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CDUHR news

Center for Drug Use and HIV Research
in the Institute for AIDS Research at the National Development and Research Institutes, Inc.

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25 Years of HIV/AIDS in NYC : A Brief Overview of Current Trends

HIV/AIDS Cases in NYC

Since 1981, over 190,000 individuals in New York City have been diagnosed with HIV/AIDS and approximately 90,000 have died.[1] New York City continues to be the epicenter of the HIV/AIDS epidemic in the United States, with the highest number of AIDS cases in the country, more than Los Angeles, San Francisco, Miami and Washington, DC combined.[2] Starting from the first reported cases of AIDS in 1981,[3] into the mid-1990's, there was a steady increase of reported cases and deaths each year. With the advent of HAART in 1996, the number of AIDS cases and deaths began to decline, and by 2000, the numbers stabilized. In June 2000, New York State's HIV Reporting and Partner Notification Law went into effect which required names reporting of cases of HIV infection in order to improve the monitoring and tracking of the epidemic. (Prior to the enactment of this law, reporting was only required for AIDS cases.)

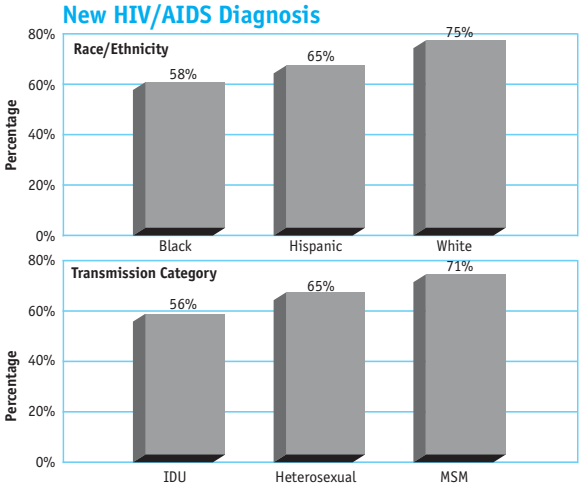
NYC continues to be the epicenter of the HIV/AIDS epidemic in the U.S. In terms of drug users, research is needed to reduce sexual transmission and enhance healthcare utilization.

From 2001-2004, the total number of new HIV diagnoses in NYC declined each year; in 2001, there were 5425 new cases, and in 2004, there were 3653 cases.[1] In 2004, racial and ethnic minorities accounted for approximately 85% of all new HIV diagnoses (Blacks 54%, Hispanics 29%, Whites 15%) and women accounted for almost one-third of these cases.[4] In 2004, 43% of new HIV diagnoses were among those 40 years of age or older.[4] HIV diagnosis rates were highest in the boroughs of Manhattan and the Bronx.[1] While injection-related transmission has been declining, sexual transmission among drug users appears to be increasing in importance. For example, a recent report showed HIV prevalence rates were similar for currently-injecting and never-injecting drug users (12-17%).[5]

Disparities in Healthcare and Mortality

Despite the availability of testing and treatment, over

Percentage in Care within Three Months of New HIV/AIDS Diagnosis



28% of those newly diagnosed with HIV in NYC, in 2004, were concurrently diagnosed with AIDS.[6] Groups more likely to be concurrently diagnosed included: those infected through heterosexual transmission and older persons (peaking among those 60 years or older).[6] Among those newly diagnosed with HIV/AIDS, over 60% began treatment within three months. Blacks were the least likely to be in care within three months (58%) compared to Hispanics (65%) and Whites (75%). Individuals infected through injection drug use were less likely to be in care (56%) compared to those infected through heterosexual (65%) or MSM (71%) transmission.[6]

Among those with HIV/AIDS, there were also disparities in HIV-related death rates by race/ethnicity, transmission risk category and neighborhood of residence. Compared to Whites, Blacks were 2.5 times and Hispanics 2 times more likely to die from HIV-related causes.[6] In 2004, IDUs accounted for 24% of HIV/AIDS cases and 42% of deaths,[1] and were more likely to die from HIV-related causes than individuals from other transmission categories.[6] HIV-related mortality rates were higher among residents in the Bronx and Brooklyn compared to other NYC boroughs; neighborhoods targeted as "high-need" for programs to reduce health inequalities had HIV-related mortality rates that were almost two times higher than those not so identified.[6]

(Continued next page.)

