

## HIV Testing and Counseling in Drug Abuse Treatment

**Lisa Metsch, PhD**  
 University of Miami Miller School of Medicine  
**Tim Matheson, PhD**  
 San Francisco Department of Public Health

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 (many slides are adapted from Dr. Branson)

## Today's Presentation

- Describe opportunity for providing HIV testing and counseling in drug abuse treatment
  - Why Test?**
- Present latest technologies to conduct HIV testing and counseling –
  - How do we test?**
- Discuss implementation issues to consider when implementing HIV testing in drug treatment
  - Is Testing easy to do?**
- Discuss various counseling approaches that can accompany HIV testing in drug treatment
  - What about counseling?**
- Present lessons learned from CTN 0032 – HIV Testing and Counseling in Drug Treatment in the U.S.
  - What have we learned?**

## Why test for HIV?

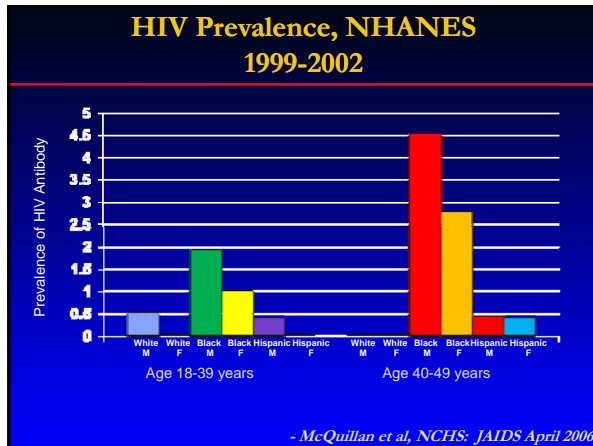
## “Seek, Test, Treat, and Retain”



## Awareness of HIV Status among Persons with HIV, United States, 2006

Number HIV infected	<b>1,106,400</b>
Number unaware of their HIV infection	<b>232,700 (21%)</b>
Estimated new infections annually	<b>56,300</b>

*Campsmith M et al, JAIDS April 2010  
 Hall J, et al JAMA August 2008*



### Drug Use Continues to Contribute to New HIV Infections

**JAIDS** JOURNAL OF ACQUIRED IMMUNE DEFICIENCY SYNDROMES

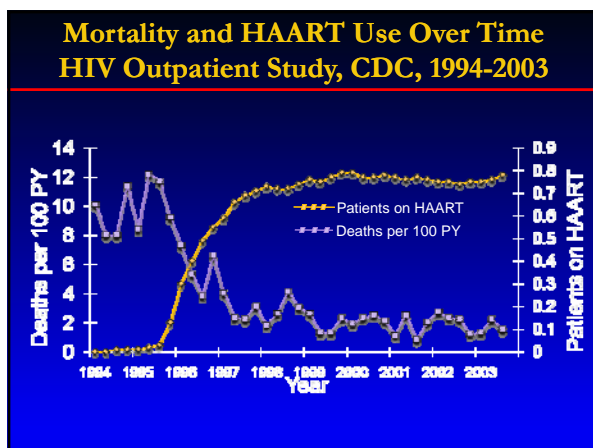
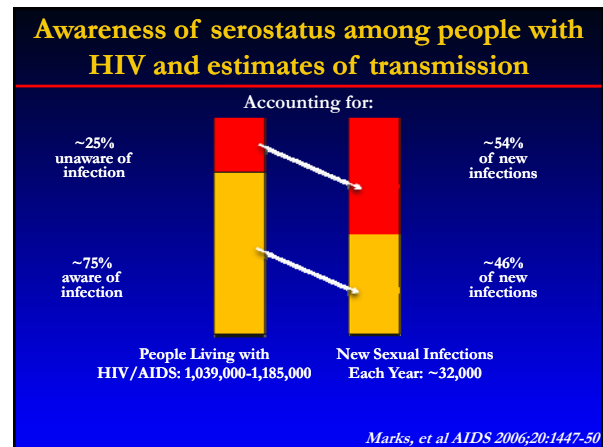
May 1, 2007 45(1)

July 1, 2009 51(3)

**The Relationship between Methamphetamine and Popper use and Risk of HIV Seroconversion in the Multicenter AIDS Cohort Study**  
MW Plankey, DG Ostrow et al.

