NATIONAL COMMISSION ON AIDS

Report

The Twin Epidemics of Substance Use and HIV

July 1991

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NATIONAL COMMISSION

ON

ACQUIRED IMMUNE DEFICIENCY SYNDROME

Report

The Twin Epidemics of Substance Use and HIV

July 1991

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Executive Summary

The failure of the federal government to recognize and confront the twin epidemics of substance use and HIV infection has become glaringly apparent to the Commission throughout its nearly two years of hearings and site visits. The federal government's strategy of interdiction and increased prison sentences has done nothing to change the stark statistics:

- Approximately 32 percent of all adult/adolescent AIDS cases are related to IV drug use.
- Of the pediatric AIDS cases related to a mother with/at risk for HIV infection, 70 percent are directly related to maternal exposure to HIV through IV drug use or sex with an IV drug user.
- 71 percent of all female AIDS cases are linked directly or indirectly to IV drug use.
- 19 percent of AIDS cases among men are directly linked to IV drug use, and an additional 7 percent of AIDS cases among men are linked to both homosexual/bisexual contact and IV drug use.
- African-American and Hispanic communities are being extremely hard hit by the twin epidemics. While African-Americans make up 28 percent of all diagnosed AIDS cases and Hispanics make up 16 percent; of the cases attributed to IV drug use, African-Americans account for 45 percent of cases and Hispanics for 26 percent.
- The city of New York has an estimated 200,000 IV drug users (who are 50 percent HIV positive) with only 38,000 publicly funded treatment slots.
- The National Institute on Drug Abuse (NIDA) recently estimated (based on provisional data) that approximately 107,000 persons are currently on waiting lists for drug treatment.

These twin epidemics transcend all economic, geographic and racial boundaries; everyone is affected. Substance use enhances the spread of HIV infection through the sharing of needles and the practice of unsafe sex related to crack (the smokeable form of cocaine), alcohol, and other substances. Despite this insidious and indisputable link between substance use and HIV infection, the Office of National Drug Control Policy continues to virtually ignore it, and neglect the real public health and treatment measures which could and must be taken to halt the spread.

Repeatedly, medical and treatment experts have come before the Commission and stressed the absolute importance of treatment on demand. Increasing treatment slots is a stated goal of the federal drug control policy, yet, as Dr. Robert Newman told the Commission, "...there seems to be nothing...to indicate that any government agency either at the federal or at any of the 50 state levels is indeed pursuing the objective of expansion

on a massive scale to make treatment for addicts who want it readily available." Providing quality treatment and treatment on demand may be an expensive proposition, but so is the unchecked spread of HIV infection. For a successful short and long-term solution we must shift our focus from expensive prison beds which represent society's failure, to less expensive treatment slots which represent our only hope, and provide easily accessible drug treatment to all those who need and request it. (See Appendix A) As the Commission Working Group on Social/Human Issues stated in its April, 1991 report, "...it is fundamentally unjust, as well as unwise, to tell those who seek treatment for drug addiction that there is no room; but then tell them that the taxpayers are willing to spend thousands of dollars a year to keep them in jail."

We must also take immediate steps to curb the current spread of HIV infection among those who cannot get treatment or who cannot stop taking drugs. Outreach programs which operate needle exchanges and distribute bleach not only help to control the spread of HIV, but also refer many individuals to treatment programs. Legal sanctions on injection equipment do not reduce illicit drug use, but they do increase the sharing of injection equipment and hence the spread of HIV infection.

If HIV transmission related to substance use is going to stop, the federal government must take a leadership role in coordinating public health and drug treatment on all levels and in creating and implementing a cohesive national plan. Currently, the issue of HIV and substance use is falling through the cracks, and without clear policy directives to the medical, public health and drug treatment communities it will continue to do so.

The federal government must also ensure that the great strides made from research and demonstration projects are not lost through cut-backs or lack of funding. Successful demonstration projects should be identified and funding made available for their continuation as active federal projects. Funding for research on substance use and HIV should be expanded, not cut back or simply held constant. Research, both sociological and epidemiological, holds the key to discovering the answers to crucial questions around HIV and substance use. Clinical trials, a key component to research, should be open to individuals with a history of, or current, substance use problems.

Finally, all levels of government and the private sector must work together to attack the deep-rooted social and economic problems which promote and sustain substance use. The poor of this nation, especially in communities of color, have been inordinately hard hit by the twin epidemics of HIV and substance use. In order to combat these epidemics which affect the entire nation, we must provide basic needs such as housing, medical care and food. HIV education and drug treatment often seem like luxuries to individuals who do not know where they will sleep at night or where their next meal will come from. To reach the point where our nation's drug epidemic is really a thing of the past, we must create communities and neighborhoods which promote health and hope, not addiction and despair.

