PRINCIPLES/IDEAS FOR PRESIDENT TO EMPHASIZE ON VIOLENCE

I. Message

o Stop the killing

o Both . . . and: law enforcement and prevention. Law enforcement can't do the job by itself. Law enforcement officers are the first to say so.

o Violence is pervasive, not just on the street. It's in families, it's against women, it's hate violence, it's sexual assault.

o There is a continuity of violence. What children see at home or experience themselves reflects itself all too often in their later behavior.

o Guns are everywhere. More gun dealers than gas stations.

o Drugs and alcohol are closely interwoven with violence. Massively associated with domestic violence, child abuse, auto accidents. Killings on streets over drug turf. All of this sends message to children that violence is the best way to settle an argument. Immensely costly to the health care system.

o Responsibility -- everyone has a responsibility: public and private across the board, but also must instill a sense of responsibility in citizens themselves, especially young people.

o Must give people hope, have to have a reason for hope. Can't build enough prisons to lock up all the perpetrators unless we create real reasons for hope.

o Must say and teach, over and over, violence is not the way to settle disputes. Stop the killing.

o This is a genuine national crisis. Everyone has to get involved.

II. Policies

o Enforce the law. Lock up the bad people. (Pass the crime bill.)

o Community policing to make the streets safe. (Pass the crime bill.)

o Build antiviolence coalitions everywhere to strengthen neighborhoods and communities. Support people in neighborhoods coming together, working with elected officials, business leaders, clergy, schools, police,

etc. to take back the streets. Mothers Against Drunk Driving as model. Federal interagency response to help build coalitions. (Examine all federal programs that support community partnerships for prevention, e.g., in the drug area, to consolidate and coordinate for effectiveness. Build on Colorado and Nebraska test cases to develop coordinated federal support for local antiviolence coalitions.)

o Massive public education. Don't use violence to settle disputes. Guns are dangerous. Real men don't beat up women. Preventive health by controlling our own behavior is the real cost containment for health reform: less violence, less drinking, less drug abuse will save billions in health care costs. (Fund Centers for Disease Control to come up with effective messages.)

o Take guns away from bad people, educate everyone about how dangerous it is to have a gun, and make guns a little less dangerous. Assault weapon ban. Juvenile possession ban. Regulate extra-destructive ammunition. Enforce concealed weapon bans and take away guns from people in the street. Tighten regulation of dealers. Ban laser sights. Stop advertising campaigns directly at women and young people. (Propose legislation as appropriate.)

o Urge media to be responsible. Cable and films as well as networks. PSAs and proactive messages in shows as well as reduction of gratuitous violence.

o Schools. Teach nonviolence. Mediation and conciliation. (Enact the Safe Schools legislation.)

o Keep kids constructively engaged -- after school and summer. Build ties to labor market. (Enact pending school-to-work legislation.)

o Lots of mentoring and adult role models. (Point to and implement youth development initiatives in the crime bill.)

o Strengthen families and parenting skills. (Implement recently enacted Family Preservation legislation.)

o Drug and alcohol treatment. (Increase investment in these activities.)

o Opportunity.

o Hope for the future.

November 4, 1993

Memorandum to David Gergen from Peter Edelman

The President is being attacked from left and right, literally, on his drug and alcohol abuse policy or lack of it. The latest salvo was from Judge Bonner, a Republican Bush appointee, who on leaving as head of the DEA blasted the President for weakness on law enforcement. To my knowledge, no defense was offered from the Administration, or at least none that appeared in any prominent place, not even the defense that this man was a partisan Republican. A couple of weeks ago the Administration's so-called interim drug strategy was released to resounding yawns and widespread criticism that it represented nothing new (i.e., it was the "same old" law enforcement-dominated approach with vague, nonspecific promises to emphasize treatment and prevention). We are losing the argument in both directions. It may be great campaign strategy to be attacked from both left and right, but that works only when one has staked out a place to occupy in the center.

We urgently need a strategy, both a substantive strategy and a communications strategy. I want to list for you some possible elements of a strategy, but I want to emphasize at the outset that none of it will be credible without a concrete investment of funds in drug and alcohol treatment and prevention in fiscal 1995. Any other combination of elements will be subject to the same criticism we are now encountering.

1. The President needs to talk more about drugs, about alcohol, and about the connection of both to crime and violence. He has been talking, passionately and movingly, about violence. He has visited trauma centers and talked about the unnecessary health costs that multiply the human tragedy. Drugs and alcohol are associated with a huge proportion of the violence that brings people to emergency rooms. They are associated with a huge proportion of the violence that victimizes women and children in their own homes. The turf wars that are killing young men and innocent bystanders in cities are about drugs. The car accidents that snuff out young lives and other lives in head-on collisions are heavily related to alcohol. Drugs and alcohol are costing us thousands of lives and billions of dollars. (Some relevant statistics are listed at the end of this memo.)

There is a larger theme here: prevention in relation to the health care reform, especially violence prevention but also all prevention of bad and costly health outcomes. If we can get people to change their behavior in relation to many things -- eating fat and cholesterol, smoking, and of course drugs, drinking, and violence -- we can have a major impact on the cost of health care

and therefore on the premiums that people are going to pay for their health insurance. This is the true cost containment. We all have the keys to cost containment in our own pockets if we will just take greater responsibility for our own behavior.

A key part of this larger theme is the public health reform portion of the health care reform, which is vitally important but has received almost no public attention. As you know, guaranteeing health security to individual Americans does not address the need for additional capacity in underserved areas, the need to promote the development of the health professions, and, especially relevant here, health promotion and disease prevention activities. The public health reform will provide support for the kind of broader prevention activity that can help induce people to change their behavior. The public education campaigns on smoking, seat belts, and drunken driving show that it can be done. Presidential leadership and public health reform go hand in hand to convince Americans that prevention is vital to our economic, social, and physical health.

2. We need a credible budget strategy which shows that we are taking greater steps to reduce demand at the same time as we remain committed to tough law enforcement. There needs to be an immediate, tangible change in direction in drug and alcohol abuse policy. The fiscal 1995 budget recommendations will be transmitted from OMB to the President on December 1. In view of the continuing negative public comment, the President might consider announcing right now, in advance of the December 1 date, that he expects to alter the balance by ending supply-reduction activities that have proven ineffective and investing more in treatment. Even a $200 million reduction in interdiction (adequately defended) and a similar increase in the treatment investment would help a lot. Together with the investment of $300 million over three years in drug treatment in federal and state prisons in the crime bill, the President could then say he is adding over a quarter of a billion dollars annually for drug treatment.

3. There is another message point that we have not made. There is an important fact that critics fail to recognize. Large elements of the President's program that are not specifically denominated drug abuse policies are nonetheless absolutely on point as drug and alcohol abuse policy:

- o community policing (and 50,000 more police on the street) will result in safer streets, more arrests of drug dealers, and less drug dealing as a consequence.

- o empowerment zones and enterprise communities will strengthen neighborhoods (and directly increase substance abuse treatment in some cases) and thereby reduce drug dealing and drug abuse.

o Head Start expansion, family preservation, and welfare reform will strengthen families and prevent drug addiction.

4. The health care reform contains a major new investment in drug and alcohol treatment. The individual benefit which is guaranteed to all Americans provides for residential care, intensive day treatment, and counseling. Beginning when health care reform becomes effective, this is a major step forward in substance abuse policy. It deserves prominent mention and emphasis as part of our drug and alcohol abuse strategy, although it will of course not become effective until the health reform is implemented. (This is separate from the public health reform mentioned earlier.)

There are two bottom lines here: 1) There is no reason for silence in the face of attacks that we are doing nothing. We are improving law enforcement, we are improving treatment, we are investing in prevention. This is not just a matter for the President. Everyone who communicates on his behalf should be able to speak affirmatively and positively about our substance abuse policy; and 2) **We are missing some key elements of substance to make our defense credible. Unless we find a way to invest more in treatment in fiscal 1995 by reducing our budget for failed interdiction activities and effectively moving funds from that area to treatment, at a level of about $200 million, the entire rest of our message will not hold together.**

(Key Facts for possible use in remarks and responses are attached.)

11/29/93
This is no longer correct. The weakness of the treatment benefits makes great attention to FY 1995 all the more important.
Peter Edelman

Key facts:

- Care related to or stemming from substance abuse and addiction costs the health care system about $140 billion a year, something like 1 out of every 7 dollars we spend on health care. The total economic cost, including treatment and all indirect costs, of alcohol and drug abuse and smoking is about a quarter of a billion dollars a year. This is about $1000 for every man, woman, and child in America.

- 75% of trauma victims test positive for drug use.

- Alcohol and/or drug abuse are implicated in something like 80% of all domestic violence, 75% of all rapes and child molestations, and 75% of all homicides and suicides.

- In 1990, there were more than 370,000 drug-related emergency-room episodes and the number has been going up since. At one major teaching hospital 28% of all intensive care admissions and 40% of all intensive care costs were attributed to substance abuse.

- With only 5% of the world's population, Americans consume 60% of the world's cocaine.

- Prevalence of violence among alcohol abusers is 12 times higher than general population, and 16 times higher among drug abusers.

- 75% of inmates in state prisons and jails have a substance abuse problem serious enough to warrant treatment.

- A third of AIDS cases are directly or indirectly related to injection drug use.

- Almost half of all traffic fatalities are alcohol-related. 2 out of 5 Americans will be involved in an alcohol-related motor vehicle crash in their lifetime.

DEPARTMENT OF THE TREASURY
WASHINGTON

ASSISTANT SECRETARY

OCT 7 1993

MEMORANDUM FOR HILLARY RODHAM CLINTON

FROM: **RONALD K. NOBLE** RKN
ASSISTANT SECRETARY
(ENFORCEMENT)

SUBJECT: **Briefing Paper on Firearms Related Issues**

Senator Moynihan has demonstrated considerable interest in several firearms related issues.

o He introduced a bill, S. 32, increasing to 1000 percent the excise tax on selected calibers of handgun ammunition. The bill would also impose recordkeeping requirements with respect to the disposition of ammunition by dealers.

- It is of note that the existing excise tax on firearms and ammunition is set by statute at 10 percent for pistols and revolvers and 11 percent for other firearms and ammunition. 26 U.S.C. 4181.

- Amounts collected under this statute are already earmarked for the Federal aid to wild life restoration under the Pitman-Robertson Wildlife Restoration Act. 16 U.S.C. 669, et seq.

- In FY '93 the firearms and ammunition excise taxes resulted in approximately $164 million in revenue. Traditionally, each of the three categories of taxable items: handguns, other firearms, and ammunition, generate roughly equal amounts of revenue.

- An amendment to the IRS code would be needed to increase the excise tax on these items.

- If any or all of the revenue collected is to be earmarked for health care costs, legislation would be required to amend or repeal the current earmark process.

o Senator Moynihan also wishes to address licensing and related problems under the current laws governing firearms and ammunition businesses.

- His concern relates to the fact that there is no licensing requirement at all for dealers in ammunition.

- The Gun Control Act of 1968 was amended in 1986 to eliminate the Federal licensing requirement for ammunition dealers.

- Although the Gun Control Act still requires that manufacturers and importers be licensed, the 1986 amendment removed all recordkeeping requirements relating to the acquisition and disposition of ammunition.

o The Senator also has an interest in the current license fee structure under the Gun Control Act. The amount of the license fee for various firearms and ammunition businesses is set by statute. The statute currently provides for a fee of $50 per year for manufacturers and importers of standard rifles, shotguns and handguns, and a fee of $10 per year for dealers in these weapons.

- The statutory fee for manufacturers and importers of ammunition for these weapons is also $10 per year. Currently, these fees do not even cover the cost of processing the applications and they are deposited into the general fund without earmarking. (Has not been increased since 1968. $10 represents over 500% per license to administer, we are actually subsidizing stores significantly
- It should be noted that Senator Simon is working on legislation to increase the license fees under the Gun Control Act.

- Senator Simon's measure is designed to simply offset the cost of administering the licensing and regulatory process. This objective would require fees to be raised to somewhere between $375 and $750, depending upon the level of enforcement activity to be supported.

- There are currently over 286,000 licensees. It is assumed that an increase in fees in the amounts under consideration would reduce this number dramatically. The ultimate universe of licensees would probably be in the neighborhood of 50,000 to 70,000.

S. 868 Senator Murray → Similar to Reynolds bill

Firearm Victims Prevention Act

Section-By-Section Analysis

Section 1. Short Title.

Section 2. Findings and Purpose. Provides findings about the increase in gun violence, particularly among youth, and the resulting increase in medical costs. States the purpose of the Act is to help alleviate the public health care cost resulting from firearm-related injury and death.

Section 3. Increase in Tax on Handguns and Assault Weapons. Amends Section 4181 of the Internal Revenue Code to impose a 25% tax on each sale of a handgun, assault weapon, cartridge, shell or large capacity magazine by a manufacturer, producer, importer, wholesaler, retailer or private individual. (Current law imposes only on manufacturers, producers and importers a 10% tax on handguns and an 11% tax on other firearms and ammunition.) Defines "handguns," "assault weapons" and "large capacity ammunition magazine," and specifically excludes firearms used for hunting and sporting purposes. Makes the new tax effective 30 days after the date of enactment.

Section 4. Health Care Trust Fund. Amends Subchapter A of chapter 98 of the Internal Revenue Code to establish within the Treasury a Health Care Trust Fund to assist hospitals, trauma centers and other health care providers in defraying the uncompensated cost of medical care for gunshot victims. All revenues from the 25% tax on firearms and ammunition and one-half of the gun dealer license fee will go into the Health Care Trust Fund. Non-profit hospitals, trauma centers and other health care providers that are in compliance with Federal and State certification and licensing standards and that have incurred substantial uncompensated costs in providing medical care to gunshot victims in the previous calendar year are eligible to apply for a grant from the Health Care Trust Fund. The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, will issue regulations 60 days after enactment governing the Trust Fund.

Section 5. License Application Fees for Dealers in Firearms. Amends Section 923 of title 18 of the U.S. Code to increase the license fee for firearm dealers from the current $30 for three years to $2,500 for three years, and directs that one-half of the license fee go into the Health Care Trust Fund.

S. 868 Senator Murray

Discussion

There are an estimated 160-200 million guns, including more than 66 million handguns, in the United States. More than 135,000 students carry handguns to school everyday; an additional 270,000 students have carried a gun to school at least once. A survey of eleventh-graders in Seattle's public high schools last year found that 34% of the students said guns were easily accessible. A 1990 CDC survey found that 20% of the students surveyed had carried a firearm to school at least once in the month prior to the survey. Nearly 3,200 teenagers fatally shoot each other every year.

The overall annual cost of firearm injury to our health care system is more than $4 billion. The estimated lifetime costs of firearm injuries in 1985 alone are expected to be $14.4 billion. The government pays about 85% of the hospital costs of firearm victims.

