NIDA, HRSA Join Forces in Studies of AIDS Risk Behavior by IV Drug Users

The Public Health Service has undertaken a one-year research effort to study the effect of various approaches on modifying the high-risk AIDS behaviors of intravenous drug users.

The study, a collaborative effort between the Health Resources and Services Administration (HRSA) and the National Institute on Drug Abuse (NIDA), will be conducted in Miami, FL, and in Newark and Jersey City, NJ, three metropolitan areas with a high incidence of IV drug abuse and infection from the Human Immunodeficiency Virus (HIV) that causes AIDS.

The New Jersey State Department of Health was given $160,000 in HRSA-NIDA demonstration program funds to conduct the research in Newark and Jersey City. The South Florida AIDS Network (SFAN), received $220,000 for a study to be conducted through Jackson Memorial Hospital in collaboration with the University of Miami School of Medicine. The funds supplement existing NIDA-supported staff and resources at each location.

Operating under the authority of the Public Health Trust of Dade County, SFAN will study the effectiveness of enhanced intervention, through case management, in changing or altering high risk behavior among seropositive intravenous drug users in the Miami area.

A minimum of 300 seropositive subjects will be recruited from drug treatment programs and the criminal justice system and then referred to the assessment center at the University of Miami and Jackson Memorial Hospital. An initial baseline assessment of risk factors, knowledge, and attitudes about existing community based services, prior use of those services, and demographic factors will be conducted before assigning subjects randomly to one of two service delivery intervention groups.

Enhanced intervention. A case manager will be assigned to the client to provide enhanced intervention, including assistance with access to services and after-care transition to the community.

Standard intervention. Subjects will receive the standard needs assessment and referral but no personalized advocacy to facilitate access to services.

After six months, subjects will receive a follow-up assessment to determine changes in AIDS-related risk behavior, knowledge and attitudes about services, service utilization and criminal activity. Subjects will also be followed for development of AIDS-related disease.

The principal study hypotheses are

- Intravenous drug users who participate in the intervention project will have increased knowledge about, positive attitudes towards, and use of medical, legal, social, and economic services.
- The drug users undergoing enhanced intervention will receive increased services, including medical, legal, social, and economic services.
- Subjects receiving enhanced intervention will exhibit decreases in AIDS-related risk behaviors.
- Subjects receiving enhanced intervention will exhibit less criminal activity.
- Subjects receiving enhanced intervention will exhibit less recidivism.

Newark and Jersey City were selected to study the effect of three different delivery interventions on the health behaviors of the IV drug users. The interventions are classified as

Case management (CM). Also known as "full feature" or "enhanced" intervention, it will be conducted by a health professional and will include an assessment of the client's service needs, counseling on the options available to him or her, the steps to be taken to obtain the needed service, and direct assistance in making the necessary appointments. The health professional will play a very strong role as tne client's advocate.

Case referral (CR). This involves hiring a trained health professional caseworker to develop a set of instructional materials to assist the clinic staff interviewers in making client referrals to human service agencies. The caseworker will be expected to review activity logs, provide general instruction, answer questions, and evaluate quality control. The assignment of a trained on-site case worker differentiates the case referral approach from the standard care approach.

Standard care. It includes in-take counseling with referrals to health care agencies in the area, making health education materials available describing the care options, and arranging a second counseling session if the client is interested.

The New Jersey project will be evaluated through intensive follow-up interviews with the clients, and comparisons will be made based on a number of criteria, including whether or not the client made use of the referral, reason for using or not using the referral, the perceived outcome of the referral, and continuing needs.

Additional information about the collaborative study can be obtained from June Horner, Office of Special Projects, HRSA, 5600 Fishers Lane Rockville, MD 20857, telephone (301) 443-0652.

—PATRICIA DELANEY, Office of Special Projects, Bureau of Maternal and Child Health and Resources Development, Health Resources and Services Administration, Public Health Service.

15 Communities Get Grants to Fight Drugs and Alcohol

Fifteen communities, ranging in size from small inner-city neighborhoods to multi-county regions, have been awarded $100,000 each by the Robert Wood Johnson Foundation to plan strategies for fighting the demand for drugs and alcohol.

In the planning phase, the communities will build on existing programs to develop a comprehensive approach based on community-wide collaboration. After two years, eight of the communities will be selected for 5-year, $3 million awards to carry out their respective strategies.

Each community numbers between 100,000 and 250,000 people and has organized a broad-based consortium to pull together civic and business leaders, public agencies, neighborhood organizations, health care providers, and others.

