

**FINAL REPORT TO  
HIV PREVENTION TRIALS NETWORK**

**COMMUNITY ACCEPTANCE AND IMPLEMENTATION OF HIV  
PREVENTION INTERVENTIONS FOR INJECTION DRUG USERS**

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## ABSTRACT

**Background:** In 1997, the National Institutes of Health (NIH) reviewed evidence of the effectiveness of HIV prevention programs for injection drug users (IDUs) and recommended that three types of interventions be implemented to prevent transmission of HIV among IDUs: 1) community-based outreach, 2) expanded syringe access (including needle exchange programs [NEP] and pharmacy sales), and 3) drug treatment. Progress on increasing the acceptance and feasibility of implementing these programs has been made at the national level, but their implementation has been varied at the local level.

**Objective:** To study the acceptance and implementation of the three interventions by communities and to identify the factors that contributed to the success or failure of communities to implement these programs on the local level.

**Methods:** Forty-three in-depth qualitative interviews were conducted with key informants in six U.S. cities. Informants included AIDS prevention providers, political leaders, activists, substance abuse and AIDS researchers, health department directors, and law enforcement officials. Cities were classified according to when they initiated interventions as 1) early adopters, 2) middle adopters, and 3) late or never adopters.

**Results:** Conditions that facilitated or deterred the adoption of interventions were identified. Coalition building and community consultation were key to the acceptance and sustainability of new interventions. Leadership from politicians, public health officials, and program directors provided necessary authority, legitimacy, and access to resources. Grassroots activists took initiative and risks in the face of opposition, but often lacked the resources to sustain their efforts. Researchers played an important role in initiating interventions and legitimizing them by providing access to the scientific information supporting their safety and effectiveness. Successful implementers worked with or avoided the opposition rather than creating polarized positions. Changes in funding and structure of publicly supported drug treatment programs have limited the implementation of new programs. Lack of leadership in the political and public health sectors, and, indeed, fear of adopting or even discussing needle exchange because of perceived political opposition, were the biggest barriers to implementation of syringe exchange programs.

**Conclusion:** Understanding the conditions under which communities accept and implement interventions can help guide effective strategies to foster the implementation of these interventions in areas where programs do not currently exist.

## BACKGROUND

In 1997, the NIH Consensus Development Conference reviewed evidence of the effectiveness of HIV prevention programs for injection drug users (IDUs) and recommended that three types of programs be implemented: 1) community-based outreach, 2) expanded syringe access (including needle exchange programs (NEP) and pharmacy sales), and 3) drug treatment (NIH, 1997). Communities have varied widely in the extent to which they have implemented these interventions.

Progress on increasing the acceptance and feasibility of implementing HIV prevention programs for IDUs has been made at the national level through the use of consensus-building venues that bring together diverse stakeholders such as conferences and task forces (Joint Statement, 1999; National Association of State Controlled Substance Authorities, 2000; Burris, 2001). However, progress in implementing these interventions at the local level has been varied. In many areas interventions for IDUs have never been initiated.

The purpose of this qualitative research was to study how communities chose whether or not to implement the three interventions in six US cities, and identify the factors related to the success or failure of attempts to implement them.

## METHODS

### Sampling Plan

We used diffusion of innovations theory (Rogers, 1982) as our primary theoretical framework for selecting the cities. Diffusion of innovation theory supports the classification of communities into “early adopters,” “middle adopters,” and “late” or “never adopters.”

Because drug treatment and outreach programs are diffuse in their funding and staffing, there was no single national database that described their implementation across cities. However, a national survey of syringe programs by city has been conducted (Paone, Des Jarlais, Clark and Shi, 1996), and using these data we divided cities into three categories of early, middle or late/never adopters based on the year they initiated NEPs. In addition, geographical location and AIDS incidence rates were also taken into account to insure diversity. We selected six cities: Seattle, Baltimore, Detroit, Miami, Newark, and Memphis. Seattle and Baltimore were early adopters; Detroit was a middle adopter, and Miami, Newark and Memphis were late or never adopters.

A preliminary list of key informants in each city included public health officials (e.g., state AIDS directors, local health directors), HIV prevention providers, substance abuse researchers, AIDS service organizations (ASOs), community-based organizations (CBOs), activists, political leaders (including mayors, governors, and any relevant legislators), and law enforcement officials. In each city we attempted to interview two informants knowledgeable about each intervention for a total of six interviews per city. One of the two informants represented an institutional perspective, such as the city government, public health department, or research institution. The other informant represented a community perspective, and included community leaders, activists, or service providers from CBOs. In addition, in cities which had opposition movements to any of the interventions, we attempted to

interview opposition leaders. However, despite much effort, we were not successful in identifying opposition leaders willing to be interviewed for this study.

### **Data Collection**

From December 2000 through March 2001, 43 telephone interviews were conducted with public health officials, researchers, policy makers, activists and providers in six cities. There were 14 interviews about NEPs, 11 about drug treatment, and 18 about outreach. Interviews were tape recorded and transcribed. Prior to the interview, informants were sent a consent form and interview guide by fax or e-mail.

The goal of the interviews was to elicit different factors that might have influenced whether or not a community implemented any or all of the three NIH recommended HIV interventions. While there was uniformity in the core interview questions, capturing the diversity of experience was considered more important than uniformity in the administration of the interviews. Therefore interviews were individually tailored based on the particular intervention and the participants' experiences. Interviewers had extensive experience in qualitative interviewing and research methods.

No opposition interviews were conducted, despite many hours of staff time spent attempting to arrange interviews with individuals who opposed NEPs, expansion of drug treatment, or outreach. Other than an e-mail message from a governor's aide opposed to NEPs, we were not successful in interviewing or receiving statements from representatives with opposing viewpoints. Several people opposed to NEP agreed to be interviewed but repeatedly canceled or were not at the specified telephone number at the agreed upon time. Staff made at least four more attempts to reschedule "no-shows," but never received a reply from the phone messages, the e-mails, or the faxes that were sent.

Naturally, in cities where programs did not exist, it was not always possible to find people to talk about why those interventions did not exist. On the other hand, in cities that responded early in the epidemic to the threat of HIV to IDUs and developed many "cutting edge interventions," people were eager to discuss their programs and to refer us to other potential interviewees. These data collection limitations resulted in some sections of this report having more data than others.

Seven interviews were conducted in Baltimore. Three were about NEPs, two were about drug treatment and two about outreach. Three were with government officials, and four were with community representatives.

Eight interviews were conducted in Detroit. Two were about needle exchange, two about drug treatment, and four were about outreach. Four were with community representatives and four were with government officials. One respondent was interviewed about both outreach and drug treatment.

Five interviews were conducted in Memphis. Two were related to drug treatment and the other three to outreach. Two were with government representatives and three were with community members. There were no interviews in Memphis about NEPs. While there were second hand reports of an underground NEP in Memphis, none of the respondents were able to place us in contact with anyone with first hand knowledge of this NEP. None of the respondents were able to identify anyone who had any plans to initiate a NEP in the future. Respondents were also unable to identify any organized opposition to NEP. There was a general consensus that the community was too conservative to accept the intervention and as such it simply remained untried. Because we felt it was important to depict a NEP within a conservative environment such as Tennessee, we conducted an interview with a community based NEP provider in Nashville. This provider operated the only NEP in Nashville, and received no funding or

support from anyone within the city government or public health department. He was not able to any provide us with another respondent who could speak about NEP in Nashville.

Seven interviews were conducted in Miami. Three interviews were conducted focusing on outreach efforts among IDUs, two on needle exchange and two covering drug treatment. There was some overlap among the three areas of concentration during the interviews since HIV prevention efforts among drug users often encompass multiple methods. Two interviews were with government officials, and the other five were with community representatives.

Eight interviews were conducted in Newark, three about needle exchange, one about drug treatment, and four about outreach. The interviews were equally divided between government and community representatives. Repeated attempts were made to interview city council members in Newark who were known to be in opposition to needle exchange. We were not granted any interviews. Other NEP opponents refused to participate. However, community members were eager to speak with us. We were successful obtaining interviews from government and health department officials about outreach and drug treatment.

Seven interviews were conducted in Seattle. Three were about NEPs, two about drug treatment, and two about outreach. Four were with government representatives and three with community representatives.

### **Data Analysis**

We analyzed data collected from various sources (interviews, literature reviews, archival information, etc.) using a grounded theory analytical approach (Glaser and Strauss, 1967; Strauss and Corbin, 1994). Through an iterative process of reading the data, creating theoretical memos, and rereading the data we developed case studies (Stake, 1995) describing the implementation, both successful and unsuccessful, of each intervention in each city. From these case studies we identified emergent themes on the implementation of these interventions in each city and across cities. We then compared and contrasted these findings within and across data sources to expand, clarify, and refine emergent findings. Through the constant comparison across data sources we integrated findings from the various data sources (i.e., triangulated the data) to derive a more complete and accurate interpretation of our findings (Fielding & Fielding, 1986).

## FINDINGS

### **1. Coalition building and community consultation are a key to the acceptance and sustainability of new interventions.**

Collaborations between local authorities, service providers, researchers and grass roots activists were key to the success and sustainability of many interventions. These collaborations blended the strengths of each group: the power and resources of the authorities, the experience and community presence of the service providers, and the determination and quick response of the grassroots activists. The drawback of collaborations was their sometimes time-consuming development and decision-making processes. Other less purely collaborative efforts often incorporated community consultation as a means to avoid public opposition and to develop buy in. In two cities with NEPs, officials underwent laborious processes of gaining community support through public meetings and consultations with community members. Both were able to implement programs with relatively little conflict, but some providers complained about the amount of time this process took. The HIV Prevention Planning Councils instituted by the Center for Disease Control and Prevention have mandated a certain level of collaboration. In some cities where IDUs and former IDUs were active on these councils, they lobbied to prioritize and fund interventions for drug users.

### **2. Leadership from politicians, public health officials, and program directors provides authority, legitimacy and access to resources**

Both in cities where interventions were initiated entirely by high ranking government officials and those in which grassroots groups collaborated with local authorities, the presence and leadership of these individuals was key to the success of the interventions. Even in those areas where authorities were lobbied for their tacit approval rather than public support, gaining their approval was seen as crucial. One respondent suggested that organizers must “know how power works in your city, and work with it.” The most obvious benefits of supportive leadership from local authorities were access to financial resources for the interventions and, in the case of NEP, reduced threat of criminal prosecution. These officials also had access to large audiences to promote their message and to the resources needed to lobby for such interventions.

When gaining the support of public officials many respondents found that working with sympathetic leaders “on the inside” was the best strategy. These leaders knew how to best frame the interventions for their peers. One mayor presented NEP and drug treatment efforts as “cost saving measures” to legislators and as “crime prevention measures” to law enforcement officials. When the activists in one city wanted the city council to approve the NEP, they had city council members from other cities that had recently supported similar initiatives flown in to speak to the council. Their initiative was successful. Conversely, a presentation to another city council by activists from a neighboring city was unsuccessful. The council members perceived them as outsiders with a specific political agenda that did not speak to their community’s interests.

