An Assessment of the HIV Prevention Needs of Injection Drug Users in Montana

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AN ASSESSMENT OF THE HIV PREVENTION NEEDS OF
INJECTION DRUG USERS IN MONTANA

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Dissertation

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ABSTRACT

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An Assessment of the HIV Prevention Needs of Injection Drug Users in Montana

Chairperson: Dr. K. Ann Sondag

The purpose of this study was to assess HIV prevention needs of individuals living in Montana who use injection drugs (IDUs). Gaps between prevention needs and services were identified and recommendations for overcoming the barriers to accessing and implementing treatment needs and services were offered.

A qualitative case study approach was used. Data collection methods included: 1) IDU interviews, 2) Key Informant interviews, and 3) Documentation collection and archival record retrieval.

IDUs represented a wide range of demographic variables. While people of both genders, a variety of sexual orientations, ethnicities, educational levels, incomes and employment statuses participated in the interviews, none of these variables appeared to be a distinct indicator of increased HIV infection risk. Factors indicative of higher risk for infection included family dynamics, identifying with being a parent and having a purpose in life, social networks, and the type of drug used. HIV prevention needs included substance abuse treatment; harm reduction services (clean syringes, educational outreach, free HIV and Hepatitis C testing, and social service organizations); and HIV prevention messages. Barriers to accessing and implementing services included lack of funding; prohibition or discouragement of services by state and federal laws; stigma and discrimination; and lack of agency networking. Recommendations for closing gaps between needs and services included: Ensure collaboration between agencies and HIV prevention services; Research options and formulate a plan for gaining access to clean syringes; Research options and formulate a plan for substance abuse treatment funding and Hepatitis C services; Ensure continued HIV prevention information dissemination through media campaigns and other educational interventions; and Ensure continued harm reduction services.

This study provides the Montana Department of Public Health and Human Services (DPHHS) valuable insight concerning HIV prevention needs for IDUs. Determining the needs of IDUs in Montana will ultimately improve the quality and availability of HIV prevention services, which in turn will improve the quality of life for IDUs and decrease or prevent the spread of HIV infection through injection drug use.
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This is dedicated to my mom, Velda Lee.
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CHAPTER I

INTRODUCTION TO THE STUDY

The time of this writing marks the 25th year since Acquired Immunodeficiency Syndrome (AIDS) was first medically recognized. AIDS is a global epidemic, and shows no sign of weakening its grip. Its impact transcends geographic boundaries, gender differences, age, sexual preferences, religious beliefs, and social-economic status. Worldwide more than 25 million people have died of AIDS. Counting both those who have died and those currently living with the Human Immunodeficiency Virus (HIV), more than 60 million people have been infected. Daily an estimated 11,000 new infections occur and 8,000 people die from AIDS. There is no cure. Treatment advances have helped people live longer, however the cost and complexities of regiments put them out of reach for most (UNAIDS, 2006).

In the United States, more than half a million people have died of AIDS. To date, an estimated one million people are living with HIV, and incidence continues at a steady rate of 40,000 infections per year. Although not everyone has access to care, more effective treatments have helped HIV+ people live longer. Due to the reduction of HIV related deaths coupled with the continuing number of new HIV infections, HIV/AIDS prevalence is at its highest level ever, and continues to rise each year. Men who have sex with men (MSM) are still the largest population infected in this country, however HIV transmission for this population has decreased from 64% of total cases in 1985 to 42% in 2004. This reduction in infection rate can be attributed to effective HIV prevention programs for MSM. In contrast, the number of cases due to injection drug use continues
at a steady rate. Nearly one third of HIV cases are directly or indirectly related to injection drug use (UNAIDS, 2006).

There are an estimated 1.4 million injection drug users (IDUs) in North America. While drug injection use is directly related to HIV infection, sexual behaviors of IDUs and those who have sex with IDUs contribute indirectly to HIV incidence. HIV transmission can occur among IDUs when injecting equipment is shared. This includes injecting drugs with a “dirty” (previously used by another IDU) syringe, as well as sharing other injection paraphernalia such as water, cookers, cottons, and spoons, or drug preparations (Koester, Glanz and Baron, 2005). In addition to sharing injecting equipment, HIV infection occurs among IDUs through unprotected sex. High-risk drug use behaviors and high-risk sexual behaviors are often linked, increasing the risk of HIV infection (NIDA, 1999).

Nationwide, efforts for IDUs have centered on a comprehensive approach to prevent HIV transmission. Several prevention strategies have shown positive results, and are most effective when they are combined and overlap. Strategies include substance abuse treatment; community outreach; interventions to increase access to sterile syringes; interventions in the criminal justice system; strategies to prevent sexual transmission; counseling and testing; partner counseling and referral services; prevention case management; coordinated services for IDUs living with HIV/AIDS; and primary drug abuse prevention (NIDA, 1999).
In Montana approximately 24% of those who are HIV+ were infected by injection drug use (DPHHS, 2006) yet there is limited information about their HIV prevention needs. For this reason it is important to identify the needs of this population in order to design interventions and services that can reduce the risk of transmission. This study is the first comprehensive HIV prevention needs assessment targeting IDUs in Montana.

**Purpose of the Study**

The purpose of this study was to assess the HIV prevention needs of individuals living in Montana who use injection drugs. Gaps between prevention needs and existing services are identified and recommendations for overcoming the barriers to accessing and implementing HIV prevention treatment and services are offered.

**Significance of the Study**

This study provides the Montana Department of Public Health and Human Services (DPHHS) and community based service providers working directly with IDUs in Montana valuable insight concerning their prevention needs. Barriers to meeting needs were identified and gaps between needs and services are described. Determining the needs of IDUs in Montana will ultimately improve the quality and availability of HIV prevention services, which in turn will improve the quality of life for IDUs and decrease or prevent the spread of HIV infection through injection drug use.

**Research Questions**

The research questions examined in this study focus on the HIV prevention needs of IDUs. They are as follows:
What are the HIV prevention needs of injection drug users in Montana?

(a) What are the predisposing, reinforcing and enabling factors that influence the behaviors of IDUs that put them at risk for HIV infection?

(b) What are the resource and service needs for IDUs?

(c) What are the barriers to IDUs accessing prevention services?

(d) What are the barriers to implementing HIV prevention services for IDUs?

**Delimitations**

The delimitations of the study are as follows:

1) The study was delimited to individuals who are over the age of 18 living in Montana who currently used or had used injection drugs in the past two years.

2) Data was collected via IDU and Key Informant interviews, documentation and archival records.

3) Data collected from participants was restricted to self reports.

4) The participants in this study were volunteers.

5) Documentation and Archival Record retrieval was delimited to information pertaining to Montana and published within the last five years.

**Limitations**

The limitations of the study were as follows:

1) Data collected via interviews were limited to what the participants were willing and able to share.

2) Data collected were limited to the honesty and accuracy of the participants.

3) Data collected were limited to those individuals who were recruited by the various sampling techniques.
4) Documentation and Archival Record retrieval was limited to the information the researcher was able to collect.

5) Data analyses were limited to the researcher's bias and ability to carry out methodologies.

Definition of Terms

**Acquired Immunodeficiency Syndrome (AIDS):** An HIV infected person receives a diagnosis of AIDS after developing a defined indicator illnesses or on the basis of a CD4 Cell count of 200 or lower (CDC, Division of HIV/AIDS Prevention, 2005).

**High Risk Behaviors:** Engaging in the reuse or sharing of syringes, needles, and other drug injection equipment and engaging in unprotected sexual contact (NIDA, 2003).

**Human Immunodeficiency Virus (HIV):** The retrovirus isolated and recognized as causing or contributing to the cause of a disease agent of AIDS (CDC, 2005).

**Injection Drug User:** A person who uses a drug (e.g., heroin, cocaine, methamphetamine) administered with a needle and syringe (CDC, 2005).

**Key Informant:** Strategically placed individual who has knowledge and ability to report on the needs of those in the priority population, who may or may not be in a position of formal authority, but are often respected by others in the community and thus possess informal authority (McKenzie, Neiger & Smeltzer, 2005).

**Needle Exchange Program (NEP):** Programs that facilitate the exchange of used syringes for clean syringes in order to reduce the spread of blood borne infections (NIDA, 2003).
CHAPTER II

REVIEW OF LITERATURE

The purpose of this study was to assess the HIV prevention needs of individuals living in Montana who use injection drugs. In this chapter a review of current literature on the HIV prevention needs of IDUs is presented along with a summary of the literature. In addition, specific research strategies for conducting needs assessments are addressed, and the PRECEDE model is discussed as a theoretical framework for assessing needs. Finally, the use of the literature review as a data collection and assessment tool is discussed.

The Incidence and Prevalence of HIV/AIDS

HIV/AIDS Worldwide and in the United States

UNAIDS/WHO published the latest statistics on the epidemic of HIV/AIDS in May 2006. Globally, approximately five million people were infected in 2004, and more than three million died from the disease. It is estimated that more than 40 million people are now living with HIV/AIDS worldwide (UNAIDS, 2006). In the U.S., it is estimated that more than one million people are living with HIV, with almost a half million diagnosed with AIDS. The Centers for Disease Control and Prevention (CDC) estimates 40,000 people become infected with HIV, and 20,000 people die of AIDS related illnesses every year in the United States (CDC, 2006).

HIV/AIDS in Montana

As of September 30, 2006 The Montana Department of Health and Human Services (DPHHS) reported 730 HIV/AIDS cases in Montana. Of these cases, 283 individuals have died, and 447 Montanans are currently living with HIV/AIDS. It is
estimated, however, that approximately 25% of those living with HIV are not aware of their positive status, which means that more than 600 Montanans are living with HIV. Fifteen to 20 Montanans are newly infected each year. Approximately 24% of those infected were possibly exposed by injection drug use, similar to the national rate for this exposure category (DPHHS, 2006).

**Quality of Life Issues, Behaviors, and Other Factors that Contribute to HIV Infection among IDUs**

Injection drug use is a major factor in HIV infection. There are an estimated 1.4 million IDUs in North America. More than one-third of AIDS cases are directly or indirectly associated with injection drug use. While drug injection practices are directly related to HIV infection, sexual behaviors of IDUs and those who have sex with IDUs contribute indirectly to these numbers. The context in which these behaviors are carried out also plays a part in the risk of HIV infection (NIDA, 2006).

HIV transmission can occur among IDUs when injecting equipment is shared. This includes injecting drugs with a “dirty” (previously used by another IDU) syringe. One can also be infected when sharing other injection paraphernalia such as water, cookers, cottons, and spoons, or drug preparations (Koester, Glanz and Baron, 2005). In addition to sharing injecting equipment, HIV infection occurs among IDUs through unprotected sex. High-risk drug use behaviors and high-risk sexual behaviors are often linked, increasing the risk of HIV infection (NIDA, 1999).

The context in which IDUs engage in high risk behaviors is a determining factor in the degree of risk of HIV infection. First, IDUs are often linked to tight social networks. The size of the group, relationships among group members, social activities of
the group, types of drugs used and how they are used can influence the risk of HIV infection (Friedman et al., 1997). When HIV is introduced into these networks, rapid transmission can occur. Also, the geographic location of a network can also affect the risk of HIV infection. Location influences types and quality of drugs available, social acceptance of certain types of drugs, and the method of drug administration (e.g., smoked vs. injected). One study suggests the use of one type of heroin over another (“Mexican black tar” vs. powder only heroin) may help decrease HIV infection risk. Because of its chemical properties, the Mexican black tar requires more rinsing of syringes to prevent clogging and more heating to enhance solubility. These practices may reduce HIV from being transmitted if the paraphernalia is shared. In addition, Mexican black tar can be injected subcutaneously or intramuscularly vs. venous injection, thus further reducing the risk of HIV infection. Geographically, locations where Mexican black tar was prevalent had lower HIV prevalence than those with powder-only heroin (Ciccarone & Bourgois, 2003).

Social status and income can affect HIV infection risk among IDUs. Those who have a higher social status and a secure income, stable housing and supportive networks may be more able to control their risk of infection. A federal decision to discontinue Supplemental Security Income (SSI) benefits to individuals who are addicted to alcohol or drugs is considered to be a contributing factor to their disability. A 1999 study showed that IDUs who lost SSI benefits because of this law were more likely to engage in illegal activities, more likely to share syringes, and injected drugs more often than did IDUs who maintained benefits (Bluthenthal et al., 1999).
Strategies for HIV Prevention among IDUs

Addressing the HIV prevention needs of IDUs is challenging because it requires addressing complex public health problems – AIDS, substance abuse and addiction. The complexity of the social, political and legal environments of these issues amplifies the difficulty of HIV prevention efforts. Prevention providers, services agencies and community based organizations usually focus on only one aspect of the problem, such as substance abuse treatment, HIV prevention education, or harm reduction.

While single methods have shown to be effective in preventing or reducing HIV infection, combining several interventions can increase the effectiveness of HIV prevention (Academy for Educational Development [AED], 2000). The Centers for Disease Control and Prevention (CDC) now recommends addressing the prevention needs of IDUs using a comprehensive approach (2000). Preventing Blood-born Infections Among Injection Drug Users: A Comprehensive Approach, is a document developed by AED under contract to CDC. This model, created from a meta-analysis of more than 160 research articles and reports, focuses on eight research-based strategies supported by four foundational principles. It was developed to be implemented across various settings, populations, life circumstances, patterns of drug use, and stages of behavior change (see illustration below). The eight strategies include:

- Substance abuse treatment;
- Community outreach;
- Interventions to increase access to sterile syringes;
- Interventions in the criminal justice system;
- Strategies to prevent sexual transmission;
- Counseling and testing, partner counseling and referral services, and prevention case management;
Coordinated services for IDUs living with HIV/AIDS; and
Primary drug prevention.

These eight strategies are supported by four principles:

- Ensuring coordination and collaboration of services;
- Ensuring coverage, access and quality services;
- Recognizing and overcome stigma; and
- Tailoring services and programs to address specific needs of IDUs.

The following paragraphs detail each strategy and discuss the importance of integrating the four principles.

**Substance Abuse Treatment**

Studies have consistently shown that participation in substance abuse treatment contributes to lower drug injection practice, lower rates of other non-injection drug use, and a reduction of other risk behaviors related to HIV infection (Metzger & Navaline, 2003; Sorenson & Copeland, 1999; Metzger, Navaline & Woody, 1998). Substance
abuse treatment is an effective HIV prevention strategy. IDUs who don’t receive treatment are up to six times more likely to become infected with HIV than those who enter and remain in treatment (NIDA, 2006). Substance abuse treatment can provide medical, psychological and behavioral supports necessary to help individuals stop using drugs and to gain their health back. Successful treatment can increase a person’s quality of life and decrease chronic conditions such as asthma, diabetes, high blood pressure and complications associated with abscesses. Treatment can also improve family life, employment opportunities and decrease involvement with crime (NIDA, 1999).

**Community Outreach**

Community outreach programs are effective in HIV prevention. For IDUs, seeking out HIV prevention services may seem unimportant and abstract in comparison to the priorities of obtaining and using drugs. Street outreach can bring services to IDUs who don’t access conventional services, and can provide services to IDUs in a familiar, safe setting. Community outreach can create a culture of risk reduction in the communities and social networks of IDUs, and has shown to decrease high risk behaviors (Wiebel et al., 1996). Community outreach workers are often recovering IDUs themselves therefore services can be delivered by someone an IDU is more likely to trust. A 2004 study showed that drug users, after participating in a peer HIV prevention outreach program, were more likely to provide bleach to drug-using network members, more likely to report providing condoms to network members and more likely to engage in HIV prevention conversations. In addition, HIV+ IDUs were more likely to report talking to sex partners and family members about HIV (Latkin, Hua & Davey, 2004).
**Access to Sterile Syringes**

Access to sterile syringes is a harm reduction method shown to be effective in reducing HIV infection (Huo, et al., 2005). It is the next best option in HIV prevention when abstaining from injecting drugs is not being practiced. Interventions to provide access to sterile syringes include pharmacy sales of syringes and needle exchange programs (NEPs). There are several barriers to accessing sterile syringes, despite the substantial research on the effectiveness of these interventions. Most states restrict the sale, distribution and possession of sterile syringes and have criminal penalties for syringe possession. Federal law prohibits supporting NEPs with federal funding. Many organizations such as the American Medical Association (AMA), the National Alliance of State and Territorial AIDS Directors (NASTAD) and the American Pharmaceutical Association (APhA) have joined efforts urging state leaders in medicine, pharmacy and public health to coordinate action to improve access to sterile syringes (NASTAD, 1999). There has been some controversy on whether NEPs encourage and increase drug injection practices however studies show that these programs do not cause an increase in injection drug use. In fact, a reduction in HIV diagnoses reported among IDUs may be attributed to the use of NEPs (Taylor & Francis, 2006).

**Criminal Justice System Interventions**

Injection drugs are illegal in the U.S., and many IDUs resort to criminal activity to support their drug addiction. The United States has the largest number of incarcerated persons of any country in the western world. More than one quarter of inmates in the U.S. are arrested for drug-related offenses including using, possessing or trafficking drugs (USDOJ, 2006). Inmates are at high risk for HIV, hepatitis and other sexually
transmitted infections, and many are already infected. Incarcerated individuals have an
HIV/AIDS diagnosis rate six times higher than the national population (CDC, 2006). HIV prevention efforts are imperative in the criminal justice system, as high-risk sexual activity, sharing injection equipment and tattooing are prevalent behaviors in correctional facilities. Prevention services and education programs can decrease HIV infection among inmates (NIDA, 2006). In addition, correctional facilities can provide an opportunity for IDUs to access basic health care, substance abuse treatment, and HIV counseling and testing. However correctional facilities are maintained by different federal, state and local entities, and services provided widely vary from site to site. Also, correctional facilities’ primary purpose is to maintain security over the incarcerated. Because of this, other services become less of a priority therefore not all inmates receive the same quality service, if at all. One study showed that although 800,000 inmates could have benefited from substance abuse treatment, fewer than 20% actually received it (Epstein & Gfoerer, 1998).

**Sexual Transmission Prevention**

Sexual transmission prevention cannot be overlooked for the IDU population. High-risk sexual behaviors are often linked to high-risk drug behaviors, including having unprotected sex and an increased number of sex partners. In addition, some IDUs will exchange sex for drugs or money. Interventions specific to IDUs should include information and education on preventing HIV infection through sexual practices (NIDA, 1999).
Counseling and Testing, Partner Counseling and Referral Services, and Prevention Case Management

HIV testing is integral to HIV prevention, treatment and care efforts. Knowing one’s HIV status is important for preventing the spread of the disease. Studies have shown that those who learn they are HIV+ reduce their high risk behaviors for HIV transmission (Marks et al., 2005; CDC, 2003). Early knowledge of HIV infection can get a person into medical care and services earlier, which in turn can reduce health problems and improve quality of life. When an individual seeks out testing services, a one-on-one opportunity arises to address high risk behaviors and other complex life circumstances that influence HIV infection risk. If an individual tests positive, partner counseling and referral services can help notify sex and drug sharing partners so that HIV infection is slowed or stopped within their social network. In addition, prevention case management can be very beneficial to high risk individuals to address HIV risk and other issues such as substance abuse, mental health problems, and social and cultural factors (NIDA, 1999).

Services for IDUs Living With HIV/AIDS

Services for IDUs living with HIV/AIDS are crucial to HIV prevention efforts. Many IDUs continue to engage in high risk behaviors in spite of their HIV status (Riehman, et al., 2004). Many times, obtaining and using drugs takes priority over HIV prevention. Unlike non-IDUs, many IDUs are less likely to access HIV/AIDS services because of the stigmatized “double whammy” of being HIV+ and an IDU (Reidpath & Chan, 2005). Negative attitudes toward IDUs can only exacerbate barriers to care. When an IDU enters care for their HIV, other issues such as substance abuse, mental health and quality of life can be addressed (NIDA, 1999).
Primary Drug Prevention

Primary drug prevention plays a key role in HIV prevention. Avoiding drug use and drug injection altogether eliminates many risks associated with HIV infection. Primary prevention interventions can be conducted in many different settings such as schools and community-based organizations, and primary prevention messages can be conveyed through different forms of media such as television and radio. Primary drug prevention interventions aimed at youth help delay substance use and may prevent many other problems such as academic issues, violence, suicides and risky sexual behaviors associated with drug use during the adolescent years (NIDA, 1999).

Four Principles of a Comprehensive Approach

The eight strategies in CDC’s comprehensive approach to HIV prevention are supported by four principles: Ensure coordination and collaboration; ensure coverage, access and quality; recognize and overcome stigma; and tailor services and programs. Incorporating these principles into HIV prevention efforts can build a stronger overall program to help prevent or reduce the spread of HIV.

Agencies and providers must work together in order for HIV prevention interventions to be successful. Different approaches and philosophies of HIV prevention among providers can be challenging, but they need to be set aside to achieve the larger goals of reducing HIV infection. In addition, ensuring that high-quality programs are accessible to IDUs and that they are actually reaching IDUs is vital to a successful program (AED, 1999).

There are many negative attitudes, stereotypes, and stigma attached to injecting drug users and their addiction. IDUs are sometimes dehumanized. To put a human face
on the problems and to understand the disease of drug addiction can help overcome the stigma attached to substance abuse. Stigma related to HIV also produces discrimination among IDUs, and has proven to be perhaps the most difficult obstacles in effective HIV prevention. Stigma may prevent individuals from negotiating safer sex, taking an HIV test, disclosing their status to partners and seeking treatment (UNAIDS, 2006). Recognizing and overcoming these barriers is crucial to HIV prevention success.

Tailoring services and programs to fit specific IDU needs is important in HIV prevention. IDUs have unique languages, cultures, life circumstances, and social supports. Taking these considerations into account can improve the overall quality and effectiveness of services and programs. Involving IDUs in planning, implementing and evaluating services will ensure that they are appropriately tailored (AED, 1999).

Summary of Literature

Quality of life issues such as homelessness, social stigma and tight social networks can encourage behaviors that contribute to the spread of HIV infection. Behaviors such as the sharing of needles and other injection equipment and unsafe sexual practices put IDUs at risk for infection. There are multiple factors that contribute to this high risk behavior. Some of the factors identified in this literature review include knowledge about the risk of HIV infection associated with high risk behaviors and access to sterile syringes and other health related services. Substance addiction in and of itself contributes to high risk behaviors. The geographic location of a network can also affect the risk of HIV infection. Location influences types and quality of drugs available, social acceptance of certain types of drugs, and the method of drug administration.
A review of policy and resources that contribute to HIV infection among IDUs reveals a lack of financial resources for primary prevention and treatment. Fragmented services contribute to IDUs not accessing or not even knowing what services are available to help them remain HIV free. Government policies that restrict needle exchange create barriers to accessing sterile syringes. Criminal penalties for drug or paraphernalia possession, the use of illegal drugs or selling/distributing drugs contributes to the “underground” IDU culture.

