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Provision of onsite HIV Services in Substance Use Disorder Treatment Programs: A Longitudinal Analysis

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ABSTRACT

The provision of HIV education and testing in substance use disorder (SUD) treatment programs is an important public health strategy for reducing HIV incidence. For many at-risk individuals, SUD treatment represents the primary point of access for testing and receiving HIV-related services. This study uses two waves of nationally representative data of 265 privately-funded SUD treatment programs in the U.S. to examine organizational and patient characteristics associated with offering a dedicated HIV/AIDS treatment track, onsite HIV/AIDS support groups, and onsite HIV testing. Our longitudinal analysis indicated that the majority of treatment programs reported providing education and prevention services, but there was a small, yet significant, decline in the number of programs providing these services. Programs placed more of an emphasis on providing information on the transmission of HIV rather than on acquiring risk-reduction skills. There was a notable and significant increase (from 26.0% to 31.7%) in programs that offered onsite HIV testing, including rapid HIV testing, and an increase in the percentage of patients who received testing in the programs. Larger programs were more likely to offer a dedicated HIV/AIDS treatment track and to offer onsite HIV/AIDS support groups, while accredited programs and programs with a medical infrastructure were more likely to provide HIV testing. The percentage of injection drug users was positively linked to the availability of specialized HIV/AIDS tracks and HIV/AIDS support groups, and the percentage of female clients was associated with the availability of onsite support groups. The odds of offering HIV/AIDS support groups were also greater in programs that had a dedicated LGBT track. The findings suggest that access to hospitals and medical care services is an effective way to facilitate adoption of HIV services and that programs are providing a needed service among a group of patients who have a heightened risk of HIV transmission. Nonetheless, the fact that fewer than one third of programs offered onsite testing, and, of the ones that did, fewer than one third of their patients received testing, raises concern in light of federal guidelines.

1. Introduction

An estimated 1.2 million individuals are living with HIV, including 1 in 7 who are unaware of their infection (Centers for Disease Control and Prevention [CDC], 2014). In 2010, the White House released the National HIV/AIDS Strategy (NHAS) outlining 3 goals: 1) reducing HIV incidence, including increasing prevention efforts among substance users; 2) increasing access to care and improving health outcomes for those living with HIV; and 3) reducing HIV-related health disparities (Office of National AIDS Policy, 2010). Furthermore, in 2013, the President issued an Executive Order establishing the HIV Care Continuum Initiative, which is aimed at improving and increasing HIV testing and treatment of those living with HIV (Department of Health and Human Services (US), 2013).

The provision of onsite HIV testing in substance use disorder (SUD) treatment programs is an important public health strategy for reducing HIV incidence (CDC, 2006a), and is linked to positive treatment outcomes (Rothman, Lyons, & Haukoos, 2007; Volkow & Montaner, 2010). Nonetheless, the majority of SUD treatment programs do not provide onsite testing to their patients, and fewer than one third of patients in programs that provide HIV testing actually receive such testing (Abraham, O'Brien, Bride, & Roman, 2011; Brown et al., 2006; D'Aunno, Pollack, Jiang, Metsch, & Friedmann, 2014; Pollack & D'Aunno, 2010; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). This suggests that federal guidelines have not made a substantial impact on the SUD treatment field.

For many individuals, SUD treatment represents the primary or only point of access for testing and diagnosis of HIV (Kyle et al., 2015). Thus, provision of HIV/AIDS services, including prevention, testing, and support services in treatment programs can make a significant public health impact among patients with high risk of infection. Beyond HIV/AIDS services, the provision of SUD treatment itself can reduce HIV incidence by reducing the rate of HIV risk behaviors among patients, including injection drug use (Metzger & Navaline, 2003; Sorensen & Copeland, 2000). While treatment programs may form linkages for patients to receive these services offsite, research suggests that onsite health services are more effective in reaching patients than providing referrals to an

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external site (Metsch et al., 2012; Umbricht-Schneiter, Ginn, Pabst, & Bigelow, 1994). Past studies (Abraham et al., 2011; Pollack & D'Aunno, 2010; Pollack, D'Aunno, & Lamar, 2006; Strauss, Des Jarlais, Astone, & Vassilev, 2003) have examined the provision of HIV testing but have often excluded other HIV/AIDS services offered by SUD treatment programs. Further, they have typically used cross-sectional data or examined outpatient-only programs. This study uses two waves of nationally representative data of privately-funded SUD treatment programs in the U.S. to examine organizational and patient characteristics of treatment programs that offer a dedicated HIV/AIDS treatment track, onsite HIV/AIDS support groups, and onsite HIV testing. Building on previous research, we hypothesize that a number of organizational factors and client characteristics may help determine whether or not treatment programs adopt onsite HIV/AIDS services and testing.

1.1. Organizational factors linked to HIV/AIDS services

The provision of SUD treatment services is typically related to available resources. Larger treatment programs tend to have greater slack resources available for implementation of ancillary services (Rogers, 2003). Organizational studies confirm the positive link between organization size and adoption of a variety of treatment services (Abraham et al., 2011; Aletraris, Paino, Edmond, Roman, & Bride, 2014; Pollack & D'Aunno, 2010). Another relevant treatment program resource is staff education, as greater educational attainment facilitates the adoption and implementation of new organizational practices (Cohen & Levinthal, 1990). Accreditation is also linked to the delivery of HIV testing services (Chriqui, Terry-McElrath, McBride, & Eidson, 2008; Guerrero & Cederbaum, 2011; Pollack & D'Aunno, 2010). The process of accreditation encourages health prevention services and requires programs to conduct comprehensive evaluations of client needs, of which HIV services are a component.

