the commitment we have to our neighbors, our communities, and our Nation. Across the country, we can make the courage and responsibility displayed by the heroes at Ground Zero endure. In this way, we will triumph over evil and devastation, and we can try to make sense out of all that we have suffered.

When I first visited the cratered field in Shanksville, and when I returned to that crash site this week, I was struck by the importance of our continued hope. I was also inspired by the strength of those Flight 93 family members, now carrying the torches of their loved ones who gave their last measure of bravery for our nation. I have resolved to make every day a memorial to September 11th by working to keep the bigger picture in mind and a better world in sight. I hope you will find your own way to keep and exhibit this renewed American spirit in your lives. May God bless you and our great country.

USDA TESTING FOR CHRONIC WASTING DISEASE

Mr. FEINGOLD. Mr. President, I rise today to urge Secretary Veneman to provide more details on the United States Department of Agriculture's recent announcement regarding chronic wasting disease, CWD, testing, and urge her to provide hunters with more testing opportunities for CWD.

On Tuesday of this week, USDA announced an increase of up to 200,000 more Government-approved tests for chronic wasting disease this deer hunting season. Prior to the announcement, USDA officials have said labs certified to test for the disease would only accommodate the needs of the Wisconsin Department of Natural Resources, DNR, and not provide testing opportunities for hunters.

I appreciate USDA's recent decision to allow Government laboratories certified by the U.S. Department of Agriculture, USDA, to offer an additional 200,000 chronic wasting disease or CWD tests to Wisconsin hunters. As I noted in my September 24, 2002, letter to Secretary Veneman, given hunters' concerns in my state, it is appropriate for USDA to offer any excess test processing capacity in the Government system to Wisconsin on a priority basis. This assistance from USDA allows Wisconsin to be able to offer testing to our hunters on request, and gives Wisconsin hunters access to the ''gold standard'' immunohistochemistry, IHC, test.

While I commend USDA for these efforts, I will be closely monitoring the implementation of the new testing program in the State, and in particular the Department's stated commitment of providing 200,000 more tests to Wisconsin hunters. It is important to note that nine of the Government laboratories that will be processing Wisconsin tests this fall have not previously conducted such tests. Given the time it took to get the Wisconsin State Veterinary Laboratory in a position to be able to process CWD tests, USDA must be vigilant in ensuring that these Government labs are ready in the next month. In addition, I also urge USDA to assist the State of Wisconsin in ensuring that the labs that will process Wisconsin's CWD tests provide accurate and prompt information regarding the test processing costs.

I commend the USDA for finally taking steps to provide more testing opportunities through Government labs. But the USDA must do more, including continuing efforts to certify private labs, like the Marshfield Clinic, and to approve rapid test kits for this fall's hunt. I want to ensure that USDA meets, and I hope exceeds, its commitment of providing 200,000 additional tests to Wisconsin's hunters for this year's hunt.

To that end, I hope that the administration will endorse my legislation, S. 3090, the Comprehensive Wildlife Disease Testing Acceleration Act of 2002. This legislation would provide hunters with more testing opportunities for chronic wasting disease by requiring USDA to develop appropriate testing protocols and to certify private labs to conduct CWD tests.

My legislation will remove bureaucratic roadblocks by requiring the USDA to expand the number of labs that can provide CWD testing to hunters. Until I am satisfied that USDA has done everything possible to bring this disease under control, I will continue to press this legislation forward.

Our 2001 deer hunt involved more than 400,000 deer. With only 250,000 tests total for Wisconsin, some hunters may still lack the ability to have their deer tested. USDA must continue efforts to provide more testing opportunities for hunters. By certifying private labs like the Marshfield Clinic and approving a rapid test this fall, USDA can ensure that Wisconsin hunters have the information they deserve.

Action on this problem is urgently needed. I am glad that the Secretary has finally begun to take a step in the right direction, and I urge her to undertake all the necessary measures to bring these diseases under control.

PRESCRIPTION DRUGS

Mr. SMITH of Oregon. Mr. President, we have been debating important issues in the Senate these past few weeks, Homeland Security, and the possibility of war in Iraq, and other issues that have resulted from 9/11. While these important debates take place here on the Senate floor and in the kitchens and living rooms across America, there is still another long-standing issue that affects the health and livelihood of our senior citizens, that of prescription drug coverage for our nation's seniors.

