THE PRESIDENTIAL COMMISSION on the HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC

HEARING ON IV Drug Abuse and HIV

December 17 and 18, 1987

August 24, 1988

TO OUR READERS:

The Presidential Commission on the HIV Epidemic held over 45 days of hearings and site visits in preparation for our final report to the President submitted on June 27, 1988. On behalf of the Commission, we hope you will find the contents of this document as helpful in your endeavors as we found it valuable in ours. We wish to thank the hundreds of witnesses and special friends of the Commission who helped us successfully complete these hearings. Many people generously devoted their volunteer time in these efforts, particularly in setting up our site visits, and we want to fully acknowledge their work.

The staff of the Presidential Commission worked around the clock, seven days a week to prepare and coordinate the hearings and finally to edit the transcripts, all the while keeping up with our demanding schedule as well as their other work. In that regard, for the Hearing on IV Drug Abuse and HIV, we would like to acknowledge the special work of Nancy Wolicki, in putting together the hearing, and in editing the transcript so it is readable.

For the really devoted reader, further background information on these hearings is available in the Commission files, as well as the briefing books given to all Commissioners before each hearing. These can be obtained from the National Archives and Records Administration, Washington, D.C. 20408.

One last note--We were only able to print these hearings due to the gracious and tremendous courtesies extended by Secretary Bowen's Executive Office, especially Dolores Klopfer and her staff, Reginald Andrews, Sandra Eubanks and Phyllis Noble.

Sincerely,

Polly L. Gault
Executive Director

Gloria B. Smith
Administrative Officer

PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC

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PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC

HEARING ON IV DRUG ABUSE AND HIV

The Hearing was held at the
Dirksen Senate Office Building
Room 138
First and C Streets, N.E.
Washington, D.C.

Thursday, December 17, 1987

COMMISSION MEMBERS PRESENT:

ADMIRAL JAMES D. WATKINS (RETIRED), CHAIRMAN

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POLLY GAULT, EXECUTIVE DIRECTOR

I-N-D-E-X

I-N-D-E-X-(continued) PAGE

PANEL FIVE(continued)

PANEL SIX

MODES OF TRANSMISSION/NEEDLE SHARING

P R O C E E D I N G S

[9:05 a.m.]

MS. GAULT: Ladies and gentlemen, members of the President's Commission, my name is Polly Gault. I serve as the designated federal official. In that capacity, I am officially opening this meeting. Mr. Chairman?

CHAIRMAN WATKIKNS: On behalf of the Presidential Commission on the HIV epidemic, I would like to extend a warm welcome to today's witnesses, public officials, medical professionals, press, and members of the public.

In our preliminary report, the Commission delineated four emergent issues that demanded the Commission's immediate attention. The problems engendered by IV drug abuse and HIV infection were one of those issues.

Nationwide, about 25 percent of AIDS cases are among IV drug abusers. In addition to the scourge of drug abuse, now the related spread of HIV infection is causing many of our nation's communities devastation.

In addition to transmission of the HIV through shared needles, approximately 70 percent of U.S. natives with AIDS attributed to heterosexual contact reported having sex with an intravenous drug abuser. In addition, approximately 70 percent of pediatric AIDS patients attributed to perinatal transmission occur in infants born to either a woman who uses intravenous drugs, or who has sexual relations with someone who does.

The National Commission to Prevent Infant Mortality indicates that the number of AIDS cases in infants and children is rapidly increasing, and expected to total between 10,000 and 20,000 by 1991 -- a number considerably beyond that predicted in many of the epidemiological projections.

Needless to say, in addition to the myriad of problems this presents, the strain on the foster care system in many heavily impacted communities is becoming painfully apparent. Despite these compelling statistics, as members of the Commission have traveled around the country talking to health care providers, patients, and others, we have been constantly told of the desperate lack of availability of treatment services for drug abusers.

In fact, a recent General Accounting Office report indicated that, quote, "Nationally, existing resources may be sufficient to treat about 20 percent of the IV drug abusers." End quote. As we noted in our submission to the President, without such programs there will be little chance to halt the growing spread of the virus among this segment of the

population. In the next two days, the Commission will hear from an impressive group of federal, state and local officials, treatment providers, criminal justice professionals, health care specialists, and others who will delineate the problem for us, and offer recommendations based on their expertise in the field.

The Commission is well aware of the urgency of this issue, and has therefore scheduled it early in our deliberations. I am delighted this morning to turn over the Chair for this particular hearing to Dr. Beny Primm, a nationally recognized leader in the field of drug abuse treatment. In addition to his work on this Commission, Dr. Primm is the President of the Urban Resource Institute, and President and Executive Director of the Addiction Research and Treatment Corporation. Dr. Primm has devoted much of his life to providing treatment for drug abusers and seeing that public policy was conducive to the provision of that treatment.

Dr. Primm, we thank you for your outstanding work in bringing together our excellent panelists for today's hearing. We will follow the procedures this morning as established during our past two hearings, giving two questions per Commissioner with follow-ups from others focused on those particular questions only, and then we will move on to the next Commissioner.

I have asked Dr. Primm to allow me to be the last questioner for each panel. With that, I will turn the Chairmanship over to Dr. Primm.

DR. PRIMM: Thank you very much, Mr. Chairman.

I would like to state that IV drug abusers represent the second largest number of AIDS cases in this country. In addition to the destruction that drug abuse has caused our community, HIV infection now presents a double threat.

As Chairman Watkins has mentioned to you, IV drug abusers also present a major source for the heterosexual and perinatal transmission of the Human Immunodeficiency Virus. During the next two days, the Commission will hear testimony from leading experts on a variety of subjects relating to IV drug abuse and AIDS.

We will hear about the scope of HIV infection in the IV drug-abusing population, and federal, state and local efforts to cope with both IV drug abuse and the spread of the HIV infection. We will also examine the impact that both IV drug abuse and AIDS is having on minority communities, on cities, and on the criminal justice system. Once we have assessed the impact of this combination of factors, we will look at the various modes of transmission of the virus as they relate to the IV drug abusers.

Those modes including needle sharing, sexual and perinatal transmission. Perhaps most importantly, the Commission will address risk reduction as we compare various treatment modalities for drug abusers, as we examine the availability of treatment programs, and review current and planned efforts at outreach education.

Preventing HIV infection among IV drug abusers is a major opportunity to alter the spread of this infection; it is also an opportunity that cannot be missed by this Commission.

These next two days represent the Commission's opportunity to continue the dialogue with leading practitioners, researchers, administrators, and educators in the area of IV drug abuse. We will be asking for their recommendations about the best means to launch a coordinated effort to halt the spread of this disease. This dialogue will be critical in the Commissioners' efforts to make the most effective recommendations to the President.

I am delighted with the outstanding quality of the witnesses we will hear from during the next two days, and I am confident that they represent the best minds in this field, and will offer us constructive advice.

I would like to welcome today our first panel. Dr. Charles Schuster, who is the Director of the National Institute on Drug Abuse, and Dr. Harvey Haverkos, the Chief of the Clinical Medicine Branch at the National Institute on Drug Abuse, who will provide us with an overview of the national situation.

Good morning, Dr. Schuster; good morning, Dr. Haverkos. We can please begin now, if you will. Dr. Schuster?

PANEL 1 - OVERVIEW OF ISSUES NATIONALLY

DR. SCHUSTER: Thank you. Mr. Chairman and members of the Commission, I would like to thank you on behalf of drug abuse patients and workers throughout the nation for devoting these two days for consideration of the problems of intravenous drug abuse and AIDS.

Many drug abuse professionals have expressed their fear to me that, with respect to AIDS amongst IV drug abusers, the nation will choose a policy of benign neglect and let the epidemic take its toll.

The fact that you have brought us here today should allay much of that fear. We are wrestling with the many policy

issues and practical concerns that this epidemic raises. The National Institute on Drug Abuse -- known as NIDA -- because it is the lead federal agency for drug abuse research, has taken a particularly active role in the issues related to AIDS and the IV drug-using population. In addition to funding a variety of projects aimed at reducing the spread of AIDS amongst drug abusers, NIDA has been conducting a number of meetings at which national and international experts in research, medicine, law, ethics and other relevant areas come together to grapple with the hard questions.

Recent meetings have dealt with methods of educating IV drug abusers about the dangers of AIDS, and with some of the more controversial approaches to AIDS control. For example, mandatory treatment for drug abuse, or the distribution of clean needles.

NIDA-sponsored meetings have also looked at the need for expansion of treatment capacity, and the cost of providing this treatment. We would be very pleased to share with the Commission the written reports from these meetings.

We have always known that intravenous use of illicit drugs can be deadly, but AIDS has added a new menace. With AIDS, it is no longer the drug abuser alone who faces death as a result of taking drugs.

One person's drug use and consequent infection can lead to the death of other people, including people who are not part of the drug culture. Many take comfort in the belief that IV drug users are a fairly isolated group and therefore their diseases are unlikely to spread to the general population.

To a certain extent, drug abusers are, indeed, isolated. Because they engage in illegal behavior, they certainly don't want to draw the attention of authorities. In addition, they are isolated by poverty -- some of which is attributable to the cost of their drug -- but some to a lack of skills or training.

Most IV heroin users are Black or Hispanic. The remaining vestiges of racial prejudice tend to keep them apart from the majority of the population. Also, as is true of any social group, IV drug abusers are likely to confine most of their affiliations to people who share their interests: in this case, drugs. Unfortunately, there is little reason for complacency, since the isolation of drug abusers is nowhere near complete. IV drug users are members of families and communities that are part of the larger society.

They can spread the AIDS virus amongst themselves, and to the non-using population as well. Among themselves, the method of transmission is mainly through the sharing of

contaminated needles. Infection from addicts to non-users occurs through sexual activity.

NIDA estimates that there are about 1.3 million IV drug abusers in this country. Eighty percent of the males are believed to have non-drug using sexual partners. Often, the sexual partner is not even aware that he or she is involved with someone who has used drugs intravenously.

Also, since both male and female IV drug users may engage in prostitution to support their habit, their sexual contacts are wide spread. Casual or constant, however, sexual partners of IV drug users are at risk for infection. So are their children.

Two-thirds of the pediatric AIDS cases involve perinatal infection related to parental drug abuse. These babies enter a world in which their parents may be dead or dying; they, themselves, are likely to suffer chronic illness and early death. Few foster homes are open to them.

For the sake of these innocent children alone, if for no other reasons, we must ensure that everything in our power is done to control this epidemic.

One hopeful note is our knowledge that many IV drug users want help. Fewer than 140,000 IV drug abusers are believed to be in treatment at any one time. There are, unfortunately, long waiting lists for treatment programs in many parts of our country.

The recent report by the mayors of major cities stated that three out of four cities in the United States have waiting lists for entry into treatment of publicly funded drug programs.

NIDA's drug abuse information and referral telephone hotline has received calls from over 9,000 IV drug users in search of help. We refer them to drug abuse treatment programs across the country. But our experience has shown that the number of drug abusers who apply for treatment is directly related to their perception of whether or not treatment is available.

As more treatment slots are developed, more and more drug users will identify themselves and ask for help. Of course, not all IV drug users are asking for help. Some drug users are not willing to quit using their drugs at this time. The threat of AIDS may motivate them, however, to stop the injection drugs, or at least stop sharing needles, or start using sterile needles and safer sexual techniques.

We need to examine closely the reasons why they engage in certain behaviors. For example, needles are not always

shared simply because clean ones are not available. There is also a social ritual that encourages needle sharing. This is most notable in the shooting galleries found in some large urban areas. There many individuals may share injection equipment, and the risk of HIV infection rises with each use.

If we are to affect changes in these practices, we must first understand the significance of these behaviors of the addicts engaging in them. Because of our research, we are beginning to understand this situation better, and deal with it realistically.

The network of drug abuse workers, epidemiologists, and treatment programs that has been in place for some time is already educating IV drug abusers about the behaviors that put them at risk for AIDS.

Drug abuse workers throughout the country are developing effective, culturally sensitive outreach programs to teach risk reduction techniques, such as the use of bleach for sterilizing needles.

Recently, NIDA began awarding grants to major cities across the country to expand these street outreach programs, modeled after those first developed in San Francisco, Newark, and New York.

In these programs, indigenous people go out on the streets to talk to drug users, prostitutes, and their sexual partners. In addition, nurses make contact with drug users in hospital emergency rooms and detoxification units.

Staff members at shelters for the homeless and for adolescent runaways provide information on the risks of AIDS by IV drug abusers. Finally, teams are trained to reach out to the sexual partners of IV drug users: their homes, churches, clinics, social service agencies, and so forth.

Finally, the criminal justice agencies, probation and parole workers, too, deliver the same strong messages about prevention and risk reduction, so that addicts will be aware of how to avoid infection and transmission.

In the context of outreach, let me mention that NIDA has provided AIDS training to well over 3,000 people who work in the field of drug abuse, and this program continues. As a matter of fact, today we have a training program that is taking place in St. Louis, Missouri, for individuals who are in the field of drug abuse treatment.

Initially we trained counselors and clinic administrators. Now we are concentrating on training trainers

who can, therefore, get to more people who are in the business of providing treatment.

What we have to understand is that drug treatment personnel are tackling a new program when it comes to dealing with the individual who is not only a drug abuser, but who has all the medical complications and the fears of AIDS.

NIDA is also using media messages as tools for prevention and education. Since last fall, we have developed public education materials on AIDS and IV drug abuse. To do this, we conducted market research to be sure that we understood the attitudes and behaviors of drug abusers, and how we could reach them with appropriate AIDS-prevention messages.

The search in New York and San Francisco showed that drug abusers will modify their behavior to reduce their risk of AIDS, despite their dependence on drugs and their involvement with needles as a cult phenomenon.

I have here two of six posters which we have developed for dissemination in areas of high prevalence for IV drug users. The first of these says: Sharing needles can get you more than high; it can get you AIDS. At the bottom, it says: Stop shooting up AIDS; get into drug treatment.

DR. PRIMM: Dr. Schuster?

DR. SCHUSTER: Yes?

DR. PRIMM: Would you just place them sort of in the middle. I think some of the Commissioners can't see them. Thank you.

DR. SCHUSTER: Unfortunately, our easel was much too large for our small posters. The bottom, after some further informational material that is given -- which I will not read, but which you can look at yourselves -- says: Stop shooting up AIDS; get into drug treatment. Call 1-800-662-HELP. That's the NIDA treatment referral hotline number.

The second one says: If you ever shot drugs, get tested before you get pregnant; don't make them the AIDS generation.

I would like to say that we were very pleased to note that in our focus groups that male drug abusers responded to the second one, that dealt with the issue of children, just as positively as women did. We have also some radio ads: one on treatment, and one a rap for young people. If I can spend one minute, I will play one of those for you.

[Whereupon, a series of short tape presentations were held.]

DR. SCHUSTER: These radio and print materials were extensively pre-tested with the target audiences before production, to ensure appropriate language, illustrations, and messages. They will be distributed through state and local drug abuse programs throughout the country, starting in January and February.

To assist these programs in using the materials, and in developing their own, NIDA has been conducting training workshops on methods of reaching the local community with drug abuse and AIDS-prevention messages.

The workshops feature communications approaches to AIDS prevention, the sharing of local resources, the development of coalitions within each community, and the presentation of materials by NIDA, CDC, and the American Red Cross.

An exciting new feature of the workshops is a video tape we just completed this week -- Drugs and AIDS - Getting The Message Out -- which dramatically depicts the communication approaches being used around the country for AIDS prevention.

Unfortunately, this video runs 27 minutes, so I will not play it this morning. However, I would like to say that I have seen it twice in the past day, and it is one you cannot sit through without being profoundly affected. I would recommend, if you would like to see a copy, we think that it is going to be very effective in mobilizing communities.

In all of our media messages, treatment is the centerpiece of our AIDS control strategy. We are convinced that treatment is a cost-effective intervention, not only for decreasing drug use but, thereby, decreasing the spread of AIDS.

Because treatment is generally needed by people who wish to stop using drugs intravenously, it will be necessary for us to expand treatment capacity. This will require effort by all levels of government and the private sectors.

It is not only money, but communities must be persuaded to allow treatment facilities to be established in their neighborhoods. This is a critical problem.

The appropriate mix of treatment modalities for each community must be identified. Programs must be developed, staff must be recruited and trained. And, finally, potential clients must be contacted and engaged in these treatment programs. This is a major undertaking, but the cost of treating a drug user is likely to be lesser compared with the cost of treating an AIDS

victim. Let me state my unequivocal belief, and this is the belief of all those who have reviewed the evidence, that drug abuse treatment does work to prevent the spread of the AIDS virus.

Our research has clearly shown that people in treatment inject drugs far less frequently than those who are not in treatment. Thus, they have fewer opportunities to become infected. More specifically, recent studies have shown lower HIV seroprevalence rates among drug users in treatment, than among those left untreated.

Now, what else do we need to do? Certainly, we must continue our research efforts. Drug abuse is a chronic relapsing disorder. With the present state of our knowledge about effective treatment, most addicts will require, at a minimum, repeated episodes of treatment throughout their life.

We need to improve the efficiency and effectiveness of the currently existing treatment modalities. In addition, however, we need new treatment modalities for all aspects of IV drug abuse. This is particularly critical with the recent epidemic of IV cocaine use.

We have some fairly effective treatment modalities for the treatment of heroin use. Quite frankly, we need a great deal more development before we can really say that we have a handle on the treatment of IV cocaine users. Continued research is essential.

I would like to finally direct my concluding remarks to those areas of the country where the AIDS virus hasn't spread rapidly as yet. It is all too easy to think that it can't happen in one's own backyard. Unfortunately, geography doesn't impress a virus.

Every state in the Union has at least one case of AIDS that is attributable to IV drug abuse. Communities that are lucky enough to have low seroprevalence rates right now should be engaging in prevention and education campaigns to keep those rates down.

We know, on the basis of data on the rapid spread of the AIDS virus amongst IV drug abusers in New York, Newark, and New Jersey, that this is an urgent problem. It can spread from virtually zero or a few IV drug users to over 50 percent of IV drug users in just a couple of years.

Thus, those cities that only have a few IV drug abusers who are currently infected, cannot take heart. They have to realize that can spread very rapidly, so we have an urgent problem.

This seems like a good time for me to turn this discussion over to my colleague, Dr. Haverkos, who will give you some of the detailed epidemiological data about the AIDS virus. Thank you.

DR. PRIMM: Thank you, Dr. Schuster. What we will do is then let Dr. Haverkos go on, and then we will take questions from the Commission after that. Dr. Haverkos?

DR. HAVERKOS: Mr. Chairman and members of the Commission, I will describe the nature and extent of the problem in three parts.

First will be a review of the results of the national surveillance of AIDS cases; second is a discussion of the results of HIV seroprevalence studies among IV drug abusers; and third is a discussion of estimates of the numbers of IV drug abusers in the United States, and the number currently in drug treatment.

Concomitant with the initial case reports of AIDS among homosexual men was a report of pneumocystis carinii pneumonia among men who denied homosexuality, but admitted intravenous drug abuse. Initially, skeptics assumed that those cases were individuals who prostituted themselves to other men to pay for their drugs.

However, as the case reports among intravenous drug abusers continued, and as female IV drug abusers were reported, it became clear that IV drug abuse was a risk factor for AIDS.

Between June of 1981 and December 7 of 1987, 48,139 cases of AIDS were reported to the Centers for Disease Control. At least 27,235 -- or 57 percent -- died. Nationwide, intravenous drug abusers constitute 25 percent of patients with AIDS, or about 11,643.

Heterosexual IV drug abusers account for 17 percent of AIDS cases -- over 8,000. Homosexual or bisexual men who also report intravenous drug abuse account for an additional eight percent of cases -- about 3,600.

AIDS among IV drug abusers is more of a problem among heterosexuals on the East Coast than in the West. In fact, three-quarters of all heterosexual cases among IV drug abusers in the United States are from New York or New Jersey.

To emphasize the geographic distribution of cases among IV drug abusers are the following statistics. In New Jersey, heterosexual IV drug abusers account for 45 percent of all cases in that state. In California, heterosexual IV drug abusers account for only two percent of all cases.

However, AIDS among IV drug abusers is not limited to a few states. As mentioned by Dr. Schuster, all 50 states, Puerto Rico, and the District of Columbia have reported at least one AIDS case among heterosexual IV drug abusers. This indicates that HIV infection has spread rapidly through IV drug abusers in the United States.

The racial distribution of heterosexual IV drug abusers with AIDS is also remarkable. Although Blacks constitute 12 percent of the U.S. population, they constitute 51 percent of heterosexual IV drug users with AIDS.

Similarly, Hispanics make up six percent of the U.S. population, but account for 30 percent of the heterosexual IV drug abusers with AIDS. Minority populations in New York and New Jersey have been hit especially hard by the epidemic among intravenous drug abusers.

The morbidity and mortality of AIDS is not limited to the IV drug abusers, but is shared with sexual partners and children of the infected IV drug abusers. Approximately two-thirds of the U.S.-born AIDS cases attributed to heterosexual contact -- which now totals 1,076 -- have reported sex with an intravenous drug user as their likely means of acquisition.

Approximately two-thirds of the 533 pediatric cases attributed to perinatal transmission in the United States were spread during pregnancy or childbirth of current infants born to from mother to child intravenous drug abusing women, or women who are sexual partners of IV drug abusers. Blacks and Hispanics are over-represented among these groups, both heterosexuals and children with AIDS.

The rate of new cases of AIDS in the United States is increasing rapidly. A year ago, CDC reported 28,000 cases. Therefore, approximately 20,000 new cases were diagnosed and reported in the last year.

That represents 55 new cases diagnosed and reported each day over the last year in the United States. Of these, 14 new cases were found among intravenous drug users each day, and two new heterosexual cases were reported. Every two days brought a new pediatric case.

Unfortunately, we expect these numbers to double again in the next 14 to 16 months, and increase further for several years to come. That increase can be expected because of the long latency period, estimated to be at least five years, from HIV exposure to the development of AIDS. However, the number of AIDS cases do not adequately describe the extent of the problem. The human immunodeficiency virus is transmitted from person to person

through sexual contact, exposure to infected blood and blood products, and prenatally and perinatally from mother to child.

Although sexual spread certainly accounts for some transmission between IV drug abusers, HIV infection is believed to be transmitted among IV drug abusers primarily through sharing of needles and syringes.

Since the vast majority of IV drug abusers share their injection equipment and seldom take adequate steps to sterilize the equipment between uses, the potential for spread of AIDS in this population is considerable.

Because AIDS surveillance only measures the effects of HIV exposure several years ago, many investigators have conducted HIV sero surveys of IV drug abusers. Most of these studies have been conducted on volunteer clients in drug treatment programs in urban areas.

I will not try to review all of the studies, but will concentrate on a few studies and discuss some of the results. The seroprevalence of HIV infection in the population of IV drug abusers increases over time.

This is illustrated by a study conducted by Novick, et al, in New York. They studied heterosexual men and women in New York City who where current or former IV heroin abusers, were on methadone maintenance, and were enrolled in a study of chronic liver disease.

Stored sera from participants were tested for HIV antibody. In 1978, zero of seven sera were positive. In 1979, 14 of 29, or 29 percent, were positive. In 1980, 8 of 18, or 44 percent, were positive. And, in the years 1981 to 1983, 14 of 27 -- or 52 percent -- were positive. In 1984, 56 percent were positive.

More recent studies in New York from several drug treatment centers have reported that HIV seroprevalence is 60 to 65 percent of new admissions in the drug treatment program.

It is not clear how rapidly the uninfected IV drug abusers will become infected. However, one hopes that some individuals entering methadone maintenance programs have stopped using drugs intravenously, are not sexual partners of infected individuals, and will remain uninfected.

Within a city, HIV seroprevalence rates among IV drug users may vary by drug using behavior, race, sexual orientation, and treatment facility. In San Francisco, Chaisson and colleagues studies 281 heterosexual IV drug abusers, in five major opiate addiction treatment programs in 1985.

Ten percent of the subjects were HIV positive. Addicts who reported sharing needles with two or more persons were more likely to be positive than those who did not report sharing needles. Black and Latino participants were more likely to test positive than Whites.

In another study in San Francisco, patients in detoxification programs were less likely to test positive than patients recruited on the streets.

Geographic differences within populations of IV drug abusers in the United States have been noted. Lange, at the Addiction Research Center of NIDA, has collaborated with investigators in six regions of the country, including Dr. Primm.

In 1985 and 1986, 1,770 IV drug abusers were tested for HIV antibody. In New York City, in the areas of Brooklyn and Harlem, 61 percent of 280 samples were HIV positive in late 1986 -- up from 50 percent, of 585 samples from the same treatment program drawn in early 1985.

In Baltimore, 29 percent of 184 samples were positive. In Denver, five percent of 100; in San Antonio, two percent of 106; in Southern California, 1.5 percent of 413; and, in Tampa, none of 102. Seroprevalence rates were significantly higher for Blacks than for Whites.

Continued follow-up and HIV testing of seronegative IV drug abusers should allow investigators to track the spread of HIV infection in IV drug abusers in drug treatment programs. However, these studies do not reach drug abusers who are not in treatment and, therefore, are more likely to practice high risk drug behaviors. Also, these studies do not necessarily test the steady or casual sexual partners or children of IV drug abusers.

Another population study that includes IV drug abusers is women with histories of prostitution. The CDC has conducted HIV sero surveys of prostitutes in seven U.S. cities. Subjects were recruited through venereal disease clinics and community advertisements, such as local newspaper ads.

HIV seroprevalence rates were highest for women who reported intravenous drug abuse, resided in areas of high AIDS prevalence, and were Black or Hispanic. Half of 568 prostitutes who were interviewed and tested for HIV antibody reported a history of intravenous drug abuse.

Forty-seven, or 76 percent, of the 62 HIV seropositive women had used drugs intravenously. Other populations believed to have significant numbers of IV drug abusers -- such as prison

inmates and the homeless -- have not yet been extensively studied.

Because of the surreptitious nature of drug abuse, it is hard to verify the numbers of persons who use drugs intravenously or subcutaneously. NIDA is currently estimating the total number of IV drug abusers in the United States at 1.1 to 1.3 million individuals.

This estimate is based on a number of sources, including published reports on prevalence of drug abuse, data generated by the National Household Survey on Drug Abuse, trends and patterns of drug use by clients admitted to drug abuse treatment programs, and estimates provided by the states.

More than 100,000 intravenous drug abusers each were reported in New York, California, and New Jersey. In fact, 39 percent of the total estimate was from those three states. The lowest estimates, less than 2,000 per state, were reported by six states, primarily in the upper Rocky Mountain region.

How many IV drug abusers are currently in a drug treatment program? The answer to this question is not as readily available as one would like. NIDA estimates that approximately 140,000 IV drug abusers are enrolled in treatment programs. Therefore, one can see that many IV drug abusers are not in treatment.

In summary, AIDS is a serious public health problem for IV drug abusers in the United States. Although AIDS and HIV infection among drug abusers are concentrated in New York, New Jersey, and California, AIDS has been diagnosed and reported among IV drug abusers in all 50 states, Puerto Rico, and the District of Columbia.

It is quite apparent that once HIV is introduced into a group of IV drug abusers, it can spread readily between IV drug abusers, their sexual partners, and their children.

Unfortunately, one can only expect HIV seroprevalence and AIDS cases will continue to increase among IV drug abusers for at least the next several years. Concerted efforts to develop, implement, and evaluate potential prevention strategies among IV drug abusers are urgently needed.

There is much work to be done, and we look forward to working with you toward defining, preventing, and diminishing the serious problem being discussed today. Thank you very much.

DR. PRIMM: Thank you, Dr. Haverkos. I am going to start off the questions with Dr. Schuster. First, I would like to make the statement that I am happy that you shared with us

your public service announcement and that, hopefully, you will give a copy to the Commission so that we can listen to it in our inner sanctum, and certainly see the video tape. We certainly would like to see that.

I would like to talk to you about the cost per year per patient for treatment in IV drug use. You had indicated that it costs far less to treat an IV drug abuser than it does to treat an AIDS patient. That has always been one of the things that I talk about, so that we can expand treatment. Perhaps you would share some of that information with us. What do you think about intravenous cocaine use, which we see in my program in New York as rather rampant? What do you feel about that?

DR. SCHUSTER: We estimate that the average cost per treatment slot per year -- now that is a technical term, meaning that the availability of a treatment place for an individual in a treatment program -- on the average, is about $3,900 per year.

It clearly varies with the type of treatment. For example, methadone maintenance in an individual who is rehabilitated but continues to need to receive the medication of methadone is relatively inexpensive.

On the other hand, a therapeutic community, which is a residential form of treatment in which people may live for as long as 18 months, can cost anywhere upwards of $15,000 to $20,000 per year. So it varies, depending on the treatment modality. Also, it varies to some extent, depending on geography. But the average cost is $3,900 per year.

The issue of cocaine use intravenously is one that we are extremely concerned about. As I said before, I think we have and are developing new techniques for the treatment of heroin addiction. I have mentioned methadone maintenance as being an effective treatment. There are other treatments.

However, in the area of cocaine abuse, this is relatively new, and we do not have large-scale treatment outcome studies which will allow us to say that any particular form of treatment is effective. We are in the process of conducting these, and a major portion of NIDA's research budget is being devoted to the development of treatment procedures for cocaine use and, specifically, for IV cocaine use.

We do have some exciting, new leads. Dr. Herb Kleber at Yale University has demonstrated very clearly now that the use of an antidepressant drug called desipramine markedly decreases the craving which people feel for cocaine, and their actual use of cocaine, after they are discharged from a hospital following a period of detoxification from the drug.

This was a placebo-controlled study. The numbers of subjects are still relatively small, but the evidence is overwhelmingly convincing that this drug is effective in decreasing both craving and actual relapse of the use of cocaine. Clearly this has to be replicated in other treatment centers, but we are very excited about it.

DR. PRIMM: Do you see a relationship between the inhalation of cocaine and the crack use that is out there, with AIDS? I am seeing around the country that people prostitute themselves for the use of cocaine. If you would comment on that, and a little bit about the poly drug abuse that we are seeing among these clients.

DR. SCHUSTER: I think you have made a very important point, Dr. Primm. It is quite clear that anyone who is addicted to a drug, no matter what route of administration they use, may engage in high risk sexual behaviors in order to procure the money to be able to obtain the drug.

Therefore we have found in many cities around the country that prostitutes report they are addicted to smoked cocaine, and they further report that their customers are willing to pay two to three times the amount of money if they do not require them to use condoms.

Their need for money impels them to engage in these higher risk behaviors because of their addiction to cocaine. Further, we also have to say that many drugs may influence behavior in the sense of disinhibition.

We all know that alcohol makes you do some dumb things. Clearly that is true with other drugs as well.

Finally, we are collecting data that indicates that these drugs themselves have profound effects upon the immune system. These direct effects upon the immune system may not only influence the possible probability of infection at the time of coming in contact with the virus, but as well the prognosis of the disease once infection has taken place.

DR. PRIMM: Thank you. I have a couple of questions for Dr. Haverkos, and then we will allow my fellow Commissioners to pose some questions.

Dr. Haverkos, deaths in New York City were underestimated by about 40 percent, as you know. That is secondary to AIDS among intravenous drug abusers. When we had a "look back" with the Medical Examiners Office, we found, instead of 35 percent of the deaths being among intravenous drug users or those who had AIDS attributed to drug abuse, that it was about 53 percent of those persons who died in New York City.

If we had a "look back" in other cities of this nation, what do you feel would be the result in relationship to the increased number of deaths, the underestimation of deaths among IV drug users secondary to infection with HIV?

You also mentioned needle and syringes as a vector for the transmission of HIV among IV drug abusers. You did not mention the cooker, nor did you mention the little sterile cotton ball that you always hear me talk about.

I would like for you to comment on those as possible vectors. In Chaisson's study, the San Francisco study, where he looked at needle sharing among intravenous drug users, if they shared with two or more persons, they were more likely to be infected.

You also stated that Blacks and Latinos were more likely to test positive. Were they more likely to test positive in the needle sharing study, or more likely to test positive in San Francisco?

I need to clear that up, because we found that Blacks and Latinos in New York did not share needles, though you indicated that geographically there was some differences in behavior among IV drug users.

Then what are we doing in the cities and the states that report less, or a low incidence, of infection among intravenous drug users? What are we doing to keep that down? What are they doing that we could export to other cities, where we have a high incidence?

DR. HAVERKOS: I am glad I wrote all your questions down.

[Laughter.]

DR. HAVERKOS: I think the first one, dealing with the question of under-reporting and some of the more recent statistics coming out of New York: two comments. One, clearly the number of cases of AIDS reported to the Centers for Disease Control is not a total count.

People have recognized that, I think, from the very beginning. AIDS can be a tough diagnosis to make. Early on in the epidemic many people died before appropriate studies were done, and therefore were not counted. The Centers for Disease Control has tried to alter the case definition again, and hopefully will pick up some of those cases that don't have all the criteria that were required before this.

Even using the rigid criteria, in 1984 I think, New York City went back and looked at their pathology reports in the hospitals, in 15 hospitals in New York that reported the largest number of cases. Clearly, hospitals that were compliant and interested in reporting disease -- and even within those hospitals, there was only about 90 percent reporting. About 10 percent of the cases in the hospitals that had actively set up a surveillance system and had a track record of reporting to the Centers for Disease Control, the numbers were less than the true numbers.

The study you referred to, looking at all deaths in New York City, reported by Stoneburner, et al, one has to be careful with, for the following reasons. We do know that IV drug abusers and other drug abusers die from other causes. They do die from pneumonia and other diseases that possibly could be related to AIDS, but also we know that are not related to AIDS. Many of the deaths in that study did not have confirmation by any HIV testing.

I think clearly some of those cases were, indeed, AIDS that were not looked for. But one must realize that IV drug abusers have about a nine-fold rate of death, compared to the general population, from diseases even prior to the AIDS epidemic.

But I think your point is well taken. There is under-reporting, and IV drug abusers may be a group that may not come to medical attention for AIDS as much as some other groups.

Your next questions dealing with the transmission vectors -- needles, syringes, cookers, cotton balls, et cetera -- is difficult. I cannot cite any specific studies that can address each of those issues. But we do know that this virus is carried in blood and body fluids, is generally more readily transmitted when it comes in contacts with cuts.

So cotton balls and cookers and areas that would contain blood or body fluids, and then put back on a site of injection where the skin is broken, are likely to be vectors of transmission in some cases. Again, how often, how many, is very difficult for me to quantify at this time.

Chaisson's study in San Francisco, in trying to tease out the difference in rates of infection -- are the Black and Latinos higher rates due to more needle sharing or other factors -- I must admit, I have not seen, that breakdown. I do not know what the percent or the amount of needle sharing is by race, and is that correlated with needle sharing. I could surely provide you with the paper of Chaisson, which I am sure you have seen, and surely contact him and get back to you if we can get that breakdown.

Finally, your last question -- dealing with why are some areas less, and what is happening in those areas where the seroprevalence rates are low -- I think is a major concern.

Many people in states in the Midwest, and the Upper Rocky Mountain areas in the south that only have a couple of cases of IV drug abusers, I don't feel are concerned enough about this problem. They hear about it in New York, in New Jersey, but they have not yet rallied to concern about this disease as I would like them -- and, I am sure, as you would like them -- to do.

We, at NIDA, are trying to educate those groups and work with you in the President's Commission to make this problem known to individuals in those states that can do something to educate the IV drug abusers.

As Dr. Schuster mentioned, we are conducting today an education workshop for drug abuse counselors and trainers in St. Louis, Missouri. We are trying to reach those groups. But, as you well know, some people only hear what they want to hear, or are only concerned when the problem is right next door. It is not yet right next door in St. Louis, Missouri, and other places. But unfortunately it may be, in the future.

One other comment, though, on why some areas are more at risk than other areas; why the East Coast versus the West Coast, for example, and why not the central areas where, as you point out, the rates of needle sharing are reported to be higher than they are in New York City among IV drug abusers. Some of those might be due to the shooting galleries, or the readily-available places in some parts of the country where people come in contact with more individuals and share needles, syringes, cotton balls, and cookers more commonly in those types of environments than in some other parts of the country, where drug abuse is done in home settings or where there is less contact with as many people. Hopefully, I have answered your questions.