By significantly increasing taxes on guns and license fees on gun dealers, the bill seeks to reduce the accessibility of guns, particularly to our young people. Escalating gun violence, especially among our youth, is placing a severe strain on medical care providers. The bill would use all of the revenue from the increased tax and one-half of the increased license fee to help offset the public cost of medical care for gunshot victims.

I. The bill will impose a 25% tax on each sale of a handgun, an assault weapon, or the ammo used in them. The 25% tax on the value would be levied each time a handgun, assault weapon or ammo for them is sold, as opposed to the current tax that applies only once to the manufacturer, producer or importer, but not to dealers or others selling guns. The bill would not affect sporting/hunting guns or those sold for law enforcement or military purposes. The current excise tax (set in 1919) on handguns is 10% (=$32 million in FY 90); 11% on other firearms (=$46 million); and 11% shells and cartridges (=$25 million). The tax can be expected to raise at least $400 million annually (counting the tax on the sale by the manufacturer/ producer/ importer and the tax on at least one sale by the dealer who purchased the gun from the manufacturer/producer/importer). This compares to $103 million raised from the excise tax alone in 1990.

II. The establishment of a Health Care Trust Fund within Treasury, funded from the 25% tax and one-half of the increased gun dealer license fee, would help reduce public health care cost from gunshot victims. The government pays about 85% of the medical cost of all gunshot victims, increasing insurance rates and placing a severe strain on medical service providers. Non-profit hospitals, trauma centers and health care providers that incur substantial uncompensated costs treating gunshot victims could apply for grants from the Treasury's Health Care Fund;

no single entity could claim more than .1% of the funds (making up to 1,000 hospitals and other care providers eligible for the funds).

III. Raise license application fees for firearm dealers from the current $30 to $2,500. There are currently more than 280,000 licensed dealers in the U.S., including more than 5,600 in Washington. In licensed dealers per capita, King County is second in the nation at 90 dealers per 100,000 residents. If one-third of the license holders renew their license annually (93,771 were renewed in 1992), @ $2,500 per license, the increased fee would produce at least $225 million a year, one-half of which would go into the Health Care Trust Fund. The rest would go into the Treasury's general fund to help reduce the deficit. There are currently more than twice as many licensed gun dealers as car dealers or service stations in the U.S.

DEPARTMENT OF THE TREASURY
WASHINGTON

ASSISTANT SECRETARY

OCT 7 1993

MEMORANDUM FOR HILLARY RODHAM CLINTON

FROM: **RONALD K. NOBLE** RKN
ASSISTANT SECRETARY
(ENFORCEMENT)

SUBJECT: **Briefing Paper on Firearms Related Issues**

Senator Moynihan has demonstrated considerable interest in several firearms related issues.

o He introduced a bill, S. 32, increasing to 1000 percent the excise tax on selected calibers of handgun ammunition. The bill would also impose recordkeeping requirements with respect to the disposition of ammunition by dealers.

- It is of note that the existing excise tax on firearms and ammunition is set by statute at 10 percent for pistols and revolvers and 11 percent for other firearms and ammunition. 26 U.S.C. 4181.

- Amounts collected under this statute are already earmarked for the Federal aid to wild life restoration under the Pitman-Robertson Wildlife Restoration Act. 16 U.S.C. 669, et seq.

- In FY '93 the firearms and ammunition excise taxes resulted in approximately $164 million in revenue. Traditionally, each of the three categories of taxable items: handguns, other firearms, and ammunition, generate roughly equal amounts of revenue.

- An amendment to the IRS code would be needed to increase the excise tax on these items.

- If any or all of the revenue collected is to be earmarked for health care costs, legislation would be required to amend or repeal the current earmark process.

o Senator Moynihan also wishes to address licensing and related problems under the current laws governing firearms and ammunition businesses.

- His concern relates to the fact that there is no licensing requirement at all for dealers in ammunition.

- The Gun Control Act of 1968 was amended in 1986 to eliminate the Federal licensing requirement for ammunition dealers.

- Although the Gun Control Act still requires that manufacturers and importers be licensed, the 1986 amendment removed all recordkeeping requirements relating to the acquisition and disposition of ammunition.

o The Senator also has an interest in the current license fee structure under the Gun Control Act. The amount of the license fee for various firearms and ammunition businesses is set by statute. The statute currently provides for a fee of $50 per year for manufacturers and importers of standard rifles, shotguns and handguns, and a fee of $10 per year for dealers in these weapons.

- The statutory fee for manufacturers and importers of ammunition for these weapons is also $10 per year. Currently, these fees do not even cover the cost of processing the applications and they are deposited into the general fund without earmarking. (Has not been increased since 1968. $10 represents over 500 pct license to administer, we are actually subsidizing stores significantly
- It should be noted that Senator Simon is working on legislation to increase the license fees under the Gun Control Act.

- Senator Simon's measure is designed to simply offset the cost of administering the licensing and regulatory process. This objective would require fees to be raised to somewhere between $375 and $750, depending upon the level of enforcement activity to be supported.

- There are currently over 286,000 licensees. It is assumed that an increase in fees in the amounts under consideration would reduce this number dramatically. The ultimate universe of licensees would probably be in the neighborhood of 50,000 to 70,000.

S. 868 Senator Murray → Similar to Reynolds bill

Firearm Victims Prevention Act

Section-By-Section Analysis

Section 1. Short Title.

Section 2. Findings and Purpose. Provides findings about the increase in gun violence, particularly among youth, and the resulting increase in medical costs. States the purpose of the Act is to help alleviate the public health care cost resulting from firearm-related injury and death.

Section 3. Increase in Tax on Handguns and Assault Weapons. Amends Section 4181 of the Internal Revenue Code to impose a 25% tax on each sale of a handgun, assault weapon, cartridge, shell or large capacity magazine by a manufacturer, producer, importer, wholesaler, retailer or private individual. (Current law imposes only on manufacturers, producers and importers a 10% tax on handguns and an 11% tax on other firearms and ammunition.) Defines "handguns," "assault weapons" and "large capacity ammunition magazine," and specifically excludes firearms used for hunting and sporting purposes. Makes the new tax effective 30 days after the date of enactment.

Section 4. Health Care Trust Fund. Amends Subchapter A of chapter 98 of the Internal Revenue Code to establish within the Treasury a Health Care Trust Fund to assist hospitals, trauma centers and other health care providers in defraying the uncompensated cost of medical care for gunshot victims. All revenues from the 25% tax on firearms and ammunition and one-half of the gun dealer license fee will go into the Health Care Trust Fund. Non-profit hospitals, trauma centers and other health care providers that are in compliance with Federal and State certification and licensing standards and that have incurred substantial uncompensated costs in providing medical care to gunshot victims in the previous calendar year are eligible to apply for a grant from the Health Care Trust Fund. The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, will issue regulations 60 days after enactment governing the Trust Fund.

Section 5. License Application Fees for Dealers in Firearms. Amends Section 923 of title 18 of the U.S. Code to increase the license fee for firearm dealers from the current $30 for three years to $2,500 for three years, and directs that one-half of the license fee go into the Health Care Trust Fund.

S. 868 Senator Murray

Discussion

There are an estimated 160-200 million guns, including more than 66 million handguns, in the United States. More than 135,000 students carry handguns to school everyday; an additional 270,000 students have carried a gun to school at least once. A survey of eleventh-graders in Seattle's public high schools last year found that 34% of the students said guns were easily accessible. A 1990 CDC survey found that 20% of the students surveyed had carried a firearm to school at least once in the month prior to the survey. Nearly 3,200 teenagers fatally shoot each other every year.

The overall annual cost of firearm injury to our health care system is more than $4 billion. The estimated lifetime costs of firearm injuries in 1985 alone are expected to be $14.4 billion. The government pays about 85% of the hospital costs of firearm victims.

By significantly increasing taxes on guns and license fees on gun dealers, the bill seeks to reduce the accessibility of guns, particularly to our young people. Escalating gun violence, especially among our youth, is placing a severe strain on medical care providers. The bill would use all of the revenue from the increased tax and one-half of the increased license fee to help offset the public cost of medical care for gunshot victims.

I. <u>The bill will impose a 25% tax on each sale of a handgun, an assault weapon, or the ammo used in them.</u> The 25% tax on the value would be levied each time a handgun, assault weapon or ammo for them is sold, as opposed to the current tax that applies only once to the manufacturer, producer or importer, but not to dealers or others selling guns. The bill would not affect sporting/hunting guns or those sold for law enforcement or military purposes. The current excise tax (set in 1919) on handguns is 10% (=$32 million in FY 90); 11% on other firearms (=$46 million); and 11% shells and cartridges (=$25 million). <u>The tax can be expected to raise at least $400 million</u> annually (counting the tax on the sale by the manufacturer/ producer/ importer and the tax on at least one sale by the dealer who purchased the gun from the manufacturer/producer/importer). This compares to $103 million raised from the excise tax alone in 1990.

II. <u>The establishment of a Health Care Trust Fund within Treasury, funded from the 25% tax and one-half of the increased gun dealer license fee, would help reduce public health care cost from gunshot victims</u>. The government pays about 85% of the medical cost of all gunshot victims, increasing insurance rates and placing a severe strain on medical service providers. Non-profit hospitals, trauma centers and health care providers that incur substantial uncompensated costs treating gunshot victims could apply for grants from the Treasury's Health Care Fund;

Daniel Patrick Moynihan
New York

United States Senate
Washington, D. C.

September 30, 1993

Dear Mrs. Clinton:

PAM OCT 1 1993

You were magnificent this morning! The Committee is hugely in your debt, and I am especially grateful for your interest in bullet control.

We are currently experiencing an epidemic of morbidity and mortality associated with handguns. We attempt to combat this by controlling the supply thereof. This strategy can have no effect, as there are some 50 million handguns in circulation. A two century supply, as you might say. On the other hand, we have about a four year supply of bullets (some 7.5 billion rounds). Bullets are the pathogen. If that supply is sharply reduced, an epidemiologist would hypothesize that morbidity and mortality would also be reduced.

Under the Federal Firearms Act of 1938, a Federal license is required to manufacture or import ammunition.

The license, issued by the Bureau of Alcohol, Tobacco and Firearms, costs $10 per year. No stipulation is made as to caliber or quantity, and no reporting is required. BATF guesses that some 2 billion cartridges are manufactured or imported each year. There are currently 284,000 BATF licenses either to sell firearms or to manufacture or import ammunition. The latter number some 7,000.

This last number would immediately attract the attention of the epidemiologist. When we were working out the epidemiology of automobile crashes, the plainest first fact was that it would be easier to change the behavior of three automobile manufacturers than of 90 million automobile drivers. Go for the weakest link! Don't swat the mosquitos, drain the swamp.

There are probably no more than 10 major ammunition manufacturers. Naturally, the BATF doesn't know which.

The power to tax is the power to destroy. By picking and choosing rounds, exempting police, possibly dispensing ammunition to legitimate sports clubs and such other controls no different than those we use for prescription medicine, we could effectively disarm a huge proportion of those individuals now ravaging our streets in a mode not conceptually different from any other plague.

Thus, a calibrated tax scheme could most likely eliminate the use of 9 mm. handguns in drive-by-shootings in, say, five years.

I have been working at this for a decade and have passed one bill banning one round (armor-piercing, "cop-killer" bullets). But the precedent is established, and the taxing power has been there for more than half a century. There is no guarantee that we would succeed, but I can attest that in the field of automobile safety, public opinion changed from incomprehension/hostility to easy acceptance in the matter of a decade.

As it happens, I spoke with the President about this on Sunday evening in New York, and at his request have sent a similar letter.

Best,

Mrs. Hillary Rodham Clinton
The White House
Washington, D.C. 20500

Letter: On Gun Control

Seat Belts, Bullets and American Lives

To the Editor:

In a letter you published in 1960, I wrote to say that epidemiologists were trying to redefine automobile safety as a public health problem with greater attention to "passive" measures such as vehicle design.

Such views were then generally greeted with skepticism, if not derision, since conventional thinking then saw the problem as driver behavior and the solution as law enforcement. Yet by 1966 Congress had enacted legislation establishing the National Highway Safety Bureau, headed first by William Haddon Jr., M.D., who had begun his career in the New York State Department of Health. Automobile safety is now a recognized field of scientific research and technological innovation with results to show for it.

I relate this in the context of "What Can the Brady Bill Really Do? A Little Gun Control, a Lot of Guns" (The Week in Review, Aug. 15). You note that since 1981, when James S. Brady, President Reagan's press secretary, was shot, "Americans have bought nearly 50 million new guns, including more than 20 million handguns." Americans may own some 200 million firearms. Would a waiting period for purchasing new weapons, which I surely support, even so make much of a difference?

You cite criminologists who are skeptical. And ought not they be? We have a two-century supply of handguns. These things last forever. Dr. Haddon *used* to say that when a car hit a tree nobody got hurt. It wasn't until the passenger hit the *car* that injury or death occurred. Therefore, think seat belts.

In the same analytic tradition can we not bring ourselves to see that guns don't kill people? Bullets do. And at most we have a four-year supply of ammunition, albeit some can be hoarded. Moreover, the Federal Government already controls, through licensing, the manufacture of bullets. Mind, the Bureau of Alcohol, Tobacco and Firearms, which issues the licenses (for derisory sums with no record keeping), isn't much interested. There is no reference to this responsibility in the bureau's job description in the Government Manual.

The publications of the National Safety Council in 1960 did not mention *automobile design*. But this *can* change. John D. Graham, who is director of the Injury Control Center at the Harvard School of Public Health, from which Dr. Haddon graduated, writes: "Bullet-related injury is barely a field of respectable scientific endeavor." But neither was vehicle design a third of a century ago.

DANIEL PATRICK MOYNIHAN

Pindars Corner, N.Y., Aug. 17, 1993

The writer is United States Senator from New York.

UNITED STATES DEPARTMENT OF EDUCATION

THE DEPUTY SECRETARY

October 7, 1993

Memorandum to: Hillary Clinton

From: Madeleine M. Kunin

Re: Violence

I was very pleased to hear you say that violence, children's issues, and welfare reform will be high on your agenda, following health care reform. We would be happy to work with you in this effort, which, as you know, is becoming of increasing concern to the public.

Linking the epidemic of violence with the health care issue, as the President has done, also strikes a very resonant chord with the public.

Not only is violence shifting the focus away from achieving high standards and overall school reform, but the prevalence of violence also heightens the public's sense of insecurity and reduces confidence in the government's ability to provide protection.

Our Safe Schools Act is a first step to help schools cope with these problems. We have also held a successful conference on school violence with the Justice Department and the Department of Health and Human Services. Through Bill Modzeleski, the department has built up considerable expertise in the area.

In addition, we are meeting with Peter Edelman, Phil Heymann, and an inter-agency working group on violence. I look forward to continuing to work with you on this difficult but critical issue.

cc: Richard Riley
Carol Rasco
Melanne Verveer

cc: Shirley
Melanne

Daniel Patrick Moynihan
New York

United States Senate
Washington, D.C.