Within collaborations the support of local authorities can bring in more “middle of the road” players. The costs of working with local authorities were their sensitivity to public opinion, reluctance to risk public opposition, and the long amount of time required to work through official bureaucracies.

### **3. Grassroots activists take initiative and risks in the face of opposition but often lack the resources to sustain their efforts**

Grassroots activists have initiated intervention for IDUs in many cities. They have come from political activist groups fighting HIV and CBOs working in highly impacted communities. The strength of the grassroots activists is their willingness to go against “the system” and public opposition. In the case of NEP this includes a willingness to risk arrest. The weaknesses are their lack of access to resources and their vulnerability to criminal prosecution. Generally, the greater the access to resources that activists had from the beginning or were able to develop, and the more they were able to align with community institutions, the more sustained success they had. In one NEP city, AIDS activists immediately developed collaborations with the health department, and through this association developed further relationships with the mayor and law enforcement agencies. In the Southern cities where we collected data, activists were working inside existing CBOs serving the affected areas. They continued to frame the interventions for IDUs within that context, that is, as services provided to their disenfranchised communities. In two of our cities without NEPs, grassroots efforts to conduct NEP have repeatedly started and disappeared. They have not been able to sustain their efforts.

### **4. Research plays a role in initiating and legitimizing interventions.**

In many cities proponents used research findings about the spread of HIV among IDUs and the effectiveness of various interventions to create initial “buy in” and/or continue to defend their work. Several outreach programs and NEPs were begun in whole or in part as research demonstration projects. Some activist initiated interventions included research evaluations in their programs to gain legitimacy among local authorities and other services providers.

Researchers have access to funds and resources not available to many grassroots organizations. At the same time they are not necessarily as sensitive to public opinion as local authorities might be. Many researchers have initiated and/or maintained interventions for IDUs. The initiation of some federal AIDS research demonstration grants put a new kind of professional in day-to-day contact with IDUs. They were public health workers, ethnographers, and epidemiologists rather than law enforcement or drug treatment staff. They came without the agendas of recovery or criminal prosecution, but with a desire to understand drug use and to stop the spread of HIV transmission. In one city with early outreach to IDUs, it was the federally funded ethnographers who became the first outreach workers. In several cities research staff have been involved in many different roles.

However, researchers are governed by local, state, and/or federal restrictions and the constraints of their own research institutions particularly regarding NEPs. Most were unable to use any of their funding to support or implement NEPs and could only evaluate existing programs. In addition, because researchers have the resources and ability to work independently in the community, it is entirely up to individual researchers whether they will build collaborations and ties to local service providers and community members. Failure to do so can lead to local opposition and “turf” struggles between researchers and the community. Finally, research funding always has finite duration. Research projects often end abruptly, because continuation of services is dependent on the next research grant getting funded. One of the cities studied has had a vigorous research program for HIV prevention among IDUs that, when funded, provided vital outreach services for the city. However, when research funding for a particular initiative ends, the outreach program ends with it.



## **5. Successful implementers worked with or avoided the opposition rather than adopting polarized positions.**

Repeatedly respondents discussed the importance of continuing to work with the opposition rather than taking an aggressive approach. Successful groups did not try to work with extreme opposition groups with whom they had no hope of ever coming to agreement. Rather they worked carefully with “fence sitters” or individuals, who while they might be personally opposed, could be convinced not to block the progress of the intervention. In order to keep a continual dialogue open with these individuals, successful groups did not force them to take a stance on the intervention(s) that they might not be able to back down from later. They tried to avoid polarization at all costs. In one city, the AIDS office at the local health department made many presentations and gave updates to the city council and health department leaders on NEP and outreach long before asking them to make a decision on proceeding with the interventions. One respondent said they wore down the internal opposition with information and persistence. The director of the NEP in another city decided it was better to not accept their first grant award rather than risk having the award debated in the city council. He knew they could gain tacit approval from officials who would never be willing to take a public position supporting needle exchange. Several programs talked about avoiding press coverage and keeping a low profile so that they would not encourage public opposition. Conversely in one state where NEPs are still illegal, one initial organizing effort around NEP was a drive to have local city councils pass ordinances supporting NEP. The effort called for the municipal authorities to take a public stance on a controversial service that was not yet being provided in their city. The effort failed in the city we studied.

## **6. Changes in funding and structure of publicly supported drug treatment have limited the implementation of new programs.**

In a few cities the local authority responsible for providing drug treatment services was shifted from one department to another during the reorganization of state and county health departments in the 1990’s. This was described both at the county and state levels. Invariably the move was described as a bad one. Drug treatment leaders felt the programs were transferred into departments where “no one wanted them.” The new departments had little knowledge and/or interest in drug treatment programs. Grants and new initiatives dwindled. In addition, the funding structures for drug treatment changed in most states during the 1990’s because of managed care. Many programs changed from categorical funding to fee-for-services. Staff reported that they had less funding under the new structures and that new programs were more difficult to start.

## **7. Sensitivity to the political and cultural norms of the region is key**

It was clear that different strategies had to be employed in different locales. One city with a progressive history was ripe for a collaborative effort. There were strong ties already existing between the health department, drug treatment, and HIV prevention providers. Public health workers in the city prided themselves on being “cutting edge.” When NEP was bogged down in the collaborative process, local activists went ahead and started the program. They were politically savvy, working with authorities from the start, managing their press coverage and were received positively by the community as a whole. In “the buckle of the Bible belt” very different implementation strategies were employed. Successful groups avoided public presentations and relied on their reputations as community-based service providers. They purposefully did not represent interventions to IDUs as a political cause. They

worked closely with local religious communities to gain community support. In the case of the NEP they did not seek political approval and did not look for active collaborations with other organizations. They worked only to educate other services providers and to nullify public opposition rather than to gain public support.

## **8. Fear of discussing needle exchange and lack of leadership are the biggest barriers to implementation**

The respondents in cities that had no needle exchange and in the historical accounts of other cities before they implemented their NEPs all expressed a fear of even discussing needle exchange as one of the primary barriers to its implementation. Often when asked to describe the most powerful opposition to NEP in their cities, respondents could only identify a general sense of trepidation and sense that “it could never be done here.” Fears cited were wide-ranging, some based in reality and others in conjecture. Public health workers feared losing their jobs, elected officials feared losing their constituencies, activists feared being arrested and having their property seized. Many respondents feared the loss of existing funding for other programs for drug users or backlash in the community, including charges of genocide by minority groups.

It is difficult to think of another public health intervention that has generated as much fear as NEP and related “harm reduction” interventions. The moral stigma related to drug use and addiction in the U.S. is pervasive and in some communities has trumped the arguments for NEP cost effectiveness and public health benefit. In the political climate of the U.S. in which the “War on Drugs” takes a harsh and unrelenting punitive stance toward drug use and few politicians are willing to risk being considered “coddling” or “soft” on drug users, many public health officials are unsure of the wisdom of considering — or their mandate to consider — any intervention which provided assistance to drug users. The lack of leadership from the federal government in support of needle exchange also feed into this fear.

These fears created an inertia around implementation that was greater barrier than any organized opposition to these programs. In cities which had overcome this initial inertia it was the presence of one or two leaders, especially those with some access to local power and resources that had overcome this barrier. If there were leaders willing to implement the programs or work with local activists to implement the programs despite the prevailing “wisdom” of dire results they could effectively change the debate. Once programs were initiated many fears were simply proven unfounded. In several cities politicians found there was actually much more public support for NEP than they could have imagined, and the popular press was largely positive. Others found community response was benign, or that with a little bit of coalition building and willingness to listen to community concerns they could be easily allayed. Once the programs are begun, and what was anathema has become reality, the nature of the debate changes from “should we or should we not have an NEP” which allows fears both real and imagined to overwhelm anticipated benefits, to “how should we run the NEP to best respond to any of the actual problems we are encountering.” In several cities respondents reported using this strategy, implementing the NEP first, with relatively little fanfare and then initiating or responding to public debate. However, in cities in which no local leader arose to take on the initial implementation the fears about the program effectively blocked its implementation.

## **COMMUNITY ACCEPTANCE IN OTHER COUNTRIES**

Because of limited resources, this study was confined to community acceptance of HIV prevention for injecting drug users in the United States. In some countries, such as the United Kingdom and Australia, HIV transmission among IDUs has been very limited, while in other countries have experienced extremely rapid transmission of HIV among IDUs (Stimson, et al. 1998; Des Jarlais & Friedman, 1998). Currently, rapid transmission of HIV is occurring in many countries in Asia and Eastern Europe (UNAIDS/WHO 2001). A study of factors influencing community acceptance of HIV prevention for IDUs in different countries would necessarily be considerably more complex than the present study of community acceptance in the United States. It would need to include consideration of cultural traditions, economic development, systems of government, the local history of illicit drug use, and the degree of stigmatization of HIV/AIDS among other comparative factors. Some data are already available from the "Rapid Assessments" that have been done in many cities throughout the world (WHO, 1998), but further work is needed. The results of such an international study could be extremely helpful in worldwide efforts to control the pandemic of HIV infection.

## **RESULTS**

### **Case Studies**

Our results are presented in a series of case studies on each city. Each case study includes the histories of the development of outreach, drug treatment and needle exchange interventions in that city.

## BALTIMORE

### City Summary

Over the last decade substance use and HIV have exploded in Baltimore, as a top official explains,

*“Baltimore is hugely decimated by substance abuse. It is like the largest problem facing this city...there is no controversy over the need for more drug treatment...everybody – conservative legislators, to the Governor, all say that we need more drug treatment...one of the issues that we're increasing drug treatment for is to deal with AIDS.”*

In 1995, 37% of male arrestees and 48% of female arrestees tested positive for opiates in Baltimore, the highest rate of heroin use ever found in the US. In 1999, more Baltimore residents died of drug overdose than of homicide. In 1999, AIDS was the leading cause of death among people aged 25-44 and injection drug use accounted for 60% of the new AIDS cases (Drug Strategies 2000).

Despite these overwhelming statistics, Baltimore has a well-developed prevention plan to combat the combined epidemics of injection drug use and HIV. Currently, Baltimore has over 7,500 free drug treatment slots for the uninsured, a drug treatment budget of \$42 million and a NEP that serves approximately 14,000 IDUs. Since the NEP began in August of 1994, approximately 1,400 IDUs have sought drug treatment through referrals from the program. By 2002, the goal of Baltimore's Department of Health (DOH) is to provide “drug treatment on request,” a plan that will allow drug users to be admitted into treatment within twenty-four hours of his or her request or court order.

