Making the Connections in the Response to AIDS: Bridging Gaps in HIV, Substance Abuse Treatment and Social Services

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I am very pleased to be here today to speak about your chosen theme, "making the connections in response to AIDS," because I think that topic is **central** to dealing with the two on-going epidemics with which we have yet to deal effectively -- HIV/AIDS and substance abuse. Illicit substance use has been with us for some time, although not so long as one might think, in epidemic terms. But for most of the twentieth century it has been neglected by medicine and public health, and has been considered almost solely as a matter for the criminal justice system to deal with.

The 1970s saw a brief respite as President Nixon backed an aggressive and effective methadone program, but by the 1980s the specter of addiction began to loom larger and larger, especially after crack cocaine made its grim appearance.

And, believe it or not, there was a time when AIDS **wasn't** -- when parents could cross their fingers and hope their kids' adolescent rebelliousness would heal itself in due course without major consequences. But then, about twenty years ago, HIV/AIDS made its entrance into communities. Especially along the east coast of the United States, the two epidemics joined forces quickly and grew to extraordinary proportions that were unimaginable at the outset.

In the early years, AIDS was viewed as a looming infectious disease crisis of awful proportions -- which it was. The reaction to the viral epidemic allowed the biomedical world to focus quickly;

but those of us in the infectious diseases community were slow to spot the centrality of substance abuse in maintaining its momentum -- nor was it widely appreciated that both epidemics were such grave threats to our kids.

I guess I was lucky to have had children who were pre-teen at that time, for I am sure that **my** sense of urgency about the perceived threat in 1981 had not only to do with my training as a microbiologist/infectious disease person, but also with the fact that my three kids were perched on the brink of their teenage years. Happily they made it to adulthood unscathed, but throughout the epidemic, I have always tried to say to myself, "There, but for the grace of God, go I." ...and as new crops of teenagers perch on that adolescent brink, I worry deeply that we are leaving them unwarned and unarmed.

Let me focus for a while on early responses to AIDS, about which I know far more than I do about substance abuse and addiction. Those early times of the HIV epidemic were momentous, and we were aware of it; something new had been launched upon the world and, at first, it almost defied description. Young people, previously healthy, were becoming immunosuppressed, wasting and dying with only their sexual or drug using histories to unite their fates, and it took nearly three years to learn that a brand newly epidemic virus was abroad in the land. It took a little longer to discover that a silent interval of seven or more years had preceded the virus' recognition through disease production, and thus that it had a massive lead-time on our ability to respond. Those features were not unheard of in veterinary medicine, but they were unprecedented in humans, and it took a little while to make the connection with animal models of retrovirus infection.

As all that unfolded, and as it became clear that infection with HIV was, ultimately, almost uniformly lethal, we were in due awe of the problems we faced. We were confronted with a need to cope with human sexuality, homophobia, adolescent self-assertion and an

on-going but interlinked substance abuse epidemic all in the same effort; and until then we had done rather poorly at any of those, not to mention our poor track record at interceding in much less mysterious unhealthy behaviors linked to known diseases such as lung cancer or heart disease.

I must say that I am proud of my colleagues in that effort: the early years of AIDS were full of heroism and astonishing accomplishment as people sought ways to deal with that deadly threat. Both nationally and globally, there was a rallying around, spurred by a sense of common cause; my late, beloved friend Jonathan Mann mobilized the Global Programme on AIDS of the World Health Organization in a way that had never been seen before, bringing the first glimpses of reality to the concept of a global village, and making a firm conceptual link between health and human rights.

And in the United States, people like Jim Curran at CDC, Tony Fauci at NIH, Gerry Friedland at Montefiore and Paul Volberding at the University of California-San Francisco saw their lives turned upside down and their young families stressed by the urgency of the new fact of life. One of the most indefatigable of all, Don DesJarlais, of Beth Israel, has worked steadily and brilliantly to bring out the AIDS-drugs connection, and I owe him much gratitude for his patients in the early years as I began to learn about substance abuse.