July 12, 1993

PAM [illegible] 2 0 1993

Dear Mrs. Clinton:

Not without a measure of temerity, I enclose a copy of the Summer issue of The American Scholar in which I have an article, "Iatrogenic Government". It began as the Norman Zinberg lecture at the John F. Kennedy School, and concerns the degree to which our present, devastating drug problem is a consequence of our own actions in trying to deal with it.

Most sincerely,

Mrs. Hillary Rodham Clinton
The White House
Washington, D.C. 20500

Enclosure

JOHNS HOPKINS
MEDICINE

Michael M.E. Johns, M.D.
Dean of the Medical Faculty
Vice President for Medicine
The Johns Hopkins University
School of Medicine
Baltimore, Maryland 21205-2196
(410) 955-3180 / FAX (410) 955-0889

James A. Block, M.D.
President
Chief Executive Officer
Johns Hopkins Health System
The Johns Hopkins Hospital
Baltimore, Maryland 21287-1160
(410) 955-0428 / FAX (410) 955-1885

September 21, 1993

President William Jefferson Clinton
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear President Clinton:

We are pleased to send you the attached information you requested on Dr. Snyder's proposal for developing a treatment for cocaine addiction. We encourage you to make this your "Manhattan Project." If we can supply you or your staff with additional information or answer any questions, please contact us.

Sincerely,

Michael M.E. Johns, M.D.
Dean of the Medical Faculty
Vice President for Medicine
The Johns Hopkins University
School of Medicine

James A. Block, M.D.
President
Chief Executive Officer
Johns Hopkins Health System
The Johns Hopkins Hospital

A "Manhattan" Project for Drug Addiction

There is no greater domestic threat to the United States of America than the drug abuse epidemic. Victims include not only the addicts but also the innocent people who are robbed and burglarized by addicts to support their habits. The economic fall out from the drug abuse epidemic reaches into every facet of life in America including health care, law enforcement, education, and employee performance.

Enormous sums have been spent to reduce the supply of illegal drugs but the epidemic continues to grow. In contrast, there has been relatively little spent on reducing demand for illicit drugs. While the National Institute on Drug Abuse has significant funding for basic research into the mechanisms of drug addiction, there is little spent on developing these discoveries into effective treatments. One approach that has been effective for reducing craving for heroin is the use of long acting opiate such as methadone. For cocaine abuse an even more effective eminently feasible approach is to develop antagonists. Dr. Solomon H. Snyder, Distinguished Service Professor of Neuroscience, Pharmacology and Molecular Biology and Psychiatry at Johns Hopkins has outlined in the attached paper the way in which cocaine blockers could be developed in a relatively short time frame.

The development of a cocaine blocker is but one of many targeted demand reduction projects that could be activated with sufficient financial support. An authorization of $95,000,000 for FY'94 for a Medication Development Program has been approved but funds have not yet been appropriated. The House of Representatives has approved an additional $20 million in funding for NIDA in FY'94, but action in the Senate is still pending.

Program to Develop a Cocaine Antagonist

By

Solomon H. Snyder

The Johns Hopkins University School of Medicine

Departments of Neuroscience,

Pharmacology and Molecular Sciences, and Psychiatry

725 N. Wolfe Street, Baltimore, Maryland 21205

(410)955-3024

Most authorities agree that the current epidemic of cocaine abuse is responsible for a major portion of crime in the United States . Together with intravenous use of heroine, cocaine abuse also accounts for many instances of blood borne transmission of AIDS. Between the destruction of human potential, vast quantities of drug related crime, and the expansion of the AIDS pandemic, the costs to the United States are conservatively estimated in many tens of billions of dollars. Were it possible to develop a safe and effective cocaine antagonist to reduce significantly the extent of cocaine dependence, the resultant benefits to society would be considerable. This essay will describe the scientific facts which make the development of a therapeutically effective cocaine antagonist a straightforward extension of our current scientific understanding of the mechanisms whereby cocaine exerts its behavioral effects. Expenditure of a relatively modest amount of monies would, with a high degree of probability, results in clinically effective agents ready for clinical use in five to six years.

- How Cocaine Acts -

First, let me explain how cocaine exerts its behavioral effects. Like almost all drugs that influence the brain, cocaine acts via neurotransmitters. Neurotransmitters are the chemical messengers released by the 10 billion neurons in the brain which account for information transfer amongst this large population of neurons. Neurotransmitters released by one neuron act at specific receptor proteins on the surface of adjacent neurons which bind the neurotransmitter with great specificity

like a lock recognizes a key. Abundant scientific evidence indicates that cocaine exerts its effects by facilitating the actions of the neurotransmitter dopamine in parts of the brain that regulate feelings of well being. How does cocaine enhance effects of dopamine? Dopamine, like most other neurotransmitters, must be inactivated quickly after it acts at receptor sites. The most common mechanism for inactivating neurotransmitters, which applies to dopamine, involves a system in which the dopamine is pumped back into the nerve endings that had released it. Cocaine inhibits this pump for dopamine so that larger amounts of dopamine are available to act at receptor sites. Evidence that this mechanism accounts for the actions of dopamine comes from experiments using numerous derivatives of cocaine. The relative potencies of these cocaine derivatives in blocking the dopamine uptake pump closely parallel their relative potencies in causing behavioral stimulant effects.

Based on the above description, one could develop drugs to block the effects of cocaine by identifying chemicals that selectively influence either the dopamine uptake pump or dopamine receptors. A drug that blocks the effects of dopamine at its receptors would be expected to decrease the euphoric effects of dopamine. The drugs currently used in the treatment of schizophrenia, called neuroleptics block dopamine receptors. Why are they not useful in treating cocaine abuse? The reason has to do with the fact that dopamine acts at a number of subtypes of dopamine receptors. The current available neuroleptics block all or most of these so that one gets many side effects in addition to the blockade of euphoria. The modern tools of molecular biology have resulted in the cloning of genes for at least five distinct dopamine receptor subtypes.

These dopamine receptors can now be made by recombinant DNA technology so that one could readily evaluate drug candidates at each dopamine receptor subtype. Accordingly, agents could be developed that would selectively block one or the other subtype. In this way, one could tailor make a drug to block only dopamine actions at receptors associated with euphoria.

One can also develop cocaine antagonists by targeting the dopamine uptake pump. Cocaine blocks this uptake pump. It should be feasible to design drugs acting at the same site as cocaine but in an opposite fashion, hence stimulating the dopamine uptake pump so that there will be less dopamine to act at receptor sites.

- Drug Development -

How would one proceed from a drug candidate that is acting in the test tube to a therapeutic agent? Once the combined work of chemists and neuroscientists has resulted in the identification of agents that exert the molecular actions predicted to block cocaine effects, then these drug candidates would be administered to intact animals. There exists excellent behavioral models of cocaine abuse in numerous animal species. Thus, drugs that block the effects of cocaine on animal behavior would have a very high likelihood of doing the same in humans. Promising drug candidates would then be subjected to toxicology analysis, a conventional process in drug discovery in which the effects of drug candidates are evaluated on many different tissues of several animal species. Drug candidates that pass this toxicologic screen would then be brought into clinical trial. In Phase I of clinical trials agents are administered in

gradually increasing doses to normal volunteers to identify the optimal dose and to look for possible toxic side effects. Agents that are effective and safe in Phase I screening are brought into Phase II studies in which cocaine abusers would be treated and the drug compared against placebos. Phase III studies involve increased numbers of patients to look for potential adverse effects that wouldn't be identified in the fewer number of subjects studied in Phase II trials.

How would a cocaine antagonist work in the treatment of drug abusers? A cocaine antagonist will block the perception of the euphoric effects of cocaine. One would utilize a system of drug administration to produce long-lasting effects from a single dose, preferably about a month. This is feasible with the current state of drug delivery technology. The most likely route of administration would be by injection such as a subcutaneous implant of the drug in a vehicle that releases it gradually over the period of a month. Individuals continuing to use cocaine would not receive any euphoric, behaviorally reinforcing effects and would gradually lose interest. Besides the treatment of chronic cocaine abuse by cocaine antagonists, such drugs would have lifesaving effects in treating individuals who are acutely intoxicated. In this instance one would want a short acting version of the drug administered intravenously.

- Costs -

What are the costs of such a drug development program? It is difficult to provide a precise cost estimate. However, an efficiently designed program might be targeted to produce effective agents after five

or six years of research effort. The first two years would be devoted to the chemical synthesis of drug candidates and their evaluation in biochemical and behavioral studies in animals. Hopefully by the end of two years of effort there would be agents that were candidates for human trials. Toxicology analysis would occupy up to a year. Phase II and III clinical trials would occupy two to three years. A rough estimate would be a total cost of about $60 million spread over six years. This figure is less than half the cost estimated by the Pharmaceutical Manufacturer Association for the development of drugs currently on the market in the United States. The lesser cost is related to the highly targeted nature of the cocaine antagonist project as well as the considerable likelihood that a cocaine antagonist will in fact block the euphoric effects of cocaine in humans.

If development of a cocaine antagonist is that straightforward, why haven't the major drug companies in the United States already developed such agents? There are two major reasons. Most major drug companies are not likely to initiate large research programs to develop agents if their annual sales are estimated to be under $100 million annually. Drugs with lower sales do not justify the large costs of drug development. Secondly, the large drug companies are loathe to become immersed in drug development in highly controversial areas such as abortion producing drugs or agents that would be used in drug abusing populations. If this is the case, who would do the drug development of a cocaine antagonist?

It is our feeling that the most effective attack on this problem will come from a consortium of a university, a Federal effort such as the Addiction Research Center of the National Institute on Drug Abuse, and a

relatively small biotech-type drug company. The anticipated market for a cocaine antagonist would be of interest to the biotech industry, though only with governmental subsidy assistance. The need for subsidy has to do with the inability of the drug abusing population to pay for drug treatment at levels that will cover the costs of drug development. Biotech-type companies are accustomed to working closely with universities, since most biotech companies are founded by university professors. One would want university research involved, as the technology being proposed for cocaine antagonist development involves the forefront of molecular neuroscience research. The Addiction Research Center might be a valuable resource at two levels. Researchers at the Addiction Research Center have been involved in studies of the molecular actions of cocaine. Additionally, the Addiction Research Center provides a valuable resource of drug abusing patients for initial clinical trials.

In summary, it is our strong sentiment that a targeted program for developing a cocaine antagonist is eminently feasible, would involve modest costs when compared to the benefits to society, and could be best approached by coordinated efforts of university research, the National Institute on Drug Abuse, and the biotech-type drug industry.

2 copies

South Florida exclusive

Scientific Breakthroughs

Brain Waves

How a UM doctor may soon unveil the ultimate cure for addictions, and uncovered the mystery surrounding sudden cocaine deaths

By Nina L. Diamond • Photograph by Jane Mitchell

Cocaine overdoses had become more common in South Florida than frostbite in Alaska. At the peak of cocaine deaths, about seven years ago, Dr. Lee Hearn, laboratory director of the Metro-Dade Medical Examiner's Department, was at a loss to explain why so many people were dying of coke overdoses when the blood-levels of the drug were much lower than what was usually considered a lethal dose.

The bodies came in, fluids and tissues were studied, and it was more of the same. Why were all these people dying?

Just a few minutes from Hearn's office near Jackson Memorial Hospital, west of downtown Miami, neuroscientist Dr. Deborah Mash, who'd known Hearn since their grad school days at the University of Miami, was busy running the UM School of Medicine's Brain Endowment Bank, teaching neurology and pharmacology, and keeping up with a full schedule of brain research. In her mid-30s then, Mash had already made a name for herself in Alzheimer's and Parkinson's disease research, and, as a specialist in pharmacology, she routinely played detective, studying the body's response not only to outside chemicals, but also to the ones the body itself created.

By 1989, Hearn had noticed something quite unusual in the blood of fatal coke overdose cases. "As I reviewed cases, I saw that cocaethylene was often present in the blood. But nobody knew what it did."

Cocaethylene, discovered about 10 years ago, is manufactured by enzymes in the liver when cocaine and alcohol are mixed. It was thought to only be present in the urine, and to be of little consequence. So, when Hearn called scientists at Yale University and asked if they knew about any cocaethylene studies, he was told that this third drug, created by our own bodies, doesn't make its way into the blood stream. "Yes it does," Hearn replied. "We see it all the time." He sent samples. Yale verified them.

With proof in hand that he wasn't imagining things, Hearn went to his old pal Mash at UM. Backed by a National Institute on Drug Abuse (NIDA) grant, Mash and her colleagues had already embarked on a study of the cocaine overdose epidemic.

"Sometimes there's more cocaethylene in these people than cocaine," Hearn told Mash.

Convinced that cocaethylene was the culprit in the majority of these surprisingly deadly overdoses, Mash was determined to prove that it was not a harmless by-product, but a killer. She and Hearn joined forces, bringing their staffs at UM and the Metro-Dade Medical Examiner's office together in the name of science.

"Cocaethylene gives a longer and stronger high than cocaine. And it's more lethal than cocaine."

—Dr. Deborah Mash

They worked on little else for the last part of 1990, and in record time—less than six months—Mash, Hearn and their team not only were the first to prove that cocaethylene is an active drug, they also had their breakthrough findings published in the January 1991 *Journal of Neurochemistry*.

"Miami is a unique place to do this research," says Mash, grabbing a precious 60 minutes out of her 12-hour work day to talk about their landmark findings and continued research, and the state of chemical addiction. At least twice a month, Mash is gone for days at a time, traveling the world to deliver research papers, conduct studies and touch base with the National Institutes of Health (NIH) in Bethesda, Maryland, where she is a consultant. For three months we spoke weekly, between her airport adventures. "Cocaine is one of the primary substances people here use and abuse. Not heroin, like elsewhere. And we have a high number of cocaine emergencies and overdoses."

Mash notes it's only fitting that, "as a transit point for cocaine entering the U.S.," Miami should also be home to the most promising research.

"We were trying to understand the toxicology. Many died from what should have been safe levels of cocaine in their bodies," she recalls. "We thought maybe there was a processing contaminant, a toxic by-product created when cocaine was made in labs. But that didn't explain it. We noticed that most people—five million Americans—combine cocaine with alcohol. It's the most frequent two-way drug combo. Could cocaethylene be the culprit? We measured it in specimens of blood, brain and liver tissues and found it *higher* in some instances than the levels of coke itself! Then we demonstrated that it's pharmacologically active. And we found that it packs the same 'reward punch' on the brain as cocaine and alcohol do separately, but cocaethylene gives a longer and stronger high and has a much longer half-life than cocaine."

This extra kick was often the *last* kick. "It's more potent than cocaine in causing deaths," says Mash. "It's more lethal than cocaine."