As the end of the legislative year looms closer, I am angry to say that we are no closer to having a prescription drug program for our seniors. When the Senate debated the addition of a prescription drug benefit to the Medicare program in July, there was clear agreement that such a benefit was badly needed and that time was of the essence for delivering such a benefit to America's seniors. Over several weeks of debate on prescription drugs, progress was made toward agreement, but unfortunately, the discussion was cut short by the August recess.

I believe this issue is so important, and so urgent for seniors, that I stand before you today to say that this Congress should stay in session until we are able to pass a prescription drug benefit for our seniors. It is not too late to pass a prescription drug bill this year.

With the help of new treatments and therapies, it is now possible for seniors to live longer and better than at any other time in history. Every day that Medicare excludes prescription drugs from coverage is a day that countless seniors will not have access to medications that could improve their health—or save their lives. In addition, every year that passes without adding a prescription drug benefit to Medicare, the cost of adding such a benefit increases substantially.

In recent weeks, there has been a lot of talk about adjusting Medicare payments to reimburse health care providers fairly for treating seniors. My home state of Oregon ranks 46th in the country for Medicare spending per beneficiary. These incredibly low Medicare reimbursement rates have made it impossible for some health care providers to continue serving Medicare beneficiaries. This means that many seniors in Oregon are now having difficulty even finding a health care provider to see them. Therefore, I am very supportive of the Medicare provider payment components of the package proposed by Senators BAUCUS and GRASSLEY, and I urge passage of this legislation before this Congress adjourns. However, I also believe there must be renewed interest in reaching a consensus on how to add an affordable, universal, voluntary prescription drug benefit to Medicare this year.

I know we have a lot of work to do this year. Urgent work, important work. But I can think of no more important issue than ensuring that our parents, our neighbors, our friends, our Nation's seniors, never have to lose their homes when they lose their health. We can pass a prescription drug bill this year, and we must. I urge my colleagues to stay in Washington until we are able to pass a prescription drug benefit for our Nation's seniors, and have it signed into law.

FDA APPROVAL OF BUPRENORPHINE/NALOXONE

Mr. LEVIN. Mr. President, last week, the fight against heroin addiction took a major leap forward after a decade of struggle. On October 8, 2002, the Food

and Drug Administration, FDA, announced the approval of a new anti-addiction drug, buprenorphine/naloxone, which, followed with the directives of a new law I authored along with Senators HATCH and BIDEN, makes a dramatic change in the way America fights heroin addiction. This new anti-addiction drug, developed under a Cooperative Research and Development Agreement, CRADA, between the National Institute on Drug Abuse, NIDA, and a private pharmaceutical company, has been the subject of extensive successful research and clinical trials in the United States. The new law, the Drug Addition Treatment Act of 2000, permits, for the first time, such anti-addiction medications to be dispensed in the private office of qualified physicians, rather than in a centralized clinic. That change can have a revolutionary reduction in the number of addicts, the crimes some of them commit, and the heroin related deaths which have occurred.

This newly approved anti-addiction medication has already been in use in France, where significant success has been achieved in getting patients off of heroin, reducing drug-related crime and reducing heroin-related deaths. For example, user crime in France and arrests are down by 57 percent and there has been an 80 percent decline in deaths by heroin overdose.

It is estimated that there are approximately 1 million individuals in the U.S. who are addicted to heroin. The new office-based system is a revolutionary change and will make our communities better and safer places to live. It will open the door to tens of thousands of individuals to get rid of their addiction, but are now unable to or are reluctant to seek medical treatment at centralized methadone clinics, where their appearance amounts to an announcement of their addiction and which for many addicts are difficult to get to for their once or twice a day use. According to a report by the Department of Health and Human Services, many individuals who want to get rid of their addiction will not go to centralized clinics, ''. . . because of the stigma of being in methadone treatment. . . .'' The report went on to say that HHS was:

. . . especially encouraged by the results of published clinical studies of buprenorphine. Buprenorphine is a partial mu opiate receptor agonist, in Schedule V of the Controlled Substances Act, with unique properties which differentiate it from full agonists such as methadone or LAAM. The pharmacology of the combination tablet consisting of buprenorhine and naloxone results in . . . low value and low desirability for diversion on the street. Published clinical studies suggest that it has very limited euphorigenic affects, and has the ability to precipitate withdrawal in individuals who are highly dependent upon other opioids. Thus, buprenorphine and Buprenorphine/naloxone products are expected to have low diversion potential . . . and should incerase the amount of treatment capacity available and expand the range of treatment options that can be used by physicians.