Besides access to resources, treatment programs are likely to provide services that are aligned with their values and mission. For example, non-profit programs are likely to place an emphasis on public health as a core mission (Wheeler & Nahra, 2000), and may therefore play an active role in HIV prevention. Past research finds a higher prevalence of testing for HIV and sexually transmitted infections in non-profit treatment programs (D'Aunno et al., 2014; Guerrero & Cederbaum, 2011). Further, several studies find that for-profit SUD treatment programs offer fewer core services as well as wraparound services, such as medical care (Aletraris, Bond Edmond, & Roman, 2015; Ducharme, Mello, Roman, Knudsen, & Johnson, 2007; Friedmann, Lemon, Durkin, & D'Aunno, 2003).

Treatment programs based in a hospital setting already have a treatment orientation that is based on a medical model and may thus see the provision of diagnostic services as falling within the domain of their organizational goals (Friedmann et al., 2003). Hospital-based programs are also more likely have access to resources and staff with the expertise to provide testing and support services (Knudsen & Oser, 2009). Programs that already provide onsite primary medical care services are likely to offer HIV/AIDS services as well (Strauss et al., 2003). Similarly, programs that use medication-assisted treatment (MAT) as a treatment strategy embrace a medical approach to treatment (Knudsen, Ducharme, & Roman, 2007) consistent with the provision of HIV/AIDS services.

1.2. Patient characteristics linked to HIV/AIDS services

Treatment programs' patient characteristics may also influence provision of HIV/AIDS services, as racial and ethnic minorities, and injection drug users (IDUs) are most profoundly affected by HIV/AIDS. Programs with a preponderance of such patients may find it beneficial to offer services in order to meet their patients' needs.

African Americans continue to be disproportionately affected by HIV, compared with other races and ethnicities. The CDC states that an estimated 1 in 16 African American men and 1 in 32 African American women will be diagnosed with HIV at some point in their lifetime (CDC, 2007). Further, African Americans represented approximately 44% of new HIV infections in 2010 and 41% of those living with HIV in 2011, even though they represent about 12% of the U.S. population (CDC, 2012, 2014). Data on Hispanics/Latinos show that they are also at an increased risk of contracting and transmitting HIV/AIDS (CDC, 2014). In 2010, they accounted for 21% of new HIV infections (CDC, 2012). Further, the rate of new HIV infections for Hispanic/Latino males is approximately 3 times that for White males, while the rate of new infections for Hispanic/Latino women is approximately 4 times greater compared to White females (CDC, 2012). A recent article found that opioid treatment programs with a higher proportion of Hispanic clients were more likely to offer HIV testing services (D'Aunno et al., 2014).

The link between substance use, particularly injection drug use, and the elevated risk of contracting and transmitting HIV/AIDS has also been well documented (CDC, 2006b; Ehrenstein, Horton, & Samet, 2004; Heimer, Grau, Curtin, Khoshkood, & Singer, 2007; Semple, Amaro, Strathdee, Zians, & Patterson, 2009; Shoptaw et al., 2013; Stein et al., 2005). Data indicate that between 30% and 40% of IDUs are infected with HIV (Battjes, Pickens, & Brown, 1995; Booth, Watters, & Chitwood, 1993; Francis, 2003). Recent CDC reports show that 16% of new HIV infections among women in 2010 were attributed to injection drug use (CDC, 2012; 2014), while 8% of new HIV infections in 2010 and 15% of those with HIV in 2011 were IDUs (CDC, 2012, 2014). Further, the majority of new HIV infections among women were attributed to heterosexual contact (CDC, 2012, 2014), often transmitted by injection drug-using partners (Tortu, Beardsley, Deren, & Davis, 1994). Approximately 40% of HIV infections among IDUs in 34 states had received late diagnoses (Grigoryan et al., 2010), suggesting that timely provision of HIV testing and treatment is critical for at-risk drug users (Guerrero & Cederbaum, 2011; Volkow & Montaner, 2010). Past studies have found that client need for HIV-related services, including the percentage of IDUs, was associated with adoption of services (Knudsen & Oser, 2009; Pollack & D'Aunno, 2010).

Finally, gay, bisexual, and other men who have sex with men (MSM) are a severely HIV-affected population. Data from 2010 show that MSM accounted for almost three quarters (72%) of new HIV infections among all persons aged 13 to 24 (CDC, 2012). Adolescent MSM are at the highest risk, accounting for the greatest percentage increase in HIV infections, and approximately 93% of all HIV infections among males aged 13 to 19. Further, at the end of 2011, MSM (including MSM who also inject drugs) accounted for 57% of those living with an HIV diagnosis (CDC, 2012). While the reasons for these disparities in HIV infections are varied, one major concern is lack of awareness of HIV status, making HIV testing especially important for groups disproportionately affected by HIV. Treatment programs that provide tailored services for their LGBT patients may be particularly likely to incorporate HIV prevention services and testing.

In summary, we expect that treatment programs will be more likely to offer HIV/AIDS services and HIV testing when there are available resources, organizational norms are compatible with a medical treatment model, and when there is a client need for such services.

2. Material and methods

2.1. Sample and study eligibility

Data were drawn from two waves of a nationally representative longitudinal study of privately-funded SUD treatment programs. Baseline data were collected between 2007 and 2008 while follow-up data were collected between 2009 and 2011. Treatment programs were selected through a two-stage sampling protocol, first stratifying all U.S. counties by population size, and then using national and state directories to enumerate treatment facilities within the sampled counties. Next, treatment programs were randomly selected within each stratum, and telephone screening was used to establish eligibility for the study.