TRANSCRIPT OF PROCEEDINGS

NATIONAL COMMISSION ON

ACQUIRED IMMUNE DEFICIENCY SYNDROME

HIV DISEASE AND SUBSTANCE USE HEARING

Pages 1 thru 238

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NATIONAL COMMISSION

ON

ACQUIRED IMMUNE DEFICIENCY SYNDROME

HIV DISEASE AND SUBSTANCE USE HEARING

Thursday, January 17, 1991

9:00 a.m.

Pan American Health Organization Building
525 Twenty-third Street, N.W.
Conference Room B
Washington, D.C.

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P A R T I C I P A N T S

MEMBERS PRESENT:

JUNE E. OSBORN, M.D., Chairman

DIANE AHRENS
SCOTT ALLEN
HARLON L. DALTON, ESQ.
DON C. DES JARLAIS, PH.D.
CHARLES KONIGSBERG, M.D., M.P.H.

ALSO PRESENT:

JAMES R. ALLEN
IRWIN PERNICK, ESQ.
MICHAEL PETERSON, M.D.

MAUREEN BYRNES, Executive Director

C O N T E N T S

C O N T E N T S [cont'd.]

C O N T E N T S [cont'd.]

P R O C E E D I N G S

CHAIRMAN OSBORN: May I ask people to settle so that we can get started? We have a rich day's testimony, and I think we should take full advantage of our expert witnesses. I want to welcome everybody to our day's hearing on HIV Disease and Substance Use. It's not the first time that the commission has addressed this topic, but then it is our feeling that it is both an urgent topic that requires readdress, and it was our feeling as we put together this hearing that it would be important even just to do the hearing in order to try and heighten and maintain the visibility of this issue which is so crucial for public health, both the substance use problems themselves and then the incredibly intimate interface with our concern of HIV spread and HIV disease.

I don't need to tell anybody how troublesome it is to think about heightening awareness today on anything other than the Persian Gulf. We regret that. On the other hand, I would like to sort of make a promise to the witnesses who have gone to the trouble to travel in these troubling times and to be with us that we will continue to try and find ways to bring these issues out, and today's testimony will be

exceptionally helpful to, to the extent that the commission can, enhance this dialogue as the initial distraction of what I hope is a very brief and casualty-free set of activities winds down.

So that is sort of a pledge from the commission that your efforts will not only be helpful to us, but we will try and follow through on our underlying agenda, keeping the level of awareness very high and trying to move the agenda forward. I am very happy, as I have been throughout the life of the commission, we are all happy that Don Des Jarlais is one of our number because his expertise in the area of substance use is internationally, not only internationally recognized, but Don's time is drained because of that in incredible ways.

I am particularly pleased that he will, has helped us in putting together such an extraordinary panel of witnesses and will introduce the topic for the day in opening remarks. Don, thank you.

DR. DES JARLAIS: Thank you, June. I will go over some brief remarks on the current situation of AIDS among IV drug users. I would first like to point out that this is truly an international problem, while here in the United

States we probably have the largest number of AIDS cases among drug users and HIV positive drug users, this is also a major problem in Europe, and it's a major problem in South America and it's a major problem in Southeast Asia.

So that there are plenty of opportunities for us to learn from other nations in terms of their prevention efforts, their policy development around the particularly difficult problem of AIDS among people who inject drugs. Currently, approximately one-third of the newly diagnosed cases of AIDS in the United States are related to injecting drug use. Most of that is among people who inject drugs themselves, but a substantial and growing proportion is also among people who are the sexual partners of IV drug users or the children of IV drug users.

The best estimates are that there are somewhere between half to 1.5 million people who inject drugs in the United States. The estimates are complicated by a definition of who do you want to include. Do you want to include somebody who has ever injected, or do you want to include somebody who is injecting at least once a week? What do you do about people who aren't injecting now but have injected in the past and are likely to inject in the future? We clearly

need to improve those estimates, but it is a truly difficult scientific problem.

The best estimates of the HIV infection rate among people injecting drugs in the United States are approximately 20 to 30 percent. Again, we need to improve those estimates. There is great geographic variation in HIV infection rates in the United States with sero-prevalence highs in the Northeast of approximately 50 percent in the New York-New Jersey area to 15 percent in San Francisco. Many cities at approximately five to ten percent. In terms of new infections, it was clear from the data presented in San Francisco that probably the majority of new HIV infections in the United States are now related to injecting drug use in terms of, again, people injecting drugs and their sexual partners and children.

There is also great geographic variation in rates of new infections. In cities like New York, HIV sero-prevalence has stabilized for the last six years or so, but that stabilization includes probably a rate of five percent a year among people who are currently sero-negative becoming infected with HIV. In thinking about prevention efforts for IV drug users, it's important to think in terms of long-term behavior change. This is not a matter of education in the

simple sense of telling people who inject drugs that sharing injection equipment transmits the virus.

Essentially all injecting drug users in the United States already know that AIDS is transmitted by sharing drug injection equipment. They may need specific information on details such as the sharing of cookers or the sharing of cotton, but they already essentially know that the sharing of injection equipment will transmit AIDS.

In terms of long-term behavior change, first we need greater availability of treatment. The current estimate is that there may be 15 to 20 percent of people injecting drugs who are in treatment. It has been estimated that we could do at least twice that. That we could probably get that up to 25 to 30 percent if we had more treatment programs and if we had better treatment programs.

One of the reasons drug users do not come into treatment programs is that they tend to be physically shabby. They tend to be understaffed. Morale in many of them is low. Staff turnover is high. We could do much to improve the treatment programs as well as to expand them. We also need to be concerned about drug users who are not currently in treatment. That is by far the majority. We do have a

national program of outreach workers, most of them distributing bleach, that the preliminary evaluation results look very promising. As a result of these outreach efforts, the follow-up data show not only people practicing safer injection but a substantial proportion, up to 44 percent in one project, of the subjects in the evaluation research actually went into treatment as a result of the outreach efforts.

So that this outreach not only leads to safer injection. It also leads to substantial reductions in the use of illicit drugs. The main problem with our current outreach program is that it was started as a national demonstration project with a three year funding. For some of the programs they've already been shut down because the three years expired. A very large number of them are scheduled to be shut down this September. Many of those scheduled to be shut down this September are already laying off staff as part of a normal phase-out/shut-down process. The original rationale was that these would be done as demonstration projects and then somebody else other than the National Institute of Drug Abuse would pick up the funding for them.

Unfortunately, that somebody else has not come forward. The city and state governments tend to be in fiscal

catastrophes at least equal to the federal so that money is not likely to be forthcoming there. There has been talk of possibly transferring some responsibility for these projects to CDC although NIDA clearly has the expertise to continue running them since NIDA was the federal agency that started up these projects.

But clearly, this has been the one really notable national success that we've had in reducing AIDS risk behavior among IV drug users, and we need to make sure that this really notable national success is not discontinued, simply because of concerns about whether NIDA or the federal government can do demonstration research but cannot provide services.

One of the troubling aspects of reducing AIDS and HIV risk behavior among injecting drug users is that while we've had very substantial success in getting them to change their injection patterns, either to reduce or stop injection, or to practice safer injection, we've had much less success getting them to change their sexual behavior. We have seen some increases in condom use, but even in the most optimistic studies, condom use tends to be at no more than about 50 to 60 percent of the persons who inject drugs.

Right now given our relative ability to change these different types of risk behavior, it's clear that we would be better off trying to prevent sexual transmission by preventing the initial infection from sharing drug injection equipment. Another issue that we will address today is providing medical treatment for drug injectors who are HIV positive. Historically, drug abuse treatment has grown up outside of standard medical health care. Many of the programs are freestanding. Even those that are part of medical centers tend to be isolated within the medical center, both physically and psychologically.

Our ability to provide good on-site treatment for HIV disease and our drug abuse treatment programs is minimal. It's clearly starting to grow. It clearly will need more funding resources, and it clearly will need also some changes in attitudes among people in health care. Finally, I want to briefly talk about our policy development around HIV and injecting drug use. I think confusion is not too strong a word to describe the national policy situation. There is confusion not only within the federal government but also within state and local governments. We have a situation where in some parts of the country health departments are

funding AIDS prevention activities, but in other parts of the country those same AIDS prevention activities when carried out by volunteers leads to the volunteers being arrested.

We have not yet fully sorted out our future policy at any federal, state or local levels as to what we are going to do about the continued spread of HIV among drug injectors. Up till now the lack of a clear policy on this issue, a clear national policy on this issue, has been sort of the responsibility of everybody involved and I think as a commission we need to look at our own responsibility for recommending or formulating policy in this area. Up till now the confusion at the policy level has really permitted a lot of creativity and innovation.

There are a lot of AIDS prevention programs in particular that have started up because a certain local area decided to go ahead in the absence of any nationally coordinated plan. However, while that innovation truly has been beneficial to the field, in looking at the next ten or possibly even 20 years of an AIDS epidemic, we do not want to, we cannot use policy confusion as a basis for controlling the epidemic on a long-term.

In terms of the policy problem, the greatest

impediment has probably been the fear that the government will somehow be encouraging or condoning drug use by providing certain types of prevention programs. This has been applied foremost to syringe exchanges, but has also been applied to the bleach distribution programs. All of the data, from studies of these programs, indicate that they do not lead to increases in drug use. If anything, they are very effective way of getting drug users into treatment to reduce their drug use, but there is still this symbolic, this fear of a symbolic act rather than a real act in terms of encouraging drug use.

And the second major problem has been an American tendency to try to determine the best thing to do about the problem and then only do that, either to only provide treatment or to only provide for safer injection or to only attempt to prevent new people from starting to inject drugs. People who inject drugs are a very diverse population. We will need a wide variety of AIDS prevention programs from safer injection to increasing treatment to providing better medical care for those who are already ill is truly not a matter of finding the best thing and doing only the best thing, but doing a variety of things at the same time.

And finally, one of the major difficulties in developing any sort of consistent policy in this country has been that in this country injection drug use is heavily concentrated among people of color. That with the history of racism and the distrust that has built up within those communities makes it very difficult to establish good working relationships among public health leaders, community leaders within the people of color communities, and the injection drug users themselves.

CHAIRMAN OSBORN: Thank you very much, Don. That's a tersely provocative and important introduction to today's testimony. I'm very pleased now to ask Linda Lewis to join us at the table. Thank you. And we're particularly grateful to Ms. Lewis for being with us. Dr. Herbert Klieber (sic) was going to be here and was unable to make it, and so we are particularly happy that you're able to be with us and we look forward to your testimony.

MS. LEWIS: I am with the Office of National Drug Control.

CHAIRMAN OSBORN: I think you're going to have to use that microphone so that the transcriber can function.

MS. LEWIS: Thank you. I'm with the Office of

National Drug Control Policy. I'm the Assistant Deputy Director for Demand Reduction with primary responsibility for focusing on the treatment and rehabilitation issues. What I want to do this morning is really present you with two pieces of information, and I will apologize if my back is to anyone, two pieces of information. One, a look at, an overview of what the federal agencies are doing to address the AIDS issue, primarily from the perspective of treatment.

If you are familiar with the National Strategy, you know that the basic policy initiatives in the treatment and rehabilitation area are primarily the expansion of treatment capacity and the improvement of treatment quality, two of the issues that Don talked about. So the references that we will make are from that perspective. And then I'm going to share just some of the general policy and planning considerations that from the treatment perspective I think we need to be looking at.

Okay. I'm going to go quickly through a wide variety of federal agencies. We'll start with the Department of Health and Human Services being, of course, the largest agency with a number of departments that have responsibility for this issue. NAPO is the National AIDS Program Office,

which has primary responsibility within the Public Health Service for coordination of the AIDS activities. Intra and inter-departmental task forces, panels and operations are the methods that they're using at this point to bring coordination within the department.

The Alcohol, Drug Abuse and Mental Health Administration, ADAMHA, has within its purview the National Institute on Drug Abuse, the National Institute on Alcoholism and Alcohol Abuse, and the National Institute on Mental Health. In addition, two other offices, the Office for Treatment Improvement and the Office for Substance Abuse Prevention, which are the two departments with major responsibility for services out in the community. If we look at the National Institute on Drug Abuse, you heard mention this morning the outreach demonstration grants which have proven to give us a great deal of information about what's going on out in the street and the people who are in need of treatment services.

Also, NIDA is involved in a wide variety of research grants. Research is their principal mission. Those grants look at a variety of issues, the natural history and etiology of HIV and a wide variety of studies that are

looking at the different impacts of drugs on the immune system. Also, the NIDA folks were involved in HIV seroprevalent studies in a limited number of drug sites across the country. Those studies are still going on, and primarily a major initiative is that of AIDS training, working with states and communities in equipping community based programs to respond to clients coming into the system with HIV infection or at risk for HIV infection.

Now the Office for Treatment Improvement, which also has a variety of grant programs, target cities programs, critical populations programs, criminal justice programs. These are grant projects that are competitive and although they do not target essentially the AIDS issue, the client populations that these grantees are dealing with certainly include those substance abusers who are infected with the HIV virus.

But I did want to point out also within the Office for Treatment Improvement is responsibility for the alcohol and drug abuse portion of the Alcohol, Drug Abuse and Mental Health block grants. This is one of the major vehicles for providing treatment capacity to our programs throughout the country, and as you know, Congress had added to that block

grand a set-aside requiring 50 percent of the drug abuse portion of that block, which is a minimum of 35 percent and is much more in many places, to be used relative to the HIV infected, IVDAs or IVDUs.

The Office for Substance Abuse Prevention has HIV and AIDS as a component also of their demonstration grants. They have a wide variety of grants focusing on the development of community partnerships, targeting youth who are at high risk for substance abuse and certainly a major initiative that very, very definitely links to and, in fact, overlaps with the HIV issue, and that of pregnancy and post-partum women and their infants who are involved with substance abuse who are also at risk for serious involvement with HIV infection including pediatric AIDS.

The National Institute of Mental Health has research on neurological and other effects of the HIV virus and research on the mental health aspect for those individuals who become ill with the virus.

The National Institute on Alcoholism and Alcohol Abuse, also primarily a research institute, is looking at the role of alcohol as a co-factor in the HIV issue, looking at the impact of alcohol on the immune system, looking at

particularly adolescents, which is a population that I think both from a treatment and HIV perspective we need to be paying serious attention to, looking at alcohol use impacts high risk behavior for adolescents, and also looking at alcohol consumption and the impact that it has on the fetal immune system suppression if alcohol is used during pregnancy.

The Centers for Disease Control, I know you're familiar with their major activities, primarily that of HIV and AIDS surveillance. Counseling, testing and partner notification is a major initiative of CDC, and they have done some activities to integrate and work to through the use of joint plans with alcohol and drug agencies provide for HIV and also the tuberculosis epidemic which is beginning to accompany the HIV issue, prevention and drug treatment centers across the country. And we'll talk a little bit more about that in a moment.

HRSA has now primary responsibility for a number of major issues that impact medical care and services for those individuals who are HIV infected. They have pediatric AIDS demonstration. They are doing a lot in regional AIDS education and training centers. Most of this training focuses primarily on medical care and practice for individuals

who work with the HIV issue. Primary care and substance abuse program reflects a grant project that is designed to set up a cooperative effort between community based treatment programs and primary care centers so that people who are in drug treatment programs that need primary care can receive it and clients coming into primary care centers, who may also be involved with substance abuse, can get the kind of treatment that they need.

And then the Ryan White Act, which was enacted this past year, that primarily has provisions for providing medical care services, a number of different types of grant projects under that that offer the ability for communities to get resources to address some of the medical needs.

Now we've looked at what is being done within HHS, let's look now at some of the other federal agencies involved. The Department of Justice through its National Institute on Justice has an AIDS clearinghouse that provides information for the criminal justice community, and they are doing work in a variety of reports that look at the issue of AIDS in the correctional facilities. You know that we are concerned about treatment services, substance abuse treatment services, for the large population who are in both state and federal

prison populations as well as in community incarceration facilities. These sources of information work for those populations.

The Department of Labor in 1987 developed a joint effort with the Department of Health and Human Services to provide advisory notices targeted to protecting against occupational exposure to the HIV virus. The Department of Veterans Affairs, which we know have veterans hospitals across the country, certainly are providing clinical care, education and research for the treatment for veterans who have HIV infection, and that includes those veterans who are in substance abuse treatment services that are part of the VA medical centers.

And then the Department of Housing and Urban Development, which has within the past two years become heavily involved in providing resources for public housing communities, the drug-free neighborhoods projects, includes an HIV, AIDS and IVDU component in training for Public Health administrators and training for people who are within the Public Health communities and HUD staff.

Now these are the major efforts at the moment within the various federal agencies. I do want to point out

under the Health and Human Services, certainly the Food and Drug Administration is there, and the work that is being done on looking at the variety of medical options that are available for the HIV infection. Now, I think one of the things that you will see, many of you are familiar with the fact or know that the Office for National Drug Control Policy produces a national strategy in looking at how we are going to respond to the drug problem in this country.

We are anticipating in probably early February the release of the Third National Strategy. While I'm not at liberty to go into detail about that, I think you will see an emphasis from the standpoint of treatment expansion and improvement on the HIV issue as it relates to substance abuse populations. These are some of the issues. Some of them have policy implications. Some of them have primarily planning and coordination implications. Certainly looking at the issue of integrating HIV related services into substance abuse treatment, we have a variety of activities that are beginning in that area. We need to do more.

Two opportunities are presenting themselves. I mentioned earlier the joint plans that link the Centers for Disease Control with the Single State Agencies. SSA stands

for Single State Agencies. These are the alcohol and drug treatment agencies in the states who manage the block grant, who manage the state resources that are directed toward treatment expansion and treatment improvement.

We are looking at what we can do to strengthen and expand the concept of the joint plans across the country for counseling, testing, partner notification. Also, in those areas that have significant problems with tuberculosis, some expanded services for that issue as well. And we are working closely with the Office for Treatment Improvement who is undertaking a major national effort to begin requiring states to provide what we call a state substance services plan.

This is essentially a needs assessment and planning document that every state will provide addressing their priority needs, how they plan to use the resources that are being given to them, what their most critical issues are in both treatment and prevention, and within that plan, there is a major focus on the issue of individuals who are involved with treatment and prevention, who are either at risk for or involved with the HIV virus.

Certainly, the expansion of substance abuse capacity as a means of reducing the spread of the HIV

infection is a major effort that we're involved with. We've seen resources put out both at the federal and state level over the last several years. We are beginning to achieve capacity expansion. This is an area that we need to continue to work in.

Now, Don mentioned the effectiveness of the AIDS outreach demonstrations that NIDA did, and they, in fact, did give us some very excellent information. And one of the things that we really are encouraged about, and that we need to continue to focus on is the expansion of outreach efforts to recruit substance abusers into treatment, both those who may be involved with or are already seropositive with HIV infection, but very, very specifically those who are not and who are at risk if they remain in a lifestyle that does not allow them to have access to treatment.

One of the issues that I think we have to be more and more concerned about are how we provide both substance abuse services and HIV related services tailored to the needs of substance abusers in small and rural communities. Access to care is particularly critical there. The primary care system in small and rural communities has its hands full, is a key player in linking with community based services. There

are a wide variety of issues that go with this.

Assessing patient care resources for substance abuse clients in need of medical care. This is something I think we're going to need to focus on. More and more, the individuals who are in substance abuse treatment are becoming seropositive and are going to be in need of medical care for the HIV illness in addition to care as part of their drug treatment.

And then just a couple of other issues related to developing coordinated efforts to link the activities directed to substance abuse treatment for pregnant and post-partum women and their children. And we talked about the fact that both through the block grant and through the Office for Substance Abuse Prevention we have had now almost three years of focus on treatment capacity for pregnant women and their children. That issue needs very much to be closely linked to the efforts that are being done at state and community levels to address the HIV infection and to look at the issue of how we impact pediatric AIDS.

Prior to coming to Washington, I served as the State Alcohol and Drug Abuse Director in Florida. We were a state with very significant HIV infection problems and very,

very significant pediatric AIDS problems, and so this is an area that we're particularly concerned about. And then developing coordinated efforts to link substance abuse treatment and expansion and improvement efforts to a variety of special populations, people of color, people in communities. The rural issue plays into this. Some of the Native American populations where we're beginning to see some serious increase in infection. These are just some of the groups where we need to really provide an extra effort at addressing these populations in making sure that the work we do in the HIV infection reduction activities also links to the substance abuse treatment area. Thank you.

CHAIRMAN OSBORN: Thanks very much. Perhaps if you want to sit through a few minutes so we can get a chance to interact with you. But I think the commissioners may want to get a chance to expand or ask questions.

MS. BYRNES: Can I just ask a quick question? I may have missed this. Was there some discussion or presentation about what programs may or may not be underway at the Department of Defense for treatment and prevention?

MS. LEWIS: We have worked with them in terms of all of the substance abuse treatment activities that are

going on within the Department of Defense and linked to that are initiatives in education, in medical care. In essence, it is almost a microcosm of the same kinds of issues that we deal with within the basic communities, and they are involved in issues. I don't have all the details on their activities, but I know that they are.

DR. DES JARLAIS: Linda, I was very pleased to hear a consideration of expansion of outreach efforts is being done presently within National Planning Office, but right now many of our effective outreach programs are shutting down, laying off workers and such because they're funded only through this September. If they shut down, it will be hard to get those staff back. You will have lost a very significant amount of trust that has been built up with drug users that the government actually is interested in providing HIV services to them. If you do have a shutdown, even if there is a start-up in the next fiscal year, you will have lost a significant amount of trust as well as major staff problems from laying people off.

Is there anything you see that can be done where your office would make a public statement of intergovernmental statement to reduce the chances of those programs shutting

down to maybe be started up, you know, six, nine months later?

MS. LEWIS: Let me make a couple of comments to that, Don. Number one, I certainly share your concern, and I think something that we really have keep an eye on not only from the standpoint of the outreach grants but from a great deal of the standpoint of the capacity that we have out in the country for treatment is that we must -- the strategy talks about this -- but we really have to work to implement a very close partnership with states and local communities.

I have been, had the opportunity to be part of a work group that the National Institute on Drug Abuse has put together to work with states specifically around the issue of trying to make sure that those states have the capability to pick up the outreach projects or to expand those projects in some cases or that they encouraged to do so.

And that is something that we will certainly continue to work toward. I did have the opportunity the other day to work with one particular state who is asking how they can work with, how they can blend their block grant money, some of their state dollars, to really begin to develop treatment resources that will link to the outreach project. I think there is a lot that can be done with that

and we will certainly continue to push for that.

DR. DES JARLAIS: Another issue, well, somewhat different issue actually, OSAP is in charge of drug abuse prevention or at least is the lead agency. The increase of HIV infection increases dramatically when you start injecting drugs, when you go from sniffing heroin or cocaine to injecting them. Do you know what programs or what amount of dollars OSAP has targeted at preventing that particular transition from non-injected drug use to injected drug use, which is a somewhat different practical problem than preventing people from starting marijuana or starting sniffing cocaine?

MS. LEWIS: I think the major activities that have been taking place over the last several years within the OSAP area really are geared at providing broad-based community activity and support for prevention projects, certainly targeting on use in pregnant women and the populations that we talked about.

I think, in part, timing is a factor here. If you look back over the last several years, the major prevention focus really has come from the work that CDC has done in working with communities in terms of testing, and I think we

were at that point where the risk reduction activities that are talked about and are focused about have really come from the health and CDC perspective as opposed from substance abuse prevention.

Now I think also that we have to be extremely careful right now, certainly the issue of injected or injectable drugs has not in any way, shape or form gone away. But we are particularly concerned and our trying to watch the trend in drug use, the link that I think you also mentioned about the sexual partners, and all of that has to be looked at in terms of a major prevention effort. And those are things that I think from again a policy and planning perspective we need to be addressing.

CHAIRMAN OSBORN: Once again thank you, then, very much for joining us and for giving us that very useful overview.

MS. LEWIS: Thank you.

CHAIRMAN OSBORN: I'm now very pleased to introduce Dr. Beny Primm, a distinguished predecessor in an earlier phase of examining HIV issues, and with Dr. Primm is Paul Gaist from the Alcohol, Drug Abuse and Mental Health Administration, and Steve Jones from the CDC. Dr. Prim is here

today as the co-chair along with Dr. Gary Noble from CDC of the National Conference on HIV and Substance Abuse recently past.

I know, Dr. Primm, that your time is quite tight. We are sensitive to that, and we very much appreciate that you've been able to join us, and we'll hope that we can take full advantage of your time. Sorry. You know the government is contracting, and we have contracted to one witness microphone. Sorry about that.

DR. PRIMM: Well, first, Dr. Osborn, let me thank you for inviting me. I'm just very, very happy to be here and to again to see so many of the friends that I've made over the years. Coming to certainly the National Commission on AIDS is like coming back home for me. Let me preface my remarks by saying that what I say here today is really preliminary to our formal report which will be out in April on the National Conference on HIV and Substance Abuse. And I have with me, of course, Mr. Paul Gaist, who was the planning chairman of that conference, and of course, Steve Jones, who was the special assistant to Dr. Noble, who was the project officer for the conference.

