

# House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies Holds Hearing on FY2007 Appropriations: Public Witnesses, Part 2

March 30, 2006

**[Click here for testimony advocating the reinstatement of Title VII funding: American Association for Geriatrics Psychiatry Testimony by Dr. Dan Blazer](#)**

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NORTHUP:

Thank you. I'm sorry you had to wait. We did have votes on the floor. I'm sure you all saw that, and I apologize. It's thrown our schedule off, but we do welcome all of our guests here this afternoon. We're eager to take your testimony and hear your perspectives and make sure that all the information you wish gets entered into the record.

Out of respect for everybody who is here this afternoon, there is a four-minute time limit. It will go by the colored lights. Green is OK, yellow when you have one minute left and red, when it's red, your time is up. And I will have to interrupt you, because I don't want people that have planes to catch, that have changed their whole schedule to have to unduly be inconvenienced.

So we're going to start now with the Afterschool Alliance, and Ms. Jody Grant and Mr. Matthew Horning, I believe, are testifying.

GRANT:

Thank you, Congresswoman. Good afternoon. My name is Jody Grant, and I'm the executive director of the Afterschool Alliance. Thank you for the honor of testifying here today.

Millions of children, families and communities across America are reaping the benefits of quality after-school programs supported by this committee. I want to personally thank Chairman Regula for his leadership in making quality after-school programs available to our children.

It's with great pride that I introduce you to my friend, Matthew Horning. He will tell you why the 21st Century Community Learning Centers initiative is so vital to his community in Alliance, Ohio. Matt will also illustrate how funding freezes and across-the-board cuts to this critically important program are impacting the kids and families in Alliance. Matt?

HORNING:

Thank you. Again, my name is Matthew Horning. I'm the Director of the Navigators Program at Alliance Middle School, which is a 21st Century Community Learning Center in our fourth year of the grant.

I want to tell you how critical the 21st Century initiative has been to our students and our community. Like a lot of the communities that get these grants, Alliance is a poor community with around two-thirds of our students qualifying for free and reduced lunch. Though we're surrounded by agricultural areas, we're basically a little inner city. And at one point in the last decade, we had the highest drug and crime rate per capita in our state.

Our Navigators Program serves almost half of the students enrolled at Alliance Middle School. Some come every day, some a couple days a week, and we serve students a snack using the USDA snack funds. Then we offer a variety of activities, including tutoring and special-interest clubs, such as robotics, cooking, drumming, scrapbooking. We even bus students to our local YMCA, where they learn personal fitness, nutrition and exercise.

Our program affects the lives of our students and their families greatly. Recently, David began attending our after-school study table. David has a history of school violence and is in danger of failing the school year. After only a few weeks, David's mom called me to thank me, because he was showing so much improvement.

For the first time all year, he had told her about an upcoming test, studied for the test and came home and told her how he did on the test. He's also been taking homework home every night, when he used to bring it home maybe twice a month. David's mom said that just knowing he had extra time after school to get his work done and his questions answered was taking such a weight off his shoulders that he's now excited about coming to school. Even his behavior has improved, because he no longer feels the need to disrupt class to cover up for not knowing the answers.

But every 21st Century program has a David, who's grown to rely on the services they provide. But like many of these programs, we're looking at a funding problem. Our current 21st Century grant will run out next year, and because of the freeze on 21st Century funds, Ohio's been cutting back on the number of new grants awarded each year. Last year, Ohio awarded only 2 percent of new 21st Century proposals.

In our community, the funding is essential, because we don't have a booming economy that would enable local businesses to give us the financial support we need. We only have one community foundation in our city, and their annual output for all of last year matched our annual budget. And we ought to be increasing the number of after-school slots to serve more children, not decreasing, but if programs like ours are forced to cut back or close, that's exactly what will be happening across the country.

So I'm here today to ask you to please continue to support after-school funding for after-school programs. There are so many non-academic barriers to school success, and that is really where after-school programs can step in. Just as we took the pressure off David by offering time after school to get his homework done, after-school programs take the pressure off daytime staff by helping students deal with all the outside issues that prevent them from being able to concentrate on academics.

The freeze on funding is causing us to fall farther and farther behind, leaving kids and their families without the after-school support that they need. Congress was wise to devise a road map of modest and

steady increases for the 21st Century initiative and the No Child Left Behind Act. Steady growth made sense then, and it makes sense now.

I thank you for your wisdom in adopting that road map, and I urge you to make good on the commitment for millions of dollars that will allow kids like David across the country after-school programs that are an answer to a prayer. Thank you very much.

NORTHUP:

Thank you very much. Thank you for the testimony you submitted. I have a note here from my staff that says, "Committee says to let the audience know that you'll be reading through their testimony as they go. Yesterday some thought maybe you were reading something unrelated."

I appreciate it, especially your chart that's attached that has what's going on in my state with the program. It's very helpful.

(UNKNOWN)

Double amen on your message.

NORTHUP:

The next one is College on Problems of Drug Dependence, Dr. Bill Dewey.

DEWEY:

Madam Chairwoman, thank you very much for giving me the opportunity to be here on behalf of the College of Problems of Drug Dependence. We are the largest scholarly organization in the world and are concerned in trying to eradicate this world of drug abuse. We also thank you and your colleagues for continuing to appropriate funds to the National Institute of Health and to the National Institute on Drug Abuse.

In particular, we are here today to encourage you to appropriate an increase of 5 percent for NIH and the National Institute on Drug Abuse for the 2007 year. The question is often asked around these parts of, "Well, just exactly what's been done with the doubling of the NIH budget?" And I want to tell you some of the things that have been done with the funds that have been appropriated, you folks have appropriated, to NIDA.

A young man gave testimony -- or gave a talk at a staff briefing right in this building about a month ago. And this young man told us that he started to abuse drugs when he was 12 years old, prescription drugs. He moved on to more expensive prescription drugs to a point where it was \$250 a day for his habit, so he stole money and so on and so forth.

He then went on to sniff heroin and then to shoot heroin. He saw one of his friends -- when he was sixteen, one of his friends died from an overdose of heroin. He said that he died one night four times. They brought him back with an injection. The injection they brought him back with was a drug which

was developed by the funds you have appropriated, which funded the research in the National Institute of Drug Abuse to bring this man back. This young fellow of 20 years old.

In addition, he also said that he got his brother addicted, and his brother died once, and he was brought back. This is happening in emergency rooms throughout this country on a daily basis.

Second aspect of what's happening with funding through the Institute on Drug Abuse is recently, you folks in Congress passed the Drug Addiction Treatment Act, which for the first time allowed professional people, physicians, lawyers, other people of that type, to be treated for their drug dependence in the office of a physician.

The reason that this works is because of the simultaneous development of a drug called buprenorphine, which is used to decrease craving of heroin. Now drug-abuse people are people from all walks of society, and these people who cannot, in fact, who will not go into a public drug treatment program, because they don't want their clients to see them there, were just not being treated. Now, thanks to you, this is an example of a cooperation between Congress and your appropriating the funds and your passing the Drug Dependence Treatment Act and the work of scientists to make this a reality.

Third example is, we have discovered drugs which help with the addiction to nicotine, one of the most strongly craved drugs that there is in society. And we all know the dangers that nicotine itself causes to many aspects of health.

Other things that's happened in recent years, there's been a 19 percent decrease in the abuse of drugs by children in the eighth, 10th and 12th grades by the recent survey, Monitoring the Future, which is done by NIDA. This is due to the increase and improvement in prevention of drug abuse for youngsters.