**Strategies for Conducting Needs Assessments**

Assessing the needs of a target population is the first step in Health Promotion programming. Several research methods can be used to conduct a needs assessment. A common method that has been used in the public health, substance abuse and HIV/AIDS fields is Rapid Assessment and Response (RAR). RAR has been used to understand public health problems so that appropriate interventions can be rapidly implemented. Organizations such as the World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS and the U.S. Office of HIV/AIDS Policy have issued guidelines for conducting RARs (Stimson, Fitch and Rhodes, 1998). These guidelines have been used to conduct several RARs worldwide on injection drug use and HIV transmission. For example, a RAR focusing on HIV prevention needs of IDUs was conducted in the Russian Federation in 1999 when HIV incidence increased rapidly and speedy intervention implementation was necessary (Burrows, Trotter, Singer, et al., 1999). In the United States RAR methods have been used to identify HIV prevention needs among African American and Hispanic communities (Needle, Trotter, Singer, et al, 2003). Although RARs focusing on HIV and substance use issues have been conducted
in more than 70 countries, most rapid assessment guides and reports are unpublished (Fitch & Stimson, 2003). RAR is used for more practical purposes, and when conventional social science research methods are inappropriate for the situation at hand. Some critics would argue that RARs are “watered down’ and inadequate to be considered as true research (Fitch, Rhodes, et al, 2003). This may explain the lack of information in the research literature on HIV needs assessments. A study conducted by the WHO however did indicate that RARs appear to be effective in linking assessment to development of appropriate interventions (Stimson, Fitch, Jarlais, et al., 2006).

While RAR has been a common assessment process used in HIV prevention, the case study is another research methodology that can be used to identify the needs of a target population. RAR and the case study designs are very similar. Both methods rely on multiple sources of evidence and data analysis using triangulation; both methods are exploratory in nature, and answer the questions “what “ or “how”; both methods can investigate a situation in which variables may not be well defined; and both methods require the research to take place in its real-life context (Yin, 2003). Specific differences between the two methods define the rationale for their use. RAR is conducted quickly, usually over a period of just days to less than six weeks. RAR is appropriate when time is of the essence and immediate action is necessary. Also, more than one researcher is always involved in RAR. This allows data collection to occur simultaneously at different locations, perhaps when a large geographical area needs to be covered in a timely fashion. The case study, on the other hand, involves a more structured research design. The case study specifies the logic of design, data collection techniques, and approaches to data analysis. Also, validity and reliability can be more easily established and controlled
in a strong case study design; a well-conducted case study has the possibility to be replicated (Yin, 2003). For these reasons, the case study design was used to conduct this needs assessment to identify the HIV prevention needs of IDUs living in Montana.

**The PRECEDE Model**

The PRECEDE-PROCEED Model is the most widely used model in Health Promotion programming. This theoretical framework provides an approach to identifying a target population’s needs. The PRECEDE Model “takes into account the multiple factors that shape health status and helps the planner arrive at a highly focused subset of those factors as targets for intervention. PRECEDE also generates specific objectives and criteria for evaluation” (McKenzie, Neiger & Smeltzer, 2005). The five phases of the PRECEDE Model include the following:

1) Social Assessment (identifying quality of life issues)

2) Epidemiological Assessment (identifying health problems that arise from or contribute to the issues identified in phase 1)

3) Behavioral and Environmental Assessment (identifying behavioral issues that contribute to health problems such as compliance, coping, self-care, etc.; as well as environmental issues such as access to services, stigma, etc.)

4) Educational Assessment (identifying predisposing, reinforcing and enabling factors that influence a given behavior)

5) Administrative and Policy Assessment (identifying policies and resources that could hinder or facilitate the development of programs).
The phases of the PRECEDE model were used as a guide for conducting a literature review of the HIV prevention needs of IDUs. In addition, phases four and five aided in formulating the research questions for this study.

**The Use of Literature Review as a Data Collection and Assessment Tool**

While it is common practice for researchers using quantitative methodologies to conduct a comprehensive review of the literature prior to collecting data, it is not always a common practice for the qualitative researcher. In fact, qualitative researchers often must determine how the literature can be used to enhance, rather than constrain, the process of development of concepts and theories. The researcher does not want to be so steeped in literature that he or she feels constrained or even stifled by it (Anslem and Strauss, 1998). There are, however, multiple ways that the literature can be used to enhance qualitative research. For the purposes of this study, the literature review served two functions. First, information obtained from the literature review aided in the development of theoretical propositions to guide data collection and analysis. Also, concepts derived from the literature provided a source for making comparisons at the dimensional level. In other words, concepts from the researcher’s data were compared to those from the literature and used to support and give specificity to emergent themes (triangulation). Second, the literature was used as a secondary source of data. Information from research publications was used as data and analyzed using the methods described in Chapter Three.

When primary data collection for this study was complete, the literature was used to either confirm the findings or to illustrate where the literature seems incorrect or incomplete. Bringing the literature into the writing of the final report for this study
allowed for extending, validating and refining the knowledge that currently exists in the field.
A qualitative case study approach was used to determine the HIV prevention needs of individuals living in Montana who use injection drugs.

**Description of Target Population**

The target population was male and female individuals over the age of 18 living in the state of Montana who currently used or had used injection drugs in the past two years. For the purpose of this study, an IDU was defined as a person who uses a drug administered with a needle and syringe (CDC, 2005).

**Protection of Human Subjects**

The human subject application material and consent forms were completed in accordance with The University of Montana Institutional Review Board (IRB) (see Appendix A).

**Research Design**

The structure of this case study was guided by the exploratory, embedded, single-case design. Case study is used to identify knowledge of individual, group, organizational, social, political and related phenomena. It is a common research methodology in community planning to understand complex social occurrences (Yin, 2003). As defined by Yin (2003), a case study is “an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident” (p. 13). Because phenomenon and context are not always noticeable in real-life situations, the case study deals with the technically unique situation in which there are many more variables of interest than
identified data points. As a result, this method relies on multiple sources of evidence and data analysis using triangulation, and benefits from the prior development of theoretical propositions to guide data collection and analysis. Hence, the case study is an all-encompassing method, covering the logic of research design, data collection methods, and specific approaches to data analysis (Yin, 2003).

This case study is an exploratory, embedded single-case design. Multiple sources of data were used to explore the HIV prevention needs of IDUs in Montana. The following figure depicts this particular design.

**Embedded, Single-Case Design (Yin, 2003)**
**Procedures**

**Instrumentation, Nature of Selected Sample, and Data Collection**

Data was collected using three methods: 1) IDU interviews, 2) Key Informant interviews, and 3) Documentation collection and archival record retrieval. The instrumentation, sample and data collection techniques for each method are described below.

**IDU Participant Interviews**

*Instrumentation.* An interview question schedule was developed using the PRECEDE-PROCEDE model for health program planning (see Appendix B). The instrument was reviewed and revised by an expert panel, and pilot tested by members of the target population.

*Nature of selected sample.* IDU interview participants were recruited using four different methods:

1) Individuals who conduct HIV testing at sites funded by DPHHS were asked to provide IDU clients with a business card that included a phone number and an invitation to call that number to set up an interview;

2) Montana Targeted Outreach Project (MTAP)* IDU outreach workers distributed the same business cards to IDU contacts;

3) The snowball technique was used to assure that individuals who were not in contact with MTAP outreach workers and who have not gone in for an HIV test were included in the sample. The technique involved the recruitment of interview participants by asking

* *Montana Targeted Outreach Program (MTAP) is a CDC funded street and community outreach project working to stop the spread of HIV and Hepatitis C (HCV) throughout Montana. MTAP works in collaboration with eight local community based organizations and tribal agencies to disseminate HIV and HCV prevention, offer rapid HIV counseling and testing, and conduct agency referrals.*

24
interviewees to give the contact business card to other IDUs in their social network; and

4) Key informants were asked to distribute the same business card to contacts.

    IDUs who wished to volunteer for an interview contacted the researcher via the private phone number found on the business card. A $30.00 cash incentive was offered to all interviewees.

    *Data Collection.* When an individual contacted the researcher via telephone, arrangements were made to conduct the interview in a convenient and private place. Before the interview, the participant was asked to read a modified consent form and verbally give consent (Appendix A). Once verbal consent was obtained, a $30.00 cash incentive was given to the participant before the interview began. In addition, participants were offered the interview question schedule prior to the interview. The researcher conducted the interview, and when the participant agreed, it was audio taped. The researcher also took written notes as determined necessary. The number of interviews was determined based upon the comparative method of data analysis (Creswell, 1998) (see Data Analysis section below).

    *Key Informant Interviews*

    *Instrumentation.* An interview question schedule was developed using the PRECEED-PROCEDE model for health program planning (see Appendix C). The instrument was reviewed and revised by an expert panel, and pilot tested by members of the target population.

    *Nature of selected sample.* Key informant interviews were conducted with professionals who offer services to IDUs. Indigenous leaders/gate keepers recommended
individuals who they believe would be able to provide the best information regarding the needs of IDUs in Montana.

*Data Collection.* Key Informants were asked to sign a consent form (Appendix A) and offered a list of the interview questions prior to the interview. Interviews were conducted one of three ways by the researcher:

1) The interview was conducted face to face. The researcher took written notes as determined necessary;

2) The interview was conducted via the telephone. The researcher took written notes as determined as necessary.

3) The interview schedule along with a consent form was given to the Key Informant in person or sent to the key informant either by postal mail, fax or electronic mail. The key informant completed the interview questions with written answers, and returned the questionnaire to the researcher.

The number of interviews was determined based upon the comparative method of data analysis (Creswell, 1998) (see Data Analysis section below).

*Documentation and Archival Records*

Collecting documentation is a customary research method in the case study design. Documentary information and archival records were used to corroborate and augment evidence, and to make inferences regarding IDUs. Inferences generated additional clues to investigate, and provided richer data relevant to the needs of IDUs in Montana. Information was collected from various types of documents and archival records including:
• Administrative documents such as meeting minutes, written reports;
• Other HIV-related evaluations conducted in Montana;
• Newspaper clippings and other articles appearing in mass media or community newsletters specific to Montana;
• Internet websites containing information specific to Montana populations at high risk for HIV;
• Service and organizational records, such as number and type of clients served, etc.;
• Maps and charts of geographical characteristics or layouts relating to HIV, such as epidemiology, populations affected, etc.;
• Survey data, such as census records or other data previously collected.

The following chart presents a description of the data sources and their contribution to answering the research questions of this study.

<table>
<thead>
<tr>
<th>Question</th>
<th>Interviews with IDUs</th>
<th>Interviews with Key Informants</th>
<th>Documentation &amp; Archival Records</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are the factors that contribute to the behaviors of IDUs?</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>What are the assistance and/or treatment service needs for IDUs?</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>What are the barriers to IDUs accessing prevention service needs?</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>What are the barriers to implementing HIV prevention service needs for IDUS?</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
Data Analysis

Qualitative Data Analysis

Data collected for this study came from IDU interviews, key informant interviews, and documentation and archival record retrieval. The identities of IDUs and Key Informants who participated in the interviews remain anonymous. No names or other identifying information are reported as part of the data analysis. All data is reported as group data.

IDU and Key Informant Interviews

Protocol for data analysis was followed as suggested by Creswell (1998). Immediately following the interview sessions, the researcher reviewed notes and the tapes. A contact summary sheet was used to record general impressions of the interview process including length of interview, location, general description of the interviewee, and any notable or unusual circumstances (see Appendix D). IDU interview tapes were transcribed completely and compared to the notes to check for accuracy.

The transcriptions were qualitatively analyzed for the existence of matching patterns and common themes using the constant comparative method of data analysis (Creswell, 1998). Transcriptions were analyzed as the interviews were conducted, rather than waiting until a certain number of interviews were completed. This method of data analysis allowed for matching patterns and themes to build upon one another as new data were continually compared to already-analyzed data. Each transcription was read numerous times, and notes were taken in margins of the transcriptions. As general themes and matching patterns emerged, each were color coded for tracking purposes. Matching patterns and emergent themes and concepts were organized into categories. In
addition, unusual and/or other significant information were identified. Interviews continued to be conducted until the data showed saturation. Saturation occurred when no new information seemed to emerge as a result of coding additional interviews.

**Documentation and Archival Records**

Documents and archival records were reviewed and analyzed for supporting interview data. As each document was reviewed, important information was recorded and categorized according to identified patterns and themes from the participant and key informant interviews. In addition, any outlying themes or emerging patterns were noted.

**Convergence of Evidence**

A case study database was created from all data collected, using the basis of the study research questions. All information was organized using these propositions to support the case study design. Triangulation of data was conducted. Converging lines of inquiry were developed from all data sources (see diagram below).

![Diagram showing Convergence of Evidence]

**Convergence of Evidence**
Construct Validity and Reliability

Two strategies were used to control for construct validity. First, multiple sources of evidence (triangulation) were used. That is, each piece of information gained, or each conclusion reached was considered tentative until it has been corroborated by information collected by other means or from other sources. This triangulation of the data served to increase construct validity. Second, a draft case study report was reviewed by key informants to enable the researcher to cross-check her constructs with those of the participants. And finally, to control for reliability, a “chain of evidence” was established during data collection. In other words, the researcher provided a clear description of what questions were under investigation, which data sources were used and how the situation and persons studied were defined. This permits a second researcher to follow the same steps, so that the case study methodology may be replicated (Yin, 2003).

Final Report

Data from all sources were synthesized into a key findings report and submitted to DPHHS. The report includes: Introduction, Purpose of the Assessment Project, Methods, Results, Conclusions, Recommendations and References. This report can be used as a tool for DPHHS, HIV prevention specialists, health service providers and HIV program directors to adapt their programs to insure that they are meeting the needs of IDUs in Montana, and HIV infection among IDUs can be minimized.
CHAPTER IV

RESULTS

The purpose of this study was to assess the HIV prevention needs of individuals living in Montana who use injection drugs. The barriers to accessing and implementing HIV/AIDS prevention assistance and/or treatment were also identified. Data was collected from the following sources: 1) IDU interviews, 2) Key Informant interviews, and 3) Documentation collection and archival record retrieval. The results for each data source are organized into the following sections:

1. Description of the Study Sample

2. Themes Related to Research Questions
   - What are the predisposing, reinforcing and enabling factors that influence the behaviors of IDUs that put them at risk for HIV infection?
   - What are the resource and/or service needs of IDUs?
   - What are the barriers to IDUs accessing prevention services?
   - What are the barriers to implementing HIV prevention services and programs for IDUs?

A chart that summarizes all of the results is included at the end of this chapter.

IDU Participant Interview Results

A total of 20 IDU Participant interviews were conducted. The researcher conducted all interviews face to face. Fifteen of the twenty interviews were recorded and transcribed. Five of the participants asked that their interview not be audio recorded. Transcriptions were read and re-read, and color-coded for emerging themes (see Chapter Three, Data Analysis).
Section 1: Description of the Study Sample

The following tables describe basic demographics and high risk behaviors of IDU participants.

Table 1. IDU Participant Demographics Summary

<table>
<thead>
<tr>
<th></th>
<th>N=20</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>Age ranged from 19 to 48 years old</td>
</tr>
<tr>
<td></td>
<td>Average age was 32 years old</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>50% (10) were female</td>
</tr>
<tr>
<td></td>
<td>50% (10) were male</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>75% (15) identified as white</td>
</tr>
<tr>
<td></td>
<td>25% (5) identified as Native American</td>
</tr>
<tr>
<td><strong>Sexual Orientation</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>80% (16) identified as heterosexual</td>
</tr>
<tr>
<td></td>
<td>10% (2) identified as MSM</td>
</tr>
<tr>
<td></td>
<td>10% (2) identified as lesbian</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>25% (5) reported having some high school education</td>
</tr>
<tr>
<td></td>
<td>30% (6) reported completing a G.E.D.</td>
</tr>
<tr>
<td></td>
<td>20% (4) reported receiving a High School Diploma</td>
</tr>
<tr>
<td></td>
<td>25% (5) had completed a G.E.D. or high school and some college</td>
</tr>
<tr>
<td><strong>Location of Residence (Refer to Appendix E for Regional Map of Montana)</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>15% (3) reported living in Region 1</td>
</tr>
<tr>
<td></td>
<td>5% (1) reported living in Region 3</td>
</tr>
<tr>
<td></td>
<td>10% (2) reported living in Region 4</td>
</tr>
<tr>
<td></td>
<td>60% (12) reported living in Region 5</td>
</tr>
<tr>
<td></td>
<td>2 in northern; 8 in central; 2 in southern;</td>
</tr>
<tr>
<td></td>
<td>10% (2) reported just traveling through Montana</td>
</tr>
<tr>
<td></td>
<td>85% (17) reported sometimes traveling and living outside of Montana. Other places of &quot;residence&quot; included:</td>
</tr>
<tr>
<td></td>
<td>Seattle, Spokane and other communities is WA</td>
</tr>
<tr>
<td></td>
<td>Portland and Eugene Oregon</td>
</tr>
<tr>
<td></td>
<td>San Francisco, San Diego, LA and other northern CA communities</td>
</tr>
<tr>
<td></td>
<td>New York City, Miami and Chicago</td>
</tr>
<tr>
<td></td>
<td>Minnesota</td>
</tr>
<tr>
<td></td>
<td>Florida</td>
</tr>
<tr>
<td></td>
<td>Texas</td>
</tr>
<tr>
<td><strong>Employment and Type of Work Preferred</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>35% (7) reported being currently employed</td>
</tr>
<tr>
<td></td>
<td>60% (12) were not working at the time of interview</td>
</tr>
<tr>
<td></td>
<td>5% (1) was on disability</td>
</tr>
<tr>
<td></td>
<td>Type of work reported included (includes type of work</td>
</tr>
</tbody>
</table>
preferred for those who were currently not working):
- Personal Care Assistant
- Carpentry/painting/construction
- Cooking/restaurant work
- Stay at home mom
- Receptionist
- Bartender
- Computer programming
- Customer service/telemarketing

| HIV Status          | • 10% (2) reported being HIV positive  
|                     | • 80% (16) reported being HIV negative with last HIV test; 8 were retested with no positive results;  
|                     | • 10% (2) reported not knowing their HIV status; both were tested with no positive results |

| Hepatitis C Status  | • 60% (12) reported being Hepatitis C positive  
|                     | • 20% (4) reported being Hepatitis C negative  
|                     | • 20% (4) reported not knowing their Hepatitis C status |

| Family Dynamics     | • All participants came from alcoholic and/or drug using families |

| HIV and Hepatitis C Knowledge | • All participants were knowledgeable about HIV transmission, and knew that needle/works sharing and unprotected sex were risky behaviors.  
|                              | • Unprotected sex was viewed as less risky for HIV infection than needle/works sharing.  
|                              | • All participants were aware and knowledgeable about Hepatitis C, as well. Many reported learning more about HIV after they learned about their positive status for Hepatitis C.  
|                              | • Participants reported learning about HIV on the street, in jail, in treatment, at needle exchange programs and in school. School education about HIV correlated with the participant's age; the younger the participant the more apt they were to have received HIV education in a school setting. |

| Age at First Use of Any Substance, Age of First Injection and Number of Years Injecting. | • Age at first use of any substance ranged from 3 to 16; average age was 11 years old.  
|                                                                                         | • Age of first injection ranged from 15 to 38; average age was 21 years old.  
|                                                                                         | • Number of years an IDU had been injecting ranged from one to 31 years, with an average of 9.5 years. |

| Current Drug Use | • 15% (3) reported being "clean", indicating that they were not currently injecting (does not include alcohol or other drug use)  
|                 | • 85% (17) reported currently injecting  
|                 | • Time from last injection ranged from "today" to two months ago.  
|                 | • All participants said that they would choose to inject their drug of choice, but also reported smoking, snorting, ingesting and |
"booty bumping" (inserting meth into the rectum).

**Drug of Choice**
- 50% (10) reported some type of amphetamine (meth, speed, coke) as their injected drug of choice
- 25% (5) reported heroin or other opiates as their injected drug of choice
- 25% (5) reported a combination of amphetamine and opiate as their injected drug of choice.

**Substance Use/Abuse Treatment**
- 45% (9) reported receiving no treatment
- 50% (10) reported receiving court ordered treatment
- 5% (1) was self referred to treatment

<table>
<thead>
<tr>
<th>Table 2. IDU Participant High Risk Behavior Summary</th>
<th>N=20</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sharing Needles/Works</strong></td>
<td></td>
</tr>
<tr>
<td>• All but two participants reported sharing needles.</td>
<td></td>
</tr>
<tr>
<td>• Every participant reported being aware of HIV infection risk at the time of sharing. Reasons for sharing included:</td>
<td></td>
</tr>
<tr>
<td>• Had only the option of sharing or not get high;</td>
<td></td>
</tr>
<tr>
<td>• Only sharing with people they knew or people they trusted;</td>
<td></td>
</tr>
<tr>
<td>• Using the needle first before anyone else;</td>
<td></td>
</tr>
<tr>
<td>• Rinsed or bleached in between shots; and</td>
<td></td>
</tr>
<tr>
<td>• Asked the person if they had HIV and trusted their answer.</td>
<td></td>
</tr>
<tr>
<td><strong>Unprotected Sex</strong></td>
<td></td>
</tr>
<tr>
<td>• All participants had reported in engaging in unprotected sex.</td>
<td></td>
</tr>
<tr>
<td>• This behavior was viewed as a lesser risk than needle/works sharing for HIV infection.</td>
<td></td>
</tr>
<tr>
<td>• For female participants, getting pregnant or being taken advantage of sexually was more of a concern than HIV infection.</td>
<td></td>
</tr>
<tr>
<td>• They reported that when they engaged in sex and were also under the influence of drugs that these issues became even less of a priority.</td>
<td></td>
</tr>
</tbody>
</table>
Section 2: Emerging Themes Related to Research Questions

Research Question: What are the Predisposing, Reinforcing and Enabling Factors that Influence High Risk Behaviors?

Theme #1: Substance Use/Abuse

Sub-theme #1: Type of Drug Used and Social Perception (Enabling).