### Outreach

In the mid 1980s, officials from a federal agency contacted the Maryland State Department of Health (DOH) about funds available to address the emerging problem of HIV transmission among IDUs. Based on the heroin epidemic in Baltimore, the State DOH contacted the city DOH about implementing an HIV prevention intervention in Baltimore. A meeting was set up between the leading outreach organization in Baltimore, the DOH and the State DOH. The three parties decided street outreach was the most appropriate intervention because they wanted to start reaching and educating people immediately. The city agreed to use their state funding for this project. They contracted with the CBO to have staff (health educators and community health outreach workers [CHOWs] who were themselves recovering addicts) provide street outreach. The CBO was not, however, funded for bleach distribution since the federal agency and the state DOH prohibited it because they believed that it promoted drug use. The DOH and the CBO both thought bleach distribution was an important component. The CBO sought other funding to pay for bleach and began distributing bleach kits, which included bleach, syringe cleaning instructions, condoms, and referrals.

In the late 1980s, a few years after the intervention began, the outreach program started to expand. The DOH added a medical van to address the health needs of IDUs as well as non-drug users. The medical van also went out at night to target sex workers. This expansion served as another way to build greater acceptance of outreach, showing that it benefited others as well as IDUs. In the late 1980s a national AIDS researcher contacted the CBO to participate in a three-city federal study of outreach. As part of this study, the CBO expanded their outreach and began to distribute bleach but only in the areas funded by research.

The mayor, the Health commissioner and the Police Commissioner were all supportive of street outreach to IDUs. Support from the police proved particularly essential to the success of this program. Initially outreach workers had problems with the police, but they were resolved quickly once they were brought to the attention of higher-ranking officers.

In order to receive the support of politicians and the community, presentations were made to the city council. These presentations not only educated city council members but also allowed them to pass the information on to their constituencies. Community forums were also held where representatives from the DOH presented to various neighborhood associations. Finally, as a requirement of federal funding, drug treatment staff was trained about HIV.

For the most part, community education met with little hostility. The distribution of bleach was an issue early on, but these community forums explained the need for such a measure. These forums also gave educators the opportunity to explain that HIV was a disease being transmitted beyond IDUs infecting non-drug-using sex partners and children. The delivery of this message was crucial in shifting community attitudes about AIDS, in gaining broad community support and explaining the rationale for bleach distribution. As a result, no major opposition was faced.

### **Drug Treatment**

In the mid 1990s, the mayor began to emphasize the need for the expansion of drug treatment because of the devastating effects that both drug use and HIV were having on many residents. The mayor increased the DOH's funding for drug treatment and shifted federal grant funds from other city agencies into drug treatment. In 1995, the oversight of drug treatment was shifted from the DOH to Substance Abuse Systems so that the expansion of treatment could be guided by a substance abuse-specific agency.

With the help of the mayor, city council, faith leaders, community members and the media, substance use became a major priority for the city. Marketed as a way to reduce crime and promote public safety, increasing drug treatment funding faced no opposition. This does not however mean that there was no need for advocacy as one interviewee explained,

*“Now, it’s much easier for them to say, ‘Yes it’s a big problem, we need to do something about it.’ It’s been harder to get them to give the funding...a lot of what I do is advocate for it. And there are now a lot of people advocating for it.”*

The interviewee emphasized two key components in building a case for drug treatment: establishing the appropriate treatment system while holding it accountable and being willing to get involved politically. The interviewee stated

*“We hold all our treatment programs very tightly accountable... We have all their data—retention rates, urinalysis positives, the arrest records of their clients in treatment...And programs that aren’t doing so well get reprimanded. They have to respond very quickly about what they’re going to do to improve. If a program has a really good result, we require or recommend that other treatment programs do the same things...So it’s been a lot of building accountability of our treatment programs so that we can use that data with politicians and with the public and say, ‘Hey, look, as an example in our methadone and residential treatment programs less than 5% of people in treatment are arrested during treatment.’”*

Through city, state, and federal funding, the city has almost tripled drug treatment funding since 1997. By the end of fiscal year 2000, the budget for drug treatment grew from \$16 million to \$42 million. This funding explosion resulted in an additional 3,400 free drug treatment slots, growing from 4,000 to 7,400, that provides treatment for an estimated 23,000 uninsured drug users.

Efforts have been made to connect drug treatment slots to specific programs whenever possible. For example, within the NEP there are 200 “dedicated” drug treatment slots. Although the increased amount of funding and the additional number of slots are not directly proportional to the vast number of drug users in need of treatment in Baltimore, the city government continues to make drug treatment a funding priority and seeks more effective and more expensive forms of drug treatment, including residential treatment. While this increase in funding for drug treatment was in response to what the interviewee described as “...the whole panoply of the consequences of substance abuse...crime, economics, school, and certainly health”, the goal is to provide “treatment on request” or treatment required by court order by 2002. “Treatment on request” refers to the city’s policy of providing drug users with treatment within twenty-four hours of their request or court order.

### **Needle Exchange**

In 1988, the mayor began to shift his drug policy focus from criminal justice to public health. As AIDS began to spread rapidly through Baltimore, primarily among IDUs, the mayor recognized that distributing bleach and educating drug users about behavior change was not sufficient. The mayor and his staff investigated HIV prevention interventions for IDUs in other cities and countries. After gathering data on NEPs, the mayor was convinced that this intervention needed to be implemented in Baltimore. In the following year, the mayor found sponsors for the needle exchange legislation and the first needle exchange bill was brought to committee.

The first attempt to legalize NEPs in Baltimore was not a success, but the mayor and his staff were determined to get legislation passed. They identified their opposition as being primarily the religious community and law enforcement, and lobbied them heavily over the next year. The Health commissioner and the mayor made lobbying for this legislation their full time job, talking about NEPs everywhere they went. The language they chose was crucial in the acceptance or rejection of NEPs. The mayor and the health commissioner diversified their approach depending on their audience. For state legislators NEPs were offered as cost saving measures, and for law enforcement officials NEPs were presented as a crime reduction intervention. They always maintained the same two points, however: NEPs were a public health measure and they would be reevaluated in three years. While church groups and law enforcement were openly lobbied, the Governor’s Secretary of Health was quietly lobbying the Governor on this issue. The Secretary knew that it was not necessary or likely that the Governor would publicly support a NEP, but knew it was key that he did not publicly oppose it. After over a year of lobbying law enforcement, churches and the Governor, the needle exchange bill was approved by one vote in 1994.

Then the DOH issued a “request for programs” to CBOs to apply to operate a NEP. In order to be approved, the programs had to have unanimous support from their community associations. The purpose of this strategy was to avoid a “Not In My Backyard (NIMBY)” community response. The legislation included specific evaluation requirements, that is, every syringe exchanged over the next three years had to be bar coded, tracked and tested for HIV. In 1997, after the evaluation found NEPs helpful in decreasing HIV, the NEPs bill passed overwhelmingly in both the House and Senate and it became a permanent law.

## DETROIT

### City Summary

*“We were really careful not to put the Mayor in an untenable position, which would force him not to do the right thing. It was not just ‘You get out there, you be the front person talking about syringes and all that.’ We were real careful not to put him in a position that would make people around him say, ‘Fool, do you want to lose the election if you decide to run again...’ So we did some harm reduction around him, and around our health officer and everything. We made sure that everything could be backed up by the facts. We tried to make sure to anticipate if there was going to be any hysteria, and get out there with people who had less to lose...”*

Surveillance data estimates that there are over 35,000 IDUs residing in the greater Detroit area, with over 80% living in Detroit. Heroin deaths have increased by 24% in both 1999 and 2000, following a 19% increase in both 1996 and 1997. By the end of 2000, it is estimated there will be twice as many heroin deaths as there were in 1996. Heroin purity is at its highest level and prices remain at low levels. Cocaine deaths in Detroit increased by more than 18% in 2000. More than six out of every ten heroin treatment admissions statewide occurred in Detroit in fiscal year 2000 (Calkins 2000). It is estimated that over 2,500 IDUs are living with HIV/AIDS. Surveillance data shows that HIV infection rates among IDUs decreased from 250 per year in 1994 to approximately 200 per year in 1997. IDUs, including men who have sex with men (MSMs) IDUs, and heterosexuals with IDU sexual partners make up a third of people living with AIDS in Detroit (Region 1 HIV Community Prevention Planning Group, 2000).

### Outreach

HIV outreach to IDUs was initially funded in 1988 by a federal grant to conduct outreach in emergency rooms and detox programs. A recovering addict was hired to do outreach in these venues. Several respondents said that outreach was successful because of his total commitment to the drug using community, and that the indigenous outreach model was widely accepted and later funded by the state and the local health department (LHD) and implemented in other community venues by culturally-specific CBOs.

Using federal funds, one CBO opened a storefront in 1989 to conduct HIV counseling and testing (C&T) and to provide services in the jails. They also had mobile services, a “one-stop-shop” and an outreach and pre treatment program (OPT). OPT consisted of two outreach workers who did outreach at bars, parks and to parents at a local Head Start program. The services were readily accepted by the community and fully utilized. Since many neighborhoods in Detroit do not have adequate public transportation, the mobile services were particularly needed.

There was little opposition to outreach partly because there were not many existing services for drug users. Drug users were grateful for any attention paid to the issue. Detroit built strong coalitions between city departments and CBOs. The Health Department worked well with the CBOs and had many meetings to plan outreach programs. Integrating AIDS prevention services wherever possible was a goal from the very beginning. Fifteen to 22 outreach teams work in the city and all the CHOWS get together once a month to share strategies, coordinate efforts, and plan joint activities.

Most of the outreach respondents seemed remarkably upbeat about the current outreach services in Detroit. One respondent had moved away and gone back to Detroit to consult for the local health department, and this person had nothing negative to say about the health department or the services, only that “Detroit itself is a bleak, rusty, dying, aging inner city with little revitalization or gentrification succeeding.” People felt that they did not face huge barriers in order to implement and conduct outreach services. However, respondents thought that the high turn over of executive directors at the CBOs and of administrative staff in various city departments caused continuity problems, and as a consequence a loss of funding and services.

### **Drug Treatment**

IDUs wanting to enter drug treatment must go through the city’s central admitting and enrolling system called Central Diagnostic Referral Services (CDRS), which is administered by the Bureau of Substance Abuse Services. Detroit considers itself a model for treatment-on-demand because clients can often receive treatment services the same day that they present at the downtown CDRS center. However, if clients go to their neighborhood treatment clinic, they cannot be enrolled or receive services until they have gone through the “Hub” at CDRS. This was seen as a barrier for IDUs who do not follow-up and go to CDRS. If they do make it downtown they often have to wait on line.

*“If they walk in today, we have to turn them away. When people get there, they are being served well, but the problem is for addicts to get themselves to that place where years ago it was much more community-based when a patient in their own neighborhood knew where the clinics were and the families all knew where the clinics are we could simply take them right into the clinic. If they walk in today, we have to turn them away... getting them to the Hub is not always the best for them.”*

The “Hub” is now able to process everyone who shows up in the morning as compared to a few years ago when people were sent away after waiting on line for many hours. Clients enrolled in one program do not have to go through the admitting procedures to receive services in 32 other programs in the system as long as they are receiving the same level of care. That is, if an IDU was initially evaluated for outpatient treatment, and then the clinic thought that they should be in a residential program, they may have to go back and be re-evaluated. Clinics repeat the intake process because they do not receive the paperwork from CDRS for a week or so and do not collect the information that the clinics feel they need.

