

HIV/AIDS and Health Related Needs Among Injecting Drug Users in Michigan

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EXECUTIVE SUMMARY

This study was conducted to fill a gap in existing knowledge in the State of Michigan on the needs of a population known to be at high risk for HIV/AIDS: persons who use injecting drugs or injecting drug users (IDU's).

The study involved 52 structured interviews and 125 street intercepts with people who self-reported the use of injecting drugs within the year prior to data collection. Participants included both those accessing and not accessing drug treatment from six communities around Michigan: Benton Harbor, Detroit, Flint, Grand Rapids, Kalamazoo, and Ypsilanti. A quota sampling methodology was employed. These interviews and street intercepts were supplemented with data collected from HIV and substance abuse program managers.

The primary goals of this needs assessment were to determine IDU's:

- Current sex and drug use behaviors, including HIV risk reduction strategies
- Primary health concerns
- Knowledge of HIV risk reduction strategies
- Perceived severity of and susceptibility to HIV/AIDS
- Perceptions of the barriers and facilitators of adopting HIV/AIDS risk-reduction behaviors
- Information seeking behaviors and preferences around health issues in general, and around HIV specifically
- Perceived importance of an utilization of health-related services

Secondary goals of this assessment were to:

- Examine HIV and substance use program manager's beliefs about the groups at risk for HIV
- Examine program manager's assessment of the HIV prevention related needs of the IDU population
- Assess the extent to which agencies have HIV preventions programs targeted toward IDU's
- Identify manner and extent to which services are communicated to potential clients
- Examine the climate that exists around provision of HIV prevention services to IDU's

Selected Findings

- ❖ Most IDUs did not identify their drug use as a health concern. Hepatitis C and HIV were each mentioned by about one third of respondents as health concerns. People accessing drug treatment were more likely than those who were not to identify HIV and hepatitis as health concerns.
- ❖ Levels of knowledge of HIV risk reduction strategies such as condom use and needle sharing were relatively high. Many participants reported using social isolation (i.e.

shooting/injecting alone) as a risk reduction strategy and some reported using inappropriate methods of risk reduction (e.g., looking for “clean” partners).

- ❖ Most IDU’s indicated they think about HIV and that they perceive it as a frightening disease. Findings were mixed regarding the extent to which participants believed they are likely to get HIV/AIDS.
- ❖ Forty-two percent of the IDU sample reported that they have at one time exchanged sex for drugs, or for money for drugs. Of the people who had engaged in this behavior, women typically reported giving sex and receiving money for drugs, whereas men typically paid for sex (rather than getting paid for sex).
- ❖ When asked about whom they talk to about HIV/AIDS, IDU’s indicated friends/peers (50%) including other IDUs; followed by their doctor (40%). Importantly, approximately 40% of the sample said they do not talk with anyone regarding HIV/AIDS.
- ❖ Participants trust doctors and health departments for information about health in general and about HIV specifically. They also trust community-based organizations (CBO’s), particularly agencies that provide HIV prevention, although many participants did not distinguish CBO’s from other organizations providing health services. Many participants indicated that they do not trust the media for information. Although people indicated that they talk to their friends or peers about HIV, they did not typically indicate peers as someone that they trust for information.
- ❖ Approximately 75% of the respondents indicated that they used a new needle the last time they injected. Only 36% of participants said they had used new works (syringes, cookers, cottons) the last time they used.
- ❖ Many people indicated that needle exchange programs are central to helping them take steps to reduce their risk for HIV/AIDS. Participants indicated difficulty trying to access needles or works from other sources (especially pharmacies) and indicated the availability of what they perceive to be needle/syringe exchange programs (NEPs).
- ❖ Generally, program managers of HIV prevention programs and substance use treatment centers view IDU’s as one of the primary populations at risk for HIV and indicated that access to sterile needles is a primary HIV prevention need for IDUs. Providers indicated that stigma and behaviors related to drug use are primary barriers to seeking HIV prevention services.
- ❖ All of the ten program managers interviewed indicated that their agencies have programs or services that they know to be accessed by IDU and eight of the agencies have programs that explicitly target IDU. None of the agencies indicated the existence of any systematic plan for marketing their services to clients.

- ❖ Program managers' assessment of the current political climate for the provision of services to IDU's was relatively mixed. Several program managers recognized that the climate is different at the federal, state, and local levels.
- ❖ The need for NEP's was expressed by both IDU's and program managers. Program manager's perceptions of the extent to which IDU's believe they are susceptible to HIV and the importance placed on HIV prevention, appears to be somewhat inflated by program managers, in contrast to level of susceptibility expressed by IDUs.
- ❖ The initiation of NEP's appears to have occurred in a similar process in those communities where NEP's are currently active, implementation resulted from a grass roots process of engagement with local authorities. The leadership and buy in of the mayor or other elected official in a community appears to be essential.

Selected Conclusions and Recommendations for Interventions

- ❖ In communities where needle exchange programs operate, survey participants indicated that these programs assisted them in taking steps to reduce their HIV-related risks. In communities where exchange programs are not active, many more participants talked openly about sharing and reusing needles. Given that the use of new needles is superior to cleaning as a prevention strategy (CDC, 2002), support of NEPs should be a priority.
- ❖ The NEP that are currently operating are not sufficiently promoting their services nor are they sufficiently addressing HIV risk reduction strategies with clients, they are simply supplying clients with new needles. Data from the program managers indicates that generally, agencies do not appear to have any systematic plan for marketing their services. Current and future programs should be assisted in developing the capacity to aggressively market their services to new clients.
- ❖ The continued risk behavior on the part of clients despite relatively high levels of knowledge and self-efficacy indicates that continued risk behavior is a result of numerous complex psycho-social factors, something addressed by several of the substance abuse treatment program managers. Future interventions targeting IDUs should incorporate one-on-one mental health counseling in order to address HIV-prevention in the context of the broader psycho-social challenges faced by IDU's. This counseling should include referral to the appropriate services with care taken to assess which form of substance abuse treatment is appropriate for the client.
- ❖ Pharmacists should be educated on the importance in HIV prevention of provision of clean needles. Many participants reported that they encountered resistance from pharmacists when they tried to purchase needles. A program manager in at least one community indicated that they have engaged in provision of educational programs and collaboration with pharmacists as part of the creation of an NEP. Pharmacists and other providers should be educated and provided with the tools to refer clients to NEP when

appropriate. Moreover, in many communities' structural barriers to providing NEP, such as antiquated drug paraphernalia laws exist. These barriers must be addressed in order to facilitate provisions of NEP-related services.