**Specific Sex Drug Combinations Contribute to the Majority of Recent HIV Seroconversions among MSM in the MACS**  
DG Ostrow, MW Plankey et al.

- ### Benefits of HIV Testing
- Decreases spread of HIV: an HIV diagnosis is associated with reduction in high risk sexual and injection behaviors
  - Improves survival: Linkage to care and treatment

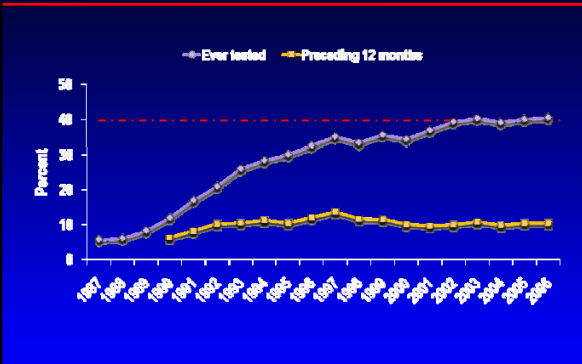


### HIV Testing and Other Routine Tests: Cost-Effectiveness Compared

Test	\$/QALY* Gained
HIV test: All inpatients†	38,600
HIV test every 5 years: People at high risk (3% prevalence)‡	50,000
HIV test one time (1% prevalence)‡	41,736
- Individual benefit only	15,078
- Including benefit to others	
HIV test one time: U.S. general population (0.1% prevalence)‡	113,000
Breast cancer test: Annual mammogram, age 50-69§	57,500
Colon cancer test: FOBT + SIG every 5 years, age 50-85§	57,700
Type 2 diabetes test: Fasting blood glucose, age >25§	70,000
Hypertension testing§	48,000

†FOBT indicates fecal occult blood test; SIG, sigmoidoscopy.  
‡Quality-adjusted life years (QALYs), which account for both longevity and health-related quality of life.  
§Palshikar et al. (2005); §Banks et al. (2005);  
\*Adapted from personal communication, Sanders and Palshikar, 2005.  
NIDA News Vol. 20 (3), 2005.

### Percent of Persons Ever Tested and Tested in the Preceding 12 Months - NHIS 2002-2006



### Source of HIV Tests and Positive Tests

- 40% of adults age 18-64 have been tested
- 18 million adults age 18-64 tested annually in U.S.

	HIV tests*	HIV+ tests**
Private doctor/HMO	53%	17%
Hospital, ED, Outpatient	18%	27%
Community clinic (public)	5%	21%
HIV counseling/testing	5%	9%
Correctional facility	0.4%	5%
STD clinic	0.1%	6%
Drug treatment clinic	0.4%	2%

\*National Health Interview Survey, 2006  
\*\*Suppl. to HIV/AIDS surveillance, 2000-2003

### What about Drug Abuse Treatment....

- Fewer than 1/3 of U.S. drug treatment programs offer HIV testing and counseling \*
- Less than 1/2 of CTN community treatment programs made HIV testing available either in the CTP, through referral or outsourced \*\*

SAMSHA, 2004 \*  
Brown et al. JSAT, 2006, AJPH, 2007 \*\*

### HIV testing and counseling in the nation's outpatient substance abuse treatment system, 1995-2005

Harold A. Pollack, (Ph.D.)<sup>a</sup>, Thomas D'Aunno, (Ph.D.)<sup>b,\*</sup>

<sup>a</sup>University of Chicago, Chicago, IL, USA  
<sup>b</sup>Columbia University, New York, NY, USA

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#### Abstract

This article examines the extent to which U.S. outpatient substance abuse treatment (OSAT) facilities provide HIV counseling and testing (C&T) to clients between 1995 and 2005. We also examine organizational and client characteristics associated with OSAT facilities' provision of HIV C&T. Data were collected from a nationally representative sample of outpatient treatment facilities in 1995 (n = 618), 2000 (n = 571), and 2005 (n = 566). Results show that in 1995, 26.8% of OSAT clients received HIV C&T; by 2005, this proportion had increased, but only to 28.8%. Further, results from random-effects interval regression analysis show that C&T is especially widespread in public and nonprofit facilities, in methadone facilities, and in units that serve injection drug users and commercial sex workers. HIV C&T was also more widespread in units that employed formal intake protocols. Despite widespread efforts to increase HIV C&T services in OSAT care, only a small and stable minority of clients receive these services. Adoption of formal intake procedures may provide one vehicle to increase provision of C&T services. © 2010 Published by Elsevier Inc.