RECOMMENDATIONS:

To help work toward these goals the Commission puts forward the following recommendations:

1. Expand drug abuse treatment so that all who apply for treatment can be accepted into treatment programs. Continually work to improve the quality and effectiveness of drug abuse treatment.
2. Remove legal barriers to the purchase and possession of injection equipment. Such legal barriers do not reduce illicit drug injection. They do, however, limit the availability of new/clean injection equipment and therefore encourage the sharing of injection equipment, and the increase in HIV transmission.
3. The federal government must take the lead in developing and maintaining programs to prevent HIV transmission related to licit and illicit drug use.
4. Research and epidemiologic studies on the relationships between licit and illicit drug use and HIV transmission should be greatly expanded and funding should be increased, not reduced or merely held constant.
5. All levels of government and the private sector need to mount a serious and sustained attack on the social problems that promote licit and illicit drug use in American society.

The Twin Epidemics of Substance Use and HIV

It is my firm belief that policies related to AIDS and policies related to drugs are so intertwined that commenting and really wrestling and getting to the solutions to one will impact the other, and that it is necessary to consider both national drug policy and national policies related to AIDS.[1]

-Kurt Schmoke, December 18, 1990

-Testimony before the National Commission on AIDS

INTRODUCTION

In this the tenth year of the HIV epidemic the nation continues to face not one epidemic, but two: the twin epidemics of substance use and HIV infection. Since the early 1980s the close and deadly link between the sharing of injection drug equipment* and HIV has been well recognized. More recently, the link between non-injectable substances, such as alcohol and crack, and unsafe sexual activity which can result in the spread of HIV infection has also become glaringly evident. Yet, instead of responding to these epidemics with public health and treatment measures to cope with both, the federal government's primary response has been imprisonment and increased jail sentences, often ignoring drug/HIV relationships. The dire results of this myopic criminal justice approach are shown in the following statistics:

- Within the estimated half to 1.5 million people who inject drugs in the United States, the rate of HIV infection has increased rapidly over the past decade.[2]
- Approximately 32 percent of all adult/adolescent AIDS cases are related to IV drug use. (IV drug use; Male homosexual/bisexual and IV drug use; and Heterosexual contact with an IV drug user).[3]
- Of the pediatric AIDS cases related to a mother with/at risk for HIV infection, 70 percent are directly related to maternal exposure to HIV through IV drug use or sex with an IV drug user.[4]
- 71 percent of all female AIDS cases are linked directly or indirectly (i.e. sexual transmission from an IV drug user) to IV drug use.[5]
- 19 percent of AIDS cases among men are directly linked to IV drug use, and an additional 7 percent of AIDS cases among men are linked to both homosexual/bi-sexual contact and IV drug use.[6]

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* The Commission uses "injection drug equipment" to refer to those paraphernalia that carry the potential for contamination: the syringe, needle, "cooker," cotton and rinse water.

- African-American and Hispanic communities are being extremely hard hit by the twin epidemics. While African-Americans make up 28 percent of all diagnosed AIDS cases and Hispanics make up 16 percent; of the cases attributed to IV drug use, African-Americans account for 45 percent of cases and Hispanics for 26 percent.[7]
- The city of New York has an estimated 200,000 IV drug users (who are 50 percent HIV positive) with only 38,000 publicly funded treatment slots.[8]
- The National Institute on Drug Abuse (NIDA) recently estimated (based on provisional data) that approximately 107,000 persons are currently on waiting lists for drug treatment.[9]

Despite these dreadful growing numbers, (see Appendices B and C) our national drug control strategy does not reflect the immediacy of the problem, the need for significant expansion of drug treatment to permit treatment on demand, or the obvious and critically important relationship between HIV infection and substance use. To address this huge public health threat, the National Commission on AIDS convened a hearing on "Substance Use and HIV" in January 1991. Through the testimony of experts and individuals who are experiencing the problems of HIV and substance use firsthand, the Commission was better able to identify certain key issues and the urgent actions the nation must take to deal with these twin epidemics. Current programs are seriously wanting.

OVERVIEW

Through the Commission's hearings and site visits over the last year and a half, the wide range and diverse nature of substance use and the population of substance users has become very much apparent. Substance use problems cross all lines of age, geography, ethnicity and economics. Infants, adolescents and adults, rural and urban, poor and rich -- all are affected. Of special concern to the Commission is the importance of recognizing the behaviors that put an individual at risk for exposure to HIV whether or not that individual believes he or she fits into the category of "drug addict." Some high school and college athletes share needles to inject steroids.[10] Individuals from cultures and countries with differing medical practices often share needles to inject vitamins.[11] Practicing these behaviors poses the danger of transmitting and acquiring HIV just as sharing a needle to inject heroin or cocaine does.

