ISSUE BRIEF | MARCH 2021

BIG IDEAS

ENDING THE HIV EPIDEMIC —
SUPPORTING ALL PEOPLE WITH HIV AND REDUCING NEW TRANSMISSIONS

IMPROVING THE HEALTH OF PEOPLE WHO USE DRUGS AND PEOPLE IN RECOVERY IS ESSENTIAL FOR ENDING THE HIV EPIDEMIC

MANY PEOPLE LEARN AT AN EARLY AGE TO STIGMATIZE PEOPLE WHO USE DRUGS, and this has led to highly punitive approaches to drug use and addiction. More recently, however, there has been a growing understanding that the so-called 'War on Drugs' has failed and that the "criminalize and prosecute" approach imposes costs on individuals and families and destabilizes communities.[1] Thus, new approaches are needed that support individuals and improve the public's health.

HIV and drug use are inextricably intertwined. The communities most heavily impacted by HIV often shoulder the heaviest burden of substance use disorders and experience structural racism and stigma through over-policing, discriminatory prosecutions, and greater involvement with the justice system. These groups also receive less access to health and preventive services and fewer economic opportunities.[2,3] Today, one in ten new HIV diagnoses in the U.S. are attributed to people who inject drugs, with other forms of drug use contributing to additional transmissions.[4] While diagnoses among people who inject drugs were declining as recently as 2008 to 2014, a period when they were cut in half, this trend has been reversed. New HIV cases among this group increased 9% from 2014 to 2018.[5,6] Success at achieving the goals of the Ending the HIV Epidemic (EHE) Initiative[7] depends on doing more to strengthen communities, reduce the harm associated with drug use, and prevent disease transmission. The need for concerted action is only heightened by the COVID-19 crisis, which has led to an increase in substance use and overdoses.[8] This is likely due to increased isolation, emotional and financial distress, disruption of services, and an increase in fentanyl in the drug supply, which greatly increases the risk of overdose.[9]

MEETING THE NEEDS OF PEOPLE WHO USE DRUGS IS PART OF FIGHTING HIV

POLICY REFORMS ARE NEEDED TO:

1. **Develop tailored plans with the meaningful participation of people who use drugs to respond to the unique challenges in each jurisdiction**
2. **Deploy effective interventions at greater scale**
3. **Decriminalize substance use and re-orient drug use policy to enhance prevention, harm reduction, and treatment of addiction**

ENHANCING THE RESPONSE TO DRUG USE AND HIV

Policy action is needed to improve the health of people who use drugs on the path to ending the HIV epidemic. Three observations can lead to critical policy action:

1. DRUG USE CHALLENGES VARY BY GEOGRAPHY AND COMMUNITY

Drug use challenges involve many substances, exist across the nation, and can look very different from

place to place or across different communities. A deeper understanding of drug use trends and dynamics is often needed.[10,11,12] This brief focuses on policy responses to opioid and stimulant misuse, although it is acknowledged that tobacco, alcohol, and cannabis (marijuana) are often more widely used and also can be associated with HIV risk behaviors.

