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CALIFORNIA LEGISLATURE
SENATE SELECT COMMITTEE ON
SUBSTANCE ABUSE
SENATOR JOHN SEYMOUR, CHAIRMAN
SENATE SELECT COMMITTEE ON AIDS
SENATOR GARY K. HART, CHAIRMAN

Joint Interim Hearing on
AIDS AND THE IV DRUG USER



Tuesday, October 20, 1987 - San Francisco
Wednesday, October 21, 1987 - Los Angeles

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1 STATE OF CALIFORNIA

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3 JOINT INTERIM HEARING

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5 SENATE SELECT COMMITTEE ON SUBSTANCE ABUSE

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7 AND

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9 SENATE SELECT COMMITTEE ON AIDS

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12 AIDS AND THE IV DRUG USER

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15 STATE BUILDING

16 350 McALISTER STREET, ROOM 1194

17 SAN FRANCISCO, CALIFORNIA

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20 TUESDAY, OCTOBER 20, 1987

21 9:30 A.M.

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26 Reported by:

27 Evelyn Mizak
28 Shorthand Reporter

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2
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Senate Select Committee on Substance Abuse

5 SENATOR GARY HART, Chairman
6 Senate Select Committee on AIDS

7 SENATOR ART TORRES

8 STAFF PRESENT

9 TERRI DELGADILLO, Consultant
Senate Select Committee on Substance Abuse

10 IRENE KAVANAUGH, Secretary
11 Senate Select Committee on Substance Abuse

12 ALSO PRESENT

13 DR. JOHN NEWMAYER
Haight Ashbury Free Clinic

14 DR. WAYNE W. CLARK, Director
15 Community Substance Abuse Services
San Francisco Department of Public Health Services

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17 School of Public Health
University of California, Berkeley

18 DR. NEAL FLYNN, Director
19 Clinic for AIDS and Related Disorders
University of California, Davis; Department of Internal Medicine

20 NAOMI GRAY
21 San Francisco Public Health Commissioner

22 DR. DONALD P. FRANCIS, AIDS Advisor
National Center for Disease Control

23 JERRY DE JONG, Executive Director
24 18th Street Services

25 ZARINAH SHAKIR
26 Multi Cultural Prevention Resource Center

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IV Substance Use & AIDS Education Coordinator
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PRISCILLA ALEXANDER
COYOTE

GEORGE WILLIAMS
Community Health Outreach Worker
Hospitality House

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P R O C E E D I N G S

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1
2
3 SENATOR SEYMOUR: Good morning, ladies and gentlemen.
4 The hour of 9:30 having arrived, I would like to begin our
5 interim hearing.

6 We have a total of twelve witnesses we're going to hear
7 from today, and I want to provide each of them adequate time in
8 which to make their presentation and offer their testimony.

9 Senator Hart, the Chairman of the Senate Select
10 Committee on AIDS, will be joining us shortly, and I believe we
11 may have a number of other Senators joining us later during the
12 hearing.

13 The Senate Select Committee on Substance Abuse has spent
14 the past four years working with public and private organizations
15 throughout the state in an all out effort to reduce drug and
16 alcohol abuse in California. Recently, our war against substance
17 abuse met an uphill battle when the AIDS virus plagued the IV
18 drug using population.

19 Now, not only must we address the debilitating effects
20 of injecting illegal drugs, but we must also focus our attention
21 on changing the behavioral patterns of the IV drug user, which
22 contribute to the spread of this infectious disease.

23 The alarming statistics underscore the urgency of our
24 efforts. For example, experts indicate that nationally over 25
25 percent of all identified AIDS victims have reported a history of
26 IV drug use. Currently in California, approximately 10 percent
27 of the people suffering from AIDS report a history of injecting
28

1 illegal drugs. Furthermore, it is apparent that with
2 approximately 425,000 needle using drug addicts, AIDS prevention
3 must be an integral part of any statewide effort to reduce the
4 illegal use of controlled substances.

5 Although almost anyone is theoretically capable of
6 spreading the AIDS virus, the increasing avenue of transmission
7 is through the IV drug user. Especially prevalent is the
8 transmission occurring as a result of contaminated needle
9 sharing. Recognizing this deadly phenomenon, I on behalf of the
10 Senate Select Committee on Substance Abuse invited Senator Hart
11 and the Senate Select Committee on AIDS to co-sponsor joint
12 public hearings to gather information from experts in an attempt
13 to answer the following questions:

14 One, what can be done to stop the spread of AIDS among
15 the IV drug user population?

16 Two, what can we, as elected officials, do to help you
17 with your efforts to curtail the spread of the AIDS virus in this
18 population?

19 Three, how should the prevention of AIDS be addressed in
20 the statewide Master Plan to reduce substance abuse in
21 California?

22 Although these hearings will cover the prevention,
23 treatment and epidemiological aspects of the relationship between
24 AIDS and IV drug users, Senator Hart and I have encouraged the
25 testifiers in responding to these questions to address the
26 following issues which are of particular concern to the
27 Committees: One, the relationship between AIDS prevention and
28

1 substance abuse treatment; two, the relationship between AIDS
2 prevention and the punishment of illegal drug activity; three,
3 the relationship between the IV drug user, AIDS, and the minority
4 population; four, the spread of the AIDS virus to the non-IV drug
5 using heterosexual population; five, the transmission of the AIDS
6 virus from the IV drug user to an unborn or infant child; six,
7 the relationship between the IV drug user, prostitution, and the
8 sexual spread of AIDS; and, as time permits, the relationship
9 between all substance abuse and the transmission of the AIDS
10 virus.

11 Curtailling the spread of AIDS by the IV drug user
12 population is a major task that could save many lives. I am most
13 confident that with the valuable assistance provided by each
14 expert witness who will testify before us at these hearings, we
15 will have the necessary components to set forth on our effort to
16 prevent the spread of the AIDS virus while simultaneously
17 reducing substance abuse in California.

18 Senator Hart, Chairman of the Senate Select Committee on
19 AIDS, has now joined us. Senator Hart, whose home is in Santa
20 Barbara, has been very active as Chairman of the State Senate's
21 Education Committee, and therefore active in carrying legislation
22 this year to ensure adequate education on AIDS in our schools.
23 And as I said, he's Chairman of the Senate Select Committee on
24 AIDS.

25 Senator Hart, do you have any opening comments?

26 SENATOR HART: Just that I want to commend you, Senator
27 Seymour, for holding this hearing. I think it's on a terribly
28

1 important subject, and you made reference to the fact that lives
2 can be saved if we take appropriate steps and actions.

3 I think this is a very timely hearing, and I'm certainly
4 looking forward to the testimony we're going to hear today.

5 SENATOR SEYMOUR: Thank you.

6 Our first witness this morning will be Dr. John
7 Newmeyer, representing the Haight Ashbury Free Clinic.

8 Dr. Newmeyer, welcome back.

9 DR. NEWMAYER: Thank you, Senator.

10 I'd like to make just five points this morning relevant
11 to the relationship of substance abuse of the spread of AIDS.

12 Before I do so, it's important to clarify what I mean in
13 my discussion of primary risk groups and secondary risk groups.
14 By primary risk groups, I mean the people who are the -- the
15 activities which first seem to be implicated in the spread of
16 this disease. These were three in number: sex between men, that
17 is homosexual sex; second, sharing intravenous needles for the
18 use of drugs; and third, the receipt of blood products either for
19 blood transfusions or part of the treatment for hemophilia.
20 These are the primary risk groups.

21 Secondary risk groups are essentially everyone else,
22 particularly those people who became infected because of contact
23 with that primary risk group member.

24 The first point to make, of course, is that in
25 California, we've mainly seen an epidemic among the first of the
26 risk group members, the homosexual and bisexual men. We like to
27 say men have sex with men, because a lot of these individuals,
28

1 especially in prisons, do not at all self-identify themselves as
2 gay or bisexual. And when we speak of heterosexual intravenous
3 drug users, it's really a much smaller proportion than the ten
4 percent you've mentioned at first. Most of these are gay or
5 bisexual men with a history of use of the needle. Roughly about
6 two percent of the total AIDS caseload has been among
7 heterosexual IV drug users.

8 However, small as these numbers are, we can't be
9 encouraged by them because what we've observed where we've had
10 the opportunity to do research on seroprevalence, that is on
11 people infected with the virus, we see approximately a doubling
12 every year. For example, the Chason data and the Watters data
13 from San Francisco between 1985 and 1986 documented an
14 approximate doubling of the infection rate among heterosexual IV
15 drug users; roughly 6 or 7 percent to about 12-15 percent between
16 '85 and '86.

17 Tomorrow, when you go to Los Angeles, you'll probably
18 hear testimony from Dr. Anglin or Joe Arnold relevant to a
19 similar doubling in Los Angeles, very roughly speaking from about
20 2 percent to 4 percent in the year '86-87.

21 So, if doubling is occurring every year, we can take no
22 comfort from the present seroprevalence rates, seropositivity
23 rates among IV drug users being either one, or two, or five or
24 ten percent range. It only takes about six doublings to get from
25 one percent to 65 percent, and only three doublings to get from
26 the current levels of 8 percent now in Alameda County, for
27 example, to a saturation rate of 60-65 percent. So, when you go
28

1 in a doubling model, you have to realize that one to eight
2 percent, that's three doublings, takes the same amount of time
3 from 8 to 60 percent. So, when we see 8 percent of
4 seropositivity rates, for example, in some of these medium-sized
5 counties, we should be very alarmed indeed.

6 Thus, the epidemic spreads independently in different
7 communities. Winning or losing the battle in San Francisco
8 County has very little to do with winning or losing the battle in
9 Sacramento county or in Shasta County.

10 The second point to make is that because of the
11 relatively small incidence to date of AIDS among IV drug users in
12 California, we've also enjoyed a relatively small amount of
13 secondary spread. One of the two papers I've given to the
14 Committee, "The IV Drug User and Secondary Spread of AIDS",
15 presents an argument and data to support the contention that if
16 you do not have an epidemic or contagion among straight IV drug
17 users, then you will not have secondary spread to heterosexual
18 partners or to children of risk group members. In other words,
19 the so-called bisexual phenomenon, that is where you have
20 bisexuals sleeping with his boyfriend on Friday night and his
21 girlfriend on Saturday night, that doesn't seem to be a
22 widespread enough phenomenon to have led to a lot of spread from
23 bisexual men to heterosexual women.

24 The spread to heterosexual women, roughly three-quarters
25 to four-fifths of it seems to have occurred from intravenous drug
26 using men to their female partners. Likewise, three-quarters to
27 four-fifths of the spread from primary risk group parents to
28

1 children perinatally, seems to have occurred from IV drug using
2 parents to their children. Very little bisexual father, or
3 hemophiliac or blood transfusion recipients involved in it there.

4 And this seems to be likely to be the case in the next
5 several years, because infections in fact are spreading faster
6 among IV drug users than it is spreading among bisexual men or
7 among hemophiliacs or blood transfusion recipients. That means
8 that in the late '80s or early '90s, we can continue to look
9 forward to total dominance of the IV drug user as an individual
10 responsible for spreading the virus to secondary risk groups.

11 What this has as a consequence is first of all that we
12 should not blame non-IV drug using gays at all in 1987 for
13 spreading the virus to the so-called general population. In
14 fact, we could contend that gays who do not engage in intravenous
15 use are responsible for zero secondary spread of the virus.

16 I think that is important for policy makers to realize
17 so that they can help to remove the onus of infection of the
18 population from the gay male subgroup. That subpopulation has
19 enough to worry about without being inappropriately blamed for
20 spreading the virus among the general population.

21 On the other hand, we do have to realize that the IV
22 drug user is responsible for the great bulk of the spread. As I
23 contended in my paper, between three-quarters and four-fifths of
24 the responsibility is upon the straight IV drug user.

25 That means that to the extent we're interested in
26 preventing secondary spread in the population, and I think that's
27 just one of many motivations vis-a-vis the AIDS epidemic, to the
28

1 extent that's our motivation, we should really focus on the
2 intravenous drug user and spend a lot of dollars per capita on
3 that individual to prevent any more of them from becoming
4 infected and to prevent them from spreading their infection to
5 their sexual partners or their babies.

6 The third point I'd like to make is that we have
7 developed over the last three or four years a fairly strong
8 armamentarium of methods that seem effective in dealing with the
9 problem of preventing AIDS among intravenous drug users. And
10 this summer, just during the last two or three months, I'm happy
11 to report some additional research data which confirms the
12 efficacy of these efforts. I won't go through the seven elements
13 in what I think are the seven methods that thus far have proven
14 themselves, just to mention them briefly.

15 First of all, the community health outreach workers, the
16 so-called bleach method, bleach and condoms, to go out into the
17 field and tell the intravenous users, "Look, you're at risk for
18 AIDS. You should be either no using needles at all, or not
19 sharing needles, or at least disinfecting your works with bleach
20 every time you share them." And going back to the same people
21 and supporting them in avoiding such risky behaviors.

22 You'll hear more about this probably from George
23 Williams, my colleague at the MidCity Consortium to Combat AIDS,
24 who will testify this afternoon on that method. But that's an
25 important method to get the user who's still out on the street,
26 instead of waiting for that person to come into treatment.

1 That also has a very important component of one-to-one
2 counseling on the street with a peer person who's street-wise,
3 and who comes back again and again to affirm, and support, and
4 reinforce reducing risky behavior.

5 The research of John Watters of the Urban Health Study
6 has supported the hypothesis that this work is efficacious. We
7 were able at the MidCity Consortium and the Urban Health Study to
8 document that some two-thirds of intravenous drug users in
9 targeted neighborhoods had used bleach as a disinfectant, and
10 nearly two-thirds of those claimed to have used it all or nearly
11 all of the times that injection equipment was shared. So, for
12 these targeted neighborhoods with an outreach program, people are
13 taking to the method and using a technique which is cheap, quick,
14 and convenient to disinfect their works.

15 The other methods in our quiver are increased treatment
16 slots, making treatment available, because treatment after all is
17 prevention, particularly if it's targeted at the intravenous drug
18 users.

19 The third approach is grease the wheel or increase
20 accessibility to treatment, particularly for the high risk IV
21 drug user. And New Jersey has instituted the coupon program,
22 which is described in my paper, for getting coupons for quick and
23 free access to treatment for the high risk IV drug users.

24 Self-help groups are very important. Of course, we have
25 the Alcoholics Anonymous, and there is such a thing as Narcotics
26 Anonymous, and today we even have "junkie unions". I think gay
27 men provide a very powerful and attractive model here that
28

1 community help itself to protect itself against the virus, and
2 our outreach workers themselves, most of them ex-users, are kind
3 of self-help ex-users helping their still using fellows to become
4 free of the threat of AIDS.

5 Increased testing availability helps users to become
6 aware of their sero status, and as John Watters puts it, "There's
7 no atheists in the foxhole." When you find out you're
8 seropositive, suddenly you become a believer in treatment, want
9 to go into treatment. You really are concerned that you want to
10 quit the use of the needle and get healthy.

11 Sixth approach, of course, is needle availability or
12 exchange, not yet legal in California, but there can be de facto
13 forms of increased availability of sterile injection equipment.

14 Finally, the approach of outreach vans has proven
15 efficacious in New Jersey, bringing a van with a physician, and
16 with counseling, with bleach and condoms, with other materials,
17 to the users in the sites where intravenous drug users
18 congregate.

19 So, we have a lot of arrows in our quiver, and a lot of
20 efficacious methods that this summer's research, I think, has
21 proved useful in approaching the problem of reducing the risk of
22 IV drug users.

23 What's really developed just this year, though, and this
24 is the fourth point I want to make, is the ability of all these
25 groups to work together to provide in a given city a menu of
26 alternatives to prevention and risk reduction that can be
27 selected among, given the political and financial constraints of
28

1 the community or county. So, it's important to provide a list of
2 alternatives so that a county which is more strapped for cash, or
3 more restrained in what it can do politically, can at least
4 choose several among these several methods as its integrated
5 approach for prevention and risk reduction among IV drug users.

6 What happens when the groups begin to work together,
7 they become more sympathetic and supportive of one another. We
8 find that in the last year, there's been a turnaround in the
9 attitude of the recovery people, the Narcotics Anonymous people,
10 in their attitude towards methadone. They've become more
11 supportive. After all, we're in this battle together and we have
12 to work against the problem of AIDS, and bury our differences in
13 philosophy about treatment.

14 So, I would encourage the Committee to consider
15 legislating or perhaps recommending to counties that they
16 establish AIDS Substance Abuse Task Forces in the counties, such
17 as has been established in San Francisco and a few other large
18 counties, to get the people who are concerned about the problem
19 of AIDS among drug users working together, talking together on a
20 monthly basis, perhaps sponsored by the county drug program
21 coordinators at their offices. This has been, as I say,
22 marvelous in San Francisco, to get people sitting in the same
23 room, and thinking that they have a common goal.

24 Not forgetting that you can involve law enforcement
25 people in this process. Law enforcement is itself a form of
26 prevention if it's judiciously applied, and there's a lot of ways
27 it can go wrong. One way to go wrong is when law enforcement
28

1 makes sterile injection equipment less available rather more
2 available to the user because a consequence is increased sharing.
3 This has been a problem. You've got to encourage law enforcement
4 people not to bust people for probable cause if they're carrying
5 around a bottle of bleach, or condoms if they're prostitutes.

6 So, as I say, I encourage the formation of task forces
7 within the counties or communities to work together and establish
8 common policy and common political pressure on their county
9 boards of supervisors to get effective risk reduction activities
10 for the IV drug users in place.

11 The fifth and final point to make is that we mustn't
12 forget that there are other aspects of substance abuse and AIDS.
13 Not only is the needle a means of spread of the virus, but the
14 abuse of substances is, first of all, immunosuppressive. Heavy
15 use of certain drugs weaken immune systems, heavy use of alcohol
16 can weaken the immune system. And second, heavy use of drugs or
17 alcohol can be a disinhibitor. You get drunk, you forget your
18 inhibitions; you forget about safe sex; you forget about safe
19 needle use; and that becomes a cause of increased risk for AIDS
20 virus contagion.

21 One of the things that can be done is encourage counties to
22 work with their gay and lesbian populations to develop self-help
23 groups. The most effective model in alcohol seems to be the
24 12-step or Alcoholics Anonymous model, and it's worked
25 wonderfully in San Francisco as a means to reduce risk among gay
26 men who, through substance abuse, might have put themselves at
27 risk through the disinhibition. So, we're encouraging people to
28

1 contact Jerry de Jong and his group at 18th Street Services to
2 find out how San Francisco does it in setting up the 12-step
3 model among the gay male population. That's the biggest thing
4 happening now in San Francisco; the largest contingent ever Gay
5 Parade in June is the gay men and women who are in recovery for
6 abstaining from alcohol through a 12-step model.

7 So, those are the points I wanted to make. To
8 recapitulate briefly, the problem is at hand. It's double every
9 year. If nothing is done, it will increase towards saturation
10 levels in each community where there are intravenous drug users.

11 Secondly, that if you don't stop it among the IV drug
12 users, you'll have a problem with secondary spread. That will
13 pretty much be absent if you don't have a problem among IV drug
14 users.

15 Third, we have at least seven efficacious methods to
16 deal with the problem.

17 Fourth, you get the people who are practitioners of
18 these several methods to work together. They will start
19 supporting one another and develop a common front and a
20 coordinated effort and will help counties or communities
21 themselves to split the pie appropriately, the prevention dollar
22 pie.

23 And fifthly, not to forget that there are other means,
24 other ways in which substance abuse leads to risk for contracting
25 the AIDS virus.

26 Thank you very much.
27
28

1 SENATOR SEYMOUR: Dr. Newmeyer, thank you. If you'll
2 just stand by for perhaps some questions from our Members.

3 I wanted to welcome Senator Art Torres in joining us
4 this morning. Senator Torres is from Los Angeles. He has been
5 very out spoken not only on the issue of AIDS, but substance
6 abuse as well. He serves in quite a number of capacities in the
7 Senate, in particular he is here today as a Member of Senator
8 Hart's Select Committee on AIDS.

9 We welcome you, and if you'd like to make some
10 appropriate comments, now might be the time.

11 Do we have any questions of Dr. Newmeyer? Senator Hart.

12 SENATOR HART: Thank you, Dr. Newmeyer. I find your
13 testimony interesting.

14 To someone who doesn't know much about the IV drug
15 culture, some of my questions may seem a bit naive, but we have
16 to start somewhere.

17 You mentioned and said that perhaps someone later is
18 going to speak about this bleach phenomenon. I've read somewhere
19 where it's not 100 percent effective.

20 Can you give me some better understanding to what extent
21 this is a safe procedure?

22 What immediately comes to mind is, like condoms, it
23 reduces risk but it's not entirely safe.

24 DR. NEWMAYER: That's true. We can't tell the folks
25 that they're 100 percent free of risk if they rinse their
26 workings with bleach. Like a condom, there could be some things
27 that go wrong: fail fully to draw back the barrel of the syringe

1 and the little virus can hide at the top; or there could be other
2 ways in which the virus is not fully destroyed by the bleach.

3 In the laboratory, even bleach in a 1-10 dilution very
4 quickly kills the AIDS virus and very completely. So, in the
5 laboratory, bleach is effective.

6 We need tests of the kind of in the street applications
7 of the bleach method. I feel, though, that we're well in the 90
8 percent efficacy range for a practical way in which the needle is
9 used or the bleach is used to sterilize the needle.

10 George Williams, I think, this afternoon will talk about
11 what he's observed on the street with the folks actually using
12 the bleach. It's important, though.

13 SENATOR HART: Your testimony is that you think when
14 this is used on the street, it's 90 percent effective?

15 DR. NEWMAYER: It's at least 90 percent effective.

16 The importance here is to get word from the street back
17 to the people who are running the programs or who are running the
18 counties. So, I would encourage that each county that sets up a
19 task force have representation from the people who are ex-users
20 or perhaps even users now. You'll hear from them that you need
21 to talk the language of the street. That language may be
22 Spanish; that language may be a kind of lower socioeconomic
23 status argot. So that you get the message across to the people.

24 The difficulty we had at first was, we tried to talk to
25 the people on the street in the language of doctors and nurses,
26 and that was a mistake. We printed nice brochures and pamphlets,
27 which beautifully spelled out the risk of AIDS, the nature of
28

1 AIDS, ways to prevent getting it, but it didn't talk to the
2 people in the language they understood. So, there's cultural
3 appropriateness that's important here, and also feedback from how
4 the bleach and how the condoms are actually being used to make
5 sure that we're getting -- approaching 100 percent efficacy.

6 SENATOR HART: Can you tell me, in your work in this
7 area, what percentage of people who use IV drugs use bleach or
8 take appropriate precautions to try and have clean instruments?

9 DR. NEWMAYER: Well, the Urban Health Study looked only
10 at the neighborhoods that we targeted heavily with the outreach
11 workers. We, as I say, found about two-thirds of them were using
12 some sort of sterilization technique at least some of the time,
13 and two-thirds of those, or a little less than 50 percent of the
14 total, were using it essentially all the time.

15 As far as knowing that they should sterilize their works
16 or avoid sharing needles, that's nearly a hundred percent in San
17 Francisco and, I think, Los Angeles. People are aware that
18 they're at risk, but to help them, you have to empower them with
19 a method that's quick and easy and convenient to take steps to
20 protect their own health.

21 We broke down the myth that the junkies and speed freaks
22 don't care about their health. They do care about their health,
23 but you've got to make it easy and quick and convenient for them
24 to take steps to protect their health. So we thought, well,
25 we'll get a moral equivalent of the condom that you can carry in
26 your pocket, thus the little bottles of bleach.

27

28

1 SENATOR HART: So it's two-thirds in areas where there's
2 been an outreach program. You're saying two-thirds use it some
3 of the time but not necessarily all of the time.

4 DR. NEWMEYER: Right.

5 SENATOR HART: In areas where you don't have outreach,
6 it's substantially less?

7 DR. NEWMEYER: Substantially, that's why we are trying
8 to blanket all of San Francisco, so at least our county's IV
9 users can protect themselves.

10 SENATOR HART: What about the issue, and I presume it's
11 politically sensitive, but giving away free needles? Has that
12 been ever seriously considered or pursued?

13 DR. NEWMEYER: Yes, we've broached it as long as three
14 years ago. It's an obvious approach that seems to work in
15 European communities.

16 However, we recognize it's politically difficult, and
17 we've, as I say, have developed six other arrows in our quiver
18 because we felt, at least in California, it's politically
19 difficult to do this particular approach now. But there is, at
20 least in San Francisco County, a de facto availability of sterile
21 needles. Especially the middle-class junkies and speed freaks
22 know how to go into a pharmacy and say, "I'm a diabetic. I don't
23 have my card with me. I need some sterile needles."

24 So, if law enforcement winks at this, in effect law
25 enforcement becomes the ally of prevention because we believe
26 this indeed -- people do this because they want to avoid sharing
27 needles, and in effect they're avoiding the AIDS virus.

1 SENATOR HART: Who is responsible for giving out the
2 bleach? Is that through some State subsidized fund at all?

3 DR. NEWMAYER: This is the MidCity Consortium to Combat
4 AIDS, and it's had support at all levels: from the county, from
5 the State, and from the federal government. And we've worked
6 closely with people in Sacramento and Washington.

7 SENATOR HART: The State is on record as supporting this
8 particular approach?

9 DR. NEWMAYER: Yes. I would emphasize, though, that we
10 take care to bring the bleach and the information to the people
11 who are already intravenous drug users, and also the first thing
12 we say to them is, "Let's get you into treatment. Are you ready
13 for treatment?" So in those ways we affirm that the best way to
14 avoid the virus is to stop using needles altogether.

15 SENATOR HART: One other question, if I may, Mr.
16 Chairman. A question of drug treatment.

17 Was it your testimony that we're already sort of
18 oversubscribed in drug treatment? If someone says, "I want to go
19 into drug treatment," you have to wait in line?

20 DR. NEWMAYER: Certainly in this county there's a
21 waiting list for all the programs, but if the State's not willing
22 to double the treatment dollar expenditure, which is obviously an
23 excellent idea because you get benefits not only from AIDS but
24 also from reduced crime and other benefits, but if the State
25 doesn't double the money, at least it could add a little bit of
26 money and say, "Look, let's make these monies especially
27 available for persons who are high at risk for the AIDS virus."

1 For example, Ward 92 here in San Francisco now focuses almost all
2 of its treatment on seropositive IV drug users or IV drug users
3 who have AIDS or ARC.

4 SENATOR HART: Thank you.

5 SENATOR SEYMOUR: Dr. Newmeyer, just a couple of
6 follow-up questions.

7 First on law enforcement being a positive force. You
8 mentioned a couple of examples were they would be a positive
9 force, I assume, for not making a bust when they carry a bottle
10 of bleach, to -- you used the words "wink at" certain conduct.

11 My question is, in what other ways can law enforcement
12 be a positive force with this problem?

13 DR. NEWMAYER: Well, law enforcement means to reduce the
14 growth of substance abuse.

15 SENATOR SEYMOUR: Right.

16 DR. NEWMAYER: And if it particularly targets cocaine,
17 methamphetamine and heroin, and it's efficacious at reducing the
18 availability of those drugs in the communities, then I think it
19 becomes the ally of the AIDS prevention effort.

20 But as I say this has to be judiciously done. There's a
21 certain elasticity in the demand for a drug like heroin, and
22 making it more scarce and expensive doesn't necessarily change
23 the prevalence of use because you're dealing with addiction here.

24 However, I think law enforcement does play a role in
25 making a career as a intravenous drug user less attractive to the
26 young person who might think of starting to use the needle, by
27 busting the dealers, busting people who might become ghetto
28 heroes if they were left free to practice their nefarious trade.

1 So, law enforcement can reduce the attractiveness of a
2 career as a user or dealer of drugs, and that's helpful.

3 SENATOR SEYMOUR: The second question has to do with
4 other politically sensitive issues, testing.

5 What is your experience relative to IV drug users who
6 check in for one or another treatment program and their desire to
7 have a test for AIDS?

8 And the second part of the question would be, to the
9 degree they do not desire that, is it of merit to consider what
10 would happen if, when checking into a program, part of the
11 program was to submit to an AIDS test?

12 DR. NEWMAYER: It would decrease the interest in the
13 program then. We have a saying that when untested blood is
14 outlawed, only outlaws will have untested blood.

15 Users are very wary of anything that is mandatory or
16 which exposes them to increased surveillance.

17 SENATOR SEYMOUR: What percentage of IV drug users
18 willingly seek a test on AIDS having checked into a treatment
19 program?

20 DR. NEWMAYER: I can't answer that question. I'll leave
21 that to my colleagues.

22 SENATOR SEYMOUR: We'll ask someone at a later time that
23 question.

24 You make it clear in the area of education that perhaps
25 the sophisticated techniques, if that's an appropriate
26 description, really isn't equipped to go into the streets to
27 provide that educational message, and that there is an entire
28

1 culture at work here that appears almost, I would assume, that we
2 need to address.

3 Are you familiar with with some specific examples of
4 programs where education on AIDS and IV drug use have been
5 successful?

6 DR. NEWMAYER: Yes, I think we can demonstrate that even
7 an hour of exposure to training or information turns around the
8 level of knowledge and the attitudes of the IV drug users. They
9 are intelligent, or as intelligent as the general population
10 about their health.

11 SENATOR SEYMOUR: You had indicated, Dr. Newmeyer, that
12 close to 100 percent of IV drug users are aware --

13 DR. NEWMAYER: Yes.

14 SENATOR SEYMOUR: -- of the dangers of contacting AIDS
15 through IV drug use.

16 On the other hand, you also made the statement that when
17 you shot up, or you're inebriated on alcohol, you don't have all
18 your faculties, and therefore you're subject to.

19 So, I'm not so interested in the hundred percent that
20 know there's a problem. I'm more interested in perhaps a feel
21 for how effective -- what are the most effective education
22 programs to the community, IV drug user community, to get them to
23 change their habits, ideally give drugs up?

24 DR. NEWMAYER: In my judgment, the most effective
25 program is one which addresses not beliefs or attitudes, but
26 behavior. And that means reinforcement on a one-to-one basis,
27 getting people who are peer counselors out there to go back to
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1 the person and reinforce, say, "That's a good thing," or, "Here,
2 I can help you. What problem are you having?" Give them,
3 empower them to say, "No, I'm not going to share," or, "I'm not
4 going to share without disinfecting that needle."

5 SENATOR SEYMOUR: One last question in that regard.

6 Do you find a significant number of current IV drug
7 users going into their community and saying, "Hey, I shoot up,
8 but if you're going to do it, use a bleach sit, clean needles, et
9 cetera?"

10 DR. NEWMAYER: Yes, I think George Williams will attest
11 to that this afternoon.

12 SENATOR SEYMOUR: Any other questions?

13 Dr. Newmeyer, we certainly appreciate your testimony.
14 Thank you for being with us today.

15 DR. NEWMAYER: Thank you.

16 SENATOR SEYMOUR: Our next witness is Dr. Wayne W.
17 Clark, who's the Director of Community Substance Abuse Services
18 for the San Francisco Department of Public Health Services.

19 Dr. Clark, thank you for taking the time to be with us.

20 DR. CLARK: I thought I might begin by just answering
21 one of the questions that Dr. Newmeyer addressed but didn't
22 complete.

23 We've been taking a waiting list now in San Francisco
24 for the last three months, and on a weekly basis have over 500
25 people waiting to get into our treatment services that are
26 potentially at risk to the spread or infection for the HIV virus.
27 We feel that is a problem that the State especially needs to
28 address.

1 My remarks are geared toward that.

2 SENATOR SEYMOUR: Dr. Clark, before you proceed, I have
3 an immediate question on the point you just made.

4 Those 500 that are waiting to get into treatment, what
5 do you do for them other than take their names? Do you give them
6 information?

7 DR. CLARK: Correct. We give them AIDS education and
8 information, and we try to keep in contact with them so we can
9 get them into treatment as quickly as possible. But
10 unfortunately, the treatment availability in San Francisco and, I
11 think, throughout the State of California, is woefully
12 underfunded.

13 My remarks today are at the less attractive part of
14 prevention, and that is tertiary prevention. Tertiary prevention
15 is an aspect of treating those people who are either infected or
16 at risk for the spread of a public health problem, in this case
17 HIV infection. And I want to talk specifically about treatment.
18 I think there will be others today that will talk about the
19 different education and information methods, modalities, outreach
20 efforts.

21 In San Francisco, we have tried to have a balanced
22 approach. We don't know anything that works 100 percent of the
23 time, but we do feel that there are a number of weapons that we
24 can employ in the battle against AIDS.

25 Every time an IV drug user is successfully enrolled in
26 substance abuse treatment, then five other person will no longer
27 be at risk for contracting HIV infection. Today I would like to
28

1 approach the development of a substance abuse treatment designed
2 to prevent the spread of HIV infection in the State of
3 California.

4 I've attached an article from the New York Times which
5 illustrates there is considerable opportunity for using substance
6 abuse, residential and out-patient treatment programs to
7 effectively reduce needle use and stop unsafe sexual practices.
8 These two practices account for over 85 percent of HIV
9 transmission and are usually performed under the influence of
10 mind altering substances. Substance abuse treatments can
11 significantly impact the spread of HIV infection until an
12 effective anti-viral agent is available.

13 We need to go beyond the quick fix. I will not focus my
14 attention today on other more common approaches to substance
15 abuse prevention, such as client recruitment, community outreach,
16 or even school-based education. Instead, I will let the many
17 other speakers focus their attention on the issue of educating
18 and informing the public. Nor will I belabor you with statistics
19 on the spread of the epidemic. I'm sure Dr. Newmeyer and others
20 will speak to that.

21 Instead I will present a strategy designed at changing
22 the drug addict's behavior, a subject in which I feel the
23 substance community is especially expert at. Substance abuse
24 treatment can be and is prevention for AIDS.

25 At this time, most public policies for substance abuse
26 related HIV infection are targeted toward primary and secondary
27 prevention. Tertiary prevention or direct substance abuse

1 treatment interventions are not considered as effective a method
2 for controlling this epidemic. Public policy seems to be relying
3 on more general prevention and outreach strategies.

4 In San Francisco, we have pioneered community outreach
5 efforts. John Watters and other from the MidCity Consortium have
6 been excellent in getting out into the communities and using
7 persons that are recovering from their addictions to go and talk
8 to others that are still sharing and using needles.

9 We attempted to balance our long-range substance abuse
10 related AIDS prevention strategies between the street outreach,
11 client recruitment, and direct treatment services. California,
12 in fact, has been a supporter of these efforts through the
13 allocation of recent federal War on Drug funds for substance
14 abuse treatment to prevent the spread of AIDS. Unfortunately,
15 these funds were one-time federal monies with no guarantee of
16 ongoing funding, and we're not matched by any State general fund
17 dollars.

18 Today there is a need for California, the California
19 Legislature, to initiate and triple the size of the substance
20 abuse budgets over the next three years. This effort would be
21 targeted toward the at risk populations who are basically under
22 the age of 60, who are future or currently sexually active
23 citizens. And this effort to increase treatment availability
24 should only be undertaken while continuing the education and
25 information activities already begun by the Department of Health
26 Services.

27

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1 We feel that we have learned many lessons in education
2 and motivation regarding substance abuse. The expansion of
3 substance abuse treatment capacity is necessary, we feel, for two
4 fundamental reasons. First of all, substance abuse treatment has
5 been shown to be effective in reducing the continued use of
6 injectable and other mind altering drugs. We must remember that
7 the reduction of needle sharing and under the influence
8 disinhibited sex is of first importance for stopping HIV
9 transmission from the infected to the uninfected. Moreover,
10 substance abuse treatment for at risk seronegatives, those who
11 are not testing positive for HIV infection, will also help
12 prevent the uninfected from becoming infected. Treatment
13 interventions ensure this reduction by fostering abstinence from
14 drugs, or we might even add, prescribing non-intoxicating
15 medicinal substitutions such as methadone for intervening with
16 the IV drug user. These efforts in the war against HIV infection
17 are accomplished through the expansion of substance abuse
18 treatment services.

19 There is a recent advertisement in the -- one of the
20 newspapers that the best prevention for AIDS is to treat a
21 treatable illness, and we feel that's substance abuse, which is a
22 treatable illness.

23 The second reason that expansion is necessary is that
24 during the current anti-drug push, there already has been an
25 increase in awareness of the dangers of drug abuse which, in our
26 community and I'm sure throughout California, has resulted in a
27 subsequent demand for services. In San Francisco, persons
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1 seeking substance abuse treatment are placed on waiting lists for
2 up to six months. There's an average of over 500 persons per
3 week that are on waiting lists.

4 Unfortunately, many drug abusers never return for
5 treatment. Instead they return to high risk behavior. This lack
6 of intervention is an intolerable but common phenomenon
7 throughout California and portends to continual spread of HIV
8 infection.

9 We think the California Legislature and the
10 administration should set some goals. We should reduce
11 seroconversion. It is my request that the California Legislature
12 adopt the following goals: To hold the seroprevalence of HIV
13 infection to within five percentage points of its 1987 rates.
14 California needs to mount a virtual Manhattan Project in the
15 research, prevention, education, and care of the AIDS patient.
16 Federal, State and local governments, universities and private
17 sector resources are needed to be amassed in order to mount the
18 war against AIDS. An entire arsenal of prevention strategies,
19 from mass media campaigns to community based activities, are
20 indeed needed. We feel very strongly that substance abuse
21 treatments are important strategies in this prevention battle.

22 The California Legislature itself needs to take the
23 leadership to create an additional \$20 million in annual
24 expenditure of general fund monies for substance abuse treatment
25 services each year for the next three years.

26 We feel that there's an example of same-day service
27 which could be very important in preventing HIV infection. The
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1 availability of services for what usually are considered under-
2 motivated health care consumers is very important, so the
3 availability of substance abuse treatment services and the
4 accessibility of treatment programs is essential to stop
5 substance abuse and thus reduce the spread of AIDS.

6 Moreover, we feel that this attempt is a realistic goal.
7 Community treatment grants could be established in key areas
8 where the IV AIDS cases are high and where there is large
9 concentration of uninfected IV drug users. Targets for these
10 grants would be metropolitan areas such as San Jose, Sacramento,
11 Anaheim, Los Angeles, Long Beach, San Diego, Sonoma County,
12 Fresno, Oakland, and then of course, San Francisco. The impact
13 of these service expansions would be dramatic and certainly bring
14 into balance the primary and secondary prevention -- the primary
15 approach of the National Institute of Drug Abuse and the Center
16 for Disease Control, into balance in the California effort.

17 I'd like to give two examples of why I think that this
18 actually works and can work. In 1986, we received some funding
19 from the State for the development of an out-patient drug
20 treatment program. Jerry de Jong will talk about that program
21 later on. That program now has served over 180 different HIV
22 infected individuals who, without that service, would have
23 continued to have either abused substances and potentially spread
24 the HIV infection.

25 Another example comes from New York City, where they
26 recently opened an additional 500 methadone spaces, and the were
27 filled within days. There is a demand for service. If services

1 were available, we would get at risk individuals off the streets,
2 abstinence from their drug of choice, not sharing needles, and
3 performing safe sex.

4 The point is that substance abuse treatment -- substance
5 abuse is a treatable disease, and with adequate resources can be
6 a powerful tool in the fight against the spread of AIDS.

7 We feel that policy makers like yourselves should not
8 enter into a new initiative without adequate assessment of the
9 impact that these have. In the case of AIDS prevention, it is
10 even more critical to know what works and what doesn't. We feel
11 that substance abuse community network grants to prevent the
12 spread of AIDS should be carefully measured for their success in
13 reducing HIV infection as well as substance abuse.

14 Never before, I would think, in the substance abuse
15 field have we felt it so important to find out what exactly
16 works, how well it works, and for what populations. Our clients,
17 our colleagues, have been infected with AIDS. Some have died.
18 We know this. We work with them, and we've tried to help them,
19 and we feel that there is no better avenue for prevention of this
20 epidemic than to help an addict get off of drugs.

21 In conclusion, I would like to reiterate the assertion
22 that substance abuse treatment is an effective weapon in the
23 prevention of HIV infection. Substance abuse funding needs to be
24 increased in California by Californians for the protection of
25 California's health.

26 Thank you very much.

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1 SENATOR HART: Thank you very much, Dr. Clark. Let me
2 ask a couple of questions.

3 I was intrigued by your comment that the State needs to
4 set goals, and you said the specific goal as it relates to the
5 HIV infection rates.

6 Could you elaborate on that a bit? Why did you pick
7 that particular figure, and why do you feel that goals are
8 important in sort of overall strategy that we're embarking upon?

9 DR. CLARK: We're currently looking at in San Francisco,
10 in fact actually in our substance abuse area, of going to a
11 retreat. We have set goals to try to keep the doubling that Dr.
12 Newmeyer expressed from happening at least two years ago. And we
13 are not doing as well as we would like to. In fact, if you look
14 at our 4 percent seroprevalence rate in 1985, and 8 percent
15 seroprevalence rates in 1986, and a 16 percent seroprevalence
16 rate in 1987, we feel that we are in fact not reducing the
17 doubling that has occurred in New York. Next year it could be 32
18 percent, and the following year 64 percent.

19 We feel that we want to set goals, look at the
20 objectives of program we've implemented to manage those goals and
21 keep the seroprevalence rates low. We feel that it's a very
22 difficult task.

23 The AIDS virus is extremely tenacious, and it's infected
24 many parts of our population. Goal setting, we think, is very
25 important.

26 SENATOR HART: And the specific goal that you suggested
27 here --

1 DR. CLARK: Keeping the seroconversion rate low, within
2 several percentage points. We think that's at least a mechanism
3 to try to take those that are infected from transmitting it to
4 others and keeping the infection rate low.

5 SENATOR HART: Let me ask one other question.

6 The Governor in vetoing funds that the Legislature had
7 appropriated has said, and his general rhetorical statement is:
8 California is already doing so much more than other states.

9 I'd be interested in your response to that, particularly
10 in light of the experience of New York and New Jersey who, as I
11 understand it, the infection rates due to IV drug use is much
12 higher there.

13 Are we doing that great a job than the other states? Do
14 we have anything to learn from other states either in terms of
15 their educational efforts or efforts on the part of the
16 legislatures or governors of those other states?

17 DR. CLARK: I think probably in actual dollar numbers,
18 it seems that we're doing more. But as far as where we are in
19 the epidemic and where we can be in the epidemic in three or four
20 years, we're doing far less than we should.

21 We do not want to have a 60-65 percent seroprevalence
22 rate among our IV drug users in another two or three years. If
23 we have that, then we will have massive Medicare and Medicaid
24 costs to the State of California.