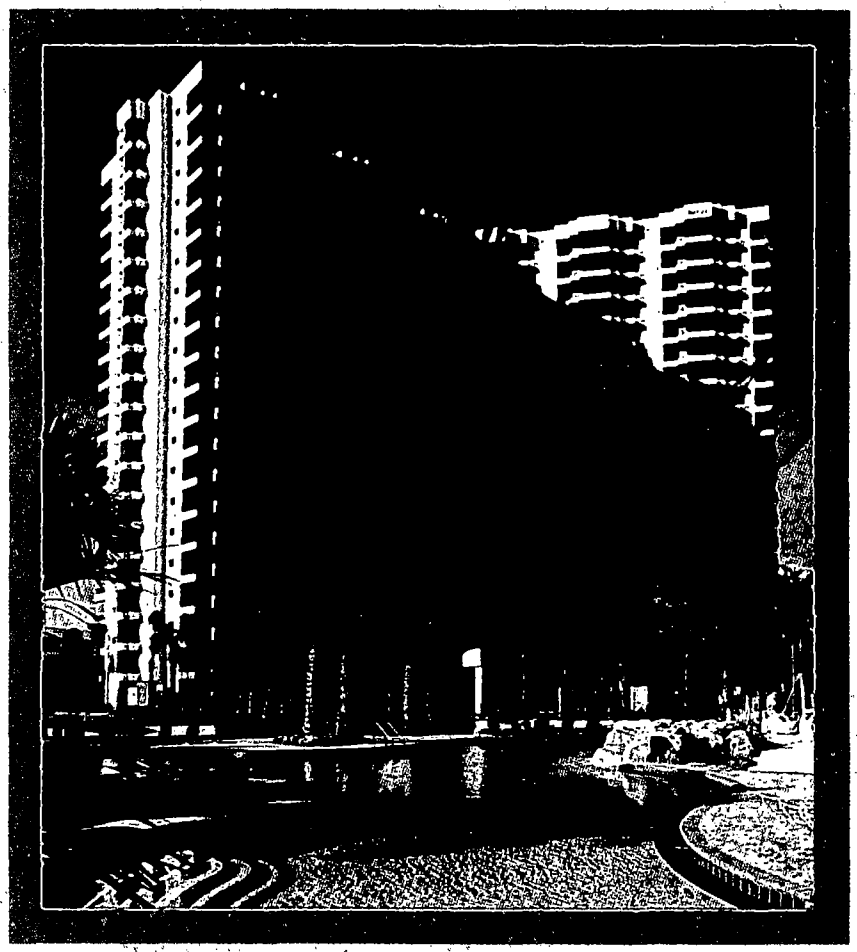
Her work, she says, is "like reading chapters of a very good detective story." The much-published 41-year-old scientist shies away from the term "workaholic." Instead, she likes to say that "science is a way of life. You don't walk away from this."

Despite the fact that she's married to prominent Dade Democratic party leader and attorney Joe Geller ("Joe who?" she quips. "I hardly ever see him."), and has been a commissioner for the City of North Bay Village since 1988, Mash's life is otherwise consumed by her scientific crusade. "Intellectually, I never grow weary of it. I love the discovery. Every day I'm faced with something new. I learn every day."

Mash grew up in Hollywood, where her teachers fast-tracked her in math and science when she showed both interest and tremendous talent. A competitive kid, she won science fairs with her biochemistry projects, and, as a senior in high school, she "discovered brain science while studying psychology." She knew then, she says, that it would be her life's work.

"I briefly toyed with being a medical doctor," she recalls. "But I wanted to devote 100 percent of my life to research."

Mash has never fit the stereotype of the stuffy scientist who's quiet, prim and unaware of life outside the lab. Far from it. In college at FSU, she looked like Cher, with waist-length black



A Lifestyle So Luxurious Can't Be Bought, But It Can Be Rented!

The elegant style is apparent in the smiles you see on our residents. And it's no wonder. The Bay Club at Aventura is South Florida's premier luxury rental community.

Like a five-star resort, The Bay Club specializes in full service. From the moment you arrive home, you are welcomed by the courteous valet and doorman. Once beyond 24-hour security, your luxury rental paradise awaits. Whether one- or two-bedrooms, lavishly furnished or unfurnished, the spacious floorplans are perfectly designed to reflect the picturesque views of beautiful Aventura. Private wraparound balconies and floor to ceiling windows afford breathtaking vistas of the majestic Atlantic Ocean and Intracoastal Waterways as well as the lush fairways of the acclaimed Turnberry Isle Resort.

Your private residence offers eat-in kitchens, washers/dryers, walk-in closets, and more. Unlimited amenities include: concierge and maid service, personal fitness training in our state-of-the-art fitness center, executive business center with knowledgeable staff, gourmet restaurant and convenience shoppe, tropical swimming lagoons, jacuzzi and sauna.

Ideally located in Aventura, The Bay Club is just minutes away from South Florida's most exclusive shopping, international airports, sandy beaches and exotic nightlife.

The decision is yours: whether short-term, seasonal or annual, we'll gladly accommodate your needs.

The Bay Club has it all and more. The only thing missing is you.

3300 Northeast 191st Street, Aventura, Florida 33180 (305) 931-3300

Brainy lady: Dr. Deborah Mash in her headline-making lab at the UM School of Medicine's Brain Endowment Bank.

curls, an exotic aura, and eye-catching, funky leather outfits. Ever the crusader, Mash spoke out against the Vietnam War and whatever other social causes stirred her passions. At his law school graduation, her husband, Joe, blurted out an impromptu plea to stop the death penalty while on stage receiving his diploma. They were—and still are—quite the couple.

Now, her crusade is to understand, prevent and treat drug and alcohol addiction, both scientifically and sociologically. "I pore over research at home, I design experiments in the car on the way to the lab. To combat abuse, we have to understand brain changes and dependency. Then we can design specific therapeutic intervention. When we understand craving, we can know how to block it," she says enthusiastically. "We want to stop the progression, to keep people off drugs and alcohol. We all pay, and it's a hefty price tag. Just look at the crack babies."

Mash and her colleagues approach the problem from all angles. "We now have the Comprehensive Drug Research Center at UM to study and bridge the relationship between scientists and treatment people," she says. "Classic treatment approaches have largely failed. It's an illness, and we have to design new treatments based on what we're learning about how these chemicals change the brain. We're also studying the long-term effects of drug and alcohol abuse."

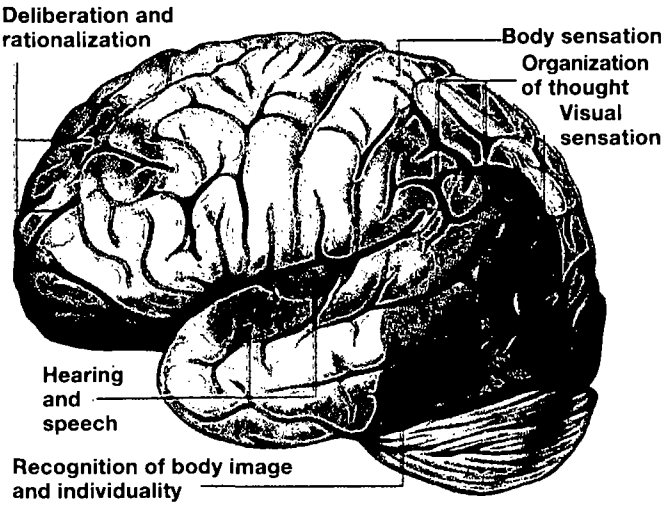
She's now researching how cocaine and alcohol accelerate cardiovascular disease. "Cocaine and alcohol do major damage to the heart and brain. We're looking at heart disease and cognitive and behavioral problems in people. Cocaine may cause depletion of dopamine in the brain, which may lead to Parkinson's disease. We already know this is true of amphetamines. People taking them over time were stricken with movement disease not unlike Parkinson's."

Combining cocaine and alcohol takes an even higher toll on the body. "The dual addiction is a harder addiction to break. We're looking into that. And it causes thickening of the arteries. We think the deterioration is happening quickly, too. Hearts that are 30 look like they're 70. We may see a young generation die

off from heart disease."

Cocaethylene also plays a role in AIDS. "It may give the HIV virus a boost," Mash reveals. "And our discovery that cocaethylene is active in the body has helped spawn this new angle in HIV research."

But the most exciting, most mind-boggling development in the history of drug and alcohol treatment is the new drug ibogaine. And guess who may get to introduce this bona fide cure for addiction? That's right—Mash and her colleagues at both UM and the Metro-Dade Medical Examiner's department. As we go to press, she's awaiting approval from the Food and Drug Administration (FDA) to conduct safety trials. This is the first step—testing ibogaine on people in a controlled scientific setting—in the official process that makes a drug legal for use in the United States.



"The FDA has been very responsive on this one," Mash says, feeling 99 percent certain that they will grant her request. "We have a congressional mandate to help people get off drugs. And we know that drugs are co-factors for HIV."

Mash is just the latest link in the ibogaine story, but the one that will bridge the gap between anecdotal evidence and the scientific proof needed for FDA approval. Ibogaine is derived from the roots of *Tabernathe iboga*, a shrub native to equatorial Africa, where tribes have long used it in small doses to remain alert while hunting, and in larger doses during sacred rituals.

Back in 1962, Howard Lotsof, then "part of the New York film scene at NYU's film school, and a heroin addict, was looking for a new high, when he discovered ibogaine," says Mash. "After his 36-hour 'trip' on ibogaine, he found he had completely lost his desire for heroin, and had no withdrawal symptoms."

Lotsof gave the substance to other addicts, and they, too, were instantly un-hooked from the drugs that previously had controlled their lives. "The International Coalition for Addict Self-Help ran underground trial testing on ibogaine," Mash says, "and it was found to cure addictions to heroin, cocaine, amphetamines, alcohol and nicotine." This so-called anecdotal evidence has shown that ibogaine cures addiction almost 100 percent of the time. In 1986, Lotsof formed NDA International and secured a use patent on ibogaine for treating drug and alcohol addiction. Scientific study began in the Netherlands three years ago, with more than three dozen addicts as test cases. Mash was among the U.S. scientists and doctors invited to Leiden, Holland to witness ibogaine in action.

"It puts you into a 36-hour waking dream state. It's a psychoactive drug, but not a hallucinogen like LSD. During this altered state of consciousness, you relive your childhood experiences," she says. "You get to the roots of your addictions."

One trip on ibogaine is like 30 years on a therapist's couch.

"Ibogaine was used as a rite of passage from childhood to adulthood in Africa," says Hearn. "And now it can be used to reprogram the addict's life. He's detached from childhood recollection while on Ibogaine, but is reexamining it, coming to grips with it, perhaps understanding it for the first time. All neuroses are solvable this way, not just the ones that lead to addiction."

Using ibogaine, then, helps address the cause of the addiction. "Drug addiction is an illness of the spirit," says Hearn. "If you're going to cure it, you have to cure it at that level."

Scientists and treatment professionals have long known that trauma, insecurities, fears and the like are the very foundations of psychological distress, which includes addiction. "With addiction, people feel good because it fills a gap in their lives," notes Hearn. "The drug or alcohol substitutes for something lacking, and it's used to cope, too."

So, when you literally "trip down memory lane" with ibogaine, you come to grips with all those experiences you swept under your emotional carpet so long ago. This miracle drug also "cures the anxiety of detachment from a long-term habit," says Hearn, whose Metro-Dade Medical Examiner's lab will be involved in Mash's FDA safety trials by analyzing the long-term blood concentration of ibogaine.

So far, no one has ever had a "bad trip" on ibogaine, and the only side effect reported is slight nausea at the beginning of the 36-hour treatment. Mash has used ibogaine on monkeys and found that "it's not toxic to the brain," she says. "And there were no adverse effects in the people who took it in Holland. Toxicity only showed up in a study at Johns Hopkins University, and it was only toxic in ridiculously high doses."

While it's evident how ibogaine works psychologically, physiologically "it's still a mystery," Mash admits. "It doesn't bind to any known receptor in the brain." It has been shown to have an effect on dopamine, causing the brain to release less of this chemical, which in turn lessens the effects of cocaine.

Mash and her colleagues will test ibogaine on cocaine addicts during the FDA safety trials. Her team includes two medical doctors—one is a neurologist and the other a psychiatrist specializing in addiction—and a social worker who is an expert on inner-child work.

"Ibogaine puts you into a 36-hour waking dream state. It's a psychoactive drug, but not a hallucinogen like LSD. During this altered state of consciousness, you relive your childhood experiences and get to the roots of your addictions."

—Dr. Deborah Mash

"Unfortunately, a negative bias has evolved surrounding the use of psychoactive drugs," Hearn laments, "because of the recreational use of drugs like LSD. But it's a mistake to label them as bad just because they're mind-active. We need to distinguish among them. Different drugs are different in their activities. This is *not* LSD. There are no bad trips, flashbacks or people wanting to jump off buildings to see if they can fly. Maybe ibogaine will change some of the misperceptions and open the door to research with psycho active drugs."

Mash agrees, adding, "Treating drug dependence with a *drug* is still considered by people to be ironic."

But, summing up both ibogaine and her non-stop work delving into the brain, she sighs: "God works in strange and mysterious ways." ■

ILLUSTRATION FROM *THE RANDOM HOUSE ENCYCLOPEDIA*, PUBLISHED BY RANDOM HOUSE, NEW YORK

UNIVERSITY OF
Miami
SCHOOL OF MEDICINE

September 17, 1993

Hillary Rodham Clinton
Office of the First Lady
The White House
West Wing, Second Floor
Washington, DC 20500

Re: Ibogaine HCl (Endabuse™)

SEP 20 1993

Dear Mrs. Clinton:

Enclosed please find a copy of the ABC News DAY ONE tape entitled "Ibogaine Report", which my husband, Joe Geller, discussed with you during your recent visit to Miami. We have previously given a copy of the tape to Hugh. We are delighted by your interest in this project, and believe that you will be excited about what you see. I would be more than happy to provide you with additional information should you so desire, including information about the status of our pending clinical trials.

Thank you for your interest in this project.

With best wishes.

Sincerely yours,

Deborah C. Mash

Deborah C. Mash, Ph.D.
Associate Professor of Neurology
and Cellular and Molecular Pharmacology

Associate Director, Comprehensive Drug Research Center

Department of Neurology (D4-5)
P.O. Box 016960
Miami, Florida 33101
(305) 547-6731

UNIVERSITY OF
Miami
SCHOOL OF MEDICINE

September 17, 1993

Hillary Rodham Clinton
Office of the First Lady
The White House
West Wing, Second Floor
Washington, DC 20500

Re: Ibogaine HCl (Endabuse™)

SEP 20 1993

Dear Mrs. Clinton:

Enclosed please find a copy of the ABC News DAY ONE tape entitled "Ibogaine Report", which my husband, Joe Geller, discussed with you during your recent visit to Miami. We have previously given a copy of the tape to Hugh. We are delighted by your interest in this project, and believe that you will be excited about what you see. I would be more than happy to provide you with additional information should you so desire, including information about the status of our pending clinical trials.

