and evaluation communities.

These recent funding reallocations and proposed budget cuts became the major impetus for the Select Committee's inquiry regarding the ability of the drug treatments/prevention community to successfully meet the escalating drug abuse problem in the United States.

1. FUNDING MECHANISMS

To fully comprehend the many facets of this complex social and administrative issue, it is necessary to understand the means by which Federal funds for substance abuse services are distributed.

Drug abuse treatment and prevention funds are distributed to the States and to treatment and prevention providers by the Federal government through the National Institute on Drug Abuse (NIDA) via two basic funding mechanisms: the Statewide Services Grant (SWSG) and the State Formula Grant.

The primary mechanism through which treatment services are funded by NIDA is the Statewide Services Grant. The provision of treatment and rehabilitation services is authorized under section 410 of Public Law 92-255. The Statewide Services Grant is a cost-reimbursement/cost-sharing agreement with State government agencies, often referred to as Single-State Agencies (SSA's), under which local drug treatment programs are sub-contracted. The Single-State Agency, or prime contractor, is responsible for drug abuse services, administration, planning and coordination within the State. As a grantee, the Single-State Agencies also have the responsibility for monitoring treatment services funded through the Statewide Services Grant. While ultimately accountable to NIDA, the Statewide Services Grants provide the Single-State Agencies with considerable flexibility in the management and administration of drug abuse treatment and rehabilitation services within the State's jurisdiction.

The amount of money allocated by NIDA under section 410 of Public Law 92-255 for *direct treatment services* in fiscal year 1980 was \$142,098,000. In addition to the funding for direct services, \$4,857,000 was designated for *treatment support* which includes contracts for monitoring treatment programs to assure compliance with Federal funding criteria as well as to provide technical service assistance. Additionally, \$7,819,000 was allocated for *demonstration projects* and \$6,226,000 was allocated for prevention and education, or a total allocation to NIDA of \$161 million:

Direct treatment services.....	\$142,098,000
Treatment support.....	4,857,000
Demonstration projects.....	7,819,000
Prevention and education.....	6,226,000
Section, 410, Public Law 92-555.....	161,000,000

The other means by which funds are distributed by NIDA to the States is the State Formula Grant, which is authorized under section 409 of Public Law 92-255. These grants are disbursed among the States and Territories for their use according to the programmatic needs of the State or Territory and are awarded as block grants, the amount of which is based upon the following formula:

1. One-third (1/3) weight on the basis of the relationship of the population in each State to the total population of all States;
2. One-third (1/3) on the basis of total population weighted by financial need as determined by the relative *per capita* income for each State; and,
3. One-third (1/3) on the basis of need for more effective conduct of prevention functions as determined by the following three (3) equally weighted factors:
 - A. One-ninth (1/9) relation of the population ages 12-24 in each State to the total population of that age group in all States;
 - B. One-ninth (1/9) the relationship of the number of hepatitis, Type B, cases in each State to the total number of those cases in all States; and,
 - C. One-ninth (1/9) the standing, in relation to all other States, of each State's *per capita* appropriations of State funds for drug abuse prevention functions.

It is thought by many drug abuse professionals that these Formula Grants are the heart of drug abuse program development within the States. Financial assistance has been provided through these Formula Grants for planning, establishing, conducting, coordinating and evaluating projects for the development of drug abuse efforts within the States.

In fiscal year 1979, \$40 million was appropriated under section 409 of Public Law 92-255. Of that appropriation, approximately 45 percent or \$17,546,910 was expended by the States in direct treatment and rehabilitation services; 24.3 percent or \$9,349,759 was spent by the States in prevention efforts; 15.2 percent or \$5,911,219 was spent in planning and coordination; and 3.2 percent or \$1,213,426 was spent on research and evaluation by the States.

B. SUMMARY OF THE SELECT COMMITTEE'S INQUIRIES

1. THE PERSPECTIVE OF THE EXECUTIVE BRANCH: THE NATIONAL INSTITUTE ON DRUG ABUSE

The National Institute on Drug Abuse (NIDA) was represented by Jack Durell, M.D., Executive Assistant to the Director, Dr. William Pollin. Dr. Durell was accompanied by Ms. Elaine Johnson, Deputy Director, Division of Community Assistance (NIDA).

Dr. Durell testified that for the last 3 years national indicators have shown a declining trend in heroin abuse and addiction, but preliminary data for 1979 indicate that some of these decreasing trends may well be levelling off. However, NIDA's review of DAWN (Drug Abuse Warning Network) and CODAP (Client Oriented Data Acquisition Program) indicate that heroin use is increasing in some cities on the East Coast of the United States, and that it might take some time for

the influx of Southwest Asian heroin entering the United States to be reflected in treatment programs in NIDA's statistical analysis of national trends. At the regional level, data for the first quarter of 1979 indicates that the Northeastern sector of the United States is experiencing an upswing in heroin abuse and addiction. Dr. Durell asserted that NIDA monitoring and forecasting resources were alert to the possibility of increased levels of heroin abuse and addiction and "in the event that the situation gets worse, every possible action will be taken."

With regard to NIDA's prevention efforts, following the enactment of Public Law 96-181 requiring that 7 percent of the funds allocated for community assistance programs be reallocated for primary prevention programs, Dr. Durell stated that NIDA "has developed a policy to shift a portion of its resources toward prevention programs."

In fiscal year 1980, over \$6 million were added to the base budget for drug abuse prevention efforts, raising the effort to \$11.27 million. Dr. Durell stated that "the largest share of the increase in this prevention funding will be made available to State drug abuse agencies" and that "special consideration will be given to grant applications for prevention programs targeted toward women, the elderly and youth".

Dr. Durell further stated that the remainder of the additional prevention funds is to be used to "strengthen NIDA's technical assistance efforts to States, local communities and parent groups." However, Dr. Durell did not provide any specifics as to the planned technical assistance efforts.

Finally, Dr. Durell stated that he could not comment on the proposed cuts for fiscal year 1980 and fiscal year 1981 in Formula Grants to the States (section 409, Public Law 92-255) eliminating \$40 million, asserting that "the matter is still before the Congress," and, "planning for how (NIDA) will deal with that . . . has not really begun in any substantive way."

Chairman Wolff stated that testimony from law enforcement/intelligence officials indicated a dramatic increase in the production of heroin and an equally dramatic increase in the amount of heroin entering this country, and that NIDA's position, as stated by Dr. Durell, presented "an optimistic view of the future" that was contrary to the testimony from the law enforcement community. Chairman Wolff commented that one of the reasons for NIDA's rather sanguine appraisal of the situation may be the time lag in receiving trend data.

In explaining the rationale underlying the Formula Grant concept and how such monies have actually been used in the Nation's overall drug strategy, Ms. Johnson stated that the State Formula Grant authorization was originally passed for the "development of a Single-State Agency (in each of the States and Territories) to be responsible for the administration, planning and development of drug abuse treatment and prevention programs." Monies were appropriated directly to each State and Territory through a formula (see Introduction and Background for explanation) to initiate, execute, and manage these activities.

Approximately 45-50 percent of the \$40 million under section 409 was used in direct treatment services. Approximately 25 percent has been used by the States and Territories in prevention and early intervention activities.

When asked if NIDA had consulted with the Single-State Agencies regarding ways in which the States might adjust to the impending severe decrease in drug abuse funding, Dr. Durell responded that "the States themselves . . . have to pay some attention to figuring out what they are going to do." The Select Committee initiated an inquiry to the Single-State Agencies regarding the role of NIDA.

In response to a comment by Chairman Wolff that it would seem that NIDA would have some obligation to offer possible options to the States in the emerging funding crisis, Dr. Durell stated that "all NIDA can do is wait and see how each State proposed to cope with this problem. . . ." Chairman Wolff countered that it was incumbent upon the Federal agencies to take meaningful and proactive steps in matters such as these and suggested that NIDA initiate a dialogue with the States regarding the proposed funding revisions.

Mr. Gilman asked Dr. Durell if NIDA had communicated with the administration recommending that the proposed \$40 million cut be restored. Dr. Durell answered that he believed that the Director of NIDA, Dr. William Pollin, "has been in close communication with the administration about his concerns for the integrity of the program." He added that NIDA has not decided whether it would be more advisable to work for the restoration of the State Formula Grant funds or to request supplemental funds "as they are needed if special situations develop."

Mr. Gilman requested that NIDA provide the Select Committee with recommendations being made regarding either restoration of the proposed cuts or the matter in which NIDA proposed to overcome the loss of these funds in the event that they are not restored.

NIDA responded as follows:

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

With respect to issues of substance abuse prevention and education and the manner in which NIDA is planning and organizing its prevention and education resources, Dr. Durell testified that approximately \$5.5 million of the newly appropriated prevention funds are being distributed to Single State Agencies and that NIDA has disseminated guidelines to the States regarding the types of prevention and education programs NIDA would prefer to see implemented. These guidelines were developed at the Prevention Branch of NIDA.

The guidelines emphasize "community based programs" and "on programs that are geared to working with families, supporting parent groups and families that are concerned with drug abuse in children." There is also support for those prevention and education efforts that will address the special needs of minority groups and the elderly.

Dr. Durell pointed out that NIDA's total prevention budget for fiscal year 1980 is \$11.2 million.

The representative from NIDA stated that a national program addressing the country's total prevention needs would cost an estimated \$500 million to \$1 billion. In light of the disparity between a national prevention effort and the actual available resources, NIDA has viewed its role not as a direct funder of prevention programs but rather as an agency that supports prevention demonstration and research projects and disseminates information on the most effective methods. NIDA has also developed a technical assistance network for communities and States to receive "on site" consultations.

The direction of NIDA's overall prevention strategy is to maximize the dollars available to it and to have an impact on the total prevention and education area. The total prevention budget of \$11.2 million for fiscal year 1980 is distributed by NIDA within two major categories. About one-half of the money is earmarked for research, evaluation, information, dissemination, and technical assistance. The other half is planned for the States to begin direct funding of community-based prevention and education efforts. The representative of NIDA did not specify what amounts are to be allocated to each of the States and Territories.

Dr. Durell stated that a conservative estimate for an effective prevention campaign conducted on a national scale would be between one-half billion and one billion dollars. Mr. Gilman asked if NIDA had recommended this estimate to the Administration. Dr. Durell responded that NIDA had made a budget request for prevention activities "in the order of the magnitude of funds that have been provided."

In response to Mr. Gilman's request, NIDA provided the Committee with a copy of its prevention strategy plan.

[The information follows:]

FISCAL YEAR 1980 PREVENTION PLAN

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Issue Study Impact Study, State Drug Usage Evaluation.—The 3rd year of a 3-year evaluation by University of Nevada of the Nevada Drug Abuse Prevention

Program using a sample of 10,000 students in grades 5, 7, 8. Len Trout, Principal Investigator.

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

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

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

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

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

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

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

Dr. Durell cited the technical assistance network as NIDA's most effective effort in drug abuse prevention and education. Given the fact that NIDA has extremely limited funds for use in prevention and education, the Institute has attempted to maximize its efforts by providing support assistance and technology transfer to a "vast number" of local and community efforts.

Regarding NIDA's school programs in drug education, Dr. Durell stated that a school drug education design is tentatively scheduled for fiscal year 1982. Dr. Durell also stated that NIDA does not presently have a national program for drug awareness.

In regard to the Heroin Strategy Work Group at NIDA, Ms. Johnson testified that the Group's purpose is to determine the resources that can be developed for treatment and rehabilitation of abusers and addicts with reduced dollars available for treatment services in the event of an increase in levels of heroin abuse and addiction. This group is a relatively new effort at NIDA, having been formed in April 1980. One of the activities of the Group has been to examine other agencies within the Department of Health and Human Services from which manpower and other resources could be drawn.

Chairman Wolff commented that in view of the information received from the law enforcement and criminal justice agencies that the nation is facing a dramatic and imminent increase in heroin availability and increased quality of heroin, that a Task Force be established im-

mediately to determine the present and future national needs regarding treatment and prevention resources. The "Task Force" would plan NIDA crisis management operations.

Chairman Wolff requested that NIDA address the overall problem confronting the Nation and that NIDA develop "new directions" in treatment, rehabilitation and prevention strategies.

2. STATE PERSPECTIVES

a. Treatment

The Division of Substance Abuse Services was represented by Commissioner Julio Martinez and accompanied by Dr. Douglas Lipton, Assistant Commissioner.

Commissioner Martinez stated that data from the Drug Enforcement Administration, the New York City Police Department, reports from hospitals and surveys conducted by his office confirm that New York State is experiencing a resurgence of heroin abuse and addiction. Statistical data reflect the following significant trends between 1978 and 1979:

1. Drug dependent deaths in New York City have increased 77 percent.
2. Heroin-related emergency room episodes in New York City increased 46 percent.
3. Admissions to drug treatment programs in which heroin was identified as the primary drug of abuse increased 26 percent throughout New York State.
4. Admissions to methadone programs (in which opiate addicts are treated) increased 22 percent and detoxification program admissions increased by 40 percent.
5. Opiate related arrests in New York City increased 11 percent.

Mr. Martinez stated that these increases are the result of increased entry of high-quality heroin entering the United States from Southwest Asia. He noted that the heroin from Southwest Asia has tripled in purity over the last year, from approximately 3 percent the summer of 1979 to the present purity level of 51 percent.

Preliminary studies by the research staff of his office indicate greater involvement with heroin by people under twenty years of age. For example, between 1978 and 1979 there was a 24 percent increase in the number of individuals under 16 years of age arrested for possession and/or sale of heroin, morphine and opium. Arrests for persons aged 16 to 20 increased 20 percent. In light of these grim developments, Mr. Martinez asked, "How are the Division of Substance Abuse Services and the State of New York going to confront and combat the impending heroin epidemic on top of our other drug problems?" He concluded by saying, "The outlook is not very promising." He observed that both Federal and State funds for drug abuse treatment have been reduced despite all of these indicators that heroin abuse is dramatically increasing. He further testified:

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

The picture on the State front is not better. State appropriations for drug abuse services have been slashed from \$137 million in 1975 to about \$50 million in 1979, our agency's workforce has dropped from 4,830 to 220. The drug problem has continued to grow steadily over that 4-year period.

In conclusion, Mr. Martinez and Dr. Lipton testified that the combined effect of the 7 percent set-aside and the proposed elimination of the State Formula Grant (\$40 million) not only critically limits treatment services but would severely hinder the States' abilities to develop and administer its program since there would be no funds to evaluate, monitor and manage State-wide drug abuse efforts.

b. Prevention

Mr. Robert E. Wallace, Chairman of the New York State Commission on Alcohol and Substance Abuse Prevention and Education, testified that the Commission has been given the task of generating awareness of alcohol and substance abuse among the general population through educational programs and dissemination of information. Mr. Wallace testified that during fiscal year 1978-80, the commission was in a position to fund \$13.6 million to school-based programs in New York State and funded 85-90 districts out of a total of 732 districts in New York State, he also stated that, with the exception of himself and an executive assistant, the commission would be "going out of business" for the lack of funds during the second half of the 1980-81 fiscal year.

For the past 9 years school-based prevention programs have been receiving funds from the Commission and its predecessor agencies. Mr. Wallace stated, "No provisions have been made for the continuation of operations training, evaluation or program monitoring."

He also contends that this nation is:

On the verge of a heroin epidemic that has the potential to be the worst we've ever seen. We are facing rampant use of marihuana, PCP, cocaine and other drugs by our children. Head shops now sell kits for converting heroin and cocaine so they can be smoked instead of snorted or injected. We are seeing vast numbers of adults who are misusers of prescription drugs. Some head shops in New York City are actually selling marihuana and illicit pills over the counter. We have high-profit PCP dealers, cheap available, high-quality heroin, rock and movie stars who tout drug use.

According to Julio Martinez, Director of New York State Division of Substance Abuse Services, there are more than 570,000 substance abusers in New York State, of whom less than 9 percent (or fewer than 50,000) can be treated by current available funds. Dr. Lipton stated that as of January 1980, 52,250 were being treated in New York State through Federal and State funding programs. According to Dr. Douglas Lipton, Assistant Commissioner of the New York State Commission on Alcohol and Substance Abuse Prevention and Education, as of June 1978 there were approximately 213,800 narcotics abusers in New York State . . . individuals who "are using heroin and methadone." By the middle of 1979, the number of narcotics abusers in New York State have been projected to approximately 240,000. An additional 387,800 individuals resort to non-narcotic, dependency-producing substances on an almost daily basis.

During this period, funding has been steadily decreasing. For example, the 1979-80 funding level (\$14.9 million) represents approximately a 50 percent decrease over the past 9 years. Of the current New

York State prevention/education appropriation 87 percent was targeted for programs in New York City, 5 percent was targeted for Nassau/Suffolk, and 8 percent went to the rest of New York State. Mr. Wallace stated that the Commission has "been hard pressed to fulfill its financial responsibilities, in light of the increased costs due to inflation and mandated increases in salaries and fringe benefits, much less to expand its efforts to additional school districts in need of State funds." These decreased resources have resulted in new programs not being funded and established programs suffering decreases in staff and program. These decreasing prevention and education resources come at a time when drug and alcohol problems are increasing, especially among young people. Mr. Wallace cited the following examples of the increasing severity of drug and alcohol problems among young people:

Almost 3.3 million teenagers (14-17) are considered problem drinkers.

Almost a million New York State high school students have used marihuana.

220,000 of these students have used hashish, glue or solvents, PCP and tranquilizers non-medically.

Every fourth person in New York State, 14 years and older, has taken an illegal drug or used a legal drug without a prescription.

While alcohol and substance abuse are complex, multi-faceted psychosocial phenomena, Mr. Wallace assured the Committee that:

the programs which include informational services, humanistic education, individual and group counselling, values clarification, peer leadership training, family-oriented services and educational alternatives within the school setting . . . seem to be most effective in reaching and helping young people at greatest risk.

Mr. Wallace also stated that the evaluations of these programs "clearly indicate that prevention-early intervention programs are effective and should be expanded".