25 There is, I think, another article, and I don't think I
26 have it for you, but it was in the New York Times. It showed a
27 man who was sitting in a hospital, basically, because he was an
28

1 IV drug user and did not have any placement in the community.
2 And at \$400-600 a day in New York City, that's where his
3 treatment was. He was fairly healthy. He needed some other
4 place to be, and the expenditure for those kind of funds in New
5 York is horrendous. They did not spend the money, that we should
6 be spending now, three or four years ago to prevent the spread to
7 the IV drug community.

8 SENATOR HART: Thank you.

9 SENATOR SEYMOUR: Other questions?

10 Dr. Clark, thank you very much for your testimony. We
11 appreciate that.

12 Our next witness is Dr. Nancy Padian from the School of
13 Public Health, University of California at Berkeley.

14 Doctor, welcome.

15 DR. PADIAN: Thank you.

16 Rather than speak about prevention, I'm going to take
17 the opportunity to review the epidemiological data associating
18 intravenous drug use and the heterosexual transmission of AIDS.

19 As of October 5th, 1987, close to 3,000 AIDS cases have
20 occurred among women. That's 7 percent of the total of 41,779.
21 And 916 cases have been attributed to heterosexual contact with a
22 person with AIDS or at risk for AIDS, approximately 2 percent of
23 the total.

24 Although 2 percent may seem like a small proportion, in
25 absolute terms this number has more than tripled over the last
26 two years. That is, although the relative distribution of cases
27 has remained relatively constant, the absolute number of
28 heterosexually transmitted AIDS cases has risen dramatically.

1 Intravenous drug users play a significant role in
2 maintaining the heterosexual spread of AIDS for five reasons:

3 One, more than half of all AIDS cases among women have
4 occurred among female intravenous drug users.

5 Two, the next largest source of infection among women
6 occurs through heterosexual transmission, sexual contact with an
7 infected partner, and intravenous drug users represent the source
8 of infection among most such cases in both male-to-female and
9 female-to-male transmissions.

10 Although I would like to point out that in contrast to
11 Dr. Newmeyer's remarks, bisexual men do in fact represent the
12 next largest source of infection for these women, so it's not
13 zero percent of spread attributed to that, but certainly
14 intravenous drug users present a much greater source of risk.

15 Three, AIDS patients with a history of either
16 intravenous drug use or heterosexual contact with intravenous
17 drug users infected with the AIDS virus occur primarily among
18 Blacks and Hispanics and thus account for a large proportion of
19 the heterosexual spread of AIDS to minority communities.

20 Four, rates of HIV transmission tend to be higher
21 between intravenous drug users and their sexual partners when
22 compared with such transmission between hemophiliacs, bisexual
23 men, or people infected from contaminated blood transfusions and
24 their partners.

25 And five, most cases of AIDS among infants due to
26 perinatal transmission have occurred among mothers who are
27 intravenous drug users or partners of intravenous drug users.

28

1 In 1982, from the beginning of the epidemic,
2 transmission of the AIDS virus was reported in female intravenous
3 drug users and between intravenous drug using men and their
4 female partners. Today, approximately 50 percent of all female
5 cases reported to the Center for Disease Control have occurred
6 among women who are intravenous drug users. In addition,
7 heterosexual transmission of AIDS cases continues to occur in
8 this group. Almost 70 percent of cases attributed to male-to-
9 female heterosexual transmission occurred through sexual contact
10 with an intravenous drug using partner. In New York City alone,
11 87 percent of all heterosexual cases have an intravenous drug
12 user as the primary source of the AIDS virus.

13 It should also be noted that most of the infection
14 observed among minority individuals is associated with
15 intravenous drug use. Statistics compiled a year ago revealed
16 that over 80 percent of all cases attributed to intravenous drug
17 use occurred among Black and Hispanics, and over 85 percent of
18 the cases of heterosexual transmission through sexual contact
19 with an intravenous drug user also occurred among Blacks and
20 Hispanics.

21 Currently, 38 percent of all adult and adolescent AIDS
22 cases have been reported among these same minority groups,
23 whereas together Blacks and Hispanics comprise only 24 percent of
24 the U.S. population.

25 In addition to acting as a reservoir for infection among
26 heterosexuals, intravenous drug users are also important because
27 rates of transmission tend to be higher among their sexual
28

1 partners than among partners of infected individuals from other
2 risk groups.

3 For the last 2½ years, I have been conducting a
4 heterosexual partners study where we recruit the opposite sex
5 partners of individuals infected with the AIDS virus or diagnosed
6 with AIDS or AIDS related complex. Most of my participants are
7 the female partners of bisexual men, and the rest are sexual
8 non-intravenous drug using partners of primarily intravenous drug
9 users or hemophiliac men.

10 Rates of infection tend to be about 25 percent among the
11 sexual partners of men in all risk groups with the exception of
12 intravenous drug users. Since the inception of the study, rates
13 of infection in this group are more than 40 percent.

14 This high rate of transmission has been confirmed in a
15 variety of studies that looked at the heterosexual partners of
16 intravenous drug users throughout the country. In fact, there's
17 a study ongoing in New York which finds rates of heterosexual
18 transmission between intravenous drug users and their partners to
19 exceed 50 percent.

20 One explanation for this phenomenon is that these
21 partners, the sexual partners, at some time were actually
22 intravenous drug users themselves, although they either deny it
23 or cannot recall this exposure at point of entry into the study.
24 Other explanations include biological parameters that may
25 differentially affect infectiousness, causing intravenous drug
26 users to be more efficient transmitters, or causing partners of
27 intravenous drug users to be more susceptible. However,
28

1 regardless of the explanation, the fact remains that whatever the
2 source of the exposure, heterosexual partners of intravenous drug
3 users experience high rates of AIDS virus transmission.

4 The importance of intravenous drug use, directly or
5 through sexual contact with intravenous drug users, has also been
6 noted among prostitutes. A study conducted by the Center for
7 Disease Control among over 1,000 prostitutes nationwide found
8 intravenous drug use and sharing needles to be significantly
9 associated with HIV infection among prostitutes. Similar
10 findings have been corroborated worldwide.

11 I found the same to be true in a study I conducted in
12 collaboration with Dr. James Carlson at the University of
13 California at Davis. We compared HIV infection rates and
14 associated risk between prostitutes working in legal brothels
15 with prostitutes who were incarcerated in the Nevada State
16 Prison. In this study, intravenous drug use or sexual contact
17 with intravenous drug using men was in fact the only risk
18 associated with HIV infection. Numbers of sexual partners,
19 numbers of sexual contacts, types of sexual behavior, use or lack
20 of use of condoms were not correlated with AIDS virus
21 transmission. This study highlighted the importance of
22 intravenous drug use in the heterosexual spread of AIDS, and the
23 fact that at this point in the epidemic, heterosexual promiscuity
24 per se probably contributes less to maintaining the spread of the
25 disease than does intravenous drug use.

26 Finally, it cannot be emphasized enough that anything
27 that promotes heterosexual transmission also promotes perinatal
28

1 transmission from others to their unborn children. Eighty
2 percent of all AIDS cases among children have been due to
3 perinatal transmission, either because their mothers had AIDS, or
4 were at risk for AIDS infection. In New York City, at least 80
5 percent of such maternally transmitted AIDS have been linked to
6 intravenous drug use. Nationwide as of last year, somewhere
7 between 60 and 70 percent of all pediatric AIDS cases were
8 attributed to either intravenous drug using mothers or to mothers
9 who were the sexual partners of intravenous drug users. Again,
10 these cases occur primarily among minority groups, with 78
11 percent of all pediatric cases currently reported among Blacks
12 and Hispanics.

13 In conclusion, much attention has been drawn to the
14 necessity of educating heterosexual individuals about adopting
15 safe sex procedures, such as using condoms and limiting the
16 number of sexual partners. The importance of such measures is
17 not in dispute.

18 However, most heterosexual transmission is actually
19 associated with intravenous drug use, either directly by sharing
20 needles or indirectly through either or both sexual transmission
21 and in utero transmission.

22 The urgency of developing prevention programs in
23 communities characterized by intravenous drug use and sharing of
24 drug injection equipment is obvious.

25 Thank you.

26 SENATOR SEYMOUR: Thank you very much, Doctor.

27 Any questions? Senator Torres.

1 SENATOR TORRES: Doctor, I'm trying to figure out
2 exactly what you've just told us, because it's somewhat confusing
3 to me.

4 When you indicate to us that 40 percent of the
5 heterosexuals which were involved in your 2½ year study, you
6 refer to the fact that some of the partners may have undergone
7 drug abuse prior to their entry into your study.

8 DR. PADIAN: Right. That's a possibility, although
9 certainly we're trying to rule that out.

10 SENATOR TORRES: What percentage would you classify that
11 as a possibility?

12 DR. PADIAN: Well, I -- based on the expertise of my
13 interviews, I would say none. But the difference between
14 heterosexual transmission between intravenous drug users and
15 their partners compared to men in other risk groups and their
16 partners is so striking, and again, it's been confirmed in other
17 studies, that certainly you would have to entertain that
18 possibility, even though we do feel as though to the best of our
19 ability we've ruled it out.

20 SENATOR TORRES: In terms of bisexual men that you
21 referred to in your study, you found the transmission rates less
22 than the IV users?

23 DR. PADIAN: And the same is true in transmissions of
24 hemophilia partners and people with contaminated blood
25 transfusions.

26 SENATOR TORRES: What accounts for that?
27
28

1 DR. PADIAN: Well as I say, one thing that I think you
2 would have to consider is perhaps there are other sources of
3 exposure that we were simply not able to ascertain at the time of
4 the study

5 SENATOR TORRES: Would that account for the fact that
6 probably both partners in your study may have been on drugs and
7 IV users?

8 DR. PADIAN: Well again, I feel as though that's a
9 possibility you have to entertain, although I feel as though to
10 the best of our ability, we've ruled this out. And I should say
11 that in other studies that have looked at partners of intravenous
12 drug users, they too feel as though they've ruled out intravenous
13 drug use in the sexual partner.

14 SENATOR TORRES: And they found similar rates of
15 transmission?

16 DR. PADIAN: Yes, yes. There are biologic parameters
17 that they're looking into. For example, it could be intravenous
18 drug users are more efficient transmitters; maybe they have
19 higher biotighters, maybe they have more circulating lymphocytes
20 that harbor the virus making it easier for them to transmit. It
21 could also be that the partners of intravenous drug users
22 represent a population of people who are, for some reason, more
23 susceptible. There could be nutritional factors, other
24 infections that make the general partner of the intravenous drug
25 user have their immune system being less competent than the
26 partner of a bisexual man, for example, and perhaps making them
27 more susceptible.

1 SENATOR TORRES: What was the income strata, average
2 income of the IV users in your study?

3 DR. PADIAN: I can't give you exact figures, although
4 certainly it was somewhat lower than the other strata.

5 What's more, another interesting factor that I neglected
6 to mention, is that it was about 50 percent of the minority women
7 in my study were in fact the partners of intravenous drug users.

8 SENATOR TORRES: And were they usually living together?

9 DR. PADIAN: Yes, almost everyone in my study was. They
10 were in -- it's not monogamous, fairly long-term relationships.

11 SENATOR TORRES: When you indicated 75 percent of the
12 children who are infected with AIDS are minorities, either Black
13 or Hispanic, are those nationwide?

14 DR. PADIAN: Yes, that's nationwide statistics.

15 SENATOR TORRES: Are they broken down by state?

16 DR. PADIAN: I think that that's available, although I
17 don't have that at my fingertips.

18 SENATOR TORRES: You don't have that figure for
19 California?

20 DR. PADIAN: No.

21 SENATOR SEYMOUR: Any other questions?

22 Thank you very much, Dr. Padian. We appreciate your
23 testimony today.

24 Our next witness is Betty McGee, who's the Program
25 Director for Bayview Methadone Program, Bayview Hunter's Point
26 Foundation. Ms. McGee? Apparently Ms. McGee is not here at this
27 time. Perhaps she will come along a bit later.

1 Is Dr. Neal Flynn here? How about Ms. Naomi Gray?

2 Fine.

3 Ms. Gray, we'll take your testimony and pick up the
4 others a bit later.

5 Ms. Naomi Gray represents the San Francisco Public
6 Health Commissioner.

7 Thank you for being with us.

8 MS. GRAY: Thank you.

9 Honorable Members of this Committee, I am pleased to
10 have an opportunity to discuss the issue of AIDS as it affects
11 Black and other minority populations. You have asked, "What can
12 be done to stop the spread of AIDS virus among the IV drug user
13 populations?"

14 Minority communities in San Francisco, like minority
15 communities nationwide, are experiencing an increase in new AIDS
16 cases, and represent 40 percent of all AIDS cases in the United
17 States. They represent 15 percent of the cases in San Francisco.

18 Recently, the San Francisco Health department expanded
19 anonymous AIDS testing to minority communities. It is only
20 within the past couple of years that attention has been given to
21 the impact AIDS is having on minority populations. However,
22 governmental efforts to stem the tide of the AIDS epidemic in
23 minority communities by providing funds for education and
24 prevention programs has only come about recently. As a result of
25 this delay, there is a denial in the Black and other minority
26 communities that AIDS is a disease that affects them. We have to
27 get past this barrier before we are able to conduct effective
28 education and prevention programs.

1 The Health Commission in San Francisco has
2 responsibility for establishing policies for AIDS programs,
3 services and funding. In fiscal years 1987-88, San Francisco is
4 spending approximately \$18 million of taxpayers' money for AIDS
5 education, services, and treatment. Additional funding is
6 received from the State and federal agencies responsible for AIDS
7 programs. We view AIDS as one of our priorities as we grapple
8 with funding issues as the AIDS crisis continues unabated.

9 The problem of the IV drug user and the AIDS virus is a
10 very difficult problem. We are trying different approaches to
11 reach and educate this group, but I am not convinced that we have
12 found foolproof methods of education and prevention.

13 We do not know if current education and prevention
14 programs are having any significant impact on the problem in San
15 Francisco and elsewhere. IV drug users will not take the time to
16 hear a lecture on AIDS and its prevention, nor will we succeed in
17 getting them to use a condom.

18 Incidentally, the use of condoms among low-income
19 minority groups is reminiscent of days past when condoms were
20 considered a birth control method, and I am not convinced that
21 this attitude has changed significantly.

22 We would hope to prevent the devastating effects of AIDS
23 among IV drug users that is currently being experienced in New
24 York City and other Eastern cities. The San Francisco Health
25 Department is conducting AIDS education, for instance, among jail
26 inmates, many of whom are IV drug users. Here again, we will
27 have to wait for the results as to the effectiveness of this
28

1 program. We have to ask ourselves what happens when these mostly
2 young people return to the community. Do they practice the
3 prevention methods that have been given to them while
4 incarcerated? How responsible will they be in preventing the
5 spread of the virus among their drug using peers and sexual
6 partners? These are unanswered questions.

7 With few exceptions, programs have not been developed
8 that deal with the cultural affects of drugs on ethnic racial
9 minority populations. Most programs are not always sensitive to
10 the different cultural factors.

11 A recent study commissioned by the Alameda County Board
12 of Supervisors, conducted by the Institute for the Advanced Study
13 of Black Family Life and Culture in Oakland, points out the
14 complexities of dealing with the effects of drugs and drug
15 trafficking on the mental health of Black children and families
16 in Oakland. The study concludes that, quote:

17 "In regards to the mental health
18 impact of drug related activity on
19 Black children and families, ex-
20 tensive public education programs
21 that inform Black children and
22 families of the nature and effects
23 of drugs and drug related activities
24 are indeed a part of the solution.
25 However, this is not enough. This
26 study clearly suggests that there
27 needs to be a concerted and con-

1 scious effort to develop culturally
2 consistent 'theory and practice' in
3 direct response to the clear and
4 present danger of the merging patho-
5 logical drug culture."

6 I would recommend this report to this Committee for gaining
7 insight into how drugs are impacting the Black community. The
8 study findings can be generalized to other similar communities.

9 The San Francisco Health Department also funded two
10 studies to determine the attitude and knowledge about AIDS in the
11 Black and Hispanic communities. A third study will be undertaken
12 for the Asian community. The Black and Hispanic studies pointed
13 out the need for intensive education about AIDS in these
14 communities. There is denial, misconception, and indeed
15 disinterest in this disease as it affects individuals and
16 families.

17 This past Sunday, the San Francisco Examiner, in an
18 article about gang activity in the drug scene, painted a grim
19 picture of teenage gangs and drug trafficking. According to the
20 law enforcement officers, gang activity is on the rise in this
21 city, as it is in other cities in California, rural and urban.
22 During the past two months here in San Francisco, there have been
23 850 arrests near and around public housing projects. As many as
24 27 major gangs are fighting to control the drug traffic in San
25 Francisco.

26 Drugs are an extremely lucrative underground economic
27 activity in poor neighborhoods. All cash transactions, no taxes

1 to pay, clear profit. Imagine a 15 year old gang member from a
2 poor family finds himself making as much as \$700 a day selling
3 crack. You can see how easy it is to recruit other youngsters
4 into this very profitable enterprise. According to the Mayor's
5 Office here in San Francisco for Criminal Justice, this
6 enterprise is handled with great sophistication.

7 In the face of this situation, which confronts other
8 cities in California, it is extremely difficult to deal with the
9 drug trafficking when there is such a high incidence of
10 unemployment among Black and Hispanic youth. For many of them,
11 job training and employment at the minimum wage does not appeal
12 to them when they can make the kind of money drug trafficking
13 creates.

14 Older drug dealers use teens and pre-teens as runners
15 because they know that the most time the youngsters will get at
16 the California Youth Authority is two years.

17 It's fairly well known that drug abuse in minority
18 communities is disproportionately worse than in other communities
19 and impacts the lives of children, adults, families, and
20 communities. For families who want to bring their children up in
21 a decent, healthy environment, and they are the majority, the
22 pervasive drug culture that is of recent duration causes them
23 anxiety, stress, and a feeling of helplessness. This has grave
24 implications for the spread of AIDS among the teenage and young
25 adult minority populations.

26 We must use whatever resources we can devise for
27 reaching and educating drug users. We need to develop programs
28 that will:

1 One, reach all segments of the community. The Black
2 middle-class professional, for instance, is beginning to get the
3 message and connection between sexual behavior and AIDS. They
4 are changing their behavior. Not so with the low-income minority
5 populations.

6 Two, reach low-income drug abusers with a message that
7 is acceptable and understandable. Word of mouth, or as we call
8 it the grapevine, is an effective way to reach a population
9 that's hard to reach.

10 Three, provide education for the clergy, especially the
11 Black clergy, round the issue of AIDS. In San Francisco, 40
12 percent of the Blacks are regular church goers, and they are the
13 mothers, the daughters, the sisters, the nieces and uncles of IV
14 drug users.

15 Four, deal with peer pressures that teenagers are under
16 to experiment with drugs. We need to identify, recruit and train
17 teens who are better able to communicate messages about drugs and
18 AIDS than adults.

19 Five, involve tenants of public housing where there are
20 shooting galleries and drug trafficking is intense. Identify and
21 employ one or more tenants who will be responsible for education
22 and prevention programs in their building.

23 Six, spread information about AIDS in schools, churches,
24 community centers, pool halls, street corners, house meetings,
25 commercial establishments, wherever people congregate.

26 Seven, make available visual aids, public service
27 announcements on radio that target the population we want to
28

1 reach. Such education programs must be culturally and
2 linguistically appropriate and acceptable.

3 In conclusion, adequate funding must be made available
4 to minority communities for minority communities to deal with the
5 high incidence of IV drug usage. We must continually evaluate
6 the effectiveness of these programs in getting the message to the
7 IV drug users, their mates or sexual partners.

8 I have appended for your information a copy of the San
9 Francisco Health Department's policy on HIV testing, which point
10 out why we believe mandatory testing of the general population is
11 not an effective tool for stemming the tide of AIDS.

12 Thank you.

13 SENATOR SEYMOUR: Thank you very much, Ms. Gray, for
14 your testimony.

15 Are there questions?

16 Just one question I would have. Not only in minority
17 communities, but in White communities, do you have the phenomenon
18 of the economic attraction to deal in drugs. You put it very
19 succinctly and, I thought, accurately when you said: Why would
20 somebody go to work at minimum wage when in fact they can make
21 \$700 a day dealing in drugs. And that transcends ethnic groups,
22 I believe.

23 On the other hand, when we're addressing minority
24 groups, what if anything can we do about that? I mean, in your
25 opinion, if you'd care to offer one, where is the break point?

26 If I'm making \$700 a day dealing in drugs, and all I can
27 get is the minimum wage, then what above minimum wage might
28 attract me to give up the drug dealing and the \$700 a day?

1 MS. GRAY: I'm not sure that I can answer that question
2 because, here again, we're dealing with a population of
3 particularly young people, whom I see are getting into this in
4 great numbers because they have no other alternatives, many of
5 them, for employment. Many of these youngsters are dropouts from
6 school; many of them are functional illiterates. They're smart
7 enough to know how to do these kinds of things. It provides
8 somewhat of an exciting opportunity for them to make money, and
9 again, to help support their families, some of whom may be on
10 welfare.

11 I really don't have the answer. I think you've just got
12 to begin to work as intensively as you can to try to get the
13 message out that this kind of activity can have severe impacts on
14 their future and that of their families.

15 SENATOR SEYMOUR: Thank you very much.

16 Any other questions?

17 Ms. Gray, thank you for your testimony.

18 At this particular juncture, we're going to take a
19 five-minute recess, and then we'll convene with Dr. Neal Flynn.

20 (Thereupon a brief recess was taken.)

21 SENATOR SEYMOUR: We'll reconvene our hearing, and our
22 next witness will be Dr. Neal Flynn, who's the Director of the
23 Clinic for AIDS and Related Disorders, UC Davis Department of
24 Internal Medicine.

25 Dr. Flynn, welcome.

26 DR. FLYNN: You asked me here today to catch up a little
27 bit on what has happened in Sacramento with regard to the AIDS
28 virus and IV drug use, and I'll try to do that very briefly.

1 We have found in the last year that there's
2 approximately a six-fold increase in the number of IV drug users
3 infected in Sacramento. We did a study one year ago which showed
4 that one person out of 178 people attending drug treatment programs
5 were infected, and this year it's six out of 200 from those same
6 programs. That may represent up to a six-fold increase.

7 Now, we also know that in other areas of the state the
8 prevalence of infection is even higher. For instance, in San
9 Francisco, published studies suggest that the rate is at 15
10 percent, and that one year ago that was as low as 8 percent, and
11 two years ago as low as 3 percent.

12 So, we see a future for Sacramento and for other cities
13 its size of a rapid increase in the number of infected IV drug
14 users. This is of importance for three reasons. The first is
15 the IV users themselves who become infected. Most of them will
16 become ill, almost all of them will become ill from the infection
17 of the virus, and will cost the public, of course, quite a bit of
18 money for their treatment.

19 The second is that they are the conduit, we believe, for
20 heterosexual spread of the AIDS virus. That is, once it's
21 established in IV drug users who are promiscuous, it spreads then
22 to their heterosexual contacts. The average IV drug user in
23 Sacramento admitted to six different heterosexual partners per
24 year on the average.

25 The third reason is that when IV drug using women, or
26 women who are sexual partners with male IV drug users, become
27 infected, we will face the problem that New York City has faced,
28

1 and that is a large number of infected infants. New York City
2 has them warehoused on wards at the present time because these
3 infants are unplaceable in foster homes. I see that same thing
4 about to happen in California if this virus establishes itself
5 and spreads at the rate we think it will among IV drug users.

6 Now, we have polled IV drug users in the Sacramento
7 area. They are aware that the virus is present. They would like
8 to do something about it, but that does not include stopping the
9 use of IV drugs. They will not do that, even for the AIDS virus.

10 And number two, they will not stop sharing their
11 paraphernalia for various reasons, so it leaves us with only one
12 alternative for the prevention or slowing of the spread of the
13 virus by IV drug groups, and that disinfection of IV
14 paraphernalia or, if it were seen fit, which I doubt that it will
15 be, a change in the law making possession of IV drug
16 paraphernalia criminal. That might have some impact, though
17 perhaps not; I'm not sure.

18 If you'll look on page two of my handout, I've estimated
19 for you the number of addicts that are in Sacramento. We
20 estimate between one-half and one percent of the general
21 population use IV drugs at some time or other. That amounts to
22 about 10,000 people in the Sacramento area out of one million
23 population.

24 If we look at a prevalence that is a percent of drug
25 users infected at 2 percent in 1986, and then it jumps to 5
26 percent at the end of 1987, that represents an additional 180
27 addicts who have become infected in that year. And if we follow
28

1 on through to 70 percent in 1991, which is the level that's been
2 achieved in New York City over a four-year span, we come up with
3 a very large number of infected IV drug users. And you'll notice
4 something else, there under new heterosexual infected people, it
5 is addicts who will contribute the most to the spread of this
6 virus to heterosexual contacts. It is not bisexual activity that
7 will put it into the heterosexual community; it is likely to be
8 IV drug users.

9 So, we come up with a quadrupling according to our
10 estimates of the number of infected people between now and 1991.
11 In the next four years, we expect four times as many people to be
12 infected in Sacramento as currently are. Our estimate for
13 Sacramento County right now is 3,000 infected people. Our
14 estimate for 1991 will be 12,000.

15 Now, each of these infections in an IV drug user puts
16 the liability on Medical and MIA of somewhere around \$10,000 per
17 year is our estimate. We base that on two things. First, they
18 will become ill within a few years of infection, many of them,
19 and require AZT, azidothymidine the drug, which is very
20 expensive and it will fall to the public first to provide
21 financing for this azidothymidine, or withhold the drug which we
22 believe to be efficacious in slowing down the progress of the
23 disease.

24 Secondly, within five years, about a quarter of those
25 individuals will have developed full-blown AIDS, and a course of
26 treatment from diagnosis to death costs the public about \$50,000.
27 So, one-quarter of those people will have cost an additional
28 \$50,000 within five years of the time they became infected.

1 At a projected liability for a county the size of
2 Sacramento, it's astronomical. The total liability we estimate
3 to be over \$200 million by the end of a ten-year span from the
4 time of infection. So, by the end of this century, we will
5 probably have a medical liability somewhere around \$200 million
6 for people infected between now and 1991. That's a tremendous
7 amount of money.

8 So, with that, I'd like to offer some suggestions, and
9 that is that California still has some time to interrupt or slow
10 the spread of this virus among IV drug users. We are at a point
11 that New York City was in about 1980 in California. They did not
12 know about the virus. They could not have taken the steps that
13 could possibly reduce this spread. We do know about the virus,
14 and we do know that it is spreading, and we do have an
15 opportunity to slow the spread among IV drug users.

16 Now, it's going to take a commitment to increase the
17 programs to IV drug users that will provide for education and
18 prevention instructions for IV drug users as intensive as
19 possible. It cannot be done with the current resources of the IV
20 drug treatment programs. It's my opinion that those programs
21 must be augmented with special funds for the creation of the AIDS
22 education prevention components of their treatment programs,
23 number one.

24 And number two, there needs to be sufficient slots in IV
25 drug treatment programs, including methadone, for all addicts who
26 desire to be enrolled. By increasing the number of methadone
27 slots, we can decrease the number of times that an individual
28

1 shares, and mathematically that translates into a decrease in the
2 spread of the virus. It is a mathematical proportion that
3 perhaps one out of a 100 times, or one out of 200 times that a
4 person shares with a person who's infected, the virus will
5 spread. It's pure mathematics.

6 So we need programs that will increase the likelihood
7 that drug addicts will get off drugs. We need to educate them
8 about not sharing, and about rinsing which has been developed in
9 San Francisco and which we're now applying in Sacramento. And
10 third, we need increased funding of drug treatment programs to
11 carry out these things.

12 Thank you.

13 SENATOR SEYMOUR: Thank you very much, Dr. Flynn.

14 Do we have questions?

15 I'd like to ask a number of questions. I find it rather
16 shocking reading the statistics that you report. Shocking
17 relative to the high degree of knowledge, the high degree of
18 availability relative to a clean needle, meaning cleaning
19 needles.

20 Your question was, for example:

21 "Was rubbing alcohol, peroxide or
22 hard liquor readily available the
23 last time you shot up?"

24 Yes, 75 percent. And so, if I'm reading the data correctly, I'd
25 like you to respond perhaps in a little more detail, because if
26 I'm reading the data correctly, I must conclude that IV drug
27 users are aware of the dangers; two, know what to do about the
28

1 dangers if they want to prevent them; three, have available, at
2 least in 75 percent of the cases, the means to do something about
3 it but yet don't.

4 DR. FLYNN: I think what my data say are, your first
5 point is true. They do know that the virus is out there.

6 The second point, do they know what to do about it, no
7 they really don't. What we asked them simply was if they had any
8 of these things available. They didn't know that any of these
9 things could disinfect their materials.

10 In fact, we took it to the laboratory and tested the
11 materials, and found that they do disinfect on a less than one
12 minute contact time. We've made that provision because we don't
13 addicts are going to rinse very long. They may rinse with one of
14 these materials, but it won't be for very long.

15 So, we need to educate them on materials that will kill
16 the virus, and under what circumstances, and then we need to
17 develop programs that can help them modify their behavior.

18 It's one thing to know what to do, and it's another to
19 make it a habit, to insert it into the ritual of sharing needles.

20 SENATOR SEYMOUR: And do you believe, Dr. Flynn, that
21 the quickest, most effective way to achieve that is through
22 education?

23 DR. FLYNN: It's a start, and I think the people to do
24 the educating are the drug counselors in the IV drug treatment
25 programs. They seem to have the best rapport with these
26 individuals, and they have the most access to them. They have
27 access for several days during detoxification, or sometimes for a
28

1 month or more during live-in situations in which they can train
2 individuals on the ease of rinsing with a disinfectant. It is a
3 simple procedure.

4 SENATOR SEYMOUR: I can understand that, it certainly
5 probably is the most effective, but then that leads to another
6 question.

7 What percentage of IV drug users seek treatment or
8 counseling?

9 DR. FLYNN: It's estimated from a study in Los Angeles,
10 about one-quarter pass through drug treatment programs each year,
11 about one-quarter of the total addicts.

12 SENATOR SEYMOUR: How do we reach the other 75 percent?

13 DR. FLYNN: Our hope is that the individuals who receive
14 education within the drug treatment program will carry it out to
15 the street. If we could get one-quarter educated in a single
16 year, we hope that the information would disperse from there.

17 San Francisco and Oakland have also had street outreach
18 programs which appear to be helpful. These are individuals who
19 go out on to the street and educate there on disinfecting
20 needles. These need to be funded. There's no funding right now
21 for those outreach programs in other cities.

22 SENATOR HART: I just have one question.

23 You said we're where New York was in 1980. Can you
24 explain that a little bit? Why is that?

25 DR. FLYNN: We don't know. You know, it's been felt for
26 several years here on the West Coast that the AIDS virus, we've
27 somehow magically escaped the AIDS virus. I think it's simply a
28 lag time.

1 Why it got started and spread so rapidly in New York
2 City is a matter of speculation. They do have a culture in which
3 needle sharing is more common and more wide. For instance, an
4 individual may go to a shooting gallery at which there are
5 hundreds, literally hundreds of individuals sharing the same
6 needles.

7 In Sacramento, for instance, the shooting galleries do
8 exist, but it's a matter of ten, fifteen, twenty, much fewer
9 people share those needles.

10 It's a matter of mathematics again. If one of those
11 needles is contaminated, and 50 people use it, the spread is more
12 rapid than if ten people use it.

13 SENATOR HART: The advantages of suburbia.

14 DR. FLYNN: Perhaps, but we do see the spread. We've
15 seen it. San Francisco has documented the increase and the
16 prevalence of the virus in their drug treatment programs. We've
17 seen a fairly rapid increase.

18 I think we have an opportunity to intervene here
19 provided that an addict can translate knowledge into behavior,
20 and that is the question here. Whether an addict can do that,
21 whether the addict sees enough incentive, i.e., avoiding AIDS,
22 living to translate that knowledge into behavior.

23 SENATOR HART: One other question.

24 You mentioned something about the number of sexual
25 partners that IV drug users had in some study.

26 How important is that? Is the promiscuity rate, or
27 whatever you call it, significantly different for IV drug users
28 than it is for the non-IV drug using population?

1 DR. FLYNN: It is higher among IV drug users, yes. Part
2 of it is due to the fact that many women and a significant number
3 of men support their habit through prostitution. That accounts
4 for a fair number of partners. But the average addict is more
5 promiscuous than the average heterosexual.

6 SENATOR SEYMOUR: Have you looked at comparative data in
7 the San Francisco area as to the rate of growth in comparison to
8 Sacramento County?

9 DR. FLYNN: Growth in the prevalence of the virus?

10 SENATOR SEYMOUR: Yes.

11 DR. FLYNN: Yes.

12 SENATOR SEYMOUR: Through IV drug use.

13 DR. FLYNN: Yes, we've compared notes with the San
14 Francisco group at international meetings and have kept in touch
15 since then.

16 We have gone to between three and four percent now.
17 They were at that level two years ago. They can give you more
18 data; they're here today. But their present level is somewhere
19 between 15 and 20 percent, and that's up from two years ago of
20 about three to five percent.

21 SENATOR SEYMOUR: So is it fair to conclude that to the
22 degree of more sophisticated, more aggressive efforts in
23 education prevention and treatment programs here in the San
24 Francisco area, as compared to Sacramento, is it fair to conclude
25 that on the growth rate, they have been successful, more
26 successful, less successful?

27

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1 DR. FLYNN: I think it is. I don't think we can
2 conclude that at all. It's going to be difficult to tell how
3 much impact they have had with their programs, as it will be
4 difficult to tell with our programs.

5 SENATOR SEYMOUR: Would you agree, Doctor, that they are
6 way ahead of Sacramento County relative to working on the
7 problem?

8 DR. FLYNN: I don't think so. We began our
9 interventions about a year and a half ago, and I think they began
10 theirs about two or a little bit longer. They can give you that
11 data.

12 I think their outreach program into the streets is much
13 more developed than ours. We relied on drug treatment program
14 individuals to disseminate information.

15 I guess what I'm saying is that we must give it a try.
16 We must try to slow the spread of this virus, because for each
17 year that we can slow it, there is a chance that we will come up
18 with a vaccine that may be helpful, or something else that will
19 in the end limit the spread of the virus a little bit more.
20 Because for each one of these addicts that get infected, we have
21 transmission to partners, and if it's a female or a spouse that's
22 infected, we have infants who are born with the virus and who
23 will in general die before the age of five. In New York City,
24 it's a travesty. We don't have to see so much in California.

25 SENATOR SEYMOUR: I guess the line of questioning I was
26 proceeding, I was trying to determine in my own mind, and perhaps
27 you have an opinion, whether there are demographics, social,
28

1 economic or otherwise, that create a differentiation between the
2 problem of IV drug users and AIDS in an area like Sacramento as
3 compared to a San Francisco, as compared to a Los Angeles, as
4 compared to a San Diego, as compared to an Orange County.

5 DR. FLYNN: I think there are differences in each of
6 those cities. That's why I think that the drug treatment
7 programs in each of those areas who have the most experience with
8 their particular area, the problems of their area, are the
9 appropriate place for this type of AIDS education prevention
10 programs to originate. I think within the drug treatment
11 programs in those local areas, that as much of the funding as
12 possible to reach them directly.

13 Yes, I think there are differences obviously. There are
14 cultural differences between Los Angeles and Sacramento; the
15 demographics of drug use are slightly different. The ways in
16 which we can reach them, reach the addicts, are different.

17 SENATOR SEYMOUR: So can we conclude from that, in your
18 opinion, that the State Legislature should recognize the locality
19 of the problem, and thereby permit maximum flexibility in
20 delivery?

21 DR. FLYNN: That's my opinion.

22 Now, there could be central observation of statistics
23 and so on, central repository for statistics, but I think that
24 the outreach programs and the actual hands-on should be local.

25 SENATOR SEYMOUR: Any other questions?

26 Dr. Flynn, thank you very much.

27 DR. FLYNN: Thank you for the opportunity.

28

1 SENATOR SEYMOUR: We appreciate you coming here to San
2 Francisco to testify.

3 Is Dr. Donald Francis here?

4 Dr. Francis is the AIDS advisor for the National Center
5 for Disease Control.

6 Dr. Francis, welcome. We're really pleased you could be
7 with us today.

8 DR. FRANCIS: It's a pleasure to be here, and I commend
9 both Senate Committees for their interest in AIDS and the concern
10 that they have.

11 I would like to take an overview of many of the previous
12 speakers, and I'm sure of the subsequent ones, in terms of where
13 we in government need to move as a government responsibility for
14 the prevention of HIV transmission and ultimately AIDS.

15 My theme is that we have an opportunity, much like
16 Dr. Flynn just mentioned, that there is an opportunity now in
17 California, in contrast to other parts of the country and other
18 parts of the world which have the same situation, to slow if not
19 stop HIV infection in multiple groups, the specific subject of
20 this hearing being in IV drug users, which I think there are
21 clear indications that we do have an opportunity to make a major
22 impact.

23 But I don't want to give you just a feeling of
24 opportunity, which you hear repeatedly over and over. I would
25 like to, as a federal official, but I could be a state or local
26 public health official in the same context, give a feeling of
27 necessity that it is our responsibility in the government sector
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1 to move ahead on this, because this is not something that the
2 private sector is going to fill in at all. This kind of
3 prevention, especially prevention of a disease in a group like IV
4 drug users, is not a free market, logical opening where you'll
5 see people rushing in.

6 Clearly, our responsibility in public health and our
7 responsibility in government, despite the aura that government
8 should not exist in many areas, this is one where it clearly must
9 exist and must take a very aggressive stand.

10 Now, the opportunity that I see is one, if I look back
11 on my early pediatric training in L.A. County Hospital in '68 and
12 '69, I recall the misery that I'd go through as a physician in
13 informing a parent about a fatal disease that their child had, and
14 nothing that we in medicine could do but care for the child and
15 make that child as comfortable as possible and the family. On a
16 single issue, that is a very difficult thing for an early doctor,
17 and late doctors, and myself now as a parent to deal with the
18 thought of a sick child.

19 But AIDS is so different in that. AIDS often comes
20 forth now, if you think about the future of AIDS in California,
21 and you look at New Jersey, the Bronx, areas in Miami, or Africa
22 for that matter, where HIV infection is well dispersed in the
23 heterosexual population, the scene is so much different that a
24 single child with leukemia.

25 The child is often the sentinel, because the incubation
26 period in young children is much shorter. It's often the infant
27 that comes up in the first year of life with the disease. And
28

1 then you diagnose that infant with a fatal disease, and you have
2 to tell the parents. Not only do you tell the parents that child
3 has a fatal disease, you end up telling the mother, "And by the
4 way, you don't have much of an immune system left and the odds
5 are you're going to die. And by the way, your husband who gave
6 you the infection is also quite ill, and half the children that
7 you've had in the last three years are also infected."

8 That's a very difficult message. That's AIDS in the
9 inner city poor populations of New Jersey, the Newark area, right
10 now.

11 It's not that situation yet in California, but it
12 clearly can be. There's no doubt from the data that you've heard
13 that HIV infection is really no different here than it is
14 elsewhere, as far as where the potentials for spread would be.

15 Let me deal with three questions that I think are
16 important for the Legislature. One, is there a problem? Two, if
17 there is a problem, can we do something about it? If we can't do
18 anything about it, there's no reason to throw resources away.
19 But if we can do something about it, what should we do?

20 First, is there a problem? Human immune deficiency
21 virus, or HIV, is a virus that in years past we in the Center for
22 Disease Control, if we knew about one reported case of this
23 virus, would mobilize all of our resources to stop further
24 transmission. Any virus that has the potential of killing at
25 least half the people it infects is a virus of a league that we
26 cannot deal with. It is a major league agent that kills large
27 numbers of individuals when it gets into their blood system. So,
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1 it's something that we see as a very dangerous agent. Yes, we
2 need to do something about it.

3 Is it transmitted effectively? It is certainly, as Dr.
4 Padian pointed out and others pointed out, it is effectively
5 transmitted both through sharing of needles and from heterosexual
6 sex from infected individuals to their uninfected partners. And
7 from women, it is effectively transmitted to their babies. So
8 this whole aura of the family AIDS is clearly something that
9 concerns us in public health.

10 But you have these modes of transmission. You've always
11 had sex; you've always had IV drug users. You need the virus.
12 If don't have the virus, then these practices may be bad for
13 other diseases, but not bad for HIV.

14 In terms of HIV in California, is there virus present?
15 There's data now to show you've had pieces of it here, you'll
16 have pieces more of it tomorrow in Los Angeles, that there is
17 virus up and down California. It's all you need.

18 I wouldn't worry if there's one percent. I wouldn't
19 worry if there's two percent. I wouldn't worry if there's ten
20 percent. I wouldn't wait for them to be 80 percent. Don't
21 worry; one percent is clearly enough to justify resources. All
22 you need to get into that amplification system is just the
23 sharing of needles and it will continue to spread, and you've
24 about about it. Last year, the year before, next year, et
25 cetera, the numbers will continue to go up. You can almost
26 predict that straight away.

27

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1 So, is it a problem? Clearly yes. It's a major disease
2 agent that is effectively transmitted through intravenous drug
3 use and through heterosexual populations.

4 Can we do something about it? You'll hear from the last
5 speaker today, I think, some of the most remarkable data
6 regarding the efficacy of intervening in the IV drug using
7 population. The data from San Francisco that Dr. Newmeyer hinted
8 to as far as if you approach in the street IV drug users,
9 somewhere in the neighborhood of two-thirds will start using
10 bleach, and of those, about 70 percent will continue to use that
11 bleach.

12 That is remarkable. That is from a program that is
13 essentially just fielded without all the research data we need to
14 know the most effective way to deliver the message, the most
15 effective way to build the support systems to raise the
16 consciousness of the community to change from a quick and dirty
17 show, that you can intervene in IV drug users.

18 A bias that we all have is that they are an immovable
19 group, that you cannot change behavior. In fact, such a high
20 proportion are using bleach that it will have a major effect on
21 slowing if not stopping the transmission.

22 The question is: Is there a will? Is there a will to
23 stop HIV transmission in the government of this country or of
24 this state? The major question is: Do we have the will to move
25 on?