But the problem isn't completely solved. Younger and younger people, children, are abusing other substances: chemicals, things in the house for cleaning, fluids and so on and so forth. And they're using these chemicals and abusing them, and they're causing toxic effects in their body.

We are learning more and more about the brain, and why do adolescents take risky behavior as opposed to adults? Is it just because they're younger? Or there must be something physiologically different about their body, their brain, than adults, and we're trying to understand that.

And when someone takes the drug, it changes the brain. We're learning that. We know that. It's changing the cells and the circuitry in the brain, and so we are learning, and that kind of information is not only useful for treating disease of drug abuse. And it clearly is a disease just like any other disease. People with drug abuse feel bad. They don't work. They don't have productive lives, and many of them, as I said for the young man from the Boston area, who said he died four times in one night, and they die from this disease. So we have to learn more to treat this disease.

Now we want to understand why youngsters, why their brain is different than the brain of adults. And to do that, there's a great deal of research into the prevention of drug abuse and to understanding the brain systems.

One more issue is the financial issue. Drug abuse in this country costs us, it's estimated, at least \$200 billion a year. The appropriation, which you so generously have given to NIDA, is \$1 billion. That's an awful lot of money. We understand that. But it's 0.5 percent of what this costs this country every year.

Finally, when we gain knowledge from the research at Institute of Drug Abuse, this also helps for understanding other diseases like Parkinson's, Alzheimer's, obesity and duo morbidities like mental health.

Madam Chairwoman, I very much appreciate the time to be here today, and I thank you very much.

NORTHUP:

Thank you very much for giving your time to us today. We appreciate your message. Thank you very much.

Next I'm going to yield to Mr. Wicker, who has someone to introduce.

WICKER:

Thank you very much. While Neil Gregory is making his way to the front, I'll tell you that he's an old and dear friend of mine, grew up in my hometown of Tupelo, Mississippi. He's speaking today on behalf of The Mended Hearts organization, which, of course, is associated with the American Heart Association.

He's actually pinch hitting for Robert Gelenter, legal representative of Mended Hearts, who unfortunately, has heart problems and was unable to be with us. So we regret that Mr. Gelenter is not able to join us, but Neil, we're real happy to see you again.

GREGORY:

Thank you very much, and I am the vice president of the Washington chapter of Mended Hearts, which is a national nonprofit organization. We have 280 chapters around the country, and looking around the table, I think there are hospitals in each of your districts that have active Mended Hearts chapters. We visit the patients in the hospitals in the cardiac facilities, sharing experiences and providing patient-to-patient support.

Ten years ago, I was sitting at my computer at my public relations firm office here on the Hill, and suddenly had a pain that wouldn't go away. A colleague took me down to GW Hospital's emergency room. The doctor greeted me with, "Mr. Gregory, you are having a heart attack," using the present tense, and I proceeded to examination, discovered four blockages. I had surgery, and I changed my sedentary lifestyle, so I exercise regularly, changed my diet and also volunteer weekly down there at GW, visiting the patients for Mended Hearts.

Robert Gelenter was scheduled to testify as Roger said, and I'm sorry he couldn't be with you, but I'd like to tell you his story, which is rather astounding.

At the age of 45, Bob was diagnosed with hypertrophic cardiomyopathy, a rare disease in which the heart enlarges. His heart muscle gradually thickened so much, the heart wasn't pumping blood effectively. About half the young athletes you hear about who die suddenly, that's the condition they have, but it affects men and women of all ages.

It's one of the main causes of sudden cardiac arrest, and there's no cure. Medication sometimes works, but there's also surgery that can eliminate the pain, and then there are organ donors for heart transplants if they are available.

The doctor who made Bob's diagnosis was trained at NIH. Initially, he received medications. He went for 10 years engaging in most activities, but then the discomfort increased, he couldn't walk more than 60 feet without doubling over in pain.

In 1988 he went to Georgetown Hospital. After a series of tests, they told him 95 percent blockage of his heart artery in the location known as the widowmaker's spot, and he was in danger of a severe heart attack with less than a 5 percent survival.

And Georgetown called in experts from NIH, and they accepted him as a patient, where he was operated on. And they used a surgery called the Morrow procedure, which was considered drastic. Even today, only a few hospitals perform this. It's considered the gold standard for treatment of that condition. And named in honor of the innovator, it was developed and improved at NIH.

Currently, there's a new experimental protocol in which the same effect is attempted by using alcohol to deaden the excessive heart tissue rather than removing a piece of the heart muscle from the main pumping chamber. This was done in Bob's case.

So Bob is now on medication, which he'll have for the rest of his life, and his condition is progressive. More than 10 years ago, he was fitted with a pacemaker, and he's working fine. He is eternally grateful to the physicians who were funded by NHLBI for the gift of life. Because of this groundbreaking research, he's lived 18 years free of pain. He's seen two children graduate from college, witnessed the birth of three grandchildren, shared those 18 years with a wonderful wife and he's returned to his profession as a lawyer.

To express his gratitude, under the aegis of Mended Hearts, he visits patients at Washington Hospital Center at the Adventists (ph). Bob's experience and his continued life are proof that the research supported by NIH benefits not just patients at the clinical center, but throughout the United States. The benefits are worldwide, and he and I ask that you continue to support NIH research generously to give others the gift of life that he and I enjoy.

WICKER:

Neil, we hope Mr. Gelenter's present condition is not too serious.

GREGORY:

No, he was having some tests today, and pacemaker, I think, was acting up. I'm not really sure.

WICKER:

Thank you for your testimony...

GREGORY:

Thank you.

WICKER:

... and thank you for your volunteer service.

GREGORY:

OK.

NORTHUP:

Thank you. Now I'm going to yield to Mr. Jackson to introduce our next guest.

JACKSON:

I thank the gentle Chairlady.

I want to introduce Kenneth Edmonds, who is speaking on behalf of the Crohn's and Colitis Foundation of America. Madam Chair, I first met Ken back in 1995, after he graduated from the University of Virginia. Ken worked on my first campaign, served in my district office as well as my D.C. office, and since 1998, has served as my chief of staff. In 1996, Ken was diagnosed with Crohn's. I look forward to Ken's testimony and determining how this committee can be helpful.

Mr. Edmonds?

EDMONDS:

Thank you, Congressman Jackson and Madam Chairwoman, Ranking Member Obey. Good afternoon and thank you for the opportunity to testify today on behalf of the Crohn's and Colitis Foundation of America.

I'm Kenneth Edmonds, and I serve on the national board of trustees for CCFA, the nation's oldest and largest voluntary organization dedicated to finding a cure for and preventing Crohn's disease and ulcerative colitis.

Approximately 1.4 million Americans are affected by the disease, collectively known as inflammatory bowel disease. I am one of them. IBD is a chronic disorder that causes inflammation of the digestive tract. It can cause persistent diarrhea, severe abdominal pain, fever and at times, rectal bleeding. It can also lead to, among other conditions, anemia, liver disease and colorectal cancer.

Thirty percent of those who suffer with IBD are diagnosed in their childhood, a devastating diagnosis that often makes them stand out at a time when they most want to fit in. Not only does IBD make them feel different, some may even look different, because IBD can cause delays in physical growth and puberty.

My diagnosis came after a long, gradual backslide into a hospital bed. In retrospect, I exhibited typical signs of IBD as early as 1993 while in college, but I responded to those signals like many adolescents and young adults. I overlooked them.