- ❖ Hepatitis A, B, and particularly C were mentioned frequently by participants. This, along with the data which indicates regular HIV testing on the part of many IDU's, indicates that HIV testing and hepatitis screening should be made widely available to IDU's through NEP's and treatment sites. Moreover, education regarding viral hepatitis should be integrated into HIV prevention and substance abuse prevention treatment efforts targeted to IDU's.
- ❖ A large number of participants reported using social isolation as a HIV risk reduction strategy. Although it is not recommended that prevention providers *encourage* social isolation, the importance of normative factors and the restructuring of peer groups is something that should be addressed in HIV prevention efforts targeted to IDU's.
- ❖ According to these data, methadone clinics are a double-edged sword for the typical IDU. Many IDU's appear to rely on methadone to help them reduce their heroin use. However, many who report receiving methadone treatment are still using injected drugs, some rather extensively. Moreover, the methadone clinics appear to harbor a drug culture in which there is strong normative pressure to continue using heroin and other drugs. This information coupled with the finding that many of those accessing treatment in some form (including methadone) were more likely to know about their HIV or HCV risk suggests two recommendations:
 - Integration of HIV prevention efforts with substance abuse services is essential and should continue, and be expanded where appropriate.
 - The multiple drug treatment options currently available appear to be appropriate for addressing the range of needs of IDUs. HIV prevention providers should work with substance abuse providers to ensure appropriate referral and screening of clients to a variety of substance use services appropriate to client needs.
- ❖ Doctors (either private or emergency room) are a frequent and trusted source of HIV-related information. Importantly, doctors may be the only point of contact in the health system for IDU's. Physicians and healthcare workers should be adequately prepared to meet the HIV-related needs of clients and be able to provide appropriate risk assessment and risk reduction activities. Provider education activities designed to build healthcare worker knowledge and skills to conduct risk assessment and risk reduction are essential to prevention targeted to IDUs.
- ❖ Across this sample, health departments appear to be a trusted source of information. This is contrary to the widely held perception among health providers and others that particular populations do not trust the local health departments – a belief expressed by program managers. Because health departments appear to be trusted and widely used by

IDU's, it is essential that health departments have the capacity to provide HIV prevention-related services to IDU's, including facilitating appropriate referrals.

- ❖ Coordination and collaboration among providers regarding the provision of services to IDU's should be facilitated in order to address the larger structural barriers to service provision that are evident in these data. Specifically, collaboration should be encouraged to build relationships among local providers likely to serve the IDU population and to aid in establishing NEP's.
- ❖ Program managers from HIV prevention and substance abuse treatment programs should be provided with technical assistance and capacity development assistance to form strategic plans for marketing their services to potential clients. This should include formalization of the use of interpersonal channels of communication (including, but not limited to referral) by current clients, outreach workers, and providers likely to interact with IDU's (emergency room doctors, pharmacists).
- ❖ The media (e.g., television, news, newspapers) is not considered by IDUs as a trustworthy source of information on health-related matters. Health communication efforts targeted to IDUs should rely on other channels viewed as more trustworthy.

Table of Contents

Introduction	7
Method	8
Sampling	8
Procedures.....	8
Participants.....	9
Program Manager Interviews.....	10
Findings for IDUs	11
Patterns of Drug Use.....	11
Primary Health Concerns.....	12
Perceived Risk for HIV/AIDS	12
Knowledge of Risk Reduction Strategies and Self-Reported Behaviors.....	14
Self-Efficacy Around Risk Reduction Strategies	17
Information Seeking Preferences.....	19
Access to Health-Related Services	20
Findings for Program Managers	21
Conclusions and Recommendations for Interventions	23
References	26
Appendixes	27

INTRODUCTION

Although injecting drug users (IDU's) remain a priority population for targeting of HIV prevention interventions in Michigan, the State has little recent, systematic, population level data on the HIV prevention-related needs of this group. This study will fill a gap in our knowledge about IDU's in Michigan by examining the current behaviors and needs of this population and the extent to which these needs can be met by HIV prevention interventions and services.

The goals of this study were to determine IDU's:

- Current sex and drug use behaviors, including HIV risk reduction strategies
- Primary health concerns
- Knowledge of HIV risk reduction
- Perceived severity and susceptibility to HIV/AIDS
- Perceptions of the barriers and facilitators of taking self-protective action around HIV/AIDS risk behaviors
- Information seeking behaviors and preferences around health issues in general, and around HIV specifically
- Perceived importance of and utilization of health-related

Secondary goals of this assessment were to:

- Examine HIV and substance use program manager's beliefs about the groups at risk for HIV
- Examine program manager's assessment of the HIV prevention related needs of the IDU population
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- Examine the climate that exists around provision of HIV prevention services to IDU's

The study involved 52 structured interviews and 125 street intercepts with people who self-reported the use of injecting drugs in the year prior to the data collection. Participants included those accessing and not accessing drug treatment and were sampled using a quota sample from six communities around Michigan: Benton Harbor, Detroit, Flint, Grand Rapids, Kalamazoo, and Ypsilanti. Program managers from HIV prevention community based organizations (CBOs) and substance abuse treatment centers were also interviewed from these communities. The data collection yielded both quantitative and qualitative data. The following sections describe the method of data collection, results of the data analysis, conclusions and implications.

Method

Sampling of IDU's

The current study was designed to gather information from IDU's in six communities in the State of Michigan. The six communities were chosen because they are urban centers and epidemiological data indicates they have relatively high HIV prevalence rates. A quota sample was employed with city, race, and drug treatment status (in vs. out) as strata. The sample size for the strata was estimated based on the State's 2000 census data for the demographic factors listed above. Sampling occurred with the help of agency staff of (CBOs) in each city in order to increase the likelihood that participants were injecting drug users without using questions or obtrusive methods to screen participants. Screening questions were not used for several reasons. First, concern for the safety of the interviewers. Second, screening based on self-reported behavioral characteristics that are not verifiable (e.g., injecting drug use history) may result in over-reporting of behavioral characteristics in order to gain incentives.

Due to the sensitive nature of the interview issue (i.e., illicit drug use), minimal identifying information was solicited, thus it was necessary to take a number of steps to avoid duplication of data. First, sampling for each city was conducted within a one-week period and, while multiple interviewers were used, one of these interviewers was present for all the interviews and intercepts. Furthermore, the small sample size meant that the interviewer would be able to recall all participants within a given city.

For both the interviews and intercepts, potential participants were approached in areas known to be frequented by IDU's. Potential interview participants were then asked to go with the interviewer to a safe place where the interview could be completed. Intercept participants completed the intercept in the place where initial contact was made. Determinations for participant inclusion in the sample were made after the interviews and intercepts were completed. Only data obtained from those participants who self-reported having used injected drugs within the last year were included in the analysis. This time frame was chosen in order to increase the accuracy of the self-report measures.

Procedure

Interviews and street intercepts were conducted over a 5-month period from January to May 2003. With the exception of the length of the interview and the incentive for participation, the same procedures were followed for both the interviews and intercepts.

After administering informed consent and requesting consent for tape recording the interviews, interviewers completed a structured interview or intercept protocol. In all cases, the first people contacted were invited to complete the interview and once the interview quota was filled for each city, the rest of the contacts were asked to participate in the street intercept.

The street intercepts were designed to supplement the information gleaned from the more in-depth interviews. All questions asked in the intercepts were also asked in the interviews. Both the interview and intercept protocol were designed based on behavioral theories of perceived

risk. The interview protocol is included in Appendix A and the protocol for the street intercepts is presented in Appendix B. All interview participants received \$20 cash compensation for their participation and intercept participants received \$10.

All interviews and intercepts were audio taped and transcribed. The transcriptions were used to create a data set of quantitative data. Thus, the data collection yielded both quantitative and qualitative data. The qualitative data were reviewed for emergent themes by the research team. In the results section presented below, direct quotes from the interview participants will be followed by the participant’s interview number in parentheses. The quantitative data were analyzed using the Statistical Package for the Social Sciences (SPSS). In the analysis, the intercept and interview data will be considered together. The results of the analysis of the data for program managers will be considered in a separate section, but will be integrated into the conclusions and recommendations.