Thank you for your interest in this project.

With best wishes.

Sincerely yours,

Deborah C. Mash

Deborah C. Mash, Ph.D.
Associate Professor of Neurology
and Cellular and Molecular Pharmacology

Associate Director, Comprehensive Drug Research Center

Department of Neurology (D4-5)
P.O. Box 016960
Miami, Florida 33101
(305) 547-6731

2 copies

South Florida exclusive

Scientific Breakthroughs

Brain Waves

How a UM doctor may soon unveil the ultimate *cure for addictions, and uncovered the mystery surrounding sudden cocaine deaths*

By Nina L. Diamond • Photograph by Jane Mitchell

Cocaine overdoses had become more common in South Florida than frostbite in Alaska. At the peak of cocaine deaths, about seven years ago, Dr. Lee Hearn, laboratory director of the Metro-Dade Medical Examiner's Department, was at a loss to explain why so many people were dying of coke overdoses when the blood-levels of the drug were much lower than what was usually considered a lethal dose.

The bodies came in, fluids and tissues were studied, and it was more of the same. Why were all these people dying?

Just a few minutes from Hearn's office near Jackson Memorial Hospital, west of downtown Miami, neuroscientist Dr. Deborah Mash, who'd known Hearn since their grad school days at the University of Miami, was busy running the UM School of Medicine's Brain Endowment Bank, teaching neurology and pharmacology, and keeping up with a full schedule of brain research. In her mid-30s then, Mash had already made a name for herself in Alzheimer's and Parkinson's disease research, and, as a specialist in pharmacology, she routinely played detective, studying the body's response not only to outside chemicals, but also to the ones the body itself created.

By 1989, Hearn had noticed something quite unusual in the blood of fatal coke overdose cases. "As I reviewed cases, I saw that cocaethylene was often present in the blood. But nobody knew what it did."

Cocaethylene, discovered about 10 years ago, is manufactured by enzymes in the liver when cocaine and alcohol are mixed. It was thought to only be present in the urine, and to be of little consequence. So, when Hearn called scientists at Yale University and asked if they knew about any cocaethylene studies, he was told that this third drug, created by our own bodies, doesn't make its way into the blood stream. "Yes it does," Hearn replied. "We see it all the time." He sent samples. Yale verified them.

With proof in hand that he wasn't imagining things, Hearn went to his old pal Mash at UM. Backed by a National Institute on Drug Abuse (NIDA) grant, Mash and her colleagues had already embarked on a study of the cocaine overdose epidemic.

"Sometimes there's more cocaethylene in these people than cocaine," Hearn told Mash.

Convinced that cocaethylene was the culprit in the majority of these surprisingly deadly overdoses, Mash was determined to prove that it was not a harmless by-product, but a killer. She and Hearn joined forces, bringing their staffs at UM and the Metro-Dade Medical Examiner's office together in the name of science.

"Cocaethylene gives a longer and stronger high than cocaine. And it's more lethal than cocaine."

—Dr. Deborah Mash

They worked on little else for the last part of 1990, and in record time—less than six months—Mash, Hearn and their team not only were the first to prove that cocaethylene is an active drug, they also had their breakthrough findings published in the January 1991 *Journal of Neurochemistry*.

"Miami is a unique place to do this research," says Mash, grabbing a precious 60 minutes out of her 12-hour work day to talk about their landmark findings and continued research, and the state of chemical addiction. At least twice a month, Mash is gone for days at a time, traveling the world to deliver research papers, conduct studies and touch base with the National Institutes of Health (NIH) in Bethesda, Maryland, where she is a consultant. For three months we spoke weekly, between her airport adventures. "Cocaine is one of the primary substances people here use and abuse. Not heroin, like elsewhere. And we have a high number of cocaine emergencies and overdoses."

Mash notes it's only fitting that, "as a transit point for cocaine entering the U.S.," Miami should also be home to the most promising research.

"We were trying to understand the toxicology. Many died from what should have been safe levels of cocaine in their bodies," she recalls. "We thought maybe there was a processing contaminant, a toxic by-product created when cocaine was made in labs. But that didn't explain it. We noticed that most people—five million Americans—combine cocaine with alcohol. It's the most frequent two-way drug combo. Could cocaethylene be the culprit? We measured it in specimens of blood, brain and liver tissues and found it *higher* in some instances than the levels of coke itself! Then we demonstrated that it's pharmacologically active. And we found that it packs the same 'reward punch' on the brain as cocaine and alcohol do separately, but cocaethylene gives a longer and stronger high and has a much longer half-life than cocaine."

This extra kick was often the *last* kick. "It's more potent than cocaine in causing deaths," says Mash. "It's more lethal than cocaine."

Her work, she says, is "like reading chapters of a very good detective story." The much-published 41-year-old scientist shies away from the term "workaholic." Instead, she likes to say that "science is a way of life. You don't walk away from this."

Despite the fact that she's married to prominent Dade Democratic party leader and attorney Joe Geller ("Joe who?" she quips. "I hardly ever see him."), and has been a commissioner for the City of North Bay Village since 1988, Mash's life is otherwise consumed by her scientific crusade. "Intellectually, I never grow weary of it. I love the discovery. Every day I'm faced with something new. I learn every day."

Mash grew up in Hollywood, where her teachers fast-tracked her in math and science when she showed both interest and tremendous talent. A competitive kid, she won science fairs with her biochemistry projects, and, as a senior in high school, she "discovered brain science while studying psychology." She knew then, she says, that it would be her life's work.

"I briefly toyed with being a medical doctor," she recalls. "But I wanted to devote 100 percent of my life to research."

Mash has never fit the stereotype of the stuffy scientist who's quiet, prim and unaware of life outside the lab. Far from it. In college at FSU, she looked like Cher, with waist-length black

Brainy lady: Dr. Deborah Mash in her headline-making lab at the UM School of Medicine's Brain Endowment Bank.

curls, an exotic aura, and eye-catching, funky leather outfits. Ever the crusader, Mash spoke out against the Vietnam War and whatever other social causes stirred her passions. At his law school graduation, her husband, Joe, blurted out an impromptu plea to stop the death penalty while on stage receiving his diploma. They were—and still are—quite the couple.

Now, her crusade is to understand, prevent and treat drug and alcohol addiction, both scientifically and sociologically. "I pore over research at home, I design experiments in the car on the way to the lab. To combat abuse, we have to understand brain changes and dependency. Then we can design specific therapeutic intervention. When we understand craving, we can know how to block it," she says enthusiastically. "We want to stop the progression, to keep people off drugs and alcohol. We all pay, and it's a hefty price tag. Just look at the crack babies."

Mash and her colleagues approach the problem from all angles. "We now have the Comprehensive Drug Research Center at UM to study and bridge the relationship between scientists and treatment people," she says. "Classic treatment approaches have largely failed. It's an illness, and we have to design new treatments based on what we're learning about how these chemicals change the brain. We're also studying the long-term effects of drug and alcohol abuse."

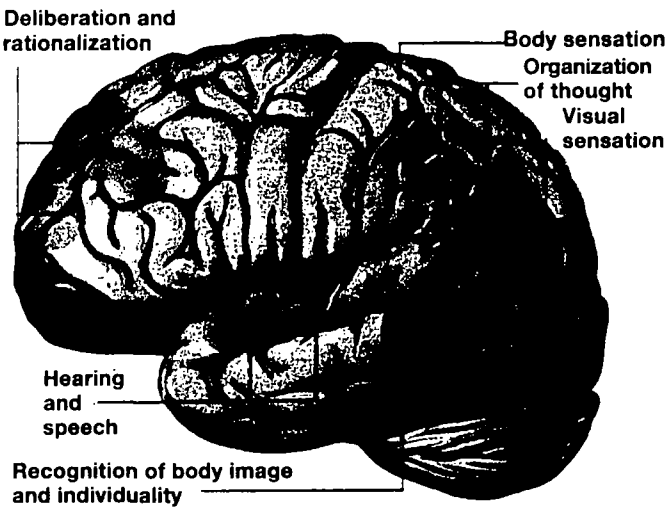
She's now researching how cocaine and alcohol accelerate cardiovascular disease. "Cocaine and alcohol do major damage to the heart and brain. We're looking at heart disease and cognitive and behavioral problems in people. Cocaine may cause depletion of dopamine in the brain, which may lead to Parkinson's disease. We already know this is true of amphetamines. People taking them over time were stricken with movement disease not unlike Parkinson's."

Combining cocaine and alcohol takes an even higher toll on the body. "The dual addiction is a harder addiction to break. We're looking into that. And it causes thickening of the arteries. We think the deterioration is happening quickly, too. Hearts that are 30 look like they're 70. We may see a young generation die

off from heart disease."

Cocaethylene also plays a role in AIDS. "It may give the HIV virus a boost," Mash reveals. "And our discovery that cocaethylene is active in the body has helped spawn this new angle in HIV research."

But the most exciting, most mind-boggling development in the history of drug and alcohol treatment is the new drug ibogaine. And guess who may get to introduce this bona fide cure for addiction? That's right—Mash and her colleagues at both UM and the Metro-Dade Medical Examiner's department. As we go to press, she's awaiting approval from the Food and Drug Administration (FDA) to conduct safety trials. This is the first step—testing ibogaine on people in a controlled scientific setting—in the official process that makes a drug legal for use in the United States.



"The FDA has been very responsive on this one," Mash says, feeling 99 percent certain that they will grant her request. "We have a congressional mandate to help people get off drugs. And we know that drugs are co-factors for HIV."

Mash is just the latest link in the ibogaine story, but the one that will bridge the gap between anecdotal evidence and the scientific proof needed for FDA approval. Ibogaine is derived from the roots of *Tabernathe iboga*, a shrub native to equatorial Africa, where tribes have long used it in small doses to remain alert while hunting, and in larger doses during sacred rituals.

Back in 1962, Howard Lotsof, then "part of the New York film scene at NYU's film school, and a heroin addict, was looking for a new high, when he discovered ibogaine," says Mash. "After his 36-hour 'trip' on ibogaine, he found he had completely lost his desire for heroin, and had no withdrawal symptoms."

Lotsof gave the substance to other addicts, and they, too, were instantly un-hooked from the drugs that previously had controlled their lives. "The International Coalition for Addict Self-Help ran underground trial testing on ibogaine," Mash says, "and it was found to cure addictions to heroin, cocaine, amphetamines, alcohol and nicotine." This so-called anecdotal evidence has shown that ibogaine cures addiction almost 100 percent of the time. In 1986, Lotsof formed NDA International and secured a use patent on ibogaine for treating drug and alcohol addiction. Scientific study began in the Netherlands three years ago, with more than three dozen addicts as test cases. Mash was among the U.S. scientists and doctors invited to Leiden, Holland to witness ibogaine in action.

"It puts you into a 36-hour waking dream state. It's a psychoactive drug, but not a hallucinogen like LSD. During this altered state of consciousness, you relive your childhood experiences," she says. "You get to the roots of your addictions."

One trip on ibogaine is like 30 years on a therapist's couch.

"Ibogaine was used as a rite of passage from childhood to adulthood in Africa," says Hearn. "And now it can be used to reprogram the addict's life. He's detached from childhood recollection while on Ibogaine, but is reexamining it, coming to grips with it, perhaps understanding it for the first time. All neuroses are solvable this way, not just the ones that lead to addiction."

Using ibogaine, then, helps address the cause of the addiction. "Drug addiction is an illness of the spirit," says Hearn. "If you're going to cure it, you have to cure it at that level."

Scientists and treatment professionals have long known that trauma, insecurities, fears and the like are the very foundations of psychological distress, which includes addiction. "With addiction, people feel good because it fills a gap in their lives," notes Hearn. "The drug or alcohol substitutes for something lacking, and it's used to *cope, too.*"

So, when you literally "trip down memory lane" with ibogaine, you come to grips with all those experiences you swept under your emotional carpet so long ago. This miracle drug also "cures the anxiety of detachment from a long-term habit," says Hearn, whose Metro-Dade Medical Examiner's lab will be involved in Mash's FDA safety trials by analyzing the long-term blood concentration of ibogaine.

So far, no one has ever had a "bad trip" on ibogaine, and the only side effect reported is slight nausea at the beginning of the 36-hour treatment. Mash has used ibogaine on monkeys and found that "it's not toxic to the brain," she says. "And there were no adverse effects in the people who took it in Holland. Toxicity only showed up in a study at Johns Hopkins University, and it was only toxic in ridiculously high doses."

While it's evident how ibogaine works psychologically, physiologically "it's still a mystery," Mash admits. "It doesn't bind to any known receptor in the brain." It has been shown to have an effect on dopamine, causing the brain to release less of this chemical, which in turn lessens the effects of cocaine.

Mash and her colleagues will test ibogaine on cocaine addicts during the FDA safety trials. Her team includes two medical doctors—one is a neurologist and the other a psychiatrist specializing in addiction—and a social worker who is an expert on inner-child work.

"Ibogaine puts you into a 36-hour waking dream state. It's a psychoactive drug, but not a hallucinogen like LSD. During this altered state of consciousness, you relive your childhood experiences and get to the roots of your addictions."

—Dr. Deborah Mash

"Unfortunately, a negative bias has evolved surrounding the use of psychoactive drugs," Hearn laments, "because of the recreational use of drugs like LSD. But it's a mistake to label them as bad just because they're mind-active. We need to distinguish among them. Different drugs are different in their activities. This is *not* LSD. There are no bad trips, flashbacks or people wanting to jump off buildings to see if they can fly. Maybe ibogaine will change some of the misperceptions and open the door to research with psycho active drugs."

Mash agrees, adding, "Treating drug dependence with a *drug* is still considered by people to be ironic."

But, summing up both ibogaine and her non-stop work delving into the brain, she sighs: "God works in strange and mysterious ways." ■

ILLUSTRATION FROM *THE RANDOM HOUSE ENCYCLOPEDIA*, PUBLISHED BY RANDOM HOUSE, NEW YORK

UNIVERSITY OF
Miami
SCHOOL OF MEDICINE

September 17, 1993

Hillary Rodham Clinton
Office of the First Lady
The White House
West Wing, Second Floor
Washington, DC 20500

Re: Ibogaine HCl (Endabuse™)

SEP 20 1993

Dear Mrs. Clinton:

Enclosed please find a copy of the ABC News DAY ONE tape entitled "Ibogaine Report", which my husband, Joe Geller, discussed with you during your recent visit to Miami. We have previously given a copy of the tape to Hugh. We are delighted by your interest in this project, and believe that you will be excited about what you see. I would be more than happy to provide you with additional information should you so desire, including information about the status of our pending clinical trials.

Thank you for your interest in this project.

With best wishes.