DR. PRIMM: Thank you very much Commissioners. Dr. Walsh.

DR. WALSH: Dr. Schuster, your report was sobering and discouraging in a sense because of the enormity of the problem with which we are faced. I have just a few questions, but one that I would like to ask is, given the mental attitude of despair for the average IV drug user, does the relation of the threat of AIDS to IV drug abuse really mean anything to him? Is he reachable by any approach that -- because AIDS is fatal, in view of the fact that he knows, too, that he has a nine times better chance of dying?

DR. SCHUSTER: We are often asked the question of whether or not IV drug abusers -- who, of course, every time they put a needle into their arm are putting in a substance of unknown purity, unknown quantity, they are risking death every time they take an injection -- whether or not they are truly afraid of AIDS. I think every bit of our evidence indicates that a large proportion of IV drug abusers are in fact concerned about AIDS; concerned enough so that in San Francisco, for example, where they have indigenous workers who go out and give them small bottles of bleach to disinfect their syringes with, that the addicts report that they take them and that they use them.

Secondly, I think we have to emphasize with them that AIDS is a very slow and a very ugly and painful death. It doesn't have the machismo of dying of an overdose. It doesn't have the instantaneous properties that most IV drug users are willing to risk. It is a lingering, slow, painful death. And as a matter of fact, some of our materials, not included in these that I have shown you, actually emphasize that aspect of it, because we hope in that way to differentiate it from the kind of risk-taking behavior that they are willing to take with their intravenous drugs.

DR. WALSH: Well, once infected, or once aware that they are seropositive have you been able to notice whether there is any modification of their sexual habits?

DR. SCHUSTER: I think that we really don't have enough evidence to be able to say at this point in time. Clearly this is a major problem. In the film that I spoke to you about, we actually show a street worker who is out trying to tell some young Hispanic kids that they should be using condoms, and one of the kids says, "I'll give it to you straight, there ain't no way I'm going to use a condom, absolutely no way," and he walks away. Unfortunately, this is all too often the attitude which we encounter, both amongst IV drug abusers and amongst many young people in those communities.

DR. WALSH: How much of your preventive efforts can be or is directed towards what I call the next generation of drug users, the adolescent who is experimenting with drugs and who may be an occasional IV drug user? Is he more reachable, or again are you able to devote much time to that group?

DR. SCHUSTER: Well, we believe that this is the best population to work with. Clearly they are not addicted at the present time, and as a consequence their drug use is still at that phase where it can be stopped more readily.

Secondly, we know that if we can get to them before they're school drop-outs that the chances of really full-scale rehabilitation and major life changes are possible.

One of the things that we are emphasizing in our research at NIDA is looking for children who are specifically at risk for later drug-using behavior. We have studies now that indicate that we can identify children as early as the first grade who have two and a half to three times the probability of becoming drug users when they are adolescents. I'm not saying necessarily IV drug abusers, but just drug abusers in general.

What we do know is that if they start using alcohol early, they begin to use tobacco early, they begin to use marijuana early, that the probability that they are going to go on to using cocaine and using other drugs, both intranasally and intravenously, is much greater.

So we are emphasizing stopping this way back there at the beginning. Many of us feel that if we could delay the age at which children experiment with drugs, such as alcohol and tobacco, if we could delay that three to five years and get them through that period of time when they have to experiment with life in general, it would have a major impact and they would not go on then to using harder drugs.

DR. WALSH: That's why with the changing percentage of incidents and the drug abuse population and so on, it just occurred to me that one of the best ways of preventing AIDS therefore may well be to concentrate initially more on prevention of drug abuse, than AIDS.

My last question, which is a simple one, is in the briefing material we have, we were made aware of a variety of agencies of government that are involved in drug abuse programs. Is that coordinated by your office, or is there a lack of coordination?

DR. SCHUSTER: Let me very briefly tell you about the National Drug Policy Board which is, of course, chaired by the Attorney General and the Vice Chairman is Secretary Bowen of HHS. This is the Cabinet level group which is responsible for coordinating all activities in regard to drug abuse, both supply side reduction involving Customs, the DEA, FBI, and Coast Guard, et cetera, as well as demand side reduction, which involves HHS, the Department of Education, and so forth.

One of the interesting things is that every single one of the 33 agencies that are involved in the area of drug abuse have, as one of their components, a prevention program. So the FBI has a prevention program in which it sends FBI agents out to schools. DEA has a high school coach's program. Everybody is involved in a variety of ways in this. Not just in their specialty, but all of them have prevention programs.

DR. PRIMM: Thank you, Dr. Schuster. Dr. Crenshaw?

DR. CRENSHAW: I would like to ask you to elaborate, on the sexual transmission and sexual practices of IV drug abusers; if there have been any studies done. If so, could you elaborate on them? I think that the shared needle form of transmission in the drug abuse population gets the most attention. But underneath that you raise, a very important issue, which is that substance abuse of any kind impairs judgment and some can induce hypersexuality among some individuals, or simply impair judgment. The other layer that is less obvious is how the IV drug abusing population becomes a bridge to non-IV drug users? What can you tell us specifically?

DR. HAVERKOS: The sexual transmission question is a very important one, and is being addressed by a few studies underway in the United States. Many of them are just getting started, so that we don't have a lot of results.

However, there is one study that's been going on for quite a while in New York City, in the Bronx, conducted by Montefiore. They have been testing and following sexual partners, and they define a sexual partner, for purposes of the study as one who has had at least 10 sexual encounters with the indexed individual, an IV drug abuser with AIDS or with HIV infection, and follows them over time.

What they have found is that there is quite a significant rate of infection over time. I don't recall the exact numbers, but it's in the range of 30 to 40 percent of these female or male partners are infected, and the rates are fairly comparable. If they're a male partner who is a nonintravenous drug-using sexual partner of a female with AIDS or HIV infection, or vice versa, though the number of male partners is much smaller than the number of female partners studied.

As far as the specific acts, the receptive anal intercourse variable comes out as more prevalent, but surely not the only variable. And only about, 15 or 20 percent of the women have ever practiced that activity with those male partners, and their rates are somewhat higher than the females who have not. But clearly the females who have never practiced that act were also infected at a significant rate.

DR. SCHUSTER: I would just say that it is simply a fact that we have not studied sexual behavior of normals for a number of years. Some people have said really since the classic study of the Kinsey Reports, we have done very little. And further, we are really now just beginning to study the sexual behaviors of these subpopulations such as drug users. We don't have nearly the information we need.

DR. CRENSHAW: Have you gotten far enough to address whether or not it's a myth that individuals who are abusing drugs are too busy with their drugs to be very active sexually? I think that's a prevailing view.

DR. SCHUSTER: I can only say to you that the coexistence of prostitution and drug use indicates that there is widespread promiscuity via that mechanism. And further, in my clinical experience, even with people maintained on relatively high dosages of methadone, they reported after coming into treatment and no longer being on the street, that they were engaging in sex more frequently than they had been when they were actually scuffling, getting the money for drugs.

So there may be some decreased sexual activity because of drug use, but there's still a lot of it going on.

DR. CRENSHAW: Thank you.

DR. HAVERKOS: I think clearly the numbers of cases attributed to sex with IV drug users with AIDS and the pediatric cases really belies that myth; that clearly there is sexual spread.

Your other question dealt with, what about tertiary spread or spread from sexual partners of IV drug users who do not use IV drugs to others? And this is a tough area, and we don't have a whole lot of data at this point, but there clearly are a number of anecdotes of individuals acquiring the disease who are not sexual partners of IV drug abusers, but are sexual partners of their sexual partners.

And also there is a whole group of patients at the CDC listed in the "undetermined" group who don't report sex with a known AIDS case or a known high risk group member, which is what is required to make it into the heterosexual category. There are a number of individuals who report sex with prostitutes, report large numbers of heterosexual contacts, or prostitutes themselves who deny intravenous drug abuse, but are not listed as heterosexual cases by the classification system at the CDC that are very likely to have been heterosexual cases like you have mentioned. You are right, this group has not received much attention, but I think the anecdotal stories in a number of these cases suggest that it occurs. And if one understands the biology of a viral sexually transmitted disease, it is very unlikely that a virus is going to stop at a certain point during the sexual sequence.

DR. CRENSHAW: I hope you will keep us advised as your study progresses, because I think the data you are collecting is, as you said, Dr. Schuster, very, very late in our culture to

gather, and without baselines for normal could be critical information that will help to guide us.

DR. PRIMM: Mrs. Gebbie?

MRS. GEBBIE: A set of related questions for either of you on the subject of waiting lists for treatment. That was mentioned, but not elaborated upon. I would like you to comment upon the length of the waiting period, either average or the range, because I know it's different around the country. What is the dropout rate of people who get on a waiting list who then get lost because they can't get in? Do you have any information on that? And then is the currently planned increase in treatment slots sufficient to reduce or eliminate that waiting list problem anywhere or in some places?

DR. SCHUSTER: Well, the issue of the waiting list is a complicated one. First of all, as I said before, there is a recent Conference of Mayors Report entitled something like the "Impact of the 1986 Anti-Drug Abuse Legislation A Year Later", and in that they state that three out of four cities reported that they had waiting lists for the publicly-funded drug treatment programs. The average was seven weeks. But there were cities which reported as long as a 28 week waiting list.

When you realize that a heroin user is probably going to be injecting themselves three to five times a day with heroin, even seven weeks means that there's hundreds of additional exposures in which they are running the risk of either spreading the AIDS virus or contracting it themselves.

So it's a significant waiting list time. But if you really dig beneath the waiting list, I can tell you that waiting lists in a sense are almost meaningless. Drug abusers are not people who deal well with delay of gratification, and therefore the word goes out, "There's a waiting list." Nobody bothers to come to sign up. We know this on the basis of studies which I conducted before I joined the government in Chicago, where if we went out into the community, into the copping areas and said, "Hey, would you like to get in treatment right now," many people would say yes and would sign up instantaneously on the spot. And those people, the outcome for them was as good as for those who had come and stayed on the waiting list.

The waiting list dropout rate, I cannot give you. I can tell you that we, in an effort to get an estimate of the national figure for a waiting list, called a lot of cities. The city of Chicago, which has a central referral unit, said, "Well, frankly, a waiting list doesn't mean much, because if people call and want to get on it, we tell them to call back in a couple of weeks, because there's not much point in even putting your name on it right now." So it is not very meaningful.

MRS. GEBBIE: But it is clearly a problem?

DR. SCHUSTER: Clearly a problem, yes. Let me just say one other thing. The $160 million which was given to the states by the 1986 Anti-Drug Abuse Act to enhance treatment capacity, we must remember that the federal government is only one step in the chain of getting that money down to treatment programs. Currently I think it is only 16 percent of those dollars that have been drawn by the states. They have been available by the federal government for a long time, but only 16 percent of them have actually been drawn down by the states.

Now there's reasons for this, but it nonetheless points to the fact that no matter how many dollars we give today, it will be eight to 12 to 14 months before it actually gets out there to the treatment programs that are so badly in need of it.

DR. PRIMM: Thank you, Dr. Schuster. Dr. -- Mr. DeVos?

MR. DeVOS: Nice try. I appreciate the help.

[Laughter.]

MR. DeVOS: Since you obviously are experts in this field and have been at it for many, many years, and you are dealing with behavior modification, just a quick answer: What are your success ratios on getting it done?

DR. SCHUSTER: If we are talking about treatment?

MR. DeVOS: I am talking about treatment. You know, you're working with people. Both of these involve complicated issues of behavior modification. How are you doing at it and what do you do that could apply?

DR. SCHUSTER: Well, let me put it this way: We're doing a heck of a lot better than surgery for lung cancer, which has a 7 percent cure rate, and it varies all over the place, but I would say this:

Every study that I know of that has been done shows that treatment is more effective than nontreatment. Now that may not be a satisfactory answer, but that's probably the best answer I can give you. We are talking about methadone maintenance programs. We have many, many studies which indicate that within two weeks after people enter methadone maintenance, there is an 80 percent drop in their use of illicit opiates. We also know that about 55 to 85 percent, depending upon the program, are retained in that program for a year. So that's pretty good.

When you go to therapeutic communities, the picture varies. For those people that stay for any significant period of time, the outcome measures are very good. Unfortunately, therapeutic communities have a very high dropout rate in the first couple weeks. So it's a complicated picture, but I can say to you that treatment is better than no treatment, and all of our estimates of cost-effectiveness indicate even pre-AIDS that it was cost-effective.

MR. DeVOS: I see things like "Teen Challenge" programs, because of the spiritual impact is there a measurable improvement in all of this? Do they do better than you do?

DR. SCHUSTER: Well, you know, actually we recommend those kinds of programs for appropriate clientele. I think the main thing that we have to improve upon is being able to have a triaging system to link appropriate clients to appropriate treatment. Because it is clear that people, many people, will not be helped by that, they will drop out of it. Others find it very effective.

MR. DeVOS: Just a quick follow-up. What percentage of people on drugs even try for treatment? Do you have any idea?

DR. HAVERKOS: If you take the proportions of numbers we have here, 140,000 IV drug users in treatment and divide that by our estimate of IV drug users in the country -- now that includes both people who are addicted to drugs and are presumably using it three or four times a day, and those who may use it only sporadically, or estimates of using it at least once in the last year, but there you can see the numbers are 10 percent.

MR. DeVOS: I appreciate the frustration you deal with, because you only get 10 percent who even try, and then out of that some are unsuccessful, it's frustrating. It's just a terrible task.

DR. SCHUSTER: I just want to say that 10 percent are in treatment at any one time. We know that most people who enter treatment have entered treatment two to three times previously. And the interesting thing is that success sometimes comes only after two or three flirtations with treatment, if I can put it that way. They come in, they back off, they come in, they back off, and finally we get a long period of drug-free behavior.

MR. DeVOS: It just brings you back to the fact you've got to keep them from getting on it in the first place. When all is said and done, you've got to cut it off at the pass.

DR. PRIMM: I think what we have to remember here, that addiction is a chronic disease entity. We must treat it

chronically also, and one-shot treatment deals are not always effective. It might take 10. Dr. SerVaas?

DR. SerVAAS: Thank you. My questions are to Dr. Schuster, and I liked what you said about communities that are lucky enough to have low sero prevalence rates right now should be engaging in prevention campaigns to keep those rates down.

I wonder if you could tell us, do you have any innovative, new ideas for effective prevention programs that legislative bodies such as the city/county council of Indianapolis, where we have low seroprevalence, might try immediately something new?

Are there any low risk cities doing model programs with some innovative, new things to keep the risk low? And do you have any idea about what is being done with the media for reaching school children, the programs such as the First Lady's "Just Say No" program? How effective are the health publications that are going into the schools and going into the private homes in getting the drug message to kids?

DR. SCHUSTER: Well, I think we have to differentiate between two types of prevention. One was already mentioned, and that is what I will call primary prevention, to try and prevent children from ever becoming involved with drugs.

The statistics we have now from our high school senior survey and from our household survey indicates that there is progress there. For example, in 1979 or 1980, the daily use of marijuana amongst high school students was almost 11 percent. This was high school seniors, 11 out of 100 were smoking marijuana daily. In 1986, a high school senior survey showed only 4 percent. And in all areas, with the exception of cocaine, we have seen a significant decrease in drug-using behavior in both our household survey and our high school senior survey.

So I think the programs and concerns such as the First Lady's "Just Say No" program, which in a sense is really -- and I think she would certainly agree with this -- very symptomatic of the fact that communities out there are saying we've had it, and she is providing national focus and leadership, but it's really the communities that are doing this, that we are having a positive impact on the number of children that are beginning to use drugs.

The issue of innovative prevention programs, I can only say that we do prevention research, and we are attempting all the time to upgrade and improve upon the kinds of prevention interventions that we have for primary prevention. A lot of it

is based upon a peer pressure model. That's how kids get started with drugs. How can you teach them to say no? How can you give them socially acceptable reasons for saying no to their peers, so that they don't feel that they are no longer going to have any friends and are going to be part of the gang?

We have a variety of strategies which we feel are working there. But the second issue, really, in terms of prevention is what do you do about people who are using IV drugs to prevent them from becoming seropositive with the HIV? And there I think that we are really just beginning, but we do have some innovative programs around the country. We are beginning now to get out our AIDS prevention messages. These are not designed for just mass publication. These are designed to go into high risk areas. These are designed to be put onto radio programs or radio stations that exist in high risk areas, where there are known IV drug abusers.

We have an estimate of how many drug abusers there are in your city. I don't know offhand, but we have an estimate of that. There are significant numbers there, I am sure. We want to intervene and teach them that they can't continue to use IV drugs, they can't continue to share needles, they can't continue to not sterilize them.

Our first message is get into treatment. But if we are going to have that as our first message, we have to ensure that there's treatment capacity there for them to be absorbed into. And secondly, we have to teach them that if they're going to continue to take drugs, they've got to stop sharing their syringes and needles and works, and if they do share them, they've got to sterilize them.

Now there are innovative programs such as those in San Francisco, where they actually have what they call CHOWs, which are community health outreach workers, these are indigenous workers who go out, talking to the IV drug users in their copping areas and saying, "Look, you know, household bleach will be effective."

DR. SerVAAS: Could I tell you, Purdue University, a lot of squares -- Rich DeVos' son graduated there -- well, a lot of straight kids at Purdue University. We had a graduate engineer there who played with drugs five years ago, just played with IV drugs. He married, his wife got AIDS, got pregnant and died, and in the meantime he had gotten her sister pregnant and she now also has AIDS.

Now how can we in a low risk area -- Purdue University, very low risk -- how can we prevent this kind of spread where we now have two women with AIDS and an AIDS carrier who didn't know he had contracted AIDS five years ago? Do you have a program?

DR. SCHUSTER: Well, we certainly do in the sense that we are providing educational materials which we would hope you can ensure get onto your local television, radio stations, because information and education is the only key to that. I think this person that you have described, if they had known the potential for their becoming contaminated with the AIDS virus at that period of time, would have thought twice about flirting with IV drugs. Now that is not true everywhere. I mean there are obviously communities where it's such an indigenous problem that it's almost the norm for people to flirt with IV drugs in certain areas in our country. It's a fact. But your situation is different. I think we really can have a major impact there, but we've got to get out ahead of it with educational materials.

The National Institute on Drug Abuse, the Centers for Disease Control, many of these people have excellent educational materials. In addition, we provide technical assistance to local groups to teach them how to organize. This is one of the things that I mentioned in my talk that we do have a community organizational technical assistance program to train people how do you get communications out about AIDS. And we are happy to provide that. That's what we are in the business of doing.

DR. PRIMM: Dr. Lee?

DR. LEE: Dr. Schuster, nice to see you again, and Dr. Haverkos, those statistics, I'm sure, will be an important part of our deliberations on the final report. They are very important. Two questions:

One, the pediatric AIDS. Admiral Watkins gave us some figures of 10,000 to 20,000 cases of pediatric AIDS cases by 1991. Now that's published -- this is from the National Commission to Prevent Infant Mortality. And when I see figures like that, which I have seen before, I can't extrapolate those figures from the 500 or 600 cases we are currently seeing. How do we really translate that to 20,000 in '91?

DR. HAVERKOS: Pediatric AIDS is an entity that is again rigidly defined. I think one of the problems is defining what we mean by the disease, and there are figures of people with opportunistic infections and life-threatening diseases that have died or are in the process of dying that have been reported to CDC, and those are the numbers that I have given you, where there are several hundred kids around the country.

Now the total number that's infected and carrying the virus is many times that. We don't have good estimates because of the lack of the ability to do extensive compilation based studies to know how many children are infected. But if one looks at some of the few studies that have been done, for example, in

Brooklyn, at Downstate, screening all the mothers that come in, about 2 percent are positive.

So again you have to be careful, what are the numbers of infected and the numbers with disease. With most infectious diseases, not everyone that's infected goes on to develop disease. We don't know whether that will be the case or not, or how long it will take for some individuals infected to develop disease significant enough to develop AIDS. I think the bottom line, these numbers are difficult to interpret because they define different things.

DR. LEE: Well, could I get from either one of you what you think the real number is? Now we're testing; obviously any baby that is born with an HIV positive mother gets a test. What is the real figure?

DR. HAVERKOS: Well, that's not true. We're not testing every mother in the country for HIV. We are testing mothers in certain populations, in research studies, or in community studies, and finding significant rates in Massachusetts and areas in New York City.

Clearly there are children infected in other parts of the country. There are children, for example, of the two women in Indiana that were mentioned. They clearly would need to be tested.

DR. LEE: So you would say that 10 to 20,000 is a possible number?

DR. HAVERKOS: That's a possible. I'd have to sit down and look and see how that number was derived, but as far as the number of infected children today in the country, that's a possible number. How many of them will go on to develop the significant disease termed AIDS and death, is another question that, of course, will require time and follow-up.

DR. LEE: Now one other question related to that. You said two-thirds of the pediatric AIDS cases are drug-related cases. Where do the other one-third come from?

DR. HAVERKOS: Two-thirds of the perinatal spread, from mother to child, is related to IV drug abuse. And they make up roughly 80 percent, I think, of the total number of cases of children. The other 20 percent that are not from mother to child are related to blood transfusions and are hemophiliacs. Those make up 20 percent of the kids.

Of those 80 percent of the kids that are mother to child, about 70 percent, its mother is an IV drug user or sexual partner of an IV drug user. The other remaining 30 percent of

the 80 percent, or about 25 percent of the children, are children whose mother is a sexual partner of a bisexual man or a sexual partner of a hemophiliac or blood transfusion recipient, et cetera.

DR. LEE: I would like to finish up, instead of starting off, with a brief statement, and that is this has interested me above any other subject, as we have gotten into the AIDS maze here. When we heard the incidence statistics here just last week, it appears that the relative incidence among gays is cresting, yet the curve is going up, and this is drug-related activity, and when I talked to Dr. McDonald, and I listened to Mr. DeVos, and I listened to the interest Admiral Watkins had within the educational process, I have to come to the conclusion that the answer really is in the demand part of the quotient, and the government doesn't seem to be able to do it. Society is going to have to cure itself, if one out of 10 people are taking drugs in this country, and it is my hope that our commission will be able to make some excellent recommendations in this regard.

A last comment. Victimless crime. I have been really changed by listening to what I hear on this commission. Prostitution, male or female, pornography, and the rest of it is not victimless crime. It is absolutely tragic in every sense of the word.

DR. PRIMM: Thank you, Dr. Lee. Chairman Watkins?

CHAIRMAN WATKIKNS: We do not have time for you to answer these, Dr. Schuster, but I would like to put them on the record, and if you would send us the material you were willing to share with us, I'd like it to come with a forwarding letter that either answers these questions, if you would, please, or if it's contained in the report, just note that.

How much would it cost to make treatment on demand for drug abusers available in the U.S.?

How should this cost be shared between federal, state, local, and private entities; a conceptual framework, if you will?

How long would it take to build the infrastructure nationally to provide such treatment? And I don't want bureaucratic barriers to get in your way; however, I would like you to identify those. If, in fact, you said, we could go faster were it not for this kind of provision under the law or some other kind of obstacle, that would be helpful.

Of the additional treatment money that was allotted in the Anti-Drug Abuse Act, how much is currently being spent by the states? You alluded a little bit to that.

Are the states reluctant to spend the money because there is no assurance that if they build up their infrastructure, there will be follow-on money? I'd like you to address that.

And then finally, I would like you to give us some feel for an amortization concept. Every time we talk about money, we get frightened away, we pass a bill here on the Hill or, we end up the next year not allotting any money to it. The image is that we're doing something; the substance is that we're not. And sometimes I think it's because we don't put an amortization regime in it with prevention vis-a-vis remediation as the goal. And it seems to me when you come up with something like $3900 a year per drug treatment slot, and you compare that to $11,000 per year to keep one drug abuser whose been convicted of a felony in jail, it seems to me that for one-third of a year, you can amortize the payment.

We know we have to have up front investment, but I've seen very few financial plans laid out that sends the Government a signal that we can amortize by going towards prevention and give some hope that we're not in the financial swamp forever if we get on with a variety of these programs.

And I think until we do that, when we put a tag on every one of these things, we frighten everybody out of the business.

But at least give us some kind of a feel for what other kinds of offsets you would get from a very aggressive national drug treatment program where we set our sites over the next several years to get this thing on track, so when people do call for help, they can get help.

And we've certainly seen it out there with the people that have made presentations to this Commission. So that input from NIDA would be very valuable to us. We have committed ourselves to a statement on this issue to the President in February, and we want to follow up on that, because we feel the sense of urgency on this whole issue is probably as high on this Commission as any of the other topics we are going to address.

So, thank you very much. I'll have one of the staff people give you these questions to make sure you have them, and we'd like you to come back just as soon as you feel comfortable with it, but we'd like to have it as soon as possible. Thank you very much, both of you, for coming.

DR. PRIMM: Thank you, Dr. Schuster and Dr. Haverkos. We'd like to call the second panel now. How are you, Ms. Serrano, Dr. Morales? Dr. Tuckson will be arriving a little late, so, Ms. Serrano, you have the opportunity to go first and to really open up things for this panel, which is "The Impact of

the Human Immunodeficiency Virus on Minorities." Ms. Yolanda Serrano.

PANEL 2 - IMPACT OF HIV ON MINORITIES

MS. SERRANO: Good morning. I am very pleased to be part of this hearing today to provide the Commission with firsthand, front line experience of the impact of AIDS on the minority community.

The Association for Drug Abuse Prevention and Treatment is a non-profit organization dealing with the impact of AIDS among minority communities through front line, grassroots, face-to-face education.

Acquired Immunodeficiency Syndrome has come to represent one of the biggest afflictions of modern time with tremendous individual and social costs. The group suffering the most profound consequences of and at greatest risk for AIDS are ethnic minorities with the lowest national incomes, limited health care knowledge, and the poorest access to health care. Historically, minorities had limited access to quality health care, primarily due to economic factors.

A minority person who develops AIDS might suffer from impaired health before the disease and might delay treatment until later in the progression of the disease. Minorities do not have private medical doctors, and they rely on hospital emergency rooms for medical care. Many persons with AIDS are neither diagnosed nor treated for AIDS-related conditions until the disease is too advanced. Many IV drug users are dying in the ARC stages.

Blacks, who comprise 12 percent of the United States' population account for 51 percent of the AIDS cases. Hispanics, who account for 6 percent of the population, account for 30 percent of the AIDS cases. 78 percent of all children with AIDS are minorities. Women with AIDS, 52 percent are black, and 19 percent are Hispanic.

AIDS is spreading at a fast rate in urban minority populations due to the disease of addiction. Dr. Primm adequately described that it is a disease which is progressive, chronic, and if left untreated fatal. Not only IV drug users, but all substance abusers, are at risk, and that is a correct statement.

Compounding the disease of addiction is HIV infection, so the addict has to deal not only with the disease of addiction but with HIV infection also. The minority communities are the most vulnerable to the spread of AIDS due to the high incidence of IV drug use. In New York City, infection rates among IV drug

users have increased and 53 percent of all AIDS related deaths attributed to IV drug use.

The consequences of the spread of infection among minorities extends beyond the drug user to their children and to their sexual partners. The course of the epidemic is being determined by IV drug users. Our Commissioner from New York City, Stephen Joseph, has made that statement. As it stands now, AIDS, intravenous drug use, and minority communities are linked. There is no separating them.

In New York City, there are an estimated quarter of a million IV drug users. It is estimated that between 70 to 80 percent of the IV drug users are infected with the virus already. Of the 1200 women with AIDS in New York City, 80 percent are IV drug users or have had sex with an intravenous drug user. Also 80 percent of the 235 children with AIDS in New York contracted AIDS through their mothers, who were IV drug users or had sex with IV drug users. More than 85 percent of the city's IV drug users are black or Hispanic. Black and Hispanic children account for 93 percent of the children with AIDS in New York City.

Nationally, 27 percent of AIDS cases reported in the United States are in New York, even though New York accounts for only 3 percent of the country's population. In Connecticut, black and Hispanic people make up 11 percent of the state's population, but 48.5 percent of the AIDS cases. As you can see, drastic differences arise in the social distribution of AIDS.

Women of color and their children are impacted by this disease. Women are the fastest growing group of people with AIDS. In New York, 55 percent or 665 women with AIDS are black. 32 percent or 414 are Hispanic. Women who are IV drug users account for 52 percent -- 52 percent are black, and 32 percent are Hispanic. Women with sexual partners, men at risk, account for 42 percent who are black and 42 percent who are Hispanic.

The number of children with AIDS continues to double every eight to nine months in New York. Over 90 percent of those infected are of color.

The New York City Department of Health estimates that there are approximately 50,000 to 60,000 women in New York City of childbearing age who are already infected with HIV, and in 1987 alone, some 3000 of these women will give birth. The chances of these babies being born with AIDS is very high.

Women who are prostitutes and are IV drug users are at extreme risk for AIDS. Our organization is working with the prostitutes. We go on the stroll with them; we give them condoms; we get them off the streets; we place them in treatment through our outreach intervention.

The incidence of AIDS and AIDS-related disease among persons who come in contact with the criminal justice system in New York is increasing. As of April '87, a total of 401 persons have died from AIDS. The vast majority of them have been IV drug users; 39 percent were black and 46 percent were Hispanic.

We also work with the inmate population in the City of New York with AIDS, and we provide outreach services to get them into drug treatment programs before they are released. We offer them jobs. They become speakers for our organization. So we are trying to keep track of them, and we're with them at their time of death, so we follow them very closely, so that they do not revert back to drug abuse and possibly infect someone else.

Prevention for minority communities for the future, ADAPT believes, must be basically grassroots. We need to get out to the streets and on a one-to-one basis educate the community. Many people in our community have a language problem. Information must be simple, culturally sensitive, and to the point.

We must provide every addicted person drug treatment. The fact is, as you've heard before, if an addict applies for treatment today, he will be placed on a waiting list, some as long as six months. There is an urgent need for Washington to hear and know that treatment drug programs equal life in the 1980s. It is a matter of life and death, not only for the IV drug user, but for his sexual partner and his children.

There are thousands in New York City, thousands of minority people -- women, men, and children -- living in single-room occupancies, welfare hotels, at the local YMCA, facing uncertain futures, dying in isolation, abandoned, starving many times, dying an undignified, painful death because of the lack of services to this population.

In conclusion, in the minority community, there has been neglect, and the result is that these communities are devastated by illness and death. I can testify to you here today that there are hundreds of neighborhoods where the virus is spreading like wildfire with no one realizing how it is slowly traveling and invading all segments of our society.

It is a real threat that this virus can become self-sustaining in the heterosexual community if we do not immediately provide the necessary funds and resources to curb this virus. It is too late, no matter what we do now, for those with AIDS, those who will develop AIDS, and children who will be born within the next few years with AIDS. Through ADAPT's work in the streets and in the shooting galleries, in the prisons of New York City, we really know and see the danger that lurks. ADAPT has seen the

tremendous concern and interest of IV drug users in protecting themselves and their families. I have seen some heroic efforts to make a change in their behavior. It is sad, it is too late for most of New York City's and other major cities' IV drug users. I have seen women facing death and wanting to protect their children. Again, it is too late, due to the lack of information and awareness of how to protect themselves. It is too little too late for many.

I spent many days in New York City's shooting galleries giving bleach, alcohol, condoms, education, and referring people -- taking people out of these shooting galleries, where I am able to witness firsthand the devastation of addiction and the slow destruction of our minority community. We need more weapons to fight AIDS, more resources.

Addicts can change their behavior. My organization is proof of this. Most of our members are recovered IV drug users, who are lawyers, who are social workers, who are nurses. The stigma of who the IV drug user is has to be looked at carefully. It's not the junkie that's portrayed in the media. An IV drug user can be anyone.

Also in the New York State Division of Substance Abuse Services, a lot of their employees are recovered people. So the addict can change, and with adequate monies made available, this information can be brought to them.

So basically I just want to thank you for allowing me to speak here to you today.

DR. PRIMM: Thank you very much, Ms. Serrano.

Dr. Morales? And may I caution you, too, Dr. Morales, that we have about five minutes, and I looked at your testimony, which is quite complete and wonderful, and I hope you can kind of adhere to our five minutes.

DR. MORALES: Yes, I will, and I will condense it, so I'll just highlight parts of it. Let me introduce myself. I'm the Director of the Multicultural Inquiry and Research on AIDS, which is part of the Center for AIDS Prevention Studies, of whom I am one of the co-principal investigators. It is a center funded by NIMH and NIDA that focuses on AIDS prevention research.

I am a clinical consulting psychologist and have been Director of the Bayview/Hunter's Point methadone program. Thank you for inviting me this morning. To spare you the overall statistics, I'm sure you are very well aware that about 40 to 41 percent of the AIDS cases are minority with 74 percent of the women with AIDS being minority and 80 percent of the children who have AIDS are minority.

I'd like to update you on some HIV estimates. In terms of the military recruits, a report was just published in the New England Journal of Medicine this summer which notes that among blacks the prevalence rate was 3.89, among Latins 1.07, and among whites .8, the point being that blacks are six times more apt to be HIV infected than whites, and Latins are slightly higher than whites.

One important point in all of these statistics that we're seeing is that the information on Asian Americans is severely lacking. We're not seeing the breakdown, and it has a lot of problems in terms of trying to interpret what the data mean when you use a catch-all phrase like "other" to include this particular group.

In San Francisco, as has been quoted earlier, the Chaisson Study noted for the statistics gathered in 1985 that the overall prevalence rate was 10 percent in the clinics, but then when you look at the racial breakdown, 16 percent of the blacks and 16 percent of the Latins were positive as compared to 8 percent of the whites.

What we are experiencing is that these statistics are doubling every 12 to 18 months in San Francisco, and so we can expect a current overall prevalence rate of somewhere between 20 and 25 percent in San Francisco with about 22 percent of the Latins being positive and blacks about 30 percent being positive.

In terms of AIDS in the Latino community, it's been extremely behind in that the translations on AIDS information did not occur until about 1985. There was no way that somebody could get information on AIDS, written information on AIDS, for example, prior to that date. And so it really leaves us somewhat behind in terms of trying prevention efforts, and especially with IV drug users and gay and bisexual men.

There is little to no information on the sexual practices of Latins, for example. The literature is totally sparse. What we do find are things on attitudes, but not on sexual practices.

Many people, in terms of the AIDS prevention message, do not see themselves in danger of being infected with AIDS, even though they engage in high-risk behaviors. In the AIDS prevention effort, the sharing of needles is associated with IV drug users. It is well-known that in many Latin countries, people have trained themselves, a family member or a trusted neighbor, to be phelebotomists, and due to the lack of skilled medical personnel, many people take vitamins and medications prescribed by physicians through injections administered by a designated person in the family or in the community. This

practice continues in the United States. There have been cases where a mother who was injecting a child with vitamins, not knowing that her first child was HIV-infected, had then injected her second child who was then infected with HIV.

It's very important to stick to the behavior. The behavior is sharing needles, which happens a lot with IV drug users, but it's not just IV drug users, and that's the point of that example.

One group that is virtually being ignored in the AIDS prevention effort is the minority gay and bisexual males. They represent 20 percent of the AIDS population, and in the different cities, there isn't really an effort zeroing in on that particular population. For example, the statistics in San Francisco note that although 25 percent of the blacks report IV drug using transmission as their risk factor in terms of getting AIDS, among the blacks, 15 percent are homosexual and IV drug abusers, whereas 9.8 percent, almost 10 percent, reported themselves as just being an IV drug user. Similarly among Latinos, 7.3 percent were both homosexual and IV drug users as compared with 3 percent who said that they were just IV drug users. So the comment earlier about how are we dealing with sexual transmission with IV drug users and also minority gays and bisexuals.

Within the minority community, many people do not identify themselves as gay or bisexual and do not necessarily identify with those particular communities. They may identify with their own ethnic community, and so again may not see themselves at risk. So again it's very important to stick to the behavior rather than deal with risk groups and populations, because then it really dilutes the AIDS prevention methods.