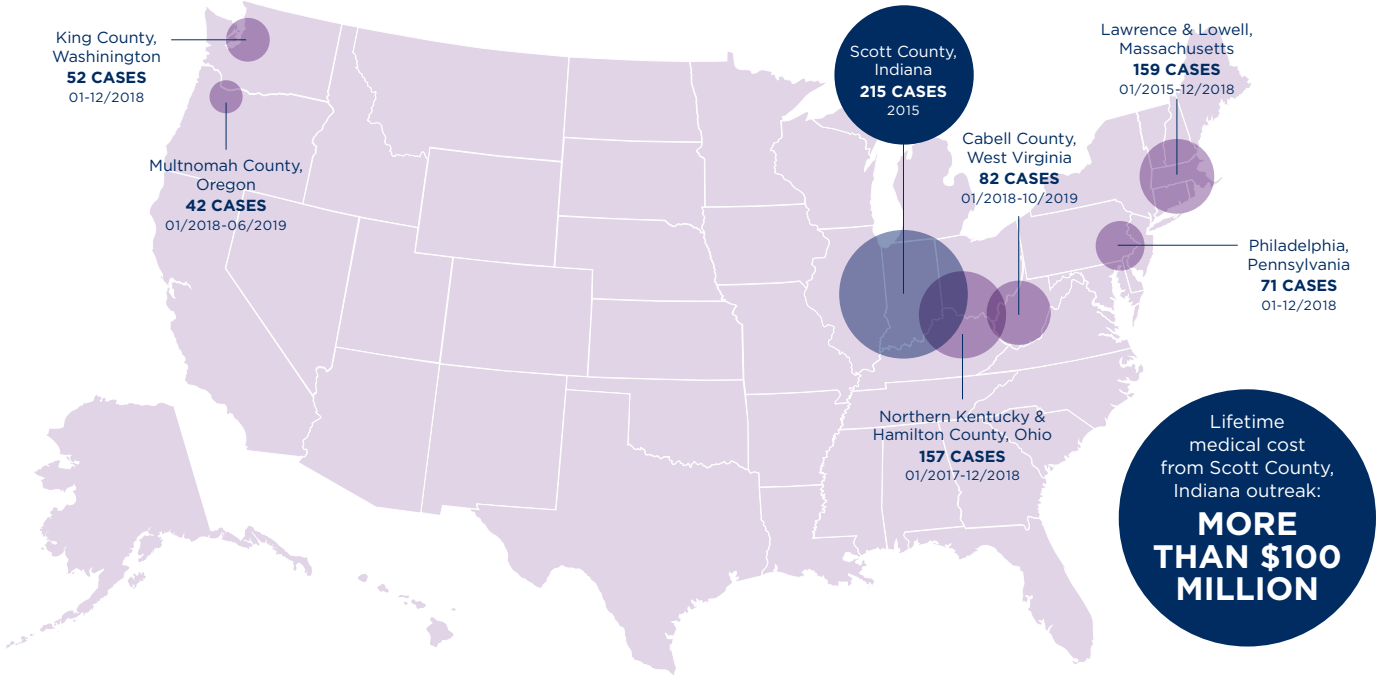
Today, the opioid use epidemic is affecting more than 2.1 million persons, with more than 700,000 deaths since 1999.[13,14,15] Opioids are both feared for their addictive properties, yet commonly prescribed for their ability to relieve pain.[16] They include codeine, morphine, oxycodone, hydrocodone, oxymorphone, heroin, and fentanyl. Responding to the opioid use epidemic should be grounded in a holistic, evidence-based response that includes greatly expanded access to treatment and harm reduction services. Harm reduction is a philosophy that involves a set of practices to reduce the harm associated with drug use.

Syringe services programs (SSPs), which offer sterile syringes, usually in exchange for used ones, and provide other services, are an evidence-based practice shown to reduce HIV and hepatitis C virus (HCV) transmissions among people who inject drugs and are a critical component of harm reduction.[17] Importantly, medication-based treatment, sometimes called medications for opioid use disorder (MOUD) or medication-assisted treatment (MAT), is the standard of care for treating opioid use disorder. It involves prescribing buprenorphine, methadone, extended-release naltrexone, and other agents to reduce the cravings and/or withdrawal symptoms commonly experienced when stopping or reducing opioid use.[18] In a recent study, people with an opioid use disorder being treated with medication-based treatment had an 80% lower risk of dying from an overdose when compared to those being treated without medication.[19]

Systemic racism has played a role in the absence of urgency for decades, but since the current epidemic is impacting more white Americans, it has generated more sympathy and public demand for action.[20] Further, aggressive marketing of prescription opioids to treat a 'pain epidemic' with the promise that these medications were not highly addictive also contributed to the current crisis, with high levels of misuse of both prescription and non-prescription opioids.[21] The consequences of these factors can be seen in Scott County, Indiana's 2015 HIV outbreak where the absence of evidence-based HIV prevention and increasing opioid misuse led to increased HIV transmission, as well as increases in viral hepatitis and other infectious diseases. In this instance, a rural county that typically documented about five new HIV cases per year experienced 215 cases in roughly a one-year period.[22,23] Following intensive mobilization

HIV OUTBREAKS RELATED TO INJECTION DRUG USE THREATEN HIV PROGRESS

HIV outbreaks have been occurring across the United States among people who inject drugs



SOURCE: Sheryl B. Lyss, et al., *Responding to Outbreaks of Human Immunodeficiency Virus Among Persons Who Inject Drugs-United States, 2016-2019: Perspectives on Recent Experience and Lessons Learned,* 222 J Infect Dis. S239-49 (Sep. 2, 2020).

from local, state, and federal agencies, including the establishment of an SSP, this outbreak was brought under control. The Centers for Disease Control and Prevention (CDC) conducted a modeling analysis and identified 220 U.S. counties at high risk for similar outbreaks, some of which have subsequently occurred (see figure on page 2), yet in 2018, fewer than 25% of these counties had SSPs.[24,25]

