

SECTION 7: INJECTION DRUG USERS (IDU)

Related information elsewhere in the Comprehensive Plan:
Appendix 1: Epidemiological Profile
Appendix 4: IDU Needs Assessment Materials and Methods
Section 2: Community Services Assessment
Section 8: Priority Interventions

Introduction

The presence of injection drug use is at odds with the bucolic images of Vermont frequently held by both Vermonters and outsiders. There is tremendous denial about the realities of both injection drug use and related HIV transmission in our rural and small-town culture. The common image of injection drug use as an exclusively urban, inner-city phenomenon still prevails. This difficulty in acknowledging the problem is but one of the many barriers to effectively dealing with the interrelated issues of injection drug use and HIV transmission in Vermont.

Seventeen percent (17%) of the cumulative reported diagnoses of AIDS in the state have occurred among users of injection drugs, and 14% of people known to be living with HIV/AIDS in Vermont are attributed as injection drug users, with an additional 5% attributed as MSM/IDU (Men who have Sex with Men who are also Injection Drug Users).

Unlike other populations affected by HIV, there is no political constituency demanding services for users. And while organized groups of current users of injection drugs have formed in some large cities, issues of legality and stigma are significant barriers to this kind of organizing, particularly in a rural and small-town environment. Even without those barriers, the reality of addiction is that many or most users of injection drugs live chaotic lives in which survival and the need for drugs are the most powerful factors, making creation of community organizations and advocacy a difficult goal.

Rural injection drug use frequently differs from urban patterns. While a visible street scene and shooting galleries exist to a limited extent in a few larger Vermont towns and cities, it appears that a more common pattern is the existence of smaller, relatively self-contained groups of friends who use together, frequently sharing a common supply source. These groups are not, however, strictly self-contained, as members interact with other groups of users, or as they access drug suppliers outside of their own local area or their own state. These external interactions, coupled with fluid group membership, offer the opportunity for introduction of an infectious agent (such as HIV) into these circles.

In particular, Hepatitis C has been notably on the rise among injection drug users in recent years. Substance abuse treatment providers report high numbers of clients with Hepatitis C, far exceeding any awareness they may have of clients who are HIV positive. Transmission of Hepatitis C, however, is a strong surrogate marker for risk behaviors that may contribute to the spread of HIV.

As to prevention, a gap exists between many of the activities which are, anecdotally, the most widely supported HIV prevention activities for this population, and the activities for which the CPG can feasibly recommend funding.

Specifically, syringe exchange; pharmacological substance abuse treatment; and non-pharmacological substance abuse treatment are activities upon which there is near consensus among advocates as to their importance. When asked what the priorities for prevention should be, IDU advocates, and IDUs themselves name these activities more than any other. However, these are not fundable activities by the Vermont Department of Health. While the CPG makes a priority of focusing on specifically fundable prevention interventions, that focus should in no way be construed as de-emphasizing the importance of these other activities.

It remains the position of the Vermont Community Planning Group that syringe exchange programs, pharmacological substance abuse treatment, and culturally competent non-pharmacological substance abuse treatment are the cornerstones of effective HIV prevention for injection drug users. They should remain a top priority among service providers and advocates. Furthermore, the CPG urges the Vermont Department of Health to support these activities to the greatest extent possible and legally allowable.

Prevention Priorities

In addition to the Interventions named in this Comprehensive Plan (see Section 8), the CPG has identified a non-binding list of priority IDU sub-populations, as well as priority venues where interventions targeting Injection Drug Users (IDUs) should be considered. These lists are intended as informational guidance. They are not meant to exclude service providers from applying to do prevention work in other locations and with other groups of IDUs.

IDU Sub-Populations

It is the position of the Vermont Community Planning Group that ALL IDUs in Vermont are at increased risk for HIV infection and/or transmission.

A comprehensive approach should take into account two things:

- 1) Data indicates that the bulk of injection drug users in this state are Caucasian adult males.
- 2) Other populations have been, and continue to be, disproportionately impacted by both injection drug use and HIV/AIDS.