Keywords: HIV counseling and testing; Substance abuse treatment; Opioid; Managed care

### Pollack & D'Aunno Analysis

Journal of Substance Abuse Treatment, 2010

- Analyzed data from three waves of the National Drug Abuse Treatment Survey (NDATSS)
  - Examined the percent of treatment clients who actually receive HIV testing (on-site or off-site) at outpatient treatment facilities
  - Examined the proportion of out-patient treatment units which reported at least 1% of clients were tested.

### Pollack & D'Aunno Analysis

Journal of Substance Abuse Treatment, 2010

	1995 (N=568)	2005 (N=500)
Percentage of clients who receive on-site HIV tests	26.8%	28.8%
Percentage of units, weighted by caseload, which provide at least some on-site HIV testing.	36.2%	35.3%

### HIV Testing – Screening Data CTN 0032, Jan – May, 2009

- Study conducted at 12 community treatment programs
- Total number of patients screened 2452
- HIV Tested...
  - In Last Year - 27.6%
  - > Year Ago - 52.1%
  - Never - 20.3%

### HIV Testing by Gender N = 2452

	$\chi^2=75.79$ $p < .0001$	In Last Yr	> Yr Ago	Never
Females		30.6%	57.6%	11.9%
Males		25.5%	48.3%	26.2%

### HIV Testing by Race/Ethnicity N= 2385

	$\chi^2=107.3$ $p < .0001$	In Last Yr	> Yr Ago	Never
Hispanic		22.3%	57.4%	20.3%
Black		41.4%	47.2%	11.7%
White*		22.2%	53.3%	24.5%

\* Non-Hispanic; Note Other Category not shown

### Late HIV Testing is Common Supplement to HIV/AIDS Surveillance, 1996-2005

- Among 281,421 persons receiving diagnoses of HIV infection, 45% had an AIDS diagnosis by 3 years after initial HIV diagnosis ("late testers"); 38.3% of persons with HIV diagnosis had AIDS within one year.
- Late testers, compared to those tested early were more likely to be:
  - Older
  - Men (Male IDUs and Male Heterosexuals)
  - Heterosexual
  - Non-White

\*34 states  
MMWR June 26, 2009

### Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings

MMWR 2006;55(No. RR-14):1-17  
Published September 22, 2006

<http://www.cdc.gov/mmwr/pdf/rr/rr5514.pdf>

### Revised HIV Testing Recommendations for Adults and Adolescents

- Routine, voluntary HIV screening for all persons 13-64 in health care settings, not based on risk
- Repeat HIV screening of persons with known risk at least annually
- Prevention counseling in conjunction with HIV screening in health care settings should not be required

**Revised CDC Guidelines for HIV  
testing in Non-Medical Care Settings**

*In Development*

**Early Indications of Progress:  
National Health Interview Survey**

	Ever Tested	Last 12 months
2005	70,036,336 (39.9%)	18,042,610 (10.44%)
2006	71,468,420 (40.4%)	17,775,006 (10.39%)
2007	73,848,002 (41.3%)	18,791,895 (10.67%)
2008	80,172,602 (44.6%)	19,055,402 (10.74%)
<b>Change since 2006:</b>	<b>↑8.7 million</b>	<b>↑1.3 million</b>

Source: National Health Interview Survey


**Estimated Cases of HIV/AIDS,  
by year of diagnosis 34 States with Confidential HIV Reporting**

2004	37,164
2005	36,640
2006	37,193
2007	42,655
<b>Change:</b>	<b>↑5,462 (15%)</b>

Source: HIV/AIDS Surveillance 2007

**How do we test?**

**HIV Rapid Test**



- FDA approved
- Only requires blood from a finger stick or oral fluid from a swab
- Results in 20 minutes
- Does not require laboratory facilities and can be done by drug counselors

**Understanding HIV Test Results**

- Traditional HIV testing can yield three results
  - Positive
  - Negative
  - Inconclusive
    - Test cannot determine HIV infection
- Rapid HIV testing can yield three results
  - Reactive (Preliminary Positive – not a diagnosis)
  - Non-reactive (Negative)
  - Invalid
    - Problem with the device or sample