There have been several efforts in San Francisco related to prevention as well as research. Our group is a group of minority researchers looking at AIDS prevention particularly in the minority communities. There are methadone maintenance programs for those who are seropositive, have ARC or AIDS, which are currently now at capacity, and there are several outreach programs to the community and those at risk, doing workshops with IV drug users, also doing general information and education to the community at large.

In summary, I would like to stress several recommendations, and one is that in developing AIDS prevention and education efforts, it is critical that ethnic minorities be included in the process of planning, developing, and implementing such efforts. This includes teams of ethnic minority scientists, community leaders, community-based agencies, and those who are in the risk groups -- for example, persons with AIDS, ARC, HIV positive, IV drug users, gays and bisexuals.

Each state, city, county, and community really should develop an AIDS plan, that has at least a five-year perspective in terms of how that community is going to be dealing with AIDS, and they really need to take charge and responsibility for dealing with that within their community.

A plan for developing human resources within the ethnic communities for the AIDS effort is critical. Specialists are sparse and are seriously needed. It's very hard to try to tell someone to really divert their career objectives and focus in on AIDS, and there are very few minority researchers that are around, and it's very hard to find them and recruit them, and it's really important to have training programs and to begin to develop a plan of how we're going to deal with this problem in human resources.

Across governmental departments, the grant cycle needs to be shortened. We're finding, for example, if we want to do an AIDS prevention program with IV drug users in San Francisco, by the time the grant goes through and gets funded, we're looking at about 12 to 18 months down the road, and at that time we may not be needing to look at prevention, but rather treatment of those who are positive. So the goals and objectives must be changed by that point in time. It's important to shorten that cycle.

As I mentioned earlier, gay and bisexual minority men are virtually ignored in the AIDS prevention effort throughout the nation, and underreporting can be expected from this group due to the social stigma associated with homosexuality. Research and prevention efforts targeted for this community are critical, and bisexuals can be conduits for transmission into the heterosexual community in the minority communities.

Unlike the white communities in the United States, there is an epidemic in the heterosexual community in minority populations, and it is imminent.

For IV drug abusers and interventions, we feel that we've had a lot of success with the one-to-one personal contact with peers communicating the message. It's important to get the message out in posters, and brochures and tapes and music and all those media, but it's not going to get them to change their behavior necessarily. We find that a lot of the addicts know about AIDS in San Francisco, but have difficulty learning or incorporating the changes that they need to make in their day-to-day practices, particularly in the use of condoms.

So we strongly feel that peer one-to-one contact is very effective, and also it's the way addicts communicate rather than using mass media and television and radio. When we say

there are openings available in clinics, the word spreads very fast within the community. Within a 48-hour period, we have waiting lists. So mouth-to-mouth is the best way to reach addicts, at least in our community.

As I mentioned earlier, changes in sexual behavior appears to be the most difficult challenge within minority communities.

In terms of bleach use in San Francisco among IV drug users, they basically are beginning to do that, and all are aware that bleach is the way to go if you want to shoot up, and I would say about 20 to 40 percent, are beginning to use bleach in cleaning their works before they shoot up.

Minority adolescents in urban areas are at greatest risk for being infected with AIDS, and prevention efforts using other minority adolescents may be an effective means of informing this group. Implementing " rap contests" on preventing STD, substance abuse, and AIDS have been used in the Bay Area and found to be effective.

Given the continued growth of the epidemic among children born to parents who are infected, by 1988 the number one cause for mental retardation is expected to be AIDS. So treatment for children who are infected, have ARC or AIDS, needs careful planning and trained personnel to implement special programs. Thank you.

DR. PRIMM: Thank you, Dr. Morales.

I would like to open the questions to Ms. Serrano. I know, through your ADAPT program, that you are the executive director of in New York, that you do go into shooting galleries, and you have been doing this for well over a year now, or more, and just have recently been funded to expand your endeavors.

How responsive is the addict community in shooting galleries to the use of condoms? I know ADAPT hands out condoms. In the packet there you also have a little bleach bottle, and instructions on how to use the bleach bottle. How effective is the issuing of those kind of paraphernalia to people? Are they using them, in the reports coming back to you? What are you doing about the other narcotic implements that are used over and over again in shooting galleries, as you well know, that could also be a vector for the transmission of the virus? If you would talk to the panel, just for a moment, about that.

MS. SERRANO: In our kits, we put the two-ounce bottle of bleach, or we give them alcohol. We have also put in caps now, because the cooker is where --

DR. PRIMM: What do you give them the alcohol for?

MS. SERRANO: The alcohol is also for sterilizing the works, or to clean the wound after they shoot up. Many times they might shoot up 10, 15 times; a lot of these people don't have veins, so they will continue to try to shoot in different places.

As a matter of fact, I was in a shooting gallery last night, and one of the men there, the day before I placed him in the KEEP program, which is a new program in New York where the person is allowed to come off the street, and he is maintained on the program -- not as a regular methadone patient, but as a KEEP patient -- and he is allowed to make up his mind whether he wants to remain on methadone and be absorbed into the regular program, whether he wants to detox, or whether he wants to go into a drug free community.

So that program is existing now in New York for people that are out in the street, and also for prisoners at Rikers Island where, instead of being detoxed now, because of the AIDS epidemic the New York State Division of Substance Abuse has implemented this program where they will maintain the person on methadone, and release them back to his program --depending on the charges, and how long he is going to be in prison.

But getting back to your question, we do give out the kit. It is comprised of the two-ounce bottle of bleach, caps, condoms. We give out cotton in there, and we also give out instructions on how to put on the condom, and how to clean the works in different ways. Boiling them, bleaching them, or alcoholizing them we call it. So we go directly into the shooting gallery, and we demonstrate step by step how they should do this.

We have gotten three different shooting galleries. Many of the people who frequent the shooting galleries will now ask for the kit before they shoot up. We leave a couple of hundred of these kits per week with the community advocate, a person that usually gives them money and helps them out, and they know that they could go to that person to get those kits. Besides leaving a supply in the different shooting galleries. Basically we are finding that they are using them, they are carrying the two-ounce bottles of bleach in their pockets. We are putting them in treatment, and they are remaining in treatment.

DR. PRIMM: How much discouraging do you do to discourage them from not using drugs at all prior to them shooting up when you are in the shooting gallery? It would seem to me that the first thing one ought to say to the people in the shooting gallery is, Don't use drugs.

MS. SERRANO: Definitely, we tell them that.

DR. PRIMM: What kind of response do you get to that?

MS. SERRANO: They want treatment. They don't refuse it. Most people, when we go out, they surround us. We don't go out there with the bleach or the condoms and the pamphlets. We know that is not going to work in dealing with the IV drug user.

We go out there with programs. In New York there are no treatment programs. But because of the nature of our organization, the board members of our organization and our membership are the directors and the nurses and the doctors from the different methadone and drug-free and detox programs.

So we are given slots when we go out in the shooting galleries, when we go out into the community. When we find the people that need treatment, the following day they are in treatment.

We are able to get these people in, even though there is no drug program in New York City. Again, because of the efforts of various people running the drug treatment programs.

DR. PRIMM: Governor Cuomo, in July, publicized the fact that he was expanding treatment capacity in New York with 5,000 new slots. You are saying now that those slots are used up, and there are not slots whatsoever? And there are waiting lists in New York?

MS. SERRANO: Yes. Out of the 250,000 -- a quarter of a million -- addicts that I spoke to you about, only about 35,000 are in treatment. The rest of the addicts are out in the street.

DR. PRIMM: Is that because there are not treatment slots, or because the addicts do not go to the programs, to apply for treatment? Or do not want to be treated? I think that we are going to have to look at that very closely.

MS. SERRANO: Addicts do go to the program and ask, but a lot of times they get turned away so they don't go back. There are waiting lists in most of the programs, so they are going.

The word spreads through the streets, Why bother going, you are going to be turned away. So they do not bother, many of them. But there is a clear need for more treatment in New York City, in view of the epidemic.

I see the danger in these neighborhoods where no AIDS education is going on, where you see the young kids starting to experiment with crack, starting to experiment with pot and

alcohol. This is the next generation that is going to get AIDS. The IV drug user usually has a wife or a girlfriend who is not an IV drug user herself. The woman is very much at risk from the sexual contact.

DR. PRIMM: Dr. Morales, you mentioned the Chaisson study; it has been mentioned a couple of times this morning. You indicated that Blacks and Hispanics were at a 60 percent seroprevalence rate, secondary to that study and Whites were at eight percent seroprevalence rate?

DR. MORALES: Sixteen percent; 16 percent, as compared to 8 percent.

DR. PRIMM: Sixteen percent, as compared to 8 percent?

DR. MORALES: Right.

DR. PRIMM: Could you tell me what is being done in San Francisco to coordinate the efforts on the part of drug treatment programs, in terms of their thrust to preventing AIDS?

It is my impression that the majority of the addicts are located in the Tenderloin District, and some in Bayview Hunter's Point, and there's one other district in San Francisco. And there are no coordinated efforts between Haight Ashbury, that clinic there, the therapeutic community that is run by Alcomporo, nor the Bayview Hunter's Point area, nor the Tenderloin Area.

We had a meeting at the Cadillac Hotel. You were invited to that meeting, as you know. I am sorry that you could not have made that; it was sort of impromptu, and called by Ron Kletter there in San Francisco.

I am terribly concerned about the lack of coordinated effort and the lack of communication between drug treatment programs and people who are interested in this problem not getting together, not cross-fertilizing one another, or transferring skills to one another. I think that that would be a unique thing that could happen in San Francisco, since you have such a low seroprevalence rate, and could keep it low with some coordination of efforts.

DR. MORALES: I think that points to the strategy of planning. How can a system plan, how can a community plan for services? I think, in terms of what is the plan for AIDS in San Francisco for the next five years, that really did not exist until about last year.

What is the plan for drug abuse, really, within the next five years is something that the Health Commission in San Francisco has mandated of its Health Department. That is, I

think, what you are looking at. Well, yes, there isn't this kind of really tightly-knit, coordinated effort among the service providers toward a plan, because the plan's not there.

But each individual program has taken on the charge within itself, and developed its own policies internally in relation to that. For example, the West Side is the other district that has a lot of drug abusers.

The West Side Clinic and the Bayview Hunter's Point Clinic, have been working jointly, referring clients back and forth and have been working very closely in relation to the AIDS effort.

The Multicultural Alliance for the Prevention of AIDS, which is part of the Bayview Hunter's Point Foundation, is just that: an alliance of the different minority health providers to come together, and to focus on how they can coordinate their efforts in their different populations. In that way, we have taken some strides in those directions.

DR. PRIMM: One thing that you did not mention in your written report or in your testimony today was the very unique program that you ran a contest for students to write rap songs--junior high school and high school students -- from the Bayview Hunter's Point program that was very successful. Would you comment on that for the Commission?

DR. MORALES: Yes. We had a contest, and we announced it on radio and on television, that there was a rap-off and there were prizes that people can get. It was targeted for adolescents. What they did was, they had to get the form, and the charge was to develop a rap and to perform it.

We had about 300 to 500 contestants who came and rapped off for a whole weekend. Then there were five that were selected who were winners, and there was a prize. I think there was $500, and the second prize of $200, and $100, plus being on a video, which is now available for public service announcements, and can be distributed throughout the nation.

It was so popular that it was decided to do it for the Bay Area, so we had a Bay Area rap-off, and Oakland was included, and San Francisco, and other towns were represented. The same procedure was followed.

It is very popular, and it is really a way for the adolescent to take charge of knowing the information, because you have to know about AIDS before you can rap about it. In that way, it was extremely successful.

DR. PRIMM: Mr. DeVos, did you -- Dr. SerVaas?

DR. SerVAAS: Thank you for your presentation. The Commissioner had the pleasure of the visiting the Bayview Hunter's Point Foundation earlier in the year. When we were there -- we were told of a problem with San Francisco police. The police used possession of the large bottles of free bleach as evidence of illicit drug use when they made arrests. It almost appeared that the police department looked upon them as being harmful, instead of helpful in decreasing the drug problem.

Could you comment on that? Is that true? They also complained there that the San Francisco government organizations prevented them from issuing condoms in the prisons, because there is a law against sodomy in prisons; and, hence, they couldn't issue the condoms.

Could you comment on that? Is that a problem? Then I would like to know how your organization is funded, and what your budget is there per year. Thank you.

DR. MORALES: I guess the bleach and the condom go hand in hand on this one. It is actually both. The police --and it is not just San Francisco; I believe it is throughout the country -- if someone has a bunch of condoms in their possession, they can be confiscated by the police.

It is part of cracking down on prostitution. Also in the prisons -- it is not just San Francisco, it is throughout the nation -- condoms are not distributed. Prostitutes or people who have condoms in prison, the police take them and punch holes in them, and give them back to them, so actually they become useless.

It is a problem. I think here is what we are dealing with, back to a plan. Health organizations can advocate the things, but it is really up to the politicians, the policy makers, the people who run government, to really take the lead and set policy around these issues, because they are the ones who control the police.

They also set policy for the prisons. Again, it comes back to a plan. It needs to be dealt with at this level, and at the President's level, at the Congressional level, as well as in the local level in terms of states and local governments.

In terms of Bayview Hunter's Point Foundation, to give you a brief description of that, it is a service organization that includes methadone services, drug prevention services for youth, drug services for Gay men. It also has two outpatient mental health clinics, two day treatment programs, legal aid; and it also has the AIDS effort, both in the service delivery and in the research.

The total budget of the Foundation right now is about $4.5 million. Much of that money comes from city, state, and federal sources, in terms of providing the services for substance abuse, or mental health.

In terms of the AIDS effort, I believe it is currently funded -- the service portion of it is currently funded at about the $150,000 level a year. In terms of the research, combining the two grants that we just recently received, our research budget is about $370,000 per year, which is funded for the next four years.

DR. SerVAAS: Thank you.

DR. PRIMM: Dr. Lee?

DR. LEE: Ms. Serrano, nice to see you again. Ms. Serrano, for the sake of the other Commissioners, is one of our stars, really, in New York City.

In early September -- Bill Walsh was there to hear you -- I commended you for your courage, because I know these places that you are going into. Dr. Primm takes it for granted, but for me, it is a horror show.

I have a question for both of you that has long puzzled me. In my contacts with Spanish communities in Europe, Mexico, Puerto Rico, I have always been impressed by the warmth of the Spanish family -- the exceptional closeness of their ties, which it seems to me, is a distinct cultural quality.

It is more than I see around me in the United States in my community, for instance. Add that to Catholicism, and I am not sure I understand why you are having this much trouble with AIDS and drug abuse. I would not have expected it. Is it sheer, terrible poverty? What is the answer?

MS. SERRANO: That plays a large part in it. I guess the family type of environment has disintegrated, for the most part. There are a lot of single women who head households, and a lot of these kids are brought up in that fashion.

A lot of these kids that are going into drug abuse are being abused themselves, or maybe their parents were engaged in alcohol or other types of substance abuse. Some of them come from very good homes that, for whatever reason -- peer pressure -- they just wanted to try it.

A lot of them are very frank and say, I want to try it; and I tried it, and I liked it. They went on from there. It started out as pleasure and before long it was no longer

pleasure, it was actually to control the sickness of addiction. A lot of people in my caseload -- I worked at Long Island College Hospital in Brooklyn besides being the President of ADAPT -- and in different programs of the City of New York -- we have policemen, we have firemen, we have doctors, we have lawyers on methadone treatment.

Some of these officers have gotten caught up in that fashion. But getting back to the family aspect, and the religious part of the family bringing up these kids, there are just so many things that contribute to that child going that way. I think most of the people that we see in the street were, many of them, abused themselves while they were growing up, and were in that kind of lifestyle.

DR. MORALES: I would agree with what she is saying. To me, it really points to the fact that we don't know, specifically when we look at it ethnically, why is one group different than another, and what are the factors that would help people stay away from drugs, versus those that would drive them to drugs.

I think it really calls for more investigation along those lines. When doing the research, and when doing the investigation, needing to break down according to ethnicity, rather than lumping things together categorically, which a lot of the research does. Therefore, you loose all this information that right now we really need.

The other point is that, piggyback on what has already been said, there are multiple problems. In my clinical experience and in working with IV drug users we find that they not only have drug problems, but many of them have emotional problems that are beyond the sociopathic acting out character-disorder type problem.

We have many dual-diagnosed people, people who have severe mental problems. A lot of them have learning disabilities. This combined package makes drugs attractive. It is a way to cope, it is a way to deal with life, and it is a way for them to reduce the stress.

DR. LEE: At the very bottom of it, isn't it the same family problem that the Black communities are facing? The deterioration of the family?

MS. SERRANO: I believe it is. I believe there are the same problems involved. Yes.

When you take the history, or the psycho-social assessments when you are admitting them into drug treatment, you begin to see that they dropped out of school in the eighth grade,

that they were abused by their parents, they were in foster homes.

The majority of them have different histories that have led them into that lifestyle. It is very rare that you get somebody that just decided, after graduating high school or graduating college, that they will start using drugs. We are seeing that more now.

DR. LEE: Thank you.

DR. PRIMM: I want to welcome Dr. Reed Tuckson, who just came in. I will just take one or two more questions before we let him present. Dr. Walsh?

DR. WALSH: Just a couple of questions. I do have one comment. I don't know whether either of you are aware of the work of Project HOPE in the Southwest, and the training of substance abuse counselors that we did with nine community colleges.

Apropos of part of what you both have been saying, the reason we went in and developed that program was that we found to reach the Hispanic community as you have said, Ms. Serrano, you really have to reach them through their own culture, through their own people. I don't know how much use, these people are being put to, or how much they are relating AIDS to the IV drug abuse problem. But if you wished to call our office, we would certainly put you in touch with this resource, because there were many, many people in the Hispanic community that were trained, and are available, for this work.

The other thing that is encouraging is that this was substantially privately supported. So there is funding out there for the kind of work you all want to do. We would be happy to direct you to the sources of possible funding for further work in this community.

The question I wanted to ask, Ms. Serrano, is if I understood Dr. Schuster correctly before, he made reference to the fact that there was a lot of funding at the federal government level and, for some reason, the states were not requesting the funding. I was appalled when I heard that, because we are always getting pressure to recommend more federal funding. With the statistics that you have given to us, and we have heard from others, regarding the lack of open slots, the lack of counselors, the lack of training: is there a reason that the states are not requesting that, of which you are aware?

MS. SERRANO: What happens is that community-based organizations and small organizations like ADAPT, in New York at least, consortiums are being built of the powerful organizations;

any money coming in is being taken by these organizations. A lot of the money is not trickling down to the organizations doing grass-roots type of work. From my knowledge, the people in New York have been applying for NIDA money, for federal money, CDC money. I don't know if you know anything different, Dr. Primm.

DR. PRIMM: I have heard what Dr. Schuster said this morning, and I can't wait until noon time -- I hope he stays around -- to ask him whether New York -- I didn't want to put New York on the spot -- but I am going to certainly ask him a little later.

DR. WALSH: That basically was my question. The last one I have is, you said something else that is very close to my heart. That was the problem with education on AIDS, and I suppose it translates into IV drug abuse, not being at the level for these communities to accept or to even understand or comprehend.

Do you have any really sound suggestions? You may not have time to give them to us now, but I think it is something that Chairman Watkins and the rest of us would love to have, because we are really troubled about the fact that a great deal of money is being expended, theoretically on education; but we are missing the mark.

We are missing the mark not only with the Hispanics and the Blacks, but we are also even missing the mark with the adolescent populations coming along. We really have to redirect it somehow, but I don't know how to do it.

MS. SERRANO: I just want to say that we are running our program with $176,000 from the New York City Department of Health. We have to cover three boroughs with that money, with 8-hours-each workers.

But we also have about 200 volunteers. With their help, we are able to saturate, at any given date, I would say four or five blocks of New York City where high drug abuse is taking place, and provide information and literature and condoms, and refer people that need treatment.

We basically are doing it on our own, because $176,000 for the City of New York is peanuts. Basically, that is what we are surviving on. I would be glad to tell Admiral Watkins about our programs and how we are doing it.

DR. MORALES: There is another level, too, to respond to your question. First on the funding. You notice the funding from the feds goes to the state. It doesn't go to a program like ADAPT that can apply directly for the funds.

That would make a difference, in terms of trying to get the funds quickly, because you have to wait for the state to do their planning process, and the county to do theirs. They are not at this accelerated pace for planning and AIDS action. This is one of the stumbling blocks, and you get this kind of trickling-down effect.

The second thing is on looking at what can we do. In San Francisco, the Instituto Familiar de la Raza developed a film, a 50-minute film, called "Ojos que no ven," which is in a novella form, a soap-opera type of form, to instruct the community.

It is very, very well done, and it has been used in the Latino community to introduce the concept of AIDS. Both on television it has been used, with an open forum, as well as in meetings and presentations. It has been very good to help people understand what is going on in terms of AIDS in the Latino community.

The difficulty with this is that the state, who originally funded this particular program to do AIDS prevention in the Latino community, will not fund the video because they say it promotes homosexuality, it promotes drug abuse, because there you are showing people how to clean their works. And you are showing homosexuality in a positive light, where people are in a positive environment, talking to each other about how they can be safe.

Here we get, again, social policy issues. At what point will the government back the program that will produce a message? Because it doesn't meet certain standards that they perceive are important, or certain standards that they perceive the Latino community must have, they won't fund it, so we are back to ground zero.

DR. WALSH: These are complex questions, for which we would like your assistance in giving us some answers.

DR. MORALES: Sure.

DR. PRIMM: Thank you, Dr. Walsh. What I would like -- Dr. Crenshaw and Mrs. Gebbie, if you would just hold your questions until Dr. Tuckson presents. Then, after that, we will entertain questions, providing the Congressional group has not come in. Dr. Tuckson?

DR. TUCKSON: Thank you, Mr. Chairman. Thank you for your indulgence. Being the Health Commissioner of a major city like the District of Columbia sometimes wreaks havoc with one's schedule. I will be very brief, given that you have given me this special indulgence. We here in the District of Columbia

are very concerned, as you are, and as this country ought to be, about the relationship between HIV infectivity and the IV drug abusing population.

In this city, our statistics are interesting, especially when compared to cities of similar demographics and similar geography in New York or New Jersey. We have had 920 cases of diagnosed AIDS in this city, of which 7 percent are in persons who are IV drug abusers, and another 7 percent are in persons who are the combination of IV drug abusers and homosexual or bisexual.

That number of 7 percent interests us, because you would think perhaps that in a city like this, that might be higher. The number has stayed consistently that number since we first began to collect statistics. That does not give us any reason for any sense of comfort. We are concerned that that number, 7 percent, is on its way to a much higher number, and we are trying to rededicate our efforts to make sure that in fact it goes down and not up.

We know that we need to in particular look at, the effect that this is having on newborns in our city. We know that in our Childrens Hospital here, there are about 120 cases of young children are positive for the virus. They have not yet been diagnosed as having AIDS, but we know that the virus is in their system and, of course, you already know the science of passive transfer and that it takes some time, of course, to be able to know. But a significant number of them, we are very concerned, will go on to develop the disease.

In our Howard University Hospital, we are following 24 youngsters who are positive for he virus. In our D.C. General Hospital, another 33. And what's important about those numbers is that the overwhelming majority of the mothers of those children in fact are IV drug abusers, and so that is one issue that gives us reason for very great and serious concern.

Because we don't know all that we need to know about the 7 percent number and whether it's going up or down, we are happy that the Centers for Disease Control has been able to support cities like the District of Columbia with the sero-prevalence testing. That is, we just submitted our application last week, and we hope to be able to have a very vigorous and intensive seroprevalence study done as the first of the year comes around.

The testing and counseling issues, though, are -- we had a very terrible experience here in this city. It was perceived by the public that some information that was related to antibody testing in the IV drug abusing community was missing, was leaked, the confidentiality was breached. That experience

taught us a great deal about the overwhelming importance of anti-discriminatory legislation and the priority that that must occur so that information that is contained in the medical records of public clinics such as those that are involved in the IV drug abuse effort must be protected at all costs; and that has given us great reason to advocate very strongly for anti-discriminatory legislation and confidentiality and those sorts of issues.

We have been able now, we think, to regain the confidence of our community, our IV drug abuse community. We have now trained all of our workers, whether they're ones that work directly for the government, or those that contract with us, in the alcohol and drug abuse system to go forward, to be able to counsel vigorously and to advocate that every client receive a confidential, in fact an anonymous and voluntary antibody test; that that information then should be shared as the client feels appropriate with the health care provider.

We have now begun to get to the point where we are resuming our testing program in the sites where the patient receives their services, so they don't have to go offsite, and that ought to be a part of the package of service delivery that we offer throughout the system.

The counseling aspects we have learned to be very, very intense about not only the question of sharing needles, but also the question of how they express their sexual behavior and what protections they offer for their loved ones.

We, despite that, began to realize that the current education efforts -- the mass media and pamphlets and that sort of business -- just does not penetrate to this population. What we have had to do is to retrain our staff members to go out and be a part of that community, their sole job is to work in the shooting galleries, to infiltrate that network. While they are very well organized in the drug abuse community for the distribution of narcotics, we are terribly poorly organized for the distribution of health education.

What we have learned when we go out is that even though awareness of this disease is present, people still are not changing their behavior. In fact, we have very dramatic studies by our staff, one of which is with me now, Mr. Gaston Neal, where they go out and even while we are talking to IV drug abusers about not sharing works, and asking them do they do it, and even while the vein is exposed in the groin, and while the blood is on the needle, and while we are asking, "Do you do this," and they say, "No, we really don't share works," while they are doing that, another IV drug abuser is tapping them on the shoulder and they are palming the works in their hand and passing it back.

So even with us on scene, right there, we are still seeing this occur. I use that example, although it is extreme, as a sense of the kind of obstacles we are up against.

We have done a quick study that tried to get a better understanding of the needle etiquette of our population and what was going on with that needle etiquette.

One of the things that we learned -- I would not put my scientific reputation on a study that's done this way. It's a hard group to study and to try to get at, so let's understand the limitations of it. But from 222 persons that we were able to interview, 48 percent say that they never shared needles; 37 percent of another group said that they shared needles rarely; and of that group that share needles, 53 percent said they had recently shared needles. Who do they share needles with? 60 percent say they share with one person only; the rest are multiple sharers.

Have they changed their behavior because of AIDS? 73 percent say no, they have not. 18 percent say yes. Some were equivocal.

Those that have changed their behavior, how have they changed it? 46 percent say they don't share needles with certain persons. 23 percent say they have decreased or eliminated their IV drug abuse. 15 percent say they have decreased or eliminated sharing of needles, and 15 percent say they have increased their cleaning of needles.

We have learned that people clean needles with just about everything that you can imagine, from the tap water on the roof of the car to the tap water on the roof of their apartment building, to the water in the toilet. And so the cleaning of needles is a very variable phenomenon as well. What also is important -- I know my time is up, and I need to end --

DR. PRIMM: Who told you that?

DR. TUCKSON: Because I saw you reaching for the microphone, Dr. Primm.

[Laughter.]

DR. TUCKSON: And I know you so well.

[Laughter.]

DR. TUCKSON: The thing that's fundamentally frustrating to me is that despite the public knowledge of the role of IV drug abuse, we still have such community opposition to establishing treatment centers for IV drug abusers in our

community. And one of the things that I think that you can do is to continue to take a very strong advocacy position that says that communities in this country cannot have it both ways. We cannot say "not in my neighborhood," which is what we say in Washington and in Dr. Primm's New York, they say "not in my back yard." Whatever the slogan is, we can't do that. We are going to have to have the money, and the community, the leadership among the people that lead the communities, to permit us to treat IV drug abuse.

The second thing we are going to have to do is to find housing for those IV drug abusers who are going to need it once they are infected with this virus and are debilitated and ill.

The one thing that the gay community has been able to do very well is to bring resources to the table in a voluntary and philanthropic way, when they sit down with local government persons like myself. And that has been useful and helpful in defraying some of the expenses for service delivery.

The IV drug abuse community is not organized politically and is not certainly going to come forward and bring dollars to the table to underwrite and offset the cost of these sorts of things, so that local municipalities are going to wind up sharing the full burden of the cost of these.

How are we going to be able to provide the buddy systems and those sorts of things is important and difficult. We now have had two houses established in the District of Columbia in the last six months for persons who are mainly IV drug abusers, who have this disease.

The other thing, though, and one of the most exciting potential interventions for this city in the civilized community of this country, is for those babies that are in the hospital, people are going to have to come forward and help take care of those babies. You cannot have a civilized society and condemn these young children to living their entire lives in a hospital ward. We now have in D.C., we will be establishing in the next couple of weeks, something called the "Grandma's House," and "Grandma's House" is a place where we will be able to take in as a foster care place those babies that have AIDS and are infants. That, I think, is very important and vital.

I will just conclude by saying that ultimately -- and I know the work of this commission is broad and comprehensive, and while you want to focus in on AIDS, Dr. Primm, I know, understands well that the fight against drug abuse and AIDS is fundamentally the fight against drug abuse. The fight against drug abuse ultimately comes down to the society, it comes down to those very chronic and deep-seated issues of the disenfranchisement of too many members of this community, the

lack of hope, and the failure of a concept of the possibility of a future for too many of our young people.

I know it may not be within the purview of the Presidential Commission on this issue, but I would at least hope and pray that as part of what you do, that you would encourage a refocusing and a redefinition on reinstating in our young people the concept that there is a future, and that it is important to be involved, especially for inner city youths, who see that more of their members go to jail than go to college. Thank you, Dr. Primm.

DR. PRIMM: Thank you so much, Dr. Tuckson. We don't have time for questioning, and I would like to do so so much, because you have so much to offer the panel, you personally from here in Washington, D.C. So what I am going to do is thank the panel very much, and have the Chairman, Admiral Watkins, also thank the panel.

CHAIRMAN WATKIKNS: We want to thank the panel. It has been very valuable for us today. As I have pointed out to others, we have our own commitment to submit an interim report to the President in February. This will be one of the issues. We think it's so urgent, and we share your views, Dr. Tuckson.

We have two members here of the Commission who have not been able to ask the panelists a question. I would like them to be permitted to send you those questions, as they would be addressed to any one of you. I have several myself, dealing with the dilemma, of the legal aspects of shooting galleries in New York and your ability to go in to help. That dilemma is a difficult one for me to understand, and I am going to be sending you a question, Ms. Serrano, about that.

So we would like to keep the door open between the panelists and the Commission, and you can expect some questions. So the testimony continues on an open basis with the Commission, if that's agreeable with you. We have to move on because the Congress has an extremely busy schedule right now, and we want to make sure we have an opportunity to hear from them. Congressman Green is with us now. Thank you so much for appearing today.

DR. MORALES: Thank you.

DR. PRIMM: Good morning, Congressman Green. We are certainly glad to welcome you to this panel, and you can begin when you wish.

PANEL 3 - CONGRESSIONAL VIEWS

CONGRESSMAN GREEN: Thank you very much, Dr. Primm, and I am honored to be permitted to share some thoughts with you this

morning. I happen to represent about 40 percent of the Borough of Manhattan in New York City, and as you know, AIDS has really become an epidemic there, and in addition, drug use and its related dangers to the spread of AIDS are a particularly severe problem in parts of my district, most notably on the Lower East Side, which has been a major drug selling and distribution point in New York City, despite a very increased police presence there in the last several years trying to at least hold it down.

It's estimated that in New York City, there are 500,000 people who would test positive for the AIDS virus, and that by 1991, some 40,000 will in fact have developed AIDS. And there are some, I would have to say, who think I'm underestimating with those numbers.

According to the most recent Health & Human Services Department update on AIDS, studies show that in the New York City area, the rate of HIV infection among intravenous drug abusers is ranging from 50 percent to 65 percent, and so it's that part of the problem I'd like to concentrate on this morning.

Obviously those statistics are very frightening statistics, and I think it is important that we remove whatever barriers may exist which prevent us from reaching out and dealing with the addict community.

One step would be to improve the access to methadone clinics for heroin addicts. As I'm sure the panel knows, methadone is a synthetic opiate which is widely used to suppress an addict's craving for heroin. Methadone maintenance has been studied now for well over two decades. The treatment was originated in the Beth Israel Hospital in my district, and it's been consistently documented as a safe and effective treatment for heroin addiction.

The Federal Food & Drug Administration regulates the use of methadone for this purpose. And what has come to be a real problem for us in New York City is that currently the Food & Drug Administration requires a minimum staffing ratio of one counselor to 50 patients in methadone drug treatment centers. I have no quarrel with that as an ideal, but the practical reality is that the current level of funding for methadone clinics makes that requirement a severely limiting factor in terms of the number of patients that can be accommodated.

Again, I appreciate the importance of counseling in the treatment of drug addicts. Ideally I would like to see more money for these clinics so they could have whatever number of counselors they need, but absent that, I really feel that we must treat as many addicts as possible and as quickly as possible, and that's got to mean if we aren't prepared to put up that extra money, providing maximum flexibility and service delivery.

In New York City, we address the sad reality that the number of addicts who want treatment but cannot get it is mounting. The methadone clinics in New York City have lengthy waiting lists and often must turn away addicts who want to enter a methadone maintenance program. According to statistics published by the National Institute on Drug Abuse, in New York City, there are more than 2500 individuals currently on waiting lists for drug treatment.

Recently I wrote to the Food & Drug Administration, expressing my support for proposed new rules concerning staffing requirements for methadone clinics. Those regulations would ease the requirement that there be one counselor for every 50 patients, and that proposed rule was published in the October 2 Federal Register.

I support the change because it will allow existing clinics to be able to serve more IV drug users who seek treatment, but frankly I don't think the Food & Drug Administration proposal goes far enough, and I think if we are not prepared to put up the money to have the required number of counselors there, then we ought to allow the methadone clinics to open the doors and take in all the patients who want the treatment.

We are really faced with a choice between leaving people out on the street engaged in intravenous heroin use and transmitting AIDS, or in letting them into the clinics without the ideal amount of counseling.

Now I realize that without the counseling, there will be some additional failures in the methadone treatment. I understand that methadone is a block for heroin, but it is not, for example, a block for cocaine, and without counseling, therefore, it is certainly possible that some of the people who come in and get the methadone maintenance will go out and start shooting cocaine instead of heroin. We know that happens.

But if the choice is between having a little more of that happen and leaving thousands of people out on the streets because the methadone clinics are not permitted by federal rules to take them in, I say let's change the rules and take them in.

Let me say that my view is shared by Dr. Robert Newman, President of Beth Israel Medical Center in New York City in my district, which operates 23 methadone clinics throughout the cty. After I visited Beth Israel's Gouvenire Methadone Maintenance Clinic in my district this past October, I am more convinced than ever that we need to open up the clinics to all who are seeking treatment.

In fact, I agree with the position that Beth Israel has taken, in no way should the unavailability of counseling and rehabilitation services result in eligible addicts being denied admission to methadone treatment. It's been estimated that with fewer restrictions of the sort I have described, Beth Israel alone could serve at least 2000 more addicts.

The second point I'd like to make to you is to urge that more be done to encourage the use of sodium hypochlorite, basically household bleach, for a disinfectant for needles and syringes of IV drug users. Sharing needles is the second most common means of the AIDS virus transmission. I strongly believe that every effort must be made to teach addicts that cleaning needles can help them to avoid AIDS.

Several important studies have been conducted which conclude that in terms of AIDS education, IV drug users are reachable. Findings indicate that there are drug users who may not be interested in treatment, but are interested in avoiding AIDS, and in my full statement, which is being submitted to your committee, I document the scientific research on that point.

But the basic point I want to make is that IV drug users are reachable if prevention methods and education are given in a nonjudgmental fashion and can be realistically incorporated into their lives.

Now certainly everyone here opposes the use of dangerous drugs. But we do know that they are used. AIDS is a medical issue, and it shouldn't be treated as a political or moral issue. Educational efforts, such as teaching addicts the benefits of cleaning needles with bleach at each use, must be targeted, direct, and widespread.

I encourage the media and this nation to include in radio and TV messages about AIDS clear advice on cleaning needles. We have provided words and pictorials on condoms. Why not provide the same on clean needles? We are not encouraging promiscuity when we talk about condoms. We are trying to protect people's lives. Why not the same attitude towards cleaning needles? The message could say, "Think twice about promiscuous behavior, but if you have sex, use a condom. Think twice about using drugs, but if you are going to inject yourself, please first clean the needle with household bleach."