I want to thank you for the opportunity to report

to you today on the National Conference on HIV and Substance Abuse: State/Federal Strategies. It was held over a two and a half day period in Alexandria, Virginia this last November. I along with Dr. Gary Noble, the Deputy Director of the Centers for Disease Control, co-chaired this conference in the spirit of collaboration which characterized this conference. I would have truly liked to have had Dr. Noble here with me today but required travel did not allow him to attend, and therefore, Dr. Jones is here with us sort of representing Dr. Noble.

As you know from the statistics and presentations you've already heard this morning, the epidemic of HIV infection among drug abusers in the United States is requiring increased coordination of traditional public health departments and substance abuse treatment programs, which typically have operated as two separate and distinct entities in the United States except for some funding and, of course, some compliance monitoring that takes place from the public health departments over the substance abuse treatment programs.

This long overdue conference focused on improving joint program planning by the state health and substance abuse treatment and prevention systems. And it focused on

increasing state and federal collaboration in addressing HIV/ substance abuse issue. I say that this conference was characterized in the spirit of collaboration because it was itself a product of the type of federal and state partnership that we hoped to foster through the conference and hoped to create and sustain, which we haven't had before.

From inception to funding to implementation to the final report, writing and follow-up, this conference has been handled by a 22-member planning committee comprised of individuals from the Alcohol, Drug Abuse, and Mental Health Administration, the Association of State and Territorial Health Officials, the Centers for Disease Control, the Health Resources and Services Administration, the National AIDS Program Office, and the National Association of State Alcohol and Drug Abuse Directors.

So you can see that this conference had among its sponsors, and, of course, its planning committee an array of individuals from all organizations that were responsible for anything that had to do with drug abuse and public health. This conference also focused on changing business as usual in addressing the prevention, medical and program planning needs with respect to HIV and substance abuse. This conference

brought together the state and alcohol and drug abuse directors and public health officials to enhance cooperative state program and policy planning with respect to HIV and substance abuse.

Through a format of plenary sessions and concentrated work groups, the over 200 state, federal and service providers representatives engaged in discussions centered on identifying barriers and making recommendations to overcome these barriers. This conference had many memorable citations in which we all may find useful guidance in our own efforts in this aspect of the epidemic.

The ADAMHA administrator, Dr. Fred Goodman, cited the value of the conference in bringing us further toward the important goal of mainstreaming of alcohol, drug abuse and mental health services, and bringing them into the general health care system.

The CDC director emphasized, as did many throughout the conference did, that we must look at and beyond injecting drug use with respect to HIV infection. Specifically he cited the alarming association between the use of crack cocaine and the increasing rates of syphilis, gonorrhea, chancroid, chlamydia, and other sexually transmitted HIV

infections including other retroviral infections. Addressing the conference, Surgeon General Antonio C. Novello spoke of the changing face of AIDS, which she said is increasingly female, increasingly child, increasingly heterosexual.

Just as with substance abuse, AIDS, she says, is no longer a disease of isolated individuals but of family units. She asserted that this presents a new set of challenges to the state health and drug abuse officials. Your own doctor, Dr. Don C. Des Jarlais presented current research, spoke to the fact that preventive work can and does lead to behavior change in substance abuse. He stated that here this morning, and I certainly concur with him.

I also concur with Dr. Jim Curran of the Centers for Disease Control when he said we must redefine the boundaries of what is now called unacceptable or impossible in working out better ways to collaborate and cooperative. There were a number of recommendations, and let me say that these recommendations are still being brought together, and the final report, as I indicated, will be out in April, but I'd like to present these recommendations to you in preliminary form and I'll give you just some of the major ones.

They were broken down into needs and then barriers

and then recommendations. The first need was cited to be integration and collaboration within states, health, education, and social welfare departments. The barriers to that need were cited to be cross-training was not taking place. There was a need for confidentiality of treatment, both for HIV infection and disease and drug addiction. There is a lack of confidentiality in all of those areas. Greater demand for treatment than available resources could afford, especially for women.

That the current system was not designed to treat the use of crack cocaine, and, of course, cocaine itself. There was a lack of coordination and communication among agencies that were responsible for treatment and support services for these individuals and there was a lack of epidemiological data. The recommendations to those barriers began with the group recommending that there should be a required focus on HIV infection and a linkage of drug treatment to HIV services, some of the same things that we see that the HRSA-NIDA initiative is doing in both drug treatment programs and community health centers.

To adopt a consistent confidentiality policy. One that has already been out there for a number of years for

methadone maintenance treatment patients should be more closely followed, and certainly the confidentiality policies concerning HIV infection and HIV disease particularly in drug treatment programs should be more consistently followed and, of course, monitored.

To increase outreach which was very important and to develop measures of evaluation. To educate the criminal justice system on how to work cooperatively, and to adopt school-based models of education for youth. The second group of needs concerned primary health care for substance abusers. The recommendations were we need funding over a sustained period for this, not just an initiative that would fall flat on its face once that categorical funding was stopped, particularly when it comes from the Alcohol, Drug Abuse, and Mental Health Administration, and goes to states, and there is no commitment to ongoing funding of such primary health care for substance abusers.

A training in chemical dependence in medical schools and schools of public health. An increase in salaries to retain a well-trained staff and treatment programs. To adopt a case management system more widely in both drug treatment programs and certainly primary care

programs. To deliver primary care in drug treatment facilities with more funding and more space and, of course, edifices that certainly are attractive and do not have a tendency to be a deterrence to treatment.

Provide follow-up of drug abusers and their sexual partners, and to adopt incentives to retaining clients and treatment, the use of coupons that have been used in New Jersey, for example.

Another need was to mobilize resources. Those recommendations included development of state plans out of my office and to share those state plans with states on a voluntary basis in a partnership kind of arrangement, state systems development plans, so that when the states sign up or go into an agreement to accept the block grant dollars, to really have a plan as to how they're going to spend them, and ongoing technical assistance from an office like my own to help them go about being successful and doing what they have said that they would do.

To adopt steps to allay fears of communities concerning facilities. To help overcome providers' fears of evaluation. And to develop agreed upon outcome measures in advance in planning programs. And to hold similar conferences

regionally as the one that we were holding.

To determine which services have priority and who should provide them. Another need was defined as improved quality and use of data on HIV and drug abuse. The barriers to that need were cited to be national surveys were not useful at the local level. There was a lack of cooperation among surveys. Insufficient funds and isolation of agencies limit the epidemiology regarding the homeless out there.

Recommendations that the 1991 health survey would hold better promise and would provide a better data, particularly on risk behaviors in minorities. That there should be national epidemiological surveys. That they would be more responsive to state and local needs. That more data on HIV infection and alcohol and drug abusers be accumulated, that we should anticipate changes in HIV infection related to substance abuse. Another need was adequate funding and standardization of training and cross-training related to HIV and drug abuse.

Barriers to those need were cited as competition among federal agencies, lack of resources, lack of training people to be trainers, high turnover of substance abuse treatment staff because of low salaries and poor attractive-

ness to these particular places to work, lack of follow-up on training or effective evaluation. The recommendations included giving continuing education credits and certificates for training, make training a line item in program budgets, mandate training at all levels in cooperation will local universities and give staff time to train, create a federal clearinghouse on training and workshops, base trainings on standards of care, developing training that is culturally sensitive.

Another need to improve the evaluation of programs, both processed and outcome for programs. Barriers were found to be federal funds are often based on state problems or failures with less incentives to report successes. Another barrier was lack of resources for evaluation. Insufficient technical assistance was cited as another barrier to those problems. Some of the recommendations was greater coordination between public health and substance abuse programs at the federal, state and local levels.

More resources should be appropriated for evaluation, and that conferences should address also primary prevention efforts as well as evaluation. In closing, I'd like to begin by saying what were the results overall of this

conference? The exit evaluation showed among other things the result that 86 percent of the state representatives participating in the conference indicated that their knowledge of HIV and substance issues was significantly expanded so that was a success. 91 percent left the conference with practical strategies to apply in their respective states. 97 percent reported, indicated a desire to participate in another meeting of this type, which we were very happy about.

Also, many new links of communications were made as a result of the conference, and most left with a desire to carry through on the goals of the conference. Dr. Noble and I have the planning committee designing right now a follow-up questionnaire to be administered to the state conference participants to directly assess what problems and what policy actions may have taken place following the conference in a follow-up kind of way.

To the commission members, I ask you to carry the results of this conference forward and to recognize it, as we do, that it is one of many needed steps to be taken for significant and lasting change and systems trying to break from years of deeply entrenched cultures, which must be changed to address the new set of critical public health

challenges facing this nation. I am going to close with that and ask Dr. Jones or Mr. Gaist if they have anything to add, and then I'll be free to answer any of your questions. Dr. Jones.

DR. JONES: I think the one observation from the meeting and which we were trying to deal with in the way the meeting was designed, and Beny made this point, but I'd like to reemphasize. It was the recognition that there are two cultures in a way of drug treatment prevention workers and agencies and public health agencies, and that there is a vast chasm between those two agencies. And the purpose of the meeting was to bring those groups together and I think we were successful in the initial way, and I think that the collaboration between the agencies that Dr. Primm cited was an excellent model for the type of thing that needs to be developed further in the future.

MR. GAIST: Thank you. Yes, I would like to reiterate and support the comments of Dr. Primm and Dr. Jones, and as well, as we have already heard this morning with just the day beginning an emphasis on state plans. For example, Linda Lewis' example of the OTI, Single State Agency State Substance Abuse Service Plans being needs assessment

and planning guides.

The conference that we held in November represents really the type of tool which fosters and facilitates this type of effort, and in and of itself does not stand alone, but again stands as an example of other types of efforts and tools that we need to make available. In that vein, it's quite interesting, Don Des Jarlais, Dr. Des Jarlais, in his emphasis on the importance of the outreach programs. One of the things that we certainly have learned through those outreach programs is that if we want to bring about significant behavioral change, one of the first steps is to build trust in those that we are trying to bring about the behavioral change.

That same dynamic seems to take place here as well in bringing the two cultures together, and I think that this conference and beyond the other types of efforts that hopefully will be stimulated by this catalyst of the conference must continue to build that type of trust, show direction, convey skills and create the right environment for this type of important behavior change to take place. Thank you.

DR. PRIMM: I would like to also add that Dr. Kabio

(sic) who had just been appointed -- I don't know his exact title at the World Health Organization -- happened to have been in town that day, and he came by and addressed the conference, and he talked about the problem facing the whole world relative to substance abuse. And invited some of us to join him in any way possible to help him try to alleviate that problem. So it was all in all, I think, a well-attended, terribly effective conference that took place, and I think we're going to see some good results. There are a number of follow-up things that are happening already from my own office.

I'm not here to talk about the Office for Treatment Improvement today, but I would just like to throw in that we have a substance abuse linkage initiative called SALI that is being run by Dr. Sol Levin out of the Office for Treatment Improvement that is continuing some of these efforts to keep people talking, bringing them together, bringing the National Medical Association, the American Medical Association, the American Society for Addiction Medicine, ASTHO, NASADAD, all the alphabet soup agencies and federal government and the private sector to continue collaborating together to bring about a sustained effort in keeping this thing in the

forefront.

MR. GAIST: I would also like to add as well in this current era of world collective action that we are seeing today in the Middle East, I would also like to thank the sponsors, and many of the speakers from our conference are present in this room today, and we thank them for that type of collective action, and I think that that again that dynamic is quite important here in addressing the HIV/substance abuse intersection.

CHAIRMAN OSBORN: As I mentioned before, I know Dr. Primm that you have a pressing time schedule this morning, and I gather also to everybody's benefit, there will be an extensive written product coming soon from the conference. I had heard anecdotally that it was an unusually productive and in some senses a model conference that would move things substantially forward. And the testimony you've all give us today makes me very enthusiastic about that.

If there are pressing questions, we could take them --

DR. PRIMM: Dr. Osborn, may --

CHAIRMAN OSBORN: Yes.

DR. PRIMM: I don't have the appointment that I

thought I was going to have, and I don't have to leave until later on this afternoon so I do have time to respond to the commission's questions.

CHAIRMAN OSBORN: Okay. If there are a couple of questions, then we could do that. I know one of our next witnesses also has pressure. So we need to stay roughly on schedule, but that's good to be able to ask anything that's quite pressing. Jim Allen.

MR. J. ALLEN: Let me address this to either Dr. Primm or Dr. Jones, and perhaps both of you could respond. Both the Alcohol, Drug Abuse and Mental Health Administration and the Centers for Disease Control have different responsibilities in terms of prevention activities, particularly, and I'm referring to HIV prevention activities particularly as they pertain to drug abusers.

Dr. Primm, there is the large ADM block grant that is available, and apart from the restriction on bleach distribution in that -- let's assume that that may not be there forever -- how effective is that going to be as a means of increasing drug abuse outreach programs for drug users that aren't currently in treatment in terms of trying to link that to treatment programs so that we've got an integrated

outreach and treatment program approach? How much should we look at other approaches, very targeted approaches towards getting very specific federal funds for outreach programs and how might we link those to the drug abuse prevention initiatives and should these efforts be coming primarily out of ADAMHA, out of CDC, and how might we more effectively link those?

DR. PRIMM: First of all, I think the block grant itself, as you know this year, 1991, is $1.2 billion. About 896 million of those dollars are substance abuse dollars. That is for drug and alcohol treatment, and there is a set aside for intravenous drug abuse which totals to about $157 million or 17.5 percent of that alcohol/drug abuse money.

Then there are other initiatives within the block grant for prevention. I think there is a ten percent set-aside, concentration on women there's a set-aside. And then for those states, for example, that do not have injecting drug users in great numbers like Maine or Wyoming and Montana and so forth, certainly can get a waiver for those dollars that have been set aside to do injecting drug users or IV drug users to concentrate in the rural areas on other kind of drug use that contributes to HIV infection and HIV disease.

In our categorical grants, that is the grants where we issue announcements about initiatives from OTI that we would like to address that we have seen as problematic in the states, we also include both prevention and, of course, HIV thrust in all of those grants. We had 99 this year for critical populations that were issued. We had 19 categorical grants in the criminal justice system. Nine for non-incarcerateds and ten grants for incarcerated people where we're focusing on HIV infection and substance abuse.

We also had a few homeless grants. This year we intend to target public housing in conjunction with the Department of Housing and Urban Development. We also intend to focus on the Job Corps with the Department of Labor, all doing prevention and convention efforts for testing, early testing, diagnosis and treatment of HIV infection, and of course, to try to do something about the drug abuse problem. So I think you ask whether it is good for it to remain in ADAMHA or joint effort with CDC, you know, we have ongoing meetings with CDC relative to a collaborative effort between those two agencies right now.

We are doing quite well with them. We had a meeting just last week, I think it was, Paul. People from

each ADAMHA agency with CDC staff are formulating a plan to further do something about this problem. The first meeting that we had with CDC I brought up some issues that I thought were really pertinent, and that was that not only they should be interested, CDC should be interested in HIV infection and only drug abuse now because of HIV infection, but I challenged them. I said what about when we find a cure for HIV, will you back away? I got a promise, public promise in the meeting, and John was there, from Jim Curran, that they would not back away. That indeed that they would concentrate on drug abuse issues and particularly diseases associated with drug abuse, hepatitis B and all the other kinds of problems that are contagious problems that drug abusers have been putting out there, transmitting to the other population for millennia.

So, indeed, I feel that we need a continuing relationship, strong one with CDC on this issue, and to keep it in the forefront.

CHAIRMAN OSBORN: Dr. Primm, I really appreciate the additional input, and Dr. Jones, if there is a quick comment. I know I do have somebody who has apparently got a very urgent need to talk and leave. So I want to make sure

that we get to take advantage of his presence, too. So if there are some final comments, I'd appreciate it. Otherwise, I think we need to proceed.

DR. JONES: I would just say one or two sentences about outreach activities. CDC has made an effort to pick up some of the NIDA programs, but in a time when the budgets are not increasing and when you have ongoing activities, that's been limited to about six programs that we've been able to so far do. There's some budget initiatives which will allow further work on an evaluation and an expansion of some outreach activities, but the problem we have in that area is that there is no new money, and the programs that are ongoing need to be continued also.

CHAIRMAN OSBORN: Thank you very, very much, then, for your help and input. We look forward to the published proceedings. As you say, it sounds like it will be an exceptional resource. And I guess Don is suggesting that I ask a quick question. Is it likely that this will be an annual event?

DR. PRIMM: I can't respond to that.

MR. GAIST: One of the things that the conference planning committee hopes to do with the follow-up assessment

is actually to be sensitive to the needs of what the state folk feel that would be best for their own needs. We felt that we broke ground with this conference, and, in essence, made linkages and communications that didn't exist before. But in terms of being able to sit down and having the alcohol and drug abuse director and the public health official from a particular state hunker down and say, well, I've got this program and you have this program, how are we going to mesh this, how are we going to develop joint policy, in two and a half days, while we went far, we didn't go far enough.

And we want to try to find the vehicle that is going to be best, whether it is state by state meetings, regional meetings, annual meetings, who should sponsor those to best carry out accomplishing the goals and objectives.

DR. PRIMM: Thank you very much.

CHAIRMAN OSBORN: Thanks again. I'm going to suggest that we ask Dr. Robert Johnson, if he would, to take his turn separately because I believe his schedule is exceptionally pressed, and then the other panelists in this panel can come along afterwards. This way we can take as much advantage as possible of your time. Thank you for joining us.

DR. JOHNSON: Thank you very much, Dr. Osborn, and members of the panel, I thank you also for your indulgence of my schedule. I have an 11 a.m. flight to catch to get back to Newark to run our clinic for adolescents with HIV. My views in this testimony are based both on my clinical experience as an adolescent health care practitioner who provides services for adolescents in Newark and in New York City and my experience as a clinical researcher. In my patient population, I have had the opportunity to care for adolescents who have AIDS as well as a growing number of teenagers who HIV infection and are awaiting the development of AIDS.

Additionally, as I've already indicated, my observations are also based on our preventive work with adolescents in Newark and our research activities which have included seroprevalent studies, AIDS knowledge, attitudes, beliefs and behavior studies, and studies of the psycho-immunology of AIDS in adolescents. The adolescent involvement in drugs and alcohol and AIDS currently plays three important roles in the epidemic. First of all, although there is evidence that substance abuse in general is decreasing in some adolescent populations and that the use of intravenous

substances is decreasing in particular, there still remains a significant population of adolescents who expose themselves to the probability of HIV infection in spite of the knowledge that they have acquired about the risks of intravenous drug use.

The promising reports we have heard about U.S. drug use or promises about those are further tempered by the observation that the surveys which are the basis of these reports fail to adequately sample populations of young people who are school dropouts, on the streets, or involved in some other high risk activities which place them at greater risk for exposure. The problem there is there is no convenient way to sample that population. And therefore, we really have very little idea about their use of intravenous substances.

I can say anecdotally that in our clinics we still see significant number of adolescents on the streets who use intravenous drugs and are exposed to the virus. Secondly, even though those adolescents who avoid intravenous drugs are in a greater number, drug use among that population still includes some substances such as alcohol, wine coolers and beer and marijuana, and the use of these substances also increases the risk for HIV infection. The issue here is that

these substances are used in conjunction with sexual behaviors, and these substances which are known as disinhibitors remove the behavioral inhibitions which one creates to protect themselves against exposure to HIV infection, things such as sexual abstinence, condom use, and avoidance of promiscuous sexual behavior.

Since the public and adolescents view these substances with little seriousness, their tends to be a tendency for these young people to ignore preventive efforts in this regard. And our last four adolescents who had heterosexual transmission of disease all had sexual behavior that was associated with alcohol use, particularly a drug form of wine cooler named Sisco (sic), and these young people who had used condoms in other situations did not use condoms with individuals who they did not know and thus exposed themselves to the virus.

Finally, and this third issue has been alluded to by Dr. Primm earlier, this issue relates to the sale of drugs, especially those adolescents who deal crack. These adolescents often trade sex for drugs with persons who are from high risk populations. That is prostitutes who are addicted to drugs, especially crack. One particular crack

dealer who is a patient of mine 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 girl friend who did not use drugs. All of this activity occurred without the benefit of the protection of condoms. In that month, he and his girl friend, and his girl friend's new boy friend, and his girl friend's new boyfriend's alternative sexual partner, all became infected with gonorrhea and chlamydia. I'm not aware of their HIV status, as all of them are afraid to receive HIV testing.

This anecdote is illustrative of an important root of spread of the HIV infection into heterosexual adolescent populations. And it, in part, explains the greater frequency of heterosexually acquired infection that we observed in adolescents. Our concerns in this area are magnified by our complete lack of access to this population of drug dealers and by the confounding effects of other aspects of their lives which interfere with any of our preventive efforts.

Our most recent seroprevalent studies detected an HIV infection rate of 1.22 percent in a low risk urban high school population. That's about 12 or 13 young people in a

school of a thousand. These are young people who were not using drugs excessively, were not engaged in what they considered to be high risk behaviors, and who did not expect that they would have any type of disease.

Given the current status of our preventive efforts or rather the lack of our efforts, we can only expect this rate will continue to increase. As we persist in our debates of whether condom distribution in high schools will encourage sexual activity in a population where the rate of sexual activity is already 85 percent, our children continue to engage in risky behaviors and continue to expose themselves to this deadly epidemic. Thank you.

CHAIRMAN OSBORN: Thank you very much. I'm awfully glad your schedule let you be here. Do you have time for one or two questions or --

DR. JOHNSON: Yes, one or two.

CHAIRMAN OSBORN: One or two. I think everybody is thinking about how to get you there by 11. But Harlon.

MR. DALTON: You mentioned the complete lack of access to this population and also the second is not necessary, the lack of prevention efforts. How would you, what would be the point of intervention if you could design the

program and the money were available?

DR. JOHNSON: Well, in August we did manage to select a population of crack dealers who were in a certain area in East Orange, and we were able to do some behavioral interventions with them. There is currently through NIMH some very good research in preventive efforts in adolescents. The problem is you need preventive effort that is specifically targeted to the particular type of population, and we know a little bit about that. Our behavioral efforts with this population, these five or six crack dealers did work.

Three of them are in jail right now, and so I think they're essentially removed from -- maybe not -- removed from the population of persons at risk. But we did begin to get them to use condoms. And it was an educational intervention with direct counseling, but that's a real small direct approach, and with that small direct approach, you can get some work. But the big problem is where do you find them. If they're in jail, you can work with them in jail, but otherwise you can't really go out in the street and identify all the crack dealers and bring all the crack dealers in to talk to them. That's one order. Just use condoms if you're going to engage in sexual activity with women who are

prostitutes. Of course, the other thing you could do is just not sell crack which would certainly be a much better method.

DR. DES JARLAIS: Have you had any concerns that someone may feel you're encouraging crack use if you're going out teaching these crack dealers safer sex?

DR. JOHNSON: Well, I was accused of encouraging sex when I said in 1985 we should put condom dispensers in high schools. I'm sure that someone is going to accuse me of that. I think that the issue of disease control, the epidemiological issue and the public health issue, is separate from the issue of substance abuse. I think we have a real concern here about the spread of this infection. We have to do what we can to stop that while at no time condoning behaviors. If we sit back and wait for a larger strategy to work, we're going to end up with an even higher rate of HIV infection in these adolescents.

DR. DES JARLAIS: Thank you.

CHAIRMAN OSBORN: Dr. Johnson, thank you very much. We appreciate your taking the wear and tear of such a quick trip. Could I then ask the rest of the panelists talking about HIV and substance use prevention issues to come to the table? Edmund Baca from the Frio Street Project in San

Antonio; Robert Fullilove from the Psychiatric Institute, New York; Jose Perez from the AIDS Project, Los Angeles; and Ray Stephens, Division of Alcohol and Drug Abuse Prevention in Arkansas.

Dr. Fullilove, I guess we start with you, as I understand it. And I would suggest so that we do have a good chance to interact that if you can focus our attention on your central points as thoroughly as you can, the commissioners like to get a chance to interact, and we'll look forward to that at the end of the four presentations, if we can have enough time. Thanks.

DR. FULLILOVE: Very good. I want to begin by focusing on the individual nature of our prevention strategies in dealing both with substance abuse and HIV. I want to underscore my points by describing the experiences my wife and other members of my research team in studying crack cocaine use amongst black adolescents in Oakland and in San Francisco in 1988 and later in ethnographic studies we've been conducting in New York City since last year.

The focus of our research was to try and find as much as we could about the relationship between sexually transmitted disease and use of crack cocaine. Dr. Johnson

has already talked about some of the dynamics of that. So I won't go into further detail. What struck us most was the dramatic contrast between what we discovered as a result of surveying 222 users individually and using standard epidemiological methods to examine the data that we collected, how that contrasted so dramatically with what we found when we walked through the streets of the neighborhoods where crack use was most prevalent and talked to individual users in focus groups.

We think we're at the limit of what can you ask people to do individually. Almost all of our research in HIV has focused on trying to identify individual factors that place one at risk for exposure to an STD or HIV. I don't know that we can design a better prevention message, a better comic book, a better video, a better public service announcement, that will get an individual who is living in a high risk neighborhood to change or alter his or her behavior.

I think the experience of folk in the drug treatment aspect of HIV prevention know that we frequently are able to get someone detoxified and even to give up use of drug for awhile, but 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 if a toxic agent that promotes addiction.