All that was then. This is now. For some strange reason, the sense of drama seems to have receded. Just as the National Commission on AIDS started up and we began the tortuous legislative process that resulted in the Ryan White Care Act, I remember being bemused to watch the urgent, national response to the the 1989 San Francisco earthquake. I was struck by the ease with which federal emergency resources were mobilized, rescue crews put to work, and engineering wizardry commandeered to deal with that **acute, physical** crisis that put a few hundred people at risk. By that stage of the AIDS epidemic, we were dealing with thousands upon thousands of desperately ill young people, and an estimated million

who were infected but not yet sick. In due course, the Ryan White Care Act came into being -- but believe me, it was a close call.

It occurred to me then that perhaps, as a society, we don't know how to deal with **chronic** catastrophe. Despite the fact that the numbers of people living with HIV is now at its highest level ever, AIDS has become part of the scenery. Individual groups and agencies "do their thing" with variable effectiveness. One hears, regularly and repeatedly, that "AIDS is **just one disease**, and has been given unfair favoritism in the national response." The inference is that we should downscale our efforts, return to the older scourges of heart disease or breast cancer -- stop coddling those people foolish enough to engage in dangerous behavior -- by which is meant substance abuse...and sex? AIDS is, after all, primarily a sexually transmitted disease, and while there are variations in efficiency of sexual spread, no gender or expression of sexuality is protected from this new risk.

Strikingly, throughout the epidemic people have responded preferentially and sometimes exclusively to **pediatric** AIDS -- to **small** children with HIV -- even though they have never constituted more than 2% of the total affected. Even though I am a pediatrician, I have often wondered what that implies -- whether, somehow, we have a statute of limitations on childhood. If we do, I fear it is at the onset of adolescence with all its difficulties and search for self-expression -- which coincides tragically with the transmission patterns of HIV.

[As a small historical note, the final spasm of resistance to the Ryan White Care Act came in the form of an amendment on the Senate floor that would have directed that 25% of funds be devoted to that 2% of cases that were pediatric AIDS. Happily, that was altered in the final minutes to read "family AIDS," thus averting a significant derailing of scarce resources].

The Ryan White Care Act was a remarkably successful innovation and helped to demonstrate that, in the best of circumstances, communities can rise to a level of coordinated prevention and care that dulls the pain of on-going loss of young, talented people who have not had time to realize their potential. But more often and increasingly, the losses are assumed to be inexorable, the pain non-negotiable, and worst of all, the scenery is commonly and harmfully painted with blame, recrimination and social stigma. That has to sound sadly familiar to those of you who have spent long careers struggling to bring about a constructive response to issues of substance abuse. Once again, the twin epidemics of AIDS and substance abuse share striking features.

At the beginning of AIDS, it was so exciting to think what we could do if only we knew....what was causing it, how to stop transmission, how to protect our youth? Who would have thought we could have reached our present stage of mal-adaptation? I suppose it could have been guessed, if one looked at the hubris of the decades preceding. No disease was considered beyond conquering. All one needed was a new drug and, ultimately, a vaccine, and the world would revert to normal. After all, it had only been a few years before the advent of HIV that infectious diseases were declared, by the U. S. Surgeon General, to be a thing of the past.

But then the world changed, and we have now lived with AIDS for nearly eighteen years. As so often happens in human affairs, familiarity seems to have bred contempt.

As I speak in 1999, the number of young Americans we have lost to AIDS is astonishing -- and two more **youth** become infected every hour in the United States! In the early years of struggle against this newly lethal hazard, a great many things were learned about potentially effective responses. Biomedical scientists made remarkable strides; social and behavioral scientists learned to intervene in useful ways in the interest of prevention. And yet, for all that uplifting progress, we are in deepest trouble because of

failure to recognize that the **coordination** of personal, family, health and social service responses -- which is to say, making the **connections** -- is central to whether we can mobilize and capitalize on the usefulness of all that we have learned.

I have been involved with the AIDS epidemic as a public health policy advisor since its beginning. As you can imagine, it has been awesome to take part in so momentous a change in the course of human history. HIV isn't smallpox -- it is much worse, because of its universally pertinent mode of transmission and the long, silent interval before its presence can be recognized overtly through the development of AIDS. What is more, it is a **prototype** of what we have learned to call an "emerging infection," and we need to learn its lessons carefully, for this is surely not the last time the global community will face a comparable threat.