26 I think can we do something is more measured on will
27 than it is in terms of practical application of any public health
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1 program. Part of that will is the constant barrage that we have
2 in public health of whatever program that we mount, there is a
3 portion of the body politic in this country and in this state
4 that says whatever we're doing, we are advocating those behaviors
5 that transmit HIV infection. Be they IV drug users, our comic
6 books are advocating more IV drug use. If it's in heterosexual
7 sex or homosexual sex, our comic books are advocating homosexual
8 or heterosexual sex.

9 People who do that, claim that we are advocating, when
10 indeed the whole purpose of the program is not to advocate to
11 that and to stop the transmission, do tremendous damage to public
12 health programs. Part of the will is to overwhelm those
13 individuals who continually play the nay-sayers role that we
14 should not be doing anything regarding this outbreak.

15 So, the answer to the second question, can we do
16 something, I think yes, we can do something in terms of public
17 health. I'm not convinced yet that we can do something in terms
18 of the political will.

19 If we assume that the latter question is yes, that we
20 can do something, what do we need to do? It is really very
21 straight forward. The message for the intravenous drug user is:
22 Do not use intravenous drugs. A very straight forward message
23 that we need to get out to the schools, to the cohort of
24 individuals coming into that risk factor.

25 But the reality that we have to deal with is that people
26 must use intravenous drugs. There are addicted people out there
27 who have no choice medically but to use intravenous drugs, and so
28 we have to take them into our message.

1 So to answer to that is: If you must use drugs, do not
2 share needles. But we have to realize the limited number of
3 needles, that there's some individuals who must use drugs who
4 must use needles. And then we have to give them the opportunity,
5 and that is: If you must use drugs and you must use needles, you
6 must also disinfect your needles between uses. This is a
7 relatively simple thing to do.

8 What do we need to get that message out? Clearly the
9 three things are: resources to do it; the resources to evaluate,
10 to do the research necessary to find out what is the appropriate
11 delivery system and what is the most effective way to optimize
12 that effect. And last is the policy strength behind us in the
13 field to allow us to carry out our programs, the resources.

14 It is incredible to me, with this virus that continues
15 to be transmitted by intravenous drug users, that there are
16 individuals out there who want to get on the oral form of
17 therapy, not intravenous drugs, such as methadone, and cannot get
18 into the programs. It just amazes me that we are still in that
19 mode now, since this disease was first recognized in 1981. Soon
20 thereafter, it was recognized that intravenous drug use spread
21 the disease. We are still in that mode where we are resisting
22 the expenditures necessary with all the benefits that they may
23 have of getting people off the intravenous drugs and onto some
24 nonrisk activity.

25 Clearly, we need to increase methadone slots. That's an
26 issue of when people are coming to us, 25 percent and 50 percent,
27 depending on the study, where we can get access to them just by
28

1 opening the door. The effect is, if they won't come to us, we go
2 to them.

3 The approach has been taken in San Francisco of getting
4 out there with knowledgeable individuals who know the streets,
5 who actually deliver the message out there, so that the actual
6 street outreach programs would be number two, besides the clinic.

7 Third would be allow the clinic to have the staff to
8 provide testing and counseling to the individuals and to their
9 sexual partners. I mean, if you realize it is in this state now,
10 not only are there not enough slots to get people into methadone
11 clinics, but those people who come in in many areas, the staff is
12 in such short supply that they're not getting any information on
13 AIDS at all. They get their methadone and go back out, and no
14 community approach. If they get off their methadone, which a
15 considerable number of them do, they go back into the street
16 without the skills to prevent infection, which are relatively
17 rudimentary.

18 So, methadone slots, street outreach, and counseling and
19 testing facilities for HIV, and counseling facilities for them
20 and their contacts.

21 And last, the community conscious raising revolution
22 that is necessary in the IV drug using community and in the
23 minority community, of which these are a large part, to actually
24 raise the conscious that one shouldn't use drugs, but if you do,
25 these are the standards. Disinfection of the syringe and needle
26 is the standard now for the use of intravenous drugs.

27

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1 Number two, besides the resources is resources for
2 information and evaluation. The programs that have had their
3 effect, we know they're effective to an extent, but we have not
4 had three different programs with a different message, different
5 delivery system, that's really been evaluated.

6 The question you asked is how good is Sacramento
7 compared to how good is San Francisco? Why is one better than
8 the other? And the question that you're going to ask three years
9 from now is, how do you know these things are doing anything? If
10 you want to dump this money and continue to dump this money into
11 government responsibility programs, appropriate evaluation is
12 critical. Tough to do. Tough to do prospective studies on IV
13 drug users, but they can be done. You can bring these people
14 back in and evaluate their behavior.

15 And last that I hinted to before, the policy issue to
16 allow us in the public sector to move ahead without the constant
17 distraction of bizarre comments by multiple individuals without
18 the support from above that we're advocating, that we're out
19 there spreading sex, we're out there spreading drugs, when indeed
20 what we're trying to do is stop the spread of infection.

21 In summary, I think from a public health standpoint,
22 this is a relatively straight forward issue that requires the
23 resources necessary now, when there is one percent infection
24 around California, and not to say we need 10,20,30 percent
25 infection. One percent is bad enough, and that we in public
26 health think it is bad and you should take appropriate action.

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1 Who will pay? I think it's well known why I'm in the
2 state of California. It's that I had difficulty with the federal
3 response in dealing with AIDS. Clearly, this an issue that the
4 federal government has difficulty dealing with. It is indeed an
5 issue that clearly the state governments have difficulty in
6 dealing with. And ultimately the movement of AIDS in terms of
7 prime examples have come from communities and county local
8 governments.

9 Unfortunately, where the issue and the concern are is
10 not where the resources and ability to mobilize rapid resources
11 is. And yet if you read Vice President Bush's statement, he made
12 it very clear what the federal policy is. It should be a local
13 issue; it should be a local issue, including financing.

14 You'll see more federal money coming down in the future,
15 but I think it is not something that I would, as a federal
16 representative here, recommend waiting for. It is something that
17 the resources are going to have to be generated at the local and
18 state level, and not to wait for ultimately the realization that
19 there is a federal responsibility for controlling this infectious
20 disease outbreak.

21 One last problem. We have in government now many laws
22 that have intersected over the years in terms of fairness of
23 hiring, fairness of spending of money, that make indeed the
24 spending of resources extremely slow once they come forth. If
25 these Committees today decide to move forth with funds in the
26 next legislative hearings and Floor debates, and the money is
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1 actually approved, we're lucky if the people necessary in the
2 programs funded by those get in the field in the next twelve
3 months. The whole process, by the time you begin or the federal
4 people begin hearings and discussions of funding, by the time the
5 program comes, we are fortunate if it's a two-year interval.

6 That is a much too long period of time in terms of
7 response to infectious disease outbreaks of this magnitude and
8 this threat to the society.

9 I would urge that the process be sped, that there is a
10 way in which fairly and equitable money can be allocated and
11 spent rapidly, and accounted for so that the people get
12 appropriate accounting for their money, and that indeed emerging
13 programs be fielded faster than they are now.

14 Thank you.

15 SENATOR SEYMOUR: Thank you very much, Dr. Francis.

16 Any questions?

17 SENATOR HART: I appreciate your testimony, Dr. Francis.

18 Can you give us some idea as to what dollar figures
19 we're talking about here in California? How many millions of
20 dollars need to be appropriated this year? Does that money need
21 to be phased in over a number of years? To what extent, if we
22 had all that money, would it be used effectively? Do we have any
23 kinds of staff that can intelligently use that money?

24 I mean, everyone seems to be saying the same thing, to
25 make a commitment, but in terms of what sort of dollar figure
26 we're talking about, I haven't heard too much.

27

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1 DR. FRANCIS: The National Academy of Sciences
2 recommended for prevention a minimum figure of \$5 per person for
3 a year, which I think is a reasonable target. Because
4 ultimately, it's going to be low. After all, it's based on San
5 Francisco, we figure.

6 SENATOR HART: So \$5 per person, and we have 25 million
7 in California?

8 DR. FRANCIS: Correct, it'll be about \$125 million for
9 AIDS prevention in California. Now, if you add on that \$20
10 million for slots for California, I think you'd have to add that
11 on to the top.

12 You're talking about major expenditures in terms of
13 public health, relatively small in terms of if we are successful.

14 Will we be successful with this money? I think so. But
15 you hear individuals with condoms, with bleach, et cetera,
16 talking about, oh, they're only 80 percent effective or only 90
17 percent effective.

18 If we had a vaccine that was 80 percent or 90 percent
19 effective, we would be thrilled.

20 So, I think that in terms of these bugs that are
21 relatively slow to transmit, that we can break the back of them
22 with programs, with as little efficacy as 60-70 percent. And I
23 think that rate of funding would at least allow us to get there.

24 Would it be effectively used at the local level? Our
25 program right now, for lack of policy, lack of staff, is
26 essentially one of moving it down to the county level and trying
27 at that point to establish programs, county by county. A
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1 relatively inefficient way to do it, I agree, but one which I
2 think has to be done considering the emergent situation and the
3 realities of policy constraints from above. You have to do it at
4 the local level, and we can piece it together once it's down
5 there.

6 SENATOR HART: One other question I had.

7 You used the phrase and Dr. Flynn as well: We have an
8 opportunity to slow or to stop the virus.

9 I understand "slow". I'm not quite sure I understand
10 "stop." Does that assume some sort of holding action and in the
11 meantime you get some cure or vaccine? Is that what we're
12 talking about?

13 DR. FRANCIS: Stop would be the ultimately 100 percent
14 effective program. I think that's more optimistic than we can
15 realize.

16 SENATOR HART: Thank you.

17 SENATOR SEYMOUR: Dr. Francis, if we were to commit in
18 California \$125-plus million a year to fight AIDS through
19 education, prevention and treatment, do you have any ideas on,
20 and one point you touched on was accountability and putting in
21 place those systems that you talked about for evaluation?

22 DR. FRANCIS: Yes.

23 SENATOR SEYMOUR: Would you share those thoughts with
24 us?

25 DR. FRANCIS: Relatively straight forward in terms of
26 public health research to have groups of individuals within your
27 --- certainly not every county and every IV drug user gets into a
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1 long-term expensive program. Take samples of those individuals,
2 and go back to them at every four to six month period, evaluate
3 their behavior and evaluate their antibody status for HIV and see
4 -- and then ask them were they part of the program; what part
5 were they in, and evaluate the actual efficacy -- ultimately in
6 terms of the process of transmission, short-term in terms of
7 behavioral change of that program. Look at those that were
8 accessed by the program versus those that were not and expect to
9 see a difference.

10 We've certainly been able to do that from the gay
11 community cohorts funded almost both by state and federal funds,
12 and seen marked changes in behavior in gay communities, and as a
13 result, marked increases in seronegativity.

14 SENATOR SEYMOUR: Would you care to offer an opinion
15 relative to what success rate we might have statewide if we were
16 to commit \$125 million-plus per year?

17 DR. FRANCIS: With the appropriation for IV drug users
18 specifically?

19 SENATOR SEYMOUR: Yes.

20 DR. FRANCIS: If you took the appropriate pieces out,
21 and I'd have to go back and look what it would be for the IV drug
22 users, I think we would optimistically expect at least 50 percent
23 reduction in infection.

24 SENATOR SEYMOUR: Over what period of time?

25 DR. FRANCIS: Over the initial year, after launching a
26 full scale program. Whether we would get 75 percent and another
27 50 percent the next year, that's 75 percent efficacious. It
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1 depends on how sophisticated our behavioral research was, how to
2 reach those lower -- it's more difficult to reach groups.

3 Realize, every behavioral study, be it seat belts,
4 smoking or whatever, the lower the socioeconomic strata, and the
5 lower the age of the individual, the more difficult it is to
6 reach them. Indeed, in terms of AIDS, it's important to get into
7 the schools and have these people come out with the information
8 that is necessary before they get into that teenage period that
9 is difficult to deal with.

10 SENATOR SEYMOUR: Thank you very much.

11 We have Mr. Jerry de Jong present. Mr. de Jong is
12 Executive Director of 18th Street Services here in San Francisco.

13 MR. DE JONG: Yes, that's correct.

14 I feel I have a tough act to follow, following Dr.
15 Francis.

16 SENATOR SEYMOUR: Well, you're welcome. We appreciate
17 you taking your time to be with us.

18 MR. DE JONG: Well thank you for the opportunity to
19 speak.

20 I know that the Committee is going to hear and will hear
21 an immense amount of information and suggestions, well thought
22 out plans for stemming this epidemic.

23 I would ask that the Committee remember that even as
24 we've been talking today, that individuals are being infected,
25 and that individuals are being diagnosed, and that individuals
26 are dying from this disease.

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1 We must move with haste, and we must move with
2 coordinated effort. And too often in this epidemic, we who
3 deliver services have been stopped from doing just that for lack
4 of resources, and strangely, the public health crisis is also
5 politics.

6 If only hearings such as this had been taking place
7 three, four years ago. I'm extremely grateful that one's taking
8 place today.

9 You've asked what can be done to stop the spread of AIDS
10 among the IV drug using population. First, I have to express
11 that overall, effective prevention requires a program-wide
12 response. This means that every treatment program in the state
13 must have training and must have knowledgeable staff to
14 understand AIDS and the substance abuse cofactors.

15 The treatment programs here, Centers for AIDS
16 Prevention, and all treatment programs must be willing to discuss
17 sexual transmission, for those that ignore that risk are deadly.

18 And secondly, I'd like to suggest a three-tiered
19 approach which incorporates the following: Street-based
20 education and outreach; treatment availability; and widespread
21 anonymous HIV testing.

22 Every treatment program should be engaging in
23 street-based outreach and education. The individuals who would
24 never walk through the doors of a clinic must be reached in their
25 neighborhoods, their taverns, their homes to hear the messages of
26 prevention and education. And they must hear it in language and
27 pictures that are relevant.

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1 Unfortunately in this state, there's often times
2 controversy in delivering that message in the language and
3 pictures that are relevant to specific groups.

4 Secondly, drug abuse programs are the front line of
5 defense, and thus waiting lists must be eliminated. I challenge
6 any of you to answer a phone at night, and someone's calling for
7 help and desperately wants to be free of their habit, and tell
8 them, "The soonest we can see them is three weeks from now."
9 Every program in the city has that type of waiting list. That's
10 deadly public health policy in the middle of an epidemic.

11 Thirdly, I feel that widespread anonymous testing must
12 be made available everywhere, and pre and post-test counseling
13 also must be available. It's clear in research and in theory
14 that the process of testing and education is valuable for
15 individuals, to offer an avenue of motivation for changing their
16 lives.

17 Finally, this disease discriminates. It is a disease
18 that strikes the already disenfranchised: the gay men, people of
19 color, intravenous drug users. These populations have to be
20 afforded treatment that is sensitive to their needs. And
21 individuals from those communities must also have input in
22 determining those needs. And sadly and unfortunately, that often
23 times has not occurred either.

24 And lastly, I've got to make the point again that
25 substance abuse treatment equals AIDS prevention. When we
26 battled the toxic shock syndrome or Legionaire's disease, every
27 tool at our disposal was marshalled. It's sad that we're
28

1 fighting a disease that seems to make people extremely
2 uncomfortable, particularly when you talk about funding from
3 federal or state levels, for we have to talk about gay sexual
4 behavior; we have to talk about drug addicts; we have to talk
5 about condoms; we have to talk about prostitution; we have to
6 talk about bisexuality.

7 We can control the spread of this epidemic, but we have
8 to have the resources. We have to have extensive street-based
9 outreach education. We must have detoxification and treatment
10 programs where there is not a wait for services. We must have
11 widespread anonymous testing.

12 Thank you for the opportunity to speak. I welcome any
13 questions.

14 SENATOR HART: I'd be interested in hearing just a word
15 or two about your own program.

16 MR. DE JONG: The program is --

17 SENATOR HART: How long have you been doing it? How
18 many people do you serve? What's your modus operandi?

19 MR. DE JONG: The program that I have is 18th Street
20 Services, and we've been in existence here in the city about
21 eight years, and we're focused directly on the gay community, gay
22 men.

23 We carry on the average about 130-140 clients a month.
24 Over 50 percent of those are IV drug users, and close to 80
25 percent have been diagnosed with AIDS or ARC or are HIV infected.

26 Clearly, with the population that my program's working
27 with, it's clear that any type of substance abuse treatment is
28

1 AIDS prevention, but it's got people taking a look at their drug
2 habits and also now engaging in unsafe sex as a result of
3 treatment.

4 SENATOR HART: Thank you.

5 SENATOR SEYMOUR: Do you provide anonymous testing for
6 those clients?

7 MR. DE JONG: No, unfortunately we don't. Where we're
8 located, Health Center Number One in the city here does offer
9 anonymous testing, often comes up as an issue for many of our
10 clients.

11 Unfortunately, with all the test centers based here in
12 the city, there's close to a four-week wait just to get in
13 initially to go through the pre-test counseling, have the blood
14 drawn, and of course a two-week wait until the time that someone
15 would receive their results. Obviously if someone's making a
16 decision to be tested, it would be ideal, just as it would be
17 ideal with treatment, if you're running into folks on the street
18 doing the street-based education and outreach, and they ask for a
19 drug treatment program, to be able to say, "You've got it today.
20 You've got it this week."

21 Sadly, we can't do it in either case, not for drug
22 treatment or HIV testing.

23 SENATOR SEYMOUR: What percentage of your clients
24 request anonymous testing?

25 MR. DE JONG: All of the clients have made it clear that
26 they prefer anonymous testing. Recent surveys from Health Center
27 Number One have shown very clearly that 75 percent of the folks
28

1 that had go through the anonymous testing program there would not
2 have gone through it if had been anything other than anonymous.

3 SENATOR SEYMOUR: The only reasons you don't provide
4 anonymous testing is lack of resources?

5 MR. DE JONG: Well, we actually couldn't provide
6 anonymous testing at our site because, of course, we know the
7 clients, we know their names, and it would be extremely difficult
8 to marshal anonymous testing at a drug treatment agency.

9 Because of the fact that we work with a very specialized
10 population, which is gay men, I think in many areas we're
11 probably much more advanced than perhaps other treatment programs
12 dealing with issues of diagnosis and HIV testing.

13 But given the fact that for any treatment program to be
14 successful in the AIDS epidemic, the climate of acceptance has to
15 exist. And I had mentioned in my remarks that the disease
16 frightens people, it makes them uncomfortable. It's difficult to
17 talk about sexual transmission, and I don't know how every
18 treatment program in the state would do with that type of an
19 order, of providing testing and being able to counsel folks
20 effectively around it.

21 SENATOR SEYMOUR: Can you construct for us conditions
22 under which you could?

23 MR. DE JONG: Frankly no, I can't. I think it would end
24 up having to take a number of approaches, number one, that the
25 type of training and education for every drug treatment program
26 in the state around AIDS has to be taking place, which it hasn't
27 been. There are some treatment programs, some regions, that are
28

1 much further ahead in realizing, you know, the reality of AIDS
2 than others.

3 I'm Chairman of the AIDS and Substance Abuse Task Force
4 here in the city and county. Recently I had sent a letter to the
5 President of the county-wide alcohol program administrator asking
6 what their response was concerning AIDS, and alcohol is a
7 cofactor because, of course, people become disinhibited on drugs
8 or alcohol and are more likely to engage in unsafe sex. That
9 group, just at this point in time, this year, is beginning to
10 convene a task force specifically around AIDS and the alcohol
11 issue. And we're how many years into the epidemic? And just
12 now, the county-wide alcohol program administrators are
13 developing a task force to be able to get information out on the
14 program to their folks.

15 SENATOR SEYMOUR: Would you tell us specifically how
16 does an anonymous testing program work?

17 MR. DE JONG: An anonymous testing program works here in
18 San Francisco when someone will call, and they're asked to give
19 two initials and a number, any number.

20 SENATOR SEYMOUR: A phone number?

21 MR. DE JONG: No, no, just two numbers. In other words,
22 say, if you wanted to call, Senator Seymour, you could say just
23 your initials, or the initials BC, and give a number of less than
24 24.

25 SENATOR SEYMOUR: That becomes my tag?

26 MR. DE JONG: That becomes your tag, exactly. And then
27 the folks go into the center, they're given some pre-test
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1 counseling on exactly what the test means, what it doesn't mean,
2 some of the more recent statistics concerning the tests going on
3 to developing AIDS or ARC. They talk about substance abuse, the
4 blood syndrome, and two weeks later the folks have to go back,
5 using the same number, receive their results from the results
6 counselor who will sit and spend whatever time is necessary.

7 SENATOR SEYMOUR: Excuse my ignorance, but why doesn't
8 your program do that?

9 MR. DE JONG: I would have difficulty with drug programs
10 doing that because primarily it's trying to serve a dual purpose.
11 A program doing substance abuse counseling shouldn't also be
12 doing HIV testing. And many of our folks elect for testing, we
13 send them to the anonymous test sites, and when it's possible we
14 try to work out kind of an option with the anonymous test site
15 that when someone who is in drug treatment, if we can get them in
16 sooner than the four or six weeks' wait, they elect to do that.

17 But it's difficult to provide the kind of anonymity that
18 people need at a drug treatment agency, and confidentiality is
19 sacred, and particularly needs to be sacred with this epidemic,
20 this disease, with some of the fears around what is going to
21 occur with insurance, what's going to be the public reaction, and
22 all of the above.

23 SENATOR SEYMOUR: Thank you very much.

24 MR. DE JONG: Thank you.

25 SENATOR SEYMOUR: Is Zarinah Shakir present?

26 I think at this time it would be appropriate for us to
27 take a very brief recess for ten minutes.

1 (Thereupon a brief recess was taken.)

2 SENATOR SEYMOUR: We'll reconvene the hearing.

3 Is Mr. Les Pappas present? Mr. Pappas represents the IV
4 Substance Use and AIDS Education Coordinator for the San
5 Francisco AIDS Foundation.

6 Mr. Pappas, thank you very much for being present today
7 and offering your testimony.

8 MR. PAPPAS: Thank you for inviting me.

9 Chairman Seymour, Chairman Hart, I want to thank you
10 again for inviting me. I'm pleased to be here and testify.

11 I'm also pleased to be among the distinguished other
12 representatives that have come before you to speak.

13 Preventing substance abuse and preventing AIDS will
14 require many similar approaches; however, they will also require
15 some very different and innovative strategies.

16 IV drug users, their sexual partners, and their children
17 are becoming infected with the AIDS virus at alarming rates. Two
18 recent studies of the infection rates in San Francisco indicated
19 that more than 20 percent of IV drug users now have the AIDS
20 virus. However, this is a relatively low percentage as compared
21 to gay men in San Francisco and IV drug users in some Eastern
22 cities, which are 50 percent and 80 infected respectively.

23 We have a unique opportunity to interrupt the
24 transmission rate among IV drug users in California. We also
25 have a tremendous responsibility to act. Years from now, we will
26 not be able to look back and say we didn't know what was
27 happening. We do know, and now is the time to do something about
28 it.

1 An effective prevention plan must be instituted
2 immediately, and it must include the following measures: One,
3 promotion and provision of substance abuse treatment for all
4 those who seek it; two, a comprehensive education campaign; and
5 three, changes in the laws regarding the sale and possession of
6 needles. I would like to address each of these three areas.

7 I know that we all want to see people freed from their
8 addiction to drugs. Getting off drugs is the only sure way to
9 prevent needle sharing. People who don't use needles don't share
10 needles. Ideally, we would like to see all IV drug users enter
11 treatment programs.

12 However, the reality is that we do not even have the
13 space to accommodate those people who are currently asking for
14 help. Almost all treatment programs in San Francisco have
15 waiting lists. A large proportion of IV drug users will not be
16 motivated to enter programs by the time their names come up. In
17 fact, they may become infected with the AIDS virus while they're
18 waiting to enter treatment programs.

19 It is clear to me that treatment programs should be
20 expanded to eliminate waiting lists.

21 Substance abuse treatment programs are also important
22 centers for AIDS education. When we are fortunate enough to get
23 people into treatment programs, we must seize that opportunity to
24 provide thorough AIDS information. When clients leave these
25 programs, whether they're successful or not, they should have
26 been taught everything they need to know regarding AIDS. The
27 staff at these agencies should be supported to continue
28 increasing their knowledge about AIDS.

1 While it is true that the fear of AIDS may provide
2 further motivation to stop using drugs, we must acknowledge that
3 the vast majority of IV drug users will continue to inject drugs.
4 This out of treatment population is the group that presents the
5 biggest challenge and is also at highest risk for AIDS.

6 IV drug users can be educated, and they do make behavior
7 changes. The ability to impact behavior change among IV drug
8 users was reported at the Third International Conference on AIDS
9 last summer. Although IV drug users may continue to shoot drugs,
10 they clearly do not want to die, to get AIDS, or to give AIDS to
11 their partners or children.

12 Educational campaigns must be designed which utilize
13 methods capable of reaching intravenous drug users and with
14 message that will be credible and effective. For those unwilling
15 or unable to stop their drug use, there are two main messages:
16 Don't share needles with anyone; and if you do use someone else's
17 needle, clean it first with bleach.

18 Some people will have access to needles and will not
19 need to use another person's needle. For those who do not have
20 their own needle, bleach will kill the AIDS virus that may be
21 left in the needle by the previous user.

22 If these warnings are to be accepted by IV drug users
23 and acted on, they must be presented in an objective,
24 non-judgmental manner. These messages must be delivered in every
25 location where we might reach IV drug users: in schools, at
26 treatment centers, residence hotels, homeless shelters, food
27 lines, in jails, and on the streets. MidCity's CHOWs are an
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1 excellent example of the kind of innovative programs that should
2 be initiated throughout the state.

3 Coming up a little later you have George Williams from
4 MidCity, and he's going to hopefully share with you their
5 experience, and that's a very innovative program.

6 Mass media efforts should also be undertaken. IV drug
7 users are difficult to reach, but we know that they see
8 billboards, newspapers, bus signs, and television. Adequate
9 funding should be provided to conduct large scale advertising
10 campaigns.

11 I've brought an example of one of the campaigns that we
12 conducted last year. It consisted of these signs inside of all
13 buses in the city, and also on billboards in neighborhoods where
14 we knew there was a high concentration of IV drug users.

15 You'll see the message is very simple, very direct, no
16 judgment involved, and what we've found is that we had a 350
17 percent increase in the number of callers to our hotline
18 regarding IV drug use. So, whether these kinds of messages are
19 totally effective in eliminating people's risks, we don't know,
20 but we do know they respond to them, and they've called and have
21 asked for more information about treatment programs. They've
22 asked for more information about cleaning needles. So, we feel
23 that we've had some success with these kinds of mass media
24 campaigns.

25 Printed materials can also be very useful if they are
26 visually interesting; if they're objective and easy to read.
27
28

1 I've brought one of our recent brochures, a comic book,
2 that we produce specifically directed at IV drug users. It's
3 very direct, very simple, and has been extremely well received.
4 In fact, we hear a lot of comments asking for when the next issue
5 or the next version is going to come out. So, I think that's
6 another good example of the nature of the materials.

7 I'd like to conclude by talking about the laws regarding
8 the sale and possession of needles. This is an issue that has
9 significant implications on the spread of the AIDS virus.

10 As you know, there are State laws which make it illegal
11 to sell or possess needles. These laws will undoubtedly result
12 in a continued dramatic increase in the transmission of the AIDS
13 virus. Because needles are illegal, the supply of clean ones
14 does not meet the demand. Under these circumstances, addicts are
15 compelled to share.

16 Furthermore, as long as it is illegal to carry needles,
17 addicts will be unwilling to bring their own needle when they go
18 to buy drugs. This means that IV drug users will use whatever
19 needle is available at the point of purchase of the drugs. These
20 needles are likely to have been used by many other people,
21 increasing the likelihood of HIV infection.

22 Needles are not illegal in most states in the United
23 States, only in those with the highest number of AIDS cases.

24 Other countries are acting quickly to allow addicts
25 access to clean needles. France and New Zealand recently
26 suspended prohibitions against the sale and possession of
27 needles. Of the Western European countries, only one still
28 requires a prescription to obtain sterile needles.

1 In addition to making needles available in drug stores,
2 Great Britain, Australia, and The Netherlands are now conducting
3 free needle exchange programs. The first needle exchange program
4 in the United States is about to be launched in Boston, where the
5 mayor has vigorously supported this recommendation from
6 Massachusetts health officials.

7 The National Academy of Sciences has also taken a
8 position in support of making needles more readily available. In
9 their report, titled "Confronting AIDS", they state that, quote:

10 "It is time to begin experimenting
11 with public policies to encourage
12 the use of sterile needles and
13 syringes by removing legal and ad-
14 ministrative barriers to their
15 possession and use."

16 Of course, simply making needles available is not the
17 solution, but it is a critical component of an overall strategy.
18 Substance abuse treatment, massive education, and increased
19 availability of sterile needles must all be enacted
20 simultaneously to be effective.

21 As Members of the Senate Select Committee on Substance
22 Abuse and the Select Committee on AIDS, you are responsible for
23 many thousands of lives. The recommendations by those of us in
24 public health are based on our experience with these issues, our
25 experience in fighting substance abuse and AIDS.

26 Please listen and act on these recommendations. Some of
27 these measures will be politically unpopular, but I have faith
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1 that you will make these tough decisions. Lives are depending
2 upon it.

3 Thank you.

4 SENATOR SEYMOUR: Thank you very much, Mr. Pappas.

5 Questions? Senator Hart.

6 SENATOR HART: Could I ask the about the material? The
7 comic book and other materials that you have produced, are any of
8 those funded in part by the State?

9 MR. PAPPAS: No, they're not. The State has guidelines
10 for materials that they will fund, and we seem to have stepped
11 over the boundaries in some areas with this material. So, they
12 will not fund a lot of the more explicit, direct and, we think,
13 effective materials.

14 SENATOR HART: Is it the guidelines -- I'm trying to get
15 a handle on that. What are the specific guidelines?

16 MR. PAPPAS: Well, for instance, there are a set of
17 words, you know, the vernacular four-letter words, that we're not
18 able to use any of those.

19 Unfortunately, IV drug users don't under the twelve-
20 letter words that are used in medical jargon. I think many of us
21 here don't either.

22 So, we feel it's useful to use street language, use very
23 basic, simple language that will convey the message and that'll
24 be understood.

25 We can talk all we want, but if we're talking the
26 language that is not understood by the person we're trying to
27 reach, then it's useless. So we're very committed to talking
28 very simply, very directly.

1 SENATOR HART: Thank you.

2 SENATOR SEYMOUR: Thank you very much for your
3 testimony.

4 MR. PAPPAS: Thank you.

5 SENATOR SEYMOUR: I believe we now have Ms. Zarinah
6 Shakir, representing the Multicultural Prevention Resource
7 Center.

8 MS. SHAKIR: Good afternoon. I'm Zarinah Shakir,
9 spelled Z-a-r-i-n-a-h, last name S-h-a-k-i-r. I'm here on behalf
10 of Sala Udin, who's the Executive Director of the Multicultural
11 Prevention Resource Center. The statement that I am about to
12 read is from him.

13 Senators Seymour and Hart, thank you for the invitation
14 to address this hearing on AIDS and the IV Drug User.

15 I apologize for not being able to make this
16 presentation, but the schedule conflicted with the annual
17 Conference of the American Public Health Association.

18 MPRC is an agency contracted by the City and County of
19 San Francisco to provide information, training, technical
20 assistance, and advocacy. We've been training the staff of drug
21 and alcohol programs and community agencies in a course named the
22 same as this hearing, "AIDS and the IV Drug User."

23 We think it is a very destructive myth to suggest that
24 it is impossible to change the behavior of drug abusers. Of
25 course, it is difficult, but with support it can be done. Drug
26 treatment programs have contributed a great deal to the body of
27 knowledge on addiction management and behavior change. What they
28 lack is not know-how, but adequate funding.

1 The primary strategy to impact AIDS infection among
2 addicts should be intervene effectively with their addiction and
3 involve them in a long-range plan for psychological and social
4 rehabilitation.

5 Methadone programs are not the only kind of intervention
6 which deserve support. Residential and outpatient centers are
7 also required. Furthermore, simply increasing the methadone
8 slots falls short of the comprehensive counseling and full
9 rehabilitation that is required, especially if the addicts are
10 also infected.

11 But addicts in treatment programs are just a fraction of
12 the total addict population, as you well know. Addicts in jail
13 and prison need an opportunity to have AIDS education upon their
14 release, and they need condoms and AIDS education before their
15 release.

16 The IV drug user in the streets can also best be served
17 by trained ex-addicts of the same cultural identity who can
18 penetrate the closed underground culture of drug addiction, and
19 who commands the respect and credulity [sic] of the addicts in
20 the street. Few others can qualify in these regards.

21 The State Drug and Alcohol Programs Office should
22 financially support, and by policy require, all funded or
23 licensed substance abuse programs to train all their staff in the
24 NIDA curriculum, "AIDS and the IV Drug User." Further, all
25 programs should be required to install thorough-going AIDS
26 education programs for all their clients.

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1 Female sex partners of male IV drug users are most often
2 IV drug users and are more difficult to reach effectively than
3 their male, IV drug using sex partners. Programs aimed at female
4 sex partners, operated and staffed by ex-addict women and other
5 AIDS educated sex partners, is needed to develop methods to reach
6 this population.

7 Many of the IV drug users are also minority gay men and
8 women who are not being effectively reached by the outreach to
9 gays nor the outreach to minorities. They need specific outreach
10 as either gay identified minorities, or ethnic identified gays.
11 Again, each target population needs to be supported by members of
12 their own cultural and sexual preference groups, supplied with
13 target literature and other AIDS education support.

14 In conclusion, I respectfully caution us against
15 mystifying the issue of how we reach addicts. It is not a
16 question of technique. It is a question of adequate funding and
17 support to the people with the right stuff.

18 MPRC stands ready to assist you in these and other
19 endeavors aimed at this problem. Again, I'm sorry I cannot be
20 with you at this time. I look forward to working with you and
21 your staff in the near future.

22 Respectfully, Sala Udin, Executive Director.

23 SENATOR SEYMOUR: Thank you, Ms. Shakir.

24 SENATOR HART: You talked about don't focus just on
25 methadone; residential out-patient centers are also required.

26 Can you explain what that means a little bit more?

27 MS. SHAKIR: What a residential center is?
28

1 SENATOR HART: Yes. If some is a heroin addict, and
2 they come to a residential center, what happens at that
3 residential center?

4 MS. SHAKIR: Well, I'm going to -- I'm not going to
5 plead ignorance on this question, but I've only recently come to
6 work for the MPRC, but I have worked with drug related programs
7 in the past.

8 Residential centers are usually places where people go
9 to live and to detox and to relieve themselves of drug addiction.

10 SENATOR HART: So when they're at the center, they are
11 not taking heroin?

12 MS. SHAKIR: They're not supposed to be, no.

13 SENATOR SEYMOUR: But methadone.

14 MS. SHAKIR: Or methadone centers, yes.

15 SENATOR SEYMOUR: Thank you very much, Ms. Shakir.

16 Our next witness is Priscilla Alexander, representing
17 COYOTE.

18 MS. ALEXANDER: Good afternoon.

19 I want to thank you for inviting me to testify today.

20 SENATOR SEYMOUR: Thank you for being with us.

21 MS. ALEXANDER: I will first briefly discuss the data on
22 prostitutes and AIDS in this country, and I've distributed a more
23 detailed summary with my testimony. Then the issue of IV drug
24 use by prostitutes, and finally COYOTE's recommendations on the
25 best ways to prevent the transmission of HIV infection in this
26 population.

27

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1 When it became clear that AIDS was a sexually
2 transmitted disease, many people thought female prostitutes were
3 an obvious reservoir of contagion through which AIDS would travel
4 to the general heterosexual population. However, numerous
5 studies have found that the risk of HIV infection among
6 prostitutes is not related to the number of sex partners, or to
7 prostitution per se, but it is dependent on either personal IV
8 drug use or an ongoing sexual relationship with a male IV drug
9 user.

10 The incidence of infection among prostitutes is directly
11 related to the incidence in the IV drug using population. Thus
12 in Seattle, where the incidence among IV drug users is low, no
13 prostitutes tested in jail or in an STD clinic tested positive;
14 while in New Jersey, where most IV drug users are infected, 57.1
15 percent of women tested in a methadone program tested positive.
16 That was the highest figure in the country and was an extremely
17 skewed population. In California, the incidence has ranged from
18 2.5 percent in Orange County in 1985, to 6.2 percent in San
19 Francisco in 1987.

20 At the same time, there's little evidence of
21 transmission from prostitutes to their customers. In fact, some
22 researchers have found that when they closely question men who at
23 first list contact with prostitutes as their only risk factor,
24 most turn out to have other risk factors.

25 Some IV drug using prostitutes were infected on both
26 coasts in the early to mid-1970s. If only a few women in New
27 York and San Francisco were infected in 1976, more than 100,000
28

1 heterosexual White men without other risk factors, most of them
2 married, would have been diagnosed by now. As of October 5th,
3 however, only 200 males cases fit that description, and I've
4 include^d a page with that statistic.

5 We do not mean to imply that there is no risk, just that
6 there are factors which mitigate against this route of
7 transmission.

8 IV drug use among prostitutes: IV drug use is very rare
9 among the 80 percent of prostitutes who work off the street for
10 massage parlors, brothels, and escort services, or independently
11 out of their apartments.

12 As for the approximately 20 percent of prostitutes who
13 work on the street, Dr. Don Des Jarlais, of the New York State
14 Division of Substance Abuse Services, found that a third to half
15 of 75 prostitutes in a New York City jail used IV drugs.

16 Street outreach workers in San Francisco believe that
17 since the beginning of the AIDS epidemic, the percentage of
18 street prostitutes who use IV drugs has increased, even as the
19 number of street prostitutes has declined, suggesting that women
20 who are not addicted have either moved off the street or stopped
21 working as prostitutes.

22 It is difficult to know without formal studies whether
23 this phenomenon is restricted to San Francisco, or whether it is
24 true generally. It is also difficult to know if the decline in
25 the number of street prostitutes in San Francisco is due to AIDS
26 to a decline in unemployment, or to a heavy crackdown over the
27 past few years.

1 Now, I wrote this before the catastrophic day in the
2 stock market yesterday, but if that crash is indicative of what
3 we're facing in the next months, I would expect an increase in
4 unemployment, which would mean an increase in the number of
5 street prostitutes. The number actually in 1982, which was the
6 year of the highest percentage of unemployment in this country.

7 Factors mitigating transmission of the virus.

8 Traditionally, street prostitutes were the most likely to use
9 condoms, partly as a health measure and partly to preserve a
10 sense of privacy with a large number of customers. An average
11 street prostitute may see 1500 customers a year.

12 Women who worked in other ways, where there was more
13 expectation of an illusion of romance, were less likely to use
14 condoms. Even so, the rate of venereal disease was relatively
15 low among prostitutes, who accounted for no more than five
16 percent of VD in this country prior to the AIDS epidemic,
17 according to the Center for Disease Control.

18 With AIDS, the use of condoms has increased at all
19 levels of the industry. For example, in Nevada, almost all of
20 the legal brothels now have an all-condom policy, in sharp
21 contrast with policies prior to 1981.

22 In San Francisco, many prostitutes have voluntarily been
23 tested, either as part of Project AWARE's study, or at the
24 alternative test sites. Some are routinely getting checked every
25 few months.

26 The experience of outreach workers who work for the
27 California Prostitutes Education Project, CAL-PEP, MidCity
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1 Consortium to Combat AIDS, and other programs, is that street
2 prostitutes are quite aware of the need to use condoms, and are
3 purchasing them as well as getting them from the outreach workers
4 and from the city clinics.

5 There are still some, generally younger, heavily
6 addicted women, who will agree to not use a condom if the
7 customer pressures them. Most street prostitutes, on the other
8 hand, report that the customers are much less resistant to using
9 condoms than before, and that some are even bringing their own
10 condoms with them. However, the women are less likely to use the
11 condoms with their lovers, many of whom use IV drugs, which puts
12 them at increased risk of becoming infected, even if they
13 themselves always clean their works before sharing, or don't
14 share them at all, or don't use IV drugs.

15 I'd like to comment that this CDC collaborative study in
16 seven cities found that 80 percent of the prostitutes use condoms
17 at least some of the time, and four percent were using them all
18 of the time, including with their lovers.

19 Now I'd like to get to what we think would help to
20 reduce the risk further. As regarding HIV testing programs, as I
21 said before, many prostitutes are voluntarily getting tested for
22 antibodies to the AIDS virus in order to monitor their own health
23 and too prevent unknowingly transmitting the virus to others.

24 We urge you to provide the funds to greatly expand the
25 existing alternate test sites, to provide tests accompanied by
26 comprehensive pre and post-testing counseling to anyone who wants
27 to be tested, without their having to wait weeks or even months,
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1 for the test. However, we strongly oppose all mandatory testing
2 proposals, except to screen blood and organs donated for
3 transplants. In particular, we oppose the mandatory testing of
4 prostitutes because it would create the illusion that all
5 prostitutes who have been infected have been identified, with the
6 result that customers would be more resistant to using condoms
7 and spermicides, as happened in West Germany.

8 In the case of Senator Doolittle's bill, SB 1007, which
9 was introduced last year, mandatory testing with results reported
10 to the Department of Justice, coupled with increased penalties
11 when someone who tested positive is arrested again, would have
12 little or no impact on the spread of the virus. In fact, it
13 might have the reverse effect as the possibility of a felony
14 charge would discourage prostitutes from being tested on a
15 voluntary basis.

16 We think that the best way to prevent the virus is
17 through education. The State Department of Health Office of AIDS
18 has given some money to community organizations in San Francisco
19 and Los Angeles, specifically to do AIDS prevention education and
20 intervention with street prostitutes.

21 The San Francisco program, CAL-PEP, has an outreach
22 worker who goes to the stroll districts during afternoons and
23 evenings to talk with prostitutes while they are working, and to
24 distribute condoms and safe sex and safe IV drug using
25 information. In addition, the outreach worker goes to the San
26 Francisco County Jail one day a week to talk to incarcerated
27 women about AIDS prevention. Once a week, CAL-PEP sponsors a
28

1 support group where prostitutes can come to talk about how to
2 better protect themselves and to discuss the merits of various
3 brands of condoms and spermicides. One evening a month they are
4 invited to bring their lovers and/or regular customers to discuss
5 the importance of male cooperation in AIDS prevention.