Applications for HIV prevention funding to provide HIV prevention interventions targeting any and all IDUs in Vermont should be considered. The need for targeting HIV prevention interventions to specific populations reflects disproportionate impact and socio-specific need among those populations, not a lack of need among the IDU population as a whole. Underserved sub-populations include:

- IDUs who are living with Hepatitis C
- young IDUs, and young opiate users who do not inject, or those who may be at increased risk for transitioning from non-injection use to injection use
- female IDUs and in particular, female IDUs living at or below the poverty line; who are sexual or needle-using partners of other IDUs; and/or those who are caregivers to children

Rationale (HCV+, Youth, Women)

- Indications among IDU service providers and current/recent injection drug users interviewed (2002 Needs Assessment project) that these populations are at increased risk and/or particularly disconnected from available services;
 - People who are HCV+ have at least some history of risk behavior;
 - Youth and Women can be particularly disconnected from services due to lack of risk awareness; transportation issues; childcare issues; and, for youth, an age requirement for accessing certain services, such as syringe exchange.
- IDUs who are members of communities of color
 - IDUs who are also men who have sex with men (IDU/MSM)
 - IDUs who are also homeless and/or seek services relating to a need for short- or long-term shelter
 - IDUs who are not currently in substance abuse treatment or seeking substance abuse treatment services; and/or IDUs who are not current clients of an existing harm reduction or HIV prevention program

Rationale (Communities of Color, MSM, Homeless, Not in services/treatment)

- Prioritized as a result of further IDU Needs Assessment committee discussion;
- Many of these populations have been disproportionately impacted by HIV/AIDS;
- Reaching IDUs who are not currently connected to services or treatment is an ongoing goal among service providers, particularly outreach workers.

In a small state like Vermont, it may not be feasible (or even advisable) to create targeted HIV prevention programs for injection drug users who fit each of these categories. A funding source too finely sub-divided for individual projects may result in a lack of program effectiveness overall. However, funded programs can be proactively inclusive of these populations. For example:

- print materials targeted to a specific audience (such as IDU/MSM; young IDUs; IDUs of color; etc.);
- use of inclusive language in the delivery of interventions (specifically, language that does not assume a certain HIV status, sexual orientation, racial background, personal ability, etc.);
- program staff that is socio-demographically reflective of specific populations (e.g., young outreach workers; counselors of varying racial/ethnic backgrounds; etc.)

These are just a few examples of the ways in which programs can, and should, be cognizant of the diversity within their target population.

The CPG recommends a balanced approach to serving the needs of the IDU population in Vermont, which is (to the extent possible), responsive to common factors among IDUs as well as the specific life circumstances among individuals and groups within that population.

Venues

Based on the 2002 needs assessment process, which involved interviews with injection drug users as well as service providers who work with them, the IDU Needs Assessment Committee developed a list of venues that might be particularly appropriate for reaching IDU in Vermont with HIV prevention services. While the primary activities that take place in some of these venues may not be fundable with federal prevention dollars, the CPG recommends that service providers consider ways in which they might leverage the opportunities presented by these venues for providing other interventions.

Note: This list is intended as informational guidance. It is not meant to exclude service providers from applying to do prevention work in other locations and with other groups of IDUs.

VENUE	DESCRIPTION/DETAIL
Syringe Exchange-based Interventions	Activities to increase access to, awareness of, and utilization of Syringe Exchange Programs <i>(excluding actual exchange of injection equipment)</i>
	Activities delivered at, through, or in conjunction with, Syringe Exchange Programs <i>(excluding actual exchange of injection equipment)</i>
Pharmacological (e.g., Methadone, Buprenorphine) Substance Abuse Treatment-based Interventions	Activities to increase access to, awareness of, and utilization of available pharmacological substance abuse treatment <i>(excluding actual delivery of pharmacological treatment)</i>
	Activities delivered at, through, or in conjunction with pharmacological substance abuse treatment facilities <i>(excluding actual delivery of pharmacological treatment)</i>
Non-Pharmacological Substance Abuse Treatment-based Interventions	Activities to increase linkages to, awareness of, and utilization of available substance abuse treatment services <i>(excluding actual delivery of substance abuse treatment services)</i>
	Activities delivered at, through, or in conjunction with substance abuse treatment facilities <i>(excluding actual delivery of substance abuse treatment services)</i>
Corrections/Probation & Parole-based Interventions	Activities targeting IDUs in Correctional facilities and through the Probation and Parole system/services

Rationale

(Venues: Syringe Exchange Programs, Pharmacological Substance Abuse Treatment Programs, Non-Pharmacological Substance Abuse Treatment Facilities)

- Consensus among providers/users and CPG that these venues represent rare opportunities for reaching IDUs in relatively large numbers, on a regular basis.
- Many who use these services are, in doing so, proactively working to reduce their HIV risk and/or substance use-related risk.
- Word of mouth: IDUs who are reached through these venues may then make referrals and/or pass on information to other IDUs in the community who are not currently seeking services, a population that is difficult and sometimes impossible for service providers to reach in other ways.

