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Express-News Online Special Feature

In a five-day series, the San Antonio Express-News continues its comprehensive investigation into the spread of HIV and the growing AIDS crisis in a marginalized population: the homeless.

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Prison Aids

Express-News Online Special Feature

Homeless-AIDS a problem that hides in plain sight

By Marina Pisano
Express-News Staff Writer

It's a rainy, bleak day, but it's even bleaker under the expressway bridge near Josephine Street - a nether world of smashed wine bottles, supermarket carts, broken furniture and scraps of clothing arranged with odd neatness.

Photo by Gloria Ferniz
A homeless HIV-positive woman, who was once a surgical nurse and does not want her face shown, walks amid her space under a San Antonio highway bridge.

Suddenly, a mound of grimy blankets stirs. A woman with sleep-tangled blond hair emerges from the black folds, grinning and smoothing out the ancient, stained mattress under her.

This is private space, "home" for the 40-year-old former surgical nurse. She ignores the disheveled boyfriend who has just joined her, ignores the nerve-jarring vibration and loud rumble of highway traffic overhead - and reveals she has HIV, the virus that causes acquired immune deficiency syndrome.

With a fatalism nourished by Thunderbird wine and the streets, she refuses to go to a shelter. And she refuses AIDS drugs, saying they make people sick. Meanwhile, the virus batters her frail body.

She accepts her prognosis with a raspy laugh and a shrug.

"I'll probably die right here under the bridge."

The nurse has plenty of company - people living and dying on the edge.

Homeless Americans have become a growing repository of HIV, spreading the virus into a marginalized segment of the population. They have limited access to treatment to improve their lives and prevention to limit exposure to others.

In San Antonio, HIV has spread to almost 2,800 homeless people, a whopping 16 percent of the total homeless population of 17,274, according to the city Department of Community Initiatives.

The number of homeless people with the virus represents 25 percent of more than 11,000 HIV cases in San Antonio. About 1,400 San Antonians suffer full-blown AIDS.

Estimates for the number of homeless people infected nationwide range from as low as 5 percent to 21 percent in some cities, according to studies by independent researchers, the Centers for Disease Control and Prevention and the federal health and housing departments.

Among the general population, the infection rate is less than 1 percent.

"Anyone who can't see the public-health issues in this has got his head in the ground," says Don Maison, founding executive director of AIDS Services of Dallas.

The grim scene under bridges and in alleys of American cities contrasts with rising hope among other HIV carriers for a life prolonged by a new class of drugs. For many homeless, those treatments are as far out of reach as a brick bungalow in the suburbs.

Often scorned by other street people and isolated from families and friends, many HIV-infected homeless are not only sick and malnourished, but sexually promiscuous, hooked on drugs or alcohol and mentally ill - all barriers to controlling the epidemic.

To many who assist the homeless, it's hard to look at the infected, multiple-diagnosed homeless and fragmented public services and not think the proverbial sky is falling.

"Sometimes you have to say that to get people's attention," says Dr. Andrew Moss, principal researcher in a seven-year study of infected homeless people at the University of California's San Francisco General Hospital. "But the sky isn't falling.

"The sky already fell."

Outlook dim

Public health and housing agencies have taken notice and are spending more money to corral the street epidemic. But the overall outlook remains discouraging:

- Researchers fear welfare reform will increase the rolls of the homeless, a surge that could coincide with more HIV infections caused by relaxed attitudes toward the virus. San Antonio's homeless population rose 5 percent from 1995 to 1996.
- Most medical treatment for the homeless comes from hospital emergency rooms, drop-in community clinics or the jail infirmary - if they receive any at all.
- Most cities suffer a shortage of transitional and long-term public housing, a gap experts say is the greatest single barrier to effective care of the HIV-infected homeless.In San Antonio, only 25 emergency shelter beds are specifically set aside for homeless-HIV/AIDS patients (at Casa Martin), and only a few of 24-hour beds are available in other shelters for people too sick to be on the street all day.
- As HIV gains ground on the street, so do opportunistic diseases such as tuberculosis. And TB - highly contagious through coughing and sneezing - could be a potential problem for the mainstream population.

Infectious-disease specialists differentiate between TB infection and TB disease, noting that not all who carry the infection develop the disease. But studies show HIV infection is the strongest-known risk factor for the development of TB disease in such carriers.

"Homeless people with AIDS are much more likely to get TB, and

TB is more easily transmitted than HIV. Lately, there's also more concern about drug-resistant TB," says Dr. Dennis Culhane, associate professor of social work and public policy at the University of Pennsylvania, who is studying the infected homeless in Philadelphia.

Dr. Fernando Guerra, director of the San Antonio Metropolitan Health District, estimates up to 10 percent of the homeless carry TB, compared with 4 percent in the population overall.

Researchers fear far-reaching implications.

"This (AIDS) is an epidemic, and you can't control its transmission when people are transient and homeless," Culhane observes.

Photo by Gloria Ferniz
Concerned that police will see his open beer, container, Randy Willey - who has AIDS - hides it in a downtown alley before looking for a place to relieve himself.

Growing public apathy presents another concern. If support wanes for homeless programs, social workers fear lawmakers will back off from model outreach efforts now under way.

The Winter 1997 Harte-Hanks Texas Poll showed 48 percent of Texans thought homelessness was a serious problem in their community. Nine years ago, 85 percent thought it was serious.

If anything, experts predict, homelessness could reach new highs as welfare reform puts more people onto the streets.

In a report last year by the U.S. Conference of Mayors, service providers in San Antonio and virtually all 29 cities surveyed said they expect to see increases in homelessness and hunger as a result of welfare reform.

San Antonio saw the largest jump - 36 percent - in requests for emergency shelter over the previous year among cities surveyed.

"There is absolutely reason for alarm," says Dr. Steven Goldfinger of Harvard Medical School and a senior psychiatrist at the Massachusetts Department of Mental Health. "Welfare reform is going to drive up the number of homeless people, dramatically."

The scope of HIV

Welfare reform is just one of the controversies facing homeless advocates. Some experts also debate the scope of HIV infections on the street.

In San Antonio, Dr. Guerra estimates the homeless infection rate at 5 percent or less, and he argues that social programs have inflated the number. No health district study has been done to confirm his estimate.

"If it were as high as they say, we'd end up having to quarantine people," he says.

But Rolando Morales, acting director of the San Antonio Department of Community Initiatives, says his department's figures - representing the 16 percent infection rate - are unduplicated counts from health and social-services providers.

Goldfinger says the HIV-infection rate is rising in the general population and among the homeless, paradoxically, partly because of recent breakthroughs in treatment.

"We are seeing people no longer viewing AIDS as a death sentence and saying, 'Oh, it will take 10 years before I'm sick, and, by then, they'll have new treatments.' Adolescents are particularly vulnerable because they think they're going to live forever."

Studies show men are more likely to get infected through intravenous drug use. But, a troubling two-thirds of homeless women in some studies had - as their only risk factor - heterosexual contact with a person at unknown risk for HIV.

For the nurse and many homeless women and men, trading sex for money, shelter or food is a means of survival.And it's a survival strategy that can end up killing them - and others.

A real threat

To anyone who thinks HIV-infected street people scrounging for Dumpster scraps and sleeping in doorways are far removed from "nice folks," says Jesse Sanchez, think again.

"I can drive down Broadway at night and see three people who I know are infected. Some of them I recognize from our food bank. And they are out there soliciting. They do what they have to do to survive," says Sanchez, executive director of the Hispanic AIDS Committee, which runs Casa Martin.

And, safe sex is not a major priority among the homeless.

The pleasure-seekers who pick them up may go on to other sexual encounters, spreading the virus. They may drive back to middle-class homes and families.

While AIDS itself can trigger a loss of income and resources and the descent into homelessness, the process works both ways. Advocates say more people are already on the streets when they get the virus.

Drawing from interviews with homeless people living with AIDS, Culhane in his study found women were overrepresented in the AIDS population that subsequently became homeless. The argument could be made, he says, that women usually have lower incomes than men to start with; so more wind up poor and on the street.

Real numbers

The state plans to use Culhane's computer program model to get its first solid number on homelessness, the Texas Count Project, says Ann Denton, who works on housing programs for the homeless for the Texas Department of Housing and Community Affairs and the Interagency Council on Homelessness.

President Clinton's new National AIDS Strategy, presented last December, addresses HIV-infected homeless with addiction or mental-health problems.And recently, the government's housing, social services and health agencies joined in an effort to improve delivery of health care to HIV-infected persons, including the

homeless and others at risk.

"This is the first time that a public-health agency has gone outside of the public-health community and linked with another agency. For us, that's very exciting," says Barney Singer, who directs the Health Resources and Service Administration's Special Projects of National Significance (SPNS) programs.

Collaborative grants have been awarded to Baltimore and San Francisco to develop programs handling the complicated needs of the HIV-infected homeless who also have addictions or mental illness. Stepped-up outreach under the expressways and in soup kitchens draws street people to a central site or to SRO (single-room occupancy) hotels for team-delivered services.

Some $4.2 million in funding is coming from the Ryan White Comprehensive AIDS Resources Emergency Act over the next five years. HUD is kicking in $7.1 million through its Housing Opportunities for People with AIDS program (HOPWA) to the two cities and six other projects.

San Antonio is not one of the collaborative grant cities. But as part of the overall community-grant initiative, the University of Texas Health Science Center at San Antonio received $400,000 for La Frontera, a partnership with community organizations that serves migrant and seasonal farm workers with HIV/AIDS.

One bright spot

Fred Karnas, the HUD deputy assistant secretary overseeing homeless programs, points to one bright spot in the fiscal and philosophical assault on public-housing programs.

"Homeless programs have (more than) doubled in the past three or four years," Karnas says - from about $100 million in funding in 1993 to $204 million in the 1998 budget.

Karnas is convinced Andrew Cuomo, the new HUD secretary, will follow the lead of former boss Henry Cisneros in advocating for the homeless. Cuomo has met with members of President Clinton's AIDS advisory council to discuss housing issues.

HIV-homeless advocates aren't so optimistic, fearing a congressional assault on Section 8 and other public-housing programs that will make already scarce stable housing even scarcer for street people.

On the street, advocates see a medical-ethical issue in getting the potent multiple drug therapies using protease inhibitors out to the homeless. The therapies are prolonging life for many with AIDS.