"This national initiative is the first of its kind," said Leighton E. Cluff, M.D., foundation president. "It has been designed to fight the demand for illegal drugs and alcohol, using preventive education and treatment to complement the important law enforcement efforts already underway."

The communities were selected by a national advisory committee, chaired by John Brademas, Ph.D., president of New York University and a member of Congress for 22 years who wrote the Drug Abuse Education Act of 1970 (expanded to include alcohol 4 years later).

"Why these 15 projects?" said Brademas. "Because they represent the broad range of drug and alcohol problems in this country and because they have the strong commitment of civic leaders and the community at large. Not only should these initiatives benefit the towns and cities where they will be carried out, but we also hope to learn how the rest of the nation can fight substance abuse more effectively. We want to know what works."

More than 300 community organizations in 46 States, Puerto Rico, and the District of Columbia applied. The 15 receiving the grants include

The City of Little Rock, AR; Castlemont Corridor Coordinating Council, Oakland, CA; Santa Barbara Council on Alcoholism and Drug Abuse, Santa Barbara, CA; Alum Rock Counseling Center, San Jose, CA; the City of Vallejo, CA; the City of New Haven, CT; Marshall Heights Community Development Organization, Inc., Washington, DC; United Way of Central Massachusetts, Worcester, MA.

Metropolitan Kansas City Task Force on Alcohol and Drug Abuse, Kansas City, MO; Boys' and Girls' Clubs of Newark, Inc., Newark, NJ; Northwest New Mexico Council of Governments, Gallup, NM; Mecklenburg County Area Mental Health, Mental Retardation, and Substance Abuse Authority, Charlotte, NC; Lexington/Richland Alcohol & Drug Abuse Council, Columbia, SC; United Way of San Antonio and Bexar County, San Antonio, TX; and Milwaukee County, WI.

The Nation's Health Bill for Smoking: $52 Billion

Smoking costs the nation more than $52 billion annually, according to a new report on the economic consequences of smoking by the Department of Health and Human Services (HHS).

The annual per capita costs of smoking-related disease are $221 nationally, ranging from a low of $56 a person each year in Utah to $284 in Rhode Island.

In releasing the report, "Smoking and Health, A National Status Report," HHS Secretary Louis W. Sullivan, MD, said, "Cigarette smoking has an adverse economic impact on every American, whether or not he or she smokes. That $221 cost comes out of the pockets of smokers and nonsmokers, alike, largely in the form of increased health care and insurance costs."

The economic impact of smoking-related disease averages $1 billion per State, but some States are much harder

