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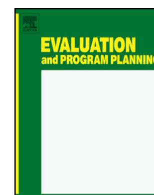

Implementing solutions to barriers to on-site HIV testing in substance abuse treatment: A tale of three facilities

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ABSTRACT

Due to the scarcity of resources for implementing rapid onsite HIV testing, many substance abuse treatment programs do not offer these services. This study sought to determine whether addressing previously identified implementation barriers to integrating on-site rapid HIV testing into the treatment admissions process would increase offer and acceptance rates. Results indicate that it is feasible to integrate rapid HIV testing into existing treatment programs for substance abusers when resources are provided. Addressing barriers such as providing start-up costs for HIV testing, staff training, addressing staffing needs to reduce competing job responsibilities, and helping treatment staff members overcome their concerns about clients' reactions to positive test results is paramount for the integration and maintenance of such programs.

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1. Introduction

People who misuse drugs are at increased risk of acquiring HIV than non-abusers; thus, substance abuse treatment has been considered both primary and secondary HIV prevention (Abraham, O'Brien, Bride, & Roman, 2011). Making routine HIV testing and prevention services available during treatment for substance abuse provides an excellent opportunity to avail individuals of services they otherwise might not receive. Agencies within the Department of Health and Human Services have long promoted routine HIV testing for certain at risk populations. The Substance Abuse and Mental Health Services Administration (2011) (SAMHSA) has recommended including HIV testing and counseling in substance abuse treatment as an evidence-based practice. Further, the Centers for Disease Control and Prevention (2006) (CDC) updated its testing guidelines in 2006, recommending at least annual testing for individuals who are at elevated risk, such as those in substance abuse treatment programs. Despite these recommendations, resources, including funding and technical assistance, generally have not been made available to providers of substance abuse treatment to allow for their widespread implementation. As a result, less than half of all substance abuse treatment programs offer HIV testing services (Abraham et al., 2011).

The evidence supporting on-site delivery of HIV testing in substance abuse treatment is substantial. This strategy is associated with greater testing and counseling utilization and improved substance abuse treatment outcomes among clients (Abraham et al., 2011, 2013; Volkow & Montaner, 2010), earlier diagnosis and treatment for people living with HIV and decreased rates of new HIV transmissions (Abraham et al., 2011, 2013; Rothman, Lyons, & Haukoos, 2007; Volkow & Montaner, 2010). Despite the clear advantages of on-site HIV testing, it is estimated that less than a third of all substance abuse treatment facilities in the U.S. offer on-site HIV testing (Abraham et al., 2013). Further, Wright, Curran, Stewart, and Booth (2013) found that only 36% of urban and 11% of rural outpatient substance use treatment centers in the US provide on-site HIV testing. These data indicate that the federal recommendations have only made a modest impact on the field.

Studies have reported a number of implementation barriers faced by substance abuse treatment programs seeking to incorporate on-site HIV testing into their regular treatment protocols (Abraham et al., 2011, 2013; Bini et al., 2011; Brown et al., 2006; Pollack & D'Aunno, 2010; Wright et al., 2013) and financial issues appear to be only part of the concern. Other

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barriers include lack of medical staff; lack of time and resources for staff training; lack of fit with core mission of program, and staff fear or uneasiness with properly handling positive test results (Haynes et al., 2011; Wright et al., 2013).

This paper describes the development of a pilot program to integrate on-site, rapid HIV testing and prevention services into the routine substance abuse treatment practice of three community based mental health centers that provide services to a region that has some of the highest HIV rates in Mississippi: the Mississippi Delta (AIDSVu, 2014). The pilot project is based upon formative research (see Robertson, Herbert, Harvey, & Gresham, 2008) that identified barriers to acceptance of HIV testing from the perspectives of both alcohol and drug (AOD) program treatment staff and clients. The findings from that research indicated that substance abusers seeking treatment through these programs were underserved in terms of HIV testing and prevention services. The primary barrier to the acceptance of HIV testing was the absence of on-site HIV testing (or specimen collection for testing) at the treatment facility. The following section summarizes the formative study on which the current research is based.