### FDA-approved Rapid HIV Tests

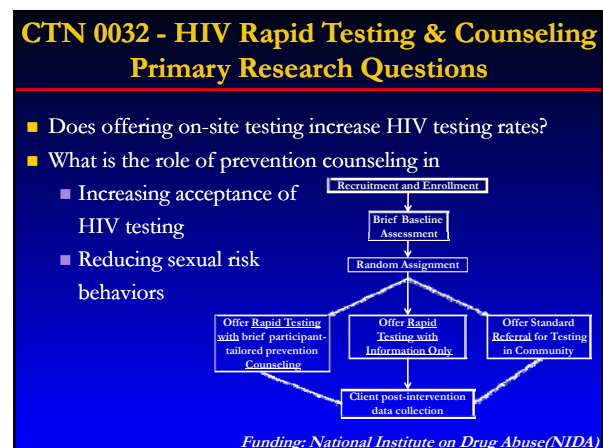
	Sensitivity (95% C.I.)	Specificity (95% C.I.)
<b>Oral fluid</b>		
OraQuick Advance	99.3 (98.4 - 99.7)	99.8 (99.6-99.9)
<b>Whole blood</b>		
OraQuick Advance	99.6 (98.5-99.9)	100 (99.7 - 100)
UniGold Recombigen	100 (99.5 - 100)	99.7 (99.0 - 100)
Stat-Pak	99.7 (98.9 - 100)	99.9 (98.6 - 100)
Sure Check	99.7 (98.9 - 100)	99.9 (98.6 - 100)
<b>Serum/plasma</b>		
Reveal G3	99.8 (99.2 - 100)	99.1 (98.8 - 99.4)
Multispot	100 (99.9 - 100)	99.9 (99.8 - 100)

- ### Confirmatory Testing
- Still requires follow-up blood draw or oral fluid
  - Takes 1 – 2 weeks to get results
  - Studies are currently evaluating using a second rapid test as confirmatory testing

- ### Logistical Issues for Routine HIV Testing
- Rapid Test Kit Storage
    - Test Kits (with expiration dates) come in boxes of 100
    - Kits and controls must be stored in temperature monitored environments (control kits require cooler temperatures)
    - Control tests must be conducted on test kits on regular basis
  - Rapid Test Sample Collection
    - Fingerstick or venous blood samples require staff to collect specimen; oral rapid fluid self-collected by patient with staff instruction
    - Collection location: lab, counseling room, or private area

- ### New Frontiers in HIV Testing
- Fourth generation HIV tests
  - Rapid Home Testing
  - New Rapid Testing Algorithm
  - Combination Rapid HIV testing

## Is HIV testing easy to do?



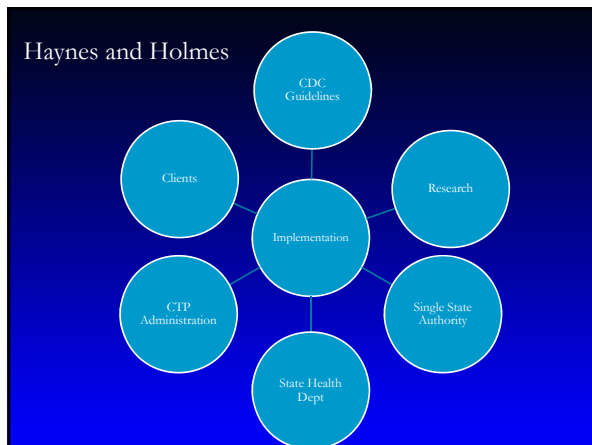
### Diverse Site Characteristics

- Primary location of recruitment
  - Outpatient/intensive outpatient: 6
  - Residential: 3
  - Methadone program: 3
- Ownership
  - Stand-alone private non-profit: 8
  - State or county: 2
  - Formerly county (recently privatized): 1
  - Academic medical center: 1
  - Varying levels of integration between substance abuse and mental health services in state agencies
- Varying levels of experience with CLIA-waived on-site laboratory testing (e.g. urine toxicology testing)

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### Management Issues for Routine HIV Testing

- Fit with CTP management priorities
  - Primary focus is dealing with recent funding cuts
  - Secondary focus is achieving effective integration with mental health services
  - HIV testing is often viewed as part of integration with medical services, therefore lower priority
- Influence of State/County funders
  - Counties are concerned that adding services will attract additional clients from neighboring counties
  - State quality mandates could be an important tool to enhance adoption
- Lack of experience interacting with health care funders
  - Few sites have established links with state health departments
- Even less familiarity with the Ryan White CARE Act funding