The Commission is also deeply concerned by the force with which these twin epidemics have struck communities of color, women, and adolescents. There are significantly elevated rates of HIV infection among blacks and Hispanics compared with whites.[12] The rates of HIV infection related to IV drug use are also growing among women, many of whom do not perceive that they are at risk.[13]

Adolescents are especially at risk. Adolescents, and others, who avoid intravenous drugs still expose themselves to the risk of HIV infection through unsafe sexual behavior

during the use of alcohol and other substances. It is important, when considering this issue, to be realistic about when young adults in the U.S. begin having sex. "In 1990, the researchers at the Alan Guttmacher Institute in New York and the Urban Institute in Washington analyzed federally funded surveys of boys and girls conducted in 1988. They reported [that] both boys and girls were more likely to be sexually experienced than those surveyed in the late '70s and early '80s. Half of girls had sex by age 17; half of boys by age 16." The survey also shows that, "...3 out of 4 unmarried 19-year old women and 5 out of 6 unmarried 19-year old men were sexually experienced."[14]

The linkage between sexual behavior and substance use is vividly reflected in the following example from Dr. Robert Johnson of Adolescent Medicine at the University of Medicine and Dentistry of New Jersey:

> [O]ur last four adolescents who had heterosexual transmission of the disease all had sexual behavior that was associated with alcohol use, particularly a drug form of 'wine cooler' named Cisco, and these young people who had used condoms in other situations did not use condoms [here]...

Adolescents, and others, are also at risk through the growing practice of trading drugs, especially crack (the smokeable form of cocaine), for sex. Dr. Johnson gave the following example which dramatically illustrates this connection:

> One particular crack dealer...in our adolescent clinic in Newark revealed that in the month of August he had sex with 30 different women in trade for crack. In addition, he carried on a sexual relationship with his girlfriend who did not use drugs. All of this activity occurred without the benefit of the protection of condoms. In that month, he and his girlfriend, and his girlfriend's new boyfriend, and his girl friend's new boyfriend's alternative sexual partner, all became infected with gonorrhea and chlamydia.[15]

While much of this, and other substance using activity, is concentrated in urban areas, there has been an increasing trend towards substance use, especially crack, in suburban and rural areas as well. The Commission previously highlighted this trend in its August 1990 report on HIV in rural America. Another disturbing trend, with serious implications for the HIV epidemic, is the resurgence of heroin use in the Northeast.[16]

It can be seen from even this small sample of issues that substance use plays a major role in the transmission of HIV disease -- indeed, a much larger role than has been generally recognized. Clearly, our nation's drug control policies must recognize this inextricable linkage between drugs and HIV disease and be designed to address the two aggressively and simultaneously.

NATIONAL DRUG CONTROL POLICY

To date, the National Drug Control Policy has failed to address the coupling of the epidemics of HIV and substance use. Indeed, thus far, the Office of National Drug Control

Policy (ONDCP) and other federal agencies have barely recognized the linkages. In the 1991 report from ONDCP, (a 161 page report), there are only three paragraphs of text addressing this issue. The failure to acknowledge this -- the obvious -- is bewildering and tragic. The first step is for the ONDCP, and other federal drug agencies to fully recognize the problem. In order to do this, the federal government must recognize that HIV and substance use is one of the issues of paramount concern within the "war on drugs." Any program which does not deal with the duality of the HIV/drug epidemic is destined to fail.

The current national approach to the problems of substance use is to deal with those who are addicted primarily by means of the criminal justice system. Clearly, this approach is not working and a public health approach is desperately needed. Despite the fact that "we [a]re incarcerating people at a greater rate than any nation in the world, and incarcerate blacks at a higher rate than South Africa,"[17] substance use continues, and transmission of HIV related to injection drug use has increased rapidly over the past decade.[18] The criminal justice system is the least viable setting for providing treatment and addressing issues of HIV and substance use. Yet this has become the primary strategy in our "war on drugs." Those forums which should have a proactive role in dealing with substance use, namely the medical and public health communities, have been seriously neglected. We must develop a system which coordinates public health and health care with treatment and outreach, both of which have shown positive results.

RECOMMENDATION 1.

Expand drug abuse treatment so that all who apply for treatment can be accepted into treatment programs. Continually work to improve the quality and effectiveness of drug abuse treatment.

Repeatedly, medical and treatment experts have come before the National Commission on AIDS and stressed the absolute necessity of treatment on demand. It has been over three years since the Presidential Commission on HIV made their recommendations for developing "a plan for increasing the capacity of the drug treatment system so that the goal of treatment-on-demand can be met." Yet we still lack the commitment we need from the federal government to achieve this goal. While treatment expansion is a stated goal of the federal drug control policy, no real gains have been made on any level. As Dr. Robert Newman told the Commission, "...there seems to be nothing...to indicate that any government agency either at the federal or at any of the 50 state levels is indeed pursuing the objective of expansion on a massive scale to make treatment for addicts who want it readily available."[19] We must also work to ensure that the quality of treatment is constantly improving. Immediately available, effective, high-quality treatment slots are the final goal. The Commission recognizes that improved quality of treatment and treatment on demand are expensive; but so is the unchecked spread of HIV infection. As the following statement illustrates, we are putting the available, much needed resources elsewhere:

> Exactly a year ago the White House issued a strategy on drug abuse control in which it made reference to a request for $1.5 billion for one fiscal year to expand by 24,000 the number of prison beds in the federal system in addition to even more massive expansion of prisons at the state and local level.
>
> Contrast those very specific and massive goals with what was said in that strategy report with regard to treatment. It was proposed that $100 million, be added for treatment expansion to allow 11,000 additional treatment slots to be created and to put that into perspective, the Institute of Medicine within the last six months referred to an estimate of 66,000 people in our country currently being identified as on waiting lists for various types of treatment programs."[20]