More official attention

One indication of increased official attention to this complex issue is the Community Team Training Institute on Homelessness being held in Washington through Tuesday. A collaborative between federal housing and health agencies, the institute and representatives from five communities are discussing the needs of homeless people with multiple disorders, including HIV/AIDS.

Whatever comes down, cautions Richard Sorian, former spokesman for the president's Office of AIDS Policy, which

coordinates federal efforts, "One thing we don't want to do is pit the mainstream population against the homeless in all this."

Agreeing is Jerry Permenter, executive director of the Alamo Area Resource Center, an agency providing many social services to people with HIV/AIDS."

We shouldn't get bogged down in the politics of blame that has affected our handling of AIDS," says Permenter, who believes tackling the homeless-HIV issue starts with caring.

"There are a thousand reasons to care. (It's) just our basic human instinct and compassion."

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The nurse

By Marina Pisano
Express-News Staff Writer

She was - is - a pretty woman with delicate features and long blond hair, and when the Thunderbird wine starts kicking in, she's animated and chatty and fun to be with.

Photo by Gloria Ferniz
The nurse tries to stay warm in the afternoon sun after a night of near freezing temperatures last winter.

Fun if you ignore her terribly thin, frail-looking body. Fun if you don't notice the unhealthy cast to her fair complexion. Fun if you don't think about the fact that this charming woman is a 39-year-old homeless person with AIDS seated on a dirty mattress under an expressway bridge.

It's a million miles from the comfortable life she once led.

"I grew up in a nice family (in Detroit). Big-time rich. I can't think of anything I didn't have - except a swimming pool. What happened was, I was a nurse, and I stole drugs at the hospital," recounts the woman who asked to remain anonymous because she has friends in nursing here.

"I worked on the surgical floor, midnight shift. All the IV painkillers the patients didn't ask for, I signed out for them, but I used them myself. I got addicted and lost my (nursing) license."

A costly addiction

Addiction cost her not only her profession, but her family. When she left Michigan she also left behind a broken marriage and a daughter, now a teen-ager living with her paternal grandmother.

"She's doing fine," the nurse says of her daughter, picking up the story."I came here with my boyfriend (about four years ago). We had money. We were working, but he got murdered. If I knew who did it, I'd kill them," the nurse says, convincingly.

Things fell apart after that.

"I got HIV from this guy who got it five years before even meeting me. He got real sick and was throwing up blood; so I went to the hospital with him. They said, 'You know what? You're HIV.'

"When they told me he was dead, I said, 'Thank God.' He's going to hell. He killed me - maybe not yet, but . . . . Because this happened, my mom hates me. My whole family hates me. But my mom visits me when I'm in the hospital."

She has been hospitalized more than 14 times in the last two years.

"Over a week stay each time. I've had pneumonia four times. I just

got my gall bladder out. I wait until I'm really sick, and then I call the ambulance. The EMS drivers all know me."

Her case worker at Casa Martin worries because she has had PCP, pneumocystis carinii pneumonia, the most common life-threatening, opportunistic infection associated with AIDS.

But the nurse plays down her condition.

"I almost had that kind of pneumonia. I'm close to that."

Photo by Gloria Ferniz
Appearing before county court at Law Judge Anthony J. Ferro on soliciting charges, the nurse pleads her case to be let out of jail.

She's no longer on Septra, a prophylactic drug to prevent infections such as PCP. She refuses to take AZT or the new protease inhibitors. The reasons defy her education and intelligence.

"They say the new drugs make you live longer. But they make you sick. You lose your hair and look like (expletive). My mother told me not to take the medication. She said it's just like cancer chemotherapy. I'd rather die young."

Living on the streets, having sex with different men, she's vulnerable to more than AIDS-related illnesses, venereal diseases and tuberculosis.

"I got my elbow crushed one night by these two little girl gangbangers. The doctors in the E.R. put seven pins in my elbow. I'm supposed to go back for surgery, but I'm afraid because they said they might have to amputate it. There's no bone left."

She hasn't gone back.

She could go to Casa Martin, the shelter for homeless/HIV-infected people run by the Hispanic AIDS Committee, and get help.

But she only goes to the agency for its weekly food bank and to pick up mail and a Supplemental Security Income disability check each month.

Truth is, she feels bored and confined in shelters and programs. Stressful as it is, she likes the free, unstructured life under the bridge - sharing a bottle of cheap wine and a cigarette, exchanging stories with street buddies, people-watching, eluding the cops at the Stop-N-Go near the Josephine Street bridge.

"I don't like the rules there," she says of Casa Martin. "They make you go to meetings all day, and then there's AA (Alcoholics Anonymous) and NA (Narcotics Anonymous) meetings, and you have to be in at 10 o'clock (p.m.). It's like being in jail."

Her boyfriend - also homeless and HIV-infected - was at Casa Martin, where alcohol and drugs are banned. But, she "rescued" him, as she puts it. He went back for a time but soon rejoined her.

Impermanence is the one constant in her life.

For a time, she rented a front room in an old house. But the once stately, now-decrepit, white-columned home is slated to be condemned.

"I find places to stay," she says. "But I always end up getting evicted because of homeless people I know. These (expletives) always find me. The landlord complains there's too much traffic in and out. Then I end up going back to the bridge."

Photo by Gloria Ferniz
The nurse and Smokey, with whom she had a brief relationship, chat in a vacant lot near U.S. 281 and Josephine Street. Smokey, a Houston man, chose to become homeless for awhile to be near the nurse, but eventually left because of her alcohol abuse.

A long arrest record

The nurse calculates that she has been in jail more than 30 times. Arrested by vice cops several months ago on two charges of soliciting for prostitution, she sits in jail for a couple of weeks before going to court. Alone and dressed in blue prison clothes, she looks like a weary child who has stayed too long at a theme park.

She pleads no contest, and Judge Anthony J. Ferro, noting her homelessness, orders her to pay court costs and serve 20 days in jail, including time served.

She doesn't deny having sex with lots of men, but she denies soliciting and rejects any suggestions of revenge sex.

"I'm very angry, but I'm very over it. I'm not out to hurt any man. They know what I have. If they want to wear a rubber when we have sex, let them. Anyway, a woman is not going to give it to a man unless he has open sores, something to contact blood. I know that from teaching it as a nurse."

AIDS experts confirm it is more difficult for a woman to transmit HIV to a man.

Her case worker says she does solicit sex and has infected several homeless men.

On the street, rationalization comes easy. But there's no talking away AIDS.

"I don't do drugs anymore," she insists. "I just drink, but I don't get drunk. But I do feel like I'm getting sicker. When I start thinking about seeing my mother, you know it's getting bad."

"The freedom is all I like about being out here," she says of the streets, her eyes filling with tears. "But I'm very nervous, and I'm very scared of dying."

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Prison Aids

Express-News Online Special Feature

Often AIDS is secondary to finding a place to sleep

By Marina Pisano
Express-News Staff Writer

Every day, the homeless encounter enormous obstacles to effective treatment for HIV and AIDS.Lack of basic hygiene and nutrition. Drug abuse. Alcoholism. Mental illness.

But, as health officials and advocates for the HIV-infected homeless population emphasize, by far the greatest single barrier to rehabilitation is the absence of stable, sustained housing.

"If an individual has HIV and has substance abuse and is homeless, HIV is not the first problem they confront every day. It's waking up under a bridge," says Barney Singer, director of the Special Projects of National Significance programs of the Health Resources and Services Administration (HRSA).

Photo by Gloria Ferniz
Randy Willey, a homeless man with AIDS, sleeps in the doorway of a soup kitchen after a long night of drinking.

We can't deal with health problems until we can get their housing stabilized."

The reality is that without a place to stay, without a reliable schedule of meals, it's difficult for even highly motivated patients to comply with complicated, rigorous multiple-drug regimens required for AIDS treatment.

Yet studies show that 33 percent to 50 percent of people living with AIDS are either homeless or in imminent danger of becoming homeless.

The scarcity of housing in San Antonio for HIV-infected homeless people and, indeed, all of the homeless, was brought home in a report from the U.S. Conference of Mayors released last December.

The city's Department of Community Initiatives counted 1,278 emergency shelter beds in San Antonio in 1996, including those for families. The city's homeless population was more than 17,000.Only 25 of the shelter beds - all at Casa Martin - are reserved for the 2,800 homeless people in San Antonio who are infected with HIV.

Sheltered lives

Case managers working with homeless men and women find they often refuse to go to shelters, preferring their freewheeling street life over shelter rules.

These facilities aren't supposed to discriminate against someone

with HIV/AIDS. But those who present a risk of transmission are barred - such as John Robert "Cowboy" Jones, a razor-wielding self-mutilator.

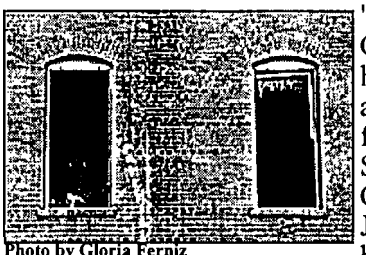

Photo by Gloria Ferniz
An abandoned hotel at Pecos and Commerce streets occasionallly is occupied by some of downtown San Antonio's homeless.

"I've been in the shelter when Cowboy said he was gonna cut himself, and people just backed away, scared of all the blood flyin'," one homeless man says. A San Antonio Metropolitan Ministry Center shelter employee confirms Jones was asked to leave because he was a danger to others.

On the other hand, many of the infected homeless interviewed say they feel unwelcome, ostracized and even victimized in shelters. Some say shelters offer minimal help.

"Being here is like living on the streets anyway," says a frail-looking Cuban-born man with AIDS at the SAMM Center who didn't want his name used. "What good is it if I have to be out on the street again by 6 o'clock (a.m.)? I'm sick."

The SAMM Center sets aside 15, 24-hour beds for women and men who are sick, often those recovering from hospital stays. But they must have a doctor's letter, and most infected homeless people don't see doctors regularly, if at all.

And there is risk for the infected as well.

Fred Karnas, the deputy assistant secretary overseeing the U.S. Department of Housing and Urban Development's homeless programs, says shelters are doing heroic work.

But, truth be told, he says, "Health is compromised in these large open settings. Shelters are not healthy places to be."