I experienced sharp, sudden abdominal pain and would double over. These cramps often created an intense urge to use the bathroom. On many occasions, my stools had traces of blood, but I was young and active, so I didn't think much about it, and I certainly didn't talk about it to anyone.

But by 1996, while in Chicago, my symptoms were too severe to ignore. I had developed sores on my tongue, making it difficult and painful to eat. In addition to the persistent diarrhea and acute cramps, I developed a tear in the lining of my anus, which caused excruciating pain and bleeding during bowel movements.

As you can imagine, this was agonizing. I deteriorated into a condition relegating me to somewhere between bedridden and bathroom-bound. A misdiagnosis, three weeks and a plane ride later, I found myself in the Washington Hospital Center under the care of my uncle, an area gastroenterologist.

I was diagnosed with Crohn's and prescribed medications. My disease is in remission, but I'm one of the lucky ones. For many, their lives continue to be hampered by painful flare ups, because they do not respond well to current treatments.

After all, Mr. Chairman, IBD is a lifelong disease, and while symptoms can be treated, there is no cure. Its cause, unknown. That's why CCFA's work is so important. CCFA has developed successful research partnerships with the NIH, forging longstanding collaborations with NIDDK and NIAID.

CCFA provides crucial seed funding to researchers gathering preliminary data, which enables them to pursue advanced IBD projects through the NIH. This approach led to the identification of the first gene associated with Crohn's, a breakthrough in understanding this disease.

To continue the progress, CCFA recommends that the subcommittee provide a 5 percent increase in funding for NIDDK and NIAID in fiscal year 2007. CCFA also requests that the subcommittee encourage these two institutions to expand their IBD research at a similar rate.

Mr. Chairman, there could be many more Americans with IBD, many like me may be misdiagnosed, or they be suffering in silence. We are extremely grateful for the committee's leadership in providing funding over the past two years for an epidemiology program on IBD at the CDC. This program is yielding valuable information about the prevalence of IBD. Therefore, the CCFA encourages the subcommittee to restore support for the IBD epidemiology program at last year's level of \$700,000.

Once again, thank you for the opportunity to testify, and I would be happy to answer any questions.

JACKSON:

Madam Chair, if I might?

NORTHUP:

Yes.

JACKSON:

Ken, thanks for your dedication to this cause and the courage to tell your story. I know how difficult it's been for you living with Crohn's disease and how difficult it's been for your family. I'm proud of the way you've overcome every challenge you have faced. I share your disappointment over the president's decision to eliminate the IBD program at CDC.

Madam Chair, this small program is making a real difference in our fight against this disease, and I hope that we can find a way to support it in this year's bill.

Ken, I understand that we are experiencing a dramatic increase in the number of children being diagnosed with IBD. Can you tell us about this unfortunate trend and what we can do to help these kids?

EDMONDS:

Mr. Jackson, doctors are seeing a dramatic increase in the number of children diagnosed with Crohn's and ulcerative colitis. There are some children that have been diagnosed as young as five years old, and I think that very fact underscores the need for increased funding for NIH research so that NIH can support the development of therapies for children who are diagnosed at such a young age and such a critical time in their emotional and physical development.

NORTHUP:

Thank you very much. OK. Mr. Jackson, I think you have the next introduction, too.

JACKSON:

Thank you, Madam Chair. Thank you, Mr. Edmonds.

Madam Chairman, I am pleased this afternoon to introduce Dr. Wayne Harris, dean of the College of Pharmacy at Xavier University in New Orleans and vice president of the Association of Minority Health Profession Schools.

Throughout my tenure on the subcommittee, I've worked very closely with the association to identify new and innovative solutions to one of America's most persistent and disturbing social problems, health-status disparities. The devastating impact of health disparities have on our nation, minority and medically underserved communities continues to be unacceptable, and we must renew our focus on this problem at the federal level.

As you know, Madam Chairman, I believe that increasing the number of minorities in the health professions is one of the most important steps we can take to combat health disparities, and it is, in fact, that minority students that graduate with a degree in medicine and dentistry and pharmacy are much more likely than other graduates to establish their practice in a medically underserved community.

Madam Chair, no organization does this more to increase the number of minorities in the health profession than the Association of Minority Health Professions. I look forward to hearing from Dr. Harris about the vital role that the federal programs play in supporting minority health institutions and combating health disparities.

Madam Chairman, Dr. Wayne Harris?

HARRIS:

Thank you, Congressman Jackson, for your great leadership in this area. Madam Chair, thank you for the opportunity to present the views of the Association of Minority Health Professions schools.

Madam Chair, historically black health professions institutions are addressing a pressing national need in carrying out their mission of training minorities in the health professions consistent with the stated objectives of Healthy People 2010.

While African-Americans represent approximately 15 percent of the U.S. population, only 2 to 3 percent of the nation's health professions workforce is African-American. This is important, Mr. Chair, Madam Chair, because the gap in health status between our nation's minority and majority populations continue to widen due in part to lack of access to quality health care services in minority communities. But we must not forget that even when barriers to health-care access are removed, minority patients still experience poorer health outcomes than the general population. People are dying from controllable diseases.

As a result, we believe it is imperative that the federal commitment to training African-Americans and other minorities in the health professions remain strong. In spite of our proven success in training health professionals and the important contributions these professionals make, our institutions continue to face a financial struggle inherent to our mission.

Madam Chair, before I go into a discussion of our association's recommendation, I would like to share Xavier's experiences with Hurricane Katrina and update you on our recovery effort.

Xavier is located in New Orleans, and the entire campus was flooded with three to six feet of water. Each building on campus had significant damage on the first floor, and the campus was shut down until January 9. During the evacuation, the university developed an ambitious plan to repair damage and resume operations on January 17, using a revised calendar.

I am happy to report that the university did resume classes on January 17 as planned. It was important to the university that we continue in our mission of educating health professionals. Overall, university enrollment dropped, however, from approximately 4,000 students in August to approximately 3,000 students post-Katrina.

The College of Pharmacy enrollment was less severely affected, with enrollment dropping from 619 to 600. Significant challenges still remain, including cash-flow problems as we deal with recover costs in the range of \$30 million, and we deal with disruption of operations of key health-delivery institutions in the city of New Orleans.

These institutions are vital to our educational program and our continued recovery. It is absolutely essential to the university and the city that health-care delivery services are restored as quickly as possible.

Madam Chair, because of our unique mission, minority health professions schools rely heavily on annual support from federal agencies. The Title VII Health Professions Training Program, National Center on Minority Health and Health Disparities at NIH, the Office of Minority Health at HHS and the Department of Education, Historically Black Graduate Institutions Program, all play a critical role in our specific mission.

The association's funding recommendations for these programs are contained in my written statement. I would, however, like to stress the importance of Hurtza (ph) Health Profession's Training Program, particularly those programs focused on diversity.

Madam Chair, if the president's program is enacted by Congress, it would be devastating to our institutions and the nation's priorities. I urge you to restore funding for these programs to their fiscal '05 levels. The Minority Centers of Excellence and Health Career Opportunity Programs under Title VII are specific concerns to our schools.

Madam Chair, at that point, I stop my testimony. I'd be happy to answer any questions.

JACKSON:

Just one, Madam Chair. I might ask also that Mr. Harris' statement, his entire statement, be added to the record.

NORTHUP:

Yes, we'll certainly do that, and thank you very much for the service you're providing in representing the institutions you represent.