Stimulants, also called uppers, can yield a sense of exhilaration, wakefulness, and focus, and they can enhance mental and physical performance. Medical uses of stimulants include treatment for attention-deficit hyperactivity disorder (ADHD) and narcolepsy. Methamphetamine (also called meth, crystal, T, ice and many other names), cocaine (coke, blow, snow, crack and other terms), and 3-4 methylenedioxymethamphetamine (MDMA, also known as ecstasy or molly) are commonly used stimulants. Meth is a highly addictive stimulant that 5.4% of the population has reported using at least once and which 1.6 million people were reported to have used in a recent one-year period.[26] In 2017, 964,000 people were reported to have a meth use disorder.[27] Nationally, meth overdose deaths are rising. In 2018, there were 12,676 overdose deaths involving psychostimulants, primarily methamphetamine, which is up from 4,298 in 2014.[28] In the same year, over 31,000 people died from overdoses involving synthetic opioids other than methadone, which includes fentanyl.[29] Prescription rates for fentanyl have fallen, while overdoses associated with fentanyl have risen significantly, an indicator that other opioids and stimulants are being laced with fentanyl, often without the knowledge of the recipient, leading to increased overdose deaths.[30] Polydrug use, i.e., the combined use of different classes of drugs, especially fentanyl combined with stimulants, has resulted in a surge in HIV, HCV, and other infectious disease epidemics throughout the United States.[31]

The use of drugs before or during sex to enhance sex, called "Party and Play" or "chemsex," can be a driver of HIV and viral hepatitis transmission through facilitating more condomless sex and more partners. This phenomenon is common among some gay and bisexual men and transgender individuals, although this practice is not limited to these communities (see page 5). Common party drugs include meth, cocaine, GHB/GBL,[32] ecstasy, and ketamine. They can be smoked, snorted, swallowed, inserted rectally, or injected. As discussed, sometimes these substances are cut with fentanyl. The way in which these drugs are used can either increase or decrease the risk of overdose and/or HIV and viral hepatitis transmission; the overdose risk is especially heightened for "opioid naïve" users.

POLICY RESPONSE NEEDED: Develop tailored plans with the meaningful participation of people who use drugs to respond to the unique challenges in each jurisdiction.

The impact of the overdose crisis is not equally spread across the country. Even within highly affected regions (such as Appalachia), there can be large differences between urban and rural areas. Meth use also varies by region. In 2016, it accounted for fewer than 1% of treatment admissions east of the Mississippi, but accounted for anywhere from 12 to 29% of admissions at treatment sites west of the Mississippi.[33] Adding to the complexity are differences by age, gender, race/ethnicity, sexual orientation, and gender identity. This highlights the need for states, tribal nations, and local jurisdictions to develop their own evidence-based plans. They should start with an understanding of the local epidemiology and involve ongoing and meaningful engagement of people who use drugs, affected communities, and other stakeholders, such as through active participation on governing boards.[34] These plans should set priorities for population outreach (including active efforts to destigmatize people who use drugs), services delivery, and the geographic placement of critical services. In early 2020, the National Academies of Sciences, Engineering, and Medicine (NASEM) published a consensus report, *Opportunities to Improve Opioid Use Disorder and Infectious Disease Services: Integrating Responses to a Dual Epidemic*.[35,36] This report offers a number of important recommendations for better integration of services pertaining to opioid use disorder and infectious diseases, including improving access to substance use disorder treatment, increasing data sharing, addressing stigma, tackling issues with workforce and training, expanding the availability of harm reduction services, and advancing access to services within correctional settings.

2. EFFECTIVE INTERVENTIONS ARE RARELY DELIVERED AT THE NEEDED SCALE

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines a substance use disorder (or addiction) as being characterized by the recurrent use of substances that causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.[37] Most people who try drugs do not develop an addiction.[38] Further, people with an addiction can recover. Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.[39] Recovery is a lifelong process, and for some, recurrence of substance use is a manifestation of the disorder. Many people are able to maintain recovery for long periods of time. In any event, an individual's health and quality of life benefits from access to holistic recovery supports, therapy, medication, and other services.