The numbers are likely even higher. NIDA has made estimates based on provisional data which indicate that as many as 107,000 persons are currently on waiting lists for drug treatment.[21] And, as early as 1988, "more than half of New York City's estimated 200,000 IV drug users were infected with HIV. At any given time, about 33,000 publicly funded drug treatment slots were available to assist these people." As of September 1990, there were a little over 38,000 publicly funded treatment slots.[22]

The reality of these numbers was made clear to the Commission through the following eloquent testimony of a woman who lives every day with the epidemics of HIV and substance use:

> I still work the streets to support a $150 a day habit of heroin and crack. I am forced to have sex with approximately ten men per day to support my habit, which is putting me at risk of further HIV infection, sexually transmitted diseases, and rape or death. What I want to tell you is that if I ha[d] been accepted into a drug treatment program three years ago, I would not be sitting here in front of you today telling you that I am HIV infected.[23]

Federal response to treatment on demand

Federal officials have questioned the wisdom of treatment on demand on three major grounds: first, there are already enough open slots in treatment programs, but poor coordination results in waiting lists; second, the efficacy of treatment methods is still unknown; and third, treatment on demand may create a "revolving door" effect with substance users moving in and out of treatment programs without ever taking treatment seriously.[24]

The government has argued that with a computerized system and increased coordination we could fill all the available slots, thus rendering new slots redundant. Further coordination between treatment centers and a computerized program to help expand access are excellent ideas, but coordination can only do so much. Treatment programs need to be easily accessible to people in need -- being shunted to another part of the city to an open

treatment slot may make treatment impossible for many substance users. Open slots in certain treatment programs may also reflect programs which are not thought to work by the substance users themselves. Whether the perception is justified or not, research should be done on what draws substance users to a particular program or type of treatment, and what drives them away.

While the Commission recognizes this need to coordinate treatment programs to make the system of providing care as efficient as possible, it also recognizes that many of the "open slots" may, in fact, exist only on paper. Budget cuts on both the state and federal levels have limited the operating capacity of many treatment programs, while leaving the original operating capabilities "on the books." Therefore, a treatment center listed as having 100 slots may in fact have only enough staff and equipment to serve 70 individuals -- leaving a "phantom" 30 spots "unfilled."

Questions about the efficacy of treatment have been raised by many medical problems. The Commission recognizes the frustration faced by those who try to treat substance use, and believes that further research into treatments for specific "new" and "multiple" substance use behaviors must be developed; at the same time we must continue to treat individuals with the methods which we have on hand. As the Commission's vice chairman Dr. David Rogers said in response to this argument, "We don't use the excuse of, 'We don't know quite how to treat you.....' to people with congestive heart failure...[or]...cancer."[25]

Finally, the Commission does not agree that treatment on demand will create a lax attitude among those who seek treatment, as officials of ONDCP have argued. Instead, the Commission recognizes the medical nature of substance use problems and the need to provide treatment for those problems. As Dr. Rogers said, "I know of no other fatal disease in which we say, 'Go away; we'll treat you later.' [Or, in which we] use the excuses of, '...[Y]ou may not behave; you may not stay in treatment.'"[26] The Commission recognizes the role of relapse in the process of drug treatment and believes strongly that treatment on demand can offer the substance user the hope of further treatment rather than the despair of waiting with further risk of death and disease.

In order for treatment to be truly available we also need to remove those barriers placed in the path of the substance user which can make it virtually impossible to gain access to care and treatment. As one witness told the Commission:

> The drug treatment system to many substance abusers is unworkable and unmanageable. Addicts must apply for treatment, and keep in mind that most are homeless and with no support services. They must have at least two pieces of identification, a permanent mailing address, be Medicaid eligible, give and pay for a urine test, have an initial first fee for screening for the screening day, go through a series of interviews and processes, and after all this they may be admitted and medicated. This is too much for an addicted person to face.[27]

Given these requirements, it is no wonder that there may be some open slots in drug treatment centers. Treatment programs, secondary to law enforcement efforts, housed in dilapidated centers, and poorly staffed, now have been charged with not only treating substance use, but also solving the problem of HIV. It is little wonder that the problem continues to grow.

RECOMMENDATION 2.

Remove legal barriers to the purchase and possession of injection equipment. Such legal barriers do not reduce illicit drug injection. They do, however, limit the availability of new/clean injection equipment and therefore encourage the sharing of injection equipment, and the increase in HIV transmission.

National drug policy must recognize the success of outreach programs which link needle exchange and bleach distribution programs with drug treatment. The Commission has visited numerous programs throughout the country which distribute bleach and some that exchange clean needles. These programs have demonstrated the ability to get substance users to change injection practices. Most significantly, these programs, rather than encouraging substance use, lead substantial numbers of substance users to seek treatment.