For all those reasons I think it is fair to predict that HIV, AIDS and (probably) subsequent emerging infections will be with us for generations to come. So when I get a chance to talk to a committed and thoughtful group about the AIDS epidemic, I tend to have to restrain myself from becoming overly ambitious. They say you can only hope to accomplish so much in an hour, and we have slightly less than that.

With that in mind, my plan for the rest of our time together today is as follows: first I want to summarize briefly where we are currently with the AIDS epidemic, highlighting trends that I consider important and ominous. Then, in the interest of timeliness, I will make some comments about one or two themes that dominate the AIDS debate at present. And finally I will deal with a few key issues concerning substance abuse and HIV that make it clear that coordinated, community-based activity is crucial for ultimate control of both epidemics. I hope, when I am finished, that there will be time for some questions and discussion.

Before I start on that plan, however, there are three major points that I want to make, in hopes of underscoring them as I go along. For an audience as experienced and sophisticated as this, they may be obvious; but if there is one thing I have learned during the AIDS years, it is not to let the obvious go un-spoken.

First, the epidemic isn't over. It isn't even "almost over," as has been inferred in recent months by many enthusiastic biomedical scientists in discussions of the new drug therapies. In fact, in my personal opinion HIV/AIDS is much more threatening now than at any time since it was first recognized in 1981, precisely **because** of the false confidence those therapies have engendered and the continued neglect of the substance abuse connection.

Second, we have learned a great deal in the first years of AIDS -- about viruses and immune responses and pharmacology, of course. But also about the critical importance of individual and community roles in behavior change, and most dramatically about the real possibility of **prevention** of HIV infection in that context. In fact, those insights about effective interventions are **the most powerful** of all that we have learned, and yet -- perhaps because they are so "low-tech" -- we have ignored them and placed new generations at risk for lack of understanding or commitment. Put most succinctly, we are not using what we know.

Third, we must not fall prey to the temptation to "wait til the vaccine comes," for **that** piece of progress, should it occur, is by definition far off into the future. Even were there a truly promising vaccine candidate ready to test (which there is not), those tests would take some years. What is more, a vaccine will be problematic in its deployment, and almost certainly less effective in prevention than the avoidance strategies we know about already.

I understand why everyone wants so much to have a vaccine, for vaccines have proved truly miraculous in the context of simpler infectious diseases. But also, the wish is there to avoid the thorny

questions that AIDS has begged. About that, I simply have to say "Sorry! The hard work of dealing with sex, drugs and adolescent experimentation cannot be avoided." If we come to grips with **that** fact of life, we will do a far better job at community-based responses to the complex dynamics of the AIDS epidemic.

Current Status of the U. S. Epidemic

Let me turn, then, to the current status of the epidemic in the United States. The numbers are quite astounding! Keep in mind that the first **five** cases of what turned out to be AIDS were reported in the Morbidity and Mortality Weekly Report from CDC only in June of 1981. From that small, deadly beginning we have escalated to almost **three-quarters of a million** Americans diagnosed with AIDS in ensuing years, of whom at least 400,000 have died.

Oddly enough, as the toll of AIDS has mounted, public interest and awareness have almost receded. I used to think that things would get tragically easier as the numbers climbed, for everyone would know someone who.... But the effect of shame and stigma dominated, and I was wrong. Rather than being recognized as a massive and uniquely deadly threat to youth by the press, coverage of epidemic events tends to be quirky, remote and episodic.

To make that point I jotted down, a couple of weeks ago, the topics of articles I came across in The New York Times on a single day that related to AIDS. There was an excellent, long article by Dr. Larry Altman, their chief medical correspondent, on issues of HIV in newborns, worries about breastfeeding transmission of the virus, use of placebos in international AIDS treatment experiments, and HIV-related problems associated with the lack of access to sterile injection equipment in the developing world. He was writing from Chicago, where an international retrovirus meeting was being held; but it would have been easy to assume that AIDS was only happening elsewhere and was not very pertinent to the average American reader.

In another section of the Times there was a well-done article about possible origins of the human immunodeficiency virus which probably transferred into the human species from chimpanzees about fifty years ago. That is a useful insight for virologists, and I was relieved to see that it was much better handled than in early years, when gauche, baseless and insulting speculation about the origins of HIV offended large populations; but it may well have activated echoes of those times, unhelpfully. And again, the remoteness of that finding -- another continent, another time -- could serve to feed the tendency to denial.