JACKSON:

Madam Chair, I just have one question. Dr. Harris, can you tell us how important this annual Title VII support is to your institution, and what would happen to the college if the funding were to be eliminated as has presently been proposed by the budget?

HARRIS:

Thank you Congressman Jackson.

There are two parts to the answer to that question, and I'd like to begin with the first one. The first one is a more practical situation for the university. The Hurtza (ph) Centers of Excellence grant that we receive accounts for approximately 25 percent of our annual budget, so there would be the resultant staff reductions and attempts to try to work within the university budget to retain those programs, which are vital, two programs in particular.

We provide clinical pharmacy services in medically underserved communities across the city of New Orleans, and we employ clinical pharmacists in those facilities, and they're used as training sites for our students. Those programs we would either have to curtail or find additional funding within the university budget. Given the effects of Katrina, that would be almost a catastrophic event, because, as I said, we're dealing with the recovery cost and difficulty in getting reimbursement.

And then the second thing, the second answer to the question, relates to the national priority to provide care and to educate health professionals in medically underserved communities. We presently supply clinical pharmacy services and clinical education in six community sites across the city of New Orleans.

We are educating health professionals to provide services to people who can't get them anywhere else, and to disrupt those services would, again, prevent us from being able to accomplish our goal of eliminating health disparities.

NORTHUP:

Thank you very much. Thank you for being with us today.

HARRIS:

Thank you.

NORTHUP:

Next, we're going to have the National Association of Anorexia Nervosa and Associated Disorders, and Mr. Ron George, I believe, is presenting.

GEORGE:

Madam Chairwoman, Ranking Member Obey, Congressman Jackson, I appreciate the opportunity to be here today to address this subcommittee on behalf of the field of eating disorders.

My name is Ron George. I'm a member of the board of directors of the National Association of Anorexia Nervosa and Associated Disorders. I've a very personal interest in this issue. My daughter Leslie died six years ago of an eating disorder in her 19th year and beginning of her second year at James Madison University.

She had suffered from this illness for over five years. In the beginning, it started as anorexia nervosa. It later transformed to bulimia. At the end, she burst her stomach from an eating binge, and the

contents of her stomach emptied into her abdominal cavity. The doctors did not realize what had happened, and in the span of the next 22 hours our insurance companies absorbed a bill for \$138,000 in heroic measures. And in the end, Leslie died. I'll always believe it could have ended differently.

If my wife, Sally, and I had known then what we know now, I believe Leslie might still be alive, but unfortunately it's still true that most parents, teachers and adults have little effective information to deal with these eating disorders and certainly few tools with which to prevent and/or deal with the illness once it's started.

Eating disorders are at epidemic proportions in the United States. It's currently estimated that seven million women and a million men suffer from eating disorders, all segments of society, young and old, rich and poor, in all ethnic groups, including African- Americans, Latinos, Asians and Native Americans.

Eating disorders cause tremendous suffering for both the victims and their families, and they represent a significant loss to our society, and they're very expensive to treat. Anorexia nervosa has the highest mortality rate of any mental illness. Almost 6 percent of those who have the disease will die. The good part is that these dangerous illnesses can be prevented, and they can be cured.

Data from a 2005 INAD (ph) study shows that eating disorders are almost as prevalent as alcohol and drug problems among middle- and high-school female students. That same study shows that far less time is spent on eating disorders prevention than on alcohol or drug prevention programs.

Seventeen percent of schools surveyed spent one hour a year on eating disorders education. Eleven percent spent no time at all. Effectively, this means that one-third of all of our middle and high schools have no program to deal with an issue that devastates our young people to this extent.

This is especially significant since eating disorders are often accompanied by or lead to severe depression, suicidal tendencies, self-mutilation and diabetes. Tens of millions of dollars are spent each year to prevent alcoholism and substance abuse in our middle and high schools. This is a good thing.

The value of these programs has been proven, and they've been accepted into the school curriculum. But with eating disorders as prevalent as both alcohol and drug problems, it is imperative that we significantly expand and implement programs at the middle- and high- school levels to prevent anorexia nervosa and the associated illnesses.

Millions of our youth can benefit from proven, low-cost services that assist not only students but also teachers and their parents to understand and avoid the dangers of eating disorders. They also promote the four elements of a healthy lifestyle: a good diet, adequate exercise, sufficient sleep and probably most importantly, self-acceptance.

These programs now exist and are readily available. We urge Congress to allocate \$2 million at \$50 per school to place these preventative lifesaving programs in every middle and high school in the United States. Thank you for your time.

NORTHUP:

Thank you very much, and your entire testimony will be part of our record. Thank you.

GEORGE:

Thank you.

(UNKNOWN)

Madam Chair, I would simply like to observe that this committee hears government witness after government witness for weeks, and we need is to have a few hours of hearing people like you tell your stories to have a sufficient appreciation for just how inadequate the administration's budget is.

I'm sorry for your loss, and I appreciate your testimony.

GEORGE:

Thank you for comments. I appreciate it.

NORTHUP:

Thank you for your service, too.

GEORGE:

Thank you.

NORTHUP:

Next, we'll have Dr. Filip Dubovsky, the Malaria Vaccine Initiative.

DUBOVSKY:

I would like to thank the subcommittee for the opportunity to testify in support of increasing funding for the National Institutes of Health. I specifically request that the committee recommend increasing funding for NIH to further malaria vaccine research.

I'm Dr. Filip Dubovsky, the Scientific Director of the PATH Malaria Vaccine Initiative. MVI works to accelerate the development of promising malaria vaccines and ensure that once a vaccine is licensed, it is made available to children in the developing world. My specific job is to build vaccines.

This is an incredibly exciting time in malaria vaccine development. Results from a recent field trial in Mozambique proved it is possible to make a malaria vaccine that can keep children from getting sick.

Malaria is a parasitic infection that's transmitted by mosquitoes. The resulting disease can attack anyone, but pregnant women and young children are most vulnerable. No vaccines are currently licensed against malaria, and up to three million people die from malaria every year. It wreaks havoc in societies and economies and is the cause and consequence of poverty.

NIH is currently the world's largest investor in malaria R&D, but only a small portion of NIH's budget is targeted specifically to malaria vaccine development.

Let me give you one example of why more malaria R&D is needed. About 70 kilometers north of Dar es Salaam is a little village called Bagamoria (ph). There's a hospital in Bagamoria (ph) where doctors treat children suffering from malaria. The waiting area's a bare cement pad where the children and their parents queue up in line for help.

These families have no means to prevent malaria, so they have to wait until they're ill and then come for treatment. But unlike us, these parents face the reality that their child could be one out of more than 2,000 children who die each day from malaria. Adding a vaccine to the malaria control arsenal could help prevent these deaths.

The core strength of the NIH, of course, is basic science and translational research, and this unflagging support for the world's best scientists for the past four decades has generated this scientific foundation that ensures us a malaria vaccine is feasible. However, there continues to be a gap in the manufacturing and testing of these potential products, because the private sector lacks incentive to invest in the development of products whose market is primarily the poor.

NIAD has developed a two-prong approach to tackle the problem. The first is a malaria vaccine development unit, which is a special unit that develops, manufactures and tests new vaccines. A number of its vaccines have already gone into clinical trials, and the most promising of these vaccines is currently being tested in Mali, Africa even as we speak.

The Division of Microbiology Infectious Disease has a vaccine manufacturing and testing contract that taps into our country's thriving biotech sector and brings together the best ideas, technologies and know-how. Through this approach, malaria vaccines are being manufactured and prepared for clinical evaluation.