It is currently estimated that 80 percent of the cases of children with AIDS have been associated with transmission from an infected parent, and in almost all of these cases, the baby's mother used drugs intravenously or had heterosexual IV drug using partners. Obviously we have an obligation in this society to prevent that trend from continuing. We must provide targeted education to the groups of women who are at high risk for being

infected by the AIDS virus; in particular, female intravenous drug abusers, the female sexual partners of drug abusers, and prostitutes.

And again, education on the effectiveness of bleach in cleaning needles must be encouraged. AIDS can't be cured currently, unfortunately, but it can be prevented, and that's got to be our tireless message.

I agree with Surgeon General Koop when he says that, "With AIDS, the first response will always be prevention." And I hope I have suggested two ways that we can help prevent the spread of AIDS.

DR. PRIMM: Thank you very much, Congressman Green. I'd like to comment particularly about the statement that you made supported by Dr. Newman from Beth Israel Hospital, in increasing the number of patients per counselor. Presently, as you know, it's 50 to one.

CONGRESSMAN GREEN: Right. Again, that's not my first choice. If the money were there and we could take on the additional patients and get additional counselors, I'd much prefer that.

DR. PRIMM: There are probably many people from the treatment field in the audience and some sitting right here that know that certain patients, for example, need a more concentrated counselor effort in order to bring about any kind of rehabilitation. A number of these patients are not even habilitative, so they need to be habilitated because if they were rehabilitated to what they were, it wouldn't be very much, and they would be back on drugs again.

So I would like to recommend great caution in increasing certainly the number of patients that are handled by one counselor, and particularly patients who have a profile like my patients, of 35 years of age, ninth to tenth grade education, seven to eight years in jail, and generally 13 to 14 years on drugs, and certainly not the kind of patient that can take less counseling, but the kind of patient that needs more counseling. With that, let me open up the questions by calling on Mrs. Gebbie.

MRS. GEBBIE: Thank you. You have already covered at least a part of what I wanted to ask about. It would be very helpful to me if you could discuss what information you have on the impact this larger treatment capacity would have on the prevention of AIDS. I appreciate your view, if we can't treat them all with the full-fledged program, let's give them all at least something, let them in the door. It is my understanding -- it may be an erroneous one, because this is not my field --

that at least some users use the methadone just to tide them over in between shooting up, getting whatever drugs they have. If we make methadone available on this sort of mass scale, without the counseling, is there any indication it will do anything to stem the tide of AIDS, to make these people more amenable to education, to change their drug-using behavior at all? Or does it just give them ready access to another substance to abuse?

CONGRESSMAN GREEN: Well, as you know, methadone blocks the high that you get from heroin. So that someone who is being treated with methadone generally will not shoot up with heroin because they will not get any kick from shooting up with heroin because of the methadone.

So to that extent, people who take methadone regularly will not be heroin abusers. As I conceded in my remarks, it is possible they will mainline other drugs, and methadone is not a blocker for cocaine, for example. But I would suggest that what we are doing now in New York City is telling people that these clinics, when they get filled up to their 50 patients for each counselor they can afford, those clinics are telling people come back in three months, come back in six months. And those people are therefore out on the street, sharing needles, shooting up with heroin. And I would say I'd rather have them being taken into the clinic. Maybe there would be some unfortunate lack of service, which we really should have, and I'd rather see the money here to have it. But given a fixed number of dollars, and thousands of people out there waiting for treatment that we can't provide them, I'd rather take the chance on giving them treatment, acknowledging there are a certain number who could succeed with the counseling and who will fail because they haven't got the counseling. That's better than their being out on the street shooting up heroin. That's all I'm saying.

DR. PRIMM: Is the reason for that, Congressman, is that we can't get counselors? Is that your reason? Or is it the reason that we can't expand treatment programs? Because I think we can get counselors if we were able to expand treatment programs, if we had the dollars to do so, and if we got communities, and particularly in lower Manhattan, to accept an expansion of treatment programs, to increase our capacity. And I think we could go a long ways if we had our congresspersons begin to try to convince communities that they must accept treatment programs, particularly if they have increased numbers of addicts in those communities.

CONGRESSMAN GREEN: Well, my understanding is that the dollars that are available to the methadone clinics for hiring counselors, that's the pinch point.

DR. PRIMM: That's not true in my clinics at all. We can get the dollars. What we need is the ability to expand our

treatment capacity. We can get the counselors. We have a number of people applying for counselor positions every day, chief counselor positions.

CONGRESSMAN GREEN: I didn't say that the people aren't available. I said the dollars aren't available.

DR. PRIMM: We can get the dollars.

CONGRESSMAN GREEN: Well, maybe you ought to share it with Beth Israel, because they tell me they can't, and they run 23 clinics.

DR. PRIMM: Beth Israel has a reimbursement rate of around $16 per patient visit for those people who are eligible for Medicaid, and certainly that's enough dollars to adequately balance the cost of counseling.

CONGRESSMAN GREEN: But as you know, in New York City, we have a large problem with people who are just above the

Medicaid line --

DR. PRIMM: We do.

CONGRESSMAN GREEN: And for which there is no money at all.

DR. PRIMM: And fee for service, of course, for those individuals helps to defray that cost of expanding counselor personnel. Dr. Crenshaw?

DR. CRENSHAW: No questions.

DR. PRIMM: Dr. Walsh?

DR. WALSH: No questions.

DR. PRIMM: Dr. SerVaas?

DR. SerVAAS: This may seem very elementary, but would it help you if we closed down the shooting galleries?

CONGRESSMAN GREEN: It is illegal. Of course it's illegal to use these drugs.

DR. SerVAAS: Well, why don't we close down the shooting galleries?

CONGRESSMAN GREEN: Well, I've got to tell you, there is so much money in it that the police arrest people all the time. We've had something known as Operation Pressure Point

functioning on the Lower East Side of Manhattan. My recollection is, it began four or five years ago with a vastly increased police presence on the Lower East Side, and it's made a difference. You don't see as much obvious dealing on the streets as you walk around the Lower East Side as you once did, and it's had a very beneficial impact, because it's not only cut down that visible crime, but it's cut down the burglary and robbery rate both in that precinct and in the surrounding precincts.

But you have problems, I'll tell you one thing that's happened. We have a large number of public housing projects nearby. The business has tended to move indoors into those housing projects. The housing police and the city police have conducted innumerable raids there, but, you've got a poor woman with several children living in a housing project, and a drug operation offers her $1000 a month for the use of her apartment to deal drugs, that's awfully tough to resist.

And once you get that, then you need a warrant. The police can't just walk into someone's apartment. You've got to have a warrant. That's expensive to do. There's only so many police, and the police department is very leery about letting anybody -- really selected police go inside and make drug buys because of the corruption problem.

So it's a very complicated law enforcement problem. And the answer is, yes, we've put a lot more police in that effort than there were when I was first elected from that district some years ago, and, yes, it has to some degree at least moved the traffic, and moving it is good, because if the buyers don't know where it is today, it takes them a little time to find out the new link, that does help.

But it hasn't killed it; it hasn't ended it. And there's just so much money there, it's just such big money that, if someone gets swept off and sent on to jail, you're only getting the small fry out on the street, and there's plenty more after them ready to make that kind of money the next day.

DR. SerVAAS: My other question is, I like your idea about giving them methadone if there just isn't enough money for counselors to go around. Would you feel that same thing might be true if there's a long delay for testing these people for AIDS, because of lack of money for enough counselors, that it would be better if they knew their condition? Is that a problem, and is there a big delay in New York?

CONGRESSMAN GREEN: In testing?

DR. SerVAAS: Yes.

CONGRESSMAN GREEN: Not that I'm aware of. I don't know of any history of people waiting, asking for tests and not getting tests. Quite the contrary. But I certainly do know of the history of people waiting to get into drug treatment programs and being told, you're going to have to come back in a few months.

DR. SerVAAS: These people at the drug treatment programs, are they routinely tested or voluntarily tested at all?

CONGRESSMAN GREEN: My understanding is, it would be a purely voluntary thing. It would not be a routine thing.

DR. SerVAAS: Thank you.

DR. PRIMM: Dr. Lee?

DR. LEE: Congressman Green, you're a very politically astute individual. Where do you think drug abuse stands in the priorities of your constituency?

CONGRESSMAN GREEN: I think my constituency is very concerned about drug abuse, and I think my constituency believes -- and I think correctly -- that drug abuse is a major contributor to our general crime problem. So I think there is fairly strong feeling in my constituency to try to do something about drug abuse.

But I've got to say, as one who has been involved in politics now for a quarter of a century, I first served in our State Legislature when we had Governor Rockefeller's first war on drugs -- that was the mandatory residential treatment program -- I had left by the time his second war on drugs came along, which was the mandatory prison sentence, but I did serve as a member of the Executive Committee of the City Bar Association a few years later when we financed the study of how that worked, and it hadn't worked either, and I just know that this drug problem is a very intractable problem, a very difficult problem.

DR. LEE: So your constituency cares, but they don't seem to care enough; is that it?

CONGRESSMAN GREEN: I don't think it's a question of caring enough. I think it's a question of what do you do about it.

DR. LEE: What we addressed before you came in our earlier discussions is, somehow society has to look to you as our leader, one of our leaders in Manhattan -- we have to approach the demand end of the equation.

CONGRESSMAN GREEN: Oh, I agree with you. I think the only way in the end that you will solve the problem is by persuading people not to take drugs. But the money is just so extraordinary that the trade will continue if people are willing to buy.

And the fact of the matter is that in the 1920s, we tried to stop the importation into this country of a product whose bulk per dollar is a lot larger, and therefore it's a lot easier to prevent, and we were totally unable to do that in the face of a population that wanted to continue to use alcohol, and I don't see how we're going to be able to stop the importation of drugs if the people are willing to pay the kind of money they're willing to pay for drugs.

If we can't choke it off by drying up the demand, we're always going to have a problem.

DR. LEE: Thank you.

DR. PRIMM: Admiral Watkins?

MR. DeVOS: Admiral, just let me get in for a minute.

DR. PRIMM: Oh, I'm sorry. I didn't see you.

MR. DeVOS: Congressman, I appreciate the war you're waging. I guess if I was fighting a war like that and losing it at this rate, and all we're going to do is figure out how to bury our dead and take care of our wounded and having more getting killed every day, I guess I'd start a new war or find a new strategy. And I think that's what the people in this town have got to start doing. We're not winning this one, are we?

CONGRESSMAN GREEN: No, we certainly aren't. But again, this is a society where people in the end decide what they want, and it's very clear that a large number of people want to use drugs.

MR. DeVOS: They also respond to leadership, if we'd show them a little better way. And I appreciate all the people here. I just think we ought to put our heads together and figure out a better approach than this one. If we were losing a war this long, we'd have gone home a long time ago.

CONGRESSMAN GREEN: That's what you're there for.

DR. PRIMM: The Lower East Side, Congressman Green, probably is one of the areas with the highest availability of drugs are. What are you doing to encourage law enforcement to be more vigilant in their efforts to curtail the drug trafficking on the Lower East Side?

CONGRESSMAN GREEN: I first got involved in this problem during the August recess in 1980, and I went around with the narcotics squad from the 9th precinct which covers that area. I went around in their unmarked car, and at that time there was a lieutenant and eight officers that comprised the whole special narcotics activity in that precinct.

We came to a building, and as we were driving by in their unmarked car, they noticed that a building which they knew the city had sealed up the previous day, an abandoned building, had its door ajar. So they dashed out, guns drawn, and there was a cinderblock wall blocking off the front of the building. They got their 100-pound ram out of the trunk and knocked it down and went in, again with pistols drawn. There was another wall with a slit through which you could pass the money and get your glassine bag out.

When they finally knocked it down and went inside, the people had obviously run out. There was a rabbit warren type of setup in back where there were dozens of ways to go through abandoned buildings and out onto the street. We didn't catch them but they had gone fast enough that they had left behind their tally sheet. They had sold over 800 bags before we got there.

At that point, as I said, there were eight policeman and one officer in charge of this whole project. I immediately got in touch with the Mayor, and big deal, we got it doubled. There are now 16 of them.

Ultimately as the political pressure mounted, the Mayor and the Police Chief threw in not another eight, but really dozens and hundreds, and people were pulled out of other precincts and worked overtime here. Operation Pressure Point has been well publicized, and you can document what it's done, and I think it's had a very beneficial effect.

There are some in other parts of the city who complain that the effect has only been to push the drug traffic onto them and away from us. But be that as it may, it's very plain that in that neighborhood it's had a beneficial effect.

But I've got to tell you that if you want to buy drugs in that neighborhood, it's not hard still, with all the police.

DR. PRIMM: I just have one more statement. Part of your district encompasses Park Avenue and Sutton Place. There you can't buy drugs unless you really know where to go.

CONGRESSMAN GREEN: That's not altogether true.

DR. PRIMM: But that's true. I agree with you it's not altogether true, but drugs are less available in that area than they are on the Lower East Side, than they are in the Harlem community, than they are in the South Bronx. My point here is that the neighbors or the residents of that community will not allow drugs in their community if they know about it, whereas the residents in these other communities are very complacent.

Is there an effort on the part of the politicians in those neighborhoods to organize those neighborhoods to be against drugs within their community, as much as there is when we have to organize those neighborhoods to get out the vote at election time? I think that would be an effective way to get some of the drugs' availability out of some of these communities.

CONGRESSMAN GREEN: Well, I have to tell you that in St. Catherine's Park on East 67th Street and First Avenue, a high-rent district, we have had a persistent drug problem, and the police take a shot at it from time to time. But it's there. We're now trying to redo the whole park to make it less inviting somehow for drug dealers to use it, and if you go by there at night, you'll see the whole place is torn up.

But I will not say to this Commission that it's only on the Lower East Side that we've got a drug problem in my district. It's all over.

CHAIRMAN WATKIKNS: Congressman Green, we had a witness before you came in the room that talked about the bureaucratic hurdles in their path hampering monies made available at the federal level from getting down to real utility at the local level. Eighteen months is routine, having to go through the state, then having to go through the counties and so forth.

In particular, one of the questions I asked -- and maybe you can talk about this a little bit for New York -- of the additional treatment money that was allotted under the Anti-Drug Abuse Act, how much of that is currently being spent by New York, and how much has filtered down to, say, your district in New York City and is really being applied? In other words, is it 50 percent? Is it 80 percent? Is it 100 percent?

CONGRESSMAN GREEN: Admiral, I can't give you that kind of specific number. I can only say that I hear from the people in the field the same sort of complaints that you evidently heard earlier this morning, that the money takes a long time to work its way through the system.

DR. PRIMM: Would you be willing, Congressman, to have your staff take a look at that specifically for your district and let me know by letter, what are the obstacles that you found in your district to getting that money that was appropriated down

to you for effective use, and is there a better way to do it from your point of view?

CONGRESSMAN GREEN: Well, let me give you some past history on that. In addition to having been in elected office, I served for seven years, from 1970 to 1977, as the Regional Administrator of the Federal Department of Housing and Urban Development, and during five and a half of those years, I was the chairman of a then institution, which has since died, known as the Federal Regional Council, which was a collegium of the Federal Regional Administrators handling grant awards and resource management, and we covered New Jersey, New York, Puerto Rico, and the Virgin Islands, the standard Federal Region II.

And on this very issue, I can recall former Mayor Ken Gibson of Newark complaining to us that he had become very painfully aware of a drug problem in Newark and wanted to try to assemble some sort of coordinated way of dealing with it. The first thing he discovered was that he had no ability to control any of the money that was flowing into Newark, and that some of it was coming from hither and some of it was coming from yon, but there was no way that he, as Mayor of the city, could really put together a coordinated effort using all of the federal resources and all the state resources that existed, but that no one could coordinate, and I think that's probably a real problem.

CHAIRMAN WATKIKNS: Would you be willing to follow up on that, Congressman, by having your staff let me know specifically for New York, what those hurdles really are and if there are some obstacles that this Commission could help alleviate, either at the federal level or inspire some leadership to talk about those kinds of obstacles?

I think it would be very, very useful to us, because we've heard that from so many sources now. And the question is, have we reached the point where we're just going to accept that bureaucratic labyrinth to get down there to where it can really be used, or is there another way?

CONGRESSMAN GREEN: I'll certainly do what I can, Admiral, to get you that material.

CHAIRMAN WATKIKNS: Thank you very much, Congressman. We appreciate very much your coming to us this morning, and we appreciate the support we have received from all members of Congress so far on the Commission. It's been a good relationship. We've made contact with a number of your colleagues, as well as those in the Senate, and we're going to keep that relationship close. And at any time you feel you have something that you'd like to convey to this Commission, we would like to receive it from you or your staff.

CONGRESSMAN GREEN: Thank you very much.

CHAIRMAN WATKIKNS: Thank you very much, Congressman.

DR. PRIMM: The Commission now would like to call a recess until after lunch, and we will convene back here at 1:00 o'clock.

[Whereupon, at 12:15 o'clock, p.m., the Commission meeting was recessed, to reconvene at 1:00 o'clock, p.m., this same day.]

AFTERNOON SESSION

[1:20 P.M.]

DR. PRIMM: Good afternoon. I would like to call the afternoon session to order and welcome Mayor Koch, from New York, and Mayor Flynn, from Boston. Your Honor, you have the privilege of leading off, especially as my mayor.

IMPACT ON CITIES

MAYOR KOCH: Thank you very much, Dr. Primm.

What I would like to do is to summarize my testimony, then take your questions which, undoubtedly, will be the better part of the hearing. What I am going to tell you, you already know. But really it is to establish a record, and getting other people to know it, and that is what is so key here.

What is remarkable is that the spread of AIDS amongst Gays seems to be coming close to control. The seroconversion rate, which I never heard of before but now know of, is less than one percent; whereas, with IV drug users, it is about eight percent.

The lesson to be learned there is education. Amongst homosexuals, they know how the disease is transmitted, and they have changed their practices. It is as simple as that. It could not have happened any other way.

With drug abusers, particularly those who are heroin users and the users of needles, there has been inadequate education. I am not even sure that education will do it. But you certainly have to try.

I say it may not do it, because the addiction and the compulsion may be so great, and the nature of the syndrome, the sharing of needles and the lack of concern about death -- after all, they face death just by overdose -- that it may not have the same positive impact that the education, with respect to Gays, has had.

But, nevertheless, we should certainly try it.

We have tried, in New York City, to get the state to allow us to have clean needles available. I don't remember what the statistic is, but most states in the Union do not require a prescription for a hypodermic.

But there are states, and New York State is one of them, where it is illegal to have the apparatus, and you may not buy it without a prescription at a drug store.

So the proposal that was made by Dr. Sencer, who was then the Health Commissioner of the City of New York, and subsequently also made again when the first proposal died by Dr. Steve Joseph, was that clean needles be available.

I am giving you information which I garnered maybe a year or more ago, so maybe it is not exactly up to date, in terms of cost. I was told about a year ago that a needle is 19 cents if you buy it wholesale, and it is $2.50 if you buy it over the counter.

Obviously, it will save your life irrespective of the cost, if you are not going to be transmitting someone else's virus-infected blood through the use of a dirty needle.

When the proposal was made for a legislative change, I -- with some pragmatism, because I don't like to spin my wheels and get involved in something that has no chance of being enacted; there are so many things that have to be attended to. If you take on those that have no chance, then you lessen the chance of getting something done where there is a chance.

So the first thing I did was to send letters with the proposal to all of the law enforcement people in the City of New York, the DA in particular. Every one of them said no.

The reasons that they gave were, one, that the culture requires an exchange of needles. That is part of the culture. Two, the addiction is such that nobody is going to stop to go and buy a clean needle.

We don't know. We know that, in San Francisco, they give out bleach. But they don't have many drug users in San Francisco. Their proportion of those who have AIDS who are infected as a result of drug use is a very small percentage.

One percent sticks in my mind; two percent. I am not far off. Two percent. With us, it is the fastest growing segment of those who have AIDS, and it will soon surpass those who are Gay. And the additional tragedies are that drug addiction is overwhelmingly to be found amongst Blacks and Hispanics. Overwhelmingly. And the women who bear infants, who as a result of infection in the womb, have AIDS when they are born, overwhelming are Black and Hispanic.

So what we are seeing is a special part of our population -- A, the drug user, and B, the wives or mistresses of the drug user -- being impacted in an astronomical way, compared with the balance of the population. So it calls out for a special response.

What we did, when we explored the question of bleach, our corporation counsel said that he thought it was wiser, from a legal point of view, that we not actually hand out the bleach, but that we hand out instructions since bleach is so inexpensive. It costs about two cents; but that we not actually hand out the bleach, but hand out instructions on how to use it.

We have workers that go out and do that. I don't know, and I doubt frankly, that it has had the impact.

The latest thing on that is a proposal by Dr. Steve Joseph submitted to Dr. Axelrod, who is the State Commissioner of Health, to do administratively what we couldn't do legislatively through a demonstration.

The original proposal submitted by Steve was rejected by Dr. Axelrod for not being a large enough proposal, in terms of the numbers to be involved. So Steve has resubmitted the proposal. The last time I talked to him, I got the impression that Dr. Axelrod was much more disposed to concurring. He can tell you that when he testifies.

When we originally got into the ad business, we do a lot of pro bono ads. We have Madison Avenue firms that donate their services, and we provide the out-of-pocket expenses.

It is not cheap, but it is worth doing. We put together television ads, and print ads, and radio ads, as it relates to safer sex. Originally, like everybody else, we referred to it as safe sex. It isn't safe -- it's safer.

That relates to the use of condoms. We do have educational programs in our public school system that encourage knowledge about the use of condoms. We make no bones about it.

Dr. Steve Joseph engaged in a program, with my concurrence, that hands out condoms in particular bars where unsafe sex practices are more prevalent. Not everywhere. In particular bars. That is both homosexual and heterosexual.

We are the only city in America that has actually closed some bathhouses -- four or five -- homosexual and heterosexual. Everybody talks about it, but nobody has done it, to the best of my knowledge.

We have actually gotten court orders where our inspectors, Consumer Affairs -- we don't use cops, but other inspectors -- find that anal sex in particular is taking place, and in public areas. We go into court, and we get court orders, and we have gotten four or five such places closed. We continue those inspections.

Steve recently advocated that the doors be removed from these stalls that are in the bathhouses, certainly, we don't want to break them down, we don't have a right to -- but they ought to be removed.

We are not talking about hotel rooms. There is a limit to how far government can go to protect you. There is just a limit. We think we are reaching that limit. Nevertheless, we are going to do everything that we can.

Our major problem on education is that the television industry is cowardly. They will not accept many of our condom ads. It is unbelievable, when you watch Dallas, that they won't accept some of our condom ads. Good taste, they say.

[Laughter.]

MAYOR KOCH: We are in constant communication with them; it doesn't help. The only thing that I think would help is if the Committee made a recommendation that the FCC require that, as part of your operating license, that you carry these educational condom ads. Otherwise it will never get done.

We even offered to pay, and they rejected them. So it isn't that we are simply imposing pro bono service. We have even offered to pay, and they have rejected them. There is no appeal from that. That is my testimony.

DR. PRIMM: Thank you very much, Mr. Mayor.

MAYOR KOCH: Can I add one more thing?

DR. PRIMM: Absolutely.

MAYOR KOCH: Senator Helms was successful in getting an amendment through, which is the most foolish amendment ever, ever to prevail in this Congress. Let me tell you what I mean by that.

The Gay Men's Health Crisis, probably one of, if not the most effective, group on education and support systems for the Gay community having AIDS, have been extremely effective in their literature.

Now, their literature is very graphic. But it is effective. Nobody gets that literature who isn't already familiar with the graphics. So they are not insulted.

Senator Helms got this literature, passed it around the Senate, and then offered an amendment that no advocacy group, in effect, encouraging anything other than heterosexual sex could receive funding from the federal government.

The Gay Men's Health Crisis is not advocating homosexual sex. It is ministering to Gay men, and therefore will relate to Gay sexual practices, and urge safer practices: use of the condom, et cetera.

As a result of what Senator Helms did, undoubtedly terrorizing the Senate -- now, how do I know he terrorized the Senate? Because only two Senators declined to vote for the Helms amendment.

Can you imagine, in that august House, that the Senators were so overwhelmed with terror, that maybe they would be accused by their putative opponents in a later election of having supported Gay rights, or homosexual activity, that they caved to Senator Helms, and only two Senators voted no.

To his great credit, Senator Moynihan and, likewise to his great credit, Senator Lowell Weiker. The only two. Then it went over to the House of Representatives. One of the members stood up and proposed that the House accede to the Senate's position in conference on that particular issue.

They had a vote. My recollection is something like 46 or 47 members voted no, and whatever it was -- 380, or so voted aye. To my surprise, only five members from New York voted no.

They all deserve a Congressional medal of honor.

He is offering about ten more amendments on this very same subject. I think the Senate is now alerted to it, and maybe they won't give in to the demagogic efforts of Senator Helms.

DR. PRIMM: Thank you very much, Mayor Koch.

Congressman Ben Gilman -- I know you have to run. I am so happy that you came.

CONGRESSMAN GILMAN: There was a call for a vote, and I will return after I vote.

DR. PRIMM: Thank you very, very much. Mayor Flynn?

MAYOR FLYNN: Thank you very much, Dr. Primm.

There are just a couple of points that I would like to make that may be of some help to this very important Commission. Let me say that it is estimated that nearly three-quarters of all known cases in the United States are in our top 20 cities, making this disease of special concern to urban officials, like myself and Mayor Koch, and other major cities throughout the country.

That is why we are on the front line on this issue. We really almost have to avoid the political expediency of the day -- whether it is the needle exchange program, as we have talked about in Boston, and encouraging our medical community, based on their recommendations -- to move forward with that particular program if, in fact, they feel that it would be helpful in minimizing the serious crises that we face in America.

One point that I would like to make. One of the most tragic consequences of the spread of AIDS into the heterosexual community has been the increased number of babies born with AIDS.

I have seen the faces of these babies myself, on a personal level, as we have opened the very first, I believe, pediatric AIDS respite center at our municipal hospital, the Boston City Hospital, to care for these tragic infants.

Many of these babies are orphans, and come from single parent families. Obviously some mothers are too ill, themselves to care for babies being born with AIDS. We have opened this facility. I might add that in every case, the children born there are children of IV drug users.

Which, I think, can galvanize public support in some respects, because I don't think anybody -- whatever their position is on the issue of AIDS -- they would want to look the other way, in dealing with the medical life and death needs of infant babies.

Let me give you just three good reasons why the pediatric center should be of special interest to this Commission. First, it is an approach to AIDS care which is not available many places, or anywhere, and certainly should be expanded to most major cities, throughout the country when needed.

Second, the center requires access to medical facilities, as well as trained health professionals. This makes it an extremely expensive proposition and, therefore, an excellent candidate for increased federal support.

Lastly, infants with AIDS serve as the most poignant examples of the changing face of this deadly disease.

As an example, as I indicated, I would just like to underscore this point -- and I think Mayor Koch has really outlined the concerns of major municipal officials, and that is that every single baby in our pediatric AIDS clinic is there as a direct result of intravenous needle sharing by parents, or their partners.

I think that, perhaps, is the most compelling reason why the information indicates that the drug users are our most significant concern in dealing with the issue of the spread of AIDS.

Like other cities in the country, education in the homosexual community has had a profound impact in minimizing the spread of AIDS. We have an AIDS action committee in Boston that has done a terrific job in enlightening the public in the homosexual community on the situation of unsafe sex.

As a result of that, you can see the percentage of AIDS reducing; but, correspondingly, you can see the increase in drug users.

So I offer those observations to this very important Presidential Commission. Again, I think that it should not be perceived as a local problem, or a federal problem, but it is education. City, state, federal governments working very closely with the community, educating the community, as to some of the real facts and the real situations I think are very, very important that we communicate to the public along these lines.

Along with Mayor Koch, I would be happy to answer any questions the Commission may have.

DR. PRIMM: Thank you very much, Mayor Flynn.

First we are open for questions now. I will start out, Mayor Koch, asking you what can we do in New York City, or what can you do, your administration, or with my help and the help of the Health Commissioner who sits right behind you --why don't you join Mayor Koch, Steve? -- to get communities to be more receptive to drug treatment programs, and the expansion of drug treatment programs.

I know you are trying. I just feel very strongly that we are not doing enough, or it is not having any effect. That's number one.

How can we mobilize blocks and communities to have less drugs sold in their areas, like we do in Staten Island, like we do, say, in the Park Avenue areas on Sutton Place?

MAYOR KOCH: Let me first take the first question, which was how can we provide more treatment for drug addicts. The City of New York has made an offer to the State of New York -- the State of New York is obliged to provide actual treatment.

It is not the City that does it, and I don't want the City to get into the position of taking over a state function, because we don't want the State paying for our cops, and we don't

think that we should take money from hiring cops to pay for drug treatment, because that is the State's obligation.

But what we have said to the State is that, since there are 1,000 people, minimum, signed up waiting for a spot to come in for treatment -- and they are told that they have to wait more than three months in many cases -- that we would immediately, if they operated them at their expense, provide them with facilities in every one of our hospitals, and every one of our dozens of health clinics run by both the Department of Health and the Health and Hospitals Corporation, which are not used in the evenings, and which could be used for providing methadone treatment, and the other modalities, that are available.

I am told that that offer has been well received by Dr. Axelrod, and he will be coming in to discuss it with the City administration shortly. So that is number one.

Secondly, with respect to what the federal government can do, two things. One, they can make monies available. It is inadequate what they currently make available for drug treatment. Secondly, they set the standards as it relates to patient-doctor or practitioner ratio.

We think that can be expanded. More clients per medical dispenser. That requires a change on the part of the federal government's regulations. I hope that you would urge that.

If the State were to take advantage of our offer, they would immediately have available 5,000 slots for additional people who need help. It is really outrageous that a drug addict who becomes motivated and makes the call -- he may never make that call again in his whole life -- and says, I want to come in from out of the cold, and they say, No, you have to stay out in the cold for another three months.

That is not acceptable. In the meanwhile, he is out there beating people up, robbing, assaulting, to get his dollars for his fix.

Now, with respect to preventing drug addiction: that was another question that you raised. I have been in the trenches, on this issue for many years. As a Congressman, as a mayor, almost every year, I testify.

We got very close, last year, to what we wanted. Not close enough, but much closer than ever before, on funding. Then the bill was gutted by President Reagan, who didn't spend the money.

In addition, we didn't get the one thing that we wanted desperately: military interdiction. Heroin and cocaine cannot grow, for climatic reasons, in the United States. Cocaine comes from four countries in Latin America. Heroin comes from many more countries around the world, and Asia is primarily a major source.

If -- and I have used this example many times, it has become trite -- but if the Russians -- and this was not glasnost -- were sending in people with bombs and grenades and dynamite over our borders, we would say, What's happened to the Army, their job?

But when we say, What's happened to the Army? They say, this is not our job. And, in truth, the law -- called posse comitatus -- prohibits the military from enforcing any of our civilian laws.

It has to be changed. I will tell you why the military doesn't want to change. Secretary Weinberger, of sainted memory, no longer with us -- just a joke -- he was against it. You know why, I believe? Because they think they will fail.

The military does not want to be given this job, because they think they will fail. Well, everybody else has tried, and we have failed. We are now in a position -- these are 1983 figures, they haven't given new ones, to the best of my knowledge -- in 1983, of 18,000 planes that came in with drugs, according to the federal government, only 203 were apprehended. About one percent.

Of every 100 boats that came in, said the federal government, only six were apprehended. Just think of that. Supposing you said it was the Russians who were coming with their planes and their boats, and those numbers prevailed.

We would say we lost the war. Well, that's exactly what you can say about the drug war. We have lost the war. It can be changed, and the amendment is known as the Bennett Amendment.

Charlie Bennett is a member of Congress. He has fought this battle, because his own son died of an overdose; therefore, it has become his major cause in life, to prevent it happening to others.

Every time, every year -- year after year -- that we get the Bennett Amendment through the House of Representatives, it fails in the Senate. We would urge that you support the Bennett Amendment.

DR. PRIMM: I appreciate that offer, because that's on one level of interdiction that I think certainly we need greater effort, and I agree with you, and I do think that we have failed considerably.

My question to you, though, is more at the community level. What can we do in the cities to mobilize the blocks, to mobilize the neighborhood, to encourage them to get in the fight, an army against drugs, at that level? So no drugs are sold on their block.

MAYOR KOCH: One of the proposals is that the federal government create a corps, an anti-drug corps comparable to the Peace Corps, with youth workers going into those communities. I don't believe it, frankly. I mean I'm for it, because you have to take as many opportunities as you can, until you try it and it fails. I do not believe that education not to use drugs will ever prevent use of drugs. Not in this drug-related society.

Now what I'm saying to you, you've heard a thousand times. We are a pill-popping society, and therefore pills in their different forms or drugs in their different forms are no strangers to the house. Alcohol, everything else, causes people not to have the same high protections in their minds against drugs that they should have.

So I believe that while we should continually educate -- I mean it's ridiculous if Mrs. Reagan -- and I really respect her, I think she's really taken a wonderful position in this matter -- if she really believes "Just Say No" is going to change drug addiction in this country. It's not going to --it's not true. It won't. Sure, we should keep saying "Just Say No." But if instead the emphasis -- and here maybe the President he got hooked on supply and demand and he decided that as it relates to the economy, it's the supply side that he wants to be supportive of. In the drug area, it's the demand side that he wants to concentrate on. It won't work. The man is not going to lessen -- look at all these people that smoke cigarettes and on the package it says "This Can Cause Your Death," and it does, they smoke, anyway. And that's an addiction, not as powerful as a drug addiction.

So somehow or other, you're talking about the demand side. We should try it. It's not the solution. The supply side is, and it is within our power to reduce and eliminate that supply, since the supply cannot be homegrown.

DR. PRIMM: Thank you. Commissioner Gebbie?

MAYOR FLYNN: Doctor, could I just touch on maybe a couple of observations --

DR. PRIMM: Absolutely, Mayor.

MAYOR FLYNN: -- I agree with what Mayor Koch said, and that is the root of the problem. The two points that I would just interject is one, I hear an awful lot of law enforcement officials in Boston, and I'm on the Commission on AIDS of the U.S. Conference of Mayors who have had this conversation about IV drug users and so forth.

I hear a lot of law enforcement officials, very, very disillusioned about the revolving door policy in our courts. Pushers are brought into court. They're back out on the street because of the huge profits that they can make. The system doesn't protect society against drug pushers and the exorbitant profits that they can make.

And number two, just last night or the night before, we had a large group of young people, particularly coming from minority communities of the city of Boston, working with us as part of our education policy, designing and promoting a particular public service campaign, and we had a competition, and the competition -- they had several spots that prevailed. They were incredible. The product that the young people came forward with in encouraging other kids not to engage in drugs was quite significant. I think that ought to be something that ought to be considered very seriously as well as part of the education.

If I had my way, education would begin at the lowest levels of children's education. I'd make mandatory programs within the school, fifth grade, sixth grade, like you have an inspector program in New York, and Boston has the same program. Mandatory programs for drug education in the schools for public and encourage private schools as well. We have seen that in terms of dealing with the crack problem, that that has had a profound positive impact.

MAYOR KOCH: May I also make an addition?

DR. PRIMM: Mayor Koch, could I ask you to indulge us just for a moment, because Mr. Gilman has to go back to the House floor, and Ben has some testimony he'd like to give.

MAYOR KOCH: Of course.

DR. PRIMM: Thank you. Congressman Gilman.

CONGRESSIONAL VIEWS
(RESUMED)

CONGRESSMAN GILMAN: Thank you, Mr. Chairman. I appreciate your accommodating us, and I regret that I had to leave the good mayors to go vote. And I want to commend Mayor

Koch and Mayor Flynn for taking the time to appear before the commission.

Let me congratulate Admiral Watkins and yourself, Dr. Primm, and the entire Commission for the good work you are doing in trying to focus attention on this very critical problem confronting our nation, and I want to congratulate the Commission for having Dr. Primm's expertise as now part of the Commission, someone we have consulted with for many years on our Select Committee.