In yet another section there was an arch statement from the Governor of New Jersey reaffirming her opposition to needle exchange programs for injection-drug-users (IDUs), asserting that the growing mound of evidence of their efficacy in preventing HIV spread was "dubious at best." That, of course, is not true; the growing body of evidence supporting needle-exchange as a consistently helpful strategy for harm reduction is virtually uniform and convincing; but the Governor chose to deal with it as if it were a matter of casual opinion. Such resistance in the face of facts was surely fueled a few months ago by further prohibition of the use of federal funds for such needle-exchange programs.

And finally on that one day of coverage, as a sad "human interest story," there was an article telling of my friend Mary Fisher's decision to discontinue the highly active antiretroviral therapies for her HIV infection because they were so toxic and distorting of quality of life that she chose to abandon them to have healthy time with her sons. The coincident timing of those latter two stories was especially poignant, since Mary's HIV infection was heterosexually acquireda from her former husband, who subsequently died of AIDS acquired on the context of I.V. drug use and probable needle-sharing.

All of that hardly sounds like an epidemic that is over! Indeed, worldwide we are approaching a cumulative total of 40,000,000

cases of AIDS, with at least as dreadful a statistic of 10,000,000 AIDS orphans by the millenium. And yet public apathy and denial is striking! I grant you, it is hard to get a handle on such massive numbers. I find myself constantly searching for comparisons in order to recapture people's attention -- for instance, the number of deaths of **young Americans** from AIDS will soon exceed the total number killed in all of our armed conflicts since the Civil War!

It is generally agreed that the recent, merciful downturn in AIDS mortality in the U. S. is likely to be a transient event -- a respite, as it were, bought largely and dearly by the deployment of the new highly active antiretroviral therapies. But it is also agreed that **new** HIV infections in our country are occurring at a constant rate of at least 40,000 per year or more, and as I have already noted, the ongoing failure to deal effectively with substance abuse means that its synergistic collusion with HIV lurks like a dreadful shadow over even that unsatisfactory "steady state."

Let's look briefly at the shape of some trends that darken that shadow. First, while many people in the United States have conveniently distanced themselves from AIDS as (and I quote) **just** a disease of "those gays and addicts," the most constant trend is an annual increase in the percentage of new AIDS diagnoses in women -- now more than 20% of the annual total. Some of those instances of AIDS in women relate directly to i.v. drug use; but increasingly they reflect heterosexual spread. That shouldn't be any surprise, since 75% of the worldwide epidemic is convincingly attributed to heterosexual intercourse; but our reaction is muted by early and dismissive misperceptions about "risk groups."

Another article in the New York Times just this week carried a reminder of a further lesson we seem to have forgotten -- that is, that bisexuality is not rare. The main point of the story was a demonstrated upswing in HIV infections among young gay men in New York -- 12% overall, and 18% seropositive among African American young gay men. But in addition, the reporter noted that

fully two-thirds of those HIV-infected men -- while self-identifying as gay -- had had intercourse with women as well as men in the recent past. That factor of bisexuality is one of which we became acutely aware ten or fifteen years ago; but it too has faded from view, to our peril.

Anyway, for a variety of reasons, women are steadily taking their place among the ranks of people with AIDS -- and of course, because of the slow expression of HIV-disease, trends concerning **AIDS** (which is its late expression) offer only an out-of-date snapshot of where the virus is now spreading. Other trends: smaller and smaller cities, rural America ..... in short, it's out there!

If that weren't enough to make one sit up and take notice, another consistent trend throughout the epidemic years has been a steady decline in the average age at time of first infection with HIV. Each year that age has gotten younger; initially one could extrapolate that about 20% of people with AIDS had been in their teenage years at the time they became infected. By now that fraction is much greater; HIV, like smoking, has become an adolescent plague.