Identifying oneself as an IDU, as well as identifying with their drug of choice was a way for an IDU to justify engaging in the high risk behavior of injecting. The needle appeared to be just one part of their persona. Those who chose methamphetamine as their primary drug of choice tended to view opiate users as "junkies" and crack cocaine users as dirty or unclean. In contrast, opiate users tended to view meth or crack users as "tweakers" and viewed them as violent and a social problem. Those who identified both amphetamine and opiates as drugs of choice, tended to view themselves as mere drug addicts, simply needing to get high. In spite of what perception an IDU had of other drug users because of the drug they chose, most participants had used both amphetamines and opiates but self-identified with one drug over another, and in their view regarded their drug superior to the others. This perception connected them to an attitude that made it "better" and justified engaging in high risk behaviors as part of their lifestyle.

Supporting quotes:

- “I don’t like tweakers man. And a crack head, he just wants five dollars for his next hit in 20 minutes, and a junkie just needs 10 bucks so he can stay high all night. A tweaker might think you’re a cop, might think you stole his dope, who knows what the dude’s thinking after he’s been up for two weeks. You know what I mean. You know you can’t trust a tweaker at all.”

- “I am very adamant about the fact that I’m not a junkie, I’m a banger. In my opinion, there is a big difference. A banger is better. My mother hates my boyfriend because she doesn’t know that we’re using, she thinks he’s just the biggest junkie in the world, because he uses needles. She uses pills, but he’s a loser.”
• “I’ve seen a dirty crack head, but that’s not a meth head. We’re clean people. I mean I know bangers who have been doing it for a long, long time, like twice my age and I never seen anybody get that bad. It’s just bullshit, it’s a lot of bullshit ‘cuz you know what, it [the Meth Project] makes people look more down on it, because like, you’re going to look like that, no you don’t. Me, personally, no. I get high, my house is spotless, everything is in order.”

• “I consider opiates my drug of choice. Yea, I’ll do ritalins, adderall, meth, whatever. But I don’t like the speeds ‘cuz the people. I will admit that I’m a drug abuser but I feel like I have a reason for doing it. And I’m not doctor shopping, I just want to take care of myself. You gotta be careful, and this town is a dangerous town for buying drugs in so I try to avoid doing it and it’s really really expensive. Speed is a bing constantly, 30, 40, 60 bucks and I was in the big city where those people were buzzing all over the place. When you’re up for a week and a half you’ll be living in a dumpster in a broke house. That’s why I don’t want to get involved with those people because I can’t deal with them.”

• “I don’t like crack, but I did it recently in Spokane, and it was like wow I like this way too much, you know. I seen so many crack heads, the lifestyle is the most saddening to me, to see what they do. This one guy lets guys suck him off for ten, five bucks to buy a rock. It really bothers me. I personally can’t understand how one could get to that point” (This is a participant that almost died the night before she came in for the interview, and has no real recollection on what her behavior was before she overdosed).

Sub-theme #2: Readiness to Change Behavior (Predisposing).

The main factor associated with decreasing or discontinuing substance use/abuse was the readiness to engage in this behavior. Every participant commented on the fact that “you’re not ready until you’re ready.” Ten participants had been court ordered to treatment, and none of them were yet clean. The view of court ordered treatment is that is does not work. They did however think that the treatment they had received through the system was helpful in educating them about substance use/abuse and may help them if and when they are ready to stop using. The one participant who volunteered to go through treatment said the only reason it worked was because she went for herself, nobody else.
Supporting quotes:

- “I believe that you won’t quit until you’re ready. I will say anything to get the court to shut up and get out of my way, but some people never are ready and find that comfort, like I’m OK.”

- “Nobody can get me clean. I gotta do it on my own and in my own time.”

- “Somebody can’t make me get clean, it has to come from inside of me. I have to do that myself.”

- “The only time I’ve ever been clean is when I was in jail. And, look at me now, did it work?”

Sub-theme #3: Availability of Treatment or Waiting to Go to Treatment (Enabling).

The availability of treatment or waiting to go to treatment was viewed as a factor in decreasing or discontinuing substance use. One participant who came in for an interview did so the morning she was released from the hospital because of an overdose. She was quite emotional and ill. During the interview, I asked her if there was a place for her to go to treatment right then if she would go and she said yes. Unfortunately, there was no immediate help for her, and she left the interview without a plan to enter treatment. Many participants agreed that if treatment isn’t available when they are ready, they will not follow through. Also, if a bed space is available in the future, and they have to wait, it is too difficult not to use while waiting because of the physical discomfort of coming off drugs without assistance, and they end up not following through with a treatment plan.

Supporting quotes:

- “I want to try and get off suboxone, but I end up drinking, and that, oh, suboxone feels like you’re gonna die, but then my alcohol and klonopin are the worst, and I’ve come off that before, and that will kill me to do it on my own.”
- "Once you get sick from heroin you know, and it's all down hill from there."

- "Every person who has to wait for it [treatment] may not make it. It has to be there when you're ready."

- "I got really high on my tolerance, and I went to get some pills, and told them [doctor] how much I was taking, and they wouldn't give me any, said there was nothing they could do, no treatment, and I had to kick it, seven days into it not sleeping, seriously considering just finding an all night pharmacy, just jumping over the counter, taking the pills right there and not care, just to make it go away. There's nothing that hurts worse than that. Yea, you could stick electrodes on your genitals and it wouldn’t hurt that much."

Sub-theme #4: **Family Dynamics (Reinforcing).**

Family dynamics was a factor in substance use/abuse. All participants reported coming from a family life that included at least alcohol abuse if not more illicit drug use. Even those who identified as having a “good upbringing” discussed their parents, siblings or other extended family members using or abusing alcohol and/or other drugs. Some also were introduced to drugs by their parents, and saw drug use as a way of life. Most of the participants who were still using (17 of 20) viewed their childhood as the catalyst for continued substance use/abuse.

**Supporting quotes:**

- "If you tell a kid they're stupid their whole life, they're gonna think they are stupid. If you tell someone they’re gonna be a junkie their whole life, they’re gonna be a junkie, and that’s just the reality of the situation."

- "My mom got busted for selling pot and methamphetamine when I was six."

- "I actually, um I, when I was seven, I cut the big red ribbon that was around the capital building for the drug free task force. And for the class of 2000, they put the big red ribbon around the capital building, and I was the girl with the big scissors that got to cut it off. And then when I was in fifth grade, I uh, got, my speech got chosen for the DARE program to read in front of the whole entire class about how I wasn’t going to be a drug addict. And, because, I don’t know, because my whole family works in the court system I learned how to pretend really really well, that everything was OK, and that I wasn’t a drug addict. And, it was my whole thing"
later that I was a “functional” drug addict and I mean, even to this day I still have that same theory in my head. I was taught my whole life to pretend, yea, pretend like everything is OK, like to be that closet junkie in the bathroom. Even most of my best friends didn’t even know I shot up drugs until like three years later, they didn’t know I shot up since I was 15 years old.”

For those who had stopped using, family support was also influential in their decision to discontinue using.

Supporting quotes:

- “My brother, he didn’t compromise what I believe in. He came over to my house in Washington after the Hep C stuff and going back to using, he sat me down and said all the things that he loved about me and he said you can be so fucking stupid, don’t forget what I said to you, but you are being so fucking stupid right now. And he was crying, and it was the hardest thing for me to hear and I stepped outside of the box that I had jumped into. Believe me not, I smoked and used crystal meth until the day that I left and got in my brother’s car.”

- “I couldn’t see my family hurt anymore. My niece almost died of an overdose, and I feel responsible for that, for turning her on to things, for not being a good role model. It’s not worth it, so I had to get out.”

When asked what may have prevented the participant from starting to use substances, all had a view of it being inevitable, regardless.

Supporting quotes:

- “It wasn’t because of this, or because of that, it was just my turn.”
- “It would have happened anyway”
- “I think if I would have had more support at home, better parental roles.”
- “If I could have had a different childhood.”

Sub-theme #5: Identification with Being a Parent (Reinforcing).

Identification with being a parent, especially for female participants, was a factor for wanting to discontinue substance use. All of the participants related that becoming a parent or being a good parent was a reason to be clean and get sober.
Supporting quotes:

- “I need to keep my shit together for my kids, and I know I’ll quit meth sometime, I just need to keep it together.”

- I’m 24 years old, and I’m gonna be 30 tomorrow, and, I just want to do something different with my life, and I want to able to have a house, and kids, and you know, a career, and that kind of stuff, so I moved back to Missoula.”

- “I just want something better for my life and my kids.”

- “We want to move to Salt Lake and hoping I can just start over and just stay away from that. I know I’m strong and I can do it I just have to do it. For my kids, you know.”

- “My kids are there, but they don’t see. I go in the bathroom. In the house, yes, but not around them.”

Sub-theme #6: Having a Purpose in Life (Reinforcing).

Having a purpose was a factor for discontinuing substance use. One participant had been clean and sober at one point for a number of years, and during that time he had been an HIV/AIDS and Addictions Counselor. When discussing this time in his life, he identified the purpose he felt in helping other people as a reason to stay clean and sober. Although many of the participants defended their life styles and drug use, they also discussed that living a meaningful life would include not using drugs.

Supporting quotes:

- “The people in my life have said things that I can’t deny, because it is true, because the spirit inside of me has never been able to deny truth. That ate me alive when I was using, and now I feel like that can let that go and really be me.”

- “I’ve done a lot, I did the education, I’ve done trainings. I like to do this type of work. I feel like its my duty to educate and to be a part of it, because I owe it, to try and help to prevent, to give back.”

- “I’m studying social work. I want to make a difference, and I know I can’t do that this way [using].”
Theme #2: Sharing Needles/Works and Unprotected Sex

Sub-theme #1: Benefit of Getting High over Being Infected with HIV (Reinforcing).

The majority of participants reported that getting high takes precedence over staying free of HIV infection. Only two of the 20 participants said they had not shared needles/works and wouldn’t, even if that was the only way to use. Unprotected sex was viewed as a less risky behavior than sharing needles/works for HIV infection. Engaging in unprotected sex was very common among the participants, especially when they were under the influence of drugs. Some participants reported having sex in exchange for drugs, even on a casual level. Many reported using condoms when not high, but when substances were being used protection seemed to be a non-issue for most.

Supporting Quotes:

- “I was aware of HIV, but it’s amazing what you don’t think about when you use. What’s important is the getting high and later, like the next day you may think about it. Oh, shit, you know.”

- “We’re all in the same game, you know what I mean? And I don’t want to see any of my friends dead, you know what I’m sayin’. Even though we are killin’ ourselves. Not much you can do about it. But when you’re there, getting high, what’s more important? Yea, you don’t care at the time.”

- “It’s just common sense just not to use a dirty rig after someone. I’ve never used a dirty needle after anyone yet. It’s just common sense not to use a dirty rig. I don’t want anything personally. (So you haven’t shared?) No. (How about unprotected sex, do you think about HIV with that?) Yea, it can be transmitted that way, and that’s happened so far. But no, I’m not really thinking about that [HIV infection] during sex. We’re like rabbits or something when we’re high, and the drug is what’s important. I don’t know. Like girls, they say I’m on the Depo shot, I can’t get pregnant, but not worried about what else they can get. I don’t ask ‘cuz it’s none of my business.”

- “Yea, if there’s only one point [syringe], you take the risk.”
• “I’m working within the boundaries, and for me I can’t stand condoms, which I think that’s drove my sex drive down to just about nil, unless I am high.”

Sub-theme #2: Type of Social Networks (Enabling).

The type of social network that participants belong to influences the sharing of needles/works and the practice of unprotected sex. Two social networks were identified, the acquaintance network and the kinship network.

In the acquaintance network, members are affiliated primarily through their drug use. A member may be a person an IDU gets the drug from, or someone they are acquainted with for only the time that they shoot together. Some of the participants reported sharing within this network, but it was not a common theme. Individuals who did share within this type of network reported that they asked if their acquaintance was disease free, and trusted the answer. Also, those who were Hepatitis C positive who shared within this network reported disclosing their status to individuals with whom they shared needles and works prior to sharing.

The other social network identified was the kinship network. Within this network, members consider their fellow members friends, family - “blood”. There is a sense of trust and loyalty among members. All participants who shared needles/works within this context commented on their trust in the people with whom they shared. Unfortunately, this trust and loyalty was not always warranted as individuals in this kinship network also occasionally shared needles outside of the network. In addition, it was not uncommon for them to engage in unprotected sexual behavior outside of the network. These high risk behaviors were not revealed to the other members of their kinship network, as revealed through the interviews.
Supporting quotes:

- “Yea, I definitely want to find out [HIV status] ‘cuz like me and A. [member of the kinship network] have been talking about getting back together and I shared a needle with this junkie in Seattle when I did it, and I did it a pocket full of times. I really do love the girl, whether she hates me or not and I’d really hate to, uh, bring something back to her. Yea. “Cuz, um, we both got Hep, she got Hep from me. That junkie said he didn’t have AIDS, but I don’t know, you know. If I do get it, I hope I don’t give it to her. But most of us junkies are pretty honest with each other about that.”

- “Well, I only share with him [a member of the kinship social network], so I don’t worry about that.”

- “I was usually the one who bought the drugs and got the drugs and so I went to the bathroom and I’d do the drugs the way I wanted to do them [inject], and then came out and did it with my friends the other way so they never even assumed.”

- “I only share with my boyfriend. We used a point with somebody we know, but we know them. (How about unprotected sex?) No, I’m with my boyfriend.”

- “I was tested [for Hep C] and was told that I have it. My boyfriend doesn’t know I have it, so this information isn’t going anywhere, right? Yes, I have unprotected sex, but only with my boyfriend for four months and we have unprotected sex and we want to have a kid and I know it is OK to have a kid with Hep C because only 6% of children get it from the parent. I know I can live 40 more years with it.”

Sub-theme #3: Knowledge about the Efficacy of Cleaning Needles/Works, and of the Risk Associated with Unprotected Sex (Predisposing).

Knowledge about HIV and Hepatitis C was high among all participants as reported earlier. Many reported cleaning needles/works as a harm reduction method for HIV infection. However participants who were Hepatitis C+ reported not knowing that simply cleaning syringes doesn't always protect against Hepatitis C infection. Also, being under the influence affected how safe participants were with harm reduction techniques and behaviors. If they were “high” they tended not to be as diligent with prevention efforts. In addition, the perception of “safer sex” influenced their decision to
engage in unprotected sex. “Safer sex” was defined as simply knowing their sexual
partner rather than using a condom every time they engaged in sex.

Supporting quotes:

- “She got Hep from me. That’s definitely from sharing. At first we didn’t, we
always kept ourselves [works] separate, and then she got drunk one night and used
our stuff and then we went to Santa Cruz and we got tested and she turned up
positive.”

- “I never knew – I was reading that thing [brochure] out there that you have on
Hep C that you have to swish it around for two minutes, and not even 100% bleach
is effective.”

- “I found out [Hep C status] when I was pregnant. Yea, I didn’t know until now
when I read that thing that bleach doesn’t kill it. We cleaned it [syringe], but that’s
probably what happened.”

- (Have you shared needles?) “Yea, but I didn’t know bleach didn’t kill Hep C. I
didn’t know that until homeboy told me. Anyway, it was my roommate [who he
shared with], nobody I didn’t know. It’s still in the back of my mind now. That takes
the whole bleach thing and throws it out the window. (How about sex?) I’m with
my girlfriend, so I don’t worry. We’ve been together for two years now.”

- “I don’t have too much to worry about, because I’m an outie [male], not an innie
[female], you know. It’s easier to get AIDS through needles than sex, you know
what I mean? I’ve done it with guys, and with girls, I like girls.”

Research Question: What are the resource and/or prevention service needs
for IDUs?

Theme #1: Access to Clean Needles

There was an overwhelming response for access to clean syringes. All
participants reported accessing Needle Exchange Programs (NEPs) when traveling or
living outside of Montana. Participants reported receiving not only clean needles and
other injection materials, but also HIV education, HIV counseling and testing, harm
reduction information for safer injection, substance use/abuse treatment information, and
Hepatitis C education and testing. If a formal NEP was not accessible, participants
suggested user-friendly pharmacies where IDUs could purchase needles without
discrimination, or physician prescriptions for clean syringes. All participants who shared
needles stressed the fact that if they didn’t have access to clean syringes they would opt
to share needles/works to get high.

For the residents of reservations, access to clean needles was identified as an
important need, although a visible NEP did not seem as viable in this location.
Confidentiality was identified as a barrier to accessing such a program, and participants
said other private means of accessing clean needles should be available.

Supporting quotes:

• “Needle exchange saved my life, I’m sure of it.”

• “Wind carries gossip around here [on the reservation]. I want clean needles, but I
don’t want my brother to know where I get them.”

• “There definitely needs to be a needle exchange, because if you’re going to do it,
you’re going to pick it up out of the gutter and do it. I’ve seen people do it. Pick it
up out of the gutter and do it. I agree, if you want it that bad, you’re gonna do it.
Nothing’s gonna stop you. Your friends can’t stop you, nobody gonna stop ya. So, I
mean, I’ve seen it, watched it, I’ve done it myself; filed it down on a match book
before, get it sharp and put it back in your arm. So, if you’re gonna do it, you might
as well be able to get a clean one and do it right. Cuz you can’t stop ‘em.”

• “I think that every town should have a needle exchange and that people should
have information on what to do if someone is overdosing. I think just educating
people on things and just having a needle exchange in itself, you know, you’re not
promoting drug use, and that’s the biggest controversy about having a needle
exchange anywhere is that if you have it then you’re saying that it’s OK to do
drugs. But that’s not the reality. The reality of the situation is that people are going
to do drugs whether you want them to or not. And you can give them the materials
so that they can be safe at least with it then you’re gonna stop the spread of
disease, you’re gonna get more aware, you’re gonna get people who are working
in these places that if someone really did want to get help that they could get them
to it.”

• “If they had needle exchange it would be good, but it could be bad at the same time
‘cuz there would be like dirty needles all along the river, like in the pond in San
Francisco, I don’t want to see that, like when I want to go someplace in a nice
comfortable place along the river and just chill, I don’t want to see like dirty rigs in the river. But, then again, it would be good if people for to stay clean.”

- “Sharp bins, sharp bins [needle exchange]. And clean up after yourself.”
- “To get points at a pharmacy, you got to show ID, you gotta sign for it, and if I gotta do that, then no, no I’m not gonna do that.”
- “With needle exchange, I always had brand new ones, didn’t matter, and I didn’t have to sharpen on a match book, and so on.”
- “They are RNs there at the exchanges, they taught people how to shoot up, how to use tie offs, and to use release, and gave the education of well, if you can’t stop using, don’t want to stop using, here is what you need to do to eat, to keep your body functioning. Not just HIV education, but things on nourishment, harm reduction, better needles, and stuff.”
- “There should be a place where you can get clean stuff, ‘cuz you know. Education is a moot point, people already know. They just, they don’t care. Stupid, they’ll do it themselves, you know. I guess I’ve done it, share.”

**Theme #2: Substance Abuse Treatment**

Participants stressed that, even though readiness is a factor in accessing treatment, the availability of treatment is vital. Participants felt that substance abuse treatment in general – in-patient, out-patient or other treatments were not available. Also, if treatment were available, the cost to go to treatment was prohibitive for most to participate.

Supporting quotes:

- “I think good or free treatment, like if you have a real problem, you can get rehab and other stuff you need. And don’t just put them on a script that they can get addicted to, like don’t give them speed if they’re addicted to meth – or xanax if they’re addicted to klonopin – duh. I was talking to my mom, she’s a nurse practitioner, and she says that’s what they do. Tradin’ Rice Crispies in for Cheerios – its all cereal.”
- “Definitely treatment. But what treatment? There is none. And I couldn’t afford it if there was.”
- “I don’t think people even know about the treatment center I went to. It’s for youth, but hardly anyone knows about it, and I don’t know how easy it is to get into it anyway.”
Theme #3: Harm Reduction Services until Ready for Treatment

Participants reported the need for harm reduction services to stay HIV free. Harm reduction services included contact with Outreach Workers, free HIV and Hepatitis C counseling and testing, and access to service organizations such as the Salvation Army, food banks and job skills training.

For participants who had been in contact with Outreach Workers, they referenced outreach work as a necessity for them. Not only did they receive HIV and Hepatitis C education and information, they received HIV counseling and testing and harm reduction supplies and referrals to other agencies. In addition, they reported that receiving these services from people they trusted was very important for them to feel safe and not judged.

Participants reported the need for free HIV and Hepatitis C testing. Every participant who did not know their Hepatitis C status received a free Hepatitis C Home Test kit. This kit costs $54.00, and all reported that they would not have taken the test if it hadn’t been free. In addition, participants reported that free testing needs to be available in settings where they feel safe, not judged and where they know their confidentiality would not be breached.

Participants reported the need for service agencies that provided food, clothing and shelter. Service agencies were viewed as organizations that provided some stability for IDUs and allowed them to make better choices. In addition to providing basic services, the need to have HIV and Hepatitis C information at these agencies was also identified.
Supporting quotes:

- “We need more people like [outreach worker]. She’s cool, and she’s been very helpful. She came to us, we didn’t have to find her. She told us about you [the interviewer]. Yea, she helped us out.”

- “Stuff on Hepatitis C, like I saw in New York City. They had free tests, free medicine, and a lot of information for us about Hep C. Yea, I think that was at the needle exchange there too.”

- “Somewhere that helps out with housing, clothing and stuff. There’s a bunch of different places out there but no one wants to help someone get on their feet. You can stay at the Povarello Center, but if you got a girlfriend, you sleep apart. I’ve seen the one-stop shopping before for all those things to help you get back on your feet.”

- “The best suggestion to influence these people is maybe like set up a day program like a day center like they had in California, a drop-in from 9-5, where people come out and talk, have support groups, stuff like that. You know, that would be wonderful, like, ‘hey, how are you doin’ today?’ Right, like something that shows that they care, ‘cuz a lot of these people feel like they don’t have no one that cares. I’ve felt like that all my life.”

**Theme #4: Reaching IDUs with Prevention Messages**

Participants reported the importance of getting HIV prevention information out into the community where it is easily accessible to IDUs. Participants identified the following best ways to reach IDUs with HIV and Hepatitis C prevention education and information:

- Sending media messages that are non-judgmental and include accurate and detailed prevention information;
- Using documentaries on people’s lives who are dealing with substance abuse problems and live with HIV and Hepatitis C;
- Providing education in schools, treatment centers, and in jails/prisons; and
- Illustrating through pictures the changes in physical appearance that occur over time with chronic drug use.
Supporting quotes:

- “Just get the real stuff [information] out there, you know. If they’re gonna do it, they’re gonna do it, just let them know what they’re getting themselves into, that’s for sure, like Hep C. If I had known, if I knew, you know this is twelve years later, but uh, I’d never done it.”