For anyone with an HIV-weakened immune system, dormitory-type shelters increase exposure to potentially life-threatening communicable diseases, such as tuberculosis or hepatitis.

Shelter alternatives

Casa Martin, named for a now-deceased, 28-year-old who was rejected by his family, prides itself on a more homelike setting. Since opening its doors four years ago, it has served more than 600 people, including families.

Jesse Sanchez, executive director of the Hispanic AIDS Committee, which operates the facility, says the shelter this summer had to turn away families for the first time.

Residents enter a highly structured program that begins at 6 a.m., providing case management, substance-abuse counseling, dispensing of prescribed AIDS medication by on-staff nurses and other services for three months - all at no cost. Non-residents get case management and groceries.

HUD money

Casa Martin has a new $67,000 grant from the Texas Department of Housing to hire a registered nurse for basic non-AIDS medical care and to pay the first month's rent for transitioning clients.

Most of its funding - about $216,000 - comes from HUD's Housing Opportunities for People with AIDS program (HOPWA) through the city's Department of Community Initiatives.

Established by Congress in 1990, HOPWA is the only federal housing program providing comprehensive community-based housing specifically for HIV-infected people. Support, social and health services are funded as well.

Such community-based programs are vital, says Karnas. HOPWA was funded at $204 million for fiscal year 1998, an increase over previous years. Most of the money is spent based on a formula using total AIDS cases and competitive bidding.

"Ninety percent of that money goes to communities based on a complicated formula," he explains. "You have to have over 1,500 AIDS cases. About 80 communities are eligible. The other 10 percent of funding is awarded on a national competition."

Karnas notes that other HUD programs fund a continuum of housing strategies for the homeless, working with community nonprofit agencies.

They include Shelter Plus Care, which funds rental assistance and supportive services, targeting persons with disabilities, including HIV/AIDS; and the Section 8 Single Room Occupancy (SRO) Moderate Rehabilitation Program, which provides long-term rental assistance for SRO units.

Funding cuts feared

But AIDS-housing advocates point out that HOPWA increases actually are going toward newly eligible cities. And they fear deep cuts in other public-housing programs for the homeless.

"The biggest problem we see is that - best-case scenario in Congress - HUD will be flat-funded in order to just fund existing Section 8 and existing housing authority projects," says Betsy Lieberman, executive director of AIDS Housing of Washington state and a nationally recognized expert on the subject, who advises agencies in other states.

Karnas admits, "Separate from the homeless programs and HOPWA, the big issue is Section 8. If we don't solve Section 8, all the other programs will be under huge pressure. But, I feel recognition of housing needs (in Congress) is better than it has been in the past."

House of Hope

One example of a long-term housing program locally is House of Hope, founded by Raye Hall in 1989 in memory of her son, Robert, who died of AIDS.

House of Hope receives $75,000 a year from HUD programs, including HOPWA money, through the city's Department of Community Initiatives. It owns 19 multiple-family properties for the disabled/HIV-infected in San Antonio, with five more units in

Corpus Christi. About 30 House of Hope dwellings are home to HIV-infected people and families.

"They (tenants) pay 30 percent of their net income (in rent)," explains Hall, who has strict rules against alcohol and drug abuse. She said the money usually comes from the federal Supplemental Security Income disability program. "Some are able to work. If their income is zero, we help them get on disability. If they're not eligible for disability, they need to get a job. We don't believe in coddling people if they can work. Our average (resident) income is less than $500 (a month)."

Jerry Permenter, executive director of the Alamo Area Resource Center - which offers hot lunches, counseling, transportation and financial assistance for the HIV-infected - uses HOPWA emergency assistance funds to lodge homeless persons in motels for a few days. It's a short respite from life under the expressways, vital in colder weather.

"We rotate that among people who need it. We also have a small benevolence fund for this purpose - under $2,000. Demand is high," Permenter says.

Not enough beds

Longer-term housing for the homeless generally is inadequate. According to figures from the Department of Community Initiatives, 332 transitional-housing units were available for individuals and families in 1996. In addition, 88 SRO units were in hotels.

As HUD's Karnas sees it, "The answer isn't more emergency shelters."

Instead, the latest strategy is to come up with low-income or assisted housing that is stable, long-term and closely tied to health care, addiction programs, psychiatric care and other social services.

Photo by Gloria Ferniz
Jesse Sanchez, executive director of the Hispanic AIDS Committee, listens to a couple of Casa Martin residents lying in the lower bunks. There are 25 beds in the Casa Martin shelder for AIDS and HIV-infected homeless.

Right now, shelters make referrals to other agencies for such services, but experts say teaming them at one site, or taking the combined services out to the homeless, will work better.

HUD and HRSA oversee grants to Baltimore and San Francisco for pilot projects following that model.

Drugs and street life

Many doctors won't even prescribe the powerful and expensive protease inhibitor-antiviral combinations for AIDS patients without some assurance of sustained housing to aid compliance.

Some AIDS drugs must be taken before eating, some with food. Some need to be refrigerated - something that can't be found on the streets.

It's crucial to take the protease inhibitors as directed, explains Dr.

Jean Smith, associate professor of infectious diseases at the University of Texas Health Science Center. If patients take them incorrectly or suddenly stop, they may develop a drug-resistant strain of the virus, dooming chances of future treatment for themselves and others.

A roof and bed are not just warm, fuzzy notions, says Karnas.

"Housing is a medical issue."

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Express-News Online Special Feature

Cowboy

By Marina Pisano
Express-News Staff Writer

He looks as if he might have worked horses in Montana or someplace, and he did for a while.

Nowadays, John Robert "Cowboy" Jones - wiry, weathered-looking, dressed in worn jeans and boots - spends his days ranging over downtown side streets. Nights, he often beds down across from the Greyhound Bus Terminal on a concrete ramp behind a fast-food restaurant.

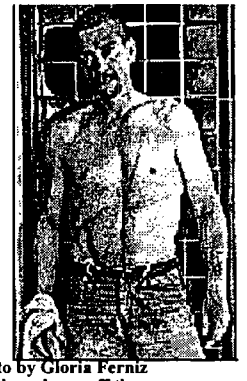

Photo by Gloria Ferniz
Cowboy shows off the scars across body from his self-mutilation.

He avoids shelters.

"In the shelter, I'd pass out drunk and wake up robbed of my money," he explains. "Anyway, they don't like to let me in ' cause of all the cuttin, (self-mutilation) I've done. They're afraid of the blood."

As Cowboy, 39, tells it, the trail to homelessness, self-mutilation and HIV infection has been a lonely, bruising ride at full gallop.

"All my life, I was mad and angry because of the life I got given. The folks who adopted me beat me, molested me, abused me - physically and mentally. Our family doctor molested me when I was 12."

As for getting infected with the virus that causes AIDS, "Who knows where it came from," he says, almost disinterestedly. "It was my promiscuous lifestyle. I was a homosexual prostitute. I was involved in pornography. I was a dope shooter. I had sex with women whenever I wanted.

"I gave it to my wife," he adds. "She said I was a (expletive) and told me to get the hell out of her life. But she knew from the git-go what I had. She said, 'We'll die together, honey.'

"It's been seven years since we broke up."

Sitting in the warm afternoon sun on the step of Community Ministries Center on North Alamo Street playing a harmonica, Cowboy looks peaceful enough.

"Sounds good. Got a good beat to it, doesn't it?" he says of the vaguely familiar tune he's blowing into the harmonica. He pulls out a collection of six or seven harmonicas from the large cloth tote bag that contains his world.

But sometimes, when his "medication" isn't working right, Cowboy gets loud and unpredictable, possibly dangerous.

His medication is speed."Crystal Meth(edrine). Speed kills. It makes some people crazy. But, it just calms me down," he claims.

God and sharp weapons

Truth is, the musician is on intimate terms with two verities: sharp weapons and the piercing word of God. He frequently quotes scripture from a small, marked-up, green-covered Bible he carries - a gift from a bikers-for-Jesus group.

"When they first told me in 1982 I was HIV, I went weird. I was an evil person. I didn't care who I gave it to. I went up and down Corpus Christi beatin' up anybody I felt like hittin'. I was ready to kill anybody who walked the face of this Earth. I was puttin' people in the hospital.

Photo by Gloria Ferniz
Cowboy heards for 'the freeway' after a man stole his money promising a nonexistant job.

"I tried to hurt myself. I broke bottles over my head. I was what they call - what is that word? Not suicidal but a self-mutilator. I cut myself all over my body. Used a razor or a knife. Once in Billings, Mont., I almost cut my jugular (vein). I was that close to death. Another time when I was stoned on pot, I took a (electric) saw and tried to take a cast off my arm. Almost took my hand off - cut the bone. I said, 'Oh, my God. What have I done?'

"He strips off his shirt to reveal more than a dozen scars from self-inflicted cuts on his abdomen, chest, neck and arms.

After one self-mutilation incident, Cowboy was taken to the San Antonio State Hospital for a psychiatric examination."They told me, 'You're a little off, but you're not psychotic.' "

Jail and violence

Cowboy ended up in jail late last year for smashing a storefront window. He went into hiding after slashing a man's face with a knife during a fight because the man's friends were after him.

Rage started building in Cowboy early last December, after a burly man called Bear befriended him and promised to take him to a ranch he said he owned in Alaska to care for his horses. It was a chance for a fresh start in a place with no bad memories.

When Cowboy's disability check arrived, Bear asked for money to buy him a bus ticket to Anchorage. But Cowboy never saw his cash or Bear again. Turns out, he had run the same Alaska horse-ranch scam on several other street people.

"Here we are homeless, and we're being victimized," Cowboy said angrily.

In the past 10 months, Cowboy has been run out of Corpus Christi by police, jailed for infractions in San Antonio, sent to the state hospital for observation, released and jailed again for aggravated assault (spitting on a police officer).

Through it all, the only thing Cowboy can count on is his little Bible and his faith.

"Praise God, I quit being a drunk and evil-minded," he says. "He's (Jesus is) gettin' to me every day. By golly, there's a change in John Jones. I don't like drunks. I used to be like 'em. The police tell me, 'We like you now that you're not drunk, John. Cool. Go on and have a nice day.' "

Photo by Gloria Ferniz
Cowboy shows off the three most impartant things to him: his boots, his harmonica and 'the Word,' in the form of a religious pamphlet.