Rationale:

Venue: Corrections/Probation and Parole

- Known high-risk group;
- Reachable population, whether individuals are currently incarcerated or part of Community Corrections (which includes the intensive substance abuse program);
- Environment can be conducive to providing specialized HIV prevention services, geared to the incarcerated;
- Indications from Vermont Department of Corrections staff that there is broad support for increased HIV prevention efforts; and that reaching groups of individuals involved in the corrections system is quite feasible.

Related Information and Recommendations

Cultural competency for IDUs in the delivery of interventions

Injection drug users continue to suffer, in their daily lives and as an at-risk population in general, from a lack of understanding in the larger population. “Addictophobia” and a pervasive view of injection drug use/opiate dependence as a criminal (versus a public health) issue can increase the barriers to effective HIV prevention. Many IDU and HIV prevention advocates rightfully make it a part of their work to increase compassion and understanding among the general population.

It is also important that the programs serving IDUs, and the people staffing those programs, are aware of what it means to be a needle user (and/or opiate dependent). This kind of cultural competency encourages service utilization as well as effectiveness.

Some key elements of cultural competency for users of injection drugs include:

- a compassionate and nonjudgmental approach to prevention and drug dependence;
- consumer input whenever possible, for program development and execution;
- inclusion of current and/or former users as service providers;
- providers who reflect the target population socio-demographically;
- an ability to make referrals for services targeted to specific populations;
- client-centered program design, accounting for:
 - the role of stigma (related to injection drug use as well as HIV infection);
 - the importance of confidentiality, and the difficulty in maintaining it in a rural environment;
 - other barriers to service utilization
- a view of drug use and addiction as a public health (as opposed to criminal) issue;
- addressing barriers associated with a rural environment (including but not limited to the above-mentioned challenges of maintaining confidentiality in the delivery of service).

Funding Issues

In many ways, HIV prevention in Vermont is shaped by the availability of funding – both the amount of funding available for prevention activities, and the restrictions placed on available funds. The primary focus of the Vermont Community Planning Group is on the allocation of federal HIV prevention dollars, as channeled through the Vermont Department of Health. At the same time, the CPG intends to continue exploring ways in which funding issues impact HIV prevention, and ways in which specific funding-related changes might improve an overall HIV prevention effort in Vermont. These include:

- The availability of state prevention dollars

While the state of Vermont has allocated funds for HIV care and services for many years, the Vermont legislature has never provided funding specifically for HIV prevention in this state. In light of 2002 budget cutbacks in Vermont (of approximately \$39M), the CPG recognizes that this may not be the time to feasibly expect an increased commitment from the state to fund HIV prevention.

However, it remains true that the allocation of state HIV prevention funds sometime in the future could distinctly improve local efforts at meeting the needs of at-risk populations. This is true on two levels: increased funds

could mean additional and farther-reaching programs; and could also potentially mean available funding for activities currently prohibited with federal HIV prevention dollars, such as syringe exchange.

The CPG encourages HIV/AIDS advocates as well as the Vermont legislature to explore future possibilities for making available state funds for HIV prevention activities.

- Cash stipends

Mixed opinions surround the notion of providing cash stipends to HIV prevention program participants. Research indicates that cash stipends (versus other incentives, such as gift certificates) are the most effective means for actively involving IDUs in certain prevention activities. These findings are at odds with the reluctance by some to endorse a system whereby a potential means for purchasing illegal substances is given to those who may be suffering from addiction or dependence on those substances.

One of the newest emerging interventions for working with IDUs is PDI (Peer Driven Intervention). The notable successes with PDI around the country have all involved the use of cash stipends to encourage IDUs to participate in an initial interview and subsequently, to educate their peers about HIV/AIDS. Whether or not this program, and others, can feasibly be undertaken using a substitute incentive besides cash is unknown.