- “If you guys were to make bill boards, make one like “Don’t Share”, instead of don’t do it. Like, have two arms, two right arms, two different people with a needle in between them and it says, “Don’t share.” That’s a great idea, you might get famous with that one, that’s right.”

- “They [the Meth Project] just try to tell you not to do it and that’s it. I think that’s crap, like the bill boards. They have a point, don’t do it, but what about the people who have already done it and are already doing it and want help and need help, you know, their whole approach is don’t ever do it. People who already do it, it doesn’t work. It’s just kind of a joke. Like, not even once. Maybe to a five year old. It’s ridiculous, irrelevant.”

- “Just to get out of denial that Montana doesn’t have drug addicts here and do something about it.”

- “To be out in the community with the information, not stuck back in the corner of a building.”

- “There’s nothing said about HIV or Hep C risk said in the Meth Project. It’s kind of a waste. Unfortunately the most I know who are infected got that way being intoxicated or out of their mind high. Why don’t they say that?”

- “Montana is growing, people are coming in, and for those of us who are positive, people are coming in, and we’re growing. We gotta let people know that.”

- “You know, like those pictures of that woman who used and got real gross, and show what really happened to her, not by just once but by ten years of the shit.”

- “Education is huge. Get the word out. Gosh, I don’t know, it takes a huge society change to have people who have been diagnosed, to be um, maybe just send me around the world to talk! People who are comfortable with it. People who have had experience with drug use or not just drug use but other abuse, be open, and talk, talk, talk. Tell the kids they are our future.”
Research Question: What are the barriers to accessing services?

**Theme #1: Stigma and Discrimination**

Stigma and discrimination were identified as the largest barriers to accessing services. While HIV/AIDS carries a stigma of its own, substance use/abuse, and being an IDU also ranks high in stigma and discrimination. IDU participants identified discrimination as a barrier to accessing services, including getting tested for HIV and Hepatitis C, accessing medical treatment and substance abuse treatment services. Participants who had accessed clean syringe programs in other states maintained that the stigma was heightened here in Montana. Also, IDU participants who identified methamphetamines as their primary drug of choice believed that the current Meth Project Campaign added to the stigma and discrimination that they experienced.

Supporting quotes:

- “I think the Meth Project has made it worse for us who use. I get treated differently, like we’re all bad people. When I go in to get medical treatment, the health people treat me like shit. And then I don’t want to say what’s really goin’ on, ‘cuz they just look at me like I’m a piece of shit.”

- “The best way to get high is to inject, but people look down on it man. Like, it’s better to smoke it or snort it or something! That’s crazy if you think about it.”

- “Put a big bill board, fucking anti-not even once commercial bill board. That would be cool. That would serve them meth people right. It just drives me nuts ‘cuz I never been a tweaker like that. Tweakers, I’ve seen some nasty shit that tweakers have done, but I’ve never see nasty people. I think they’re [the meth ads] stupid. Everybody knows that meth’s not like that. That’s not how it really is.”

- “Not looking down on people. Especially for shooting up. There’s a real stigma attached to it. In my opinion, it’s one of the cleanest ways. Like when you smoke it you get all that other shit your lungs and crap.”

- “The fear. They all stare at you like they want to see you on America’s Most Wanted.”
I don’t care what people think of me or how they look at me like, I just think people should be more accepting of knowing that there is help out there, free help, free ways to express love for yourself, by getting checked out, you know."

“I think people think people shouldn’t even go into places like that [needle exchanges], that it’s wrong to even go into a place like this because it’s wrong to be putting yourself at risk.”

“They’re embarrassed and scared. Being seen as a drug user.”

“You don’t want to go in and have people tell you that what you’ve been doing is bad. No matter what anyone says when you’re coming off something it don’t help anything that you’re feeling inside. Feeling like shit already don’t need another dose of it. You don’t need to hear about how bad of a person you are because of what you’ve done and then you’re feeling like crap already.”

“We need people who are in it that we can trust, people like you. Your vacation to Colorado [interviewer going to treatment], you know, when you share that, it feels more trusting with you. I can come and talk to you, and that’s what people need. Even if there is some type of buddy system, get to know people, help people love themselves more, or like themselves at least.”

**Theme #2: Confidentiality**

Confidentiality was viewed as a barrier to accessing services, especially for IDU participants who resided on reservations. Confidentiality was seen differently than stigma and discrimination. It wasn’t a fear of being treated poorly, but rather a fear of close friends or family knowing that they were accessing services.

Supporting quotes:

- “It’s like the moccasin telegraph out here.”

- “Wind carries gossip around here [on the reservation]. I want clean needles, but I don’t want my brother to know where I get them.”

**Theme #3: Fear of Being Arrested and Incarcerated for Drug Possession**

Although not an overall consistent theme, the fear of being arrested was identified as a barrier to accessing services. Some participants reported the need to decriminalize the possession of paraphernalia. If this law was changed, these participants
felt that they would be more willing to dispose of dirty needles appropriately and to access services more readily.

Supporting quotes:

- “Instead of busting somebody with a dirty point in their pocket, get down on the bigger guys. Not the person who is crying out for help or don’t even know they are cryin’ out for help. And that’s the truth of it.”

- “Yea, our friend was fallin’ out [overdosing], and we couldn’t do anything but take her up to the ER door and run.”

Key Informant Interview Results

Section 1: Description of the Study Sample

Key Informant interviews were conducted during and after IDU Participant interviews. Data collected was used to corroborate and augment the IDU participant interview data.

Seventeen Key Informant interviews were conducted. Twelve interviews were conducted face to face, four were conducted via telephone, and one was conducted by the Key Informant answering the interview questions with pen and paper and returning them to the researcher via postal mail. No direct quotes are included in this section of the results, because the Key Informant interviews were not audio recorded. Rather, detailed notes were taken during the interviews. All regions of Montana (see Appendix E) were represented in the study sample. Professional affiliation of the key informants included:

- City/County Health Departments (2)
- Corrections/Drug Court (2)
- HIV/AIDS Service Organizations (1)
- IDU Outreach Services (4)
- Mental Health Services (1)
- Needle Exchange Services (Washington state affiliated) (2)
Section 2: Identified Themes Related to Research Questions

Research Question: What Factors Influence High Risk Behaviors?

Theme #1: Substance Use/Abuse

Sub-theme #1: Availability of Treatment (Enabling).

The availability of treatment or waiting to get into treatment was viewed as a factor to decreasing or discontinuing drug use. Specifically, when IDUs decide to discontinue using drugs, immediate availability of treatment services is a major determinant of whether or not they follow through with the behavior change. If IDUs have to wait for treatment, it is more likely that they will change their mind before something is available to them. Also, most key informants acknowledged that treatment, in general, is not available to IDUs.

Sub-theme #2: Having a Purpose in Life (Reinforcing).

Key informants identified having a purpose in life as a factor for discontinuing drug use. Low self-esteem, feelings of hopelessness and lack of motivation were identified as factors to continuing using drugs.

Research Question: What are the resource and/or prevention service needs for IDUs?

Theme #1: Substance Abuse Treatment

Key informants stressed that while the availability of treatment as vital to recovery, in-patient, out-patient or other treatments are not readily available to IDUs. In addition, longer, more effective treatment is needed for methamphetamine users, and
should be accessible through means other than the criminal system. Even if treatment were available, the current cost to go to treatment is prohibitive for most. In addition, treatment that allows mothers to keep children in their care while in recovery was identified as a need. For IDUs within the correctional system (drug court), harm reduction treatment services are needed to provide IDUs with education and support to decrease or stop using drugs while waiting for a space in treatment. Drug rehabilitation rather than long term jail sentences is needed for individuals incarcerated for drug possession crimes.

**Theme #2: Free Hepatitis C Testing and Other Hepatitis C Information and Education**

Key informants reported the need for free Hepatitis C testing and distribution of Hepatitis C information. Key informants said that Hepatitis C is the disease that IDUs identify with more so than HIV. IDUs can be engaged in HIV prevention through Hepatitis C education and services. In addition, free testing needs to be available in settings where participants feel safe, not judged and that their confidentiality would not be breached.

**Theme #3: Access to Clean Needles and HIV Education and Information**

Access to clean syringes was identified as a need for IDUs. Key informants felt IDUs would share needles/works if clean injection supplies are not accessible. One key informant reported that past efforts to collaborate with pharmacies to provide clean syringes “fizzled”. In addition to clean needles, HIV educational information, HIV counseling and testing and harm reduction information for safer injection was identified as a need for IDUs. One Key Informant said that although they were not allowed to use
funds to distribute clean needles, they would support and refer clients to services that offer clean syringes.

Research Question: What are the barriers to IDUs accessing services?

Theme #1: Stigma and Discrimination

Stigma and discrimination was the largest barrier identified for IDUs accessing services. All data paralleled that of IDU Participant interview data.

Theme #2: Cost of Treatment

The cost of substance abuse treatment was identified as a barrier to IDUs accessing services. Substance abuse treatment on all levels needs to be very low or no cost for IDUs to be able to access these services.

Theme #3: Services Not Available

The mere fact that services such as access to clean syringes and substance abuse treatment options are not available in Montana was identified as a barrier to accessing services.

Research Question: What are the barriers to implementing services?

Theme #1: Lack of Funding

Lack of funding was the largest barrier to implementing services. Key informants recognized the importance of HIV and Hepatitis C prevention and how these topics are interrelated to issues such as substance abuse; however the lack of funding for substance abuse treatment alone creates a large barrier to implementing adequate services for IDUs. The lack of funding for substance abuse treatment in jails and prisons was also noted.
**Theme #2: Lack of Agency Networking**

Lack of agency networking was viewed as a barrier to implementing HIV prevention services to IDUs. There is a lack of coordinated efforts between HIV prevention, mental health and treatment services. For example, agency collaboration between HIV/AIDS service organizations and substance abuse treatment programs is needed to provide HIV prevention education to those who are in treatment. Also, agency networks that provide other social services such as food, clothing and shelter should collaborate with HIV/AIDS service organizations to educate and inform clients of services available for HIV and Hepatitis C.

**Theme #3: Services Prohibited or Discouraged by State and Federal Laws.**

Although access to clean syringes was identified as a need for IDUs, Key Informants also identified barriers to implementing these services. Montana state law is written to criminalize those who possess syringes. Also, access to clean syringe services cannot be funded by federal dollars.

**Documentation and Archival Records Results**

**Section 1: Description of the Study Sample**

Documentation review and archival record retrieval was conducted during and after the collection of IDU Participant interview and Key Informant interview data. The documentation and archival record information collected was used to corroborate and augment IDU participant and Key Informant interview data. The following data sources were researched:

- Internet searches specific to HIV/AIDS websites for Montana;
- Montana State Departments (Health and Human Services, Addiction and Mental Health Services, Department of Corrections, Department of Justice);
• State statistical data for correctional and substance abuse facilities;
• Major Montana newspaper media sources;
• Montana task force and council documents specific to HIV and drug use;
• National data sources that included Montana specific data;
• Major Montana television sources; and
• Published media articles specific to HIV, IDU and Montana.

More than 10,000 Montana newspaper articles related to injection drug use were accessed through a search done for the period of January 1, 2002 through September 26, 2006 (see Table 4 below). In addition, more than fifty internet websites were accessed and hundreds of documents were reviewed for data collection. The documents cited below are those that were relevant to answering the research questions and that supported IDU Participant and Key Informant interview data.

Section 2: Data Contributing to Answering Research Questions and Supporting Interview Data.

Research Question: What Factors Influence High Risk Behaviors?

Theme #1: Substance Use/Abuse

Sub-theme #1: Type of Drug Used (Enabling).

Methamphetamine use in Montana is prevalent. Nationally, the rate of substance abuse treatment admissions for primary methamphetamine abuse increased between 1993 to 2004 from 13 per 100,000 to 85 per 100,000 population aged 12 or older. In 2004, 18 states had rates in excess of the national rate; Montana ranked 9th highest with a rate of 133 per 100,000. The route of administration differed by rural/urban status: the percentage of methamphetamine admissions that smoked the drug was highest in the most urbanized counties (62%) and lowest in the most rural counties (48%). In contrast,
the percentage of methamphetamine admissions that injected the drug was lowest in large metro areas (14 to 15%) and highest in small and non-metro areas (24 to 25%) (SAMHSA, 2006).

According to the Montana Department of Corrections (DOC), 80 to 85% of all offenders in the criminal justice system have a drug or chemical dependency problem; about 53% of female inmates identify methamphetamine as one of their drugs of choice, and about 36% of male inmates identify methamphetamine as one of their drugs of choice (Board of Crime Control, 2006).

Admissions to Montana state-approved chemical dependency treatment programs in which patients listed methamphetamine as their primary drug have increased 70% over the past six years. This data is reflected in Table 3 below.

Table 3. Methamphetamine Admissions to State-approved Treatment Programs, 2001-2006.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>734</td>
</tr>
<tr>
<td>2001</td>
<td>820</td>
</tr>
<tr>
<td>2002</td>
<td>903</td>
</tr>
<tr>
<td>2003</td>
<td>1012</td>
</tr>
<tr>
<td>2004</td>
<td>1124</td>
</tr>
<tr>
<td>2005*</td>
<td>1246</td>
</tr>
</tbody>
</table>

* Of the 1,246 patients in 2005:
  - 42.8% named injection as the primary route of use
  - 711 (57%) were men, 535 (42%) were women
  - About 65% were ages 18-34

Source: Montana Department of Justice, 2006.
Research Question: What are the resource and/or prevention service needs for IDUs?

Theme #1: Substance Abuse Treatment

The Montana State Department of Public Health and Human Services Addictive and Mental Disorders Division endorses 69 chemical dependency treatment programs throughout the state (see Appendix F). These programs offer detoxification, out-patient, in-patient, Assessment Course & Treatment (ACT) classes, Minor in Possession (MIP) classes, or a combination of these services. Of these programs, only five offer in-patient residential treatment. Montana Chemical Dependency Center (MCDC), located in Butte, MT, is the only state funded in-patient treatment facility available in Montana. For this reason, MCDC is the focus of the documentation review.

Montana Chemical Dependency Center

The Montana Chemical Dependency Center (MCDC) currently has 76 beds, with 70 treatment beds and six detoxification/medical beds. Treatment services are provided 24 hours per day, seven days a week, 365 days per year. Patient admission can be voluntary, court ordered or court committed. Patients are responsible for payment of services based on their individual ability to pay, which is assessed at the time of admission and is determined by annual income. Applicable third party payments for services may also be utilized. Individuals determined to have no ability to pay may receive service at no charge.

MCDC 2005 Annual Report

MCDC had a 3.2 million budget for fiscal year 2005, a steady increase from $2.6 million in 2001. The cost of treatment has increased from $139.43/day in 2001 to
$170.14/day in 2005. The average length of stay for a MCDC patient is 34.5 days, which makes the average total cost of treatment in 2005 approximately $6,000.00. Total admissions for MCDC decreased from 816 in 2001 to 542 in 2005. In the MCDC 2005 Annual Report sites the following reasons for this decline:

“We continue to suffer from critical clinical staff vacancies and extended illness of some of the remaining staff. The staffing pattern of MCDC is very low, making us very fragile when we experience staff absence for any reason and this is exponentially compounded when it occurs for any length of time, as we have no depth in staffing to call on for these situations. The most notable impact is evidenced in our average daily population and total admissions that continue to be below bed capacity, but are consistent with patient to staff ratio requirements of 8:1. We have made some adjustments to our admission practices which allow us to address patient needs more effectively and insure admissions with a very modest waiting period, while accommodating emergency admissions” (page 5).

To summarize, MCDC’s annual admissions has decreased from 816 to 542 patients (a difference of 274) not because of available space but because of inadequate staffing. In addition, the cost of care has increased from $139.43/day to $170.14/day since 2001, an increase of $30.71/day, or an average total cost of approximately $1,075 for an average 35 day stay. Furthermore, the average length of wait to get into MCDC is approximately three to six months (MCDC, 2006).

Montana Department of Corrections and Other Substance Abuse Treatment Data

The Department of Corrections Advisory Council reported, “The Probation Intervention Project has been initiated to create designated inpatient chemical dependency treatment beds at Montana Chemical Dependency Center for probation violators at risk of revocation. Eight beds will be available throughout the year for DOC
placements referred from Probation Hearing Officers and recommended by Licensed Addiction Counselors.”

A 2001 Needs Assessment on Integrated Substance Abuse Treatment for Montana concluded that “Montana would be justified in considering expanding its treatment services.” The analysis produced evidence of a substantial number of people who had an active addictive disease in the past year but on a small percentage of them received treatment in the past year and in their lives” (McAuliffe, Dunn and Sahady, 2001, page XII-15). The Office of Applied Studies, Substance Abuse & Mental Health Services Administration (SAMHSA) reported that in 2003-2004, Montana ranked in the top 5th percentile for Needing But Not Receiving Treatment for Alcohol Use or Illicit Drug Use in Past Year among Persons Aged 12 or older.

**Theme #2: Hepatitis C Testing**

Statewide, through City-County Health Departments, an individual can receive a Hepatitis C antibody test for $45.00. It takes one week to receive test results. In Missoula County, more than 60 Hepatitis C tests have been positive so far this year, and more than 100 were positive in 2005 (Goldberg, unpublished data, 2006). The reported risk behavior was sharing needles.

The Department of Veterans Affairs has started offering Hepatitis C testing in the past year.
Research Questions: a) What are the barriers to IDUs accessing services? and b) What are the barriers to implementing services?

Themes: #1) Fear of Being Arrested and Incarcerated for Drug Possession; and #2) Services Prohibited or Discouraged by State and Federal Laws

The Academy for Educational Development, with funding from CDC, produced documentation on the impact of criminal laws of the safe disposal of used syringes by IDUs in Montana. The document addresses four domains of law that could influence syringe behavior of IDUs:

- Drug paraphernalia laws;
- Syringe prescription laws;
- Laws and regulations governing syringe exchange programs; and
- Drug possession laws.

Under the **drug paraphernalia law**, The Drug Paraphernalia Act states:

“It is unlawful for a person to use or to possess with intent to use drug paraphernalia to… inject, ingest, inhale, or otherwise introduce into the human body a dangerous drug. A person who violates this section is guilty of a misdemeanor and upon conviction shall be imprisoned in the county jail for not more than six months, fined an amount of not more than $500, or both.” (Mont. Code Ann. § 45-10-103)

Under the **Syringe Prescription Law**, a prescription is not required for the purchase or possession of a syringe.

Under the **Syringe Exchange Legislation**, Montana has no legislation specifically authorizing syringe exchange.

Under the **Drug Possession Law**, Montana law states:
“A person commits the offense of criminal possession of dangerous drugs if the person possesses any dangerous drug, as defined in 50-32-101.”

The drug paraphernalia law makes it a crime to use a syringe for drug injection. Under this law, the used syringe would be evidence of a past crime. By exposing an IDU to arrest, the paraphernalia law in Montana could have an impact on IDU behaviors to retain a used syringe for proper disposal. The drug possession law does not specify the minimum amount of drug required to constitute possession. The possession of residue of drug in the barrel of a used syringe may be viewed as a crime. In that case, fear of arrest for drug possession could deter IDUs from retaining syringes for proper disposal.

The Academy for Educational Development’s recommendations include:

- Amending the drug paraphernalia law to exclude syringes;
- Amending the controlled drug act to require a minimum specified quantity to ground a possession conviction;
- Amending the controlled drug act to exclude trace amounts found in syringes;
- Developing standard operating procedures within law enforcement that avoid stops, arrests or prosecutions based on drug residues in syringes; and
- Educating IDUs and law enforcement to appreciate the importance of appropriate syringe disposal and the legality of possessing syringes in the course of disposal activities.

In contrast to Montana state laws, Washington state laws are similar to that of Montana, however under Syringe Exchange Legislation, Washington law specifies:

“Under Title 70, Chapter 70.24 (entitled “Control and Treatment of Sexually Transmitted Diseases”), there is a broad state statute setting out the state’s HIV
prevention plan; Wash. Rev. Code Ann §70.24.400. The plan contemplates a variety of potential interventions and private as well as public providers, engaging, inter alia, in “[i]ntervention strategies to reduce the incidence of HIV infection among high-risk groups, possibly including needle sterilization and methadone maintenance.”

Other Important Data

Theme #1: Lack of Information and Documentation of IDU HIV Risk

The following table illustrates the lack of attention that the risk of HIV infection from injection drug use receives through media, specifically from Montana newspaper sources. Of the fifteen results from the search words of both “HIV and/or AIDS and injection drug use” or combination of those words, only four of them were specific to risk here in Montana, even though more than 20% of Montana’s HIV + population was infected through injection drug use. Interestingly, a June 06, 2006 publication in the Billings Gazette reported that in Wyoming, more new cases of HIV in 2005 were attributed to injection drug use than men having sex with men. Also, just as of November 16, 2006, Michael Gulledge, publisher of the Billings Gazette, was appointed the chairman of the Montana Meth Project. This may explain the large number of published articles on drug use in this media newsprint, and will more than likely continue to increase.

<table>
<thead>
<tr>
<th>Media Source</th>
<th>Search Word(s) Used</th>
<th>Number of Results</th>
<th>Number of Results with both “HIV/AIDS” AND “injection drug use”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billings Gazette</td>
<td>AIDS Substance Abuse Injection Drug Use HIV HIV Prevention</td>
<td>1169 7092 802 376 661 291</td>
<td>2</td>
</tr>
<tr>
<td>Bozeman Daily Chronicle</td>
<td>AIDS Drug Use Substance Abuse Injection Drug Use HIV HIV Prevention</td>
<td>857 757 97 10 37 7</td>
<td>0</td>
</tr>
<tr>
<td>Great Falls Tribune</td>
<td>AIDS Drug Use Substance Abuse Injection Drug Use HIV HIV Prevention</td>
<td>110 200 125 8 57 20</td>
<td>0</td>
</tr>
<tr>
<td>Great Falls Tribune</td>
<td>AIDS Drug Use Substance Abuse Injection Drug Use HIV HIV Prevention</td>
<td>4430 2530 287 108 190 82</td>
<td>7</td>
</tr>
<tr>
<td>Helena Independent</td>
<td>AIDS Drug Use Substance Abuse Injection Drug Use HIV HIV Prevention</td>
<td>70 16 12 -- 150 --</td>
<td>0</td>
</tr>
<tr>
<td>Missoula Independent</td>
<td>AIDS Drug Use Substance Abuse Injection Drug Use HIV HIV Prevention</td>
<td>2745 2408 269 95 160 69</td>
<td>6</td>
</tr>
</tbody>
</table>
Summary of Results from All Data Sources

The following table summarizes all data results in this chapter.

Table 5. Summary of Themes as Related to Research Questions.