Smoking-attributable economic costs by State, 1985, in millions of dollars

State	*Direct morbidity*	*Indirect morbidity*	*Indirect mortality*	*Pediatric-mortality*	*Total*	*Per capita*[1]
Alabama	349.6	174.4	367.5	10.1	901.6	226
Alaska	34.7	16.4	28.8	2.4	82.3	165
Arizona	294.9	109.8	195.6	7.1	607.5	194
Arkansas	196.0	101.1	222.7	6.3	526.1	224
California	2,932.4	1,059.8	1,766.7	53.2	5,812.1	223
Colorado	329.3	109.8	157.3	7.3	603.8	189
Connecticut	348.7	123.6	222.2	6.9	701.4	222
Delaware	69.5	27.5	51.3	3.4	151.7	246
D.C.	19.0	26.0	82.0	3.0	130.0	211
Florida	835.2	407.4	790.1	28.1	2,060.7	183
Georgia	537.9	257.7	534.4	18.0	1,347.9	228
Hawaii	88.1	32.1	50.5	2.8	173.5	174
Idaho	68.6	25.6	46.8	1.3	142.2	143
Illinois	1,325.7	514.8	934.6	40.2	2,815.4	245
Indiana	563.9	448.1	231.4	14.4	1,257.9	229
Iowa	192.7	45.6	177.3	4.1	419.6	146
Kansas	159.4	70.3	136.4	4.9	370.9	153
Kentucky	327.0	170.0	397.5	12.3	906.9	246
Louisiana	263.8	138.4	302.9	8.8	713.9	160
Maine	24.7	57.0	128.4	6.0	316.1	273
Maryland	446.6	185.3	360.9	13.8	1,006.5	232
Massachusetts	847.5	288.4	462.0	21.2	1,619.1	279
Michigan	1,103.9	275.8	699.6	31.2	2,110.4	233
Minnesota	483.1	154.3	230.0	9.7	877.0	209
Mississippi	210.2	98.8	210.1	7.4	526.6	203
Missouri	594.7	232.0	434.6	11.5	1,272.9	254
Montana	39.9	20.6	46.3	1.8	108.7	132
Nebraska	156.4	56.3	91.8	3.0	307.6	193
Nevada	121.1	47.6	91.4	3.5	263.6	283
New Hampshire	95.0	40.4	81.6	1.8	218.9	220
New Jersey	701.7	301.1	604.2	16.3	1,623.4	215
New Mexico	71.9	33.1	62.4	4.6	172.0	120
New York	1,865.1	907.3	1,780.9	58.5	4,611.8	260
North Carolina	491.6	267.5	606.6	15.4	1,381.1	225
North Dakota	93.7	36.6	29.8	1.0	161.1	239
Ohio	1,246.2	481.7	885.5	24.0	2,637.4	246
Oklahoma	339.6	259.3	135.5	9.1	743.5	227
Oregon	151.6	83.5	192.3	6.3	433.7	161
Pennsylvania	1,403.7	542.4	954.6	24.7	2,926.3	247
Puerto Rico[2]	38.8	33.0	95.2	11.5	178.5	54
Rhode Island	133.0	48.7	90.0	1.0	272.5	284
South Carolina	227.9	124.3	282.0	8.4	642.5	196
South Dakota	60.7	24.2	42.0	2.0	129.0	184
Tennessee	284.4	352.6	157.2	11.7	806.0	170
Texas	1,618.9	617.0	1,079.2	29.4	3,344.5	206
Utah	43.2	27.0	18.1	3.8	92.1	56
Vermont	52.0	19.8	38.5	1.1	111.2	208
Virginia	534.4	236.0	455.7	6.9	1,243.0	224
Washington	428.7	153.0	281.2	14.3	877.1	202
West Virginia	199.1	93.2	206.2	3.4	501.9	259
Wisconsin	469.5	266.7	266.7	9.0	1,011.8	212
Wyoming	38.9	15.1	27.3	4.6	85.8	170
Total	23,653.9	10,237.9	17,823.8	623.3	52,338.9	221
Highest State	2,932.4	1,059.8	1,780.9	58.5	5,812.1	284
Lowest State	19.0	15.1	18.1	0.8	82.3	54
Average	454.9	196.9	342.8	12.0	1,006.5	205

[1]In dollars, based on 1985 resident population estimates, U.S. Bureau of the Census. [2]Based on 1983 data.

hit than others. California leads the list with yearly smoking-related costs of $5.8 billion. Close behind California, in order, are New York, Texas, Pennsylvania, Illinois, Ohio, and Michigan. The economic cost of smoking is lowest in Alaska—$82 million per year. (The accompanying table provides data on smoking-attributable economic costs for each State.)

The annual cost to smokers is considerably greater than the $221 average, the Secretary noted, because they spend some $40 billion a year for cigarettes, cigars, and pipe tobacco.

Calling the information in the status report "both startling and distressing," Dr. Sullivan said that smoking kills nearly 400,000 Americans each year, is responsible for more than one of every six deaths in the United States, and is becoming increasingly concentrated in the low-income, less-educated populations.

"I am especially concerned," the Secretary continued, "that we make more progress in reaching young people, women, minorities, and blue-collar workers with accurate and compelling information about smoking and its devastating impact on their health."

Minorities have higher rates of smoking than their white counterparts, and they have a much higher incidence of smoking-related disease and death. Nearly 90 percent of adult smokers began smoking before the age of 20. Today, 20 percent of female high school seniors smoke, compared to 16 percent of males.

"Smoking and Health, A National Status Report. A Report to Congress. Second Edition" was produced by the Office on Smoking and Health, Centers for Disease Control, Public Health Service. Limited copies of the report DHHS (CDC) 87-8396 (revised 2/90) are available from the Office on Smoking and Health, 118 Park Bldg., 5600 Fishers Lane, Rockville, MD 20857.

WHO Unveils Emergency AIDS Action Plan for Romania

The World Health Organization (WHO) and the new government of Romania have announced emergency measures to prevent and control AIDS and infection with the human immunodeficiency virus (HIV) that causes AIDS.

The new Romanian national AIDS program, which was developed among the WHO Global Program on AIDS in Geneva, the WHO Regional Office for Europe in Copenhagen, and the Romanian Ministry of Health, has already been activated and will involve major technical assistance from WHO offices and experts.

The plan was developed following the visit to Romania by a WHO expert team composed of Dr. David Heymann, a specialist in epidemiology from the WHO Global Program on AIDS, and Dr. Alexander Gromyko, a specialist on AIDS at the WHO Regional Office for Europe in Copenhagen. They visited Romania at the request of the new government in response to an emergency situation.