Most of the HIV prevention activities recommended by the CPG as priorities do not involve stipending participants at all. However, where incentives do come into play, the CPG remains interested in exploring ways in which this issue might be resolved – either through a feasible and effective substitution for the use of financial remuneration; and/or through further study of this issue and dialogue among all interested parties.

- Syringe Exchange and Pharmacological Substance Abuse Treatment

As mentioned throughout this document, syringe exchange and pharmacological substance abuse treatment (i.e., methadone; buprenorphine) are two of the most widely regarded HIV prevention activities among IDU advocates and HIV prevention experts. The CPG maintains that these activities can and should be an inherent part of any comprehensive approach to meeting the HIV prevention needs of an IDU population. The CPG also recognizes that federal funds are prohibited for use on either of these activities.

The CPG strongly encourages the Vermont Department of Health to support these activities in any way that it may legally do so; and that

venues where these activities take place be used, as feasible, for the delivery of other HIV prevention activities (for example, promoting available individual and group counseling, HIV testing, etc., to those who participate in syringe exchange or methadone treatment).

The CPG also recommends that IDU and HIV prevention advocates continue to explore ways of making these interventions as widely available in Vermont as possible, including advocating for increased funding from any and all sources.

It should also be noted that funding for these activities is one of several interconnected issues, which can also include institutional capacity; social norms; and community resistance. In other words, making available funds for these activities is just one of several things that must be done before they can be implemented, or increased.

- Capacity Building

Another key question the CPG faces are the ways in which the capacity for IDU-targeted services of any kind can be increased. It is not within the scope of the CPG's work to actually work with providers to increase their ability to work with IDUs; or to create new resources in the community. However, the CPG does have a vested interest in supporting this kind of work.

In an environment of extremely limited (and potentially shrinking) prevention dollars, the CPG would like to see additional funding streams, including perhaps one-time federal supplemental funding, directed toward improving the capacity of existing and potential providers to perform HIV prevention services. As the HIV/AIDS epidemic changes and evolves, resources should be allocated to ensure that local HIV prevention efforts evolve with it.

Stigma and the difficulty of doing this work

The stigma surrounding injection drug use and addiction are intertwined in any effort at effective HIV prevention for IDUs. Part of what happens as a result of this stigma is a "facelessness" to the population. Injection drug use is often viewed as "someone else's problem," and the number of active users, private citizens, or legislators who are either able or willing to advocate for this population is small.

Contrary to commonly held beliefs, injection drug use crosses all socio-demographic boundaries in Vermont. IDUs are a population of all classes, races, genders, sexual identities, etc. The growing public awareness of heroin usage in Vermont has not necessarily increased the level of public agreement about how these issues should be addressed.

Stigma is also a barrier when it comes to bringing an IDU voice to the community planning process. Many active users are understandably reluctant to self-identify, especially in a public process like community planning. Our 2002 needs assessment interview project helped us gather more first-hand information than we have previously had to work with. We hope to continue increasing the depth of participation by this population in the future.

The importance of harm reduction-based programs

Harm reduction examines the behaviors and attitudes of the individual to offer ways to decrease the negative consequences of the targeted behavior. In a harm reduction model, complete abstinence from risky behaviors should not be the only objective of prevention services because it excludes a large proportion of people. Instead, complete abstinence from risk behaviors should be understood as a possible goal in a series of harm reduction objectives. Individuals are engaged to help them identify the steps they need, steps they are ready and able to make toward reducing their risk for HIV infection, and individuals are rewarded for their success and encouraged in their attempts. The most effective way to help people minimize their risk behaviors is to provide attractive, user-friendly services that empower them to reduce their risk.

The CPG maintains its commitment that harm-reduction-based strategies must be part of HIV prevention for users of injection drugs.

In 2002, the CPG's IDU needs assessment project yielded strong anecdotal evidence of broad-based support for the inclusion of harm reduction-based strategies in human services. We interviewed 14 service providers in Vermont working with users of injection drugs. They included mental health, substance abuse treatment, corrections, and HIV prevention providers. All of them expressed support for harm reduction-based strategies when working with injection drug users. This unanimous support was echoed at a 2002 meeting, initiated by the CPG, to discuss HIV prevention issues with representatives of various state agencies, including mental health, the Office of Alcohol and Drug Abuse Programs, Department of Corrections, and Department of Education.