6 CAL-PEP has discovered, however, that it is hard to
7 working street prostitutes to take the time out to come to a
8 support groups. When they are working, they are usually
9 desperate for money for a fix, and are unwilling to take much
10 time out for a discussion. The project is developing plans,
11 assuming that funds can be found from a governmental or private
12 source, to purchase a van to take to the stroll districts to
13 provide a place where the women can come in for coffee, a snack,
14 and some AIDS prevention talk without having to leave the stroll.
15 This approach, which has been used successfully by New York's
16 Judson Memorial Church, would be effective in other California
17 cities as well, particularly where there are several stroll
18 districts.

19 Another problem has to do with the need to get State
20 approval of all distributed educational materials, even those
21 that are not produced using State money. There is a conflict
22 between the State's requirement that educational materials not be
23 sexually explicit, or use words or pictures that could be
24 considered obscene by some, and the need to provide clear
25 information to people who engage in sex for their livelihood and
26 who, in many cases, are barely literate.

27
28

1 Understandably, the State does not want to be seen as
2 encouraging people to engage in prostitution; however, the
3 reality is that people will continue to work as prostitutes for
4 the foreseeable future, and it is imperative to provide them with
5 accurate, clear, easily understood information if they are to
6 prevent the transmission of the AIDS virus, either to themselves
7 or to others.

8 Another problem is police practices. In most cities in
9 California and in other states, when police make a prostitution
10 arrest, they confiscate condoms as evidence of intent to commit
11 prostitution. They are also likely to confiscate bottles of
12 bleach and/or works as evidence of illegal drug activity.

13 Clearly there is a conflict here between law enforcement
14 and public health priorities. In San Francisco, under pressure
15 from the Department of Public Health and others, the District
16 Attorney stopped requiring the confiscation of condoms and bleach
17 bottles last Spring, and the Police Chief issued an order, a copy
18 of which is attached.

19 However, they still confiscate needles and other drug
20 paraphernalia. Unfortunately, fewer works on the street means
21 more shared, unsterile needles, and ultimately more transmission
22 of the AIDS virus.

23 Given that the Legislature is unlikely at this time to
24 authorize the legal needle exchange program, although England,
25 Holland and Australia already have such programs, and
26 Massachusetts is about to begin one, legislation that would at
27 least bar the use of the possession of condoms, bleach bottles or
28

1 works as evidence of criminal intent would be helpful to AIDS
2 prevention efforts.

3 And finally, I want to talk about alternatives to
4 prostitution. There is an urgent need for increased services to
5 prostitutes, and increased is sort of a joke, because there are
6 almost no services to prostitutes. But there is an urgent need
7 for increased services to prostitutes, including many more slots
8 in residential drug treatment programs for women and their
9 children. Many prostitutes are single mothers. Specialized job
10 retraining programs that would help women find appropriate
11 alternative employment are also necessary. And that means it has
12 to be employment above the minimum wage.

13 One possibility would be to model the program on GAIN,
14 although on a voluntary basis, with the addition of special
15 support groups to deal with the stigma associated with
16 prostitution, and how to apply for jobs when your prior work
17 history has to be kept secret.

18 One of the things Les Pappas said made me think about
19 something. I have a friend who is a Black man who's diabetic.
20 If he goes into a drug store to get needles, he has to show all
21 kinds of ID showing that he's a diabetic and is entitled to get
22 the needles.

23 If he sends a White friend into most drug stores in this
24 State to get needles, they don't ask any questions. Which may
25 explain the reason that minority IV drug users have a much higher
26 incidence of infection than Whites.

27 I'd be glad to answer any questions.
28

1 SENATOR SEYMOUR: Very good, Ms. Alexander.

2 In your opinion, what percentage of prostitutes are IV
3 drug users?

4 MS. ALEXANDER: Of the total population, maybe 10
5 percent.

6 SENATOR SEYMOUR: Relative to the study that Tom
7 Pendergast --

8 MS. ALEXANDER: Those women were jailed, which means
9 that they were street prostitutes, which means that maybe 50-75
10 percent are IV drug users.

11 SENATOR SEYMOUR: So when you quote 25 percent, you
12 include street prostitutes?

13 MS. ALEXANDER: When I say 10 ten percent of prostitutes
14 are IV drug users, I'm including street prostitutes, who
15 represent about 20 percent of prostitutes. Most prostitution is
16 less visible. It's mostly street prostitutes who get arrested,
17 however, except when the police run out of street prostitutes to
18 arrest, then they go into the hotels and they start answering
19 ads.

20 I can tell you lots of stories about police practices if
21 you're interested.

22 SENATOR SEYMOUR: Well, not so interested, perhaps
23 another time relative to street prostitution.

24 Today we're more interested in IV drug use.

25 MS. ALEXANDER: The big focus in -- I also work with the
26 California Prostitution Education Project, and I have been
27 working with public health departments around the country who are
28 trying to set up education projects for prostitutes.

1 The big concern is preventing AIDS transmission has to
2 cover all prostitutes, because in cities where there has not been
3 as much publicity about AIDS as there has been in San Francisco,
4 it may be that fewer prostitutes have switched to an all-condom
5 policy. So, it's important to get the information to the off the
6 street businesses as well as the street.

7 But the intense concern is with the street prostitutes
8 because of the much greater likelihood that they are using IV
9 drugs, or that their regular sex partners are IV drug users.

10 SENATOR SEYMOUR: Which puts them at risk themselves.

11 MS. ALEXANDER: Yes, through sexual contact.

12 SENATOR SEYMOUR: If only four percent of them are using
13 condoms with their lovers, and it's also true that large
14 percentage of their lovers are IV drug users, aren't they just
15 almost totally exposed?

16 MS. ALEXANDER: Well, in the total number of
17 prostitutes, that's not true. Again, it tends to be on the
18 streets that their lovers are IV drug users.

19 And there has been increasing publicity on all of the
20 studies that are being done and also trying to educate. All the
21 CDC studies have a component of education attached to them, so
22 that when they're interviewing prostitutes, they're also
23 educating them. And what they're finding is that as time goes
24 on, use of condoms is increasing.

25 But there are problems with men who are resisting
26 condoms. I think it's important that the IV drug programs that
27 work with men really be stressing the need to use condoms.

28

1 In Canada, the prostitutes have actually developed what
2 they call "double bagging", which is using two condoms. They're
3 using one with Nonoxynol-9 and one without, so that the two
4 condoms plus the Nonoxynol-9 gives an extremely effective barrier
5 against the virus. And that's what we have begun recommending.

6 SENATOR SEYMOUR: To what degree does the pimp help,
7 hinder, or effect in any way the educational or preventive
8 aspects of IV drug user transmission of AIDS to prostitutes?

9 MS. ALEXANDER: In terms of working, the pimps appear to
10 be quite cooperative.

11 Pimp is a very loose term that covers a wide range of
12 relationships. Any lover of a prostitute who receives any money
13 from that prostitute is legally a pimp, or any persons who
14 receive money on a regular basis.

15 SENATOR SEYMOUR: Not so much the legal aspects as
16 what's done on the street?

17 MS. ALEXANDER: On the street it varies greatly. There
18 are -- the vast majority of pimp-prostitute relationships are one
19 man and one woman. And it's essentially a personal relationship,
20 maybe 60 percent. And they negotiate, and sometimes he's not
21 able to earn much money, and she works as a prostitute because of
22 all sorts of issues around discrimination.

23 It's going to vary a lot in relationships, as it does.

24 In terms of prostitutes working, the pimps are not
25 objecting to the use of condoms. The problem is in the personal
26 relationships. Some of them are feeling threatened by the demand
27 that they use condoms.

1 SENATOR SEYMOUR: I'm sorry, I didn't understand that?

2 MS. ALEXANDER: Well, one of the problems is the one
3 women have had around birth control. With birth control,
4 contraceptive measures have been effective, but the male resists
5 taking responsibility for it.

6 So, if -- you know, men have this male myth, actually,
7 that if you have sex with a condom, it's like taking a shower
8 with a raincoat on.

9 In fact, at the International AIDS meeting, one of the
10 studies reported that it was younger men who were saying that,
11 tThe men who had no experience with condoms. Older men
12 remembered a time when they had used condoms, and did not give
13 that as an excuse. They were more ready to use condoms. So it
14 appears that it's a cultural myth and not so much a reality.

15 Prostitutes report -- many prostitutes put condoms on
16 their customers without the customer being aware of it. They
17 always have. They have sort of illusionistic methods, and the
18 customers are not aware, so it doesn't appear to reduce --

19 SENATOR SEYMOUR: You indicated 60 percent of the pimps
20 have a one-on-one relationship. I think I understand that.

21 But the corollary, then, is that 40 percent of the pimps
22 have a number of prostitutes?

23 MS. ALEXANDER: Some prostitutes don't have a pimp on
24 the street.

25 SENATOR SEYMOUR: I'm interested in the role of pimps
26 with prostitutes --

27 MS. ALEXANDER: Where money is available --
28

1 SENATOR SEYMOUR: Excuse me, I would like you to focus
2 for us on the pimps that work more than one prostitute, and what
3 effect they have, negative or positive, on this problem of AIDS.

4 MS. ALEXANDER: They appear to be cooperative with the
5 need for the women to use condoms.

6 The Project AWARE has found that -- and they have only
7 been funded to test prostitutes and other women. The male
8 partners of prostitutes are coming, asking to be tested. So, I
9 think they are -- they may try to get money to do that, or some
10 other agency get money to start testing the male regular sex
11 partners.

12 They're all interested in preventing AIDS. The issue
13 gets into the same kind of issues as with other heterosexual
14 relationships, about whether the men are willing to use a condom,
15 or whether the -- I mean, I know the experience in West Germany,
16 and this came up at the World's Whore's Congress, which was held
17 last year in Brussels with the European Parliament, the West
18 German women were being tested, and they said that the customers
19 were refusing to use condoms, and they would say, "I know you're
20 clean because you tested."

21 And women in this country, before AIDS, always got that.
22 I mean, if they wanted to use a condom, the customer would say,
23 "I'm clean. You're clean. I trust you."

24 And it's hard then to say to a customer, "Yeah, but if I
25 make an exception for you, how do you know, because these things
26 are not detectable immediately."
27
28

1 It also has taken for prostitutes that did not use
2 condoms, I think it took about a year for them to change their
3 practices totally. It's difficult. It's a slow process.

4 One of the problems is that the press has been very
5 cautious about talking about condoms, or giving enough
6 information, or not carrying ads so that we live in a country in
7 which advertising allows people to pick and choose which brand
8 they should use, we get familiar with them, and know which ones
9 are good and which ones aren't. And condoms need that kind of
10 filtering process. And the public media, the radios and
11 television stations, refuse to carry the ads. So, there's no way
12 for the public to get ongoing regular information.

13 SENATOR SEYMOUR: Anything else you'd like to add?

14 MS. ALEXANDER: I really think it's important that the
15 police stop confiscating the condoms.

16 SENATOR SEYMOUR: Condoms and the bleach kits, as they
17 have done here in San Francisco.

18 MS. ALEXANDER: Well actually, we didn't deal with the
19 works originally, and I may go back to them because they are
20 taking works, which means that someone who doesn't have access to
21 another needle is going to have to share. They don't always have
22 bleach on them.

23 SENATOR SEYMOUR: Any questions?

24 Thank you very much.

25 MS. ALEXANDER: Thank you.

26 SENATOR SEYMOUR: We appreciate your testimony.
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1 Our final witness today will be Mr. George Williams,
2 who's a Community Health Outreach Worker for Hospitality House.

3 MR. WILLIAMS: Good afternoon and thank you.

4 SENATOR SEYMOUR: Good afternoon and thank you, sir.
5 We're looking forward to your testimony.

6 MR. WILLIAMS: The feeling's mutual.

7 Outreach, community outreach has been mentioned at least
8 15 times today, so I kind of want to lean on that to kind of
9 stress the importance, and how everybody in the room, or most of
10 the folk in the room, tend to agree with that.

11 Community Health Outreach Worker, CHOW, C-H-O-W. We're
12 also known as -- at least I'm known as the AIDS man, or the
13 rubber man, or the bleach man, or the street outreach worker, et
14 cetera, et cetera. And some of the names I'm known by, I won't
15 mention.

16 I want to first of all point to the agenda. I think the
17 agenda was arranged quite appropriately, because much of the
18 information which is education that we've heard today is in many
19 of the brochures that you all have that I distributed. And in
20 distributing that information, there's a lot that goes on around
21 intravenous drug use, AIDS, substance abuse, drug use, et cetera,
22 et cetera.

23 As a Community Health Outreach Worker, to have a good
24 message is one thing, okay? We tend to think that we have a very
25 good message at Hospitality House.

26 But having a good message and find a good head is two
27 different kinds of situations. We know that the information is
28

1 very good, it's helpful. But getting an individual to plug into
2 that is one of the obstacles with the outreach. But above all
3 else, I give you some idea about how it started.

4 There was a study done in the Tenderloin. The
5 Tenderloin is where I work. It is thought to be an area with the
6 highest sex trade activity, and the highest intravenous drug use.

7 A couple of researchers went in, did some research, and
8 came up with the fact that the virus was there. That determined
9 the attention that that area should get. So, of course, we
10 started in that area.

11 One of the other areas is the Mission District.

12 But something we recognized in going into that area is
13 the cultural, the whole cultural scene. It's almost like a
14 melting pot: Blacks, Whites, Asians, South Pacific Islanders, et
15 cetera, et cetera. And we realized that the message we had was
16 good, but we were going to have to destroy some of those barriers
17 to get in to give up the information and to have individuals to
18 accept the information.

19 There was a lot of resistance, not only from the
20 community itself, but from other individuals who were doing other
21 kinds of things, and just in general objected to the street
22 outreach efforts.

23 But I tend to think that we have to cast aside all
24 formalities. We have to cast aside pomp and ceremony. And we
25 have to look at what's really going on.

26 We have an epidemic that has the potential to literally
27 devour mankind. But the backdrop for this epidemic, especially

1 around prostitution and intravenous use, is an emotional one.
2 That is, most of the decisions that are made around prostitution
3 and intravenous drug use are fraught with emotion. Few facts
4 have gotten through.

5 In doing the outreach, I've discovered that many of
6 those barriers fall in the face of persistence. So what I did
7 early on, I developed a capacity for rejection, because I already
8 knew that 90 percent of the individuals that I would make contact
9 with would probably reject what I had to offer. And then I went
10 on to develop a willingness to be tolerant of individuals who are
11 different from myself. And that's what I put out to everybody.
12 Get busy and develop a tolerance for folk who are different from
13 us: socially, economically and politically. Those individuals
14 have a right to any and all information that's available,
15 irregardless to the rung of the ladder that they happen to be on.

16 Community outreach work allows me the opportunity to do
17 that, to go in, work with the individuals who are unempowered, or
18 considered to be unempowered by the powers to be. Work with
19 those individuals around public health in general, not just AIDS,
20 but public health in general and more specifically AIDS.

21 Something else research showed was that while there is
22 roughly 12-18,000 intravenous drug users in San Francisco, if you
23 look real closely, you'll see that about 7,000 use heroin. And
24 of that 7,000, maybe 5,000 are in treatment. So, you've got a
25 couple thousand that are not in treatment.

26 The other portion of that 12-18,000 are speed users.
27 There is virtually nothing for an individual who's intravenously
28

1 using speed, so you've got that individual out of treatment.
2 Roughly speaking you've got, oh, maybe 8-9,000 individuals who
3 are out of treatment, thus possibly not being exposed to any
4 information at all.

5 That is the target group that the Community Health
6 Outreach Worker is primarily working with.

7 A profile of the individual for the area that I work in,
8 and remember that this will change, a profile of the individual
9 that I work with basically is between 30-50 years old, say 90
10 percent of them are males, unemployed, not plugged into the
11 system, the powers to be, circumvent those powers to be every
12 opportunity they get. But again, I insist that those individuals
13 have a right to the information.

14 So, my job is to deliver, or the job of the CHOW, is to
15 deliver that information. The program I'm with is a
16 comprehensive, educational outreach program of which two
17 intervention strategies happen to be a part of: condoms and the
18 bleach.

19 We also make referrals. We also do some advocating.

20 So, it isn't that we give an individual information, or
21 tell an individual what he or she can do to reduce risk, but we
22 are also able to follow that up with referrals, and even get an
23 individual to those spots.

24 Senator, I'll put it to you. What's the lesser of the
25 two evils? To have folks to continue to shoot dope and have
26 unsafe sex, and we do nothing at all, or we let go of the
27 traditional ideals, look into some of the creative methods, and
28 save a few lives.

1 The comic book, much of the information has been accused
2 time and time again of encouraging promiscuity, sexual
3 promiscuity, or encouraging drug use. In the face of this
4 epidemic since day one, all of the choices we've had to make have
5 been between two evils. That's how it's been since 1981. You
6 don't give enough money to the -- State money for the AIDS
7 prevention, you give it to the intravenous drug users. And the
8 gay community is left at risk if you do that same thing with the
9 intravenous drug user.

10 Those kinds of decisions have had to be made. We've had
11 to make the lesser of the two evils.

12 The decisions we make from this point on are in that
13 same ramification. I'd rather have the literature out there than
14 to not have it out. And speaking of literature, I brought a
15 couple pieces with me.

16 This is the latest effort by one of the programs here,
17 the Coalition for AIDS Education in San Francisco. Much of this
18 stuff is part of what's distributed to the community, and much of
19 it is specific, like say for the sister. And there's Spanish and
20 Japanese information, and information in Tagalog. All of that
21 information must be gotten out to the community. The Community
22 Health Outreach Worker is able to do that, and we are doing that.

23 But what I look at overall is how everybody in the room
24 is a Community Health Outreach Worker of a sort, because if we go
25 back to the first two policies I mentioned, a capacity for
26 rejection and the tolerance of those who are different from us, I
27 think that puts us all in that category, whether we're talking to
28

1 10,000 or 10 or two or one. We can all get involved in stemming
2 the epidemic.

3 We cannot do it alone. One individual cannot do it
4 alone. We need the help of each and everybody. You're all
5 affected. We're all affected.

6 What comes out of education is a sense of safety and
7 security. If I understand that touching a doorknob behind
8 someone who has AIDS is not going to put me at risk, I can get a
9 sense of safety out of that. If I know that I can use a bathroom
10 without concern, even if someone who has AIDS has used it, that's
11 a sense of security.

12 Everyone has a right to that. Not only the individuals
13 who get the direct services, but the so-called worried whale.

14 What I've done as an attempt to deal with that is, I
15 leave my designated community, which is bound by Market Street.
16 I go to Market Street, and once we can at least distribute 100
17 pieces of material, whether an individual is an intravenous drug
18 user or not, whether I see any indications of that or not, my
19 position is that we all deserve the information. We all need a
20 sense of security. We all need to know that food prepared by
21 someone with AIDS does not put us at risk.

22 And you may be surprised, those ideas still exist. Five
23 or six years later, you have folks who say, "Yeah, but if I drink
24 out of that same glass, won't I get AIDS?" And at that point,
25 it's my job to explain that even if that could happen, he would
26 not get AIDS, but he would simply be exposed to the virus.

27

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1 It is that kind of information, the real grass roots, if
2 you will, that's needed.

3 When are we going to get free needles? That kind of
4 question comes up. I say, "When we and the officials get
5 together to decide that that's the way to deal with the virus."

6 "Well you know, George, that would help us, man, because
7 then we wouldn't have to be involved in what's going on around
8 transmitting the virus."

9 "Yeah, I understand."

10 "Well God damn it! Get out there, brother! Tell those
11 people what's going on!"

12 I mean, I'm bombarded with that kind of response to the
13 officials getting involved.

14 If we can see it here at this level, why can't they see
15 it?

16 So what this kind of meeting does is allow conduits from
17 many areas to let you all know what's going on.

18 Community Health Outreach Worker's alive and well. It's
19 being supported vigorously. The attitude in the community I've
20 watched go from indifference, to tolerance, to concern. I've
21 watched that unfold. I've gotten at least two pimps, what I like
22 to call -- I have at least two gentlemen who manage women who get
23 at least 50 condoms from me a week. That needs to not only
24 happen in the Tenderloin, but that needs to happen broadly and at
25 length.

26 So, we need to take off the rose-colored glasses and
27 begin to look at our homophobia and our addictaphobia, and be
28

1 brutally frank with ourselves: Why do I have a problem with
2 intravenous who want to medicate themselves intravenously? Why
3 do I have a problem with an individual who has a different sexual
4 preference than mine? That's what I suggest. Take a look at
5 those kinds of issues, and be frank with yourself, because you
6 will not be able to extend services to those individuals if your
7 head is not screwed on right.

8 Fortunately, I had opportunities to deal with those two
9 phobias. Being an ex-heroin addict from Chicago, and shooting
10 dope with many individuals who were gay and bisexual, et cetera,
11 et cetera. We need to really look at what's going on, and look
12 at those individuals who do their thing a little different than
13 we do: White, Black, Red, Yellow, whatever. Sensitivity
14 increase, I guess, is what I'm asking for. Just be a little more
15 sensitive to the whole issue of AIDS, minorities, poor people,
16 women, children, and continue to support the Community Health
17 Outreach.

18 That's going to be the savior, I believe, getting right
19 at the roots, right at the ground level.

20 I'm going to continue to distribute information every
21 opportunity I get. I'm going to remain involved in a holistic
22 kind of situation.

23 See, I'm not going to just ask individuals that I deal
24 with who get direction information to change. I'm going to ask
25 the Select Committee to change. I'm going to ask the Select
26 Committee to join me in suggesting that other folk change.

27

28

1 We're going to have to start looking at the situation a
2 little differently.

3 Thank you.

4 SENATOR SEYMOUR: Thank you, Mr. Williams.

5 Obviously the work that you've accomplished to date has
6 been effective with the limited resources you've had to
7 accomplish it. Let me make a statement before I have some
8 questions, and perhaps Senator Hart does as well.

9 I hear you loud and clear, and I respect and appreciate
10 not only your work, but your relationship with the some 8,000
11 people you're trying to work with, that you define as your
12 market.

13 And I agree with you that I myself represent the powers
14 to be, and we don't relate with the people you work with, and
15 never will probably, because we don't have any credibility with
16 them. And I understand that; I accept that.

17 And on behalf of at least the philosophies of the
18 constituents that I represent, I'm prepared to lead to some
19 movement that you've requested.

20 On the other hand, politics is clearly the art of
21 compromise. We live in a democracy, and no one individual, no
22 one group, gets their whole way all the time.

23 Therefore my statement to you is, I think people like
24 Senator Hart, and he can certainly speak for himself, and I can
25 speak for myself, I'm prepared to lead and move. But I don't
26 want to leave you with any illusions.

27

28

1 I'm not sure at all, in fact I doubt, that I could lead
2 and stay alive all the way over with everything you've asked for.
3 So what I'm saying is, sure, we've got movement now. I think the
4 proper leadership will create more movement. But not to the
5 entire pole that you're suggesting.

6 Therefore, the folks that you represent, they need to
7 realize that, that somewhere we come together and we make a
8 difference.

9 MR. WILLIAMS: As a response to that, the Community
10 Health Outreach Workers, there are three of us, went into the
11 community with the goal of stimulating the community to get
12 involved itself. Out of that came TAN, the Tenderloin AIDS
13 Network. We occur as individuals, we come to the meetings, join
14 in the dialogues. Last year we had a public health forum set up
15 with City officials who came out and listened to the community,
16 and the community listened to the officials.

17 So you're right. Part of that is the understanding that
18 the individuals in the community are going to have to take some
19 responsibility for their activities and their behavior, sure, but
20 I don't want to give you the impression that they should in that
21 fight alone.

22 SENATOR SEYMOUR: Sure, I hear you.

23 Some questions, Mr. Williams. I am sincerely
24 appreciative of your time. My consultant tells me that you're
25 working so hard out there that you've got an answering service,
26 and she's lucky if she's been able to get hold of you one every
27 two weeks. That tells me you're out in the field working, and so
28 I am deeply appreciative that you're here today.

1 Let me ask you this question: First of all, how many
2 years have you been working the Tenderloin?

3 MR. WILLIAMS: Eighteen months.

4 SENATOR SEYMOUR: So for eighteen months --

5 MR. WILLIAMS: I've been living in the community three
6 years.

7 SENATOR SEYMOUR: So you have a pretty good feel for it.

8 MR. WILLIAMS: Right.

9 SENATOR SEYMOUR: Have you made any appreciable dent at
10 all that you can relate to us relative to the last 18 months'
11 work?

12 MR. WILLIAMS: I'm glad you asked that question.

13 You mentioned success earlier. If we're going to talk
14 about success, we're going to have to be willing to redefine what
15 we mean by success.

16 Now, if you mean I'm going into the field to stop
17 everybody from shooting dope or sharing needles, no.

18 But if you kind of change that a little bit, and ask me
19 if I've gone out and gotten individuals concerned about their own
20 health through knowledge, and that knowledge has changed the
21 education base, and then have those individuals to make personal
22 assessments and then get involved in promoting good health
23 activities, then yes, we've done that. We have done that.

24 SENATOR SEYMOUR: I know this is difficult. You've only
25 been there 18 months, and 8,000 is a large market to get to.

26 But do you have any idea, just off the top of your head,
27 how many people you've gotten to in the way you've just described
28 in the last 18 months? Is there any way of knowing?

1 MR. WILLIAMS: No. If I'm pushed to the wall, I'd have
2 to say that the population I work with, the entire population has
3 changed.

4 Let me qualify that now. I don't mean they've stopped
5 sharing needles and stopped shooting dope. But they are at least
6 now inquiring about the information, okay? "Where do I go to get
7 tested?" "What is testing all about?" "I want to get the AIDS
8 test."

9 Those kinds of situations come up, and I present this
10 information.

11 Nine months ago, you did not have that kind of concern,
12 if you will; you did not have that.

13 The research I mentioned came up with three percent of
14 the individuals involved in the study nine months ago, ten months
15 ago, reported using condoms or using bleach sometimes every now
16 and then. Nine months later, over 70 percent reported using
17 bleach.

18 SENATOR SEYMOUR: That's significant.

19 MR. WILLIAMS: Sure, sure it is.

20 SENATOR SEYMOUR: You indicated that two of your
21 clients, as I recall your words, were gentlemen that managed two
22 women.

23 MR. WILLIAMS: Well, three women, right.

24 SENATOR SEYMOUR: Does that mean one gentleman is
25 managing three women, or that two gentlemen managing three women?

26 MR. WILLIAMS: That's one gentleman, and that's the
27 number he gave me. It's probably six.

1 SENATOR SEYMOUR: My question is this: We heard earlier
2 from Ms. Alexander, representing COYOTE, and she gave us -- she
3 was obviously very informed and COYOTE as an organization has a
4 lot of data. I'm just trying to test the marketplace here.

5 You indicated that the two gentlemen that managed two
6 women, and maybe it's three women or four women, you gave them 50
7 condoms a week?

8 MR. WILLIAMS: Yeah.

9 SENATOR SEYMOUR: My quick math tells me that ain't
10 sufficient.

11 Therefore, my question of you is: Is it your opinion
12 that those prostitutes, the women being managed, are really as
13 aggressively requiring the use of condoms as was suggested to us
14 earlier?

15 MR. WILLIAMS: Yes.

16 SENATOR SEYMOUR: You think so?

17 MR. WILLIAMS: Sure, straight out they tell me, "I'm not
18 going to --"

19 SENATOR SEYMOUR: Where are they getting their condoms?
20 You're not giving them enough.

21 MR. WILLIAMS: Well, there are other agencies. There
22 are other spots. We have depots. I've got five hotels where I
23 leave condoms and bleach.

24 SENATOR SEYMOUR: I got you.

25 MR. WILLIAMS; There are condoms and bleach at the AIDS
26 Visual, located in the United Nations Plaza.

27 We've got the bases covered, Senator.

(Laughter.)

1
2 SENATOR SEYMOUR: Mr. Williams, part of our job, and
3 it's obviously going to be a tough one, and that is to pump
4 money, taxpayer money, into effective programs. So the reason
5 I'm asking these questions, I'm trying to find out how effective
6 you are.

7 MR. WILLIAMS: Come on with us! Come on!

8 SENATOR SEYMOUR: What percentage of your clientele is
9 minority?

10 MR. WILLIAMS: Ninety percent.

11 SENATOR SEYMOUR: Ninety percent?

12 MR. WILLIAMS: Ninety percent, sure.

13 SENATOR SEYMOUR: Obviously you, as an ex-heroin addict,
14 relate?

15 MR. WILLIAMS: Sure.

16 SENATOR SEYMOUR: Do you see others out there trying to
17 provide outreach that perhaps don't have the background you do,
18 and are they as successful, less successful, more successful,
19 than you?

20 MR. WILLIAMS: The success depends on the effort the
21 individuals make. Yes, they are.

22 SENATOR SEYMOUR: Let me ask another question.

23 Could I ever make it in your business?

24 MR. WILLIAMS: You sure could. You sure could.

25 See, I'm into street outreach. The heading is
26 "outreach". That could be hotels; that could be with businesses.
27 That kind of outreach is going on now in the hotels. You've got
28

1 St. Anthony's and some of the other agencies going to the hotels
2 to do that kind of outreach.

3 I do the street outreach. You don't have to street
4 outreach to be effective. You don't have to do the street
5 outreach to reach folks.

6 We do presentations. At least one presentation a week
7 is going on in the Tenderloin, and at least two or three others
8 are going on across San Francisco: the Mission District, south
9 of Market Street, et cetera, et cetera.

10 So no, you may be very good with facts and figures,
11 okay. We can use you. And when I say "use", I mean not misuse.
12 We can use you. You're very good with facts and figures. You'll
13 go around to other folks. We can use you. You have contacts!
14 We can use you!

15 SENATOR HART: Fundraising. Get him into fundraising.

16 (Laughter.)

17 MR. WILLIAMS: Right! I'm working on that.

18 So, everybody can fit in, and I think Dr. Martin Luther
19 King said that everybody can serve.

20 So, it's not to do what I do. I do it in one fashion,
21 but there are at least three other stratas that must be reached.

22 SENATOR SEYMOUR: Relative to the material that you pass
23 out, you held up the booklet, "Where Can I Get A Test for AIDS".

24 MR. WILLIAMS: Yes.

25 SENATOR SEYMOUR: Is that your most popular piece?

26 MR. WILLIAMS: No.

27 SENATOR SEYMOUR: What's your most popular piece?
28

1 MR. WILLIAMS: My most popular piece. That's just
2 material, now, not condoms and bleach?

3 SENATOR SEYMOUR: Right, material.

4 MR. WILLIAMS: The most --

5 SENATOR SEYMOUR: Most popular educational piece.

6 (Laughter.)

7 MR. WILLIAMS: Okay.

8 The most popular piece at one time was "AIDS, Substance
9 Abuse and People of Color." But I heard that somebody objected
10 to that because the word "shit" was in there in the brochure. So
11 now anybody's who getting State money can't be involved in
12 issuing that brochure, the comic book.

13 So the most popular piece at that time was "AIDS,
14 Substance Abuse and Minorities." And right after that, it was
15 the comic book.

16 SENATOR SEYMOUR: Let me ask some questions relative to
17 the point, and you've made it several times, and a number of
18 witnesses made it today. That is the difficulty that you have in
19 doing a good job out there when your material, if you're going to
20 use State funds, can't, let's say, tell it like it is. It's not
21 in the street language.

22 Let me tell you what happened on the other side. The
23 other side, and it happened about a year ago, some of the
24 publication pieces here in the San Francisco area relative to
25 safe sex in the homosexual community got into the hands of
26 various citizens and organizations throughout the state who found
27 out it was tax supported or some tax monies were used. They were
28

1 -- right, wrong, or indifferent -- were absolutely flabbergasted.
2 Obviously they couldn't relate, because they'd never been on the
3 street. And I mean they become outraged.

4 The result, cut off. Now, that's the other pole.

5 So you're over here, and they're over there.

6 The question is: Is it impossible to tell the story,
7 obviously not with the people in power language -- that's not
8 even English to your folks -- but is there some language, short
9 of the depiction and language that makes it easier for you to
10 disseminate your material and make it meaningful, is there short
11 of that where maybe we can be a little creative, and you get
12 yours, and we're able to get money into the program to fund
13 educational pieces? Yet we and the taxpayers and other groups,
14 maybe right wing fundamentalists, maybe don't become so outraged?
15 Is there a middle ground?

16 MR. WILLIAMS: Yes, there is a middle ground.

17 Let me say this, Senator, that by the time we reach that
18 middle ground, it would be curtains. That's what happened in New
19 York. By the time the City officials, the laymen, and everybody
20 stopped bickering among themselves, or stopped reminding: "It's
21 not mine. I'm Black. He's White. He's a White boy. I'm a
22 Black boy." By the time the folks stopped doing that, the
23 epidemic was upon them.

24 So, that's the result of waiting to reach the middle
25 ground.

26 SENATOR SEYMOUR: No, I'm asking, I guess, if there can
27 be effective literature created without four-letter words?
28

1 MR. WILLIAMS: Sure, sure. But I've got to meet with
2 you and do that. Meanwhile, folks in the street need services.

3 SENATOR SEYMOUR: Absolutely. That's why we're holding
4 these hearings. We're trying to get a handle on things, and I
5 hope, and I'm sure Senator Hart does, we hope to make some
6 positive moves.

7 But it's a real world that we deal in.

8 MR. WILLIAMS: Sure it is.

9 SENATOR SEYMOUR: And we realize that probably the
10 greatest thing we can do is be a source of funding and let the
11 folks who know what they're doing out there, don't try to
12 reinvent the wheel, a lot of good jobs are being done, just fuel
13 it.

14 But you've got to be able to cooperate with us in such a
15 fashion that we won't get our heads chopped off as we move ahead.

16 MR. WILLIAMS: Right, right. I'm looking forward to
17 that.

18 SENATOR SEYMOUR: Senator Hart, any questions?

19 SENATOR HART: It's been interesting dialogue. A couple
20 questions.

21 One, what's the biggest misconception about the people
22 that you work with that people up here on this side of the dais
23 and other places, the sort of establishment straight community,
24 have about your clients?

25 MR. WILLIAMS: Let me say this first.

26 You all just happen to be asking the right questions
27 today, too.

1 SENATOR SEYMOUR: That's because we're so intelligent.

2 MR. WILLIAMS: Right.

3 (Laughter.)

4 MR. WILLIAMS: The notion that AIDS is a gay disease is
5 the biggest bugaboo, and that comes from the younger brother or
6 the younger sister right on up to some of the older adults.

7 "Hey, I'm not a sissy. I don't fuck around, man! I don't need
8 to do that! I don't need to protect myself. I don't deal with
9 gays. I don't deal with fags."

10 And many times I have an opportunity, a golden
11 opportunity, to diffuse some of that if the individual will just
12 stick with me. But for the individual who says that to me and
13 then don't give me an opportunity to respond immediately, then
14 I'm trying to make sure that I'm there the next day, because
15 there is a misconception that you don't have to be gay to
16 contract the virus. You can just not manage your life well
17 sexually and intravenously and end up infected, not with AIDS,
18 but infected.

19 So, every opportunity I get to explain that difference,
20 I do my best to do exactly that. As a matter of fact, just on my
21 own what I did in my community to reinforce my efforts to dispel
22 that was to take on a gay volunteer man, okay? I just took on a
23 gay volunteer man so that -- and he worked with me for about
24 three weeks. So that when that issue, or the issue that "Send a
25 fag over to some island and drop him", when that came up, then we
26 had an opportunity to deal with it, not only from my perspective
27 as a sympathizer, if you will, but from a dude, from a man who
28 was actually gay and using stuff.

1 So, that gave both of us an opportunity to dispel a lot
2 of that. And that's what it's all about. Isn't that what it's
3 all about? It's education?

4 And it's a mistake for us to expect that the first round
5 is going to do it. That's another misconception. We were out
6 there one day, that's okay. It isn't like that.

7 For what we're doing is likened to basic education. I
8 mean, if you learn everything in the first grade, then you
9 wouldn't have to go to the eighth grade, you would never go to
10 high school, right? It's no different than this kind of stuff
11 here.

12 When I hear, "I'm not gay. Get away from me with that
13 shit. I don't like rubbers. I like the meat to meat feeling,"
14 or "I've been shooting dope like this all of my life, man, and
15 I'm still okay. I'm still alive, ain't I? So I don't need to do
16 any new things." When I hear that, I'm encouraged. I'm
17 encouraged.

18 Those kinds of statements never say, no other statement
19 ever says to me more that we are needed than when I hear
20 individuals talk like that.

21 And again, I get a grip on my emotions so I don't say,
22 "What's the matter with that dumb head?" Or "Doesn't he know
23 what' good for him?" I've managed to control those kinds of
24 responses and remember that we just don't all learn at the same
25 pace. Some of us play football, some play baseball, some of us
26 shoot pool, some of us shoot craps. You know, it's the kind of
27 thing where you have to be there.
28

1 So, visibility plays a big, big part in our job. At
2 least once a week I'm in the community, and I may not pass out
3 more than ten bottle of bleach. I may not pass out more than a
4 hundred condoms, but I may answer 50 relevant questions. I may
5 answer 50 nonrelevant questions, but it doesn't matter; the
6 relevancy doesn't matter.

7 My being there to act as a conduit for those questions
8 matters. Nine, ten months ago, 18 months ago, in this particular
9 community, there was no iota of any concern, agency
10 representative, or anyone else. Since that time, TAN has at
11 least stimulated dialogue between the Public Health Department
12 and the community.

13 There is not going to be any way possible to continue to
14 discuss AIDS prevention and treatment without including
15 street-based outreach. There is just no way.

16 SENATOR HART: Let me ask another question.

17 If we somehow have the political will to move forward
18 with funding, San Francisco's much more sophisticated in dealing
19 with this disease than other communities.

20 Do you have any advice or recommendations for other
21 communities or the Legislature in establishing programs in
22 communities, say, in Orange County, or Fresno, or San Jose, where
23 maybe they aren't doing it now? Are there certain key things
24 that we need to either do or avoid in setting up with the kinds
25 of programs that you're talking about that are street-based?

26 MR. WILLIAMS: Sure. You need, first of all, to be
27 conscious of the composition of the community racially, okay? I
28

1 even had to change clothes, because of the style of clothes that
2 I wore, because with a briefcase and a suit and tie, I
3 represented the establishment. And when I changed clothes, I
4 didn't stop representing the establishment, but I stopped looking
5 at if I represented the establishment.

6 So, be cognizant of what's going on in the community.
7 Get to know the community.

8 But Senator Hart, that cannot be done unless an
9 individual is willing to sit down at the same table with gay
10 folks, sit down at the same table with someone who might have
11 just fixed, okay? To sit down at a table with individuals who
12 are different from ourselves. Until we are able to do that,
13 until we're able to work on why it is we just do not like gay
14 folk, we can't do any of that stuff.

15 And that's what education is all about. Education
16 offers us an opportunity to do that if an individual remains
17 open.

18 So my job is to stimulate that. And I'm hoping that
19 that's what the four of you all do, stimulate information
20 gathering and knowledge gathering around the whole issue. Please
21 do that, please do that.

22 SENATOR HART: Is there any kind of network of what I
23 would call, for want of a better term, street activists like
24 yourself around the state or around the nation? I mean, all the
25 public health officers get together and have these conferences
26 all the time.

27

28

1 Is there ever an opportunity for people like yourself to
2 network with people in other parts of the state or country?

3 MR. WILLIAMS: That's what we encourage in San Francisco
4 in the Tenderloin and the Mission Districts. We want folks,
5 whether they're using or not, to get involved. We use those
6 opinions. So at some of the meetings, we open the meetings up to
7 individuals from the community.

8 SENATOR HART: But I'm saying, do people in San Jose, or
9 Fresno or Chicago get a chancer to hear what you're saying?

10 MR. WILLIAMS: Oh, sure, sure. As a matter of fact, as
11 part of the training there were representatives from San Jose,
12 representatives from Sacramento, and representatives from Los
13 Angeles, Chicago, even.

14 So, yeah, right. There is that kind of network.

15 SENATOR HART: The last question I had was, you're
16 affiliated with Hospitality House. Could you tell us just a
17 little bit about Hospitality House? How is that funded and how
18 you came to work there?

19 MR. WILLIAMS: Hospitality House gets funds from the
20 three official stratas: the City, the State and then some
21 federal funding, and also United Way pitches in, and there are
22 some contributions, private contributions made.

23 When the researchers realized what was happening in the
24 Tenderloin, they also realized that Hospitality House needed a
25 component, someone to be connected with Hospitality House and yet
26 part of that huge delivery system. They had to get someone to do
27 that.

28

1 And so, upon hiring, they just submitted, or at least I
2 submitted a resume and was interviewed and was hired, and was
3 trained and sent out to the community. And to toot my own horn a
4 little bit, I was very successful.

5 SENATOR HART: I believe that.

6 Hospitality House, then, gets most of its funding from
7 the government?

8 MR. WILLIAMS: I don't want to say most of it. I want
9 to say a portion of it.

10 SENATOR SEYMOUR: Mr. Williams, you've been very
11 enlightening. Continue your good work, and hopefully with the
12 testimony that you've provided today, and the testimony that some
13 of the others have provided today, Senator Hart and I and other
14 legislators concerned with this issue might be better equipped to
15 do a more effective job in helping you to do what you do so well.

16 Thank you.

17 MR. WILLIAMS: Thank you.

18 SENATOR SEYMOUR: This will conclude the hearing.

19 (Thereupon this Interim Joint
20 Hearing was terminated at
21 approximately 1:25 P.M.)

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1 STATE OF CALIFORNIA

2
3 JOINT INTERIM HEARING

4
5 SENATE SELECT COMMITTEE ON SUBSTANCE ABUSE

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7 AND

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9 SENATE SELECT COMMITTEE ON AIDS

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11
12 AIDS AND THE IV DRUG USER

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14
15 L.A. UNIFIED SCHOOL DISTRICT BOARD ROOM

16 450 NORTH GRAND AVENUE

17 LOS ANGELES, CALIFORNIA

18
19
20 WEDNESDAY, OCTOBER 21, 1987

21 10:00 A.M.

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26 Reported by:

27 Evelyn Mizak
28 Shorthand Reporter

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State Department of Alcohol and Drug Programs

DR. NEIL R. SCHRAM, M.D.
Internal Medicine/Nephrology

JOE ARNOLD, AIDS Research Coordinator
UCLA Neuropsychiatric Institute

DR. LESLIE POTPENBERG, Director
Program in Medical Ethics
UCLA School of Medicine

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Educating Black Community

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DR. FORREST TENNANT

Community Health Projects, Inc.

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P R O C E E D I N G S

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2
3 SENATOR SEYMOUR: Good morning and welcome to this
4 interim hearing. This is a joint hearing between the Senate
5 Select Committee on Substance Abuse, of which I, and my name is
6 John Seymour, am Chairman, and the Senate Select Committee on
7 AIDS, chaired by Senator Gary Hart.