Participants

The initial sample consisted of 204 total participants. Twenty-seven individuals who indicated that they had not used injecting drugs in the year prior to data collection were excluded from the final analysis. The final sample (N=177) consisted of 52 interview participants and 125 street intercept participants. Across the intercepts and interviews, twenty-five percent of the sample were people who reported currently being engaged in some form of drug treatment. The breakdown of number of interviews and intercepts per city is presented in Table 1 and 2 below. Interviews conducted in Kalamazoo and street intercepts conducted in Flint yielded only participants who did not meet the criteria for the sample and who were subsequently dropped from the sample, a fact not discovered until data analysis occurred. The interviews were primarily conducted in an outreach van in areas with high concentrations of IDU’s, but interviews and intercepts were also conducted in drug treatment facilities, methadone clinics, street corners, needle exchange programs (NEP’s), and in the participants’ homes.

Table 1 Number of interviews in each city.

		City in Which the Interview was Conducted			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Grand Rapids	6	11.5	11.5	11.5
	Detroit	31	59.6	59.6	71.2
	Ypsilanti	6	11.5	11.5	82.7
	Flint	4	7.7	7.7	90.4
	Benton Harbor	5	9.6	9.6	100.0
	Total	52	100.0	100.0	

Table 2 Number of street intercepts in each city.

City in Which the Street Intercept was Conducted		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Grand Rapids	15	12.0	12.0	12.0
	Detroit	74	59.2	59.2	71.2
	Ypsilanti	21	16.8	16.8	88.0
	Kalamazoo	5	4.0	4.0	92.0
	Benton Harbor	10	8.0	8.0	100.0
	Total	125	100.0	100.0	

The participants were asked to self-report their sex and race/ethnicity. Participants, 62% of whom were male, were primarily Black or African American (64%), followed by White (28%), Hispanic/Latino (2.3%), Mixed race (2.3%), and American Indian (1%). Most participants were heterosexual (89%), followed by behaviorally bisexual (8%), lesbian (2%), and homosexual (1%). The average age was 44.75 (S= 9.73) with a range from 18 to 84 years of age. Ninety-five percent of respondents reported that they have been tested for HIV. Of those who had been tested, most reported that test was negative (n=168; 94%). Several indicated they are HIV positive (n= 4) or said that they did not learn the results of the test (n=7). About 25% of the sample indicated they are currently accessing some form of drug treatment.

Interviews with Program Managers

In addition to the methodology described above, program managers from five communities (Detroit, Flint, Grand Rapids, Kalamazoo, and Ypsilanti) were interviewed during the same 5 month period as the IDU interviews and intercepts. For each community, one program manager from an HIV prevention community-based organization and one from a substance abuse treatment center took part in the interview resulting in a sample of 10 program managers. Program managers were chosen for the sample because these individuals generally control the targeting, design, and implementation of programs for an agency. The interview protocol for these interviews is presented in Appendix C. The findings for this group will be discussed in a section separate from the findings for IDU's.

FINDINGS FOR INJECTING DRUG USERS

Patterns of Drug Use

Most of the participants (n=150; 85%) indicated that they used injecting drugs in the week prior to the interview. Those who did not report injecting in the week prior to the interview or intercept were typically in treatment programs. For those who reported use of injected drugs in the last week, the sample size (n) mean, median, and standard deviation for each type of injected drug are presented in Table 3. Heroin is the primary drug used by those in the sample. The number of times in the prior week ranged from zero to 84 times with people on average reporting using 2-3 times a day, seven days a week. Injecting cocaine was less common with 10% of the sample reporting having injected in the last week with a range of 1-25 times. Nine percent of the sample reported injecting speedballs (heroin and cocaine combined) ranging from 1 to 30 times. Only two people reported injecting amphetamines in the week prior to the study. The other drugs participants reported having injected were methadone and OxyContin.

For those who reported not having used injected drugs in the last week, they were asked to discuss the reasons they had not injected. Most said it was because they were receiving some type of drug cessation treatment (n=19), because they had made the decision to get clean (n=6), they would have to go back to jail or prison if they used (n=3) or other reasons.

Table 3. Total number [N], mean, median, and standard deviation for the number of times injected each substance in the last week.

	Number of times injected heroin in last week	Number of times injected coke in last week	Number of times injected speedballs in last week (Heroin and Coke)
N Valid	150	150	150
Mean	16.4667	.7733	.4867
Median	14.0000	.0000	.0000
Std. Deviation	14.8436	3.0436	2.7944

At the time of the interview, participants were asked to estimate the length of time it had been since they last used injected drugs. For many participants, particularly those not accessing substance abuse treatment, this time was calculated in hours rather than days (n=28). Participants reported an average of 5.71 hours (S=5.65) since they last injected drugs (ranging from 30 minutes to 22 hours before the interview). For those who had not used in the 24 hours prior to the interview, the mean was 105 days (S= 105.33) or about 3.5 months (with a range from over 2 days prior to the interview to 360 days).

Interview participants were also asked about substances they had used in the last week other than injected drugs. Many respondents reported not using other substances (approximately 30% of participants). Of those who reported using other substances most used alcohol, crack, or

methadone. Other drugs reported less frequently were marijuana and painkillers (e.g., morphine), OxyContin, or non-injected heroin or cocaine.

Primary Health Concerns

IDUs mentioned a wide variety of health concerns associated with both mental and physical health issues including anxiety, ulcers, diabetes and poor circulation. Hepatitis, and particularly hepatitis C, received frequent mention among all health concerns. HIV/AIDS was mentioned as a concern by less than one third of respondents. One respondent said, “I don’t know, like I might be damaging my liver.... It’s seems like I’ve been shooting up drugs since I’ve been eighteen and I’m fifty-six now. I might wind up with HIV or whatever. I share needles and I haven’t even been tested for HIV.” (47) Those in treatment were more likely to mention hepatitis and HIV/AIDS and more likely to mention having been diagnosed with hepatitis than those not in treatment. About 25% of interview respondents spontaneously reporting being infected with hepatitis C.

There were a number of participants who indicated that they had no health concerns and, interestingly, most people did not mention their drug use as a health concern. When drug use was addressed as a concern, it often wasn’t the drug use itself that was the concern—it was problems that respondents believed were a result of their drug use (or methadone treatment). For example, one respondent reported muscle aches and another liver problems and back problems that they believed to be a result of drug use.

Perceived Risk for HIV/AIDS

Research indicates that perceived risk motivates adoption of protective behaviors. Individuals perceive themselves to be “at risk” if they find a health threat, such as HIV, frightening or severe (i.e., “perceived severity”) and they also believe themselves to be susceptible (i.e., “perceived susceptibility”) to the health threat. Research indicates that without perceptions of both severity and susceptibility, people will not adopt or sustain risk reduction behaviors (Witte, 1992). Thus, it is important to understand the extent to which IDU’s perceive that HIV is a severe health risk and their likelihood of contracting it given their behaviors (susceptibility) in order to target these factors with health interventions.

Perceived Severity of HIV/AIDS

In the initial general question that asked respondents about their greatest health concerns, HIV/AIDS was mentioned as a concern by about a third of respondents. Later in the interview, before asking explicit questions about HIV/AIDS, participants were asked whether or not HIV/AIDS was something that they thought about. Most participants reported that they do think about HIV/AIDS. Some indicated that they think about it very frequently or at least when they are prompted by some event. Most respondents indicated that they are most likely to think about HIV/AIDS when they are engaging in risky behaviors, particularly sex and sometimes while they are injecting. One male respondent said “I think about it constantly man because you know like I love women you know, some of them they just... it’s just scary.” Another said “I can honestly

say every time I inject, I think about it. Yeah. I may not dwell on it, but I think about it.” (143) Generally, most of those who said they think about HIV/AIDS indicated fear, around becoming ill and/or dying from AIDS.