Several outreach staff have worked both in AIDS prevention and in drug treatment for over 10 years. Many drug treatment programs have AIDS in-reach programs inside their centers, which includes HIV education and prevention to clients. Like many other cities, Detroit’s drug treatment services have been negatively impacted by the change to fee-for-service. Fee-for-services have also hurt CBOs ability to participate in regional and local HIV meetings. Contractors are “forced” to attend monthly meetings.

*I wish it was much more of a team approach to doing things but it is just disseminating information at those meetings.*

Most HIV prevention in drug treatment is centered on training for staff. All staff are required to attend a 2-day HIV training. Staff are not paid to attend the training, and do not often take advantage of the other more specialized training because they are not paid to do so. For contractors to be in compliance, they must submit verification that staff attended the two-day HIV training. Many staff felt that the 2-day



training could have taken place in 2 hours. There seems to be little evidence that AIDS prevention funds have been used in drug treatment beyond staff training. One provider said that he couldn't remember any AIDS prevention funding opportunities.

### **Needle Exchange**

Detroit implemented its NEP through a coalition of grassroots activists, community service providers, researchers, health department staff and key political figures. While it took almost five years to legalize NEPs, the volunteer activist exchange continued to provide syringes every week.

In the early 1990's a man started the exchange out of the trunk of his car in nearby Pontiac. Once the exchange became legalized, "he went away and no one has heard from him since". There is not much known about him, and no one could even remember his name. They know that he approached the mayor of Detroit after about a year of conducting the NEP to request that he not get arrested. The mayor was impressed and asked the Health Department to "look into it" and made sure he never was arrested.

Other activists joined this man and began collaborating with other CBOs, researchers, health department staff, and key political figures. The representatives from the LHD, although completely supportive of NEP, decided that their role should be to provide legitimacy and certification to the organizations that wanted to run NEPs. Local researchers joined the growing NEP coalition and utilized existing research and information from other NEPs around the country to develop a plan to gain the support of the City Council. Instead of having the NEP activists speak to them, the NEP coalition decided to ask the local ASO to give them \$10,000 to fly "experts" to Detroit to present to the city council. At first the organization refused. One of the researchers involved in the coalition called the director to find out why they would not fund this plan. He invited the director to come out to observe the NEP. The ASO director was so impressed with what he saw that he gave the NEP coalition the funding they requested. They flew in a council member from New Haven who had initially been opposed to NEP, but had "seen the light." So they had "like talking to like." They brought in other prominent researchers to present findings from other studies. Researchers, in particular, seemed to understand that city council members were not going to be convinced, unless people with shared perspectives and concerns spoke with them. After that presentation, all of the council members supported the NEP.

Then the coalition held a meeting with opponents and proponents together. They made it a point of the meeting to hear the concerns of the opponents respectfully, never discounting their concerns. They then politically mapped out a strategy to gain the support of the Detroit Substance Abuse Committee.

The Health Department was able to get a city attorney assigned to write the city's position paper in favor of needle exchange. This would be the beginning to drafting enabling legislation for NEPs in Detroit. CBOs, law enforcement, ASO, and City Council members were all involved. This group was careful to make sure that the individual activists who were running the NEP would still be able to do so after the legislation was passed. The enabling legislation was written in such way that agencies or individuals could be certified to do NEP. A non-profit status was not necessary. "An individual could provide syringes out of the back of their car."

The requirements for certification to conduct a NEP included the following: 1) At least one certified AIDS Pre/Post Test Counselor on site; 2) at least one person who could make drug treatment referrals but they did not have to be a drug treatment professional; 3) A relationship with a biohazard waste company for disposal of syringes; and finally 4) A \$10 licensing fee. However, the city was never told how to collect this fee, so they never did.

Once the NEPs had begun there was some initial opposition in the faith community and among African American leaders and charges of genocide were made. The NEP coalition dealt with the opposition by keeping dialogue open and never disregarding their opinions. They held numerous community meetings and simply continued to listen to the opposition viewpoints. They did not make changes in the NEP and eventually through this process, coalition members were able to get the opponents to agree to not come out against needle exchange. Respondents believed they were successful in this because of the attention the opposition concerns were given. The coalition always stressed that NEP was part of a larger comprehensive approach to meet the needs of IDUs. To this day there has not been any “backlash” about NEPs in Detroit.

Respondents made the history sound simple, although it took almost five years to get NEP approved in Detroit. People got discouraged along the way. But the model they developed was appropriate to Detroit and they followed it through. Below is a description of the history of needle exchange from one of our government respondents. Two other participants told the same history.

When asked what was one of the keys to their success, one public official replied:

*“...the incredible amount of positive momentum that could happen when you have different branches, disciplines, all working together doing what they do best. There were some things that the community did, that we probably would not have been able to accomplish, like getting the City Council that fired up, and motivated and all of that. That is something that the community group did. Quite honestly, I don't think that the community group would have been able to cause the legal department to sit down and work day after day after day on getting that ordinance re-written, and getting the other ordinance written. That's something that really took the movement, and the request of the health officer to get that done...And I think that that's what caused -- it really caused a lot of momentum, and caused it to move much quicker than most things move, when it requires, you know, ordinance changes and agreement between City Council, and Mayors, and the community and all of that. And we kept each other informed and didn't step on each other's toes and really tried not to rain on each other's parades.”*

## MEMPHIS

### City Summary

*“We are the buckle of the Bible belt. People are afraid to talk about condom distribution.”*

Memphis, which is located in Shelby County, has the majority of AIDS cases in Tennessee. In 2000 Shelby County reported 4,410 HIV infections and 2,928 cumulative cases of AIDS. African Americans represented 23% of population and 50% of HIV cases. (Tennessee Department of Health, 2000; Shelby County Regional Advisory HIV Prevention Planning Group, 2000).

Memphis was repeatedly described by respondents as “the buckle of the Bible belt”, where even handing out condoms was questioned because it might promote pre-marital sex. Interventions for IDUs were reportedly unpopular with both the state legislature and the general public. There are no HIV prevention interventions specifically targeting IDUs in Memphis, and no publicly subsidized methadone treatment. The local health department is small, with a generalized outreach and community education department that focuses primarily on bringing HIV C&T to the community. Other services are contracted out to local CBOs. HIV prevention planning has focused primarily on the African American community because of the disproportionate rates of infection. Local treatment and outreach providers report that crack use and its attendant sex trade are the largest problems within the African American community, and that is where they target their HIV prevention efforts. Outreach and education to IDUs, that was originally funded under federal grants, has since been reduced.

### Outreach

In 1985 HIV counseling and testing (C&T) only targeted MSMs. It was not until the late 1980’s that C&T targeted other populations in Memphis. The state provided some funding for street based outreach in 1991. But again, these efforts focused on MSMs. However neither gay men nor IDUs were ever explicitly targeted when state HIV funding was planned, debated and approved. State lawmakers were not willing to discuss issues of homosexuality or drug use when funds were issued. They would only acknowledge the need for education to youth, women and the African American community. As a result statewide planning and funding has never included any specific strategies for reaching IDUs. Public health officials at the state level also avoided developing plans for working with IDUs. They felt the populations were too difficult to reach, and they were not willing to openly discuss injection drug use. They were also uncertain how they could provide information to IDUs without violating drug paraphernalia and other narcotic related laws. Community planning began in 1992 but had little effect on programs or funding for IDUs. The HIV Prevention Planning Council also wrestled with the same issues as the legislatures and “realized the limitations of working with the IDU population”. Community and state-wide planners ultimately decided to let “other agencies” provide services to IDUs, removing the State DOH from any controversy for enacting programs for IDUs.

Staffed by DOH, street based outreach began targeting African American women of childbearing age and youth. With the start of the community planning process, the DOH started to subcontract services with local CBOs.

There was both a will among African American activists and a willingness on the part of the state and local health officials to focus on the African American community, rather than on specific behaviors

within and beyond that community that put them at risk. Planners that focused on race alone, excluding a larger focus on IDUs or MSMs, realized that crack use, and sex trade related to crack use were the issues most impacting the African American community at that time.

In 1988 a manager at the DOH convened a group of African American CBOs to apply for a cooperative grant from a federal agency for street outreach to IDUs. The cooperative included a community corrections agency that supervised non-violent offenders. This CBO was responsible for the outreach component of the program, which also included HIV C&T. The CBO developed a street outreach program without a model. They used surveillance teams to “map” high crime areas, looking for discarded paraphernalia and drug dealing activity. They hired former IDUs as outreach workers and included two civil rights ministers on their staff that then provided them access to two churches. The program included condom and bleach distribution, and education on safer sex. The outreach program was also able to use the church van to conduct outreach in different communities. Some key churches opposed the program because it targeted African Americans, and because HIV was still considered a “gay disease” by many in the community. Secondly they opposed the distribution of condoms and bleach kits as a means for encouraging immoral behavior.

*“Memphis is the Bible belt...and you’re talking about advocating safer sex practices. They view that as an endorsement of out of wedlock sex and promiscuous activities...some people took it as a moral issue. Is it right to give people paraphernalia to have sex with? There was some concern from the community in regards to the outreach teams having a section that dealt with sterilizing paraphernalia that was promoting drug use.”*

Conversely churches spent a great deal of time educating the public about “causal contagion.” There was a great deal of fear in the community. Outreach workers had to provide copies of their presentations in advance to the church staff, and often “objectionable” parts were deleted by the staff.

The participation of the DOH in the collaboration provided the program with credibility in the community. However, within the higher levels of the DOH there was opposition to the outreach program. Interviewees described them as “set in their ways”. Some argued that it was not a good intervention, and at that time there was very little data available to support it. The DOH administrators had low expectations of the street based outreach program. In the cooperative agreement, the outreach component received the least amount of funding. They suffered from high staff turn over among outreach workers because they were unable to pay higher salaries. Lower level DOH staff understood and supported outreach programs; however they were severely understaffed. There was only one person responsible for all community health education in Memphis.

Their outreach efforts were welcomed in areas of high drug sales and prostitution, and in public housing projects with high crime rates. They focused their activities there rather than on organizations that opposed them. They educated the community block by block where they worked. They recognized the need for a larger social marketing campaign to gain the support of the community, but there was no funding for this kind of a campaign.

In 1991, funding for the outreach program was continued by another state agency. The outreach program had been moved from one CBO to a new drug treatment agency started by African American providers. Although the funding was targeted to African American IDUs, it provided outreach to non-injectors as well. The focus of the outreach program swiftly changed from IDUs to African American crack users and sex workers involved in crack use. The program decreased emphasis on information to IDUs and availability of bleach kits. Information was only offered upon request, and not to anyone

under the age of 18. This was in response to both the predominance of crack and the opposition of the local community to safer injection messages. When asked about the program's response to the opposition to safer injection education one interviewee responded.