Unless we are able to stabilize the communities in which drug abuse, particularly in non-white areas, 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 than any of the public service campaigns that we've been able to mount thus far. I think substantial research done in other areas that looks at the relationship between social networks and the maintenance of health indicates very strongly that individuals do not in and of themselves typically have the power to reverse the deleterious effects of an addiction to alcohol or to some other pernicious substance.

They need the support of family. They need the support of social networks that are reasonably stable. 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.

Robert Sampson in the Bulletin of the New York Academy of Medicine cites some statistics that really talk about the relationship between this resegregation of the poor and its concentration in certain specific areas of our urban population. It talks about the Robert Sampson houses, the Robert Sampson project -- excuse me -- the Robert Taylor projects in Chicago. He points out that those 28 high rise buildings which house some 20,000 people contain one-half of one percent of the population of the Chicago. However, residents of this particular high rise account for nine percent of the rapes, ten percent of the murders, and 11 percent of the aggregated assaults that are committed in the city of Chicago each year, a tremendous disproportionate representation of one particular social unit on the crime statistics of a city.

It's a way of describing the degree to which the breakdown of the social fabric of the inner city has con-

tributed to the higher rates of HIV seroprevalence and the higher rates of drug abuse that we're observing. Until we're able to stabilize these communities, there simply is no place for the seed of the individual prevention measure to take fruit. Unless we're able to do something dramatically to alter the economic structure of these neighborhoods, we really fear very, very strongly that the things that we have been embarked in for the last nine or ten years simply are not going to see the kinds of results that we desire so strongly. Thank you.

CHAIRMAN OSBORN: Thank you. We'll look forward to getting a chance to ask some questions and so forth when everybody is finished. Mr. Baca.

MR. BACA: I would like to thank the commission for inviting me to speak today. It's quite an honor to be in the very prestigious company of physicians, educators, and research in this field. There are few opportunities for local players such as myself in a grassroots position to share experiences with men and women who spent decades studying, researching, and educating about challenging and social medical problems such as drug abuse and AIDS.

For this reason, I again thank you for inviting me

to present my personal ideas and philosophy on HIV and substance use prevention issues. Through my years as a substance abuse treatment provider and most recently as a quasi-researcher and outreach worker in the AIDS prevention field, I have developed strong ideas regarding these issues which I feel are viable across the nation.

The ideas I present to you are my own and not necessarily those of my employer, the Metropolitan Health District of San Antonio, Texas. Most problems, whether substance use or risky sexual behavior, do not exist in a vacuum. They permeate our society in such a way that there is not a man, woman or child left unaffected. This is a frightening thought. By own behavior, we can all be part of a risk group that we discuss.

An effective way to combat these problems is to focus our attention on the family. Whether we are talking about prevention, treatment, intervention or education, until we access and address the family as a whole, we will be hardpressed to make a lasting effect on the individual. If we are unable to make a lasting effect on the individual, we won't begin to touch our society. Individuals are complex and families even more so. Having a system with disjointed

approaches and unconnected service providers cannot begin to address the complexities. A multi-discipline arrangement on a community level involving treatment agencies, health organizations, social service providers, hospitals, health care professionals, community based organizations, schools, neighborhoods and certainly the church, must all play a role in problem solving.

We as professionals in the field need to insist that our respective communities utilize this multidisciplinary approach to combatting AIDS and substance abuse. This is not just the federal government's problem. Private industry must be involved, and across the nation we see this happening. San Antonio is beginning to use this approach through the good work of volunteers, community based organizations, and consortiums. Private industry is working with schools and other organizations to assure the education of our young people.

Time and time again community leaders in these fields have called upon everyone to join in and give what they can. Many have joined and many have not. The in-fighting and the turf disputes must come to an end. As professionals, we must be a part of this. Individual

philosophies can be held dearly to while at the same time one's mind must be open to divergent philosophies. A variety of treatment modalities must be available to meet the needs of the entire population. Localities must be willing to provide them. A variety of interventions must be developed to address diverse issues. Case management style programs are developing across the nation including San Antonio to combat AIDS, and they are working.

Professionals from many disciplines are joining in the fight for our individuals, families and communities. Substance abuse professionals must be involved. Family and individual needs must be addressed effectively and immediately. The user, the abuser, the addict and persons living with HIV and AIDS must be able to access these services. Case management can provide such access. To talk in such terms is to talk in terms of prevention, prevention of HIV and AIDS, prevention of substance abuse.

We cannot talk prevention without talking treatment. We cannot talk treatment without discussing treatment on demand and we are nowhere near treatment on demand. In San Antonio, there are literally thousands of drug users, IV and otherwise, with nowhere to turn but to the bottle, the rock

and the needle. It is no different in any other city or town in the United States. We must fight for enough treatment slots for every individual needing one, and we must continue to fight until we get them.

But there is always in the meantime. What do we do now? We do what many cities have been doing for several years now including San Antonio. We take it to the streets. We take treatment to the user. We take intervention to the user. We take education to the user. We take prevention to the children and their families. Prevention is all of the above. We take hope to people who have no hope. We become advocates. We become transportation. We bring food and clothing to those who have no food and clothing. We let the user, the addict, and the persons living with HIV and AIDS know that we truly care.

We open doors for them that previously were shut. Treatment doors, emergency care doors, medical care doors and whatever doors remain locked. This is quite a task ahead that I'm proposing and certainly all of these issues cannot be relieved immediately. But we must try. When I was asked to make the presentation, I was not asked to develop a specific program but rather to share my own philosophy and

concepts about prevention. I've raised many issues, all of which, I believe, are important to eventual success. There are certain strategies that I would like to suggest to make the concepts outline work.

First of all, outreach must play a major role in the case management programs. Number two, outreach must include dissemination of educational materials which are culturally diverse. Number three, outreach must include bleach and condom distribution. Four, outreach must be performed by a variety of programs to reach a variety of people. Needle exchange programs must be allowed to flourish. Substance abuse treatment must be available in a variety of modalities, drug free, methadone, Trexane, Antibuse, detoxification.

Number seven, we must be prepared to provide treatment to all these needing it, not just those wanting it. We must approach the church effectively to gain its support. We must support school prevention and health programs. HIV counseling must include much more than the traditional pretest and post-test education available. And finally we cannot wait for the people to come to us. We must go to them. I'd like to leave you with one departing thought. We

must remember who is getting the work done for the people we are serving is our line staff, the men and the women who are in the trenches on a daily basis slugging it out with drugs and AIDS.

Many of these staff have been there themselves and the reasons we raise are not distant to them. They are real issues that they battle on a personal basis everyday of their lives. They are on a mission, and that mission must become ours. We must remember that these are really our key people. We must trust them, listen to them, support them and respect them and adequately compensate them for the answers to the questions we are raising today lie in their hands.

CHAIRMAN OSBORN: Thank you very much. I think the people in San Antonio are very fortunate to be the beneficiaries of your commitment. Mr. Stephens.

MR. STEPHENS: Thank you, Dr. Osborn. I thought I was going to be last on the panel so what I was fixing to say was that from a rural low incidence state perspective, we don't have the massive problems that the state of Texas, New Jersey and California and New York have. However, the problems that we do have are significant to us. I'm a little bit different from the standpoint, too, that I represent a

state substance abuse agency so I'm not in the trenches as my colleagues are.

What I do have to say to you, though, is that many of the things that have been spoken about before are true for us as well. The substance abuse caucus recommendations at the Tri-Regional AIDS-HIV Summit held in Santa Fe, New Mexico, in September of 1989 stated to the conference participants that treatment for alcohol and other drug abuse is primary prevention against HIV infection.

Treatment services are available in the state of Arkansas through a network of 19 state supported comprehensive residential treatment centers. However, on any given day, there are from 175 to 200 individuals on a statewide list waiting to enter a residential treatment center. These individuals will wait nearly two weeks to enter treatment. In 1988 ADAMS block grant distribution formula was modified. The state of Arkansas took the largest percentage cut in the nation, which was 12.7 percent. The removal of the hold harmless provision from the FY '92 ADMS block grant will result in a 6.5 percent reduction in funding for the state of Arkansas which will further hamper our ability to provide alcohol and other drug abuse services.

The 6.5 percent reduction, again, will be the largest in the nation, and is indicative of the discrimination experienced by most rural states. Arkansas has traditionally been viewed as a low incidence level state for both the AIDS cases and numbers of intravenous drug users. However, when the next statistical update is released by the Arkansas Department of Health, the state will rank 19th in total number of reported AIDS cases. As a result of this perception, the availability of AIDS related services is often non-existent. The Arkansas Department of Health estimates that approximately five percent of the individuals who present themselves for AIDS testing self-disclosed that they have used drugs intravenously.

However, according to that same department, the incidence of AIDS is higher among crack users than among intravenous drug users indicating that drugs for sex is a current concern. It also points out that substance use and abuse of all types places an individual at high risk of HIV infection. The Arkansas Department of Health provides AIDS testing and pre and post-test counseling for each of the state supported comprehensive residential treatment centers at no cost to them. My division, the Division of Alcohol and

Drug Abuse Prevention and the Department of Health coordinate AIDS activities by means of a cooperative agreement.

Quarterly meetings facilitate joint training, discussion of issues and other related matters. In fact, as Dr. Primm and his colleagues were talking, there's a high degree of cooperation and coordination in our state. Not only does the health department and my division support each other actively, but the division serves on the Arkansas AIDS Advisory Council. Additionally, the Arkansas AIDS Foundation is involved with community-based alcohol and other drug abuse treatment programs in joint grant applications and provides invaluable community resources. The foundation has participated in division-sponsored training and has a staff person who is part of the NIDA certified Arkansas training cadre.

Other states do not enjoy the benefits that this cooperative environment generates. My division has designated an AIDS coordinator to work with our treatment programs. This individual provides information updates, arranges for training, and serves as the agency liaison with the Department of Health. In addition, the agency has developed an AIDS policy which among other things states that a person may not

be denied services based solely upon an individual's HIV-AIDS status.

Each of our state supported treatment providers has designated an AIDS coordinator who is responsible for current AIDS information dissemination and training for that staff, for collecting resource information, for an AIDS policy development, for providing a prevention program for clients, and serving as a point of contact for the provider on AIDS related issues. In addition, each provider is required to have an AIDS policy in place. Our division began providing AIDS related training to service providers in January of '89 through the Department of Health. In August of the same year, our agency accessed technical assistance from National Capital Systems on developing an AIDS needs assessment.

During the period January through March of '90, the Center for AIDS and Substance Abuse Training, a contractor for NIAAA and NIDA, presented three center courses, one for administrators of substance abuse facilities, one for substance abuse counselors, and one to evaluate and qualify a group of Arkansas trainers to be NIDA certified to replicate the two mentioned courses. 13 individuals were awarded NIDA certification. The first such replication will occur next

month and will be observed by a center staff person.

A second replication will occur later in the spring. During April of this year, the center will present two additional courses to the 13 NIDA certified trainers to qualify them to present these additional courses. At this year's Mid-South Summer School on Alcohol and Drug Abuse Problems, a workshop will be presented on legal and other administrative issues regarding HIV positive clients. I mention these items in detail to point out that we attempt to access technical assistance and training from any available source and especially for those which there is no charge as in the case of the National Capital Systems and Center for AIDS and Substance Abuse Training Prevention contract and would encourage them to continue.

There's a need for additional safe environment extended living facilities for individuals after completing residential alcohol and other drug abuse treatment. These chemical free living centers allow an individual to continue in outpatient treatment while remaining in a supportive atmosphere which is conducive to continued recovery. In order for HIV infection prevention to be effective, alcohol and other drug abuse counseling must include sexual behavior

counseling and be reinforced continuously for there to be any hope of modifying an individual's sexual behavior.

An integral part of any AIDS prevention program must be the education of our young people. HIV infection can be prevented, but only by having a thorough understanding and knowledge of this disease. Educating our rural populace is our challenge. I'd like to close with one other point. Low incidence level states do not compete well with high incidence states for categorical grant funding. Each grant announcement should include a base level of funding for each state and territory to conduct AIDS prevention outreach activities so that the lower incidence level states will not become like their high incidence level brothers and sisters. Thank you.

CHAIRMAN OSBORN: Thank you. That's very important additional perspective. Mr. Perez, welcome.

MR. PEREZ: Good morning. I've got an ear infection so it sounds funny when I speak, but my name is Jose Perez, and I fall under that CDC definition of gay-bi-IVDU person with HIV. I was recently diagnosed with AIDS. I tested positive for the HIV virus in '84. I immediately had a relapse for my IV drug use which has been my biggest observation and my fear of friends, many are bi, many are straight,

many are gay, et cetera, and who span the nation, and who are IV drug users. They've all had to suffer the relapse. Some were infected because of the IV drug use and some were infected for unprotected sexual contact.

But nonetheless, all of them at one point or another after their test have suffered at least one or two relapses. The whole issue of preventing relapses in people with AIDS who have a history of IV drug use, in particular, and also other substances such as alcohol and marijuana, et cetera, is very important.

I'm going to try to keep this short. I'm having a rough time. But another group of people that nothing has been designed for are gay men of color. Gay men of color who fall under IVDU, gay-bisexual, they've completely been ignored. They've been ignored by the AIDS service organizations such as Gay Men's Health Crisis, AIDS Project, Los Angeles, where I work at, and other agencies, and they've been ignored by minority-based drug treatment and substance abuse centers. There is absolutely nothing that brings these two types of organizations together at this point. I know in Los Angeles, AIDS Project Los Angeles and Ultimate Health Care Corporation, and their drug abuse program, their

methadone program is trying to create a linkage to answer that.

And it looks good. But still the insensitivity that is found inside some of these drug treatment centers to gay men of color and the insensitivity that is found for people who use IV drugs in a quote "gay oriented AIDS service organization" has really left a lot of people in dire straits. I just want to emphasize the prevention of relapses for people with AIDS, particularly now that we have, you know, an abundance of treatment options, and we've got methods of prolonging life, et cetera, we shouldn't short-change this community by not offering some kind of assistance, more likely through counseling than anything else. I mean like I would want to use the term "severe counseling," but some very close counseling that also integrated some medical case management and case management for an individual and not for a group.

If they don't stop using it, they're going to die. And all the treatments that they're taking, et cetera, are going to be for null. Also, there needs to be some kind of strategy to increase research on IVDUs who are HIV positive, and who can't take, for instance, AZT, or whatever, but there

seems to be a higher intolerance to AZT in the IV drug use populations. And that needs to be looked into. We need to know why that is, and we need to know -- if that's not a good treatment, then we need to let other treatments, you know, out such as DDI and DDC immediately.

And I'll close with that. I'm having a really rough time. Thanks.

CHAIRMAN OSBORN: Thank you. It's hard to hear you having a rough time, but we're very glad to have your testimony.

MR. PEREZ: Thank you.

CHAIRMAN OSBORN: I think we do have time for some questions from the commissioners. Harlon.

MR. DALTON: Mr. Perez, actually I'd like to ask you a question, but I think I'll spare you. No, I did want to ask JEGO (sic) -- my Spanish is real rusty. What is that?

MR. PEREZ: Me?

MR. DALTON: Yes. One of your organizations I noticed is LLEGO, and I assume that's an acronym. But I was wondering --

MR. PEREZ: Yes. It's the National Latino Lesbian

and Gay Organization.

MR. DALTON: But in Spanish, what does the word mean?

MR. PEREZ: JEGO, They've Arrived.

MR. DALTON: Okay. Thank you. I was trying to -- Dr. Fullilove, I was really quite struck by your testimony. You captured something that has been floating around in my head, I think. You said we are at the limits of what we can accomplish through focusing on individual behavior change. Historically in dealing with AIDS, we've focused in on the individual. That's probably a bit overstated for the reasons that Mr. Perez has suggested, that there is lots that needs to be done at the individual level with respect to relapse and intensive therapy.

But your point, I thought, was really quite profound that we begin to need focusing on the environment, on rebuilding communities, on dealing with those kinds of social and economic factors that in Mr. Baca's words leave people with nowhere to turn but the bottle, the rock and the needle.

I think you're right, but that's going to require a real major shift in the way that people around this table

talk about the AIDS epidemic because I think there has been this kind of tacit community of interest between people who historically focus on the individual, on individual responsibility for changing quote "deviant behavior" and others of us who spend a lot of time focusing on kind of the community on social forces that led to individual disintegration.

With respect to AIDS, there has been this kind of coming together because those of who at other times would focus at the societal level or the community level have talked about volunteerism, have talked about individual behavior change as the vaccine to deal with this epidemic. We've all been talking the language of the individual, of individual change even as there's been a messy little problem of relapse, not simply with respect to IV drug use but with respect to non-IV drug using gay men in the epicenters as well.

And so I'm afraid the debate has gotten framed in a way that makes it now hard to again begin talking about the need to rebuild and restructure communities to look at social forces including economic forces that essentially leave people with little alternative but the needle, the rock and the bottle. And so I guess I wonder how we're going to do

this? I mean how do we now begin talking and doing?

DR. FULLILOVE: Well, let's be clear that as we look at the history of our efforts to combat HIV, we began with what was first defined as a medical problem and had essentially epidemiologists and virologists doing most of the work to tell us what was going on. Slowly, but surely, we began to understand that there were behavioral antecedents to a lot of the risk behavior that placed people in danger of contracting HIV, so behavioral scientists were brought in.

I'm from an AIDS research center that concentrates on issues of prevention that uses the word "interdisciplinary," an implicit understanding that slowly but surely we're beginning to see more and more very separate disciplines link their efforts to try and combat this virus. Dr. Primm talks now about the degree to which the government has come to understand that issues of HIV and drug abuse now have to be linked, that initiatives need to try to see where, how and under what circumstances it is possible for us to link those things together.

I'm trying to continue that momentum to talk about the kinds of things that Coate McCord (sic) mentioned in his article about Mortality in Harlem that appeared in The New

England Journal of Medicine almost exactly a year ago where he points out that in the poorest, most densely concentrated census tracts in that area, of course, HIV is the first cause of death amongst people between the ages of 20 and 44, but cirrhosis, cancer, heart disease, problems that have been with us since the turn of the century, since, in fact, the birth of human kind, are also there in equal numbers and all seem to derive from the same things.

If we can link NIDA, NIMH and other agencies together and see that there is common ground for us to begin to talk about initiatives that we share in common, it seems to me that we can continue to make a step and start to look at the federal agencies that are dealing with issues of homelessness, with community rebuilding, HUD it seems to me has a direct role to play in a lot of the things that I've described here to the degree that metropolitan cases per 100,000 of HIV are so much higher in the Northeast than they are in other parts of the country, we really are talking about an environmental phenomena that does require that more and more of our efforts diverge from the particularistic and the individualistic and more towards consortium building.

And just one last point. You said that perhaps I

had overstated it. Yes, in six minutes, there isn't much of an opportunity to do anything but give things in terms of sound bites. But I thought Mr. Perez' points were very well taken. We can teach individuals how to get off drugs, but to the degree that relapse is a community event, not an individual event, that is the degree to which individual strategies probably have done just about all that they can. We can make them a little bit better, but until the community ceases to be a toxic agent that promotes relapse we haven't done the job.

CHAIRMAN OSBORN: Dr. Konigsberg.

DR. KONIGSBERG: I'd like to get the opinion from the panel, just anyone who wants to respond, on two kind of public policy issues that relate to prevention, I think, that we picked up from our background reading and other experiences. One has to do with the concept of methadone maintenance with some of the support services and the comprehensiveness that goes with it, just really trying to concentrate on that when there is no other option.

Then the other is the very controversial needle exchange issue. And I know that New York City has been kind of a hotbed for controversy on that. I guess I was reassured

by, I guess I was reassured by some of my reading that there is no evidence that needle exchange problems promote drug abuse. Somehow common sense would tell me that, too, but if I have to go out as a public health official and quote-unquote "sell that," it won't be as easy as saying it here.

So on both those issues, I'd kind of like some discussion, if we could.

MR. PEREZ: I just want to say that in Kansas City, you can get all the needles you want whenever you want. And in the suburban areas of Houston, of New York, Connecticut and Los Angeles, you can get all the needles you want without a card or anything. So the concept of needle exchange, my middle class and white upper middle class friends who IV drugs, who are functional, they can just run down to the drug store and either have their doctor prescribe them for them or just, buy them themselves. Normally they just go in and buy them and so I don't understand this controversy with needle exchange because certain people from certain classes and certain races already have, you know, complete access to them.

MR. STEPHENS: Well, speaking from the state agency standpoint that depends heavily upon the ADMS block grant,

needle exchange and bleach programs are prohibited by that program. We depend very heavily upon the ADMS block grant for our funding, and therefore we have written into our plans that we will not do that type of thing. That, I think, Mr. Perez, is where a lot of us are coming from.

The other point, sir, that you had --

DR. KONIGSBERG: Methadone maintenance without all the support services.

MR. STEPHENS: Yes, methadone. Well, also coming from a state that does not have and will not have methadone treatment, we were against the proposal this past year to allow that type of activity to go on from the standpoint that an individual needs to have as much comprehensive services as possible, and we still maintain that.

DR. KONIGSBERG: I guess the point that I kind of gleaned from doing some reading with the methadone maintenance, I don't think anybody would argue that the people need the comprehensive services. I think that what people are maybe grasping at is anything that can be done in a very, very inadequate drug abuse treatment situation in this country overall to try to decrease the use of injectable drugs, seeing that as an HIV control strategy, it's certainly

far less than ideal. I think that was done -- Don, maybe I'm off-base on this -- but that seemed to be the philosophy.

I don't like it either, just as a thought. It isn't the way I like to do business either, but just in a real practical sense. The needle exchange issue, that raises, that's an interesting perspective about it. And I wonder if there are some other opinions about that some people can get needles and some people can't, and how is that going to be viewed in certain communities.

CHAIRMAN OSBORN: I think, Charlie, if I can interrupt. That's very much the topic of the next panel, and perhaps instead of getting ourselves, losing the chance to interact on other issues, we might want to save that for the specific focus. I know Diane had a question or comment, and Don Des Jarlais, and Irwin Pernick, and then I think at that point we probably try and get ourselves to the schedule to the extent we can. Diane.

MS. AHRENS: Dr. Fullilove, I think our commission is sort of struggling at this point with how we or even if we should speak about the issue of poverty as it relates to AIDS in terms of the documents that we would be drafting. And if I understood what you said that you have done in your

studies, you have some data that would indicate that in spite of the intervention that is done, that going back into the culture of sort of no-hope, that it's evident -- I think you said it's evident that the individual intervention is not going to be very effective in the long run.

I wish you'd talk a little bit more about that. I think it's kind of important for all of us to hear your perspective on that.

DR. FULLILOVE: Our focus group work with young dealers made one thing abundantly clear. A lot of these young men and women below the age of 16 had become heads of households. Why did that happen? Because the economic collapse of the community was so great, both the loss of unskilled jobs, well paying unskilled jobs, meant that their parents no longer could be breadwinners. In fact, the glue that holds the nuclear family together had for all intents and purposes disappeared.

Enter a designer drug that is sold in bulk that can bring fabulous fortune. Enter a marketing and production and dissemination policy that says let's use kids because the juvenile justice laws make it possible for them to come back on the street even after multiple arrests. Result: much of

the economic life of the community now, because there are no other alternatives for these youngsters, revolves around young people selling this drug, marketing it to their peers, and marketing it as an aphrodisiac, something that enhances sexual activity.

This would not have been possible in the Newark, New Jersey that I grew up in 20 years ago when the structure of a quote "poor community" included lots of middle class folks like my dad, who was a physician, lawyers, a whole host of folk, who were stable enough in the community to really carefully monitor the behavior of young people. With their departure to the suburbs and with the decline in the economic infrastructure of the city, crack cocaine has become the entrepreneur's dream. It's the only way in which many of these young people have any kind of future.

To the degree that any market absolutely demands advertising and the pressing of the product, that's the degree to which people are really being drawn, dragged, kicking and screaming into a life that includes the exchange of sex for drugs and a dramatic increase in the incidence of STDS ranging from chlamydia, gonorrhea, to HIV. My basic premise remains the same. Crack would not have gotten the

toe-hold it has in our urban areas had the economic infrastructure of the community been what it was 20 years ago, and to the degree that poverty continues to make sure that it and other designer drugs will continue to be introduced into these communities as markets that are ripe for being exploited is the degree to which I think this commission really does have to address that issue directly and forcefully.

If these young people had alternatives, you would see them, we'd really, I think, see some dramatic changes. One thing I think is very important from the San Francisco experience. A lot of people really believe that because kids can make hundreds of thousands of dollars in a year selling crack that we should give up the notion that we need to offer them jobs that are paying minimum wage. It's sort of an excuse for saying, hey, there's no point in doing anything at all. In point of fact, I know anecdotally from some people who work in the criminal justice system there that when crack dealers were offered an opportunity to choose entry into some very low level jobs as opposed to going to jail, they chose them almost uniformly.

And that the results a year later indicate that recidivism levels were very, very, very low. And it suggests

that we don't need to offer them jobs as the CEOs of major corporations in order to provide them with the incentive to do something other than deal crack. Because these are some of our brightest and most capable youngsters, given them an opportunity to get into a lifestyle and into a job that has far fewer risks than those confronted by most crack dealers is something that a lot of these kids would jump out. We need to make sure that people are aware of that.