Several people linked their fear of HIV/AIDS with the belief that they would be stigmatized if they had HIV/AIDS. As one respondent said “I think about dying and the way I'll be treated by other people. Well I know that being a junkie, there's already that stigma when you go the hospital, I mean they can see your arms....you get treated different. They don't like it and that's just a fear I have you know I mean it would be worse if I was a junkie with AIDS.” (18) Others mentioned that when they thought about HIV, they thought about what others (e.g., friends, family) would think about them if they had it.

Some participants who expressed concern about HIV/AIDS indicated that when they thought about HIV, they think about their family and the potential impact of their HIV status on their family members or the possibility that family members might also be putting themselves at risk. As one respondent said, “I think about HIV and my family...bringing something back home, destroying my career and everything else, which I have done already. Just being out here, doing what I'm doing now, it's destroying my family.” (13) A number of respondents had family members or close friends who died of AIDS and they reported that this caused them to think about HIV/AIDS frequently.

It was less common for people to say that they never think about HIV/AIDS. Of those who said they do not think about it at all, it was often because of a sense of fatalism and/or a desire to avoid knowing about their status. One male respondent said, “I feel like this, if I'm going to die, I'm going to die. I'm doing drugs and if I got it, then I'll just have it. I don't want to know. I don't want to know if I have HIV.” (40) Another respondent attributed his lack of concern about HIV/AIDS to his drug use; “When you're getting high, you really don't think about it. To be honest with you, you don't think about it until you clean up your act a little bit.” (53) Others said that they do not think about HIV/AIDS because they perceive that they are not doing anything that would put themselves at risk for HIV. As one participant said, “I don't think I can get it. Simply because I don't share needles, and I'm monogamous with my girlfriend.” (8)

It is apparent that for the most part, IDU's in this sample do perceive that HIV/AIDS is a serious potential threat and fear what they believe are the possible outcomes of getting HIV/AIDS including sickness, dying, destruction of their family, and stigma.

Perceived Susceptibility to HIV

Perceptions of susceptibility were quite varied. Many respondents indicated a strong belief that they were not likely to get HIV and often indicated that this is because they practice risk reduction activities in order to avoid exposure to HIV. “I don't think about (getting HIV). I'm pretty safe you know. I always come (to the needle exchange program), I get clean works I'm very careful about using mine only and so I'm being pretty clean you know.” (7) Others clearly indicated that they believe that because of their past and current behaviors they are very likely to get HIV/AIDS. Some indicated fairly feeling susceptible to HIV based on highly improbable events. As one respondent said: “Yes. I think that I could get it you know...(from) getting in a

fight with somebody. We will get in a fight and both of you guys bleeding. That's my...fear.” (34) Some respondents indicated a belief that they were already infected even though only four people in the sample had been diagnosed with HIV infection.

Knowledge of Risk Reduction Strategies and Self-Reported Behaviors

Participants were asked several questions designed to understand their knowledge of HIV risk reduction strategies and whether or not they engage in risk reduction behaviors.

Generally, respondents had high levels of general knowledge methods of HIV risk reduction. Nearly all respondents indicated that using condoms during vaginal (and sometimes oral) sex and not sharing needles or works were things that people could do to reduce their risk for HIV. Others indicated that monogamy and the avoidance of IV drugs, blood transfusions, fights where blood may be drawn, and homosexual sex as risk reduction strategies. Many respondents mentioned abstinence as a strategy. Another said: “don't mess with a person that have sores and stuff around” and “don't mess with whores”(47).

When asked about their own behaviors, use of condoms and not sharing needles or works were the things most frequently mentioned by participants. Not surprisingly, a large number of respondents reported that when they are not high, or trying to get high, they do not usually do things that put them at risk for HIV. This was most clearly stated by those who are currently in treatment. Participants indicated that they are most likely to be at risk for HIV/AIDS when they are trying to get drugs, high, or drug sick. Generally, people talked about their behaviors in terms of engaging in safer sex behaviors or safer shooting practices.

Safe Sex. Respondents indicated that using or trying to use male condoms was one thing that they do to protect themselves from HIV/AIDS. Many people admitted to sporadic condom use. Often people who reported not wearing condoms did so because they were having sex with someone they believed to be a monogamous spousal or non-spousal partner. As one participant said “Well I don't basically protect myself from HIV. If I contract it, it would be from one source, and that would be my wife. I couldn't protect myself from that anyway. I don't have outside sex, I don't share needles outside of me and her.” (146) When asked specifically if they used a condom last time they had sex, 58% of interview respondents indicated that they had not used a condom.

Some participants reported they were not interested in and were not having sex for reasons ranging from the fact that heroin reduced their sex drive to viewing abstinence as a self-protective strategy.

Other participants indicated that their attempts to use condoms were sometimes hindered by their partners. Importantly, 42% of the sample reported that they have at one time exchanged sex for drugs or for money for drugs. In this sample, women generally reported receiving money for drugs, and men typically paid for sex. Several women reported currently working as commercial sex workers (CSW's). Among those who exchanged sex for drugs or money some said, particularly women, that they know they often won't get paid if a condom is used during intercourse, so they don't. As one woman said “Sometimes it's hard to out here. Guys don't want

to wear condoms and you ...you need the dope, I mean It's kind of hard sometimes to say well I ain't going to do it if you don't wear a condom. I need to go ahead and go through with it. Yes. Money is too hard to come by." (45)

Safe Shooting. Participants talked about not sharing needles or sharing needles only with someone that they believe is "clean" (e.g., spouse, brother, or friend) as things they do to reduce their risk for HIV. One participant said: "I use my own paraphernalia and needles. And if I use a stem behind someone else, I always clean it. But I usually have my own. Maybe one time out of a hundred times, I might use someone else's. But I always make sure I clean it." (30) One participant indicated that she typically shares with her boyfriend and that they share needles that they buy off the street: "Me and him had been sharing needles. We don't have that many needles. I just buy them off the streets, off people." (47) As one man indicated about sharing with his wife: "...sometimes I run out (of needles) before she runs out. I don't want to you use a dull needle. I'll use one of hers. But I don't consider that sharing because I'm not getting it from my buddy down the street. I know she's clean, so I really don't consider that sharing." (101)

In those cities with relatively active needle exchange programs (NEP); (Detroit and Grand Rapids, in particular), the importance of these programs was clearly stated by participants. One participant in Detroit said:

I just appreciate Life Points, the needle program. A lot of times people don't have that kind of money to spend on new needles all the time and I appreciate that they are doing it for this area. I've been in the program for about three years now. I've been able to get condoms, every thing you need except the drug itself, the truck gives, you know, alcohol pads, the caps, the cotton swabs, and everything you need and that's helps you to cleanly use your drugs. (125)

It was primarily in cities without these programs or where the NEP have a more limited reach where it was more likely to hear participants talk about never or rarely using clean or new needles and works. However, in all cities there were people for whom risk reduction was not a priority. As one participant said, taking steps to reduce his risk for HIV around shooting "Never crossed my mind." (67)

Participants in the interviews were asked about their behaviors the last time they used injected drugs. About 75% of the respondents indicated that they used a new needle the last time they injected. Participants were less likely to report having used new works (syringes, cookers, cottons), with 36% of participants indicating use of new works the last time they used. When asked the frequency with which they had used clean needles over the last week (scaled from never to always), 43% indicated "Most of the Time" and 40% indicated "Always". The remaining 17% indicate they "sometimes" or "never" used a new needle.