Mr. Wallace termed the 7 percent set aside for prevention in NIDA's budget "an embarrassment." He stated that the manner in which this money was added to the prevention effort, that is, the diverting of funds previously allocated to treatment services "represents an even greater embarrassment."

Mr. Wallace concluded his testimony by calling for a nationwide prevention effort and support for the "national trend . . . toward increased funding of prevention efforts in the area of health, mental health, substance abuse . . . etc." He stated that the nation needs an "independent prevention mechanism" that would coordinate the activities of the States into a viable, comprehensive, and effective national effort working toward the goal of the reduction of substance abuse among this Nation's youth.

3. THE PERSPECTIVE OF THE TREATMENT PROVIDERS

a. Project Return Foundation, Inc.

Edmund H. Menken is the President of the Project Return Foundation, a voluntary, non-profit human services agency based in New York City. Mr. Menken warned: "There is a time-bomb ticking away in our midst that is about to explode." He stated that the evidence indicates that the United States is facing another heroin epidemic,

"the likes of which has never been seen before in this country." He continued that public complacency has allowed the issue of drug abuse to lose its immediacy and as a result of this complacency and increasing apathy this country is now facing a potential disaster. He noted reports of increased drug use in the San Francisco Bay Area, particularly high concentrations of "Persian heroin" that can be processed ("free based") so that it can be smoked rather than injected. According to Mr. Menken,

This means that tens of thousands of young people who reject the idea of an intravenous high, but indulge quite comfortably with smoking marihuana, may be very susceptible to a new but devastating euphoria.

Individuals who have previously been reluctant to use heroin are now appearing at treatment facilities. The potential for young people to become involved in heroin abuse through smoking is very real.

Mr. Menken stated that his colleagues throughout the Nation are claiming that heroin availability has created a threat of epidemic proportions and that while service providers have been attempting to treat increasing numbers of drug abusers, they have had to face a governmental posture "which, at best, has been unresponsive and, worse, negligent."

Mr. Menken pointed out that under Public Law 96-181 the treatment sector would lose "a minimum of \$11 million or 7 percent of its allocation." When this is considered in light of the Administration's proposed budget cut to eliminate the entire State Formula Grant funds of nearly \$40 million, the loss of approximately \$28 million for the treatment sector will severely hamper State efforts to treat and rehabilitate the increasing numbers of substance abusers. According to Mr. Menken,

The capability of the states to deal with their respective drug abuse problems will be virtually destroyed by this move since they rely so heavily upon 409 money for the administration of their State drug abuse efforts.

Mr. Menken described a recent informal study of the eight New York Regional Therapeutic Communities of America programs that revealed information regarding the cost-effectiveness of treatment programs.

In 1979 there were approximately 355 graduates of these affiliated programs. Using HEW's figures, these former addicts accounted for roughly \$47.5 million in costs to society related to their untreated addiction in the streets. The total governmental cost to treat and rehabilitate these young men and women was barely \$2 million. They came off the welfare rolls, out of the public dependency syndrome and away from the drug scene. They currently return, through their combined income, over \$3.2 million a year to the economy of this nation and their tax contribution is in excess of \$500,000. Clearly, the government investment in drug abuse treatment is miniscule when compared to the benefits gained by society for each person who is rehabilitated. Our Federal Government is truly guilty of being penny-wise and pound foolish.

Mr. Menken concluded by urging the members of the Committee to work toward the restoration of the proposed \$40 million cut in State Formula Grants and to consider appropriate increases in funding to all areas of the country that have experienced an increase in heroin abuse. He also called upon the Congress to amend Public Law 96-181 to return monies set aside for prevention to the treatment sector.

b. Addiction Research and Treatment Corp.

Beny J. Primm, M.D., a highly respected clinician and researcher in addictive diseases, is the Executive Director of the Addiction Research and Treatment Corporation (ARTC). ARTC serves the communities of Bedford-Stuyvesant in Brooklyn, Harlem and East New York, and operates a women's center in Harlem to meet the specialized clinical and rehabilitative needs of female substance abusers.

Dr. Primm presented a series of charts illustrating sociological factors that interact with drug abuse problems in New York City and Central Harlem.

In his first example, Dr. Primm compared New York City's overall felony rate from 1969 to 1979 to the total felony rate in Central Harlem (110th Street to 155th Street and the East River to Amsterdam Avenue). From 1969 until 1971 there was a high incidence of felony crimes in both New York City and in Central Harlem. A decrease in the number of felony crimes reported for Central Harlem occurred with the infusion of funds into New York City for substance abuse services. This decrease (see figure No. 1) began in 1971, felony crimes increased slightly in 1975 and continued to decline in 1979. However, Dr. Primm noted that there is an increase in felony crimes in Harlem after 1979 and that this increase is coincident to a decrease in funds available for substance abuse treatment.

Dr. Primm suggested that drug addicts chronically participate in grand larceny and burglary to support their drug habits. The number of arrests for grand larceny and burglary have precipitously declined in Central Harlem relative to their incidence in New York City, which Dr. Primm attributes to the infusion of Federal and State funds to substance abuse treatment programs. (See figures No. 2 and No. 3.)

FIGURE 1.— Number of total felonies in New York City and central Harlem, 1969-79.

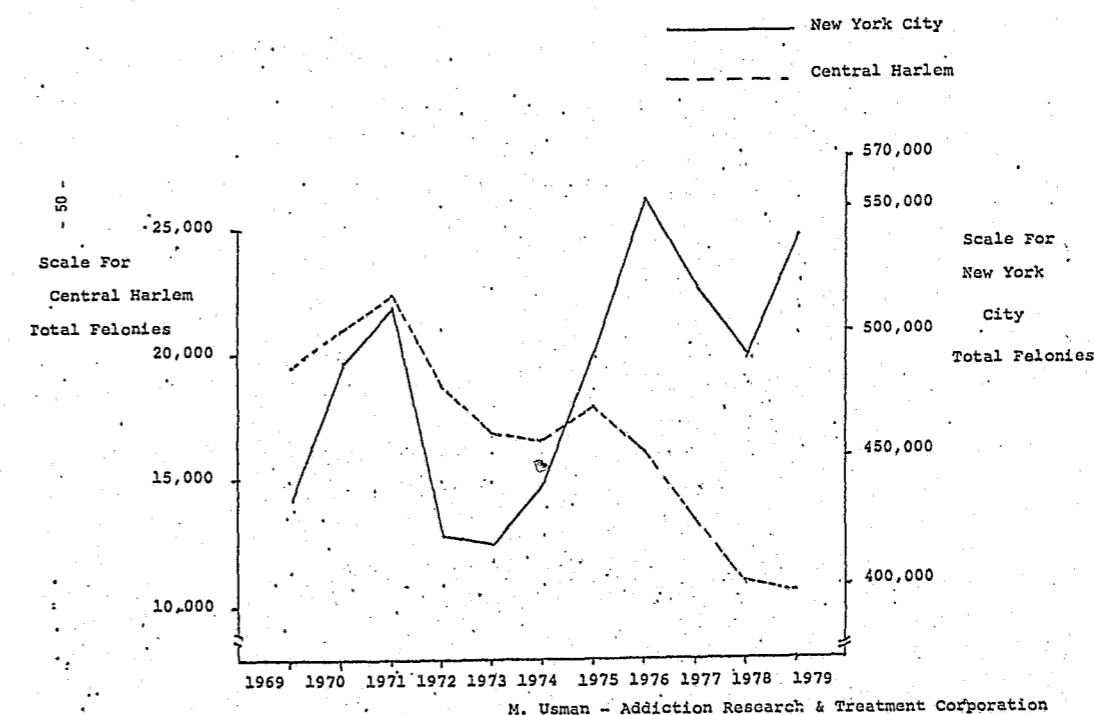


FIGURE 2.—Number of burglaries in New York City and central Harlem, 1969-79

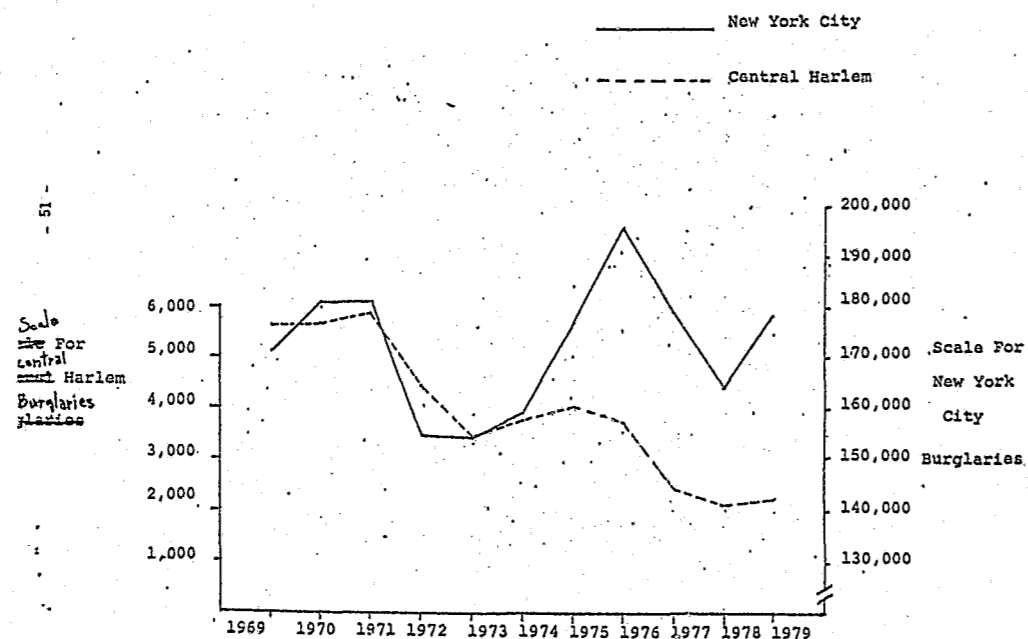
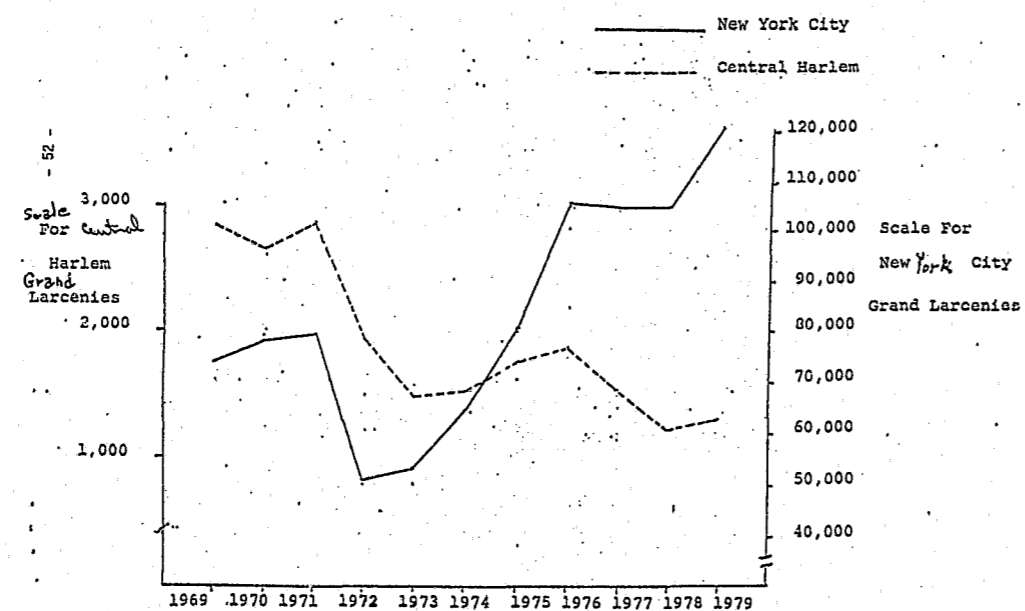


FIGURE 3.—Number of grand larcenies in New York City and central Harlem, 1969-79

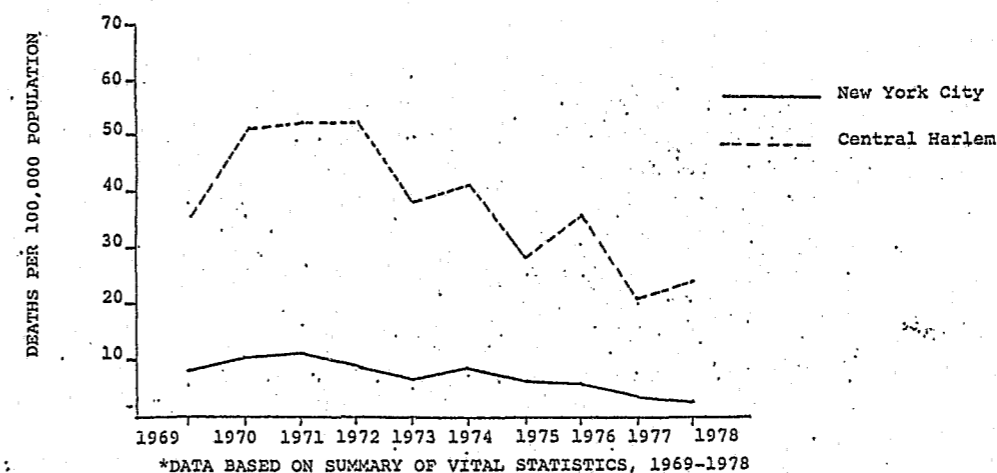


The number of deaths occurring in Central Harlem as a result of drug dependence per 100,000 population was described as "tremendous" by Dr. Primm when compared to overall New York City mortality figures. Dr. Primm pointed out that the amplitude of Central Harlem is included in the total number of deaths documented for New York City. That is, if Central Harlem's deaths due to narcotic ingestion were to be eliminated, the number of deaths for New York City would flatten out over the time period represented on the graph. The bulk of narcotic overdose deaths occurring in New York City occur

in Central Harlem followed by Fort Green and Brooklyn. Dr. Primm warned that "any reduction in drug treatment money will increase the amplitude of this particular line . . ." That is, more people will die of drug overdoses.

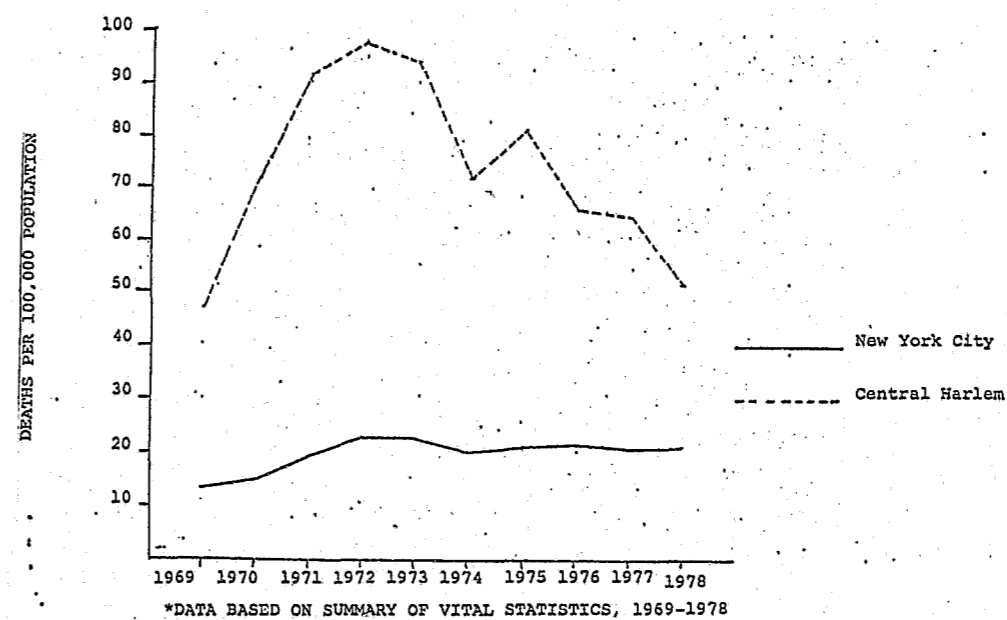
Dr. Primm next discussed homicide rates in Central Harlem and New York City. And stated that the leading cause of death for Black males in Harlem, ages 15 to 35, is homicide. A young Black male living in Harlem has a seven times greater chance of becoming a homicide victim than in any other part of the city. He attributes the infusion of treatment funds into New York City to the decline in the rate of homicides in Central Harlem. (See figure No. 5).

FIGURE 4.—Crude death rates from drug dependence for New York City and central Harlem, 1969-78*



M. Usman - Addiction Research & Treatment Corporation

FIGURE 5.—Crude death rates from homicides for New York City and central Harlem, 1969-78*



M. Usman - Addiction Research & Treatment Corporation

Tuberculosis is a preventable disease and its occurrence is associated with such social factors as alcoholism, drug addiction, poor housing, undernourishment, and general poverty conditions. Forty-five percent of all patients admitted to Harlem Hospital for tuberculosis are also narcotic addicts. Yet, Dr. Primm stated that 9 out of 22 tuberculosis clinics were closed in Harlem.

Dr. Primm emphasized that any diminution of rehabilitation efforts, especially the 7 and 10 percent set asides for prevention and the proposed budget revision to cut \$40 million in State Formula Grants from NIDA's authorization "will inevitably exacerbate and accelerate these intolerable conditions . . ." in communities such as Harlem and Bedford-Stuyvesant.

Men, women and children who make up the Harlem community live under conditions of social and economic inordinate stress. While mortality rates in New York City are steadily declining, Harlem has exhibited a dramatic increase in those disease entities and mortality indices that are most closely associated with substance abuse, with chronically stressful conditions and with the grinding poverty that is the reality of life in Harlem in 1980: homicide; cirrhosis; tuberculosis; cardiovascular and renal diseases. Dr. Primm stated:

Harlem is in a climate of fiscal austerity, steadily shrinking employment opportunities and a sharp decrease in human services resources.

There is no single city in America more greatly affected by drugs than is New York, specifically those communities with high minority populations.