No medicines

Cowboy doesn't take anything to fight AIDS because, he says, Jesus - the ultimate protease inhibitor - is on the case.

"I don't get any medical treatment. Don't need it," he explains. "I'm not gonna die of AIDS because Jesus healed me. By his stripes, he healed me. I believe he did. But, they keep coming back with a positive reading. I can't explain it. I don't know what God's planned."

Cowboy was rushed unconscious to University Hospital in early September. The doctor told him he had bacteria in his lungs and put him on antibiotics. His hepatitis was getting better, but his viral load, the amount of HIV in his blood, was high. He refused AIDS medication but demanded the doctor tell him his T-cell count. Cowboy's count has been as low as zero, well below the 200 level for full-blown AIDS.

He senses his life is rushing toward an ending straight out of "the scary book" in the Bible - Revelations.

"You can't tell by looking at me, but I'm movin' fast. I'm ridin' a fast train. Sometimes it slows down like a little roller coaster. Then it goes back up again.

"I say, 'Lord, don't let me die like this.' But he's not gonna let me die like this. Y'all are my sisters; so I'll tell you. He talked to me on paper. He told me he had called me and loved me, but his patience was runnin' out fast."

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Prison Aids

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AIDS drugs offer hope but new treatments for homeless raise questions

By Marina Pisano
Express-News Staff Writer

With recent advances in the treatment of AIDS , the stakes have changed dramatically for both the HIV-infected homeless and public policymakers.

"It used to be we'd rehabilitate them out of homelessness - for what? To die of AIDS . That's changing. People are living longer," says Rolando Morales, who oversees homeless programs for the San Antonio Department of Community Initiatives.

New drug therapies combining antivirals such as AZT and DDI, and protease inhibitors such as saquinavir and indinavir, aren't cures. But doctors are finding that for many patients, they are a way to turn certain death into a chronic illness to be lived with for years.

Protease inhibitors slow the pace at which HIV makes new copies of itself. Effects are tracked by measuring the viral load, or the amount of HIV in the blood.

Stunning declines in blood viral load, in some cases to zero, have been seen, though experts caution the virus may remain somewhere in the brain or other organs.

Though the shortage of long-term, stable housing among the infected homeless is the biggest obstacle to state-of-the-art medical care, some researchers are having limited success with treatment.

"Living under a bridge doesn't mean they can't follow a routine," says Dr. Joshua Bamberger, a researcher and clinician at the University of California's San Francisco General Hospital. "I'm not saying it's common or easy. But, some people are remarkable at being able to organize their lives around pill-taking."

Still, additional addictions and multiple health problems among the homeless , coupled with the stigma of AIDS , make the triumphant march of medical science academic.

Most infected homeless people receive their only health care in hospital emergency rooms or walk-in clinics. Some don't know they are HIV-positive until they become sick with AIDS -related diseases, such as pneumocystis carinii (PCP), pulmonary tuberculosis, recurrent pneumonia or invasive cervical cancer.

A vicious circle The toll of street life is easy to spot, says Dr. Jean Smith, an associate professor of infectious diseases at the University of Texas Health Science Center in San Antonio. She treats many homeless AIDS patients at the downtown FFACTS

clinic - Family Focused AIDS /HIV Clinical Treatment and Services.

"I remember one (infected homeless) man who came in terribly emaciated," Smith says. "He had thrush in his mouth and horrible esophagitis; so he couldn't swallow anything. Our social workers got him a place to stay. We got him on medication, and two weeks later he was doing much better. Then, he disappeared.

"I didn't see him again for four months, and then he showed up in the E.R."

The man's medical condition had again deteriorated, Smith says.

Physicians treating these patients often find tuberculosis as well. While not everyone who carries TB infection actually develops the TB disease, the progression is far more likely in the HIV-infected, whose weakened immune systems mean they become sicker, faster.

Clinic social workers used to refer HIV-homeless patients to the San Antonio Aids Foundation, which has skilled nursing care. But, the foundation now offers residential hospice care mainly to those in final stages of the disease.

"The last stages of AIDS come a whole lot faster when you don't have tender-loving care," says Raye Hall, who runs the nonprofit House of Hope, a more permanent housing program for homeless people, most disabled by HIV/ AIDS .

"I would say the average person living on the streets with AIDS - you'd be lucky to live six months."

Toxic treatment While some people make it into clinics, others walking the streets with the AIDS virus get their only medical treatment when they're arrested by police and jailed.

"We are seeing more and more who are infected come in here, including women who are picked up for prostitution," says Dr. John C. Sparks, who directs Bexar County's 84-bed jail medical facility. "We always have three or four people in the infirmary who are at a stage where they have very little immunity left; so we segregate them to protect them from disease."

Booze and drugs

Among the obstacles to effective treatment are alcohol and drug addiction - the very behaviors that frequently land people on the streets.

Indeed, the two biggest entry points into homelessness are prisons and substance-abuse treatment centers. Intravenous drug use and unprotected, promiscuous sex, endemic on the streets, are the most frequent modes of HIV transmission.

Smith says booze and drugs directly collide with advanced, multiple drug therapies.

"All these protease inhibitors are liver-metabolized, and alcohol can complicate that. Some people abuse drugs; so they abuse AIDS drugs. They think taking twice as much is better, but with some of these medications, you increase the toxicity when you

take more."

Dr. Elena Villavicencio, who treats some shelter residents at the Camden Clinic, insists patients be stable and sober before she will prescribe the multiple-drug AIDS therapies.

"They need to have a healthy lifestyle to do this. They can't be drinking or using drugs," she explains, adding, "We give patients lots of support in this with nutrition and psychological help." Mental illness is yet another huge barrier to effective medical treatment and compliance.

It's common to see delusional street people talking to themselves or acting out. Fully one-third of the homeless have a major mental illness.

"Not just mild emotional disorders," says Dr. Steven Goldfinger of Harvard Medical School, who has researched psychiatric problems of the homeless . "But severe manic-depressive disorder or schizophrenia."

The combative, unruly, sometimes psychotic behavior of mentally ill homeless people bars them from some shelters for safety reasons - excluding them also from available social services and health-care agencies.

Then there's denial, not unusual among AIDS patients dealing with a deadly disease, but far more serious in delusional people. Some say they don't believe their HIV test results or T-cell counts. They are convinced they're cured of the virus and refuse medical care.

In addition, AIDS -related dementia may develop and become another impediment.

As Smith points out, "The first thing you have to do with these mentally ill patients is stabilize them with psychiatric treatment."

Success is possible

There are potential successes.

Ruth, one former Casa Martin resident in San Antonio, says she was infected by her abusive husband and fled home with her two children, now 16 and 11.

With the new combination-drug treatment, her viral load -the amount of HIV virus in the blood - has dropped from a count of several hundred thousand to 7,000. Her T-cell count has soared from 88 to 488.

T-cells are white blood cells that play a crucial role in regulating the immune system. Anything over 500 is considered normal, and healthy people usually have counts of about 1,000. Full-blown AIDS is defined as a count under 200 with the presence of certain AIDS-related illnesses.

Ruth moved into an apartment with HIV-infected boyfriend Jose in January. Doctors say his viral load is now undetectable, thanks to protease inhibitors, and he is working again.

Ruth has gained weight and feels healthy enough to volunteer at the Casa Martin food bank.

"In the beginning, I was afraid because I thought I was going to die right away," she says. "But, with the new medication, I hope to live for many years.

And for the first time since becoming infected andhomeless , Ruth is allowing herself and her children the luxury of hope.

Fragmented help

Fragmented help Not all patients respond so well to the potent drugs. Others improve, only to become sick again if the medications stop. Long-term effects aren't fully understood.

The lack of a well-developed, coordinated public-health strategy among agencies remains a barrier to offering anything beyond crisis care. Homeless people with no calendars or clocks and few coping skills can't make connections or appointments.

But perhaps the ultimate barrier to large-scale treatment of the infected homeless is the enormous cost - $15,000 a year or more for multiple drug therapies and six-figure annual health-care bills for each person with AIDS .

The FFACTS and Camden clinics treat patients without money or insurance. And, for people without insurance or Medicaid who qualify, Texas has a prescription-drug assistance program to help pay for expensive medications.

But some question whether public money should be spent on the homeless - people who often won't obey shelter rules, won't get drug or alcohol-abuse counseling and won't take medications.

"I do not think that we should spend our tax money on anyone who will not take care of themselves and obey shelter rules and take some responsibility. Giving them the new medications would be like pouring money down the drain," argues Hall of the House of Hope. "We have rules, we expect people to abide by those rules."

Others, such as Jerry Permenter, executive director of the Alamo Area Resource Center, which provides services to HIV-infected persons, see things differently.

"Health care in this country should be a civil right," he flatly declares.

Doctors and researchers raise deep concerns about the ethics of denying life-prolonging AIDS treatment to people on the margins of society - in effect, making the homeless a disposable subclass.

Goldfinger says there isn't a prayer things will improve until awareness increases of the HIV-infected homeless issue and its public-health and social implications.

"This is an intensely complicated social, political and medical issue," Goldfinger says.

There's no quick, neat solution or single piece of legislation to fix things. And, given the tight fiscal and political climate, not much optimism about bold solutions to this complex problem.

"Most localities do not have the funding or the political will to provide quality care to this population," Goldfinger ventures. "For someone on protease inhibitors and AZT with any kind of reasonable care and follow-up, the medical costs can run more than $100,000 a year. We don't even want to spend that on taxpayers."

Still momentum for action is building.

Cities such as San Francisco and Baltimore have come up with integrated-service pilot projects that may get more HIV-infected homeless to come in out of the cold for effective care.

For the HIV homeless , time is running out.

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Randy

By Marina Pisano
Express-News Staff Writer

"You're lookin' good today, honey. You're lookin, fine."

Randy L. Willey turns on the old male charm as a woman gets out of a nearby car, but the worn-out line is a triumph of reflex over reality.

It's not likely the woman is going to look at a shabby, bearded street person dressed in a bizarre-looking, long, red woman's coat and hurling jeremiads. The preppy striped shirt he wears isn't likely to fool her for a second.

Resigned to rejection, Randy, as a point of pride, pulls an old driver's license out his pocket.

"This is what I used to look like," he says, smiling and fingering the face of a handsome, clean-shaven young man with startling green eyes and sandy-colored hair. "Looked like a movie star, didn't I?"