I am certain that with Dr. Primm's contribution to the Commission, additional insight will be gained regarding the many problems that affect the intravenous drug abusing community. Dr. Primm has worked with our Select Committee on Narcotics.

I'd also like to commend the Presidential Commission for recognizing that IV drug abuse-related AIDS warranted additional investigation, something that our Select Committee has been attempting to focus attention on for many months. And I welcome this second opportunity to discuss the matter with you today. We all regret that such a follow-up is necessary, since it indicates the seriousness of the problem. Yet perhaps together we can fashion a workable solution.

Permit me also to commend the Conference of Mayors, and particularly Mayor Koch for arranging a municipal conference on AIDS not too long ago that brought many of us together to seek some solutions nationwide. And I think that helped to raise the consciousness of the problem, something that is sorely needed to attempt to find an eventual solution.

Mr. Chairman, less than three months ago, Chairman Rangel and I appeared before this Commission to discuss the growing dangers of AIDS among intravenous drug abusers, and ultimately the heterosexual community.

Unfortunately, though, in this past quarter, the situation hasn't changed, which in this case means that things have gone from bad to worse. There are currently some 47,000 diagnosed cases of AIDS, and the percentage of those which are IV drug-related has remained stable at about 25 percent. The vast majority of IV drug users suffering from AIDS are black and Hispanic, and they are mostly heterosexual.

IV drug use constitutes 50 percent of the cases of females with AIDS, and the HIV virus is now the leading cause of death for women in New York City between the ages of 25 and 34. What we need to combat the HIV virus as it affects the drug-abusing population specifically are more effective programs to inform and to treat IV drug users at risk for AIDS.

On the heels of information comes the need to implement a comprehensive course of treatment and prevention for those many individuals. And I want to commend you for focusing attention on those needs in your recent preliminary report.

Prior to the enactment of the landmark Anti-Drug Abuse Act of 1986 -- and I might note once again that we provided for the first time major resources to try to combat narcotics abuse and trafficking in our nation, close to some $3 billion over a three-year period -- prior to the enactment of that measure, we learned that in New York, for instance, many drug treatment facilities were running at over 100 percent capacity. Even with the influx of additional federal dollars, many centers are still having to turn people away, Beth Israel Methadone Clinic, I understand is running almost a year to a year and a half behind in being able to take care of methadone patients. Add to this the need to cope with the AIDS problem among the drug-abusing population, and we all recognize the real need for an added federal response to the epidemic of AIDS.

Last summer the Select Committee conducted a mission to Europe and to North Africa, where the discussion of drug-related AIDS was high on our agenda. We met with Dr. Raymond Dedonder, Director of the Paris-based Pasteur Institute, one of the leading research institutes in the European continent, as well as with Dutch officials and other health professionals.

The need for a global strategy to respond to this newest part of the HIV epidemic is clear. The French government believes that up to 200,000 people in France may be carrying the AIDS virus. Between 60 to 80 percent of heroin addicts in France are already carriers. There are over 1000 reported cases of AIDS in England and Scotland and Wales. The British, however, have mounted a $30 million media campaign which specifically aims at drug addicts and potential drug users.

In Scotland, intravenous drug abusers represent 56 percent of the more than 1200 people in Scotland known to be infected with the virus. And the figure is 7 percent in the remainder of Britain.

These few examples graphically illustrate the need for stepped-up efforts worldwide, efforts to expand research, prevention, and treatment activities. And although a great deal of information about the AIDS virus and its modes of transmission has been publicized in this nation, it is obvious that we need much more of it. We need to stress implementation as well. And we need to follow up informational efforts with viable programs to implement our goals of prevention, of treatment, and reduction of transmissibility.

Others have testified before this Commission of the gaps which exist in treatment of HIV, short of hospitalization. If we do not address the problem of IV drug abuse-related AIDS soon, the Centers for Disease Control will have to adjust its grim figures. As you may be aware, Chairman Rangel and I introduced legislation earlier this year which would authorize $400 million in grants for a variety of AIDS-related drug treatment and drug abuse prevention services. H.R. 3292, which is entitled "The Intravenous Substance Abuse and AIDS Prevention Act of 1987." It's viable and forward-moving legislation that I think deserves serious consideration by the Commission, and we would hope you would take a look at it and make some comment with regard to it.

These grant monies would allot $200 million for treatment and counseling services for IV drug users; $100 million for demonstration projects to reduce the incidence of AIDS in infants. I wish the Commission could have been with us when we visited Harlem Hospital at the invitation of Mayor Koch and saw some of the boarder babies that were there as a result of this infectious disease.

The remaining $100 million would be for projects that prevent the spread of AIDS through IV substance abuse. This would include educational outreach efforts, such as media communication, and yet we are all cognizant of the fact that AIDS is still a controversial topic on Capitol Hill, which has led to a stalemate legislatively.

Therefore, Mr. Chairman, and our good Commission members, we look to your Commission for the kind of leadership and guidance and impartial expertise that is so sorely needed if we are going to combat this newest epidemic. And we commend you for your initial report. We encourage you to go further, and our committee stands ready to give assistance in any manner. And we hope that the new year will help us all bring new insights and a redoubling of efforts to find a comprehensive and compassionate solution to this tragedy that's inflicting so much harm and so much tragedy on nations throughout the world. And we assure you of the Select Committee's readiness to assist the Commission in whatever instructive proposal you may bring forth. Thank you.

DR. PRIMM: Thank you, Congressman Gilman. Do we have a question for Congressman Gilman before he has to leave? Anyone?

CHAIRMAN WATKINS: Before we ask any questions, I'd like to acknowledge Congressman Gilman's leadership role in Congress. I think he and Chairman Rangel have done an incredible job, courageous job in exposing this lethal hazard. We will do everything we can, to air this issue further and to try to move it into programs in some very specific way. So we very much

appreciate the work you have done, Mr. Gilman, and we want to continue to work with your committee. As the heterosexual relationship to IV drug abuse begins to get exposed even more, as the incidence rates in the gay community come under control, as was mentioned by Mayor Koch earlier, I think it's going to have a sobering impact on the nation. Many of us feel the projections are underestimated, and some of the latest reports coming out of the Committee on Children, Youth and Families in the House, plus special infant mortality commissions under Senator Chiles have indicated we have 10,000 to 20,000 projected pediatric AIDS cases in '91, and not the few hundreds that are now projected.

So with all the ramifications that we know, it's very serious, and we very much appreciate the leadership role you have taken.

CONGRESSMAN GILMAN: Thank you, Admiral Watkins. And I want you to know that the Congress will look very carefully at what your recommendations will be, and we look forward to receiving those at an early date. And again, I want to commend the two mayors for their great work in keeping this issue before the public. Thank you.

DR. PRIMM: Thank you very much, Congressman Gilman, for your well wishes, and would you thank Congressman Rangel for me. Mayor Koch?

MAYOR KOCH: I just wanted to add, I was just given a note by a member of the audience saying that he was disappointed that I had not voiced concern about the federal government's research program, which is woefully inadequate, and for the very simple reason that it's not my expertise. I'll leave that to Dr. Steve Joseph. There is no question, in my judgment, that we are being much too careful in allowing the various experimental drugs to become available.

We in New York City have made AZT available in our hospital at no cost, and we provided funding for 800 people who would come in -- I think at this moment 536 have come in. And if that cap of 800 is not adequate, and more come in, we will raise the cap.

It's not my field, it is Steve Joseph's and yours, to determine whether or not all of the laboratory requirements in terms of experimentation are being adequately funded. But obviously it is a very serious matter, and I hope you address that as well.

DR. PRIMM: Commissioner Gebbie?

MRS. GEBBIE: Yes. A question really for both mayors, asking for some more comments.

A lot of us separate the educational struggles we have educating people such as IV drug users, who are already at risk for this infection, from our next generation which hasn't yet become at risk, but needs to know what to do to prevent it, and mentions are even made of the sort of social schizophrenia of having various kinds of drugs around, but saying no to drugs; having very sexually explicit programming, but not wanting to run certain ads.

MAYOR KOCH: Right.

MRS. GEBBIE: What do you have to offer about the political hazards of elected officials --

MAYOR KOCH: There aren't any --

MRS. GEBBIE: The whole leadership role of how we start sorting out some of that schizophrenia? For both mayors.

MAYOR KOCH: Let me say, I believe that there is no political hazard facing any public official who speaks out with respect to AIDS. Drug addiction surely is not an issue any more, and being opposed to it; everybody is for being opposed to it. As it relates to AIDS, I have never ever felt any political repercussions, that I have taken a very active role here.

Thinking of Senator Helms, to me it is amazing that an entire Senate would knuckle under to such a knuckle-headed amendment. That's my belief. And yet they did. Because they believed that somehow or other they're going to be held up to public ridicule, contempt, and maybe some demagogue in their district will run against them and say they were supportive of gay rights, which people should be, or that they somehow or other were assisting people with AIDS, which they should be, that this somehow or other will affect them adversely. Not at all. I don't believe it. And even if it did, on matters of conscience -- and surely this is a matter of conscience -- if you are a minority of one, you should stand up.

MAYOR FLYNN: I would add to that, for example, people at the City Hospital in Boston came forward to me and said, even though we've been in the forefront on the issue of AIDS as it relates to the homosexual community in dispensing a lot of public information, and I think we are one of the first cities out front on it and dealing with it, we are very proud of the stand that we did take on it, but an issue that I thought did generate the predictable political opposition was the needle exchange program. It doesn't have media support; didn't have -- no other political people were willing to come forward. But gradually, as people become more and more aware of it, that dirty needles are the fastest growing increase of AIDS, it's like

taking bullets out of a loaded revolver, this type of program. People just don't understand what they're dealing with. They think somehow it's encouraging drug use. And that's really not what it is, as we all know.

So it does require, a little bit of political fallout until we reach the period of time when people are sufficiently educated-- would you say, Mayor?

MAYOR KOCH: Yes, could I just add to that? I do a lot of speaking in community groups and churches, and ofttimes I will ask the question before I give an explanation. I will say how many people here believe that we should provide condoms so as to limit the spread of AIDS? How many people here think we should provide clean needles? And invariably the vote is against the issue on both cases, and then I say well, now, let's talk about it. If you have to choose between providing a condom, which you think is immoral, and you have a right to that, and if you believe that it's going to prevent in a great number of cases someone getting AIDS and passing it on to their female companion or their child, what about that? And I have found that people change.

Now with respect to the needles, Ray is right. That seems to be more difficult to overcome. But the fact of the matter is that the people who are suffering the most as it relates to drug addiction and the spread of AIDS because of contaminated needles are blacks and Hispanics. And what we have got to get across to particularly the black and Hispanic community is they have to be up there speaking out, because I believe that we're not getting as much encouragement from different levels of government because the two groups most vulnerable happen to be gays and happen to be minorities; that if this disease were spreading like wildfire amongst whites, like smallpox might, that you'd have whatever it takes. You'd have a Manhattan Project in World War II.

Now we have got to alert people, and I say particularly the gay community is alerted. I mean they are out there and advocating, and quite properly, and they should be commended for it. The black and Hispanic community is not. And they should be.

MAYOR FLYNN: We have been holding periodic meetings with black and Hispanic clergy members in the city of Boston, and starting off, a number of the clergy people were philosophically opposed to many of the things that we are talking about here. But, nevertheless, we told them we have an epidemic here that we have to take extraordinary means to deal with an extraordinary problem. And despite the fact that you may have a moral disagreement on a dramatic health crisis in our country is something that we have to deal with. And so we are gradually

getting a number of black and Hispanic leaders of the clergy -- who, by the way, have a tremendous amount of influence, as I find --

MAYOR KOCH: The most.

MAYOR FLYNN: -- the most, over their constituency, and again, that is beginning to make significant progress. As a matter of fact, one of the last points that we -- what we do as well is we have trained educational in-house workers, street workers and medical workers going into the neighborhoods, into the back alleys of areas of the city like minority areas of the city of Boston, seeking out people who are likely to be engaged in drug use, and encouraging them to participate in various programs and be part of our educational program. That also is working very well.

DR. PRIMM: Thank you very much. Dr. Crenshaw?

DR. CRENSHAW: Mayor Koch, you made a suggestion about how to interfere with the supply of drugs to the United States, and I would be interested if you have any additional suggestions, particularly in view of what I read about the international politics of supply and demand in America?

MAYOR KOCH: I do.

DR. CRENSHAW: And then secondly, what is your opinion of the value or lack thereof of drug testing in America on job sites or other circumstances?

MAYOR KOCH: Okay. Let me take the first one on diplomatic actions to be taken.

There is an existing law -- and Charlie Rangel, I believe, was the initiator of that law, and it goes back more than ten years -- and it says that if a country is not doing enough to interdict drugs within its borders, that we should cut off military and economic aid, and if we don't, that the President has to certify that it's in the national interest, notwithstanding that, to continue the aid.

So the President on the last occasion said that the three countries that -- if I can recall them correctly -- that we know that are not doing enough are Afghanistan, Iran, and Syria. We don't give them any aid, so there's nothing to cut off. And the countries that do not do enough and permit the export to us, which would be Bolivia, Peru, Columbia, and Mexico, which we do give aid to, that he finds it in the national interest to continue the aid. Now he took one small step recently, I think for Bolivia.

It's not enough. Listen, those people are killing us. I want to go a little bit further and use your question, if I may, to say something that probably most of you don't agree with.

[Laughter.]

I believe in the death penalty for major drug purveyors. I'm not talking about the little guy on the street who's selling drugs for his personal fix. I'm talking about the people who are making multimillions of dollars and occasionally -- rarely, but occasionally -- we catch them. And very often we let them go out on bail, and then they skip, and they go back to their countries of origin. That's not anecdotal; that's a fact. It's happened. I think in one case they posted -- maybe it was a $10 million bond; it was a huge bond -- they left it. They can triple that and save their lives by fleeing back to their countries.

You know, in Malaysia they don't have a drug problem anymore. They don't, because they imposed a rule that says if you sell da-da, which is what they call drugs, you are subject to execution, and they have, in fact, over the last ten years executed -- the last time I looked at it, it was like about 27 people. Nobody gave a damn about it until they executed two Australians, and then the whole world said, "How can they execute these" -- they didn't worry about the Malaysians who were being executed. They saw a little racism that was involved there. Suddenly it's two Australians, and it becomes a big deal. I don't think there's been another Australian who has sold drugs in Malaysia since the last two were executed.

[Laughter.]

Now what's wrong with that?

DR. PRIMM: Thank you, Mr. Mayor. Dr. Lilly?

DR. CRENSHAW: My second question, would you comment on the testing of Americans for drugs?

MAYOR KOCH: Testing is a very difficult issue. At this moment, the position that we have in the City of New York -- and here I take my lead from Dr. Steve Joseph; he's the expert, and I agree with him -- is that there should not be mandatory testing.

Oh, drug testing? I thought you meant on the AIDS virus.

DR. CRENSHAW: Drug testing. Do you think it's of any value?

MAYOR KOCH: I'm going to tell you what we believe on drug testing. We believe the courts are crazy. That's what I believe.

[Laughter.]

The courts in those cases that I have reference to have said that you cannot test people who are in what we refer to as high hazard occupations, like cops and firefighters, where your life depends on their not being under drugs. The court cases thus far that I'm aware of say that unless you have reasonable cause or a reasonable basis, that you can't do drug testing at random.

Our Police Commissioner wants to do drug testing at random, and I'm for it. I'm absolutely for it. But we are always going to do what the courts tell us, unless we can find a way not to.

[Laughter.]

That's legal. That's legal. I want to make it clear.

[Laughter.]

It's got to be legal.

DR. PRIMM: Dr. Lilly?

DR. LILLY: Mayor Koch, I also have a couple of questions. I'm just wondering, you don't seem to have a very high opinion of the ultimate value of education against drug abuse.

MAYOR KOCH: It isn't working.

DR. LILLY: I'm wondering if you think that we'd be wasting our time to try to push safer sex education among the drug using population?

MAYOR KOCH: We should do both.

DR. LILLY: Would you be equally pessimistic about the --

MAYOR KOCH: Listen, we should do both, spend as much money as we can. If the FCC required as part of your license, which they currently or used to do, that you had to do some public service programming -- I don't know; probably President Reagan removed that already; I don't know -- but if they still have to do some public service -- or if they don't, then we should require that they do -- these ads, I mean this is a

national tragedy. This is a situation where people are dying. The numbers are growing exponentially. And the best advertising in the world is TV. There's nothing that compares to it.

DR. LILLY: You're talking about advertising in the media now. I'm under the impression that that is not perhaps the best route to get to drug users.

MAYOR KOCH: What's the best route, then, Doctor?

DR. LILLY: Personal contact within the community.

MAYOR KOCH: I'm not opposed to it. But, you know, I will tell you why I don't think it's the best --

DR. LILLY: I'm just not sure that the message will get there.

MAYOR KOCH: People who run for public office over the years have gotten a little experience on what causes people to vote for them and what's the best contact you can make. And if you look at where people who are running for public office spend their media money, it's overwhelmingly in television.

DR. LILLY: But have you ever aimed your vote-getting drives to the IV drug user community?

[Laughter.]

MAYOR KOCH: No, no. I'm not talking about that. No, no. I am talking about just making a point with anyone, not just the drug user. I'm talking about as opposed to knocking on a door, which is what you're talking about, only talking to a drug user.

DR. LILLY: I'm just saying that I don't think the IV drug using community really pays a great deal of attention the way much of the rest of the population does to the major media.

MAYOR KOCH: You may be right. And I'm not opposed to it. And maybe you ought to commission a study on that as to what would most impact on the drug abusing community. If you're right and it is the personal contact with someone talking or giving a leaflet, let's do that.

But until I'm convinced otherwise, I believe the most impacting message comes from the television tube.

DR. LILLY: Another question. We have a tendency to believe that we can't win the war on drugs by trying to prevent their importation, and that even trying to get at the drug sellers is not going to work terribly well.

MAYOR KOCH: I disagree with that. I think if we apply --

DR. LILLY: Well, I hope you're right. But I detect a tendency in the public to feel that we ought to go against the drug users themselves with criminal penalties.

MAYOR KOCH: Well, that's hard to do unless you are a pusher. I don't believe anybody in his right mind is going to want to have enormous punishment for the personal drug abuser, as bad as it is, who is committing a form of suicide, but is not selling to somebody else. It is not a violation of the law to be a drug user. It is a violation of the law to be in possession of drugs. Just because you know someone is a drug user, you cannot arrest them. Possession of drugs or the paraphernalia is what is a violation of law; sale is.

So I haven't given up on the supply side. I believe if we put the resources -- the Army, the Navy, the Air Force --at our borders to do the work, that we would stop the supply.

DR. PRIMM: Dr. Walsh?

DR. WALSH: Mayor Koch, I have one or two questions, but I want to make a comment first, and that is that apropos of your comments on research, I think that's a little bit unfair.

We have made remarkable progress in research on the AIDS virus, not only here but worldwide.

MAYOR KOCH: I said I didn't have the information.

DR. WALSH: But you accepted the criticism.

MAYOR KOCH: I did, yes.

DR. WALSH: And I think that really on that score, our scientists, both in the public sector and the private sector, have done a pretty remarkable job, and I think Dr. Joseph would bear that out, in a relatively short time.

Now whether we were a long time in recognizing or not, that is something else again. And we have never been in a better position than we are today to do competent and good research. That's the one hopeful sign I think we have on the horizon.

MAYOR KOCH: Good. I'm glad to hear that.

DR. WALSH: I think the second comment I wanted to make is that the idea that the European experience in saturation television and so on that Congressman Gilman referred to as

working is a myth. They are having precisely the same experience despite this, and Australia saturated television for two years before they did, of the disease spreading to minorities, just as we have in this country, along with what Frank has said. They are having difficulty reaching precisely the same populations, and I think we can benefit from that experience and learn from it, because when we do get a media response, let's get the right kind of media response and give them the right stuff.

MAYOR KOCH: I agree.

DR. WALSH: Now the question I have is just one. I happen to agree with your idea. I would love to see the military interdict the importation of drugs, and you equate this really to an absolute war on drugs and also war on drug-related AIDS and the like.

Does this in any way affect your views on confidentiality and contact tracing of people suffering from AIDS who also are spreading the disease knowledgeably? I'm just curious.

MAYOR KOCH: I'm going to tell you. It was Commissioner Joseph who believed and stated that he thought that the doctor has an obligation to assist the spouse or companion or lover of the person, and therefore there should be a tracing, and I adopt and support his position.

DR. WALSH: I know Steve talked about that to us the other day. Would you advocate legislation along that line?

MAYOR KOCH: I don't know. What's your position on that, and then I'll tell you whether I agree.

[Laughter.]

DR. WALSH: Well, you tell me what my position on it should be, and then I'll give it, and then you can decide whether you agree.

There are 45 bills up here in the Congress, and we're reading them all, and they're confusing us.

MAYOR KOCH: I have a philosophy, but I'm not an expert.

DR. WALSH: Right. I understand that.

MAYOR KOCH: And I want to hear from the experts.

DR. JOSEPH: Let me say three things in response to your answer, Bill.

DR. WALSH: Okay.

DR. JOSEPH: The first is, I think some of the Mayor's remarks have been misinterpreted as to whether we think it's TV or street work or whatever. Our policy in New York is that you have to do it, as I said last week, all across the board. You talked to the ADAPT people this morning; we fund ADAPT. We have workers on the street.

DR. WALSH: I agree.

DR. JOSEPH: We think you need mass media. We have, I think, the hardest-hitting TV spot showing people sticking needles in their arms. We can't get the TV networks to run that spot. It has to be done all across the board. There is no magic bullet.

On the individual protections versus the protection of society issue, it's the same thing. There has to be a balance. There has to be a balance between the protection of society and the protection of the rights of the individual.

DR. WALSH: Right.

DR. JOSEPH: That balance may well change in different stages of the epidemic. To this point in the epidemic, because of the chilling nature of the stigmatization and discrimination related to information related to the HIV virus, it has been very important from the public health point of view as well as the individual civil liberties points of view to avoid mandatory testing, to avoid forced registration, to avoid any kind of forced contact tracing. And our position has been strongly that testing should be voluntary, medically confidential, counseling based; that it is important, as I said last week, to go forward aggressively with the notification of contacts and the physician's obligation to warn the partner who is at significant risk, but to do that in a context of voluntarism.

We believe there ought to be legislation that supports the protection of those confidentialities, but also protects the use and disclosure of information when it is appropriate and not for inappropriate matters.

DR. WALSH: Fine.

MAYOR KOCH: I concur.

DR. PRIMM: Mr. DeVos?

MR. DeVOS: Mr. Mayor, you mentioned you had closed a few bath houses. I just wonder how many you think you have in

New York City. They talked about 10,000 or more crack houses in Detroit the other day.

MAYOR KOCH: Bath houses are not the same.

MR. DeVOS: I understand that. But I really reference the point, because they were speaking of the numbers. Do you have any idea how many you have in a city like New York?

MAYOR KOCH: Bath houses?

DR. JOSEPH: Many less.

[Laughter.]

MR. DeVOS: I hope so.

DR. JOSEPH: No. I mean that to make a point. I think again our policy has been across the board, the carrot and the stick, the educational approach as well as the appropriate legal sanctions. Four establishments have been closed in New York City. Many more have closed voluntarily. Much of the activity that took place before the implementation of these efforts have changed the kinds of activities that take place.

We think there's still much work to be done, and that is what resulted in the request that we've made to the State Public Health Council that the Mayor mentioned a few moments ago.

DR. PRIMM: There is a lot of sex that goes on in crack houses, too, where women are there who are pretty much stripped and just waiting for a fix.

MAYOR KOCH: The difference is a crack house is an illegal establishment. It's not licensed in any way, whereas bath houses are. So if we know a crack house is there, irrespective of the sexuality that may be practiced there, if the cops can make a buy, we're going to arrest the people who are there.

DR. PRIMM: I wanted to make that distinction, Mayor Koch, because we're finding a number of people in crack houses that are prostituting themselves to buy crack.

MAYOR KOCH: Sure.

DR. PRIMM: Because it's such a short acting drug, and it certainly plays a significant role in this whole transmission of the virus.

MAYOR KOCH: We agree.

DR. PRIMM: Because of the sex act. Yes, Dr. SerVaas?

DR. SERVAAS: I congratulate you on closing those bath houses. Do you close shooting galleries? And my question is, if we can't enforce the law in New York City, you can't keep people from using illicit drugs, have you considered --I'm not advocating this, but have you thought of asking for legislation making drugs legal?

MAYOR KOCH: No, absolutely not. We're against it, and we think that that would not solve the problem. And without giving you all of the arguments, they did it in England, and then they changed the law because it spread the use of drugs. So I am unalterably opposed to legalization.

Secondly, with respect to what we are, in fact, doing to interdict on a local level, 68,000 people who were pushing drugs were arrested, and this year the number will be up to 80,000. It is impossible for the courts and the jails to handle that; that's easily shown. We only have 16,000 cells in the city of New York, and they're all occupied.

[Laughter.]

And the state has 35,000 cells. The whole national prison population is only 40,000. We have 10,000 more people in jail than does the Federal Government.

The Federal Government should open up large jails. I have advocated in the deserts of Nevada and in the tundra of Alaska, so that there not be this rotating system where you arrest them, and they spend three days in jail, and then they're out on the street.

DR. PRIMM: Thank you. Dr. Lee?

DR. LEE: I wonder, are you going to keep the chapter in the book that you and Cardinal O'Connor are writing on condoms?

MAYOR KOCH: Somebody said to me today that the Cardinal criticized the Bishop's report, and the reporter said to me, "Well, what's your position on that?" I said, "Have you ever heard of the old line, render unto Caesar that which is Caesar's and unto God that which is God's? When you're talking to me, you're talking to Caesar."

[Laughter.]

DR. LEE: I concur.

MAYOR KOCH: I said in our public schools, we educate on condoms and we will continue to do that. What they do in parochial schools is God's work, and there you go talk to the Cardinal. And I have no criticism of anybody's religious feelings. But in our public schools, we teach what condoms are all about. And we also preach and teach abstinence as the safest sex of all, and particularly for juveniles and adolescents. We have commercials that do that.

DR. LEE: Could you elaborate on your proposal to use the military more extensively in the drug war?

MAYOR KOCH: The reason that we now prohibit the military under posse comitatus from interdicting drugs or enforcing any of our other laws goes back to racism in the Civil War when the Army was used to enforce the rights of the freed slave, and when the South rose again, as they referred to it, they got the Congress to eliminate the Army from enforcing civil rights. That's the history of this thing. People think that the Army is barred, the Armed Forces are barred because of civil liberties. Just the other way, historically. The Army and our Armed Forces were used for enforcing civil liberties and civil rights, and then it was the Ku Klux Klan and their supporters who got the Congress to eliminate the Army. I believe the Army should be used at our borders.

DR. LEE: One last question. I'm sorry Mayor Flynn is not here, because he talked about education at the five year old level. Any studies that I've read where education is a value in preventing drug abuse gets the family into it.

MAYOR KOCH: Sure.

DR. LEE: Now you are chairman of the board of the worst blackboard jungle in the United States --

MAYOR KOCH: I disagree with you on that. What city do you come from, Doctor?

DR. LEE: Greenwich, Connecticut. No. I come from New York City.

MAYOR KOCH: You come from New York City.

[Laughter.]

MAYOR KOCH: You know what President Johnson referred to that as? Urinating in the well.

[Laughter.]

MAYOR KOCH: That was his line, not mine. Now, the truth of the matter is, without spending all of your time on it, when it comes to comparing New York City with any other major city -- Chicago or Boston or Detroit, the major cities in this country -- we are as good or as bad as the best and better than most in every single area of doing math and reading scores above the national norm, our drop-out rate is equal to the best, and better than most with our demographics. So we don't have to be ashamed. We are obviously desirous of not just being as good as the best of the worst, which would be the large cities; we want to be better, and so we are going to take whatever actions we can to improve. But we don't have to be ashamed when we are compared with others.

There are three ways that you compare yourself:

One is how do you compare with the way you were? Take some 10 years back. How do you compare with another city equally situated today? And the third, which is what any decent person would do, how do you compare with what you'd like to be?

And with respect to the first two, we are better than most. With respect to where we would want to be, we are far from there.

DR. LEE: Thank you.

DR. PRIMM: Mr. Chairman, you have the last word.

CHAIRMAN WATKINS: Mr. Mayor, just one point on the military and the total intervention process. I was heavily involved during my tenure as Chief of Naval Operations even before the Vice Presidential Commission on interdicting drugs. I made a public speech in which I pointed out the urgent need for the nation to have an integrated strategy from foreign exporters of drugs through our borders into the cities, and with both supply and demand taken into consideration in that strategy. Unless we do that, I can guarantee you it cannot do solved. The military cannot solve the drug problem and do every other thing this nation demands of the military today.

So it is very important we understand that because, remember this, during the periods of time when we devoted the full military resources to change the drug pattern just out of Colombia alone, we were able to make a significant impact for a very short period of time.

Now we could sustain that operation, if you take our ships out of the Persian Gulf, take them out of the Mediterranean, take them off the shores of Japan at the time when the Olympic Games are coming up in Korea, and so forth. So the nation has to put that in perspective.

So unless the demand approach is taken and, the supply interdiction includes the diplomatic -- tough diplomatic steps that are necessary, it will not work to look at any one of these.

So it's an integrated national strategy that's important.

And let me just say another thing on posse comitatus. I am a very close friend of Charlie Bennett's, and I agree with his bill. What we were able to do in changing the posse comitatus law for the Navy was to permit the boarding of our ship by own Coast Guard representatives who have the legal authority under domestic law, and we can interdict and we can do everything we have to do.

MAYOR KOCH: I'll tell you something you're not aware of --

CHAIRMAN WATKINS: We don't need a change to posse comitatus --

MAYOR KOCH: You're wrong --

CHAIRMAN WATKINS: -- what we need is a national strategy.

MAYOR KOCH: I hesitate to tell an admiral that he's wrong, but I'm going to tell you you're wrong, because the change, which I'm familiar with, because I helped get it, of hiring -- authorizing 500 additional Coast Guardsmen who would then be put on Navy ships, the fact is they didn't even hire them. They hired -- in the first year they hired --

CHAIRMAN WATKINS: That's not true, Mr. Mayor. It is not true. We have onboard our ships --

MAYOR KOCH: They hired 200 of -- in the first year --

CHAIRMAN WATKINS: The Coast Guard will give us any we want. It's a question of can you put the ships there to take them onboard?

MAYOR KOCH: I'm just saying they did not hire the full complement they were authorized. And the second thing about the ships, now, and then maybe we'll conclude, because I have to go to another hearing -- but, you talk about the Persian Gulf and it's introducing a different note, but I want to say this to you, Japan gets 60 percent of its oil from the Persian Gulf. Germany gets 10 percent of its oil from the Persian Gulf. We get 5 percent of our oil from the Persian Gulf. The Germans and the Japanese haven't put up a single yen or mark or ship or

personnel. Our people are being killed there or exposed to danger, and we are spending multimillions of dollars. I think we're nuts. They, who get the benefit of the Persian Gulf oil, ought to be paying for the operation. And in the best of all worlds, sending their ships there, their personnel, not ours.

Our kids are dying in this country because drugs are coming in from all over the world, and you just said that our Navy is spread out all over the world. So even if the Navy were given the job, you don't have the ships to do it. I think that's what you said, Admiral. I'm saying --

CHAIRMAN WATKINS: The Navy doesn't have that -- we can't elect that decision. We follow the direction of the Congress and --

MAYOR KOCH: I agree with you. I agree with you. Well, let's send the message to the Congress.

CHAIRMAN WATKINS: But remember this, at the time that I made this great speech about this integrated strategy, within a few days in The Washington Post, in the lead editorial I was accused of raising this issue because I was trying to support an enhanced military budget. So when you have that kind of response in this country, how do you get there from here?

MAYOR KOCH: You've got to have a thick skin.

[Laughter.]

CHAIRMAN WATKINS: But we got nowhere with a thick skin. It's a good point, but --

MAYOR KOCH: You've got to keep trying.

CHAIRMAN WATKINS: I think we're going to keep trying.

MAYOR KOCH: Thank you.

CHAIRMAN WATKINS: And Mr. Mayor, thanks for coming down.

MAYOR KOCH: Thank you very much.

CHAIRMAN WATKINS: Take your time. Thank you so much.

DR. PRIMM: Thank you very much, Dr. Joseph. I'd like to call panel No. 5, Mr. Quinlan, Mr. Stewart, and Mr. Coughlin. Michael J. Quinlan, Director of the Federal Bureau of Prisons, please proceed.

IMPACT ON THE CRIMINAL JUSTICE SYSTEM

MR. QUINLAN: Mr. Chairman and members of the Commission, it is my pleasure to be here this afternoon. I would like to introduce the Medical Director, who is with me, of the Bureau of Prisons, Dr. Kenneth Moritsugu, who is a career Public Health Service physician. He just recently became the Medical Director of the Bureau of Prisons.

If I could, I'd like to summarize the statement that I submitted to the Commission about AIDS in the federal prison system. The federal prison system operates 47 correctional facilities around the United States and has 44,000 persons in its custody at this time.

Since 1981, we've had a total of 151 full-blown AIDS cases. There are currently 63 of those 151 cases still in our custody. We also have through our testing program identified 291 inmates who are positive for the HIV antibody.

We began in 1986 a fairly massive education program for inmates and staff in the federal prison system; that is, a mandatory education program for both groups, and that has been running since the beginning of 1986.

In the summer of 1987, based on the President's and the Attorney General's initiative, a testing program began on June 15th and ran through September 30th during which all newly committed prisoners to the federal prison system were tested along with all prisoners who were about to be released along with any men or women who volunteered for the test, and of course we also continued to test all those cases that were clinically indicated.

During that three and a half month testing program, a little less than 3 percent of those tested were positive for the HIV virus. The testing basically showed that about 2.46 percent of the new commitments were positive, 2.17 percent of the persons ready for release were positive, 3.26 percent of the volunteers were positive, and 11.64 percent of the clinically indicated cases were positive for the HIV virus.

I might mention that those prisoners committed during the period June 15th through September 30th, the test period, will be retested. All those new commitments will be retested at the three month, six month, and every six months thereafter while they are in the federal prison system, so we can hopefully determine what the transmissibility rate is in prison.

I might point out that of the first 2000 or so of the retests of those admitted during that test period, one has been a seroconversion, and we're not at this point clear whether it was a false negative report initially or whether the individual was

infected before coming in and just now is showing positive or exactly what the situation was. But one out of the 2000 retests has shown a positive HIV test.

Also it is interesting to note that contrary to the results in the community, 75 percent of those testing positive for the AIDS virus are former IV drug abusers; 14 percent admit to prior homosexual activity. That is completely the reverse, I think, of the statistics that are found in most communities outside of prison.

On November 1 of this year, we started Phase II of our testing program, and it basically has five different distinct groups. One, we test all inmates that we ascertain through either records or observation or disciplinary records that they are predatory or promiscuous inmates. If they are positive after testing, then they will be segregated.

We also continue to test all those where there are clinical indications. We also are now testing 100 percent of those inmates prior to release, whether that release be on a temporary basis such as a furlough or a halfway house or a full release on parole or expiration of sentence. And part of that community testing group is a requirement that if the offender is positive and has a spouse or a significant other person in their life who they would likely have sexual relationships with, they are required to notify that person, which is then verified by the Bureau of Prisons medical staff prior to release or participation in the community activity.

A fourth group that we're testing now, we continue to test the volunteers, and the fifth part of the program is a 10 percent sample of all those newly committed federal prisoners, and that 10 percent group will again continue to be retested at the three, six, and six-month periods thereafter, again to try to determine what the transmissibility rate is.

Now our major emphasis throughout the entire period that we've been working with the AIDS problem has been on education. We feel very strongly that the education program both for inmates and for staff is the most important part of dealing with this issue in federal prisons.

With regard to staff, we warn staff, since you can never be certain as to who is positive or negative, and since we must assume, I think, that even if the test results are negative, that there's a possibility that the person may be infected, we tell staff to consider all inmates with whom they come in contact as positive for the virus and deal with them accordingly.