DR. DES JARLAIS: To try to summarize some of the issues that have gone through this, particularly, Bob, your comments around poverty and racism, but also Edmund's comments, I think one of the issues that we as a commission are concerned about is that it's clear that poverty aggravates HIV transmission as well as a variety of other health problems, and that we need to address that in our commission reports. At the same time, we do not want to be in a position of saying that until we cure poverty, there is no point in giving condoms to school kids or operating a bleach distribution program because the chances of reducing HIV transmission through immediate direct action programs are still quite great. And that we can't ignore the need for those programs, some of which are running out of funding

while we tackle the bigger issues.

But, Bob, if I could perhaps summarize your comments on poverty by saying that the study of economics and the study of sociology should receive equal funding within National Institute of Drug Abuse, National Institute of Mental Health, as the study of neurotransmitters, which I do not think is the case right now.

CHAIRMAN OSBORN: Thank you. I think that's a very helpful summary and perhaps a good place to take a break. I want to thank the panel for very powerful testimony which we must appreciate your giving us. I'd like to ask the unreasonable, which is that we try to make it a 15 minute break since we are running quite tight on the schedule.

(Whereupon, a short break was taken.)

CHAIRMAN OSBORN: My 20 minute break didn't work, but nonetheless, we shall try to keep going in an orderly fashion. I think that Yolanda Serrano and Yvette aren't here at the moment, but I would like to ask Dave Purchase and Sandra Vining-Bethea to join us at the witness table and perhaps we will locate the others and have them join you if you don't mind a little bit of shifting around. I guess, Sandra, do you want to go first and then Dave. Welcome, and

thank you for joining us on a terribly important topic on a rather tense day.

MS. VINING-BETHEA: Thank you for having me. I'm Sandra Vining from the Bridgeport Women's Project.

CHAIRMAN OSBORN: You may need to lean into the microphone just a little bit more, and Dave, I'm sorry. I should have warned all the witnesses, you now have joined a distinguished group of people who have soaked themselves with those water pitchers.

(Laughter.)

CHAIRMAN OSBORN: Thank you. If you can move in on the microphone just a little bit more. Thanks.

MS. VINING-BETHEA: The Bridgeport Women's Project was funded by the National Institute of Drug Abuse, a research, prevention and education. I come from a little different area because the research, I know is very important as far as getting funds, but when it comes to dealing with people in the streets and my population there, IVDUs, sexual partners of the IVDUs and prostitutes, better known as women in the sex industry. I think what I really wanted to talk about today is my topic was reaching people not in treatment, and predominantly that's all my population has been due to

the fact that you have to have accessible treatment programs to get them into.

I'm a little confused as to why we keep setting up these types of programs to work towards helping people when we're not working from the bottom up, and the bottom up to me first is to have the available stuff that's needed in order to service their needs. The women I'm working with that are street girls, you do get them in, but what I've found in the last three and a half, four years, is to educate them I need to take care of some of the basic needs. I missed some of the program this morning, but I heard something as far as the housing issues. When I left yesterday my program, I had 12 women that are full-blown AIDS with nowhere to live. I've called everywhere that I can call to try to obtain housing for them.

So trying to get them housing and to deal with their drug problem at the same time, I think the housing issue was the first one on the list because until I can find a place for these women to live, I can't even begin to deal with treatment issues. Then I also try to get a woman in treatment on Monday, and because she's been shooting dope for 15 years but she has never been arrested, I could not get her

in the program because I couldn't document. There was no documentation that she was an IV drug abuser. So what I ended up doing was going into the streets and getting IV drug abusers who shot drugs with her to sign affidavits to get her in treatment.

Then I have the woman who comes to my program who wants to be clean, so she comes everyday for two weeks. She comes and she spends every night at my home so she doesn't go back into the belly of the beast, and I get her finally after three months accessing, trying to get her in the program, I get her there. They don't take her because now she don't have no dope in her system. So when you talk about, I mean I have a lot of things I would really like to talk about, but you all have geared me to one topic and that's reaching people not in treatment.

Why aren't they in treatment has a lot of reasons why these individuals who want to make change. I'm into treatment on demand. And I think it's something if we are going to combat the problem, we need to deal with what the real issues are. Then I'd also like to talk about the issues as far as the street girls, and it covers a large array of things. My girls, according to my invoices, which speak for

themselves, I give out plenty of condoms, but then I have johns who live in the suburbs, who by the way I ran checks on their license plate numbers to find out who they are, where they are, and just how deep is this problem, when we're talking about the spread of this virus.

So once I found the information that I wanted to obtain, now we need some kind of treatment for these gentlemen to educate them. So we're coming into it. We're dealing from the street level. We're talking about the drug abuser and trying to get them into treatment. There aren't any treatments available. Women -- my program has just been impregnated to the Bridgeport Women and Men's Project because I could not obtain funds for women. So I think the treatment issues are a lot of issues, and the issue I really talk about is, yes, I go in the shooting galleries. I work in the crack houses. I go to the brothels, if I may.

And I work anywhere that someone is in need of help, but what I'm finding is that my girls are dying rapidly. I've buried 167 women in a matter of a year and a half. I look at the statistics and the numbers that come in on my desk which make me sick because they're not telling the story. And if we're going to make change based off of

numbers, then we are going to once again be right where we started, ten years behind, and we're already behind. Then I have an issue dealing with street girls that are 13 and 14 years old, who are crack addicted.

I can't even begin to get any kind of service or treatment for them. You can't get them tested without parental consent. But then once we test them, and we find out that they are HIV positive, we don't even have a program for the babies. When I say babies, I'm talking about any of God's children who are not capable of taking care of themselves. So treatment issues, to me, are reaching people not in treatment. This is what I've been doing for quite awhile, and I only got six minutes, but I got about 60 days of stuff that I'd like to tell everyone on here, and I hope I get the opportunity to come back and speak to you again.

But if it's anyone's power sitting in this room, and it's your duty, and I say duty because we've been charged with saving people's lives, and if we're going to go through the motion, because that's what they tell me that I'm doing for them -- Sandy, you keep going through the motion. Everyday I cry. I cry often. And I think until, and I'm sorry I have to be here and sit here and say this, but until

this hits home more and more, and I'd like you to know it's hitting home more and more, when I say that it's not just a minority problem.

It's not just happening in the ghetto. I am meeting women on 95, if anyone knows, that's Interstate 95, the Connecticut throughway, I'm meeting women from Greenwich, Westport, Weston, Georgetown, who will not go to their doctors in their areas, who are well-to-do women, whose husbands have infected them, and they need treatment. We need all kind of treatment. We need to deal with this issue as it's happening. We need to look at it for what it is. And we're not doing that.

And I don't know why we're not. And I can't even get into it's about the money because, see, when it comes to getting money, we get money for everything else we need in this world. But when it comes to saving life, it seems that now everyone is having a problem with it. What I'm having a problem with in the state of Connecticut, matter of fact, Bridgeport, Connecticut, if everyone is up on it, was going to go into bankruptcy.

We get no money from anywhere. I speak all over the country, and I donate my money to the Bridgeport Women's

Project so that I can bury my women. So I'm here today because I was invited, and I'm happy to be here. And I'm sorry what's going on in the world, but we're having more than just a war in the Middle East. We are having a war that's going on in everybody's neighborhood, and it's getting closer and closer to home. So I think that we need to go ahead and do what is we have to do because you already know what you got to do. I ask the gentleman when I came in here what are we talking about now? When are we going to start doing and taking the research, taking all the agendas that have been made, putting them together, and coming up with a solution, and dealing with the problem?

And if you want to go back into it, then we need to start from the bottom up, and we need to start thinking about what are we going to do about the children who are going to be homeless. We need to think about the babies that are HIV infected, which I have quite a few of them. So if anybody would like to donate Pampers, I'll leave my address. We need to think about the issues of the basic needs that we need to do because we can't get them in treatment until we take care of their basic needs. It's hard to educate a woman who is homeless and hungry. That's what I have to say.

CHAIRMAN OSBORN: Thank you ever so much.

MR. PURCHASE: Some third rate generalissimo puts his UA in our collective gas tank, and we are immediately willing to spend billions of dollars, risk the lives of thousands and thousands of men and women and children, in order to turn the country of Iraq into waffle, and there is no doubt in my mind but with the money that we have spent in the last 16-1/2 hours to destroy things, regrettably, but perhaps rightly so, I could provide what cannot be provided at the present time to the vast majority of the population of the United States, the simple, effective and inexpensive tools to prevent the spread of that damn virus.

And those are condoms and sterile syringes and bleach. The idea that the federal government in its wisdom should prohibit the spread of bleach to me is absolutely inexcusable. The needle exchange program in Tacoma will be looking at three years in August of this year. So we're two and a half plus years old. We grew quite rapidly and much to the credit of local political and health department leaders in Tacoma, we are presumably successful.

At the present time, and/or by the fourth of next month, when we move into a storefront, we have two vans at

our disposal, which are used at both for roving outreach and AIDS prevention as well as fixed sites on the street that are advertised to our customers, we hope to have in the new storefront a medical exam room where we can do some, hopefully, OB-GYN work with folks on the street as well as hopefully some basic medical treatment, we do, and we have for a couple of years provided food because they're hungry, clothing because they're cold, TB testing, HIV testing, STD testing. There was one other medical thing I can't remember. I forget sometimes what we do. One of the first things that we became was the largest referral source to treatment in our county.

It's estimated in Tacoma-Pierce county area, and I don't know how they figure this sort of stuff out, but that we have about 3,000 people who are injecting drugs, and we refer, just the needle exchange site, just Point Defiance, we refer 30 to 40 a month to treatment. That's going to stop because we filled up the treatment spots. We have research starting in September of '88 and ongoing. And the results from our research are essentially the same from research in the United States, in Canada, in Europe, in New Zealand, in Australia. Don knows this much better than I do, but essentially there is no scientific medical epidemiological

reason why syringe exchange programs should not be part of AIDS prevention effort in every appropriate community in this world.

That being the case, why don't we have that? They're not expensive. The one in Tacoma costs approximately, if we consider all the funding, about $130,000 a year. It costs 25 to $40,000 in Pierce County to treat one person with AIDS. We have 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. Or their behavior prior to using the exchange. You know, pick a number. We stopped the spread of the virum five times in a week, five times in two weeks, five times in a month, whatever that number is. The rest of the time, in effect, we create financial resources for our county.

If the situation with AIDS, in general, and specifically with syringe exchange programs was a question of fact versus lack of information, then I wouldn't be here today. Sandy wouldn't be here. You folks might not even have to meet. Some of you know better than what the government is doing at the present time. I appreciate your ability to serve on one of its commissions and still put up with its

idiocy. And I'm accustomed to governments and committees being silly on occasion. I mean after all we are human beings. We make mistakes. But these mistakes are being made about the lives and deaths of our children. And they are not excusable.

What we have instead of information against a lack of information is we have fact against belief systems. And that kind of conversation is one of the most difficult that human beings can have. If I tell you that's a 14 foot wall, and you say, no, that's an 18 foot wall, and we can argue about what believe about how high the wall is until one of us chooses to measure the wall. Now once we measure the wall, and we find out you're right, it's 18 feet, and I persist in my belief that it's 14 feet, for whatever inner fear I have of the truth, what the hell are you going to do with me?

Now, we have, it seems to me, perhaps three groups. We have those folks who are "Helms'ed" into a belief system which has nothing to do with the reality of the human condition and, in fact, might be generated by much darker motives than they profess in order to prevent the spread of prevention of the virus. And they, given information, and knowing that they have the accurate information, people like

that, if they persist in their resistance ought to be charged with manslaughter.

We have other folks who see gain in the continued, in a sense, mythology of the war on drugs, a $7.5 billion popgun against a $250 billion cannon. And perpetuate among perhaps 80 percent of the population where the reality of the problem of drugs does not strike them directly, and they get their information second-hand, in stirring, in a sense, hysterical response to the problem of a very severe illness, compulsion disease, pick a word for it, in this country.

And we have the recipients of all of this misinformation. If the country is like the place where I come from, and I have no reason to believe that it isn't, then given the opportunity, the public will make just decisions. And within four months in the Tacoma-Pierce County area, a certified research poll -- I'm told it was scientifically accurate, showed that we had a 68 percent approval rate across age, ethnicity, and culture and economics, et cetera, for the work that we were doing there.

I would like to see us nationalize that kind of education, and if there is a small number of people who still persist in their belief, who do not have dark motives, as it

were, but persist in their belief, I think we should let them go their flat earth society meetings and let the rest of us get on with the act of saving life. Thank you.

CHAIRMAN OSBORN: Thank you very much, Dave. I think Yolanda Serrano and Yvette are here now, and I wonder if you'd like to come and join the others at the table. And once we've had a chance to hear from you, get an opportunity to interact with everyone. Thank you for joining us, and I hope you didn't mind that we went ahead in order to use our time best. We're on a one microphone diet today. So take turns.

MR. SERRANO: Hello, everybody. I'm sorry. I apologize for arriving late. I've brought Yvette with me, and she'll present her testimony right after I speak on some of the issues. Thank you again for inviting me to speak to you today. The HIV epidemic among current and former drug users, their sexual partners, and their children is widening. IV drug use is the direct or indirect cause of the majority of cases among people of color, most cases of AIDS among women, and virtually all cases among children. Today, I would like to cover a few issues which are critical to the survival of the substance abuse population.

First and foremost is that the majority of drug users are not in drug treatment nor are they being reached. Drug abuse treatment is available to just a fraction of those who need treatment. The existing system does not have the resources or capacity to cope with the impact of HIV at the current time. Most are struggling in the streets, in the subways, in the transportation terminals and many are in our hospitals because there is no place to discharge them to.

These people have fallen between the cracks. Their addiction is not being treated, and they are not being protected from HIV. Everyday I witness the anguish, destitution, homelessness, hopelessness, and death in our community. We return day after day to the battle where we have no ammunition and no battlefield in which to stand.

There is an unwillingness to try to save the lives of drug users, but they are not dying alone. They are not dying by themselves. Every time we speak about a drug user, whether male or female, we are dealing with the whole family. Drug addiction is a family disorder, sometimes spanning three generations. Clearly, the prevention and education efforts that specifically targeted to substance abusers are underfunded and inadequate to meet the ever increasing needs.

There is a public complacency about the AIDS epidemic because it is happening to others.

Some people believe AIDS is the cure, not the problem, a dangerous thought. There are many barriers to services which substance abusers encounter such as the lack of drug treatment, the waiting list, the payment for treatment, the not-in-my-backyard syndrome, homelessness, lack of health care, crack use, being a mentally ill chemical abuser, not recognizing relapse as a part of recovery, the increasing use of the heroin users using crack and crack users using heroin. 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. The emergency has been amply documented, and we must make this process easier. We must work on an

emergency basis, not as if we have all the time in the world. We don't. The most important thing to keep in mind is that the vast majority of AIDS cases have not yet been identified.

Not acting now will lead to greater cost and suffering later. It is now possible to delay the onset of HIV related illnesses and to treat those illnesses. However, people must have access to health care, and our population does not. There is convincing evidence that strategies such as outreach programs to drug users and their sex partners can prevent HIV transmission. There are innovative ways that can be used to stop the further spread of AIDS.

Two of them are the needle exchange program and bleach distribution. There has been neglect and the end result is that the drug using community is being devastated. There are hundreds of thousands of neighborhoods where the virus is spreading at alarming rates very quietly. The substance abuse community is not expandable to this nation. Any barrier which stands in the way of reaching substance abusers, their families and the community at large must be eliminated. At this time, I want to present Yvette. Yvette is a person I have been working with in a Williamsburg-Brooklyn, who has been attempting to change her life. She

will talk to you about why she has not been able, and thank you.

YVETTE: Hello. My name is Yvette Cruz. I'm 24 years of age. I started using drugs at 19 years of age when my husband introduced my to drugs. I began snorting heroin. They I started using intravenously. I have used drugs steady for the past five years due to the disease of addiction and because of waiting lists, I was forced to work the streets, which was the beginning of hell for me which I have not been able to get out of. I still work the streets to support also $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 for further HIV infection, sexually transmitted diseases, and rape or death.

I have been raped twice. Last week I had a gun put to my head and my leather coat was taken by a date. It is a truly dangerous and humiliating existence I endure to not being able to secure proper treatment. What I want to tell you is that if I have 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. Someone failed to protect me along the way. Someone failed to

protect my friend Sheila, and now she is dead.

What you would have seen on the film is real. This is my everyday existence except worse. This is what happens everyday is where me, my friends go because there is nowhere else to go. There is no programs for us. The program ADAPT in Williamsburg was terminated due to the lack of funding, and no one seems to care whether we live or die. There are thousands of us who are dying, both men and women, and your cities are filled with people like me who are suffering from the disease of addiction.

The loss of my mother, the loss of my three children, the lack of services has left me with a wish for death. I do not care if I live or die, but I do not have the nerve to kill myself so I am doing it slowly. But then I think I want to live. And I want to stop using drugs, but I need someone to care for me. Right now I have known for two years that I am HIV. Fortunately, I have not gotten sick. A problem is that because I do not have the full-blown AIDS I cannot gradually, I mean qualify for benefits nor early intervention treatments. Let me conclude by begging you to immediately address the needs of active drug users who are dying without help. Please help us. Thank you.

CHAIRMAN OSBORN: Yvette, thank you very much for your courage. It's hard to talk to such a huge group in a big room, but we very much appreciate getting to know about the concern you have for everybody in your situations. Thank you. Harlon.

MR. DALTON: Yvette, I know that's hard. Everything about it is it's hard. It's hard to come in this room and say I still work the streets and try to imagine what's in people's heads. It's really important for us to hear that. It's important for us to have an answer to people who say why don't folks go in treatment? Why don't they do this? If they just had some backbone -- you know all the stuff.

YVETTE: Yes.

MR. DALTON: And we need to be able to respond to that. And you've been just enormously helpful to us. Your friend Sheila would be incredibly proud of you. I'm proud of you. I want to say the same thing to Sandra that, you know, you talked about why aren't people in treatment. That's important for us. And you started to give us some stories, some of which have to do with just the screwiness of the rules in terms of treatment programs. I mean we know something about waiting lists, but there's a lot of other

nonsense like proving that you have been shooting drugs for "x" period of time, or if your system is clean, you can't get in. All that is stuff that we need to know and to be able to lay out to respond to all those folks who say, well, listen, if these people cared about themselves, they'd do something differently.

So it's really helpful, and I'm really glad you did what you did, Yvette, and Sandy, I was hoping that you would just take a tape recorder because I know it's hard to find time to write and just spend about a half an hour just kind of answering the question of why aren't people like Yvette in treatment from your own experience on the stroll in Bridgeport.

I also want to say -- you said sort of casually that the Bridgeport Women's Project has now become the Bridgeport Women's and Men's Project because you couldn't get funding. And I mean there is something criminal about that, that one of the few NIDA or government funded projects in this country that are focusing on women and, in particular, women sex workers, can't, I mean has to become a women's and men's project. What's that going to do with the focus of that project because of lack of funding? So I just wanted to

underscore that.

MS. VINING-BETHEA: I think what we really needed to hear behind that is due to the fact that research is such an important fact for our funds to come into areas, but they come in, and they abuse people. They set them up, again, for the let-down. You start a program. It works. We were a demonstration. We became the model. How do you take a model? How do you take something that came from the ground up and worked when now they're studying us as to why did our program work versus traditional aftercare programs? I mean give me a break. I'm what the study is about. It worked because people care, and when you care, when it's not about making money. That's why we are at war today. It's about money.

It's not about lies. And this is what needs to be heard. And people look at it -- okay -- she's shooting drugs so, therefore, she brought this on herself. But let's look at the conditions. We don't never look back. We look into the moment. We have to go back and look at why people's lives end up where they're at.

I'm recovering. You know it's like people say, oh, Sandy, you made it, don't tell no one else. No. I'm going

to tell the world. I am her. Yes, I pulled myself up, and so can she pull herself up if we stop closing the door. So now when research leaves, you know, we left, them 2500 women that I reached. That's who you leave, and what do they go back to? And the mike is not working.

(Laughter.)

DR. KONIGSBERG: I'd like to come back to the issue of needle exchange. To Mr. Purchase, the question would be how and why did needle exchange quote "sell" in Tacoma, and Yolanda, nice to see you again, how and why did needle exchange seem to fail in New York City? Or at least it's the perception. I know there's a real contrast on this.

MR. SERRANO: Well, we don't feel it failed in New York City. It was closed because it was sort of like a campaign promise that it would be closed. I believe that if you took one or 100 people who are HIV positive and through the needle exchange people place them in drug treatment program, it became a bridge to treatment, another way of putting people, getting people help that they weren't getting before.

So the needle exchange program was evaluated after ten months, and basically it was found to be successful. It

was in an inappropriate place. It should have been in a community setting. It was a very limited amount of people that were involved, about 300 people, and it needs to be at a community setting, and it needs to be reopened again, and the issue is not dead in New York. We just have a lot of other fiscal things that are going on, but the issue is being pressed. And the needle exchange is ongoing underground by other groups in New York City. We're hoping that the Mayor and the Commissioner will reconsider it again.

MR. PURCHASE: Usually the short version I give about why Tacoma is why not Tacoma, you know, and the real question is why did it happen like it did in New York, why isn't there one in Tulsa and New Orleans? Why aren't there 10,000 other people like ourselves working at it? I mean you can find plenty of us. You just can't find the money to pay us.

But also, the director of the health department declared AIDS the number one health emergency four or five or six years ago now, I guess. Our health department is jointly operated by the city and the county, and since it's one of the largest budgetary items for both the city and the county, the mayor and the county executive and a member of the county

council and a member of the city council sit on the health department board. And as a consequence were AIDS educated.

The person who is currently chief of police, whose first response when he was told that I was going to go out on the street said don't we have one of those already, was also AIDS educated and had been our sheriff prior to that, and had a tremendous community health program with the number of syringes on the street, the refusal of the sanitation and everyone else to pick up the syringes. His harness officers were out with heavy leather gloves and stick boxes. There's now 200,000 plus syringes in Tacoma that were not that thrown away on the street, which have been disposed of in a medically appropriate way.

So there's that background. There's the fact that the chief chose not to arrest me so instead of having a media event that lasted 24 hours and using the trial as an education experience, we were able to continue. Don showed up in three weeks, I think it was. Holly Hagen who is our epidemiologist began the studies then, and so since we were able to continue to exist and since there isn't any inherent flaw in what Don first called user friendly outreach and syringe exchange programs, that they are not in and of themselves a media

event, but are medically appropriate, you know, we were able to prove -- we were given the opportunity to prove that what we said we would do we did.

I mean at the risk of sounding -- what's that -- melomania, I mean, you know, truth is on our side. It's as simple as that.

CHAIRMAN OSBORN: Let me make one comment of my own just before we finish, Sandy, something that I thought deserved an answer because it was a very appropriate thing to have said. Why another meeting? Why yet one more discussion when we're not doing the basic things we know about? And there is an answer to that. We are trying to keep this issue up there and not that one can promise that keeping it up there we'll do better, but letting it get down here for sure won't. So I was particularly sympathetic to your comment. It must be very frustrating to be asked one more time to give as much power of yourself as you did in your testimony and the same to Yolanda and Dave, Yvette particularly, and yet, as Harlon said, you do help us greatly. I think we all feed on each other's energies in times like this, but in particular, you give us just yet more insight and to keep us motivated.

Don, do you want to comment?

DR. DES JARLAIS: Again, I think I speak for the commission in saying we are very grateful for all of you coming here, and following up a little on June's comment of why meetings now, why another meeting? One of the particular things that we are concerned about in the AIDS epidemic is the relationship between research and delivery of services. That there have been a number of areas where AIDS services occurred only because there was research money. I mean that's certainly true for outreach including bleach distribution, for building bridges into treatment. It should have been true for needle exchange, but the federal government decided not to fund research on syringe exchanges, and it's been particularly true for treatment for HIV infection that much of the actual provision of antiviral treatment has come through research projects.

And now we are reaching a critical state in research both through outreach to people not in treatment and for the delivery of antiviral treatments where we know some things work. So that the research justification is being reduced. But we don't have a system in place for getting those outreach services, for getting people into treatment,

for getting a variety of antivirals to people once the demonstration projects lose their money. And that is really one of the critical issues that this commission is going to be looking at, and we greatly appreciate your contributions on this. Thank you.

CHAIRMAN OSBORN: Thanks very much. Before we all disperse, I have been concerned about the afternoon program, given that the commission is reduced in numbers due to illness of a couple of members and absence of a couple for important reasons that if we had people with early planes, we might end up seeming disinterested, which is not true. But because I'd like the maximum number of commissions to get the maximum benefit out of very important witnesses this afternoon, I have asked Maureen to see if we could move things up a bit.

Do you want to give a revised schedule that everybody who wants to be listening on all sides of the table can know about it?

MS. BYRNES: The plan at this point would be to come back at 1:30 instead of 2:00 o'clock. I think, in fact, that's a little ambitious given that we're usually off a couple of minutes. But if we could plan to try to reconvene

at 1:30, I think we'll have most of the testifiers for that panel and anyone who is not here, we can certainly accommodate as they come on in since we'll be starting a little earlier than we had indicated to them.