Sincerely yours,

Deborah C. Mash

Deborah C. Mash, Ph.D.
Associate Professor of Neurology
and Cellular and Molecular Pharmacology

Associate Director, Comprehensive Drug Research Center

Department of Neurology (D4-5)
P.O. Box 016960
Miami, Florida 33101
(305) 547-6731

2 copies

South Florida exclusive

Scientific Breakthroughs

Brain Waves

How a UM doctor may soon unveil the ultimate cure for addictions, and uncovered the mystery surrounding sudden cocaine deaths

By Nina L. Diamond • Photograph by Jane Mitchell

Cocaine overdoses had become more common in South Florida than frostbite in Alaska. At the peak of cocaine deaths, about seven years ago, Dr. Lee Hearn, laboratory director of the Metro-Dade Medical Examiner's Department, was at a loss to explain why so many people were dying of coke overdoses when the blood-levels of the drug were much lower than what was usually considered a lethal dose.

The bodies came in, fluids and tissues were studied, and it was more of the same. Why were all these people dying?

Just a few minutes from Hearn's office near Jackson Memorial Hospital, west of downtown Miami, neuroscientist Dr. Deborah Mash, who'd known Hearn since their grad school days at the University of Miami, was busy running the UM School of Medicine's Brain Endowment Bank, teaching neurology and pharmacology, and keeping up with a full schedule of brain research. In her mid-30s then, Mash had already made a *name for herself in Alzheimer's and Parkinson's disease re*search, and, as a specialist in pharmacology, she routinely played detective, studying the body's response not only to outside chemicals, but also to the ones the body itself created.

By 1989, Hearn had noticed something quite unusual in the blood of fatal coke overdose cases. "As I reviewed cases, I saw that cocaethylene was often present in the blood. But nobody knew what it did."

Cocaethylene, discovered about 10 years ago, is manufactured by enzymes in the liver when cocaine and alcohol are mixed. It was thought to only be present in the urine, and to be of little consequence. So, when Hearn called scientists at Yale University and asked if they knew about any cocaethylene studies, he was told that this third drug, created by our own bodies, doesn't make its way into the blood stream. "Yes it does," Hearn replied. "We see it all the time." He sent samples. Yale verified them.

With proof in hand that he wasn't imagining things, Hearn *went to his old pal Mash at UM. Backed by a National Institute* on Drug Abuse (NIDA) grant, Mash and her colleagues had already embarked on a study of the cocaine overdose epidemic.

"Sometimes there's more cocaethylene in these people than cocaine," Hearn told Mash.

Convinced that cocaethylene was the culprit in the majority of these surprisingly deadly overdoses, Mash was determined to prove that it was not a *harmless by-product, but a killer. She* and Hearn joined forces, bringing their staffs at UM and the Metro-Dade Medical Examiner's office together in the name of science.

"Cocaethylene gives a longer and stronger high than cocaine. And it's more lethal than cocaine."

—Dr. Deborah Mash

They worked on little else for the last part of 1990, and in record time—less than six months—Mash, Hearn and their team not only were the first to prove that cocaethylene is an active drug, they also had their breakthrough findings published in the January 1991 *Journal of Neurochemistry*.

"Miami is a unique place to do this research," says Mash, grabbing a precious 60 minutes out of her 12-hour work day to talk about their landmark findings and continued research, and the state of chemical addiction. At least twice a month, Mash is gone for days at a time, traveling the world to deliver research papers, conduct studies and touch base with the National Institutes of Health (NIH) in Bethesda, Maryland, where she is a consultant. For three months we spoke weekly, between her airport adventures. "Cocaine is one of the primary substances *people here use and abuse. Not heroin, like elsewhere. And we* have a high number of cocaine emergencies and overdoses."

Mash notes it's only fitting that, "as a transit point for cocaine entering the U.S.," Miami should also be home to the most promising research.

"We were trying to understand the toxicology. Many died from what should have been safe levels of cocaine in their bodies," she recalls. "We thought maybe there was a processing contaminant, a toxic by-product created when cocaine was made *in labs. But that didn't explain it. We noticed that most people*—five million Americans—combine cocaine with alcohol. It's the most frequent two-way drug combo. Could cocaethylene be the culprit? We measured it in specimens of blood, brain and liver tissues and found it *higher* in some instances than the levels of coke itself! Then we demonstrated that it's pharmacologically active. And we found that it packs the same 'reward punch' on the brain as cocaine and alcohol do separately, but cocaethylene gives a longer and stronger high and has a much longer half-life than cocaine."

This extra kick was often the *last* kick. "It's more potent than cocaine in causing deaths," says Mash. "It's more lethal than cocaine."

Her work, she says, is "like reading chapters of a very good detective story." The much-published 41-year-old scientist shies away from the term "workaholic." Instead, she likes to say that "science is a way of life. You don't walk away from this."

Despite the fact that she's married to prominent Dade Demo*cratic party leader and attorney Joe Geller ("Joe who?" she* quips. "I hardly ever see him."), and has been a commissioner for the City of North Bay Village since 1988, Mash's life is otherwise consumed by her scientific crusade. "Intellectually, I never grow weary of it. I love the discovery. Every day I'm faced with something new. I learn every day."

Mash grew up in Hollywood, where her teachers fast-tracked her in math *and science when she showed both* interest and tremendous talent. A competitive kid, she won science fairs with her biochemistry projects, and, as a senior in high school, she "discovered brain science while studying psychology." She knew then, she says, that it would be her life's work.

"I briefly toyed with being a medical doctor," she recalls. "But I wanted to devote 100 percent of my life to research."

Mash has never fit the stereotype of the stuffy scientist who's quiet, prim and unaware of life outside the lab. Far from it. In college at FSU, she looked like Cher, with waist-length black

Brainy lady: Dr. Deborah Mash in her headline-making lab at the UM School of Medicine's Brain Endowment Bank.

curls, an exotic aura, and eye-catching, funky leather outfits. Ever the crusader, Mash spoke out against the Vietnam War and whatever other social causes stirred her passions. At his law school graduation, her husband, Joe, blurted out an impromptu plea to stop the death penalty while on stage receiving his diploma. They were—and still are—quite the couple.

Now, her crusade is to understand, prevent and treat drug and alcohol addiction, both scientifically and sociologically. "I pore over research at home, I design experiments in the car on the way to the lab. To combat abuse, we have to understand brain changes and dependency. Then we can design specific therapeutic intervention. When we understand craving, we can know how to block it," she says enthusiastically. "We want to stop the progression, to keep people off drugs and alcohol. We all pay, and it's a hefty price tag. Just look at the crack babies."

Mash and her colleagues approach the problem from all angles. "We now have the Comprehensive Drug Research Center at UM to study and bridge the relationship between scientists and treatment people," she says. "Classic treatment approaches have largely failed. It's an illness, and we have to design new treatments based on what we're learning about how these chemicals change the brain. We're also studying the long-term effects of drug and alcohol abuse."

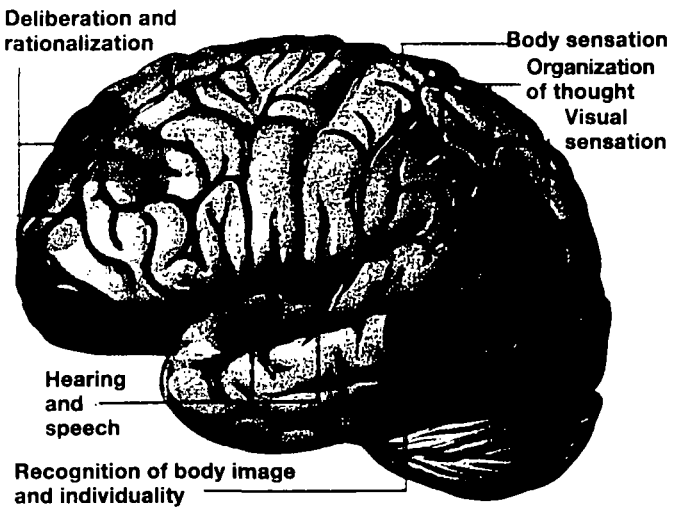
She's now researching how cocaine and alcohol accelerate cardiovascular disease. "Cocaine and alcohol do major damage to the heart and brain. We're looking at heart disease and cognitive and behavioral problems in people. Cocaine may cause depletion of dopamine in the brain, which may lead to Parkinson's disease. We already know this is true of amphetamines. People taking them over time were stricken with movement disease not unlike Parkinson's."

Combining cocaine and alcohol takes an even higher toll on the body. "The dual addiction is a harder addiction to break. We're looking into that. And it causes thickening of the arteries. We think the deterioration is happening quickly, too. Hearts that are 30 look like they're 70. We may see a young generation die

off from heart disease."

Cocaethylene also plays a role in AIDS. "It may give the HIV virus a boost," Mash reveals. "And our discovery that cocaethylene is active in the body has helped spawn this new angle in HIV research."

But the most exciting, most mind-boggling development in the history of drug and alcohol treatment is the new drug ibogaine. And guess who may get to introduce this bona fide cure for addiction? That's right—Mash and her colleagues at both UM and the Metro-Dade Medical Examiner's department. As we go to press, she's awaiting approval from the Food and Drug Administration (FDA) to conduct safety trials. This is the first step—testing ibogaine on people in a controlled scientific setting—in the official process that makes a drug legal for use in the United States.



"The FDA has been very responsive on this one," Mash says, feeling 99 percent certain that they will grant her request. "We have a congressional mandate to help people get off drugs. And we know that drugs are co-factors for HIV."

Mash is just the latest link in the ibogaine story, but the one that will bridge the gap between anecdotal evidence and the scientific proof needed for FDA approval. Ibogaine is derived from the roots of *Tabernathe iboga*, a shrub native to equatorial Africa, where tribes have long used it in small doses to remain alert while hunting, and in larger doses during sacred rituals.

Back in 1962, Howard Lotsof, then "part of the New York film scene at NYU's film school, and a heroin addict, was looking for a new high, when he discovered ibogaine," says Mash. "After his 36-hour 'trip' on ibogaine, he found he had completely lost his desire for heroin, and had no withdrawal symptoms."

Lotsof gave the substance to other addicts, and they, too, were instantly un-hooked from the drugs that previously had controlled their lives. "The International Coalition for Addict Self-Help ran underground trial testing on ibogaine," Mash says, "and it was found to cure addictions to heroin, cocaine, amphetamines, alcohol and nicotine." This so-called anecdotal evidence has shown that ibogaine cures addiction almost 100 percent of the time. In 1986, Lotsof formed NDA International and secured a use patent on ibogaine for treating drug and alcohol addiction. Scientific study began in the Netherlands three years ago, with more than three dozen addicts as test cases. Mash was among the U.S. scientists and doctors invited to Leiden, Holland to witness ibogaine in action.

"Ibogaine puts you into a 36-hour waking dream state. It's a psychoactive drug, but not a hallucinogen like LSD. During this altered state of consciousness, you relive your childhood experiences and get to the roots of your addictions."

—Dr. Deborah Mash

"It puts you into a 36-hour waking dream state. It's a psychoactive drug, but not a hallucinogen like LSD. During this altered state of consciousness, you relive your childhood experiences," she says. "You get to the roots of your addictions."

One trip on ibogaine is like 30 years on a therapist's couch.

"Ibogaine was used as a rite of passage from childhood to adulthood in Africa," says Hearn. "And now it can be used to reprogram the addict's life. He's detached from childhood recollection while on Ibogaine, but is reexamining it, coming to grips with it, perhaps understanding it for the first time. All neuroses are solvable this way, not just the ones that lead to addiction."

Using ibogaine, then, helps address the cause of the addiction. "Drug addiction is an illness of the spirit," says Hearn. "If you're going to cure it, you have to cure it at that level."

Scientists and treatment professionals have long known that trauma, insecurities, fears and the like are the very foundations of psychological distress, which includes addiction. "With addiction, people feel good because it fills a gap in their lives," notes Hearn. "The drug or alcohol substitutes for something lacking, and it's used to cope, too."

So, when you literally "trip down memory lane" with ibogaine, you come to grips with all those experiences you swept under your emotional carpet so long ago. This miracle drug also "cures the anxiety of detachment from a long-term habit," says Hearn, whose Metro-Dade Medical Examiner's lab will be involved in Mash's FDA safety trials by analyzing the long-term blood concentration of ibogaine.

So far, no one has ever had a "bad trip" on ibogaine, and the only side effect reported is slight nausea at the beginning of the 36-hour treatment. Mash has used ibogaine on monkeys and found that "it's not toxic to the brain," she says. "And there were no adverse effects in the people who took it in Holland. Toxicity only showed up in a study at Johns Hopkins University, and it was only toxic in ridiculously high doses."

While it's evident how ibogaine works psychologically, physiologically "it's still a mystery," Mash admits. "It doesn't bind to any known receptor in the brain." It has been shown to have an effect on dopamine, causing the brain to release less of this chemical, which in turn lessens the effects of cocaine.

Mash and her colleagues will test ibogaine on cocaine addicts during the FDA safety trials. Her team includes two medical doctors—one is a neurologist and the other a psychiatrist specializing in addiction—and a social worker who is an expert on inner-child work.

"Unfortunately, a negative bias has evolved surrounding the use of psychoactive drugs," Hearn laments, "because of the recreational use of drugs like LSD. But it's a mistake to label them as bad just because they're mind-active. We need to distinguish among them. Different drugs are different in their activities. This is *not* LSD. There are no bad trips, flashbacks or people wanting to jump off buildings to see if they can fly. Maybe ibogaine will change some of the misperceptions and open the door to research with psycho active drugs."

Mash agrees, adding, "Treating drug dependence with a *drug* is still considered by people to be ironic."

But, summing up both ibogaine and her non-stop work delving into the brain, she sighs: "God works in strange and mysterious ways." ■

ILLUSTRATION FROM *THE RANDOM HOUSE ENCYCLOPEDIA*, PUBLISHED BY RANDOM HOUSE, NEW YORK

JOHN KERRY
MASSACHUSETTS

United States Senate

WASHINGTON, DC 20510

PERSONAL AND ~~CONFIDENTIAL~~

MEMORANDUM

TO: MRS. HILLARY RODHAM CLINTON

FROM: SENATOR JOHN F. KERRY

DATE: OCTOBER 5, 1993

RE: CRIME AND VIOLENCE

Again, many thanks for inviting me to join you on the journey to the United Nations. Per your suggestion, I am following up on our conversation during the flight. I know how deeply you care about this issue and also how committed the President is to limiting violence.

My own involvement in this area goes back to the 1970's when I was a prosecutor and chief administrator of one of the largest District Attorney's offices in the country. I saw what worked then and know we can do better today.

As I mentioned to you, I am deeply concerned that the national response to our current epidemic of violence is anemic to say the least. The risks for our party and for the country are enormous. It is our watch now. For 12 years, I and others have been critical of the phony Reagan/Bush war on drugs and response to crime. Yet almost a year into the new Administration, we have proposed and funded little that is different. I am deeply concerned that our approach is too "Washington" -- too much business as usual -- too distant from the real fears and concerns of average citizens.