We have had a very positive reaction on the part of staff in dealing with this problem, a very professional response

of which we're very proud in the Bureau of Prisons of how they have dealt with this problem.

In terms of dealing with the positive inmates, we only segregate those who have been identified as predatory or promiscuous or those who are in the end stage of AIDS. They are segregated at either the Medical Center for Federal Prisoners if they are male or at the Federal Correctional Institution in Lexington, Kentucky, if they are female.

All other positive HIV cases or those who are asymptomatic cases are mainstreamed in federal prisons if the fact that they are positive has not been disclosed.

Another part of the AIDS program that we think is significant is the drug testing of inmates in the federal prison system. The number of tests has increased dramatically over the last three years. We've gone from 45,000 tests to 61,000 tests in 1987. And the most meaningful part of this increase in testing, has been the reduction in the number of positive drug tests, from 7.5 percent in 1985 on the average to 3.7 percent in 1987. And of the 3.7 percent positive, 57 percent were positive for marijuana, THC; 16 percent for cocaine; 17 percent for opiates; and 18.5 percent for amphetamines, barbiturates, and other drugs.

So we're trying to stay on top of the AIDS problem through the education efforts. We are also doing a massive amount of counseling of those who are positive for the virus, and we are attempting to continue our efforts to keep drugs, the use of drugs, out of federal prisons or keep it to a minimum. Thank you, Mr. Chairman.

DR. PRIMM: Thank you, Mr. Quinlan. Mr. Stewart?

MR. STEWART: Mr. Chairman, Dr. Primm, members of the Commission, I appreciate the opportunity to testify at today's hearing on IV drug abuse and HIV infection.

You have already received materials on the National Institute of Justice's research on the impact of AIDS on the criminal justice system, and you are going to receive a recent AIDS bulletin from the National Institute of Justice authored by Don Des Jarlais, who will present testimony today on needle sharing. But today's focus on IV drug abuse and HIV infection is particularly important to criminal justice professionals because of their frequent contact with IV drug users. Michael Quinlan, whom you've just heard, talked about his experiences in the federal prisons, and you will hear shortly from Tom Coughlin, who will speak on the proportion of prison inmates with histories of IV drug use.

The National Institute of Justice's correctional surveys are based on self-reports and have repeatedly found that most cases of HIV infection among inmates are attributable to injecting drugs. Now through a new National Institute of Justice program, we are developing for the first time empirical, scientifically reliable data on the level and the types of drugs being used amongst arrestees and defendants, people with whom law enforcement, courts, and probation have to deal on a daily basis.

The program is called the Drug Use Forecasting System, or DUFS. It is now operating in 12 major cities and will be expanded to 25 cities over the next year. It involves voluntary anonymous interviews, urinalysis of about 250 arrestees every three months, and to date every city, well over half tested positive for one or more drugs, and in many cities the figure approaches or surpasses 80 percent. And we plan to release the first national findings next month and do that on a regular basis.

But with respect to intravenous drug use by city, the percentages positive for heroin, for amphetamines, and the proportion of cocaine users who report that they typically inject, as well as interview findings on needle sharing, we will be able to provide you with solid information about what the prospective look at HIV people who will be coming into the prisons, be coming in to our jails, would be under the criminal justice system.

One hopeful note is that those who acknowledge needle sharing in the last five years, many report changing their needle sharing behavior because of fears about AIDS.

Now given the level of HIV and IV drug abuse in the offender population, you can understand the concern that criminal justice professionals have. And there are three major issues as policy that we have to confront.

One is the safety of the staff. The second is the protection of the uninfected, and the third is appropriate health services for those infected. Criminal justice administrators need to assure the safety of their staff in situations involving contact with blood or body fluids, not just in dealing with offenders, but also responding to victims of crime, responding to accidents, and other situations.

They are also concerned with protecting the uninfected, both the offenders under their supervision and the broader public, from potential infection. This need poses complex questions such as the appropriate pretrial release policies or sentencing options for the seropositive offenders who appear likely to continue their high-risk behavior if released.

Administrators are also concerned about ensuring the rights of infected individuals to equitable treatment by the justice system and quality medical care when the need arises.

Finally, of course, they are deeply and legitimately concerned about the money, the time, and other special resources required to meet those responsibilities.

Now in both law enforcement and corrections, education and training are seen as key, both at the state level and at the federal level, as you've just heard Director Quinlan say. Almost all correctional systems now have mandatory training for both staff and inmates, and increasingly law enforcement agencies are providing both written materials and in-service training with question-and-answer sessions, critical in quelling rumors and misinformation.

Specific AIDS-related policies and procedures are being developed in many agencies, often based on the existing policies in the control of such infectious diseases as hepatitis B. Recommendations for precautionary measures and protective equipment normally follow the CDC guidelines for health care workers when exposed to blood or body fluids.

This poses a particular challenge to law enforcement officials, since they can't predict when they're going to be exposed to body fluids or blood. Many times they rush to the scene on impulse to treat a victim who may be bleeding and who many have infectious hepatitis or may have AIDS or HIV, but on the other hand, to constantly wear protective equipment is seen as unnecessary and would send, in fact, the incorrect message.

Now policies on HIV antibody testing, particularly mass screening, remain an issue of debate. However, ten state correctional systems now screen all inmates, compared to only three a year ago. NIJ is not aware of any routine testing in law enforcement settings, although legislation has been proposed in some states to permit court ordered testing of defendants involved in assaults on officers or alleged offenders in sexual assault cases.

With two correctional experts here, I won't dwell on the impact of AIDS in prisons or jails. But I would note one finding from NIJ's surveys of correctional facilities.

Between November '85 and October 1986, the confirmed cases of AIDS rose 61 percent in the systems surveyed, a large increase, but it wasn't as large as the general population which rose 79 percent. Now to obtain the needed information on the rates of HIV infected persons, the Institute is now working with the Centers for Disease Control to mount a blinded seroprevalence

study in ten correctional systems. These studies are part of CDC's response to President Reagan's directive to develop national data on HIV infection.

There is not time to touch on the complex questions that HIV is raising for our courts and community corrections. But in closing, let me simply say that NIJ's work to date convinces me that the vast majority of criminal justice professionals are confronting the HIV epidemic with courage and are committed to the equitable delivery of quality services to all segments of our community. They seek only necessary resources and the best available information to do so. Research can help provide a greater range of options for public policy and should be pursued. Thank you very much, gentlemen and ladies.

DR. PRIMM: Thank you, Mr. Stewart. Mr. Coughlin?

MR. COUGHLIN: Thank you very much, Commissioner Primm, and thank you, Chairman Watkins and members of this Presidential Commission, for allowing me to come here and speak to you today.

It is appropriate that correctional professionals be accorded the opportunity to address this panel, and I would like to summarize my remarks that were submitted to the panel.

AIDS is the leading cause of death among inmates in at least the New York State prison system. In the first eleven months of 1987, there were a total of seven inmate suicides and/or homicides, while 142 have died from AIDS. There have been 577 confirmed AIDS cases among inmates incarcerated in the state prison system. Of that number, 326 have died; 99 remain in custody; 152 have been released.

We have seen a rate of three confirmed AIDS patients for 1000 new admissions for the past three years, a level rate.

Let me draw a profile for you of the inmate AIDS patient in New York State. He's 34 years of age, but he will die within 19 months of admission to the system. The chances are one out of two that he's Hispanic and one out of three that he's black. He's an IV drug abuser from New York City and was convicted of a drug-related offense.

We have, since we have the unfortunate distinction of being involved with this since 1981, offered a policy for dealing with AIDS inside of state correctional facilities. We believe that prisons are a microcosm of society, and we believe inmates are entitled to treatment equivalent to what they would receive on the outside.

We do not segregate seropositives, nor do we isolate confirmed AIDS cases. We provide inmates with the same medical

treatment they would receive on the outside, either in a hospital or as an outpatient. We do not do mass screening for AIDS, because there is no test for AIDS. There is a test for HIV exposure. And just what would you have me do with the results of this mass testing for HIV exposure?

The only time we use HIV testing is if a physician wants to rule AIDS in or out of a patient's diagnosis.

Where do we go from here? The future does not look very encouraging. In Fiscal Year 1986-'87, we spent $22 million for specialized medical services. Of that amount, 20 percent or roughly $4.5 million was devoted to less than 1 percent of the inmates, those inmates who suffer from AIDS or ARC. We owe every sick person medical care that is humane regardless of their ability to pay for it. We must encourage them to maintain their dignity and their self-respect, regardless of the cruelty with which some mock their illnesses.

No one has discovered a cure for the slurs that are directed at this disease and the people who suffer from it. Maybe together we can find a cure for both the disease and the misinformation spread about its origins and victims. Thank you.

DR. PRIMM: Thank you, Mr. Coughlin.

I've had the pleasure of reading all of your testimonies, and I just found them so very, very enlightening. I wanted to say that from the outset both to you, Mr. Quinlan, and you, Mr. Stewart. I hadn't had the pleasure of reading Mr. Coughlin's; I just looked at it now. But our first question is from Dr. Lilly.

DR. LILLY: I was struck by the fact that the federal system is doing extensive testing, has a lot of experience with it now, and the New York State system is doing very little and certainly no systematic testing.

I was wondering, how do you reconcile these? Each position -- each of you seems to be convinced of your position.

MR. COUGHLIN: Well, let me see if I can respond to that. We made the decision in New York State early on in this crisis, back in 1981 when the first AIDS person died, that we would follow as a prison system -- remember, let's make some distinction here; we're prison administrators, not public health administrators. And we would follow the direction of the public health people, either from CDC in Atlanta or through the Commissioner of Health in New York State, Dr. Axelrod.

Consistently over the years, they said mass screening is not appropriate or needed.

Now in my written testimony that I have submitted, you will note that we are doing a blind study to ascertain the HIV level within the system, but not every person who comes into the system is going to be tested for HIV positivity.

DR. LILLY: Mr. Quinlan?

MR. QUINLAN: Yes, if I could just further respond, Doctor, the Bureau of Prisons feels that since we do have, if you'll excuse the expression, a captive audience, that it would be appropriate for us to measure what the rate of prisoners coming into the system have in terms of the HIV virus, and that's why in Phase II we are testing 10 percent. And we also think that not only for our purposes, but also for the Public Health Service's purposes, it is important to be able to detect the transmissibility rate of persons in custody.

DR. LILLY: Through a form of experimentation.

MR. QUINLAN: Experimentation of trying to learn as much as we can about how many people are involved in terms of the infection and how, if it is being transmitted in prisons, what other steps we should take to prevent that transmission.

We're very conscious that this is an evolving problem. We're taking it a step at a time. At this point, we think a 10 percent sampling is the appropriate level at the federal level. We don't suggest that that has to be the level at any other level, in state corrections obviously, but from our standpoint we would like to know, from an experiential standpoint, what the transmissibility rate is.

DR. LILLY: Are you concerned with the question of confidentiality of those test results?

MR. QUINLAN: Oh, absolutely, absolutely. We have a requirement in our policy that the results of the tests be kept to only those who have a need to know, and that it is not widely known in the prison as to who among the prisoners is positive.

DR. PRIMM: Who receives the information? Does the physician get it, or is it kept in the hospital or in the warden's office?

I've seen too many movies where the trustee in the warden's office steals the paper and let's everybody else know in the prison, and you know what happens in those Alcatraz movies that we see.

[Laughter.]

MR. QUINLAN: So much of the corrections history has been written by Hollywood and others that it's unfortunate that we have that characterization, I think at times. First of all, the initial information is received by the medical staff at the facility, by the doctor or the physician's assistant who is treating the individual inmate or who has tested the individual inmate.

The information is then only shared with the people who have a need to know. Now in most cases that will probably only be the warden. If it happens to be an inmate who fits into another category, like a predatory or promiscuous inmate, it would be shared then probably with the Chief Correctional Supervisor or the captain. But it is held on a very confidential basis, and we feel that it's important not only from the inmate's standpoint to maintain the confidentiality, but from our standpoint.

Our responsibility is not only to maintain their security while the person is in custody, but also to maintain their safety. And if the information is widely dispensed and known in the prison, we cannot guarantee their safety, because others might take it upon themselves to remove that particular threat of the person with the HIV infection from the inmate population, and we don't want that to happen.

DR. LILLY: Are the tested individuals informed?

MR. QUINLAN: Yes, they are.

DR. PRIMM: Dr. Walsh?

DR. WALSH: Perhaps one of you could help me answer a question I was asked yesterday, and that was, is it proper in your system in the state, Mr. Coughlin, for a, say, a first offender with a three-year sentence to go into prison with a three-year sentence and come out with a death sentence? How do you prevent that?

MR. COUGHLIN: Well, first of all, let me give you some fact. There has not been a single case, recorded case, of AIDS being caught within the New York State prison system, not one.

DR. WALSH: Is that true of the federal prison system, too?

MR. QUINLAN: Well, as far as our information, Doctor, of the testing period since June 15 and the retests, as I indicated, there has been one serocoversion. Now it may well be that that person came in with the virus; it just didn't show either because of a false negative test or because he hadn't fully developed the antibody.

DR. WALSH: Somebody asked me that question just yesterday. I couldn't answer it.

MR. COUGHLIN: Well, AIDS, as you well know, is a completely preventable disease.

DR. WALSH: Sure.

MR. COUGHLIN: And in a large institutional system like we have, from the day the person walks into that system until the day he leaves, it is drummed into his head or her head the ways to prevent catching AIDS in prison. It's done in two or three languages.

An interesting thing has happened in prison populations with the advent of AIDS. You see people, the inmates themselves, becoming a lot more conservative, and behavior that used to be somewhat more prevalent prior to 1981 or '82 is on the marked decrease.

There are drugs in prison. There's no question about that. The use of IV drugs in prison has reduced dramatically. We have marijuana; we have cocaine that can be smoked; we have pills. But the incidence of finding works and heroin powder is on the dramatic downward slide.

So the inmates, after all these years of education, both in prison and while they're on the street, are starting to pay a little bit more attention. It's very simple. If you don't want to die, don't shoot drugs in your arm and don't have aggressive homosexual relationships. And it seems to be working.

MR. STEWART: I would like to also say that the National Institute of Justice did a survey of the prison systems across America, back in 1985 when this was a problem, and there were threats of work stoppages. We looked at the transmission of AIDS within a prison population and found out that it was not being transmitted, and the prohibited conduct from which you normally contract that is not as high as anecdotally reported, and quite the contrary the case has been that they have not turned out to be a hotbed of AIDS transmissions. And I think it's a credit to the correctional administrators and the efforts that all have done in terms of education.

So when they considered all kinds of precautions and early releases, it turned out to be unnecessary, because the transmission did not appear to be occurring at all.

DR. WALSH: Well, that's certainly the first bright side of the picture we've heard. But I wonder, the implications of that for controlling transmission on the outside among a

similar population. I mean, you have a controlled environment admittedly. But you said they could do it, if they wanted to, and yet you found some answer despite the fact that so many of them are IV drug users.

How can the implications of this be transmitted to the outside?

MR. COUGHLIN: Well, very clearly we do have, as Mike said, a captive audience, and it's very easy to look these folks in the eye and say that the guy in the next cell or in the next bunk to you has AIDS, and that's the way you should look at it. And that seems to work in prison.

I don't know whether it's the education plus the controlled environment that makes it work. When you move to the non-prison environment, as the mayors talked about here earlier today, is when they get back into the drug use, the heavy drug use, get back into the heterosexual relationships that produce the problems.

I'm not a public health administrator.

DR. WALSH: Have you done any follow-up to determine whether the lessons you taught them in prison have lasted? In other words, do these people stay educated, or when they leave the controlled environment, does the education go down the tubes?

MR. COUGHLIN: We have not done any significant follow-up studies on the lasting effect of education.

MR. QUINLAN: I'd like to add one footnote to your question with regard to the young first offender and whether that should be a short three-year sentence or a life sentence, and just point out to you some research that was done in the early '80s before AIDS was a problem, before it was known to be a problem, some research on people as they were leaving federal prisons.

We wanted to know on a confidential interview basis what percent had been involved in homosexual activity while in prison, both consensual and as a result of an aggressive rape type situation. Less than one-tenth of 1 percent of the research group claimed that they were ever a victim of a homosexual rape, aggressive homosexual activity in prison. 2 to 3 percent admitted consensual homosexual activity in the federal prisons.

DR. PRIMM: Do you think they would be reluctant to admit such to --

MR. QUINLAN: Well, there may be reluctance on the part of some; however, it was a confidential exit interview as they

were leaving the federal prison system. They may have felt that this might change their opportunity for release. We can't guarantee that. But I think that there is some validity to the statistic.

DR. WALSH: It's remarkably low. That shows you what the movies have done.

MR. QUINLAN: Exactly.

DR. PRIMM: We were just discussing how effective you say that behavior modification is in the prison system and why intravenous drug users do not seem to comply in that manner.

Well, I explained that away by saying that the prison is a captured audience and that there can be constant bombardment of these individuals with all kinds of information and repetitive bombardment, and somehow they get the message.

If, for example, we had it mandated that people who were on probation, and sometimes this is the case, or mandated to a drug treatment program, and we had the hammer of the criminal justice system behind us to keep that individual, or that individual must stay in drug treatment lest he go back to prison, we'd do well with that kind of patient in our drug treatment programs.

As you know, the federal system refers people to drug treatment programs while they're on probation and while they're out on parole. So maybe we should take a page out of your book to do something like that on the outside.

I'd like to ask Mr. Coughlin a question about the New York State prison system, and that is, you don't test going in, test while they're in as the federal system does, and test when they're coming out.

MR. COUGHLIN: That's correct.

DR. PRIMM: You don't do anything of that nature.

MR. COUGHLIN: We are engaging in a blind research study right now being run by the Department of Health within New York State, testing a certain number of incoming inmates at the reception centers right now to see if we can ascertain the incidence or prevalence of the HIV positives in a certain group of the population.

We do not test as a matter of course, and we do that on the advice of the Department of Health, Dr. Axelrod, and as far as I know up until yesterday, CDC was not recommending mass testing.

This, and I really want to emphasize this -- from our perspective as prison administrators, it becomes a manageable problem for us. It is a serious public health problem, and the public health issues should be dictated by the public health profession, not by prison administrators, not by criminal justice types.

DR. PRIMM: What about drug testing in the New York City prison systems, random drug testing?

MR. COUGHLIN: We do significant random drug testing around the whole system. There are -- I don't have the numbers off the top of my head, but close to what Mr. Quinlan was talking about.

DR. PRIMM: You had given some statistics that indicated some reduction in drug use secondary to your urinalysis testing, and that's why I --

MR. COUGHLIN: Well, the reduction -- I don't think I said drug use per se -- the reduction in contraband needle works, we have seen a dramatic drop in that. Whereas you might have picked up ten or twelve sets of works in a year, now we're down to if we pick up one set of works a year, it becomes significant.

DR. PRIMM: Are you still as vigilant about looking for them as you were two or three years ago?

MR. COUGHLIN: Absolutely, absolutely. So what I'm saying is, the use of IV drugs within the prison system has reduced dramatically.

They're still smoking grass, because they can get it in through the visiting rooms and through the packages very easily. They are still using barbiturates, amphetamines. But the use of heroin through needles has dramatically reduced.

DR. PRIMM: Just one more statement, and that is, I read in the New York Times where the New York City prison system, we even bring people from Riker's Island who have been thoroughly searched, and they have razor blades in their pockets or they have scissors in their cookie box. It's quite startling to me that that could happen. And even end up slashing people in the courts. So I'm wondering about those search and seizures that go on in prisons, how thorough they are, and I think it's quite startling.

Did we have some questions down on this end? Yes, Dr. SerVaas?

DR. SERVAAS: My question was, are more than half of your drug abusing women in prison AIDS antibody positive, and if they are, can you still justify permitting -- is it conjugal visitations that you allow for the prison inmates, and do you have AIDS babies being produced in the prisons?

MR. COUGHLIN: I don't know whether more than half of the drug abusing women are HIV positive. I just don't know that. That could be, and it could not be.

We do permit conjugal visits for inmates who meet certain criteria. We do make available condoms for those conjugal visits, and it involves some pretty intense counseling on the use of condoms during those conjugal visits.

We will not allow a confirmed AIDS patient or an AIDS-related complex patient to have a conjugal visit.

DR. SERVAAS: Thank you. Do you have a list of things you do for the AIDS-positive individuals on medications and things that you do do to protect them from going on to developing AIDS-related complex or AIDS? There are quite a lot of things doctors do for them.

MR. COUGHLIN: We don't -- since we don't test as a matter of course, we don't know who is positive in terms of the HIV virus. If a person comes down and there's a clinical indication for testing and there's a protocol for it; we have a rather sophisticated protocol -- we then do the testing as a confirmation to whatever problem the person might have, and then he would fall into either the category of confirmed AIDS or AIDS-related complex, and he's dealt with on a medical basis from there. But I don't know if they're HIV positive.

DR. PRIMM: What about in the prison system itself? Are there ongoing lectures -- there seems to be, but I just wanted to get it on the record; any one of you could respond -- ongoing education and prevention efforts with the inmates in relationship to HIV education?

MR. QUINLAN: If I could possibly start with that, Dr. Primm, in the federal prison system since the beginning of 1986, we have had a program, a mandatory AIDS education program for staff and inmates, and that has been ongoing, and we are constantly increasing the materials that are available for use in those training programs.

As I've indicated, I think that the key, in terms of prison systems, is education. Commissioner Coughlin, I think, agrees fully that as long as we get the word out to every inmate and every staff member about how it's transmitted, we can dispel some of the fears, but we can also create in the environment of

the prison the fear that there might be someone in the cell next door or the bunk right in the same room with you, someone might be infected, and so it's going to hopefully inhibit anyone from getting involved in high-risk activity. And so for that reason, I think education has to be continued, and we are redoubling our efforts in the education area to make it absolutely the pinnacle of our program to deal with the AIDS problem.

MR. STEWART: Let me also add to that, Dr. Primm, that our surveys across the state systems indicate that on a regular basis education is used not only to protect people from infection, but really to help manage the entire situation, because you have people who are concerned about contracting it through a variety of ways that are more superstitious and mythological and who are afraid. That's not only with the staff, but it also turns out to be with the prisoners themselves. And so in order to better manage the populations within the prison, that understanding the AIDS risks and how it's transmitted and to realize that it's not high-risk groups, but high-risk behaviors that transmit the AIDS virus is the one thing that seems to be going across. It seems to be very, very popular with prison administrators across these United States.

DR. PRIMM: Thank you.

DR. LILLY: Are condoms available in prisons?

MR. QUINLAN: They are not available in the federal prison system.

MR. COUGHLIN: They are not available in the state prison system except for inmates involved in the family reunion program, the conjugal visit program. The general prison populations do not have the availability of condoms.

MR. STEWART: Our surveys indicate that only, I think, two states consider the use of -- making condoms available. The other 48 states do not as a matter of policy, since that's prohibited conduct.

DR. PRIMM: Dr. Crenshaw?

DR. CRENSHAW: Could you please comment on and then elaborate on the percentage or the numbers of sex offenders, both adult and child, in your prison systems and with particular comment about repeat offenders, because it's very common in the sex offender population that you see them on several occasions during different terms, and what, if any, responsibility is being taken to ensure that in between terms they're not infecting other people on the outside?

MR. COUGHLIN: That makes the assumption that all sex offenders are HIV positive, doesn't it?

DR. CRENSHAW: Are you testing any of them?

MR. COUGHLIN: No; we are not. We have probably three or four percent, maybe not that high, of our total population of over 42,000 to 43,000 inmates, who are sex offenders. There are programs within the system for sex offenders and hopefully all of our sex offenders are involved in those specialized programs.

Now, I don't know of any jurisdiction right now that tests a particular segment of society like sex offenders. I have to keep coming back to you saying prison is a reflection of what is going on out in the street. Just because we have them held for a couple of years, I don't believe we should do something more onerous to them than we do to the people on the street.

When someone makes a decision out there that we are going to test for HIV, everybody, then we will start testing in the prison system. Until that happens, I don't think it is necessary.

DR. CRENSHAW: I might comment that among sex therapists and those in the sex offender treatment programs that success in rehabilitating sex offenders is considerably lower than for substance abuse. Although efforts continue to be made, it is considered quite a unresponsive population to rehabilitation sexually.

I'd like comments from any of the other members of the panel on how they feel about testing for sex offenders on release, if at no other time.

MR. QUINLAN: First of all, we test all Federal prisoners upon release; all; 100 percent. We do not have a large number of sex offenders. It is not Federal generally; unless it occurs on a Federal reservation, it is not a Federal offense. We have a very small number.

If the sex offender is in our definition a predatory, promiscuous inmate, he would meet our classification requirement to be tested and he would be segregated, he or she would be segregated from the rest of the inmate population. Obviously, we would also work very closely in trying to counsel those individuals so that they would hopefully be better off when they leave the facility than when they came in.

MR. STEWART: Dr. Crenshaw, our information at the National Institute of Justice is that most of the people who have AIDS, by far the vast majority are IV users. As we begin the test in the ten prison systems, blind for seroprevalence, we will

be able to see what kinds of people are coming in and get a much better handle on your particular question scientifically, but as of now, the prevalence is clearly with the IV drug abuser.

DR. PRIMM: Yes, Dr. SerVaas?

DR. SERVAAS: I interviewed a prison doctor in the Washington, D.C. area who said we don't test the prisoners he believes because we just don't have the money to buy AZT for them and they would insist on it, is there any validity to that in the New York area?

MR. COUGHLIN: We have been using AZT since it became permissible in March or April of this year. I have the numbers in my written statement -- I want to say that we have over 100 people on AZT right now. The dollars have never been an issue with us. We have a private hospital in the City of New York, St. Clare's Hospital, that we have assisted in renovating. We are going to have probably a 60 bed secured AIDS unit there. Money has not been an issue in this fight; no.

DR. SERVAAS: Thank you.

DR. PRIMM: Mrs. Gebbie?

MRS. GEBBIE: Two comments and then a question. One, Mr. Coughlin, Oregon law beginning this next July will allow the screening by a health care worker of those convicted, not incarcerated, convicted, of drug related and sex related crimes and if that health worker deems it appropriate, they can be tested without consent. That is a system change that is coming in.

The other comment is actually an observation from the Federal results that would indicate that voluntary testing within prisons actually works quite well, since your voluntary system got a higher rate of positivity than your universal screen. Those at higher risk seemed interested in being tested and do come forward.

The question is, I was asking for comment really from both the state and the Federal level of a difficult area to understand and to talk about, and that is the problems encountered in bringing together two separate systems, the criminal justice system and the public health system, each of which may be seen as having different goals, speaking different languages, doing different things.

To figure out policies like this, you really need a system where both understand each other, speak very clearly to each other, don't have barriers in the way of that communication, don't have external constraints that put one in more charge of

inappropriate areas or so on, from either the New York system or the Federal system.

Do you feel that communication is really open, is really fair, so that the best of both systems can be put on the table together and talked through or are there barriers to that negotiation around policy issues that need to be gotten out of the way?

MR. COUGHLIN: Let me see if I can respond. I have had a very positive experience with the public health officials in New York State and on the Federal level, by the way. We have chosen, as I said earlier, to follow their direction. As we all know, there isn't nothing solid in this AIDS business. It changes every day. If the decision was made based on the information available to the public health officials that we should change our policy, for example, on testing, then we do it.

Until that happens, as I said, the public health people, the Health Department, CDC in Atlanta, are the ones who are calling the shots for most of the prison systems, because we are not prepared to do that.

MR. QUINLAN: I would just say we have attempted and I think have been successful in blending the needs of both the public health service and the public health community and the prison community in terms of what should be done for people who are infected and what should be done for those who are not infected in terms of trying to maximize their protection. I think it is evidenced by the fact that the Medical Director of the Bureau of Prisons is a public health service physician, and it makes it a little easier probably for us, but we have had no difficulty at all in marrying the two concerns.

DR. PRIMM: Mr. Stewart, one of the things that you recommended in your paper was instruction on how to do CPR. I wanted you to talk about that for a moment relative to patients with AIDS or patients with human immunodeficiency virus infection.

MR. STEWART: Dr. Primm, the key is that people who may suffer heart stoppage or breathing stoppage that may be in custody or may be in an automobile accident, electrocution, they may not be a suspect, they may be a victim, that the fear of contracting AIDS on the basis of rumor may result in our enforcement personnel not rendering aid to someone who appeared to be in a high risk category.

In order to assure that aid could be rendered safely, there should, be and we highly recommend that airways be provided and training be provided in a way that shows that it is in fact safe to provide life giving emergency services to people who may

be in a high risk category, if what we consider to be routine and fairly modest precautions are taken.

I think armed with the information about what works makes all our jobs much easier and permits us the opportunity to render emergency services to people who need it, rather than letting it linger with the state of fear.

That is why the instruction on CPR, I think, is so important to correctional personnel, law enforcement personnel, who do come in contact quite frequently with people who are bleeding profusely, who need emergency services.

DR. PRIMM: I don't want to pick on this issue, I was just wondering. I am an anesthesiologist by specialty training. I am just wondering how you do the breathing, mouth to mouth resuscitation without touching the patient. Do you have a special instrument that you use?

MR. STEWART: Yes, an airway.

DR. PRIMM: Each one of your correctional officers carries that around with them?

MR. STEWART: They carry that and so do law enforcement personnel as well. They use an airway to do that with.

MR. QUINLAN: They don't necessarily carry it in the Federal prison system although they are available throughout the institution.

DR. PRIMM: That's excellent. Very good. Burt?

DR. LEE: I have the greatest respect for you gentlemen. You are in a very tough business. My belt clip is a tie pin of a New York Department of Corrections Prison Officer, who is one of my favorite patients. He works in Greenhaven Prison. I have recently finished "Bonfire of the Vanities" and I now have an extremely great respect for the prison system. Have any of you read it?

[No response.]

DR. LEE: Read it.

MR. STEWART: Yes, sir.

[Laughter.]

DR. LEE: I had one small question. I missed the statistics on what drugs they are using in this AIDS population in prison. The percentage was somewhat unusual.

MR. QUINLAN: I gave the percentages for all drug tests for 1987, not merely those who were HIV positive. The percentages I gave were 57 percent were positive for THC, marijuana derivative; 16 percent, cocaine; 17 percent, opiates; 19 percent, amphetamines, barbiturates and other drugs. That is a combination figure of three groups of tests that we do. We do random testing of 5 percent of all prisoners every month. We also test every month those who are in our suspicious group. We test all prisoners upon return from any community activity. That's a composite figure.

DR. LEE: Thank you. Lastly, is the capacity problem going to overwhelm you people? Do you think you are going to be able to handle it? These hearings are on drug abuse, and if people really went all out on drug enforcement, I would imagine you are out of business, aren't you? What are your future plans on this capacity problem?

MR. QUINLAN: Right now, we have 44,000 prisoners. We have an expectation that ten years from now, 1997, we will have at minimum, 76,000. The Sentencing Commission which now has sentencing guidelines which became law on November 1st, has an estimate of a Federal prison population conservatively of 78,000. Worse case scenario, 125,000 by 1997.

We are doing everything we can. This Administration currently has 7,000 prison beds under construction. We have a request pending for another 2,000 in the 1988 budget. We have a very large request that we hope to make for the 1989 budget and for future years. We hope to keep up with the growth, so we do not become overwhelmed and it does not create a gridlock system for the entire Federal criminal justice system.

DR. LEE: New York State has a much worse problem.

MR. COUGHLIN: No, I think we are in much better shape. We have about 42,000 inmates in the system right now. The capacity of the system is probably around 40,000. About 2,000 inmates are in what we would call less than standard settings. We have put on since 1983 over 11,000 new prison cells.

When I became Commissioner in 1979, we had about 18,000 inmates and 18,000 cells. Now we have 42,000 and 42,000 cells.

Our projections are not quite as dramatic as the Federal system. We have a worse case scenario projection, as all prison administrators do, that leads us to somewhere around 65,000 to 68,000 by 1992/1993. Our best case scenario puts us around 48,000 or 49,000 in that same period of time.

I am relatively confident that we are going to stay within that best case scenario. Now, what is interesting in prison populations is the make up of the crimes. We have seen, for example, back in 1983, about 2,500 new admissions in a year for drug related kinds of crime. That went to over 8,000 this particular year, through the first 11 months of this year. We are seeing a major change in the kind of crime people are coming to the New York State system for.

The number one crime of admission right now is robbery. Traditionally the second crime had been burglary. That was surpassed this year by drug related crimes. That's what we see happening.

MR. STEWART: Dr. Lee, your question is a very good one. Unfortunately, in the Federal prison, they have well managed, it is going well, but across this nation in 1979, we had about 220,000 people in prison in our states. Now we have 650,000 in just eight years. There has been a dramatic increase. The crowding in the state prisons is considerably higher than in the Federal system. I think there were 38 state systems that are currently under court order to release or expand capacity.

Our drug use forecasting system that I talked about that the National Institute of Justice is doing where it tests people who are being arrested for the kinds of drugs they are using, shows that the opiates, the amphetamines and the injectable cocaine has increased since 1984, particularly in New York City, that it has gone from 40 percent of the robbery suspects, positive for cocaine in 1984, to 80 to 92 percent in 1987. We have seen a dramatic increase. This corresponds to what Tom Coughlin said about the number of admissions, that robbery traditionally is a predatory crime and may be driven by the desire to acquire more drugs.

These people are already robbers, they just may rob more actively. If you eliminated the drug problem, you would still end up with the robbery.

The projections for prisons as regards HIV is for many states a very real problem that they are facing. That is why the education and research I think is so important.

DR. LEE: We had Dr. Tuckson from Washington, D.C. here. He said that in certain communities, we have more people in our present day society today, more people going to jail than are going to college. If we don't turn that one around, you will be saturated here. That's a very sad statistic.

MR. STEWART: I think Dr. Primm was beginning to allude to it. There are some bright spots on the horizon. One of the things that the National Institute of Justice has tried is pre-

trial release, where a person is released before they go to trial on bail or an OR, if they give a urine specimen beforehand in Washington, D.C. and test positive for drugs. They are then released but are required to provide a specimen on a weekly basis to show they are staying off the drug. For those that stay in the program and stay off the drug, the re-arrest rate is 50 percent lower.

Maybe the suggestion that we can't have a prison environment in terms of total custody outside, but we could provide some incentives to people to cut their drug use. The IV drug use threatens to be the bridge for HIV to the general population and it threatens to contaminate all of our populations very quickly because of the way they do inject the drug through booting and using the mixing of the blood in the needle and then trading the needle to the next guy with the blood still loaded in it.

DR. PRIMM: The most difficult problem we have in drug treatment programs is to try to keep people in treatment on a continuous basis. We don't have the kind of leverage that can do that, particularly with the AIDS crisis. For example, we are pretty much told that if someone violates the program regulations or takes drugs or their urines are positive for illicit substances like cocaine, et cetera, we can't discharge them or do anything punitive to make them be program compliant.

One thing that could help us considerably is just what you are talking about, being remanded to a drug treatment program based on clean urinalysis in lieu of probably being adjudicated and going to court. That would help us considerably.

MR. STEWART: I would like to share this with the panel, that rather than try them for use of drugs again and lock them up for 90 days, it has turned out to be very effective to have them come back for four or five more tests in a week, which uses up a lot of their time, and then go to eight hours in the judge's holding chamber and then go for two days where they are in custody and then released again. They know people are essentially watching their high risk behavior. We think that offers or suggests the opportunity for a real breakthrough without having to build massively larger prisons and to have massive testing underway.

The preliminary results at least are very encouraging.

CHAIRMAN WATKINS: We are going to close out the questions. I wish Mr. Coughlin hadn't gone. I am really concerned about what I am hearing. On the one hand, I am hearing imaginative ideas coming from the National Institute of Justice. I am listening to a very logical approach taking on prisoners in the Federal prison system. I find it impossible to believe that

the people in the State of New York, if they were to hear these words today, that we are not testing sex offenders that are put in our prisons in the State of New York or drug related offenders, where we know there is a high proclivity for HIV infection, even when they come out of the prison. We put them back out in society unknowing of where they stand. I think the people in New York would be shocked. That's my own personal opinion. Maybe not. Maybe this has all been put to the test.