Then I think to be perfectly frank, we need to play the rest of the afternoon by ear. I don't know how many of the 3:15 panelists will be here prior to that time. But what we'll try to do is do as much as we can early on because I know some people have made the commitment to try to stay with us through the day to hear other people testify and to take some time to share with us as a group some of what you've heard, some of what you've come to share, and some of the things that we need to very concretely walk away with when we end our meeting today. So to some degree we're also trying to provide that summary discussion time that was left on the agenda, and I really think I'll need to sort of get back to you after the first panel after lunch to see where we are on timing.

As usual, that's a somewhat complicated announcement from Maureen Byrnes, but the bottom line is 1:30 after lunch, and lunch has been arranged for the commissioners at the hotel that you're staying in. For those of you who are from

out of town, many of us ate at a Chinese restaurant across the street yesterday which was quite lovely and relatively affordable, and there is a cafeteria, I believe, on the fifth floor in this building, if you choose to say in here. Some may obviously be looking for TV sets and radio stations and other things during the lunch break. We'll be happy to help you if you need any other assistance.

(Whereupon, at 12:15 p.m., the meeting recessed, to reconvene at 1:35 p.m., this same day.)

A F T E R N O O N S E S S I O N

CHAIRMAN OSBORN: Thank you very much. I'm grateful to you for having adjusted your schedules so we can get started a little earlier to be sure that we take full advantage of the talented witnesses that are going to be with us this afternoon and those who have stayed from the morning. Could I ask the next panel on Availability of Drug Treatment: Meeting the Demand to join us at the table there. And I'll make my morning's apology that since the government is shrinking in all sort of other ways, we are also shrunk to one microphone so you'll have to share a little bit, in the spirit of the '90s.

I am told that the order of speaking, if you can do that, is Dr. Robert Newman, who is President of Beth Israel Medical Center in New York; Mr. David Mulligan, Commissioner of Public Health for the State of Massachusetts; Ms. Ann Thompson, Durham, North Carolina; and Dr. James Sorensen, Chief of Substance Abuse Services, San Francisco General Hospital and Substance Abuse Services for San Francisco, California. And welcome to you all, and Bob, thank you for starting off for us. Good to see you.

DR. NEWMAN: Thank you very much. It's a great

privilege to participate in these very, very important and serious deliberations. I have had the honor of appearing in testimony and giving testimony before various committees that a number of the commissioners participated in and as you will know, I'm really a one issue person, and for years my theme has been that there absolutely has to be treatment on demand for every single addict who wants it.

For somebody who has only one issue, it's a little bit frustrating when suddenly there seems to be a consensus agreeing with that position. I think I will have to find something else to proselytize, but the fact of the matter is that today a wide variety of different observers have, in fact, embraced the concept of treatment of demand. It really started, I guess, about three years ago with a series of New York Times editorials strongly advocating massive expansion of treatment. More recently, the Presidential Commission on AIDS, as I believe it's very first recommendation, urged very strongly that treatment be available on request to everybody who seeks it, to every addict who seeks it.

More recently, the Congressional Committee on Government Operations embraced exactly the same principle, Senators Moynihan, D'Amato. Governor Cuomo just two weeks ago

in the State of the State Message in New York also endorsed this. I guess I should feel happy. The problem is I don't because even though everybody seems to agree that treatment on demand is a necessity, there seems to be nothing, as far as I can tell, to indicate that any government agency either at the federal or at any of the 50 state levels is indeed pursuing the objective or expansion on a massive scale to make treatment for addicts who want it readily available.

Just briefly I would contrast the lack of pursuit of a goal, treatment expansion at the federal level, with the stated goals and what has been indicated would be done to meet the goal with regard to prison capacity expansion. 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.

This is even though we know that our country has the dubious distinction of incarcerating more of its citizens than I believe any other country in the entire world. Contrast those very specific and massive goals with what was

said in that strategy report with regard to treatment, the treatment. It was proposed that $100 million, $100 million, be added for treatment expansion to allow 11,000, 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.

So I think what is being proposed by the federal government is just totally out of context with what the nature and what the extent of the problem is. It's possible that some people feel that treatment on demand is a lofty goal, but simply is too costly or too difficult to achieve, and I would like to impress upon the commission that, in fact, that type of skepticism is not called for. 20 years ago in New York City, in a period of just over two years, the overall addiction treatment capacity was raised from 12,450 to 52,780, an increase of 40,000 filled addiction treatment slots in New York City alone in the course of just two years.

Significantly, the expansion was across all modalities. Methadone expanded in this two year period from 6,600 to 32,000, two years period. At the time I operated a

program for the New York City Health Department which within 24 months grew from zero patients to well over 10,000 patients. We utilized hospital facilities, health care facilities. At one point I had the distinction of being the captain of a de-commissioned Staten Island ferry boat on which we treated 1,000 patients alone.

I think that experience in New York City 20 years ago clearly indicates what can be done and what I feel must be done. What I would urge this commission to consider is requesting from the relevant federal and state government agencies who are charged with a responsibility for drug abuse control to enunciate their targets, their goals, what do they expect to accomplish, how do the expect to accomplish it, in what time frame, with regard to addiction treatment expansion, to move toward a goal that clearly is embraced very, very widely now as absolutely indispensable in dealing with the related problems of AIDS and drug abuse. We know that a tremendous amount can be done.

Government at all levels has to be held accountable for laying out their plans for what they will do in the next 12 months, 24 months, and then commissions such as this, congressional and state legislative bodies, and the public at

large can first of all decide whether the targeted goals are adequate, and secondly, maintain monitoring to see that those goals are met. I thank you very much, and I'd be delighted to answer any questions you might have.

CHAIRMAN OSBORN: Thank you very much, Bob. I have to interrupt because you didn't give your best line, and I must. About three years ago when the Presidential Commission, Admiral Watkins came out with his statement about that, I happen to have been in a meeting where Bob Newman was to be the first speaker. He walked in with The New York Times and held it up and showed that the front page headline was what he was to have given his whole speech about. And he made reference to himself as a single issue person, and said I feel like a puppy dog who had spent his entire life chasing cars and suddenly caught one.

(Laughter.)

CHAIRMAN OSBORN: So thank you very much, and I appreciate the brevity of your comments, not because we don't want to hear more from you but because we want to have a chance to interact, and that is something that we thoroughly enjoy when we have experienced witnesses with us. Mr. Mulligan.

MR. MULLIGAN: I'm Dave Mulligan. I'm Commissioner of Public Health in Massachusetts. I'm just going to give you some bullet-like thoughts, too, and then hopefully we can have a discussion on them. I was here this morning, and I can't help but start commenting on this issue that came up about socioeconomic status and poverty and how much do we focus on that versus how much do we focus on treatment expansion itself.

In the past year, I've spent a good deal of my time working on the infant mortality issue. One of the major things we've done is expand the number of prenatal sessions and improved adequacy of prenatal care. And I think we've done that with such intensity in the state that everyone is now going to be looking to see terrific improvement in infant mortality rates. I don't think we're going to see that, and I think the reason is that while prenatal care and adequacy of it is really important for all women, that in and of itself, if one doesn't address teen pregnancy, nutritional issues, inadequate housing, homelessness, we are not going to see a lot of movement in the rate.

And I think as we talk about drug addiction that that same balance has to be achieved. If we approach this

only from a technical perspective and try to improve treatment, and even make treatment available to all people but don't look at some of these social issues that Dr. Fullilove talked about this morning, I think that while we will help many individuals, we may not see an overall improvement in the climate.

And I think it's very important to balance all of those things because we find hardcore addiction in lower income groups, more of it in communities of color. A lot of that is related to opportunity in those communities, to socioeconomic status. I think we will do a disservice to the larger picture if we don't comment on that. In terms of treatment on demand, we have a treatment on demand rally in Massachusetts each year. Larry Kessler, who's there, and I, we've marched in it, I think, for the past two or three years.

I am a total advocate of it, and I think publicly we should speak on behalf of treatment on demand. I think we also have to be realistic. We got the number of IV drug users in Massachusetts in care from, I think, 6,085 to just about 16,000 in '89. Last year we lost 1,000. I think this year we're probably going to lose 1,000. The economy in the Northeast is suffering. We're going to spend a lot of

dollars on this war that was begun yesterday, and I think we should publicly fight as hard as we can for it.

But I think with realism I'm seeing things go the other way. And I think that forces us to look at what we have and using what we have in the wisest possible way. I think strategies like getting beyond these silly fights between drug-free and methadone programs. I think within the methadone programs, all kinds of strategies that will make it readily available and user friendly, we've gone from seven to 25 sites largely using vans. We could try to doing it in emergency rooms, but I think that we need to find ways to expand what we have.

I think also we must look beyond just the treatment strategies and other things that are user friendly for addicts at any moment in time. The bleach programs, the outreach, condom distribution programs, the needle exchange programs in some areas have been successful. I think we need to move in those directions. We've started some acupuncture programs and one thing about those is they're instantly available everyday for anyone who wants them. We've begun several in the inner city. Acupuncture may not be the response for every person, but it can buy you time to get

them the kind of slot that they need. So I guess I would recommend multiple strategies.

One of the major problems we're having in our programs is just the dearth of single room occupancy housing and the drying up of low income housing markets. It has tremendous influence on our addicts because when they graduate from our programs, those are frequently the kinds of places that we need. So I think working with other people, I think some of the comments this morning to get beyond kind of a single treatment focus and to look at the band of issues that our clients are going to need if we're going to respond to their problems well.

Government money is going to be tight. We've experimented in Massachusetts recently with the determination of need process where we've been granting some capital projects but with conditions that people make one and two percent commitments of the project to low income projects. The two kinds of projects we're focused on are infant mortality and AIDS projects, and we're getting into one or two that will do some substance abuse work.

So there might be a way to leverage people who ordinarily don't contribute to these kinds of issues directly

to contribute in new ways. The last point I'd make is on corrections and I couldn't agree more with Bob Newman's comments. We're incarcerating people at a greater rate than any nation in the world. We incarcerate blacks at a higher rate than South Africa.

And I think that national strategy must be looked at. There was an excellent article in last week's paper that was picked up, I think, from a New York paper, where in 1980, 70 percent of the people incarcerated were incarcerated for violent crimes. That's only 50 percent today. And I think that we need to rethink that strategy and think more in terms of rehabilitative strategies than punitive ones. We are spending money on addiction. We're spending it in the courts. We're spending it in jails. And I think we need to speak out a bit more of reprogramming some of the money we're spending in order that it truly might be helpful to people. So those are brief comments, and hopefully they will lead the way to some discussion.

MS. THOMPSON: My name is Ann Thompson. I'm from Durham, North Carolina. I'm a recovering heroin addict. I've known that I am HIV positive for four years. I've been clean and sober for three years. I've been to treatment

seven or eight times. I lost track after awhile. But the way the situation is in North Carolina today is that there are several corporate run treatment centers, and if you don't have insurance, you can forget about going there.

And the problem is there are always one or two indigent beds, but needless to say they are kept filled. And even if the addict is persistent in wanting treatment, their options are definitely limited. There was one therapeutic community in Greensboro which has closed down. I don't know what the reasons were for that. But the whole situation looks pretty bleak, and for the people who are HIV positive and know that they are HIV positive, they have even less options. I'm not saying that they will be turned away from the treatment centers. That's not true. However, there are several halfway houses that will not take you if you're HIV positive.

There's no transitional housing. And see if you lie about it -- I just don't think that starting in recovery with carrying around a lie is going to lead to successful recovery Having to live the lie of your medical situation in order to have a place to live. My heart went out to the young girl that was up here seeming so distress, and I've

been where she was. And I've been homeless, and I lost my children, and my husband died of a heroin overdose when I had six months clean, but I rose above it somehow. I'm involved in the 12-step program, and I was surprised I hadn't heard anything about that today because that is definitely growing and has been very successful.

In North Carolina, in Narcotics Anonymous, they do not talk about AIDS. It is considered an outside issue. I would imagine once people start dying from it which there's only been one person I know of so far. So that's not quite enough to make a difference unfortunately. But, you know, people are recovering today, and I've been on methadone. My feelings about methadone are completely, totally mixed. I see no point in putting anyone on long-term maintenance, but I do think that methadone is a powerful, powerful tool to get the addict to do what you want them to do.

One of the reasons that I got clean is because they told me that I would never be on methadone in the State of North Carolina, and I really wasn't in the mood to move. So I had to take a look at that. And the way they have the testing set up now in the methadone clinics is if you get tested in a methadone clinic, it will be reported. So

obviously no one is getting tested, and I think that's a crime because, you know, here are people that the chances that they're HIV positive are real good. And they're not going to get tested because they don't want their anonymity broken.

And there are some certain elected officials, one in particular, in North Carolina that's making this whole situation a lot worse. You know for me I don't need treatment today, but some day I might, you know. I only have today. I might be out shooting dope tomorrow. I don't know. And it scares me. And I've worked hard to get where I am, and I own my own home today, and I'm planning on going to law school, and I'm trying to live my life. But if I get sick, I'm going to lose all of it because I have no insurance.

And that's a real scary thought. And if I relapse, and I have to go back into treatment, I don't know what my options are today. So that's why I just think that I'm going to use today, and I don't need to worry about that. But, you know, these are fears that I have, and I just don't see anything -- it just seems to be getting worse. North Carolina is going to lose anonymous testing and it's just terrible the way things are working out. I think the main

thing is that we need halfway houses, transitional housing for people who are trying to recover.

As far as the needle exchange program goes, and promoting drug use, drug addicts are going to shoot dope whether they have a clean needle or not. And, you know, if you can provide them with clean syringes that's wonderful and people will use them, but it's not going to promote the use of drugs. It's not even an issue, and the other thing about the bleach is I think it's a good thing to have bleach, but if it comes down a sick addict getting ready to do dope with a dirty needle, it takes two minutes to clean out a set of works, and they're not going to take that time to do that.

And it's not a cure all/end all solution by any means, but for the addict who does have the time, it's good that he would have the bleach to do so. You know I'm glad to be here today to show you that, you know, that there are real live heroin addicts walking around that aren't shooting dope today, and there is some hope in this whole fight, and if I can just carry the message of recovery and walk the walk of a responsible productive member in society, maybe someone else can see me do that and try to follow in my footsteps. Thank you.

That coupled with this mounting epidemic just makes these programs very ripe for burnout. At our treatment program before AIDS, we would have one or two deaths a year among our patients. Last year we had 13 deaths a year. So it's frustrating in that way. These drug treatment programs, I guess I wanted to make four points. One of them was simply that the burden is difficult on programs. A second one is that these programs can be good, I think, in two ways. Part of the drive seems to be to get people in treatment with the idea that if they're in treatment, it will have direct effects on their needle use. And I think that's a very good effort. The other thing, though, is the indirect effects of drug treatment programs can be very good if they're of high quality.

At our own program, we've tried to use the methadone maintenance clinic as a platform for offering medical services, and I'm very glad to see you're talking about these primary medical care issues later today. A third point I wanted to make was simply a little bit about how methadone maintenance, in particular, can be useful in coping with HIV disease, but also drug treatment programs in general.

As you know, there are self-help treatment programs

and there are residential programs, and there are a number of more medical model ones. These programs can be useful as springboard for, say, small group interventions, which is something we've been involved with to alert people to AIDS and then practice things like condom use skills, and needle cleaning skills. I want to echo the frustration that some have remarked on about not having treatment be available. In our program for awhile we had coupons given out by community health outreach workers to get into our detox clinic at Ward 92. We did that as part of a research project, and we never would have been able to do it without research money.

When the research money ended, we gave up the coupons because we had such a long waiting list for the drug treatment program there was no point in simply lengthening it. So we're active in our own program with trying to solve ways to deal with the AIDS epidemic. One thing that I would very much recommend that you recommend has to do with combining treatment modalities.

Some people, I think, have talked about one stop shopping. In our treatment program, those 50 percent of drug users who weren't getting into, with AIDS, very few of them were getting into the medical care system. So we brought the

doctors over to the patients instead of having the patients go to the clinics. The doctors came to our methadone maintenance program, and it boosted the number of number of people on AZT and the amount of medical care that they were getting considerably. Now the issue is going to be how we get them to take AZT, say, more than once a day when they're out on the streets. We can give it to them with methadone, but how beyond that.

The final point I wanted to make is a worry. I'm afraid that AIDS awareness is decreasing in drug treatment programs from a level that really was never sufficient in the first place. For example, at our own program, we have some money from this waiting list program, which was designed originally as an AIDS prevention intervention to get people into treatment. Now it has been, the waiting list thing is still there, but it's becoming now, the focus is getting a little more diffuse. Now it's dealing with pregnancy and addiction and other kinds of programs, and my fear is that there is not just a diffusion, but also a sense of the federal government saying let the states pay for it now, and the states saying let the government pay for it, and meanwhile the patients need treatment.

So I think one thing, my suggestion, that you might consider is calling on the federal government to renew their support and renew their commitment to AIDS in these kinds of programs, not letting it get fragmented by other priorities. The other illustration is just a personal one about AIDS fading into the woodwork in these programs. I visit a lot of drug treatment programs. My wife complains that I've taken her to some of the worst neighborhoods in America as we go on vacation and things. My fear is that there really are more programs out there screening AIDS out than are really specializing in treatment of it. And in programs you see, in drug treatment programs you see AIDS posters, you see brochures, but the brochures are dog-eared and the posters are fading. They're becoming part of the wallpaper now so that nobody pays attention to them.

And it is a concern I have, and I hope that you will be able to renew your efforts and the efforts of all of us to make AIDS a drug issue and drug abuse and AIDS issue. Thank you.

CHAIRMAN OSBORN: Thank you very much. I would like to invite the commissioners to take advantage of the expertise we have. And is there someone who wants to start.

Don.

DR. DES JARLAIS: Bob, I think your comparison to the New York City situation is particularly instructive because as we've held hearings, we keep coming up with reasons why treatment is not going to be expanded beyond ten percent, 15 percent or some minimal figure. And I wonder if you could expand a little bit on what was the political will that arose in the late '60s that seems to be missing today?

DR. NEWMAN: I think you really just said it, Don. I think what's missing today is the will. In the city government in the early '70s, it was very straightforward. The mayor and with the mayor's endorsement, the health services administrator at the time, Gordon Chase, made a commitment that they would expand, and they would expand immediately and massively so that every single person who wanted treatment could get it.

The key ingredient was not money, was not brains, was not administrative talent, was not staffing. The key ingredient was a commitment that absolutely nothing could stand in the way of a massive expansion so that if people with a deadly habit -- it happens also to be a terribly expensive social for society as a whole -- but where people

have a deadly habit and what treatment, not to let them in, to make them stay on the streets shooting dope was just so irrational that it was simply a given that nothing could be worse.

One of the things that we did, and I think is very instructive today, is while we were massively expanding the traditional, if you will, methadone maintenance program and drug free programs at the same time, the city initiated four, what was called holding programs at the time. And these were four big clinics, each with a capacity for 500 patients who received methadone with virtually no counseling services until they could be moved into a full-fledged comprehensive program. That was done without discussion, without debate, without anybody challenging the rationale because the alternative was staying on the streets.

That commitment that nothing, absolutely nothing can justify forcing people to stay on the streets shooting dope when they want help, that's all that's missing. It's not a question of money. It's not a question of staff. It's not a question of facilities. All those problems can be overcome. What's lacking is a commitment not to tolerate this insanity that we have today.

MR. DALTON: Actually I want to follow on that. What created that commitment? Was it Mayor Lindsey? On the part of the mayor and on the part of the health commissioner? I think we're conned into thinking that politicians respond to pressure for constituents. Is this a good person theory that if you have the right person in the right position they will do the right thing, or is there some other way to create the kind of commitment and political will?

DR. NEWMAN: It's a very, very excellent and critically important question. I believe in that instance it was the people involved. I think it was Lindsey, and I think it was Gordon Chase. I think Lindsey was convinced there would be no apparent downside political risk to expanding treatment if this young aggressive administrator, Gordon Chase, was willing and able to do it. So he didn't see any risk. And he said try it. See what happens.

But I do want to point out that there's an example from a different part of the world where it wasn't an individual issue, where it was sheer pragmatism, the common-sense that nothing can tolerate sending people back to shoot dope if they want help, and that was in Hong Kong. And Hong Kong made a decision in 1975 that absolutely nothing would

prevent them from having a treatment capacity big enough to accommodate everyone immediately, I mean the same day. Within two years, they had a network of 28 clinics, maintained their drug free programs, and indeed, after two years not only could accept all-comers, but for the last 15 years, they have nightly announcements on every TV program. They have posters all over the colony that say if you or a friend have a heroin problem, immediate help is available. Here is a number you can call.

I believe there is not one single city in our great country that can have such a poster because if people call, they'd say, oh, you're in luck. It's only a four month waiting period.

CHAIRMAN OSBORN: Bob, I wonder if you would comment or anyone would comment on there's a lot of discouragement among people who only hear bits of the dialogue when it rises above a certain level about the efficacy of treatment in general and most notably treatment for cocaine. There has also been testimony at the commission about mixed addiction, and the fact that that's really, the mixed substances are really the rule and single substance addiction is an exception. Could you go into that just a little bit or

anyone who wishes so that that set of comments is dealt with?

DR. SORENSEN: Well, briefly, I think the noise above the din has been made that methadone programs often are troubled by cocaine addiction. They're not designed to fight it, and so consequently they don't have an effect on it, and nothing else works. Well, I think to some extent that is true, and that is a worrisome thing. And that these programs were designed for narcotic addiction. Of course, narcotic addiction is where the needle is used most frequently, and that's where much of HIV has been spread until now.

So I think we shouldn't forget that the narcotic addiction programs do work. There's also evidence that residential therapeutic communities work as well with cocaine people as they do with non-cocaine people. I think we should keep in mind, though, that we can't ask these programs to do everything. I know that there is a lot of research underway at National Institute on Drug Abuse to develop serotonergic agents, dopamine agents that will be useful as pharmacotherapy in cocaine abuse, but also on the psycho-social side there are treatments being developed.

So what we have now was not designed for this new problem, new meaning in the last five years it really came

upon us. Research is underway, and what we have in these generic programs isn't bad. I think the other thing that I want to follow up on the point that Ann made is these self-help programs have been very, very active with cocaine and alcohol and narcotics. And we shouldn't forget about them.

DR. NEWMAN: If I could just add one other comment, Dr. Osborn, and that is that the evaluation of the effectiveness of methadone treatment, and I speak of methadone just because I know it best, which has studied parameters of social productivity, health, HIV positivity among the patients, those studies which consistently have shown methadone to be tremendously successful, effective, which include the Institute of Medicine study, the congressional Office of Technology Assessment, and clearly disinterested objective groups, those studies have been carried out at a time that cocaine already was extraordinarily widespread among the heroin using population.

I think it's absolutely wrong to think that because there is no pharmacological effect of methadone on cocaine, therefore, for the heroin addict who also uses cocaine, one doesn't have anything to offer. Again, the bottom line to me is can any treatment effort be so totally futile that one is

justified in saying, therefore, it is just as good, if not better, that this person stay on the streets shooting heroin, using cocaine, and I think that that's simply not consistent with the evidence of effectiveness of therapeutic communities, of some prison programs like staying out, in New York, the self-help groups that Dr. Sorensen referred to. We know that these programs have effectiveness, not as great as we might like, not as effective with regard to the broad range of problem, but heaven knows, they've got to be better, and they are better, vastly better, than telling people, listen, your problems are just so complex and are so mixed up with all these different kinds of drugs, stay out on the streets until we come up with a new medication.

And if it doesn't get rejected the way methadone has gotten rejected, maybe then you'll be able to get on the waiting list so that five years after that you can get into treatment. That is insanity, but that seems to be what our governments seem to be endorsing.

MR. MULLIGAN: And I would just add a point that Bob made, and I've made before, that many times the response by people who question the validity of treatment is, well, punishment is the answer. And I don't think there's any

evidence that punishment reduces addiction. Clearly, treatment, drug addiction is something that develops over time. It's subject to relapse, but to those who enter and stay with treatment over time, I think it's most effective.

DR. NEWMAN: I just can't help adding one more comment, and that is if a high expectation of effectiveness, effectiveness, were the criterion by which we would justify expenditures should be tolerated, there would be no prisons in America. I mean let alone $1.5 billion to expand just the federal prisons, before we even get to the state ones. There probably wouldn't be any bombing of the Peruvian jungles and all the other wonderful -- and all these dogs that sniff cocaine. They'd be out of work.

So that I think if we say if you can't demonstrate at least 85 percent success, then why should we fund your programs, there wouldn't be anything being done.

MS. AHRENS: I really wish that I could say that I agree with what you're telling me. But I have to say that I came upon the scene in terms of the social service local official system about in the early '70s, and to go back to that era when things frankly were doable, and say that it is a question of will and not money, I can't relate to that

today. And I'll tell you why. Back in the '60s and early '70s, there was money. There was more money out there. We had Title 4A. We had Title 20. We didn't have ten years of social deterioration of our social infrastructure, and we weren't competing all of these issues. These enormous social issues were not out there competing with each other.

That is what we have today, and I think it is a question of money. Now you can say it's also a question of will, but it is a question of money. And even if we had a wonderful federal plan and a wonderful state plan and a wonderful local plan, the systems under which, at least my experience is, and which we have to now operate, still wouldn't allow us to do what we know needs to be done.

