Barriers to On-Site Rapid HIV Testing in New Jersey Substance Abuse Treatment Programs

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Introduction

•Prior to 2003, testing for HIV infection was a lengthy process that required patients return for their test results.
•In 2003, rapid HIV testing was approved for use which allowed for providers to give results during the same encounter with a patient.
•The CDC, in 2006, recommended testing all persons aged 13 to 64 for HIV in all health care settings, including substance abuse treatment centers, by way of an opt-out system, and to repeat screenings annually for persons at high risk for contracting HIV.
- •However, the 2010 Behavioral Risk Factor Surveillance System data showed that only 40.3% of randomly sampled persons in the U.S. had ever been tested for HIV and only 21.5% reported being tested in the past year.

•Given that injection drug users contributed to 12% of the new HIV cases in 2009 and to 19% of all people living with HIV in the US, it is important that this high risk group is screened regularly.
- •It has been shown that substance abusers are more likely to engage in high-risk behavior such as increased alcohol consumption and having sex with known injection drug users, in exchange for money or drugs, and without a condom.

•Few studies have investigated HIV testing implementation in substance abuse treatment settings. Studies that have been done have shown:
- •28% to 49% of substance abuse treatment programs in the United States have reported offering HIV testing to their clients.
- •Programs that are hospital based, run by the federal government, and provide general health services are more likely to have HIV testing.
- •Reported barriers to HIV testing include funding, health insurance, and patient acceptance.

•In 2005, to target high-risk populations, the Substance Abuse and Mental Health Services Administration (SAMHSA) initiated a rapid HIV testing program, administered by the NJ Division of Mental Health and Addiction Services (DMHAS). This program provides NJ substance abuse treatment programs with rapid HIV testing kits and appropriate training on administering the tests, HIV counseling, and documentation at no cost to the programs
- •Free rapid HIV testing kits are currently available to approximately 19 licensed substance abuse treatment centers in NJ.
- •However, uptake of rapid HIV testing in these programs has been slow

Objective

To inform initiatives to increase on-site rapid HIV testing in substance abuse treatment, we sought to gain an understanding of the current HIV testing practices in New Jersey substance abuse treatment centers and to identify barriers to implementing rapid HIV testing in these settings.

Methods

•An email with was sent to administrators from 205 substance abuse treatment programs in New Jersey. The e-mail included:
- •a link to a SurveyMonkey (a secure online survey service) survey
- •a description of the study along with the risks/benefits of participation.
- •instructions for the administrators to complete the online survey or forward the e-mail to the person most knowledgeable about HIV testing practices in their agency

•Survey Measures:
- **•All treatment programs** were asked about services provided, importance of HIV testing, perception of risk of client population, percentage of clients tested, licensure, and availability of onsite rapid HIV testing.
- **•Programs that currently offer on-site rapid HIV testing** were asked about method of collecting samples, percentage of clients offered testing, reasons for testing refusal, documentation of test results, intake processing, perceived barriers to testing, and initiatives to increase testing.
- **•Programs that do not offer on-site rapid HIV testing** were asked about how HIV testing is done, reasons for lack of on-site rapid testing, and future plans for on-site rapid testing.

• Data was also collected from a NJ Division of Mental Health and Addiction Services database which contained aggregate demographic information of each site's client population from February 2011 to March 2012. Data included:
- •distribution of race/ethnicity, insurance status, gender, age, living condition, injection drug use, co-existing psychiatric disorder, and insurance status

•The aggregate data was then linked to the survey responses by a unique site identification number.

Results

•Of 205 programs e-mailed, 109 completed the survey.
•No significant differences in client demographics between the programs that responded to the survey and those that did not.
•28 programs reported having a license to provide on-site rapid HIV testing (19 received free tests and training from NJ DMHAS).
•58.7% of respondents were administrators.
•Median importance of HIV testing to their program administration was 9.0 (IQR 4.0-10.0; on a scale from 0 [not at all important to 10 [extremely important])
- •However, 23% reported that HIV testing had low importance or was not at all important to their program administration

•Percent of programs that reported 50% or more of their clients have been HIV-tested (either on or off site and by any method)
- •39% of all programs
  - –52.6% of programs that receive rapid HIV testing kits and training from NJ DMHAS.
  - –36.3% of programs that do not receive rapid HIV testing kits and training from NJ DMHAS.
- •The difference in testing percentages between programs that receive testing kits from NJ DMHAS and those that do not is not statistically significant.

Table 1. Barriers to on-site rapid HIV testing

	% all programs that endorsed issue as a barrier to on-site rapid HIV testing N=109[a]	% of programs that receive rapid HIV testing kits and training from NJ DMHAS n=19	% of programs that do not receive rapid HIV testing kits and training from NJ DMHAS n=90
Other HIV tests are offered	12.8	5.3	14.4
Prefer to refer elsewhere for testing	42.2	5.3***	50.0***
Work load	22.0	15.8	23.3
Inadequate staffing	27.5	21.1	28.9
Lack of administrative support	12.8	10.5	13.3
Lack of clinical staff support	13.8	10.5	14.4
Client disinterest	21.1	31.6	18.9
HIV related stigma	11,0	26.3*	7.8*
Program culture	7.3	5.3	7.8
Not a priority	18.3	5.3	21.1
Phlebotomy not available	36.7	15.8*	41.1*
HIV counseling not available	27.5	5.3*	32.2*
Lack of referral resources	8.3	5.3	8.9
Inadequate staff knowledge about HIV and risk	8.3	5.3	8.9
Lack of bilingual staff	17.4	5.3	20.0
Cost	36.7	5.3**	43.3**
Inadequate system to handle positive results	28.4	5.3*	33.3*