For example, the Tacoma, Washington project conducts a syringe exchange and other AIDS prevention activities, as well as providing some basic services. Soon after its establishment it became the "largest referral source to treatment in [the] county."[28] Studies of demonstration projects like these have shown that they are an immediate and effective way of addressing the public health threat of HIV and of reducing demand. Yet, state to state, and even city to city, policy and practice on this issue differs to such a degree that outreach workers may have the full cooperation of the local police in one area, and be arrested in another. There must be increased coordination between law enforcement officers and outreach workers. The very real fear that clean syringes and bleach vials will be used as evidence for arrest and prosecution may be having a "chilling effect" on drug users' practice of safer injection behaviors. These legal sanctions on injection equipment thus serve to increase the sharing of injection equipment and, through this behavior, the transmission of HIV. It is imperative that we remove these legal barriers so that the transmission of HIV can be lessened for those who cannot stop injecting drugs.*

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* Twelve states currently require prescriptions to obtain needles.
Source: AIDS Policy Center, Intergovernmental Health Project, The George Washington University, June 1991.

Examples from some U.S. cities and the U.K., the Netherlands, and Australia show that cooperation of law enforcement and public officials can make a major difference in the success of outreach programs. In Tacoma, where the city and county jointly run the health department, all city and county representatives who sit on the health board have been educated about AIDS. The chief of police is also "AIDS educated" and was able to cooperate with the outreach programs in the city. This syringe exchange and basic needs outreach program in Tacoma has resulted in "approximately an 80 percent reduction in risk behavior in terms of injecting practices of the people that use the exchange as opposed to those who don't."[29] In the documentary "Taking Drugs Seriously," a film about the Merseyside Regional Health Authorities' harm reduction approach in the U.K., Allan Parry, Director of the Maryland House in Liverpool, believes that "the main reason we're keeping down the spread of the virus is because of the police support of [syringe exchange] activity." Detective Superintendent and Drug Squad Chief Derek O'Connell explains that while they do not support decriminalization..., "because of the AIDS problem which is now recognized by the government as a very, very serious problem, it would be remiss if we didn't give support wherever it was needed." In fact, since beginning their new "cautioning" program which steers individuals toward drug dependency programs instead of prosecuting, they have seen "an 85% success rate; that is, people not re-offending."[30]

RECOMMENDATION 3.

The federal government must take the lead in developing and maintaining programs to prevent HIV transmission related to licit and illicit drug use.

To date, no single agency or group has taken charge of this issue of overwhelming importance to the national health. In drug treatment programs, a level of awareness about AIDS which was never sufficient to control the epidemic now seems to be fading.[31] One woman with HIV disease told the Commission that "[i]n North Carolina, in Narcotics Anonymous, they do not talk about AIDS. It is considered an outside issue."[32] Some individuals with HIV disease are even denied access to treatment programs because of their HIV infection.[33]

Public health and health care agencies have ignored the problem from the other side -- not confronting the substance use issues involved with individuals who have HIV infection or who may be at risk. Although in the rest of the developed world, medical and public health professionals have directed national drug policy to target prevention of the spread of HIV within the injecting drug user community, there has been no parallel in claiming such policy-setting responsibility here in the U.S.

The real responsibility for these shortfalls lies with the federal government. Because of the lack of coordination and planning on the federal level with regard to HIV in general, and substance use and HIV in particular, groups in both public health/health care and drug

treatment lack direction in the face of the epidemic. The Commission applauds such efforts as the November 1990 "National Conference on HIV and Substance Abuse: State/Federal Strategies" sponsored by ADAMHA, ASTHO, CDC, HRSA, NAPO and NASADAD,* which attempted to coordinate state and federal agencies and discover new directions for action.

The conference focused on a number of inter-related issues: the need for increased coordination of traditional public health departments and substance abuse treatment programs; improvement of joint program planning by state health and substance abuse treatment systems; and the need to increase state and federal collaboration in addressing the HIV/substance abuse issue.[34] The recommendations which came out of the conference in the areas of provision of services, evaluation of services, training, and research are insightful and relevant. Examples include many recommendations which reflect the concerns of the Commission:

> Provide HIV prevention services in drug treatment settings and services for drug users in public health clinics; Provide outreach to drug users who are not in drug treatment and to the sex partners of drug users; Improve and expand the capacity of drug treatment; Provide drug treatment services in primary health care facilities; Provide primary health care in drug treatment centers; Provide training and cross-training of staff; and, Improve the evaluation of HIV/substance abuse programs.[35]

The question now is, where do we go from here? Without a cohesive national strategy which assigns responsibility, provides leadership and vision, and follows through on coordination, these excellent recommendations and advances will be lost. In order for coordination to truly work, there need to be incentives for public health and drug treatment providers to join together in seeking grants and other federal monies. The present system discourages rather than encourages such cooperation. Demonstration projects need to be set up with a component for evaluation and further funding already in place so that valuable people, time and resources are not lost. Increased federal action in the areas of evaluation, technical assistance and development of training, guidelines, and models can help bring about the cooperation and coordination of health care and drug treatment which are essential to meeting the goal of providing primary care to substance users with HIV disease.[36]

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* The Conference was sponsored by the following organizatons: Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA); Association of State and Territorial Health Officials (ASTHO); Centers for Disease Control (CDC); Health Resources and Services Administration (HRSA); National AIDS Program Office (NAPO); and the National Association of State Alcohol and Drug Abuse Directors (NASADAD).