8 We had a similar hearing yesterday in the City of San
9 Francisco, and this of course is our second and final hearing on
10 the subject, the subject being the connection between IV drug
11 users and the dreaded disease of AIDS.

12 We will have a number of Senate Members present with us
13 today. To my immediate right is Senator Milton Marks, who serves
14 San Francisco and all of Marin County, almost all of the Bay
15 Area. Senator Marks has had a very distinguished career and
16 serves in a leadership position in the State Senate as the
17 Democratic Caucus Chairman. He has long been a very vocal and
18 strong voice of support relative to this particular issue of AIDS
19 as well as other gay rights and homosexual issues.

20 Senator Marks, we're very pleased to have you with us
21 today.

22 Out in the corridor and joining us briefly will be
23 Senator Art Torres, and I think I'll wait until he returns before
24 I more appropriately introduce him.

25 In the meantime, let me make some opening comments, and
26 then ask Senator Marks if he has any opening comments, and then
27 we'll proceed with our witness list.
28

1 The Senate Select Committee on Substance Abuse has spent
2 the past four years working with public and private organizations
3 throughout the state in an all out effort to reduce drug and
4 alcohol abuse in California. Recently, our war against substance
5 abuse met an uphill battle when the AIDS virus plagued the IV
6 drug using population.

7 Now, not only must we address the debilitating effects
8 of injecting illegal drugs, but we must also focus our attention
9 on changing the behavioral patterns of the IV drug user, which
10 contribute to the spread of this infectious disease.

11 The alarming statistics underscore the urgency of our
12 efforts. For example, experts indicate that nationally over 25
13 percent of all identified AIDS victims have reported a history of
14 IV drug use. Currently in California, approximately 10 percent
15 of the people suffering from AIDS report a history of injecting
16 illegal drugs. Furthermore, it is apparent that with
17 approximately 425,000 needle-using drug addicts, AIDS prevention
18 must be an integral part of any statewide effort to reduce the
19 illegal use of controlled substances.

20 Although almost anyone is theoretically capable of
21 spreading the AIDS virus, the increasing avenue of transmission
22 is through the IV drug user. Especially prevalent is the
23 transmission occurring as a result of a contaminated needle, or
24 needle sharing.

25 Recognizing this deadly phenomenon, I on behalf of the
26 Senate Select Committee on Substance Abuse invited Senator Hart
27 and the Senate Select Committee on AIDS to co-sponsor joint
28

1 public hearings to gather information from experts in an attempt
2 to answer the following questions:

3 One, what can be done to stop the spread of AIDS among
4 the IV drug user population?

5 Two, what can we, as elected officials, do to help you
6 with your efforts to curtail the spread of the AIDS virus in this
7 population?

8 Three, how should the prevention of AIDS be addressed in
9 the statewide Master Plan to reduce substance abuse in
10 California?

11 Although these hearings will cover the prevention,
12 treatment and epidemiological aspects of the relationship between
13 AIDS and IV drug users, Senator Hart and I have encouraged the
14 testifiers in responding to these questions to address the
15 following issues which are of particular concern to the
16 Committees: One, the relationship between AIDS prevention and
17 substance abuse treatment; two, the relationship between AIDS
18 prevention and the punishment of illegal drug activity; three,
19 the relationship between the IV drug user, AIDS, and the minority
20 population; four, the spread of the AIDS virus to the non-IV drug
21 using heterosexual population; five, the transmission of the AIDS
22 virus from the IV drug user to an unborn or infant child; six,
23 the relationship between the IV drug user, prostitution, and the
24 sexual spread of AIDS; and, as time permits, the relationship
25 between all substance abuse and the transmission of the AIDS
26 virus.

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1 Curtailing the spread of AIDS by the IV drug user
2 population is a major task that could save many lives. I am most
3 confident that with the valuable assistance provided by each
4 expert witness who will testify before us at these hearings, we
5 will have the necessary components to set forth on our effort to
6 prevent the spread of the AIDS virus while simultaneously
7 reducing substance abuse in California.

8 Senator Marks, would you care to make any opening
9 comments?

10 SENATOR MARKS: I'll make a very brief one.

11 Let me say that I'm very pleased to be here at this
12 hearing. I think it's a very important thing that we are doing
13 what we can to try to help the lowering of the AIDS epidemic,
14 which is of such concern to all of us.

15 I'm a Member of the Senate Select Committee on AIDS, and
16 I welcome any testimony that can be helpful in this regard, and I
17 look forward to participating.

18 SENATOR SEYMOUP: Thank you.

19 Now approaching the dais is Senator Diane Watson,
20 representing the Los Angeles area.

21 Diane, good morning.

22 Senator Watson is the Chairperson of the Senate Health
23 Committee and has been very actively involved on our Senate
24 Select Committee for Substance Abuse, as well as being a very
25 distinguished leader in the whole health care field.

26 Senator Art Torres, who I introduced in his absence in
27 the hall and wanted to reintroduce as he approached the dais, has
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1 been kind enough to permit us to meet here within Senator Torres'
2 district, and we appreciate the hospitality, Art.

3 SENATOR TORRES: You don't need a green card here.

4 SENATOR SEYMOUR: In any event, Senator Torres, having
5 had a very distinguished career in the Assembly and in recent
6 years in the State Senate, certainly has risen to a position of
7 prominence and leadership in the State Senate in this most
8 important issue of AIDS and health care, as well as many others.

9 So Senator Watson and Senator Torres, I made some brief
10 opening remarks, and Senator Marks did likewise, and if you have
11 something appropriate, now would be the time.

12 Senator Watson.

13 SENATOR WATSON: Thank you so much, Senator Seymour.

14 To all of the members in the audience and my Committee
15 members, I think all of you are aware that we are learning that
16 intravenous spread of AIDS is one of the most insidious problems
17 we're having to face in battling this disease.

18 We are told that drug users don't care about other
19 people, that educating them about AIDS prevention and getting
20 them into treatment programs is next to impossible. We have
21 heard that providing them with clean needles only encourages them
22 to continue their drug use.

23 However, yesterday's hearing of the Joint Committees on
24 AIDS and on Substance Abuse provided testimony to the contrary.
25 Although I was not at that hearing, I understand that testimony
26 was given attesting to at least partial success in enrolling
27 needle-using drug users in treatment programs and in educating
28

1 them about ways to prevent the spread of the AIDS virus if they
2 insist on continuing to shoot up.

3 We all realize that we have a long way to go in finding
4 out answers to the many questions we have about the best ways to
5 fight the spread of the disease. Hopefully here today, we'll get
6 some responses to some of the most serious questions about AIDS
7 and the drug using population.

8 I would hope some of those would include:

9 Is the spread of AIDS in the drug using population worse
10 in some communities, particularly in minority communities?

11 To what extent are intravenous drug users willing to
12 enroll in drug treatment programs?

13 Are these programs successful in teaching them how to
14 stop the spread of AIDS through needle use?

15 Do we have enough drug programs available to treat the
16 people who want to quit?

17 If not, what kind of waiting periods are we talking
18 about, particularly in a city as large as Los Angeles? And
19 what's the impact of this waiting period on people who want to
20 quit their drug habits?

21 What's the impact of mandatory testing proposals and of
22 reduction of the confidentiality law? What effects will they
23 have on the drug using population? Will such policies help or
24 hurt our efforts to get people into treatment and off drugs, or
25 at least to get them to quit spreading the virus through needle
26 sharing?

27

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1 Are the public information materials that the State is
2 funding adequate to reach the drug using population? If not,
3 where are we failing?

4 Are there suggestions for more effective outreach and
5 information to drug addicts that are not enrolled in drug
6 treatment programs?

7 Now, we have heard that condom use and the use of bleach
8 to disinfect needles will help stop the spread of AIDS, at least
9 to around an 80 percent effectiveness rate. Is an 80 percent
10 effectiveness better than nothing? Or does it instill false hope
11 in those who practice these kinds of behaviors?

12 These are just some of the things that I hope can be
13 raised and hope that we can get responses to from the general
14 public.

15 Along with other Legislators at this hearing that we're
16 having, I'm interested in the straight talk that will come from
17 experts: from those of you who are on the streets every day
18 working with the drug users; from those people who have AIDS; and
19 those people who out there teaching in the schools who are
20 watching behavior of young people, behavior that will lead to
21 very high-risk kinds of activities. And I'm hoping you will give
22 us the benefit of your experiences.

23 We feel that you are the experts, you that are here
24 today. We're here to listen; we're here to raise questions;
25 we're here to get answers. And later on, I hope that we will ask
26 you for your assistance and your support on legislation that I
27 hope can be introduced that reflects the practical application of
28 your remarks.

1 We know that we don't have much more grace time to move,
2 and we're trying to move in a very orderly fashion with as much
3 information as we can.

4 Thank you, Mr. Chairman and Members.

5 SENATOR SEYMOUR: Thank you, Senator Watson.

6 Senator Torres.

7 SENATOR TORRES: I would just like to thank the
8 leadership of this Committee, Senator Seymour and the staff, who
9 I thought provided a very informative hearing yesterday in San
10 Francisco. Many of the witnesses were very interesting and
11 provided, I believe, new information to this Committee and both
12 of these Committees that talked about not only the tremendous
13 impact that intravenous drug users have on the AIDS continuing
14 and spiraling population, but also the tremendous danger that we
15 all feel towards children in this regard.

16 So, I'm looking forward to hearing the testimony today,
17 and I look forward to the time that I spent with you in San
18 Francisco yesterday, a very, very well-done hearing.

19 SENATOR SEYMOUR: Thank you very much, Senator Torres.
20 We appreciate the fact that you took the time to also join us in
21 San Francisco yesterday.

22 Our first witness will be Dr. Penny Weismuller, who is
23 the AIDS Coordinator from the Orange County Health Care Agency.

24 DR. WEISMULLER: Senator Seymour, Senator Marks, Senator
25 Torres, Senator Watson, and distinguished guests, I'm very
26 pleased to be with you today.

27

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1 In Orange County, we've identified 538 AIDS cases and
2 219 AIDS Related Complex cases since 1981, and 341 of these
3 individuals have died.

4 Intravenous drug abuse has been identified as the
5 transmission risk factor in 2.6 percent of our AIDS cases and 3.4
6 percent of our ARC cases. This contrasts markedly to the United
7 States' figures in which a much higher percentage of AIDS cases
8 have been related to intravenous drug abuse, and to the statistic
9 we heard this morning, that 10 percent of California cases are
10 related to IV drug abuse. These cases are due to the exchange of
11 blood infected with Human Immunodeficiency Virus, the AIDS virus,
12 when IV drug users share contaminated drug paraphernalia.

13 Although we don't have a systematic program of AIDS
14 virus testing in Orange County to pinpoint the prevalence of
15 infection amongst our IV drug abusers, we have run over 3,000
16 tests on IV drug abusers in our alternative test site, and a
17 voluntary testing program that Public Health runs in the Women's
18 Jail, where we offer voluntary confidential testing to women who
19 are IV drug abusers and prostitutes, and also through
20 confidential testing at our sexually transmitted disease clinic.

21 These tests show that 3-7 percent of the IV drug abusers
22 tested are positive for antibodies to the AIDS virus. This also
23 contrasts markedly with the evidence from certain areas of New
24 York and New Jersey, where 50-70 percent of IV drug abusers have
25 shown evidence of AIDS virus infection. This evidence in Orange
26 County of a low percentage of infected drug abusers indicates
27 that we have an excellent opportunity to intervene and prevent
28 further transmission of the AIDS virus.

1 However, we already have danger signs, even with our low
2 percentage of infected drug abusers, that we can no longer delay.
3 All of the seven AIDS virus infected babies in Orange County have
4 been born to IV drug abusing mothers. And we just had our first
5 perinatal case of AIDS, which was really a tragedy. The IV drug
6 abusing mother had been identified as AIDS virus positive during
7 her first pregnancy, had wanted to get into a drug treatment
8 program, was not able to get in immediately and was lost to
9 follow-up. She became pregnant before she came into the system
10 again. She was already pregnant again. She delivered an
11 infected baby just recently, and the baby died prior to six weeks
12 of age of AIDS virus pneumonia.

13 In addition, we have evidence in the jail screening
14 program where we have tested a number of women more than once, in
15 fact we've tested about 250 women more than once, and we have
16 nine women who have sero-converted from negative to positive for
17 the AIDS virus.

18 Because addictive behavior is not usually changed
19 without specific drug treatment, the first and most important
20 intervention we need is to make more drug treatment placements
21 available, both in outpatient and in residential settings.

22 As I was leaving work last night, I had a memo from
23 several staff members who were expressing their dismay at having
24 identified a prostitute, an IV drug abusing prostitute, who is
25 AIDS virus positive. She wanted to get into a residential
26 treatment program, and despite the efforts of our mental health
27 nurse and our social workers, we were unable to locate a
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1 placement that was available to her in the time that she wanted
2 to get into the treatment program. And she was lost to follow-up
3 early this week, and we don't know when we'll hear from her
4 again. Now she's out there on the street, and we're concerned
5 that she may be spreading the AIDS virus.

6 Barriers to treatment, such as waiting lists, need to be
7 eliminated. Most drug abusers are poorly motivated to follow
8 through with bureaucratic treatment entrance requirements and
9 would benefit from an advocate who would assist them in entering
10 a drug treatment program as quickly as possible once the drug
11 abuser expresses the desire to be in treatment, and this
12 predisposes that we've got placements to put them into.

13 Secondly, specific AIDS education needs to be provided
14 to those enrolled in drug treatment programs regarding sexual and
15 perinatal transmission of the AIDS virus. Instruction needs to
16 be provided on safer sex guidelines, including the use of
17 condoms.

18 We've had some concern expressed by parents who have
19 adolescents in drug treatment programs that providing safe sex
20 information would entice adolescents to engage in sexual
21 behavior.

22 Individuals in treatment also need to have information
23 about voluntary serological testing for the AIDS virus and about
24 available family planning services. This is particularly
25 important for the IV drug abusing woman who has tested positive
26 for the AIDS virus. She needs to have information about how a
27 pregnancy would effect her health and how a pregnancy would have
28 an adverse impact on her unborn child.

1 Thirdly, outreach needs to be made to addicts not in
2 treatment in order to provide prevention information about sexual
3 and intravenous drug use transmission of the AIDS virus. This
4 education also needs to include safer sex guidelines as well as
5 information about not sharing works, and information about
6 cleaning works if they are shared in order to prevent AIDS virus
7 transmission.

8 Anecdotal reports from New York and San Francisco, where
9 street outreach programs are in place, indicate that addicts have
10 modified certain risk behaviors with increasing their demand for
11 clean works. In our AIDS testing and counseling program for IV
12 drug abusing prostitutes in the Orange County Jail, women are
13 reporting to our screening nurse that they are having more condom
14 use and they're having less sharing of works than when they were
15 on the streets.

16 However, this information has been too late for some of
17 the women we have provided counseling to. We've identified a
18 group of nine women from a barrio in Orange County who shared
19 needles together, and all nine of them are infected.

20 The outreach worker in a street outreach program can
21 serve as a first contact with a drug treatment program and should
22 actively assist with entry into a treatment program should the
23 addict desire treatment. Encouraging voluntary serological
24 testing is important for addicts not in treatment in order for
25 us, as health officials, to determine the extent of AIDS virus
26 infection among this group. That way we can tell whether we're
27 being successful in our efforts in providing educational outreach
28 and voluntary testing.

1 Experimental programs, such as in Amsterdam, have
2 decreased AIDS transmission among heterosexuals by providing
3 clean needles and syringes to IV drug users, according to Dr. Van
4 de Wyngaart who directs the Addiction Research Institute at the
5 University of Utrech, Netherlands.

6 As elected officials, you can help curtail the spread of
7 the AIDS virus among IV drug abusers by providing adequate
8 funding for expansion of drug treatment programs and for
9 providing AIDS education to IV drug abusers. We know measures
10 that can be effective, and we're hampered by not having adequate
11 funding to put those programs into place. Additional drug
12 treatment placements are cost effective when compared to the cost
13 of AIDS treatment. Mr. Bill Edelman, Director of Drug Abuse
14 Programs in Orange County, estimates the cost of outpatient
15 methadone treatment in our county at \$2,000-5,000 annually as
16 compared to treatment costs of \$70,000-150,000 annually for an
17 AIDS patient.

18 You also can help in influencing public opinion that
19 targeting blunt and direct AIDS prevention information to drug
20 abusers, particularly information about cleaning drug
21 paraphernalia, will not lead nonusers to drug experimentation.

22 We also need to explore ways that public policy can
23 remove legal barriers to the possession of clean needles and
24 syringes. I might say also condoms. One problem that we ran
25 into early on in providing information to the prostitutes in the
26 jail was that we were encouraging condom use, and when they were
27 arrested, any condoms that we had provided them were confiscated
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1 as evidence. The same thing is true -- we've heard this from IV
2 drug users, when we've encouraged them to obtain their own set of
3 works, just to use that, don't share it with other people. And
4 they say, "But if I'm caught with drug paraphernalia, I can be
5 arrested just for that." So we have -- I know it's a very
6 complex question, but there is this discrepancy between what
7 public health officials can provide in educational information to
8 drug abusers and what legal intervention will be taken.

9 I would recommend that the prevention of AIDS be
10 addressed in the statewide Master Plan to Reduce Substance Abuse
11 through a combination of increasing drug treatment placements and
12 increasing targeted AIDS educational efforts to IV drug abusers,
13 including those in treatment programs as well as those not in
14 treatment. In addition, education for health professionals is
15 needed to develop expertise in dealing with clients who have a
16 dual diagnosis of IV drug abuse and AIDS virus infection or
17 disease.

18 Right now, particularly in our county, we have
19 professionals who are very experienced in dealing with IV drug
20 abuse. We have professionals that are experienced in dealing
21 with AIDS. And we don't have much crossover. We need to provide
22 training opportunities for professionals to help address this
23 problem.

24 We have the opportunity to vigorously intervene among IV
25 drug users here in California, and particularly in Orange County
26 where our rates of AIDS virus infection are quite low. Although
27 this group has been traditionally hard to reach, reports from
28

1 already established AIDS and drug abuse intervention projects
2 indicate that even this hard-to-reach and hard-to-motivate group
3 can make positive behavior changes when they're confronted with
4 the specter of AIDS. Effective intervention now, vigorous
5 intervention now, can save California the burden of many
6 additional AIDS cases, including the really tragic cases of
7 transmission to unborn children that would otherwise result from
8 this risk group.

9 Thank you.

10 SENATOR SEYMOUR: Thank you very much, Dr. Weismuller.

11 Senator Watson, a question.

12 SENATOR WATSON: Yes, I want to thank Dr. Weismuller
13 for, I think, a very compelling piece of testimony.

14 One of the things that I'm concerned about, you're able
15 to identify groups that share the use of works, as you called it,
16 or needles.

17 How long after identification of the various individuals
18 do you see behavior changes? Do they actually get the point and
19 they change their ways of usage?

20 DR. WEISMULLER: We provide, in the County program that
21 we've been providing to IV drug abusing prostitutes in the Orange
22 County Jail, we've reached over 1200 individuals. And
23 unfortunately, many of those people come back for additional
24 results, arrests for prostitution, but they are reporting that
25 they have increased condom use if they are engaging in
26 prostitution, that they are trying to have their own works,
27 trying to use the information we've given them about cleaning
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1 works. And this is a very sensitive kind of education when
2 you're providing it in the jail setting. We have to really
3 commend our jail officials for letting us do this in the jail.

4 But we do have evidence that the behavior is changing.
5 Like I say, for some people the information comes too late, and
6 that's the unfortunate part.

7 SENATOR WATSON: Do they actually understand the risk
8 that they're under?

9 DR. WEISMULLER: Yes, I believe they do.

10 SENATOR WATSON: One of the things, I got a letter in my
11 office day before yesterday from a citizen who happened to be in
12 a men's restroom and saw a fellow throw a syringe into a trash
13 basket. And he asked him what that was, and he said, "I'm giving
14 myself daily injections of insulin. I'm a diabetic."

15 And he thought that that diabetic could also be carrying
16 the AIDS virus in that syringe, you know. He said, "Oh, there's
17 no problem," the user said, "because I just break the needle, or
18 bend the needle."

19 But that needle goes into the plastic bag, and you know
20 we are picking up plastic bags, and that needle then could
21 puncture someone's skin.

22 So, the educational process has to go beyond the user
23 and into the people who make the policy now. We've got to look
24 at the way we allow syringes to be discarded, and just bending
25 the needle now doesn't prevent the problem that we're concerned
26 about at the current time.

27

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1 So, in your public health education, and I'm sure you're
2 doing this, we're going to have to broaden out its application
3 throughout the whole system, and we've got to get to the health
4 care professionals and say, you know, "Not only do you have a
5 responsibility for treatment, but you have a responsibility --"

6 DR. WEISMULLER: For education. In fact, we have just
7 formed a professional education focus group of our HIV advisory
8 committee in the County. And one of our emphasis is to involve
9 health professionals more in providing education about AIDS.
10 They are looked to as leaders. We need to get them correct
11 information so they can play a significant role in the education.

12 We also need to develop their capacity to provide for
13 care for the increasing number of AIDS patients we expect.

14 SENATOR WATSON: This is a suggestion to our Committee
15 Members and Chair, that we might want to look at the discarding
16 of this paraphernalia, needles and so on, for all other uses,
17 too.

18 SENATOR SEYMOUR: Other questions? Senator Torres.

19 SENATOR TORRES: Of counsel to the Committee, the
20 witness testified that condoms were being confiscated by
21 prostitutes for evidentiary purposes.

22 Is that the present law now?

23 MS. DELGADILLO: They're using that as evidence of
24 intent to solicit.

25 SENATOR TORRES: Intent to solicit.

26 What about anyone who today should be carrying condoms
27 if they want to have any kind of sexual relations? Given the
28 AIDS crisis, is anyone subject to that?

1 MS. DELGADILLO: I think it's just -- my understanding
2 is it's a piece of evidence to compile with other evidence to
3 show that there was intent to solicit.

4 SENATOR TORRES: Is that uniform enforcement across the
5 state, or is that just in Orange County?

6 MS. DELGADILLO: No, we heard that in San Francisco
7 yesterday also, Senator.

8 SENATOR WATSON: It couldn't be used by itself, in other
9 words?

10 MS. DELGADILLO: Correct.

11 The same with the bleach kits. If the bleach kits have
12 been found with other paraphernalia, they can be used as
13 evidence. But unless there's something else to substantiate the
14 intent to solicit, we haven't heard anything that the condom
15 alone has been the basis.

16 SENATOR TORRES: So anyone who is not a prostitute can
17 carry a condom in his or her possession and would be subject to
18 the same charge?

19 SENATOR SEYMOUR: No, I think it's more, Senator Torres,
20 the testimony that was provided in San Francisco shows that it is
21 a locally determined policy by policy makers as to whether or
22 not, for example, bleach kits -- if I had a bleach kit in my
23 pocket, and I were picked up for suspected drug use, that bleach
24 kit would become evidence, much the same as a condom evidence for
25 prostitution.

26 But in San Francisco, they have relaxed those policies.
27 Other communities throughout the state have not.

1 SENATOR MARKS: Are you working? I commend you for your
2 testimony. I think it's excellent.

3 Are you working with members of the gay and lesbian
4 community on this particular problem?

5 DR. WEISMULLER: Yes, we are.

6 We -- the AIDS Response Program, which is a program that
7 is in the Gay and Lesbian Community Service Center, Orange
8 County, and also the AIDS Services Foundation are working closely
9 with us in developing educational interventions. We are also
10 working with the newly funded educational contractor that's
11 reaching out to the Black community in terms of providing
12 education in the county.

13 We within public health have a funded program that has
14 made specific outreach efforts to the Hispanic community, trying
15 to work on this problem.

16 SENATOR MARKS: That's very good, thank you.

17 SENATOR WATSON: Two more questions before she leaves;
18 she's such a good witness.

19 First, I guess I heard on the news, and I'm not clear on
20 this even and maybe you can clarify it for me, was Orange County
21 given permission to test a drug to treat AIDS, or given
22 permission to use a drug that's been tested in a laboratory? Do
23 you know?

24 DR. WEISMULLER: The County of Orange?

25 SENATOR WATSON: Uh-huh.

26 DR. WEISMULLER: I don't have information about that,
27 I'm sorry.

1 SENATOR SEYMOUR: Maybe I can clarify that, Senator
2 Watson.

3 The answer is a private company who has done research
4 has been given approval to dispense the drug to those who have
5 contacted AIDS.

6 SENATOR WATSON: Very good.

7 The other thing, too, what are you learning in Orange
8 County in terms of the Black population and their receipt of
9 educational information?

10 We held a hearing, the Health and Human Services
11 Committee held a hearing at Exposition Park. Right down the
12 street at Davidson Center, USC had a combined group of community
13 groups, and they held a hearing also. They ran from nine to
14 five.

15 Combined, we did not have over a hundred people. We had
16 the known experts throughout the state. We had people with AIDS
17 there. We had community leaders, and we had no audience.

18 So, we figured out the way we did it was the wrong way.

19 What have you learned? What would you suggest?

20 DR. WEISMULLER: What we've learned, and we're trying to
21 address this problem by establishing a specific minority
22 subcommittee to our advisory group, because in Orange County, I
23 think early on in the AIDS epidemic, we heard from other
24 communities that minority groups felt that AIDS wasn't their
25 disease. It was a White gay male disease.

26 And unfortunately, the statistics look that way in
27 Orange County. We have 2 percent of our population Black, 2
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1 percent of our AIDS cases are Black. About 15 percent of our
2 population is Hispanic, 10 percent of our AIDS cases are
3 Hispanic.

4 So you see, there's not the adverse impact. We have
5 really the responsibility to provide targeted education to
6 minority communities so they can see they don't have to be the
7 victims of really a disproportionate spread of AIDS in minority
8 communities that have occurred on the East Coast.

9 That's one of the challenges that's facing me, and we're
10 hoping to put that into place.

11 SENATOR SEYMOUR: Thank you very much, Dr. Weismuller,
12 for your testimony and being with us today.

13 Our next witness is Dr. Forrest Tennant, representing
14 the Community Health Projects, Incorporated, Research and
15 Education Division of West Covina, also in association with the
16 UCLA School of Public Health, Division of Epidemiology, and the
17 UCLA Center for Health Sciences in Los Angeles.

18 DR. TENNANT: Thank you, Senator. It's kind of you to
19 invite me here.

20 First off, I'm principally here to represent the agency
21 that I spend most of my time direction, Community Health
22 Projects, Incorporated, which I will address. I have a number of
23 other positions that perhaps get me better known. One of the
24 reasons why it's so nice to be here today, I have the, I guess,
25 dubious distinction of being the National Football League's drug
26 advisor and Medical Director, and it's nice to be back talking
27 about condoms and AIDS and drug addicts rather than facing
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1 Mr. Upshaw and his troops in the last month. So, I guess one bad
2 thing may lead to another these days.

3 I have a number of other positions which I may mention
4 as I go along, of which in summary I might just say that I have
5 for many years been law enforcement's primary consultant for the
6 Highway Patrol, or Civil Addict Commitment Program under the
7 Department of Justice. And I'll mention a few things about that,
8 since one of the things that's very involved, of course, with the
9 IV drug user today is our Civil Addict Program at our California
10 Rehabilitation Center in Norco, where I serve as the Medical
11 Consultant to the Board there.

12 My real involvement with AIDS comes primarily due to the
13 fact that Community Health Projects, Incorporated, I believe,
14 operates the biggest system of treatment for IV drug users in
15 this state. We have about two dozen clinics, depending on how
16 you count them, located in about 15 cities. And we carry each
17 day about 1600-1700 IV drug users in treatment. The vast
18 majority of those would be heroin addicts; there's some cocaine
19 users, of course, that are IV drug users.

20 I should state that certainly from my perspective, when
21 we talk about IV drug users today, we're primarily talking about
22 the heroin user. Yes, we have a few intravenous amphetamine
23 users and cocaine users today, but they're almost rare relative
24 to the problem of heroin addiction.

25 Some of our clinics go on up into the midpart of the
26 state, and we are the primary providers of services for IV drug
27 users in Fresno County, Santa Barbara County, and Ventura County.
28

1 Most of our facilities are located in the eastern part of Los
2 Angeles County, where we have facilities in Pasadena, Whittier,
3 El Monte, Pomona, and they go on out into Ontario and almost to
4 San Bernardino.

5 It's been now about one year ago that the National
6 Institute on Drug Abuse asked us if we would be their federal
7 monitoring sites for AIDS antibodies in the IV drug user. And to
8 that effect, we have been consistently gathering blood samples
9 and forwarding them to the National Institute on Drug Abuse to
10 have them analyzed in their laboratory.

11 It's been quite a surprise, but I did put here in my
12 testimony that when samples -- seroprevalence studies have been
13 done over a fairly wide area in Southern California, our
14 prevalence has been quite low. I'm pleased to say that last
15 week, we sent 100 blood samples to the National Institute on Drug
16 Abuse, and not a single one of those patients were AIDS positive.
17 Not a single one.

18 And if you'll take a look at my testimony, the first
19 study done in California that was over a fairly wide area was
20 done in 1985, done by Dr. Levy of UC Davis. We contributed some
21 samples to his group at that time. And since that time, at least
22 when samples have been taken on addicts entering treatment, that
23 percentage has been running down under two percent.

24 Now, I just heard from the doctor from Orange County who
25 said in a jail population it was slightly higher. I suspect that
26 that would be somewhat true. If you had a way of sampling jail
27 populations, or people other than those coming to treatment, you
28 will probably find that it would be slightly higher.

1 Nevertheless, the most amazing thing about this, which
2 has caused quite a bit of discussion in Washington, certainly,
3 is: why is our rate so low in California, particularly Southern
4 California, as opposed to the rest of the big cities in the
5 country?

6 On Page Two, I gave you some of the data. Early this
7 year, the National Institute on Drug Abuse has been sampling
8 other large cities in the country, and we are running -- the only
9 other place that's as low as us is Tampa, Florida. In other
10 words, Brooklyn, Harlem were up to 61 percent; Newark, 56;
11 Baltimore, 29 percent; New Haven, Connecticut, 30; San Francisco,
12 9; Denver, 9; San Antonio, 2; Tampa, 0; and we're clear down near
13 the bottom also.

14 I would like to just give you some of my ideas on why I
15 think we are lower than other states. And I have one bottom line
16 for you, and that is, we in Southern California, and California
17 in general, and Southern California in specific, for your
18 information, has gone about a heroin control system since 1961
19 different than any other state in the Union. And I'd like to
20 tell you what some of those differences are.

21 One of my bottom lines is, in this state, and I would
22 highly recommend to you on your Committees that we keep doing
23 what we're doing now, and let's try to add to it, but our system
24 has been immensely successful and is fast becoming, certainly in
25 the circles that I'm in, the envy of the country relative to
26 dealing with heroin addiction.

27

28

1 Now let me tell you what is different about our state
2 relative to every other state in the Union. In 1961, the State
3 of California passed something called the Civil Addict Commitment
4 Program. And with that, they took over the old Naval Ordinance
5 at Norco and made the California Rehabilitation Center. Now,
6 that led to a number of events over a long period of time, of
7 which many involved, obviously, the State Legislature.

8 One of the things that happened was that in 1972 or '3,
9 perhaps somebody even on the Committee may have been around then,
10 you added the 11550 amendments to our Health and Safety Code. At
11 any rate, it's been somewhat of a controversial bit of
12 legislation, I suppose, in some circles, but from law
13 enforcement's point of view and from treatment's point of view,
14 it has turned out to be extremely successful.

15 But here is the bottom line. One needs to understand
16 that California is the only state in the Union that incarcerates
17 heroin addicts for being under the influence. No other state has
18 that law except now the State of Nevada, and their law has been
19 on the books for years; it was never implemented until about a
20 year ago when they came to the Highway Patrol Academy, took
21 classes -- that's where I teach, that's where we teach our
22 officers at the Academy -- and we set up an agreement where I and
23 other people would go into Nevada to help teach them. So they
24 are now implementing that same law.

25 The law sounds very coercive because if you're arrested
26 for being under the influence of heroin, you may spend up to 90
27 days in a county jail. But the good thing that's turned out with
28

1 that is that you will come out of jail, and you will probably end
2 up on parole or on probation with the felony charges. But the
3 probation officers in this state have gotten very good at making
4 sure that person then gets into some kind of treatment as a
5 follow-up.

6 So, it's turned out to be a pretty good identification
7 system. The sworn officer identifies the individual; the
8 judiciary sees that there's some kind of sentencing given, and
9 then that probation officer may see that some kind of treatment
10 also is accompanying that whole system.

11 SENATOR TORRES: Question.

12 SENATOR SEYMOUR: Senator Torres.

13 SENATOR TORRES: I am very interested in your testimony,
14 especially in reviewing over the statistics and the rationality,
15 but it's almost in opposition to what at least I heard yesterday
16 during part of the hearing in San Francisco.

17 They argued there that methadone treatment is not easily
18 accessible, that we need to provide more money for methadone
19 treatment. They argued there that the type of treatment that
20 they had been receiving was clearly a problem of education, and
21 we needed more education and prevention.

22 Yet you argue that further education and information
23 efforts may not be very effective because of the fact that all
24 addicts are now aware of the needle risk and safe sex practices.

25 Is there that much of a difference between San Francisco
26 and Southern California?

27

28

1 DR. TENNANT: Let me just say this for the record: I
2 always find it very interesting to talk to my colleagues in San
3 Francisco, because it's sort of like talking to another planet.
4 I'm being very candid now.

5 All I can tell you is that I find this entire issue very
6 frustrating to analyze and deal with. I tell what I can from my
7 perspective. I don't know that I'm right. I don't quite know
8 what to do about this problem.

9 I was -- quite candidly --

10 SENATOR TORRES: You're speaking from the Southern
11 California experience?

12 DR. TENNANT: Yes, sir. I cannot speak from being
13 sitting there with my friends at Haight Ashbury in that
14 particular city, and if they tell you something that's different
15 from what I tell you, if you hear something different from what I
16 hear today, I wouldn't be surprised.

17 And I guess one of my other recommendations would be is
18 that it does seem to me that around the state, we've had a great
19 deal of emphasis from the gay and lesbian communities with the
20 problem, but the people who have been involved with narcotic
21 addiction, I've never been asked to talk about this in public
22 until you invited me. And yet, I run the largest program for
23 intravenous drug users in the state. You'd have thought somebody
24 might have at least given me a telephone call somewhere along the
25 line.

26 I'm not sure I'm right. All I can do is tell you what I
27 see. My facilities will certainly have to be a big part of
28

1 whatever you people on the Committee or the Legislature decide to
2 do, and we're certainly willing to cooperate.

3 I'm giving you my best shot, is what I'm telling you,
4 Senator. I just don't know whether I'm right.

5 SENATOR TORRES: I respect your expertise. Clearly your
6 credentials are excellent.

7 I'm just wondering, do we need to have -- sometimes in
8 the Legislature, you know, we try to put a uniform system
9 together, and maybe we need two difference approaches: one for
10 Northern California and one for Southern California.

11 DR. TENNANT: Incidentally, that is not surprising.
12 I've also had this same difference in talking to deal with my
13 friends in New York or Baltimore, and a lot of it has to do with
14 the wide open spaces in Southern California. And let me get to
15 that.

16 SENATOR TORRES: They don't occur on the freeways here.

17 DR. TENNANT: Well, that's true.

18 I just don't know.

19 SENATOR WATSON: May I just interject.

20 Even between Orange County and Los Angeles County,
21 you've heard the percentages of Hispanics and Blacks compared to
22 the other populations, and it's much much larger, maybe turned
23 around, when you get on to L.A. County.

24 SENATOR TORRES: They've taken all the Mexicans out of
25 Orange County.

26 SENATOR WATSON: But there is such a difference, even
27 from community to community. So as we go through making a State
28

1 policy, I don't know if we really can make a policy for treatment
2 that will be effective in every area.

3 DR. TENNANT: Well, I am glad you're recognizing that,
4 because I've found this difficulty for years.

5 SENATOR MARKS: Could I just ask one question?

6 SENATOR SEYMOUR: Sure, Senator Marks.

7 SENATOR MARKS: I'm not being defensive of San
8 Francisco, but I'm just curious to know, and unfortunately I was
9 unable to be at the hearing yesterday in San Francisco, but is
10 there a program like yours in San Francisco?

11 DR. TENNANT: Yes, there are similar programs.
12 Certainly in Southern California we dwarf their numbers because
13 of our size. But I would say that yes, as far as treatment
14 programs, yes, they would be very similar.

15 SENATOR MARKS: And are the results of their findings in
16 San Francisco similar to yours?

17 SENATOR SEYMOUR: No.

18 DR. TENNANT: No.

19 SENATOR MARKS: Why would that be?

20 DR. TENNANT: I really don't know.

21 In other words, one of the things that's a little bit
22 mysterious, the National Institute on Drug Abuse studies found
23 that our addicts, for example, share needles as often as they do
24 in New York, and we certainly have got the poverty and the
25 minorities that they do in Harlem and Brooklyn and Newark.

26 So, we really don't know some of the reasons on why our
27 prevalence is so much lower than the East Coast, or why we're
28 lower here than in San Francisco. I really don't know.

1 SENATOR MARKS: Is there a waiting time for methadone
2 use, to get methadone here in Los Angeles?

3 DR. TENNANT: We don't think so. We did have at one
4 time, but I think that the County of Los Angeles has certainly
5 over the years worked hard to build programs. We have had to go
6 the route here for many years of relying on patients' fees and
7 third-party payments and not government funding, because we just
8 had so many people here in Southern California. So, we don't
9 rely on government funding here. Very little in my programs are
10 funded by the government.

11 SENATOR MARKS: Can I ask a question of the Chairman? I
12 wasn't at the hearing yesterday.

13 Did you get any testimony yesterday of what is being
14 done in San Francisco in this area?

15 SENATOR SEYMOUR: Plenty of testimony.

16 Let me try to address your question, at least relative
17 to the testimony we received yesterday and the perception of the
18 problem as it exists in San Francisco, and perhaps an explanation
19 of the differences, and Senator Watson's already touched on the
20 bottom line answer, and I agree with her.

21 That is, whatever the State is going to do, they cannot
22 afford to take the issue and put it in one neat, little package.
23 It needs, whatever we do, needs to be very flexible, depending
24 upon the cultural aspects of the community, the degree of the
25 problem, and who is impacted and who isn't.

26 So in a word, I think, Senator Watson hit it right on
27 the head. What we need to do is to provide maximum flexibility
28 at the local level.

1 To answer your question, yes, very aggressive treatment
2 programs, very aggressive outreach programs, very successful
3 ones. On the other hand, dramatically, as Senator Torres has
4 already spoken to, dramatically different statistics.

5 For example, 100 percent in a survey, 100 percent of the
6 IV drug users in the community were aware that in fact there was
7 a high risk of contracting AIDS: 75 percent of that population,
8 when asked, "Well, the last time you shot up, was there liquor,
9 bleach or water available to clean your needle?" And 75 percent
10 of them said yes. But yet when asked, "Well, did you use it?" A
11 very low percentage, as I recall something like 25 or 30 percent,
12 said, "Well, yes, we used it."

13 Why is that? One of the explanations that we were given
14 is that although they were aware, and they'd been educated
15 relative to the risk, they were hardly aware what to do about it.
16 Even though those materials were available in the room, they
17 chose not to use it. Now, some of them chose not to use it
18 because they were already high. When you're high on the alcohol
19 or you're high on drugs, your conduct obviously is different than
20 when you're not. So, certainly that's part of it.

21 But Senator Marks, San Francisco, like Los Angeles, like
22 Orange County, like San Diego, are different populations,
23 different cultures, different ethnic makeups, and therefore
24 needing entirely different approaches.

25 SENATOR MARKS: Thank you.

26 SENATOR SEYMOUR: Senator Torres.
27
28

1 SENATOR TORRES: Your population that you talk about,
2 references on your studies on page one, studies three and four,
3 which come from your projects --

4 DR. TENNANT: Yes.

5 SENATOR TORRES: -- you indicated that your patients
6 usually rely on third party payers or direct payment to you,
7 because you said you don't rely on government contracts?

8 DR. TENNANT: Well, a lot of those. These would be a
9 mixture. For example, a number of these particular people would
10 be poverty level people from such places as El Monte, East L.A.

11 SENATOR TORRES: But overall in terms of your sample
12 used for the purposes of your studies, what does your average
13 client look like in terms of economics?

14 DR. TENNANT: The average person we would have, around
15 30 percent of those would be at the poverty level, and another 30
16 percent would be what you would call the medically indigent
17 category, and about a third would be -- have regular jobs,
18 primarily in the blue-collar type jobs.

19 You want to keep in mind that --

20 SENATOR TORRES: Who are covered by a third party?

21 DR. TENNANT: And when I say third party payments,
22 you're primarily talking about the Medi-Cal system in this state.

23 SENATOR TORRES: That's government?

24 DR. TENNANT: That's government funding; that's right.

25 SENATOR TORRES: So 60 percent of your clients are
26 government funded.

27 DR. TENNANT: In one form or another, that's correct.
28

1 SENATOR TORRES: And 30 percent are --

2 DR. TENNANT: Would be able to pay for their own --
3 their own way, yes.

4 SENATOR TORRES: -- third party payments?

5 DR. TENNANT: That's correct, yes.

6 SENATOR TORRES: Is the IV drug addict, then, from your
7 statistics in Southern California, more hip to what's happening
8 out there than those in Northern California?

9 DR. TENNANT: I don't know. I can tell you this, that
10 today, when we go in to take an AIDS counselor to talk to them
11 about condoms and needle sharing and all of that, they don't want
12 to hear it. They've heard it so much. They're very well aware.

13 That's why I'm saying, I would like to give out the
14 opinion that I think there are other things that are more
15 important right now than education, because these addicts are
16 very knowledgeable.

17 SENATOR TORRES: But as Senator Seymour said, they're
18 knowledgeable in San Francisco, as we heard, but they're not
19 smart because they don't use --

20 DR. TENNANT: That's just universal. In other words --

21 SENATOR TORRES: That's also the case here in your
22 situation?

23 DR. TENNANT: Yes, yes. But if I could educate them, I
24 would have changed a lot of their habits.

25 SENATOR MARKS: One more question, if I may.

26 DR. TENNANT: Yes.
27
28

1 SENATOR MARKS: Do you get government funds? State of
2 California funds?

3 DR. TENNANT: Yes, in some areas. For example, the
4 funding for IV drug user treatment is very complex, very
5 multifaceted. And I suspect my system of facilities would have
6 every type of funding mechanism you could think of, ranging from
7 the typical State funding to -- see, there's even some federal
8 funding left in Ventura County, for example, Medi-Cal, Blue
9 Cross, Kaiser fees, so the funding is very diverse.