The compelling need for this new system of treatment is borne out in some astonishing data. A recent study by the U.S. Office of National Drug Control Policy, ONDCP, released in January of this year, shows that illegal drugs drain $160 billion a year from the American economy; and that the majority of these costs, $98.5 billion, stem from lost productivity due to drug-related illnesses and deaths, as well as incarcerations and work hours missed by victims of crime. The report found that illegal drug use cost the healthcare industry $12.9 billion in 1998. Commenting on the release of the study, ONDCP Director John P. Walters said:

Drugs are a direct threat to the economic security of the United States . . . and results in lower productivity, more workplace accidents, and higher health-care costs, all of which constrain America's economic output. Reducing substance abuse now would have an immediate, positive impact on our economic vitality. When we talk about the toll that drugs take on our country, especially on our young people, we usually point to the human costs: lives ruined, potential extinguished, and dreams derailed. This study provides some grim accounting, putting a specific dollar figure on the economic waste that illegal drugs represent.

Another recent study, released in September of this year, determined that the majority of drug offenders in our State prisons have no history of violence or high-level drug dealing. The study found that of the estimated 250,000 drug offenders in state prisons, 58 percent are nonviolent offenders. The authors concluded that these nonviolent offenders ''. . . represent a pool of appropriate candidates for diversion to treatment programs . . . .'' They went on to say that ''The 'war on drugs' has been overly punitive and costly and has diverted attention and resources from potentially more constructive approaches.''

Of the juveniles who land behind bars in State institutions, more than 60 percent of them reported using drugs once a week or more, and over 40 percent reported being under the influence of drugs while committing crimes, according to a report from the Bureau of Justice Statistics. Drug-related incarcerations are up and we are building more jails and prisons to accommodate them, more than 1000 have been built over the past 20 years. According to the July 14, 1999 Office of National Drug Control Policy Update, ''Drug-related arrests are up from 1.1 million arrests in 1988 to 1.6 million arrests in 1997—steady increases every year since 1991.''

In a September 3, 2001 interview with the New York Times, then-Drug Enforcement Administration nominee Asa Hutchinson underscored the need for drug rehabilitation for nonviolent offenders, saying that we are ''not going to arrest [our] way out of this problem.''

I believe that the system that we have finally put in place will effectively put America on the right road to fighting and winning the heroin addiction war. It has been a long and difficult road for over a decade. First, in providing the resources to help speed the development and delivery of anti-addiction drugs that block the craving for illicit addictive substances. Second, authoring a law that would allow for such medications to be dispensed in an office-based setting rather than centralized clinics, by physicians who are certified in the treatment of addiction. In 1996, the Senate adopted my amendment to the budget resolution to steer $500 million over 6 years to the National Institute on Drug Abuse, which resulted in substantial increases in funding for research conducted by the National Institute on Drug Abuse. Then, in 1997, when Senator Moynihan and Senator Bob Kerrey joined me in convening a panel of experts to present their expert views at a Drug Forum on Anti-addiction Research, in an effort to assess the level of progress and needed support to expedite new anti-addiction discoveries. In October, 2000, the Drug Addiction Treatment Act, was enacted into law. Today, we are taking a giant step forward with the Food and Drug Administration's approval of this new anti-addiction drug, which will allow for the appropriate and long awaited, conventional, office based approach to addiction treatment in this country.

The protections in the new law against abuse are as follows: Physicians may not treat more than 30 patients in an office setting; appropriate counseling and other ancillary services must be offered. Under this legislation the Attorney General may terminate a physician's DEA registration if these conditions are violated and the program may be discontinued altogether if the Secretary of HHS and Attorney General determine that this new type of decentralized treatment has not proven to be an effective form of treatment.