<table>
<thead>
<tr>
<th>Research Question</th>
<th>Theme</th>
<th>Sub-theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factors that Influence High Risk</td>
<td>Substance Use/Abuse</td>
<td>Type of Drug Used and Social Perception</td>
</tr>
<tr>
<td>Behaviors</td>
<td></td>
<td>• Identification of being an IDU was viewed as a</td>
</tr>
<tr>
<td></td>
<td></td>
<td>justification of using/sharing needles, and just</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“their way of life.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Identification with type of drug used formed the</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IDU’s perception of their social status.</td>
</tr>
<tr>
<td>Readiness to Change Behavior</td>
<td></td>
<td>Treatment was important, but not effective until</td>
</tr>
<tr>
<td></td>
<td></td>
<td>the person is ready to quite using drugs.</td>
</tr>
<tr>
<td>Availability of Treatment</td>
<td></td>
<td>If treatment isn’t available when a person is ready</td>
</tr>
<tr>
<td></td>
<td></td>
<td>to go, they will not follow through.</td>
</tr>
<tr>
<td>Family Dynamics</td>
<td></td>
<td>Being a member of an alcoholic and/or drug using</td>
</tr>
<tr>
<td></td>
<td></td>
<td>family was common and viewed as a factor in substance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>use/abuse.</td>
</tr>
<tr>
<td>Identification with Being a Parent</td>
<td></td>
<td>Becoming a parent or being a good parent was a</td>
</tr>
<tr>
<td></td>
<td></td>
<td>reason to be or get clean and sober.</td>
</tr>
<tr>
<td>Having a Purpose in Life</td>
<td></td>
<td>Not using drugs was part of having a meaningful,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>productive life.</td>
</tr>
<tr>
<td>Sharing Needles/Works and Engaging in Unprotected Sex</td>
<td>Benefit of Getting High over Being Infected with HIV</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>-----------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>• Getting high takes precedence over staying HIV infection free.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Context of Social Networks**

- Kinship and acquaintance social networks were identified, and sharing needles/works and also engaging in unprotected sex was common among the kinship network.
- Members of the kinship network reported sharing needles/works outside of their network and within the acquaintance network.

**Perception of Safety of Cleaning Needles/works, and HIV Risk Associated with Unprotected Sex**

- Knowledge level was low regarding cleaning needles/works was not effective against killing Hepatitis C.
- Being under the influence of substances affected harm reduction techniques and decisions to engage in protected sex.

<table>
<thead>
<tr>
<th>HIV Prevention Service Needs</th>
<th>Barriers to Accessing Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Access to Clean Needles</td>
<td>• Stigma and Discrimination</td>
</tr>
<tr>
<td>• Substance Abuse Treatment</td>
<td>• Confidentiality</td>
</tr>
<tr>
<td>• Harm Reduction Services until Ready for Treatment</td>
<td>• Fear of Being Arrested and Incarcerated for Drug Possession</td>
</tr>
<tr>
<td>• Free HIV and Hepatitis C testing</td>
<td>• Cost of Substance Abuse Treatment</td>
</tr>
<tr>
<td>• Services for clothing, food and shelter</td>
<td>• Availability of Treatment and Services</td>
</tr>
<tr>
<td>• Social Outlets and Alternatives to Substance Use</td>
<td>• Prevention Messages</td>
</tr>
<tr>
<td>• Prevention Messages</td>
<td>• Lack of Funding for Treatment and Services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Barriers to Implementing Services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lack of Agency Networking</td>
<td></td>
</tr>
<tr>
<td>• Policies and Laws</td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER V

DISCUSSION

This chapter provides a synthesis of all data, and is organized in relation to answering the research questions. It begins with a brief discussion of demographic and behavioral data, and continues with an examination of factors that influence HIV risk behaviors. Treatment and service needs related to those factors are discussed along with barriers to implementing and accessing services. Strategies and recommendations for closing gaps between needs and services are offered and conclusions are addressed.

It is important to note that most of the themes identified in this study related to more than one research question. In other words, a theme might be described as a factor that influences risk behavior, it might also be described as an HIV prevention need, and it also might represent a barrier to accessing or implementing services. Therefore, variations of several themes are discussed in more than one section of this chapter. For quick reference, a summary of all themes is located at the end of chapter four.

Demographic Variables of IDU Participants

IDU participants in this study represented a wide range of demographic variables. While people of both genders, a variety of sexual orientations, ethnicities, educational levels, incomes and employment statuses participated in the interviews, none of these variables appeared to be a distinct indicator of increased risk of infection with HIV. There were, however, several other factors that were indicative, not only of a higher risk of infection for IDUs, but also represented a greater risk of transmission of the virus to a person who does not use injection drugs. These factors are discussed below.
Factors that Contribute to High Risk Behaviors

In phase four of the PRECEDE Model, the educational and organizational diagnosis identifies and classifies factors that may influence a behavior. Predisposing factors include a person’s knowledge, attitudes, values, beliefs and perceptions. Enabling factors are comprised of resources, skills and societal forces or systems that facilitate or create barriers to behavior change. Reinforcing factors comprise types of rewards that one may receive that either encourage or discourage certain behaviors (McKenzie & Smeltzer, 2005). The following is a discussion of factors that were identified in this study, and how they influence high risk behaviors for HIV infection.

Family Dynamics, Identification with Being a Parent and Having a Purpose in Life

Family dynamics, identification with being a parent, and having a purpose in life were all reinforcing factors that either encouraged or discouraged drug use. The family dynamic that all the IDU participants in this study had in common was that of growing up in an alcoholic family. Often drugs and alcohol were introduced by a parent or sibling and became a way of life. Using was seen as inevitable. IDU participants’ negative view of their childhood acted as a catalyst for continued substance abuse. On the other hand, while family dynamics were often seen as reinforcing drug use, for those few who had stopped using, family support by a recovering family member was influential and reinforced their decision to discontinue using.

The second reinforcing factor was identification with being a good parent. Several IDU participants stated that the desire to become a parent, or to be a better parent, was a reason to be clean and sober. The desire to be a good parent related to the third reinforcing factor of having a purpose in life. Although many IDUs defended their
lifestyle of drugs and alcohol, their definition of living a meaningful life included not using drugs. The influence of family, the significance of children, and the need to have a purpose in life are important factors to consider when developing HIV prevention education materials and disseminating information.

**Social Networks: Their Context and the Type of Drug Used within the Network**

A major theme relating to social networks was identified. Three enabling factors that influenced HIV risk behavior was the type of social network to which the IDU belonged, the context of that social network, and the type of drug used within the network. Two social networks were identified, the acquaintance network and the kinship network. In the acquaintance network, members are affiliated primarily through their drug use. A member may be a person IDUs get their drug from, or someone they are acquainted with for only the time that they shoot together. The other social network identified is the kinship network. Within this network, members consider their fellow members friends, family - “blood”. There is a sense of trust and loyalty among members.

There are several issues to consider in relationship to HIV infection within social networks. First, some participants were members of both an acquaintance network and kinship network, and reported sharing within both networks. Members of the kinship network were not aware that some members were sharing outside of their network. Also, members of the same kinship network were not disclosing all personal information. In one instance, a participant was Hepatitis C +, but had not disclosed this information to another member who happened to be not only a needle sharing partner but also a sexual partner. Furthermore, members of the same kinship network were engaging in unprotected sex together. In one case, two women who had the same male sex partner
were not aware that their male sex partner was engaging in sex with the other woman within the network. These attitudes, beliefs and behaviors increase all members’ risk for HIV infection. The diagram below maps possible routes of HIV infection in this social network.

Possible Routes of HIV Infection within Social Networks.

The influence of social networks on behaviors that put IDUs at risk for HIV infection is supported in the literature. Rhodes et. al identified social networks as a critical factor in HIV risk (2005). Drug injecting consequences are shaped by shared social and group norms, as well as by the structure of social and IDU networks. In addition, social and IDU networks play a role in shaping risk perceptions and behaviors among IDUs (Latkin et. al, 2003).
Not only does the type of social network influence risk behavior, but the context in which the social network exists also influences that behavior. Individuals who engage in needle sharing and unprotected sex often are lulled into a sense of security in rural states like Montana that exhibit a low prevalence of HIV. Results from this study and from the literature reveal the falseness of that sense of security. Population movement and mixing contributes to the spread of HIV infection (Rhodes et. al, 2005), and unfortunately, most of the IDUs interviewed reported living or traveling outside of Montana and sharing needles. All of them reported engaging in unprotected sex when living/traveling outside the state. The geographical locations where participants lived or traveled were places where HIV is prevalent, and thus, these individuals undoubtedly increased their risk of being infected outside of Montana and then bringing the infection home.

The social network also influences the type of drug that IDUs use, which in turn influences the risk of HIV infection. Specifically, IDUs whose drug of choice was amphetamines were at higher risk. There are several reasons for this increased risk: a) amphetamine users typically inject more times than an IDU who chooses opiates, due to the fact that amphetamine needs to be administered more often for a steady high; b) methamphetamine can increase libido and lower inhibitions, thus those under the influence of methamphetamine may engage in behaviors that increases HIV infection risk such as unprotected sex; c) methamphetamine users who are MSM reported engaging in a behavior called “booty bumping”, where methamphetamine is inserted into the rectum; this is a high risk behavior due to the possibility of the substance causing irritation to
sensitive tissues and causing more bleeding, hence putting the individual at higher risk for HIV infection. (CDC, 2006).

It is evident that methamphetamine is prevalent in Montana, and is a major issue in HIV infection risk. In 2004, Montana ranked ninth highest in the U.S. for substance abuse treatment admissions for primary methamphetamine abuse (SAMHSA, 2006). Over the past six years, methamphetamine treatment admissions to Montana state-approved programs increased 70 percent, and nearly half of those admitted named injection as the primary route of use; higher than the national average of 25 percent for rural areas (DPHHS, 2006). Also, in the criminal justice system in Montana, approximately half of female inmates and one-third of male inmates identify methamphetamine as one of their drugs of choice (DOC, 2006). Furthermore, more than half of the IDU participants in this study reported amphetamines as their drug of choice, and that they were engaging in high risk behaviors with other social network members. These data depict a major concern for HIV infection risk in relation to social networks and methamphetamine use in Montana.

HIV Prevention Needs

Many HIV prevention needs for IDUs were identified in this study. The needs are discussed below in relation to identified factors that influence high risk behavior.

These needs include: 1) substance abuse treatment; 2) harm reduction services including needle exchange; and 3) prevention information and education about risk reduction.
Substance Abuse Treatment

Substance abuse treatment in general was identified as a need for IDUs. The unavailability substance abuse treatment was particularly salient and is an enabling factor that influences high risk behaviors. When IDUs decide to discontinue drug use, immediate availability of treatment services is a major determinant of whether or not they follow through with the behavior change. Unfortunately, as all data sources reveal, substance abuse treatment is not easily available or accessible to individuals seeking assistance. As discovered in the documentation review, there are 69 organizations sanctioned by the state to treat people with substance abuse issues, but only one treatment center in Montana that is funded by the state and thus affordable for the majority of IDUs. This treatment center is understaffed and thus underutilized. It is worth noting that The Office of Applied Studies, Substance Abuse & Mental Health Services Administration (SAMHSA) reported that in 2003-2004, Montana ranked in the top 5th percentile for Needing But Not Receiving Treatment for Alcohol Use and Illicit Drug Use in Past Year among Persons Aged 12 or Older. Funding of substance abuse treatment is a major issue in accessing and implementing treatment.

Availability of Harm Reduction Services

For the most part, treatment services are only effective when individuals are ready to make a change. For individuals who are not ready to give up their drug use, the availability of harm reduction services is an enabling factor that influences high risk behaviors. Harm reduction services umbrella many needs identified in this study, and include access to clean needles, educational outreach services, free HIV and Hepatitis C testing, and access to other basic services. In addition, for IDUs within the correctional
system (drug court), harm reduction treatment services are needed to provide IDUs with education and support to decrease or stop using drugs while waiting for a space in treatment. Harm reduction services are addressed in detail below.

**Access to Clean Needles:** By far, the most important harm reduction service identified by IDU participants is needle exchange. The need to get high, a reinforcing factor that obviously influences high risk behavior, often supercedes the need to be HIV and Hepatitis C free. If a clean syringe is not available when the urge to get high is there, the IDU will opt to share dirty equipment. The availability of clean needles is paramount in preventing HIV and Hepatitis C infection. As identified by IDU participants, Needle Exchange Programs not only provided them with access to clean syringes and works but also HIV educational information, HIV counseling and testing, harm reduction information for safer injection, substance abuse treatment information, and Hepatitis C education and testing. The fact that all participants who shared needles stressed that if they didn’t have access to clean syringes, they would opt to share needles/works to get high is a direct indication that access to clean needles should be high priority for IDUs. Unfortunately, many barriers were identified for accessing and implementing this intervention.

**Educational Outreach Services:** Knowledge about harm reduction, such as cleaning needles/works and engaging in protected sex, was identified as a predisposing factor that influences high risk behavior. Educational outreach is the best known strategy for disseminating harm reduction services. Through outreach workers, IDUs can gain access to HIV and Hepatitis C prevention information education about cleaning needles/works and practicing safer sex, free HIV and Hepatitis testing and substance
abuse treatment options. In fact, the educational role of outreach workers appears to be one of the only ways that IDUs receive information about harm reduction. Contact with outreach workers influence IDUs to reduce their high risk behaviors, and is important for HIV and Hepatitis C prevention (CDC, 2006).

*Free HIV and Hepatitis C Testing:* Knowing one’s status can influence risk behaviors and is part of harm reduction. Through the act of getting tested, IDUs not only learn their status, they also have the opportunity to become more educated and aware of how their behaviors directly affect their risk for HIV and Hepatitis C infection. Free HIV testing is currently available in Montana, however as identified in this study, free Hepatitis C testing is not available and yet is prioritized as a high need by IDUs. There are approximately four million cases of Hepatitis C in the U.S., compared to more than one million cases of HIV. In Missoula County, more than 60 Hepatitis C tests have been positive so far this year, and more than 100 were positive in 2005 (Goldberg, unpublished data, 2006). The reported risk behavior in nearly all cases was sharing needles. Because Hepatitis C is more prevalent, it is the disease that IDUs identify with more so than HIV. IDUs can be engaged in HIV prevention through Hepatitis C education and services.

*Service Organizations such as Salvation Army, Food Bank, Housing and Job Skills Training:* In addition to education and free HIV and Hepatitis C testing, harm reduction also includes access to social services such as food assistance, job skill training and housing assistance. IDUs identified access to such services as an important need. When basic life needs are being met, IDUs may be better able to deal with HIV infection issues (Wiebel et al., 1996). In addition, participants emphasized the advantages of “one-stop shopping” venues where needs for clothing, food and shelter could be accessed.
simultaneously. Some participants who had traveled outside Montana described drug-free, safe and nondiscriminatory venues where they could go to socialize, receive information about HIV and Hepatitis C, access social services and feel that they were part of something. No such venue was identified by IDUs in Montana.

**Reaching IDUs with Prevention Messages**

Disseminating HIV prevention information was identified as an important need for IDUs. Clearly, there is a lack of attention given to the risk of HIV infection from injection drug use in the media; particularly from Montana newspaper sources. Study results revealed only minimal documentation of the relationship of injection drug use and HIV infection from local media sources, even though more than 20% of Montana’s HIV + population have been infected through injection drug use (DPHHS 2006). On the other hand, the media has given a great deal of attention to the primary prevention of drug abuse. The appointment of Michael Gulledge, publisher of the Billings Gazette, as chairman of the Montana Meth Project in November of 2006 may explain the large number of published articles about drug use in the Billings media newsprint. While this media attention is positive for the primary prevention of substance abuse it does not address those who currently use drugs and the risks associated with injection drug use and HIV infection.

**Barriers to Accessing and Implementing Treatment and Prevention Services**

Many HIV prevention needs were identified in this study along with factors that influence behaviors that put IDUs at risk for HIV and Hepatitis C infection. While IDU interviewees primarily identified treatment and service needs, key informant interviewees offered insight into barriers to accessing and implementing services designed to meet
these needs. Funding for services, policy and law issues, stigma and discrimination, and agency networking were identified as barriers, and are discussed at length below.

**Funding**

The lack of funding is a major barrier in many human service areas. It is not surprising that lack of funding was identified as the largest barrier to accessing and implementing services for IDUs. While “readiness for change” is a major factor in the success of substance abuse treatment, the unfortunate fact is that when IDUs residing in Montana believe they are ready to give up their substance use, it is difficult not only to access services, but also to pay for the services that are available. Add to that the lack of funding for substance abuse treatment in jails and prisons, the limited funding for HIV prevention and treatment, and the near zero funding for Hepatitis C services in Montana, and the issue almost seems insurmountable. This issue was the umbrella to many other themes throughout the study. An “if only we had funding” tone was central to all key informant interviews.

**Services Prohibited or Discouraged by State and Federal Laws**

Although access to clean syringes was identified as a need for IDUs, Key Informants identified barriers to implementing these services, and the documentation review supported these findings.

Literature supports the fact that access to clean syringes and works is an effective intervention for HIV prevention. Jarlais (2000) reported that increasing the availability of sterile injection equipment through pharmacy sales or syringe exchange is one of the most common and best-studied structural interventions for HIV prevention. CDC supports access to clean syringes as a proven method to reduce or prevent HIV infection.
At least six government studies of HIV infection among IDU in the U.S. concluded that needle exchange programs significantly reduce new HIV infection without increasing drug use or the initiation of injection drugs (UNAIDS, 2006). Despite the results, political opposition still prohibits needle exchange. Organizations that provide access to clean syringes cannot be funded by federal dollars.

Unfortunately, needle exchange is not available in Montana. Policies and social norms are barriers to these services being available. Our state law is written to criminalize those who possess syringes. Fear of being arrested was identified by participants in the study as a barrier to accessing harm reduction services. This is an issue that cannot be overlooked when discussing needle exchange. If this law was changed, IDUs may be willing to access services more readily.

As detailed in chapter four, The Academy for Educational Development (2000) document addresses four domains of law that could influence syringe behavior of IDUs. In summary, in Montana, it is unlawful for a person to use or to possess drug paraphernalia, and a person who violates this law can be incarcerated and fined. The drug paraphernalia law makes it a crime to use a syringe for drug injection. In addition, the drug possession law does not specify the minimum amount of drug required to constitute possession. In some cases the possession of residue of drug in the barrel of a used syringe may be viewed as a crime. Exposing an IDU to arrest because of the paraphernalia law and the drug possession law could have an impact on IDUs willingness to access and properly dispose of syringes.
Stigma and Discrimination

Because stigma and discrimination have been major issues in addressing HIV/AIDS from the onset of the pandemic, it is not surprising that stigma and discrimination were identified as the greatest barriers to accessing services. While HIV/AIDS carries a stigma of its own, substance use/abuse, and being an IDU also ranks high in carrying stigma and discrimination. IDU participants identified discrimination as a barrier to accessing services, including getting tested for HIV and Hepatitis C, and to accessing medical treatment and substance abuse treatment services. Participants who had accessed clean syringe programs in other states maintained that the stigma was heightened here in Montana. Also, IDU participants who identified methamphetamine as their primary drug of choice believed that the current Meth Project Campaign added to the stigma and discrimination that they experienced.

Agency Networking

Agency networking is vital in order to maximize limited resources and capitalize on HIV prevention efforts. Lack of agency networking was viewed as a barrier to implementing HIV prevention services for IDUs. There is a lack of coordinated efforts between HIV prevention, mental health, corrections and substance abuse treatment services. For example, agency collaboration between HIV/AIDS service organizations and substance abuse treatment programs is needed to provide HIV prevention education to those who are in treatment. Also, agency networks that provide other social services such as food, clothing and shelter should collaborate with HIV/AIDS service organizations to educate and inform clients of services available for HIV and Hepatitis C prevention and treatment. At first glance, this theme may seem insignificant compared to
other themes identified in this study. However, to overlook the obvious could detract from possible positive outcomes in HIV prevention in Montana. For example, research shows that coalition building and community consultation are critical steps for the acceptance and sustainability of syringe exchange programs. Communities that successfully implemented syringe exchange programs were those with activists willing to push the agenda, public officials willing to exercise leadership, researchers able to present authoritative findings, and proponents who effectively mobilized resources and worked to build community coalitions, using persistent but non-adversarial advocacy (Downing et. al, 2005).

**Recommendations for Closing Gaps between Needs and Services**

Closing gaps between the HIV prevention needs of IDUs and current services available can improve HIV prevention efforts in Montana. Recommendations are as follows:

*Ensure collaboration between service agencies and HIV prevention services.*

Agency networking and collaboration is vital to HIV prevention education as well as to providing needed services for IDUs. Researchers recommend developing an HIV Prevention Coalition where service agencies provide a continuum of assistance and services to IDUs. Not only could this coalition address specific HIV prevention needs of IDUs in Montana but also provide networking among agencies to increase substance abuse treatment services, expand Hepatitis C education and services, address policy issues and work to eliminate stigma and discrimination of IDUs and HIV/AIDS. An example of such a coalition is Missoula’s At Risk Housing Coalition (ARHC). This coalition model has been successful in providing housing assistance on a continuum and
Research strategic options and formulate a plan for gaining access to clean syringes.

HIV prevention specialists in Montana have recognized the need for access to clean syringes for many years (MTAP, unpublished data, 2003; Keup, 1999). CDC has myriad information regarding the effectiveness of clean needle access on preventing HIV infection (CDC, 2006). A strategic plan to implement a working program for access to clean syringes in Montana is greatly needed at this time. To decrease the barriers to accessing services for clean syringes, The Academy for Educational Development’s recommend the following (CDC, 2006):

- Amend the drug paraphernalia law to exclude syringes;
- Amend the controlled drug act to require a minimum specified quantity to ground a possession conviction;
- Amend the controlled drug act to exclude trace amounts found in syringes;
- Develop standard operating procedures within law enforcement that avoid stops, arrests or prosecutions based on drug residues in syringes; and
- Educate IDUs and law enforcement to appreciate the importance of appropriate syringe services and the legality of possessing syringes in the course of disposal activities.

Considering these recommendations would be an initial step to decrease the barrier to accessing services for clean syringes and works in Montana. In addition, examining the policies of states that have successfully implemented needle exchange programs may be a starting point for Montana. In December 2006 New Jersey adopted a needle exchange program policy. A copy of the legislative document (Appendix G) could serve as a
model for Montanans to research and review.

Research strategic options and formulate a plan for securing additional funding for substance abuse treatment, Hepatitis C services and coordinated HIV prevention efforts.