10 One interesting project you should be aware of that we
11 have had going for some time, and it's sort of -- at least
12 considered by the Department of Corrections a little bit on the
13 innovative side, primarily in the East Los Angeles area here, in
14 which we are using the new drug naltrexone almost on an
15 innovative basis for those people because of the overcrowded jail
16 situation. In the IV drug use, naltrexone is the newest thing in
17 our armamentaria to try to treat these individuals. That that
18 program --

19 SENATOR MARKS: Are those funds available statewide?

20 DR. TENNANT: No, no they are not.

21 SENATOR MARKS: They're just limited to your area?

22 DR. TENNANT: At this particular time, we --

23 SENATOR MARKS: Why would that be?

24 DR. TENNANT: I think what has happened is that various
25 government agencies find other organizations like mine that they
26 want to work with, or can work with. In other words, funding is
27 very -- government funding is very sporadic. It is very hit and
28

1 miss, and there's many vagaries to it. And in fact, it seems to
2 me that the time has come if you're going to put in any more
3 funding into treatment, I'd like to see that funding, rather than
4 the categorical vagaries that categorical funding brings,
5 institutionalize it. Put it through the Medi-Cal program, or
6 something; something we can count on from now on.

7 SENATOR MARKS: If Northern California were to apply for
8 these funds, they would be available or not?

9 DR. TENNANT: I just don't know. As I say, it's a huge
10 state. What happens in Fresno County, and what happens in L.A.
11 County, or what happens in Ventura County, just in my own areas,
12 are so different. It's so difficult for me to just give you a
13 blanket statement about financing.

14 SENATOR MARKS: Mr. Chairman, I'd like to know whether
15 those funds are available throughout the State of California.
16 Maybe they're not applying for them.

17 Are those funds available?

18 SENATOR WATSON: We can get you a list of funds that are
19 available statewide.

20 DR. TENNANT: For example, in Los Angeles County, the
21 only government funding that we have would be through the
22 Department of Corrections, for example, and through the Medi-Cal
23 program as far as government funds. We have no other type of
24 funds in L.A. County.

25 SENATOR MARKS: Bear in mind, I'm not critical of your
26 program. I think it's a fine program.

27

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1 I just want to make certain that funds for programs
2 similar to yours are available in other parts of the state.
3 Whether they use them or not, that's another question.

4 SENATOR SEYMOUR: We have a witness representing the
5 State Department that could probably address your question,
6 Senator Marks.

7 Would you proceed?

8 DR. TENNANT: Surely.

9 Let me just state the one thing that I wanted to make
10 you aware of, and I brought along a few displays for you, and to
11 tell you what my major thing that I would certainly request the
12 Committee's help on.

13 For those addicts that fail the residential programs and
14 what we call the behavioral treatments, our standard, of course,
15 has been the methadone programs. And they have frankly been very
16 successful. In fact, it's the only thing we have.

17 And I will pass around a bottle of methadone. Not real
18 methadone, but that's what it looks like.

19 It's not well appreciated, but the whole idea of course
20 in stopping the spread of AIDS in the IV drug users is to keep
21 the person from putting that needle in their arm as often as they
22 must if they are addicted to heroin. It's not well appreciated,
23 but heroin only has an activity in the bloodstream of four to six
24 hours. Therefore, the heroin addict, once they are addicted,
25 must stick the needle in their arm four to six times every 24
26 hours. Therefore, in a one-month period of time, a heroin addict
27 must inject at least 100-200 times.

1 I'm going to pass this around just to illustrate what
2 we're doing between my facilities and a project with the National
3 Institute on Drug Abuse, and what we're hoping is our best shot
4 for something new for AIDS.

5 Methadone's been highly criticized, but it shouldn't be,
6 because it's real simple. Methadone stays in the bloodstream 24
7 hours, and they can take it orally. So, they don't have to share
8 needles. They can take one dose of this medication every 24
9 hours and transfer their addiction. That's what methadone
10 treatment is.

11 We have an experimental drug. It's been declared an
12 orphan drug by the Food and Drug Administration, by the Congress.
13 It's called Levo-alpha-acetylmethadol. We need this drug
14 desperately. This drug can be taken every third day and stays in
15 the bloodstream 48-72 hours.

16 SENATOR WATSON: What's the effect of that drug and
17 methadone?

18 DR. TENNANT: Same effect. We don't believe it's as
19 addicting; we don't think it's as heavy a drug.

20 But what I'm getting at, we have -- we have a research
21 project on this. We've now given this drug to about 800 and some
22 patients, and I've given you a summary research document. I'll
23 pass this around.

24 This particular drug can be taken every -- on Monday,
25 Wednesday and Friday. Therefore, it would lower our cost, but
26 the big thing is, people -- everybody must understand that
27 methadone is not an acceptable treatment to a lot of addicts, and
28

1 neither is naltrexone, the new heroin blocker. And we have in
2 our studies been able to show that for every two heroin addicts
3 who will accept our naltrexone or methadone treatment, there is a
4 third one out there on the street, continuing to inject, who will
5 take the Levo-alpha-acetylmethadol treatment. They will take it.
6 They will take it, and it works.

7 The drug is an interesting drug in that the formulas
8 were actually captured along with the methadone formulas out of
9 the German concentration camps right after World War II.

10 And this drug is one that I would certainly like to
11 have, and I believe you could help. At this particular time,
12 this drug is the only drug that the federal government's ever
13 tried to produce on its own, and it's not doing too well. It is
14 bogged down in bureaucracy in Washington at this time. As of
15 about one month ago, I've been appointed as the Drug Abuse
16 Chairman -- or the Chairman for the Drug Abuse Advisory Committee
17 for the Food and Drug Administration. I'm not quite sure what my
18 authority or potential will be to help things along, but I'm
19 going to do my best.

20 But irrespective of that, the drug is available to the
21 National Institute on Drug Abuse, and if we had a legislative
22 mandate, the California Research Advisory Panel could make that
23 drug available to treatment programs throughout the state.

24 Now, there's a precedent for this. Prior to the time
25 that methadone was commercially made available and licensed in
26 the state, the Research Advisory Panel had the methadone programs
27 under research. You could do the same thing with LAAM. In other
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1 words, you could pass legislation mandating that the California
2 Research Advisory Panel make that available to anyone who wanted
3 it; programs would apply. And they have done that before, and I
4 think the cost would be nominal.

5 The California Research Advisory Panel operates pretty
6 cheaply, and they would need very little money, I think, to
7 implement that, and the drug is available through the National
8 Institute on Drug Abuse.

9 I've thought a lot about this. I think I could do more
10 to help the AIDS problem in my facilities if I had that drug
11 available, because I know that I could increase the numbers of
12 people in treatment dramatically, and we do know that the
13 families of those addicts and the addicts will pay for it. It's
14 cheaper than methadone, because they only have to attend the
15 clinic three times a week rather than seven. So, we need that
16 orphan drug, is what I'm getting at. We definitely do need it,
17 and if we wait for the federal government to simply act, it'll be
18 another one or two years down the line.

19 I'd like to just make one or two other comments that I'd
20 like for you to consider as you move along; things from my
21 perspective that I think would help us.

22 The second problem I am having in running my facility is
23 a problem that is starting to become quite universal in the
24 health care system, and that is we have run out of nursing
25 personnel. We have no nurses.

26 This particular drug, the naltrexone, is the treatment
27 of choice for the heroin addict today. This is the one hope that
28

1 a heroin addict has, at least in large numbers, of rehabilitating
2 themselves and reaching a drug-free status.

3 This drug blocks heroin. When you take naltrexone, you
4 cannot use heroin. And not only does it block heroin, but makes
5 what we call the endorphin system rev back up. And for the first
6 time in my career, we have been initiating these programs about
7 three years ago, for the first time I'm seeing heroin addicts
8 starting to rehabilitate themselves and achieve a drug-free life
9 for the first time in my career, in large numbers. Oh, we've
10 always had a few that came out of our residential programs, et
11 cetera.

12 The key to this drug, however, is the nursing staff.
13 You have to have highly trained nurses whose skill, in my
14 estimation, would be somewhat -- let's say about 50 percent
15 better than the best intensive care nurse; would be about the
16 same caliber as a nurse anesthetist; highly trained nurse; has to
17 have several weeks of hands-on experience; has to have methadone
18 experience; highly trained.

19 We have the largest naltrexone program in the United
20 States between our clinics in Pasadena, El Monte, West Covina and
21 Fresno, and we have one in Santa Barbara now, and there is a
22 small naltrexone program in San Diego. I don't operate it, but
23 it's there, and there's a small one, I believe, with the Parole
24 Department in Sacramento, some of it being used in San Francisco.

25 But the point is, I don't have nurses. That's my
26 holdup. In other words, you're going to hear a lot about needs
27 for money. Everybody would like more money, but I would rather
28

1 have the LAAM and nurses. I think we can take care of the money
2 later.

3 The State Medi-Cal program has already seen the benefits
4 of this and made this a Medi-Cal benefit. They pay well for it.
5 They will cover its costs. It's very expensive to give this
6 treatment, much more expensive than methadone, very expensive.
7 One little tablet, I'll pass it around, costs \$2 wholesale. You
8 need at least one or two tablets a day, and you calculate just
9 the cost of the pills.

10 But if we had the nursing staff, my problem is, they're
11 hard to recruit, nurses. I would highly encourage this Committee
12 to write into your plan some availability of programs like my own
13 to take aides and medical assistants and upgrade them to LVN
14 status, and to take LVNs and upgrade them to RN status.

15 And I will tell you that I can't get too many more
16 people into treatment in my clinics if I don't start identifying
17 nurses. It's getting very discouraging.

18 I will just give you an illustration. Take the City of
19 Santa Barbara.

20 We were unable to recruit a single nurse in our drug
21 clinic there after advertising for two months. Still haven't
22 found one. In other words, there are no nurses available. You
23 must keep in mind that these programs must have nursing
24 personnel.

25 Two or three other things I wanted to bring to your
26 attention that you might want to consider. I also feel that the
27 State Drug Office has very burdensome regulations to operate
28

1 methadone programs. The Food and Drug Administration is about to
2 totally revise their federal regulations to cut costs. The
3 regulations in California are adding at least 50 percent to the
4 cost of delivering methadone services, above and beyond what I
5 believe needs to be done. Those regulations desperately need
6 revisions because nobody -- we're getting to where nobody can
7 afford to pay for it any more, including the government. We need
8 some regulatory assistance.

9 Some other things that I think we need, rather than
10 having more categorical funding through the Department of
11 Corrections or through health departments, I would highly
12 recommend that what we call methadone maintenance treatment,
13 IAAM, those things be put -- paid for by Medi-Cal. Medi-Cal
14 seems to be very responsive. I've been one of their consultants
15 for some years. They now pay for the naltrexone program, and
16 they pay for 21 days of methadone treatment, but the methadone
17 treatment really needs to be about six months.

18 So, I think any funding, I would highly recommend it be
19 put through the institutionalized channels so we can count on it
20 year after year. That's been the big problem with funding. We
21 just can't count on a grant that's coming through the local
22 health department or through the Department of Corrections.
23 That's just not the kind of help we need to make sure that we can
24 deal with something as bad as the AIDS and drug problems.

25 Ladies and gentlemen, those will complete my formal
26 remarks. I'd be glad to take any questions.
27
28

1 Also in closing, I would like to say, I'd be glad to
2 assist with my facilities and my own staff, and me personally, on
3 anything I can do with your Committee or your staff, we're at
4 your service.

5 SENATOR SEYMOUR: Thank you very much, Dr. Tennant.
6 Thank you for your testimony.

7 Our next witness is Dr. Irma Strantz, Director of the
8 Los Angeles County Drug Abuse Program.

9 Welcome, Dr. Strantz.

10 DR. STRANTZ: Senator Seymour and other esteemed Members
11 of the combined committees, it gives me great pleasure to testify
12 before you today.

13 In Los Angeles County, as of August the 31st, 1987,
14 there were 3,529 diagnosed cases of AIDS. The risk factor of
15 intravenous drug use account for 387, or 11 percent of these
16 cases. When we subtract cases where male homosexual risk factors
17 were also reported, the number of IVDU cases was actually 97, or
18 2.75 percent of the total AIDS cases reported.

19 In Los Angeles and San Francisco, the AIDS caseload is
20 dominated by the gay male risk factor, unlike New York City and
21 New Jersey, where 32 percent to 50 percent of the cases are
22 heterosexual intravenous drug users. It has been reported by the
23 Center for Disease Control in Atlanta that 70 percent of the
24 persons who have contracted AIDS through heterosexual contact
25 have been involved with intravenous drug users. And that with
26 perinatal transmission of AIDS, 75 percent of the cases have been
27 maternal intravenous drug use, or the mother has had a sex
28

1 partner of -- has been a sex partner of an intravenous drug user.
2 Thus we can see that while the spread of AIDS into the IVDU
3 population in Los Angeles County is still quite small, the risk
4 group should be considered the major gateway to the heterosexual
5 community.

6 Human immunodeficiency virus, HIV, prevalence among IV
7 drug users in Los Angeles County appears to have doubled in the
8 past year. In a 1986 study of 728 clients in methadone
9 detoxification and maintenance clinics, the rate was found to be
10 about 1.8 percent. Approximately one year later, in July, 1987,
11 in a study of 293 IV users in residential treatment, it was found
12 that the rate had risen to 4.8 percent, slightly more than
13 double.

14 While Los Angeles is still in the early phases of the
15 epidemic, it is proceeding rapidly and an increase to 10 percent
16 can be expected within 12 months. In the 1987 study, it was
17 found that the seroprevalence rate among IV drug using males with
18 a history of homosexual activities was 25 percent greater than IV
19 drug using straight males. However, the greatest increase in
20 seropositivity over the past year was noted in the straight
21 males, that is from 0.6 percent to 7.3 percent, a 12-fold
22 increase.

23 Among different ethnic groups, while Black IV drug users
24 were under-represented in the voluntary sample, they represented
25 15 percent of the total, they were over-represented in the HIV
26 positivity findings, 36 percent. Since local drug abuse
27 indicator data has shown that in the Black community, cocaine or
28

1 crack is replacing heroin as the primary drug problem, it is not
2 surprising that Blacks were under-represented in the sample of
3 clients in residential treatment.

4 In contrast, while Hispanics and Whites represented 24
5 percent and 58 percent of the sample, they were under-represented
6 in the HIV positivity results: 14.3 percent and 50 percent,
7 respectively. With regard to the five Blacks found to be HIV
8 positive, four were male and three were bisexual. Their average
9 age was 40 years.

10 Half of those who tested positive for exposure to the
11 AIDS virus were White, and 71 percent of these were heterosexual
12 males with an average age of 38 years. In the comparison with
13 their sex and ethnic counterparts, White IV drug using males were
14 less likely to use a condom and were also less likely to practice
15 needle hygiene.

16 It was also found in this study of 278 IV drug users
17 that since 1979, they had used drugs intravenously for an average
18 of 45 months, one to two times a day, and 96 percent had shared a
19 needle as frequently as one or two times per week. While 24
20 percent said that they always cleaned needles, 77 percent
21 reported that the cleaning consisted of rinsing with water.

22 Forty-seven percent of the Blacks and 48 percent of the
23 Hispanics reported that they had little or no knowledge about
24 AIDS, as compared to Whites, where only 31 percent reported
25 little knowledge. Heterosexual IV drug users were less likely
26 than homosexual IV drug users to report having known someone with
27 AIDS or having changed their risk-related behaviors due to
28 finding out about AIDS.

1 It was particularly alarming to find that women IV drug
2 users in all ethnic groups, despite apparent low level of HIV
3 infection at the present time, are at greater risk for
4 contracting the disease because of: one, their higher frequency
5 of needle sharing, 98-100 percent reported sharing needles
6 regularly; and number two, higher level of needle sharing with
7 gay males, 18-42 percent reported that behavior; and number
8 three, more frequent, at least weekly, use of shooting galleries,
9 28-43 percent of the women reported that; and four, larger number
10 of unprotected sex acts, 50-85 percent reported that.

11 Also, with regard to engaging in sex with men for money
12 or drugs, 80-83 percent of the lesbians of all ethnic groups, and
13 40-48 percent of straight women, so reported.

14 The 1987 sample as a whole, when asked what specific
15 risk behaviors were changed as a result of learning about AIDS,
16 the reported behavioral changes in descending order of frequency
17 were: number one, reduction in the number of sexual partners;
18 number two, ceasing IV drug use; number three; ceasing needle
19 sharing; and number four, using safe sex practices.

20 In comparison with males in the sample, females were
21 less likely to report changes in risk-related behaviors.

22 I believe that the following steps must be taken to stop
23 the spread of AIDS in the IV drug using population: Number one,
24 we need to address the initiation of IV drug use behaviors by
25 high risk youth. Young people who are currently experimenting
26 with drugs, especially cocaine, are likely candidates for IV drug
27 use, whether with heroin or amphetamines. Drug use, drug sales,
28

1 gang involvement at an early age are commonplace in certain areas
2 of the County. We must expand our efforts to provide programs of
3 prevention and early intervention in the schools, in the sports
4 and recreation centers, and in the housing projects. The message
5 to youth about the dangers of IV drug use should clearly and
6 simply show how AIDS is spread and they personally are at risk if
7 they engage in these behaviors.

8 Secondly, AIDS related knowledge and skills of
9 counseling staff in drug treatment programs must be regularly
10 maintained and updated. Staff in drug treatment programs must
11 properly educate and counsel all drug users, especially IV drug
12 users, with whom they are in contact.

13 In Los Angeles County, we have just completed a second
14 series of AIDS trainings for personnel in drug abuse agencies.
15 The 2½-day AIDS and the Intravenous Drug User Training was
16 delivered six times to a total of 134 persons; 124 were staff in
17 39 drug abuse programs, and the remainder were County staff,
18 including representatives from the Probation Department and
19 Juvenile Hall.

20 Initially, drug programs were reluctant to send staff to
21 these trainings on the basis that all agencies had participated
22 in AIDS trainings during the prior year. Furthermore, they felt
23 that they were complying with the County contract requirements in
24 terms of providing to all clients admission information regarding
25 AIDS and risk reduction behaviors.

26 However, the trainees soon found and reported to their
27 peers in other agencies that the second County training was
28

1 particularly valuable, especially those segments which provided
2 opportunities for role playing and dealing with issues of death
3 and dying, grief and loss. On a pre and post-test of perceived
4 level of knowledge and comfort in discussing AIDS issues with
5 clients, there was a positive increase in knowledge scores by 26
6 percent and comfort scores by 12 percent.

7 These trainings will be continued in 1988. Selected
8 drug abuse program personnel will be trained in November to
9 deliver the course to others, and the cost of their services will
10 be paid with federal Anti-Drug Abuse Act monies.

11 We must expand our outreach efforts to intravenous drug
12 users in the community. In fiscal year 1986-87, over 24,000
13 intravenous drug users entered County contracted and private
14 methadone programs, not including chemical dependency recovery
15 hospitals. Almost three out of every ten clients admitted
16 reported that they had never been in treatment before.

17 There are many intravenous drug users who continue to
18 practice dangerous behaviors such as needle sharing and
19 promiscuous sex, and who are oblivious to the risks because they
20 associate what little they know about AIDS with being gay, White
21 and male. They need to find out about free or low cost treatment
22 programs. They need to learn about the availability of free HIV
23 testing. They need to learn about the dangers of sharing
24 contaminated needles and about safe sex practices. Among the
25 poorest informed IV drug users are Hispanics, Blacks, and females
26 who frequent shooting galleries on a regular basis.

27

28

1 We intend to implement, via contract, a pilot project in
2 two areas of the County: East Los Angeles and South Central Los
3 Angeles. Specially trained street-wise outreach workers will
4 visit areas frequented by intravenous drug users to provide AIDS
5 information and referral, with encouragement to enter treatment
6 as soon as possible. This program will be evaluated in terms of
7 its cost effectiveness in a large metropolitan area in comparison
8 to similar programs in San Francisco and San Joaquin County.

9 The next area to focus on is to provide treatment for
10 those who are unable to pay. It goes without saying that the
11 more intravenous drug users you have in treatment, the fewer AIDS
12 candidates that you will have engaged in the practices of needle
13 sharing and prostitution. Additionally, opportunities for AIDS
14 education and rehabilitation will also be increased.

15 There are insufficient treatment resources for
16 intravenous drug users who have no insurance because they have no
17 legitimate means of support in this County. The situation is
18 especially critical because of reductions in public funding in
19 1981-82, coupled with the annual rate of inflation over the past
20 five years. Drug abusers who wish to enter free or low-cost
21 residential treatment or methadone maintenance programs must wait
22 at least three months. If female and pregnant, the IV drug user
23 may wait as long as six months for residential treatment.

24 Los Angeles County received an allocation two months ago
25 of \$1.9 million of federal Anti-Drug Abuse Act monies earmarked
26 for treatment programs supportive of AIDS risk reduction. Local
27 priorities for the use of these funds include:
28

1 One, expansion of residential rehab service beds for
2 intravenous drug using women and their infant children,
3 especially those who are HIV seropositive or who are pregnant:
4 half a million dollars.

5 The expansion of residential rehab service beds for
6 intravenous drug using males and females, especially those who
7 are HIV seropositive and who are homeless, 48 beds: \$600,000.

8 Expansion of methadone maintenance services to the
9 indigent, especially those receiving federal categorical
10 assistance and who are HIV seropositive, 165 slots: \$500,000.

11 The new federal Anti-Drug Abuse Act funding will assist
12 the County to recoup some of the treatment slots lost in 1981-82,
13 and to stave off the threatened collapse of local publicly-funded
14 drug treatment programs due to the rising costs of operation,
15 including liability insurance. Of the 300 residential beds lost
16 since 1981-82, 68 or 23 percent can be reinstated. Of the 670
17 methadone maintenance slots lost since 1981-82, 165 or 25 percent
18 can be recovered.

19 Federal Anti-Drug Abuse Act funds have been clearly
20 identified by the State as one-time monies. There has been no
21 second year appropriation by Congress to date, and from recent
22 accounts, the prospect of further funding under the federal Anti-
23 Drug Abuse Act looks particularly dim.

24 Therefore, it is with some misgivings that we propose to
25 expand existing programs and, where necessary, open new ones with
26 federal funding. On the one hand, there is the urgent need to
27 address the AIDS epidemic through the provision of services to IV
28

1 drug users who want treatment but cannot afford to pay for it.
2 Yet on the other hand, is it wise or even ethical to briefly
3 expand staff and client caseloads, especially for methadone
4 maintenance, a long-term program in which a substitute narcotic
5 is administered?

6 The State's allocation of federal money for AIDS
7 treatment in the amount of \$1.9 million clearly cannot be
8 utilized solely for one-time or short-term projects, like
9 training and outreach. Additionally, to implement outreach
10 programs without assuring that treatment slots are available for
11 those who are motivated to respond would be very wrong.
12 Therefore, we have no choice but to expand treatment capacities,
13 and by demonstrating the rapidity by which these new services are
14 utilized, provide a cogent message to Congress that the War on
15 Drugs cannot be waged in the course of a single year.

16 The last area we should address is involved community
17 organization in AIDS prevention. Health and social service
18 organization, both public and private, schools, churches, law
19 enforcement, and leaders in business and industry need to be
20 informed regarding AIDS and how it is likely to spread to the
21 heterosexual populations. Representatives of some of these
22 organizations are in contact with IV drug users, and they must be
23 trained to detect drug use and to provide for, either directly or
24 through referral, AIDS risk reduction education and counseling.

25 In Los Angeles County, several public and private
26 organizations have launched programs of community AIDS education,
27 but the focus has been general rather than targeted to specific
28

1 risk groups such as IV drug users. Also, some trainings have
2 been provided to staff in County departments, such as Children's
3 Services, where as many as 40 percent of the children under
4 supervision have parents involved in drug abuse. More AIDS
5 trainings are needed in order to prepare every health and human
6 service worker to educate and counsel every IV drug user
7 regarding elimination of their exposure to AIDS.

8 As elected officials, you can help to curtail the spread
9 of the AIDS virus in this population in the following ways:

10 By assuring that the increased level of funding for
11 treatment, outreach and prevention through the federal Anti-Drug
12 Abuse Act is maintained for several years, either through federal
13 appropriation or through State appropriation on the premise that
14 neither the AIDS epidemic nor the IV drug use problem can be
15 dealt with in one year.

16 Number two, by establishing policy and funding to
17 provide for: One, HIV testing, voluntary and confidential, in
18 each drug treatment program; and two, appropriate medical
19 supervision and medication for immune system enhancement
20 available to all IV drug users who test positive.

21 Number three, support the continuing collaboration of
22 the State Department of Health Services and the State Department
23 of Alcohol and Drug Programs in public education, seroprevalence
24 studies, prevention and treatment efforts directed at the IV drug
25 users in particular, and substance abusers in general.

26 With regard to the statewide Master Plan, the following
27 elements should be included which would support the prevention of
28 AIDS:

1 Number one, regional resource centers should be
2 established which can provide for local AIDS related training to
3 substance abuse program staff, and the development of print and
4 audiovisual education tools for program staff to use in client
5 and community education efforts.

6 Number two, various State departments, such as the
7 Department of Corrections, the California Youth Authority, and
8 the Office of Criminal Justice Planning should be assisted in the
9 development of education and counseling programs for substance
10 abusing clients in their custody or in funded local programs.

11 The State Department of Alcohol and Drug Programs should
12 be appropriated sufficient new program funding to allocate to
13 counties according to their share of the State's IV drug using
14 population in order to curtail the AIDS epidemic by the year
15 1990. If unchecked, California's HIV seropositivity rate in 1990
16 is expected to be between 32 and 40 percent in the IV drug user
17 risk group.

18 Thank you very, very much.

19 SENATOR SEYMOUR: Thank you, Dr. Strantz.

20 Questions? Senator Watson.

21 SENATOR WATSON: I just want to commend the witness.
22 This is probably one of the most comprehensive reports we've
23 received. I think our work is done for us; we just follow her
24 plan.

25 DR. STRANTZ: Thank you.

26 SENATOR MARKS: I also want to commend you.
27
28

1 I'm not trying to make this a partisan matter, but I
2 think the information you gave regarding the community
3 involvement points out that I believe, strongly believe, that the
4 Governor was in error in vetoing the ARC bill, which would have
5 provided understanding of the problem of AIDS. It was a great
6 mistake.

7 SENATOR TORRES: Doctor, your statistics and comments
8 and conclusions seem to be in opposition to our previous witness,
9 yet you both represent the Southern California area.

10 What accounts for those different conclusions?

11 DR. STRANTZ: It may be that the information that we
12 collect in the Office of the County Drug Program Administrator is
13 more broadly based. We're collecting information from a wide
14 range of facilities.

15 We've also been involved in doing these seropositivity
16 studies through a wide range of facilities.

17 SENATOR TORRES: Does your study include those
18 facilities which are represented by Dr. Tennant?

19 DR. STRANTZ: The 1986 study in methadone maintenance
20 and detox included a sample of clients in Dr. Tennant's programs.
21 We are now embarked on a two-year study in methadone maintenance
22 and detox, 1987, and Dr. Tennant's clinics are cooperating with
23 them as well.

24 SENATOR TORRES: So, your most current data is '86?

25 DR. STRANTZ: In methadone. In residential it's '87.

26 You see, we're now in our third study.
27
28

1 SENATOR TORRES: His studies are May and September of
2 '87 and October of '87.

3 DR. STRANTZ: But I believe that those are in some
4 clinics in the San Gabriel Valley, and then some clinics in other
5 parts of the state that are operated by Community Health
6 Projects.

7 Our study is involving all methadone programs, public
8 and private, the whole County and all areas of the County.

9 SENATOR TORRES: I see. I understand that, Doctor, but
10 I'm concerned that your information and conclusions aren't
11 similar to the previous witnesses' conclusions in that people are
12 aware of what's out there but not utilizing their good sense.

13 DR. STRANTZ: I don't believe that they are, in terms of
14 the clients in this most recent study in the residential
15 programs, in terms of actually being aware of their own personal
16 risk to AIDS --

17 SENATOR TORRES: This is September, '86?

18 DR. STRANTZ: No, I'm talking about July, '87.

19 If you look at the different ethnic groups and sex
20 groups, and what their understanding was, it was something like
21 26-40 percent.

22 I believe that I can get that information for you but --

23 SENATOR TORRES: The 26-40 percent who what?

24 DR. STRANTZ: Who knew very, very little about AIDS and
25 their risk because they felt it was primarily a White male gay
26 disease. And when they talked about -- when those who said they
27 had changed behavior, the number one thing they said they had
28 done was reduce the number of sexual partners.

1 SENATOR TORRES: Yes, I understand that, but your
2 statement also indicates that females did not change as quickly
3 as males.

4 DR. STRANTZ: That's right.

5 SENATOR TORRES: What accounts for that?

6 DR. STRANTZ: I think that female intravenous drug users
7 live a more precarious existence than male intravenous drug
8 users, and many of them support their habits through
9 prostitution. Therefore, they are not in a position to even,
10 let's say, demand the use of condoms, or reduce the number of
11 males that they're in contact with.

12 SENATOR TORRES: So they're economically more
13 vulnerable?

14 DR. STRANTZ: Exactly.

15 SENATOR TORRES: Therefore it's not a matter of choice?

16 DR. STRANTZ: Right.

17 SENATOR TORRES: Is it really a matter of choice,
18 though, in prostitution or drug abuse? Isn't that the real issue
19 here, that we're not dealing with someone being able to make a
20 choice?

21 DR. STRANTZ: If there is treatment --

22 SENATOR TORRES: Changing patterns?

23 DR. STRANTZ: If there's no treatment available for
24 those who cannot afford to pay, if there's no treatment
25 available, then they are not truly given an option. If someone
26 enters a treatment program and has the appropriate counseling and
27 information provided for them, and then they fail, then you could
28 say, okay, they made a choice.

1 SENATOR TORRES: But unless the countervailing balance
2 of economic security is there, they'll go right back into it.

3 DR. STRANTZ: Yes, part of rehabilitation should be job
4 training, job skills development, assistance in finding
5 employment in the mainstream.

6 SENATOR TORRES: Have you used any of the acupuncture
7 techniques which have been looked at in some studies by the
8 Legislature in terms of the treatment?

9 DR. STRANTZ: We do not currently fund any acupuncture
10 programs. There is one in Los Angeles County; I believe there's
11 one in the San Francisco area.

12 SENATOR TORRES: And you have not measured the efficacy
13 of those programs?

14 DR. STRANTZ: No, we have attempted to find out about
15 the program.

16 Acupuncture is just another way of providing
17 detoxification.

18 SENATOR TORRES: I understand that.

19 DR. STRANTZ: And you need to have the treatment,
20 planning, the counseling, the rehabilitation component with it.
21 And it does not appeal to every drug user in the community, just
22 as methadone doesn't appeal to every drug user.

23 SENATOR TORRES; So we could have millions of dollars
24 for education and prevention, but unless we change the economic
25 model, we're wasting money; aren't we?

26 DR. STRANTZ: Unless we change the economic model?

27 SENATOR TORRES: By which they must operate.
28

1 In other words, you can educate everyone about what the
2 problem is, but if they don't exercise a choice because of other
3 economic factors, we're really throwing away money.

4 DR. STRANTZ: Because of having skills to work, to be
5 self supporting, yeah.

6 SENATOR TORRES: Otherwise we're back in the same --

7 DR. STRANTZ: I agree. You must have a strong
8 rehabilitative element along with every one of these programs:
9 residential or methadone maintenance. It doesn't matter. There
10 has to be in that treatment plan a means to help that person get
11 back into the mainstream.

12 SENATOR TORRES: Thank you, Dr. Strantz.

13 SENATOR SEYMOUR: I'd just like to thank you, Dr.
14 Strantz.

15 I'd just like to add before we break, Senator Torres,
16 yesterday in San Francisco we received testimony relative to a
17 study done in Oakland in which, and this speaks to the economic
18 point that you make and I think you're right, a kid in a
19 neighborhood pushing drugs can get paid on the average of \$700 a
20 day. And the reason they do that is that they may be the sole
21 support of their family, and it's pretty easy money.

22 The question arises: Through all the rehabilitation and
23 job training preparation, how are we going to find a job that
24 gets anywhere near, anywhere near, \$700 a day? And most of those
25 jobs, you know, and you have spoken on the issue, Senator Torres,
26 are of minimum wage.

27

28

1 Now, even if minimum wage or the job they were trained
2 for, if they did get \$10 an hour, \$20 an hour, it's not in the
3 same league.

4 So, you're right. There's a lot of economic drive in
5 making this decision.

6 On the other hand, I raised the question: how do you
7 convince somebody who's pushing drugs at \$700 a day that they
8 ought to be a plumber, or an electrician, or a doctor, an
9 attorney, or what have you?

10 Thank you, Dr. Strantz.

11 At this point we'll recess very briefly, five minutes,
12 and then reconvene.

13 (Thereupon a brief recess was taken.)

14 SENATOR SEYMOUR: We'll reconvene our hearing.

15 Our next witness is Geni Cowen, who is the Executive
16 Director for the Gay and Lesbian Resource Center.

17 Ms. Cowen, thank you for taking the time to be with us
18 today.

19 MS. COWEN: Thank you.

20 Senator Seymour and Members of the combined committees,
21 I am honored to be asked to participate in this hearing.

22 I am the Director of a small social service organization
23 in Santa Barbara, California. I don't have the experience of
24 metropolitan communities other than having lived in them for
25 periods of time, but I have a great deal of concern about
26 nonurban communities since that's the population that our agency
27 serves.

1 I have made available to you some remarks that my
2 remarks will be based on, and since you have the written part,
3 the part I want to give you is the part that wasn't written.

4 I want to emphasize the need for educational services in
5 nonurban communities. What we found to be true is that the
6 incidence of substance abuse, of IV drug abuse, and other
7 substance abuse in nonurban communities is rather high and hard
8 to identify.

9 In the Santa Barbara area and north, of course you know
10 we have quite a population of migrant farmworkers. It's more
11 than difficult to identify those among that population who are
12 abusing drugs or who are using intravenous drugs, yet we are
13 aware that it's an increasing problem in that community because
14 of economic factors and social factors, combined with the issues
15 of immigration.

16 What we've done in Santa Barbara County is, we've
17 managed to establish an education program that outreaches the
18 general community. However, that only outreaches the people who
19 are located in semi-urban areas, like Santa Barbara itself, Isla
20 Vista, Goleta, some in Santa Maria and Lompoc. As the
21 communities get smaller, the education program has less outreach.

22 What we need and what appears to be needed in
23 communities similar to ours and counties similar to ours is an
24 outreach program that is based on field workers; based on people
25 who have been trained and who have the familiarity and knowledge
26 of the subculture to be out in the street, out in the farms, out
27 in the communities talking to the people who are abusing drugs,
28

1 and who are using intravenous drugs, that will not come in for
2 treatment for fear of being discovered for their illegal status,
3 or for fear of being literally jailed for possession or use of IV
4 drugs. We need people who are out there, not people who are in
5 my office or other clinics or treatment centers like mine in the
6 community, because people don't come into see us to get the
7 information. People don't listen to television to get the
8 information. They're not listening to the radio to get the
9 information. They're not really concerned about the information,
10 not having heard it in such a manner that they can identify
11 themselves as being at risk.

12 We've identified an outstanding need in communities like
13 ours, nonurban, semi-rural, rural areas, farm communities, for
14 this kind of an outreach program.

15 We emphasize treatment in the current outreach that we
16 do, but we have to face a few realities, one of them being that
17 in all of our best efforts to prevent substance abuse, all of our
18 best efforts to treat substance abuse, we have noticed that the
19 problem isn't going away. The incidence of substance abuse in
20 any of our communities will not be curtailed by the danger of
21 AIDS. We have to face that as a fact. The incidence of
22 substance abuse in minority communities, Black and Hispanic, is
23 rising all the time. And we don't have effective methods to
24 outreach those people at this point, not for treatment and not
25 for educational services.

26 Methadone treatment programs in Santa Barbara County
27 have been effective, but we have come up with -- I've been told
28

1 by the Director of the Substance Abuse Program in Santa Barbara
2 County that people coming into the methadone treatment programs,
3 by and large, only come in when the streets are dry. They come
4 in so they'll have something to hold them over until there's a
5 new source. So, we can use that particular period of time that
6 they're coming in to get their methadone treatments to give them
7 education and information, but we'll lose them once they hit the
8 streets again. So, we're back at the same problem of not having
9 adequate time or adequate staff or adequate information to give
10 when people do come in. If it's voluntary and they do come in,
11 we're lucky, but that's very, very few.

12 We also see a problem in our correctional institutions,
13 and one of the major problems that we face in that area of the
14 state is a denial on the part of the staff and administration of
15 our correctional system. They aren't all that supportive of us
16 providing information or HIV testing in the correctional system.
17 We can guarantee anonymity, and they still aren't supportive. We
18 can guarantee one-to-one counseling; they still aren't
19 supportive. They've come up with just about every reason in the
20 book to keep us out. Yet still, it's in the correctional
21 institutions where we have almost a greater opportunity than in
22 treatment centers to deal with these people.

23 So, I would say as elected officials from a community-
24 based operation standpoint, we count on you. We rely on you to
25 provide us with leadership to get us to the places that we can't
26 get to on our own.

27

28

1 There's a stigma attached to AIDS. There's a stigma
2 attached to substance abuse. I would like to remind you that
3 it's not just IV drug abuse that puts a person at risk. The
4 impaired judgment that goes along with any kind of substance
5 abuse immediately increases an individual's risk of contracting
6 the virus just because they can't judge their behavior. They
7 can't take the necessary precautions because they aren't able to
8 make a reasonable judgment for themselves.

9 So in my office, although we do not have a methadone
10 maintenance program, and the number of IV substance abusers that
11 we see is very, very low, we see a large number of other
12 substance abusers, other chemical dependent people. And our
13 treatment program includes a very strong educational component
14 for these people about impaired judgement, about the effects of
15 substance abuse. That cannot be left out of addressing this
16 problem.

17 AIDS is not going to go away without even more
18 concentrated efforts of education, not only about AIDS, but about
19 those risk factors associated with it. We deal largely with a
20 gay and lesbian clientele, and we have to educate gay men about
21 safer sex. That's part of our job. We can tell them about AIDS
22 until we're blue in the face very literally, and they will have
23 absolutely no response until we give them specifics. This to me,
24 based on my experience, is the larger need.

25 The largest need, of course you're going to hear, as
26 you've been told before, about the need for funding. But I think
27 we also have to face the realities of available funding. Now, my
28

1 center operates probably about 75-80 percent on government
2 contracts, both county and State. Our discretionary income,
3 those funds given to us through client fees, donations, and so
4 on, are very, very small. When we talk about AIDS, of course we
5 have a better community response, but we can't count on the
6 community to deal with the AIDS crisis.

7 We have to count on government leadership, and again, we
8 look to the government to provide us with adequate funding to
9 train the staffs of our local drug abuse treatment centers. The
10 training need up there is just phenomenal. Some place like Santa
11 Barbara is looked at as less needy because of the lower numbers,
12 but we have had 71 reported cases of AIDS. That's quite
13 different from the 3529 in Los Angeles County. Seventy-one cases
14 of AIDS does not make Santa Barbara less needy. The entire
15 county is at risk. The two counties both north and south of us
16 are at risk. Rural areas like ours are at risk.

17 We need adequate funding to reach all of those people.
18 It's more difficult for us because we're more spread out. We
19 don't have access to people quickly and easily. We have to
20 travel a hundred miles to get to the next community.

21 So, you see, there are influencing factors that have to
22 do with our ability to educate and our ability to help curb the
23 spread of AIDS that we have to rely on elected officials to help
24 us with. As a small agency, with a budget of much, much less
25 than \$500,000 a year, I'm working with a primarily volunteer
26 staff. Again, I'm looking to the community to help us curb this.

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1 This kind of energy, and this kind of outpouring of
2 human compassion is not enough. It's just simply not enough.
3 So, we look to you for leadership. We look to you for a public
4 presence. It's our elected officials who often have the greatest
5 impact on the general community. If our general community can
6 look to their elected representatives and say, well, So-and-So is
7 standing up and telling us that we need to be educated about
8 AIDS, he should know, or she should know. They look more to you
9 elected officials than they do to those of us who are so-called
10 on the front lines. We need that public presence. We need your
11 support.

12 We need policy decisions, and leadership, and
13 legislation. The rights of AIDS patients, of course, has been
14 violated many, many times over, and that's an ongoing concern.
15 We would like to see things change in that area, and we'd be more
16 than willing to work with whomever would like to work toward
17 that.

18 But the primary concern is to stop the spread of it
19 altogether. It's just not going to be an easy task.

20 So, we have to return to those strategies and those
21 methods which will reach the most people at the highest risk.

22 Those are my comments. There's really not much I can
23 tell you because you've heard the statistics, and I don't think
24 you need to hear all that again. It doesn't make a whole lot of
25 difference. What you end up with is the same scenario over, and
26 over, and over.

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1 I would just encourage you to focus some attention on
2 nonurban areas, where the numbers may be lower but the risk is
3 just as high.

4 Thank you.

5 SENATOR SEYMOUR: Thank you, Ms. Cowen.

6 Question, Senator Marks.

7 SENATOR MARKS: Let me first commend you for your
8 testimony. I'm pleased that you came here and testified, and I
9 appreciate your testimony.

10 There's a question that I'm concerned with, and maybe
11 you can tell me. We've heard a couple of doctors testify in
12 support of the programs they're doing. I want to be sure that
13 the gay and lesbian community has been asked to work with these
14 doctors.

15 Have you been asked?

16 MS. COWEN: Our agency --

17 SENATOR MARKS: Because you should be.

18 MS. COWEN: Our agency works very closely with the
19 Tri-Counties AIDS Project in Santa Barbara, which is an education
20 project. We also have an AIDS patient care program, and we work
21 with the County medical facilities on that in providing patient
22 care for those patients referred to us by the County and their
23 medical staff.

24 Other than that, we haven't been asked to participate.
25 And there's -- I'm in the midst of writing a program specifically
26 addressing the substance abuse problem in Santa Barbara this
27 week, because Santa Barbara County has just received additional
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1 funding to start to put that together. This is a first. We've
2 never had this before. It's been a long battle to get the
3 cooperation of our substance abuse facilities.