Dr. Primm also pointed out the following distribution of liquor stores in Harlem compared to other sections of New York City:

Harlem: One store per 2,870 population;

Bronx/Brooklyn: One store per 4,500 population; and

Queens/Richmond: One store per 5,000 population.

Dr. Primm questioned why the State liquor licensing authority continues to issue licenses for retail outlets in Harlem considering the evidence available on the high rates of cirrhosis of the liver which is available from the New York State health authorities.

Dr. Primm concluded his presentation by stating:

Harlem has a paucity of health and mental health services, an anticipated reduction in those that presently exist, a density of liquor stores that exceed that of all other New York City communities, and is the hub and supermarket of East Coast licit and illicit narcotic traffic.

It is plagued with insufficient funding for substance abuse resources and now faces State and Federal reduction in support.

You have already heard from previous speakers mounting evidence of increased importation of illicit high quality Middle Eastern heroin. The alarming statistics presented here reflect malignant neglect and racism. Unrest, anxiety and depression pervade our communities rendering them fertile for epidemic implosion.

c. Phoenix House Foundation, Inc.

Ronald L. Coster, Senior Vice President of Phoenix House Foundation, a private treatment facility in New York City, represented Dr. Mitchell S. Rosenthal, President of Phoenix House, who was unable to attend the hearing, and delivered Dr. Rosenthal's statement. Mr. Coster was accompanied by Mr. Kevin McEneaney, director of the Phoenix House drug education and intervention unit.

Dr. Rosenthal's statement confirms the testimony made by other witnesses appearing before the Select Committee: namely, that the Nation is facing a heroin crisis. Treatment agencies have already felt

the impact of readily available and high quality heroin present in many areas of the country. Mr. Coster stated that individuals entering treatment with heroin as their primary drug of abuse have increased 42 percent between January 1978 and the third quarter of 1979. He further stated:

There is no question but that we are going to have another heroin crisis. What we should be asking ourselves is what kind of a crisis we are going to have. If we imagine we will be seeing a replay of the late 1960's or 1970's then we are in for a considerable shock.

Addiction in the coming decade, however, will be a truly egalitarian phenomenon. It will run throughout all of our society and throughout every community, and its primary victims will be the young.

Between 1975 and 1978, regular marihuana use among high school seniors increased by more than one third to 37 percent, while the number of daily users doubled. Recent studies in Maine and Maryland showed one high school student in six using marihuana on a nearly daily basis.

Drug abuse among school children becomes more alarming when one considers the growing numbers of adolescents who do not restrict their substance abuse to marihuana. A 1978 New York study that found 125,000 marihuana users also found that 118,000 school-age children had tried cocaine and that 125,000 youngsters had tried PCP for the first time. A study conducted by NIDA in 1979 found a 100 percent increase in the number of high school seniors using cocaine on a regular basis, between 1975 and 1978, and a 47 percent increase in 1979.

Dr. Rosenthal's statement for the record warned of "stepping stone" prognosis in the usage of less potent to more potent substances. He stated:

So we are facing today a tragic constellation—a growing number of younger users each year, a movement by younger users from marihuana to more potent drugs, and the availability of more and more lethal heroin.

In light of increased numbers of young people experimenting with and abusing drugs and the increased availability of high-quality heroin, "this heroin crisis of the 1980's will strike hardest and most devastating, the young." Dr. Rosenthal expressed alarm that, despite the evidence of increasing heroin availability, the nation is not adequately preparing for the heroin crisis.

Local treatment programs in New York are, according to him, operating at 96 percent of their capacity, yet funds for providing treatment at the local level have been cut. Treatment programs must not only absorb cost increases for such necessities as food, fuel and rent—but must also absorb reduction in funds.

New York State receives \$26 million from NIDA for its drug treatment program, \$3 million, or more than 11 percent, is section 409 money that is subject to the Administration's proposed drug abuse budget cut. Since section 409 funds are allocated by formula rather than need, New York State, which has one of the largest number of drug addicts in the nation, does not receive as much Federal funding for drug treatment and prevention as it should.

According to Dr. Rosenthal:

The bulk of this 409 money goes to support statewide services, many of which have been mandated by the Federal Government. Funds for statistical studies required for funding and for the preparation of a comprehensive State plan all come out of the State agency's 409 pocket.

Now, clearly, these services won't be eliminated should the money to pay for them disappear. \$3 million will have to come from somewhere else, and the somewhere else will most likely be local treatment.

That means treatment programs—facing what amounts to an incipient client population explosion—will get no help meeting inflationary cost increases, will lose 2 percent of present State funds plus the NIDA 410 dollars that will have to go to cover the loss of 409 dollars.

He also stated that it was extremely important to increase prevention efforts in each State, but not at the expense of treatment programs. He pointed out that prevention and treatment are not mutually exclusive entities but are parts of the same effort. The two fields have a direct relationship and have impact upon one another. Many treatment agencies have a direct role in prevention activities. He stated that parents, communities, schools and other groups involved in prevention and education consult treatment facilities for information and assistance. Phoenix House now receives 200 requests each month for information and assistance.

Dr. Rosenthal envisions the growth of prevention and education in drug-free treatment programs. Parental involvement is a necessary ingredient in drug education and prevention, and drug-free programs have been working with parents and parent groups as part of treating substance abusers. Dr. Rosenthal stated that the reduction of funds available to treatment agencies will inhibit the very activities in prevention and education that should be enhanced. The set-aside will produce little initial movement on the prevention scene; yet denying those funds to treatment programs will limit their growing involvement in prevention and educational activities. The net result will be a setback for prevention efforts and will also be a "disaster" for treatment.

Dr. Rosenthal concluded by explaining that when a new prevention effort is begun, public and parental awareness of drug abuse is heightened. Schools acquire a capacity to identify substance abusers. Thus, the first product of a prevention program is invariably a sizeable number of hitherto undiscovered candidates for treatment. Hence, in order to have an effective prevention effort it is also necessary to maintain a local treatment capacity.

d. Addicts Rehabilitation Center (ARC)

The Addicts Rehabilitation Center, a private organization, is located in Harlem and has been providing treatment, rehabilitation, prevention and education services to the community for 22 years. Mr. James Allen, Executive Director of ARC, spoke of drug abuse and addiction as part of a larger societal-cultural process in which the entire community is victimized.

Last year, ARC provided treatment for 2,500 abusers, of whom 951 lived in the residential drug-free program. Of the 951 drug abusers, 364 worked while living in the residence, earning \$2.2 million.

Drugs are a visible, inescapable fact of life in Harlem. They are easy to procure and the young people of Harlem are being incessantly victimized by the deluge of drugs on the streets of their community. In the late 1960's and early 1970's the process of locating and purchasing heroin was a furtive, risk-laden activity. That has changed now. By 1980, heroin is easy to obtain in Harlem and in other communities in New York—a true "buyer's market" has developed.

Recently, heroin dealers have resorted to the standard merchandising principle known as "product differentiation", whereby name brands and different labels are affixed to the product, in this case heroin. The drug addict or abuser no longer takes whatever substance can be found on the street. Rather, the abuser shops around for the heroin that is considered to be the most potent or the cheapest on any given day. Dealers must now compete with one another and at many locations in Harlem one can actually witness dealers and "steerers" hawking their deadly wares to strolling shoppers.

In discussing prevention activities in Harlem, Mr. Allen stated that the quality of education in Harlem is so poor that it is doubtful that the schools could mount an effective drug abuse education and prevention program.

When asked whether NIDA provided any guidance regarding implementation of the 7 percent set-aside, several panelists indicated that NIDA provided little guidance. While the intent of Public Law 96-181 was to develop prevention and education programs the witnesses claimed that very little has been actually implemented within the existing drug abuse network.

It was suggested that before NIDA establish prevention guidelines, the Institute convene people with experience in such areas as prevention, rehabilitation, education and community affairs and that NIDA utilize this experienced cadre in designing prevention and education strategies.

Dr. Primm spoke to the issue of the newly authorized prevention funds by observing that in all probability the grants and contracts will be awarded to evaluative and feasibility studies and that very little will find its way to actual prevention and education efforts. Dr. Primm suggested that the committee undertake a thorough review and investigation of federally funded drug abuse research as well as the review processes involved in making grant and contract awards. Dr. Primm stated that neither NIDA nor any other Federal agency responsible for prevention and education activities "produce anything that (is) particularly effective in Black and Hispanic communities."

C. FINDINGS

1. The State Formula Grant (section 409 of Public Law 92-255) is a critical component in this nation's organizational and programmatic ability to combat and prevent drug abuse. Aside from the significant portions of the Formula Grant monies which are used in direct treatment, rehabilitation and prevention/education activities and services the Formula Grant mechanism also permits the States to monitor, evaluate, manage and develop the quality of care and services delivered within the individual State.

2. The proposed budget revision which would eliminate the State Formula Grant program would, if implemented, have both immediate and long-term devastating impacts on our society. The immediate effect of such a drastic budget cut would be the forced closing of countless treatment and primary prevention facilities throughout the country (see Appendix). These facilities provide vitally needed services to thousands of substance abusers, school-age children, communities. Another short term effect of the loss of the State Formula

Grant appropriation will be a rapid diminution of the ability of the individual State to monitor and manage the programs within its jurisdiction.

Some of the long- and intermediate-range effects of the proposed budget cut are equally alarming. The inability of treatment and prevention programs to provide needed services will result in increased numbers of abusers who must go untreated, or who will receive less than adequate care. The closure or forced reduction of prevention and education services funded by the States through the Formula Grants will result in at-risk populations moving deeper into the life-styles and mind-sets of substance abuse. One of the results of these abusers and at-risk individuals being denied adequate services will be a rise in the social ills which are attendant to drug abuse and addiction: increased crime rates; increased welfare rolls; increased unemployment; increased mortality; decreased productivity. The \$40 million "saving" envisioned by the Administration will prove to be cost-ineffective as the increased social effects of increased addiction will necessitate increased expenditures for law enforcement, welfare programs, food stamps, and a host of other social welfare programs. Beyond the financial costs of increased drug abuse, the ultimate prices will be lost lives and crushed families.

3. The 7 percent set-aside (Public Law 96-181) which increases prevention dollars at the expense of treatment service creates counter-productive competition for dollars within the drug abuse industry. Treatment professionals and prevention/education professionals receive much of their funding via the same appropriation (section 410, Public Law 92-255). The unfortunate result of this need to share has been and is a quasi-adversary relationship between treatment and prevention/education specialists. This sort of competition can only result in diminished effectiveness of both areas. Prevention and education are viable and necessary components in any nation's community's overall drug strategy and must receive the full budgetary and legislative support of the Congress and the Administration.

4. NIDA has failed to formally advise and counsel the Single State Agencies regarding the manner in which the proposed elimination of the State Formula Grants will impact on the national service delivery system the manner in which the individual States will be affected. In brief, there has been insufficient formal communication between the States and NIDA in this critical service delivery issue.

D. RECOMMENDATIONS

1. The Director of NIDA should appoint a Task Force that would be responsible for the development of crisis management capabilities. The Task Force would seek to determine the ways in which future drug crises in this nation may be anticipated and the ways in which the nation's treatment system might best respond. It is further recommended that the Director of NIDA maintain close coordination with other drug-related agencies in this effort.

2. The Congress must restore the funds for the State Formula Grant (Section 409, Public Law 92-255) proposed for elimination by the Administration. If not restored this nation's substance abuse health delivery system will be unable to meet critical health needs.

3. To better achieve the intended objective of promoting drug prevention; the Congress should consider providing separate and sufficient funding for drug prevention programs rather than mandating a percentage set aside for such purposes taking from funds specifically allocated for drug treatment programs.

APPENDIX A

MEDICAL EXAMINER LAG TIME—CALCULATED ON DATA THROUGH FEBRUARY 1980

	Lag time (months)	Date: Current through—
Atlanta.....	3	December 1979.
Baltimore.....	5	October 1979.
Boston.....	2	January 1980.
Buffalo.....	2	Do.
Chicago.....	7	August 1979.
Cleveland.....	2	January 1980.
Dallas.....	2	Do.
Denver.....	3	December 1979.
Detroit.....	4	November 1979.
Indianapolis.....	3	December 1979.
Kansas City.....	1	February 1980.
Los Angeles.....	5	October 1979.
Miami.....	4	November 1979.
Minneapolis.....	2	January 1980.
New Orleans.....	4	November 1979.
New York City ¹	11	July 1979.
Norfolk.....	3	December 1979.
Oklahoma City.....	2	January 1980.
Phoenix.....	2	Do.
San Antonio.....	4	November 1979.
San Diego.....	3	December 1979.
San Francisco.....	3	Do.
St. Louis.....	4	November 1980.
Seattle.....	2	January 1980.
Washington, D.C.....	3	December 1979.
Philadelphia.....	(²)	Estimate 3 mo. delay, e.g., data current through December 1979.

¹ New York City processes data only once every 3 mo.

² No information available on Mar. 18, 1980, computer printout.

APPENDIX B

In an effort to ascertain the effects of the 7 percent set-aside (Public Law 96-181) and the proposed elimination of the \$40 million State Formula Grant (section 409 of Public Law 92-255) on the health and human services delivery systems in substance abuse treatment and prevention, the Select Committee queried the directors of several Single-State Agencies. The committee also sought to ascertain the amount and nature of formal communications between NIDA and the individual State agencies. The following material indicates some of the probable effects of the proposed budget cuts in 12 States (including the District of Columbia and Puerto Rico) and in 2 metropolitan areas. The material also discusses the role of NIDA in assisting and advising the individual States in adjusting to these programatically crippling funding changes.

SUMMARY OF SELECT COMMITTEE'S INQUIRY TO SINGLE-STATE AGENCIES

I. The following States and cities provided data to the Select Committee regarding the impact of the proposed \$40 million cut in State Formula Grants to Single-State Agencies and the implementation of the 7 percent set-aside for drug prevention and education programs:

District of Columbia, California, Connecticut, Florida, Illinois, Maryland, New Jersey, New York, Ohio, Pennsylvania, Texas, Puerto Rico, Philadelphia, and Detroit. Detailed and complete statements of the Single-State Agencies follow this summary.

II. A survey conducted by the National Association of State Alcohol and Drug Abuse Directors found that "the Federal Drug Abuse Formula Grant program in fiscal year 1980 supports nearly 1,000 publicly funded drug abuse programs."

Eight hundred thousand are provided direct service through these 1,000 programs.

Three hundred forty-two are treatment programs, 381 are prevention programs.

All face closing down under a cut of Formula Grant funds.

A. DISTRICT OF COLUMBIA

Loss of six prevention programs for youth, loss of one prevention program for the elderly, loss of one vocational program, loss of one educational program, loss of the District's entire planning unit for drug abuse prevention.

B. CALIFORNIA

Loss of prevention services to 17,400 clients, loss of treatment services to 759 clients.

C. CONNECTICUT

Loss of 60 treatment slots; 6 prevention projects will be affected; dissolution of monitoring teams in program management, thereby eliminating the monitoring, evaluation, planning, fiscal and quality control capabilities of this Single-State Agency.

Annual cost per methadone patient is \$2,000 per annum, annual cost of prisoner maintenance is \$11,089.

D. FLORIDA

Reduction of over 40 prevention projects serving approximately 76,000 clients statewide.

Immediate impact on treatment services appears nominal (five treatment programs funded from section 409 funds). However, the Florida Single-State Agency states "one can predict with certainty an unabated demand for treatment services if prevention programs are not on line to reduce this demand."

E. ILLINOIS

In addition to 323 funded treatment slots, the viability of the State's substance abuse toxicology and much of prevention, information and monitoring functions are dependent on section 409 funds.

Loss of staff would severely impair ability to carry out statutory mandates.

F. NEW JERSEY

The Single-State Agency estimates that approximately 1,350 patients will lose drug treatment services.

The 7 percent set-aside reduced outpatient treatment slots by 335.

The combined effect of the set-aside and the Formula Grant cuts will "seriously impact New Jersey's capacity to provide treatment services by approximately 25 percent."

"NIDA has not furnished any guidance on the implementation of this set-aside."

G. NEW YORK STATE

The formula grant "supports 129 agency staff positions and direct services to approximately 4,000 clients per year."

Programs affected by section 409 cuts include:

Training and Resource Development, Committee on Prescription Drug Misuse, Criminal Justice Treatment Projects, Vocational Rehabilitation, Community Development, Program Management and Performance Review, Research and Evaluation, and Planning and Administration.

H. OHIO

As of May 1980, Formula Grant funded programs served (a) 615 out-patient clients, (b) 15 day-care clients, and (c) 8 residential youth clients. With new admissions and discharges over the year, the annual figures for section 409 funded treatment clients approximates 1,500.

Formula Grant funds are used in providing court diagnostic and referral service to 700 clients per year, hotline and crisis intervention services to 15,000 clients per year and drug abuse prevention and education services to approximately 35,000 individuals per year by 35 funded agencies.

I. PENNSYLVANIA

Discontinuance of 10 treatment-rehabilitation programs, discontinuance of five prevention programs, discontinuance of two counsellor training programs.

J. TEXAS

Immediate termination of 24 drug abuse prevention programs state-wide reaching 30,000 persons annually in counselling, youth alternative programs, and education-informational programs.

The Single-State Agency projects that if 600 high-risk youth currently in section 409 funded programs become dysfunctional drug abusers, their annual cost to society (treatment, crime, lost productivity) would be approximately \$10,500,000.

IV. Of the Single-State Agencies responding to the Select Committee's inquiry only 2 States (New Jersey and Texas) stated that NIDA initiated consultations with the States regarding the proposed cut in section 409 funds.

LETTER TO DIRECTORS OF SINGLE-STATE AGENCIES

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

On May 2, 1980, the Select Committee on Narcotics Abuse and Control held a hearing in New York City to assess the extent of increased flow of Southwest Asian heroin into the United States, the

impact of that influx on treatment programs, and the effect on treatment providers of the recent proposal to cut Formula Grant money (\$40 million).