The Crime Bill, as it is currently drafted, will not significantly alter our commitment or Americans' perceptions, notwithstanding Joe Biden's good leadership and desire to do more. He has simply been told the resources won't be there to do more, leaving many of us to wonder why? And why aren't we fighting for more resources? I dare say that after the strutting and the breast beating in the Congress is over and the current Crime Bill is passed, not many Americans will walk out of their homes with an

increased sense of safety or a new perception of real government action that makes a difference to their lives. The Administration should, at least, be pushing for significantly more than they will get and, more importantly, for a real response to the issues that concern people.

I believe we must summon a national program that is unlike any past presidential effort. There must be a much greater sense of urgency in the administration's response. We must mobilize not just the government but the nation and its spirit.

Prosecutors, police, probation officers, victims, prison administrators, judges, and, most importantly, the vast majority of our citizens are waiting for leadership -- for something real to happen that will make clear to everyone in this country we are prepared to re-claim our communities -- that we are prepared to assert a different set of values about how people protect and care for each other in the context of community -- that we are prepared to restore order where disorder has overwhelmed people's hopes and aspirations.

How? By making a systemic commitment -- by treating the criminal justice system as a system, where each component understands its importance to other components, and an overall resource commitment permits each component to make the rest of the system work.

For instance -- police have no prayer of making deterrence work or of diminishing peoples' fears, or even of maintaining order or their own morale, if there is no place to put the people they apprehend. A system that releases people early or never jails them at all because no one will guarantee space is available or wastes critical space on people who are non-violent, is a system doomed to fail. That is precisely what we have today -- despite years of warnings and countless celebrated incidents.

I suggest this nation is rich enough and competent enough to coordinate state, local and federal prison systems as well as boot camps and surplus and existing federal properties to guarantee that people who should be taken off our streets -- in one form of restraint or another -- are, and that alternatives are available for those who shouldn't be. But we don't do this -- because no one has challenged us or lead us to undertake this task. It is an absolutely achievable goal but only with vision, leadership and resource commitment.

Another example is drug treatment. We have had 6 or 7 declarations of war on drugs. Some say we have lost this war. I say we have never really waged it.

Currently, only 20% of the addicts in America receive treatment. On its face, this is unacceptable after 6 years of so-called commitment. Moreover, only 55% of our children are educated about drug use. Treatment, education and law enforcement at home continue to suffer resource starvation while supply side efforts draw a disproportionate share of our focus often in quixotic enterprises. It's not that we don't know what to do. It's simply that we haven't made the decision to do it.

The result is that you can go a few blocks from the Capitol in the light of day and watch addicts shoot up. You can do this in most cities in America, and most Americans know it. Recently, I rode around in a cop car in Boston to watch drug deals going down from corner to corner. The cops know who the offenders are but feel powerless to do anything because of clogged courts and prisons. Worse still, the addicts and dealers know that our lack of commitment means they can operate with near impunity, understanding that society is not really serious. When 80% of all addicts know that they can't get help at a given moment, the street message is clear -- the system is not serious. And so, they continue to tear apart the fabric of communities -- not to mention their own lives. In the 9 years that I've been in the Senate, this has not changed.

Yet another example: The President committed to put 100,000 more police on the street. I am told the Crime Bill offers only 50,000 police over 5 years though, in reality, the money allocated will produce <u>far</u> fewer police than that. This is a dangerous reversal of a promise which threatens not only administration politics but policy. To properly implement community policing we must significantly augment our force level. Twenty years ago, there were 3 police officers for every violent crime. Today we have 3 violent crimes per police officer. We must keep the 100,000 commitment and struggle to do more.

The bottom line, I have come to believe, regrettably, is that government and country are not really serious about these issues -- or leadership at the highest levels has been unwilling to show how we can, in fact, do something about these problems. Either way, unless something changes dramatically, the Administration will be fairly attacked for having lost its moment and squandered the opportunity to be different.

I believe the administration should offer a comprehensive plan for re-claiming our communities. The five most important short-term components of this plan should embrace: (1) sufficient resources to guarantee adequate community policing throughout the country, including the Police Corps; (2) emergency and, in some cases, temporary measures for incarceration and detention so that <u>anyone</u> who should be jailed is; (3) proposals for bail modification

combined with speedy trial capacity to avoid any flight of drug dealers or other criminals who encourage people to treat our system with disregard; (4) emergency court capacity to provide swift and certain punishment; and (5) treatment on demand for drug addiction. In addition to these five key components, there must be further proposals for diversion for certain youth with adequate counseling or boot camp availability; high school equivalency requirements for parole or release; a major federal grant program to provide incentives for state action and cooperation with bail, gun law and other requirements; a set of emergency inner-city resources to schools for tutoring, counseling and evening hours.

This is only the beginning -- but I believe the most important place to start. I and my staff stand ready to help in any way possible to develop and implement these initiatives.

I have enclosed a speech I delivered at Yale last year which addresses this and related issues. I hope it is helpful.

JOHN KERRY
MASSACHUSETTS

United States Senate

WASHINGTON, DC 20510

EMBARGOED/FOR RELEASE UPON DELIVERY ONLY, APPROX. 8 P.M. TONIGHT

Race, Politics And The
Urban Agenda
Senator John Kerry
Yale University
March 30, 1992

This is, as you may have noticed here in Connecticut last week, an election year.

We are, as we have been so often in the past, inundated with the trivia of politics, but sadly we are deprived of its essence. For politics at its best is not about media horse races, photo opportunities or freeze-dried messages microwaved before each primary; the politics that interests me and matters to you is not trivial and not separable from the reality of life as it is lived in this country today.

What is that reality? Well, for some--I expect for most of you--it is the obvious-- a reality filled with anxieties about classwork, social relationships and future choices. But it is also, for most of you, a reality shaped by high expectations, a certain degree of confidence in self and the support of peers and family. And while the horizons you see when you look ahead may not be quite as cloudless as those that I and others perceived when sitting in your place a few years ago, I sense the optimism is still there,the almost boundless sense of possibility and the impatience to experience the full measure of life and promised success.

For the next few minutes though, I ask you to consider a different part of the reality of America today; a violent, drug-ridden, rat-infested reality; a reality in which the institutions of civilized social life have broken down; of disintegrated families; boarded up storefronts; schools that have become armed camps and crackhouses replacing community centers as the focus of neighborhood life.

I ask you to consider a reality where more than 80% of babies are born to single mothers; where young men die violently at a rate exceeding that of any american war; where only one child in three finishes high school and even then, too often, can barely read; where the spread of AIDS and homelessness rips so visibly at the fabric of community; where far too many families are on welfare for far too long; and where far too many children carry guns instead of lunch boxes to school.

I ask you to consider a reality that is ruled not simply by poverty, but by savagery; a tragic, inescapable and cruel reality

that increasingly affects all of us and that is eating away at the American soul.

Sadly, we have always had poverty in this country. We have always had violent crime. From the days of the first wayward Pilgrim, we have had problems with alcohol and drugs.

But we have never seen in America the kind of problems that we see in our worst urban neighborhoods today.

We have never seen children talk matter of factly about blowing each other away or about living in a world where guns are as common as water or about going to sleep at night and waking up each morning with shooting or getting shot the first thing on their minds.

We have never seen an America where a two-year old girl could be found at a day care center with eleven vials of crack in her pockets thinking that they were candy or where a kindergartner could find a gun in a stroller and use it to kill his little sister.

We have never tried to raise children in an environment where the glorification of violence in movies and music has such immediate relevance to so many; where Hollywood tries and tries but cannot out-shock reality; and where some rap musicians celebrate murder in cold blood while murder records are broken every year.

Today, this land of the free has the highest incarceration rate of any nation in the world; we imprison black males at five times the rate of South Africa; and a violent crime is committed in or around one of our schools every six seconds.

Today, too many places in this land of opportunity have for many become forbidden lands, deserted by working families and functioning businesses; deserted by children's laughter; deserted by hope; deserted by everything but the desperate desire to survive and the grim realization that for too many survival provides no escape.

So let us be honest. A lot of us would like to believe that this is not happening. Or we hope that if we're careful, the urban devastation just won't touch our own lives. Or we have concluded that there is nothing that can be done about it. Or we believe it is someone else's responsibility rather than our own. We have adopted a national policy of rationalization and avoidance -- and worse, exploitation.

In this, regretfully, too many take a cue from a President and Vice-President who ridicule welfare recipients and encourage racial divisions, or we take a cue from any of the other politicians in both parties who will tell us only what we want to

hear.

Before I say more, I want you to know that I have always agreed with Mark Twain that it is sometimes better to keep one's mouth shut and be thought stupid than to open it and remove all doubt. Well, despite the risks, I am compelled to share with you my conviction that America is not going to be liveable; it's not going to be safe; it's not going to be the America we want it to be unless we find a way to save our cities and to provide hope and opportunity to the people who live in them.

Just a very few years ago, when I sat where you sit now, the mere mention of poverty and suffering would have brought forth a strong response not only from the young but from much of our society. I remember how my own first real political commitment came as a result of hearing an activist named Al Lowenstein speak here at Battel Chapel about the massive injustice of segregation and repression in Mississippi and all through the South.

We were not, in those days, embarrassed to feel guilty about those who were less fortunate than ourselves; Ronald Reagan hadn't legitimized selfishness yet.

We did not think it was vain to believe we could design and implement programs that would generate real benefits for people; we thought that was what government was for.

We had faith in America's promise of equal opportunity; we took inspiration from the movement for civil rights; and we had not yet shared an experience with American failure or frustration in the post-war, pre-Vietnam world.

Today, we are a lot more cynical--all of us. We are fed up with a government that is simply not working, paralyzed by the rivalry between a Democratic Congress and a Republican President. We are skeptical, after decades of scandal and waste, that any federal program will achieve its goals, even if we agree the goals are important. We have become fatigued by constant appeals to our compassion and generosity, not only from within but from outside our borders, and we are conscious that we lead the world not only in military power and economic production--but we lead in debt, as well.

Despite these concerns, we know most of us, deep down, that we cannot continue on the road we are on. We understand that we are not going to be competitive internationally if too many of our young people cannot compete at all. We are not going to get out of debt if we must allocate billions more each year to prisons and prosecutions, emergency health care, drug rehabilitation, added security and higher welfare. We know, even on this campus, that no amount of locks, metal detectors or fancy suburban fences can protect our families or our children from what has become by

far the most violent society in the industrialized world. And no amount of rationalization can make us wholly indifferent to the suffering and unfairness of what is happening in our cities especially to the very young.

Twenty-seven years ago, my Senate colleague Daniel Patrick Moynihan warned that: "from the wild Irish slums of the 19th century eastern seaboard, to the riot-torn suburbs of Los Angeles, there is one unmistakable lesson in American history: a society that allows a large number of young men to grow up in broken families...never acquiring any stable relationship to...authority, never acquiring any rational expectations about the future--that society asks for and gets chaos. Crime, violence, unrest, disorder--most particularly the furious, unrestrained lashing out at the whole social structure--that is not only to be expected; it is very near to inevitable..."

Today, urban gangs literally seize the young from their mothers before they turn ten. Why? How has it happened? The trends that Pat Moynihan spoke of were barely beginning a quarter century ago. How is it that in the short span of twenty-seven years, this phenomenon of disintegration and violence has overwhelmed whole communities and created new and dangerous cultures?

The questions themselves intimidate -- so much so people avoid asking them? How is it, for example, that since 1965 the percentage of black children living with both parents through the age of 17 has gone from 50% to 6%? And this is not a trend exclusive to the black community. Nor are any of these problems exclusive to minority communities. They are simply exaggerated there because the starting point is so much worse and because the impacts of social change always seem to hit hardest at the most vulnerable parts of our society.

But we must ask ourselves whether this social disintegration is merely a symptom of deteriorating values that have struck all sectors of our society to some degree. We must ask whether it is the result of a massive shift in the psychology of our nation that some argue grew out of the 1960s -- a shift from self-reliance to dependence, from caring to self-indulgence, from public accountability to public abdication and chaos.

I am neither a psychologist nor a social scientist. I don't know the answers to these questions, but as a public person, I know that we must start asking the questions, that we must find answers and that we must, at the very least, begin talking about them openly and honestly at all levels of our society.

And as a public person, I also know that I have a responsibility to do all that I can do to end this journey into despair, this merry-go-round of murdered ambitions and wasted lives.

What is clear to me is that the bleeding has gone on so long there is no single remedy, no magic wand. Our strategy must now be to restore the entire institutional fabric of these communities. No less than that will get the job done. That means dealing with all aspects of community -- parenting, child care, education, housing, youth sports -- all the threads in the fabric.

But above all, there must be a starting point, a foundation, upon which you can begin literally to create and lift the self esteem of an entire population. The most obvious and undeniable starting point can be summed up in three words spoken recently in a different context by a certain, former first baseman for Yale -- and those three words are "jobs, jobs and jobs."

For more than a quarter century, American cities have been losing industrial jobs--the kind of jobs you can get with a high school or even a grade school education--the kinds of jobs that were available to our immigrant parents and grandparents. Six hundred thousand of these jobs have been lost in New York City alone, millions nationwide. Most are physical jobs, muscle jobs, in auto plants and textile mills and shipyards and candy factories. And at exactly the same time these jobs have been disappearing, the population of teenage males in northern cities has been doubling and the number of women entering the workplace has been exploding. More people seeking fewer jobs means more people without jobs; which means fewer people able to support families, which means more people turning to crime, which means more working families leaving the cities, and on and on down the spiral of frustration to despair.

The only way I know to end this downward spiral, is to define a beginning place and get to work. For me, that essential building block must be the restoration of good jobs and of good job skills and the restoration of public order in these communities. I cannot think of anything that would do more for the future of our country than for us to design such a program and make it work.

But all of us know that there are obstacles to this. Some neighborhoods--and some people--are so wracked by drugs and crime or so inured to the culture of dependence that they may be beyond help; the economic forces that robbed our cities of industrial and manufacturing jobs are growing stronger, not weaker; most businesses don't want to invest in the poorest neighborhoods; and we're up to our eyeballs in red ink. But towering above all these there is another, even more serious obstacle and that obstacle is america's unwillingness to confront the issue of race.

The fact is that the majority of the white majority in this country doesn't want to invest more of their scarce tax dollars in minority neighborhoods or in what many believe to be predominately minority problems. Tragically, we have come all too

often to view the urban crisis simply as a question of "us" vs. "them"; thereby preventing real dialogue and real progress.

It would be simple to blame all this on racism, and there is no doubt that white racism persists in our society, that it is ugly and insidious and present everywhere in housing and education and employment.

But the issues and the reasons for our dilemma go deeper and are more complex than that. They have their roots in the changing nature of the movement for civil rights, in the turbulent history of race relations and the persistence of racial stereotypes.