As discussed, a harm reduction approach is critical. Whereas drug policies historically have been based on punishing people for using illicit substances, harm

reduction starts from the perspective that people have rights to be protected, including the right to control their own bodies, and seeks to identify strategies that facilitate individuals making choices that both protect their health and reduce the consequences of drug use for families and communities. While harm reduction can help persons with substance use disorders reduce their drug use and create pathways to recovery, its success is not dependent upon individuals stopping the use of drugs. The harm reduction toolkit includes a range of approaches and evidence-based practices, including SSPs and medication-based treatment. Various forms of therapy (including cognitive behavioral therapy,[40] contingency management,[41] and behavioral activation therapy[42]), along with peer-based recovery supports, services to address trauma and other life stressors, and fostering strong personal and/or community support systems, are also components of harm reduction.

Medication-based treatment is recognized as the most effective way to treat opioid use disorders and is also being used to treat meth addiction and other stimulant use disorders, although current therapies have not proven to be as effective as for opioid use disorders.[43] Therefore, more and better tools are needed, including more pharmacological agents to treat meth and other stimulant use disorders. While there are many pathways to recovery and abstinence-based approaches to addiction are effective for some, especially for people with alcohol or non-opioid substance use disorders, overwhelming evidence points to medication-based treatment as a safer and more effective approach to reducing overdose deaths.[44,45] Studies also have found that medication-based treatment increases rates of HIV viral suppression in persons with HIV and opioid use disorders.[46,47]

A major national challenge is that access to effective interventions and supportive harm reduction services can be extremely limited. Waiting lists exist for opioid treatment programs and other treatment services, there are too few eligible buprenorphine prescribers, people who inject drugs often face discriminatory barriers to curative treatment for hepatitis C (the infectious disease that, prior to the COVID-19 crisis, killed more Americans each year than any other),[48] and SSPs remain illegal in 12 states.[49] SSPs offer a critical bridge to other health services, including COVID-19 care, mental health and social services,[50] yet access can be limited in terms of hours of operation, program rules, local policies, and travel time to an SSP, thus rendering access meaningless.[51] In 534 counties, individuals must travel (on average) more than 195 miles to the nearest SSP.[52] In 3 counties, persons must travel more than 195 miles to the nearest substance use disorder treatment facility that provides at least one form of medication-based treatment.[53] Oftentimes, syringe distribution policies, such as one-for-one exchanges and caps on the number of syringes that can be exchanged, are very restrictive. As of 2016, only 11% of persons with an opioid use disorder received MOUD.[54]

POLICY RESPONSE NEEDED: Deploy effective interventions at greater scale.

To curb the impact of problematic drug use and reduce HIV and viral hepatitis transmission, effective interventions, including SSPs and medication-based treatment, need to be sufficiently accessible to persons who use drugs.[55] The NASEM report[56] recommends eliminating requirements for prior authorization for physicians to prescribe medications for opioid use disorders and for Congress to change the law that limits the number of patients for which providers can prescribe buprenorphine and that requires prior training before prescribing medications for opioid use disorders (i.e., X-Waiver requirement). Additionally, a greater focus needs to be placed on harm reduction and expanding service delivery options such as through mobile health units, as well as navigator programs that can create more timely and effective connections to a range of clinical and social services. CDC, along with SAMHSA, the White House Office of National Drug Control Policy (ONDCP) and the Office of National AIDS Policy (ONAP), and other partners should develop new metrics for assessing service capacity beyond travel time, and such indicators should be used to guide scale-up of critical services and remove prescribing barriers. The sustainability of services also must be considered: some perceive SSPs as a temporary measure to address outbreaks, but to slow HIV transmission, SSPs must be utilized as prevention tools that are implemented before outbreaks occur and exist for as long as there are people who need these services. Further, Congress should eliminate its prohibition on the use of federal funds for the purchase of syringes when used as part of an SSP in order to facilitate greater SSP capacity.[57]

Within the context of HIV prevention, more needs to be done to expand access to HIV screening, pre-exposure prophylaxis (PrEP), and post-exposure prophylaxis (PEP) services for people who use drugs. The HIV community was at the forefront of the development of SSPs and other critical services, such as methadone expansion, and this same attention is needed to push for the development of, and greater access to, behavioral and medication-based interventions for opioid and stimulant use disorders, and to push for the legalization and deployment of overdose prevention services. Overdose prevention services, including establishing safe spaces that allow for the use of drugs with medical supervision to test the safety of substances (i.e., provide fentanyl test strips), and that provide wound care, overdose education, and naloxone provision, are critically important and should be embraced as natural extensions of existing SSPs. They also offer an opportunity to remove siloes and create more holistic responses to prevent and treat HIV, viral hepatitis, and other infectious diseases, as well as treat opioid and other substance use disorders. Although public health officials and community advocates have sought