The photo was taken after the abuse at home but before years of drugs, promiscuous sex and scruffy life on the road took their toll.

At 34, Randy is homeless and has AIDS. His wild temper has made him unwelcome at the very places that might help him. He's scary. And, sometimes, he's scared.

"I pull my own teeth. (He keeps a self-extracted molar on a string.) I sew my own wounds when I get shot or stabbed. Everytime I try to go get help, they say, 'Step on the property, you get arrested,'" he sarcastically parrots people who have driven him out of one clinic or agency after another.

"Try to get my teeth fixed - try to get medical treatment - 'Step on the property, get arrested.' Oh sure, I get AZT. Yeah, right. People are knocking themselves out trying to give me stuff."

Life, as he recounts, started out bad and got worse fast. "I'm from Lincoln, Delaware. I've been on my own since I was 11. I've gone coast to coast 22 times. It finally caught up with me because I've done everything imaginable. You name it. Only thing I never done was stick no needle in my arm. That's why I never did heroin. Now they keep stickin' needles in my arm to draw blood. I can't stand those damn needles.

"The lover I was with did drugs. That's how I got (HIV) infected - about 12 years ago. I didn't do nothin' about it because I was in denial. When he died (in 1995), I knew. He died a horrible death because he trusted AZT and those damn drugs. Just made him die faster.

"You will never get me to take those drugs. Never," Randy vows. "Those drugs have chemical imbalances that will destroy the

immune system. The government makes those new AIDS drugs to kill us. They say, 'They're faggots. Let's kill 'em off.' Now, there's the truth. God has put the truth in my mind. He talks to me."

Instead of medical science, Randy puts his faith in "beer vitamins," God and terrifying prophesies.

"You know what the antichrist is? Heaven and hell. Here I am. Here I sit. Heaven and hell. And, I'm not going anywhere. Not yet. That's the truth. Believe it or not. I could tell you things of the universe that you would not believe.

"I can tell you this. In the year 2003, the resurrection starts. Aliens will come. I'll tell you how to destroy 'em in case I'm not around. All you have to do is pour salt on them. Pour salt on them."

One moment, Randy, who usually camps along undeveloped stretches of the river bank downtown, smiles nicely and hands a coin to a passing child. The next, he is a wild-eyed Jeremiah.

Police officers say be careful, he can get hostile with people, especially if they don't give him change.

Randy claims the cops harass him. The day after being jailed briefly for a disturbance, hes furious over "police brutality."

When he's angry, Randy, who is almost 6 feet tall, jumps to his feet, the pupils of his eyes hypnotic, drugged-out pinpoints, his voice as deep and lyric as a Shakespearean actor's. Pushing his face close, he spits as he pours out wrath, daring the listener to back away.

Just as quickly, he laughs and sits back down on the sidewalk.

Randy's past run-ins with the law turn far more serious when he is arrested for aggravated sexual assault. He currently is being treated in the jail medical unit.

Out on the street, before his arrest, Randy issued a dark waqrning: His twin brother, Rickey, is coming to visit.

"I'm the good twin. He's the evil one,'" he points out. "But I can control him. He will behave around me because I can knock him out with one blow. But he is truly a madman, and he is evil. He worships the devil. I worship the Lord thy God. God had a purpose when he made us. You cannot have good without evil. You cannot have evil without good. Everything that happens to me, happens to him. Everything that happens to him, happens to me.

"But, remember, when I introduce you, do not attempt to talk to him. He will converse through the mind, and you'll have the interview of a lifetime. You may photograph him, but he will come out as a black blur. He's coming. He's getting closer. And, he is truly scary."

On another day, Randy (CUT) is lying flat on his back on the sidewalk. He coughs repeatedly and admits he's exhausted.

"I can walk a block or so, and then I gotta sit down. I feel like crap. It's (AIDS is) deteriorating me. I got these spores on my body. Had pneumonia twice. Now, my eyes, every now and then, go fuzzy and black. I'm afraid I'm just fallin' apart. Jesus has

healed my legs though (AIDS-related neuropathy that affects legs). They feel better. But, he's got a way to go."

Still, as he says in Biblical-epic tones, AIDS holds no terror for him.

"I fear not death - do you? The greatest thing that can happen to me is if I die. I'm God's greatest warrior, but I'll be even more powerful when I'm dead. Then I'll really do God's work.

"Power is when I'm mad. I can jump up and have the strength of 10 men -100 if I want to. I hope you never see it. If you do, just walk away. Walk away."

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Prison Aids

Express-News Online Special Feature

Settling an unsettled problem

By Marina Pisano
Express-News Staff Writer

SAN FRANCISCO - This progressive city, a hotbed of the AIDs epidemic, could lead the way in the struggle to bring better treatment and prevention to America's HIV-infected homeless.

San Francisco's Bridge Project, launched in April, is on the leading edge. It has received one of two innovative, collaborative grants awarded by the federal government. Its goal is to develop community programs that offer integrated, multidisciplinary services for HIV-infected homeless who have addictions or mental illness.

Advocates know what hasn't worked. They say fragmented health and social services and the lack of stable, long-term housing have defeated efforts to serve the infected homeless .

This new program changes that. Here, treatment starts with a stable place to live.

"The whole idea is to make the client the center of the services vs. the agency being the center," says Patricia Chiapellone, author of the Bridge Project proposal.

The Bridge will receive $1.2 million over the next three years from the federal housing department and $2 million over five years from the federal health department.

With those resources, its multidisciplinary teams go to several SRO (single room occupancy) hotels in the downtown, skid-row Tenderloin area and recruit clients - up to 90 people at any one time.

The program subsidizes part of their rent and provides them with primary medical care, nursing, substance-abuse counseling, support groups and other services.

Affordable housing is critically lacking in San Francisco, where the vacancy rate is 1 percent and rents can be prohibitive. Compounding the shortage have been reductions in public housing and Section 8 rental-assistance funding and the increase in homelessness, says Anna D'Amato, housing coordinator for the San Francisco AIDS Foundation.

"You hear complaints that people die while they're waiting for housing - and some do die," she says.

The housing crisis is especially painful for the 30,000 people infected with HIV in San Francisco, D'Amato says. More than 7,000 are living with AIDS in this city of 730,000 people.

San Antonio, with about 1 million people, has 1,380 AIDS cases, and it's estimated that more than 10,800 people in Bexar County are HIV positive.

The city's Department of Community Initiatives says 2,764 of San Antonio's 17,274 homeless people are HIV-positive. The Centers for Disease Control and Prevention estimates that up to 21 percent of the nation's homeless are infected.

The Bridge Project approaches alcohol and drug addiction from the "harm reduction" model, which means substance abusers and alcoholics are not required to be clean and sober to be in the program.

"That's the most controversial piece," Chiapellone says. "The most visible form of harm reduction is needle exchange, but we are not a needle-exchange program."

But the Bridge can link clients with programs that teach people how to clean needles. Its overall approach is to build from the self-esteem that comes with having a place to live, curb HIV-spreading behaviors and gradually reduce drug dependency.

"Obviously, we would like to see people enter treatment," says Stephanie Eng, Tenderloin AIDS Resource Center program supervisor and part of the Bridge review committee. "But, if they're strung out on drugs and not ready for it, is there not a system to help them in that in-between level? We think there is."

Ellen Dayton, an HIV-homeless outreach nurse practitioner at the Bridge-affiliated Tom Waddell Health Center, says primary health care can work wonders for the infected homeless , even if few are able to take the new AIDS combination-drug therapies.

"There are some very basic things you can do," she says, "immunizations, TB testing, check for hepatitis A and hepatitis B, prevention treatment. If they're mentally ill, depressed, I can treat depression. And, I see a lot of depression with drug addiction. I see a lot of sickness in older alcoholics. But treatment starts with a stable place to live."

Across the country, Health Care for the Homeless Inc. of Baltimore, the other recipient of special federal grants, is taking a different path to reach the same goal with a collaborative grant of almost $2 million over three years.

Baltimore outreach workers go out to parks, abandoned houses, soup kitchens and emergency shelters, building trust with HIV-infected street people and bringing them into a main downtown site for case management, comprehensive primary health care, therapy, help for substance addiction, transportation, food, vocational counseling and other services.

Housing counselors, working with city departments, get them into transitional and long-term housing.

Many approaches

Meanwhile, other cities also are trying multiservice projects.

Seattle, with an estimated 20,000 homeless , is renovating the historic Lyon Building into a 64-unit residence for infected homeless. About $1.25 million in funding is coming from foundations, corporations and government sources. Services include 24-hour security, shared meals, health services and mental

health and substance-abuse counseling.

AIDS Services of Dallas opened Hillcrest House last September, currently home to 64 HIV-infected, formerly homeless persons, many with chronic alcohol or drug-abuse problems. "I think we have the best program in the country," says Don Maison, whose agency also operates two other residences for people with HIV/AIDS.

San Antonio projects

In San Antonio, Casa Martin is the closest thing to housing with integrated-services for the infected homeless . Residents enter a highly structured program that includes case management, mental-health services and substance-abuse counseling. Nurses supervise AIDS medication prescribed by doctors out in the community.

But with funding for just 20 beds and a three-month stay for clients, the program can't accomplish all that it might, says Jesse Sanchez, special projects director for the Hispanic AIDS Committee, which runs Casa Martin. The agency is working with state and corporate funding sources to buy another building.

"The ideal situation," Sanchez says, "would be to transition people, after three months, into an apartment where they are assuming responsibility for their lives but are still required to come every day to meetings or twice a week to counselors and continue some sort of structure. That's what we hope to do."

Dr. Steven Goldfinger of Harvard Medical School is writing a white paper for the federal government on AIDS among the homeless-mentally ill, and he is convinced prevention - especially condoms and clean needles - is the best solution.

Targeted communities

Important prevention and education work is being done on San Antonio's streets.

BEAT AIDS has a strong presence in the San Antonio African-American community.

The Mujeres Project focuses on HIV-infected women and children. And the San Antonio Metropolitan Health District passed out condoms to help stabilize an outbreak of hepatitis in the city's young gay community last summer.

But Jerry Permenter, executive director of the Alamo Area Resource Center, has a more ambitious goal. He's writing a proposal for a federally funded project he hopes will reach greater numbers of San Antonio's HIV-infected homeless , especially those with multiple diagnoses.