WHO will dispatch another team of experts to Romania shortly to continue assessing the situation and working with the government on the national AIDS plan.

As of February 1, 1990, the Government of Romania had officially declared 74 cases of AIDS to the World Health Organization, 50 of them in children younger than 5 years. The first known case in Romania occurred in an adult male in 1985. Preliminary investigations by the Romanian government suggest that AIDS among children first occurred in mid-1989 and involved infants who had received blood not screened for HIV. Microtransfusions, involving small amounts of blood or plasma, were given to malnourished, often abandoned children.

An additional 550 children thought to be HIV-infected have been identified, mainly in the districts of Constanta, Giurgiu, and Bucharest. The majority of these children have a history of multiple hospital admissions.

The newly formed Ministry of Health has discontinued the policy of microtransfusion and, as of February 5, 1990, HIV screening of all blood used for transfusion and blood products has begun in Bucharest.

The emergency plan for Romania includes assistance from WHO in

- developing a complete national epidemiologic surveillance network and creating a national AIDS program, including the training of national and district program managers;
- an investigation into the extent of the problem among all age groups;
- courses on medical care to patients, and on medical prophylaxis within medical premises;
- counselling of patients and their families;
- development of general health education, as well as health education regarding sexuality and family planning;
- training teams of new district health officers; and
- assistance for biological screening and the development of diagnostic procedures.

The last element of the program will involve provision by WHO of necessary equipment for automated diagnostic tests and diagnostic kits as needed following a preliminary shipment of more than 100,000 tests. Currently, there is a 2-month supply of the tests in Romania, according to Romanian and WHO officials, although in some areas, supplies are difficult to obtain. Screening of donor blood will require an estimated 1.5 million tests a year, the WHO experts said.

According to the WHO specialists, testing for HIV infection was extremely limited until early this year. In addition, donor blood was not screened for HIV infection until January 1990, and disposable and single use syringes were unavailable in the country. As a result, WHO guidelines for AIDS prevention and control were not implemented.

New Report Suggests Ways and Means of Analyzing Nursing Labor Market

Data from surveys of both nurses themselves and of people who employ them are necessary to answer key policy questions regarding the nature of the nursing labor market, a new report from the Project Hope Center for Health Affairs indicates.

Prepared under a Health Resources and Services Administration (HRSA) contract, the report recommends minimum data elements and an action plan that could be used to develop a comprehensive data base for analyses of the nursing market.

The top priority for improving nurse data, the report suggests, is to investigate the feasibility of establishing and maintaining master files of registered and licensed practical nurses. Obstacles to establishing such a system have included nurses' simultaneous licensure in several States, lack of standardization in State boards' data systems and in the timing of license renewal, and some States' reluctance to participate in a standardized system.

While computerization and changes in State attitudes seem to be diminishing many barriers, "even ballpark estimates" of the costs of such a system are not known. Investigation of logistical obstacles is necessary before an

informed decision can be made about whether this is the best plan for improving the chances of obtaining nurse data, the report says.

With regard to employer surveys, support should be given to efforts that will collect nursing data in nonhospital settings using the expanded Master Facility Inventory of the National Center for Health Statistics (NCHS), the report recommends. Taking advantage of the NCHS system as it is being developed "represents the most economical means of obtaining consistent data in a wide array of nonhospital settings."

The report also has specific recommendations for public and private agencies that conduct nursing data surveys. With master files in place to provide an unduplicated list of licensed nurses, a variety of sample surveys of nurses could be fielded, the report says.

The report calls for further development of quality of care indicators sensitive to nursing, suggesting that one of the first steps must be to define valid, reliable, and easily collected indicators. It recommends that the American Nurses Association, which already has taken an active role on this issue, continue to take the lead. Inclusion of the quality indicators in Medicare databases or in projected surveys of facilities on the Master Facility Inventory would be the "most viable" routes to improved data collection, the report says.

A major objective of the minimum set of nurse data is to describe the supply of nurses at a given point in time and how that supply is changing. Another key objective is to permit modeling of factors that influence a nurse's decision to enter the labor market.

Master file data would include only those necessary for maintaining an unduplicated registry of licensed nurses and items such as birth date, racial-ethnic background, and sex, which remain constant over time but can reduce future sampling costs. Data on employment status, settings, and earnings were recommended for annual collection. These would be enriched every 3 years by data on educational status, household characteristics, functional role, and other characteristics that might influence a decision to work.