Securing funds for any service is a huge undertaking. It is evident from this assessment that more funding is needed to provide services to those who need it in Montana. Collaborating with substance abuse treatment agencies to secure funding for both substance abuse treatment and HIV/Hepatitis C services together would increase available funds in Montana for these services.

One specific example of possible funding is the SAMHSA Targeted Capacity Expansion for Substance Abuse Treatment and HIV/AIDS Services (TCE/HIV). The purpose of the TCE/HIV grant program is to enhance and expand substance abuse treatment and/or outreach and pretreatment services in conjunction with HIV/AIDS services. This grant funding opportunity is open to domestic private/public nonprofit entities, public or private universities and colleges, and community and faith-based organizations. The targeted publication date for the request for proposals is Fall 2007. Opportunities such as this may provide not only additional funding for the state but also an occasion for agency networking. Information regarding this funding is available at: http://www.samhsa.gov/Grants/2007/fy2007opps.aspx.

Ensure continued HIV prevention information dissemination through media campaigns and other educational interventions.

Participants talked candidly and at length about the importance of disseminating HIV prevention information that is accurate, detailed and non-judgmental. Several
participants suggested creating documentaries about people who are dealing with substance abuse problems and living with HIV and Hepatitis C. IDU participants in this study perceived the current “Not Even Once” methamphetamine campaign as creating even more stigma and discrimination for IDUs, and creating greater barriers to accessing treatment and services.

Media campaigns have the capability of addressing predisposing, reinforcing and enabling factors while decreasing the barriers to accessing services for IDUs. It is important that Montana continue its current HIV prevention media campaign. This campaign, although limited in scope, targets IDUs with accurate prevention messages in a non-judgmental and humane way. Expanding this campaign with an increased focus on the IDU population could serve a multipurpose in eliminating stigma and discrimination, educating target populations and the general public on HIV, and ultimately helping to reduce HIV and Hepatitis C infection in Montana.

**Ensure continued harm reduction services.**

Continuing to provide current harm reduction strategies such as educational outreach, free HIV counseling and testing, and access and referrals to social service agencies throughout Montana is an important component in HIV prevention. Educational outreach should include strategies that focus on the predisposing, reinforcing and enabling factors identified in this study such as knowledge, self-esteem building and readiness to change behavior. Social outlets and alternatives to substance use that include HIV and Hepatitis C education and information should be considered for harm reduction strategies. Not only do these services provide access to the target population, they also
provide IDUs with the opportunity to engage socially and to take full advantage of HIV prevention efforts here in Montana.

CONCLUSIONS

Everyone who reads this report and cares about the welfare of IDUs in Montana will draw their own conclusions about where the greatest needs lie. The preponderance of evidence from this research project, however, points to the fact that access to clean needles is a priority need for IDUs in Montana. Research has demonstrated that access to clean needles is an effective intervention for both HIV and Hepatitis C prevention (CDC, 2006), and yet this service is not available in Montana. It is imperative that this service be looked into as an HIV prevention measure. A related issue that cannot be ignored is the fact that approximately 60 percent of IDUs acquire Hepatitis C within their first year of use (CDC, 2006). Unfortunately, few resources for Hepatitis C prevention are available here. Thus, it seems logical and efficacious that HIV prevention interventions, like access to clean needles, also address the Hepatitis C epidemic in Montana.

In addition to access to clean needles and Hepatitis C prevention, other recommendations are important and need to be considered. First, efforts to eliminate stigma and discrimination faced by people who use injection drugs should be a part of all prevention strategies. Second, individuals who are ready to seek help for substance abuse problems should have access to treatment services. And finally, we should continue to provide free HIV testing and HIV prevention education in addition to considering other interventions such as alternative social outlets that can further the efforts of HIV prevention.
In view of all of the recommendations that emerged from this study, organizing a coalition for HIV prevention in Montana seems to umbrella all facets. Collaborating with other service agencies to provide valuable services and joining forces with substance abuse treatment programs to secure additional funding can improve HIV prevention efforts in Montana. Under the umbrella of a coalition, policy issues can be researched and community involvement can be obtained to maximize efforts.

Some of these strategies may seem out of reach to Montanans. However a comprehensive prevention plan is crucial to optimize HIV prevention among IDUs. With diligent work and collaboration, these interventions are possible.
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Publications: London.
Appendix A

University of Montana Institutional Review Board Approval
Date:    February 7, 2006
To:    K. Ann Sondag, HHP
From: Sheila Hoffland, IRB Chair
RE: IRB action on your proposal titled: “An Assessment of the HIV Prevention Needs of People Living in Montana who Use Injection Drugs”

The revisions made to consent form, and the additional information provided, satisfactorily address the conditions that the IRB placed on approval of the above referenced proposal. Approval for this study is granted as of the date of this memo and continues for one year from the date of the Conditional Approval (12/22/05). Please use the signed and dated forms as the “masters” for making the copies.

If the study runs more than one year, a continuation must be requested. Also, you are required to notify the IRB if there are any significant changes in the study or if unanticipated or adverse events occur during the study.

Sheila Hoffland
IRB Chair

Attachments
PARTICIPANT INTERVIEW

PARTICIPANT INFORMATION AND CONSENT FORM

TITLE
- Determining the Needs of Injection Drug Users in Montana

PROJECT DIRECTOR
- Dr. Annie Sondag: University of Montana
  McGill Hall, Missoula, MT 59812
  (406) 243-5215

The language in this consent form may be unfamiliar to you. If you read any words that are not clear to you, please ask the person who gave this form to you to explain.

PURPOSE
The purpose of this project is to collect information about the HIV prevention needs of people living in Montana who use injection drugs (IDU). Information gathered will be made available to the Montana Department of Public Health and Human Services (DPHHS). Information will be used to identify the needs IDUs, and determine the gaps between needs and the services and assistance actually being offered. By participating in this interview you will help provide valuable information that will be used to develop better services and care for IDUs in Montana.

PROCEDURES
Interview participation for this project is voluntary. You are asked to read this consent form. If you agree to participate you will be asked a number of questions regarding your perceptions of the needs IDUs living in Montana. The interview may take approximately one hour. The session will be audio recorded and transcribed for accuracy of responses. You will receive $30.00 cash for participating in this interview.

RISKS/DISCOMFORTS
Having your identity known could pose a risk to you. Interviewers will make every attempt to keep your identity confidential and minimize this risk. Procedures for minimizing risk are outlined below under CONFIDENTIALITY. You may find some of the questions personal, you may feel you do not know the answer, or some of the questions may make you feel uncomfortable. You are welcome to refrain from answering any question for any reason or to discontinue your participation at any time.

BENEFITS
Your help with this study will provide valuable information to DPHHS. By participating in this study, your answers will help staff offer services and develop programs to meet the HIV prevention needs of IDUs in Montana.
CONFIDENTIALITY
All information collected during this interview will be confidential. Researchers and interviewers will avoid recording any identifying information. They will not use your name or any other identifying information in reports or any other materials related to this study. Specifically:
- The identities of all interview participants will remain confidential and will not be associated with research findings in any way.
- Audio tapes will be destroyed as soon as they are transcribed.
- No information related to participants’ identities will appear in the transcription of the audiotapes.
- All the data collected during this study will be reported and examined as group data.

COMPENSATION FOR INJURY
The project team believes the risk of taking part in this study is minimal. However, the following liability statement is required in all University of Montana consent forms:

In the event that you are injured as a result of this research you should individually seek appropriate medical treatment. If the injury is caused by the negligence of the University or any of its employees, you may be entitled to reimbursement by the department of Administration under the authority of MCA, Title 2, Chapter 9. In the event of a claim of such injury, further information may be obtained from the University’s claims Representative or University Legal Counsel.

VOLUNTEER PARTICPATION/withdrawal
Your decision to take part in this research study is entirely voluntary. You are free NOT to answer any question and to discontinue participation at any time. You also may withdraw from this study for any reason. If you do withdraw from the study, you keep the incentive money you received for any participation prior to withdrawing.

QUESTIONS
If you have any questions about the research now or later, you may contact Dr. Annie Sondag at (406) 243-5215 or Annie’s Research Assistant, Nancy Cunningham at (406) 396-0782.

CONSENT
I have read the above description of this project. I have been informed of the risks and benefits involved, and all of my questions have been answered to my satisfaction. Furthermore, I have been assured that any future questions I may have will be answered by a member of the project team. I voluntarily agree to take part in this study. I am at least 18 years old. I understand this is my copy to keep of this consent form.

THANK YOU VERY MUCH FOR YOUR PARTICPATION
KEY INFORMANT INTERVIEW
PARTICIPATION INFORMATION AND CONSENT FORM

TITLE
- Determining the HIV Prevention Needs of Injection Drug Users in Montana

PROJECT DIRECTOR
- Dr. Annie Sondag: University of Montana
  McGill Hall, Missoula, MT 59812
  (406) 243-5215

The language in this consent form may be unfamiliar to you. If you read any words that are not clear to you, please ask the person who gave this form to you to explain.

PURPOSE
The purpose of this project is to collect information about the HIV prevention needs of people living in Montana who use injection drugs (IDU). Information gathered will be made available to the Montana Department of Public Health and Human Services (DPHHS). Information will be used to identify the needs IDUs, and determine the gaps between needs and the services and assistance actually being offered. By participating in this interview you will help provide valuable information that will be used to develop better services and care for IDUs in Montana.

PROCEDURES
Interview participation for this study is voluntary. You are asked to read this consent form. If you agree to participate you will be asked to answer a number of questions covering various topics concerning those people you facilitate and/or have contact with who are IDUs. The interview will take approximately one hour. The session will be audio recorded and transcribed for accuracy of responses.

RISKS/DISCOMFORTS
You may find some of the questions personal, you may feel you do not know the answer, or some of the questions may make you feel uncomfortable. You are welcome to refrain from answering any question for any reason.

BENEFITS
Your help with this study will provide valuable information to Montana DPHHS. By participating in this study you will assist in determining the needs of IDUs in Montana, your answers will help health professionals offer services and develop programs to meet the HIV prevention needs of IDUs in Montana.

(continued on back)
CONFIDENTIALITY
All information collected during your interview will be confidential. Interviewers will avoid identifying any of the participants. Interviewers will not use your name or any other identifying information in reports or any other materials related to this study. Specifically:
  o The identities of all interview participants will remain confidential and will not be associated with research findings in any way.
  o At the conclusion of the study, any and all data containing information about participants will be destroyed.
  o All the data collected during this study will be reported and examined as group data.

COMPENSATION FOR INJURY
The project team believes the risk of taking part in this study is minimal. However, the following liability statement is required in all University of Montana consent forms:

In the event that you are injured as a result of this research you should individually seek appropriate medical treatment. If the injury is caused by the negligence of the University or any of its employees, you may be entitled to reimbursement by the department of Administration under the authority of MCA, Title 2, Chapter 9. In the event of a claim of such injury, further information may be obtained from the University’s claims Representative or University Legal Counsel.

VOLUNTEER PARTICIPATION/WITHDRAWAL
Your decision to take part in this research study is entirely voluntary. You are free NOT to answer any question and to discontinue participation at any time. You also may withdraw from this study for any reason.

QUESTIONS
If you have any questions about the research now or later, you may contact Dr. Annie Sondag at (406) 243-5215 or Nancy Cunningham at (406) 396-0390.

If you have any questions about your rights as a research subject you may contact the Chair of the Institutional Review Board in the Research Office at The University of Montana – Phone (406) 243-6670.

CONSENT
I have read the above description of this project. I have been informed of the risks and benefits involved, and all of my questions have been answered to my satisfaction. Furthermore, I have been assured that any future questions I may have will be answered by a member of the project team. I voluntarily agree to take part in this study. I am at least 18 years old. I understand this is my copy to keep of this consent.

------------------------------------------  ------------------------------------------
Signature                                      Date

THANK YOU VERY MUCH FOR YOUR PARTICIPATION!
Appendix B
IDU Participant Interview Questions
IDU Participant Interview Schedule

Date/Time of Interview:
Place of Interview:
ID/Name:
Age:

Gender (sexual identity):

**Employment/Education**
What kind of work do you do?
How much do you make?
How much education do you have?

**Geographical Information**
Where do you currently live?
Where did you grow up?
Moves/geographical cures:
How did these moves influence your drug use?

**Drug Use**
Age of first drug use: ______________________
Number of years used: ______________________
Currently using? __________________________
Using at time of interview? __________________
Date of first injection: _____________________
Date of last injection: _____________________
Drug of choice: ___________________________
Modes of administration:
Other drugs used:
Treatments for drug use if any:
How do/did you pay for your drugs?
Have you ever been assaulted while high or because of drug use?
Are there children around when you use?
Why did you start using? Reason(s) for onset of drug use:
What factors do you believe have influenced your use?
What did you learn in your youth about drug use? (DARE, Just Say No, etc.)
In retrospect, what reasons/factors may have prevented your first use?

**HIV Information**
What do you know about HIV infection?
What/how have you been taught about HIV? (School, family, friends, etc.)
What behaviors have you engaged in that you believe have put you at risk for HIV infection?
Factors that contribute to engaging in behaviors that increase HIV infection risk:
Behaviors:
Service, Assistance and Treatment
What do you think are the greatest assistance and/or treatment needs of IDUs?
What types of assistance and/or treatment services that IDUs in Montana need but aren’t getting?
How satisfied do you think IDUs in Montana are with current assistance and/or treatment services?

Barriers
What barriers do you see IDUs face in regards to accessing assistance and/or services?
What barriers do you see IDUs face in regards to decreasing or discontinuing using drugs?

What are the best ways to reach IDUs in Montana who are not currently being served?

What other thoughts do you have regarding the needs of IDUs in Montana?
Appendix C

Key Informant Interview Questions
Key Informant Interview Questions

1. What are the greatest HIV prevention assistance and/or treatment needs of IDUs?

2. What types of HIV prevention assistance and/or services that IDUs in Montana need but aren’t getting?

3. How satisfied do you think IDUs in Montana are with assistance and/or treatment services?

4. What barriers do you see IDUs face in regards to accessing assistance and/or services?
   - Structural barriers?
   - Organizational barriers?
   - Cultural barriers?
   - Individual barriers, such as knowledge, physical or mental well-being, community, etc.?

5. What barriers do you see IDUs face in regards to decreasing or discontinuing using drugs?
   - Structural barriers?
   - Organizational barriers?
   - Cultural barriers?
   - Individual barriers, such as knowledge, physical or mental well-being, community, etc.?

6. What are the best ways to reach IDUs in Montana who are not currently being served?

7. What other thoughts do you have regarding the needs of IDUs in Montana?
Appendix D
Contact Summary Sheet
CONTACT SUMMARY SHEET

Date ___________     Interview Length _______
Interview No. ______     Interview Location ___________

1. Physical description/impressions.

2. Main themes and issues.

3. Research question most directly addressed.

4. New working hypothesis or speculations.

5. Problems or questions.

6. Direction of information needed for next interview.
Appendix E

Regional Map of Montana
The substate regions defined here were provided by the Chemical Dependency Bureau of the Montana Department of Health and Human Services and are defined in terms of the State's 57 counties.

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<td>Roosevelt</td>
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<td></td>
<td>Silver Bow</td>
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<tr>
<td>Rosebud</td>
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<tr>
<td>Sheridan</td>
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<tr>
<td>Treasure</td>
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<tr>
<td>Valley</td>
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<tr>
<td>Wibaux</td>
<td></td>
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</tbody>
</table>

MONTANA – Substate Regions (defined in terms of counties)
Appendix F

State Approved Chemical Dependency Treatment Programs
## State Approved Chemical Dependency Program Listing By City

<table>
<thead>
<tr>
<th>Area Code</th>
<th>Program Name and Details</th>
<th>Manager/Contact Person</th>
<th>Address</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td>258</td>
<td>Western MT Addictions Services Alcoholism Services of Anaconda-Deer Lodge</td>
<td>Don Simpson Office Manager</td>
<td>118 E 7th Ste 2E Anaconda MT 59711-0758</td>
<td>Deer Lodge</td>
</tr>
<tr>
<td></td>
<td>Services: Outpatient I &amp; Outpatient II, Act, MIP</td>
<td>Phone 1: (406) 563-6601, Phone 2: (406) 563-5248, Fax: (406) 563-7719</td>
<td></td>
<td></td>
</tr>
<tr>
<td>273</td>
<td>EMCMHC - Substance Abuse/Dependency Svcs Baker Satellite Office Fallon County Courthouse</td>
<td>John Rex</td>
<td>Baker MT 59313</td>
<td>Fallon</td>
</tr>
<tr>
<td></td>
<td>Services: Outpatient &amp; ACT</td>
<td>Phone 1: (406) 232-1687 (Miles City), Phone 2: Fax:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>206</td>
<td>South Central Regional Mental Health Center (SCMRMHC) Journey Recovery Program</td>
<td>Colleen O’Connor</td>
<td>P.O. Box 236 Big Timber MT 59011</td>
<td>Sweet Grass</td>
</tr>
<tr>
<td></td>
<td>Services: Outpatient &amp; ACT</td>
<td>Phone 1: (406) 932-5145, Phone 2: Fax: (406) 932-5924</td>
<td></td>
<td></td>
</tr>
<tr>
<td>202</td>
<td>Rimrock Foundation</td>
<td>Mona Sumner COO (Chief Operations Officer)</td>
<td>1231 North 29th Street P.O. Box 30374 Billings MT 59101</td>
<td>Yellowstone</td>
</tr>
<tr>
<td></td>
<td>Services: Detox (12 bed), Inpatient free-standing (45 bed), Outpatient, IOP, Day Txt &amp; ACT</td>
<td>Phone 1: (406) 248-3175, Phone 2: 1-800-227-3953, Fax: (406) 248-3821</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Office Hours:</td>
<td>Email: <a href="mailto:monasumner@aol.com">monasumner@aol.com</a> Email 2: Website: <a href="http://www.rimrock.org">www.rimrock.org</a></td>
<td>County: Yellowstone</td>
<td></td>
</tr>
</tbody>
</table>

109
| 202 | New Choices  
Rimrock Foundation  
1220 Poly  
Billings MT 59102 | Coralee Goni,  
Adol Services Coor |
|------|---------------------------------------------------------------|
|      | **Phone:**  
1: (406) 248-3175  
2: 1-800-227-3953  
Fax: (406) 248-3821  
Crisis Phone: | Email: Email 2:  
Website:  
www.rimrock.org |
| **Services:** | Adolescent Program |
| **Office Hours:** | M-F, 8-5 |
| **County:** | Yellowstone |

| 206 | South Central Regional Mental Health Center  
(SCMRMHC) Journey Recovery Program  
201 N 25th Street  
Billings MT 59101 | Dot Reichert  
Coordinator |
|------|----------------------------------------------------------------|
|      | **Phone:**  
1: (406) 254-1314  
Fax: (406) 254-1650  
Crisis Phone: | Email: dor@vcn.com  
Email 2: Website: |
| **Services:** | Outpatient, IOP & ACT |
| **Office Hours:** | Monday - Friday |
| **County:** | Yellowstone |

| 277 | Indian Health Board of Billings  
1127 Alderson Ave  
Billings MT 59102 | Marjorie Bear Don’t Walk Exe Director |
|------|--------------------------------------------------------------------------------|
|      | **Phone:**  
1: (406) 245-7318  
2: (406) 259-3920  
Fax: (406) 248-5912  
Crisis Phone: | Email: Email 2: Website: |
| **Services:** | Outpatient, IOP, Continuing Care |
| **Office Hours:** | |
| **County:** | Yellowstone |

| 222 | Boyd Andrew Community Services  
Boulder Satellite Office  
Human Services Building  
P.O. Box H  
Boulder MT 59632 | Ron Napierala |
|------|----------------------------------------------------------------|
|      | **Phone:**  
1: (406) 225-4071  
2: (406) 443-2343  
Fax:  
Crisis Phone: | Email:  
rmapieralaboydandrew.com  
Email 2: Website:  
www.boydandrew.com |
<p>| <strong>Services:</strong> | Outpatient &amp; ACT |
| <strong>Office Hours:</strong> | Tue, 1:00 - 4:00 |
| <strong>County:</strong> | Jefferson |</p>
<table>
<thead>
<tr>
<th>201</th>
<th>Alcohol &amp; Drug Services of Gallatin Co.</th>
<th>Shelly Johnson Director</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>502 South 19th Avenue - Ste 302</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bozeman MT 59718-6827</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Phone 1: (406) 586-5493</td>
<td>Email: <a href="mailto:adsgc@imt.net">adsgc@imt.net</a></td>
</tr>
<tr>
<td></td>
<td>Phone 2:</td>
<td>Email 2: Website:</td>
</tr>
<tr>
<td></td>
<td>Fax: (406) 587-1238</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Crisis Phone:</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Services:</strong> Outpatient, IOP, ACT and Continuing Care - Recovery Home (transitional living)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Office Hours:</strong></td>
<td>County: Gallatin</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>273</th>
<th>EMCMHC - Substance Abuse/Dependency Svcs</th>
<th>Rafael Zarsosa</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Broadus Satellite Office</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Power River County Courthouse</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Broadus MT 59317</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Phone 1: (406) 232-1687 (Miles City)</td>
<td>Email: Email 2: Website:</td>
</tr>
<tr>
<td></td>
<td>Phone 2:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fax:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Crisis Phone:</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Services:</strong> Outpatient &amp; ACT</td>
<td>County: Powder River</td>
</tr>
<tr>
<td></td>
<td><strong>Office Hours:</strong> Thur</td>
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</tr>
</tbody>
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<table>
<thead>
<tr>
<th>212</th>
<th>Crystal Creek Lodge</th>
<th>Pat Calf Looking Director</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>P.O. Box 450</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Browning MT 59417</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Phone 1: (406) 338-6330</td>
<td>Email: <a href="mailto:calf_looking@hotmail.com">calf_looking@hotmail.com</a></td>
</tr>
<tr>
<td></td>
<td>Phone 2:</td>
<td>Email 2: Website:</td>
</tr>
<tr>
<td></td>
<td>Fax:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Crisis Phone:</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Services:</strong> Inpatient Free Standing &amp; ACT</td>
<td>County: Glacier</td>
</tr>
<tr>
<td></td>
<td><strong>Office Hours:</strong> Mon-Fri, 8:00 a.m. - 5:00 p.m.</td>
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<table>
<thead>
<tr>
<th>259</th>
<th>TLC Recovery, Inc</th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>CHR Building (Old Welfare)</td>
<td></td>
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<tr>
<td></td>
<td>Browning MT 59417</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Phone 1: (406) 873-2155 (Cut Bank)</td>
<td>Email: <a href="mailto:tlccarol@ttc-cmc.net">tlccarol@ttc-cmc.net</a></td>
</tr>
<tr>
<td></td>
<td>Phone 2:</td>
<td>Email 2: <a href="mailto:georgeanne59442@yahoo.com">georgeanne59442@yahoo.com</a></td>
</tr>
<tr>
<td></td>
<td>Fax:</td>
<td>Website:</td>
</tr>
<tr>
<td></td>
<td>Crisis Phone:</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Services:</strong> Outpatient &amp; ACT</td>
<td>County: Glacier</td>
</tr>
<tr>
<td></td>
<td><strong>Office Hours:</strong> Wednesday</td>
<td></td>
</tr>
<tr>
<td>Phone 1: (406) 496-5400</td>
<td>Phone 2: (406) 496-5437</td>
<td>Email: <a href="mailto:dpeshek@mt.gov">dpeshek@mt.gov</a></td>
</tr>
<tr>
<td>------------------------</td>
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</tr>
</tbody>
</table>