The project calls for a 40-unit, long-term housing facility with on-site case managers, health care, substance-abuse counselors and other services. Permenter estimates the project would need $600,000 to $1 million and a major commitment by his agency, other community agencies and city officials.

He says the San Antonio AIDS Coalition, an umbrella organization of about 20 AIDS -related agencies, could play a role

in reaching the infected homeless .

Whatever the city, one thing is clear: Any hope for effective, lasting solutions rest as much with better strategies and innovative coalitions as with money.

"Funding is critical and important, but sometimes we can be more creative when we take the time to look at what resources there are and how to connect them off," says Rolando Morales, acting director of San Antonio's Department of Community Initiatives, which oversees homeless programs and delivery of services.

Moral issues

But one model may not suit all. Certain aspects of the projects in San Francisco, Baltimore or Seattle may not fly in San Antonio, especially if, as San Francisco AIDS/homeless researcher Dr. Andrew Moss cautions, treatment bumps up against moral issues, as with San Francisco's harm-reduction model.

Morales urges cities to look beyond the short-term. "We have to prioritize prevention over intervention - nonjudgmental AIDS -prevention education, including information on abstinence and condoms," he says.

In the end, reaching an isolated community may come down to public willingness to foot the steep bills for AIDS treatment - more than $100,000 a year, per person - plus mental health and substance-abuse treatment costs.

Meanwhile, there is a certain ambivalence among advocates about raising awareness about the needs of the HIV-infected homeless . They fear turning a light on the subject may spark a backlash against this community of people, further marginalizing them.

But Tom Henderson, the lone Texan on the president's 35-member National AIDS Advisory Council, is pressing the issue.

"What the council can do is make sure we keep this very high on the agenda of the president, the cabinet secretaries and the executive branch," says Henderson, who is HIV-infected and works in Texas Land Commissioner Garry Mauro's office in Austin.

"You can't isolate HIV and act as if it doesn't have anything to do with homelessness or substance abuse or other problems in a person's life."

Hard life goes on

While solutions are explored, the isolated, stigmatized HIV-infected homeless scrape through another day on the urine-soaked streets of the Tenderloin and debris-strewn lots of San Antonio, living on the edge.

Panhandling near San Francisco's historic St. Mary's Church, Michael Shepard, 36, who has AIDS and became homeless six months ago, yearns for healing but prepares for the worst.

"You know, there are a lot of people who have chosen this (the street) as their lifestyle. Not me," he says. "If I thought I had to do this the rest of my life, I'd be out there on Golden Gate Bridge."

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Express-News Online Special Feature

Ed

By Marina Pisano
Express-News Staff Writer

SAN FRANCISCO - Seated on his bed by the window, the late-afternoon California sun igniting his red hair and beard, Ed looks frail, almost caved-in, his face deeply lined and gaunt.

"I came out here 17 years ago from Houston for the gay life," says the former restaurant kitchen manager. "Came out for a visit and decided to stay. Texas was pretty hostile to gays."

He's not sure how he got infected with HIV, the virus that causes AIDS - "sexual or IV (intravenous drug use)," he reckons.

He does know that it was eight years ago and that today his T-cell count is down to 50 - a count under 200 is considered full-blown AIDS. His blood HIV viral load is in the hundreds of thousands. He has lost 70 percent of the vision in his right eye, he has neuropathy in his legs and unspecified intestinal problems.

Perhaps worst of all, he has the AIDS-wasting syndrome, signaling advanced disease and already has dropped 80 pounds from his once-strapping 6-foot-tall frame.

"I'm 38," he replies to the inevitable question about age, politely ignoring the reaction on visitors' faces. He looks 20 years older.

No, he doesn't do drugs or alcohol anymore. Can't.

"My stomach doesn't seem to function anymore," he observes during an interview in March. "The first thing I do every morning is take my anti-nausea pill. Usually I can gauge my day on whether I can keep anything down. I have to be very cautious. A cold milkshake is one of the few things I can stomach."

Next to Ed's hospital-type bed a portable TV sits on a chair. IV equipment is within reach, along with shopping bags containing the liquid nutritional supplements that keep him alive. For 14 hours every night, he hooks himself up and takes in food through a permanent IV line. He gets infection-fighting antibiotics for several hours.

Ed receives most of his primary medical care at San Francisco General Hospital, but the new protease inhibitors are of no use to him. He can't keep them down any more than he can soup-kitchen suppers or fast-food tacos.

The one bright spot in his life is that, unlike this city's many HIV-infected homeless, he's not living on the street anymore. He has a dreary walk-in closet of a room and bath - rent $450 a month - on the fourth floor of the Ambassador Hotel, a landmark in the city's seedy downtown Tenderloin area.

Warren Goldenberg, an AIDS social worker, says "it's one step up from the street."

The hotel became a celebrated gay-friendly address decades ago. When the AIDS epidemic hit San Francisco in the early 1980s, it also became a safe, non-discriminatory place for infected gays to live and die.

Nowadays, the SRO (single-room occupancy hotel) is a rundown shadow of its former self. Water regularly leaks from broken pipes. A creaky elevator breaks down often, and then there's the fecal matter in the dilapidated communal bathrooms. Rats and roaches carry out nocturnal raids.

Catholic Charities manages Ed's disability benefits and assists with rent, and visiting nurses check on him regularly. But the Ambassador Program, once a model for HIV-infected homeless services, is in a state of uncertainty and flux.

The Bridge Project, a federally-funded program run by Lutheran Social Services, is putting infected homeless into better-maintained SRO hotels where they are served by teams of health and social services providers.

Having a place of their own means everything to them, even if the furnishings come out of Dumpsters, says Goldenberg, who worked for the Ambassador Program but is now with the Bridge Project.

One of the few meaningful personal possessions in Ed's room is a compact disc recording by Sheryl Crow. "I like her singing a lot," he says of Crow's folk-with-an-edge style.

"Here. You take it," he says to his visitors. "I don't have a CD player, and I'll probably never get a chance to listen to it. You take it. Enjoy it."

If Ed hasn't lost his generosity, he has lost touch with his family. One of his closest friends died of AIDS.

But while Ed's body and world shrink, he still finds pleasure in walking around the Tenderloin, "bonding" with street people and sharing the food he can't eat.

Later, in the dark hallway outside Ed's room, Goldenberg says that most termminal- AIDS residents prefer to spend their last days in the Ambassador rather than a hospice.

"Everybody dies alone. But at least here in the hotel, there's a sense of community. People don't feel so alone."

Ed died Sept. 4 of complications from AIDS. Friends at the Ambassador recently gathered for a memorial. He was cremated, and his ashes were sent to relatives near Houston.

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Prison Aids

Express-News Online Special Feature

Leaders demand action

By Marina Pisano
Express-News Staff Writer

Mayor Howard Peak, a state public health official and advocates of the homeless Wednesday called for better ways to meet the needs of a small, but growing population of HIV-infected homeless who receive limited and fragmented services.

Peak said Wednesday he has asked the city's top public health official for a status report on the HIV-infected homeless and plans to ask a City Council committee to add the needs of this population to its agenda.

The newly formed San Antonio AIDS Coalition, lamenting the lack of coordination between agencies, also says it will study the issue. The Hispanic AIDS Committee, which operates the only emergency shelter specifically for this group, is joining with other organizations to form a task force to conduct a needs assessment among the homeless . It also is launching a fund-raising campaign to buy a building to provide transitional housing for HIV-infected homeless .

And in Austin, a member of President Clinton's 35-member National AIDS Advisory Council said San Antonio's dilemma demands new ideas and alliances.

Disturbed by a series of reports about HIV-infected homeless people in the San Antonio Express-News this week, Peak said he has asked for a public- health perspective report on the matter from Dr. Fernando Guerra, director of the San Antonio Metropolitan Health District.

"It's disturbing in a number of respects that we have (homeless) people out there with these problems. I don't know what we can do for some of them, but we need to figure out who we can reach," Peak said.

Guerra did not return telephone calls seeking comment.

Peak also plans to ask the council's Committee on Social Services to add the needs of homeless persons with HIV/ AIDS to its current examination of gaps and duplications in services provided by public, community and nonprofit agencies.

"With the committee's assessment, we'll be in a better position to know what we need to do," the mayor added.

Right now, there are almost 2,800 homeless persons walking around San Antonio with HIV/ AIDS , according to the city's Department of Community Initiatives. Many of these men and women face other medical problems, mental illness or drug or alcohol abuse. Some of the women are victims of domestic violence.

Peak's concern was echoed in Austin.

"We do see the homeless population becoming more disproportionately affected by this disease, and we will turn our attention to it," said Dr. Charles Bell, director of the HIV Bureau of the Texas Department of Health.

But Bell said "This is a difficult population to reach because AIDS treatment may not be a priority for them. Housing and food are higher on their agenda. We are going to have to develop new strategies to help them. I'd like to see more of a dialogue on this with housing (department). I'd like to see more partnering with them."

That kind of innovative approach and collaborative effort is already under way between federal housing and health and human services departments in the funding of projects in San Francisco and Baltimore, which are considered in the forefront of such programs.

Housing Opportunities for People with AIDS, the federal housing department's cornerstone program for this population, is one example of that kind of partnering in Texas, Bell said.

Today, the City Council is scheduled to consider more than $700,000 of new funding for that program, which covers housing and support and social services administered through the Department of Community Initiatives. The HOPWA funding is expected to be approved, Peak said.

Health officials and advocates for the HIV-infected homeless say the greatest single need for this population is stable, sustained housing.

Housing ensures better delivery of HIV/ AIDS treatment, especially the new, potent "cocktails" of protease inhibitors and more established AIDS drugs that are having dramatic results with many patients.

The treatments require a strict regimen of dosages before and after meals. Sustained housing also provides some stability for alcohol, drug, mental health and HIV-related social services. Model programs around the country combine services with housing.

Bexar County Commissioners Court Judge Cyndi Krier says the county has seen "the same need for housing that you have seen with your series, and they've acted on it."

The HIV Health Services Planning Council is the body appointed by the Commissioners Court to allocate federal funds under the Ryan White CARE Act Title I. Krier, the county's highest elected official, is responsible for distributing Title I money.

In fiscal 1997, the county had no Title I funds allocated for housing. Next year, the county will get more than $100,000 for housing and housing-related services.