Some of the participants who did not use new needles or works indicated that they cleaned their needles. Participants were less likely to report cleaning works. Of those who said they cleaned either their needles or works, however, almost none of the participants indicated using the CDC recommended three times bleach/water rinse. Participants most frequently indicated that they

clean with alcohol or bleach and water (but not three times). Other substances participants mentioned they use to clean needles and works were water alone, ammonia, and antibacterial soap. Many participants recognize that when they clean, it may not be an effective method for reducing their risk for HIV. Participants talked about being afraid of using cleaned as opposed to new needles and noticing that even after cleaning (with some substance or another) there was still blood in the needle.

Additional Commonly Mentioned Risk Reduction Strategies. There were several risk reductions strategies that came up frequently during the interviews that are important to highlight.

Social Isolation. A number of people reported that using only when they are alone or using only with close friends or family members was a strategy that they use to reduce their risk for HIV. One participant said “If I use, I use in my own house. I’m not on the streets. People I do know that are clean, I use their syringes.” (99) According to these participants, isolating themselves from others allowed them to: avoid sharing needles/works or at a minimum, only share with someone they believe is “clean” (either uninfected or having good personal hygiene); avoid being asked by others to share or having others use their works, needles or water without asking, and avoid “mixing up” their needles with others. As one respondent said, “I worry about using needles... just about the needle getting mixed up on the table or something like that. That's why I try not to let anyone else be around when I'm doing it.” (121)

Cleanliness. A number of participants, particularly older participants, reported doing things such as keeping clean in order to protect themselves from HIV. For example one man reported that by being in his home, he was able to protect herself from HIV. He said, “My home is clean. I know that everything is sanitized and stuff at home (76).” Others reported always checking to make sure eating utensils and glasses were clean before using them in order to avoid getting HIV.

Several respondents reported taking showers or baths with sex partners before having sex as a protection mechanism or checking to make sure their potential partner is clean: “When I have sex, I always make sure the person’s hands are clean and I always use protection.” (30) One man indicated he used condoms at his discretion and his decision to use a condom was based on how the potential partner looked, he said “I guess appearances, attractiveness, cleanliness on the outside, dress well.” (61) Another man said “I’m very careful when it comes to protecting myself. Some of the guys be saying ‘You clean, you’re a clean dope fiend’.” (88)

Other Strategies. Some participants mentioned avoiding things that were not likely to happen or not likely to result in transmission of HIV. One participant said he avoided fights in order to reduce his risk for HIV: “...Not getting into fights... Well if you get a cut on you and they blood get on you, they say you can contact it that way.” (90) The same participant also said: “Going into strange building like that you know and trying to shoot up and maybe stepping on a needle or either putting my hand on a needle that might have been dirty.” (90) Another woman said: “I don’t wear other people earrings. I don’t use needles. I have all of my own personal items like tooth brush and personal items. Keeping my hygiene clean.” (50). One participant indicated: “I don’t drink behind nobody, I don’t eat behind nobody, I don’t smoke behind nobody.”(94)

Self-Efficacy Associated with Risk Reduction Strategies

With some exceptions, respondents appear to have moderate to high levels of self-efficacy associated with reducing their risk for HIV through using new needles, not sharing needles, and using condoms, except when they are drug sick or really need to get high. Although efficacy appears to be typically high, most respondents report not always engaging in risk reduction behaviors. There is, however, some evidence of a sense of fatalism or helplessness among some respondents. One respondent said: “I don’t think about (HIV) because I feel like this, if I’m going to die, I’m going to die. If I’m doing drugs and if I got it, then I’ll just have it. I don’t want to know. I don’t want to know if I have HIV.” (40)

Barriers and Facilitators to Risk Reduction

Participants were asked about the things that make it easier or more difficult to take steps to reduce their risk for HIV/AIDS.

Barriers to Risk Reduction. Participants often cited other people on the streets and their friends as factors that made it difficult to take action to reduce their risk for HIV. Sometimes they blamed strangers, for example, “People doing sneaky stuff...selling some works that are used and they claim they are new.” (92) Several people mentioned that others would sometimes use their needles without asking their permission or telling them about it. Other people blamed friends or family for making it harder for the participant to engage in risk reduction. As one woman said: “He’s my friend and when I’m on the methadone clinic and I’ve actually been clean now for almost six months but he uses every day and he throws it in my face and he will shoot me up with his needle if I want, and it’s hard. It’s hard to have that in my face all the time. And that makes it very difficult.” (18si)

Several people also indicated that accessing treatment programs including methadone clinics actually made it more difficult for them to do things to reduce their risk for HIV. One person mentioned the name of a particular drug treatment facility as a barrier and when asked to explain he said: “Because everybody in here have something going on. Almost everyone - even the staff. We had the director here today earlier just a little while ago he said all this drug activity going out of here. You see most of it is going on by the people that...that stays here and he knows it.” (13) Another person said of the methadone clinic: “There’s probably more drugs here than any where else. Yeah, you bet, pills anything you want you can get it here. And it’s frustrating for me cause I try to stay clean and to see everybody else using and they just keep coming back and keep on using you know I mean the clinic don’t give a sh---.” (18)

Other barriers mentioned frequently included:

- Addiction to drugs and accompanying drug sickness if they are unable to access heroin: “The addiction itself, because you be so addicted, so sick, that you need heroin in you that if you don’t have a clean needle, you will use somebody else’s needle.” (146)
- Lack of access to clean needles either from not being able to access a NEP or from being unable to buy needles from pharmacies: “When there’s a limited

supply of needles for one. There's not enough to go around and again you have to find the bleach and the water and just being broke in general... (2) and "I know I've tried to buy like needles at pharmacies before and have them tell me no. It's happened probably like three or four times. They want a diabetic card." (14si)

- The environment of the street: " Well, I would think the environment you know. If you go into an environment where everybody's jabbing and stabbing or you know I would say like the old bath houses out in San Francisco you know way back when." (22si)

Facilitators. Many people mentioned needle exchange programs as a factor that helped them to reduce their risk for HIV. As one person indicated: "I think that the truck that comes by here and give out the needles and stuff, I think that makes it real easy for me to be able to protect myself. I think that's real that's as a matter of fact that's the reason how I protect myself. Because of the condoms that they give out and the syringes, you know. If it wasn't for the trucks that gave out the syringes and stuff, you know, I would find myself in some hellava predicament."

People also mentioned that being alone or staying off the streets helped them to avoid doing things that put them at risk for HIV. Others mentioned surrounding themselves with what they termed "positive people" and involvement with a church as a protective strategy.

Risk Reduction vs. Drugs. As an attempt to uncover the situations in which participants overcame barriers in order to protect themselves from HIV, participants were asked if there were times when protecting themselves from HIV was more important than using. This question elicited primarily three responses: always, never, and always, except when the participant was drug sick.