2. Preliminary assessment of substance abuse treatment and HIV testing in Mississippi

In Mississippi, community mental health centers (CMHC) are certified by and receive funding from the Mississippi Department of Mental Health (MDMH) to provide low cost outpatient and residential alcohol and drug abuse treatment services. MDMH mandates that providers assess HIV risk for anyone seeking substance abuse treatment and refer at-risk clients to a local health department for further assessment and testing (Mississippi Department of Mental Health, 2002). While neither the MDMH nor CHMC record the number of AOD clients that are offered and subsequently undergo HIV testing, interviews with program staff suggested there is a stark difference in rates of testing between CMHCs but in general, rates were very low. Based on staff assertions that few substance abuse clients receiving services through CMHCs were being tested for HIV, researchers sought to explore client and provider factors that impacted testing rates. Researchers conducted a series of focus groups with 30 AOD treatment staff and individual interviews with 58 clients of the three CMHC treatment facilities located in the Mississippi Delta. Treatment staff participants included nurses, regional coordinators and clinical or program directors, outpatient counselors, outreach/aftercare workers, and staff of adolescent and adult residential programs. Approximately half of the staff participants were from outpatient/aftercare treatment and the other half were from residential treatment facilities. In addition, we conducted individual interviews with 28 outpatient and 30 residential treatment clients (roughly 20 from each Delta CMHC) about their HIV testing experiences and preferences regarding HIV testing methods. We also anonymously surveyed 214 staff and clients from treatment programs throughout the state on their knowledge of HIV/AIDS, attitudes towards HIV infected individuals, and ratings of possible barriers to HIV testing (Robertson et al., 2008). All research procedures for the formative research were approved by the Institutional Review Board at Mississippi State University.

One of the primary concerns of administering on-site testing was the lack of resources available to the CMHCs. The publically funded treatment programs receive grants from MDMH and charge clients on a sliding fee scale based on income, but these sources of revenue barely cover operating costs. Furthermore, neither MDMH nor the Mississippi Department of Health provides funding to cover the costs of on-site HIV testing.

Also, findings from the preliminary study revealed that perceived barriers to testing were inter-related, but the precipitating factor appeared to be that on-site testing (or specimen collection for testing) was not universally available through Mississippi substance abuse treatment programs. This impacted both the regularity with which staff offered HIV testing and the frequency of client uptake of the service. Existing operating procedures required treatment staff to screen clients for HIV risk and refer or transport those "screening in" to the local health department for further assessment and testing. CMHC staff argued that when HIV testing was not available on-site, limited resources and constraints on their time hindered them from transporting clients as required. Some staff suggested that their clients refused testing at the local health department due to perceived stigma and concerns that confidentiality could not be guaranteed in small communities. In addition, clients reported that structural barriers, such as cost, clinic hours, and distance to testing facilities impacted testing decisions and that they often were not willing to wait two weeks to obtain test results.

Nearly every client interviewed expressed the desire to know his/her HIV serostatus and stated a preference for rapid testing if given a choice of testing methods. According to treatment providers, clients were more motivated to request disease screening and medical services after they had received health education on TB, HIV, and other sexually transmitted diseases (STD). Thus, if screening was offered after clients received this information and was more immediate (on-site), clients would likely opt-in. Ironically, while AOD treatment staff agreed that the presence of on-site, rapid testing would increase the number of clients who were tested, many of them were uncomfortable with administering the test; they felt ill-equipped to conduct the required pre- and post-test counseling; had concerns about interacting with HIV infected individuals; and worried about delivering positive results to clients. Their hesitance was not without merit; the literature reveals that few publicly-funded treatment providers had staff with sufficient training to deliver high-quality HIV prevention education (D'Aunno, Vaughn, & McElroy, 1999). There was consensus among staff participants that substance abuse treatment providers would benefit from specialized training on HIV risk reduction counseling, testing procedures, and disease progression and treatment.

In sum, client centered barriers to HIV testing included lack of immediate access to testing and test results, limited access to testing facilities (transportation, clinic hours, location, etc.) and concerns related to stigma and confidentiality. Staff focused barriers reflected a lack of confidence in delivering prevention/testing/education messaging, uncertainty regarding their ability to counsel clients after testing and other training related issues. Impacting contextual factors that affected client testing rates, other than increasing access to on-site testing, were beyond the scope of this project, thus, researchers opted to focus on improving provider capacity to offer on-site testing as a means of encouraging providers to institute on-site rapid testing as a routine part of their client care services. Based on the findings and recommendations of the formative research, funding was obtained from the Delta Health Alliance (an organization established to address health status in the Delta) to improve and standardize client HIV/STD education across substance abuse treatment providers, to incorporate risk assessment and the delivery of tailored risk reduction messages during individual counseling sessions, and to implement on-site, rapid HIV testing at the three publicly-funded substance abuse treatment facilities located in the Mississippi Delta. This paper describes the collaborative efforts to increase staff offering and client acceptance of HIV testing.

3. Method

The pilot project to integrate on-site, rapid HIV testing and prevention services into the routine substance abuse treatment

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