This great success would not have been possible without the scientific genius, leadership and steadfast support of many individuals, including, Dr. Alan Leshner, who, during his 7-year tenure as Director of NIDA, energetically led the government initiated partnership that produced buprenorphine/naloxone for the treatment of heroin addiction; Dr. Frank Vocci, a brilliant scientist who heads up Medications Development at NIDA and whose tutoring has led me to a better understanding of the science of addiction; Dr. Charles Schuster of Wayne State University, a past director of NIDA who has conducted clinical trials on buprenorphine/naloxone, the results of which have been presented in testimony before Congress. Dr. Schuster has been my resource and my guide on this issue from the very beginning and his advice and expertise continues today; Dr. James H. Woods, Director of Drug Addiction Research Projects at the University of Michigan, has long been a progressive force in the area of addiction research, and has been an effective voice in the formulation of legislative policy in the area of addiction

both at home and abroad. Dr. Herbert Kleber, Professor of Psychiatry at Columbia University and one of the Nation's foremost experts on drug addiction and treatment, provided invaluable assistance to me in putting together this new system of treatment. Dr. Chris-Ellyn Johanson, President-elect of the College on Problems of Drug Dependence and Professor in the Department of Psychiatry and Behavioral Neuroscience at Wayne State University, has made major contributions to understanding the basis of the buprenorphine therapeutic effects in the treatment of heroin abuse and dependence; and Dr. Stephanie Meyers Schim, former president of the Michigan Public Health Association, who has helped us to understand that drug addiction is a public health problem that is in crisis and that our health policies should reflect this reality.

In closing, I would like to thank those who too often go unnoticed, the Senate staff members who kept this legislation on track despite the many twists and turns and the unforeseen challenges along the way. My Deputy Legislative Director Jackie Parker, whose commitment and diligence in moving this issue was characteristically unwavering. Bruce Artim, who serves Senator HATCH on the Judiciary Committee and Marcia Lee of Chairman BIDEN's Subcommittee on Crime and Drugs were undeterred in their resolve to move all obstacles that came in the way of making this new system of treatment a reality.

Finally, I ask unanimous consent that the remarks of Dr. James H. Woods of the University of Michigan, Dr. Chris-Ellyn Johanson and Dr. Charles R. Schuster of Wayne State University, and Dr. Herbert Kleber of the New York State Psychiatric Institute, along with a list of participants, be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

DR. JAMES H. WOODS, UNIVERSITY OF MICHIGAN, PRESS CONFERENCE ON FOOD AND DRUG ADMINISTRATION (FDA) APPROVAL OF BUPRENORPHINE/NX (BUP), OCTOBER 9, 2002

There are a variety of reasons for the scientific and medical excitement today celebrating the approval of buprenorphine for the pharmacotherapy of narcotic abuse. It fits in what I hope will be a succession of new therapies for drug abuse that will be employed under The Drug Addiction Treatment Act to change the way we view addictions and how they may be treated.

There are, of course, many different groups of individuals who are responsible for this important day. We need to show our considerable appreciation to Senators Levin, Hatch, and Biden for their support for The Drug Addiction Treatment Act. Having worked most with Sen. Levin, I know that he has been long interested in the important problem of drug abuse. He has visited us at the University to see firsthand what we were up to in evaluating different, novel approaches to pharmacotherapy of drug abuse. He has kept the problems of developing these therapies in mind and has worked long and hard to bring this legislation into being. I know the Senator believes fervently that buprenorphine's approval is going to produce some major changes in the treatment of narcotic abuse because of the ways that it will be used in conjunction with The Drug Addiction Treatment Act. I wholeheartedly agree and I hope what we are seeing today with buprenorphine will be replicated with increasing frequency in the future.

In my opinion, we will see the individual physician taking an increasingly important role in dealing with narcotic addiction in a different way. They will be dealing with individuals who would not otherwise present themselves for the kinds of treatment currently available. Those who prefer the privacy of individual physician treatment can be allowed that privilege with this new medication for it is very, very safe. When we consider that 5 of 6 narcotic abusers are not in treatment, it is clear that this new approach to therapy is sorely needed.

We need to show our appreciation to the National Institute on Drug Abuse and their efforts toward medications development. Were it not for their support in developing buprenorphine, we would not be having this meeting today. They have supported strongly both the effort to move buprenorphine along towards this drug abuse indication, and related research toward the development of other much needed therapies in the field of drug abuse. Thus, knowing a bit about what they have in mind for the future, I think we will be seeing more of these meetings.