I would be hopeful if my experience told me that what you're telling me was right on. I would have some hope. But I do think it's a question of money, and it's different from -- today's money issue is very different from the issue of the '60s and early '70s, at least as I experienced it.

DR. NEWMAN: If I could just comment, I'd probably lose my job as a hospital administrator if I didn't quickly say you're absolutely right, we need more money. I did not want to -- I'm serious though -- I did not want to suggest

that money wasn't important.

I think exclusively in the field of drug abuse, I really think it's exclusively in this field, we analyze what can be done by first setting the fairly ideal model of what the experts say should comprise treatment, and then we say, well, how much money is available to provide this ideal model, and that's what we will do for those whom we can accommodate. And anyone who can't get into the ideal, we're not going to do anything for. It's as if one said what does it take to provide shelter for 35,000 homeless in New York, and one said, well, one certainly should have a kitchenette, one should have a private bathroom, one should have security, and you end up with a certain model.

And then you say, okay, we have enough money for 800 families, and the other 30,000 will have to stay out on the streets. We don't do that. We do the best we can. We spread whatever limited inadequate resources we have available. We spread it to the extent that the resources have to be spread. But we don't say, and I run a general hospital, and there are many things I'd like to do for my patients that I don't have the resources to do, but I don't say, I wouldn't say, and I wouldn't be permitted to say, we're going to

simply close the door at three o'clock in the emergency room, an let the other people just stand in line until the following morning because we can't accommodate them.

Only in drug abuse are we required by government regulations to tell people I'm sorry; we have 50 patients for one counselor, you're the 51st person, we can't accept you, stay out on the street. So really it's a question of what do we do with the resources? We have to expand them and stretch them as much as it has to be stretched.

MR. MULLIGAN: I agree with that last point. I think that sometimes our ideal of what drug treatment should be precludes our being creative, and I think many times people tell me, 75, 80 percent of the people in prison have drug problems. 75 percent of the people in our state it's social services, but mothers who have problems with their children, those work, rather than think only of the one-stop shopping where we build up comprehensive drug programs, I think we need to train those people to provide drug treatment at all of those sites.

We've started providing it at prenatal sessions in health centers because so many of the young women coming in who are pregnant have drug problems. And I think that side

of it, getting it out to other settings, is important, and I think that can be done with training, and can be done somewhat cost effectively, and it provides something for those people. We need to do more of that.

MR. DALTON: Just a quick question for Ann. You said that you've applied to law school and you're waiting to hear, and I wanted to know where you've applied and where you'd like to end up?

MS. THOMPSON: Well, I'd like to end up at Harvard, but I don't think that's going to happen. Actually, I've only applied to one place, and that's at North Carolina Central University in Durham. And I hope that I get in.

MR. DALTON: I'd be happy to try to help.

MS. THOMPSON: Well, I appreciate that, thank you. I haven't told them that I'm a heroin addict, but --

MR. DALTON: Actually I would not suggest -- you'd do better at Harvard or Duke than North Carolina saying that.

MS. THOMPSON: Right.

MR. DALTON: So I'd keep it to myself.

MR. S. ALLEN: I have a question for Ann. You're talking about NA and it being an outside issue -- by the way congratulations for three years.

MS. THOMPSON: Thank you. Thank you.

MR. S. ALLEN: That's great stuff. What about -- are you able to talk in your NA meetings about the HIV, your HIV status, or have you kept that confidential?

MS. THOMPSON: I do not, actually when I went down to Myrtle Beach last year, I was fortunate enough to have the courage to bring it up in a meeting. There were some people that I knew at that meeting, but, and I've thought a lot about this. And I'm certainly more okay with it today than I was when I first came into the program. But, you know, Chapel Hill and Durham is a small area, and I'm not quite ready to be the pioneer. I have gone in front of 500 health care students at the University of North Carolina and talked about what was going on with me. So I'm not totally in the closet about it.

The other thing is that I have to consider that a lot of the people are in NA are at pretty sensitive stages of their lives, and they love me. And I've had a couple of people who do know fall apart on me, thinking, you know, they already had me buried, you know. So I have to look at that, too. But I see it changing. I was at convention in November, and there was a seminar on illness and recovery, and you

know, some guy got up there and started going off on how he's HIV positive and he can't take it anymore.

And I got up and shared, I didn't tell them that I was HIV positive. I told them that I was dealing with illness and recovery and shared my experience, strength and hope on that, figuring that they could get what they want out of it without knowing my exact problem. But I do know that there are addicts that are in complete denial about this issue, and, you know, I can say that I, since I did my last shot of dope three years ago, I have not infected anyone, you know. I don't know about before that.

But, you know, the bottom line is when I stopped using drugs, I started behaving responsibly. And I was glad to read in the NA text that I'm not responsible for my disease, I'm only responsible for my recovery. That lifted a big load off my shoulders. But, you know, I'm sure one of these days it will come out and I'll be okay with that. It's just a big risk to take, and I have young children, and they're at the meetings with me a lot of the time. It's just not time yet. So --

MR. S. ALLEN: Do you sense a lot of denial within the community about the HIV? You mentioned denial briefly.

But --

MS. THOMPSON: Yeah.

MR. S. ALLEN: Everyone is afraid to think about it or talk about it?

MS. THOMPSON: Well, I mean addicts in general have this misconception that they're immortal, and the whole AIDS issue came to North Carolina, I think I first heard about it in '83. You know we were all sitting around the table, getting drunk, saying, well, it will never come to Durham, you know, we're fine. And, you know, and it just didn't work out that way. My six year old's father who I was never married to, but he committed suicide five months after he found out he was HIV positive. And then the man that I was married to died of a heroin overdose.

I mean I know there are people who just give up, you know, and I just decided to use all that energy that I was running around getting dope with and just turn it into some positive energy, and I know that saved my life. But I think people are relapsing behind it because they can't go and talk about it. I go, there is one support group that I go to that's not substance abuse related, and I'm in there with 15 gay men. And what I need to do is focus on the

similarities and not the difference. I mean a gay man telling his father he's gay is pretty equivalent to me telling my father that I was shooting dope, you know. It doesn't go over too well.

(Laughter.)

MS. THOMPSON: And I can relate to that person on that, but as far as, I mean it's getting better. It's just been a slow process. And I think it's keeping people, it's living with a lie, and you can't recover if you're not honest. That's the whole key to freedom is being honest about what's going on with you.

MR. S. ALLEN: One more question about the testing issue in North Carolina. You said that you're losing your anonymous testing facilities?

MS. THOMPSON: Well, it looks that way. And they just had a hearing the other day, and I'm not sure what has happened, but what they're going to do over the next four years is phase out anonymous testing. And so the best thing for anybody who lives in North Carolina to do is to go get tested now and then, you know, practice safe sex and not shoot dope in the meantime because eventually it's going to be reported. And it's a very scary thing. And I think that,

you know, they're basically setting a precedent by doing this. And like I said, this one senator is just causing all sorts of problems.

MR. S. ALLEN: Yeah, I've heard of him.

MS. THOMPSON: Yes. We tried. We tried, you know, but he's got a lot of money --

(Laughter.)

CHAIRMAN OSBORN: Don.

DR. DES JARLAIS: We'd like to thank all of you very much. We're in the process of moving towards our final report and possibly even an interim report on AIDS and substance abuse, and it helps very much to have the personal issues brought forward very clearly around these two intertwined epidemics and to hear a statement of the problem where the illogic of our present system is brought to its really absurd conclusions, and then also I think it was very important to hear what David and Jim said, that rather than getting better, the present situation is probably going to get worse as staff burnout and funding problems at the state and local level continue.

That to do nothing means that the situation is going to get worse as the epidemic also continues rather than

benign neglect and hoping things will get better. So we'd like to thank you very much.

CHAIRMAN OSBORN: I think we will now take a 15 minute break and hope to be able to start the next panel somewhat earlier than scheduled. At least one and perhaps two of the people who were going to speak to us are in the process of arriving, and I think that will fit best with everybody's schedule. For those of you who didn't hear before, we're trying to make sure that as many of the commissioners as possible get the advantage of as many of the witnesses as possible so we're trying to move the schedule up a little bit in order to accommodate changes in travel plans and so forth. So 15 minutes and then we'll be back.

(Whereupon, a short break was taken.)

CHAIRMAN OSBORN: Let's reconvene. I'd like to particularly ask the commissioners to take their seats, wherever they may be. While we're getting the last of the arrangements for some slides one of the speakers has, let me welcome the panel. We have tried to move things up so that we could get as much benefit of your efforts to attend as we could, and therefore, the fourth member of the panel, Dr. Davis, is going to be joining you belatedly. But we think it

would be wise to proceed, if that's all right with you. And so let me welcome to Dr. Molly Coye, LaShaun Evans, Peter Selwyn, and I don't know. Do you have an order in which you're to proceed?

Okay. Molly, why don't you start anyway, and thanks for joining us. We're looking forward to hearing from you.

DR. COYE: Thank you very much. Thank you for the opportunity to appear before the commission today. My name is Molly Joel Coye, and I'm currently head of the Division of Public Health in the School of Public Health at Johns Hopkins University. I'm also co-chair of the HRSA AIDS Advisory Committee, and in that capacity we've been looking at very carefully the implementation of the CARE bill.

From 1985 to 1990, I was first advisor to the Governor of New Jersey on health issues, and then the Commissioner of Health for the State of New Jersey. In light of the many months that you've spent on issues of HIV prevention and treatment and your own backgrounds and expertise in this area, I know that I don't have to convince you of the need to provide primary care for substance users as for all people, and that substance abusers who are in

treatment need primary care. Those who are not in treatment but who enter the primary care system should be offered the opportunity to enter substance abuse treatment as well.

What I would like to use these few minutes to point out are some grim realities that are going to make this very, very difficult, and to make a few practical recommendations that are not in this era budget breakers. First of all, we know that primary care is not available to many people who are not substance abusers and who are not either HIV infected or particularly at risk of HIV infection.

Primary care is also not utilized by many people to whom it is at least theoretically available. Both of these statements are particularly true of the two overlapping groups that we're concerned with today: substance abusers and people who are HIV infected. Both of those statements are also very true of the minority populations and poor populations in which HIV infection is increasingly concentrated.

So while good models exist for primary care, there are very little resources for the expansion of primary care. Those resources are currently drastically inadequate, and it is going to require substantial resources in order to meet this need. Now the solutions to primary care and substance

abuse treatment as they're usually proposed fall into three areas.

First is to provide primary care in drug treatment centers. The second is to provide substance abuse treatment in primary care centers, and the third occasionally is to try and pilot some third type of entity. There is no one model that is the correct model. And I assume you've heard during the day a little bit about some other models, and you'll hear right now on this panel about some very successful models to solve this problem.

But the current medical diagnostic and referral capacity in most drug treatment programs is minimal to non-existent. So if we begin with the issue of trying to provide primary care in drug treatment centers, that level of health care of screening and referral that is supposed to exist is, in fact, very, very inadequate in most centers. Most of these programs are staffed by part-time physicians with little training even in the health effects of drug use. These physicians are not integrated into the larger medical care systems in their communities, and there is almost no quality assessment of their work and no systematic support for improvement in the care that they provide.

Obviously, there are major, even inspiring exceptions to this generalization, and Dr. Selwyn will describe one of these to you. But most of the exceptions are in drug treatment centers that have strong ties to teaching centers, to academic medicine of one kind or another, and in addition, have strong community oriented primary care interests and in addition have federal grant monies, and in addition have significant subsidies from the medical institutions with which they're affiliated, hospitals and medical schools. So these are very exceptional circumstances.

When she arrives, Dr. Davis, I'm sure, will talk about another grim reality, and that is the extent to which the primary care system in its turn is overwhelmed and how difficult would be to provide substance abuse in primary care centers. I can assure you that her description of New York would be equally true for New Jersey, with which I'm very familiar. The first problem is obviously the very limited staffing in many of these centers. Secondly, the physical plants are at this point usually full to bursting. The ability to expand services without having new buildings is very, very limited.

An additional problem that is more delicate to get

at is that in many primary care settings, there is a profound desire on the part of the providers and the patient population not to be providing treatment to or being treated next to people who are substance abusers. Community health centers, ambulatory clinics, many other centers have struggled for a long time to be viewed as mainstream and to attract working insured patients. So there is an uphill battle to get them to be interested and again with obvious important exceptions to get them interested in this population.

A third grim reality is that primary care providers themselves are abysmally unprepared to treat drug abuse. There is no training in medical or nursing education, essentially, on any issue of substance abuse. What has been done is a small amount of alcohol. There continues to be almost nothing on drug abuse.

Secondly, there are almost no clinical protocols or guidelines in existence to help primary care practitioners who would be interested in taking this on. The development of such protocols and clinical guidelines is an urgent task, and it is the normal responsibility that the federal government takes when they want to change clinical practice. So it's not an unusual step to take at all.

There are a series of policies, mostly federal, but often replicated at the state level, that actively discourage drug treatment in primary care settings, the most important of which is the regulation of methadone, which is regulated very differently from many other controlled substances, and which significantly limits the ability to and interest in providing drug treatment on the part of physicians.

The fourth factor in this is that a large proportion of substance abusing patients have co-morbidities of mental illness, and again most medical providers are not prepared to deal with mental illness, and the overlay of this aspect makes it even less likely that they will take on dealing with this population. So what we are dealing with is on both sides in the primary care providers and in the substance abuse treatment providers a series of problems. Most of the proposals made to this point would require complex changes in reimbursement systems, in administration recordkeeping and referral systems, expensive modifications to physical plants and increases in staff capacity, the creation of protocols and clinical guidelines, professional training, and quality assessment activities, research and evaluation so we can learn from what we're doing and begin to actually institute

the quality controls that we should have, and technical assistance so that the many overwhelmed primary care and drug treatment centers can institute part or all of these proposals.

At base we're dealing with two very different cultures, each of which for explicit and historically understandable reasons is quite unprepared to deal with the problem before us. There are some important resources. City clinics, community health centers, teaching centers, and substance abuse providers who see the need for work in this area, and there are federal and state agencies that have recently begun to try to provide the kind of support that I listed. Specifically, I would mention both the NIDA/HRSA demonstration projects. I believe Dr. Selwyn's is one of those projects so I'll leave it to him to describe it to you.

Secondly, ASTHO, the state health commissioners, strong interest in this, and thirdly, the Office of Treatment Improvement linkage initiative to try and develop linkages between substance abuse treatment and primary care, working with professional organizations in the area. And I'd be glad to answer questions on that if you're interested. I think it has the potential to influence professional practice long-

range.

I would finish with four areas that I think federal action could be taken that would significantly move these two cultures together and improve the chances of these populations getting the services that the need with relatively modest investments. The first is the rapid evaluation of the NIDA/HRSA demonstration projects and other demonstration projects and pilot programs to integrate primary care and substance abuse even if they aren't funded by the federal government, and the dissemination of those findings.

That effort should look at the clinical care provided, both in primary care and substance abuse, the retention rate of patients in treatment, and the cost of effectiveness of various approaches. Secondly, the federal agencies should take the responsibility to develop a typology of models which are reasonably successful at solving these problems so that there are alternative strategies well described for states and local governments that want to support these efforts.

Secondly, the clinical guidelines and protocols that I mentioned before should be produced in greater number, specificity, and rapidity than the early efforts of OTI to

date. There should be a series of cost analyses produced leading to norms and guidelines. I'm not talking about standards, but just to give the local health providers and the government agency some idea of what's reasonable for these efforts to cost on the different types of strategies they might employ.

And finally, the provision of technical assistance capacity to cities, counties, states, and hospitals and clinics that want to try and do this. The third area is long-term professional development in primary care medicine and nursing and substance abuse treatment. The primary care substance abuse linkage initiative of OTI will do part of this and is very important. But a great deal more needs to be done to establish fellowships in all the traditional ways in which the federal government supports the development of a new field. I was very much the beneficiary of that in the field of occupational health in the '70s. So I know what the federal government can do when it decides that we need to have a new scientific discipline or to have further development in an area.

Fourthly is to bring rigorous examination to the current reimbursement systems for primary care and drug

treatment, and allow more waivers and latitude to states and local governments that want to experiment with new approaches to combine both block grants and Medicaid and other reimbursement streams in order to support these efforts. Let me conclude there. Those would be my recommendations.

CHAIRMAN OSBORN: Thank you very much. That's very helpful testimony. Dr. Selwyn, welcome, and can we get you to go next, please.

DR. SELWYN: Thank you very much. I'm very pleased to be here. As Dr. Coye suggested, I was planning to speak about and still will speak about our program at Montefiore Medical Center in New York in terms of the implications for one example, at least, of trying to integrate primary care and substance abuse treatment, particularly with relevance to the AIDS epidemic. I was also planning to talk about some of the substantive and policy issues involved in this endeavor. Most of the issues have been touched on quite expertly by Dr. Coye so I won't spend a lot of time on the more generic issues, but will present our experiences, perhaps one example of how these issues have been addressed.

Can we start, do you think? Oh, great. I'd also, while we're waiting for the slides to get set up, there are

two reprints that I have asked to be circulated to the commissioners, one detailing the impact of the AIDS epidemic on patterns on morbidity and mortality within our methadone program during the middle 1980s.

Another one which hasn't yet arrived describes our preliminary efforts in providing primary care within the same methadone treatment setting. Let me just start first before going into the details of the program by mentioning that as with many things in the AIDS epidemic related to substance abuse, geography is a very important factor which here, as indicated by CDC's seroprevalence data, is demonstrated in not surprisingly the concentration of HIV infection among drug users in the Northeast and Puerto Rico.

These data were published in JAMA in 1989, and there are more recent date available, although still the notion of geographic distinction with regard to HIV among substance abusers holds true. I think the implications of this in terms of medical care and primary care for AIDS in the setting of substance abuse treatment is that the clinical burden and the administrative and organizational challenge of the AIDS epidemic will really vary quite remarkably at this point by region.

In the Northeast, for example, our challenge has been essentially to try to organize and deliver care for HIV infected substance abusers who average about at least one-third of the population of most northeast drug treatment programs, particularly methadone programs. In the Midwest and in the Northwest, for example, the challenge at this point is probably less organizing clinical service on a massive level but more in the area of prevention and issues related to education and attempts to reduce the transmission of HIV.

So I think it's an example of how, particularly with drug users, the epidemiology of AIDS and HIV infection is really very closely linked to and predictive of the needs for clinical service in different settings. Going back to our particular situation, Montefiore Medical Center is a teaching hospital in the central Bronx in New York City. I am the medical director of the drug treatment program at Montefiore. I'm also an attending physician at the AIDS Center are Montefiore, and in the Department of Epidemiology and Social Medicine at Albert Einstein College of Medicine, and have been involved in clinical care and research involving AIDS and substance abuse since 1984.

This is the main campus of the hospital. The reason I show it is both to help orient in terms of the relationship between this and what I'll subsequently show in the setting of the drug treatment program. Also, ironically, as you may notice, the wrought-iron railings on the second floor in the background painted green are a remnant of the era when Montefiore was a tuberculosis hospital in the early part of the century when people were sent to the bucolic north country north of New York City to breathe the fresh air and have the southern exposure in the pre-chemotherapy era.

Ironically now, as will not be a surprise, Montefiore has again become a center for tuberculosis although at this point because of the important relationship between tuberculosis and HIV in inner-city settings such as the Bronx.

This, on the other hand, is the entrance to the drug abuse treatment program at Montefiore which is located about two miles to the south in the South Bronx. As you can see, quite a different feel from the entrance to the main hospital, and in a sense, this relationship, I think, typifies some of the issues that Dr. Coye alluded to before in terms of their relationship between drug treatment, which

is quite often marginalized, out of the mainstream, on the periphery, and mainstream medicine, even within the same institution. Questions of how to relate satellite activities, particularly in a setting such as this, to what goes on at the main hospital, the relationship between substance abuse, treatment, and other clinical services, these are very critical issues, and even within a center where we've been able to coordinate and organize care effectively, they still are attentions that are very important.

The clinic that I just showed the front entrance to, and this, by the way, is just a few directly facing the front entrance of that same clinic, is a clinic which now provides care to 750 patients in long-term treatment, primarily methadone maintenance. The patient population is 50 percent Latino, primarily Puerto Rican; 30 percent black; 20 percent white; 45 percent of the patients are female; mean age of the population is 36 years. So we have a young adult population, primarily a population of color, and a substantial proportion of women, which has had implications both for the social and economic effect of AIDS on our population, and also with issues directly related to pregnancy and perinatal transmission of HIV.

Inside the clinic, basically drug treatment is provided. The orange labeled bottles on the right are methadone bottles, which are given to patients when they come into the clinic to receive methadone anywhere from once a week to six times a week. Our basic strategy has been to link both clinical care and research to our frequent contacts with patients, particularly arranged around their frequent clinic visits to receive methadone.

I think it's an example of how really the drug treatment system is at a critical juncture with relationship to the AIDS epidemic. As I mentioned earlier, particularly in the northeast, one-third or more of patients in drug treatment programs are infected with HIV. The frequent contact that one has with such patients does offer a great opportunity in terms of being able to provide HIV related care, and yet at the same time the concentration of HIV infection in these settings implies that one of the weakest links in the health care system, drug treatment, is most heavily burdened with patients who are increasingly becoming ill and requiring service.

We have a small laboratory on site although most of the blood tests and cultures are sent out and basically what

we've done is provide primary care in the same physically limited setting that we provide routine state-mandated care for methadone treatment which consists basically of just an admission physical exam, an annual physical exam, and orders for methadone dosing and detoxification. There is one examining room in the clinic that we've outfitted with a negative pressure ventilation system to deliver aerosolized pentamidine which we've done for the past two years. Although interestingly here also, the issue of drug treatment being both in an advantageous and yet vulnerable position with regard to AIDS is particularly compelling.

We've had serious concerns about environmental sanitation in our setting. Our ventilation system is inadequate. We have many patients with tuberculosis and other respiratory diseases because of HIV infection, and yet we are ill-prepared to really respond on a way that we can ensure even safety for staff in some instances. The only way that we were able to provide this system for introducing negative ventilation to administer pentamidine was because we happened to have money on a research, on a foundation grant that we were able to apply to this purpose.

So the sheer physical plant capacity and level of

existing drug treatment programs is, as Dr. Coye suggested, a particularly precarious factor with regard to developing services around HIV. Just to give a sense of what the impact of AIDS has been in the population, and these are data from the paper from the American Journal of Public Health that is being circulated at this point, what we were struck by with these data is between 1984 and 1987 in a treatment program population that was essentially stable between eight and 900, we saw an increase in the crude death rate from 13.3 per thousand to 44.2, a tripling over that three to four year period.

Fortunately, since 1987, we've seen something of a leveling off which we believe is associated with our introduction of anti-retroviral therapy and other therapies for HIV infection, which have improved longevity, but nevertheless a very compelling increase and something which also, as I was suggesting, highlights the vulnerability of drug treatment settings. Even for patients already enrolled in drug treatment, the fact that many of them had already been infected by the time they came in implies that even endogenously there will be a growing need for service in these patient populations, not even to mention patients with AIDS

referred in for treatment.

When we looked at cause specific mortality in the same population, what we found interestingly was that both AIDS, which we expected, was a substantial contributor to the increase represented in yellow, but also deaths from pneumonia, particularly bacterial pneumonia and sepsis, infections which are not recognized by the current CDC AIDS case definition, and which support observations made by Dr. Des Jarlais and others early in the epidemic that narcotics addicts in New York were dying, in fact, from what were most probably HIV related conditions which were not considered AIDS defining.

When we analyzed in our cohort who the patients were who were dying of pneumonia and sepsis, these were patients who did not qualify either pre or post-mortem for AIDS diagnoses and yet they were all either known to be HIV infected or had unknown HIV status.

Now I just want to talk a little bit after having set the stage in terms what the impact of the epidemic has been on our efforts to provide care in this setting, and as Dr. Coye mentioned, we have been fortunate to receive a grant from HRSA as part of the NIDA/HRSA demonstration project

cycle to enhance and support our activities providing primary care in this setting. These are some of my colleagues who have working with me on this project in which we have both provided primary care within the methadone program that I've just shown you and also provided substance abuse treatment at an affiliated community health center also run by our institution in the Bronx.

The primary care efforts have been going on for the past seven years. The HRSA funded project which has allowed us to expand these efforts has been funded only for the past year and a half. Essentially, the project consists of a core team which coordinates activities between three main sites, the teaching hospital campus which I showed you originally, 1200 bed hospital in the Central Bronx, the methadone program, 950 patient program I've just described with clinic sites located to the south of the hospital in South Bronx, and a freestanding community health center administered by Montefiore as part of the Department of Family Medicine, which is the site at which we are introducing substance abuse services.

I won't focus much further unless people have an interest in the question period on the Family Health Center,

and I'll limit my remarks at this point to the methadone program. These are preliminary data. They're rough. They're not definitively analyzed at this point, but just to give a sense of what the primary care experience has been, these represent primary care visits within the methadone program from October 1 '89 through September 1, 1990, the first 11 months of the HRSA funded project.

The first thing that I think is noteworthy is that there were almost 3,000 visits, 2,851 visits, to medical staff within the methadone treatment program made by patients enrolled in the program. These are visits that are distinct from the routine state-mandated admission and annual physical exams that I mentioned earlier. These are patient initiated visits for primary care. A total, if you look at the bottom, a total of 617 patients out of a program population total of 1,093 or 56 percent sought care for a primary care indication during that period of time.