In order to gain a nationwide perspective on this critical issue, I would appreciate it if you would supply the Select Committee with the following information:

1. What is the impact of the proposed \$40 million cut in State Formula Grants on your State? That is, what services will be affected, how many treatment slots will be cut, what are the secondary social costs (e.g., increased welfare rolls, crime rates, etc.) estimated as a result of the proposed budget reductions?

2. Has the National Institute on Drug Abuse (NIDA) initiated any consultations with your agency regarding the manner in which the proposed budget cut will impact on your State, or have you initiated contacts with NIDA on this matter? What was the substance and the result of those consultations?

3. How will the 7 percent set-aside impact on treatment services in your State? Has NIDA furnished any guidance on implementation of the set-aside?

4. Of the new NIDA prevention budget of \$11.27 million, how much is being allocated to your State? What stipulations or restrictions, if any, has NIDA attached to any increases in prevention funds for your State? That is, are you being given guidelines or conditions on how the money is to be spent?

Answers to the above questions will enable the Select Committee to communicate the actual social costs of the proposed budget cut to our colleagues in the Congress.

I deeply appreciate your attention to this matter and your efforts in answering my request. I look forward to your prompt response.

Thank you for your cooperation.

Sincerely,

LESTER L. WOLFF,
Chairman.

[Responses]

NATIONAL ASSOCIATION OF STATE ALCOHOL
AND DRUG ABUSE DIRECTORS,
May 5, 1980.

"The Administration's proposed elimination of the alcohol and drug abuse formula grants will bring about a drastic reduction in services for alcoholism and drug abuse throughout the country," said Jeffrey Kushner, President of the National Association of State Alcohol and Drug Abuse Directors (NASADAD). "The revised Federal budget for fiscal year 1981 will force the eventual closing down of over 2,000 publicly supported programs now serving 2.3 million persons in need of alcoholism and drug abuse services through education, prevention and treatment," Kushner said.

Authorized by Public Laws 91-616 and 92-255, the formula grant programs provide \$56.8 million annually to State Alcoholism Authorities and \$40 million to State drug abuse agencies for support of alcoholism and drug abuse services and programs throughout the country. "These formula grant funds are the only tax dollars sent to

Washington which come back to the States with flexibility so that they can be used in the States to fit into their respective continuums of care. The President's revised budget for fiscal year 1981 would completely wipe out these programs next year, as well as rescind \$2 million from each in fiscal year 1980.

"According to a NASADAD survey of State Alcoholism Authorities, 38 States who responded spent \$25.8 million of the Federal formula grants annually in direct treatment and rehabilitation services primarily through grants and contracts with local agencies and voluntary programs. They spent an additional \$3 million for intervention programs, \$7.3 million for prevention, \$1.5 million for training, \$0.8 million for research, \$1.2 million for administration, and \$5 million for planning and coordinating alcoholism services," Kushner said. "NIAAA had only \$78.7 million for treatment and prevention in fiscal year 1980. Elimination of the formula grant will result in a reduction of over 30 percent in treatment and prevention capacity alone in fiscal year 1981 unless the funds are restored.

"The Federal formula grant for alcoholism services supported nearly 1,200 programs, of which 622 are treatment, 197 are intervention, and 204 are prevention. When these services are eliminated, nearly 1.5 million persons now receiving direct services from these programs will be without publicly supported alcoholism programs."

"For drug abuse, forty-one State drug abuse authorities responding to the NASADAD survey reported that they allocated \$10.7 million of the formula funds directly to treatment and rehabilitation programs, through grants and contracts with local communities and local governments. Another \$7.3 million is spent for prevention programs, \$3.0 million for training, \$2.5 million for research, \$2.5 million for administration, \$3.2 million for planning, \$0.7 million for management information and \$0.8 million for criminal justice diversion. The Federal drug abuse formula grant program in fiscal year 1980 supports nearly 1,000 publicly funded drug abuse programs, providing direct services to over 800,000 persons. Among these 1,000 programs, 342 are treatment programs and 381 are prevention programs. All face closing if the cuts are accepted by Congress. It seems ridiculous to close down cost effective programs currently operational and serving thousands of clients while the Administration asked for large increases in other parts of the budget even within the health care budget," Kushner stated.

"Indirectly, the Federal formula grant programs affect far more than the 2.3 million persons reported to be receiving direct services because of the large amount spent in both alcoholism and drug abuse on prevention programs. These prevention programs, such as those on fetal alcohol syndrome and alternative programs for youth, reach millions of people throughout the States and localities."

Speculating on the reasons for the Administration's cuts, Kushner stated that the formula grant programs are not the same as State revenue sharing. "These are discrete service programs specifically authorized by the Congress to combat two of the most serious and costly public health problems facing the nation today. To think that State tax dollars will replace these Federal formula fund dollars is nonsense when the States are also being asked to assume the cost of many other programs now Federally funded and the States are already

paying for over one-third of the alcoholism and drug abuse services in the country. The current budget proposal will gut the programs and turn millions of Americans in need of these services into the streets and has the potential to destroy the National effort to impact alcohol and drug abuse in this country."

For information on the impact of the cuts on your program, contact your State Alcoholism Authority or Single-State Agency for Drug Abuse Prevention.

THE ADMINISTRATION'S PROPOSED ELIMINATION OF ALCOHOL/DRUG ABUSE FORMULA GRANTS

	Alcoholism	Drug abuse
Alabama.....	\$1,085,850	\$636,981
Alaska.....	200,000	222,323
Arizona.....	566,373	448,605
Arkansas.....	633,060	389,235
California.....	5,336,759	3,918,627
Colorado.....	627,287	494,909
Connecticut.....	695,294	699,121
Delaware.....	200,000	187,439
District of Columbia.....	400,000	575,015
Florida.....	2,074,445	1,509,658
Georgia.....	1,353,533	917,875
Hawaii.....	239,478	200,593
Idaho.....	226,395	136,586
Illinois.....	2,573,966	1,787,574
Indiana.....	1,368,101	832,966
Iowa.....	730,919	466,140
Kansas.....	567,692	357,361
Kentucky.....	987,606	589,075
Louisiana.....	1,140,981	599,613
Maine.....	305,067	181,081
Maryland.....	971,608	775,370
Massachusetts.....	1,405,761	941,102
Michigan.....	2,168,016	1,539,496
Minnesota.....	1,000,471	803,058
Mississippi.....	755,548	460,048
Missouri.....	1,241,105	786,033
Montana.....	200,000	144,318
Nebraska.....	390,391	272,751
Nevada.....	200,000	175,358
New Hampshire.....	212,211	134,808
New Jersey.....	1,822,208	1,268,550
New Mexico.....	338,273	445,262
New York.....	4,494,212	2,979,613
North Carolina.....	1,517,529	937,245
North Dakota.....	200,000	154,214
Ohio.....	2,693,046	1,698,516
Oklahoma.....	761,376	458,860
Oregon.....	589,553	581,870
Pennsylvania.....	3,035,277	1,951,338
Rhode Island.....	238,710	241,685
South Carolina.....	842,797	572,200
South Dakota.....	200,000	133,333
Tennessee.....	1,200,642	813,419
Texas.....	3,442,761	2,077,522
Utah.....	339,428	240,000
Vermont.....	200,000	133,333
Virginia.....	1,268,648	902,752
Washington.....	935,412	637,069
West Virginia.....	530,308	305,426
Wisconsin.....	1,195,419	772,249
Wyoming.....	200,000	133,333
Guam.....	32,271	212,856
Puerto Rico.....	982,601	891,805
Virgin Islands.....	29,095	141,098
American Samoa.....	9,228	6,370
Trust Territories.....	38,476	24,960
Northern Marianas.....	4,813	
Total.....	56,800,000	40,000,000

ESTIMATED USE OF DRUG ABUSE FORMULA GRANT FUNDS

[From fiscal year 1979 to fiscal year 1980]

Program/service category	I. Expenditure of drug abuse formula grant in major program categories	II. Expenditure of drug abuse formula grant for State personnel		III. Expenditure of drug abuse formula grant for program personnel		IV. Expenditure of drug abuse formula grant for local programs		V. Persons who receive services supplied by drug abuse formula grants	
		Positions	Obligated	Positions	Obligated	Programs	Obligated	Direct	Individuals
Treatment and rehabilitation.....	\$10,656,869	68.3	\$1,390,367	604.36	\$5,922,621	342.66	\$8,437,969	46,553	97,890
Prevention.....	7,263,352	25.3	445,684	330.77	2,311,669	381.5	5,100,312	461,557	4,471,000
Training.....	2,797,565	73.8	1,431,037	18.31	258,007	118.5	1,048,558	278,126	5,100
Research.....	2,494,115	29.3	755,881	2.9	30,692	6.3	814,640	200	0
Administration.....	2,534,540	114.55	1,789,567	17.75	154,374	84	135,329	0	32,392
Planning.....	3,247,016	100.53	2,538,007	20.24	188,215	14	310,844	160	0
Management information.....	734,255	24.1	383,484	1	7,000	1	45,000	12,000	0
Criminal justice diversion.....	843,178	2.5	47,519	60.72	357,246	50.55	281,008	11,420	2,600
Total ¹	30,570,890 ² (30,963,331)	438.38	8,781,546	1,056.05	9,229,824	998.51	16,173,660	810,016	4,608,982

¹ These totals represent the responses of 41 States. The following 15 States did not respond to the survey: Alaska, Arizona, District of Columbia, Hawaii, Massachusetts, Michigan, Minnesota, Missouri, Nevada, New Mexico, Oregon, Utah, Wyoming, Puerto Rico, American Samoa.

² State totals which did not incorporate categorical breakdowns of funds.

Note: Information is to be given for the current State fiscal year, or for the most recent fiscal period for which information is available.

GOVERNMENT OF THE DISTRICT OF COLUMBIA,
DEPARTMENT OF HUMAN RESOURCES,
Washington, D.C., July 18, 1980.

LESTER L. WOLFF,
Chairman, Select Committee on Narcotics Abuse and Control,
U.S. House of Representatives,
Washington, D.C.

DEAR MR. WOLFF: This letter is in response to the information you requested in your letter dated June 16, 1980 regarding proposed cuts in Formula Grant money.

During the past eight years, the District of Columbia has utilized State Formula Grant funding to supplement existing Drug Abuse treatment and rehabilitation resources and to establish new programs based on identified need.

The proposed elimination of the State Formula Grant program would have a drastic impact on the District of Columbia's ability to combat a rapidly expanding drug abuse problem particularly at a time when the availability of potent inexpensive heroin from South-west Asia is dramatically increasing on the east coast. The elimination or reduction of the formula funding would seriously hamper the District's ability to adequately plan, monitor and implement treatment and rehabilitation services in the District.

Although the District does not directly fund treatment slots with the State Formula Grant, the District does fund a variety of supportive rehabilitation and prevention programs which are designed to enhance the effectiveness of the treatment process. These programs include six prevention programs for youth, one prevention program for the elderly; a vocational program for drug-abusing offenders and an educational program for drug abusers in the District's Alcohol and Drug Abuse Services Administration.

Consequently, the reduction or elimination of formula grant funds would pose serious problems for the District in its effort to combat the problem of drug abuse.

Also, the District's current financial crisis will exacerbate these problems in that the projected drug abuse budget for the Alcohol and Drug Abuse Services Administration for fiscal year 1981 is \$4,346,400 nearly \$800,000 less than fiscal year 1980 budget.

In terms of secondary social costs, the limited availability of summer jobs for youth coupled with the increased availability of drugs indicate that there may be many idle youth who may experiment with drugs out of boredom during the next few months. The lack of funding for prevention and educational programs could result in an epidemic of drug abuse among youth that could parallel that of the late sixties and early seventies. Crime statistics already indicate an increase in property crimes and robberies. However, this increase may be due to a variety of factors.

Finally, the elimination of formula funds would have a major impact on the District's ability to plan and monitor the delivery of services. Planning is particularly important since the District has few dollars and a multitude of competing priorities. The elimination of the formula funds would result in the loss of the District's entire planning unit for drug abuse prevention. This would include 13 staff positions.

Unfortunately, neither the District nor has NIDA initiated any consultation regarding the Section 409 formula cuts. There has been discussion on the impact of the 7 percent set-aside on the District's Statewide Services Grant (SWSG) Program. NIDA furnished two letters explaining how the 7 percent reduction in Section 410 fund was applied to District's SWSG.

The District SWSG treatment slots were reduced by 22 slots, 10 residential and 12 outpatient. The dynamic capacity for these slots is 20 clients for the residential and 36 clients for the outpatient slots. Therefore, the District Statewide Services treatment program will serve 56 clients in 1981. Here again, the District treatment resources are reduced at a time when the demands for services has sharply increased.

In terms of prevention, NIDA has indicated that \$60,000 is available to the District for prevention services in fiscal year 1981. In our renewal application for the State Prevention Coordinator program, the District is requesting \$67,000 salaries, supplies and equipment; \$45,000 for prevention projects and \$30,000 for a Channel One Program for a total of \$142,000 for the period October 1980 through June 1981. If this grant application is approved, the District will be required to spend the money in accordance with the conditions of the grant award and HEW regulations for administration of grants. NIDA usually issues these guidelines at the time the award is made.

These answers to your questions should be helpful to the Select Committee in assessing the impact of the formula cuts on the District. However, if you need further data or clarification, please contact me. Also, please accept my apology for not responding to your letter sooner.

I would urge the Select Committee to thoroughly review the impact of the Formula Grant reduction on the States and give full and fair consideration to problems that will occur if the Formula grants are reduced or eliminated. Thank you for giving me the opportunity to present my views on this critical matter.

Sincerely,

SIMON HOLLIDAY,
Chief, Alcohol and Drug
Abuse Planning Division.

STATE OF CALIFORNIA, HEALTH AND WELFARE AGENCY,
DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS,
Sacramento, Calif., June 30, 1980.

MR. LESTER L. WOLFF,
Chairman, Select Committee on Narcotics Abuse and Control,
Washington, D.C.

DEAR MR. WOLFF: This is in response to your request for information regarding NIDA's budgetary issues and anticipated impacts on California.

1. What is the impact of the proposed cut in State Formula Grants on your State?
2. Has NIDA initiated any consultations with your agency regarding the manner in which the proposed budget cut will impact on your State?

No.

Have you initiated any contacts with NIDA on this matter?
 There have been many contacts initiated by this Department, and many from the California constituency as a result of information sharing and advocacy efforts of this Department.

In addition, I have also actively advocated for retaining formula grant monies as an officer of NASADAD. As a member of the NIAAA Advisory Council, I sponsored a resolution relating to this issue.

3. How will the 7 percent set-aside impact on treatment services in your State?

Holding other programs to existing funding levels, NIDA did not provide the Statewide Services Grant with a cost-of-living increase. NIDA's policy, however, required California to give programs a 3% cost of living in 1980 and another 3% cost of living in 1981 (totaling a 6% cost of living over two years). This necessitated a reduction in treatment slots. NIDA had requested that the cuts be taken in outpatient drug-free programs, but this Department implemented cuts across the board (480 slots) because the cost of living was granted to all programs.

Has NIDA furnished any guidance on implementation of the set-aside?

NIDA provided guidelines on implementing the cost of living.

4. Of the new NIDA prevention budget of \$11.37 million, how much is being allocated to your State?

\$260,000.

What stipulations or restrictions, if any, has NIDA attached to any increases in prevention funds for your State?

California is to comply with the requirements of the NIDA State prevention grant application.

I hope that this letter has responded to your concerns. If you have further questions or comments, I would welcome your call.

Regards,

RITA SAENZ,
 Director.

Enclosure.

DRUG ABUSE FORMULA GRANT FUNDS

	Expenditure of drug abuse formula grant			Persons who receive services supported by drug abuse formula grant (direct)
	In major program categories	For program personnel (positions)	For local programs (number)	
Treatment/rehabilitation.....	\$635,359	66	11	759
Prevention.....	1,317,444	149	54	17,405
Training.....	479,313	5	6	50
Evaluation/research.....	720,422	1	5	
Administration.....	44,920			
Coordinating/planning.....	587,252	17		110
Management information.....	49,459			
Criminal justice.....	111,157	18	4	1,160
Total.....	3,945,526	256	80	19,520

CONNECTICUT ALCOHOL AND DRUG ABUSE COUNCIL,
 Hartford, Conn., July 9, 1980.

Hon. LESTER L. WOLFF,
 Chairman, Select Committee on Narcotics Abuse and Control,
 U.S. House of Representatives, Washington, D.C.

DEAR CONGRESSMAN WOLFF: This letter is in response to your request of June 16, 1980 in which you asked the Connecticut Alcohol and Drug Abuse Council (CADAC) in its capacity as the Single State Authority (SSA) to provide the Select Committee with information by responding to four (4) questions.

In my capacity as the Executive Director of CADAC, it is my pleasure to address the following questions you have raised so that you can evaluate the impact of the proposed \$40 million cut in Drug Formula Funds at the grassroots level:

1. What is the impact of the proposed \$40 million cut in State Formula Grants on your State? That is, what services will be affected, how many treatment slots will be cut, what are the secondary social costs (e.g., increased welfare rolls, crime rates, etc.) estimated as a result of the proposed budget reductions?

It must be emphasized, that any cut in State Drug Formula Grants funds will have a deleterious effect on the drug abuse prevention, treatment and rehabilitation efforts of the SSA and other States especially the States in the tri-State region consisting of Connecticut, New York and New Jersey. This issue is addressed in the last portion of this letter.

A cut of \$40 million would directly affect services in three (3) treatment environments/modalities; outpatient/methadone maintenance, outpatient/drug free, and residential/drug free. Drug Formula Funds ("409") are utilized to augment the Statewide Services Grant (SWSG) ("410") in order to provide additional funds to support three (3) programs which are directly involved with the treatment and rehabilitation of heroin abusers. The fourth program which will be directly affected by this cut will be the Facilitating Integration and Reentry Experience (FIRE) project which is the Department of Correction's principal reentry program for prisoners with drug abuse problems. Therefore, the cut in Drug Formula Funds equates to an approximate loss of forty-one (41) outpatient/methadone, three (3) residential/drug free and sixteen outpatient/drug free slots for a total of sixty (60) treatment slots. Any cuts in funding will create a loss in services and slots directly affecting treatment program personnel as well as clients. It is anticipated that a cut of \$40 million in drug formula funds would create a loss of five (5) treatment professionals in these drug programs.