To say this is a public health department issue and we in the prison system can't impact on it, I find that very difficult to take.

Mr. Stewart, my question to you, without Mr. Coughlin being here, is what is the system for coordinating the policies regarding HIV infected prisoners as they come out of prison, how do you get together? How do you get together with the state and territorial health officers if in fact they don't already work with the prison system well, so you can share these views?

I noticed in Mr. Des Jarlais' report and other studies, there has been some lessons learned in the prison systems regarding AIDS in the last couple of years and a balanced approach taken by the Federal prison system where selected persons are weighed coming in for a lot of reasons that we need to have that data, and all coming out, so we can properly bridge individuals coming out and monitor them and put them in the kinds of programs Dr. Primm is talking about.

It seems that in the absence of that, I would be greatly concerned that there is a fragmentation apparently among the states. It is only 4 to 6 percent of 40,000. That is a lot of people coming back that probably have AIDS or are HIV positive.

How do you reconcile this? Do you bring them together and try to share these views and share the lessons learned and try to bring Federal and state prison system leaders together and look at the AIDS problem in a new way?

MR. STEWART: We do. Our states are 50 separate systems that are sovereign in many instances. Public health issues really reside at the local level. CDC can merely provide information and analysis, but it really remains with the local officials, the same way that we have to deal with the prison problems and the National Institute of Justice fortunately was created by Congress to provide information and a range of options to state and local people about what works in crime control and helps criminal justice. We do provide regular bulletins. We have recently, in fact, that is why we started in 1985 to see about the transmission and occupational risks --

CHAIRMAN WATKINS: Have you had a national conference of the leading prison officials from the states, state and territorial health officers and yourself, to try to pull them together on this one issue, to try to share lessons learned, try to look at this to see if we are having the best balance between public health and criminal justice? We know there are resource problem but is that your role?

MR. STEWART: It is our role. What we have done is work with the American Corrections Association on a regular basis. They have published our reports. I have spoken before the American Corrections Association's national convention. They have reprinted much of our information and provided that as mandatory minimums that they are beginning to use. We have met with the judges. We had a state-of-the-art conference for judges and Tom Coughlin was one of the speakers who spoke to 300 judges from across these United States, to help try to illuminate some of the pressures that the prison officials were feeling and we had the officials there as well.

It does not go far enough.

CHAIRMAN WATKINS: Do you believe it is correct to allow either one time or multiple sex offenders and drug related crime inmates to leave those prisons without being tested and go back to the public? What is your personal opinion?

MR. STEWART: At the Federal level, they are testing all of the people --

CHAIRMAN WATKINS: I am asking you, do you agree that the State of New York not testing anyone coming out is following the best public health practice?

MR. STEWART: I think the State of New York, and I am not trying to dodge your question, but --

CHAIRMAN WATKINS: It sounds like it.

MR. STEWART: I have to say it is up to the State of New York what they want to do. Dr. Lee --

CHAIRMAN WATKINS: What is your strong recommendation to the State of New York, Mr. Stewart? I recognize the sovereign rights of the states. I am just trying to say what do you at the Federal level suggest they might follow.

MR. STEWART: I think it is very important that we know who are the people that do have high risk and we do provide counseling for those people and do provide proper notification. I think the Federal model is one of some envy, I think, that many of us can look towards for some guidance.

CHAIRMAN WATKINS: Has that been the position taken by the National Institute of Justice, you go out to all the state officials, that we think the Federal model makes a lot of sense or at least in those aspects where clearly the public would be appalled were these individuals to come back and spread the AIDS virus the same way they were spreading it before they went in?

MR. STEWART: Our position in the National Institute of Justice is we provide a range of ideas that work and allow the states to select which is best for their state. That has to be our position. We can't impose directly on the states. I would certainly write editorials and other things --

CHAIRMAN WATKINS: Who can I talk to at the right level that would be able to answer the question? Would it be the Attorney General? Do I have to talk to each governor?

MR. STEWART: I think that would be --

CHAIRMAN WATKINS: Has there been any attempt to try to --

MR. STEWART: Yes.

CHAIRMAN WATKINS: Suppose 35 states now require, at least in this category, testing upon release?

MR. STEWART: There are now 10 states that do so. There were only three states a year ago. There is this kind of momentum that is building, but it is the kind of power that a commission of this nature and statute can bring --

CHAIRMAN WATKINS: Are you recommending that we take a

Commission position that as a minimum, those coming out of the Federal prison should be required to take that test and there be a transitional bridge demanded of those individuals coming back to ensure they are watched in this one area, perhaps linked in some way with methadone maintenance centers or whatever, if in fact they are HIV positive as a result of drug abuse.

MR. STEWART: In the drug area, it has worked very well in terms of just paying attention to people. I think in the high risk categories of drug use, those who might spread it through drug use, their probation officers and people like that ought to know that.

CHAIRMAN WATKINS: Could you advise the Commission of what the states are doing in this regard in all the prison systems? We would like to have that from the National Institute of Justice.

MR. STEWART: Yes.

CHAIRMAN WATKINS: With some detail, if you would, exactly what they are doing today so we can look at the fragmentation of policy in this area and maybe make some sensible recommendations.

MR. STEWART: I think that would be excellent. That would be a big help to us and to the states as well, by getting the information out so they can make their decisions.

DR. LEE: May I make just one point, Admiral Watkins? Mr. Coughlin is doing this because of Commissioner Axelrod, he is taking Commissioner Axelrod's position, and how do you control Commissioner Axelrod? There is only one person he reports to and that is the Governor.

CHAIRMAN WATKINS: I understand that, do you want to take a vote on the panel, of the Commissioners, do we think it makes sense?

MRS. GEBBIE: May I comment before you start on that vote? You didn't get your full answer to your question, which is have the state and territorial health officials met with the state directors of corrections, and the answer to that is no, although each of us meets separately, we have not all met together.

Mr. Coughlin's approach comes closer to that being proposed by the preponderance of public health people than does the Federal program. Neither is exactly what public health people in general have recommended. I think it is important that we hear more fully from the public health side of the recommendation. There are reasons that Dr. Axelrod recommended what he did. It wasn't just arbitrary and it wasn't just negligent of society. That's why I made the point earlier in my question, that we have corrections living in one culture and one world with one set of responsibilities and public health living in the same world, but starting from some different premises, and translating those two into policy is extremely ticklish and difficult.

CHAIRMAN WATKINS: Can you give me a couple of reasons why you wouldn't want to follow such a policy from a public health point of view?

MRS. GEBBIE: The two pieces of that are one, a point that is already evident in the Federal information, that persons most at risk will volunteer to be tested, so voluntary testing works with prison existing populations just as it works in the general public --

CHAIRMAN WATKINS: I wouldn't have any problem with voluntary.

MRS. GEBBIE: The second piece of that is out in society, for ex-prisoners, just as for everybody else, the dominant ways one gets infected are things to which you submit voluntarily. Every one of us can protect ourselves from these ex-prisoners by our own choices about drug use and sex, with very limited cases, and it is those very limited cases that made us in Oregon support mandatory testing for drug related and sex related crimes.

I don't have a perfect answer here today. My point is simply to remember that we need to hear from both sides of this policy debate before we conclude as a Commission where we are going.

CHAIRMAN WATKINS: The Commission will send letters to the various public health officials of the states and we will ask the question. I really believed we were doing things at least in the general direction of the Federal system. It seems to me a bit appalling that we are not doing the other.

I can't think of any reason why we would not do it, for that particular population, and to say we are not doing it in society as a whole, therefore we should not do it in the captive audience we have coming out of prisons, it doesn't seem to be that logical to me.

We want to thank you very much for coming here today. It was very helpful. The papers you have provided have been superb.

MR. STEWART: Thank you, Mr. Chairman. We will be glad to provide that which you asked for, and that was what the states are doing in particular detail. We will have that undertaken quickly for you so you will have it before the end of your time.

CHAIRMAN WATKINS: Thank you.

DR. PRIMM: I want to welcome Dr. Pickens, Dr. Des Jarlais and Dr. Brown, our last panel, modes of transmission/needle sharing. Dr. Pickens?

MODES OF TRANSMISSION/NEEDLE SHARING

DR. PICKENS: Mr. Chairman, Dr. Primm and members of the Commission, I am Dr. Roy W. Pickens, the AIDS Coordinator for the National Institute on Drug Abuse, also known as NIDA, and Director of the Division of Clinical Research at the National Institute on Drug Abuse.

NIDA has now fully implemented a program that was begun two years ago, of research, training and technical assistance regarding the drug abuse aspects of AIDS. The Institute's program includes five basic elements ranging from number one, work to ensure there is adequate treatment capacity for intravenous drug abusers in the United States; two, to implement a public education program to ensure that all individuals at risk know of the dangers for AIDS, the risk factors for AIDS, and how they might reduce those risks; three, a community demonstration program to get money out to cities who are being affected by the AIDS epidemic. This includes cities that currently have high rates of intravenous drug abuse and AIDS among intravenous drug abusers, as well as cities that currently have high rates of intravenous drug abuse but low rates of AIDS among intravenous drug abusers in an attempt to prevent the rapid increase of AIDS in those cities.

Four, we have implemented a seroprevalence monitoring system to monitor trends in HIV infection among intravenous drug abusers around the nation and the fifth element involves a basic program of research that is designed to improve the effectiveness of existing drug abuse treatment strategies and to develop even more effective strategies for the treatment of drug abuse as well as to develop more effective ways of educating the public and individuals at risk about the dangers of AIDS and its association with intravenous drug abuse.

In my remarks today, I will concentrate on our current knowledge regarding needle sharing by intravenous drug abusers and their response to the AIDS epidemic.

First, I would like to talk about the magnitude of the intravenous drug abuse problem in this country. At present, we do not have accurate data on the prevalence of intravenous drug abuse. While a number of abused drugs are injected intravenously, heroin and cocaine are thought to account for most cases of intravenous abuse. Heroin addicts often use cocaine intravenously in addition to heroin and the use of cocaine by heroin addicts appears to be increasing. A sizeable number of individuals are using cocaine intravenously without also using heroin. Significant numbers of intravenous users of PCP, amphetamines and barbiturates are also known to exist.

Obtaining information on the size and the characteristics of this population has been difficult because intravenous drug abusers actively avoid public attention due to the illicit nature of their drug use and associated activities. Those activities are criminal acts that are often associated with intravenous drug abuse.

Based on our best estimates, we are currently estimating there are between 1.1 and 1.3 million individuals in this country today who are intravenous drug abusers.

Concerning needle sharing by intravenous drug abusers, detailed systematic data on the needle sharing practices of intravenous drug abusers are not currently available, for the same reason we have difficulty in estimating the number and the extent of intravenous drug abuse in this country.

Data that are available indicate that opiate addicts commonly share injection equipment including needles, syringes and cookers which are used to prepare drugs for injection. The rate of needle sharing by intravenous drug abusers varies considerably from city to city around the country. Drug use practices also differ widely across the United States.

For example, shooting galleries where addicts can rent injection equipment are common in New York, whereas residential hotels are a common locale for needle sharing in San Francisco. Among Mexican Americans in the southwest, needle sharing tends to occur within established social networks. Although there are regional and cultural differences in drug use practices, the sharing of drug injection equipment among intravenous drug abusers is common throughout the United States.

Needle sharing among intravenous drug abusers occurs because it fulfills both practical and social functions. Sterile needles are not readily available to intravenous drug abusers in the United States. Several factors contribute to the scarcity of these needles. In some states, generally those states with the largest intravenous drug abuse problem, sterile needles and syringes are not available without a prescription. Even where prescriptions are not needed to purchase needles, pharmacists may be unwilling to sell needles to intravenous drug abusers. Also, the possession of needles for purposes of injecting illicit drugs is generally prohibited under state paraphernalia laws. Fearing arrest, addicts are hesitant to carry their own injection equipment with them.

Also needle sharing makes it possible for addicts to inject drugs with minimum delay and without the legal risk of carrying injection equipment.

In addition, within small groups of intravenous drug abusers, needle sharing may reflect a sense of camaraderie and trust.

While intravenous drug abusers commonly share injection equipment, most addicts do not adequately clean their equipment between users. For example, among San Francisco addicts who acknowledged sharing needles, only 19 percent reported always

sterilizing their needles while another 16 percent reported they usually sterilized their needles. Even so, the accuracy of these self reports cannot be validated.

It is important to recognize that the places where many addicts congregate, purchase and inject drugs, that is street corners, back alleys, abandoned buildings, do not lend themselves to adequate needle cleaning between users. Rinsing with water may be used to keep the needle from clogging, but this is not adequate protection against the AIDS virus.

Concerning the response of intravenous drug abusers to the AIDS epidemic, intravenous drug abusers in various parts of the country appear to be aware of the AIDS epidemic. In some areas, such as New York City, addicts are concerned about their risk for AIDS and many are attempting to reduce their risk. However, risk reduction is not risk elimination. Risk reduction efforts are frequently inadequate such as reducing the number of people one shares with or rinsing the syringe with water, are inconsistently applied, that is cleaning needles some but not all the time. In other areas where relatively few intravenous drug abusers have contracted AIDS, many intravenous drug abusers are still denying their personal risk of acquiring AIDS and do not know how they can protect themselves and are not even reducing their risk.

It is encouraging to note the concern among intravenous drug abusers in New York City and the resulting behavioral changes, even though these changes are not always totally effective. This experience provides hope for the prevention of AIDS in this population. However, it is also apparent that a massive prevention effort at the Federal, state and local levels must be implemented immediately to significantly impact on the spread of the AIDS epidemic.

Finally, regarding prevention of AIDS among intravenous drug abusers. Certainly, the most effective way to prevent the spread of AIDS among intravenous drug abusers is for abusers to stop using drugs. As long as individuals continue to inject drugs, it is likely they will continue to share needles. It is just that simple. Therefore, high priority must be given to helping addicts discontinue their drug use.

Drug abuse treatment has been demonstrated to be an effective means for accomplishing this goal. Since drug abuse treatment programs across the U.S. are already over subscribed, it is important that the treatment capacity be rapidly expanded to make treatment readily available to all intravenous drug abusers who can be convinced to participate. Outreach programs must also be expanded to encourage intravenous drug abusers to enter drug abuse treatment.

While helping addicts to quit using drugs must be our ultimate goal, many intravenous drug abusers will be unwilling to enter drug abuse treatment and will continue to inject drugs. Some users who enter treatment will subsequently relapse and return to drug use. An effective AIDS prevention strategy must therefore go beyond a focus on drug abuse treatment alone. We must help those individuals who continue to inject drugs reduce their risk for contracting or transmitting the AIDS virus. Thank you, Mr. Chairman.

DR. PRIMM: Thank you, Dr. Pickens. Dr. Des Jarlais?

DR. DES JARLAIS: Thank you, Dr. Primm, Chairman Watkins, the rest of the Commission. I would first like to thank the members and staff of the Commission for the opportunity to testify.

AIDS is the most important public health problem of our times and unless we develop successful strategies for limiting the spread of the human immunodeficiency virus, the causative agent of AIDS, it will be an even greater problem for future generations.

Intravenous drug users will play a critical role in the epidemic. They are the second largest group of persons to have developed AIDS in the United States and Europe, and they are the primary source for both heterosexual and perinatal transmission of AIDS in the United States and Europe.

I would like to also acknowledge the efforts of my colleagues at Narcotic and Drug Research, Inc., New York University Medical Center, Beth Israel Medical Center and the New York City Department of Health for their tireless collaboration in the research that forms the basis for my testimony. Additionally, I would like to acknowledge the support of the National Institute on Drug Abuse and the Centers for Disease Control that have been the primary financial support for this research.

A research article detailing recent findings in the field of AIDS and intravenous drug use has been presented to the Commission staff, so I will use this testimony only to give an overview of the current situation. Many of the recent findings are the opposite of previous common sense beliefs about AIDS and intravenous drug use.

First, in the absence of awareness of AIDS and prevention efforts, the HIV virus can spread very rapidly among IV drug users once it has been introduced in a geographic area.

[SLIDE.]

DR. DES JARLAIS: This slide shows stored sera that had been collected in Manhattan, Edinburgh, Italy, and Scotland, that had been stored from various studies on drug users, and once the HIV antibody test was available, people went back and thawed that frozen serum, tested it for HIV, and it shows the rapid spread of exposure.

Typically, where we have had this frozen sera from drug users available to look at the spread of HIV, we find for example in year zero, you find your first seropositive sample, then three or four years later, you are typically up around 40 percent of all the drug users in your study, that have already been exposed. We see the possibility of very rapid spread. This has been shown in data from Manhattan, Scotland, Italy and Spain. Clearly, even in cities in the United States right now, where HIV exposure is at very, very low rates among drug users, we have the potential for very rapid spread and of course, once that rapid spread occurs, we then have the potential for both perinatal transmission to the children of IV drug users, and for heterosexual transmission from drug users to persons who do not inject drugs but who have sexual relationships with drug users.

There have been two behavioral factors associated with this rapid spread of the virus among drug users. The first is frequency of injection, the more someone injects drugs, the more likely they are to share equipment with someone who is carrying the virus. The second is the sharing of drug injection across friendship groups, such as occurs in the shooting galleries that Dr. Pickens mentioned, where people go in and rent drug injection equipment, use it, return it to the person who runs the shooting gallery, who then rents it to someone else coming in.

Our research staff has observed 40 to 50 different individuals using the same needle and syringe in shooting galleries in New York.

In cities other than on the East Coast, where shooting galleries are not very common, there is sort of a functional equivalent called a house works or dealer's works, a person who is selling heroin or cocaine for injection, who will typically keep an extra needle and syringe available for use by customers. The customer will come in, purchase drugs, borrow the needle and syringe from the person selling the drugs, inject there and then return that needle and syringe to be used by the next customer coming in.

[SLIDE.]

DR. DES JARLAIS: As bad as AIDS is, it probably greatly underestimates the fatal consequences of HIV infection among IV drug users. This slide shows deaths among IV drug users in New York City from 1978 through 1985. You can see the total

deaths have increased dramatically from about 250 in 1978 to about 1,600 in 1985. We are currently analyzing 1986 data and that will be about 2,000 deaths among IV drug users.

The top band, the dark orange, represents deaths from AIDS. Those clearly have increased dramatically over the last 10 years, but they do not account for all of the increased deaths among IV drug users.

There have been dramatic increases in deaths from bacterial pneumonia, from tuberculosis, from endocarditis, a wide variety of infections that IV drug users typically encounter, but prior to background HIV infection, drug users tended to recover from these infections. Now that HIV is present in the community, we see drug users developing bacterial pneumonia, endocarditis, tuberculosis, and dying from these diseases at much greater rates than we ever saw prior to AIDS.

DR. PRIMM: Don, would you go over the colors? We are all straining to see the explanation of the colors. The first one on the far left says?

DR. DES JARLAIS: This first one says "drug" and the bottom represents overdoses. That has been relatively constant, indicating we probably do not have any large increase in the number of IV drug users.

DR. PRIMM: The red?

DR. DES JARLAIS: The bottom has been constant. This is AIDS, clearly increasing. This yellow band represents deaths from pneumonia and this does not include pneumocystis pneumonia which would be in AIDS. Deaths from pneumonia have clearly increased. There were approximately 190 of them in 1985, back 1981, there were about 30. You see these increasing. This band, it's hard to see, is tuberculosis. That has increased from three in 1980 to 30 in 1985. The green band is other, that includes endocarditis.

The basic point is if we look only at AIDS, we are missing all of these other increases that represent HIV infection but are not counted in our official way of looking at the AIDS related deaths. We look just at people who have developed AIDS and see how many of them die. When we look at drug users, where we have a high background of poor nutrition, poor health and other infections, we see massive increases in other causes.

In terms of New York City, we have estimated that to get the true number of HIV related deaths, you should take the AIDS deaths, which are about 1,800 to date, and multiply by 2.5 to get about 4,300 deaths. AIDS captures only about 40 percent of all of the HIV related deaths among drug users in the City.

[SLIDE.]

DR. DES JARLAIS: The third point I wanted to make is that contrary to the common belief that IV drug users do not care about their health, they are very concerned about AIDS and they will change their behavior in order to reduce their risk to developing AIDS. This slide is data from drug users we interviewed in 1984 in New York. This was prior to any of the official AIDS prevention efforts in the City aimed at drug users.

At that time, essentially all of the drug users we interviewed knew about AIDS. Over 90 percent knew it was transmitted through the sharing of drug injection equipment. Fifty-nine percent reported they made at least one behavior change in order to protect themselves from developing the disease. The most common behavioral changes were to increase their use of illicit sterile needles or to reduce their sharing of equipment with large numbers of people. They were similar to the studies in gay men who reduced their sexual partners. Drug users were reducing the number of needle and syringe sharing partners.

DR. PRIMM: Unfortunately, Don, it is not discernable from this, would you make that part of your submission, this particular chart?

DR. DES JARLAIS: Yes. Let's go to the last also unreadable slide.

[SLIDE.]

DR. PRIMM: I think if you talk to us while you go across, we could translate it.

DR. DES JARLAIS: This slide really just shows different areas where research has been conducted on behavior change and risk reduction among drug users. The first was New York City where the most common behavior change was the increased use of illicit sterile drug injection equipment and reduced numbers of sharing partners. That has been reported in a number of publications.

I also want to comment on the present New York City situation. We currently have ex-addicts who are going out into the streets in New York, doing face to face AIDS education with drug users they meet in high drug use areas. They provide rapid access for antibody testing. Any drug user in the street who we meet who wants to be tested for HIV antibody is immediately taken to an alternate test site where they are provided with pre-test counseling, the test if they want it, and then post-test counseling.

These ex-addict educators are also providing explicit instructions on how to sterilize drug injection equipment, including the use of bleach and alcohol to sterilize equipment.

One of the interesting things they are finding is as they do this street AIDS education, many of the people they come into contact with want to get into treatment, they say, yes, it is fine to try to sterilize my equipment, but what I really need to do is get into treatment, get my drug use under control, if I am physically addicted and injecting three or four times a day, it is going to be very, very difficult for me to try to always use a sterile needle, therefore, what I really want to do is get into treatment and while we started out with the idea that we would just do education, we now find that we are developing into a treatment referral system and a street counseling system. There our biggest problem is simply that the treatment system is full in New York and it is very difficult to take somebody immediately into treatment.

A similar thing occurred in New Jersey, where they sent out ex-addicts trained as AIDS educators with the specific intention of getting people to sterilize their equipment. They found the dominant response was people saying, please get me into treatment. New Jersey has since expanded their treatment capacity. Because of funding cutbacks, they had been forced to charge a $50 down payment for drug users to get into treatment. They have now set up a voucher system where their AIDS educators out in the street distribute a voucher that can be redeemed for free treatment. They have found that over 85 percent of the vouchers they have distributed have been redeemed by people coming into treatment.

They are also interviewing people coming into treatment and they find that approximately 50 percent of drug users going into treatment in New Jersey cite concern about AIDS as one of their primary reasons for coming into treatment.

Again, an effort that started just as an educational program, trying to get people to stop sharing their drug injection equipment and to sterilize it, led to increased demand for treatment.

The third city where we have reasonably good data is San Francisco, over the last year, they have been distributing small bottles of bleach in San Francisco that provide for very easy and rapid sterilization of needles and syringes. It takes about 30 seconds to rinse out the needle and syringe twice with the bleach. You then follow that by rinsing out the needle and syringe two or more times with water. Prior to distributing the bottles of bleach, only about 3 percent of the drug users they studied were sterilizing their equipment. That has now gone to

somewhere between half and two-thirds of the drug users in the City that are now using bleach to sterilize their equipment.

The final city is Amsterdam. There, as you may know, they have a needle exchange program. They had that needle exchange prior to concern about AIDS. It was set up originally as a way of trying to reduce the spread of Hepatitis B among drug users in Amsterdam. They have massively expanded the needle exchange system in Holland, going from about 25,000 sterile needles and syringes per year to now, up to 600,000 sterile needles and syringes per year.

Under this exchange system, a drug user brings in a used needle and syringe, trades it in for free for a sterile needle and syringe. This provides for the possibility of therapeutic contact between the health authorities and the drug user. It also provides for safe destruction of the potentially AIDS carrying needles and syringes.

As that needle exchange system has expanded, they have also found that drug users in Amsterdam are reducing their frequency of drug injections. In the latest reported data from Amsterdam in a sample study by Van den Hoek and colleagues, two and a half years ago, 87 percent of the subjects reported they were injecting at least daily and they have now reduced that to where only 48 percent of the subjects were injecting daily. They have also found that the number of people coming in for treatment, in Amsterdam, has increased as the needle exchange system has been expanded.

Contrary to the belief that the needle exchange system would encourage people to inject drugs, they are finding that drug users are actually reducing their frequency of injection and there has been no slackening in the demand for treatment in Amsterdam as sterile needles have been made more readily available.

Again, this is similar to the findings from New York and New Jersey, that when you go out and do honest non-judgmental AIDS education with drug users, they are very receptive. They are concerned about AIDS and while many of them want to practice safer injection, honest AIDS education also leads many of them to want to come into treatment. The idea that trying to teach safer injection will encourage drug use, seems to really be contradicted by the results to date, where teaching people about safer injections and providing for safer injections has actually stimulated demands for treatment and has led to reductions in drug use. Thank you.

DR. PRIMM: Thank you, Dr. Des Jarlais. Dr. Brown?

DR. BROWN: Mr. Chairman, I want to offer my sincerest gratitude for the opportunity to discuss with you and the other Commissioners a phenomenon that greatly threatens nearly every fabric of society.

I have had the opportunity to read your preliminary report and I was most impressed with its indepthness, and I would like to in a sense talk about two portions of that. One is the subject of these hearings currently, and the other is with regard to patient care.

I would also like to salute you for your perseverance in a sense that given that we are near the end of the day and many of you who are health practitioners know that when we take food and present it to the GI tract, there is redistribution of the blood. Unfortunately, that redistribution is at the expense of the brain, notwithstanding the seats that you are currently sitting in, and it is commendable for you to continue to stay alert and bright as you continue to be.

I serve as the Vice President for Research and Medical Affairs of The Addiction Research and Treatment Corporation, an organization that has prided itself in serving the hard core, lower socioeconomic and predominantly black and Hispanic addicted since 1969. As a not for profit minority operated organization, ARTC has provided a wide range of comprehensive health care and treatment services to well over 20,000 patients since its founding.

Currently, ARTC serves a 2,100 patient population and six treatment clinics in Brooklyn and Manhattan.

The AIDS epidemic has had astounding effects on the health care and social well being of the patients, the recruitment and efficacy of treatment staff, and the resources in the urban centers in which these facilities reside, and in which drug abuse promulgates.

The fact that this section of your hearings are dedicated to needle sharing is testimony to your concern of the pivotal role that intravenous drug abuse plays in AIDS and HIV infection among heterosexual men, women, children and ethnic racial minorities.

While my comments will in the main be focused upon the extent of needle sharing and the responses presently proposed to reducing HIV transmission through this commonly practiced custom among parenteral drug abusers, I would also like to offer you some additional evidence about the efficacy of treatment and some thoughts about some additional merits of expanding the scope of what is currently thought as drug treatment.

That drug treatment enrollment truly represents this potential has been demonstrated in a collaborative study between ARTC, the Addiction Research Center, and the National Center on Drug Abuse. Of the nearly 500 patients who participated and received extensive pre-test and post-test counseling, those persons who tested positive for the virus had a statistically significant shorter enrollment in our program than those who tested negative.

[SLIDE.]

DR. BROWN: As this slide demonstrates, those who were in the program less than one year had a higher seroprevalence rate than those in the program for any greater period of time.

While this finding may be suggestive of a positive role of treatment, one cannot conclude that by just opening more positions, our problems with AIDS will be adequately resolved. In the era of AIDS epidemic, quality is equally important. For example, one need but look to New York State and the response of its single state agency. While this agency aggressively encouraged treatment programs within the state to expand, there was little concurrent response to provide proportionate resources for the wide array of medical and psychosocial consequences associated with the HIV infected intravenous drug abusers.

The problems of the drug addict suffering from AIDS or an AIDS related disorder is many times those of the non-infected. It has always amazed me as a health care practitioner, why our health care system is not receptive to improve the level of primary medical care in drug treatment programs, at least as a means of early recognition of HIV related consequences and hopefully early intervention, but is willing to invest in expensive tertiary care services that are either not available for this population or of little utility by the time drug abusers present themselves for hospitalization.

A perfect example of this is the concurrent rise as mentioned by Dr. Des Jarlais in tuberculosis and AIDS in intravenous drug abusers, and the communities in which they live. While HIV infection is not casually transmitted, tuberculosis infection is not that limited. In fact, based upon communication with the New York City Department of Health, a large number of tuberculous infected patients with whom they have lost contact are IVDAs, some currently enrolled in drug treatment. Because of the limitations placed upon treatment programs, prophylactic treatment is unavailable.

This is but another intervention that is in the interest of the public health of this country and also will save valuable health care dollars by avoiding costly hospitalization later on.

Let me make it abundantly clear. I am not against highly technological health care. Quite the contrary. As the attending physician on the medical wards, and I think parenthetically to me, this allows me to get another perspective on the AIDS epidemic, not only from the standpoint of ambulatory services but actually to see patients once they are admitted to the hospital, also from the standpoint of doing community outreach, and to the extent I can, to provide assistance in policy development as you are providing leadership here.

As an attending physician on one of the medical wards of Harlem Hospital recently, I complained bitterly about the limited availability of intensive care unit beds resulting in management of patients requiring respiratory support on under staffed general medical wards. One-third of my 35 patients were hospitalized due to AIDS related disorders and nearly all of those with AIDS related illnesses had histories of intravenous drug use. This appears to be another legacy of the addicted.

Returning to the issue of needle sharing, we have also discovered that the practice of needle sharing may also have some significance for HIV transmission from IVDAs to the general community. Inquiring about the number of sex partners from 1977 to 1985 of approximately 100 intravenous drug abusers, we noted that males were more likely than females to have sex partners who are not drug abusers.

[SLIDE.]

DR. BROWN: Females were more likely to become exposed to HIV virus through their own intravenous drug use and the sexual transmission from an IVDA mate.

[SLIDE.]

DR. BROWN: If you look at the percentages of the males who had sex partners who were not intravenous drug abusers, there were 68 percent, they almost turned the tables, that the females who had sex partners who were intravenous drug abusers was 63 percent. If we then focused on the needle sharing, those admitting to needle sharing at a greater rate, you will see for the males, that went up to 74 percent of sex partners who were not intravenous drug abusers, and for the females, their sex partners who were intravenous drug abusers, it also went up to 77 percent.

[SLIDE.]

DR. BROWN: When we evaluated each sex separately, we noticed that needle sharing did not change the propensity for male IVDAs to have a non-IVDA sex partner. That is whether the

males shared needles or not, they still have the same propensity to have a sex partner who was a non-intravenous drug abuser.

[SLIDE.]

DR. BROWN: In contrast, needle sharing female IVDAs were significantly more likely than their non-needle sharing female counterparts to have sex partners who were IVDAs. This suggests to us that needle sharing has a greater risk for perinatal and sexual transmission for female IVDAs as compared to their male IVDA counterparts. Given the prospects for perinatal transmission of HIV infection, effective responses to needle sharing are paramount.

A number of proposals besides treatment expansion, have been offered as responses to intravenous drug abuse associated HIV transmission. These include from needle sterilization programs using bleach to needle exchange projects. While I salute the intentions of many of these efforts, there are a number of caveats that I feel compelled to share, since this is a particularly important public debate, that even most of us in the drug treatment community need to recognize the limitations of some of our interventions and need to plan the projects based on that recognition.

The needle and syringe are not the only instruments involved in IV drug use that can become contaminated with the HIV virus. The cooker, as mentioned earlier, which is commonly used and shared can also contain infectious material along with any sediments of unused drugs. Further, it should be understood that not all IVDAs will receive similar benefit from these suggested interventions.

For example, in another collaborative study with the National Institute on Drug Abuse, we found that controlling for injection frequency and injection setting, sharing needles could not explain the greater prevalence of HIV infection experienced by black and Hispanic IVDAs as compared to their white counterparts.

[SLIDE.]

DR. BROWN: As you see here, while the blacks and Hispanics had higher seroprevalence rates, their self reporting of sharing was lower than their white counterparts. I might also add that we have heard a number of times during today about the Chaisson study. They also similarly found that black and Hispanic IVDAs had a higher seroprevalence rate, despite the fact that they reported a lesser frequency of sharing.

Even so, given the ravages of this epidemic and the potential bridge that infected IVDAs may play in expanding this

disorder to other portions of society, it is my belief that all proposals deserve adequate discussion and debate. We must be mindful that this discussion, while extremely sensitive to all the medical, legal, socioeconomic and public health consequences, must be firmly based on scientific and epidemiologic evidence.

Given this litany of problems, let me offer a few ingredients that I think may be useful in a rational response. First, let me agree with my colleagues to say that drug abusers are capable of change. Based on a number of surveys that have been suggested to you today, many have received the message, a very large number claim they no longer share needles, and a surprising portion claim to even use some form of liquid to clean their needles prior to use.

Thus, we sorely need more messengers and more messages. The messages should be well founded in science and should be culturally sensitive. As for the messengers, I agree with the comments of Dr. Lilly earlier, that television, newspapers and pamphlets are insufficient vehicles for communication to the drug addicted.

There is a need for a cadre of foot soldiers to get out and deliver the word and we have seen some evidence of their efficacy. For drug treatment programs to attract and retain addicts in treatment, there is considerable need for improvement in the quality of services.

When one compares the exteriors of drug treatment programs in many urban settings with that of other types of health care facilities, it is no wonder why drug abusers are not as encouraged to attend.

Needle sterilization programs should be explored with the understanding of their potential advantages and limitations. Adequate mechanisms of assessment are crucial to their evaluation. Finally, the quality of primary medical services must be enhanced, and I want to stress that, must be enhanced in drug treatment, and I come to you first as a physician and a healer, if we are serious about impeding the progression of HIV related consequences, or about early intervention prior to greater morbidity and mortality to the drug user or as in the case of tuberculosis, to the communities in which intravenous drug use is abundant.

Again, Mr. Chairman, I want to thank you for providing me with the opportunity to share with you and the Commissioners some of the thoughts and concerns of my colleagues and staff about their ability to respond to this very devastating epidemic and most importantly, about the significantly unmet needs of the drug addicted in our communities.

DR. PRIMM: Thank you very much, Dr. Brown. You have eloquently stated the problem as per the corporation. I want to thank you very much.

Dr. Brown, as most of you know, is my Vice President for Medical Affairs and Evaluation, and I'm extremely proud of him. He's been with me now for, some 14 or 15 years, since he was a medical student at New York University. So he is part of the corporation that I have.

I've also worked with Dr. Don Des Jarlais and Dr. Pickens, and I'm so very proud that they're all here and all seem to agree on one point, that we do need more services, an expansion of treatment, and certainly a better quality of service.

Dr. Pickens, I wanted to open the questioning by asking you about the expansion of services. I don't know whether you were here during Congressman Bill Green's testimony. He talked about the expansion of services and the reduction of regulations by the FDA so that we could expand services and probably have a higher patient/counselor ratio. In other words, instead of a 50:1 patient/counselor ratio, it would go up higher, and that would allow immediate expansion of drug treatment programs, particularly methadone maintenance programs.

I did some extensive questioning of Congressman Green, and I was a little perturbed by that because the kind of profile that our patients present, about 35 years of age and maybe a 9th or 10th grade education and seven to eight years in jail, and generally 14 to 15 and even longer years using intravenous substances, that that kind of counselor/patient ratio would only result in a real diluting of services and less efficacy on the part of methadone maintenance as a modality.

I'd like for you, as a member of the National Institute on Drug Abuse staff, to comment on that if you would, if you could.

DR. PICKENS: I'll be happy to, Dr. Primm.

Of course, we spend all of our time wrestling with the issue of AIDS, particularly AIDS among IV drug users.

I think the Congressman was correct in saying that we need to expand treatment capacity. We need to do something more than we're doing at the present time.