Minimum items to be collected in employer surveys in hospital and nonhospital sectors would include vacant and filled positions for various categories of nursing personnel; average hours worked by full- and part-time personnel; use of overtime hours and agency personnel; compensation data; measures of nurse productivity, patients' severity of illness, and employers' capacity or output; and patient outcome indicators that are sensitive to nursing inputs.

Full implementation of the plan recommended by Project Hope would require at least until the end of 1995 under an "optimistic" time schedule, the report says. Either a nursing commission established by the Department of Health and Human Services (HHS), the Interagency Conference on Nursing Statistics, or another committee should be charged with coordinating implementation of the plan.

Support of both the public and private sectors would be critical to successful implementation. The Federal Government must be prepared at least in part to support data development and maintenance if it wishes to guarantee availability and public access to the minimum data set, the report says. However, the report calls on private sector and nursing organizations to recognize limitations in Federal resources and commit their own funds to activities that they see as essential.

The study was initiated by HRSA in response to a recommendation of the HHS Secretary's Commission on Nursing, which reported in December 1988 on the national shortage of nurses, but pointed to inadequacies in the data available to policymakers.

In calling for publicly and privately supported research on the effects of its recommendations and for development of a nurse database, the Commission sought to avoid situations in which policymakers find themselves forced to make decisions about the labor market without sufficient or reliable information, the report says.

In developing its recommendations, Project Hope utilized guidance from a panel of 38 nursing and data experts which met for 2 days in September 1989 and developed background papers on nursing data sources, data inadequacies, and options for remedying deficiencies.

Information about the study, "An Action Plan for the Establishment of a Minimum Nursing Data Set," is available from the Division of Nursing, Health Resources and Services Administration, Room 5C-04, 5600 Fishers Lane, Rockville, MD 20857, telephone (301) 443-6315.

—BLAKE CRAWFORD, Public Affairs Specialist, Office of Communications, Health Resources and Services Administration, Public Health Service.

WHO To Intensify Campaign Against Drug Epidemic

The World Health Organization (WHO) has announced plans to intensify its activities at all levels to fight the global drug epidemic.

In a summary plan presented to the United Nations General Assembly Special Session on Drug Abuse in February 1990, WHO outlined its intentions to reduce the demand for drugs and control the supply of psychoactive substances.

Based on current trends, drug abuse is escalating, both in countries where there has been a long history of problems, as well as in countries which were previously relatively free from drug abuse. Counting all those who abuse drugs, or are dependent on them, the world total of those afflicted could be in the hundreds of millions. Although it is difficult to quantify the number of persons abusing drugs, the United Nations has estimated that there are more than 5 million injecting drug users in the world.

In addition, the global epidemic of drug abuse threatens to expose millions of people to an explosive spread of HIV infection and AIDS.

The intensified WHO program will have three main objectives:

1. To prevent the spread of drug abuse in individuals, families, communities, and countries;
2. To develop effective approaches to the treatment of drug dependence and associated diseases; and
3. To collaborate in controlling the supply of licit psychoactive substances.

WHO is uniquely placed to monitor and assess the world's drug problem and play a leadership role in mounting a speedy and appropriate response. Its vital role in the worldwide effort to halt the spread of AIDS has already demonstrated WHO's capacity to act swiftly and efficiently. Through promotion of the key role of the health sector, WHO can lead in mobilizing, supporting and sustaining effective action to reduce the demand for drugs, from the international to the community level.

Proposed Activities

The WHO program for drug control will involve elements including

- promoting effective prevention programs at the community level, as well as in the workplace, and strengthening the

capacity of families to respond to drug abuse;

- intensifying prevention and treatment of drug injecting behavior in order to slow the spread of HIV and AIDS through sharing of injection equipment;
- expanding contact of drug users with treatment facilities, by assessing their effectiveness and producing guidelines for improving clinical management of drug addicts at every stage of recovery;
- monitoring, assessing, and evaluating the health consequences of the policy options available to WHO's 166 member states;
- developing national systems for assessing health trends in relation to drug use and abuse;
- expanding education and training of health care personnel on the rational use of psychoactive drugs;
- expanding contacts with the media;
- intensifying collaboration with the United Nations system in controlling the supply of licit psychoactive substances.

Future Action to Promote Research

New combinations of psychoactive substances are frequently emerging. The so-called designer drugs are a good example of this trend. So as to be able to develop ever more effective programs of prevention and treatment, WHO is committed to promoting research on drug abuse.

Gaps in current knowledge will be identified and research to fill those gaps will be stimulated. It will lead to new insights about the reasons for the demand for drugs and how best to focus future action.

Notice to Librarians Re Bound Volumes of PHR

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