We need to thank the firm, Reckitt Benckiser, for sponsoring buprenorphine. It was clear early in the study of buprenorphine that it might have potential as a pharmacotherapy. This has been demonstrated quite well. The drug has been fascinating to opioid pharmacologists ever since it was made public, and its interesting pharmacological properties were described. Though some of its pharmacology remains elusive to us, it is clear that we may have happened upon just the right molecule for opioid abuse treatment. Our Narcotic Center Grant at the University, funded by NIDA for some 30 years, has had the objective of improving upon some of the effects of buprenorphine. We have made and studied extensively hundreds of chemical relatives and found many compounds comparable to buprenorphine, but none superior to it in safety or duration of action. Thus, we believe that buprenorphine is a substance that will be the best of its kind for this type of therapy.

I appreciate the concert of effort that it takes to bring this new type of attention to the problem of drug abuse. It is only with the combined legislative, governmental, pharmaceutical, and scientific efforts that these problems will be dealt with effectively.

DR. CHRIS-ELLYN JOHANSON, WAYNE STATE UNIVERSITY, PRESS CONFERENCE ON FOOD AND DRUG ADMINISTRATION (FDA) APPROVAL OF BUPRENORPHINE/NX (BUP)

My name is Chris-Ellyn Johanson and I am a professor in the Department of Psychiatry and Behavioral Neurosciences at Wayne State University and the incoming president of the College of Problems of Drug Dependence. When I joined the Wayne State faculty in 1995, I was fortunate enough to become a part of a research center at the University of Michigan, headed by Dr. James Woods and funded by the National Institute on Drug Abuse. This center is devoted to the development of safer and better opiate drugs and has been continuously funded by the National Institute on Drug Abuse for over 30 years. My research has focused on trying to understand how buprenorphine exerts its therapeutic effects in the treatment of heroin abuse and dependence.

I have been fortunate to work in collaboration with Jon-Kar Zubieta, also from the University of Michigan, using state-of-the-art neuroimaging techniques in conjunction with behavioral measures to understand the biobehavioral basis of the therapeutic efficacy of buprenorphine. Our studies have clearly demonstrated that because buprenorphine's unique pharmacology as a partial mu agonist, it can block the dependence-related effects of heroin-like drugs and in many ways combines the characteristics of the agonist treatment agent methadone and the antagonist treatment, naltrexone. Further, its pharmacology makes it a drug with a long duration of action and a remarkable margin of safety.

So I am very pleased to be here today to welcome buprenorphine into the armamentaria for the treatment of heroin addiction. Not only will buprenorphine allow the expansion of treatment options for clinicians, but because of the legislation sponsored by Senator Levin to allow office-based practice for drugs such as buprenorphine, this option will be available to an increased number of opiate-dependent patients. I want to personally thank Senator Levin and his staff for their efforts in promoting more rationale treatment for heroin addiction. The Drug Abuse Treatment Act of 2000, which allows qualified physicians to treat opiate addicts in their office, brings the treatment of heroin addiction into mainstream medicine. This will not only increase the availability of treatment but will as well destigmatize it. Without this legislation, buprenorphine's unique advantages could not be effectively utilized.

I would also like to thank Senator Levin and his staff on behalf of the College on Problems of Drug Dependence. One of the major goals of this scientific organization, which has been in existence since 1929, is the development of safer and more useful medications for the treatment of addiction, including heroin dependence. Most of the scientists who have been responsible for the development of buprenorphine are members of this organization and have presented their findings with buprenorphine at its annual scientific meeting. Because of this, CPDD has been very involved in pushing for the approval of buprenorphine and has been appreciative of the help of Senator Levin in getting approval.

DR. CHARLES R. SCHUSTER, WAYNE STATE UNIVERSITY

My name is Charles R. Schuster and I am a Professor of Psychiatry and Behavioral Neuroscience at the Wayne State University School of Medicine.