Since 1977, CADAC has embarked on a program to expand the drug prevention program throughout Connecticut. The fiscal strategy has been to increase the amount of State appropriations for prevention while decreasing the amount of "409" funds to be utilized in the prevention category while attempting to gradually reduce "409" fund support to treatment programs. The cut of \$40 million will directly affect six (6) prevention projects which are solely funded by formula funds.

In addition to the cuts having an effect on treatment slots, personnel and prevention programs, a termination of funding of this magnitude would eliminate eighteen (18) critical positions in this SSA which are supported by these "409" funds. On July 1, 1978 CADAC was designated in Public Act 78-127 as the SSA for Connecticut. During this period of time, this Agency has continued to develop and expand its mandated planning/budgeting/funding functions in response to the ever expanding substance abuse effort. These developments necessitated a plan to develop a responsive monitoring and evaluation capability over the past two (2) years. The impact of any cut in funds will result in dissolution of the monitoring teams in the Program Management Division and a loss of planning and fiscal personnel thereby eliminating the monitoring, evaluation, planning, fiscal and quality control capabilities of this SSA which will not be in conformance with the letter and spirit of Public Law 93-641, National Health Planning and Resources Development Act of 1974, as amended.

2. Has the National Institute on Drug Abuse (NIDA) initiated any consultations with your agency regarding the manner in which the proposed budget cut will impact on your state, or have you initiated contacts with NIDA on this matter? What was the substance and the result of those consultations?

As of this date, NIDA has not initiated any formal or informal consultations with the SSA concerning how the proposed \$40 million cut will impact on Connecticut. Members of CADAC staff have attempted to work in close coordination with the NIDA Project Officers. It appears that the Project Officers seem to be sympathetic to our inquiries but are unable to provide any definitive responses to the serious concerns of this SSA.

I have spoken to the Institute Director personally about the impact of this loss on Connecticut's programs. In addition, I have informed him, in writing, about the increase in heroin abuse in the North East and asked for emergency spot funding as all methadone clinics in this State have waiting lists. I received a sympathetic ear.

3. How will the 7 percent set-aside impact on treatment services in your State? Has NIDA furnished any guidance on implementation of the set-aside?

Simply stated, the 7 percent set-aside has resulted in a loss of one hundred-seventy seven (177) treatment slots under the SWSG while the "bottom line" dollar amount of the grant for fiscal year 1980-81 remains the same as fiscal year 1979-80 without any inflationary increase. NIDA did provide this SSA with an explanation of the set formula and guidance on implementing the set-aside. What is unknown, at this time, is what effect the anticipated 10 percent set-aside will have on the fiscal year 1981-82 budget.

4. Of the new NIDA prevention budget of \$11.27 million, how much is being allocated to your State? What stipulations or restrictions, if any, has NIDA attached to any increases in prevention funds for your State? That is, are you being given guidelines or conditions on how the money is to be spent?

To date, this SSA has not received any indication from NIDA prevention staff members concerning Connecticut's allocation from the NIDA prevention budget of \$11.27 million, nor any stipulation,

restrictions, guidelines and/or conditions. It appears from our staff inquiries to NIDA that this issue has not been resolved which creates a vacuum in the SSA planning cycle.

In the face of this proposed cut of \$40 million in drug formula funds for fiscal year 1981, we have detected a serious increase in the heroin problem which has recently surfaced. The Connecticut Alcohol and Drug Abuse Council is deeply concerned over the alarming recent increase in the purity and availability of heroin in Connecticut, New York and New Jersey. The Hartford Office of the U.S. Drug Enforcement Agency (DEA) reports that the purity of heroin exhibits seized in Connecticut is now about 5 percent, which is slightly above the purity level of 3 to 4 percent of several years ago. The majority of the heroin seized is the "white" heroin suspected to be of Southwest Asian origin. These findings by the DEA are supported by the activities of the Statewide (Connecticut) Narcotics Task Force. This Task Force reports that heroin purity in this State is increasing and that the drug is most available in the large urban centers.

In view of the increase in the availability and purity of "white" heroin in Connecticut, CADAC has been monitoring the heroin situation very closely since September 1979. Enclosed with this response are tables which provide first and readmissions data for heroin abuse to include other opiates and synthetics. Of particular concern is the calendar year indicator data which compares 1978 and 1979 heroin trends. This data indicates that heroin abuse appears to be reaching epidemic level. The data indicated the following:

Heroin admissions show a considerable increase of +30% while total admissions expanded by 20 percent.

In terms of age at time of admission for heroin abusers, the 26-to-35 age group showed the largest expansion (plus 39 percent).

Heroin admissions by major cities and towns of residence indicate large increases for almost all major urban centers with Bridgeport (plus 45 percent), New Haven (plus 40 percent), Stamford (plus 29 percent) and Hartford (plus 30 percent).

Other localities showing sharp increases were Danbury, East Haven, Waterbury, Shelton and Ansonia.

These indications of increased heroin abuse coupled with the current 105 percent utilization rates and waiting lists at our methadone maintenance clinics in Connecticut reinforce the concern of this agency and irony of the anticipated dilemma as heroin abuse continues to rise in an era when State drug formula funds would be eliminated or drastically curtailed, at best.

Over the past few years, experience indicates that if we can move heroin users into a methadone maintenance program, we can keep them out of Criminal Justice system with reasonable success. Their recidivism rate drops when placed on methadone. Approximately 55 percent of these clients go back to family life and gain employment thereby removing themselves from a welfare status. It is difficult to determine the exact social costs involved with maintaining heroin addicts on a methadone maintenance program. The prisons in Connecticut are currently at maximum capacity with an annual maintenance factor of \$11,089 per prisoner as compared to approximately \$2,000 per methadone slot. This Agency would like to continue to

move heroin addicts into methadone maintenance so that there can be a reduction in secondary social costs associated with drug abuse.

I hope that this letter will be of assistance to the Select Committee as the fate of the proposed cut of \$40 million in State drug formula funds is deliberated in the immediate future. If I or any member of my staff can be of any assistance to you or your committee, please feel free to contact me by phone (203-566-4145) or letter.

Sincerely,

DONALD J. McCONNELL,
Executive Director.

DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES,
Tallahassee, Fla., July 9, 1980.

Representative LESTER L. WOLFF,
*Chairman, Select Committee on Narcotics Abuse and Control,
U.S. House of Representatives, Washington, D.C.*

DEAR MR. CHAIRMAN: Thank you for your letter of June 16 requesting input on the impact of Formula Grants and 7 percent set-aside reductions. I will attempt to address each question in the order presented in your letter.

1. What is the impact of the proposed \$40 million cut in State Formula Grants on your State? That is, what services will be affected, how many treatment slots will be cut, what are the secondary social costs (e.g., increased welfare rolls, crime rates, etc.) estimated as a result of the proposed budget reductions?

The elimination of approximately \$1.5 million in 409 Formula Grant funds would cripple Florida's prevention effort. The loss of these prevention dollars would result in a reduction of over 40 prevention projects which are estimated to serve approximately 76,000 clients statewide. The elimination of these funds would also severely hamper the ability of the SSA central office staff to respond to community demands for technical assistance and consultation to local providers of prevention services.

The immediate impact on treatment services deceptively appears to be nominal, since the bulk of 409 Formula Funds are earmarked for local prevention services. (There are only five treatment programs currently funded from 409 funds and we anticipate converting them to our 410 Statewide Services Grant in 1980-81.) However, one can predict with certainty an unabated demand for treatment services if prevention programs are not *on line* to reduce this demand.

2. Has the National Institute on Drug Abuse (NIDA) initiated any consultations with your agency regarding the manner in which the proposed budget cut will impact on your State, or have you initiated contacts with NIDA on this matter? What was the substance and the result of those consultations?

This office has received no formal consultation from NIDA regarding the manner in which the proposed budget cut would impact on our State. We have, however, had informal discussions with various NIDA staff regarding the effect of the elimination of these funds and have made known to the National Association of State Alcohol and Drug Abuse Directors our feelings.

3. How will the 7 percent set-aside impact on treatment services in your State? Has NIDA furnished any guidance on implementation of the set-aside?

The 7 percent set-aside will result in an overall reduction in treatment slots for 1980-81 and also for 1981-82. It is safe to assume that an overall reduction in treatment dollars will precipitate a definite negative impact on any State's treatment system. This year, beginning July 1, 1980, we were able to lessen this negative impact on treatment providers by taking an overall 1 percent cut in treatment dollars for all providers throughout the State. If we assume that our 410 Statewide Services Treatment Grant maintains a 90-95 percent utilization rate, then we can foresee some very real problems in any reduction in either treatment slots or Federal dollars related to these slots in 1981-82. Our overall utilization rate this year under this grant has run approximately 88-92 percent. If we are faced with another cut next year we may find ourselves in a position of not being able to provide quality services to those individuals seeking treatment in Florida. NIDA has been most cooperative in allowing the State latitude in determining how and where cuts for 1980-81 would occur. We have enjoyed ready access to key NIDA staff, particularly Mr. Robert J. Robertson, Director of NIDA's Division of Community Assistance; Mr. Paul Curtis, Assistant Director for Program Inspection and Compliance; Mr. Tom Sevy, Assistant Director for Treatment Services; and NIDA's Project Development Specialist for Florida, Mr. Greg Frankel. Each of these individuals has gone out of his way to offer ideas and suggestions to Florida in order to minimize the negative impact of a reduction in treatment dollars for 1980-81.

4. Of the new NIDA prevention budget of \$11.27-million, how much is being allocated to your State? What stipulations or restrictions, if any, has NIDA attached to any increases in prevention funds for your State? That is, are you being given guidelines or conditions on how the money is to be spent?

Under the 1980-81 State Drug Abuse Prevention Grants Program, NIDA has allocated to Florida roughly \$150,000, of which \$115,000 is new money this year. Of this amount, approximately \$35,000 is made available for prevention coordination at the statewide level. The balance is required by NIDA to be earmarked for local prevention service and demonstration programs. This grant program, however, offers Florida only one-tenth the amount which was available under 409 Formula Funding. Extensive guidelines for the use of these funds have been promulgated by and are available from NIDA.

NIDA's Bernard McColgan and his prevention staff have provided tireless and excellent assistance to our staff in our planning for utilization of these funds.

I have been requested by NIDA's Heroin Strategy Task Force to chair a meeting in Miami July 24 to examine the impact of a purported increase of pure white heroin into our State with regard to the impact on treatment strategies and resources. Certainly this speaks well for NIDA's ability to initiate appropriate responses to the unforeseen treatment problems created by the irregular flow of all illicit drugs.

Your staff has been most responsible in keeping me informed as to the interests of your Select Committee on Narcotics Abuse and Control; please be assured of our continuing interest and support.

Sincerely,

FRANK D. NELSON,
Administrator, Drug Abuse Programs.

STATE OF ILLINOIS,
DANGEROUS DRUGS COMMISSION,
Chicago, Ill., July 8, 1980.

HON. LESTER L. WOLFF,
*Chairman, Select Committee on Narcotics Abuse and Control,
Washington, D.C.*

DEAR CONGRESSMAN WOLFF: I am happy to respond to your letter of June 16, and hope that the information relative to our situation in Illinois will contribute to the national picture that the Select Committee needs to accurately assess the impact of any loss of drug abuse funding. I will address your questions in the order contained in your letter.

1. Enclosed is a memorandum prepared for our Advisory Council outlining the impact of formula grant cuts for Illinois, along with a copy of the Advisory Council's response to this information. As you can see, the response has been forwarded to all of the members of the Illinois Congressional delegation, the White House, Senator Magnuson, and also to the National Association of State Alcohol and Drug Abuse Directors (NASADAD). While it is impossible to say with any degree of certainty what the social impact of such cuts might be, it is certainly safe to project that increases in both welfare and crime rates might well follow; perhaps an even more important social consideration is the impact of the loss of much of our early intervention programming activity, whereby individuals in the beginning stages of drug abuse are often able to resume a drug-free lifestyle before irreparable damage to themselves or society results. These effects are difficult to measure, but the absence of early intervention, education and outreach activities would surely prove to be costly.

2. The National Institute on Drug Abuse (NIDA) has not initiated any consultations with this Commission concerning the proposed Federal budget, although members of our staff have discussed the situation with various NIDA representatives. I should stress, however, that those discussions have taken place on an informal basis and as a result of the contacts our staff have developed and maintained with NIDA staff, rather than as a result of any specific effort to ease the potentially painful results of their proposed cuts.

3. The 7 percent set-aside of earmarked prevention money creates a difficult situation in Illinois (as, of course, in other States) in that the rigidity of the guidelines provided by NIDA allows little room for decisionmaking on the part of the States as to what methods might be preferable under the State's individual circumstances. In this particular area NIDA has set forth explicit instructions concerning the reduction of our treatment capacity over the next two years, resulting in a decrease of 268 out-patient treatment slots during that

period. We perceive a lack of sensitivity to the impact of such a cut-and-dried approach on the part of NIDA in this regard, as well as a lack of Federal understanding of the States' individual needs for flexibility in terms of set-aside implementation. While we fully support increased prevention emphasis, the Federal approach leaves something to be desired.

4. We have been informed that Illinois will receive approximately \$200,000, or approximately 1.7 percent, of the new NIDA \$11.27 million prevention budget. While instructions in this area have not been specific, it is our understanding that we should not request any additional monies over and above the Prevention Services Program (PSP).

I hope that this information is helpful to the Select Committee by providing some details about the Illinois situation. While we are fully sympathetic with the need for fiscal responsibility and some expenditure reductions, we are extremely concerned, as I know you are, with impacts that are not thought through, and initiatives which may appear to be promising, but which are not tailored to the needs of individual populations and situations, and which will likely turn out to be more costly in the long term. As always I will be happy to assist the Select Committee in any way as you proceed with these questions.

Sincerely,

THOMAS B. KIRKPATRICK, Jr.,
Executive Director.

Attachment.

MEMORANDUM

To: Dangerous Drugs Advisory Council.
From: Thomas B. Kirkpatrick, Jr.
Date: May 13, 1980.
Subject: 409 funding.

Federal funds provided to the Commission under Section 409 in fiscal year 1980 amounted to approximately \$1.8 million; for fiscal year 1981 Illinois has been awarded \$1.65 million. During the previous calendar year, we paid for sixty positions out of the 409 funds, as well as funding 13 programs. For this calendar year, our budget indicates 62 staff positions to be paid out of 409 funds, as well as continuing program funding at reduced levels. From this you can readily see that nearly two-thirds of our own staffing, including all of the toxicology lab and much of our prevention, information services and monitoring functions, are dependent on the 409 funds as currently budgeted.

In addition to the internal losses the Commission would suffer with the elimination of 409 funds, 323 treatment slots are supported by this funding source, virtually all in the outpatient drug free category, which in many instances includes early intervention, education, prevention and outreach work. The programming is evenly distributed around the State, meaning that in terms of both modality and geography, we are supporting our NIDA-approved priorities in large part with threatened funds.

Unreplaced loss of the staff and programs dependent upon 409 funds would severely impair our ability to carry out our statutory mandates. Indicated in the attached sheets are those programs whose

services would be cut back or eliminated as a result of any reduction or abolition of funding. We are assuming a pro-rata application rather than selecting specific programs for closure, for the purposes of this discussion.

STATE OF MARYLAND,
DRUG ABUSE ADMINISTRATION,
DEPARTMENT OF HEALTH AND MENTAL HYGIENE,
Baltimore, Md., June 27, 1980.

LESTER L. WOLFF,
Chairman, Select Committee on Narcotics Abuse and Control,
Washington, D.C.

DEAR CONGRESSMAN WOLFF: Your letter of June 16 has been received and the Maryland Drug Abuse Administration is honored to have the privilege of responding to your question, in the hope that you may influence the restoration of formula (409) drug abuse funds.

In fiscal year 1980, the Maryland Drug Abuse Administration received over \$775,000 in Formula Grant monies, which provided funding support for thirteen (13) direct treatment service programs, two (2) treatment coordination efforts (Baltimore City Health Department, Baltimore County Health Department), and two (2) Training and Education programs (OETAS, SCODAE).

The thirteen (13) treatment programs funded in whole or part by the Formula Grant have a combined static capacity of 666, while the projected number of clients served in fiscal year 1980 by these programs is 2,438. Client census figures indicate a 90 percent utilization rate in the formula funded programs, indicative of the need and usefulness of these available slots in the Maryland Drug Abuse Treatment network. Fiscal year 1980 projections also indicate a total of 1,132 criminal justice referred clients in treatment at these thirteen (13) programs, 46 percent of all clients served. Of the 2,438 client total to be served by formula grant programs, 15,585 are white (65 percent), 853 non-white (35 percent). These figures include 1,877 males (77 percent), 561 females (23 percent), with 341 clients (14 percent) under the age of 18, and 2,097 clients (86 percent) in the 18 year or over category.

In analysis of this data, however, it must be considered that formula grant funds do not support any direct treatment programs in Baltimore City, resulting in a possible distortion of overall utilization and race figures presented in this report.

Other formula grant monies support administrative grants to both Baltimore City Health Department (30,000) and Baltimore County Health Department (30,016). These funds provide for coordination of all drug abuse treatment within the respective subdivisions, allowing a certain degree of autonomy and flexibility in the operation of programs in accordance with local planning and implementation objectives. Training and Education programs are also funded by the Formula Grant Award, and these programs are provided for the entire State network's participation and enrichment. Through these funds, program staff are certified at the numerous levels of drug abuse treatment, and kept informed of the latest developments in counseling and programming.

As can be surmised, formula grant funds reach all levels and areas of drug abuse treatment in Maryland, and any decrease in such funding

would have a detrimental effect on all facets of the drug abuse treatment effort by the Drug Abuse Administration.