- ❖ Always: "I would say keeping myself healthy is always more important than drugs, cause I had a needle with no bleach, if I knew that person had AIDS that use it before, I'm not going to use it. I'd rather stay sober than high for five minutes than get sick for the rest of my life." (5)
- ❖ Never: When one person was asked if these types of situations exist, the participant said: "To be honest, there are none." (60)
- ❖ Always, except when drug-sick: "...especially if you're dope sick you just want to get that fix, so it's like well do I want to wait till I bleach this out or just get high, I'll just get high."(2) and "...at the time, it don't seem to matter because I got to have the dope. If I absolutely knew somebody had it (HIV), I would definitely refuse it. Well I can't even say that. I don't know, I guess not. If I was sick and needed the drugs real bad, I don't know I might go through with it and do it. (45)

Information Seeking Preferences. Participants were asked both who they talk to and who they trust for health-related information in general, and HIV information specifically. Much of the sample appears to be not particularly discriminating about sources of such information. That is, many indicated that they were willing to accept and believe information from a variety of sources. Several people said “anyone” when asked about who they would trust for health information and others said “you” (referring to the interviewers) or someone like you” although the participants had no previous relationship or contact with the persons conducting the interviews.

General Health Information. Participants were asked who they talked to about their general health worries or problems. Most participants said they primarily talked to their own doctor or emergency room doctors about their health concerns. People also frequently mentioned family members (e.g., spouse, children, parents) with whom they discussed health issues. Other sources mentioned by participants included: friends, fellow CSW’s, God, and people who work the NEP. Not surprisingly, many participants appear to be lacking access to health information and services.

When asked about the sources that they trust for health-related information, participants indicated they trust doctors and the health department. Many also indicated that they trust community-based organizations (CBO’s), but often people did not make the distinction between CBO’S and the health department or reported that they did not have experience with CBO’s. Most people indicated that they do not trust the media as a source of health information. As one respondent said in reference to the media, “They sometimes they say stuff that’s not investigated or don’t tell the whole thing. Because the media will try to feed off what the community says and they will take it and flip it to make it sound like they want to.” (37)

Some respondents expressed a belief that doctors don’t trust IDU’s. According to one respondent “...doctors think you are trying to trick them to get drugs.” (1) As was mentioned in a previous section, another indicated that IDU’s are stigmatized in the health care system. He said: “Well I know that being a junkie, there's already that stigma when you go the hospital... I mean you get treated different” (18)

HIV Information. Participants were asked who they talk to about HIV/AIDS and who they trust most to give them information about HIV/AIDS. In terms of who they talk to, many people indicated first their doctor (about 40% of participants) or their friends/peers (about 50% of participants) including other IDUs. Importantly, about 40% of the sample said they do not talk with anyone about HIV/AIDS. Interestingly, despite the fact that many agencies, in the areas that were sampled, including NEPS, provide HIV prevention information, most of our sample reported never talking to anyone from such agencies about HIV. Sadly, several people indicated that the interview in which they were taking part for this study was the most that they had ever talked to anyone about HIV.

Access to Health-Related Services

General Health. Participants mentioned a range of health services that they perceived as personally important to them. Many people talked about the importance of and their need for mental health services, including counseling. Participants consistently talked about their need to end their drug addiction. Others talked about the importance of Medicaid and of the importance of particular hospitals and clinics, often in terms of emergency services. Detroit Receiving, Detroit Health Department (Herman Kiefer), and the Veteran's hospital were mentioned many times as having services that the participants valued.

Some of the other health services mentioned by respondents included:

- ❖ Dental health services
- ❖ Hepatitis vaccination and education
- ❖ Pediatric services for their children
- ❖ Prescriptions

Access to Needle Exchange Programs (NEP). The most common health-related service mentioned by participants as important to them, particularly in Detroit and Ypsilanti, was the NEP. For example, one participant indicated "The health services that are most important to me are like the needle exchange program. That's very good for me. Also I'd like to get into a program, a methadone program." (143) It is important to mention that the emphasis on NEP was probably due, in part, to the fact that in order to access IDU's much of the sampling occurred around NEP sites so needle exchange was more salient for participants. Those in several other communities (particularly Benton Harbor and Flint) reported no knowledge of access to clean needles and works. People from these communities were also more likely to be using previously used needles/works and cleaning in unconventional ways. Participants in Grand Rapids appeared to have knowledge of places where one could go to exchange needles, but few indicated going there.

Access to Substance Abuse Treatment Programs. In general, people not accessing drug treatment indicated a belief that it would be relatively easy to access treatment if they wanted to do so. Others already in treatment indicated it was easy to get into treatment. This was due, in part, to the fact that many of the participants reported that they entered treatment because the judicial system required it as part of sentencing. The other reasons people cited for getting into treatment were:

- ❖ Exhausted/stressed out from the drug lifestyle (people commonly said they were "tired" of the drug lifestyle)
- ❖ Family prompted them, either explicitly or implicitly
- ❖ A "big event" occurred that made them reassess their lifestyle (e.g. stole money from family member, got in an accident, etc.)

Of people who reported a belief that it would be difficult or reported that they had had difficulties gaining access to substance treatment it was typically because they lacked the necessary identification, had other commitments that they believed could not be interrupted by

treatment (e.g. job, children, etc.) or didn't have the money or insurance necessary. Participants from Ypsilanti and Benton Harbor were particularly likely to believe it was difficult to access treatment.

Several participants indicated that they did not feel satisfied with existing substance abuse treatment facilities. This woman hinted to the complexities of treating IDU's:

“I would want to go where that one, where they teach you about doing things outside, somewhere where they teach you about doing things outside and not just focus on the drug itself. We already know about the drug, but my point is when you go into treatment, they stereotype for you to go to treatment and you talk about dope, dope, dope, dope. If you are a dope user or drug addict, you don't want to hear about that, you want to hear about something that will keep you occupied besides the drug.” (174)

In terms of access to methadone specifically some participants indicated that because they were on probation they were unable to access methadone and several mentioned that methadone caused them health problems (i.e., bloating, muscle soreness). Moreover, several participants talked about the drug culture that exists in methadone clinics, including drugs for sale at the clinics and perceived pressure to use drugs from others at the methadone clinics.

FINDINGS FOR PROGRAM MANAGERS

Beliefs About HIV Risk Populations

Before explicit mention of IDU's by the interviewer, program managers were asked which populations they believed were most at risk for HIV. All but two of the respondents indicated IDU's as one population at risk for HIV. Interestingly the two who did not mention IDU's were from HIV prevention programs. Other risk populations specifically mentioned by the program managers were MSM, CSW's, African-American women, pregnant women, youth, high risk heterosexuals, and sex partners of IDU's.

HIV Prevention-Related Needs of IDU's

Eight of the ten program managers explicitly mentioned access to sterile needles as a primary HIV-prevention need for IDU's. Only three of the respondents explicitly mentioned access to treatment as a primary need for IDU's, two of whom were substance abuse treatment program managers. Five of the respondents mentioned education about transmission as a primary need. Interestingly, when asked a more general question about the primary needs of their clients prior to the question regarding HIV-specific needs, half of the respondents indicated access to health care as a primary need, but none mentioned this as an HIV-related need. This combined with the limited variation in response to the question regarding HIV-related needs suggests that providers may have a relatively narrow definition of what constitutes an “HIV-related need”.