I am extremely excited by the news that the Food and Drug Administration has approved the marketing of two buprenorphine preparations, Subutex and Suboxone, for the treatment of opiate dependence. These products are the first to be available in a new model of office-based treatment of opiate dependence allowed under the Drug Abuse Treatment Act of 2000. We can thank Senator Levin for his incredible thoughtfulness and tenacity in fighting to get this legislation through Congress.

One of the major advances that has been made in the past several years by a joint effort between Reckitt-Benckiser Pharmaceutical company and the National Institutes on Drug Abuse/NIH is the development of buprenorphine for the treatment of opiate addition. I am privileged to have had a role in the development of this safe, effective treatment both during my tenure as the Director of NIDA and subsequently as a NIDA

grantee. Under the auspices of a NIDA funded treatment research project I have utilized buprenorphine as a maintenance therapy and have been very impressed not only with its effectiveness in curtailing heroin use, but as well with its acceptance by patients who would not have considered treatment with methadone. Thus this medication may reach opiate addicts who currently are resistant to enrollment in opiate maintenance programs that use ORLAAM and methadone. I have letters on my desk from patients whose lives have been turned around by the buprenorphine maintenance treatment we have provided them. I have even more letters from opiate addicted people who are asking where they can find such treatment. Because of the approval by the FDA of two buprenorphine preparations and the passage of the Drug Abuse Treatment Act of 2000, it is now possible to give the answer. Find a qualified physician in your area of the country and be seen as a regular patient in their office receiving a prescription for buprenorphine. Tragically, I see young people every day who are in need of medications to ease their need for heroin so that they can become invested in rehabilitation activities that can return their life trajectory to a normal, productive and fulfilling course. Currently the available medications, methadone and ORLAAM, are extremely useful but ensnared in regulations that grossly limit their potential effectiveness. Having a safe, effective narcotic preparation like buprenorphine that can be used by qualified physicians for the treatment of opiate addition that is unfettered by the methadone regulations is a major advance in our ability to provide badly needed services in a cost effective manner.

I am very proud as a resident of the state of Michigan to have Senator Levin as my representative in the United States Senate. He and his staff have worked tirelessly to secure the passage of the Drug Abuse Treatment Act of 2000. This landmark legislation represents a major shift in policy in how we view and treat the problem of opiate addition. This advance in our policies regarding the treatment of opiate addition has been a long time in coming. But thanks to the efforts of Senator Levin, it has finally arrived. I join in celebrating this achievement which has the potential for providing significant help to those attempting to overcome the ravages of opiate addition. Individuals seeking help for their opiate addition do not have much political power and are rarely heard in drug abuse policy debates. Fortunately for them they have a compassionate and steadfast advocate in Senator Levin.

REMARKS OF DR. HERBERT KLEBER AT PRESS CONFERENCE ON FDA APPROVAL OF BUPRENORPHINE/NX

Today marks an important milestone in the treatment of substance dependence disorders. Buprenorphine, both in the combined form with antagonist naloxone and in the mono-form, have just been approved by the Food and Drug Administration, the first therapies approved for in-office prescribing under the Federal Drug Addiction Treatment Act of 2000. The path has been a long and at times torturous one but a careful one. It can hardly be described as a rush to market: my first research paper on buprenorphine was published in 1988 and colleagues had published earlier. During this decade and a half we have learned much about this agent and it's potential for the treatment of narcotic addition. I am very grateful for the help from certain key senators, both in passing the Drug Addition Treatment Act and for their continued encouragement during this long and difficult process. Senator Carl Levin of Michigan has been a special stalwart in this process but the effort has truly been a bipartisan one with Senators Orrin Hatch of Utah and Joseph Biden of Delaware both playing active roles along with Senator Levin.

The importance of this day, however, is much more than the particular medications involved. Buprenorphine to be sure should help in combating opioid dependence in formerly underserved communities. It is estimated that there are up to 1 million opioid dependent individuals in the United States of whom less than 200,000 are in treatment. The annual cost to society of opioid addiction is more than 20 billion dollars. Buprenorphine may increase the likelihood of people who have not currently sought out treatment to do so, thus reducing the enormous toll, both in health and in crime, that addiction takes on society. Injecting drug users and their sexual partners, for example, have become the largest new group of individuals becoming HIV positive. While buprenorphine is neither a panacea nor a magic bullet, it has major advantages in terms of safety, duration of action, and ease of withdrawal in comparison to existing medications on the market. That plus the ability to be treated in the privacy of the doctor's office are all important advances.