There are long waiting lists in some of the major cities with high incidence of AIDS, and we must work to insure that there is adequate treatment capacity for those individuals.

However, I think we should be very careful in terms of how we go about approaching this. The idea here is that if you could expand methadone programs by reducing some of the services and allowing more patients to go through those programs, that that would be a good approach to this problem.

I don't think so for one important reason; that is, that heroin addicts aren't just heroin addicts. Heroin addicts use a variety of drugs in addition to heroin.

Methadone takes care of heroin addiction. It's a very effective substance in terms of reducing illicit opiate use. However, it doesn't have that much effect, really, on other types of drug abuse.

What I'm talking about now specifically is cocaine abuse. Cocaine abuse is increasing markedly among heroin addicts. Providing more methadone and just methadone to heroin addicts might be a way of stopping the opiate abuse, but it won't do anything about the other types of drug abuse. It won't do anything about the cocaine abuse in particular; won't do anything about marijuana use; it won't do anything about alcohol use. These are three drugs that are often used by heroin addicts.

So we think it's very important not just to concentrate on heroin use by heroin addicts but also to recognize that heroin addicts use these other drugs, too, and the methadone won't reach these other drugs.

Therefore, we think it's very important to offer counseling services along with methadone in methadone treatment programs. What we would like to do is see just the reverse. We would like to see a strengthening of the counseling services that are available in drug abuse treatment programs so these programs -- and here, I'm speaking specifically of methadone maintenance -- can address not only the heroin addiction but also the cocaine abuse and the marijuana abuse and the excessive use of alcohol that also occurs among clients to those programs.

DR. PRIMM: Thank you, Dr. Pickens. Any other comments? Dr. Walsh.

DR. WALSH: I have just a couple of questions that I would like to ask.

One, Dr. Des Jarlais, the experience that you described in the needle exchange program in Amsterdam and then the experience that you described in New York where you said one of the incentives for people getting off drugs and getting into treatment or at least getting into treatment was that they had to wash their needles two or three times a day and that reduced it.

Then you said the needle exchange in Amsterdam seemed to not give them an incentive to use more drugs; and, yet, the use of needles would jump from 40,000 to 600,000.

I wondered whether in your studies this was more the fear of AIDS than a desire to get off drugs that had the result of reducing the problem in Amsterdam.

DR. DES JARLAIS: In the Amsterdam experience with the needle exchange, there are always problems of having a sterile needle. The needle exchange is not open 24 hours a day. People do inject after it closes. Even with a needle exchange, there are problems in terms of having a sterile needle available.

So the drug users realize there are problems and realize even with the needle exchange they need to have their drug use under control at a minimum or, hopefully, eliminated if they're going to protect themselves against AIDS.

So it has been really the concern about AIDS that is leading them to reduce their levels of injection, but they are reducing their levels of injection at the same time that the needle exchange expanded, and the same people who are increasing their use of the needle exchange are also reducing their levels of injection.

DR. WALSH: The second question, and this is my only other question, is in the slide that you showed us about the incidence of death and so on among drug users, one of the things that persists in disturbing me is the way in which we continue to differentiate between what is AIDS and what is ARC and so on.

I wonder, are we just deluding ourselves when you see the amount of people with tuberculosis, the amount of people with pneumonia that's not pneumocystic pneumonia but obviously they're related to a diminishing of the immune system's ability to fight infection?

Why are we continuing to kid ourselves, and why don't we call it all one thing or another? Because, to me, the definition of AIDS means that you are now so terminal you're going to die, and we know you're going to die soon relative to others.

But I don't think that we are able then to tell the American people properly the threat of this epidemic, and I wondered if any of you would like to comment on that?

DR. DES JARLAIS: Yes, I think you're quite correct.

When the CDC first decided to define AIDS, it was before any virus had been discovered. Their main concern was

that cases of AIDS had to be a case of AIDS, and they were willing to miss a lot of cases as long as they knew that every case they counted really had AIDS, and, therefore, they had a very limited number of opportunistic infections, pneumocystis pneumonia, Kaposi's sarcoma and such.

Now that we have the virus identified, we have tests for it, we can expand our definition of AIDS without pulling in a lot of false positives, without mislabelling as AIDS things that really are not.

For example, if an IV drug user dies of endocarditis and we know that he's been infected with HIV for several years and we know that his T4 cell count is at about 200, that would seem to be a very reasonable person to classify as having AIDS. As we do that in New York, we see the number of AIDS deaths going from 1,800 to about 4,300, which I think is a much better picture of what's going on.

DR. WALSH: That's what concerns me, because, I think, you know, when we're looking at projections for 1991 and we talk about 270,000 patients with AIDS but an additional half million with ARC, we're just kidding ourselves, and we're kidding the public.

I just hope that those of you who are really up to your eyeballs in the trenches with this will try to convince CDC perhaps to rethink this. Yet, it just worries me because the American people don't realize the extent of it.

DR. BROWN: If I could add something to that. In fact, part of this is a dovetail on the question that Dr. Primm had asked Dr. Pickens.

To me, based on the comments of Congressman Green, I really think we should also go in the opposite direction. I think that --

DR. WALSH: I didn't hear you, Doctor.

DR. BROWN: I really think we should go in the opposite direction of improving the quality of services and drug treatment.

Because you talk about tuberculosis, something that we could really do something about but we don't have the appropriate resources in which to provide that. At the same time, they're getting drug treatment daily.

Why should we not be able to provide them with INH?

There are also other HIV-related disorders that are also rising in the inner cities, syphilis infection. We're still not clear to what extent that serves as a co-factor either with the exposure or infection or the progression of the disease.

Why should we not have the ability to be able to treat those patients in these facilities where, in ours, for example, they come four and a half days a week?

It does not make sense for us to talk about expanding without also talking about improving the quality. If we really want to do something in the public interest, we do recognize the limitations of HIV transmission. Those limitations do not hold for tuberculosis or syphilis, for that matter.

It doesn't seem to me that the response is rational enough to take care of the other aspects of the HIV-related epidemic.

DR. WALSH: I think it gets back to our chairman's constant point of the last few weeks in which he's asking for much more of a coordinated program in this whole thing. This just does distress me. Thank you.

DR. PRIMM: Dr. Lee.

DR. LEE: We've been learning last week about some facts about incidence, and one of the elder statesmen from the CDC was explaining to us when the curve shoots up like this with very rapid acceleration in the incidence curve, that you saturate the system relatively rapidly.

The gay community seems to have saturated and has crested. Mayor Koch brought that out again.

I've been told, Don, that you are finding your patients to be aging. Is this panel finding drug addiction, and AIDS-related problems, going up at the same rate, or do you think it's about to crest?

DR. DES JARLAIS: The national data on IV drug use, particularly heroin addiction, where we have better data, would indicate that the main age group we have right now are drug users between 30 and 40, many of them who began their heroin use in the late 1960s/early 1970s. So that was really an epidemic of heroin use.

That age cohort has continued on. That cohort is basically in its 30s. That's where we see the most common AIDS case. The average age of an IV drug user with AIDS in the United States is about 35.

We are conducting some studies of people who are not yet injecting but are at risk; specifically, young adults who are sniffing heroin and cocaine but have not started to inject it.

It is clear that they are not starting to inject it anywhere near the rates that we saw in the late 60s and early 70s, but that some of them still are starting to inject.

But we clearly do have an aging cohort with probably enough new IV drug users coming into the system to replace the ones who have been leaving, either who are stopping on their own, successful treatment or dying.

So that we have probably a fairly constant total number of IV drug users over the last seven or eight years, where in the late '60s/early '70s, the total number of IV drug users was increasing dramatically.

DR. PICKENS: If I might add a postscript to that, what Don is talking about here, the heroin addicts, let's bring cocaine into this picture, because I think that's an important but largely unrecognized drug in the AIDS epidemic.

Our best estimates based on our national household survey at NIDA indicated there are as many as 6 million recent users of cocaine in this country.

Now, if we say that there are 500,000 heroin addicts in this country -- this is hardcore heroin addicts -- that's the best estimate we have.

DR. LEE: What was that last number?

DR. PICKENS: Five hundred thousand hardcore heroin addicts.

That is a small number compared to 6 million individuals who are currently using cocaine. By that, I mean they admit to using within the last month.

Now, a certain percent of those individuals are using cocaine intravenously. Even if that's a small percentage, a small percent of 6 million is going to turn out to be a lot of people.

Among all of the types of drug abuse that we're seeing in this country, all types of drug abuse appear to be stabilized or decreasing slightly except for cocaine. The use of cocaine is going up in this country.

I think when we talk about intravenous drug abuse, we have to be very careful not to limit what we're saying to heroin

addiction. I think everyone on the panel will agree to that. It's the cocaine use that may eventually, in the next year or two, become more recognized as being a major vector by which AIDS is affecting individuals.

But I might add one further item, too, and that is that it's not just intravenous drug abuse that's involved with AIDS. All types of drug abuse can be involved with AIDS, crack in particular, although crack is smoked cocaine. It's not intravenously-injected cocaine.

There are individuals out there who are prostituting themselves for drugs, for crack. Dr. Primm, I think, or someone earlier, talked about what goes on sometime in these shooting galleries.

Now, that's the way the AIDS virus can be transmitted sexually, with drug abuse being involved in the transmission but it not being intravenous drug abuse, and we should not let that go unrecognized.

DR. LEE: So what I'm hearing is, do you agree, Dr. Brown, that this thing is increasing? We're not looking at a thing that might crest here?

DR. BROWN: I think that we are looking at different portions of drug abuse-related phenomena that are increasing. I agree with Dr. Des Jarlais, that if the people who we're talking about, just IV heroin users, you might say that population is relatively stable.

But what Dr. Pickens is talking about which is more frightening are particularly the females who are prostituting themselves for cocaine, whether it's in the form of crack or injectable, who then have a sex partner who's an IV drug abuser. They share a needle, and then they go out and prostitute to get money so that they and their partner will be able and purchase more drugs.

So we have a phenomena that is expanding because they're different drugs that are being used to, you might say, promulgate the HIV epidemic.

DR. LEE: There's one other thing that hasn't been brought out here today, but, obviously, all these people that are taking these IV drugs are not paying for it by working as a secretary or in the sanitation department. They're prostituting themselves or stealing, and they end up in prison.

How do you people handle that? Do you just turn the other cheek? They all have to be criminals that are doing that; isn't that correct? Practically all of them?

DR. DES JARLAIS: Certainly because the drugs themselves are illegal, they are engaging in criminal activity. A very large percentage engage in criminal activities to obtain the money to purchase drugs.

How to best prevent the spread of HIV among this group and interfacing with the law enforcement system is a very, very difficult situation.

One situation in New York City that we've been working on over the last several years is to take people who go into the jail system, Riker's Island, who are addicted when they go in, to start them on methadone maintenance actually before they leave jail and then take them directly from jail to a methadone treatment program so that they do not simply go out of jail, go back to street crime and street drugs before they get into treatment.

So there are efforts being made to work with the jail authorities to attempt to reduce the spread of HIV by getting people if they are identified with a drug problem, to go directly from the prison system or the jail system to the treatment system.

DR. PRIMM: Mr. DeVos.

MR. DeVOS: I hear all this conversation about the need for money to get at the problem or better services or quality services, and I don't think there's anybody in this country that's going to object to that if you can show a success pattern and it solves something.

Until you can, in my opinion you're barking up the wrong tree.

Now, I learned today from Dr. Pickens that methadone really doesn't do it. We have nice centers, but it only does a little bit of it. It really doesn't get them off drugs; it just gets them off one drug.

DR. PICKENS: I would hate to give you that impression. Methadone is a highly effective drug for the treatment of opiate dependence. It's very specific for that.

MR. DeVOS: I understand what you're saying, but the fact of the matter is what you're also saying to me, and maybe I'm wrong or I didn't hear you right, you're saying it doesn't really solve the problem. It doesn't solve the bigger problem

DR. PICKENS: No. I think the issue earlier was the role of the counselor in drug abuse treatment.

The point I was trying to make at that time is that the counselor serves a very important function because the counselor in methadone treatment programs can address the other drug issues.

If you eliminate the counselor from those programs, then methadone would only address the opiate problem; therefore, we need to keep the counselors in those programs.

MR. DeVOS: It may be my lack of understanding of what we're coming at, in that a methadone treatment center normally includes counseling and, therefore, would normally lead us down to hopefully getting a person off of drugs.

DR. PICKENS: Methadone maintenance is a highly effective treatment strategy. I would be more than willing to spend as much time as you would desire going over the different types of treatment modalities and reviewing for you the effectiveness of each one.

MR. DeVOS: I appreciate your expertise in this, and I accept that.

All I'm trying to get at is you leave a little crack in my mind here that says we're going to get you off one but we're going to leave you on the others. Therefore, my success ratio is that we've got you off heroin now, but you're going to be on coke and you're going to slip back to the heroin later on.

Now, if that's not true, you can tell me then that we have success.

DR. PICKENS: We have success.

MR. DeVOS: Good. Now, what level is that success? I'll tell you why.

Because when I look at two piles of money over here, we've got one is treatment dollar pile, and the other one here is this pile of money that people are making on this stuff. I'm not sure if the treatment pile is ever going to catch up with the profit pile.

Because this system over here is driven. I used to think I had a good sales organization until I learned about drugs. I tell you, we're a bunch of pikers. I've never found an organization so motivated, so on fire to get a sale made; which means that this sales force is expanding and driving across this country. This isn't just peer pressure. This is a sales group that's dynamic in every sense of the word, and they're going to catch up with that curve.

So this pile of money is just rolling over here and over here. Maybe you can give me a little hope. All I'm saying is you've got to see some success that we're gaining in this war, or you're not going to get any more funding for the war maybe beyond a certain level.

DR. PICKENS: With every type of major treatment modality, we can demonstrate conclusively to anybody's satisfaction that that modality, that each and every one of those modalities is effective in terms of reducing illicit drug use; it's effective in terms of improving employment among addicts; it's effective in terms of reducing criminality by addicts; it's effective in terms of improving social functioning.

MR. DeVOS: Let me see if you can give me some hope, then. These are effective?

DR. PICKENS: They are effective.

MR. DeVOS: Are we gaining at all, or are we losing the war yet? We're getting some off, but are we getting more on faster than we're getting some off or not?

DR. PICKENS: One of the major limitations right now is the number of treatment slots we have out there.

MR. DeVOS: Alright, but you increase the treatment slots?

DR. PICKENS: The message is that we have an effective strategy for dealing with this problem, but right now that's just saturating. Right now, I think New York City is operating at 107 percent capacity in their methadone treatment program.

We have a strategy that's effective. We need more slots in order to get more people into those treatment programs.

Let me make one other point while I'm here. That is, we've all agreed, and I've heard this said several times today, that ultimately we want to prevent drug abuse and not just to treat it after it's occurred.

While treatment is effective, we have to understand that if we're ever going to prevent drug abuse, we're first going to have to treat those individuals out there who are currently drug abusers. Now, why do I say that? I say that because they are the suppliers of the drugs. The individuals who are the current drug abusers out there are the people that are selling drugs to the other individuals who are being lured into experimentation with drugs. They constitute the supply and distribution network.

You've got to deal with the drug abuse, or you've got to treat that drug abuse. If you could remove the drug abuser in terms of effective treatment of those individuals, then what you do is you take away that supply distribution system that's now responsible for enticing other people into using drugs and supplying them with those drugs.

MR. DeVOS: Now, that's the best news I've heard all day, because the pattern amongst people here -- and I know you're all friendly with Dr. Primm here because he's got you in his camp someplace.

[Laughter.]

MR. DeVOS: I know you're friendly witnesses, and we're all trying to get to the same point here.

The temptation amongst witnesses here is to blame the federal government or Jesse Helms or somebody. They wave their arms and say we're doing great things. But somehow, somebody has got to do something.

Now, I appreciate the little self-aggrandizement. I don't care whether you're mayor or what you are, but you come down to something that tells me we have a chance. Up till now, I've heard fingerpointing, so I didn't hope to realize that there's a chance.

Now, I think money is available if you can demonstrate that you can beat this game. But we haven't seen it. I haven't. All I see is a war where we're losing. Somebody says give me more money over here and I'll win, but nobody demonstrates it.

If you guys can give us some data, I tell you, I think there's a whole lot of people in this country that will get on your team. But the average American is not convinced.

I'm thrilled to know that you think that's a winnable war. That's what you're telling me. It may take a lot of money, but you think it's winnable because we can pull these people out faster than they get sucked in, and the driving pressure of this money that has to be made to push somebody else into it isn't uncontrollable.

DR. PICKENS: Absolutely. I'll say it again.

We have an effective strategy. It's being saturated now in terms of the availability of treatment slots. If we had more treatment slots, we would be reaching more people.

The other point I'd like to make is that it's very important that we treat individuals, because it's the untreated drug abuser that's out there who is maintaining that distribution network. They are the ones responsible for getting drugs to the high school and adolescent students who are now experimenting with them, and it becomes absolutely essential that we do something about the existing drug abuse problems in individuals if we're ever going to get a handle on the prevention of drug abuse.

MR. DeVOS: If somebody comes to me in our company with a proposal for some new expansion of product or service, they come with a cost justification proposal of what that's going to end up being and a return investment when it's going to pay off.

I'd sure like to see somebody develop the document that says you give me an extra billion dollars or whatever --and maybe that's a big number for you, maybe it's a small number. I don't know. But, as I said, if we had a billion dollars on this, I can show you a return on investment that in so many years you will have saved $5 billion and $10 billion in lost people, lost causes, lives destroyed, families uprooted, murders committed.

DR. PICKENS: That has been calculated. There are publications showing the cost effectiveness of drug abuse treatment.

Methadone maintenance is $3,900 per year. That figure was used here this morning.

MR. DeVOS: I am naive in that one, and I don't even know some of the terminology you use. It scares me just hearing you.

But, I tell you, that, to me, is a message that's probably not as well communicated as the fact that you can die from AIDS.

DR. PICKENS: I think that's where you can help us. I mean, sometimes we feel like we're saying the same thing over and over and over again, and no one is listening to what we're saying.

I can't tell you how many times I've said that drug abuse treatment is effective. I can't tell you how many times I've talked about the need for additional treatment capacity.

But no one is hearing this. We have an effective strategy. We keep saying it over and over again, but no one is listening to what we say.

DR. PRIMM: I think what happens, as we get very successful business people, and no pun intended, Mr. DeVos --

MR. DeVOS: You're not including me.

[Laughter.]

DR. PRIMM: And others who second guess the people who are experts in this field. I think it's wrong that it happens.

I think what you're witnessing finally here today is someone who is saying that to you and it's seeping in. I think it's really important.

With that, let's turn to Mrs. Gebbie, who had some questions for the panel.

MRS. GEBBIE: A couple of more practical, sort of limited questions in this last discussion, which I think was very, very helpful and effective, one for Dr. Des Jarlais and one for Dr. Brown.

Dr. Des Jarlais, the needle exchange issue, as I suspect you know, is a very difficult one to even discuss in some states. Alcohol and drugs in my own state kind of become strange when you talk about them.

At a more practical level, states are considering changes in their needle prescription laws. Those of us in states that have no such law see bills introduced to make needles available only by prescription. I don't know that any state that has a prescribing law has considered removing it because of AIDS.

What recommendation would you make, based on your information, about the effectiveness of making or the importance of making any changes in those laws, regardless of what we might do on needle exchange programs?

DR. DES JARLAIS: If a needle exchange is not possible for a variety of reasons -- they certainly are difficult to implement -- and there is no prescription requirement, then it would seem fairly reasonable to educate drug users in that state that they can purchase needles and syringes from pharmacies; to work with pharmacists, to encourage pharmacists to sell them because there are instances where pharmacists simply refuse to sell them; and to, therefore, work towards less spread of the virus by having drug users purchase needles and syringes where that can be done.

That solution is being adopted in a large number of European countries, such as France, where France actually changed, removed their prescription law. Some of the cantons of

Switzerland also removed their prescription requirements so that regular pharmacies could serve as distribution points for sterile equipment and there would be less requirement to share injection equipment.

MRS. GEBBIE: So you recommend leaving the laws the way they are where a prescription is not required.-

DR. DES JARLAIS: Yes, there have been states that have considered changing their prescription laws. None of them have yet, but several European countries did change their prescription requirements.

MRS. GEBBIE: Just an additional comment. Then I think you run into the problem of the local sheriff or law enforcement officials telling the pharmacist if you know that purchaser is a drug user rather than a diabetic, you are, in fact, aiding and abetting in a crime, and we're back in that.

DR. DES JARLAIS: That actually happened in Edinburgh, Scotland, where the law permitted anybody to go in and buy needles and syringes. The police decided that they would have a crackdown on drug use.

They went in and they convinced the pharmacists not to sell needles and syringes to drug users. Unfortunately, they were doing that at about the same time that HIV was introduced into Edinburgh, and it went from the first seropositive to about 50 percent of drug users seropositive in about two and a half years.

So that, certainly, the Edinburgh experience would make one very, very cautious about trying to increase legal restrictions on sterile drug injection equipment.

MRS. GEBBIE: That's the first time I've heard that description of the reason Scotland went up so fast. Thank you.

Dr. Brown, my question to you is related to your point about lack of coordination in primary health care services and other necessary services for the people you are seeing.

I'm concerned about your point about lack of INH therapy, TB prophylaxis. If in at least some jurisdictions a program like yours could get access to publicly purchased INH, publicly purchased treatments for other sexually-transmitted diseases if you were willing to administer them using the staff you have, is the problem that the public health system, isn't able to supply you with the drugs, is a mechanism not available, or you simply don't have the staff time to become involved with administering it if they wanted it, or just what is the problem?

DR. BROWN: We are currently in discussion with the New York State Department of Health about provision of the appropriate medication. The problem is, though, staffing. If you're talking about increasing the amount of treatment slots without actually also improving the amount of resources, unfortunately then you get the problem of where you're going to get the nurses, for example, to administer.

The other reason I mentioned primary care is because I believe that outpatients really get the messages that we deliver. If we turn a nurse into a glorified cocktail waitress instead of a person who's going to actually provide primary medical services, primary nursing services when that patient is in front of them, then to a certain extent we're sending a signal to the drug addict that this is a different type of medical personnel, when in fact once they have sworn an oath to perform services, they should provide the same level of primary care as elsewhere.

My problem is the fact that we don't get enough resources to provide services for this patient population. Even when we try to refer them to outside agencies we have problems. These patients don't go.

I think that's a very important question about not going. It's not that they're lazy. The issue is that time is also important to them. Some are of the belief that time is not important to the poor. Time is just as valuable to the poor as it is to the well off.

The other issue is the people who are on the other end that are receiving these patients. The stigma associated with drug addiction is not only in general society but also in the medical profession. So they're a microcosm of the general society, so they tend to not hear the complaint because of the stigma associated with drug addiction.

It is my belief, that we've got to provide more services in-house. A perfect example of this is, as you've heard from Dr. Landesman a week ago or so, that they had a very good program for prenatal care.

Why is it a very good program? Because the services are closely associated with a drug treatment program. We try to refer our patients out for prenatal care, and we get a poor response.

MRS. GEBBIE: Thank you.

DR. PRIMM: Dr. Crenshaw.

DR. CRENSHAW: If I've understood you correctly, I've gotten the message loud and clear that you have dispelled many myths prevailing in society today about drug abuse, such as they don't want help; you can't help them anyway; and that you can't get sustained results.

It seems to me that I'm also hearing, and correct me if I'm wrong, that counseling and quality care, if it's done properly, is cost effective in the long run because quantity care that's ineffective just recirculates substance abusers into our society.

My question is with society, not the drug abusers, looking for a quick fix on the drug problem such as a segmental shotgun approach, what can we do to help you get beyond that?

I heard your frustration, Dr. Pickens, but I'm saying this over and over again and no one's listening. In particular, I'll add that the counselors that you're so asking for and feeling are needed to pull these programs together, even if you are completely successful in getting and sustaining substance abuse treatment slots, if you didn't have that counselor to counsel an HIV positive recovered drug addict on sexual practices, AIDS would still spread.

So if you would elaborate a little, we'd love your help, and I'd love to help.

DR. BROWN: Dr. Crenshaw, I think you have a very important point there, and I think part of it stems from society's feeling about addiction.

While I don't mean to say that the analogy that I'm going to give you is a straight one to one, we need to recognize that addiction is a chronic disease. We have in our society a number of chronic diseases, and the argument that we also hear are those are diseases they didn't have a choice in getting while these patients have a choice in being addicted.

Is that really true? Mr. DeVos talked about an economic system, where he wished that we could give them something that would wave the magic wand about the supply and demand parts of economics.

Really, the analogy there is also incomplete, because we're talking about a patient population which, to a large extent, comes from poverty.

Now, if you say that poverty is also something that they have an equal opportunity to get out of. I believe that we really need to look at the crux of what is the underlying problem with addiction. Addiction is a chronic disease, and just as

with hypertension and diabetes, where you're going to need some type of response lifelong, you very well may need some type of response with addiction.

I think one of the major goals that this Commission might, in fact, achieve is a re-education of our society on what addiction really means. If we are not well versed on what addiction means, then we're going to have these continuous shotgun responses.

DR. PRIMM: Dr. SerVaas. Oh, I'm sorry, Don.

DR. DES JARLAIS: I would just like to say something perhaps in defense of Congressman Green.

As I understand his approach, and it's something of a common approach among some people who run methadone programs, it's not that the 1:50 counselor to patient ratio is put in there to keep the quality of care down and that you need to expand to 1:75 and provide worse care.

It's an approach that feels that that type of regulation where you specify a client to counselor ratio and you say you can't go above it doesn't really lead to good medical practice; that good medical practice really comes out of a good trusting relationship between the patient and the medical staff, and that when you set regulations on programs, how many counselors they must hire and no fewer than this, not more than that, and you have to document every time you've given a patient take-home medication or when he went on vacation and such, that overregulation prevents high quality of care rather than encouraging it.

So many of the people who are saying let's do away with these regulations are not saying let's flood the market with lousy treatment. What they're saying is let's rethink this as to whether or not this regulation approach is really leading to quality care or it's interfering with quality care, and that removing the fixed ratio of patients to counselors may lead to better counseling. It may lead to evaluating treatment by treatment outcomes rather than judging treatment programs by whether or not they conform to a rather stringent set of regulations. So I don't think that anyone is arguing for poor quality care, but there are a number of people who say that the methadone regulations interfere with quality of care rather than promoting it.

DR. PRIMM: I would like to comment on that just a moment, because you were stationed on 125th Street, where a number of addicts are in treatment in methadone maintenance treatment programs.

Probably the greatest concentration of people in treatment in this country on methadone is right where you were stationed. One block east of where you were stationed is a program that has permissive take-home policies. You can walk in that block anytime, and you can see people selling their methadone on that street. I see it all the time because I am one block west of where you were. Probably on certain take-home days you can see probably from my program.

But I want you to personally comment on permissive take-home privileges and why that law was put in there. That law was put there to prevent entrepreneurs who are dilettantes who come into this field to make money and have few counselors and lots of patients to turn over dollars.

Tomorrow we will be having hearings, and we will have some of the people who are opponents of that, who are opposed to the reduction of some of these regulations just for the fear of that. Maybe you should comment on that.

DR. DES JARLAIS: Whenever I take the Lexington Avenue subway to work and walk from the subway station to my office, people come up and offer me methadone. I do not think I look like I'm strung out on heroin, but you're right. You walk past certain street corners in New York City, and methadone diverted from programs is being offered.

There is a real problem in trying to maintain quality of care in methadone treatment, particularly with Medicaid. There's a possible funding source.

What I wanted to bring up is that there are alternative ways rather than in regulating counselor to client ratios that you could look at for maintaining quality of care.

You can look at how many people do they retain in treatment over a year. A bad program tends not to retain people.

You can look at employment rates of people coming in and employment rates as people stay. In a good methadone treatment program, you should probably be seeing those employment rates go up.

You can look at the urines that are collected to examine for heroin use and cocaine use, other drug use. Those in many programs are good quality data. There are a variety of ways that you can try to measure the quality of methadone treatment, and, yes, there are some methadone programs that should be shut down.

But I think there are alternative ways of trying to promote quality rather than the regulation approach that we've

fallen back on because we weren't willing to pay or better ways of trying to maintain quality.

DR. PRIMM: Dr. Des Jarlais, I think that's a good point that you made.

We are very much concerned about the quality of methadone maintenance programs for several reasons. The better quality programs have the better outcome results, so we'd like to keep the quality up as much as possible.

We're concerned about diversion of methadone from therapeutic purposes to on-street sale. We'd like to prevent that, and the reason we'd like to prevent that is the fact that there's already community resistance to the establishment of new methadone programs. If there's diversion, if addicts are going out and selling their methadone and this is happening in the neighborhood, there's going to be even greater resistance to those programs.

So what we're saying, I think, is we don't want to be short-sighted. We have to not only look at the immediate crisis that AIDS has caused but also we have to look down the road five years from now. We don't want bad methadone programs to drive all methadone programs out of business.

So we want quality control in what we're doing. We don't want to rush into anything that might create more problems down the road.

Dr. Servaas, I'm sorry, but I just took the liberty of the privilege of the chair to make those statements. I'm very sorry. Dr. SerVaas.

DR. SERVAAS: Dr. Brown, your mentor, Dr. Beny Primm, told me that in New York a drug abusing rapist who's been in prison and is released without ever being tested for HIV; a rapist in New York. I want to know, if you were in control in making the decisions, would you continue that policy?

DR. BROWN: Dr. SerVaas, I wish even for a second that I was in control of something --

[Laughter.]

DR. BROWN: Because I can assure you that I have very different feelings about the response that needs to be taken with regard to drug abuse.

I have some concerns about that area. I must say that I am also a public person, too. So I need to be concerned about what precedents those things set.

Plus the fact that I also need to be concerned about their being a rapist versus their ability to transmit the infection?

To me, we need to handle those and discuss them separately and then decide what the decision should be.

I salute you and I often welcome challenges that I could not give you a very simple answer to that question.

DR. SERVAAS: Then I have another question.

Long ago when I was in med school, they'd say look to the right and left. One of the three of you will become a drug addict, and we're high risk in this area.

Then they told us that if we went to treatment at the federal drug abuse program in Tennessee that the chance of recovery after ten years would be 3 percent. That's how I remember it.

Now, I just wonder if you have a bottom line figure for Rich DeVos here. What do they now bandy around in teaching the med students? What is the percent of recovery from drug abuse today?

DR. BROWN: Well, I think that, again, that question brings up the issue I wanted to really stress. We cannot look at treatment as all being the same. Even though we talk about them, I'm sure you've heard about different modalities.

DR. SERVAAS: Average treatment.

DR. BROWN: There has been, in fact, a number of surveys that have shown some very positive responses, some that are, in fact, greater than 50 percent over time.

So I think that it's a matter of what goes into that basket, that recipe called treatment. It is not only the issue of treatment, it's also what's in that recipe.

If, as Dr. Pickens points out, there is extensive counseling, vocational or educational support and if there is also primary medical services, I believe that you have the greatest prospect of getting, Mr. Devos, a great return on your dollar.

I really honestly believe that we're talking about the return not only in the productivity of that person but we're also talking about a reduction of costs related to either criminal behavior of that person, loss of income of persons

whom they assault, or loss to society in terms of costs of hospitalizing these patients because they were not taken care of, prophylactically or in primary care.

So I believe that there is very good evidence. I don't have the numbers I quote you now, but I am confident that we could provide you with this. I'm sure Dr. Pickens --

DR. PICKENS: We would be more than happy to provide you with that information.

DR. BROWN: I would also like to parenthetically say that Dr. Pickens and I have done a fantastic job in terms of really clarifying and raising many of these issues. I know that I, in fact, enjoyed myself when the three of us got together at the needle sharing conference. In fact, when I told some of my colleagues that I went to a needle sharing conference, they were saying medicine has really gotten very specialized.

To share with you and members of the Commission about some of the findings in that, I think you would find that quite enlightening.

DR. PRIMM: Treatment in many instances has certain goals, and it's relative for certain people.

I think if you're looking for complete abstinence from drug use, I think that it's often been said that people who accept it as a goal are doomed to failure when they treat the people who are addicted. I actually believe that.

I think that there's a certain level of function that you can achieve with treatment and not look for Utopia. If you manufacture a product and you sell 60 percent of it and you make a profit, you do well if you're going to compare it to business. You can stay in business.

We don't want to impose our value system, which is Utopian, on human beings who are imperfect. God didn't make us all perfect. Some of us might need certain substances, certain chemotherapeutic substances that substitute for those that God put in us that don't function properly. For example, some of the neurotransmitters; I'd like to go into that. I think tomorrow we're going to hear some of that from Dr. Mary Jeanne Kreek, and Dr. Loretta Finnegan.

But I just don't think today we have enough information on which to really base some of these conclusions.

With that, I would like to personally thank the panel. It's been excellent, and you have awakened us. As you said at the end of the day, with the boldness of food in our stomachs and

the sacrifice of blood to the brain and some anoxia and hypoxia, we are all awake at this hour, and I'm very happy about that. Mr. Chairman.

CHAIRMAN WATKINS: Dr. Pickens, you should know that we tasked the director of NIDA, to provide just the information we talked about over here. We would like very much to see some kind of a presentation to us on cost offset strategies, because we don't talk enough about the amortization of this thing, and it seems to me that for the very reason that Dr. Brown talked about, let's get specific. There's no reason not to keep it right within the IV drug abuse batch of problems that cost us a great deal.

So if you can take just that community and cost it out of what you would do were you to be successful to the rate you think you can achieve success in the various clinics, then we can use that in our presentation to the President to say there is a way to eventually transition from the up-front investment problems to amortize over a period of time and get out of this, at least theoretically.

We're not saying we're going to achieve the very ultimate that we'd like to, but from our success projections to date we think we could eventually get this thing, and maybe it's in New York alone if you want to take an example to cost it out for us.

That kind of thing would be very important to Mr. DeVos' financial group as well as to all of us, even for our interim report on drug abuse to the President.

Dr. Brown, we've had presentations last week in the incidence and prevalence hearing from minority representatives, that had made certain recommendations to CDC on packaging up epidemiological data in such a way that would be much more useful for minorities to target their own programs, particularly if it could be done for certain areas, and that we're unable to get that data packaged up that way. Do you have a similar feeling?

DR. BROWN: I very much sympathize with those sentiments, because I really believe that part of the concern by many people and various agencies, and I understand that, the concern not to offend, not to seem racist.

I think, quite the contrary, that we're doing more of a disservice to minorities by not providing the information. To me, the issue that adolescents, for example, only make up a small number of the cases, but I think it would be particularly pertinent for us to get data that separates adolescents from the people who are above 21 to see what those cases really are comprise of. To see how many of those drug abusers, how many of

those are black and Hispanic youth? That has a greater significance than just seeing them lumped together time and time again as adults and adolescents.

CHAIRMAN WATKINS: Dr. Primm, I'm sure, would agree to have you prepare for us what you recommendations would be along those lines. We'd like to compare those with Dr. Jane Delgado, who presented some interesting sort of disaggregation concepts for the Hispanic community.

I think it would be helpful to us to know specifically what you would like to see, what would be most helpful and compare those two, and perhaps we can make some suggestions along those lines.

Lastly, I'd like to say to Dr. Des Jarlais that I think that the work you did for the National Institute of Justice on your AIDS and intravenous drug use was a superb document. It is one of the finest encapsulations of this problem that I've seen. It's readable; it's short to the point.

So we very much appreciate the work that you and Dr. Hunt did in collaboration on that document.

DR. DES JARLAIS: Thank you very much.

CHAIRMAN WATKINS: I want to thank you all for coming today and the time that you've devoted to this and the time that I hope you will continue to devote as you interplay with this Commission. We do want to keep the doors open to each one of you and keep the dialogue moving.

Anything you feel later on that perhaps you didn't quite say right or you'd like to say better, feel free to write the Commission.

The Commission now stands adjourned until tomorrow morning at 0900. We'll be in room 628 in this building.

[Whereupon, at 5:50 p.m., the hearing in the above-entitled matter adjourned, to reconvene at 9:00 a.m., Friday, December 18, 1987.]