HIV/AIDS IN NEW YORK CITY *Continued*

Research Needs and Recommendations

Research is needed to further understand and reduce disparities in healthcare utilization and mortality, among neighborhoods, transmission risk groups, and racial/ethnic groups. Prevention efforts targeting sexual transmission among drug users are needed. It is critical to continue the monitoring of HIV/AIDS in order to track its constantly changing characteristics, and to help develop and target prevention efforts.

1. Torian, L. of the NYCDOHMH (2006, November). HIV/AIDS in NYC: State of the epidemic, 2004. Presented at IAR/CDUHR AIDS Seminar, New York.
2. NYCDOHMH (2006). Expand access. Improve patient care. Stop HIV in NYC. Available at: http://www.nyc.gov/html/doh/downloads/pdf/ah/ah-summary.pdf
3. Centers for Disease Control and Prevention (1981). Pneumocystis pneumonia – Los Angeles. Morbidity and Mortality Weekly Report, 30, 250-252.
4. NYCDOHMH (2005). NYC HIV/AIDS Surveillance Statistics, 2004, updated November 10, 2005. Available at: http://www.nyc.gov/html/doh/html/ah/hivtables2004.shtml
5. Des Jarlais, D. C., Arasteh, K., Perlis, T., Hagan, H., Abdul-Quader, A., et al. (in press). Convergence of HIV seroprevalence among injecting and non-injecting drug users in New York City. AIDS.
6. NYCDOHMH, HIV Epidemiology Program (2006). 1st semiannual report covering January 1, 2005-June 30, 2005.

NEW CDUHR PROJECTS

In this section of the newsletter, information regarding new CDUHR projects are described. A total of eight new projects have been added since August 2006.

Honoria Guarino & Lisa A. Marsch

Computer Delivery of Effective Psychosocial Interventions in Methadone Treatment (NIDA)

Principal Investigator: Lisa A. Marsch, Ph.D.
Project Staff: Honoria Guarino, Ph.D., Senior Research Associate

Methadone maintenance has been shown to be safe and effective in the treatment of opioid dependence, and to be most effective when provided along with psychosocial interventions that address an array of client needs (e.g., patient education, skills training). However, methadone programs typically offer little drug counseling or educational services and have the highest client-to-staff ratios relative to other types of drug treatment programs. In this project, an interactive computer-delivered, evidence-based psychosocial intervention – the Therapeutic Education System (TES) – will be evaluated for its effectiveness. The TES contains over 65 modules to improve skills and behaviors including: family/social relations, communication and decision-making, management of negative moods and time management. Many modules relate specifically to drug use (e.g., drug refusal skills, prevention of HIV and hepatitis C). New patients entering methadone treatment will be randomly assigned to receive standard methadone counseling, or standard methadone counseling plus TES. Clients in both groups will be compared on drug use (using urine toxicology), treatment retention, self-reported drug use, HIV risk behavior, therapeutic alliance and psychosocial functioning. In addition, a comprehensive economic analysis of adding TES to standard methadone treatment will be performed.