Thirty years ago, a supporter of the civil rights movement could agree with John Kennedy that the proposition that "race has no role in American life and law" is a "moral issue as old as the scriptures and as clear as the constitution." But for the past two decades, that same movement has depended on laws and rulings that have, in fact, strengthened the role of race in American life and law.

Where once Martin Luther King could depict the struggle for equal rights as a mighty battle between good and evil; a battle where pot-bellied sheriffs and attack dogs squared off against hymn-singing children dressed in their Sunday best; today, the civil rights arena is controlled by lawyers and the winners and losers determined by rules most Americans neither understand nor fully accept. This shift in the civil rights agenda has directed most of our attention and much of our hope into one inherently limited and divisive program--affirmative action.

Let me be clear. I support affirmative action. Affirmative action has opened doors for women, persons with disabilities and countless minorities. It has helped create a large and growing black middle class. It has helped minority businesses and opened up bastions of prejudice like the Alabama State Police, which had no black members at all in a state that is 30% black. It has caused employers to re-think the standards and tests they use to qualify people for employment. And it has given the benefit of the doubt to diversity over uniformity on campuses and in workplaces across America. This is the positive side.

But there is a negative side and we can no longer simply will away the growing consensus of perception within America's white majority. We must be willing to acknowledge publicly what we know to be true: -- that just as the benefits to America of affirmative action cannot be denied neither can the costs. Too many politicians, particularly in my own party, have not acknowledged these costs for fear of undermining the very goals of affirmative action. By that failure, we send a message to many of those who feel alienated or abandoned by their government that we simply don't care about them, and that we don't realize

that it is they, far more than we, who have borne the burden of compliance with the law. The truth is that affirmative action has kept America thinking in racial terms and as Yale law professor Stephen Carter has recently and so provocatively asked: "is it a good thing, is it a safe thing, to encourage white America to think in racial terms?"

In 1964, when the Civil Rights Act was being debated, Senator Hubert Humphrey assured reluctant colleagues that nothing in the bill would "require hiring, firing or promotion of employees in order to meet a racial quota or to achieve a racial balance."

But the controversy Senator Humphrey sought then to put to rest remains with us today. Not only by legislation, but by administrative order and court decree, a vast and bewildering apparatus of affirmative action rules and guidelines has been constructed. And somewhere within that vast apparatus conjured up to fight racism there exists a reality of reverse discrimination that actually engenders racism. No question: this reality has been exaggerated by subjective perception and by politicians eager to exploit it, but out of that reality has come a resentment that is real and widespread and dangerous. It is a resentment fed by memories of court-ordered busing and images of riots and looting and raised fists and by a sense of being singled out to compensate for historical sins which today's white workers did not commit.

This issue of white resentment cannot simply be dismissed. If we truly care about racial progress and about our cities, we must rebuild the consensus that will make a difference to those cities. We cannot equate fear of crime or concern about deteriorating schools with racism and then expect those we have called racists to invest in the very neighborhoods they have fled. We cannot lecture our citizens about fairness and then disregard legitimate questions about the actual fairness of federal regulation and law. We cannot deride as politically incorrect the anger of taxpayers who work hard to support their families and then find themselves supporting generations of welfare families as well.

For all of these reasons, we must maintain affirmative action as an indispensable remedy against past discrimination, but we've got to work harder to end the perception that it must lead inevitably to reverse discrimination. We cannot hope to make further racial progress when the plurality of whites believe, as they do today according to recent data, that it is they--not others--who suffer most from discrimination.

We cannot make further progress if we continue to put all our energies and emphasis into a remedy that in fact does relatively little for the blacks and other minorities who are in the greatest need of help. We cannot continue indefinitely to allow

the debate over quotas to drive a wedge between white and black; between white and hispanic; between white and Asian; between our government and so many our government represents.

We must find a way--and we must find it soon--to escape once and for all from the politics of resentment in which we are trapped today; for if we do not, we will sign the death warrant for our economic future and our social peace. We must stand up and say to Bush and Buchanan, David Duke and Al Sharpton--that we are not going to fall for this pandering and exploitation any more. And we must reach out to each other, not on the basis of race, but as Americans, to narrow divisions and begin a process of healing and understanding and communication.

But even this does not answer the key question. Let's say we've got Americans more comfortable with one another. Let's say we've moved beyond the worst of the finger-pointing and blame-making. So what? What does that mean for our cities? The drugs are still there; the crime is still there; the poverty is still there--and the jobs are still somewhere else.

I would forfeit all credibility with you if I were to say that I have a surefire solution for all of what ails urban America. I do not. But I would argue that we can begin by waging war on two myths: the Democratic myth that merely re-distributing wealth will create wealth, and the Republican myth that government cannot be a force for positive change. In their place, I would substitute a new version of the social contract, a covenant wherein every right is matched with a responsibility; and where rapid, inclusive economic growth is our overriding goal.

This new social contract demands an approach to investing in our people that avoids the crippling perception of racial favoritism, an approach that accepts William Julius Wilson's view that "in the last few years of the 20th century, the problems of the truly disadvantaged will have to be attacked primarily through universal programs that enjoy the support of a broad constituency."

This new social contract must be designed specifically to reinforce the values of hard work both at school and on the job; it must be aimed at ending, rather than prolonging, dependence on welfare; it must minimize the potential abuses of political patronage and bureaucratic waste; and its overriding goal must be the restoration of American economic leadership in the world and our social health at home.

So what does that mean specifically?

It begins, in my judgment, with the simple restoration of order, a serious and sustained and stepped up battle to re-claim our streets and apartment houses and neighborhoods from the criminals

and gangs who now control so many of them, either physically or by intimidation.

You know, the year before I came to this campus, the city of New Haven experienced a grand total of 6 murders, 4 rapes, 16 robberies and 72 assaults. In 1990, it was 31 murders, 168 rapes, 1784 robberies--an increase of more than 100 times--and 2008 assaults. Let's not kid ourselves. We aren't going to rebuild our cities if we're so worried about intended or random violence that we're afraid to enter them.

The Department of Justice tells us that 83% of all Americans can expect to be the victim of a violent crime at least once in their lives. That is simply unacceptable; we can't live like that; and we must understand that while crime affects all of us to a greater or lesser degree, it hits poor, inner city neighborhoods especially hard. Crime creates poverty. Each murder, each rape, each burglary and each mugging makes it more likely that a business will close, a working family will leave or an investor will look elsewhere. In this sense, controlling crime is virtually a precondition to any serious attempt at social or economic reform.

Urban crime--although much of it is intra-racial--is also the most deadly poison there is to improved relations between black and white Americans. In shaping opinions and defining behavior, fear will defeat fairness virtually every time.

That is why we need to have more police -- not simply to put people in jail, but to reclaim the tranquility that is a pre-requisite to any social reforms. A generation ago, there were three times as many police officers as there were violent crimes. Today, we have three times as many violent crimes as we have police. In Boston, just to cite one example, budget cuts are reducing our police to the lowest level in five years. That's just crazy. In the face of a persistent and deadly assault, we are literally disarming ourselves.

The anti-crime bill approved by Congress but opposed by the President is far from perfect, but it does include a plan I and others worked for to establish a Police Corps that could add 20,000 young people annually to police forces around the country. That, plus increased federal support for state and local law enforcement, would do far more to combat crime than the President's demand for 57 flavors of the death penalty.

By putting more police on the streets, we can help reestablish community order; we can help remove the most destructive force in our cities today, which is fear; we can help the broad array of urban ethnic groups gain confidence in each other; and by deterring and detecting and punishing crime, we can help provide a shield behind which communities in trouble can rebuild and kids

in trouble can recover. Clearly our purpose is not to fill our prisons more; but we must establish an environment within which drug rehabilitation, teen centers, counseling programs and the simple basics of family life have a real shot at success. That will be good for minorities, for our cities and for our country.

The second thing we must do is help directly those we have the greatest capacity to help--the infants and children who have not yet assimilated the harshest lessons of the city and not yet accepted the limits on their abilities or expectations. The time has come, after years of delay, to make a real commitment to pre-natal care, to infant nutrition, to child immunization and finally, to fully fund Head Start. For those who say that costs too much, I say that we'll get back every dollar three or four times over in reduced costs for drug rehabilitation, law enforcement and the construction of new jails. None of this is to ignore the other education demands, but we must begin somewhere.

Third, we must go into our cities and help the courageous people who have never stopped struggling to rebuild the basic institutions that support community life. Head Start or not, kids without real families get crushed if there's no place to go after school or at night or on the weekends or in the summer. They need role models that are closer to them than the star athlete and better for them than the local drug kingpin.

Before coming here tonight, I thought about simply repeating my prior call for a new domestic Peace Corps; but that's not what we need. We need an army of civilian volunteers to involve themselves in these communities. We need a professionally organized and run institution that serves to train and teach and discipline its own recruits while carrying out public service missions primarily in urban America. We could begin with a core of experienced people from our down-sized armed forces. We've been willing to spend billions to keep our troops deployed in dangerous spots around the world. Now, rather than rewarding them with unemployment, let's put them to work confronting the new threat here at home. And we can build on that with recruits from all walks of life who are willing to teach, to counsel, to run academic and recreational programs and to help rebuild some of the hardest-hit neighborhoods in our country.

There are no guarantees, but if anything would give disadvantaged kids something real and good to emulate it just might be an organization whose members themselves are tough without guns, disciplined, drug-free, of diverse backgrounds and reaching out to them every day on their own home turf.

Fourth, we need to continue replacing entitlements with incentives in every state and federal program we can. We're already requiring the able-bodied on long term welfare to seek

work or to accept training that will give them the skills they need to work--but we must fund that training more adequately and do more to generate suitable jobs. We should also provide incentives for corporations to find summer jobs for kids who stay in school and stay off drugs. We should set strict standards for participation in youth job training programs so that we can be sure to help those with the strongest drive to help themselves.

And we should enact the legislation that is now pending in congress to guarantee college opportunity to every child in America who has graduated from high school and who wants to continue his or her education.

Fifth, we need an all out integrated program of economic development and growth. I, for one, do not accept the view that America can never again hope to compete industrially; the fact is--we haven't tried. Urban Enterprise Zones have been on the drawing boards for decades, but never made a reality. The President's capital gains proposal is a joke; but job-creating incentives for the startup, modernization and expansion of companies are urgently required. A Teacher Corps that will encourage our most talented young people to work where they are most needed is long overdue. Microenterprise loan programs can be designed to help the jobless and other low income people establish themselves as entrepreneurs. And partnerships between American firms and their counterparts in Eastern Europe, Asia and the former Soviet Union can open huge new markets for American goods and services overseas.

As political leaders, parents, teachers or just plain friends, we have to get the message across to all our citizens that the barriers of poverty or unemployment or hard luck or even racism do not excuse behavior that is both self-destructive and harmful to our national community. Even the most disadvantaged of us have choices. Explaining aberrant behavior on the grounds of poor family circumstances is one thing; excusing that behavior is another.

This may seem a hard line, but remember who suffers most when children literally get away with murder because of their age; or when students are allowed to drift through school without learning or even trying to learn; or when teenage girls are left pregnant and alone; or when public housing tenants turn their apartments into crackhouses. This hurts all Americans to an extent; but it crushes the people who live next door.

It has long been known that poverty leads to crime; but recent experience has confirmed that crime also leads to poverty. Make no mistake, we do these families no favor when we are permissive towards criminals or drug peddlers. We also do no favor to those who are in trouble, for their only hope in the long run is to change the kind of choices they make.

I know from experience in Boston and the other large cities of my state that there are thousands of decent, honest and struggling families in what we call disadvantaged neighborhoods--families too determined, too proud, or too poor to move. And there are hundreds of organizations and individuals on the front line every day, struggling against the tide.

If you are looking for true heroes in America, many of them are right there, trying against all the odds to keep their kids straight, working two and three jobs to make ends meet, trying to hold communities together that have long since been declared dead by a media more interested in the trauma of crime than the drama of daily life. They desperately need our help - now.

To restore respect for values, we must restore respect for authority and that is going to take some time. After a decade of dozen digit deficits, government scandals, insider trading, greed, callousness and the self-destruction of everyone from John Sununu to the evangelist Jim Bakker--the question of who has a right to preach to whom is in grave doubt. Lectures about sexual responsibility, hard work, honesty and abstinence from drugs impress few when given by representatives of institutions that are thought to reflect none of those qualities. A government that continually ducks hard choices can hardly blame adolescents for doing the same.

I do not have the time tonight--or perhaps in what remains of this millennium--to prescribe a full remedy for the public's alienation from government, but a serious approach to the problems of our cities and of race and racism would be an important step in the right direction. That, alone, will require a great deal more honesty, creativity, leadership and courage than we have seen in recent years.

But the sole burden does not belong on government. As individuals, we have to face our own responsibility-- a responsibility, first of all, to understand that there is nothing abstract or theoretical about any of this. We're talking about real children dying, not halfway around the world, but literally right next door, yesterday and today and tomorrow, and there is a pretty strong impression out there that nobody really gives a damn.

Your generation has real reason to hope that you will never be called upon to go to war; that none of you will ever lie beneath a white cross at arlington or face the gut-wrenching pride and terror of combat in service to your country.

You may feel that your personal skills and experience and character are not equal to the intimidating challenge of urban violence and problems and hope accordingly that here, too, no call to duty will ever come.

Well, I think that call to duty is here tonight.

There is no higher law that says children must be gunned down by children in the street, or that lives barely lived must be lost, or that America's cities must die.

There are no problems that through neglect we have created that by caring we cannot resolve. There are no divisions that ignorance has created that understanding cannot erase. And there is no better time than now -- when you are young-- to chart a course of challenge and commitment and constructive rebellion at the status quo.

So I call upon you to work ceaselessly to change and to rebuild and repair the fabric of this society. I call upon you to consider careers in law enforcement or teaching or drug counseling or urban government that you may never have considered before. I ask you -- if you are not already -- to reach out within this very city to the educators and community organizations and teenage kids who need your help. I ask you to do this not out of altruism, but because it will enrich your lives immeasurably and because you cannot afford to take with you upon graduation from this campus not only a diploma but a calloused heart.

More broadly, I ask you to join in the struggle that is now ongoing for America's very soul. Do not cede that struggle to the bitter or the bigoted or the morally blind. Do not accept or tolerate or rationalize racism. Do not permit emotion to overcome the voice inside you that reminds you every day how much we all have in common and just how important it is to overcome artificial divisions and how sometimes the most dangerous sound there is is the sound of silence.

These are your communities; this is your country. And we have to work to make the understandable pride we feel in our own ethnic identities a generous, un-threatened and un-threatening pride, a pride that shares and teaches and learns, rather than divides and excludes.

There is not one among us who has the background or the credentials to read a fellow citizen out of the American dream. The minds that conceived this country; the muscles that built it; and the blood that has so often defended and nourished its freedoms is today so mixed in the soil of our history that we can never forget--and should never try--to separate ourselves from the collective and diverse "we" that defines the America of yesterday and will inevitably determine the destiny of America tomorrow.