Harrison Grindle, program coordinator for Ryan White Title I funding, says the amounted is small compared to the more than 700,000 allocated for medical services for people with HIV/ AIDS regardless of their housing status.

"But it's a start, it's something," said Grindle, who noted that

persuasive testimony from several homeless people and Jesse Sanchez of the Hispanic AIDS Committee convinced council members of the pressing need.

Sanchez, executive director of the Hispanic AIDS Committee, said he and other organizations have their own plan of action action. They are forming a task force to conduct a needs assessment of this often hidden segment of the city.

The Hispanic AIDS Committee operates the 25-bed Casa Martin, the only emergency shelter in the city specifically for the HIV-infected homeless .

The task force will include homeless people, as well as agencies such as the Center for Health Policy Development and the Health Education Training Centers Alliance of Texas at the University of Texas Health Science Center.

Sanchez also is launching a fund- raising campaign to buy a building to provide transitional housing for HIV-infected homeless moving from Casa Martin into longer-term housing.

The issue cries out for new ideas and alliances, said Tom Henderson, a member of President Clinton's 35-member National AIDS Advisory Council, who is HIV-infected and works in Texas Land Commissioner Garry Mauro's office in Austin.

"The problem, as your articles point out, is you have to deal with a multitude of problems," Henderson said. "Until we are prepared to deal with homelessness and HIV/AIDS in some comprehensive fashion, we're not going to get anywhere."

Dianne Sherman, recently named director of the Department of Community Initiatives, agreed.

"One thing we need to do more of is better coordination within the city. We can make better progress if we coordinate with housing and community development. We do that with HOPWA money, but we could do more with the health department and the county without duplicating services," she said.

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Prison Aids

Express-News Online Special Feature

Mario

By Marina Pisano
Express-News Staff Writer

Mario Ibarra thought he was holding it all together pretty well until that morning last year in September when he woke up and found his wife, Jan, lying next to him.

Dead.

"I'd never seen a dead person that close before. They (police) said she was probably dead for about three hours," he recalls. "She was on a lot of medication. Guess she OD'd. If they gave her 60 pills, she'd eat 'em all in two days. Eat 'em like candy. I don't think she meant to kill herself. She probably just wanted to get away for a while."

His wife had AIDS . She was taking AZT and abusing it and other drugs -holding "pill-swapping parties," he says, with an HIV-infected homeless man who was on medication for depression.

At the end, Mario, 32, became her full-time care-giver, bathing her and making sure she ate. The intense, dark-haired man, who describes himself as an alcoholic and recovering drug addict, also is infected.

"I got it (HIV virus) from my wife. She had it for five years and didn't know it. She got tested when she found out her ex-boyfriend was full-blown AIDS . She got tested, and then I got tested (April 1996) and found out I had it. I haven't been to a doctor since I got diagnosed. My T-cell could was 333 (then).

"I'm not pissed off," he adds. "If she hadn't infected me, it woulda been somebody else. I had a problem with drugs from 20 to 27. I used other people's needles. I knew it was gonna happen, sooner or later."

Some street people who knew the couple say Mario took advantage of his wife and used her SSI check - Supplemental Security Income disability benefits -to buy illicit drugs.

Mario credits Jan with pulling him out of homelessness - they met on a bus while she was working as a waitress. When she could no longer work, her disability income was the only thing between him and the street. Her death plunged him back into homelessness .

So, yeah, he admits. In a way, he's angry.

"She died and left me stuck (financially and emotionally). You finally met someone you want to spend your life with, and she comes home one day and tells you, 'Hey, I'm sick. You gotta get tested.'

"Now it's pretty much just movin' from one bridge to another bridge," he says of his life and "work" - panhandling. Mostly he

hangs behind some businesses, off Broadway near the Brackenridge Park golf course.

"It's hard when you got cops harassin' you for bein'homeless . They don't catch no criminals, but they always find time to bother people trying to make it."

Mario likes to point out he's a home-town boy.

"I was born at home over there on 24th Street. Lived right here all my life. The first time I got married, I was 14 - straight out of seventh grade. I got a 18-year-old daughter and 11-year-old daughter. I haven't seen either one of 'em for a long time. My ex-wife remarried. I've had three common law (marriages)."

"We're not a real tight family," Mario says. "My dad says it's my own fault I'm homeless . But when you done it and seen it all before, it (street life) becomes natural."

Still, he observes, "my mom and dad, the little bit they can give me means a lot. They loved my wife for who she was. And, bein' their son, they feel there's a lot of good in me. They love me."

Mario has a sister who takes him home from time to time. He gets cleaned up and rests for a few days. But he always goes back to the street.

"I've never even thought about goin' to a shelter. It's too confining , like bein' in jail," he says, a place he is familiar with. "The same with Casa Martin (a shelter and substance-abuse program for HIV-infected homeless). They wanted me to go there, but that's like a jail, too. I'm not a convict. I'm an alcoholic. And, I need my sauce."

Last winter, the Alamo Area Resource Center, where Mario often goes for a hot lunch, used some of its funds to put him up in a motel room for a week. Recently, the center got him into more permanent housing, but he soon was evicted for breaking the landlord's rules.

"He's slowly drinking his life away on the streets," says his sister.

A case worker at the center helped Mario with his application for SSI disability benefits. But, with new, tougher requirements, he was denied.

It doesn't help that he avoids medical treatment. Mario once walked out of a detox program at the veterans hospital that was required before doctors could treat his bleeding ulcer.

As for HIV/AIDS , "I don't like doctors and I sure as hell don't like taking medication. Sometimes I feel sick or I'm runnin' a fever, but I've learned to live with it. I can just keep on goin', keep on goin', keep on goin'. I don't like pills. I'm not gonna carry around a bedroll and a sack of pills. I know people who get AZT, and they don't even take 'em. They throw 'em in the river."

Picked up for vagrancy several weeks ago, he is released a few hours later and returns to the only life he knows.

"He's slowly drinking his life away on the streets," says his sister.

But, "It was easier to be homeless before I got sick," Mario admits. "Now I worry that if I catch cold or pneumonia, I might not come out of it. Everything's different now."

A year after finding his wife lying lifeless beside him, Mario is still grieving, still adrift in his hometown and still infected.

"It was weird. She was sick, but there were some good times. I was there for her. Now it's like it's just me. I've had me for 32 years now, and I've gone nowhere.

"I was talkin' to this guy one time about my wife and cryin' and cryin'," he recounts. "These guys come up to me and said they'd pray with me. They asked me what was wrong. And, I said, 'Other than my wife dyin', nothin'.' They said, 'Oh, you'll meet somebody.'

"And, I said, 'Oh yeah. Show me the scenario here. I'm gonna meet somebody and when I tell 'em I'm sick, infected, they're gonna embrace me and love me.'

"The best thing that could happen to me is to meet another infected person. But then it's gonna happen all over again. Someone's gonna die on me, or I'm gonna die on someone else.

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JAMA®
The Journal of the American Medical Association

Commentary - July 2, 1997

Protease Inhibitors in the Homeless

Homeless people are often thought not to adhere to therapy. Should we try to make protease inhibitors available to them? The new therapies for human immunodeficiency virus (HIV) infection are expensive, and their use may lead to the development of drug resistance. Do these drawbacks outweigh the ethical imperative to make effective drugs available to an underserved population?

In late 1995, the first protease inhibitor was licensed by the Food and Drug Administration for persons infected with HIV. In combination with reverse transcriptase inhibitors, protease inhibitors give unprecedented improvements in CD4+ cell count, viral load, morbidity, and mortality.[1] One press report used the term "Lazarus effect"[2] to describe the return to functional status of some patients with end-stage acquired immunodeficiency syndrome (AIDS). Driven by both science and enthusiasm, the standard of care for HIV-infected patients has quickly become combination antiretroviral therapy with a protease inhibitor.[1,3] The price of treatment is $12,000 to $15,000 per year.[1]

In spite of the apparent benefit, there is debate about whether the new drugs should be made available to the homeless and marginally housed—the people living in streets, shelters, and residential hotels who make up a substantial subset of the urban poor.[4,5] In recent studies, between 8.5% and 20% of this population has been infected with HIV,[6,7] and the prevalences of mental illness, alcoholism, and drug abuse are high. We suggest that there is an obligation to make standard therapy available to this underserved and largely minority population.

An analogy between discriminatory treatment in the HIV epidemic and the infamous Tuskegee Study was made by Thomas and Quinn in 1991.[8] There are important differences between the 2 situations—withholding therapy in a study of the natural history of syphilis in the Tuskegee Study and withholding therapy because of concerns about nonadherence in the current case. But the history of the Tuskegee Study reminds us that the health care system has not always provided equitable care regardless of race. There is also evidence that the system has failed to offer appropriate care to minority patients with HIV. African Americans are less likely to get zidovudine therapy and *Pneumocystis carinii* pneumonia (PCP) prophylaxis than are white patients, even when the rates are controlled for insurance status, injection drug use, and demographics other than race, education, and place of residence.[9] Lower treatment rates in minority populations have been documented in coronary artery disease, analgesia for long bone fractures, alcoholism, erythropoietin for end-stage renal disease, and rehabilitation after mastectomy.[10-15] The Tuskegee Study itself has passed into folklore, and in San Francisco we are no longer surprised to hear it brought up by patients or study subjects. Given this history, clinicians treating an indigent, largely minority population like the homeless should take a determined approach to making effective therapy accessible.

But there are reasons for caution in prescribing protease inhibitors for the homeless. First, adherence to treatment is thought to be poor enough that effectiveness is in doubt. Second, poor adherence may lead not just to low effectiveness but also to problems of drug resistance. And third, the costs of protease inhibitors might be better spent on other interventions. In the first section of this essay we consider these issues. In the second section we make a series of recommendations for physicians who treat the homeless and marginally housed.