**Services:** Inpatient Free-Standing (76 beds), Detox, Co-Occuring Disorders Treatment

**County:** Silver Bow

<table>
<thead>
<tr>
<th>Phone 1: (406) 497-5070</th>
<th>Phone 2: Fax: (406) 497-5063</th>
</tr>
</thead>
</table>

**Email:** chemicaldependency@intch.com

**County:** Silver Bow

<table>
<thead>
<tr>
<th>Phone 1: (406) 759-5615</th>
<th>Phone 2: (406) 622-3211</th>
</tr>
</thead>
</table>

**Email:** tlccarol@ttc-cmc.net
georgeanne59442@yahoo.com

**County:** Liberty

<table>
<thead>
<tr>
<th>Phone 1: (406) 262-9299</th>
<th>Email: <a href="mailto:tlccarol@ttc-cmc.net">tlccarol@ttc-cmc.net</a></th>
</tr>
</thead>
</table>

**Email:** georgeanne59442@yahoo.com

**County:** Blaine
<table>
<thead>
<tr>
<th>Number</th>
<th>Organization</th>
<th>Address 1</th>
<th>Address 2</th>
<th>County</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>283</td>
<td>Golden Triangle - Teton County</td>
<td>19 3rd St NE</td>
<td>P.O. Box 1139</td>
<td>Teton</td>
<td>Do not have mail delivery at street address.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Choteau MT 59422</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Nancy Semenza, Counselor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone 1: (406) 466-5681</td>
<td>Phone 2: (406) 466-5683</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fax: (406) 466-5683</td>
<td>Crisis Phone:</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Services: Outpatient &amp; ACT</td>
<td>County: Teton</td>
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<td></td>
<td></td>
<td>Office Hours: Tue, Wed and Thursday a.m.</td>
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<tr>
<td>273</td>
<td>EMCMHC - Substance Abuse/Dependency</td>
<td>Colstrip Satellite Office</td>
<td>417 Willow P.O. Box 750</td>
<td>Rosebud</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Svcs</td>
<td>Colstrip MT 59323-0750</td>
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<tr>
<td></td>
<td></td>
<td>Karla McDonald</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone 1: (406) 748-2800</td>
<td>Phone 2:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fax:</td>
<td>Crisis Phone:</td>
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<tr>
<td></td>
<td></td>
<td>Services: Outpatient &amp; ACT</td>
<td>County: Rosebud</td>
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<tr>
<td></td>
<td></td>
<td>Office Hours: Thur &amp; Fri</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>209</td>
<td>Flathead Valley Chemical Dependency</td>
<td>North Valley Office</td>
<td>110 Nucleus Avenue Ste B</td>
<td>Flathead</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinic</td>
<td>P.O. Box 2418</td>
<td>Columbia Falls MT 59912</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patty Morrison</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone 1: (406) 892-7900</td>
<td>Phone 2:</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Fax:</td>
<td>Crisis Phone:</td>
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<tr>
<td></td>
<td></td>
<td>Services: Outpatient, IOP &amp; ACT</td>
<td>County: Flathead</td>
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<tr>
<td></td>
<td></td>
<td>Office Hours: Monday - Friday</td>
<td></td>
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</tr>
<tr>
<td>206</td>
<td>South Central Regional Mental Health</td>
<td>(SCRMH) Journey Recovery Program</td>
<td>410 East Pike P.O. Box 238</td>
<td>Stillwater</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Center</td>
<td></td>
<td>Columbus MT 59019-0238</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Colleen O'Connor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone 1: (406) 322-4514</td>
<td>Phone 2:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fax: (406) 322-4515</td>
<td>Crisis Phone:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Services: Outpatient</td>
<td>County: Stillwater</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Office Hours: Monday</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 259 | TLC Recovery, Inc  
809 Sunset Blvd  
Conrad MT 59425  
Phone 1: (406) 278-5245  
Phone 2:  
Fax:  
Crisis Phone:  
Email: tlccarol@ttc-cmc.net  
Email 2: georgeanne59442@yahoo.com  
Website:  |
|---|---|---|
| **Services:** Outpatient & ACT  
**Office Hours:** Thursday  
**County:** Pondera |

| 259 | TLC Recovery, Inc  
1210 E Main St - Courthouse Annex  
P.O. Box 696  
Cut Bank MT 59427-0608  
Phone 1: (406) 873-2155  
Phone 2:  
Fax: (406) 873-2155  
Crisis Phone:  
Email:  
Email 2: georgeanne59442@yahoo.com  
Website:  |
|---|---|---|
| **Services:** Outpatient & ACT  
**Office Hours:** Tuesday  
**County:** Glacier |

| 258 | Western MT Addiction Services  
Powell County Satellite Office  
304 Milwaukee - Ste 27 P.O. Box 147  
Deer Lodge MT 59722-0147  
Phone 1: (406) 846-3442  
Phone 2:  
Fax: (406) 846-1596  
Crisis Phone:  
Email: dsimpson@wmmhc.org  
Email 2:  
Website:  |
|---|---|---|
| **Services:** Outpatient & ACT, MIP, Adult & Adol Services  
**Office Hours:** 9:00 a.m. - 5:00 p.m. - Mon - Thur -Services hours in evening.  
**County:** Powell |

| 270 | Treasure State Correctional Training Center  
1100 Conley Lake Road  
Deer Lodge MT 59722  
Phone 1: (406) 846-1320 X 2110  
Phone 2:  
Fax: (406) 846-2969  
Crisis Phone:  
Email: theaton@state.mt.us  
Email 2:  
Website:  |
|---|---|---|
| **Services:** Outpatient  
**Office Hours:**  
**County:** Powell |
| 271 | Montana State Prison CD Program  
500 Conley Lake Road  
Deer Lodge MT 59722-9755 | Blair Hopkins Program Director  
Phone 1: (406) 846-1320 x 2225  
Phone 2:  
Fax: (406) 846-2951  
Crisis Phone:  
Email:  
Email 2:  
Website:  
**Services:** Outpatient  
**Office Hours:**  
**County:** Powell |
|---|---|
| 231 | Southwest C D Program  
Beaverhead County  
38 North Atlanta P.O. Box 527  
Dillon MT 59725 | Dave Blodget LAC  
Phone 1: (406) 683-4305  
Phone 2:  
Fax: (406) 683-9767  
Crisis Phone:  
Email:  
Email 2:  
Website:  
**Services:** Outpatient & ACT  
**Office Hours:** Monday - Friday  
**County:** Beaverhead |
| 231 | Southwest C D Program  
Madison County Satellite  
FNI Building P.O. Box 896  
Ennis MT 59729 | Bob Clarkson LAC  
Phone 1: (406) 682-7190  
Phone 2:  
Fax: (406) 683-9767  
Crisis Phone:  
Email:  
Email 2:  
Website:  
**Services:** Outpatient & ACT  
**Office Hours:** 1st, 2nd & 3rd Thur  
**County:** Madison |
| 209 | FVCD - Eureka Office  
North Lincoln County Annex  
P.O.Box 1409  
Eureka MT 59914 | Rick James Couslor  
Phone 1: (406) 296-2822  
Phone 2:  
Fax: (406) 296-2822  
Crisis Phone:  
Email:  
Email 2:  
Website:  
**Services:** Outpatient, Act  
**Office Hours:** Monday-Friday  
**County:** Lincoln |
| 273 | EMCMHC - Substance Abuse/Dependency Svcs Forsyth Satellite Office 1093 Main Street P.O. Box 1257 Forsyth MT 59327 | Jan Frederick |
|     | Phone 1: (406) 346-7654 Phone 2: Fax: Crisis Phone: | Email: Email 2: Website: |
| **Services:** | Outpatient & ACT | County: Rosebud |
| **Office Hours:** | Wed | |

| 259 | TLC Recovery, Inc Courthouse Annex P.O. Box 459 Fort Benton MT 59442 | Carol Richard Director |
|     | Phone 1: (406) 622-3211 Phone 2: Fax: (406) 622-5141 Crisis Phone: | Email: tlccarol@ttc-cmc.net Email 2: georgeanne59442@yahoo.com Website: |
| **Services:** | Outpatient & ACT | County: Choteau |
| **Office Hours:** | Mon - Fri | |

| 273 | EMCMHC - Substance Abuse/Dependency Svcs Glasgow Satellite Office 1009 6th Avenue N Glasgow MT 59230-1626 | Deborah Knox |
|     | Phone 1: (406) 228-9349 Phone 2: Fax: Crisis Phone: | Email: Email 2: Website: |
| **Services:** | Outpatient & ACT | County: Valley |
| **Office Hours:** | | |

<p>| 211 | District II Alcohol &amp; Drug Program 119 South Kendrick Glendive MT 59330 | Jerry Schlepp Director |
|     | Phone 1: (406) 377-5942 Phone 2: Fax: (406) 377-3050 Crisis Phone: | Email: <a href="mailto:distii@midrivers.com">distii@midrivers.com</a> Email 2: Website: |
| <strong>Services:</strong> | Outpatient, IOP, ACT, MIP | County: Dawson |
| <strong>Office Hours:</strong> | Mon-Fri, 8a - 5p or as scheduled | |</p>
<table>
<thead>
<tr>
<th>Phone 1: (406) 727-2512</th>
<th>Email: <a href="mailto:judy@gatewayrecovery.org">judy@gatewayrecovery.org</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone 2:</td>
<td>Email 2:</td>
</tr>
<tr>
<td>Fax: (406) 727-7451</td>
<td>Website: <a href="http://www.gatewayrecovery.org">www.gatewayrecovery.org</a></td>
</tr>
</tbody>
</table>

**Services:** Outpatient, IOP & ACT

**Office Hours:** Mon-Thur 8a.m.-8p.m. / Fri 8a.m.-5p.m.

**County:** Cascade

<table>
<thead>
<tr>
<th>Phone 1: (406) 452-6655</th>
<th>Email: <a href="mailto:rmtc@att.net">rmtc@att.net</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone 2:</td>
<td>Email 2:</td>
</tr>
<tr>
<td>Fax: (406) 452-6561</td>
<td>Website: <a href="http://WWW.RMTC-Care.com">WWW.RMTC-Care.com</a></td>
</tr>
</tbody>
</table>

**Services:** Inpatient Free-Standing (28 beds), Day Treatment

**County:** Cascade
<table>
<thead>
<tr>
<th>Area Code</th>
<th>Facility Name</th>
<th>Address Details</th>
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<td>258</td>
<td>Western MT Addiction Services Ravalli Co.</td>
<td>209 N 10th St, Ste. #C P.O. Box 902 Hamilton MT 59840-0902</td>
<td>Jim Mason Office Manager</td>
<td>(406) 532-9140</td>
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<td>206</td>
<td>South Central Regional Mental Health Center (SCMRMHC) Journey Recovery Program</td>
<td>809 North Custer Hardin MT 59034-1311</td>
<td>Dean Big Horn</td>
<td>(406) 665-8730</td>
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<tr>
<td>259</td>
<td>TLC Recovery, Inc City Hall P.O. Box 579 Harlem MT 59526</td>
<td></td>
<td></td>
<td>(406) 262-9299</td>
<td></td>
<td></td>
<td></td>
<td>Email:</td>
<td><a href="mailto:tlccarol@ttc-cmc.net">tlccarol@ttc-cmc.net</a></td>
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<td>Phone 2:</td>
<td>Fax: (406) 265-1071</td>
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<td>TLC Recovery, Inc Courthouse Annex 314 4th Ave Havre MT 59501</td>
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<td>(406) 262-9299</td>
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| 222 | Boyd Andrew Community Services  
The Arcade Building - Ste 1E  
P.O. Box 1153  
Helena MT 59624-1153 | Mike Ruppert CEO |
| --- | --- | --- |
| | Phone 1: (406) 443-2343  
Phone 2:  
Fax: (406) 443-5490  
Crisis Phone: | Email: dblock@boydandrew.com  
Email 2:  
Website: www.boydandrew.com |
| **Services:** | Outpatient, IOP & ACT | **County:** Lewis & Clark |
| **Office Hours:** | Mon-Fri, 8:00 a.m. - 5:00 p.m. |

| 222 | Boyd Andrew Community Services  
Transitional Living Facility for Men  
410 9th Ave  
Helena MT 59601-3721 | Sandy Jones |
| --- | --- | --- |
| | Phone 1: (406) 443-1241  
Phone 2: (406) 443-2343  
Fax: (406) 443-1241  
Crisis Phone: | Email: sjones@boydandrew.com  
Email 2:  
Website: www.boydandrew.com |
| **Services:** | Intermediate Care (Transitional Living 7 bed for men) | **County:** Lewis & Clark |
| **Office Hours:** | Mon-Fri, 8:00 a.m. - 5:00 p.m. |

| 209 | Flathead Valley Chemical Dependency Clinic  
1312 North Meridian  
P.O. Box 7115  
Kalispell MT 59904-0115 | Mike Cummins Director |
| --- | --- | --- |
| | Phone 1: (406) 756-6453  
Phone 2:  
Fax: (406) 756-8546  
Crisis Phone: | Email: fmichaelcummins@fvdc.net  
Email 2:  
Website: |
| **Services:** | Outpatient, IOP & ACT | **County:** Flathead |
| **Office Hours:** | Monday-Friday |

| 274 | Pathways Treatment Center  
200 Heritage Way  
Kalispell MT 59901-3180 | Leslie Nyman Interim Manager |
| --- | --- | --- |
| | Phone 1: (406) 756-3950 xt 6403  
Phone 2:  
Fax: (406) 756-3957  
Crisis Phone: | Email: lnyman@krmc.org  
Email 2:  
Website: |
<p>| <strong>Services:</strong> | Inpatient Hospital (40 beds) and Day Treatment | <strong>County:</strong> Flathead |
| <strong>Office Hours:</strong> |  |</p>
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<th>206</th>
<th>South Central Regional Mental Health Center (SCMRMHC)</th>
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<tr>
<td></td>
<td>212 Wendell P.O. Box 44</td>
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<td></td>
<td>Lewistown MT 59457</td>
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<td></td>
<td>Phone 1: (406) 538-7483</td>
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<td><strong>Services:</strong></td>
<td>Outpatient, IOP &amp; ACT For services in Stanford and Harlowton, please call the Lewistown office.</td>
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<th>Mark Clark Coordinator</th>
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<tr>
<td></td>
<td>101 Woodland Road</td>
<td></td>
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<td></td>
<td>P.O. Box 756</td>
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<td></td>
<td>Libby MT 59923</td>
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<tr>
<td></td>
<td>Phone 1: (406) 293-7731</td>
<td>Email:</td>
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<td>Fax: (406) 293-8530</td>
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<th>Southwest C D Program</th>
<th>Jean McCauley Program Director</th>
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<tbody>
<tr>
<td></td>
<td>430 East Park</td>
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<tr>
<td></td>
<td>P.O. Box 1587</td>
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<td></td>
<td>Livingston MT 59047-2746</td>
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<tr>
<td></td>
<td>Phone 1: (406) 222-2812</td>
<td>Email:</td>
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<td>Fax: (406) 222-4764</td>
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<tr>
<th>273</th>
<th>EMCMHC - Substance Abuse/Dependency Svcs</th>
<th>Deborah Knox</th>
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<tbody>
<tr>
<td></td>
<td>Malta Satellite Office</td>
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<tr>
<td></td>
<td>1009 6th Ave North</td>
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<tr>
<td></td>
<td>Malta MT 59230</td>
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<tr>
<td></td>
<td>Phone 1: (406) 228-9349 (Glasgow)</td>
<td>Email:</td>
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<td>Phone 2:</td>
<td>Email 2:</td>
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<tr>
<td><strong>Office Hours:</strong></td>
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| 250 | Wilderness Treatment Center  
200 Hubbard Dam Road  
Marion MT 59925-9708 | John Brekke Director |
|---|---|---|
|  | Phone 1: (406) 854-2832  
Phone 2:  
Fax: (406) 854-2835  
Crisis Phone: | Email: wtc@digisys.net  
Email 2:  
Website: www.wildernesstreatmentcentr.com |
| **Services:** Inpatient - Free Standing (35 beds)  
**Office Hours:** 8:00 a.m. - 5:00 p.m. | **County:** Flathead |
| 275 | Alternative Youth Services Center Inc.  
4880 US Hywy 93 S  
Kalispell MT 59901-7985 | Richard Balas Director |
|  | Phone 1: (406) 857-2506  
Phone 2:  
Fax: (406) 857-2503  
Crisis Phone: | Email:  
Email 2:  
Website: www.aycare.com |
|  | **Services:** Juvenile Transitional Living Facility  
**Office Hours:** | **County:** Flathead |
| 273 | EMCMHC - Substance Abuse/Dependency Svcs  
2508 Wilson P.O. Box 1530  
Miles City MT 59301 | John Rex Program Director |
|  | Phone 1: (406) 234-1687 (Clinic)  
(406) 234-0235 (Office)  
Phone 2: 1-800-597-6604  
Fax: (406) 234-1698 (Clinic)  
Crisis Phone: | Email: rex_john@hotmail.com  
Email 2:  
Website: |
| **Services:** Outpatient, IOP & ACT | **County:** Custer |
| 224 | Missoula Indian Center  
Bldg 33, Fort Missoula Rd  
P.O. Box 16927  
Missoula MT 59808 | Steve Lohning Clinical Supervisor  
Phone 1: (406) 721-2700  
Phone 2: (406) 829-9151 or 9516  
Fax: (406) 829-9519  
Crisis Phone: 24 Hour – (406) 721-2700 | Email: slohning@montana.com  
Email 2:  
Website:  
Services: Outpatient, IOP, MIP, Assessments/Evaluations, Adolescent & Family Txt  
Office Hours: Mon-Fri 8 a.m. - 5 p.m.  
County: Missoula |
|---|---|---|---|
| 254 | St. Patrick Hospital –  
ATP 500 West Broadway  
P.O. Box 4587  
Missoula MT 59806-4587 | Linda Bradford Director  
Phone 1: (406) 327-3020  
Phone 2:  
Fax: (406) 327-3500  
Crisis Phone:  
Email: bradford@saintpatrick.org  
Email 2:  
Website:  
Services: Inpatient Hospital (18 beds) - IOP Adults/Adolescents  
Office Hours:  
County: Missoula |
| 258 | Western Montana Addiction Services  
Turning Point  
1325 Wyoming  
Missoula MT 59801 | Emery Jones Acting Director  
Phone 1: (406) 532-9800  
Phone 2:  
Fax: (406) 541-3032  
Crisis Phone:  
Email: ejones@wmmhc.org  
Email 2:  
Website:  
Services: Outpatient, IOP, Adult & Adol Svcs - ACT, MIP  
Office Hours: 8:30 a.m. - 8:30 p.m. - Mon - Thur - Services hours in evening  
County: Missoula |
| 258 | Share House  
1330 S 4th Street West  
Missoula MT 59801 | Sue Rajacich Program Director  
Phone 1: (406) 532-9830  
Phone 2:  
Fax: (406) 541-3031  
Crisis Phone:  
Email: srajacich@wmmhc.org  
Email 2:  
Website:  
Services: Transitional Living - Men & Woman / Detox  
Office Hours: 24 Hour  
County: Missoula |
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<td>Carol Graham Home</td>
<td>1335 Wyoming Missoula MT 59802</td>
<td>Sue Rajacich Program Director</td>
<td>(406) 549-8309</td>
<td></td>
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<td></td>
<td><a href="mailto:srajacich@wmmhc.org">srajacich@wmmhc.org</a></td>
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<td>Transitional Living - Women &amp; Children</td>
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<td>(406) 549-8309</td>
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<td>273</td>
<td>EMCMHC - Substance Abuse/Dependency Svcs</td>
<td>Plentywood Satellite Office Sheridan County Courthouse Plentywood MT 59254</td>
<td>Anita Plann</td>
<td>(406) 765-2550</td>
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<tr>
<td>251</td>
<td>Lake County Chemical Dependency Program</td>
<td>802 Main Street - Ste C Polson MT 59860-3200</td>
<td>Theresa Oakland Director</td>
<td>(406) 883-7310</td>
<td></td>
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<td><a href="mailto:toakland@lakemt.gov">toakland@lakemt.gov</a></td>
<td>Email 2:</td>
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<tr>
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<td><a href="http://www.lakecounty-mt.org">www.lakecounty-mt.org</a></td>
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<tr>
<td>206</td>
<td>South Central Regional Mental Health Center (SCMRMHC) Journey Recovery Program</td>
<td>5 East 9th Street P.O. Box 482 Red Lodge MT 59068-0482</td>
<td>Jack Cummins</td>
<td>(406) 446-2500</td>
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<td>Phone 1: (406) 323-1142</td>
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**Services:** Outpatient & ACT
| 222 | Boyd Andrew Community Services  
| Jefferson County Alcohol Services  
| 102 N Brooke St  
| P.O. Box 1156  
| Whitehall MT 59759 | Ron Napierala |
| Phone 1: (406) 287-3219  
| Phone 2: (406) 443-2343  
| Fax:  
| Crisis Phone: | Email: rnapierala@boydandrew.com  
| Email 2:  
| Website: www.boydandrew.com |
| **Services:** Outpatient & ACT  
| **Office Hours:** Tuesday, 9:00 a.m. - 12:00 p.m.  
| **County:** Jefferson |

| 273 | EMCMHC - Substance Abuse/Dependency Svcs  
| Wolf Point Satellite Office  
| Roosevelt County Courthouse  
| Wolf Point MT 59201-0328 | Deborah Knox |
| Phone 1: (406) 653-1872  
| Phone 2:  
| Fax:  
| Crisis Phone: | Email:  
| Email 2:  
| Website: |
Appendix G

New Jersey Needle Exchange Law
"Bloodborne Disease Harm Reduction Act"; permits establishment of sterile syringe access programs.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel

AN ACT providing for sterile syringe access programs, supplementing Title 26 of the Revised Statutes and Title 2C of the New Jersey Statutes and amending P.L.1989, c.34.