*“When I came in they had pretty much decreased the part regarding education and even materials... ‘cause at one time we had safer sex kits and the paraphernalia kit which included alcohol, cotton swabs and something else we’d use to clean the works. There was a decrease in that. It was made known that the outreach teams could educate you on that but it wasn’t part of the protocol. It was only upon request.”*

In another interview a drug treatment provider reported there was virtually no AIDS prevention information available to Memphis IDUs, and no bleach distributed by any program.

One drug treatment agency director was on the regional HIV Prevention Planning Council (HPPC). He supported the focus on crack use within the African American community. The outreach program had worked closely with the local African American churches. They are considered critical to gaining acceptance in a community and transmitting information and attitudes within the community. They have found pastors who are accepting and work with them, but they must approach them carefully. They approached more progressive pastors and presented their program to them. Outreach workers did their “street” presentations to pastors using graphic language. They realized that was a mistake.

*“You can’t be smarter than the pastor. You must get him to accept it and bring it to the congregation.”*

The DOH also continues to offer outreach, education and HIV C&T to community groups in the jails. However, none of this outreach is targeted specifically to IDUs. The state continues to be unwilling to target programs to MSMs or IDUs. They repeatedly call for more funds for youth and women of childbearing age.

### **Drug Treatment**

Until 1987, the Memphis DOH provided drug treatment through their own methadone clinic, including free treatment for those unable to pay. In 1987 the state cut funding for methadone programs. The DOH clinic was closed and that same year a private, for-profit methadone program opened. One respondent described this methadone program as “evil and terrible because they don’t care about people. They just want to make money.” They are the only private methadone provider. Recently two other methadone clinics have tried to open and met with opposition. To date neither has been successful in receiving local approval. Memphis has several other residential and outpatient drug treatment programs. One 30-bed residential treatment facility focused on the African American community also has the DOH contract to conduct the local HIV street based outreach program. One former treatment director described the demographics of drug users in his program from 1990-2000 as approximately half IDUs. Dilaudid was the drug of choice, but over the last 6 years heroin use has risen with the increased purity of the drug on the street. IDUs in his program tended to be white males with a median age of 25 years. He described the Hepatitis C epidemic in Memphis and said that 85 to 90% of people with Hepatitis C are IDUs.

In the early 1990’s fraud was suspected in the state agency responsible for substance abuse services and the Bureau of Alcohol and Drug Use was transferred to the Tennessee Department of Health (DOH). One respondent commented:

*“DOH did not want the program. They were the bastard child of DOH. They did not try to get any funding or develop any new programs.”*

1992 was the peak of the crack epidemic in Memphis. More treatment facilities were needed and there were no facilities that were focused on sensitive to the needs of African Americans. African American drug treatment providers started a new community based drug treatment program with a grant from the Tennessee Bureau of Drugs and Alcohol. This is the same program that runs the Memphis CBO based outreach program. The treatment program included HIV education and case management for HIV-positive clients. Because the focus of the program is the African American community, the director felt injection drug use was not the most pressing problem in the community, but it was rather crack use and sexual risks related to crack use. Outreach workers are trained to provide information about cleaning needles and safe injection but have more call to discuss safer sex issues.

There was very little opposition to this program. It was located in a very old African American community with a local pastor as a co-founder. The program director stated that these kinds of programs must come from the community. To be successful, they must work with local opinion leaders and gain their support first.

Treatment providers agreed that funding is more difficult to secure now. There is virtually no grant funding available. Funding comes through contracts with the state and is based on fees for services only. The African American program receives funding through Tenn-Care (the state Medicaid system) for Tenn-Care eligible patients enrolled in the program. However, these funds have been cut drastically. The program also receives clients mandated through the local drug diversion courts. One respondent felt that programs are run much more like businesses now than in the past and this might make it more difficult for new programs to start.

### **Needle Exchange**

During the 1988 collaborative meeting, bleach kits were distributed and NEPs were discussed as a possible intervention. A DOH program manager tried to encourage others to apply for funding from a private foundation to start a NEP. However needle exchange was too controversial, and no one wanted to get involved and the issue died. One interviewee reported about that time and said,

*“I like my job. I want to keep it. So I am not going to talk about NEP.”*

Although there were some reports of underground NEPs in Memphis, researchers were unable to obtain any contact information or anyone who reported any direct knowledge of a NEP. None of the respondents we interviewed thought NEP was a tenable option for Memphis. There was no single leader or group identified as “the opposition” to NEP. The consensus of respondents was that Memphis was simply too conservative a community to ever accept NEP and that anyone who attempted to initiate such a program would immediately lose their job. Unlike other cities that have tried and failed to implement an NEP, needle exchange in Memphis remains, as far as we can determine, untried. None of the respondents reported any plans, discussions, or even hopes to implement an NEP in Memphis in the future.

Because we felt it was critical to describe a NEP program operating in a conservative state we collected information from the Nashville NEP program. The program is fairly well known, and is run out of a local African American church.

*"In the environment there is always going to be the issues of dealing with the conservative voices. But we've been able to get around that by not being adversarial and doing our work with a level of consistency that people respect who we are and what we do."*

In 1983 a local African American congregation became involved with IDUs and substance use issues. The church had a long history of involvement in public health issues, civil rights, poverty relief, and many other areas of community work. Over time they became involved in the HIV/AIDS crisis. They believed the relationship between HIV and injection drug use within the community was clear. In 1991 they began distributing bleach kits to IDUs and began to explore the possibility of starting a NEP.

In 1993 a woman who had been involved in organizing and working with NEP in New York moved to Nashville. She wanted to begin an NEP in Nashville and began working with the church. In 1994 they began a small NEP program with their own funds, utilizing the church's outreach services. They quickly developed a collaborative application for a NEP with the local DOH to a private foundation. The grant was funded; however, the church ran into its first opposition before the funds could be received. Because the DOH was involved, the city council had to approve the receipt of the funds. It became clear that, while there were supporters on the council, when it came to a vote the funding would be rejected. Even more importantly, the church did not want the issue to come to a full debate, causing various members of the council and other city health and law enforcement officials to take public stands against NEP. They quietly withdrew the proposal. They knew they would be able to gain tacit approvals and a "gentlemen's agreement to look the other way" from various city officials if they did not force these officials to take a public stand. It is under this "gentlemen's agreement" that the NEP has successfully functioned illegally to this day in Nashville.

*"There is an understanding that as long as we are consistent with adhering to the protocols we have developed and shared with the powers that be, that we would be allowed to continue and not have to deal with any repercussions. But it is clear that there are very conservative people in the community who would turn it into a public issue that would impede our being able to do the work if it became highly visible. So we work hard at keeping it as low key as possible. But every year we are doing more and more work."*

After withdrawing the collaborative proposal, the church made a decision then to keep the NEP a grassroots church-based program. The church became the recipient of the foundation grant and was able to significantly expand their operation. They developed a research component for the NEP in part to maintain the respect of the health and law enforcement officials. However, they believe that it is due to their reputation as a group that provides a wide variety of social services in poor communities that has been the most important factor in the acceptance of the NEP.

*"I think there was a lot of respect for the work that we do period. Not that people always agree with us, but they respect and are not adversarial to us."*

The NEP has avoided media and other public exposure as much as possible; however it becomes more and more difficult as the volume of the exchange increases. They provide referrals to HIV C&T, drug treatment and other services. The NEP attracts many people into their services who they would not otherwise be able to reach. All of the funding for the NEP comes from the congregation and private foundations. They are very careful to ensure that funding they receive for their other services does not go into the NEP. It has been difficult for them to maintain credibility with IDUs who are wary of official institutions and with local law enforcement, the DOH, and other city agencies.

The minister does a great deal of education among community members, other service providers and community leaders about NEP. The church is beginning to have a few more allies especially among treatment providers who will speak out in favor of the NEP. Because the church is involved in so many different community services and organizations, they are able to educate many other providers and activists. The church points to the interrelationship between HIV, substance use, criminal justice, poor education and poverty to help others understand their work. Their position as a religious institution is also critical to their stance on needle exchange and their acceptance within the community.

*“Depends upon who’s carrying the message and how it’s presented to the community. I think you could have syringe exchange in Memphis. I think the issue is who’s going to bring that to the table and I think that if indeed there were folks within the faith community advancing the initiative, then it would be accepted. There aren’t many folks who are willing to use the language of the church as the way they justify doing syringe exchange. I think that because we are a church and we have developed our rationale for doing what we do around our belief, I think then our language for the proposition is different from anyone who came advancing the idea on the basis of the science. Because at some point people have to believe it’s the morally right thing to do. Because even if the science is good, if people don’t believe in it, it doesn’t make any difference.”*



## **MIAMI**

### **City Summary**

According to the CDC's December 2000 HIV/AIDS Surveillance Report Miami has the highest rates of AIDS in the United States (CDC, 2000). Miami's unique mix of cultures has required HIV prevention efforts for drug users to encompass the many religious, political, linguistic, and community norms represented in the area.

*"The problem in the Latino community that we come across is that they're a very close knit family. It's a problem. They like to hide it within the family. And so it's harder to reach that community, because they will not let you know that there is a problem... Puerto Ricans have a culture of injecting much more than the Cubans do. The choice of drugs and the preference for administration of the drugs are very culturally bound here. And we have so many different Latin groups that you can't view them as a homogenous group at all. And the Hondurans are very different from either of those. And then, of course, the other Caribbean populations, the Haitians are very different from the Hispanic groups and so on. The diversity in our community makes it very difficult for the groups to get a voice. Because there is such great need, and such great diversity, that it's kind of difficult for each group to be heard. And our politics are now dominated by a very conservative constituency."*

As many as 75% of new HIV infections in Miami are among persons who are substance users or in sexual contact with substance users (Holmberg, 1996). The drugs of choice for the southern United States and Florida have been crack cocaine and heroin (Community Epidemiology Work Group, 1998).

Poor people, women with a history of abuse or domestic violence, African-Americans, and Hispanics suffer high rates of HIV infection. (Community Based Organizations Resources Network, 2000). The epidemic in Miami-Dade County has shifted to increasingly impact poor and minority residents. African Americans carry a significant part of the disease burden, accounting for over 70% of IDU HIV/AIDS cases. Latinos represent 16% of the disease burden among IDUs. Injection drug use accounts for approximately 15% of the over 30,000 HIV and AIDS cases in Miami/Dade County. (It is important to note that for HIV and AIDS cases reported through February 2000, 10,144 (33%) were not attributed to any exposure category. Some of these cases may be attributable to injection drug use.)

### **Outreach**

HIV outreach to IDUs in Miami have largely come out of a research group affiliated a large state university in Miami, which conducts research among the five to ten thousand IDUs in the county. The university received NADR funding to initiate street outreach to drug users in 1986. Early ethnographic studies guided the design of street outreach efforts among IDUs. Early outreach efforts consisted largely of education and bleach and condom distribution programs. These efforts were eventually buttressed by Miami's largest ASO when they began a street outreach program which distributed bleach, cottons, "cookers," and condoms. The DPH also conducts outreach to drug users. This is largely done by funding drug treatment centers and contracting with ASOs.