GAY AND BISEXUAL MEN, METHAMPHETAMINE USE, AND HIV

JUST AS NEW APPROACHES ARE NEEDED FOR GOVERNMENT POLICIES, NEW STRATEGIES ARE ALSO NEEDED FOR COMMUNITIES so that they can limit the harm of drug use while respecting and supporting members of the community. Meth use in some communities of gay and bisexual men is a significant factor in HIV transmission and poor treatment outcomes. Thus, community leadership and government policy need to foster heightened commitment to tackling these issues through more education, dialogue, and productive responses. Meth use among gay and bisexual men is connected to several complex social factors, including homophobia, racism, and exploitation (a). It can increase risk for HIV and other infectious diseases, with a recent study finding that one-third of HIV seroconversions among sexual and gender minority men engaged in regular meth use (b). Data indicate that meth use is increasing among Black and Latinx gay and bisexual men in certain parts of the country (c). A 2019 study found meth is the substance contributing most to negative outcomes in HIV viral suppression (d).

People often use drugs because it provides pleasure. For gay and bisexual men, they can derive pleasure from meth alone, or as a way to facilitate more pleasurable sex and to enable long periods of sex. This can lead to more sexual partners and higher risk sexual practices that may have the effect of increasing HIV transmission. Long-term use of meth is associated with changes to the pleasure sensors in the brain that may reduce the enjoyment of sex in the absence of meth and that also may lead to increasing meth use. It is estimated that about 10-27% of gay and bisexual men have used meth in the last year, a level that is 5-10 times the estimated level in the general population (e, f).

WHAT IS TO BE DONE?

- **Create more supportive communities and make health care settings welcoming to people who use drugs:** Too frequently the LGBTQ+ community has relied on avoidance and shaming when faced with meth use. More and sustained investments are needed in community dialogue, stigma reduction, and the creation of more welcoming communities for people in recovery and people who use drugs. Advocacy is also needed to make health care settings safe and welcoming for people who use drugs and to expand the competency of providers to treat people with substance use disorders and refer them to harm reduction services.
- **Expand access to cognitive/behavioral therapy and contingency management interventions and accelerate the development of medication treatment options for meth addiction:** Cognitive/behavioral therapy and contingency management interventions have been shown to reduce meth use, and expanded access to these interventions is critical (g, h). Some providers are using stimulants such as methylphenidate and risperidone as medication treatment for methamphetamine use disorder (MUD). While some promising data on the use of naltrexone and bupropion as medication to treat MUD exists (i), the evidence for effective medication treatment of MUD is inconclusive, and there is no medication approved by the Food and Drug Administration for treating MUD. Accelerated research to develop medication treatment options for MUD is needed.
- **Provide status-neutral HIV services in settings that support people who use meth:** Given the association between HIV transmission and meth use, it is important to integrate PrEP, PEP, and HIV treatment or navigation services within programs that offer harm reduction and substance use treatment services for people who use meth.
- **Increase education about meth and raise awareness of harm reduction and substance use treatment services among people who use meth and who are not connected these services:** Inadequate knowledge about meth may leave gay and bisexual men unaware of serious harms. Further, many of these men may be unaware of programs for people who use meth, and stigmatizing responses to meth use may prevent individuals from accessing programs. More efforts are needed to educate people about meth, inform people who use meth about harm reduction and substance use treatment services, and connect people to these services.

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COMMUNITY RESPONSES OFFER A PATH FORWARD

"NOTHING ABOUT US, WITHOUT US" is a mantra of many advocates. The following is a brief selection of innovative programs or agencies that rely on active leadership from, or have partnerships with, people who use drugs:

The Eastern Band of Cherokee Indians in North Carolina (ebci.com) identified substance use as a main priority in a recent Tribal Health Improvement Plan and has taken steps to address it. American Indians have one of the highest rates of substance use disorders compared to other groups. The Eastern Band has established the Analenisgi Recovery Center, which offers therapies, treatment, and peer support groups, created a Unity Healing Center for youths battling substance use disorders, and has also started an SSP.

Philadelphia Safehouse (safehousephilly.org) seeks to be the first safe injection site in the U.S. and will provide a range of overdose prevention services, including safe consumption and observation rooms, recovery counseling, education about substance use treatment, and more. Safehouse is an example of the type of program that is necessary to prevent overdose deaths and create more pathways to health and recovery services. And although the recent 3rd Circuit decision regarding Safehouse's right to operate was not in its favor, the possibility of further litigation remains.