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

1. (New section) This act shall be known and may be cited as the "Bloodborne Disease Harm Reduction Act."

2. (New section) The Legislature finds and declares that:

   a. New Jersey, in comparison with other states nationwide, has the highest rate of HIV infection among women, the third highest pediatric HIV rate, the fifth highest adult HIV rate, and a rate of injection-related HIV infection that is almost twice the national average;
b. About one in every three persons living with HIV or AIDS is female;

c. Sterile syringe access programs have been proven effective in reducing the spread of HIV, hepatitis C and other bloodborne pathogens without increasing drug abuse or other adverse social impacts; yet New Jersey remains one of only two states nationwide that provide no access to sterile syringes in order to prevent the spread of disease;

d. Every scientific, medical and professional agency or organization that has studied this issue, including the federal Centers for Disease Control and Prevention, the American Medical Association, the American Public Health Association, the National Academy of Sciences, the National Institutes of Health Consensus Panel, the American Academy of Pediatrics, and the United States Conference of Mayors, has found sterile syringe access programs to be effective in reducing the transmission of HIV; and

e. Sterile syringe access programs are designed to prevent the spread of HIV, hepatitis C and other bloodborne pathogens, and to provide a bridge to drug abuse treatment and other social services for drug users; and it is in the public interest to encourage the development of such programs in this State in accordance with statutory guidelines designed to ensure the safety of consumers who use these programs, the health care workers who operate them, and the members of the general public.

3. (New section) The Commissioner of Health and Senior Services shall prescribe by regulation requirements for a municipality to establish, or otherwise authorize the operation within that municipality of, a sterile syringe access program to provide for the exchange of hypodermic syringes and needles in accordance with the provisions of this act.

a. The commissioner shall:

(1) request an application, to be submitted on a form and in a manner to be prescribed by the commissioner, from any municipality that seeks to establish a sterile syringe access program, or from other entities authorized to operate a sterile syringe access program within that municipality as provided in paragraph (2) of subsection a. of section 4 of this act;

(2) approve those applications that meet the requirements established by regulation of the commissioner and contract with the municipalities or entities whose applications are approved to establish a sterile syringe access program as provided in paragraph (2) of subsection a. of section 4 of this act to operate a sterile syringe access program in any municipality in which the governing body has authorized the operation of sterile syringe access programs within that municipality by ordinance;

(3) support and facilitate, to the maximum extent practicable, the linkage of sterile syringe access programs to such health care facilities and programs as may provide appropriate health care services, including mental health and substance abuse treatment, to consumers participating in any such program;
(4) provide for the adoption of a uniform identification card or other uniform Statewide means of identification for consumers, staff and volunteers of a sterile syringe access program pursuant to paragraph (8) of subsection b. of section 4 of this act; and

(5) maintain a record of the data reported to the commissioner by sterile syringe access programs pursuant to paragraph (10) of subsection b. of section 4 of this act.

b. The commissioner shall be authorized to accept such funding as may be made available from the private sector to effectuate the purposes of this act.

4. (New section) a. In accordance with the provisions of section 3 of this act, a municipality may establish or authorize establishment of a sterile syringe access program that is approved by the commissioner to provide for the exchange of hypodermic syringes and needles.

(1) A municipality that establishes a sterile syringe access program may operate the program directly or contract with one or more of the following entities to operate the program: a hospital or other health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.), a federally qualified health center, a public health agency, a substance abuse treatment program, an AIDS service organization, or another nonprofit entity designated by the municipality. These entities shall also be authorized to contract directly with the commissioner in any municipality in which the governing body has authorized the operation of sterile syringe access programs by ordinance pursuant to paragraph (2) of this subsection.

(2) Pursuant to paragraph (2) of subsection a. of section 3 of this act, a municipality whose governing body has authorized the operation of sterile syringe access programs within the municipality may require within the authorizing ordinance that an entity as described in paragraph (1) of this subsection obtain approval from the municipality, in a manner prescribed by the authorizing ordinance, to operate a sterile syringe access program prior to obtaining approval from the commissioner to operate such a program, or may permit the entity to obtain approval to operate such a program by application directly to the commissioner without obtaining prior approval from the municipality.

(3) Two or more municipalities may jointly establish or authorize establishment of a sterile syringe access program that operates within those municipalities pursuant to adoption of an ordinance by each participating municipality pursuant to this section.

b. A sterile syringe access program shall comply with the following requirements:

(1) Sterile syringes and needles shall be provided at no cost to consumers 18 years of age and older;

(2) Program staff shall be trained and regularly supervised in: harm reduction; substance abuse, medical and social service referrals; and infection control procedures, including universal precautions and needle stick injury protocol; and programs shall
maintain records of staff and volunteer training and of hepatitis C and tuberculosis screening provided to volunteers and staff;

(3) The program shall offer information about HIV, hepatitis C and other bloodborne pathogens and prevention materials at no cost to consumers, and shall seek to educate all consumers about safe and proper disposal of needles and syringes;

(4) The program shall provide information and referrals to consumers, including HIV testing options, access to substance abuse treatment programs, and available health and social service options relevant to the consumer's needs;

(5) The program shall screen out consumers under 18 years of age from access to syringes and needles, and shall refer them to substance abuse treatment and other appropriate programs for youth;

(6) The program shall develop a plan for the handling and disposal of used syringes and needles in accordance with requirements set forth at N.J.A.C.7:26-3A.1 et seq. for regulated medical waste disposal pursuant to the "Comprehensive Regulated Medical Waste Management Act," P.L.1989, c.34 (C.13:1E-48.1 et al.), and shall also develop and maintain protocols for post-exposure treatment;

(7) The program shall maintain the confidentiality of consumers by the use of confidential identifiers, which shall consist of the first two letters of the first name of the consumer's mother and the two-digit day of birth and two-digit year of birth of the consumer, or by the use of such other uniform Statewide mechanism as may be approved by the commissioner for this purpose;

(8) The program shall provide a uniform identification card that has been approved by the commissioner to consumers and to staff and volunteers involved in transporting, exchanging or possessing syringes and needles, or shall provide for such other uniform Statewide means of identification as may be approved by the commissioner for this purpose;

(9) The program shall provide consumers at the time of enrollment with a schedule of program operation hours and locations, in addition to information about prevention and harm reduction and substance abuse treatment services; and

(10) The program shall provide aggregate data on a quarterly basis to the commissioner, on a form and in a manner determined by the commissioner, that includes: the number of consumers served by the program, the number of syringes and needles distributed each month, and the number and type of referrals provided to consumers.

c. A municipality may terminate a sterile syringe access program established or authorized pursuant to this act, which is operating within that municipality, if its governing body approves such an action by ordinance, in which case the municipality
shall notify the commissioner of its action in a manner prescribed by regulation of the commissioner.

5. (New section) a. The Commissioner of Health and Senior Services shall report to the Governor and the Legislature, no later than one year after the effective date of this act and biannually thereafter, on the status of sterile syringe access programs established pursuant to sections 3 and 4 of P.L. , c. (C. ) (pending before the Legislature as this bill), and shall include in that report the data provided to the commissioner by each sterile syringe access program pursuant to paragraph (10) of subsection b. of section 4 of P.L. , c. (C. ) (pending before the Legislature as this bill).

b. The commissioner shall report to the Governor and the Legislature no later than six months after the date that the initial sterile syringe access program, which is approved by the commissioner pursuant to section 3 of P.L. , c. (C. ) (pending before the Legislature as this bill), commences its operations, and shall include in that report:

(1) an assessment of whether an adequate number of substance abuse treatment program slots is available to meet the treatment needs of persons who have been referred to substance abuse treatment programs by sterile syringe access programs pursuant to paragraph (4) of subsection b. of section 4 of P.L. , c. (C. ) (pending before the Legislature as this bill); and

(2) a recommendation for such appropriation as the commissioner determines necessary to ensure the provision of an adequate number of substance abuse treatment program slots for those persons.

6. (New section) a. The Commissioner of Health and Senior Services, in consultation with the Commissioner of Environmental Protection and pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of sections 3 and 4 of P.L. , c. (C. ) (pending before the Legislature as this bill).

b. Notwithstanding any provision of P.L.1968, c.410 to the contrary, the commissioner shall adopt, immediately upon filing with the Office of Administrative Law and no later than the 90th day after the effective date of this act, such regulations as the commissioner deems necessary to implement the provisions of sections 3 and 4 of P.L. , c. (C. ) (pending before the Legislature as this bill), which shall be effective until the adoption of rules and regulations pursuant to subsection a. of this section and may be amended, adopted or readopted by the commissioner in accordance with the requirements of P.L.1968, c.410.

7. (New section) The possession of a hypodermic syringe or needle by a consumer who participates in, or an employee or volunteer of, a sterile syringe access program established pursuant to sections 3 and 4 of P.L. , c. (C. ) (pending before the Legislature as this bill) shall not constitute an offense pursuant to N.J.S.2C:36-1 et seq.
This provision shall extend to a hypodermic syringe or needle that contains a residual amount of a controlled dangerous substance or controlled substance analog.

8. Section 3 of P.L.1989, c.34 (C.13:1E-48.3) is amended to read as follows:

3. As used in sections 1 through 25 of this act:

"Board" means the Board of Public Utilities.

"Collection" means the activity related to pick-up and transportation of regulated medical waste from a generator, or from an intermediate location, to a facility, or to a site outside the State, for disposal.

"Commissioners" means the Commissioner of Environmental Protection and the Commissioner of Health and Senior Services.

"Departments" means the Department of Environmental Protection and the Department of Health and Senior Services.

"Dispose" or "disposal" means the storage, treatment, utilization, processing, resource recovery of, or the discharge, deposit, injection, dumping, spilling, leaking, or placing of any regulated medical waste into or on any land or water so that the regulated medical waste or any constituent thereof may enter the environment or be emitted into the air or discharged into any waters, including groundwaters.

"Facility" means a solid waste facility as defined in section 3 of P.L.1970, c.39 (C.13:1E-3); or any other incinerator or commercial or noncommercial regulated medical waste disposal facility in this State that accepts regulated medical waste for disposal.

"Federal Act" means the "Medical Waste Tracking Act of 1988" (42U.S.C. s.6903 et seq.), or any rule or regulation adopted pursuant thereto.

"Generator" means an ambulatory surgical or care facility, community health center, medical doctor's office, dentist's office, podiatrist's office, home health care agency, health care facility, hospital, medical clinic, morgue, nursing home, urgent care center, sterile syringe access program operating pursuant to sections 3 and 4 of P.L. , c. (C. )(pending before the Legislature as this bill), veterinary office or clinic, animal, biological, clinical, medical, microbiological, or pathological diagnostic or research laboratory, any of which generates regulated medical waste, or any other facility identified by the departments that generates regulated medical waste. "Generator" shall not include individual households utilizing home self-care.

"Regulated medical waste" means blood vials; cultures and stocks of infectious agents and associated biologicals, including cultures from medical and pathological laboratories, cultures and stocks of infectious agents from research and industrial laboratories, wastes from the production of biologicals, discarded live and attenuated vaccines, and culture
dishes and devices used to transfer, inoculate, and mix cultures; pathological wastes, including tissues, organs, and body parts that are removed during surgery or autopsy; waste human blood and products of blood, including serum, plasma, and other blood components; sharps that have been used in patient care or in medical, research, or industrial laboratories engaged in medical research, testing, or analysis of diseases affecting the human body, including hypodermic needles, syringes, Pasteur pipettes, broken glass, and scalpel blades; contaminated animal carcasses, body parts, and bedding of animals that were exposed to infectious agents during research, production of biologicals, or testing of pharmaceuticals; any other substance or material related to the transmission of disease as may be deemed appropriate by the departments; and any other substance or material as may be required to be regulated by, or permitted to be exempted from, the Federal Act. The departments may adopt, by rule or regulation and pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), a more specific definition of regulated medical waste upon the expiration of the demonstration program established under the Federal Act.

"Noncommercial facility" means a facility or on-site generator, as the case may be, which accepts regulated medical waste from other generators for on-site disposal for a cost-based fee not in excess of the costs actually incurred by the facility or on-site generator for the treatment or disposal of the regulated medical waste.

"Transporter" means a person engaged in the collection or transportation of regulated medical waste.

(cf: P.L.1989, c.34, s.3)

9. (New section) a. The board of chosen freeholders of each county and the New Jersey Meadowlands Commission, in accordance with standards adopted by the Commissioner of Environmental Protection in consultation with the Commissioner of Health and Senior Services, shall prepare and adopt a sharps disposal component as an amendment to the district solid waste management plan required pursuant to the provisions of the "Solid Waste Management Act," P.L.1970, c.39 (C.13:1E-1 et seq.) to provide for the proper and safe disposal of medical waste generated at home within the district.

b. The sharps disposal component of each district solid waste management plan shall be developed in consultation with a work group established by the governing body of the affected county and the New Jersey Meadowlands Commission, in the case of the Hackensack Meadowlands District, that includes persons not employed by or affiliated with the county or the commission, as the case may be, who have a demonstrated interest or expertise in the use and disposal of sharps, including, but not limited to, representatives of waste management companies, persons with diabetes and licensed health care facilities.

c. The Commissioner of Environment Protection shall provide such financial assistance as may be available to the commissioner for the purpose of this section to the
various counties to implement the sharps disposal component of the district solid waste management plan. The commissioner shall be authorized to accept such funding as may be made available from the private sector to effectuate the purposes of this section.

10. (New section) a. The Commissioner of Environmental Protection, in consultation with the Commissioner of Health and Senior Services and pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of section 9 of P.L. , c. (C. ) (pending before the Legislature as this bill).

b. Notwithstanding any provision of P.L.1968, c.410 to the contrary, the commissioner shall adopt, immediately upon filing with the Office of Administrative Law and no later than the 90th day after the effective date of this act, such regulations as the commissioner deems necessary to implement the provisions of section 9 of P.L. , c. (C. ) (pending before the Legislature as this bill), which shall be effective until the adoption of rules and regulations pursuant to subsection a. of this section and may be amended, adopted or readopted by the commissioner in accordance with the requirements of P.L.1968, c.410.

11. This act shall take effect immediately.

STATEMENT

This bill, which is designated the "Bloodborne Disease Harm Reduction Act," permits the establishment of sterile syringe access programs to prevent the spread of HIV/AIDS, hepatitis C and other bloodborne diseases.

Specifically, the bill provides as follows:

-- The Commissioner of Health and Senior Services is directed to prescribe by regulation requirements for a municipality to establish, or otherwise authorize the operation within that municipality of, a sterile syringe access program to provide for the exchange of hypodermic syringes and needles.

-- The commissioner is to:

(1) request an application, to be submitted on a form and in a manner to be prescribed by the commissioner, from any municipality that seeks to establish a sterile syringe access program, or from other entities authorized to operate a sterile syringe access program within that municipality as provided in the bill;

(2) approve those applications that meet the requirements established by regulation of the commissioner and contract with the municipalities or entities whose applications are approved to establish a sterile syringe access program as provided in the bill to operate a
sterile syringe access program in any municipality in which the governing body has
authorized the operation of sterile syringe access programs within that municipality by
ordinance;

(3) support and facilitate, to the maximum extent practicable, the linkage of sterile
syringe access programs to such health care facilities and programs as may provide
appropriate health care services, including mental health and substance abuse treatment,
to consumers participating in any such program;

(4) provide for the adoption of a uniform identification card or other uniform
Statewide means of identification for consumers, staff and volunteers of a sterile syringe
access program; and

(5) maintain a record of the data reported to the commissioner by sterile syringe
access programs pursuant to the bill.

-- The commissioner is authorized to accept such funding as may be made available
from the private sector to effectuate the purposes of the bill.

-- A municipality may establish or authorize establishment of a sterile syringe access
program that is approved by the commissioner pursuant to the bill to provide for the
exchange of hypodermic syringes and needles.

(1) A municipality that establishes a sterile syringe access program may operate the
program directly or contract with one or more of the following entities to operate the
program: a hospital or other licensed health care facility, a federally qualified health
center, a public health agency, a substance abuse treatment program, an AIDS service
organization, or another nonprofit entity designated by the municipality. These entities
will also be authorized to contract directly with the commissioner in any municipality in
which the governing body has authorized the operation of sterile syringe access programs
by ordinance pursuant to the bill.

(2) A municipality whose governing body has authorized the operation of sterile
syringe access programs within the municipality may require within the authorizing
ordinance that an entity as described in the bill obtain approval from the municipality, in
a manner prescribed by the authorizing ordinance, to operate a sterile syringe access
program prior to obtaining approval from the commissioner to operate such a program, or
may permit the entity to obtain approval to operate such a program by application directly
to the commissioner without obtaining prior approval from the municipality to operate
such a program.

(3) Two or more municipalities may jointly establish or authorize establishment of a
sterile syringe access program that operates within those municipalities pursuant to
adoption of an ordinance by each participating municipality.

-- A sterile syringe access program must comply with the following requirements:
(1) Sterile syringes and needles are to be provided at no cost to consumers 18 years of age and older;

(2) Program staff are to be trained and regularly supervised in: harm reduction; substance abuse, medical and social service referrals; and infection control procedures, including universal precautions and needle stick injury protocol; and programs are to maintain records of staff and volunteer training and of hepatitis C and tuberculosis screening provided to volunteers and staff;

(3) The program is to offer information about HIV, hepatitis C and other bloodborne pathogens and prevention materials at no cost to consumers, and seek to educate all consumers about safe and proper disposal of needles and syringes;

(4) The program is to provide information and referrals to consumers, including HIV testing options, access to substance abuse treatment programs, and available health and social service options relevant to the consumer's needs;

(5) The program is to screen out consumers under 18 years of age from access to syringes and needles, and refer them to substance abuse treatment and other appropriate programs for youth;

(6) The program is to develop a plan for the handling and disposal of used syringes and needles in accordance with requirements set forth at N.J.A.C.7:26-3A.1 et seq. for regulated medical waste disposal pursuant to the "Comprehensive Regulated Medical Waste Management Act," and also develop and maintain protocols for post-exposure treatment;

(7) The program is to maintain the confidentiality of consumers by the use of confidential identifiers, which are to consist of the first two letters of the first name of the consumer's mother and the two-digit day of birth and two-digit year of birth of the consumer, or by the use of such other uniform Statewide mechanism as may be approved by the commissioner for this purpose;

(8) The program is to provide a uniform identification card that has been approved by the commissioner to consumers and to staff and volunteers involved in transporting, exchanging or possessing syringes and needles, or provide for such other uniform Statewide means of identification as may be approved by the commissioner for this purpose;

(9) The program is to provide consumers at the time of enrollment with a schedule of program operation hours and locations, in addition to information about prevention and harm reduction and substance abuse treatment services; and

(10) The program is to provide aggregate data on a quarterly basis to the commissioner, on a form and in a manner determined by the commissioner, that includes: the number of consumers served by the program, the number of syringes and
needles distributed each month, and the number and type of referrals provided to consumers.

-- c. A municipality may terminate a sterile syringe access program established or authorized pursuant to the bill, which is operating within that municipality, if its governing body approves such an action by ordinance, in which case the municipality is to notify the commissioner of its action in a manner prescribed by regulation of the commissioner.

-- The Commissioner of Health and Senior Services is directed to report to the Governor and the Legislature, no later than one year after the effective date of the bill and biannually thereafter, on the status of sterile syringe access programs established pursuant to the bill, and is to include in that report the data provided to the commissioner by each sterile syringe access program pursuant to the bill.

-- The commissioner is further directed to report to the Governor and the Legislature no later than six months after the date that the initial sterile syringe access program, which is approved by the commissioner pursuant to the bill, commences its operations, and is to include in that report:

(1) an assessment of whether an adequate number of substance abuse treatment program slots is available to meet the treatment needs of persons who have been referred to substance abuse treatment programs by sterile syringe access programs pursuant to the bill; and

(2) a recommendation for such appropriation as the commissioner determines necessary to ensure the provision of an adequate number of substance abuse treatment program slots for those persons.

-- The possession of a hypodermic syringe or needle by a consumer who participates in, or an employee or volunteer of, a sterile syringe access program established pursuant to the bill will not constitute an offense pursuant to N.J.S.A.2C:36-1 et seq. This provision extends to a hypodermic syringe or needle that contains a residual amount of a controlled dangerous substance or controlled substance analog.

-- Each county freeholder board and the New Jersey Meadowlands Commission, in accordance with standards adopted by regulation of the Commissioner of Environmental Protection in consultation with the Commissioner of Health and Senior Services, is to prepare and adopt a sharps disposal component as an amendment to the district solid waste management plan required pursuant to the "Solid Waste Management Act" to provide for the proper and safe disposal of medical waste generated at home within the district.

(1) The sharps disposal component of each district solid waste management plan is to be developed in consultation with a work group established by the governing body of the affected county and the New Jersey Meadowlands Commission, in the case of the
Hackensack Meadowlands District, that includes persons not employed by or affiliated with the county or the commission, as the case may be, who have a demonstrated interest or expertise in the use and disposal of sharps, including, but not limited to, representatives of waste management companies, persons with diabetes and licensed health care facilities.

(2) The Commissioner of Environmental Protection is to provide such financial assistance as may be available to the commissioner to the various counties to implement the sharps disposal component of the district solid waste management plan, and is authorized to accept such funding as may be made available from the private sector for this purpose.

-- The bill directs the Commissioners of Health and Senior Services and Environmental Protection to adopt rules and regulations, pursuant to the "Administrative Procedure Act" (APA), to effectuate the purposes of the bill; however, notwithstanding any provision of the APA to the contrary, the commissioners are to adopt, immediately upon filing with the Office of Administrative Law and no later than the 90th day after the effective date of the bill, such regulations as they deem necessary to implement the bill, which are to be effective until the adoption of rules and regulations pursuant to the APA and may be amended, adopted or readopted by the commissioners in accordance with the APA. (It is the sponsors' intent that the Commissioner of Health and Senior Services may consult with the Public Health Council established pursuant to N.J.S.A.26:1A-4 in the adoption of rules and regulations to effectuate the purposes of the bill.)

It is the opinion of the sponsors that a municipality which establishes or authorizes a sterile syringe access program pursuant to this bill and its employees would be covered by the provisions of N.J.S.A.59:6-3, which provides as follows: "Neither a public entity nor a public employee is liable for an injury resulting from the decision to perform or not to perform any act to promote the public health of the community by preventing disease or controlling the communication of disease within the community."