Naomi Braine

Evaluation of Implementation of Harm Reduction Services in MMTP (amfAR & NYCDOHMH)

Principal Investigator: Naomi Braine, Ph.D. (BIMC)

A significant proportion of clients in methadone maintenance treatment programs (MMTPs) continue to use illicit drugs after initiating methadone treatment. This puts them at risk for HIV and other blood-borne infections, as well as for drug overdose. MMTPs focus on reducing or eliminating drug use and have not provided health services to reduce the risks associated with continued drug use. This study will evaluate the process and outcomes of implementing overdose prevention education, providing Naloxone[1] prescriptions and other risk reduction education services at a clinic in the Beth Israel Medical Center MMTP system. Baseline and follow up interviews will be conducted with clinic staff to evaluate the process of service development and implementation, and with clients to determine who uses the new services and outcomes of service implementation. Interviews will also be conducted with senior MMTP management and state regulatory officials to identify potential institutional and regulatory barriers to the development of risk reduction services within drug treatment contexts. The findings will enable identification of positive (e.g., risk reduction) and negative (e.g., resumption of drug use) outcomes from the implementation of these new services and analysis of institutional processes that shape the integration of risk reduction services and drug treatment.

1. Used to treat or reverse the effects of opiate drug overdose.

Top Row: Monica Macri, Lorena Borjas, Jeffrey Becker & Sel Hwahng; Bottom Row: Bali White, Larry Nuttbrock & Mona Rae Mason

HIV/STD Infection in an Urban High Risk Population[2] (NIDA)

Principal Investigator:
Larry Nuttbrock, Ph.D.
Project Staff: Mona Rae Mason, Field Coordinator; Jeffrey Becker, Monica Macri & Bali White, Research Associates; Sel Hwahng, Investigator, Administrative Supplement; Lorena Borjas & Michelle Maldonado, Special Consultants

High rates of HIV and other sexually transmitted infections (STIs) have been found among biological males who define themselves as females (trans women). This study will identify the behavioral and risk factors for HIV and other STIs among this group. Trans women are being recruited and tested for HIV, chlamydia, gonorrhea, syphilis, and hepatitis B and C. Prevalence and incidence rates will be determined. HIV negative participants will be tracked for three years to determine changes in their risk factors and HIV and STI infection or reinfection. Aspects of injection drug use (for illicit drugs and female hormones) and high-risk sexual behavior will be evaluated as behavioral modes of HIV and STI transmission. The study will also explore associations among economic hardships, paid sex work, and validation sex (seeking out sexual relationships to legitimize a sense of themselves as females). Findings from this study will inform future interventions for this population.

2. This project, located in NDRI's Institute for Treatment Services Research, has been ongoing since 2004; it currently is also part of CDUHR.

Roberta Berry, Patrice Joyner, Marjorie Goldstein & Elizabeth Eckhardt

The Science of Addiction for Deaf High School Students – Phase II (NIDA)

Principal Investigator:
Marjorie F. Goldstein, Ph.D.
Project Staff: Elizabeth Eckhardt, Ph.D., Co-Investigator; Patrice Joyner, M.S.W., Project Director; Roberta Berry, M.F.A., Senior Research Assistant

In phase I of the project, three segments from the National Institute on Drug Abuse curriculum *The Brain: Understanding Neurobiology through the Study of Addiction* were selected for adaptation and translation into American Sign Language (ASL) for deaf high school students. Each section was digitized and programmed into a CD-ROM prototype for feedback from deaf students and science teachers of deaf students. This feedback suggested that all modules follow a specific format: an introduction, description of individual elements, and a summary of how the individual elements relate to the whole. An expert consultant in science education for deaf students also recommended that "self-test" questions be included throughout each module in order to hold students' attention. In addition, wide variation in reading levels of students should be taken into account, since some deaf students who use ASL read at or near grade level, while others have poor reading skills. It was also suggested that 3-D graphics and more "action" be incorporated. In phase II of this project, the full curriculum will be adapted, digitized and programmed onto CD-ROM and evaluated for its efficacy as a teaching tool. The CD-ROM will be marketed and distributed to companies that sell educational materials for deaf students.