Successes that exist appear to stem from the ability of outreach workers, particularly those working from the university, to establish trust and credibility among drug users. The base of success has been to

understand the culture of drug use and try to meet their immediate needs within the realm of HIV prevention. The university earned respect and credibility among drug users by hiring former addicts and others who are familiar with the culture of drug use and the communities they are working in.

One of the bigger challenges among outreach efforts for IDUs is the lack of continuity and institutionalization of proven services. Many outreach efforts are carried out as research projects and are halted when funding runs out. There appears to be a need to adopt outreach efforts that are shown to be effective, by either the public health department or CBOs.

Local government and politicians have been reluctant to support prevention efforts among IDUs and have even criticized outreach activities. The only recent local political support came in 2000 from the mayor's wife, when she gave a strong supportive statement for the just issued assessment and evaluation of HIV among people of color saying that she would "keep the city on top of this and that HIV would no longer sit in the back room."

There appears to be little formal opposition to HIV outreach efforts for IDUs. The Catholic Church in Miami is the most prominent opponent given its past opposition to the distribution of bleach and condoms. With the high prevalence of Catholics among Latinos, this message carries tremendous weight in Miami's Latino community.

The police offered some early resistance to bleach and condom distribution since these efforts were seen as drug paraphernalia. Subsequent meetings allowed an understanding of who the outreach workers were and what they are doing to be communicated to the police and alleviate further confrontations.

There are several groups working to stop the use of drugs, advocate for drug treatment and support a strong criminal justice system, but their efforts do not appear to undermine outreach efforts.

### **Drug Treatment**

*"Miami's no different than any other community. I mean, originally HIV planning councils were comprised predominantly of gay men, white gay men. Then as the disease changed, and as more services needed to be provided, and more CBOs that represented specific minority groups became more relevant in the planning process, that's when actually substance abuse treatment started to get a little more visibility. Because, it wasn't the white gay community using residential substance abuse treatment. It was the African American men and women, the Latin men and women, you know, the homeless, the agencies that service people that were homeless. So, I mean, and recently substance abuse wasn't considered an issue, because it wasn't -- because the type of person that uses substance abuse treatment doesn't fit your typical profile of what a board member would've been like ten years ago.*

The first evidence of HIV infection among IDUs first appeared in Miami around 1985. During the early days of the epidemic, from the mid 1980's to about 1996, the primary prevention strategy was to get IDUs to stop using drugs. In 1993 the state of Florida provided funding for substance abuse prevention and drug treatment block grants. This funding allowed for pre and post test counseling for IDUs as well as a vehicle for bringing people into treatment. As people with AIDS began to access the services funded by Ryan White, it was realized that substance abuse treatment was a pertinent area. Substance abuse currently is the most heavily funded priority category through Ryan White in Miami.

In 1994 residential and out patient treatment programs were started for people with HIV. Respondents reported that before then HIV positive drug users were not always allowed into treatment programs. Apparently the treatment community was not very sympathetic to having HIV-positive individuals in treatment. It was related to the fact that these people had more medical conditions as well as dealing with the stigma of having HIV-positive clients in their programs.

It appears that new programs are more receptive to treating HIV positive clients. But there are apparently some programs that will not apply for Ryan White funding for residential treatment because they do not want to serve HIV-positive clients.

In 1999 there was an increase in HIV early intervention funding that provided outreach to IDUs and encouraged them to get tested before going into a treatment program. There have been HIV collaborations between the university and county agencies on activities that overlap, including outreach activities.

Funding for services drives many of the programs that are implemented. A substance abuse and mental health committee reviews all funding recommendations. There is a clear understanding of the different agencies that it is important to include the various players in the planning of services for IDUs. Support has been provided by the state drug czar's office by including goals about risk reduction and harm reduction.

The Department of Children and Families which authorizes who gets accepted into a state funded residential drug treatment program, has been able to monitor that certain racial or ethnic groups have not been excluded from services. It was expressed that in the past providers were choosing individuals who they wanted in the programs, and that African-Americans were often excluded. There currently is some concern that with the governor's desire to increase the capacity of some community agencies and in turn reduce the role of governmental agencies, service providers will exclude certain racial groups and the homeless from treatment programs. Three providers in the Miami area currently provide methadone services.

### **Needle Exchange**

*"...Needle exchange is where the dividing line is drawn. I think they see it as something that should not happen...that it's aiding drug use. ...I think that we're even a more conservative community than the national community is."*

NEP in Miami is yet another part of the puzzle of services provided or not provided to prevent HIV transmission among IDUs. All current NEP activities in the Miami area appear to be very independent and have a very limited ability to reach a significant number of IDUs. Each effort can hardly be termed a "program" but do fit a traditional grassroots model. The more active individual provider, who independently operates an exchange in the Homestead area, has received funding from a national needle exchange network and condoms from the DPH. He exchanges about 300 needles a month. There have been NEP efforts in central Miami up through 1999 but they have recently ceased.

There appears to be a sense of fear or unwillingness to "rock the boat" among people working with the drug-using community with regard to setting up a NEP. Needle exchange is not legal in the state of Florida as it is illegal to possess, distribute or sell drug paraphernalia. Researchers at the university are careful to stay within the legal system to work with drug users, conducting outreach, distributing bleach, condoms, and related paraphernalia but do not get involved in trying to implement NEP. There have

been lobbying efforts from faculty at the university to try and have statutes changed. But to date these efforts have been unsuccessful. The university receives money from the state and federal government and the Miami/Dade DOH. and they are not willing to jeopardize their relationships to begin conducting NEPs.

Within the DPH it is less clear why there have not been large efforts to promote NEP. The most commonly heard reason is because it is not legal. But this has been the case in other cities, and things have changed after a few people promoted NEPs. There is a reluctance that seems to go deeper than legal reasons.

Additionally, the local government is considered very conservative and not supportive of HIV prevention activities among drug users. The fact that Miami's mayor is of Cuban descent and the city council is made up entirely of Latinos may be a factor when one considers the often-heard statement that Latinos are silent about HIV/AIDS.

*"I think that we have a very conservative government here relative to HIV prevention. We've needed better access to needles or syringes for a long time...the government still does not support those efforts."*

The HPPC seriously considered implementing a NEP when they debated declaring an HIV state of emergency. However, the "cure" for AIDS in the form of the new AIDS "cocktails" appears to have railroaded these efforts.

## NEWARK

### City Summary

*“We’re not in the 21<sup>st</sup> century in this city. We’re a third world town. We’re a third World City when it comes to AIDS and when it comes to drug use, it’s a third World City. One of the greatest difficulties here is that drugs are the probably the second largest employer in the city of Newark. And everybody is involved in the drug trade. This is the economics of the city of Newark...The hardest barrier to overcome is the general citizen’s belief that drug use is about a person not having enough character—not being strong enough—being weak, and that HIV is punishment, and not a world health pandemic.”*

Newark has the sixth highest AIDS rate in the country. There is a prevalent myth in Newark that drug users in their town do not inject their drugs despite the fact that injection drug use accounts for over 60% of all HIV/AIDS cases (New Jersey HIV Prevention Community Planning Group 1998). Heroin use in Newark has been on the rise since 1991 among all ethnic groups and across all age groups (Mammo 2000) despite a decrease in the use of other substances. Heroin injection did begin to decrease during the early 1990’s but the CEWG reported a small, but steady increase starting in the mid 1990’s especially among the 18 to 34 year olds and especially among Whites and Hispanics. There is also a rise in the number of senior African Americans injecting heroin. The purity of heroin has risen and the price has sharply decreased since 1997 (Mammo 2000) in Newark.

Respondents complained that there are very old-fashioned attitudes about drug users in Newark, almost an “Old Testament quality”. “They are bad people who are sinning and who deserve what they get.” They also complained that there is little understanding of what constitutes “harm reduction.”

### Outreach

Outreach to IDUs was first funded in 1988 with federal research demonstration grants to the state Department of Health to designated cities in NJ, including Newark. Indigenous community health outreach workers (CHOWs) were hired from Newark to provide AIDS education and prevention in their communities. The model of hiring recovering addicts, often from therapeutic communities or methadone drug treatment programs was quickly accepted and implemented in Newark. Many types of CHOW programs were funded by both the city and the state to units in the Newark Department of Health and Human Services, CBOs, drug treatment programs, and churches.

There is a considerable amount of outreach dollars allocated to Newark, although there seems to be a lot of confusion among the outreach service providers as to who is actually providing AIDS education and prevention in the community. One CBO director said her program was the first in 1994, but then they lost funding until 1996. They did some limited outreach in 1997 and then a received a large federal grant in 1999. At the time of the interview (1/01) she believed that “her program was the only program funded to do street outreach other than some church groups that provided food and clothing.” When asked if they knew what happened to the CHOWs who were funded in 1988, they replied,

*“I have absolutely no idea. I know the city of Newark itself has tried to do some outreach and has stopped. As far as I know, they’re not doing any outreach.”*

There was not sufficient data to confirm or deny this perspective or to develop a clear picture of the relationships between CBOs and the Department of Health and Human Services.

Several outreach program directors had never heard of “CHOWs.” One CBO director believed that “none of those other programs were ever out there,” and that if they were providing any street outreach services, workers would only go to selected sites that they considered safe. They did not want to go into any abandoned buildings, particularly the boarded-up public housing projects that have been “squatted” for years, or along the railroad tracks, or some of the container trailers that are used by drug users.

Bleach kits and condoms were distributed early on as part of the outreach protocol, but respondents reported that they have not been readily accessible to the most at risk populations. Hiring, retention, supervision, and training were singled out as barriers to mounting effective outreach programs. Drug use in Newark has been described as one “big hot spot” with very few “cold spots.” Therefore it is very difficult for CHOWs to saturate any one area thoroughly. Burn-out, lack of leadership, lack of coordination within agencies and between agencies, and a sense of helplessness as to accomplishing HIV prevention within the context of the political and historical forces pervaded many of the interviewees.

Another health department respondent spoke of the challenges of hiring qualified outreach staff. The outreach program primarily attracts women as the ones who want to do the outreach but they believed that there are spots where they can't send women because it is too dangerous. Another hiring and staff retention issue is work place drug testing. Qualified potential CHOWs from the target areas cannot be hired because they test positive for heroin or cocaine. The people who are willing to go to those areas late at night when it is possible to reach the most people are the ones who are still engaged in that lifestyle. Or as one respondent put it “Who else would you find to do that work?”

### **Drug Treatment**

Newark was at the forefront of developing innovative drug treatment programs in response to the AIDS epidemic among IDUs. In the late 1980's, CHOWs distributed methadone detox treatment coupons. There was some initial opposition to the idea of using money as an incentive to get people into treatment. The program was quite successful, but suffered from funding problems and was discontinued in the early 1990's.