The slot reduction in the Statewide Services Grant is the result of an overall 7 percent reduction in NIDA Community Service programming, with the bulk of the reduction monies being diverted to Drug Abuse Prevention funding areas. The decreased Statewide Services Grant slot allocation and resultant funding level does not allow the Statewide Services Grant mechanism to fully support the two (2) NIDA programs proposed for inclusion in the fiscal year 1981 SWSG; the costs for forty (40) outpatient slots must be absorbed by either the State general fund or NIDA formula monies to maintain current levels of treatment.

Although the slot reductions represent only a 2 percent decrease in proposed treatment capacity, it is a 5 percent decrease in needed SWSG capacity; if not for the high utilization of SWSG programs (indicating additional slot needs) program reductions would undoubtedly have been more substantial.

Level funding and/or slot reductions have kept the SWSG from increasing its treatment capacity to meet the increasing demands of the drug abusing community, and fiscal reductions in any area of service delivery will only increase this demand.

The 7 percent decrease in community program funding has impacted on State's total treatment effort, but to a lesser degree than other States. Maryland has such a high utilization of slots in that NIDA, in evaluating overall program cuts, did not depreciate the Maryland slots as much as other States.

At this time, the 7 percent increase has not benefited the State Prevention effort. The Maryland Drug Abuse Administration has not received any portion of the increase in prevention funds, but is in the process of submitting a three part Competing Application for funding and expanding its Drug Abuse Prevention efforts. It is expected that this application will result in increased funding levels for Drug Abuse Prevention Programs.

Definite rules and regulations are given to the State to follow in preparing present and future prevention proposals. The NIDA prevention budget marc is communicated to the State prior to the time the State makes formal application. This marc is pre-determined by NIDA.

At the present time, \$55,538 has been appropriated to the State of Maryland for its prevention coordinator program. Additional funding for new prevention programs is available on a competitive basis. The State of Maryland is in the process of applying for its share of these funds.

In answer to your questions concerning social costs and utilization rates, please see the attachment to this letter which goes into detail in these areas.

To date this agency has received no direct communication nor consultation from NIDA in these matters. They have been discussed with a few NIDA staff and at a recent meeting of the National Association of Alcohol and Drug Abuse Directors (Austin, Texas, June 9-12). We have not received any information as to a formula for distributing the new prevention money. It is our understanding that most of it will be distributed by a competitive bid process. It is our strong opinion that a formula grant process based upon a required

prevention plan developed by the Single State Agency would be a better and more productive protocol.

If we can be of further help in this matter, please call.

Sincerely,

RICHARD L. HAMILTON,
Director.

Enclosures.

ESTIMATED SOCIAL COSTS DURING FISCAL YEAR 1982 OF PROPOSED CUT IN FEDERAL 409 FUNDS TO MARYLAND

An analysis of the socio-economic costs of drug abuse in Maryland, performed through contract by PACE Management Associates for the Drug Abuse Administration, was completed in calendar year 1978. The study of socio-economic costs was conducted as part of a larger project designed to provide estimates of the incidence and prevalence of drug abuse in the State and its subdivisions, in addition to the social cost analysis.

Social costs were defined for purposes of the study as encompassing those economic costs borne by society for:

- (a) services provided to drug abusers;
- (b) crimes committed by drug abusers;
- (c) judicial and correctional processing of drug abusing offenders; and,
- (d) lost productivity of those drug abusers whose use and dependencies prohibit a normal livelihood.

For purposes of preparing estimates of drug abuse prevalence, the definition of drug abusers was limited to those individuals who are active abusers of drugs or who are most at risk for becoming dysfunctional and/or for needing treatment or other drug abuser specific services. The prevalence estimates exclude those persons who experiment with a drug or drugs or who use them infrequently for recreational purposes and do not progress beyond minimal levels of involvement with drugs.

One objective of the study was to provide an estimate of the benefits of drug abuse treatment, as measured by the reduction in costs to society which could be attributed to treatment. Calculation of the benefits of treatment was based on reduction in: (1) law enforcement costs; (2) costs of property crime; (3) decrease in unemployment; (4) costs to the Department of Parole and Probation; and, (5) costs to the Public Defender's Office.

Estimates of the reduction in social costs by source from calendar year 1977, adjusted for inflation to fiscal year 1982, are provided in the following table:

TABLE I.—DISTRIBUTION OF THE ESTIMATED BENEFITS PRODUCED BY MARYLAND DRUG ABUSE TREATMENT/PREVENTION PROGRAMS EXISTING REVENUE, INCLUDING 409 FUNDS, FISCAL YEAR 1982

Source	1st yr benefits	2d yr benefits
Property crime.....		
Law enforcement.....	\$4,938,294	\$5,129,209
Employment.....	2,518,806	2,616,184
Parole and probation.....	6,138,322	7,885,978
Public defenders.....	926,441	962,258
	240,089	249,370
Total benefits.....	14,761,952	16,842,959
Combined 2-yr benefits of treatment/prevention equals.....	\$31,604,951	

The foregoing projections of benefits from treatment/prevention are based on the assumption that the level of treatment and prevention services has basically remained stable during the period calendar year 1977 through fiscal year 1982.

The loss of \$735,000 in Federal 409 funds in fiscal year 1982 will result in a reduction in the drug abuse treatment/prevention budget of 8.75 percent. Assuming that the reduction will affect all types of modalities, environments and programs equally, the following lowered projections of benefits are presented.

TABLE II.—DISTRIBUTION OF THE ESTIMATED BENEFITS PRODUCED BY MARYLAND TREATMENT/PREVENTION PROGRAMS EXISTING REVENUES, EXCLUDING 409 FUNDS, FISCAL YEAR 1982

Source	1st yr benefits	2d yr benefits
Property crime.....	\$4,506,193	\$4,680,403
Law enforcement.....	2,298,410	2,387,268
Employment.....	5,601,219	7,195,955
Parole and probation.....	845,377	878,060
Public defenders.....	219,081	227,660
Total.....	13,470,280	15,369,346

The differences between the figures presented in tables I and II represent the estimated increases in social costs to the State of Maryland which would occur in fiscal year 1982 as a result of the loss of \$735,000 in Federal 409 funds. The projected increases are distributed by source in table III.

TABLE III.—DISTRIBUTION OF PROJECTED INCREASE IN SOCIAL COSTS IN MARYLAND THROUGH LOSS OF FEDERAL 409 FUNDS FOR DRUG ABUSE TREATMENT/PREVENTION FISCAL YEAR 1982

Source	Social costs		
	1st yr increase	2d yr increase	Combined 2 yr increase
Property crime.....	\$432,101	\$448,806	\$880,907
Law enforcement.....	220,396	228,916	449,312
Employment.....	537,103	690,023	1,227,126
Parole and probation.....	81,064	84,198	165,262
Public defenders.....	21,008	21,820	42,828
Total.....	1,291,672	1,473,763	2,765,435

The treatment benefits projected from all sources for the first year following treatment was \$11,809,562 in 1977. Using a conservative inflation factor of 25 percent in treatment benefits for the period calendar year 1978 through fiscal year 1982, yields an updated estimate of \$14,761,952 in treatment benefits for the first year following treatment. Second year estimated benefits of \$13,474,398 become \$16,842,999, when adjusted for inflation. When divided by the total budget for drug abuse treatment and prevention allocated through the Drug Abuse Administration (\$8,399,062), the benefits per dollar spent in treatment/prevention is 1.76. This figure can be interpreted as projecting that every dollar spent in treatment yields \$1.76 in reduced social costs to the citizens of Maryland. The second year ratio of treatment benefits to the cost of providing treatment is 2.01, or a reduction in social costs of \$2.01 for every dollar spent in treatment/prevention. The current estimate of treatment/prevention benefits

during the two years following treatment for every dollar spent in treatment/prevention is then \$3.77. A loss of \$735,000 in treatment/prevention monies, then, would result in a loss of \$2,770,950 in treatment benefits over a two-year period. This translates into a projected increased burden of social costs in the amount of \$2.77 million to the citizens of Maryland.

STATE OF NEW JERSEY,
DEPARTMENT OF HEALTH,
Trenton, N.J., July 24, 1980.

Mr. LESTER L. WOLFF,
Chairman, U.S. House of Representatives,
Select Committee on Narcotics Abuse and Control,
Washington, D.C.

DEAR MR. WOLFF: This is in reply to your recent correspondence regarding your Committee's interest in the increased flow of South-west Asian heroin into the United States and its impact on treatment programs in light of the proposed Formula Grant fund reductions. I will attempt to respond to the four questions as presented.

1. The proposed State Formula Grant elimination will seriously impact New Jersey in that we will lose \$1,300,000. With this loss, 57 service delivery positions will have to be eliminated which will adversely effect 11 drug treatment programs and approximately 1,350 patients will lose drug treatment services. The secondary costs, welfare, crime in the streets, etc., are difficult to estimate. However, 1,350 patients will be without treatment and all have the potential of reverting back to street crime.

2. We have had numerous discussions with different NIDA officials regarding the proposed budget cuts for treatment and its impact on New Jersey, and most of these contacts were initiated by me or my staff. The basic results of these discussions, to date, has been sincere concern on behalf of NIDA but no constructive alternatives were presented.

3. The 7 percent set aside of treatment funds this year reduced our outpatient slots by 335 and we anticipate a similar reduction next year. This along with Formula cuts will seriously impact New Jersey's capacity to provide treatment services by approximately 25 percent. NIDA has not furnished any guidance on the implementation of this set aside.

4. Of the new \$11,000,000 NIDA Prevention budget, we anticipate receiving approximately \$164,000 broken down as follows:

a. State prevention coordinator.....	\$34,000
b. Prevention service programs.....	90,095
c. Channel One Program.....	40,000
Total.....	164,095

The only new monies made available under this new Prevention budget is the \$90,000 identified above. The State Prevention Coordinator and the Channel One Program are essentially a continuation funding level. The Channel One Program is somewhat disturbing in that most of our current funding cannot be used because Prudential Insurance Company is not "prepared" to go into most of the cities we have suggested.

One concern that I have is that the enabling 7 percent Prevention set aside legislation was designed to provide significantly more Prevention funding to States and community programs. In this set-aside process, we have lost 335 treatment slots or an equivalent of \$402,000 in treatment money and yet we are only realizing an additional \$90,000 for Prevention programming. The issue that needs to be immediately addressed is the discrepancy between the tremendous loss of treatment funding from States and the disproportionate amount returned to States for Prevention activities.

On a more positive note, NIDA has made a pioneering effort in the development of a policy which truly reflects a federal/state partnership. Thus, while providing a general outline, locally, States have the options and alternatives as to how the monies are to be expended. New Jersey is fortunate in that we have a Statewide community organization model which we are currently replicating throughout New Jersey. Additional, New Jersey has played a key role in organizing the ten northeastern states into a working consortium to begin to collectively plan and organize local communities. Additionally, an affiliation has been established in the northeast region with Adelphi University training through the United States Office of Education. We feel this type of regional infrastructure is important, unique, and a prototype for other States to follow.

In addition to the specific questions enumerated in your letter, I am enclosing several pieces of correspondence which I previously sent to Lee Dogoloff of the Domestic Policy Staff of the White House on this same issue. Similar information was also sent to Dr. Pollin of NIDA.

If I can be of any further assistance, please feel free to contact me.

Sincerely,

RICHARD J. RUSSO, M.S.P.H.
Assistant Commissioner
Alcohol, Narcotic and Drug Abuse.

Enclosures.

STATE OF NEW JERSEY,
DEPARTMENT OF HEALTH,
Trenton, N.J., July 22, 1980.

Mr. LEE I. DOGOLOFF,
Associate Director for Drug Policy,
Domestic Policy Staff,
The White House,
Washington, D.C.

DEAR LEE: Thank you for your July 2 reply to my June 17 letter regarding the serious outbreak of heroin use in the State of New Jersey.

Your statement that almost one-third of those seeking heroin treatment in the United States are former veterans is news to me. New Jersey's experience indicates that less than 10 percent of those needing treatment for heroin qualify under the veterans eligibility. Perhaps you can provide me with the source of your information.

We have had a positive ongoing relationship with the Veterans Administration's drug treatment facilities in New Jersey for years. The Veterans Administration provides residential, drug free, detoxification, counseling and referral at the East Orange Hospital, and outpatient methadone maintenance, drug free, counseling and referral

services on Central Avenue in the city of Newark, and we have had an ongoing contract for reimbursement of services with the Veterans Administration for well over eight years. For "eligible" clients, we are reimbursed \$150 per month per client for outpatient methadone maintenance and \$45 per month per client for outpatient drug free services.

Recent discussions with the Veterans Administration in New Jersey indicate that they have been experiencing increased demands for both inpatient and outpatient services over the past 15 months and their capacity is currently taxed to its maximum. This increased demand for treatment is consistent with other drug treatment facilities in New Jersey as I have previously documented to you. Therefore, it appears, at present, that the Veterans Administration in New Jersey is not in a position to absorb the overflow of those "eligible" clients seeking heroin treatment.

Our situation in New Jersey is even more critical today than when I wrote you a month ago and unless we receive increased fiscal support for several New Jersey high impact cities, we will be forced to close intake and begin to turn clients away from treatment.

Your consideration, as always, is appreciated.

Sincerely,

RICHARD J. RUSSO, M.S.P.H.,
Assistant Commissioner,
Alcohol, Narcotic and Drug Abuse.

THE WHITE HOUSE,
Washington, D.C., July 2, 1980.

DEAR DICK: Thank you for your letter of June 17, 1980, regarding the very serious outbreak of heroin use in New Jersey and the increased demands on the New Jersey treatment system. Your letter provided more than adequate documentation of the seriousness of the problem and we have already used some of the information to determine the best course of action to respond to the problem.

As you are well aware, the influx of Southwest Asian heroin into the entire United States is most acute in New York City and Newark, New Jersey. In May, the interdepartmental steering group on Southwest Asian heroin set up 10 working groups to undertake specific activities to combat the problem. One of these working groups focuses specifically on the treatment response to the Southwest Asian heroin problem. Thus far, the group has concentrated its attention on the current four impacted cities in the United States: New York, Newark, Baltimore and Washington. Given the present situation, we believe that direct and concerted attention on these areas will not only ease the most acute problems but also provide a way of responding that can be duplicated in other cities, should the heroin influx expand across the United States.

Mrs. Elaine Johnson of NIDA has already contacted you and SSA directors/project officers with programs in New York City, Newark, Baltimore and Washington and advised them that the Veterans Administration, through its medical center, is more than willing and ready to absorb the overflow of those in need of heroin treatment who

qualify under veteran's eligibility. It is our understanding that almost one-third of those seeking heroin treatment in the United States are former veterans. Additionally, the VA is sending out a professional services letter this week to advise the directors of VA medical centers that the treatment centers in the impacted areas are experiencing a very serious treatment shortfall related to Southwest Asian heroin, and should take the initiative to check with their local treatment centers to determine where the VA can provide support. Dr. Stuart Baker of the VA has already contacted the medical directors in Boston, the Bronx, Manhattan, Montrose, Buffalo, East Orange, Baltimore and Washington and will follow-up with the aforementioned professional services letter.

Additionally, the Office of the Assistant Secretary for Health at the Department of Health and Human Services and NIDA are identifying the NIDA funded slots in the CMHCs in the impacted cities, to see if they can absorb some of the overflow, possibly the non-opiate abusers, thus freeing up slots for heroin treatment. As an affiliate agency of the CMHCs, HHS is also looking to the CMHCs to pick up non-opiate abusers.

It is my understanding, that in addition to these changes, the State of New Jersey has been advised to prioritize treatment using a 90 percent utilization rate and that you have already taken very positive steps, such as transferring slots from Atlantic City to Newark to deal with the problem.

In these times of budgetary duress, it is encouraging for us to see the very welcome steps that the State of New Jersey is taking to respond to the problem. During July, a team from NIDA will be visiting seven trend-setting cities (Newark included) to solicit additional ideas and suggestions on how we can best meet the Southwest Asian heroin treatment needs and in those cities, yet unaffected, learn how they will respond if the heroin problem expands. I know the NIDA personnel will be in touch with you at that time and I look forward to your invaluable contribution and expertise to their findings and recommendations. In the interim, should you feel there are some additional steps we can take immediately, please do not hesitate to call me.

Sincerely,

LEE I. DOGOLOFF,
Associate Director for Drug Policy,
Domestic Policy Staff.

STATE OF NEW JERSEY,
DEPARTMENT OF HEALTH,
Trenton, N.J., June 17, 1980.

Mr. LEE I. DOGOLOFF,
Associate Director for Drug Policy,
Domestic Policy Staff, The White House, Washington, D.C.

DEAR LEE: There are a number of indicators that strongly suggest New Jersey is in the midst of a very serious outbreak of heroin use with tremendous increased demands on our treatment system. Some of these indicators are as follows:

NORTHEAST

The Drug Enforcement Administration has documented a three-fold increase in heroin seizures and a general trend of increasing purity. The number of individuals arrested and charged with heroin offenses increased 25 percent in 1979.

NIDA's Forecasting Branch recently presented documentation to the National Advisory Council on Drug Abuse which indicated that heroin availability was on the increase in the following Northeast cities: Boston, New York, Newark, Philadelphia, Baltimore, Washington. The Branch also reported a three- to four-fold increase in heroin availability from the "Golden Crescent."

Your Domestic Policy Staff recently confirmed that your office is aware of the "increasing heroin threat on the East Coast." Dr. Pollin and other NIDA staff also have indicated their awareness of increased heroin availability in the Northeast.

NEW JERSEY

Total admissions to New Jersey drug treatment programs in 1979 were 17,278, an increase of approximately 55 percent over the 1978 figure of 11,112.

For the first time in several years, there has been an increase in the proportion of admissions (for all drugs) with no prior treatment experiences. First admissions for 1978 were 3,961 and in 1979 6,534, an increase of 65 percent. This change suggests that there has been an increase in the number of new drug abusers, since the 65 percent increase in first admissions is greater than the 55.5 percent increase for all admissions.

While total admissions increased from 1978 to 1979 by 55 percent, admissions of heroin abusers increased significantly more from 7,712 to 12,846, an increase of more than 66 percent.