Kamyar Arasteh

Secondary Analysis of Alcohol and Sexual and Injection HIV-Risk Behaviors (NIAAA)

Principal Investigator:
Kamyar Arasteh, Ph.D. (BIMC)
Project Staff: Don Des Jarlais, Ph.D. & Theresa Perlis, Ph.D., Co-Investigators

Several studies suggest that alcohol use is associated with HIV risk and lower probability of antiretroviral treatment. Among drug users, alcohol use is prevalent. Despite this, the role of alcohol use in HIV-related processes has not been adequately investigated. In this study, secondary analyses of data collected from three CDUHR-affiliated studies[3] will be conducted. The data sets include data from over 15,000 drug users collected over a period of 14 years of the HIV epidemic across 14 different national settings. The study will determine the association of alcohol consumption on sexual risk behavior, injection risk behavior, HIV testing and the probability of being on antiretroviral treatment (for those who are HIV-positive.) The study will also explore the relationship between alcohol use and HIV among IDUs in environments with many versus few prevention programs and in developing and transitional countries.

3. The CDUHR studies and their funding sources: Puerto Rican Drug Users in NY and PR: HIV Risk Behavior Determinants (NIDA; S. Deren, PI); Risk Factors for AIDS Among IDUs (NIDA; D. Des Jarlais, PI); WHO Survey Coordinating Center, Drug Injecting Study (WHO; D. Des Jarlais, PI).

Janetta Astone-Twerell & Shiela M. Strauss

STOP Hep C – Outpatient (Josiah Macy, Jr. Foundation)
Principal Investigator:
Shiela M. Strauss, Ph.D.
Project Staff: Janetta Astone-Twerell, Ph.D.

Hepatitis C virus (HCV) education currently provided to staff in drug treatment programs typically consists of a brief component in a didactic session on infectious diseases. As a result, staff are often uninformed about hepatitis C risk factors, transmission, etiology, testing and treatment. Services for HCV (e.g., testing and medical support) are often not provided, and when they are provided, they are often underutilized. Staff perspectives and counseling can influence patients' behavior, including their use of existing services, and providing up-to-date information to staff may positively influence the health behavior of patients. This project is therefore implementing and evaluating an evidence-based training for clinical and medical staff in five outpatient drug treatment programs in the NY metropolitan area. The goal of the training is to increase staff knowledge on the HCV epidemic among drug users, and to provide skills to increase delivery and coordination of HCV services to clients. In order to reinforce the information in the training, and to sustain its impact on the program, participants' manuals and other resources will be provided. Using this information, a key staff person in the program will be able to deliver the training to new staff.

Supporting Alcohol Reduction in HIV+ Patients: A Training for HIV Care Providers (NIAAA)
Principal Investigator: Shiela M. Strauss, Ph.D.
Project Staff: Janetta Astone-Twerell, Ph.D., Co-Investigator/Project Director; Corinne Munoz-Plaza, M.P.H., Principal Research Associate

The consequences of alcohol use among individuals with HIV and HIV/HCV co-infection include: accelerated disease progression, reduced effectiveness and access to antiretroviral therapy, and increased probability of HIV sexual risk behavior. HIV care providers are in the position to screen and counsel patients about reducing alcohol consumption, but rarely do so, often because of limited skills and knowledge. This study will develop and evaluate a training for providers to support the systematic use of NIAAA's Brief Intervention (BI) to reduce alcohol use in four Designated AIDS Centers in New York City. The training will teach providers to screen patients for alcohol use and effectively counsel them to reduce alcohol consumption. The project will assess the impact of the training on patients' alcohol use and providers' skills, knowledge, attitudes and actual use of the BI. In addition, the project will assess the HIV provider organization regarding changes in organizational climate towards dealing with alcohol and HIV and HIV/HCV co-infection, and impact on services to reduce alcohol use.