In our treatment program, which I mentioned just in general in the beginning, but to put this in the perspective, 40 percent of the patients in the population are HIV infected. The percentages are higher for new entrants to the program. When we broke down these visits not pictured on the slide by

HIV status, we found that two-thirds of the visits were accounted for by patients known to be HIV infected; one-third of the visits, patients known to be HIV seronegative, or of unknown HIV status.

What's noteworthy about the breakdown of diagnosis, and this represents simply the leading diagnoses, or primary diagnoses for the visits accounting for more than one percent of the total during that period of time, is that 25 percent of the visits, the top three indications, by far the most common, were visits in which either AIDS related complex, AIDS or HIV infection were listed as the leading diagnosis, the reason the patient was there. Many of those visits were for zidovudine prescription, aerosolized pentamidine administration or other prophylactic or in some cases chronic or acute treatment interventions related to AIDS.

If we include, in addition to that, jumping further down, pneumonia, bronchitis, tuberculosis and some of the other conditions such as syphilis or some of the dermatologic manifestations, it would turn out that probably about 40 percent of the leading diagnoses for these visits were, in fact, HIV related. What's striking, though, at the same time as that's clearly a higher burden of HIV related disease than

one would see in a routine primary care setting is that, in fact, at least half of the visits were not HIV driven, but were a combination of preventive health, health instruction, health education, prenatal care, and also common illnesses that one would see in a young adult population as well as some medical complications of drug abuse, hypertension, asthma, diabetes, as well as anxiety disorder, alcohol abuse and so forth. Psychiatric diagnoses, by the way, are primarily excluded. The anxiety disorders somehow crept in there by mistake.

But I think the point that should be made is that based on this slide is that even though there is increasingly and thankfully attention being paid to the need for HIV related primary care and drug treatment, and even though HIV may, in fact, be the engine by which such care is stimulated, it's important to realize that what we're really in need of is comprehensive primary care, not strictly HIV related care. It's not simply a question of a technical fix of handing out zidovudine along with the methadone. What's required is really primary health care for a patient population that has many other health needs aside from HIV infection.

These data are from the second paper which hopefully

will arrive at some point during the session. Unfortunately, I can't seem to get it focused. These were taken from a brief report in the Annals of Internal Medicine last November, in which we basically looked at issues of compliance and continuation of treatment for certain HIV related therapies in the same treatment population. What's relevant about this slide is essentially reducible to the fact that the acceptance level for some of these therapies, INH, chemoprophylaxis for positive PPDS, multi-drug therapy for tuberculosis, zidovudine, and aerosolized pentamidine, all exceeded 60 or 70 percent of the patient population that was offered such treatment.

So initial high acceptance of these treatments. And then when we look at those who continued treatment, over 80 percent, even 90 percent in many cases, continued treatment more than three or six months depending on the period of time the patients were evaluable. So both high acceptance and high compliance rates. The patients who stopped treatment stopped primarily because of either toxicity or a return to active drug abuse, which is an important factor, and serves to underline the need for really linking substance abuse treatment with primary care. Even though we've successfully

provided primary care within the methadone program, if patients had active substance abuse problems and are not able to come in and willing to be followed for treatment, then ability to provide primary care is compromised.

Let me just end then by touching on a couple of the issues which from a more generic standpoint, I think, we have faced. Many of these were already described by Dr. Coye. But just going down them very quickly, to start with, as I alluded to, one needs to be prepared in caring for HIV infected drug users not only for the standard HIV related diagnoses that one sees, but also bacterial infections, as well as sexually transmitted diseases and tuberculosis. So it's a broader notion of what care is required even in an outpatient setting. In addition, the fact that not only in our treatment program but in many others, women are very heavily represented, means that issues having to do with the natural history of HIV infection in women, which has been an issue of much importance and debate lately, as well as issues relating to pregnancy and transmission of HIV are also very important to address in these settings.

The fact that with the recent trend toward early intervention, one is talking about both symptomatic and

asymptomatic patients is something which has had enormous impact in terms of a treatment system which, again, is starting out quite marginal. For several years, we had a kind of grim luxury in a sense of only having to identify patients who were symptomatic as being eligible for treatment. Now we're talking about perhaps a third of the entire clinic population eligible for care which has posed a great burden for existing resources. Regional variations, as I mentioned earlier, depending on where one is in the epidemic, the need for service and the need for kinds of service may be quite different.

One has to think about not only prevalent cases, which in our case is most of the patients, patients already infected in the methadone program, but also incident cases, patients either newly infected in areas where transmission is still occurring, or patients diagnosed with HIV infection who are then referred into the substance abuse treatment system posing an additional need for service. The rationale for HIV antibody testing in substance abuse treatment has been discussed since early in the epidemic, whether such testing promotes a destabilization of drug abuse treatment goals and so forth, an issue which still needs to be addressed, and

highlights the importance of, again, looking at both substance abuse issues and medical care issues in the care of substance abusers with HIV.

Confidentiality in drug treatment setting is always an important issue. When you add HIV to it, it adds another dimension. Patients may be stigmatized as being HIV infected, and that's something which again requires attention. Cost and reimbursement, as Dr. Coye mentioned, major issues. We only with difficulty were able finally to be reimbursed for primary medical care, which for years had not been reimbursed, essentially because the initial formulas for reimbursing drug abuse treatment did not cover primary care on a fee for service basis, and so we essentially were providing unreimbursed care for several years.

The fact that we've been able to do that, I think, is encouraging and may provide an example for other settings to obtain support for primary care activities. The issue of staffing and education can't be overemphasized. The fact that we finally have obtained enough support to be able to move from a crisis mentality to one of planning for long-term treatment goals has meant that we now have to identify staff willing and able to work in drug treatment settings, something

which unless one looks really at very basic issues involving medical education and health professions training will be left, I think, ultimately with a system that cannot be supported.

And finally, as was alluded to earlier, no one model of care really would be considered standard depending both on geographic region, also the relationship of the drug treatment center to the larger AIDS center or medical center, as the case may be. And I think one of the things that perhaps may come from this is that as in many areas, the AIDS epidemic, I think, has brought out some of the inherent weaknesses or weak spots in the system. The fact that drug treatment in general has been so marginal is something which is really brought to the fore by the AIDS epidemic, and perhaps as a result of some of this activity and the motivation to develop new systems, we may, in fact, help integrate substance abuse treatment into the mainstream and be able both to provide better care for a particularly vulnerable population of HIV infected patients and also to enhance treatment for substance abuse. Thank you. I'll stop there.

CHAIRMAN OSBORN: Thanks very much, Dr. Selwyn. Let me ask LaShaun Evans to talk with us. I think we need to

share the microphone.

MS. EVANS: I'd like to thank the commission for allowing me to be here. My name is LaShaun Evens. I am coordinator for Women's Services at the D.C. Women's Council on AIDS and I am also a woman living with HIV disease, and I've been listening to a lot of what has been just said to us, and I believe that it would benefit me and benefit you a lot more if I talked from a personal perspective, not only as a recovering drug user but as a woman, again, living with this virus on a daily basis and as a professional in this field.

One of the greatest tragedies of this disease is the stigma and the discrimination that we're faced with daily, but a greater tragedy of HIV disease is that when people need support the most, there is oftentimes no one there for them. I believe that people living with this virus should be given priority treatment. As a person who used to do street outreach, we ran into people almost daily who said I want to get into a drug treatment program, but I've been told that there is a six month waiting list. I've been told that there is a four month waiting list or whatever the case may be, and these people are continuing to use illicit drugs

and tearing away at their immune system which is already compromised.

Another great problem that I have personally faced as a recovering drug abuser is that I believe the medical profession needs to be sensitized to the fact that, sure, we should be followed closely when we're given medication, especially narcotic medication because our bodies do not know the difference between prescribed medication and illicit drugs. It just knows that it gets a good feeling. But do not deny me medication if I am in pain, which is what happens in some cases. People living with this virus are denied medication simply because the medical profession does not want to give a person who is a drug abuser narcotic medication, but at the same time what are you going to do, let that person suffer in pain?

The other side of the coin is you have doctors that, again, because they're not sensitized, they're just giving away medication as if it's chocolate candy. So I believe that -- I mean we're all here, but I believe doctors, including infectious disease specialists should come to these conferences. It should be mandated that they are educated about the population they're dealing with when they're

dealing with a person who is HIV positive, quote-unquote "has AIDS," and is also a drug abuser or a recovering drug abuser. One big issue with drug users is that we never paid too much attention to nutrition. We didn't eat well if we ate at all.

That's another issue that doctors need to address, the fact that proper nutrition needs to be pointed out to people living with this virus. We're not educated about that on a whole. A lot of people don't know that proper nutrition needs to be addressed. There's the psychological aspect of this virus, and I'm going to give you a prime example of someone who is in a drug treatment program. I used to work as a director at a testing site. And the drug treatment program would call and say, well, we have someone who wants to be tested. That person is tested. We're required to give that person their results, and we do pre-test, post-test counseling with that individual.

They're sent back to the drug treatment program. We do not see the individual anymore, and HIV education is not a part of their treatment so they're not educated about nutrition. They're not put in touch with an infectious disease specialist, not only an infectious disease specialist, but one that works with HIV disease. From my own personal

experience, when I was initially diagnosed, the doctor that I was sent to gave me a lab slip and a little piece of paper and told me to go about ten miles away to have my blood drawn and a chest X-ray, and I asked why. And the doctor simply said to me my nurse is afraid to draw your blood, and without trying to be too very sarcastic but pretty upset about it, I said I don't know much about medical school because I'm not a doctor, but if they taught you anything, I'm sure they taught you how to draw blood.

Why is you cannot draw my blood? I was not given an answer. The shame and degradation I felt when I left that doctor's office told me that something has to be done about this. Needless to say, I never went back, and I've been put in touch with a wonderful doctor who is sensitive to the needs I've been talking about. But there are so many others that aren't.

Another issue that we see too often is the lack of knowledge in the medical profession between the interaction of these illicit drugs -- what do you do with someone who is still using drugs on the street, who is still shooting dope, or smoking crack or snorting dope or whatever? What do you do with these people if they're diagnosed HIV positive? Do

you not treat them with some of the medications that we use to treat people? What do we do with these people? I think that has to be addressed. The interaction between these illicit drugs that people are still using and the drugs that are used to treat people with this virus.

I'm not going to spend a lot of time. I guess what I really want to emphasize is that people living with this virus should be given priority treatment. That the medical profession needs to become more aware of drug use and drug abuse and HIV disease and the interaction between these drugs, and to leave you with the fact that I did not plan on getting HIV disease. None of us did. The disease is not between those of us that live with it and the disease itself. It impacts on everyone as you heard here. And it affects everyone. It has to become everyone's fight, and with that, I thank you so much.

CHAIRMAN OSBORN: Thank you very much. I'm particularly pleased that you were willing to share your personal experiences with us. I think Dr. Davis is here, and I wonder if you could join the other witnesses at the table so that we get a chance to hear from you and then have a general discussion. Thank you for racing on down here. I

appreciate it. Welcome.

DR. DAVIS: Thank you for the opportunity to speak here today, and actually I have to thank Ms. Evans because she's taken away most of the vignettes that I wished to express this afternoon so I'm very appreciative. I will make mine very brief. I wish to discuss actually primary care and in the context of primary care and the reason why as a direct care provider primary care as a model of health care that attempts to comprehensively integrate all the various forms of medical care, which includes prevention, access to specialty care. It acts as a gateway for the improvement of long-term health issues, whether those issues are hypertension, chronic illnesses, the pick up of acute illnesses, and their long-term sequelae, and adequate intervention to prevent those diseases which we can about which we have knowledge.

Now substance abuse, which I would also like to define from my perspective, is use of substances, a number of substances. So that I will not distinguish between illicit and what is called legal drug use because the primary killer and one of the fastest rising groups with HIV disease presently are based on people who are addicted as well to legal and to illegal drugs. There are very few poor addicts

in this world, and I have rarely seen an addict who was addicted to heroin who was not addicted to cocaine who was not addicted to cigarettes, and who have not at some point been powerfully addicted to alcohol.

So poly-drug abuse, I think, is the first issue that I wish to put on the table in that context. Now when we discuss poly-drug abuse and poly-drug addiction, then I think we also need to talk about issues of addiction. Now to help you perhaps gain some perspective, I would like to talk about the training of, structure of how health care systems deal with addictive behavior.

Now we have a woman here who has to fit into a size 10 dress for her wedding. This is a personal perspective. She is personally addicted to Nestle's Crunch, has a long history, long family history of diabetes, hypertension, and comes from a culture where let's not call it obese, but healthy women are respected. Do you disagree? Okay. Respected in reference to proportions. And I use this as a rather humorous and personal anecdote because I'm determined to fit into the wedding dress because when I go to any physician who is not of my culture and my background and must therefore adjust to my culture and my background, their usual

position is, well, you're over the chart.

They do not instruct me. Nor do they ask me questions about my nutrition. What do I eat, the usual body size of the rest of my family, any other patterns of addictive behavior, how that addictive behavior is supported by the society I live within, the job experiences that I have, how my addictive behavior is dealt with from the viewpoint of the people I work with. Needless to say, if we move therefore from food to heroin, cocaine, alcohol, cigarettes, or other forms of addictive behavior that, thank goodness, doctors with their rigid selves don't have to deal with --

(Laughter.)

DR. DAVIS: It's very obvious that the lack of training in this area, therefore it becomes a critical issue. Now let's talk about physicians who want to learn how to train in those areas. There is not a single medical school in this country that presently offers adequate clinical based coverage, continuity or continued training in the areas of addiction. Even when they are on-site as Dr. Selwyn's is. How many residents do you have running through there, Peter?

DR. SELWYN: A handful.

DR. DAVIS: A handful, and are they all self-

chosen? They are all self-chosen. In other words, in a city known as the South Bronx, mecca heaven for drug abuse, a resident is allowed -- they're not allowed to do that with the coronary care unit -- okay. They're not allowed to do that with any other form of medicine that is considered integral to the preparation of a physician. So I think that this is a necessary discussion because there are no systems of primary care in this country. We still do not have any structure within the medical system that adequately allows us to teach primary care, whether it's for diabetes, moderate obesity, cigarette smoking or drug abuse.

So now we can throw in another chronic illness, HIV. Okay. So now this is a very easy issue. Okay. Now you're faced across the table with someone who is of a culture, often a race, often a -- and possibly a sex different from yours, but certainly having behavior that most doctors like to think of themselves as never having indulged in. And you want that person to someone go across all those barriers and then begin to engage that person in some type of behavior where they can begin to cope with having this fatal illness.

Doctors don't do well with that when it's cancer. You know they hem and they haw about your mammogram. Most

physicians who tested for this HIV in this country do not have to take any counseling courses. And I can assure you that an M.D. license is not a sufficient way to learn how to counsel. So I'm just trying to point out some of the inequities in the system before we ever get to talking about primary care.

This country is not training primary care providers. It is without question not training primary care providers who can handle the issues of poly-drug abuse or can they pick up, the majority of the people that I treat are what is called working class abusers. In other words, I can't use their insurance because nobody knows including their wives. I've had a man who's been wearing for 17 years long-sleeved pajamas. His wife just thinks he's weird. It never occurred to her that he usually does it on Fridays, and that's usually because that's the day he shoots up.

If you don't begin to deal with the very real realities of the society in which you live, and drug abuse at all levels of our society is so common and so pervasive, and I'm sure the statistics have been recited time and time again today -- well, all those statistics are wrong. Because if my patients are a reality of who has been in contact with drug

abuse and drug use, believe me we have severely deluded ourselves to the reality of drug use in this society.

Doctors, however, are not trained in a system outside of this society. They are trained in the societies where they are put in very rigid systems of medical hierarchy and medical care, and they are told what is real medicine and what is non-real medicine. Nurses are taught the same thing. X-ray specialists are taught the same thing. Everyone is taught from that same model, and told what is real, what is available, and what you can change and what you cannot change. Most issues in primary care which are issues of chronic illness, you are told that those are issues that you cannot change because you cannot give somebody a pill and make it go away.

The second thing, I can assure you that given substance abuse, most individuals really think it's a matter of culture. Since there are no issues of cross-cultural training taught in any major medical institutions in this wonderful nation of ours, that also leads to a predominance of issues that then become obscured in a mire of attitudes. Let us take a working mother of two who last used drugs five years ago, and now presents with recurrent vulva-vaginal

candiditis (sic) and an episode of septosemia bacteria in her blood. So here is this woman who is a supervisor at her job, and she's now in an institution where these little young people who never go to sleep and have great big circles under eyes and spend two minutes a day with her say this is Mrs. Jones, IVDU. So she asks me, that's the attending doctor, when they come in what is an IVDU. I say it's an intravenous drug user. She said she's done something. So naturally, normally, I mean how many of you would like to hear five people in the hall saying that she's an IVDU, not discussing you in the context of your history, your relationship with other people in life, whether you're a good mother or a bad mother. You've just been put into a category of people that are considered somewhere below the rug.

And I just bring up these vignettes and bring it in a personal perspective because that's the way doctors are trained everyday in this country and everyone around them. Now what are the solutions that we can therefore have that I think are really integrated and necessary to begin to affect this epidemic? One is that you have to look at medical systems of model and care. The type of modeling care we give. You have to look at the reality that most of the money

that it goes from any tax structure toward financing of medical education in this country goes to continuing a system that was deemed as outdated during a time when there was still a Democratic president. That gives you some idea of just how long it's been.

I think that we if we are not able to recognize fully the liability and continued extent of how much money it will cost us in the long-run to train people who have an inability to go across cultures, ideas, mores, values and are taught how to communicate. You know it's not a natural-born gift. You don't come out here and say, wha-wha, I want to be a doctor when I grow up, and someone taught you how to communicate. You have to learn how to communicate across all the perspectives of medical care, whether as the physician, the person who is being allowed to listen to some very difficult issues, or the person who is acting as that gatekeeper. Without that capability, and I use that word as a communicator very flexibly, you cannot explain why T-cells are necessary, AZT, what does it mean versus immune modulators, what does it mean versus holistic health measures, what does it mean for your long-term health care?

You cannot give someone a graded way of looking at

their care overall, if you are in anyway about to empower the individual who was infected with the virus we're discussing. So back to the medical models, that means then that the majority of money that we are using for a chronic illness for which the best treatment that we have at present is prevention is that we are spending the bulk of our money on research that is not only entered toward the populations that are presently being affected. There is no research in this country presently going on that can tell us about AZT and the use of cocaine consistently.

Hopefully, it will come out of the AZT and methadone protocol that's presently being run because there is a high incidence of crack use among methadone users. But that's a very silly way to obtain research knowledge, scientific knowledge.

So I would like to really close by saying that we have to restructure, and as we restructure we will not be able to shore up all areas. But I cannot at this point sit up here and discuss primary care when it is easier for me to take care of someone who now has nobody left and has multiple organ system failure, and I'm allowed to spend $5,000 a day on that person and I'm not allowed to do any preventive work

with any other non-HIV infected individuals in the family of the patient that I am caring for.

So I think that the most primary issue that I would like to get used, as a primary care practitioner, I do not feel that either the medical system, the financing system, the insurance system, or the educational system supports and help me in my mission, and my mission is to defeat HIV before it starts. Thank you.

CHAIRMAN OSBORN: Thank you very much, Dr. Davis. Now I'd like to get a chance for the commissioners to interact with this panel of witnesses. Harlon.

MR. DALTON: I started the day depressed for rather obvious global reasons. But I think I'm even more depressed after this panel, and Dr. Coye, you started it. Your analysis of the problem of providing primary care for drug users was, I thought, devastating, whichever direction you take it, whether you're trying to provide primary care in drug treatment programs, and you outlined the problems, or trying to provide drug treatment in primary care centers.

Maybe the solution is to create lots of teaching hospitals, lots of Montefiore's, maybe Cornell's, but short of that I haven't heard much. You gave four recommendations

which I think were sort of deceptively simple. And the rest of the panel has been busy unpacking one of them, that is more training for health care professionals. But I don't know what it would take to train the doctor who won't even draw your blood. I mean this person may not be educable.

Dr. Davis certainly didn't give me a whole lot of hope, and that's just one of the -- the alternate reimbursement mechanism is fine, but as you suggested in your analysis, that's a very complex difficult, long-term proposition. I don't normally sort of insist that people try to make me not be depressed, but is there something that you can say that suggests that there may be some answer somewhere other than Montefiore which, in fact, has its own problems which we really need to talk about today?

DR. COYE: Okay. At the risk of sounding overly optimistic, I think, in fact, that there are a lot of things that are relatively simple and straightforward that can be done and that are derived pretty directly from activities that federal agencies do in other areas when they want to achieve an end seriously.

The training piece, sort of going point by point through what you raised, the training piece, if you noticed

it was number three, and the reimbursement was number four. There are other things that come before that in terms of the immediate impact that it might have. Under training, however, while the long-term change in professional practice is a matter of decades, you can see changes as quickly as four to five years after a major investment, in some cases two or three years later. In occupational health, when Congress established eight regional training centers with full faculty stipends, fellowship support for clinical fellows, research grants, and a whole series of other things that go with that, an enormous number of people who previously defined themselves as toxicologists and other kinds of things redefined themselves, discovered the field of occupational health.

If this kind of support --

MR. DALTON: Yes, but that's such a clean field relative to --

DR. COYE: Oh, oh, oh, uh, uh --

MR. DALTON: Okay. I withdraw that.

DR. COYE: I'm sorry. I spent a long time working with labor unions, and believe me this is a very political, highly charged, and not at all easy field. So I'm sure now

is not the time to get into that. But, in fact, I would suggest that there is some pretty interesting analogies here.

The second point under training I would make is that in the '70s, CDC and actually for several decades before that, CDC did an absolutely superb job of developing training modules, quality assurance systems, et cetera, for those clinical problems that are defined as public health problems because they're not profitable. If you look at the market failure in the health system and you see tuberculosis, sexually transmitted diseases, all those diseases which occur in populations that can't pay or for which the care is long-term chronic and difficult. That falls to the public health system, and CDC had done a great job.

Now when you get block grants in, you stop collecting data and you took down the support for a lot of that infrastructure work, then the capacity has eroded. But a similar program that would develop the guidelines and protocol standards, come in and do regional training of the staff and substance abuse in primary care in this area, that kind of effort can make a real dent in a short period of time. So I would, without being overly optimistic, there are strategies that already are well-known and tried, but they

just haven't been tried in this area.

The second area is under reimbursement. One of the key things that HCFA can do, Health Care Finance Administration can do, is issue waivers to states so that they have more flexibility in the use of Medicaid funds. One of the key things which HRSA can do is allow states more flexibility in the use of Maternal and Child Health block grant funds. One of the key things which OTI under ADAMHA -- this is great alphabet soup -- can do is waivers or exceptions in the administration of block grants.

Some of these now you can only do marginally what you'd like to, and you need some congressional help to authorize, particularly under ADAMHA, some of the work you'd like to see. Under MCH and under HCFA, those agencies now could do a great deal more. And this is something that could happen within six to 12 months. So, again, a decision centrally to try and facilitate this could make a significant amount of difference. Now that kind of experimentation should then lead directly to what I was saying before earlier about evaluation and the typical evaluation, whether you're talking about NIDA or OTI or HRSA, the HRSA demonstration grants, you put money out there and you contract with

somebody, and four or five years down the line you get your evaluation results.

It's usually not widely disseminated, rarely academically published. It's certainly not disseminated from a technical assistance point of view to the people who might want that information. As a result, by the time it's distributed, it's pretty much out of date and not very helpful. What is needed and has been referred to again and again by expert panels in this area is to have rapid assessment teams go in and look at these projects, develop typologies of what works, the kind of costs associated, the kind of training needed, and develop that into useful technical dissemination materials.

That kind of activity could, again, take place within six to 12 months. So I would suggest all of these things are not major new funds. All these things are the kind of money that gets chewed up in administrative expenses in most large agencies and could make a significant impact. Let me stop there.

DR. DES JARLAIS: Molly, you chair the HRSA Advisory Committee on AIDS?

DR. COYE: Uh-huh.

DR. DES JARLAIS: Supposing despite everything the four of you have to say about integrating primary care and drug abuse treatment, the HRSA demonstration grants are successful, you know, despite the things that depressed Harlon, and it actually works in the demonstration mode, what happens next? I mean have people thought through maybe these demonstration projects will work and how many drug treatment programs are in the country that then should have primary care and how will we staff that, how will we fund it?

DR. COYE: Yes. I think that one of the things that federal agencies do poorly is translating from knowledge into action, and one of the reasons that's so is because of the tremendous political restrictions on the Feds from telling the states what to do. And as a state commissioner of health, I certainly understand that, and I'm sensitive to it, and ASTHO often warns -- the Association of State and Territorial Health Officers -- often warns federal agencies hands-off, stay away from implying what we ought to do.

What that has led to combined with the demise of federal planning monies in the late '70s and early '80s is an absence of the capacity to plan within federal agencies and within most state agencies as well. Ironically, what you see

because of AIDS and because of associated epidemics in the Maternal and Child Health field and other is new congressional funding for small planning efforts so that you've got the councils mandated by the CARE bill now. That needs more technical assistance support than HRSA is able going to be capable of doing because, again, of the administrative restrictions on the CARE bill.