4 So, we're hoping that we'll be able to outreach those,
5 but the reality is that there is this stigma attached that's
6 going to make it very difficult for our community to be of
7 assistance, although we probably have more expertise based on
8 experience than those substance abuse facilities located in the
9 county.

10 SENATOR MARKS: That does bother me very much, because I
11 don't know what to do about it specifically, except maybe we do
12 it from a standpoint that if funds arrive or are given from the
13 State of California, that we must make certain that these
14 agencies work with you, because I think they should.

15 MS. COWEN: Well, my suggestion has been and continues
16 to be that training be required on the part of substance abuse
17 staff in our particular county. I would suggest it statewide,
18 but my focus of concern naturally is the county where I'm
19 working.

20 I have suggested this to the County substance abuse
21 program office, and over, and over, and over we've had this same
22 excuse of not having enough funding.

23 I'd like to see that change, and I cannot guarantee that
24 we'll be able to get that program approved this year, but that's
25 the goal, to at least start there, to hire some field workers to
26 go out and outreach the people in the streets and on the farms,
27 and that has to work through those substance abuse clinics. And
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1 what I need is approval. I need support for that proposal once
2 we get it into the County.

3 SENATOR MARKS: I'm also concerned, and I'm not again
4 trying to make this a partisan issue, but I am concerned that a
5 number of programs have been cut out by the administration, which
6 I think would have been very helpful to the problem, which is a
7 problem which effects not just the gay and lesbian communities,
8 but effects the whole wide community. And I would hope that the
9 administration would look very carefully upon these programs,
10 because when we have a huge reserve in the bank, it seems to me
11 that an expenditure of a relatively small amount of money would
12 do an awful lot of good for the whole community.

13 I would hope that you, Senator Seymour, might prevail
14 upon the Governor to possibly institute some additional programs.
15 I realize that they have done some, but they haven't done enough.
16 I think more should be done.

17 SENATOR SEYMOUR: Well, the only thing I would respond,
18 Senator Marks, you introduced the subject and myself, obviously
19 you know that I've been supportive where I can.

20 SENATOR MARKS: I know you have.

21 SENATOR SEYMOUR: On the other hand, I would remind you
22 that we missed an opportunity as a State Legislature to ensure
23 some additional funding for AIDS when we could not come to an
24 agreement on a \$700 million rebate and a \$400 million
25 augmentation to various programs, including some funding for
26 AIDS.

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1 SENATOR MARKS: I've heard you say that a number of
2 times. I didn't agree with you at any time.

3 SENATOR SEYMOUR: Well, but that's the truth and the
4 fact, and so we didn't have a \$700 million rebate; we now have a
5 \$1.1 billion rebate.

6 SENATOR MARKS: We didn't want the rebate to be returned
7 anyway.

8 SENATOR SEYMOUR: I understand that.

9 SENATOR MARKS: We felt that it should be used for
10 education and a number of other programs which we felt were much
11 better than sending back a small amount of money to people.

12 SENATOR SEYMOUR: That's because you felt that way, and
13 Republicans felt exactly the opposite, people like me who were
14 willing to see an additional \$400 million go into programming and
15 \$700 million to the taxpayer, a middle ground, our voice didn't
16 get high enough, I guess.

17 SENATOR WATSON: And on to other things.

18 SENATOR SEYMOUR: Senator Watson.

19 SENATOR WATSON: You reiterated for me a problem that I
20 suspected while we were hearing legislation in the Judiciary
21 Committee. There was a proposed piece of legislation that would
22 have required all those going into penal institutions to take
23 tests.

24 The thing that concerned me at the time, and I think you
25 referenced it, is that what happens after the tests are taken?
26 Do you simply just isolate the person who appears to have an
27 active case, or even appears to have the syndrome, or do you
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1 treat that person? And if you do treat them, where do you treat
2 them, and what's going to be the level of treatment?

3 All of those questions were not answered. There were
4 references to answers, but there were no answers.

5 You just pointed up something that I feared, that you're
6 having problems with correctional institutions related to AIDS,
7 whether it's AIDS testing, treatment, or whatever. You're having
8 problems because there appears to be very little cooperation.

9 And I was concerned, too, with the representatives from
10 those institutions, and the California Correctional Department
11 didn't seem to really have a handle on it.

12 And I would hope that my colleagues would join me in
13 trying to fashion, if we're going to test across the board, then
14 we'll be testing people going into these institutions but we
15 certainly have to go the next step. We're going to have to make
16 it possible for programs like yours to go in and do what they do
17 inside of these institutions, because you probably have the
18 expertise, whereas we would have to build that expertise.

19 And what I heard from the doctors who treat inside these
20 institutions, they didn't seem to be that concerned about how to
21 treat the patients.

22 And I'm hearing you say that you're having a real
23 problem taking your experience inside.

24 MS. COWEN: I have to say that we have a bit of
25 experience with people coming out of correctional institutions
26 and being afraid for their lives. We have had clients, I have
27 had staff, volunteer staff, who have come out of penal
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1 institutions and looking for support have come to us, and looking
2 for a place to interact and to be around people, they've come to
3 us and asked to volunteer, which is fine.

4 My personal contact with them and that of my staff has
5 shown that one man, for instance, was tested while he was in
6 prison during his last six months. And he spent the last six
7 months in terrible fear because he was told his test was
8 positive. At the end of the six months, when he was being
9 released, they said, oh, they'd made a mistake; it was really
10 negative.

11 That's tragic. The man required quite a bit of
12 treatment just to deal with the anxiety by the time he got out of
13 prison.

14 My concern is that prison staff may possibly show some
15 concern and be willing to get involved with testing, with
16 treatment, whatever, but I don't think they're educated. They
17 must not be to treat an inmate like that. Granted, I can't say
18 that treatment of inmates is good, or bad, or indifferent,
19 because I'm not working in a penal institution, but based on that
20 experience, to me that shows that there's a requirement for
21 further and more intensive training of prison staff, and that
22 someone with the expertise not only do the testing but do the
23 follow-up; suggest whatever treatment needs to be done or needs
24 to be implemented with the medical staff. Where ever it needs to
25 happen, the expertise needs to be available, and it's not.

26 SENATOR WATSON: One of the things that always confounds
27 me is that the doctors that come from the correctional
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1 institutions have names I cannot pronounce and accents I cannot
2 understand.

3 I'm wondering if we're relegating the treatment of
4 prisoners to people who come from a different kind of training
5 and experience and educational background in other countries,
6 whose standards of health care are quite different from ours.
7 That's another point that I think we're going to have to look at
8 real seriously.

9 MS. COWEN: I think when you look at the number of
10 people of other ethnic groups that are in prison and in jail,
11 local facilities, in Santa Barbara County it's phenomenal. Most
12 of the inmates are Hispanic, and the next highest group
13 represented are Black, and the lowest group represented are, of
14 course, White in Santa Barbara County.

15 So that means we have to have some Spanish speaking
16 people, because their culture is entirely different. So whatever
17 we do, educationally or in a testing program or in a treatment
18 program has got to be culture sensitive, and that's one of the
19 places where we fall down the most.

20 One of the things I wrote in my written remarks was that
21 all materials and all strategies used have to be culture
22 sensitive. That's one of the places where I see our governmental
23 leadership falling down because there's so many restrictions and
24 so many limitations on what can be distributed under government
25 sponsorship, that we end up losing quite an audience.

26 As a private nonprofit, we have taken the initiative to
27 go ahead and purchase and develop some materials that our
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1 Tri-Counties program cannot because their administration won't
2 allow them to, and our materials have been more effective than
3 theirs.

4 That concerns me a lot, because we've got all these
5 people of minority groups who do not understand the information,
6 or have no interest in it because it's not culture sensitive to
7 them, doesn't mean a thing to them.

8 SENATOR WATSON: I think you make a very cogent point
9 that we're going to have to deal with when we look at policy,
10 because in Southern California, for instance, questions were
11 being raised as to why does Orange County look different from San
12 Francisco County, and San Francisco looks different from Los
13 Angeles.

14 When you consider the demographics of Orange County
15 versus the demographics of a Los Angeles County and San
16 Francisco, and when you speak of what I feel is very important if
17 we're going to be effective, culturally sensitive ways of
18 treatment people, and materials, and procedures, and modalities,
19 I think that's key, because if the population we're trying to
20 treat cannot relate to the persons giving the treatment, the
21 materials, the equipment and so on, we probably have lost them
22 from the beginning.

23 MS. COWEN: It's necessary in terms of personnel, too,
24 and this is one of the issues that we struggle with constantly,
25 being Black in Santa Barbara is quite an interesting experience.

26 SENATOR WATSON: You're aware of it yourself.
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1 MS. COWEN: Yes. And so, it's up to me, because of
2 being so well informed and having worked with the AIDS issue for
3 so long, it's up to me to outreach the Black community all of a
4 sudden as an individual. That may only be 2-4 percent of Santa
5 Barbara County's population, but I am one person, and I am
6 limited because I don't have culture sensitive personnel to
7 assist me with that job.

8 The same is true for the Hispanic population. We have
9 one health educator in Santa Barbara County who is addressing the
10 issue of AIDS among the Hispanic population, and he also has to
11 work in Ventura County and in San Luis Obispo County.

12 So you see, a culture sensitive personnel is just as
13 important as our treatment and education strategies and our
14 materials. Everything that we use has got to be designed
15 specifically for our target populations, and we're limited in
16 doing that because of limited funding, and because we don't have
17 enough information out there for our professionals who support us
18 and who assist us with this process. We've got to train them as
19 much as we do the general community.

20 SENATOR SEYMOUR: Thank you very much, Ms. Cowen. We
21 appreciate your testimony and the time you've taken to be with us
22 today.

23 MS. COWEN: Thank you.

24 SENATOR SEYMOUR: Our next witness is Dr. Thomas M.
25 Mundy from the Department of Pediatrics, Cedars Sinai Medical
26 Center.

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1 DR. MUNDY: Thank you, Mr. Seymour, and other Members of
2 the Committee.

3 I am Thomas Mundy from Cedars Sinai. I am a pediatric
4 immunologist, which in the 1980s means I take care of children
5 with AIDS full time.

6 I'm going to limit my remarks today to stemming the tide
7 from the IV drug use community into the pediatric community. You
8 will hear from others of the approximately 3,000 women in the
9 U.S. that have AIDS, half of whom's risk factor is IV drug use.
10 You'll hear from others of the more than 100 in Los Angeles
11 County who have AIDS, over half of whom's risk factor is IV drug
12 use or sexual contact with an IV drug user. You'll hear from me
13 of 558 children in the U.S. with AIDS, and 19 children in Los
14 Angeles County with AIDS.

15 Now I would like you to hear from me to throw all of
16 those figures away. They are gross underrepresentations.

17 I sit on a committee of the Academy of Pediatrics for
18 Southern California, and in April and May of this year, we did a
19 very informal survey. What we surveyed was the 11 physicians
20 that we could think of that we knew would have seen some AIDS
21 cases in Los Angeles. Five of that eleven sat on the committee.

22 We did a very informal mailing over two months this
23 year, asking those 11 physicians: How many patients with AIDS,
24 AIDS related complex, or that were known or suspected to be
25 seropositive that they had personally treated in their
26 institution.

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1 There were 183 known infected children in Los Angeles
2 County. We knew this was going to be a gross under-
3 representation because this was only the 11 basically pediatric
4 subspecialists who treated AIDS. There were 253 children known
5 or strongly suspected to be infected with the virus; there were
6 about 50 who had not been tested and confirmed.

7 I am here to tell you that half of the children infected
8 with the AIDS virus in America are not treated by 11
9 pediatricians in Los Angeles. The CDC is counting 552, this was
10 August data, and we had 234 in Los Angeles County alone. Those
11 are not accurate figures.

12 Even that 234 is a gross underrepresentation. That was
13 only the ones that had gotten referred to subspecialists.

14 Most of the children with AIDS in Los Angeles County
15 have died and were never known to have had AIDS. It is a major
16 problem not only in Los Angeles County, in the State of
17 California, and in the U.S. in general.

18 SENATOR WATSON: May I ask a question about this?

19 DR. MUNDY: Sure.

20 SENATOR WATSON: You said they have died. They were
21 never identified as having AIDS.

22 Is it because they use one of the side effects of AIDS
23 as a cause of death, or is it because it's a newborn and they're
24 at risk during a certain period of time? Why is it they have not
25 been identified?

26 DR. MUNDY: For pediatrics, part of the problem is that
27 pediatric AIDS looks somewhat different than adult AIDS. And for
28

1 the first about five years, we were using basically the same
2 definition and we were missing some pediatric cases. That
3 accounts for part of the underrepresentation.

4 I must remind you again, at the time we found 183 known
5 infected, the County was carrying 18 AIDS cases, a factor of 10.
6 They were catching one out of ten.

7 Part of it was that I would agree, not all the 183 met
8 CDC definition of AIDS, but we found CDC definition of AIDS in
9 two to three times as many as they were counting.

10 Most of us pediatricians are not thinking of AIDS. They
11 are to asking the questions of IV drug use in families. They are
12 not asking the questions of bisexuality in fathers. They're not
13 even asking the questions of babies that got transfusions as
14 neonates or as older children. They're not thinking of AIDS.

15 These children are chronically ill, undiagnosed or
16 underdiagnosed, and they're coming in with infections and dying.

17 One of my reasons for saying that most of them are dead,
18 I'm involved in a study, a large study, sponsored by the Center
19 for Disease Control where we're looking back at about a thousand
20 recipients of blood transfusions. In looking for those children,
21 we have found a very high number of children who have already
22 died at two and three and four years old. We're looking all the
23 way back to 1980, so some are up as old as six or seven years
24 now. We're finding a much higher incidence of children that have
25 died than you would expect from national statistics.

26 We haven't gone back and looked, but it's my assumption
27 that many of those children died infected with the AIDS virus.
28 In fact, died of AIDS or other similar infections.

1 So part of it is, the pediatricians are not thinking. I
2 don't really think it's wanton underreporting. I think it has to
3 do with the definitions.

4 SENATOR WATSON: They don't know what they're looking
5 for.

6 DR. MUNDY: But we are writing this in a letter to the
7 Journal of Pediatrics with our main point being, we will agree
8 that 18 children in Los Angeles County is not a major public
9 health problem. Well over 253 is a major public health problem,
10 and we know that that 253 may be under by half.

11 SENATOR WATSON: I just want to mention this, if I may,
12 Senator Seymour, I must leave for a meeting with CMA.

13 Senator Chiles has been successful in establishing an
14 Infant Mortality Commission that has a one-year life, and it was
15 approved by Congress.

16 We're going to hold a hearing here in Los Angeles, and I
17 think that AIDS related death among newborns is going to be a
18 prime target with us. I would like to invite you, and through
19 your staff anybody else that can speak. We're going to have a
20 lot of visibility around this particular hearing. We'll have
21 about four throughout the country.

22 But I certainly want to draw in the AIDS related deaths
23 under this whole umbrella that we're working on also.

24 DR. MUNDY: I'd be happy to.

25 Even mildly extrapolating our figure factor of ten times
26 under in Los Angeles County, there are thousands if not tens of
27 thousands of women infected with the AIDS virus in California,
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1 and virtually all of these women fall into the child bearing
2 ages. Most of these women don't know they're infected. Most of
3 them do not consider themselves to be in a high risk group or
4 their sexual partners to be in a high risk group.

5 Most mothers who deliver children with AIDS, children
6 who later develop AIDS, do not know that they, the mother, are
7 infected until the child is diagnosed. There are many well
8 seropositive women delivering children who, within a year or two,
9 develop AIDS, and that's the point of the mother finding out that
10 she is infected.

11 SENATOR SEYMOUR: On that point, Dr. Mundy, do you have
12 any feel whatsoever as to how many doctors, when providing
13 pregnancy tests for a woman, inquire as to whether they use
14 drugs, and if they do and the response is positive, test them for
15 AIDS?

16 DR. MUNDY: I'm getting to that later. My guess is that
17 very, very few, well under ten percent, ask them the question.
18 And even a smaller percent than that offer testing.

19 That was a recommendation that the old Los Angeles City-
20 County AIDS Task Force made, that obstetricians be much more
21 aware of AIDS and offer to discuss AIDS and AIDS risk factors
22 with their women; hopefully, women contemplating pregnancy, not
23 women who are already in for their first visit.

24 A major problem in the IV drug user community is that
25 these are not women who come in for their prenatal care early.
26 As we say, they get elevator prenatal care on the way to the
27 delivery room.

28

1 SENATOR SEYMOUR: Thank you.

2 DR. MUNDY: A statistic that you probably most want to
3 know is: What percentage of women who are infected pass on that
4 injection to their children?

5 On close looking, the lowest percentage that I can find
6 is 35 percent; the highest is 65 percent. It appears that there
7 may be slightly less risk of passing on AIDS to a child in the
8 first pregnancy than there is in subsequent pregnancies. The 35
9 percent was a first pregnancy one. That may just have to do with
10 age of the woman and length of time of being positive. But we
11 can safely say somewhere around 50 percent, which is what the
12 pediatric community thinks, somewhere around 50 percent of women
13 pass the infection to their children.

14 It can be as early as the 15th week of pregnancy that
15 the infection's passed along. From there probably any time later
16 up until delivery and including the time of delivery, and a
17 couple of cases of transmission by breast milk after delivery in
18 a child who was not infected previously.

19 But you can safely figure 50 percent transmission.

20 So, what can we do to limit this passage from women,
21 particularly IV drug using women, to children?

22 Education is my first recommendation, as you've heard
23 obviously before. Not just the drug rehabilitation programs, but
24 at sexually transmitted disease clinics, and at prenatal care
25 clinics. But remember, as you well pointed out, not every women
26 who receives prenatal care or delivers a baby in California is
27 taken care of by someone funded by the State. It's not all the
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1 clinics, so only doing it at clinics will not answer the
2 question.

3 We have to encourage gynecologists, who, probably of all
4 the specialties who really need to be involved in AIDS, have been
5 least involved. We really need them thinking about asking those
6 questions as you said: At the time of pregnancy testing, at the
7 time of first visit contemplating pregnancy, at the time of
8 seeing a teenage girl for her first gynecological exam at 16,
9 again talking about risk factors for AIDS.

10 I think we need to make available for widespread
11 voluntary counseling either at the time of pregnancy diagnosis or
12 contemplating pregnancy, and we need to make available, I
13 believe, more anonymous alternative site testing for children. I
14 don't know if the Committee is aware, by a quirk under the Roos
15 bill of now three or four years ago which set up alternative
16 testing sites, those testing sites are requested by the State not
17 to perform testing on anyone under 12 years old, which means that
18 we are totally leaving out the pediatric population as having any
19 alternative test sites.

20 I didn't know this myself until, oh, about March of last
21 year when the CDC made some major recommendations on testing
22 transfusion recipients. And at that time I sent a memo to all
23 the Los Angeles County alternative test sites saying that I
24 realized they were not supposed to be doing that -- I think for
25 very good reasons. Testing children, counseling children,
26 drawing blood on children is very different as it is in adults --
27 and offered our services basically under our CDC grant to do
28

1 free. It can't be totally anonymous testing; that's not the way
2 we're set up. But it can be confidential testing. I think there
3 needs to be the same anonymous testing for children as there is
4 for adults.

5 There are also some things that we should not do, and
6 those basically in my mind center around mandated either
7 premarital or prenatal testing. There was a nice study which I
8 can leave a copy of with the record if you like. The Journal of
9 the American Medical Association, October 2nd, where a public
10 health group from Boston basically costed out the cost and cost
11 effectiveness of testing every couple getting married in the
12 United States. There are approximately -- their figures were a
13 bit father back; they had about 2 million. Now there are about
14 2½ million marriages each year in the U.S. Assuming two people
15 per marriage, that's about 5 million tests a year.

16 Their cost figures were that it would cost well in
17 excess of \$100 million to test that group, and that we would
18 detect fewer than one-tenth of one percent of all the people
19 infected in the U.S. In that group, we would tell 350 people
20 that they were infected when in fact they were not. And even
21 worse, we'd tell 100 people that they were not infected when in
22 fact they were. The false positive and false negative rates.
23 And at most, they figured we would prevent 250 births of children
24 with AIDS.

25 As far as usual CDC and any public health officials cost
26 effective data, \$100 million to prevent that number of cases is
27 way out of line. We could spend the money better elsewhere.

1 The same data would hold up, it was not specifically
2 done in that study, for testing of pregnant women; the same data
3 would hold up there. There turned out to be approximately as
4 many births a year as there are marriages a year. Because
5 counseling is the major cost component of that, the costs would
6 not come down much below 100 million, and you would prevent well
7 under 250 births because you're talking about pregnant women, not
8 all of whom would chose not to continue that pregnancy. And many
9 would be tested farther than would be able to not continue that
10 pregnancy. And some would not be in favor of not continuing a
11 pregnancy in any event.

12 SENATOR SEYMOUR: Question, Dr. Mundy.

13 The same false-positive statistical information you
14 provided on testing, is it equally applied to alternative test
15 centers? Do they have the same experience, false-positive? Or
16 is there some kind of testing that is different here?

17 DR. MUNDY: It would be somewhat better in the
18 alternative testing sites for the following reason. When your
19 testing is a statistical quirk, when you're testing a very low
20 risk population, which couples getting marriage licenses in the
21 U.S. would be because it is by definition for the most part a
22 heterosexual population -- yes, they are young adults, but the
23 majority of them are not IV drug users, therefore they don't have
24 a risk factor -- when you're testing a low risk population, you
25 have an astronomically high false-positive rate. Most of your
26 positives -- I've heard estimates actually at the hearings in
27 Sacramento earlier, the testimony by the guy who runs the lab at
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1 U.C. Davis -- in the low risk population, 9 out of 10 of those
2 initial positives will be false positives.

3 The alternative test sites probably have slightly better
4 false positive-false negative rates because they're testing a
5 higher risk population.

6 SENATOR SEYMOUR: Thank you.

7 DR. MUNDY: You must remember that testing of pregnant
8 women for AIDS is not the same as other prenatal testing. It's
9 easy to make the argument where we test in newborns, let's say,
10 for PKU, or we test pregnant women for aortal tube defects,
11 because of the profile that AIDS has in the community, you must
12 have discussion with those women before about what this test
13 means, the false positivity and false negativity rate, what will
14 happen if you're positive, so the costs go up astronomically,
15 mostly because of the counseling component. It is not the same
16 as doing heel stick on a newborn and putting it on a blot of
17 paper, or throwing in one more test for a pregnant woman.

18 That money, I feel, would be much better spent educating
19 the high risk groups very aggressively, not testing a very low
20 risk population, with either married women or all women seeking
21 marriage or all pregnant women.

22 Even though children whose risk factor is mothers or
23 fathers who are IV drug users is not my primary concern now in
24 Los Angeles, because in Southern California so far, over half of
25 our cases are transfusion related in pediatrics, not IV drug use
26 related.

27

28

1 But I must tell you, in every segment that we have
2 looked at in AIDS, San Francisco has been but a few months to
3 perhaps a year behind New York and New Jersey, and Los Angeles
4 has been right on the heels of San Francisco. And you know
5 pretty well the data in New York and New Jersey. We are not to
6 be far behind.

7 Transfusion related pediatric AIDS cases, transfusion
8 related cases in general, are no longer. Some people will
9 continue to get sick, but the transmission is no longer there.

10 But I'm anticipating a deluge of cases from IV drug
11 using mothers and fathers in the years ahead.

12 I can't leave without saying one word about
13 confidentiality. As I said, my primary study is talking to
14 approximately 1,000 parents, telling them that their children got
15 transfusions, and offering them AIDS testing. And I stress
16 offering. I in no way coerced them. I think it is really a
17 decision that they have to make, but we're offering it to them.

18 As I've said before, when Sacramento talks about
19 relaxing confidentiality, not votes in committee, not votes on
20 the Floor of the Senate or the Assembly, when it talks about
21 changing confidentiality, my patients cancel appointments. Quite
22 literally, on a Monday morning after a Sunday Los Angeles Times
23 article about the general bills that are pending on relaxing
24 confidentiality, three parents call Monday morning and cancel
25 appointments.

26 There must be confidentiality protections for this
27 population. People will not undergo testing if it is not
28 anonymous and very confidential.

1 Thank you.

2 SENATOR SEYMOUR: That concludes your testimony?

3 DR. MUNDY: Yes, sir.

4 SENATOR SEYMOUR: Thank you very much. You certainly
5 have given us a bit different insight than perhaps some of the
6 other witnesses. We thank you for your time.

7 Our next witness is Mr. Rick Davis, who is a Chemical
8 Dependancy Specialist working with the AIDS Project in Los
9 Angeles.

10 Mr. Davis, thank you for being here.

11 MR. DAVIS: You're welcome, sir. Thank you for having
12 me.

13 I'd like to change the focus just a little bit as has
14 the doctor before me. I would like to explain some of the
15 problems I think at APLA which we're incurring with IV drug abuse
16 and AIDS.

17 The first thing I'd like to mention is that in Los
18 Angeles County, if you are seropositive, there is a very limited
19 amount of help you can get initially, and that includes APLA.
20 You have to be diagnosed as having either AIDS or ARC.

21 At that point, we act as a very good referral source for
22 all kinds of things. One of those things that we're not able to
23 fulfill is drug treatment for an individual who has AIDS or ARC.

24 There are a couple of reasons for that. Several AIDS
25 patients are indigent; therefore, it is very difficult for them
26 to procure a fee for service at the common places for drug
27 treatment that are there. As for agencies that are funded by
28

1 either the federal government or the County, should the
2 individual be seeking a 28-day program, detoxification and so on,
3 you're looking at roughly a 35-40 day stay, I receive calls on
4 the average of probably twice a week from individuals seeking
5 therapy, but they cannot meet medical criteria in order to get
6 into treatment. In other words, they're just too sick. They
7 cannot be taken. They cannot get clearance from a physician to
8 be able to enter treatment. Either they've had a bout of PCP or
9 something similar to that, and that cannot go to a physician and
10 get clearance as would be mandated by the facility in order for
11 them to get treatment, which makes it extremely difficult, when
12 it leaves them back out on the street.

13 Unfortunately, when they are left out on the street to
14 their own devices, again they will revert back to the best way
15 they know how to survive, and in certain cases that's the
16 inappropriate use of themselves in order to procure money so that
17 they may survive.

18 Also there is the problem of confidentiality that goes
19 on. Not a lot of people who are addicted to drugs and have the
20 dual diagnosis of AIDS are real willing to go into a treatment
21 facility, have that known in the facility itself, and go through
22 the whole issue of homophobia, drug addiction and AIDS all at the
23 same time. It gets a little more complex, I think, than the
24 average.

25 Also, as for funded agencies, either by the County,
26 State or federal government, it's that there's a lot of real
27 healthy alcoholics and addicts out there. They don't have to go
28 dig up AIDS patients to give treatment to.

1 If you would take an AIDS patient into treatment at one
2 of these facilities, there's the possibility, which is weighed by
3 these agencies, that the individual might come down with
4 pneumonia while in treatment. If you're under your contract to,
5 let's say, the County of Los Angeles, you're to maintain census
6 at 80 percent; you have to discharge this person; they go to the
7 hospital. How long are they going to be there? Two weeks, three
8 weeks, ten days. Do you bring them back into treatment? And the
9 whole time they're under the guise of, well, we can't fall below
10 80 percent census for our beds or we're going to get in trouble
11 with the County Auditor or the State Auditor. So, it poses a
12 problem for those individuals also to give treatment to people
13 with AIDS.

14 There has been no definitive study that I can find on
15 the correlation between how many people who have AIDS still abuse
16 drugs or alcohol. An initial survey with our own mental health
17 people, where we tracked 1112 patients as of August, '87, their
18 best guess was 50 percent continue to abuse drugs or alcohol. My
19 counterparts at Ward 92 at San Francisco General, the clinicians
20 there, their best guess is 85 percent.

21 Dr. Larry Siegal, who is an internist in Key West,
22 Florida, I spoke to him on the phone last week. He has written
23 some articles about this issue, and in treating 100 AIDS
24 patients, 90 percent of them use drugs or alcohol.

25 San Francisco General itself did a study, and out of 300
26 patients, only 12 did not use either drugs or alcohol.

27 SENATOR SEYMOUR: Excuse me, Mr. Davis.
28

1 MR. DAVIS: Yes.

2 SENATOR SEYMOUR: I appreciate those are extraordinary
3 statistics, but I want to make sure I understand what you're
4 saying.

5 You're saying "use alcohol or drugs." As opposed to an
6 intravenous drug user?

7 MR. DAVIS: Well, the difficulty with trying to explain
8 this is that there hasn't been any research done specifically to
9 say.

10 My feeling, from my position at my job and also other
11 therapists that I have talked to, is that the AIDS patient will
12 return to using drugs, and if they were a needle user before,
13 they will return to using a needle.

14 SENATOR SEYMOUR: But that is the point. And certainly
15 I'm not in defense of in any way, shape or form illicit drug use
16 or substance abuse of any kind. But, unless you've got some
17 information other than IV drug user, intravenous needles, does
18 one's use of cocaine and alcohol or other drugs make them more
19 prone to AIDS, other than the fact that their conduct is less
20 inhibited? Set that aside.

21 I don't have any knowledge. I'm asking you if you have
22 any knowledge where these folks are at more risk than anybody
23 else in the population?

24 MR. DAVIS: I think -- my feeling is that, yes, that
25 they are.

26 SENATOR SEYMOUR: Would you explain why?
27
28

1 MR. DAVIS: Well, I don't think there's any remarkable
2 news in the fact that substance abuse, whether it's the use of
3 alcohol, or marijuana, or PCP not being a disease, or cocaine, or
4 crack or anything in that line of a psychoactive, is -- lowers
5 the immune system of the individual. It's very harmful.

6 Statistically it can be proven without too much problem
7 that alcohol addicts or addicts just overall, if you remove the
8 AIDS issue out the row, have more hospitalizations, more mental
9 needs and --

10 SENATOR SEYMOUR: So they're more prone to contract the
11 disease?

12 MR. DAVIS: Yeah, very much so.

13 One of the things that we see going on at APLA is the
14 accidental, and I do mean accidental, addiction to some of the
15 individuals. The common scenario for it is simply this.

16 The individual who, I will cite one case specifically
17 just to give you an example, had been an IV drug abuser for 11
18 years; was found out to be seropositive. That moved into ARC,
19 and then he is now into AIDS. He quit using and became drug free
20 in that sense. But through treatment, he received several
21 medications that are psychoactive. He receives methadone for his
22 diarrhea; he receives paregoric for the problems with his
23 stomach; he receives percadan for the generalized pain that he
24 has overall; he receives a sleeping medication Anzanex. This
25 individual slips periodically, through anxiety and fear of his
26 disease issue, his deteriorating health, and also his
27 deteriorating mental ability, and he is not uncommon.

28

1 We see -- I would not say overly prescribed to, but
2 certainly a lot of individuals who already have AIDS who are
3 trying to clean up, being more or less pushed right back into
4 using drugs again through no fault of their own, and through no
5 fault of the medical community because there's only so many ways
6 you can treat the disease. And unfortunately, things like
7 methadone, which are very good at eradicating diarrhea, they're
8 also very immunosuppressive. And that is a very complex issue.

9 Dr. Siegal in his article relates to that, too. He's
10 one of the few individuals in the country who's kind of on the
11 bandstand about this whole area right now.

12 I would like to also while I'm here address the issues
13 of the minorities, because we find that to be very important. Of
14 our clients that we have, from August of '86 to August of '87, we
15 had an increase in our Black clients by 73 percent -- excuse me,
16 I need to correct that. Our Hispanic and Latino increase was 73
17 percent, and for Blacks it was 64 percent, and for women it was
18 29 percent, 29-30 percent, which in one way is good in that they
19 are seeking help in a certain form, and in another way it's also
20 very distressing in that the finger continuously keeps being
21 pointed towards the minority communities, and it is a very
22 difficult group of individuals to get to, I think, as Ms. Cowen
23 has already alluded to. It's very hard to get those individuals
24 to come in to find information out about AIDS. I believe it
25 would be appropriate for us to be going to them.

26 Even that in itself becomes very difficult and making
27 sure that the material is culturally sensitive enough, and that
28

1 the people do not get involved more in whether it was culturally
2 sensitive, and that they have the ability to understand what's
3 being said to them.

4 I will hurry along here. The general recommendation
5 that I would like to make is, first off, the one that I already
6 mentioned, the culturally appropriate material be taken care of
7 in the Black and Latino communities. And most of all, funding
8 for agencies is my biggest recommendation outside of from the
9 State directly to the agencies.

10 The reason why I feel that this is appropriate is that
11 agencies that do not have to meet policy and procedure by several
12 other agencies over the top of them can do, I feel, a more
13 appropriate job. I believe Ms. Cowen alluded to one, is that her
14 situation was she needed pamphlets done in a more culturally
15 responsible manner, but due to the circumstances she couldn't do
16 that; where I feel if the money was directed from the State
17 directly to the agencies, that they would be able to solve those
18 problems quicker.

19 Also, another very important point with that is that
20 agencies such as APLA, where we have 1112 clients, we also have
21 1,000 volunteers. County agencies can't take, I think, adequate
22 effective volunteers in the way that we can. We're set up to do
23 it; we have the training programs for them, and I believe we
24 would do a better job with that.

25 I'd like to thank you for your time.

26 SENATOR SEYMOUR: Thank you, Mr. Davis.
27
28

1 One last question. Relative to the dissemination of
2 materials that are culturally sensitive, and Ms. Cowen certainly
3 raised the point, others have, and now you have. I'd like to ask
4 you a question in return.

5 The same testimony was given, by the way, in San
6 Francisco yesterday. My question of the individual, or one of
7 the individuals that raised that yesterday: If I can
8 appropriately describe the material you're talking about, and
9 clarify for me if I'm wrong, the material in order to be
10 successful needs to be written in such a fashion that it may use
11 very explicit four-letter words. On the other hand, the material
12 that the State, quote-unquote, approves uses 12-letter words,
13 which nobody understands, much less the recipient of the
14 information.

15 My question is this: If that's true, isn't it possible
16 that we may be able to find some six-letter words to use in this
17 material?

18 I say this for a very pragmatic political reason. You
19 make a good point. All those who have said that make a good
20 point, but it shows little empathy or understanding for what
21 takes place in the political world.

22 We know that would work. I know that would work. But I
23 and my colleagues are going to lose our heads. Those very
24 colleagues who want to help are going to lose their heads over
25 it.

26 And so, my question is: Isn't there some common ground
27 here somewhere where you can be effective with your material, and
28

1 we get off the bureaucratic 12-letter words, but yet we stay out
2 of the politically tumultuous four-letter words?

3 MR. DAVIS: Well, I believe that it would certainly be
4 appropriate.

5 It is my feeling from talking to individuals who do
6 outreach into minority communities that there does have to be
7 that area that's the six-letter word. The reason why I feel it
8 needs to be the six-letter word is that in minorities, church
9 plays a very important role in their lives. I cannot believe
10 you're going to be able to use four-letter words in a pamphlet in
11 the church, but I believe if you have a six-letter word in the
12 church that bridges the difference between bureaucratic
13 gobbledygook over here and street stuff over here, is that the
14 individuals will be able to be reached.

15 Not saying that the four-letter word doesn't have its
16 appropriate place, nor the 12-letter, but I feel it is more
17 appropriate if it would be the six-letter, where it's done in
18 good taste and not offensive, and it just needs to be straight
19 forward.

20 SENATOR SEYMOUR: Thank you, Mr. Davis. We really
21 appreciate your time today.

22 At this particular juncture, we're going to take a five-
23 minute recess and give our court stenographer an opportunity to
24 rest her weary fingers. Then we'll pick up with Mr. Dennis Webb.

25 (Thereupon a brief recess was taken.)

26 SENATOR SEYMOUR: We'll reconvene.
27
28

1 Our next witness is Mr. Dennis Webb, representing the
2 Office of AIDS, State Department of Health Services.

3 Mr. Webb, thank you for taking the time to be with us
4 today.

5 MR. WEBB: Yes, thank you.

6 Mr. Chairman, Members of the Committee, on behalf of Dr.
7 Kizer, the Department Director, and Thelma Frazier, the Chief of
8 the Office of AIDS, I am glad to be able to come before you and
9 testify.

10 A clearer understanding of the relationship between AIDS
11 and IV drug abuse is a critical adjunct in our efforts to design
12 effective and reasoned intervention strategies.

13 I'd first like to give a role of the Office of AIDS as
14 it relates to IV drug abuse and our general role. The Office of
15 AIDS was created in 1985 to provide information and education,
16 epidemiologic investigation and surveillance, research, and
17 treatment to address the public health problems related to AIDS.
18 The Office of AIDS monitors the incidence of AIDS cases and HIV
19 infection in California, and is particularly concerned with the
20 trends among IV drug using populations.

21 AIDS and IV drug abuse in the United States -- in the
22 United States, IV drug abuse is the second most commonly reported
23 risk factor for the transmission of AIDS virus, and a major route
24 for HIV infection into the heterosexual population. So far, the
25 vast majority of AIDS cases associated with IV drug abuse have
26 occurred in the northeastern United States where, in New York and
27 New Jersey, more than 50 percent of reported AIDS cases are IV
28 drug related.

1 In California, the proportion of such cases is much
2 smaller. Heterosexual IV drug users account for approximately
3 two percent of California's AIDS cases, and gay and bisexual male
4 IV drug users account for approximately 11 percent of all cases.
5 It is clear that California is in the early phase of the AIDS
6 epidemic, and although in some drug -- epidemic curve for IV drug
7 abusers, although in some drug using populations in San Francisco
8 a dramatic rise has already been observed.

9 Specific issues. It is within the general context of
10 this the concerns raised by this Committee must be viewed. I
11 will now discuss the issues which the Committee has invited the
12 Department of Health Services to address in its testimony.

13 First off, the relationship between AIDS prevention and
14 substance abuse treatment. Twenty-three percent of the Office of
15 AIDS budget of \$11.7 million has been allocated for AIDS
16 education contracts for education prevention programs for IV drug
17 abusers.

18 Of the 89 local agencies who have education contracts,
19 70 percent have some activities planned for IV drug user
20 populations. Activities specified in these contracts include:
21 street outreach programs; training for substance abuse treatment
22 providers; training in methadone clinics, training in court-
23 ordered drug diversion programs, training and support for
24 partners of IV drug users.

25 The relationship between AIDS prevention and the
26 punishment of illegal drug activity. The majority of drug
27 treatment referrals are from the criminal justice system, and
28

1 these referrals serve to increase the interface between addicts,
2 treatment and education. Thus, the law enforcement approach is
3 potentially advantageous because it provides an opportunity to
4 modify behavior.

5 The reverse side of the coin is that on occasion when
6 law enforcement officials have stepped up arrests for possession
7 of drug injecting paraphernalia, this has decreased the
8 availability of needles and increased the sharing of needles
9 among addicts.

10 The Office of AIDS also has a contract for prevention
11 training for correctional officers and prison inmates.

12 The relationship between IV drug users, AIDS, and the
13 minority population. The cumulative incidences of AIDS among
14 Blacks and Hispanics are over three times the rates for Whites.
15 Nationally and in California, the rates of infection among Black
16 military recruits is four times higher than the rate among White
17 applicants, White recruit applicants.

18 A recent study revealed that among heterosexual addicts
19 in San Francisco, Black and Latino addicts were three times more
20 likely to become infected than the White addicts.

21 Serological and risk factor data recently collected
22 among 1800 Californians with a history of IV drug use revealed an
23 overall positivity of two percent. However, among Black addicts,
24 the rate was significantly higher.

25 The spread of AIDS virus to the non-IV drug using
26 heterosexual population. In the United States, as of the end of
27 September, 1980 or 4 percent of the adult AIDS cases are reported
28

1 as having contracted the disease through heterosexual contact.
2 In California, the figure is much lower. There have been
3 approximately 100 contact cases, or one percent of the total
4 cases for the state. It is estimated that in 70 percent of the
5 heterosexual contact cases, the infected partner was an IV drug
6 user.

7 The transmission of the AIDS virus from the IV drug user
8 to the unborn or infant child. For pediatric AIDS, 78 percent of
9 the cases nationally and 51 percent of the cases in California
10 are associated with a parent at risk of AIDS. Of these, it is
11 estimated that roughly 61 percent had an IV drug using mother and
12 another 14 percent were born to mothers who had an IV drug using
13 partner.

14 The relationship between the IV drug user, prostitution,
15 and the sexual spread of AIDS. AIDS virus infection among
16 prostitutes varies widely among geographic areas, ranging from
17 zero percent in southern Nevada, where prostitutes are licensed,
18 to near 60 percent in Newark, New Jersey.

19 HIV prevalence estimates among California prostitutes
20 are available for San Francisco and Los Angeles, and are
21 respectively six and five percent.

22 About half of all prostitutes are estimated to be IV
23 drug users, and of HIV positive prostitutes, close to three-
24 fourths are IV drug users. Seroprevalence among IV drug using
25 prostitutes is four to five times higher than among non-IV drug
26 using prostitutes.

27

28

1 The Office of AIDS has committed to an extensive program
2 for serological monitoring to test approximately 60,000 persons
3 in this fiscal year, of which IV drug abuse population has been
4 significantly identified as the population to be tested.

5 I recently attended a conference in Atlanta in which the
6 CDC is going to be testing in 30 cities across the United States
7 the seroprevalence rates among six populations, one of them being
8 IV drug abusers. And San Francisco and Los Angeles are part of
9 that 30-city study.

10 That concludes my testimony. I would be happy to
11 entertain questions from the Committee if you should have any.

12 SENATOR SEYMOUR: I have two questions.

13 First, your statistics relative to Nevada of prostitutes
14 and the fact that they are licensed, and therefore zero percent.

15 Do you have any data that would indicate whether or not
16 Nevada prostitutes, or what percentage of them, are IV drug
17 users?

18 MR. WEBB: I don't have that data. I do know from my
19 experience, I used to work in the Sexually Transmitted Disease
20 Program, and they monitored the prostitutes at the brothels for
21 specific STD infections, and they were also very concerned that
22 the prostitutes be relatively clean of drugs.