RECOMMENDATION 4.

Research and epidemiologic studies on the relationships between licit and illicit drug use and HIV transmission should be greatly expanded and funding should be increased, not reduced or merely held constant.

While the definite link between HIV transmission and substance use is well-established, many questions about the relationship between substance use and HIV remain unanswered. What effect does continued substance use have on the progression of HIV disease? What behaviors place individuals at the greatest risk for transmission? Although further research is essential to help us answer and provide solutions for these and related questions, much has been learned thus far -- policy makers are not in a scientific vacuum. Since the beginning of the epidemic we have learned much more about injection drug use and substance use and sexual practices which are linked to HIV. Research into these topics should not be relegated to private sponsors because of a mistaken perception that substance use and HIV are not critical national problems. Such research falls squarely under the aegis of the federal government.

There are two issues of particular concern to the Commission within the larger context of research on HIV and substance use. First, the future of projects funded through demonstration grants and second, the potential cuts in the number of federally funded investigator-initiated grants. The Commission's concern for demonstration projects is reflected in the discussion above on outreach projects. The whole concept of "demonstration" projects needs to be better defined; the evaluation process should be designed so that successful projects can be identified at an early stage. Funding can then be made available for their continuation as on-going federal projects. A consistent policy must be developed to prevent the shut down of successful programs and the loss of trust, staff and progress.

The Commission is also concerned with proposed cuts in funding for investigator-initiated grants and the numbers of programs to be covered in the coming years. The Commission believes strongly that funding for research on HIV and substance use should be increased and is specifically concerned with the potential cuts in the numbers of grants available under ADAMHA. The Commission believes that the basic and applied research funded through this mechanism is often among the most productive and creative and holds great potential for progress in finding the answers to crucial questions around HIV and substance use. To cut these innovative programs, either in funding amount or numbers of grants, would delay once again the answers to questions which are crucial in curbing the spread of these epidemics.

Clinical trials are a key component of research and can offer both immediate and future benefits in treatment and care of HIV disease. The Commission believes strongly that those with a history of, or current, substance use problems should be actively enrolled in clinical trials. As with the provision of primary care, it may be appropriate to look to

increased cooperation with treatment centers for finding participants and conducting these clinical trials.

RECOMMENDATION 5.

All levels of government and the private sector need to mount a serious and sustained attack on the social problems that promote licit and illicit drug use in American society.

The combined epidemic of HIV and substance use has hit hardest the individuals in our society who are least equipped to deal with it -- the poor. The poor of this nation, especially within communities of color, lack access to medical care, housing, food, and other basic needs. Substance use treatment and HIV education may often seem like luxuries to people who do not know where they will sleep at night or where their next meal will come from. As Sandra Vining-Bethea of the Bridgeport Women's Project told the Commission, "It's hard to educate a woman who is homeless and hungry."[37]

Those who live in poverty are also subject to extremes of social neglect which can add to the likelihood of substance use and risk practices. As Dr. Robert Fullilove of the Psychiatric Institute in New York told the Commission:

> The one thing we know about poverty in this country in the last 20 years is that it has really altered the structure of many of the neighborhoods in the United States. Blacks and Latins are increasingly concentrated in areas that are becoming poorer and poorer, and with that concentration has come a tremendous increase, not just in HIV infection, not just in the prevalence of drug abuse, but a whole host of other serious social problems ranging from crime to just about anything that you can possibly describe."[38]

If the nation is to provide treatment and education which will move people away from substance use problems and the risk of HIV infection, it must recognize the role which poverty plays in this dilemma.

As Dr. Fullilove went on to tell the Commission:

> ...the most common feature of drug abuse is relapse. And we think relapse is related to environmental factors, the degree to which people live in neighborhoods where the neighborhood itself is a toxic agent that promotes addiction. ....Unless we are able to stabilize the communities in which drug abuse, (particularly non-white communities), unless we're able to stabilize these neighborhoods and provide them with some kind of economic base, the underground economy which pushes and promotes crack cocaine addiction is going to do far more to damage our efforts to reach individuals....[39]

While attacking the problems of HIV and substance use in the short-term with the methods discussed above, the federal government must lead the way in simultaneously addressing the larger social issues of poverty, homelessness and lack of medical care. We must work cooperatively with both the public and private sectors to remove these barriers to prevention and treatment.

Notes

1. Schmoke, K. (1990) Testimony before the National Commission on AIDS. Baltimore, December 18. Transcript at pp. 141-2.

2. DesJarlais, D. Personal Communication, May 30, 1991.

3. Centers for Disease Control (1991) "AIDS/HIV Surveillance." (U.S. AIDS cases reported through May 1991) pp. 9 & 10.

4. Ibid.

5. Ibid.

6. Ibid.

7. Ibid.

8. The Citizens Commission on AIDS for New York City and Northern New Jersey. (1991) AIDS: Is There a Will to Meet the Challenge? p. 31.