Adherence

Adherence to protease inhibitor treatment is the central issue. Questions about the effectiveness of protease inhibitors in the homeless revolve around the belief that homeless people will not adhere to medical regimens that include 20 pills per day in 2 or 3 divided doses. Combination chemotherapy with protease inhibitors must be timed around meals, with some drugs taken with meals and some taken on an empty stomach, and patients must be monitored for multiple drug interactions. Some drugs need to be refrigerated (eg, ritonavir), and the risk of adverse effects with or without symptoms means that frequent blood tests are required.[1]

The problems of adherence among the homeless are best known from tuberculosis. In San Francisco, only 26% of a representative homeless population was able to complete 6 months of daily preventive therapy with isoniazid when offered standard care (J.P.T., unpublished data, 1995). In a famous study at Harlem Hospital in New York, the rate of adherence to 6 months of once-a-day multiple-drug treatment for active tuberculosis was only 11%.[16] Such poor adherence to relatively simple regimens raises serious concerns about antiretroviral therapy.

However, barriers to adherence are often as much system related as patient related. Poor adherence to tuberculosis therapy in New York in the 1980s was often blamed on the patients, but adherence improved and tuberculosis case rates declined when the health care system was adapted to meet the needs of the indigent.[17] The directly observed therapy program at the same Harlem Hospital reported a 91% adherence rate when on-site and home-visit supervised therapy was made available to tuberculosis patients. The new program uses a surrogate family model, providing daily meals, transportation tokens, toiletries, and clothes.[18] Providing protease inhibitor therapy to the homeless also requires us to overcome institutional (not just individual) barriers to adherence. Adherence requires convenient clinic locations, flexible appointment scheduling, secure places to store medications, and perhaps transportation to clinic and pharmacy. One lesson of tuberculosis in New York is that the delivery system must be organized in a way that makes it possible for the patient to adhere.

Second, not everybody in the homeless population is unstable. Many HIV-positive homeless persons are in regular contact with the health care system. In San Francisco, 72% of homeless and marginally housed HIV-positive persons can name a primary care clinician, and the median number of visits in the past year is 6 (D.B., unpublished data, 1997). Patients in regular primary care must be considered as candidates for protease inhibitors. Those in methadone maintenance (15% of HIV-positive homeless and marginally housed persons in San Francisco) may be more likely to adhere to protease inhibitor therapy than out-of-treatment patients. Those living in residence hotels are more likely to adhere than the literally homeless population of street and shelter dwellers (and at least as likely to be HIV-positive[6]).

Physicians should recognize that stably functioning homeless people may be able to cope with complex treatment regimes. But equally important, we suggest, is that physicians are under an obligation to stabilize their HIV-positive patients before starting treatment. That is, physicians should include efforts to provide regular medical care, stable housing, and drug treatment and mental health referrals in the treatment plan for patients being considered for protease inhibitors. If system barriers are removed and if physicians are working to stabilize their patients' lives, adherence will improve.

It is ethical to delay treatment until the patient's life stabilizes if there is a strong likelihood that immediate treatment will lead to the development of resistance. Though early treatment may be important in the case of occupational or perinatal infections or of postexposure prophylaxis,[19-21] there is no evidence otherwise that the time of starting therapy is critical over a period of months. If a patient can be stabilized, waiting until functional status is improved is probably more important than trying to treat immediately. Outreach and rehabilitation can stabilize housing status in mentally ill adults after discharge from a homeless shelter.[22] Case management can decrease hospitalization and improve adherence to medications as well as stabilize housing.[23,24] Immediate prescription of protease inhibitors may be a disservice since patients who develop resistance while they are unstable will have lost the benefit of therapy.

Evaluating the Benefits of Protease Inhibitors

There is no guarantee that the benefits of therapy in highly selected clinical trial populations will be seen in the homeless. Thus, there must be formal evaluation of the new therapies in clinical practice. Benefit at the aggregate level can be measured by population-based morbidity and mortality data. This approach can help determine which clinical care settings (eg, methadone maintenance clinics, visiting nurses in low-income hotels) have the highest chance of success. To maximize benefit we need to know which settings maximize adherence.

Benefit at the individual level should be evaluated too, with the possibility of discontinuing therapy. Benefit can be measured by reduction in viral load, increase in CD4+ cell count, and improvement of health status. When these measures do not improve, we suggest that physicians should make a determined effort to improve adherence and should also consider changes in the treatment regimen. Physicians may choose to recommend 2 reverse transcriptase inhibitors, possibly with the addition of a nonnucleoside reverse transcriptase inhibitor (NNRTI). This permits a twice-daily regimen rather than the 3-times-daily regimen of most protease inhibitors. Those who fail to derive any benefit from treatment in a system that has made a concerted effort to remove barriers to adherence should not continue therapy. There is no obligation to provide ineffective treatment.

Resistance

Nonadherence will lead to suboptimal levels of drug, and this may lead to the selection of drug-resistant HIV strains.[25,26] Suboptimal protease inhibitor levels can quickly lead to drug-resistant HIV-1. Given that resistance to multiple drugs may arise in response to sequential therapy, there is at least a theoretical possibility of disseminated multidrug-resistant HIV. The transmission of protease inhibitor-resistant virus has not been demonstrated, but the sexual transmission of zidovudine-resistant HIV has been seen.[27] Transmission of resistant HIV is a concern in the urban poor because they are at high risk for sexual and parenteral HIV transmission.[28] They have also been a high-risk population for multidrug-resistant tuberculosis and methicillin-resistant *Staphylococcus aureus* via injection drug use.[29,30] The example of tuberculosis is alarming given the rapid kinetics and high mutation rate of HIV.[31,32] However, sexual transmission is probably less likely than airborne transmission to produce epidemic spread of resistant strains.

Given these considerations, surveillance for resistance is a necessity in this population. However, treatment cannot be denied before there is any evidence of resistance. We would suggest that at present the answer is to monitor drug resistance carefully at the population level. Increasing resistance in new seroconverters would be a warning signal about protease inhibitor prescribing in this population.

Cost

The third constraint on use of the protease inhibitors is their high cost. In Washington, DC, drug costs in the AIDS Drug Assistance Program have gone up 50% since the advent of protease inhibitors.[5] Most of the homeless are not covered by federally supported medical programs and are dependent on county and state programs for medically indigent adults. Paying for protease inhibitors, it may be suggested, will compromise other pressing health care needs, including other aspects of HIV care. We suggest that certain aspects of HIV care should indeed take priority over antiretroviral treatment. These are PCP prophylaxis for those with CD4+ cell count of less than 0.20×10^9/L (200/μL), and isoniazid prophylaxis in those who are purified protein derivative (PPD) skin test positive. These therapies are simpler than protease inhibitors but probably confer similar benefits.[33,34] However, we do not believe that 1 service should be substituted for another in this underserved population.

The most important thing to recognize is that complications of drug use and trauma are the leading causes of death in the homeless.[35-37] Housing in a low-cost residence hotel in San Francisco costs less than $5000 per year. The life expectancy of an HIV-infected homeless person might well be increased more by $15,000 of housing (or of treatment for mental illness or chemical dependency) than by $15,000 of antiretroviral therapy. Where possible, stabilization of housing and health problems is a priority. The costs of protease inhibitors are better spent on stable patients.

Recommendations

With the recognition that treatment is evolving rapidly and that daily protease inhibitor regimens may eventually become available, we propose the following:

1. Patients must be informed. Clinicians have an ethical responsibility to inform patients who are competent decision makers of their treatment options, regardless of homelessness. To fail to inform is to run the risk of withholding treatment. To make access equitable, clinicians must describe treatment options and must involve patients in decision making. Patients need to be informed of both benefits and risks, including the dosing schedule and the risk of developing drug-resistant HIV if doses are frequently missed.

2. As much as possible, patients must be stabilized with respect to housing, contact with the health care system, chemical dependency, and mental illness. This is more important than choosing the best antiretroviral regimen. If the patient agrees, treatment with protease inhibitors should be delayed until the patient's life stabilizes. In our experience, most patients who are informed of these issues feel that addressing the conditions of life should take precedence over starting antiretroviral therapy. Stability is thus the initial goal, and it typically requires working as a team with social workers and others.

3. For stable patients, management depends on CD4+ cell count and PPD skin test status. For those with CD4+ cell counts of less than 0.20×10^9/L, PCP prophylaxis is the first priority. For those who are PPD positive, the first priority is preventive therapy with isoniazid. If patients are successful with these regimens, therapy with a protease inhibitor should be considered.

4. For those patients who are ineligible for PCP prophylaxis or isoniazid preventive therapy, the first priority remains stabilization. If this is successful, we believe it is reasonable to put the patient who wishes to begin

treatment on protease inhibitor therapy—after a detailed description of the demands of the therapy and the risk of losing future benefits if the patient is unable to adhere. If there is doubt about stability, 2 reverse transcriptase inhibitors can be recommended, with or without an NNRTI. After the patient stabilizes, a protease inhibitor can be started, perhaps with 2 new reverse transcriptase inhibitors.

5. For those who remain unstable, the risk of losing future benefit if the patient is nonadherent should be explained and, if the patient agrees, 2 reverse transcriptase inhibitors are recommended.

6. For those who remain unstable but insist on protease inhibitor therapy after explanation of the risks of nonadherence, we believe there is an obligation to prescribe if the patient is competent to decide and has indications for treatment. In our experience, such patients are rare. Therapy should not necessarily be provided on the first visit. The chance of success may be improved if the patient demonstrates persistence and reliability in medical follow-up. In this setting, we believe it is best to err on the side of treatment.

In summary, in facing up to the use of protease inhibitors in the homeless, we are obliged to develop interventions that maximize the chance of adherence and therefore of benefit. It is ethical to withhold treatment until the patient's life is stabilized. Prophylaxis for opportunistic infections may also take precedence over more complex therapy. The impact of drug treatment must monitored, as well as viral resistance. If health status and survival are not improved or if transmission of resistant HIV is seen at the population level, then the use of these therapies must be reevaluated. Finally, although evaluating the risks and benefits of the new therapies is daunting, it is much better to debate the appropriate use of effective drugs than ineffective ones.

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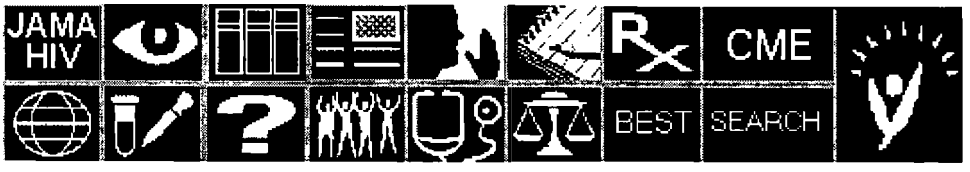

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