HIV Prevention Programs Targeting IDU's

All of the ten program managers indicated that their agencies have programs or services that they know to be accessed by IDU, and eight of the agencies have programs that explicitly target IDU. Of the two that did not have IDU- specific programs, one was an HIV prevention agency doing

outreach in substance abuse clinics. Three of the substance ABUSE treatment programs reported partnerships with HIV prevention organizations for the provision of HIV prevention interventions. HIV counseling and testing, basic education (i.e., “AIDS 101”) and needle exchange were most frequently targeted to IDUs.

Program managers were asked about what they perceive as the barriers to IDU’s accessing HIV prevention services. All of the participants reported that stigma related to injecting drug use hindered people’s ability to access HIV prevention services. Implicit and, sometimes, explicitly related to this belief is the notion that somehow IDU’s do not trust providers or the “system” in part because of the legal issues surrounding their disclosure of their use of illicit substances. One participant said “They believe that the health department is the way it used to be in the old days where you know you have to stand in long lines to get services, they don't....they have heard so many negative things about the system they are not really ready to come back into the system.”

Communication About Services

All of the respondents indicated that word of mouth was the primary way that they communicated their services to potential clients. The word of mouth communication was generally accomplished by the agency’s counselors or outreach workers or by a referral from another agency. Outreach workers were cited as a communication source primarily by the HIV prevention agencies—only one of the substance abuse treatment program managers mentioned the relatively systematic use of outreach workers for informing people about the agency. Several of the program managers mentioned other methods for communicating about the agency’s services including brochures, flyers, and advertisements. Importantly, none of the communication strategies seemed to be very systematic in nature. One HIV prevention program manager reported on the successful marketing of the agency’s NEP program by placing cards in pharmacies that no longer sell syringes without a prescription.

In terms of referral strategies, most agencies indicated that they refer their clients to sources internal and external to the agency for a variety of services including hepatitis and STD screening, food and shelter, and NEP. All the HIV prevention program managers reported referring to substance abuse treatment centers and all of the substance abuse treatment centers reported referring to the HIV prevention agencies.

Six of the agencies do some kind of tracking of referral, but most indicated that it was done informally or inadequately.

Political Climate and Provision of Services to IDU’s

The program managers were asked for an assessment of the current political climate for provision of services to IDUs. The responses indicate community by community differences in climate, but several issues emerge as important. First, the belief among providers is that IDU’s are viewed as the dregs of society who people would rather ignore or arrest than help. Second, the extent to which NEP programs exist or do not exist appears to be due primarily to the political will on the part of the mayor of the community. Several participants explicitly mentioned mayors who facilitated or hindered the creation of NEPs.

CONCLUSIONS AND RECOMMENDATIONS FOR INTERVENTIONS

There are several conclusions and recommendations that are clear given these data.

- ❖ In communities where needle exchange was available, many participants talked about the extent to which these programs helped them take steps to reduce their risks. In communities where exchange programs are not active, many more participants talked openly about sharing and reusing needles. Access to new needles and works through needle exchange programs (NEP) or pharmacies is preferable to teaching participants cleaning techniques. According to the CDC “using syringes that have been cleaned with bleach and other disinfectants is not as safe as using new, sterile syringes “ (CDC 2000:2). The steps necessary to clean are too cumbersome given the constraints faced by most IDUs who often may be too sick to clean.
- ❖ According to these data, it appears that the NEP that are currently functioning are not sufficiently promoting their services nor are they sufficiently addressing HIV risk reduction strategies with clients, they are simply supplying clients with new needles. Some IDU’s who passed by the NEP each day did not know what it was. Many participants (at least 40%) reported never talking with anyone about HIV. Data from the program managers indicates that generally, agencies do not appear to have any systematic plan for marketing their services. Capacity to target and promote services must be addressed.
- ❖ The continued risk behavior on the part of clients despite relatively high levels of knowledge and self-efficacy indicates that continued risk behavior is probably a result of numerous complex psychosocial factors, something indicated by several of the substance abuse treatment program managers. Future interventions targeting IDUs should incorporate one-on-one HIV prevention counseling in order to address HIV prevention in the context of the broader psychosocial challenges faced by IDU’s.
- ❖ Hepatitis A, B, and particularly C were frequently mentioned by participants and, without being asked, a number of participants indicated they had tested positive for some form of hepatitis. This, along with the data which indicates regular HIV testing on the part of many IDU’s, indicate hepatitis screening and vaccination should be made widely available to IDU’s through NEP’s and treatment sites. Moreover, education regarding viral hepatitis transmission risk factors and preventative strategies should be integrated into HIV prevention and substance abuse prevention/treatment efforts targeted to IDU’s.
- ❖ Participants report accessing needle exchange programs, mental and dental health services, and hospital care as services central to their health needs. For many participants, it appears that doctors (either private or E.R.) are a frequent and trusted source of HIV-related information. Importantly, doctors may be the only point of contact in the health system for IDU’s. Doctors should be prepared to meet the HIV-related needs of clients and be able to engage in appropriate risk assessment and risk reduction counseling activities. Provider education activities designed to build provider capacity in this regard is essential to serving the needs of IDUs.

- ❖ Across our sample, health departments appear to be a trusted source of information. This is contrary to the widely held perception among health providers that particular populations do not trust local health departments. Because health departments appear to be trusted and widely used by IDU's, it is essential that health departments have the capacity to provide HIV prevention-related services to IDU's.
- ❖ Generally, the media does not appear to be a source of information that is considered trustworthy by participants. This has several important implications for HIV prevention efforts using media-related channels. First, most research indicates that mediated communication can serve to increase awareness of products or services or to increase the salience of these services, but is unlikely to result in substantial attitudinal or behavioral shifts. Second, these data indicate relatively little potential impact from mediated sources in this target but that any mediated efforts targeting IDU's should be clearly linked to one of the sources of information discussed as credible by participants in this study (e.g., health departments, doctors).
- ❖ According to these data, methadone clinics are a double-edged sword for the typical IDU. Many IDU's appear to rely on methadone to help them reduce their heroin use. However, many who report receiving methadone treatment are still using, some rather extensively. Moreover, the methadone clinics appear to harbor a drug culture in which there is strong normative pressure to continue using heroin and other drugs. This information coupled with the finding that many of those accessing treatment in some form (including methadone) were more likely to know about their HIV or HCV risk suggests two recommendations:
 - Integration of HIV prevention efforts with substance abuse services is essential and should continue
 - The various forms of drug treatment available appear to be more/less appropriate for various people. HIV prevention providers should work with substance abuse providers to ensure appropriate referral and screening of clients to a variety of substance use prevention and treatment services.
- ❖ A large number of participants reported using social isolation as a risk reduction strategy. Participants also talked about the detrimental effects of environmental and social forces on their ability to practice HIV risk reduction activities. Although it is not recommended that prevention providers *encourage* social isolation, the importance of normative factors and the restructuring of peer groups is something that should be addressed in HIV prevention effort targeted to IDU's.
- ❖ All of the ten program managers indicated that their agencies have programs or services that they know to be accessed by IDU, eight of the agencies have programs that explicitly target IDU. None of the agencies indicated the existence of any systematic plan for marketing their services to clients. Program managers from HIV prevention and substance abuse treatment programs should be provided with technical assistance and capacity building assistance to form strategic plans for marketing their services to potential clients. This should include formalization of the use of interpersonal channels of

communication (including, but not limited to referral) by current clients, outreach workers, and providers likely to interact with IDU's (ER doctors, pharmacists).