The major importance of the FDA approval and the Drug Abuse Treatment Act, however, go well beyond the particular medications and instead to how we think about addiction. Papers by myself and my colleagues have emphasized that opioid dependence as with other addictions is a chronic relapsing disorder, not a character flaw, failure of will, or lack of self-control. These drugs change our brains, changes that can persist long after the individual has stopped taking the drug and lead frequently to relapse. When a patient who cannot stop smoking on his own seeks help from his physician, he is seen as a patient who needs help and the physician will respond with a variety of medications and behavioral interventions. Likewise, it is my hope that with the advent of these medications the treatment of opioid dependence will be able to be mainstreamed. Individuals who are dependent either on street opioids like heroin or on prescription opioids will be able to receive help in doctors' offices and medical clinics. They will hopefully one day be treated with the same dignity with which we treat the patient trying to give up smoking or the diabetic or the hypertensive, all individuals that have chronic relapsing disorders involving both physical and behavioral components.

Addiction is initiated by a voluntary act but this initial voluntary behavior is in many cases shaped by pre-existing genetic factors and there are early brain changes, which may evolve into compulsive drug taking less subject to voluntary control. It is important to recognize, however, that drug dependence erodes but does not erase a dependent individual's responsibility for control of their behavior. Many patients with other chronic illnesses fail to see the importance of their symptoms and thus may ignore physician's advice, fail to comply with medication, and engage in behaviors that exacerbate their illnesses. While such patients may not be as disruptive, demanding, or manipulative as alcohol or drug dependent patients, the patterns of denial of symptoms, failure to comply with medical care and subsequent relapse are not particular to addiction. One thing, however, that does separate addiction from other illnesses is the waiting list for treatment throughout the United States which contradicts assertions that addicted persons do not want help.

Compassion or sympathy is not the basis for the argument that physicians should treat addicted individuals. Medically oriented treatments can be quite effective. In addition, addiction treatments have been effectively combined with legal sanctions such as drug courts and court-mandated treatments. Medical interventions should be taught in medical schools and primary care residencies. If physicians develop and apply the skills available to diagnose, treat, monitor, and refer patients in the early stages of substance dependence, there will be fewer late-stage cases.

I have been involved in treatment and research with substance dependent individuals for over 35 years, initially at Yale University and the last decade at Columbia University. In between I spent approximately 2½ years as the Deputy Director of the Office of National Drug Control Policy under Bill Bennett and the first President Bush. The new era in office-based treatment of opioid dependence is a worthy successor to efforts made by our Office back in the early 1990's to expand the number of individuals in treatment with substance dependence. My appreciation—and that of many future patients—to the legislators and federal agencies that made this possible.

Thank you.

PRESS CONFERENCE PARTICIPANTS, FDA APPROVAL OF BUPRENORPHINE/NALOXONE, OCTOBER 9, 2002, SR 236

Senator Carl Levin.

Senator Orrin Hatch.

Dr. Frank Vocci, Director of the Division of Treatment Research and Development, National Institute on Drug Abuse.

Dr. Steven K. Galson, Deputy Director, Food and Drug Administration's Center for Drug Evaluation and Research.

Dr. Wesley Clark, Director, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

Dr. Herbert D. Kleber, Professor of Psychiatry and Director, Division of Substance Abuse, Columbia University.

Dr. James H. Wood, Professor, Department of Psychology and Pharmacology and Director of Drug Addiction Research Projects, University of Michigan.

Dr. Chris-Ellyn Johanson, Professor of Psychiatry and Associate Director of Substance Abuse Research, Wayne State University.

Dr. Charles Schuster, Professor of Psychiatry and Behavioral Neuroscience, Wayne State University.

THE IMPORTANCE OF ENERGY LITERACY TO A NATIONAL ENERGY POLICY

Mr. ALLARD. Mr. President, I wish to bring the Senate's attention to the importance of energy literacy to a national energy policy.

The National Energy Policy Development Group recommended an energy literacy project in the May 2001, National Energy Policy. You can find it on the first page of Chapter Two, entitled ''Striking Home.'' The recommendation states, ''The NEPD