David Perlman

HIV and Hepatitis Care Coordination in Methadone Treatment (NIDA)
Principal Investigator:
David C. Perlman, M.D. (BIMC)
Project Staff: Noami Braine, Ph.D., Project Director; Don Des Jarlais, Ph.D., Albert Min, M.D. & Randy Seewald, M.D., Co-Investigators

Injection drug users (IDUs) have high rates of HIV and viral hepatitis including hepatitis A (HAV), hepatitis B (HBV) and hepatitis C (HCV). Drug users experience significant barriers to accessing prevention and care services. An integration of HIV and hepatitis prevention, screening and health care services into drug treatment programs may increase engagement in and adherence to medical care. This study will examine the effectiveness of a strategy of HIV and hepatitis care coordination (HCC) consisting of testing, education, counseling and vaccination for methadone maintenance patients compared with standard testing, education and counseling (TEC). In HCC, HIV and hepatitis screening, education, counseling and case management to promote HIV and HCV evaluation, plus HAV and HBV vaccination, will be provided on-site. In TEC, hepatitis screening will be conducted on-site, but vaccinations will be provided by an off-site referral. The two groups will be compared on adherence to HAV and HBV vaccinations, attendance at an initial appointment to an HIV and/or HCV care provider, HIV and hepatitis knowledge, HIV-related risk behaviors and alcohol use.

National HIV Behavioral Surveillance Among Injection Drug Users: New York City

Principal Investigator: Holly Hagan, Ph.D.;
NYCDOHMH PI: Christopher Murrill, Ph.D.
Funding Agency: CDC through the NYCDOHMH

Project Staff:

Travis Wendel, J.D., ABD
Project Director

Alix Conde
Noel Trejo &
Aundrea Woodall
Research Associates

Libertad Guerra
Research Assistant

Samuel Jenness
Research Scientist,
NYCDOHMH

Background and Objectives

In 2004, the Centers for Disease Control and Prevention (CDC) began funding projects in 25 metropolitan statistical areas (MSAs)[1] to implement a behavioral surveillance system for three groups at highest risk for HIV: men who have sex with men (MSM)[2], injection drug users (IDUs) and high-risk heterosexuals (HRH). The surveillance system was intended to provide nationwide tracking of changes in HIV-related risk behavior over time, with each of the high-risk groups surveyed in alternating 12-month cycles. This project is the New York City IDU component of the national study, conducted in 2005.

The objectives of the study were to:

- Estimate HIV prevalence among IDUs
- Determine the frequency and correlates of HIV risk behavior
- Assess HIV testing history and patterns
- Assess the use of HIV prevention services in NYC

Participants and Methods

The first phase of the project was to describe the IDU community in NYC. Key informant and focus group interviews were conducted, in addition to ethnographic observations and mapping, and a review of published reports on HIV/AIDS and drug use in NYC. This phase helped guide recruitment and the development of local prevention questions. In the second phase, participants were recruited using respondent-driven sampling (RDS).[3] Survey participants were asked to provide a blood sample for HIV and HCV testing.

Travis Wendel, Noel Trejo, Aundrea Woodall, Libertad Guerra & Alix Conde

To be eligible for the study, participants were required to: 1) be an active injector (in the past year) of unprescribed drugs; 2) have visible signs of injection, or detailed knowledge of injection practices; 3) be over 18 years of age; 4) be a resident in the NYC metropolitan area; 5) have a valid study coupon; and 6) be alert and able to complete the survey in English or Spanish.

A total of 1,332 coupons were distributed and 555 potential participants were screened for eligibility. Recruitment was complete when 500 participants were determined to be eligible and completed the survey; approximately half were tested for HIV. Interviews were conducted at syringe exchange programs (SEPs) in the Bronx, Brooklyn, Manhattan and Queens. Participants were primarily male (72%); over half were Hispanic (57%, 27% Black, 16% White); most were between the ages of 18-49 (12% were 18-29, 27% were 30-39, 39% were 40-49, 21% were 50-59); 48% were homeless in the past year; and 15% reported being bisexual or homosexual.