In such a context, talk of "life-styles" can be lethally self-defeating. As a pediatrician I have always looked at adolescence as an age of experimentation. Some of those experiments have turned deadly now, and yet we are failing to warn! Recent CDC studies report that almost three-quarters of high school seniors are sexually active -- and keep in mind that such data omit out-of-school youth. The reluctance to talk about "safer sex," or indeed anything but abstinence, while trying to counsel about the risk of STDs including HIV, has to arise from **denial** of those facts, for nothing otherwise could explain our failure to warn new generations of youth who **are** sexually active youth about the lethal menace around them. It is no comfort to note that the single most reproducible fact of the AIDS epidemic around the globe is, indeed, **denial.**

But back to kids for a moment. People used to say -- when we got to that stage of discussion -- that after all, youth think they are immortal and nothing can be done. Not necessarily so: in early years of the epidemic, impressive work was done to mobilize youth, to establish supervised peer counselling, and to take advantage of school-based or community-based clinics where teens could seek information and guidance. I am sure such efforts continue, but I suspect they are spotty and, in some places, under community attack.

Nowhere is the youth issue more urgent than in the context of substance abuse, which is the next trend I want to mention. [I am aware that I am skirting the important issue of alcohol use, which plays a demonstrably serious role in "unsafe sex" and risky behavior. I do so only for lack of time, and because I think this audience knows much more about that than I do].

Turning, then, to illicit substances: with each passing year of the American AIDS epidemic, injection drug use has played a larger and larger role. The **efficiency** of transmission of HIV when injection apparatus is shared in the context of illicit drug use has always constituted a potential "wild card" in predicting the pace and scope of HIV spread. Whereas sexual transmission is generally somewhat inefficient -- except when coexistent with other sexually transmitted diseases -- the sharing of needles and "works" was recognized early on as a major vehicle for rapid spread. In city after city around the world, populations of injection drug users have gone from minimal levels of infection to over 50% -- sometimes as much as 90% infected -- within the course of just one year. Not only are they at risk, but so are their sexual partners and offspring.

The importance of substance abuse in the U. S. epidemic was evident along the east coast from the outset; thus far we have been spared comparable devastation in other parts of the country, where infection rates among IDUs hover between 10% and 15%. But such a reprieve is not something we should count on, for the "flashfire potential" of injection drugs as a mechanism for dissemination of HIV

is striking, and the substance abuse "epidemic" is not under control. Indeed, each year substance abuse contributes directly or indirectly to a greater fraction of cases of AIDS -- now over 50% of the total. I'll get back to that topic later.

Two other trends bear noting. First, there has been an inexorable advance of HIV in communities of color, facilitated in part by an understandable but crippling mistrust of the so-called majority. That stems, in part, from the awful racial stresses and divides that continue to threaten our society; but most directly, it reflects reaction to revelations about the Tuskegee syphilis experiment, in which a dreadful, government-sponsored observational study of untreated syphilis in African American men was allowed to proceed for decades after it should have been stopped when effective treatment became available (if it ever should have been started in the first place).

Since that awful piece of history was revealed just before the advent of AIDS, it is not so strange to find that the AIDS virus itself is suspected by many to be an escapee from a government lab or other nefarious source. The pall cast by that suspicion was such that many communities were slow to respond to the AIDS threat, and it is still a challenge to share insights and interventions promulgated by "the government." Even in majority settings I have found that it is easy to set off a wave of laughter with the phrase "I'm from the government and I'm here to help you;" it is just that much more difficult to achieve trust in communities where additional suspicions are in the way.

The final trend I want to mention is, on first glance, a happy one -- and surely that is true in the short term. I am speaking, of course, of the marked decline in deaths from AIDS and in diagnoses of full-blown AIDS, both of which occurred in synch with the fairly widespread use of the new, so-called highly active antiretroviral therapies, which began in early 1996. That is surely wonderful news, for many people who thought themselves as good as gone are

back to leading productive lives. But there are some cautionary notes to that upbeat tale.

First, those therapies are toxic, as Mary Fisher said in the article I quoted earlier -- so much so that as many as half of those who try to maintain the regimen cannot do so. That isn't trivial, since it is advocated that the drugs be taken starting very early in HIV infection, at a time when good health would otherwise prevail. Furthermore, it has thus far proved impossible to discontinue those drugs without suffering a return of the virus. Adding to the reality-problems associated with these new antivirals, it is noteworthy that the rigor of the therapeutic regimen is extreme. Medical "compliance" is a difficult accomplishment even in much less demanding circumstances; but with the highly active antiretroviral therapies, not only must dozens of pills a day be kept track of, bult some doses must be taken on an empty stomach, others on a full, and NONE missed, lest the virus develop resistance (which it sometimes does anyway).