Patient Incentive Programs (PIP) now operate at high volume drug treatment centers. PIP provides non-financial incentives such as clothing to participants who remain in treatment. But the program has been reduced from 180 days to 45 days to accommodate the funding cycles of treatment facilities and to increase retention. One CBO respondent believes that clients sell their vouchers or incentives whenever possible. There has been a struggle to convince funders that it is appropriate to use AIDS prevention dollars to fund drug treatment, but the funding for this program is currently steady, although the number of slots available for Newark is small and there is a two-week waiting list.

HRSA funding has allowed for the development of targeted, multi-service programs to be established by several CBOs. One-stop shops, open during evening and weekend hours, provide a range of drug treatment and psycho-social services to several different target populations (e.g., homeless, drug-using women, men who have sex with men, etc.). These types of programs call for formal coalitions between agencies to provide different components of the services. Some respondents thought that the programs worked well together while others thought that was certainly not the case for their agency.

*“There’s a lack of cooperation here. We are a very poor city, and everybody is at everybody else’s throat to get money. I don’t get any money from either the city, the county or the state. I’ve been cut out by all three. I only get federal money. So, in a sense, it’s easy for me to look at it, and see the complete lack of cooperation, pathetic as it is...people going for the same bucks, and it’s just murderously difficult to get them, and so, there’s a general lack of cooperation.”*

Despite these innovations, Newark drug treatment suffers from a variety of problems as identified by the respondents. One claimed that there are sufficient treatment slots in Newark, but the reputation of the services as perceived in the community keeps people from utilizing many programs. People “will go to East Orange before they would enroll in one of the programs in Newark.”

Even among savvy service providers, myths about how certain programs treat IDUs negatively and what they make them do or not do abound. One respondent laughed when asked what she knew about another drug treatment program.

*“One of my clients told me last week that he wasn’t going to X program because ‘I’m not putting on no dress...’ It seems when a client has broken a rule, that they have been known to make the client, male client, put on a dress and walk down the main street of town. A kind of homophobia of Newark and of individuals.”*

When asked if she had checked out this rumor with the agency in question, she laughed.

Another myth about drug treatment in Newark is that programs have “waiting lists” **and** “empty beds. When asked how this could be so, a director replied:

*“Well, the question is, how do you have both? And one of our staff followed up on it, and found out that they were not taking people unless there’d been insurance clearances. This is about money.”*

One CBO director, when asked what they knew about innovative drug treatment as an AIDS prevention, replied

*“Everything has just gone into methadone clinics. And not every IDU wants to go on methadone. In Newark, there’s a very strong perception among IDUs that methadone is just another drug, and they do not want to be on it.”*

### **Needle Exchange**

Needles are very scarce in Newark and can cost as much as \$5 on the street. Needles are sharpened on matchbooks and used over and over again until they wear out. We were told that discarded syringes are never found on the street, the railroad tracks, alleyways, etc., and that IDUs do not know about cleaning syringes with bleach. No one we interviewed knew of any drug users who utilized New York NEPs on a regular basis if at all.

No one we interviewed had ever heard of any kind of illegal needle exchange program ever operating in Newark. As of May, 2001 there is still no evidence of any underground needle exchange efforts in the city. When asked to comment on the possibility of the implementation of needle exchange one interviewee replied,

*...Politically that [needle exchange] is not going to happen anytime soon... A woman presented information on needle exchange... City Council members laughed at the idea... Politicians in Newark are in denial.*

A New York City AIDS activist organization opened an office in New Jersey in order to launch a “statewide public education campaign designed to build awareness about needle exchange and to develop consensus among the leadership of the most hard-hit communities in support of needle exchange.” This group believed that there was “substantial constituency support for needle exchange that has never been mobilized” (Lanier, 1999). They worked with other NJ cities including Newark to get local resolutions passed to approve needle exchange if the state ban were lifted. Activists from the group made a presentation to the Newark City Council and gained the support of several council members. However, one interviewee criticized the organizers because

*“They weren’t the right people for the job. They came in with their own agenda. What the agenda should have been was to educate people to make up their own minds, and letting people see what their own prejudices, preconceptions, etc are... They had a forum and it didn’t work because they didn’t understand the local culture. They had a white boy from New York... and you can’t do that in Newark, it doesn’t work... You have to be very sensitive to what the issues are locally. It just wasn’t one of their better moves.”*

The CARE Council in Newark and some local church groups passed resolutions in support of the ordinances, but the campaign was not successful in Newark as it was in other cities in the state. Eventually the group ran out of funding and closed their New Jersey office.

One respondent when asked if they thought the injection rate was low in Newark and that’s why there was no push for needle exchange said

*“Well, that’s interesting because even if there were one person injecting, that would be a good reason for an exchange. It’s not about numbers.”*

Aside from the usual arguments against needle exchange, such as that it promotes drug use, another interviewee noted that the strong hold of African American churches on the government and the general community prevents needle exchange from being implemented in the city. However this remains to be an issue of much debate. When asked to comment on what role the African American churches might play in keeping needle exchange from becoming implemented an interviewee remarked,

*“...I think that’s a bogus explanation, whenever they say it can’t be done in Newark that’s when they point to the fact that established Black churches would be offended but I think that is a convenient excuse that just doesn’t hold any water.”*

Of all the reasons surrounding the lack of implementation of needle exchange in Newark, all the interviewees unanimously agreed that the political climate successfully prevents groups or individuals from starting underground NEPs. Stories of activists in another New Jersey city being “locked up” and all their possessions confiscated spread to Newark, intimidating all those who wanted to start an underground effort. The effort to establish a NEP in Newark has been abandoned. The founder of the other New Jersey exchange was interviewed and denied that anyone lost their house or possessions. They were upset that this rumor was used as an excuse for people not to start a NEP in Newark or anywhere else in the state.



Only one respondent talked about clean syringes being available from certain medical providers at the local hospitals or clinics. However, that person also admitted that not many high-risk individuals could access syringes via this method.

*“There is a particular doctor, who most of us know at one of the local hospitals, who is very loose about ‘scripts. He will ‘script for almost anything. And he does give ‘scripts for needles, supposedly...”*

Another agency director said that three years ago they were asked if they wanted to distribute 10,000 syringe kits. The outreach staff really wanted to do it, and they discussed it at length.

*“We’re a small agency with so many funding problems, that we just couldn’t undertake to do an illegal needle exchange. We didn’t have the kind of back up that we would need to do it, so we did not do it.”*

The former governor made her position on needle exchange very clear early in her administration. Numerous letters (Whitman 1996) and editorials (Whitman, 1998) and personal communications via her staff, have firmly outlined her opposition to any kind of needle exchange program. In a communiqué dated December 26, 2000, shortly before she left office, the governor’s aide wrote the following to us:

*“...After reviewing the recommendations of her Advisory Council on AIDS, the Governor remains firmly opposed to such programs....she believes policy that directly or indirectly encourages illegal drug use is irresponsible.”*

The acting governor as of this date maintains the same position. Several respondents were contacted at the end of May to provide an update on the status of needle exchange in Newark. Some of their responses when asked if they had heard of any attempts to establish any kind of harm reduction or needle exchange programs in Newark were “Sadly, the answer from me is still no.” and “I do not know of anything NEPs or distribution activities in Newark.” The future of needle exchange in New Jersey is not even being considered at this time.

## SEATTLE

### City Summary

*“Seattle’s experience was pretty smooth and featured an awful lot of cooperation.”*

As of June 2001 there were 6,246 cumulative AIDS cases reported for King County, of which Seattle is part. However, the health department estimates that between 6,000 and 9,000 residents of the county are currently infected with HIV (Seattle and King County Department of Public Health, 1999).

The Seattle and King County Department of Public Health estimates between 10,000 and 25,000 drug injectors in the county. Prevalence of AIDS cases IDUs has remained low. As of July 1998, 286 IDU cases were reported, (not including MSM IDUs), representing 5% of all King County’s AIDS cases. This is five times fewer the proportion of AIDS cases attributed to IDUs in the US. MSM IDUs account for 10% of cumulative AIDS cases in King County. (Seattle and King County Department of Public Health, 1999) HIV prevention advocates and public health officials have pointed to these low rates as evidence of the success of early interventions among IDUs in Seattle. They have pointed to the much higher rates among IDUs in other US cities as a warning of what could happen if interventions were not initiated and maintained.

In 1983, long before such planning councils were mandated under the Ryan White CARE Act, Seattle developed a community advisory council for HIV and AIDS spending. Within a few years, IDUs and drug treatment providers were represented on this council. Their presence was influential in gaining support and coordinating services for HIV prevention for IDUs.

### Outreach

*“Seattle was relatively unique in that there was agreement among several key players from the start that outreach was crucial...and there was a fair amount of cooperation and collaboration between those different agencies.”*

In the mid-1980’s, before any official discussion of prevention for IDUs had occurred, the AIDS Prevention Program (APP) of Seattle and King County Public Health Department started a bleach distribution program in their building. Their offices were housed across the hall from methadone program and APP staff felt compelled to do something for IDUs they saw every day entering that program. From this beginning, a bleach and pamphlet distribution program slowly expanded to include local bars, shelters, drug treatment centers, and other drop-off sites. There were no outreach workers assigned to this until much later; it was a volunteer effort within APP.

In 1985, APP collaborated with the alcohol and drug research group at the local university to conduct an ethnographic study of IDUs. Ethnographers became the first informal “outreach workers.” They started distributing bleach, condoms, and information because they felt it needed to be done.

*“There was a lot of spillover of function and role and so on. It was just a bunch of people trying to address a problem, and there was a feeling you couldn’t just go out and be an ethnographer and kind of stand there and ask people questions and observe their risk behavior without offering*

*something, without doing something both because it was a moral injunction and, second, because as any ethnographer knows, reciprocity is the name of the game.”*

Upon returning from the International AIDS Conference in Amsterdam in 1987, the APP director formed a committee within the health department to examine the feasibility of implementing interventions for IDUs that had been used in other countries. He held a meeting of all Seattle agencies interested in and working with IDUs. Representatives from the health department, police, universities, drug treatment centers, health maintenance organizations (HMOs), ASOs, and CBOs discussed strategies and prioritized them. Outreach was considered the most beneficial and feasible of all the interventions. Interested parties continued to meet and formed the collaboration that eventually became part of the national AIDS research project.

Throughout the next several years the APP director and his colleagues met repeatedly with internal opponents, community groups, and city and county officials. They presented reviews of data supporting the interventions, tried to humanize IDUs as part of the Seattle community and pointed to the rising rates of infection among IDUs in other parts of the US. They described their strategy as never forcing anyone into a polarized position by asking them to approve or disapprove of the interventions. Rather than “winning” the debate ultimately one respondent said, “we wore them down with information and persistence.”

The national AIDS research project began in March of 1989, with two of the ethnographers who had been doing “unofficial” outreach hired as outreach workers. The Outreach Coordinator (OC) was also an ethnographer who had worked in Tacoma establishing their IDU outreach and NEP. The project opened a storefront research center in a neighborhood with a lot of drug use. At the same time, Seattle AIDS activists started a NEP in the same neighborhood, working closely with APP and outreach workers. The OC became the liaison between the city and the volunteer NEP.