There isn't enough money and enough staff positions in there to make it even conceivably possible for HRSA to do what they might like to do, much less what we would like to see them do. If the demonstration projects you're talking about are successful, the kind of work that I was describing needing to be done would require probably four or five fulltime staff people's time to prepare the technical dissemination of materials, someone from HCFA fulltime on waivers, all of the kinds of things you would want to do.

That's probably about, I would guess maybe somewhere between a tenth and a 20th of the entire HRSA staff available on HIV. So things are not structured right now, and this requires congressional action to shake it loose, for those federal agencies that could do it. I would say that my experience is they're pretty aware of what needs doing, but

it just is not in the cards right now.

Iris is on, I should have pointed out that Iris is on the advisory committee with me and one of more quiet and unassertive members. So --

CHAIRMAN OSBORN: We already figured that out.

(Laughter.)

DR. COYE: Do you want to add anything?

DR. DAVIS: I would just have to reiterate, I think, that in terms of a federal mandate, licensing is always done on a state level, but there are a number of national organizations in medicine which have been affected by this commission very strongly, and I think you have a number of influential members who have contact with those.

Basically, there has to be a mandate. The mandate that you are serving has to come from more than the Feds. Because the Feds don't license, for example, on the state level. I don't know any doctor that is allowed to take, or to practice medicine basically without knowledge of hypertensive drugs so how doctors can do the same in other areas or not appropriately refer or be mandated to learn -- and I just use doctors because I happen to be one -- but I think there are some other long-term structural issues in terms of who

you can get to mobilize.

I mean cholesterol is a major problem in this country. Well, so is an epidemic that can eventually have the long-term impact and effects of HIV, and I think that the way in which we have, the medical community, in general, has mobilized itself has not allowed us to often look at the fact that we had an inadequate and poorly structured organization to work with.

So when we talk about the organization, for example, that exists within HRSA, which is not oriented toward working primary care, that occurs in almost every bureau of major health care delivery from NIAID to NIH to whatever. You have to look at how to restructure the system consistently with federal agencies to consistently support efforts that will begin to change what's out there on the other side.

DR. COYE: Could I just add one? Okay. I just have a very quick thing. I think especially in light of the budget difficulties in the next fiscal year and the Gramm-Rudman restrictions on the administrative pieces of lots of programs, that one of the key issues of the commission, if it's not already, might want to consider looking at is the

ability of HRSA to provide technical assistance and support in the implementation of the CARE bill because the kind of thing you're asking about really is something that I think HRSA is quite aware of the need for and doing its best on, but doesn't even have a shred of the kind of capacity it would need.

DR. SELWYN: Yes. I just wanted to say, and also I should preface this by saying I don't know whether this will have the anti-depressant effect on Mr. Dalton or not, I think there may be a trap and sometimes this comes up in assuming that, for example, if our model has been successful, it's only been because we happen to have been at a major teaching hospital with a big academic AIDS program and clinical program and so on and so forth. There has been just a lot of activity within New York, at least, which is what I'm most familiar with although it's not limited to New York, that is consistent with what Molly has been suggesting in the sense that not a lot of money, in, fact, can have a very strategic effect.

The ability for enhanced reimbursement around AIDS related care initiated by the State Department of Health in New York has resulted in a lot of interest and some activity

within drug treatment programs of all sorts, not just hospital affiliated methadone programs, to provide primary care services around HIV, at least as a focus. And there's been some movement in that area including therapeutic communities, freestanding community-based programs, and so forth.

Also, even though it may ultimately take a very major effort in terms of looking at health professions training to really integrate substance abuse treatment into the mainstream, there are also ways in which sort of initiatives can have perhaps a more broad-based effect. For example, also in New York, there's been an initiative to develop an HIV-substance abuse training fellowship, post-graduate training fellowship for recent graduates of primary care or general medical residency programs, and there has been a lot of interest in that. It's something which just started out over the last six months. There is now some foundation support for similar kinds of fellowship training, which could, in fact, even though it won't change the whole medical training system, at least provide a group, a core group of people trained to be sensitive both to issues related to AIDS, HIV and substance abuse in the settings in

which they're likely to be found.

And finally, there's also been some interest and activity around trying to address really on a local level this basic contradiction between the -- really it's a technology transfer issue almost although not to over, kind of simplify it -- thank you -- but there have been ways in which, for example, through arrangements between hospital centers and community based primary care centers, there's been a rotation of AIDS center staff, for example, to do rounds in community health centers, act as preceptors on a basis in which really a little bit goes a long way.

There's a lot of interest on the periphery for having contact with people who work in teaching centers. At the same time, we've started a program to have substance abuse staff be available for doing rounds and consultation on inpatient medical units where there has been a lot of enthusiasm so that even though the schism is great in many instances, it's already been gratifying that in certain ways without a lot of effort some very important contacts can be made. So I think there is reason for optimism.

CHAIRMAN OSBORN: I wanted to be sure that we took full advantage of everybody who has taken the time to stay

with us throughout the day's discussion, and who had been witnesses before. I think what I might suggest is that people who would like to participate in sort of a roundtable from our prior witnesses as well as these join us along the side here and try to be sort of literally around the table with you folks staying put if you feel comfortable there.

And I know that starting around 4:30 there's going to be a visible exodus because of airplane schedules and so on which is one reason we tried to move the schedules up a bit. All of that -- move up, Dave, and if you can come up, join us so that we do try and get a circle of people, and therefore, we can see if somebody wants to participate. And I think, I've asked Don Des Jarlais if he'd be willing to make sure that we do get full advantage of your thoughts and to facilitate some discussion for these last few minutes in order to complete the day's understanding.

MS. BYRNES: Just by way of explanation for those who may not be aware of the purpose of this time in the day, one of the things that we've heard from the commissioners and we've struggled with as a staff is to really try to find the time after we've heard a day of a lot of powerful testimony and interesting ideas to share a little among ourselves but

also with some people who may have some answers or suggestions given what they've heard over the day and what they may hear the commissioners question after hearing a variety of thoughts and suggestions.

So there is really no structure. I'm thrilled that Don has agreed to facilitate it. It's really a time for us to sort of make some sense of a lot of things that we've heard today and also ask any questions that may have come up since other witnesses have left the witness table, if that helps to clarify.

DR. DES JARLAIS: Okay. We'd like to start by asking people who have been here, who have testified, what they would like to see the commission do, and we're scheduled for another nine months.

CHAIRMAN OSBORN: Eight.

DR. DES JARLAIS: Eight months. Time runs out even faster. We have one final report. From the things you've heard today, which is pretty much what we've heard in less powerful form before, what is your sense of what the commission should try to do, policies we should recommend at a national level and to the extent that we have influence, where money, into what areas money might be shifted to really

have an impact on the two epidemics of drug dependence and AIDS? So if anyone wants to try taking that on.

MR. STEPHENS: Don, Ray Stephens from Arkansas. One of the key things that you mentioned was the shifting of funding. Many times we find, particularly with the block grant, ADMS block grant, is that we have a set-aside placed on us, but no additional funding. And so we are continually bombarded by additional set-asides which means the pie stays the same, but the pieces get smaller in other areas in order to be able to adequately serve this given population.

We'd like to see some additional funding go along with those. When I was originally invited to come, I was to be on the third panel, which was the availability of treatment, and this is a key issue to us because of the waiting lists that we have. Granted, they're not as great as other areas, but to be able to provide some additional funding for treatment is a key thing. When I have a treatment provider sit down with me and pour out his guts and say I lost one last week that was on a waiting list because he OD'd, you know, that shouldn't happen. We have to have treatment on demand.

DR. SORENSEN: Another related suggestion, I think

if you could make some effort to follow some of the recommendations of others about providing low threshold care, I think it would be helpful because it is so -- I guess I take to heart the suggestion of Dr. Newman that it's really hard when you have to create such a high quality program that you have to screen so many people out of it. So one suggestion would be if you could stand up if making low threshold care at least an option I think it would be helpful.

I don't know exactly how to integrate that with the suggestion that also providing primary medical care, which I really believe in. I guess I agree with Dr. Des Jarlais said early on is we need a wide spectrum of services being available and not trying for just the one best thing.

MS. VINING-BETHEA: I guess if I had a wish list, I would have a bunch of things on it, but I would be very much interested in seeing if we're going to do any more needs assessments, let's assess the needs of the programs that are already existing, the ones who are supposed to be providing the types of services that our clients need should be monitored. And also I'd like to also see, due to the fact that there is such a low amount of numbers of programs that are designed with a woman's model in place, I'd like to see a

Porterhouse for after a woman gets out of incarceration, especially due to HIV virus, being homeless, can't get into shelters. So I think we need to look in avenues of approach for some kind of housing situation for women who have children, who if they access the Division of Youth Services for help, they are, in my state anyway, they are considered abandoning their children, then have to go through, and by the time they go through the process of getting the kids back, most of them have became deceased. So the kids are still in the institution. So I think maybe some types of programs that are longevity for women.

MS. BYRNES: Could I ask that you identify yourself prior to speaking just so the transcriber can take that down for the record. Dr. Sorensen and Sandy, I think we have you, but now on if we could do that, that would be great. Thanks.

MS. THOMPSON: My name is Ann Thompson. I would really like to see ya'll write a letter to the state of North Carolina suggesting that perhaps the idea of doing away with anonymous testing might not be such a good idea and that, I mean as far as I can tell, it will be promoting the spread of HIV infection in North Carolina, and I think it could set a very dangerous precedent for this country. Thank you.

DR. JONES: I think one area that needs more attention is -- this is Steve Jones from the CDC -- excuse me -- is corrections, criminal justice system rather than all the four parts of it, and the interaction with substance abuse treatment, provision of care within walls or within the structure of how they're administering their programs and transition from incarceration back to the street. I think if we talked about a huge chasm between substance abuse and public health people, it's huger, deeper, wider, and darker between the criminal justice system and public health and substance abuse as well.

CHAIRMAN OSBORN: I might just comment on that that -- no way that you could know -- but that has been a subject of major study, the artificial separation, just to make it approachable, and we will be having quite a bit to say, and it sounds like you will like what we had to say about that.

MR. PURCHASE: Well, I would encourage you to have a constitutional amendment which would require all public leadership not to use flowery words or start nonsense, and require every action that purports to be based on someone's moral view that involves health, that that action has to also be substantiated by medical evidence.

CHAIRMAN OSBORN: Written so that we can get it through three-quarters of the state legislatures.

MR. PURCHASE: Yes, yes. I mean there is -- bless your hearts back here on this side of the country, you know, and I spend a lot of my time on the street, but there is an awful lot. I mean there really is a lot of nonsense, and I can't believe that everybody involved in it doesn't recognize this. Human beings are creatures of habit. That is the reason we have so much trouble with this damn virus. And I think that we are not in the habit of being confronted by lethal disease, and we haven't, the way Randy's book talked about, we collectively haven't had our before and after yet.

I spend too much time with friends who have no friends left, and some of them are professionals in this business, and in the meetings that I go to in my little frog pond, they are quite frequently discounted, and it usually goes, yeah, that's so and so, but you know, he's got HIV, you know. Or yeah, that's so and so, but you know, she's got AIDS, you know. Where, in fact, I'm convinced, at least the individuals I'm speaking of, are the most controlled people I know.

And were in their situation, I mean I would have a

weapon in every hand. You know this desk wouldn't be right side up when I left the room. I mean I meet a lot of people in positions to make decisions who I get no sense from that they know exactly what the hell it is we're up against, you know. Well, that's enough. I talk too much.

DR. DES JARLAIS: Questions or comments from -- this is not meant to exclude questions, comments from commissioners. Yes.

MS. AHRENS: I'm not sure after listening to this my comment is really worthy. I wanted to go back to the issue of licensing that I heard because it may provide a more rapid way to get professional change than going through the quote "medical school system," if that's what I heard some of you saying.

And I wanted to ask a question about -- we were talking primarily about the medical, the physicians. But I'm wondering about the nursing profession as well. And what I wondered if at some point staff could do a little investigating there. We had a meeting, I guess, four or five months ago where we did have quite a bit of testimony from quote "the nursing profession" and talked about the lack of adequate nursing personnel, et cetera, et cetera.

And back where I come from I sort of went home and checked this out, and our people were saying, well the problem is not the lack of people going in and so forth. The real problem is the licensing of the professionals, and that when we're looking to try to license Mong (sic) in my community that have to take care of other Mong and no one else can really do the taking care of because of the language situation and so forth, they can't pass the test. That's not because they haven't been trained and can't do the job because, in fact, we're sort of letting them do the job anyway, but under some other title. But they can't pass the test. It seems to me that we need to somehow look at the licensing and get some information for the commission so that we can deal with that perhaps in the report. It might be a faster way of getting at some of these issues.

MS. PIEMME: I'm Joan Piemme, staff of the commission. I think Molly did point out that there's not a lot of education in nursing programs as well as in medical programs, and I hear what you're saying about licensing, but you can't put test questions on licensing exam if you haven't given the people any background in order to take those. So I think the same type of examination that needs to be done in medical

curricula also needs to be done in nursing curricula. There's a little bit that is dealt with in terms of the use of alcohol.

I think it's been a few years since I've been on a nursing school faculty, but there was absolutely nothing to do with substance use, and I think that's probably still true today or maybe there is an hour or two. So I think that first you need to get the information into the basic curriculum. Then you'll have a basis to ask the questions on the licensing exams to make sure that people do know about it, but it's very inadequate.

DR. COYE: There is an additional aspect of licensing, though, that I think is an option to consider which is the relicensing of professionals already in practice. In our experience in occupational health, drawing on that analogy again, after a small number of schools had begun to put occupational health into the curriculum, they put occupational health questions on the boards. So without waiting for all schools to have them, they put those questions on the boards in internal medicine and then slowly in OB and a number of other fields. And that certainly got the rest of the schools very fast to scramble and put that education in

because they would have three or four years warning to get their people geared up.

So I think that you can use that. But the other part is relicensure, and some states are beginning to talk about that, just because there is so much interest of recredentialing in many different professional areas. So I hesitate to say that, at least from my opinion, I think the commission should require it as a condition of relicensure because I think working with professional societies that in a number of areas you get a better kind of change when you try and work with them as long as they're willing to work in certain areas than by mandating this kind of thing because we all know, you know, you can produce cardiology in Maui seminars, and it may not actually result in people being willing to see HIV patients and know how to take care of them.

But I think at least trying to build that in or set up more continuing education with those kind of professional society backing can be very important. Unfortunately, up until now it's tended to be the kind of thing that is offered out of HIV centered programs which tend to just reach the converted a lot of the time rather than the larger mass of practitioners.

MR. J. ALLEN: Dr. Selwyn, could you briefly describe what type of medical fellowship programs or whatever is available to try to get young physicians to become specialists in taking care of people who are substance abusers? I honestly don't know. I'd be interested in what is the process to try to get people into this area as a specialty? How many programs are there, and about how many young people come through on an annual basis?

DR. SELWYN: I can't answer all those questions, but some of them perhaps. There are probably, at least of what I'm most aware, five to ten programs I can think of nationally that are post-graduate medical training fellowships in substance abuse. As I mentioned just earlier, there's been a lot of interest in substance abuse training linked to AIDS training, and there have been several just within the last year that have been developed strictly geared towards training people to work in areas involving both AIDS and substance abuse. But separate from that, there are, I would say, perhaps five to ten, again, of what I'm familiar with.

In general, in terms of sort of movement towards integration into medical school curricula, I wouldn't say that there is any integrated process or systematic process

going on at all. It's really just in the schools where there happens to be a strong critical program. Usually what has resulted has been that there has been some integration into the core curriculum. Interestingly, though, and it gives something of a historical perspective, there were a series of fellows in substance abuse initiated by NIDA or NIDA's predecessor agency back, you're talking about 10, 20 years ago, before I personally was involved in the field, but from what I've heard many of the people who are now sort of leaders in substance abuse treatment, both clinical and research aspects were graduates essentially of these early substance abuse training programs.

So it's in a sense a very topical example of how sort of strategically geared fellowship and post-graduate training funds can, in fact, result in a process which then takes on sort of implications beyond that. So at this point, it's not something systematic, but there are certain examples and we have probably historical precedent for the success of that kind of activity.

There is a professional association of physicians primarily -- it's called the American Society of Addiction Medicine. It used to be called the American Medical Society

for Alcoholism and Other Drug Dependencies. And I think they decided that if they had any hope of making it as a professional organization, they had to streamline the acronym a little bit, so it's now called ASAM as opposed to AMSAODD, and they have a -- there's a certification exam, and in fact, it even requires recertification, which has been given. I'm not sure when the first exam was given. Perhaps someone here might know, but there's been a great increase in people being credentialed through this system.

It's not a board. It's not a specialty board, but it is a certificate, and it's becoming sort of the standard for people who work in substance abuse fields. And there are some people also working in HIV who have been certified or credentialed in this way. So I think there is some movement in terms of what one has seen in other areas as disciplines have moved towards being recognized. But I would characterize it still as preliminary.

MR. J. ALLEN: Would I probably be correct in assuming that for these five to ten programs that you mentioned that most of them take a handful, two to three per year?

DR. SELWYN: Yes, I think that's --

MR. J. ALLEN: Dr. Davis?

DR. DAVIS: One or two.

MR. J. ALLEN: One or two.

DR. SELWYN: Yes.

MR. J. ALLEN: Two or three is being generous?

DR. SELWYN: Yes.

MR. J. ALLEN: I almost said one or two, and then I decided, well, okay. Very obviously in terms of a physician backbone to treatment programs, we've got a woefully inadequate number of people coming into the field annually, quite apart from training for all of the other professionals that are needed to help provide the range of services that are critical.

DR. DAVIS: I just would like to say to give this poor man hope, you know, I'm getting ready to become a director of a primary care fellowship in HIV, which I believe is one of the first of its kind in the country. I'm allowed to have two people, not that I think it's going to change the entire face, but at least in the sense of what Peter is talking about in this historical precedent. He and I also came out of a public health care model which was very specific which was the National Health Service Corps.

And now that the National Health Service Corps is going to be given new direction, I do think that's certainly an area that you can impact on because I keep running into he and I trained together, and she was a name to me, and you were a name to me, and there is a whole group of individuals who come through the medical system of care in whatever profession they may be in who all know each other because those were the type of medical care models they were already interested in. I just, often we think we can't find the models. There's something wrong that an internist who reads any general -- and I'm just using one example -- any general book of internal medicine, any regular journal, had to find AMSAODD by going through her local -- what's its new name again? Oh, but anyway -- I'm still used to AMSAODD or whatever.

But there's something wrong that as an internist who wanted to know more about substance abuse, when I wrote my local county whatever, they didn't know how to tell me to train myself in substance abuse, and I was already at Harlem Hospital. So there's obviously a little discrepancy going on here, and I do think that on that level, you know there have to be supportive programs that are already doing what we're

talking about. And I do think when Molly was discussing reapportioning those type of funds and everything, we have to look very carefully -- if I hear Dr. Fauci with the kindness of all his heart say one more time, well, you know, there is just no way to give health care in those structures, well, he's never trained in that structure, he's never worked in that structure, and I don't think he's surrounded by anyone who has ever worked in those structures. And I think there is hope, and if Dr. Fauci will listen, if we can get somebody close to him fast that has worked in those structures.

But when you work in a system where nobody you know who knows anybody else has ever worked in those structures, you cannot change the structures. So, I know that sounds very round about and like what is she trying to say, but that means that like Fauci won't know how to use my fellowship program, and he won't know how to use Peter's, and he won't know who to give the NIAID grants to. So they keep going to the same list of people.

So there has to be a different level of what -- what I want the commission to do is somehow change the power base of medicine. Now is that a large enough mandate?

(Laughter.)

DR. COYE: I wanted to just add one other thing, though, is that we've been talking a lot about medical education of physicians, the nursing education as well, but there is this huge body of physicians who are contracted by substance abuse treatment programs right now. A whole lot of them are physicians who are absolutely regarded as the dregs of the profession, not necessarily because they are not innately capable of being better than what they're regarded as but because of the prejudice against having anything to do with substance abuse.

Frequently, the only people that substance abuse clinics can hire are foreign medical graduates who can't get jobs anywhere else in a community, and so they piece together their time between substance abuse and a few other kinds of places. If you put in place a program that developed intensive training for them, offer them two or three week fellowships where they came to NIH and got training, and you lifted the prestige of what they were doing, and you said what they are doing is important, for a little bit of money relative to what it costs to train an entire, even a fellow, much less a medical student or something else, very rapidly you could raise the level of training. Give them protocols

about when to refer.

They're not referring these patients. Develop systems for follow-up to make sure they get into primary care somewhere else. So I think again, looking at these problems, not only at long-term strategies, but short-term where can a little bit of work make a lot of difference, could really change the level of care that people in substance abuse experience.

MR. PERNICK: What you say really makes a lot of sense especially for myself who is probably the least informed health care in the whole health care world. Wow. But what you've also been suggesting has to come from within the health care or the medical profession. I represent an agency, the Department of Veterans Affairs, which despite all of its benefits and all the good things it does, has the least regarded within the body of doctors in this country, who probably would rather commit suicide before admitting having had or having an affiliation with Department of Veterans Affairs.

It seems to me that with more people having some sort of an addiction than some of the other problems you are forced to study in medical school, that the whole notion of

addict behavior or addiction in general is something that you should be required to study. Get your profession to make the changes. The AMA, all the other organizations except AMSAODD, which seems to exist already, all three of them; right?

(Laughter.)

MR. PERNICK: I feel the same way. I'll join you.

DR. COYE: If I can just reply. I do see some hopeful signs in the beginning of this substance abuse/primary care linkage initiative that Dr. Goodwin at ADAMHA, and OTI, Dr. Primm, are supporting. I really think for the first time they've got the primary care professional associations at the table with the substance abuse professional associations, and they're going through the same kind of painful process that happened two decades ago in occupational where people sort of feel out their territory and figure out what this is all about.

But if there are some resources to support the recommendations that come out of that group nine months from now or so, I think that they will do what you're suggesting. I think they will suggest from the professional societies themselves the kind of things they can do as well as the

things that federal or state agencies can do. I really agree.

I think it's very important that some of that come of the professional organizations, and they seem to be ready, at least at the level of the representatives nationally, to begin to do that.

DR. SORENSEN: There's another area that we haven't really talked about today that I'm sure you've thought of and you may want to deal with with in your report. In a time where money is shrinking, you probably can't offer much in terms of more money to people, but if you could offer the argument that these activities will cost people less in the long run, I think it really could be helpful. I think that the outreach and prevention obviously are very cost effective, and treatment and providing the HIV medical care in these sites, it saves millions of dollars.

There are studies going on that are doing this. I think, Peter, and your shop has done some, and Ann Stikofski (sic) and Phil Lee over at UCSF. So I would encourage you, given the current situation where we're exploding billions of dollars a day across the water, we are probably going to have to talk in terms of what will save people money. And you may want to put a cost benefit part in every one of the recommen-

dations you make.

MR. STEPHENS: Don, to piggyback a little bit on that as well, the fact of providing a base level of funding for all of the states, no matter what their level of incidence in HIV-AIDS is, would be extremely helpful rather than having your lower incidence states competing with the higher incidence states and losing out continually. So that we can do these prevention and outreach activities and not get to be that further, higher ranking group. Anything that the commission can do, we'd appreciate.

MR. BACA: Talking about shrinking money, one of the issues that I raised this morning was in regards to in-fighting and turf issues. I hadn't heard a whole lot more about that. I guess that San Antonio is the only one who has those problems.

(Laughter.)

CHAIRMAN OSBORN: That's right. That's brand new stuff to us.

MR. BACA: One of the things that I would recommend would be that when we as community agencies are applying for money to the various NIDAs and this, that, and the other thing, that we come together as groups in the community, and

that if we can't talk contractual type agreements, that we at least talk cooperative agreements, and that the people who sit on the panels, who says we're going to get money and who says we're not, look at those issues as priorities and prioritize those and make those number one that are going to work together, and those that apparently are not, sorry, there is no money for you.

CHAIRMAN OSBORN: I think we've gotten to a point, Don, unless there are other pressing things, where I need to take the opportunity to thank people so that they can start meeting their travel obligations in a difficult travel week. You've all been extremely helpful. As I said at the beginning of the day and some of you weren't here, this is not our first visit to the topic of substance abuse because we consider it to be intensely important.

We bring it up not because -- in some instances I must say some of you have expressed yourselves so powerfully that we do keep hearing new things, but we also are hoping that we can help others hear the main themes that have not been listening as well as we agree with you they should. So we'll do our best to keep the conversation going. If it means repeating ourselves, so be it, but thank you so much for your input on behalf of the commission.

(Whereupon, at 4:40 p.m., the meeting adjourned.)

C-E-R-T-I-F-I-C-A-T-E

I, Vicky McLaughlin , the Official Court Reporter for Miller Reporting Company, Inc., hereby certify that I recorded the foregoing proceedings; that the proceedings have been reduced to typewriting by me, or under my direction and that the foregoing transcript is a correct and accurate record of the proceedings to the best of my knowledge, ability and belief.

Vicky McLaughlin