Poderosos (poderosos.org) is based along the US-Mexico border and focuses on improving health outcomes of all Latino communities, but particularly emphasizing those who are LGBTQ, those living with HIV, and those battling substance use disorders. In 2021, Poderosos launched a 3-year project with the University of Texas – El Paso to design, evaluate, and publish the results of a contingency management program for Latino MSM who use meth.

The Police Assisted Addiction & Recovery Initiative (paariusa.org), which began in one county in Massachusetts, has grown into a national network of nearly 600 police departments across 34 states, each working to implement customized non-arrest programs in their communities. Multiple entry points and cross-sector partnerships between law enforcement and clinicians and social workers have allowed early diversion programs to be successful, thus helping to reduce overdose deaths and expand access to treatment and recovery.

The San Francisco AIDS Foundation's (sfaf.org) Positive Reinforcement Opportunity Project (PROP) is a model contingency management program for reducing meth use, and Tweaker.org is a unique harm reduction resource for gay men who use meth and other party drugs.

approval to administer these services in several places, including Philadelphia, San Francisco, Seattle, and Vermont, to-date, they are not currently being deployed in this form, in the U.S.

3. CRIMINALIZATION OF DRUG USE CAUSES GREAT HARM

In 2018, there were more than 1.6 million drug arrests, with more than 86% being for drug possession alone.[58] Being arrested for the possession or use of drugs does not appear to be an effective deterrent to drug use and is frequently highly racially discriminatory in who is arrested and prosecuted.[59,60] Arrest and prosecution harm individuals in ways that destabilize families and communities. It is traumatizing, can cause people to lose possessions and money, can cause job loss or harm future employment, and for people living with HIV or other health conditions, can cause interruptions in treatment, with harmful effects.[61]

Responding to drug use challenges is often framed as a false binary choice between maintaining longstanding punitive approaches and not recognizing the harms of drug use. There is a growing movement, however, that acknowledges that new approaches are needed. This includes decriminalizing personal drug consumption through the elimination of criminal penalties for use and possession, possession of equipment used to administer drugs (that hinder the effectiveness of sterile syringes at preventing infectious disease transmission), and low-level drug sales, as well as continuing to offer medication-based treatment to persons even after an arrest, including in jails and prison and those on parole and probation. The latter can be maintained through strong linkage programs to communities, including increased access to medications and SSPs. In December 2020, the House of Representatives passed the Marijuana Opportunity Reinvestment and Expungement Act of 2019, indicating legislative support for some forms of decriminalization.[62] Twenty-six states and the District of Columbia also have decriminalized small amounts of cannabis under state law.[63] Further, in November 2020, the voters of Oregon decriminalized small amounts of cannabis and other substances, including stimulants and opioids,[64] and the voters of the District of Columbia voted to make the enforcement of penalties for laws against the use of natural plant medicines among the lowest law enforcement priorities.[65] The most prominent evidence of the impact of decriminalization comes from Portugal,

which decriminalized drug possession in 2001, a move that has been widely viewed as successful.[66] Since Portugal enacted its changes, overdose deaths and new HIV cases have declined.[67] These benefits, however, may stem from other aspects of the country's reform, as decriminalization was paired with greatly expanded access to substance use disorder treatment and other initiatives.

POLICY RESPONSE NEEDED: Decriminalize substance use and re-orient drug use policy to enhance prevention, harm reduction, and treatment of addiction.

The purpose of drug use policy should be to prevent harm and support recovery. Arrests and prosecutions punish individuals for a manifestation of their addiction, and the ongoing impact of arrest and involvement in the justice system creates barriers to recovery, employment, and stable housing, and can produce stresses that increase the risk for further use and/or relapse. Some current investments in law enforcement could be more effective if allocated to community-supported, evidence-based prevention, and treatment programs.

THE TIME IS NOW

Respecting the rights and protecting the dignity of all people sounds easy, but in practice, laws, policies, and even some programs have led to stigmatization and harm to many groups of marginalized people, including people who use drugs. As we commit to finally ending the HIV epidemic, we need to implement an integrated and sustained approach that prioritizes greatly expanded access to comprehensive harm reduction services, focuses on addressing substance use disorders and HIV education, and lifts up all members of our communities. We can improve health outcomes and reduce HIV transmission, but this will require thinking differently about addiction and substance use and doing more to promote public health, support recovery, and foster more resilient communities.

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