So, while the new treatments are powerful and worthy of celebration, they should be greeted for the **reprieve** they provide, not as a remedy for an ongoing, global problem. Even where they can be afforded, they are no solution to the massive HIV epidemic. Nor will the addition of more and different drugs constitute an adequate public health solution in and of themselves. An unwaveringly **biomedical** approach to AIDS is doomed to disappointment and potential disaster. There has never been an antiviral drug to which the targeted virus didn't develop resistance; and I fear that it is likely that the striking propensity of HIV to develop resistance means that the end of the reprieve is just around the corner, in which case the happy trend of a downturn in AIDS morbidity and mortality could be just a transient break in the relentless epidemic curve.

A Few Issues of Concern

Let me turn now to a couple of issues that have been much in the news of late, but which have not generally been related to community considerations. First there is the issue of mandatory HIV reporting. That debate has been with us since earliest days of antibody testing; from the beginning there was a loud clamor for official rolls of names of infected individuals. The assertion was that we should use "good old-fashioned public health practices" just like those used for other sexually transmitted diseases. [The fact that our dealing with other sexually transmitted diseases had been a worrisome failure seemed not to daunt the arguers].

For a time that debate settled uneasily on a compromise -- cases of **AIDS** were required to be reported, but individuals who were HIV positive were not subject to the same requirement. While it would obviously be somewhat easier to track the path of the epidemic with such information, the "down-side" of such a reporting requirement caused serious concern. That down-side took the form of avoidance of testing (which was well documented in areas where state rules put it in force) and, for that matter, avoidance of available care. I don't suppose the argument would have gotten so heated were it not for the stigma associated with HIV, which took on such non-trivial forms as difficulty with insurance, employment and housing opportunities. The Americans with Disabilities Act of 1991 was intended to redress some of those worries; but in fact it became clear rather quickly that federal legislation alone did not translate directly into community action or redress.

The situation began to change, for better or for worse, as states or communities took to screening infant cord blood samples in an "unlinked" or anonymous manner, in order to get some grasp of the magnitude of heterosexual spread. Such testing, of course, identified infected **mothers** but did not say which 25% of their infants was truly infected and which simply carried antibody that had crossed the placenta.

Then a major finding reframed the discussion. In 1995 it was found, in an NIH-sponsored study fondly referred to as "076", that treatment of HIV-infected mothers with AZT during the last 8 weeks of pregnancy and during delivery, coupled with treatment of infants for six weeks thereafter, resulted in a 2/3 diminution in the number of infected infants -- a drop from 25% in the untreated group to 8% in the treated infant-mother pairs. The study was well done, and the finding represented the first dramatically encouraging therapeutic success against HIV. It was immediately embraced without qualification and became the standard of care in the developed world.

The effect differed, however, in the developed versus the developing world. It wasn't long, in the U. S., before it became evident that treatment of adults with HIV had to include three drugs at least to achieve the results of the highly active antiretroviral therapies. The 076 study actually didn't deal with sustained treatment for mothers, only for their infants; but nonetheless the issue of so-called "monotherapy" prompted further studies that are now nearing completion, and it seems most likely that those complex regimens will soon replace the initial recommendation for AZT alone, but will be virtually mandated for HIV-positive mothers and their infants. I worry about that, since many of those young women already avoid prenatal care, and coercive intervention surely won't help. On the brighter side, European studies have suggested recently that only the peripartum and infant treatment intervals are needed to achieve the effect of 076. Thus, the exact protocols for dealing with HIV-infected women are under review, but the complexity of the multiple problems often implicit in such circumstances seems to have been lost in the discussion..

All that notwithstanding, the perceived success of the first trial is such that the argument for mandatory HIV testing of pregnant women has gained momentum dramatically, with all its complexities intact -- including the issues of stigma already noted, problematic access to care, even more problematic access to substance abuse

treatment as needed, and a background of spousal abuse that often accompanies revealed HIV infection. I am delighted that fewer infants are acquiring HIV, make no mistake, for pediatric AIDS is dreadful. But this is an area in which the complexities of community response **must** be factored into any policies, especially mandatory ones.