NIH has been highly successful in manufacturing vaccines for testing, thereby bridging this manufacturing gap, and this has led to a critical mass of products moving forward through clinical testing. Results from some of these trials are expected later this year. More NIH support would enable even faster progress and a greater number of candidates moving through the pipeline.

Malaria vaccines are not science fiction. They're being made a reality by NIH's efforts. The message I want to leave with you today is clear. NIH has been a great steward of its current available malaria vaccine resources and could do even more with increased support.

Public dollars invested in malaria vaccine development are paying out, yielding concrete results that are making a difference as we tackle this devastating disease. I urge the committee to increase

funding for NIH, and allow the agency more flexibility to increase support of the malaria vaccine research.

Thank you.

NORTHUP:

Thank you very much. I have to share with you, I had a son, who lived in outside of Dar es Salaam in a Catholic seminary for a year and volunteered in the clinics that were there, so I know firsthand, or through him, how devastating, how much poverty there is, the need for health services, and thank you very much for your help.

Next, we have Mother Dolores Hart, Neuropathy Association.

HART:

Madam Chairman and members of the subcommittee, my name is Mother Dolores Hart. I am the prioress of the Abbey of Regina Laudis, a monastery of contemplative Benedictine women located in Bethlehem, Connecticut.

I am here on behalf on the Neuropathy Association, a nonprofit organization dedicated to helping those afflicted with peripheral neuropathy and to finding a cure for this disorder. I have undertaken this mission as public spokesperson for the Neuropathy Association because my community knows from firsthand experience the devastating affects of this disease. And as women of prayer, we could not leave the 20 million Americans who suffer from it without a voice.

My professional background has prepared me to serve as that voice. Before I was a nun, I was an actress, appearing on Broadway and starring in 11 films, during which time I had the chance to work with many gifted artists, among them my first costar, Elvis Presley, as well as Jeff Chandler and Anthony Quinn. I learned at an early age to love life passionately and to speak out whenever it is at risk.

What is peripheral neuropathy? In simple terms, it is a neurological disorder that causes weakness, poor coordination and debilitating pain. It occurs when nerves are damaged or destroyed by disease or injury and cannot carry messages from the brain and spinal cord to arms, legs, joints, skin and the internal organs of the body.

Peripheral neuropathy comes in many forms. One type affects about one-third of all diabetics, or about five million people. Other forms of neuropathy are associated with cancer, kidney disease and hepatitis. Others are autoimmune or inherited. Still others are caused by traumatic injuries, poor nutrition or even certain medications.

If you have never heard of peripheral neuropathy, you are not alone. Neither have I until 1997, when I had a root canal from hell. And I said from hell.

(LAUGHTER)

The fact that I was not able to eat after this procedure certainly came as no surprise. What alarmed me was that I was not able to walk either, and that was just the beginning. My pain became so constant that I developed TMJ from clenching my teeth all the time. At times I felt my feet were like on fire, and then they were freezing. I developed chronic pain in my ankles and legs.

As time passed, the pain spread with no observable pattern or warning, attacking my hips, back, bladder and face and causing an incessant ringing in my ears. I went from physician to physician with no results. Some prescribed medication for diseases I didn't have.

Mistaken diagnosis led to serious complications that landed me in an emergency room and proved nearly fatal. One doctor even suggested a psychiatrist. He said the pain was all in my head. I went home and wept and wept, and then, ladies, I just got mad.

I put my hand on the phone and called another neurologist. I hit the dial and prayed, and my prayer was answered. "No," he assured me, "you are not crazy. Pain is real." And finally, eight months after my symptoms first appeared, I was diagnosed with autoimmune sensory idiopathic peripheral neuropathy.

I have subsequently received invaluable treatment, which though not curing the disease, allow me to live with its effects and able to once more serve my community. I am no longer in a wheelchair, but in the almost nine years since my diagnosis, the only thing I know for sure is that idiopathic means nobody knows why.

The National Institute of Health spent only about \$50 million on peripheral neuropathy research last year, a disorder that affects as many as 20 million Americans. Unless we invest more money in research and discover more effective treatments or find a way to cure peripheral neuropathy, millions more will be stricken. We cannot afford to wait any longer. This disorder is not going away. In fact, the numbers climb.

Madam Chairman, I hope you and your colleagues can find it in your hearts to recommend that more funding be designated immediately for the research necessary to conquer this horrible disorder. Please do not turn your backs on the opportunity to affect the lives of millions of Americans for whom relief from this crippling disease would be nothing short of a miracle.

And I thank you very much for this opportunity to meet with you, and I hope you don't have any questions for me.

(LAUGHTER)

NORTHUP:

Sister, thank you for coming and sharing your story with us today.

HART:

You're very welcome.

NORTHUP:

I'm going to turn the chair over to the chairman of this committee. Thank you.

REGULA:

We wear a lot of hats off the record, a lot of hats in this job. We just had 80 eighth-graders. I had to get them into the gallery, but it's a big thrill. I used to teach eighth-graders once upon a time, and it's a great age. And we as members have the opportunity to get them into the Capitol -- and they're doing a tour -- and take a picture with them.

That's important, so 25 years from now, they'll remember their visit. And my guess is, we're going to see a lot more school groups. Sort of dried up after 9/11, but they're back in force. I have another group tomorrow, and I told them they lucked out. The cherry blossoms are probably at their peak today, tomorrow, maybe until we get a heavy rain, so we thank you for being here, and we'll try to get things finished.

Who else...

(UNKNOWN)

(OFF-MIKE)

REGULA:

OK. We're going back to the head of the list here. They saved him. Oh, Ms. Christine Fowler Shearer. They saved Christine since she's from my district. Christine, OK. Thanks for coming.

FOWLER SHEARER:

Thank you.

REGULA:

Tell us your story.

FOWLER SHEARER:

Chairman Regula, Congressman Obey and distinguished members of the subcommittee, thank you for the opportunity to testify this afternoon on behalf of the American Association of Museums on the fiscal year 2007 budget of the Institute of Museums and Library Services.

I am Christine Fowler Shearer, Director of the Massillon Museum in Massillon, Ohio. I ask that my full statement be made part of the official record.

The American Association of Museums is a national service organization that works to enhance the value of all museums to their communities through leadership, advocacy and service. My own museum is an accredited member of the association. In 1933, our museum first opened its doors to the community, as the realization of a dream of Mr. and Mrs. Frank Baldwin, who bequeathed their house and grounds to the 1920s for use as a museum.

Today our museum is located in downtown Massillon in the former Stark Dry Goods Store, which in the mid-1990s was transformed into a state-of-the-art facility. We are an integral part of our community's cultural activity and serve as a center of learning for the public.

One of the key elements in our growth and success has been the support of grants from the Institute of Museum and Library Services. We have received technical assistance from the Museum and Conservation Assessment Programs and funding that has helped build our education program from the Learning Opportunities Grant Program.

The museum grant programs at IMLS are the primary federal means of assisting museums and improving their public services. The administration's \$41,385,000 request for fiscal year 2007 is a vital and necessary investment in our nation's more than 15,000 museums. I respectfully request that the subcommittee approve the president's request.

Leadership and funding from the federal government is critical at this time of change for our nation's museums. As we at the American Association of Museums celebrate our centennial this year, my colleagues and I within the museum community are celebrating the contributions our institutions have made to American life over the past 100 years.