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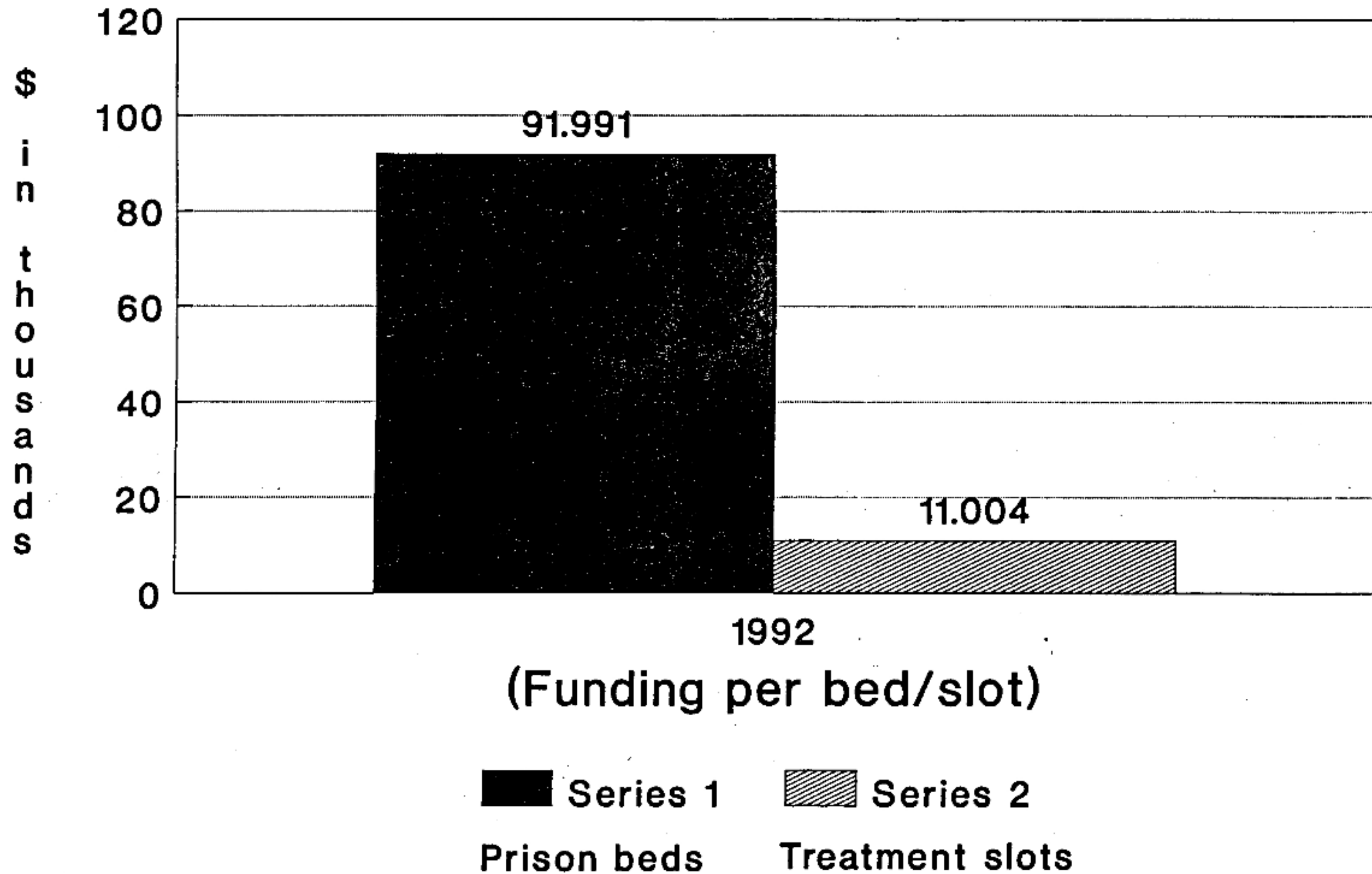
39. Fullilove, R. (1991) Testimony before the National Commission on AIDS. Washington, January 17. Transcript at p. 62.

Appendices

APPENDIX A

Proposed Funding for New Prison Beds vs. New Treatment Slots in 1992



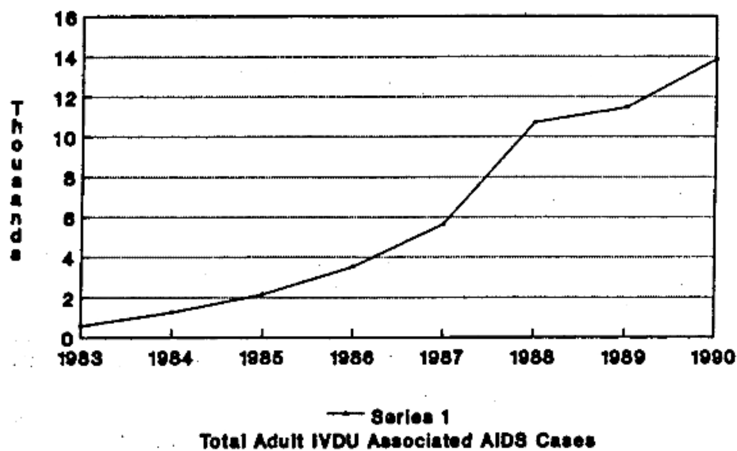
Data for proposed new prison bed funding for 1992 from, "FY 1992 Congressional Budget Estimates." p. 5. & "National Drug Control Strategy: Budget Summary, 1991." p. 56. The "New Construction figure" includes the new construction estimate of $285,169,000 and an additional $46,000,000 which is expected to be transferred from the Special Forfeiture Fund.