I can't take time to dwell on the even greater complications surrounding this issue in the developing world. It is a fact -- not a bit of hyperbole -- that in many of the countries where HIV is entirely out of control, infecting as many as 25% of women of child-bearing age, the average health expenditure per year **per person** is under $10. Furthermore, the effects of perinatal treatment for HIV are steadily eroded if children then breastfeed; and yet where the water supply is not secured and nutritional resources are marginal, breastfeeding may be the only genuine life-line for infants, regardless of their mothers' HIV status. These matters aren't susceptible to ready solution, and we certainly don't have time for them here; but I mention them because there has been what I consider to be quite simplistic press coverage over recent months of what is a truly thorny conundrum for the global community.

Finally, on to substance abuse

That brings me, at last, squarely to the issue of the twin epidemics of substance abuse and AIDS, and here is where community dynamics permeate the problem completely. As you know, and as I noted earlier, our "war on drugs" hasn't been working very well, and especially not in youth. The so-called "war" has been waged largely at the borders, with truly disappointing outcomes for the $17 billion of federal funds expended annually. Inside those borders, three-strikes-and-out laws have meant that people caught up in substance abuse and addiction are increasingly concentrated in our prisons. The sheer numbers of people incarcerated are astonishing; the fraction that are there for substance abuse and

related crimes is high and rising steadiy. And AIDS has, for some years now, been the leading cause of death in prison.

I referred, at the beginning of this talk, to the almost complete dissociation of physicians from issues of substance abuse. That has assured a disconnection between the treatment efforts undertaken in hard-pressed communities and the potential for diagnostic and therapeutic contributions that might be offered by medicine. It has also resulted in a profound ignorance among physicians about the illnesses and issues associated with substance abuse. While public health has sometimes been a middle ground, there is much room for improvement in connecting the links of care for people caught in the path of addiction.

I think the assumption is held by many that substance abuse treatment doesn't work, and therefore that the disconnection is of little consequence. Let me take the last few minutes to tell you about an activity generated in the past year by a group of physicians to try to redress their lack of involvement. The group is called Physician Leadership on National Drug Policy, and is constituted by 37 physicians who can be characterized by their high visibility -- not their direct involvement in substance abuse research or care. It was brought together under the leadership of Dr. David Lewis, Director of the Center for Alcohol and Addiction Studies at Brown University, who serves also as Director of the group.

I am privileged to be its Chairwoman, and Dr. Lonnie Bristow -- immediate past president of the American Medical Association -- is vice-chair. The membership includes most of the past assistant secretaries for health (from either side of the aisle); former Secretary of Health and Human Services Louis Sullivan; former Surgeon General Antonia Novello; Nobel Laureate and Emeritus President of the Institute of Medicine Frederick Robbins, editors of eight leading medical journals, and the heads of most of the professional academic medical societies including the American College of Physicians, the American Psychiatric Association, and so on.

The group first met in the summer of 1997 to see if there was a common medical ground from which such collection of physician leaders could work. That turned out to be remarkably easy: a unanimous consensus was quickly reached that led to the following statement: (read PLNDP)

In the months since that first consensus meeting, we have had surprising success at pressing our message on Capitol Hill, and in addition we have been aided by very distinguished experts in the field of substance abuse who have pulled together the data and studies that document the favorable efficacy of treatment for substance abuse relative to other chronic, relapsing disorders; the remarkably greater cost-effectiveness of therapy versus incarceration; the dramatic lack of availability of drug treatment in prisons, and a series of other compelling facts that bolster the claim that we have been sorely missing a treatment component in our so-called "war against drugs." We have also urged systematic changes in medical education in order to address the problem of physician ignorance.

Along the way, we have created a brief videotape that has been proving effective in presentation to a variety of audiences, both lay and professional; and we have established an associates network to which interested physicians can belong, through which we send out intermittent updates and reports of the ongoing studies.

The PLNDP, therefore, represents a new locus of action that we hope can be helpful. By no means is there an intention to suggest that physicians can come racing to the rescue in this difficult area -- far from it; instead, it is an acknowledgment, in part, that physician input has been sorely lacking as the nation struggles with the drug problem, and that we hope to join more effectively with the other components of community response.

If you are interested in learning more about that, the person and address to contact is: Dr. David Lewis, Box G-BH, Brown University, Providence, RI 02912....

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