23 That doesn't include Reno and Las Vegas, which do not
24 have -- which have freelance workers, so to speak.

25 SENATOR SEYMOUR: The other question I had is, what is
26 the State's position in their education and outreach programs
27 relative to the use and dissemination of bleach kits?
28

1 MR. WEBB: In terms of our education and prevention
2 activities, we are stressing education in terms of use of
3 condoms, the methodology of transmission, and one of the factors
4 of course is to stop using drugs and exercising the option of
5 saying no. There are different modalities to prevent the disease
6 from being transmitted in the IV drug abuse population, and we
7 have not specifically made recommendations on the use of bleach.

8 SENATOR SEYMOUR: You don't talk about it? When you say
9 "modality", do you include in modality the bleach kits?

10 MR. WEBB: We say that in the education projects, they
11 would indicate that that would be an option, but that's certainly
12 not a policy endorsement from the State.

13 SENATOR SEYMOUR: We took testimony yesterday in San
14 Francisco of an outreach program, 80 percent funded, as I recall,
15 county, State and federal, that not only through educational
16 process talks about bleach kits, but disseminates them.

17 That would seem to be an endorsement. And I'm not
18 saying it's wrong. I'm trying to get to the facts.

19 MR. WEBB: I can say, Senator, that it is not a policy
20 of the State to advocate sending out bleach kits, but --

21 SENATOR SEYMOUR: But you don't prohibit.

22 MR. WEBB: We would say that would be one option that
23 they would have.

24 SENATOR SEYMOUR: Okay.

25 Thank you very much, Mr. Webb.

26 MR. WEBB: Thank you.
27
28

1 SENATOR SEYMOUR: Our next witness is Mr. Richard
2 Bayquen, who is the Chief Deputy Director of the State Department
3 of Alcohol and Drug Programs.

4 Mr. Bayquen, thank you for taking the time to again be
5 with us. You continue to provide a tremendous resource for the
6 work of the Committee.

7 MR. BAYQUEN: Good afternoon, Mr. Chairman.

8 My name is Richard Bayquen, Chief Deputy Director of the
9 Department of Alcohol and Drug Programs. I'm here today
10 representing Director Veatch who unfortunately could not be with
11 you. As you know, this is an area where he does have a profound
12 interest, and prior commitments precluded him from being here
13 with us today.

14 SENATOR SEYMOUR: Thank you, Mr. Bayquen, for being with
15 us today, and my best to Chauncey Veatch for permitting you to
16 testify.

17 MR. BAYQUEN: Thank you for the opportunity to provide
18 testimony about the population and needs of the intravenous drug
19 user, who although now comprising the second largest AIDS risk
20 group, are expected to become the most serious cause of HIV
21 transmission in the next several years.

22 In the interests of time, Senator, and also in the
23 interest of not being redundant with some of the prior and very
24 excellent testimony, I'd like to glean from my remarks at this
25 point.

26 SENATOR SEYMOUR: Very good.
27
28

1 MR. BAYQUEN: In California, we estimate that there are
2 450,000 people who use needles associated with illicit drug
3 activity. Approximately half of these are believed to be chronic
4 cases; that is, they are addicted to the compulsive use of
5 heroin, cocaine, or other drugs that can be injected.

6 In California, heterosexual IV drug users are presently
7 identified as comprising about 2 percent of the total AIDS cases
8 in our state, although another 11-12 percent of those in the
9 homosexual-bisexual risk groups share histories of IV drug use as
10 an associated risk factor.

11 Nationally, IV drug users account for 17 percent of
12 adult cases. Added to this group are another 8-9 percent of
13 homosexuals or bisexuals who have the associated risk factor of
14 being IV drug users. So far, about 75 percent of the IV drug
15 user AIDS cases have occurred in New York and in New Jersey.
16 However, it is anticipated that California merely lags behind New
17 York, and that the number of AIDS cases amongst IV drug users
18 will increase dramatically if appropriate steps are not taken.

19 A disproportionately high percentage of all AIDS cases
20 nationally occur in the Black and Hispanic populations.
21 Currently, 61 percent of cases are White, 25 percent are Black,
22 and 14 percent are Hispanic. These variations may represent
23 differences in susceptibility or increases in high risk
24 behaviors, especially IV drug use and needle sharing.

25 Once infected, the drug user can serve as a vector of
26 transmission to other populations. As has been mentioned
27 earlier, infected women can transmit the virus to their children
28

1 prenatally. AIDS can also be transmitted sexually from IV drug
2 users to non-using partners. Nationally, 70 percent of
3 heterosexual AIDS cases involve transmission from a drug user to
4 a non-drug user. In New York City, this figure is closer to 90
5 percent.

6 Unfortunately, we are short on epidemiological data
7 which will allow us to successfully determine the spread and
8 scope of the HIV virus. However, the Department of Health
9 Services has funded new and expanded studies to allow us to track
10 the progression of the virus in California, and we hope to
11 eventually be able to have an effective epidemiological network
12 which will return timely information on seroprevalence among IV
13 drug users.

14 Specifically, the Committee has asked us to respond to
15 three questions. On the issue of what can be done to stop the
16 spread of AIDS among IV drug users, ideally, the solution to the
17 problem of AIDS in the drug using population would be to convince
18 drug abusers or drug users to stop using drugs.

19 However, in the absence of the ability to accomplish
20 this, the Department of Alcohol and Drug Programs generally
21 supports the following guidelines and recommendations which have
22 been developed by leading experts in the field of AIDS research,
23 and in particular, those recommendations which directly affect
24 AIDS, addiction, and alcoholism by focusing on the following:

25 Development of an information base to monitor the spread
26 of HIV exposure within the IV drug using population. I touched
27 on that earlier in terms of the study the Department of Health
28 Services is funding.

1 Secondly, encourage within the IV drug use community, to
2 encourage voluntary testing for the HIV infection, but with
3 strict adherence to confidentiality laws. Towards this end, we
4 also believe that it is necessary to develop effective
5 motivational techniques for achieving greater utilization of the
6 HIV test sites by IV drug users.

7 SENATOR SEYMOUR: On that point, again, we took
8 testimony in San Francisco yesterday, and they bore out, and
9 today we're hearing the same thing, and that is length of time it
10 takes to obtain, voluntarily obtain a test, confidential test, at
11 the test centers.

12 To what degree is the Department attempting to respond
13 to what we were told yesterday, I believe, it was up to a five-
14 week delay?

15 MR. BAYQUEN: The Department, Senator, is not directly
16 involved with the test centers. But what we are involved in are
17 the drug treatment programs, the methadone programs, to try to
18 get people into those services.

19 SENATOR SEYMOUR: So this is more Department of Health?

20 MR. BAYQUEN: Yes, sir.

21 SENATOR SEYMOUR: I should have asked Mr. Webb. Has he
22 left? I think so; he had a plane to catch.

23 Thank you.

24 MR. BAYQUEN: I'm sorry I can't answer that for you.

25 SENATOR SEYMOUR: It's quite all right.

26 MR. BAYQUEN: I'll certainly pass that question on to
27 the Department of Health Services.

28

1 SENATOR SEYMOUR: Thank you very much.

2 MR. BAYQUEN: Additionally, we believe that an increase
3 in the number of slots at drug treatment and methadone
4 maintenance centers are very important. Towards this end, the
5 Department has revised emergency regulations to increase the
6 methadone treatment capacity during the AIDS crisis. This has
7 allowed qualified methadone programs to temporarily treat more
8 addicts than their license would normally allow.

9 Also, the Department has allocated in the current fiscal
10 year an additional \$5 million to the counties in the battle
11 against AIDS. These funds have been allocated to all 58
12 counties. I think you heard earlier, Los Angeles has received
13 about \$1.9 million; San Francisco, \$660,000; and San Francisco
14 [sic] \$473,000 -- excuse me, San Francisco, \$660,000; and Orange
15 County, \$473,000. And these funds have been allocated to the
16 county drug programs to increase prevention education and more
17 importantly, treatment programs for the IV drug users.

18 Additionally, in the current year, the Department has
19 allocated \$12 million of federal funds to alcohol and drug
20 programs. These funds have been earmarked by the Department and
21 by the Legislature, where they have been given a priority to
22 focus on youth, to focus on special populations meaning minority
23 populations -- Blacks, Hispanics, females -- and also to focus on
24 the homeless. So, there has been a tremendous amount of
25 additional dollars that the Department has put out in the current
26 year specifically for AIDS, but also available for alcohol and
27 drug treatment programs on an across the board basis.

1 SENATOR SEYMOUR: On that point, Mr. Bayquen, you heard
2 my question to Mr. Webb relative to bleach kits?

3 MR. BAYQUEN: Yes, sir.

4 SENATOR SEYMOUR: Would you respond to the same
5 question, please?

6 MR. BAYQUEN: On that particular point, I think you're
7 talking about the MidCity Consortium project in San Francisco.

8 SENATOR SEYMOUR: Yes.

9 MR. BAYQUEN: That program is funded by San Francisco
10 County. San Francisco County gets State and federal dollars from
11 the Department basically in a block grant or in a subvention.
12 They in turn match that with their own dollars and any other
13 sources they have, and in turn, choose programs that they believe
14 will be effective at reaching out to the clients, serving the
15 needs and providing treatment services.

16 That's a decision that San Francisco has made. They
17 feel that that's an appropriate way to try to deal with the issue
18 of needle sharing.

19 I know that our position is that, recognizing the
20 diversity within California, and consistent with the block grant
21 approach, that each locality is in a best position to know the
22 unique needs and the best ways to get to people within their
23 county to make sure that they are brought into the programs, that
24 they're educated, and that prevention programs are made available
25 to them.

26 And I think that's an issue that the local people need
27 to decide.

28

1 SENATOR SEYMOUR: I certainly commend the Department for
2 that policy.

3 MR. BAYQUEN: Furthermore, we believe that development
4 of diversified and innovative education campaigns aimed at
5 challenging unsafe sexual and needle sharing behaviors are
6 necessary. We believe there is a need for a continued focus on
7 research, especially in the area of AIDS as it relates to IV drug
8 users.

9 SENATOR SEYMOUR: In relationship to that point, Mr.
10 Bayquen, did you hear Dr. Tennant this morning as he talked about
11 the new drug that --

12 MR. BAYQUEN: Talking about LAAM?

13 SENATOR SEYMOUR: Yes, the alternative to methadone.

14 MR. BAYQUEN: Yes, I did hear that.

15 SENATOR SEYMOUR: Do you have a reaction to that at all?

16 MR. BAYQUEN: Well, I think the issue or the question
17 that was raised at that time was in terms of whether or not
18 additional funding would be available for the northern part of
19 the state.

20 As I understand --

21 SENATOR SEYMOUR: No, I'm confused then. I thought the
22 question that was raised was the need, legislatively I guess, or
23 at least through regulation, to permit the usage of this drug in
24 place of methadone.

25 MR. BAYQUEN: Okay, that's an issue that is currently
26 being explored by the Federal Drug Administration. In fact,
27 there have been a number of experiments with the drug, I think,
28

1 for close to ten years now. And the Federal Drug Administration,
2 for whatever reason, has not yet made a decision on whether or
3 not that should be available beyond just a trial or experimental
4 basis.

5 SENATOR SEYMOUR: What, if anything, can the State do to
6 either hasten the process or circumvent the FDA process?

7 MR. BAYQUEN: Well, in response to that, Senator, I
8 really don't think it's fair for me to comment, because I
9 personally am not that familiar with LAAM. I don't know what the
10 pros are, I don't know what the cons are.

11 SENATOR SEYMOUR: No, I was more asking, Mr. Bayquen,
12 and perhaps you can't comment, but I was more interested in the
13 process than the drug. I don't know anything about the drug
14 either.

15 MR. BAYQUEN: I think in terms of the process, if in
16 fact one believes that LAAM is appropriate, is necessary, is
17 good, then I think it really comes down to a matter of advocating
18 or lobbying with the FDA to get on with the process.

19 SENATOR SEYMOUR: It nevertheless would await the FDA.

20 MR. BAYQUEN: Yes.

21 SENATOR SEYMOUR: Thank you.

22 MR. BAYQUEN: I think in terms of process, that's where
23 it lies.

24 As elected officials, what can you do? I think we would
25 look for your continued support of the Department and the drug
26 field in fulfilling the following objectives:
27
28

1 One, to continue providing high quality drug abuse
2 treatment in California.

3 Two, to initiate a primary prevention against the spread
4 of AIDS and HIV infection.

5 Three, to implement a second prevention program in
6 symptom recognition and risk reduction/health promotion.

7 Four, to institute an AIDS treatment and assistance
8 program that supports clients who have been infected by HIV or
9 developed ARC or AIDS.

10 Additionally, we believe that drug programs must also be
11 encouraged and assisted in carrying out four secondary roles:

12 One, to advise and advocate for individual clients,
13 their sexual partners, and significant others.

14 Two, to reach out and bring the high risk drug users
15 into treatment.

16 Three, to advocate for drug abusers among other service
17 providers and resource controllers.

18 And lastly, to conduct community education activities
19 towards reducing initiation into IV drug use and the spread of
20 AIDS.

21 Drug treatment programs are now wrestling with the
22 various issues inherent in attempting to cope with the fact that
23 more and more of them will be seeing infected patients as the
24 crisis grows. Program needs are specifically these:

25 One, providing staff with guidance and support which is
26 responsive to their potential anxieties about AIDS, training
27 needs, work overload, and burnout.

1 Two, develop a program of protocol for counseling
2 clients about the advisability of knowing their own
3 seropositivity.

4 Three, reviewing, revising procedures to ensure
5 confidentiality, protection, release of client information,
6 avoidance of discrimination and legal liabilities.

7 Four, developing prevention education programs for
8 clients, their sexual and needle sharing partners, and IV drug
9 users not in treatment.

10 Five, devising policy and procedural responses to the
11 anticipated impact of AIDS on medical nursing care, treatment and
12 service delivery mechanisms, client flow, and community linkages.

13 And lastly, number six, developing effective strategies
14 for increasing resources and improving other public support for
15 AIDS programming.

16 On the issue of planning, the Department of Health
17 Services is the State agency that has responsibility for master
18 planning as it relates to AIDS. We believe that that
19 responsibility is appropriately vested; however, we believe that
20 the Department of Health Services and the Department of Alcohol
21 and Drug Programs have and will continue to consult regularly in
22 increasing cooperative efforts to share information and creative
23 approaches.

24 In anticipation of the increasing problem to be
25 presented by AIDS over the next five years, absent a cure or a
26 vaccine, our two Departments will continue to work jointly
27 towards finding common solutions to the challenges that lie
28 ahead.

1 And lastly, we would like to thank the Committee for the
2 opportunity to testify, and we think this, too, is an invaluable
3 tool in facilitating progress on all of the fronts that I've
4 touched on in dealing with this very important issue.

5 SENATOR SEYMOUR: I'd like to ask you a question
6 relative to this last point, or the last question, and that is
7 how should the prevention of AIDS be addressed in the statewide
8 Master Plan to reduce alcohol and drug abuse in California.

9 If I understood your response, you indicated that your
10 Department and the Department of Health Services are both charged
11 with, your words were, "a plan." Could you share with us what
12 your five-year plan is?

13 MR. BAYQUEN: Senator, on the issue of the five-year
14 plan, as you're aware, that's an idea or a concept at least in
15 terms of development of that plan that we have not supported that
16 concept. I think if anything, quite frankly, that the example of
17 AIDS has demonstrated, at least to me, that five years ago, AIDS
18 was not as much of an issue. And today, it is very much of an
19 issue, not only as it relates to public health, but also as it
20 relates to drug abuse and IV drug users.

21 And I think that we, as a Department, need to identify
22 for at least the next 12-18 months what the pressing needs, what
23 the pressing priorities are for the dollars for the resources
24 that we have available, and then to make sure that those dollars
25 are allocated, those resources are allocated throughout
26 California consistent with meeting the needs throughout the
27 state, be it in San Francisco, Los Angeles, or in the rural
28 counties.

1 SENATOR SEYMOUR: I don't want to put words in your
2 mouth, Mr. Bayquen, and I certainly don't want to be derogatory
3 in any fashion whatsoever, because I think your Department is
4 doing an outstanding job with the resources they've been
5 provided, but if I could paraphrase for you the answer you just
6 gave me, it is your view, or your Department's view, that their
7 responsibility is to prioritize funding, available funding, year
8 by year to ensure that the taxpayer is getting maximum bang for
9 the buck and those resources are being accurately used.

10 But beyond that, you don't have a plan; don't intend to
11 develop a plan.

12 To project where we will be, let's just take this
13 particular issue, much less substance abuse, IV drug use and
14 AIDS, to project a plan where we might be five years from now,
15 and what it might take to address where we might be, you don't do
16 that?

17 MR. BAYQUEN: That's correct, Senator.

18 I did outline some of my reasons for the Department not
19 developing a plan. I think also in Irma Strantz's testimony
20 earlier, speaking very frankly, that the issue of the federal
21 funding, we have difficulty, and so much of the funding that is
22 available in the area of alcohol and drugs, it is available from
23 the federal government.

24 But we don't know, on a year to year basis, what
25 additional federal dollars will be available, and it does become
26 very, very difficult for us to develop a plan and a plan that
27 makes sense.

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1 The \$18 million that I touched on that we've allocated
2 to the counties that came to us under the auspices of the federal
3 Anti-Drug Abuse Act, we don't know what's going to happen;
4 whether or not there will be reauthorization. The
5 reauthorization of the block grants is an issue that is the
6 subject of great debate in Congress at this time, and the issue
7 of equity funding between all of the States of the Union:
8 whether or not New York will lose money; whether or not Texas
9 will gain money; whether or not California will maintain the
10 status quo or move forward or move back. And we just don't know.
11 It's very difficult, and it's very difficult in the absence of
12 that type of knowledge to develop a plan that you're looking for,
13 I believe.

14 SENATOR SEYMOUR: Well, I certainly respect that
15 position, and I understand all those unknowns and what that
16 means.

17 On the other hand, and this is just my opinion, Mr.
18 Bayquen, despite all the unknowns, despite the rapidly changing
19 environment, it seems to me only intelligent if you're going to
20 use, if we are going to use an intelligent process for attacking
21 substance abuse, in this case IV drug use and AIDS, somebody's
22 got to have the courage to sit down and look into the future, as
23 cloudy as that future might be, and to the best of their ability
24 estimate where we're going to be in the status of the problem.
25 And having done that, assuming we're as correct as we can be,
26 then devise a plan and make the commitment to achieve the plan,
27 knowing full well that any plan is not laid in concrete and needs
28

1 to be flexible so that you could change it, amend it, as you
2 progress. But nevertheless, you've got common goals that you've
3 agreed to.

4 In any event, I appreciate your being with us today, as
5 you have in the past, and appreciate all the fine work your
6 Department does.

7 MR. BAYQUEN: Thank you very much, sir.

8 SENATOR SEYMOUR: Our next witness is Dr. Neil Schram,
9 who is a practitioner of internal medicine and nephrologist.

10 Thank you, Dr. Schram, for being here today.

11 DR. SCHRAM: Thank you.

12 Mr. Chairman, Members of the Committee, my name is Neil
13 Schram. I am the former Chair of the Los Angeles City/County
14 AIDS Task Force, which was in existence from September, 1984
15 through May, 1987. And I appreciate you inviting me to testify
16 before you today.

17 I am certain you have already heard a great deal about
18 IV drug users and AIDS. You have undoubtedly heard that most IV
19 drug users with AIDS are Black or Latino. You have heard that 42
20 percent of Blacks and Latinos with AIDS are IV drug users. You
21 have heard that most of the heterosexual spread of AIDS is from
22 IV drug users to their sexual partners. You have heard that most
23 children with AIDS are the result of one or both parents being
24 infected with the AIDS virus via IV drug use. Thus, you have
25 heard that to realistically try to prevent the spread of the
26 virus heterosexually and to unborn children, we must effectively
27 address the problem of IV drug use.

28

1 There are two important aspects of AIDS and IV drug use
2 that are often overlooked. The first is that IV drug users not
3 only infect their sexual partners and the unborn children, but
4 they infect other IV drug users as well. In a 1986 survey in Los
5 Angeles County of IV drug users, fewer than two percent were
6 infected. That figure has risen to greater than four percent
7 this year. And if we only talk about the problem instead of
8 effectively dealing with it, when hearings are held next year,
9 perhaps eight percent of IV drug users will be infected.

10 We keep tracking the disease, and I think you just heard
11 from one of the last two speakers that we will continue to keep
12 tracking the disease in California. When will we start
13 effectively trying to stop its spread among IV drug users?

14 The second and perhaps most important mistake is to
15 assume that IV drug users are self-destructive, and therefore
16 cannot be reached by AIDS prevention programs. That is not
17 correct.

18 In a presentation at the Third International AIDS
19 Conference in Washington, in June of this year, it was reported
20 that in Amsterdam, where needles are exchanged, there were
21 approximately 25,000 needles exchanged in the first year of the
22 program. The latest year there were 600,000 needles exchanged.

23 There are continued reports of sterile needles being
24 purchased by addicts in New York City on the street, which
25 unfortunately are very often dirty needles in a new package.

26 Another excellent example is an article that I gave a
27 copy to you from the British Medical Journal in September of this
28

1 year. In a report from three drug treatment centers in London,
2 of 150 IV drug users who were educated and counseled about AIDS,
3 35 stopped injecting drugs, and 52 stopped sharing needles or
4 equipment. IV drug users can be reached.

5 You've heard talk about prostitutes and IV drug use.
6 One other point that's been found with prostitutes is that they
7 often use condoms with their clients, but will not use condoms
8 with their lovers. That again is something that counseling is
9 needed to be changed.

10 I cannot say it too strongly: The problem is real. We
11 can either continue to talk about the problem and observe more
12 infections, or we can start spending major sums of money. We can
13 either try to pass punitive legislation, or we can start dealing
14 with the problem. You know the answers. They're to increase
15 treatment programs, develop better outreach programs, exchange
16 needles, not give away free needles, but exchange needles,
17 develop more counseling programs for IV drug users and their
18 sexual contacts, to promote low risk sex, and the stopping of
19 needle sharing.

20 We've known these answers for years. We just don't do
21 it.

22 Testing of IV drug addicts is not going to solve the
23 problem. We've already seen that just testing people doesn't
24 change behavior.

25 I'm going to give a sideline that's not in here just on
26 the results of testing, because I think it's important that you
27 understand it. There's a study going on through the National
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1 Institutes of Health of hemophiliacs and their wives. Twenty-
2 four couples, these are married, heterosexual couples. The men
3 are infected and known to be infected. The women are not
4 infected, and are known not to be infected. So, they're tested
5 and they know the results. And 18 of those 24 couples continue
6 intercourse without condoms. And the study that's going on is
7 watching the wives becoming infected.

8 So I submit to you, Senator, the answer to this is not
9 testing programs. The answer to this is repetitive counseling
10 programs. And that will require large amounts of money.

11 Too many words have been written and spoken about this
12 epidemic. Doing something effective for IV drug users as well as
13 for the many others at risk is long overdue. We know the
14 answers. Let's please start acting on them.

15 Thank you.

16 SENATOR SEYMOUR: Thank you very much, Dr. Schram. Just
17 one question.

18 Do you have any idea on a statewide basis, have you
19 read, heard, discussed any figures, dollar figures, as to what
20 type of commitment, financial commitment, would be necessary
21 annually on the part of the State to address this issue?

22 DR. SCHRAM: No, sir. I don't know that anybody has.

23 I just, again, want to focus on what we're watching. In
24 San Francisco two years ago, if I remember the figures correctly,
25 and I haven't seen them lately, there were approximately two
26 percent of IV drug users who were infected. In San Francisco, I
27 believe that figure is up to around 15 percent. Los Angeles is
28 likely to follow.

1 SENATOR SEYMOUR: We're very familiar, Dr. Schram, with
2 all the statistics. We've had plenty of those in the last two
3 days, and I'm thankful for it.

4 We had a witness testify yesterday, and that's why I
5 asked the question of you. We had a witness testify yesterday
6 that a minimum investment, and it's looked upon as an investment
7 because it protects against the health of California citizens and
8 future citizens, and investment of \$500 for every man, woman and
9 child would be necessary on an annual basis. I think, if I
10 recall correctly, the witness that gave us that figure
11 represented the National Disease Center.

12 Oh, it was \$5, you're right. It was \$125 million a
13 year, and was that for all of AIDS, or was that IV drug users?

14 DR. SCHRAM: Sir, I believe that figure came from the
15 National Institute of Medicine, the National Academy of Science,
16 which recommended a billion dollars a year for education efforts.

17 SENATOR SEYMOUR: That's education only?

18 DR. SCHRAM: Education only.

19 What I'm suggesting, sir, is that there's a lot of talk
20 about education being necessary for AIDS, and there is. But
21 education alone does not change behavior.

22 SENATOR SEYMOUR: Of course.

23 DR. SCHRAM: We have to spend lots more to change
24 behavior.

25 Very frankly, the figures are going to be astronomically
26 high.

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1 SENATOR SEYMOUR: But you see, Dr. Schram, this is what
2 I have to deal with, and you have to help me. If you don't help
3 me, or others who are interested in this, then we ain't going to
4 get anything done. We're going to sit here in another hearing
5 next year, nothing done.

6 Somebody on your side has got to say, "Here's what it's
7 going to take." You just heard me raise the question to
8 Mr. Bayquen about a plan. Now you're just saying whatever it is,
9 spend it.

10 We don't know what it is, and we are accountable to
11 taxpayers.

12 And I'm not saying we shouldn't commit it, but
13 somebody's going to have to come up with an intelligent estimate.
14 If it's five bucks per head for education, what does that mean,
15 and what is it for treatment? What is it for research?
16 Somebody's got to tell us that.

17 DR. SCHRAM: Yes, sir, and I think --

18 SENATOR SEYMOUR: And somebody also has to provide us
19 with information as to how we can then go back to the taxpayers
20 with the reporting system that accounts for the investment of
21 those funds.

22 DR. SCHRAM: What I'm suggesting, sir, is that there are
23 programs that have been tried in New Jersey, in London, in
24 Amsterdam, and they work.

25 SENATOR SEYMOUR: I understand that.

26 DR. SCHRAM: But they have costs attached to them.

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1 SENATOR SEYMOUR: Look, we're way ahead of them. We
2 know that the State of California puts up 50 cents for every
3 dollar in this country on AIDS. And that's not enough
4 commitment. We need a greater commitment. But what is it?

5 DR. SCHRAM: What I'm suggesting, sir, is that I don't
6 know how much it costs, and I don't know anybody who does for
7 going out and trying to identify every IV drug user in Los
8 Angeles County, let alone in the State of California.

9 After you identify all of those individuals, then you
10 have to try to encourage them either into a treatment program, or
11 at least into a counseling program. I don't know. It's never
12 been done.

13 Therefore, we can't tell you how much it's going to
14 cost. AIDS is new. I'm sorry. It doesn't fit into anything
15 that we've dealt with in our lifetimes.

16 We need new rules, and we need new ways of answering the
17 questions your asking, but you, sir, have the money to do it.
18 I'm only a physician in private practice. I haven't got the
19 capability of trying to go out and answer your question, but it
20 does need answering.

21 And I believe the State has the capability of trying to
22 find those answers and has to fund the program to answer your
23 question.

24 SENATOR SEYMOUR: Maybe what it all points to is the
25 necessity of this Master Plan I keep talking about.

26 DR. SCHRAM: That clearly is an important part.
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1 SENATOR SEYMOUR: Dr. Schram, thank you very much for
2 your testimony today and being with us.

3 DR. SCHRAM: Thank you.

4 SENATOR SEYMOUR: Our next witness is Joe Arnold, who is
5 the AIDS Research Coordinator for the UCLA Neuro Psychiatric
6 Institute.

7 MR. ARNOLD: Senator Seymour, thank you for having me
8 here.

9 I represent the UCLA Drug Abuse Information and
10 Monitoring Project, which is funded by the State Alcohol and Drug
11 Programs, under the direction of Chauncey Veatch.

12 Everything I have here on my notes was mentioned today,
13 and I support them wholeheartedly.

14 I would like to, however, cover what I feel are the
15 important issues that you, as elected officials, can deal with in
16 your own consciences of what needs to be attacked first in this
17 epidemic.

18 Basically what can be done to reduce the spread of HIV
19 infection has been clearly articulated through the MidCity
20 Consortium to Combat AIDS, John Newmeyer, John Watters, and other
21 colleagues up in San Francisco. It's evident that a one-to-one
22 contact is necessary to have an effective -- to be effective in
23 reaching the IV drug user and educating them as to the risks.

24 One of my other functions was that I coordinated the
25 seroprevalence studies that Dr. Strantz mentioned. And in our
26 data, it was clear that the IV drug user was relatively
27 uninformed about AIDS. Of course, they had heard about it
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1 because of the media campaigns targeting the gay community;
2 however, very few of them were aware that bleach was an effective
3 method of disinfecting their rigs or their works.

4 I can only wholeheartedly support that a similar
5 campaign be launched in Los Angeles County similar to the San
6 Francisco campaign, partly because Los Angeles County has the
7 largest uninfected pool of IV drug users in the nation, and
8 potentially, with the infection rate being somewhere around 4-5
9 percent now, and that figure has been validated by the UNITA
10 study that Bob Batchy is coordinating, that Dr. Tennant was part
11 of, however it unfortunately needs to be off the record that
12 there is approximately 4-6 percent seroprevalence rate amongst
13 IVDUs in methadone maintenance treatment, which would validate
14 our previous study in residential, and we will get more
15 conclusive evidence with this next study that is going on as we
16 speak in methadone maintenance treatment slots.

17 Increasing availability of treatment slots would be
18 ideal; funding is necessary. Mr. Veatch has advocated increasing
19 treatment slots.

20 Of a program I'm not sure has been mentioned is the
21 coupon program that is used in New Jersey. Was that mentioned
22 yesterday?

23 SENATOR SEYMOUR: No, it was not.

24 MR. ARNOLD: Joyce Jackson is the researcher in New
25 Jersey who coordinates that effort, and it is similar to the
26 MidCity Consortium outreach in that it's canvassing the streets,
27 targeting the IVDU who we can't reach in treatment because, as
28

1 Dr. Tennant mentioned, there are those that elect not to seek
2 treatment. However, because they are on the streets and do
3 exhibit more extreme behaviors, they are placing themselves at
4 higher risk for HIV infection. So, that's the population we need
5 to target the most, are the people on the street.

6 This coupon program basically goes out and offers free
7 coupons to the IV drug user who would choose to go into treatment
8 if it were available, but because of financial resources, they
9 can't afford it, or because there are waiting lists, they elect
10 not to go into treatment. So there are people on the street that
11 would elect to be involved in treatment, but because of finances
12 don't.

13 The coupon program has been very successful. They've
14 disseminated thousands of coupons and a high percentage, in the
15 70 percentile range, of the people have elected to come into
16 treatment as a direct result of that.

17 A study by Mary Jane Creek in New York has shown that
18 people who are in substance abuse treatment, overall, have a much
19 lower infection rate for the HIV, and it makes common sense. If
20 people stay in treatment, they shoot less often. It is true that
21 people in methadone maintenance still continue to shoot drugs on
22 occasion, but the methadone at least limits the number of needle
23 shares that occur.

24 Our objective needs to be stop IV drug use. As we all
25 know in substance abuse plans, we're having a difficult time in
26 attaining that goal. With the AIDS epidemic, we have a window of
27 opportunity that is closing very rapidly.

1 I hope that John Newmeyer yesterday discussed his
2 epidemiological curve, and with San Francisco now hitting
3 actually the 20 percent range, they in some respects have lost
4 the opportunity to further reduce the spread of infection. We in
5 Los Angeles County have an opportunity, at 4-5 percent. We
6 basically have just one year. When it hits 10 percent, then it
7 goes off geometrically and we lose a major percentage of the IV
8 drug users to infection.

9 People have mentioned the Amsterdam program, and I know
10 it's very controversial because it's a needle exchange issue.
11 California is one of the states that does prohibit the possession
12 of needles without a prescription. However, I think that the
13 Amsterdam program needs to be monitored. At least it has shown
14 that 600,000 needles were exchanged last year, and it has also
15 shown that needle sharing has been reduced from 70 percent down
16 to 15 percent in that one year. And again, needle sharing is the
17 method of transmission that we want to limit at the most.

18 What can elected officials do? Basically don't mince
19 words with these people. I understand the four and the six and
20 the twenty-letter controversy, and I agree that six-letter words
21 will work effectively.

22 But with the bureaucratic inertia in our system of
23 getting things approved, it's very frustrating because we as
24 researchers know that, for example, John Newmeyer's cartoon that
25 shows the IV drug users -- did he show you that cartoon?

26 SENATOR SEYMOUR: We have a copy of a comic book as a
27 matter of fact.

1 MR. ARNOLD: There is just about a four or five section
2 cartoon that's on a cardboard.

3 SENATOR SEYMOUR: I don't think we saw that, no.

4 MR. ARNOLD: I could get you a copy of that.

5 SENATOR SEYMOUR: We'd appreciate it.

6 MR. ARNOLD: It's very easy for the IV drug user to
7 understand, partly because it's pictorial. We have to realize
8 that a large percentage of the IV drug users are illiterate or
9 have difficulty in reading traditional AIDS literature. This is
10 a cartoon that shows two people shooting up together, but with
11 the one drugee saying, "Wait a minute. I need to clean my
12 works." And then they have a little interchange about, "Oh, do
13 you think I have AIDS?" It's addressing that subcultural behavior
14 that needle sharing is a bonding issue.

15 The needle sharing will continue. We can't stop that.
16 But we can at least incorporate the cleaning of the rigs with
17 this bleach. And as they have shown in San Francisco and New
18 Jersey, that people are incorporating the use of bleach as long
19 as they know that it works.

20 As was mentioned earlier, yes, people have bleach and
21 alcohol and liquor in their homes, and choose not to use it, but
22 that's only because they don't realize that bleach is such a
23 quick and safe, effective means of disinfecting their rigs.

24 On the statewide plan issue, something that I foresee
25 happening that could address your concern about what is the
26 long-range goal, and your questions to Dr. Schram about what is
27 the dollar figure that you need to support, so you can go to the
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1 Legislature and say, you know, X number of dollars will do
2 something, will do the trick.

3 I am involved in helping coordinate a statewide
4 conference amongst IV drug researchers who are involved with
5 AIDS: John Newmeyer, John Watters, Harvey Feldman, Papernacky,
6 who are all nationally known figures for their work in IV drug
7 use and AIDS. But to date, we haven't been able to get together
8 to pool or to brainstorm on what can we do in California. We
9 have an opportunity. We only have this much time left. So, we
10 are advocating a conference that I would like to solicit your
11 support, and the rest of the commission, either through financing
12 or at least your endorsements and perhaps tracking what occurs in
13 this conference.

14 We're slating it to occur in March-April of this year
15 with a possibility of Prevention '88, which is funded by the
16 Alcohol and Drug Program.

17 Are you familiar with that?

18 SENATOR SEYMOUR: Yes, I am.

19 MR. ARNOLD: That would hopefully -- it is on the
20 drawing table, but we foresee it happening somewhere in the fall.
21 So at the March conference and brainstorming, hopefully we'll be
22 developing some sort of statewide plan that we could at least
23 disseminate to the thousands of people that attend Prevention
24 '88.

25 SENATOR SEYMOUR: I'll be happy to endorse that.

26 MR. ARNOLD: Great.
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28

1 I know we're running late. We all know the issues that
2 heterosexual cases occur because of IV drug use. There is a
3 researcher up in Sacramento, Dr. Neil Flynn, that feels that up
4 to 75 percent of the cases in California by 1991 will be caused
5 indirectly or directly by IV drug use. And that figure is
6 frightening. That's if we don't do anything today.

7 Prostitution, we know that occurs within the IV drug
8 using population. In our study, we found 80 percent of the
9 female IV drug users engaged in prostitution, while only 4
10 percent always using condoms or having their partners use
11 condoms. And 32 percent of the male IV drug users engage in
12 prostitution with males or females, and only two percent report
13 consistent use of condoms.

14 And then basically the role of all substance abuse.
15 Substance abuse acts as an inhibition reducer. A problem that we
16 see with heroin addicts is that when they are trying to get off
17 the drug or can't afford it, they turn to alcohol. Alcohol is a
18 more socially acceptable means of self-medication. They are then
19 back into the mainstream of society, interacting at parties, and
20 possibly infecting other people through sexual contacts. So,
21 substance abuse as a whole is a major problem for the HIV
22 infection.

23 I think that's about it. Part of my role as AIDS
24 Research Coordinator is to stay on top of what's ongoing
25 throughout California. There is some good research going on. We
26 have a computerized bulletin board called the Drug Abuse
27 Information Monitoring Project, a bulletin board, and it allows
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1 anyone with a computer and a modem to hook into us free of charge
2 to find out what the drug abuse and AIDS trends are. That also
3 is funded by the State ADP, and we see an increasing role,
4 particular to AIDS, as the epidemic spreads.

5 So that is my testimony to date.

6 SENATOR SEYMOUR: Thank you very much, Mr. Arnold, for
7 your testimony, and please feel free as you develop more
8 information that would be helpful to us to share that with us.

9 MR. ARNOLD: Okay.

10 SENATOR SEYMOUR: Obviously we are on the cutting edge.
11 We don't know enough about it. Learning new things every day;
12 therefore, the faster we can communicate with one another as
13 things new and different develop, the more effective we'll be.

14 MR. ARNOLD: Right. I need to apologize for Doug
15 Anglin, Dr. Anglin. He unfortunately came down with the flu.

16 SENATOR SEYMOUR: Hope he's better soon.

17 Thank you, Mr. Arnold.

18 MR. ARNOLD: Thank you.

19 SENATOR SEYMOUR: Our final witness for the day is Dr.
20 Leslie Rothenberg, who's the Director of Program in Medical
21 Ethics in the UCLA School of Medicine.

22 Thank you, Dr. Rothenberg.

23 DR. ROTHENBERG: Senator Seymour, I've provided some
24 written testimony, and I know it's late in the day and you
25 probably want to get back to Sacramento. So, I'd be more than
26 happy to defer the presentation of this testimony and let you
27 just have it in writing, and respond to any questions later that
28 you may have.

1 It's up to you, sir.

2 SENATOR SEYMOUR: I appreciate that, and I'll take you
3 up on your kind offer, Dr. Rothenberg.

4 While we have your expertise here, I don't know how long
5 you have been with us this morning, but to whatever degree, might
6 you have a perception or a view on what you've heard?

7 DR. ROTHENBERG: Well, I'm sorry to say I've only been
8 here for about the last hour or so, sir. Just from your
9 comments, I get a sense of what the earlier testimony may have
10 been.

11 I'm not an expert in IV drug use. I'm not an expert,
12 for that matter, in AIDS. I'm someone who works on ethical
13 issues that arise in the treatment of patients, and I happen to
14 be involved with a group of people who are taking care of AIDS
15 patients since 1981, including people who happen to be IV drug
16 users.

17 I've mentioned in my remarks that I think the most
18 crucial role that you may be able to play and which is very
19 cheap, because it doesn't cost a dime in terms of money but
20 requires enormous potential political costs, is to provide
21 leadership in terms of your constituents and the state population
22 generally engaging in the rather easy practice of making moral
23 judgments about the persons who come down with this disease
24 process, instead of focusing on the virus and dealing with its
25 prevention.

26 I've taken the liberty of indicating that scriptural
27 comment about "Let those who are without sin cast the first
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1 stone," but I think it really goes beyond that. I understand why
2 people are frightened, and they're not simply people who are
3 outside the health care or drug abuse programs area. There are
4 people within those programs who are equally frightened.

5 But the way in which we address these issues, and the
6 tone of the public debate, is going to make a great deal of
7 difference in terms of what you're going to be able to sell, in
8 terms of legislative programs, as well as getting people to start
9 thinking through these issues and not engaging in a lot of stone
10 casting.

11 SENATOR SEYMOUR: Dr. Rothenberg, you are absolutely
12 right.

13 You know, the scary thing about the minority statistics,
14 for example, provides those individuals who seem to approach
15 things with a knee-jerk, Neanderthal type response all the time,
16 those minority statistics just are really scary, because then I
17 can see the potential for that type of reaction against Blacks,
18 against Hispanics. If anything we can do, and you can help us,
19 because you have a great, perhaps, greater credibility with the
20 public than we do, but somehow together we have got to get the
21 message out that we're fighting a disease, not a people.

22 DR. ROTHENBERG: Well, as a matter of fact, as I
23 mentioned in my testimony, the problem in the Black and Latino
24 communities is made even more complicated by the fact that I'm
25 told that in those communities, AIDS or HIV infection is
26 identified with homosexuality. And because of the strong
27 negative feelings in those communities about homosexual or gay
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1 sexual practices, the tendency is to abandon heterosexual IV drug
2 users who come down with AIDS simply because they're identified
3 as being homosexual by virtue of the disease.

4 And I've suggested there may be a useful opportunity in
5 involving religious leaders in those communities, while
6 remembering of course that the largest number of persons affected
7 with this virus in this state continue to be White or Anglo, and
8 not to put the burden on the Black and Latino communities.

9 But it is a very difficult dilemma to talk about this
10 candidly and compassionately without falling victim to the knee-
11 jerk reaction because I think everyone is frightened.

12 It's easy to understand that response, but it's going to
13 mean that Master Plan or not, we're not going to get much public
14 acceptance of the expenditure of funds, or the diversity of
15 educational approaches unless people understand that this is a
16 threat to all of us.

17 SENATOR SEYMOUR: Dr. Rothenberg, we will certainly
18 review your written testimony with interest. We thank you for
19 being so kind as to take the time. I apologize for the lateness
20 of the --

21 DR. ROTHENBERG: Quite all right, sir.

22 SENATOR SEYMOUR: -- of the meeting. Again, my thanks.

23 DR. ROTHENBERG: Thank you.

24 SENATOR SEYMOUR: With that, the meeting is adjourned.

25 (Thereupon this Joint Interim Hearing
26 of the Senate Select Committee on Sub-
27 stance Abuse and Senate Select Committee
28 on AIDS was adjourned at approximately
2:00 P.M.)

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CERTIFICATE OF REPORTER

I, EVELYN MIZAK, a Shorthand Reporter of the State of California, do hereby certify:

That I am a disinterested person herein; that the foregoing Joint Interim Hearing of the Senate Select Committee on Substance Abuse and the Senate Select Committee on AIDS, held on Wednesday, October 21, 1987 in Los Angeles, California, was reported in shorthand by me, Evelyn Mizak, and thereafter transcribed into typewriting.

I further certify that I am not of counsel or attorney for any of the parties to said hearing, nor in any way interested in the outcome of said hearing.

IN WITNESS WHEREOF, I have hereunto set my hand this
4/4 day of November, 1987.


EVELYN MIZAK
Shorthand Reporter