*p<.05, **p<.01, ***p<.001

Table 2. HIV testing practices among programs that receive rapid HIV testing kits and training from NJ DMHAS (n=19)

Sample Collection Method (%)	
Orally	0.0
Fingerstick	94.4
Blood draw	5.6
Don't know	0.0
Percentage of current clients OFFERED on-site rapid HIV testing (%)	
>75%, but not all	16.7
100%	83.3
Percentage of admissions tested for HIV with an on-site rapid test since receiving rapid HIV tests and training from DMHAS	
None	6.3
Less than 25%	25.0
25% to 45%	18.7
About 50%	12.4
55%-75%	25.0
>75%, but not all	6.3
100%	6.3
How often are clients who tested negative for HIV or refused testing typically offered testing again (%)	
Never	0.0
Inconsistently	5.9
Less than annually, but offered again at some point	5.9
Annually	5.9
Every six months	70.6
Once per month	5.9
More than once per month	5.9
Other	0.0
Reasons clients refuse on-site rapid testing (% that report clients frequently or always refuse for this reasonon a scale from 0 [never] to 3 [always])	
Client already knows status	47.4
Client doesn't believe he/she is at risk	31.6
Not a priority to client	15.8
Client doesn't want to know his/her HIV status	15.8
Fear	36.8
Client wants to get tested elsewhere	5.3
Number of staff members trained to conduct rapid HIV testing (median [IQR])	3.0 (1.8-6.0)
Program has a designated person or persons responsible for HIV testing (%)	100.0
Program has written procedures for conducting on-site rapid HIV testing (%)	94.1
Frequency on-site rapid HIV testing conducted at program (%)	
Less than monthly	5.6
Monthly	11.1
Weekly	16.7
2-3 Times per week	11.1
Daily	27.8
Other/don't know	27.8
Other than on-site rapid HIV testing offered in program	33.3
Frequency pre and post test counseling provided with HIV testing	
Never	5.6
Always	94.4
Program's approach to testing clients (%)	
Opt-in (clients are asked if they want to be tested)	55.6
Opt-out (all clients are tested unless they refuse)	44.4
When HIV testing offered (% report frequently or always on scale from 0[never] to 3[always])	
During client intake/assessment	100.0
During individual counseling sessions	44.4
During group counseling sessions	38.9
By the clinic physician	33.3
By the HIV case manager	60.0
When a client asks for it	94.1
Other HIV related services offered (%)	
None	5.3
Counseling	84.2
Treatment referral	84.2
Coordination of care	63.2
Medical care	21.1
HIV risk routinely assessed as part of intake process (%)	100.0
Complete health assessment part of intake process (%)	100.0
Medical exams routinely performed at intake (%)	83.3
Program has had initiatives to increase HIV testing in program (%)	61.1
What has been done to increase testing (among those who had initiatives to increase testing)	
Staff education	45.4
Client education	72.7
Staff reminders to offer testing	72.7
Designated staff to promote testing	63.6

•In bivariate analyses, among programs that received rapid HIV testing kits and training from NJ DMHAS (n=19), testing 50% or more of admissions since becoming eligible to receive the tests and training had a significant positive relationship with:
- Percentage of client population that is Black (p<.05) and age 31-50 years old (p<.05)

And negative relationship with:
- Clients frequently or always refusing testing because it is not a priority for them (p<.05) or they do not want to know if they are HIV infected (p<.05).
- Percent of client population that is White (p<.05), uninsured (p<.05), and age 19-30 (p<.01).

- **Further, race and age distribution were significantly** (p<.05) **associated with frequency of refusing testing due to not wanting to know HIV status, and percent uninsured was significantly** (p<.05) **associated with frequency of refusing testing due to testing not being a priority.**

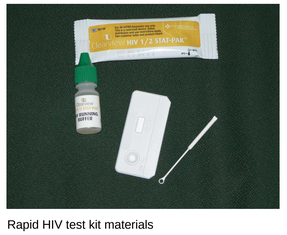
Conclusions

•The importance of HIV testing in substance abuse treatment is of little or no importance to almost 1/4 of NJ substance abuse treatment administrators.
- •More HIV related education may be necessary for some administrators.

•The majority of clients in substance abuse treatment in NJ are not being HIV tested.
•Most programs that receive rapid HIV tests from the NJ DMHAS take an "opt in" approach.
- •"Opt out" approach policies may increase testing.

•The main barriers to on-site rapid HIV testing are:
- •Preferring to refer elsewhere for testing, lack of phlebotomy or HIV counseling, cost, and inadequate staffing or system to handle positive results (among programs that do not receive tests from NJ DMHAS)
  - –Infrastructure may need to be improved to allow for HIV testing in these settings.
- Client disinterest and HIV related stigma (among programs that receive tests from DMHAS)
  - –Interventions for substance abuse treatment clients that provide HIV related education and are designed to reduce stigma may help to improve testing uptake.

- **HIV testing rates among programs that receive free rapid HIV test kits and training are related to race, age, and insurance coverage of client population and clients' motivation/desire to know HIV status.**
  - Greater outreach and education to increase client motivation for HIV testing may increase testing rates.
    - – Outreach and education may be particularly helpful for certain client demographic groups who may not perceive themselves to be at risk or for whom HIV testing is not a priority relative to other needs.



Rapid HIV test kit materials

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