As we look to our future, we embrace the opportunities and challenges that face us as we seek to serve new audiences and the next generation of museum-goers. Funding from IMLS is a key ingredient in ensuring our nation's museums have the capacity to continue providing the public with learning experiences that help them understand the world around them and to continue caring for our collections.

Collectively, we are the stewards of a vast national collection of our natural and cultural heritage that is held in the public trust. My colleagues and I rely on both public and private sources to help us operate 21st-century museums that fulfill both our educational and stewardship responsibilities. Our profession continues to evolve and improve as we learn more about preservation and collections care and seek new ways to respond to the changing needs of the public.

Audiences are demanding more from their museums. New technology offers us the opportunity to present information in different and engaging ways. But we also need to continue to invest in the scholarship that is not always transparent to the public but intellectually underpins all of our exhibitions and activities and in the protection and conservation of our immense public collections.

Collectively, we are responsible for the care and preservation of nearly a billion objects that embody the richness and diversity of our heritage. The recent Heritage Health Index, the first comprehensive survey ever conducted of the condition and preservation needs of our nation's collections, found that artifacts in the vast majority of our collections are at risk and need immediate attention and care.

Hazards to our collections include humidity, light, temperature, pollutants and dust and pests. Environmental controls are the most preservation need within our institutions. This is a challenge as museums are both aging and expanding. While some of us struggle to repair and retrofit old buildings, others seek to keep up with the growing cost of operating larger facilities.

Here in the nation's capitol, the Smithsonian Institution faces aging facilities and systems that officials estimate would require a \$2.3 billion investment over the next nine years to solve the most pressing problems. While this high-profile situation caught the attention of the media and, I am certain, members of Congress, many of us in smaller communities from small institutions face the same situation but are more limited in our capability to make our infrastructure needs more visible.

Congress, through IMLS, has helped museums advance our missions of public service and collections care and preservation by providing a pool of competitive funding from which we can apply for grants. These highly competitive grants offer the leverage and recognition we need to attract additional support from individual donors, businesses and foundations as well as state and local government.

Annually, IMLS must turn down many excellent projects, because there is just not enough money to go around. I recognize you face difficult choices in allocating resources to all the many worthy and necessary programs that are within this subcommittee's jurisdiction. My appeal today is to ask you to consider what we lose if we do not continue to invest in our nation's museums.

We have a longstanding tradition of educating and inspiring our nation's children, of creating treasured family memories and providing each community with a place to reconnect with its achievements in history. As we struggle financially to sustain our institutions and our missions, we need the federal government's participation with other funders to meet our needs and fulfill our public responsibilities.

Without that help, we risk losing the places in our society where we can dream about our past and our future and explore from the smallest bugs and plants to the vast expanses of our universe and where we can inspire the young and old to lead creative and productive lives.

Earlier this year, you and your colleagues in Congress recognized the valuable role museums play in communities across this country by passing a House resolution supporting the goals and ideals of the year of the museum, which gives communities an opportunity to celebrate the contributions museums have made to American life over the past 100 years.

We hope that recognition can not only be in words, but indeed, by supporting additional funding for IMLS in their fiscal 2007 budget. We appreciate the opportunity to testify before the committee today, and I'm happy to answer any questions.

REGULA:

The president's budget give you an additional \$15 million, which is one of the few places there's any increase, so I'm sure you're happy with the president's budget.

FOWLER SHEARER:

Yes, we are happy.

REGULA:

You'd like more, of course, but it's better up than down.

FOWLER SHEARER:

Yes.

REGULA:

Mr. Obey?

OBEY:

No, it's a miracle. (LAUGHTER)

REGULA:

There aren't many of those miracles in that entire budget. Mr. Kennedy?

KENNEDY:

Fine. Thank you, Mr. Chairman. Rhode Island has the distinction of having more places on the National Historic Register of any state in the country, so we appreciate history very much, and thank you for your work in keeping history alive for future generations.

FOWLER SHEARER:

Thank you.

REGULA:

Thank you for being here. OK, we'll get the American Associate for Geriatrics Psychiatry. We have three witnesses left. For those of you who have been very patient in staying, we're soon down to the end.

BLAZER:

Turn it off, yes. I am a psychiatrist. I would like to just go on the record as saying I would never tell the Reverend Mother that the pain was in her head. Sometimes a pain in the leg is just that, a pain in the leg.

Mr. Chairman and members of the subcommittee, I'm Dan Blazer, and I'm here to testify today as past president of the American Association of Geriatric Psychiatry. I'm a physician, professor of psychiatry at Duke University and have been treating older adults with psychiatric disorders for over 30 years.

AAGP appreciates having this opportunity to testify about funding priorities for the Department of Health and Human Services.

The White House Conference on Aging, which was convened by President Bush in December of 2005, recognized the current health and mental health needs of older adults and the challenges awaiting as the Baby Boom generation ages. I was privileged to be among the delegates who placed mental health and geriatric health professional training issues at the forefront by voting them among the top 10 resolutions.

I will focus my testimony today on specific ways that this subcommittee can help meet those challenges.

With the Baby Boom generation nearing retirement, the number of older Americans with mental disorders is certain to increase in the future. Medicare funding for existing services is severely challenged. Therefore a national crisis in geriatric mental health care is emerging, and action must be taken now to avert serious problems in the near future.

While many different types of mental and behavioral disorders can occur later in life, they are not an inevitable part of aging process and continued research holds the promise for improving the mental health and quality of life for older Americans.

The crisis in the delivery of mental health care, that the elderly and the future generations can be averted when more efficient and effective therapies are identified through research. The New England Journal of Medicine has just published an important study funded by NIMH that suggests we can significantly decrease relapse rates in depression among older adults, which lead to fewer physician visits and hospitalizations by continuing those patients for longer periods of time on antidepressant medication,

In addition, studies such as the impact model for treating late- life depression suggest that effective treatment of depression in primary care reduces the cost of general health care in those settings. We need the infrastructure and vigorous agenda at NIMH to develop and fund research on causes, prevention and treatment of late- life mental disorders. We need to ensure the implementation of evidence-based practices by increasing support for the small existing program for mental health outreach and treatment for the elderly within the Center for Mental Health Services at SAMSA, which was initiated five years ago at the behest of this subcommittee.

Despite growing evidence of the need for more geriatric specialists to care for the nation's elderly population, a critical shortage persists. For the current fiscal year, Congress has inexplicitly (ph) eliminated all funding for geriatric health professionals' programs under Title VII of the Public Health Services Act. The loss of these programs could have a disastrous impact on physician and other

HERSETH workforce development over the next decade with dangerous consequences for the growing population of older adults who would not have access to appropriate specialized care.

These programs are critical for the nation's ability to provide the kind of health care that will allow the Baby Boom generation to be independent and productive as they age. AAGP in the strongest terms urges the subcommittee to restore funding to this program at funding year 2005 levels of \$31.5 million.

AAG firmly believes that investment in research and training in the service of better care for mental illness among the elderly will not only improve the quality of life of older adults, but it's going to save money as well. AAG appreciates your consideration of our views on these funding issues.

(UNKNOWN)

Thank you.

BLAZER:

Thank you. I think I...

KENNEDY:

What made you think that, Mr. Chairman? I want to thank you for your testimony and say we look forward to trying to pass the Positive Aging Act, which will help highlight the fact that we've got major demographic changes in this country, and as a result, we have big challenges that are heretofore not been faced in this area.

BLAZER:

And I want to thank Congressman Kennedy for his support and help for many years for just what is a very important issue.