Detoxification admissions (the vast majority of which are heroin detoxifications) rose in the same time period from 4,502 to 9,386, an increase of 108 percent.

Admissions directly into methadone maintenance during the same time period rose from 1,072 to 1,587, an increase of 48 percent.

Our Department of Health's Narcotic Monitoring Laboratory has analyzed in excess of 850,000 patient urine samples for drugs of abuse over a five and one-half year period. Analysis of these samples indicates that the monthly rates of quinine and morphine positives reached a level in the last several months significantly higher than any previously recorded information (see attached).

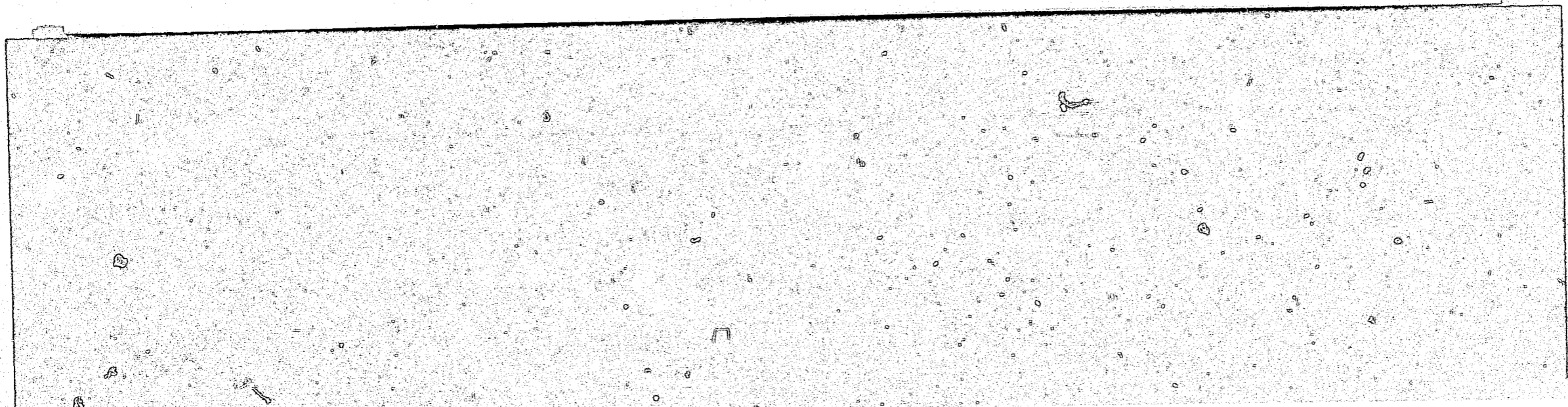
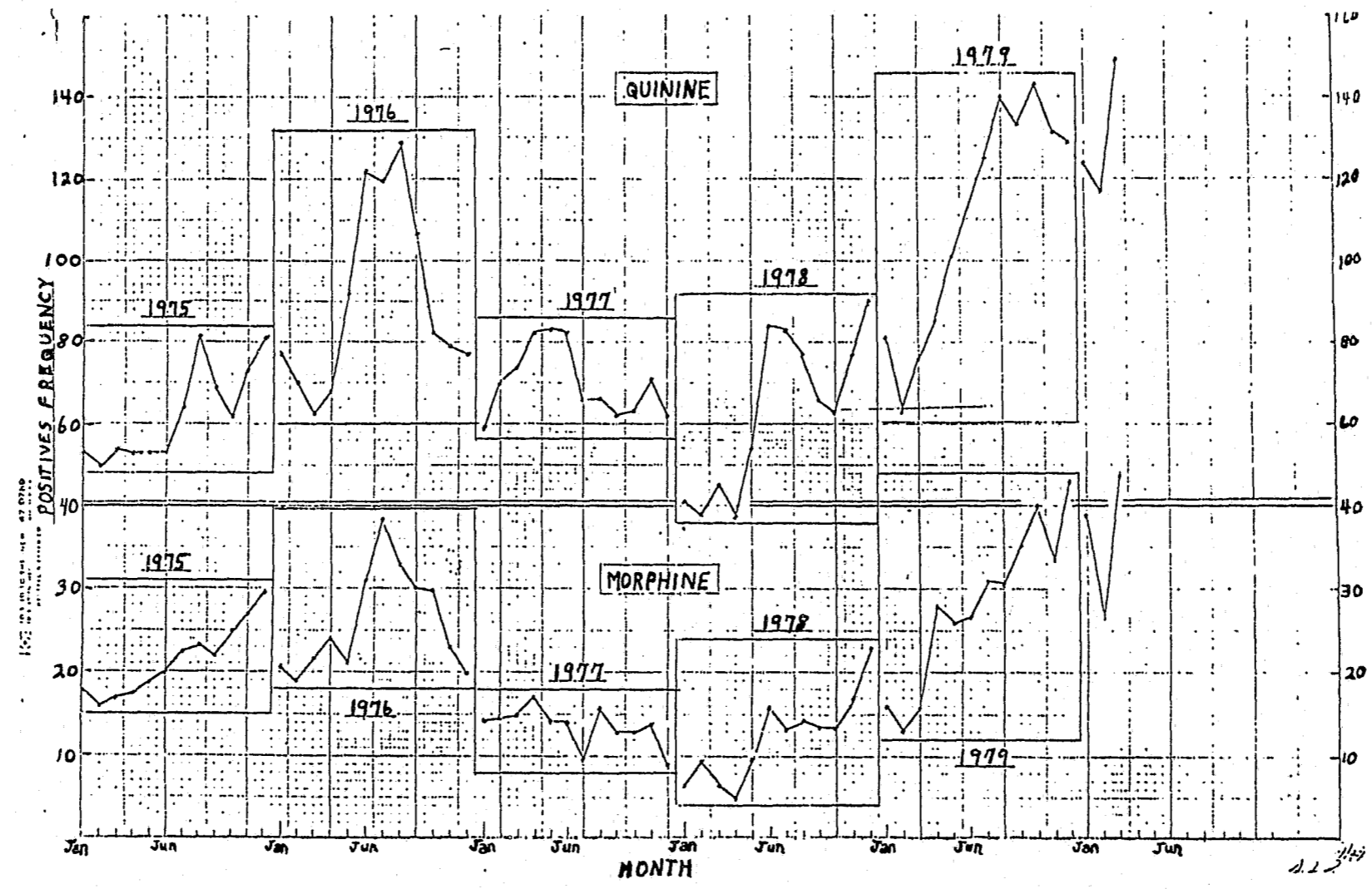
Our current Statewide utilization is approximately 109 percent of capacity and 24 specific programs are significantly above this percent. Because of NIDA's mandate to reduce our Statewide Services Grant treatment slots, we are in the process of reducing treatment slots based on CODAP figures, onsite reviews of case files, and other monitoring devices. Thirty-seven (37) programs in New Jersey funded under the Statewide Services Grant will be reduced by a low number of one slot to a high number of 63 slots, and some of these same programs have utilization rates over 100 percent.

I believe the above indicators provide adequate documentation for New Jersey's increased treatment needs, primarily based on the documented increased availability of heroin, and our high demand for treatment. I understand from my recent discussions with Dr. Pollin and information received from your office, NIDA is studying the feasibility of insuring that adequate treatment services are available to those areas of the country most in need by reviewing means of targeting additional slots to those areas having the most severe problems with increased heroin availability. New Jersey is definitely one of those areas with this severe problem and I urge your support for providing additional slots to help us deal with this most important issue.

If additional documentation is needed, please feel free to contact me. Your cooperation, as always, is appreciated.

Kind regards,
Sincerely,

RICHARD J. RUSSO, M.S.P.H.,
Assistant Commissioner,
Alcohol, Narcotic and Drug Abuse.



NYS DIVISION OF SUBSTANCE ABUSE SERVICES

IMPACT OF ELIMINATION OF NIDA FORMULA GRANT PROGRAM

Elimination of NIDA's drug abuse formula grant program in fiscal year 1981 would severely curtail a variety of critical services and special emphasis programs currently conducted by the Division. This grant program, which has provided approximately \$3 million annually, supports 129 agency staff positions and direct services to approximately 4,000 clients per year. Since fiscal austerity measures are also being imposed at the state level, elimination of NIDA formula grant funding would necessitate the termination of many of the Division's programs and services which are described below:

TRAINING AND RESOURCE DEVELOPMENT

Number of Agency Staff: 21 (entire program).—The purpose of this program is to train approximately 8,900 state and local drug abuse workers annually. Program goals are to enhance the skills of those providing primary services to substance abusers, increase awareness regarding substance abuse problems of those working in other human services fields and disseminate information of substance use and abuse to segments of the general population. The Training Bureau also maintains an up-to-date resource library and information services for use by both local and state agency staff.

COMMITTEE ON PRESCRIPTION DRUG MISUSE

Number of Agency Staff: 7 (entire program).—The major emphasis of this initiation is to utilize intervention, treatment, training and awareness techniques to service and inform the general public, health care providers, drug manufacturers, and industry regarding problems of prescription drug misuse. Specific services include the conducting of seminars and community presentations, development of public information materials, and provision of technical assistance to industries, community agencies and labor organizations.

CRIMINAL JUSTICE TREATMENT PROJECTS

Number of Agency Staff: 14—Number of Clients Served: 1,200 per year.—A series of projects have been developed and implemented by the Division to provide comprehensive drug treatment services to individuals confined within adult detention and correctional facilities. During fiscal year 1979-80, such services were provided to inmates at the State Ossining, Arthur Kill, Bayview and Hudson Facilities and at three New York City correctional facilities on Rikers Island.

VOCATIONAL REHABILITATION

Number of Agency Staff: 7—Number of Clients Served: 2,500 per year.—This program concentrates on the development and direction of comprehensive programs to assist the treatment community in the planning, development and delivery of vocational rehabilitation services. Agency staff also assume an advocacy role with the public and private sector to facilitate access of clients to vocational services and employment opportunities.

COMMUNITY DEVELOPMENT

Number of Agency Staff: 13 (entire program).—This bureau is responsible for linking the substance abuse treatment network with other existing resources and for increasing community support for local treatment programs. Bureau staff assist local programs to establish and maintain liaison with community planning boards, neighborhood associations, community leaders, local designated agencies, and other health and/or human services providers. The Bureau also assists local treatment programs in developing a continuum of projects designed to benefit both the client and the community.

PROGRAM MANAGEMENT AND PERFORMANCE REVIEW

Number of Agency Staff: 39.—These programs are responsible for conducting contract management, monitoring and technical assistance activities to ensure that quality client services are provided through local treatment programs. Staff within three Division bureaus conduct on-site reviews, collect program data, and assess service provider operations to insure compliance with existing contracts and local, state and federal regulations.

RESEARCH AND EVALUATION

Number of Agency Staff: 20.—Through the conduction of a variety of data analyses and program assessment activities, the Bureau of Cost Effectiveness and Research is responsible for: assessing the cost effectiveness of local and state operated drug abuse programs; developing data regarding the effectiveness of treatment in various types of programs in the state; monitoring the incidence and prevalence of substance abuse among New York State residents; and conducting and releasing studies that examine various behavioral aspects of substance abusers.

PLANNING AND ADMINISTRATION

Number of Agency Staff: 8.—A variety of additional administrative activities are supported through the NIDA formula grant program. These include: approving applications to operate voluntary, non-profit drug abuse treatment and prevention services through the Division's Licensing Unit; preparation of comprehensive, statewide plans for the provision of treatment services to substance abusers; and developing plans to insure that all federally-funded drug abuse programs become accessible to handicapped persons in compliance with Section 504 of the Rehabilitation Act of 1973.

OHIO BUREAU OF DRUG ABUSE,
Columbus, Ohio, July 10, 1980.

HON. LESTER WOLFF,
U.S. House of Representatives,
House Office Building,
Washington, D.C.

DEAR REPRESENTATIVE WOLFF: Thank you for your letter of June 16, 1980 requesting information on the impact of the loss of federal formula grant (drug) monies to Ohio. After discussing the issues with staff members, I've summarized responses to your questions below:

1. (Impact of formula grant to Ohio)

Ohio's share of the 40 million dollar cut is in excess of 1.7 million dollars. The bulk of this funding (over 95 percent) is distributed to approximately 65 agencies in Ohio through competitive grants following the same guidelines and format as NIDA's (410) Statewide Service Grants. The Bureau of Drug Abuse (Single State Agency) funds only the planner and her secretary with formula money as indicated in Public Law 92-255, e.g., funds for developing the state drug plan, and a small amount (\$30,000) for statewide training events and conferences. Thus the loss of formula grants will severely affect direct programming. As of May 1980 the formula grant funded programs were providing services to: (a) 615 outpatient clients, (b) 15 day care clients, and (c) 8 residential youth clients. The figures for May, 1980 would be similar to 100 percent utilization of the same number of NIDA (410) Statewide Service Grant slots. With new admissions and discharges over the year, the annual figures for 409 funded treatment clients approximates 1500. In addition to clients in treatment, formula grant funds are used in providing court diagnostic/referral services to over 700 clients per year in (ten) agencies, telephone hotline and crisis services to 15,000 clients per year in agencies, and drug abuse prevention/education services to approximately 35,000 individuals by (35) funded agencies providing such services.

The secondary social costs are extremely difficult to estimate as the loss of formula grants may force the state into redistributing state and other federal funds and thereby creating an overall across the board cut to all of the (approximately) 150 state and federally funded agencies whether in rural or urban areas. The potential costs due to increase in crime rates, welfare roles, Medicaid costs, school problems, etc. would be in the millions of dollars, multifold the costs of providing services.

2. (NIDA's consultation re: the impact of the budget cut.)

Although I indicated two months ago in writing to NIDA that we have not been consulted with regarding the loss of dollars, I have still received no communications regarding losses. The primary emphasis of NIDA has always been on the 410 dollars and utilization, and only regarding 409 when the state plan is reviewed. Most of our consultations and communications on formula grant losses have been through the National Association of State Alcohol and Drug Abuse Directors and the Alcohol and Drug Problems Association.

3. (The impact of the 7 percent set-aside.)

For Ohio the effect of the 7 percent set-aside is to prevent the funding of: (1) approximately 100 outpatient treatment slots and (2) the more adequate funding of 1,568 outpatient slots (i.e., to within \$50.00 of the NIDA maximum slot allocation). To date we have received no guidance from NIDA on implementation of the set-aside.

4. (The prevention allocations and guidelines.)

Ohio's share of the \$11.27 million prevention budget will be approximately \$200,000 beginning October 1, 1980. NIDA Prevention Branch has provided liberal guidelines for utilization of the funds formerly used to provide treatment services (i.e., \$131,000 of the \$200,000). However, it is tragic that this slight reallocation of \$131,000 will hardly offset Ohio's formula grant losses to prevention programs where over one half of the formula grant monies (approximately 1 million dollars) are allocated to the 35 agencies providing such services. I am

concerned that in spite of the losses in formula grant monies to states and the subsequent closing of prevention programs, NIDA may be adding up to 16 staff members to its Prevention Branch, including regional project officers. My experience in the past with such additions to federal offices has been an increase in monitoring requirements and accompanying paper work for staffs, with less funds and staff at the state level to carry out the extra work.

I hope that my responses will be useful to the Select Committee on Narcotics Abuse and Control and our Representatives in the Congress. Please do not hesitate to contact me for any further information that will help Congress in making a positive decision to restore the formula grant funds.

Thank you for the opportunity to provide information.

Sincerely,

JAMES M. SHULMAN, Ph. D.
Chief, Ohio Bureau of Drug Abuse.

COMMONWEALTH OF PENNSYLVANIA,
GOVERNOR'S COUNCIL ON DRUG AND ALCOHOL ABUSE,
Harrisburg, Pa., July 3, 1980.

HON. LESTER L. WOLFF,
Chairman, Select Committee on Narcotics Abuse and Control
U.S. House of Representatives, Washington, D.C.

DEAR CONGRESSMAN WOLFF: In response to your questions relative to the impact NIDA's proposed \$40 million cut in Formula Grants will have on the Commonwealth of Pennsylvania, I am pleased to provide the following information:

1. For fiscal year 1979/80, Pennsylvania received \$1,933,753 in Drug Formula Grants. These funds were used for (a) employment of 25 headquarters staff, (b) expenses of policy-making Council, (c) 80 program people involved in treatment and rehabilitation, and (d) four prevention and training program personnel.

The proposed elimination of NIDA Formula Grant money will require the discontinuance of 10 treatment and rehabilitation programs, five prevention programs and two programs for training 1,093 treatment counselors.

Pennsylvania has been required to reduce the number of outpatient treatment slots by 250. This is not, however, a result of proposed elimination of Formula Grant monies, but rather the reduced funding levels by NIDA in treatment monies.

The estimated secondary social/economic costs to the Commonwealth of Pennsylvania, due to the loss of NIDA treatment monies of \$791,342, will be \$4,788,658. This figure was arrived at in the following manner:

cost of treatment equals \$791,342
total number of clients treated equal 744
success rate equals 50 percent equals 372 clients successfully treated
*cost of drug abuse/abuser as of 1980 equals \$15,000

* The cost of \$15,000 per abuser is based upon NIDA figures for 1975 as found in the 1980 report "Management Effectiveness Measures For NIDA Drug Abuse Treatment Programs", Volume II. By apportioning Pennsylvania's cost to the total and allowing for an 8% inflation factor for each year of five years, divided by the approximate number of abusers in Pennsylvania, which equals 100,000, we arrived at the cost of \$15,000 per abuser.

Therefore: \$15,000 per client times 372 clients equals \$5,580,000 minus \$791,342 treatment cost equals \$5,788,658—Pennsylvania's net loss to society.

2. As of this date, there has been no contact with NIDA concerning the proposed budget cut and its impact on Pennsylvania.

3. and 4. At the present time, the NIDA prevention budget is somewhat in a state of confusion, based upon the 7 percent set-aside. We estimate this will equal \$175,000 to \$180,000, however, we have not received confirmation from NIDA, nor have we received guidelines or conditions relative to the use of these funds. Therefore, it is not possible to determine exactly what treatment services will be affected. It is, however, safe to assume additional treatment services will be affected.