In November 1990, two years before the federal funding was to end, the outreach workers worked with others to form an independent non-profit to continue their work. They did not want the outreach program to become a part of the health department, feeling they would become too bound by city and county policies and restrictions.

*“It became clear to of a variety of us here in Seattle that the Feds were going to do what they always do: provide money for a few years and, once you actually get the thing up and running and proving that it’s working, pull the money. So, in November of 1990, a group of people, both those involved in the project and those completely unaffiliated with the project, got together and decided to start an independent non-profit in hopes that we would be able to hit the ground running as soon as the NIDA funding ran out.”*

In 1992 when the federal funding ended, the new CBO received funding in the form of grants, city contracts, and donations to continue their outreach and HIV prevention work with IDUs. In 1997 they took over two volunteer-run needle exchange sites. The two new sites were in neighborhoods where needle exchange was more controversial and the city’s process of coalition building to develop new NEP sites was too slow.

Currently, the CBO conducts outreach, operates needle exchange sites and provides a drop-in center seeing over 300 people a day. The center offers referrals and assistance with drug treatment, housing, food, and clothing vouchers, and hosts AA, NA, women’s support group, and English and Spanish-language user meetings.

Eighty-five percent of the CBO's current funding comes from contracts with the city. The benefit to this is stable funding and the ability to work with a relatively liberal health department. Yet, they still feel somewhat impeded by the bureaucracy of a governmental agency that must respond to elected officials. However, funding through other sources has been difficult to find. In addition they are under renewed pressure to relocate by local business groups as the downtown area has gentrified over the last decade.

### **Drug Treatment**

One private, non-profit methadone clinic in particular has worked very closely with the APP. The leadership of its director in collaborating with the APP, and the HIV HPPC was seen as key to curtailing opposition among the local drug treatment providers toward interventions for IDUs.

In 1989 an early collaboration between the Health Department and local methadone providers, the Integrated Services Project, placed primary care physicians in Seattle drug treatment centers and provided methadone vouchers to primary care providers in local community health centers. The voucher system soon became widely used in the NEP, as a way to link NEP clients to drug treatment. Ryan White, the State and the HPPC have provided funding for the vouchers.

In 1993, a collaboration between an outpatient treatment center serving gay men and APP began. This project is unique in that it combines peer-based outreach in bars and social venues, secondary needle exchange by outreach workers in those venues, and outpatient drug treatment. It is also one of the only programs for MSM IDUs in the country. While staff members at the drug treatment center were wary of this program at first, APP provided harm reduction training to the staff. Now the treatment center provides on-site needle exchange as well and is thought to be one of the first drug treatment centers to embrace harm reduction.

In 1995, the methadone program that had worked most closely with APP expanded from one clinic to two. The agency now serves 900 IDUs in Seattle. They have encountered some resistance to the expansion of their programs by both the city and county councils. Many restrictions were placed on methadone programs because of community fears of drug users "hanging out" in the surrounding neighborhoods. Each clinic was limited to 350 clients, and the effort to expand to a new site encountered a great deal of "NIMBY" opposition.

In 1999, the program expanded again to include a mobile methadone treatment program. The mobile program was adopted as a way to expand services without having to battle neighborhood opposition to additional fixed sites. The methadone van parks outside the community health centers. Although there was trepidation on the part of some health centers to participate, most concerns were relieved by providing a security guard with the van.

The van serves several communities in King County, providing more accessibility to C&T and NEPs. The program also links methadone clients to the county health care system. The van's drug counselors work with both the methadone patients and the health centers' patients and staff. Counselors are given offices in the health centers and are available to the clinics' staff and patients for assessments, consulting, and counseling. Through these relationships, the drug counselors are able to give their methadone patients direct referrals to providers in the health centers for primary health care.

While most developments among the drug treatment community have been positive, there is some concern about the transfer of alcohol and substance abuse services to the health services department. Respondents felt the move resulted in a reduction of resources for the division.

*“I think the detriments of this move are becoming increasingly clear to most service providers, and certainly to most public health practitioners...Now we are in separate departments – [with] competing agendas—competing for resources.”*

### **Needle Exchange**

There was opposition to the idea of NEP within both the health department and drug treatment agencies. The APP director and the OC held many briefings with health department officials and city council members to support NEP. As there was little scientific evidence on the effectiveness of NEP at this point, it was advocated as a way to make contact with IDUs and get them connected with services. The APP director and OC also pointed to high rates of HIV infection among IDUs in East Coast cities, emphasizing that Seattle’s low rates could skyrocket without intervention. Careful never to back their opposition into a corner by forcing them to make a decision to actively support or oppose the interventions, they simply kept the meetings and conversations going. They finally “wore down” the opposition through persistence and a sense of urgency arising from increased national press coverage of HIV infection among IDUs at the time.

At the 1987 International AIDS Conference in Amsterdam, national experts presented information on interventions being used around the U.S. to prevent HIV among IDUs. Representatives from the health department, police, university, drug treatment centers, HMOs, and ASOs discussed different strategies and prioritized them. NEP came out at the bottom of the list because it was viewed as politically unviable.

In 1988, an AIDS activist organization was started in Seattle. This group was somewhat unique because it included experienced organizers not only from mainstream gay activism, the social-justice movement, gay Republican leaders, and civil libertarians, as well as current and former IDUs involved in social services for drug users. Most members had a decade or so of organizing experience. They used this experience to establish coalitions, work with local authorities and handle the media. These actions were ultimately the key to the successful start-up and maintenance of the NEP.

In the fall of 1988, a local activist started a NEP in Tacoma, inspiring Seattle AIDS activists to form a subcommittee to plan their own NEP. They met with Tacoma and San Francisco activists and set a start date. In the spring of 1989, the activists contacted APP, stating that Seattle needed an NEP. APP replied that the health department would need approvals from the Mayor, city council, county council, and police department.

*“[The activists] said, ‘You do what you need to do. But you do it fast. In the meantime, we are going to start a NEP.’”*

Though APP staff had already begun this process, the imminent start date of the exchange moved everything into high gear. They met with the city council, chief of police, and the mayor. The political savvy of both the APP staff and the AIDS activists was instrumental in “working the system” and gaining approvals.

The activists networked with other NEP activists on the West Coast and learned a valuable lesson about community opposition, especially within the African-American community, and how it could impede NEP efforts. Therefore, they sought endorsements from popular, high profile African American community leaders, among others. They encountered no resistance to the program in this community.

*“Part of the task was to convince people within the health department that needle exchange was a reasonable thing to do...and that was a slow process, a very slow and difficult process. God knows where it would have gone if not for the activists ...What they did was to galvanize the health department, force it into a situation in which it had to do something, you know, fish or cut bait...the health department organized this meeting with the head of the health department, the head of the police department, and some of the local representatives...and members of the activist group all together in one big meeting to talk about what was going to happen and how we're all gonna handle this, and do so politely. In advance of that meeting, the health department was able to get the police convinced that this was a public health issue, and not a police enforcement issue. And so, they promised that whatever the health department decided was the right thing to do, they would support, and they would not go out of their way to harass the needle exchange.”*

On March 22, 1989, the Seattle NEP began. The AIDS activists had only a few hundred dollars they had raised and a small amount of syringes. APP and the outreach workers contributed condoms, bleach, literature, and referral materials. Police were informed of the date of the first exchange, but not its exact location. A few press members were invited to come and do a story with volunteers at the site a few hours before it opened. Press had to be gone when exchange actually began. The NEP received positive press. The activists and the outreach workers had spread the word about the NEP among IDUs, and they were able to gain trust and acceptance among the IDUs quickly.

Once the press on the new NEP came out, the Washington State Pharmacists Association announced that they wanted to donate the syringes. By its third month, the NEP was succeeding beyond the activists' capacity to sustain it, and the city stepped in to assume its continuation. Encouraged by the lack of negative press or public opposition to the program, health department officials convinced the city and county councils that, since the program was going to happen anyway, it would be best if they had control of it. The APP established funding through the mayor's office and took over the NEP.

The NEP operated with city-funded outreach workers and volunteers. The following year, additional funding from the county was granted. The OC became the NEP coordinator. The city established a methadone voucher program, providing treatment for NEP clients. The city-funded NEP had a full-time staff person making referrals to drug treatment programs, tracking openings, and keeping waiting lists.

The activists had not planned on having the city take over the exchange so quickly. They had assumed that they would continue to run it on a volunteer basis for many years. In retrospect, NEP activists would have preferred to have kept the organization separate, with funding from the health department, rather than have it become a health department program. Then they would have retained the ability to make decisions. The health department was seen as too slow to open new sites, and seemed not to put sufficient effort into developing new volunteers. Activists felt an independent NEP could have lobbied against police harassment more strongly.

There was little organized opposition to the NEP. Despite official police approval of the NEP, there was occasional opposition from precinct captains. Police harassed and sometimes arrested NEP clients. The police would often stand right next to NEP table, and they would give NEP volunteers jaywalking

tickets. One NEP director had to go to court 15 times for jaywalking. NEP workers kept a log of the harassment incidences, including the badge numbers of the officers involved, and were in contact with a local police accountability organization. Finally, a new police chief was appointed who supported the NEP and discouraged harassment.

The State Supreme Court ruled that needle exchange was legal and appropriate on two grounds: 1) the Washington State Omnibus Bill passed by the House and Senate clearly allowed for NEPs; and 2) the Washington State Constitution assigned broad powers which overrode other sanctions of statutory law allowing public health officers to do whatever they felt was necessary to contain the spread of communicable disease in their jurisdictions.

Whereas volunteers liked conducting a sidewalk exchange, a survey of clients found that they preferred to be off the street, in an inconspicuous spot. Thus, the downtown exchange was moved into a small storefront. The downtown site is now open six days a week, four-and-a-half hours a day. They exchange 60-70,000 syringes a month, seeing 300-350 individuals in a typical afternoon. The downtown storefront is very small, which limits their ability to add new programs. The NEP now maintains a drug treatment waiting list of 600 people and follows them for a year to get them into treatment. They offer HIV and hepatitis testing and maintain an abscess clinic.

In choosing new NEP sites, the city goes through a careful process of talking to all local stakeholders, both IDU and non-IDU. They conduct formative research with local users to design the site, then go to neighborhood and business association meetings. They have contracted some sites to other CBOs who have circumvented this process. Among CBOs there has been some frustration with the time the city takes to establish new sites.

*"When the city has gone to a new site, I can't think of a site they've opened in less than a year. They go in and they talk to everybody, they talk to the barbershops, they talk to the restaurants, they talk to the bars, they talk to the neighbors. And what that's meant is that they've been able to open each new site with a relative minimum amount of controversy and no press. But the NEP in the U District and the one on Capitol Hill were done independently because the city was just going to take way, way too long to move."*

While over two-thirds of the county residents supported NEP in a survey, "NIMBY" sentiments prevents it from expanding. The downtown area has gentrified and now includes a new, upscale shopping area on one side and a tourist attraction on the other. The NEP is right in the middle. They are unable to find any other location for the downtown exchange.

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