This is not to say that harm reduction-based approaches have uniform support among every individual providing services to this population in Vermont. Sometimes these mixed opinions can occur within the same organization, sending mixed messages to those who are receiving services. For example, one substance abuse treatment provider described an antagonism between those staff who make referrals to syringe exchange programs, and those who view such referrals as antithetical to their work.

It is not realistic to expect all service providers to agree philosophically on a single approach to prevention. However, the prevailing research, as well as the experience of those interviewed in the 2002 Needs Assessment, indicate that

abstinence-only based approaches should never exist to the exclusion of harm-reduction-based approaches, which recognize the role of relapse in the recovery process. All users of injection drugs who access services in Vermont, and moreover, all recipients of HIV prevention services in this state, should be assisted in making informed decisions about the full range of available services and treatment modalities.

The state of Syringe Exchange and Pharmacological Substance Abuse Treatment in Vermont

The implementation of syringe exchange, and pharmacologically-based opiate addiction treatment in Vermont has been a slow process, due to a lack of consensus among Vermonters as well as Vermont legislators. The general movement, however, has been toward providing services in Vermont, albeit incrementally.

Syringe Exchange Programs

Vermont now has three syringe exchange programs in operation. The newest program, in St. Johnsbury, began operation in the summer of 2002. Existing programs continue in Burlington and Brattleboro. Because of limitations on use of federally provided funds, these programs are independently funded.

The CPG strongly supports a thoughtful, evidence-based expansion of syringe exchange in Vermont. All reasonable methods should be considered to help serve the needs of an already difficult-to-reach population in a rural environment. The CPG also encourages the Vermont Department of Health to continue as a partner in this process, examining feasible options and supporting these efforts in whatever capacity it may legally do so.

Pharmacological Treatment

Methadone

Vermont's first methadone clinic serving people who are opiate dependent began operation in the Fall of 2002. It is located in Burlington and is the only on-site methadone clinic in the state.

In 2004, a contract was awarded by the Office of Alcohol and Drug Abuse Programs for implementation of mobile methadone provision in Vermont's Northeast Kingdom (Orleans, Essex, and Caledonia Counties). This service is expected to begin in 2005.

Methadone is otherwise available in Vermont under limited circumstances only. Healthcare providers may prescribe it for chronic pain but not for

opiate dependence. The exception to this is among opiate dependent pregnant women, for whom methadone is made available through at least one health care facility. It is also available as part of one short-term detoxification program in southern Vermont.

Buprenorphine

Opioid dependence treatment using buprenorphine is available through the University of Vermont Substance Abuse Treatment Center, and through a limited number of certified private healthcare providers in Vermont, who may offer this service to no more than 30 clients each. There is a widely perceived lack of such providers and of available buprenorphine treatment in general. The Vermont Community Planning Group urges the lifting of any caps on buprenorphine treatment in the state, such that the supply for this service can more feasibly meet the demand.

Given the limitations on federal funding and the absence of Vermont state HIV prevention funds, it is beyond the scope of the CPG to recommend direct funding for syringe exchange or pharmacological treatment. However, the CPG strongly endorses any efforts by other parties to increase the availability of both syringe exchange and pharmacological treatment as part of an overall, comprehensive approach to meet the HIV prevention needs of injection drug users in Vermont.

Hepatitis C

As needle and heroin usage increases in Vermont, so will the transmission of HIV and even more so, Hepatitis C (HCV). Anecdotal reporting by Vermont health care workers, IDU service providers, and active needle users, bears out much of the current national dialogue: that among injection drug users, HCV is prevalent, and is of greater personal concern to current users than HIV. The Community Planning Group supports the incorporation of hepatitis prevention efforts with existing HIV prevention efforts targeting users of injection drugs in Vermont. This effort is already underway in many places. Many service providers recognize the link between HIV and HCV prevention, including the fact that for many needle users, HCV is not only a more prevalent topic, but it can be more easily introduced and may act as a means of bridging to the subject of HIV/AIDS.

- END OF SECTION 7: INJECTION DRUG USERS (IDU) -