[$331,169,000(New Construction)/3,600(Proposed beds)=$91,991/bed.]

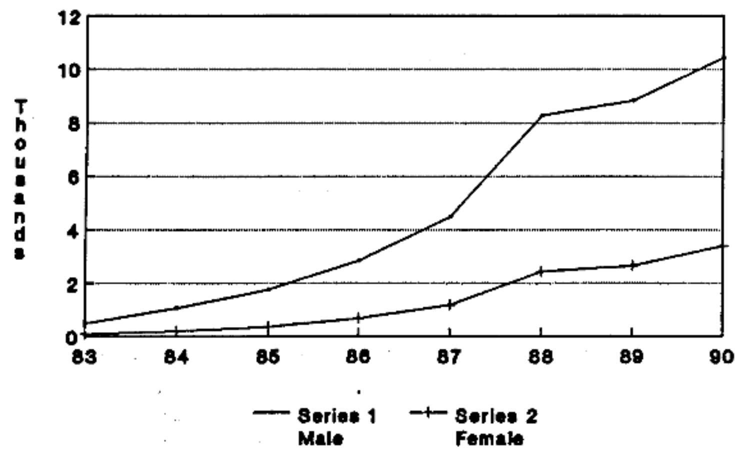
Data for proposed new treatment slot funding for 1992 from, "National Drug Control Strategy: Budget Summary, 1991." p. 157. [$99,000,000(CEP)/8,997(proposed slots)=$11,004/slot.]

APPENDIX B

Total Adult IVDU Associated Cases by Year



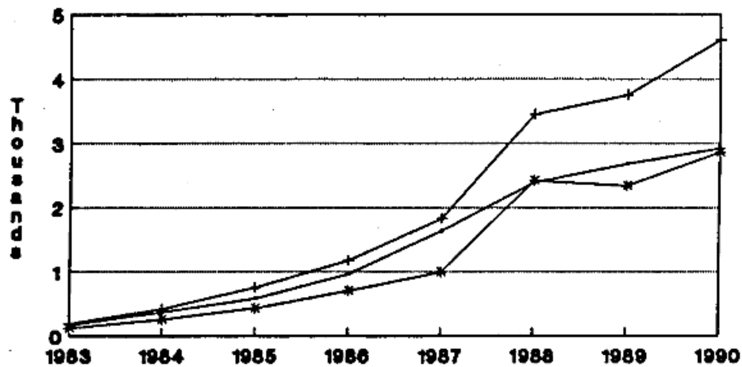
Adult IVDU Associated Cases by Sex and Year



Intravenous drug use (IVDU) associated cases include: IV drug use/Heterosexual; Male Homosexual/Bisexual contact and IV drug use; and, Heterosexual Contact: Sex with an IV drug user.

Centers for Disease Control AIDS Data as of December 31, 1991.

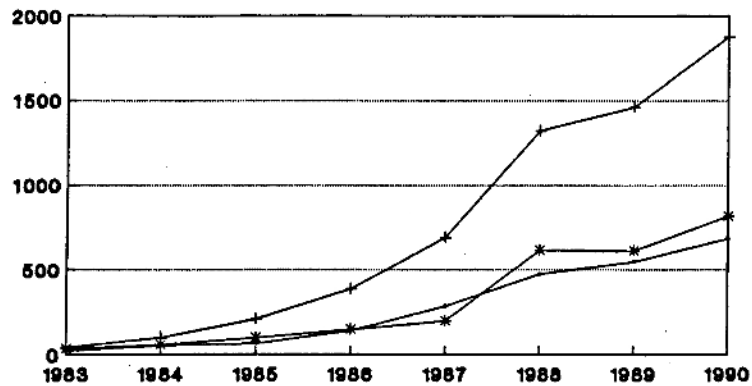
Adult Male IVDU Associated AIDS Cases by Race and Year



Series 1 White — Series 2 Black — Series 3 Hispanic

Native Americans - 54 total cases. Asians - 56 total cases.

Adult Female IVDU Associated AIDS case by Race and Year



Series 1 White — Series 2 Black — Series 3 Hispanic

Native Americans - 21 total cases. Asians - 25 total cases.

Intravenous drug use (IVDU) associated cases include: IV drug use/Heterosexual; Male Homosexual/Bisexual contact and IV drug use; and, Heterosexual Contact: Sex with an IV drug user.

Centers for Disease Control AIDS Data as of December 31, 1991.