Preliminary Findings

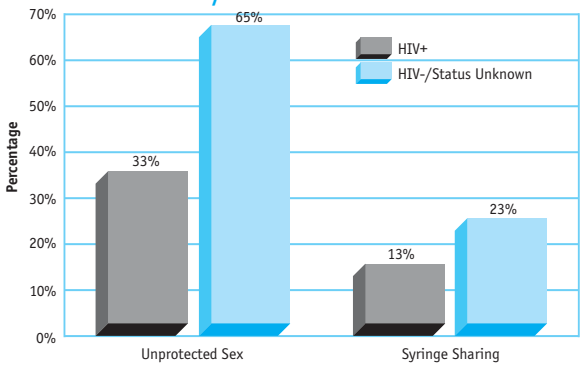
HIV prevalence: Self-reported vs. HIV testing—Overall in the four boroughs, 20% self-reported as HIV-positive. The highest rates of self-reported HIV were among those recruited in the Bronx (34%), followed by 14% in Manhattan and Queens, and 12% in Brooklyn. Of those who were tested for HIV, overall, 18% were HIV-positive. The highest prevalence rate from HIV-testing was among IDUs in Queens (40%), followed by IDUs in the Bronx (34%), Manhattan (11%) and Brooklyn (8%).[4]

HIV testing by sex, age and race—There were no significant differences between men and women, or among those in different age categories, regarding reporting ever being tested for HIV (96-100%). Those who were 25-39 years of age were more likely (80%) to report having been tested in the prior 12

months compared to those who were older (62%) and younger (69%). When the data were adjusted for reported HIV status (i.e., those who already reported being HIV-positive were removed from the analysis) Hispanic IDUs were 1.8 times more likely than Black IDUs to report having an HIV test in the prior 12 months.[4]

Sexual-risk risk behavior in the prior 12 months— For the total sample, 59% reported unprotected sex, 26% reported exchanging sex for drugs or money, and 23% reported having a past sexually transmitted infection diagnosis. Among those who were HIV-positive, 33% reported having unprotected sex in the past year; 65% of those who were HIV-negative/status unknown reported unprotected sex. Factors associated with unprotected sex included: residing outside Manhattan, consuming alcohol during sex, sharing injection paraphernalia, and reporting sexual orientation as heterosexual or bisexual.[4]

Unprotected Sex and Syringe Sharing among HIV+ and HIV-/Status Unknown IDUs



Drug-related risk behavior in the prior 12 months— Approximately 70% of IDUs injected at least once a day, 90% had injected 1-3 types of drugs and 77% reported non-injection drug use. When asked where they obtained syringes over the past year, a significant number reported using potentially unsterile syringes: 55% reported obtaining syringes from a friend, partner or relative, 29% reported obtaining them from a dealer, shooting gallery, or the street. Seventy-one percent reported obtaining syringes from SEPs, 51% from pharmacies and 11% from a hospital or clinic. Almost half (47%) reported any sharing behavior (e.g., sharing cooker, cotton, water, syringe, dividing drugs with a syringe). Approximately 13% of HIV-positive IDUs reported syringe sharing, while 23% of HIV-negative/status unknown, reported syringe sharing. Factors associated with syringe sharing included: being homeless, being arrested in the past year, injecting more than two drugs, obtaining all syringes from potentially unsterile sources, and reporting sexual orientation as homosexual or bisexual.[4]

Implications and Recommendations

These estimates from the RDS-recruited sample have not been adjusted for recruitment patterns, thus they should be viewed as preliminary estimates. Nonetheless, several important observations can be made. Engaging in unprotected sex and syringe sharing, while higher among HIV-negative/status unknown IDUs than HIV-positive IDUs, was reported in both groups. Continued efforts to further reduce risk behavior are needed. Male IDUs who have sex with men and women were a subgroup that engaged in particularly high rates of injection-related and sexual risk behaviors, indicating the need for enhanced prevention efforts. Not obtaining syringes from SEPs was the strongest predictor of syringe sharing (and was reported most often among Brooklyn and Queens participants). Efforts to increase the use of sterile syringe sources in these areas are needed. There was a wide range of HIV prevalence among IDUs from the different boroughs of NYC indicating that sampling from different boroughs is recommended to assess NYC prevention needs as a whole. Respondent driven sampling was found to be an effective method for reaching IDUs and may be useful in future studies.