REGULA:

He's demonstrated some interest in mental-health issues.

BLAZER:

He has. That's good.

REGULA:

Thank you for being here. OK, the National Association of Chronic Disease Directors, Cynthia Boddie-Willis. Am I right?

BODDIE-WILLIS:

You're correct.

REGULA:

Good.

BODDIE-WILLIS:

Thank you.

REGULA:

OK. Thank you for coming. We'll put your testimony in the record. If you'll summarize, we'll appreciate it.

BODDIE-WILLIS:

Mr. Chairman and members of this committee, thank you for the opportunity to appear before you.

My name is Dr. Cynthia Boddie-Willis. I am president of the National Association of Chronic Disease Directors. The NACDD is an association of public-health professionals with expertise in state-based chronic disease prevention and control. We have three priorities for 2007: expansion of the CDC Heart Disease and Stroke Prevention Program, enhancement of the CDC Diabetes Prevention and Control Program and preservation of the Prevention Health Services Block Grant. I am here to support these priorities.

Our first goal for 2007 is expansion of the Heart Disease and Stroke Prevention Program. The economic impact of heart disease and stroke in 2005 totaled \$394 billion. The CDC currently funds 32 states and the District of Columbia, but they are funded at such a low level that statewide intervention is not possible.

Nineteen states, including Ohio, receive capacity-building grants. Fourteen states receive basic implementation funding to support evidence-based interventions. Heart disease and stroke are the first and third leading causes of death, yet 18 states currently have no funding from the CDC. This ignores a clear and present danger to our nation's health.

Congress appropriated \$44.5 million for this program in 2006. The president's budget proposal for 2007 has only \$43.9 million. We respectfully request a \$10 million increase over the 2006 funding level for the Heart Disease and Stroke Prevention Program.

Our second priority, Mr. Chairman, is the Diabetes Prevention and Control Program. Over 20 million people in this country have diabetes, and over 41 million people have pre-diabetes. Diabetes-related costs are \$132 billion per year. Studies have shown unrealized opportunities to not only prevent diabetes but to prevent the complications of diabetes as well. Our written testimony has specific examples of how this works in states.

The \$63 million appropriated for diabetes prevention and control in 2006 funds only 28 states at the basic implementation level. The NACDD respectfully requests a \$10 million increase in 2007 to support additional states at that level.

Our third priority, Mr. Chairman, is Preventive Health Services Block Grants. The elimination of the prevent block in the president's 2007 budget proposal will lead to devastating cuts in critical public health services. NACDD has surveyed states recently to determine the impact of these cuts. Specific state examples are noted in our written testimony.

NACDD also has grave concerns about the proposal to allow states to reallocate up to 5 percent of categorical funding. This proposal incorrectly presumes that all categorical programs are funded in every state and that they operate with surplus resources. Neither presumption has ever been the case.

In closing, Mr. Chairman and members of the committee, NACDD respectfully requests a \$10 million increase over 2006 funding for the Prevent Block Grant, the Diabetes Prevention and Control Program and the Heart Disease and Stroke Prevention Program.

Thank you for the opportunity to address the committee regarding these urgent realities.

REGULA:

Thank you.

(UNKNOWN)

Mr. Chairman, just one comment. Your statement and the many others that we heard yesterday and today indicate what a tough job Mr. Regula's going to have. The House budget resolution was put together last night. It sticks pretty closely to the president's budget. Contrast to that, the Senate resolution that passed added over \$16 billion to show you how inadequate the Senate felt the president's budget was.

BODDIE-WILLIS:

Yes.

(UNKNOWN)

\$10.5 billion of those amendments came from Republican members. \$5.5 billion came from Democratic members. I would happily take the Senate product and run with it, and I would simply suggest that what this demonstrates is for the programs you've mentioned and the programs that others have mentioned, that if that budget resolution passes as is, and if this committee has to live within its confines, Mr. Regula is going to have to be a magician in order to meet the president's priorities and do anything close to what you or any of the others have been talking about. So I think you had better hope that that budget resolution goes down until somebody comes to their senses.

BODDIE-WILLIS:

We always hope that.

(LAUGHTER)

(UNKNOWN)

Thank you.

BODDIE-WILLIS:

Thank you.

REGULA:

Mr. Kennedy.

KENNEDY:

Thank you, Mr. Chairman. I know, Mr. Chairman, you often hear me harp on the fact that mental illness is a physical illness and that addiction and alcohol is a mistreatable. For those of us who have had family members who have been affected by this disease and as individuals who have suffered from it, I can tell you we owe an enormous debt of gratitude to people like Robert Shapiro, who has taken one of the most personal events and tragic events that could befall any human being, and that is to lose a child, and to turn that into a mission to ensure that other children are not lost to this deadly pervasive epidemic disease of addiction and alcoholism in this country.

And I admire him for using his celebrity and his position in being able to get attention and bringing that attention on this issue, which as you know, Mr. Chairman, is so often overlooked, and I'm honored to present him to the committee now. Mr. Shapiro?

SHAPIRO:

Thank you very much...

REGULA:

Thank you, Mr. Shapiro, for coming here, and we especially welcome you, because you're the last witness of...

SHAPIRO:

I can imagine, and I'll...

REGULA:

We've covered 60. We've had two days totaling 60 outside witness groups to give people an opportunity as you've heard here to bring their case, and you are number 60, so we especially welcome you today.

SHAPIRO:

Well, thank you very much, and I will not keep you very long, but hopefully I can get across a message very clearly.

REGULA:

You're pretty successful in getting across messages. I know your background.

SHAPIRO:

Thank you very much.

REGULA:

He was O.J. Simpson's lawyer, for those of you that are not -- many of you are too young to know that, but go ahead.

(LAUGHTER)

SHAPIRO:

Thank you very much for those kind words, Mr. Chairman, Congressman Obey, and thank you very much, Congressman Kennedy. If somebody had asked me on October the 9th of 2005 what my life was like, I would say I was living the American dream. I have a beautiful, loving wife of 35 years. I had two sons. My oldest son, Brent, was on the dean's list at USC ready to go to law school. His younger brother, Grant, was graduating from a distinguished music college, and I had a successful legal practice. I was a named partner in a major law firm in California.

And then on October the 10th, I got a call. You know those calls when the phone rings a little bit too long, and the hour is a little bit too unusual, and it's Sunday morning and it's 7 o'clock a.m. And my son's fiance hysterically is telling me, "Brent is not breathing."

My heart stopped, as any parent's would, and I knew that when I got to the emergency room before the paramedics, the news was not going to be good, and it wasn't, because the next day, we had to make that terrible, difficult decision of what to do on life support. And when he had arrived at the hospital, he was already brain dead.

If there's anything that could have been done to change that, I would change everything in my life, and it could have been changed. It could have been changed very easily because Brent had been sober for 18 months. He was doing great in college. He was engaged to be married. The wedding was planned.

And he had come to the conclusion that he was a drug addict and that he would never again use drugs the rest of his life. He had been in two or three recovery programs and finally had come to a wonderful program in Virginia, a sober living house. He lived here for eight months, went to school, and came back and was a model of a citizen, as a child, as a son and as a student.

But he could never come to the grips that he was an alcoholic. And after 18 months of sobriety, he convinced his fiance that maybe he could have a drink now and then. Maybe he could just experiment.