- ❖ Program manager's assessment of the current political climate for the provision of services to IDU's was relatively mixed. Several program managers recognized that the climate is different at the federal, state, and local levels.
- ❖ The initiation of NEP's appears to have occurred in a similar process in those communities where NEP's are currently active –and it has involved a grass roots process of engagement with local authorities. The leadership and buy-in of the mayor or other elected official in a community appears to be essential. Coordination and collaboration among providers regarding the provision of services to IDU's should be facilitated in order to address the larger structural barriers to service provision that are evident in these data. Specifically, collaboration should be encouraged regarding building relationships with local providers likely to serve the IDU population and the establishment of NEP's.
- ❖ The need for NEP's was expressed by both IDU's and program managers. Program manager's perceptions of IDU's perceived susceptibility to HIV and the importance placed on HIV prevention, appears to be somewhat inflated by program managers, a fact mentioned by several HIV-prevention program managers.

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Appendix A

Interview Protocol

Date: _____

Site (city, location): _____

Situational Factors (safety etc.): _____

Verbally Administer Informed Consent Yes No

Thanks for agreeing to talk to me. The questions I ask you will focus on health issues and where you go for information about your health. I would first like to ask you a few questions about your health.

1. What are your biggest health worries or problems?

Probe: What other problems?

2. Who do you usually talk to about your health worries or problems?

Probe: Friends or family members?

Probe: Doctors or nurses?

3. Who do you trust the most to give you information about your health?

Probe: Do you ever look to the media?

Probe: Community Organizations?

Probe: Health Departments?

Probe: Why do you trust/not trust these sources?

4. What health services are most important to you personally?

5. In the last year, have you used injected drugs?

No Yes

If "Yes", continue with the next question. If "No" Skip to question 17.

6. In the last week, which of the following have you injected? (check all that apply)

Heroin Alone If check: How many times in the last week? _____

Cocaine Alone If check: How many times in the last week? _____

Amphetamines (speed etc.)
If check: How many times in the last week? _____

Speedballs (heroin and coke)
If check: How many times in the last week? _____

None of the above in the last week (please explain)

7. What other substances have you injected in the last week?

Other _____
If check: How many times in the last week? _____

Other _____

If check: How many times in the last week? _____

Other _____

If check: How many times in the last week? _____

If participant reported IDU in question 6 or 7 ask the following questions:

8. When was the last time you used? _____ (days or hours)

9. Last time you injected, what did you do?

Probe: Did you use a new needle?

Probe: Did you clean your needle? How?

Probe: Did you use a new syringe, barrel or cooker?

Probe: Did you clean your syringe, barrel or cooker? How?

10. In the last week when you injected, how often did you use **new needles**?

Always Most of the Time Sometimes Never

11. In the last week when you injected, how often did you use **clean needles**?

Always Most of the Time Sometimes Never

For Participants Not in Treatment:

12. How hard or easy would it be for you to get into drug treatment if you wanted to?

Probe: Why would it be hard/easy?

Probe: Where would you go?

13. Is there any one event or thing that could happen that would make you decide to go into treatment?

Probe: If yes, please describe this event.

For Participants In treatment:

14. Was there a particular event or thing that happened that made you decide to go into treatment?

Probe: If yes, what was that event?

15. How hard or easy was it for you to get into treatment? What made it hard (easy)?

Probe: How long have you been in treatment (this admittance only)? _____

For ALL Participants

16. Where can you go to exchange your works (needles and syringes)?

Probe: Is there anything that stops you from going?

Probe: Anything that makes it easy for you?

Now that we have talked about health, we would like to talk with you about a particular health issue: HIV/AIDS.

17. Do you think about HIV/AIDS? How often do you think about it?

Probe: Do you ever think about whether or not you could get HIV/AIDS?

18. What are some of things people can do to keep from getting HIV?
19. What are the things you do to protect yourself from HIV?
 Probe: What else?
 Probe: Around sex?
 Probe: Around shooting?
20. What are the things that make it easier for you to protect yourself from HIV?
 Probe: Things or people who help you?
21. What are the things that stop you from trying to protect yourself from HIV?
 Probe: Things or people who make it hard for you?
22. Is there ever a time when protecting yourself from HIV is more important than using drugs?
 Probe: Describe this situation and how you felt.
23. Who do you talk to about HIV?
 Probe: Are there any people in HIV prevention that you talk to?
 Probe: Do you talk to friends? Family?
24. Who do you trust to give you information about HIV?
 Probe: Why?

*Finally, we would like to ask you a couple of questions about yourself.
 (If refused answer, place a "99" next to the question).*

25. Sex (interviewer circle one): Male Female
26. Your age? _____
27. Your racial or ethnic background? _____
28. Do you have sex with...
 Men only Women only Both men and women, mostly men
 Both men and women, mostly women
29. Have you been tested for HIV? Yes No
- 29a. If yes** The last time you were tested, what was the result?
 Positive Negative Didn't find out results Don't Remember
30. The last time you had sex, did you or your partner do anything to protect yourselves from getting/transmitting STDs or HIV? Yes No
 If yes, what?

Appendix B

Street Intercept Protocol

Interviewer: _____ Participant ID: _____

Date: _____ Site (city, location): _____

Situational Factors (safety etc.): _____

Verbally Administer Informed Consent Yes No

1. Do you ever think about whether or not you could get HIV/AIDS? Yes
 No

1a. **(If yes)** What do you think about?

1b. **(If yes)** When do you think about HIV/AIDS?

2. Are there things you do to protect yourself from HIV? (list all)
Probe: What are they? Around sex? Around shooting?

3. What are the people, places, or situations that make it easier for you to protect yourself from HIV?
Probe: Things or people who make it easier for you?

4. What are the people, places, or situations that make it hard for you to protect yourself from HIV?
Probe: Things or people who make it hard for you?

5. Who do you talk to about HIV?
Probe: Friends? Family? Are there any people in HIV prevention that you talk to?

6. Who do you trust to give you information about HIV?
Probe: Why?

7. Sex (**interviewer check one**): Male Female

8. Your age? _____ 9. Your racial or ethnic background?

10. Do you have sex with... Men only Women only
 Both men and women, mostly men Both men and women, mostly women

11. Have you ever exchanged sex for drugs or money? Yes No
11a. Please tell me more about this.

12. Have you been tested for HIV? Yes No
11a. **(If yes)** The last time you were tested, what was the result?

Appendix C

Interview Protocol: Program Managers from HIV, Mental Health and Substance Treatment Centers

1. What do you think are the biggest health concerns for the people you serve?
Probe: What about HIV/AIDS?

2. Who do you believe are the primary groups at risk for HIV?

I would like to ask you more about one particular population: injection drug users.

3. What do you consider the greatest HIV prevention-related needs for IDU's?

4. What do you perceive as the barriers to IDU's seeking HIV prevention-related services?

5. Are there existing programs or interventions in your agency that specifically target IDUs?

Probe: (If yes) What are these programs or interventions?

6. Are there other interventions that do not target IDU's specifically, but are accessed by IDU's?

Probe: (If yes) What are these programs or interventions?

Probe: Are there services you wish you could offer to IDU's but don't?

What are they?

7. Approximately how many IDU's do you serve?

8. Are IDU's being referred to other services?

Probe: (If yes) Where?

Probe: (If yes) Is completion and outcome of referral tracked?

9. How do you communicate available services to IDU's?

Probe: Outreach workers?

Probe: Media?

10. In your opinion, what is the local political climate around provision of services to IDU's?