1. For a complete list of the 25 MSAs, go to: http://www.cdc.gov/programs/hiv09.htm
2. From 2003-2004, the MSM cycle was conducted in 16 MSAs.
3. Recruitment began with an initial group of 15 individuals called "seeds." Seeds were asked to recruit three similar people in their social networks, to whom they gave a coupon with a serial number. New recruits were interviewed and asked to recruit three more people in their networks. Coupons were used to track connections from recruiter to those they recruited.
4. New York City Department of Health and Mental Hygiene, HIV Epidemiology Program (2006). HIV prevalence and risk among injection drug users in New York City: Results form the National HIV Behavior Surveillance (NHBS).

For additional information on this study you may contact Holly Hagan, Ph.D., Principal Investigator – e-mail: hagan@ndri.org

Correction

In the Spring/Summer 2006 issue of the CDUHR news, the last line in the article *David Perlman Joins CDUHR as Director of the Biomedical Core* was omitted due to a printer's error. The last sentence should have read: "He practices general infectious diseases, including HIV medicine." We regret any confusion this may have caused.

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The NDRI Training Institute

The NDRI Training Institute (A. Osborne, Director) provides training for the New York State Department of Health AIDS Institute and conducts courses by special request. Following are courses available from January – June 2007, offered at no cost. All courses are held at the NDRI main offices unless otherwise noted. Please note: the schedule is subject to change. Go to the website (www.training.ndri.org) for the complete schedule and to register for courses.

Date	*Course*
1/17-1/19	Reducing the Risk and Harm of HIV (Three days)
1/23	HIV & STDs (3 hours)
1/23, 3/27, 5/18	◆ Overview of HIV Infection and AIDS (3 hours)
2/1	◆ Domestic Violence in Lesbian, Gay, Bisexual & Transgender Communities (One day)
2/8-2/9, 4/9-4/10	◆ Mental Health Services (Two days)
2/13	What's New in HIV/AIDS? (3 hours)
2/13, 4/17	◆ HIV Testing in NYS: 2005 Guidance (3 hours)
2/15, 4/19	◆ HIV Testing Skills Practice Session (One day)
2/21-2/22	◆ It's Time: Integrate Viral Hepatitis Into Your Work (Two days)
2/27, 6/21[a]	◆ Addressing Prevention in HIV Positive Clients (One day)
3/20-3/22	Skills Practice and Implementation of Stage-Based Behavioral Counseling (Three days)
3/27	HIV Disclosure (3 hours)
4/12, 5/22	◆ Building Bridges to Cultural Competency (One day)
4/17, 5/24	HIV/AIDS Confidentiality Law (3 hours)
4/24	◆ Introduction to Case Management (One day)
4/26[b]	Addressing Prevention in HIV Case Management (One day)
5/1[a]	◆ Enhancing the Partnership Between Client and Case Manager (One day)
5/15-5/16	Serving Families: From Assessment to Service Plans (1½ days)
5/18	HIV Treatment Fraud (3 hours)
5/24	◆ Promoting Adherence to HIV Treatment (3 hours)
5/30-5/31	VOICES/VOCES (Video Opportunities for Innovative Condom Education and Safer Sex) (Two Days)*
6/4-6/7	◆ Community HIV/AIDS Educator Training (Four days)*

a Samaritan Village, Queens
b Bronx AIDS Services

◆ Training courses are provided under NYS OASAS Education and Provider Certificate Number 0305 and are acceptable for CASAC credits.
* Course requires screening and confirmation via telephone for enrollment.