So that Saturday afternoon, he went to the USC football game. It was a beautiful California day, and with his friends he had a couple of beers. And that night, his fiance invited him to a birthday party of a friend of hers. It wasn't a kids' party, a 30th birthday party. And again, he had a couple of more drinks, and for reasons that I'll never know, he decided to take a half a tab of Ecstasy.

As a result, he got very, very ill. He went into what later we found was convulsions, and nobody reported it. They said, "Oh, he's probably had too much to drink. He'll just sleep it off. Let's help carry him into the car and get him into bed, and just watch him. Make sure he's OK through the night."

Had anybody called the paramedics, we wouldn't be here, but nobody did. They didn't because it's a shameful disease. They didn't because they didn't want other people to know. They didn't because they were afraid that the relapse would have such negative repercussions.

When we buried him two days later, people said, "What is your favorite charity? What can we do in lieu of flowers?" And spontaneously, I said, "You know, I'm going to start doing something I've been thinking about my entire career, and that is give something really back to society."

And we started the Brent Shapiro Foundation for Drug Awareness, because in my view, after listening to all the testimony here today, and I'm sure yesterday, we've heard story after story, compelling, of disease after disease, yet when it comes to alcoholism and drug disease, there is a stigma. We don't look at it like any other disease, and we don't treat it like any other disease.

It's a shameful disease. We want to brush it aside. We don't want to talk about it. We don't want to deal with it, but I'm here to tell you, it's an epidemic of enormous proportions. Be aware it's everywhere. It's not North, South. It's not East and West. It's not black and white. It's not rich and poor. It's not Democrat or Republican, conservative or liberal. It is everywhere in this country today.

It affects the youth. It affects the middle-age people. It is not a question of whether it's an illegal drug or a prescription drug. The disease is the same. It doesn't matter whether or not it started out as a recreational use or was given as a pain killer when you went to the dentist and too many Vicodin were given. It results in the same thing. It is a progressive, degenerative, horrendous disease that last year killed 120,000 people directly and indirectly an equal amount. Two hundred and fifty thousand people died as a result of drug and alcoholism.

We have a program that we've started at the foundation called the PACE program. Prevention. You talked about, Mr. Chairman, as a school teacher in the eighth grade. By the eighth grade it's too late. Forty percent of the kids have already tried drugs.

We have to start when they're younger. We have to start in the fifth grade, in the fourth grade, in the third grade and the first grade. We have to start with programs that tell kids to be smart and don't start, but let them know realistically and honestly what the pitfalls are.

We have to do genetic research to find out whether there are genetic markers, to find out whether people are going to be predisposed for this disease. Just as we would not give a potential juvenile diabetic a chocolate cake for his birthday, we should know what warning signals lie ahead for those who might be celebrating other birthdays.

Awareness. Let the people know that this is an epidemic, and it is a disease.

Communication. Had somebody just spoken about this, we wouldn't be here today speaking about it to you. Teachers must talk to parents, and the reverse must be true. Parents must talk to children, and children, adolescents and young adults, must talk to each other.

We must help people who need help. No one would think twice about telling somebody who had a physical ailment, "Go to the doctor," but we don't do that with people who have alcoholism or drug disease.

And finally, education. The doctors who people go to don't know what to tell the parents. We don't speak about this. We don't educate about it.

We are doing certain things at the Brent Shapiro Foundation. First, we have Governor Kenny Guinn, the head of the Republican Governors and Governor Bill Richardson, the head of the Democratic Governors, who have issued proclamations proclaiming Sober Day USA the first Monday every May, a national day of drug awareness to let people know about the drug disease.

We're going to do town hall meeting with both of them, and then we're going to go back to my city in Los Angeles and have a gigantic Sober Day party to let people know that you can have a good time without alcohol and drugs.

We're doing public service announcements with the theme, "That's My Story. What's Yours?" We're going to be honest. We're going to be forthright, and we're going to save some lives. We need your help.

We need your help because money has to be spent on the demand side of the problem. The supply will never end, whether it's legal or illegal. The pharmaceutical companies are manufacturing much more than is needed for Oxycontin for people who are in the last stages of cancer. It can be bought on the Internet and delivered by Federal Express without prescription.

Nobody is walking around saying, "I can't buy drugs today." We're never going to solve the problem based on the supply side. Put the priorities where they should be. Spend your money in the appropriate places. Prevent and education. Communicate and make aware. Thank you very much.

REGULA:

Thank you. Mr. Obey.

OBEY:

Chairman, let me simply thank the witness for his comments, and I hope that we listen to you.

SHAPIRO:

Thank you very much.

REGULA:

Mr. Kennedy.

KENNEDY:

I do want to thank Bob for being here and say that I look forward to working you on expanding awareness but also trying to fight for additional resources within the NIH to both study behavioral research as well as genetic and brain disease so that we can get to better answers as to how to properly intervene and prevent the kinds of tragedies that befell Brent, and that we'll do everything we can to save other lives.

And I thank you for your public work and making a very painful situation into a situation where people can benefit from the work that you do.

SHAPIRO:

Thank you very much, Mr. Kennedy. Thank you very much.

OBEY:

I'd also like to say one other thing. You have one thing in common with a lot of people the last two days. You have been willing to come here and lay out your personal story even though it's pretty painful.

SHAPIRO:

Very painful.

OBEY:

That's a very hard thing to do, and we understand that, and we appreciate the fact that you did it.

SHAPIRO:

Thank you.

REGULA:

Do you have any familiarity with the D.A.R.E program?

SHAPIRO:

I do.

REGULA:

What do you think of that as an effective tool?

SHAPIRO:

I question the idea that police officers...

REGULA:

Yes.

SHAPIRO:

... can go to public schools...

REGULA:

Yes.

SHAPIRO:

... and demonstrate to young people what drugs are, what the effects of drugs are and then to expect that they're not going to experiment or try them.

I met this morning with the chair of the National Institute on Drug Abuse, and one of the things that she had told me was that planting in the minds of kids the idea about drugs creates the desire to experiment with drugs. So I have met with the chairman of D.A.R.E. on several occasions. One of my law partners is the president of D.A.R.E. I think that there are better approaches.

REGULA:

We'd be interested in that if you ... I don't know if your statement includes some of your suggestions of what this is.

SHAPIRO:

It does. It does.

REGULA:

Well, we'll read that with great interest and care. I only want to say you've probably made some very powerful closing arguments in the courtrooms of America, but none is more important than the one you made today, and perhaps none that has more far reaching consequences for people, and we'll take into consideration your ideas.

We thank you for coming here and sharing with us your thoughts and your ideas of what we might be able to do to help other young people in America.

SHAPIRO:

Thank you. We'll work together, and we'll do something good.

REGULA:

Thank you.

SHAPIRO:

You're welcome.

REGULA:

This concludes the hearing. Thank you all for being part of it.

## List of Speakers

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U.S. REPRESENTATIVE PATRICK J. KENNEDY (D-RI)  
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WITNESSES:

CHRISTINE FOWLER SHEARER, AMERICAN ASSOCIATION OF MUSEUMS COMMITTEE ON APPROPRIATIONS  
JODI GRANT, AFTERSCHOOL ALLIANCE  
MATTHEW HORNING, AFTERSCHOOL ALLIANCE  
KENNETH EDMONDS, CROHN'S AND COLITIS FOUNDATION OF AMERICA  
DR. WAYNE HARRIS, ASSOCIATION OF MINORITY HEALTH PROFESSIONS SCHOOLS  
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ROBERT GELENTER, MENDED HEARTS, INCORPORATED  
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