In conclusion, Congressman Wolff, let me say that we here in Pennsylvania are deeply concerned and alarmed at the proposed budget reduction. Our indicators show a definite rise in heroin use in Pennsylvania over the past several months. Of particular concern is the increased purity of heroin available on the street. A recent report for the Philadelphia area shows that 53 percent of drug-related deaths are as a result of heroin. This is more than two times greater than heroin-related deaths noted for the previous two reporting periods. Therefore, I urge you to take whatever action may be necessary to have NIDA Formula Grant monies restored. If I can be of any assistance, please do not hesitate to call me.

Sincerely,

GARY F. JENSEN,
Executive Director.

TEXAS DEPARTMENT OF COMMUNITY AFFAIRS,
June 26, 1980.

Congressman LESTER L. WOLFF,
Chairman, Select Committee on Narcotics Abuse and Control,
U.S. House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN WOLFF: I appreciate your continued involvement and leadership in our efforts to deal with the drug abuse problem in this country. My responses to your questions follow. Please call me at (512) 475-6351 if any additional information or discussion is needed.

RESPONSE TO QUESTION No. 1

The impact of the proposed cut in state drug abuse formula grants in Texas will be felt in several ways. The current funding level of this program in the state is \$2,052,073. A direct result of the elimination of this grant program will be the immediate termination of approximately 24 drug abuse prevention programs spread across the state. The program locations are:

Amarillo—Amarillo MHMR.
Arlington—North Central Texas Council of Governments.
Austin—Austin/Travis County MHMR; Austin Child Guidance Center; Education Service Center XIII; Trabajadores de la Raza; and Texas Public Employees Association.
Beville—Boys' Club of Beville.
Bryan—Brazos Valley MHMR.

Corpus Christi—Corpus Christi Drug Abuse Council.
 Dallas—Methodist Hospitals of Dallas.
 Del Rio—City of Del Rio.
 El Paso—Aliviane; El Paso Center for Human Development.
 Galveston—Gulf Coast MHMR.
 Houston—Houston/Galveston Area Council.
 Midland—Permian Basin COG.
 Mineral Wells—Dunbar Neighborhood Council.
 Paris—Lamar County Alcohol and Drug Abuse Council.
 San Antonio—Alamo Area Council of Governments; City of San Antonio; Drug Abuse Central.
 Sweetwater—Sweetwater Council on Alcohol and Drug Abuse.
 Temple—Central Texas Council on Alcohol and Drug Abuse.

These programs reach approximately 30,000 Texans each year in counseling programs, involvement of youth in activities as alternatives to drug abuse, informational and educational programs.

In addition, some 600 persons at high risk of drug abuse (experimenters, social users of drugs) participate in highly structured programs of counseling and recreational activities so that their limited use of drugs does not progress to a more serious drug problem. If formula funds were cut, a majority of these persons would undoubtedly progress to a more serious state of drug abuse. The social costs of allowing these individuals to progress to a more serious state of drug abuse would be incalculable. It should also be mentioned that these 600 individuals are youth ranging in age from 12 to 21 years old. The greatest likelihood of helping persons with their drug abuse problem is during this time period and lack of available help would surely be an immeasurable loss to society just as these young men and women are beginning to approach their most productive years.

With estimation methods and data from cost studies in other areas, we project that the potential costs to society (in economic terms only) should these 600 youths go on to become dysfunctional drug abusers would be \$10,500,000 annually. This includes both direct costs of treatment, related crimes, and criminal justice costs, as well as indirect costs of unemployability, hospitalization and other medical costs, absenteeism, and drug-related deaths. Bear in mind that this is a crude economic cost estimate. It does not include the great unquantifiable social costs that are involved in the disruption of the lives of everyone associated with these people.

In addition to losing the 24 prevention programs, the budget would render the Drug Abuse Prevention Division of the Texas Department of Community Affairs unable to conduct statewide planning of drug abuse efforts, provide technical assistance to communities, maintain drug abuse data systems, and distribute drug abuse information and education literature to schools, parents, and others who regularly request this type of information. Currently this program provides some 80,000 pieces of literature a year to individuals requesting assistance in combatting drug abuse. This resource would be lost to the citizens of the state if funding cuts were imposed.

RESPONSE TO QUESTION No. 2

NIDA staff have consulted with this agency regarding the impact of the proposed budget cuts. The nature of these consultations was informal and the thrust of these conversations revolved around their

genuine concern for the maintenance of the system of state-level planning and management of drug abuse programming. My impression is that NIDA has not initiated the request for this kind of budget cut and does not support it. A much more reasoned approach would be to let NIDA have the leeway for determining where, within the total agency budget, \$40 million may be saved. Better yet, that responsibility could be handled at the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) level to spread out the cuts among various programs in all three institutes. One of the anomalies of this budget is that some programs are being *increased*. See the attachment to this letter for a list of these projects.

RESPONSE TO QUESTION No. 3

The 7 percent set aside will have a minimal effect on treatment services in this state this year. The reason for this is that we have made some major reallocation of treatment resources around the state realizing greater utilization of treatment slots and greater cost efficiency. By doing so, we have absorbed this reduction of treatment funding without having to turn clients out of treatment. NIDA has consulted with us during this process but they have relied on the state to develop and implement the administrative solutions to required budget reductions.

RESPONSE TO QUESTION No. 4

Of the new NIDA prevention funds, Texas will receive \$161,168. The primary condition imposed on the expenditure of this money is that it cannot be used to hire additional state level staff to manage or administer prevention programs, but the money must be spent on direct services, i.e., to fund prevention programs at the local level. A detailed plan for the expenditure of these prevention funds must be developed and approved by NIDA prior to implementation.

I hope this information is helpful to you in your effort to obtain a nationwide perspective on this issue.

Sincerely,

RICHARD T. SPENCE,
 Director, Drug Abuse Prevention Division.

Enclosure.

DEPARTAMENTO DE SERVICIOS CONTRA LA ADICCION,
 Rio Piedras, Puerto Rico, August 11, 1980.

MR. LESTER L. WOLFF,
 Chairman, Select Committee on Narcotics Abuse and Control,
 Washington, D.C.

DEAR MR. WOLFF: Reference is made to your letter of June 16, 1980. In relation to the information asked about the effect of the recent proposal to cut Formula Grant money, we are including the following answers:

1. The new grant award reduced our treatment slots from 1,224 slots to 1,143 slots. The reduction of 80 slots in the Drug Free Modality didn't have an impact in overall budget since cost of slots was increased.

2. There has been no consultations between the National Institute on Drug Abuse (NIDA) and our Agency regarding the impact of the proposed budget cut.

3. NIDA has not furnished guidance on the implementation of the 7 percent set-aside. We are not aware of the set-aside impact and have received no information about the set-aside.

4. We are not aware of the new NIDA prevention budget or its impact on our budget.

On July 31st, we called NIDA and spoke to Ms. Evelyn Simmons to see if she could offer us more information in relation to the impact of this proposed budget cut. However, she wasn't able to offer us a clear view of the situation and only provided us with a general overview.

We hope the above information could be useful to the Select Committee. We will be pleased to send any further information you may need.

Sincerely,

SILA NAZARIO DE FERRER,
Secretary.

COORDINATING OFFICE FOR
DRUG AND ALCOHOL ABUSE PROGRAMS,
Philadelphia, Pa., July 14, 1980.

HON. LESTER L. WOLFF,
*House Select Committee on Narcotics Abuse and Control,
Washington, D.C.*

DEAR MR. WOLFF: As you know, Philadelphia is a member of the National Association for City Drug Coordination (NACDC). In this role, I am writing to you as Chairman of the House Select Committee on Narcotics Abuse and Control to provide you with information on the heroin indicator and treatment situation in Philadelphia at the current time. I have enclosed a detailed trend report prepared by this Office. This report, which was submitted to NIDA's Community Correspondence Group, analyzes major heroin indicators in Philadelphia. This Office has the ability to generate such epidemiological information in a timely and ongoing fashion.

In brief, the City of Philadelphia is seeing an increase in both the quality and quantity of street heroin. This increase has been with us now over the past several months. Faced with this increase in heroin availability, we have had some increase in the utilization in treatment slots during this period. It should be noted that we have not at this time exhausted treatment availability in Philadelphia. Methadone maintenance utilization has in particular returned from the low levels of 1978 and early 1979 and has continued to increase slowly. At this time, we are not seeing an overwhelming rush to treatment, but rather a slow and steady increase in demand.

As you know, this increase in demand for treatment is accompanied by a proposed reduction in available NIDA treatment slots due to the proposed reduction in formula funds and the 7 percent prevention requirement. Fortunately, the City of Philadelphia allocates significant resources (over two and one-half million dollars to this Office) to serving drug and alcohol involved individuals. These funds, in

addition to significant State allocated funds, (approximately four and one-half million dollars) allows for a sizeable treatment system. Even in the face of this capability, the impending reduction in NIDA treatment slots in Philadelphia will have a negative impact. In particular, the loss of formula funds to the State will directly result in the need for termination of a large adolescent poly-drug program which has been funded for over four years. Proposed cuts to NIDA will also reduce the ability of Philadelphia to flexibly respond to further increases in the demand for heroin treatment. As NACDC has stressed in the past, drug abuse finds its home in the large urban Cities of this Country. The need to respond to heroin addiction in a timely and appropriate fashion is found in these same urban Cities. I would again respectfully ask for your assistance in increasing the Federal understanding of the role of Cities in drug treatment. In particular, as we look at potential restoration of formula funds, I would again offer the important potential of Cities in responding to drug abuse prevention and treatment.

As I have noted earlier, CODAAP follows epidemiological trend indicators in a regular fashion. Our role in local government allows us regular access to information necessary to assess heroin trends. This information is available with limited turnaround due to our ongoing involvement with the variety of agencies which provide such data. For these reasons, I would recommend to you the important role of Cities in understanding national heroin trends.

I hope that you find this information helpful. If I can be of any assistance to you in the work of your Committee, please do not hesitate to contact me. I greatly appreciate the fine work of you and your staff and look forward to working with you in the future.

Sincerely,

NICHOLAS L. PICCONE,
Director.

DEPARTMENT OF HEALTH,
Detroit, Mich., July 10, 1980.

DETROIT SITUATION REPORT ON HEROIN—1980 (FIRST 6 MONTHS)

By George D. Gaines, Jr., MSW, MPH, Deputy Director

INTRODUCTION

This report is being compiled at the request of U.S. Representative Lester Wolff, Chairman of House Select Committee on Narcotics Abuse and Control. The Select Committee expressed concern about a "Heroin Epidemic" because of new and less controllable sources of Heroin: Afghanistan, Iran, Pakistan. Since early this year there has been governmental concern about the increased size of opium crops in Iran, Afghanistan, Pakistan (Golden Crescent), as well as Burma, Thailand, and Laos (Golden Triangle).

In this report we will look at our conventional "indicators" in order to assess Detroit's experience with Heroin. The indicators will be (1) data on Hepatitis B (serum); (2) street purity levels reported by Detroit Narcotics Bureau; (3) treatment seeking behavior by our

clients; (4) a review of drug episodes at Detroit Receiving Hospital; (5) a review of deaths from narcotics in Wayne County. Most of the indicators reviewed used the format of a comparison of January through June 1979 to January through June 1980.

SERUM HEPATITIS—DRUG RELATED

Intravenous drug use is responsible for many hepatitis cases. The Detroit Health Department routinely monitors these cases. The following summary is from those reviews. In 1980 (first 26 weeks) we have confirmed 79 total hepatitis B cases. In 1979 we confirmed 122 cases during the same period. The five-year median (taking highest and lowest years) is 122 cases. The prevalence of this drug-related disease is down and the general trend in this disease is down.

POLICE REPORTS

Detroit Police through its Narcotics Bureau routinely and regularly monitors the purity of Heroin through street buys; they report street purity at ½ of 1 percent and holding. Inspector Dwyer, our liaison, was aware that other cities were seeing 2-3 percent purity on the street but that this situation does not obtain in Detroit.

In 1979, 202 positive Heroin samples were analyzed by the Detroit Police. The first 5 months of 1980, 112 samples thus far. The rate of Heroin positives is increasing this year. The 112 for January through June 1980 is one less than all positive samples in 1978!

TREATMENT-SEEKING BEHAVIOR

Detroit Health Department routinely records the percent of utilization of 19 drug treatment programs in our service network. This includes nine (9) methadone maintenance clinics, one (1) short-term detox clinic, two (2) residential programs (a short-term detox and long-term treatment facility), four (4) day treatment programs, three (3) drug-free programs. The overall utilization rate as of July 1, 1980 was 104 percent of capacity.

There has been about a 25 percent increase in clients this year over last year. In 1979 (first 26 weeks) our clinics averaged 78 percent of matrix; in 1980 it was 104 percent for the same period. Out of 1,879 treatment slots, we are using 2,034. The clients in the first six months of 1980 do not vary in demographics from previous year. However, 30 percent of the clients in 1980 are first treatment clients. This is a new client group. Although the economic situation in Detroit is believed to be a factor in these new clients coming into treatment, the overall utilization of 104 percentage points to the magnitude of the Heroin abuse problem.

DETROIT RECEIVING HOSPITAL

DRH was the city's principal emergency hospital until June 16, 1980. We have had a special project at DRH to intercept and refer drug abuse including Heroin emergencies. The first four months of 1980*—261; the first six months of 1979 show 328.

*The project closed in May. However, at the rate clients were being seen during the first 4 months, we would have seen about 491 in 1980 compared to 328 in 1979.

MEDICAL EXAMINER (WAYNE COUNTY)

Detroit is covered by the Wayne County Medical Examiner's Office. The Medical Examiner routinely records deaths from narcotic addiction. In 1979 January-June, there were 24 deaths. In 1980 January through June—51 or a 100 percent increase. This data is the most significant in terms of the general objective of our report.

SUMMARY AND CONCLUSIONS

The most significant data of this report is narcotic death: 100 percent increase from 1979 to 1980. Deaths from narcotics have been generally accepted as a good indicator of the prevalence of narcotic use. In general, more narcotic deaths signifies more narcotic use.

Also important is the utilization rates in our treatment network. Increased client utilization in clinics also can mean more widespread use of drugs. However, our Detroit economic crisis (unemployment and inflation) has to be considered as an important factor in the increased rate of utilization by clients. The fact that the Central Intake Unit is seeing 60 percent first time for treatment clients is an important factor of the prevalence of narcotic use. This new population seems to represent what has been called the "hidden population"; that is, it collaborates the fact that narcotic use is much more widespread than treatment data often indicates.

RECOMMENDATIONS

1. More primary prevention: (a) better control over supplies coming into U.S.; (b) increased resources to at-risk populations to strengthen the potential clients, i.e., more employment programs and educational resources to risk populations.
2. Additional resources for secondary prevention—that is, early identification and early intervention, i.e., outreach activities and followup activities.
3. Improve direct contacts with large urban areas where the problems of heroin use are concentrated, i.e., Detroit, Chicago, New York, Los Angeles, Philadelphia, New Orleans, Baltimore, Newark, Gary, etc. Note: The only contact with Detroit on this problem has been from the Select Committee!

IMPACT OF NATIONAL INSTITUTE ON DRUG ABUSE FUNDING FORMULA CUTS ON DETROIT

PROBLEM

The President's fiscal year 1981 budget eliminates funding in the amount of \$40 million which currently goes to the support of drug programs. Of that amount, \$4 million will have to come from the current Michigan substance abuse services budget. Suggestions have been made for providing phase-out funds and for supplementing the contracts budget to make up for the loss in formula funding. However, the basic drive of Congress will be to cut not rearrange the budget.

IMPACT

Currently, drug abuse programs in Detroit are at a high level of reported utilization. This parallels two related ecological factors—a high unemployment rate and the reported influx of large amounts of new heroin. It may be assumed that unemployment may peak shortly and may begin to decrease steadily throughout fiscal year 1981 and fiscal year 1982 as production of new car models is phased in.

The influx of heroin may continue to increase for several more months and may continue to feed a renewed epidemic throughout fiscal year 1981. It is impossible to predict the potential effectiveness of future law enforcement responses to the increased flow of illicit drugs.

With more certainty we may predict that treatment utilization levels are likely to continue at the current level of close to 100 percent. It would seem, therefore, that a substantial cut in service levels would have direct effects in the health of Detroit citizens.

This is not necessarily the case. Detroit's share in the cut would be about \$1.2 million. If the cuts were to be passed on across the board, then, of course, many patients at already overcrowded clinics would be inconvenienced, to say the least.

However, two of the current clinics are grossly underutilized and could easily be closed entirely with minimal inconvenience to clients. Further, the recent practice of converting outpatient slots to day care slots thereby doubling per patient costs and halving slot availability could be reversed, generating again more service slots. Counseling levels in clinics could be reduced to the minimum required by licensing rules. In the absence of any clear data to the contrary, it cannot be proven that these steps will make patients any more at risk.

Finally, the clinics which are currently staffed by City employees could be run contractually at additional savings; again with no impairment of the health status of the City's population.

All of the above changes would mean considerable work and inconvenience to the City's administrative staff and would result in a loss of status and power for various bureaucrats. Therefore, they will tend to be regarded as infeasible for one reason or another. In this context, it is difficult to say whether any decline in services would truly be causally related to a cutback in funding.

It is quite clear, however, that continued unemployment on the one hand, or inability to properly police narcotics trafficking on the other hand, will feed continued high drug-related death rates. Therefore, the important thing is to adopt whatever policies are necessary to increase employment and to reduce the available supply of narcotics. Besides these objectives, the preservation of the current treatment network in its present costly format pales by comparison.

ABILITY TO GENERATE TIMELY INFORMATION

Detroit Department of Health, Statistics Division: 1979 data is available in March, 1980. 1980 data will be available in March, 1981.

DAWN—One year, three month time lag.

MESC—Two month time lag.

Detroit Crime Lab—One month time lag.

Intake Data—2 weeks after the end of the quarter.

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