For a complete listing of courses, the curriculum of Special Request courses, CDUHR-sponsored Training Institute courses, and information on the courses listed above, call the Training Institute at (212) 845-4550.

The Center for Drug Use and HIV Research is funded by the National Institute on Drug Abuse (Grant # P30 DA011041) to provide an infrastructure to support the HIV/AIDS-related research projects at NDRI. It is the first center for the socio-behavioral study of drug use and HIV in the United States and is dedicated to increasing our understanding of the drug use-HIV epidemic.

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CDUHR Projects

Applying Web Technology to Buprenorphine Treatment (NIDA)
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Community Vulnerability and Response to IDU-Related HIV (NIDA)
PI: Samuel R. Friedman, Ph.D.

Computer-Assisted HIV Prevention for Young Drug Users (NIDA)
PI: Lisa A. Marsch, Ph.D.

Computer Delivery of Effective, Psychosocial Interventions in Methadone Treatment (NIDA)
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Couples HIV Intervention Randomized Controlled Trial (NIDA)
PI: James M. McMahon, Ph.D. (IRYAR)

Etiology and Prevention of Blood-Borne Viruses in IDUs (NIDA)
PI: Holly Hagan, Ph.D.

Evaluation of Implementation of Harm Reduction Services in MMTP (amfAR & NYCDOHMH)
PI: Naomi Braine, Ph.D. (BIMC)

Expanding Computer-Based Drug Abuse Prevention (NIDA)
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HIV and Hepatitis Care Coordination in Methadone Treatment (NIDA)
PI: David C. Perlman, M.D. (BIMC)

HIV Knowledge and Risk among Deaf Adolescents (NIDCD)
PI: Marjorie F. Goldstein, Ph.D.

HIV Risk and Substance Use in Adolescent Couples (NIDA)
PI: Noelle R. Leonard, Ph.D.

HIV/STD Infection in an Urban High Risk Population (NIDA)
PI: Larry Nuttbrock, Ph.D. (ITSR)

Increasing HCV Knowledge and Service Use in Drug Treatment Programs (NIDA)
PI: Shiela M. Strauss, Ph.D. (ITSR)

An Intervention for Migrant Puerto Rican Drug Users (NIDA)
PI: Sherry Deren, Ph.D.

Interventions for HIV-Positive Mothers with Drinking Problems (NIAAA)
PI: Marya Viorst Gwadz, Ph.D.

National HIV Behavioral Surveillance Among High-Risk Heterosexuals: New York City (NYCDOHMH)
PI: Holly Hagan, Ph.D.

Risk Factors for AIDS Among IDUs (NIDA)
PI: Don C. Des Jarlais, Ph.D. (BIMC)

The Science of Addiction for Deaf High School Students – Phase 2 (NIDA)
PI: Marjorie F. Goldstein, Ph.D.

Science-Based Treatment for Opioid-Dependent Adolescents (NIDA)
PI: Lisa A. Marsch, Ph.D.

Secondary Analysis of Alcohol and Sexual and Injection HIV-Risk Behaviors (NIAAA)
PI: Kamyar Arasteh, Ph.D. (BIMC)

Staying Safe: Long-Term IDUs Who Avoided HIV & HCV (NIDA)
PI: Samuel R. Friedman, Ph.D.

STOP Hep C – Outpatient (Josiah Macy, Jr. Foundation)
PI: Shiela M. Strauss, Ph.D. (ITSR)

Supporting Alcohol Reduction in HIV+ Patients: A Training for HIV Care Providers (NIAAA)
PI: Shiela M. Strauss, Ph.D. (ITSR)

Synthesis: HCV Epidemiology and Prevention in Drug Users (NIDA)
PI: Holly Hagan, Ph.D.

WHO Survey Coordinating Center, Drug Injecting Study- Phase 2 (WHO)
PI: Don C. Des Jarlais, Ph.D.