### Operational Issues for Routine HIV Testing

- When to offer the test?
  - At program intake
  - During program after establishing relationship with the client
- Who conducts the test?
  - Certain counselors are trained and provide counseling and testing at specified times
  - All counselors are cross-trained
  - Training requirements depend on counselor turnover
- Differences between program settings
  - Outpatient program clients have limited time availability (e.g. attending evening sessions)
  - Residential /detox clients can be scheduled more flexibly
  - Methadone clients have annual medical assessments

### Financial Issues for Routine HIV Testing

- Diversity of payers
  - Government grants and contracts
  - Public or private insurers
  - Medicaid can be important but is not usually the primary payer
- Substance programs are unable to bill for HIV testing
  - Medicaid programs (and other insurers) reimburse HIV testing as a medical service
  - Substance abuse treatment programs are prohibited by Medicaid from billing for medical services
- Reimbursement for counselors vs. testing supplies
  - HIV test counselor time may be considered a reimbursable counseling session (even if RESPECT counseling is not delivered)
  - Still requires source for testing supplies (state health departments?)

### Funding is Available

- CDC Expands Funding for HIV Testing- \$142.5 million over next three years
- Funding available from SAMHSA
  - [David.Thompson@SAMHSA.hhs.gov](mailto:David.Thompson@SAMHSA.hhs.gov)
- Contact your state/local health departments

## What about counseling?

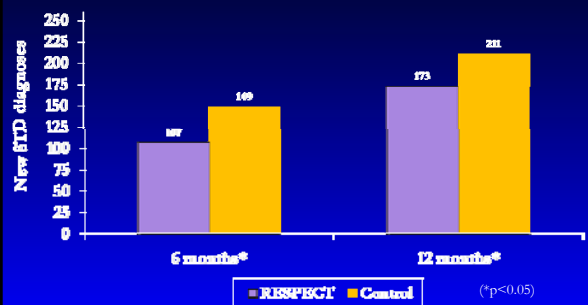
### Counseling in the rapid testing era

- Everyone who tests HIV positive receives counseling
- Unclear effect on HIV-negatives
  - Based on assessment at intake, do we triage high-risk persons for counseling?
  - What is the effect of counseling on person's decision to get HIV tested?
  - Does HIV testing alone reduce risk behaviors among HIV-negatives (is HIV testing a prevention strategy)?

### What are the benefits of counseling?

- Project RESPECT: Evidence-based counseling that demonstrated significant reduction of STD incidence
  - Brief, client-centered, individually administered 2-session counseling intervention that has been conducted on mass basis in STD clinics
- Multiple counseling studies demonstrate reductions in self-reported risk behavior of around 25%

### Project RESPECT: Counseling reduces STI incidence



Kamb, M.L., et al., JAMA, 1998

### RESPECT updated

- RESPECT-2:
  - Adapted RESPECT for rapid testing era
  - 2-visit, 2-session RESPECT vs. 1-visit rapid RESPECT
- More persons in rapid arm received results
- Overall no difference in STIs between arms
  - Higher incidence among men
  - Higher incidence among MSM

Metcalf, STD 2005

### David Holtgrave: *Costs and Consequences of the New CDC Testing Guidelines* (June, 2007; [www.plosmedicine.org](http://www.plosmedicine.org))

- Article questions costs and consequences of new CDC guidelines regarding routine HIV testing without risk reduction counseling (compared with a more targeted counseling and testing strategy)
- Uses scenario and cost-effectiveness analysis
- Concludes that abandoning counseling would have real public health consequences in terms of HIV infections that could have been averted

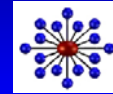
**David Holtgrave: *Costs and Consequences of the New  
CDC Testing Guidelines* (June, 2007; [www.plosmedicine.org](http://www.plosmedicine.org))**

Editor's note says that Holtgrave's article

*"has a major limitation in that it tried to predict what might happen in the future – it did not study the actual impact of the two different types of testing on a group of people."*

## CTN 0032

NIDA Funded National Drug  
Abuse Treatment  
Clinical Trials Network



### Research Questions

Among persons who attend substance abuse treatment and report being HIV negative or not knowing their status...

- (1) What is the more effective testing strategy to ensure they get HIV tested and receive their results?
- (2) What is the more effective testing strategy to decrease their risk behaviors?

### Three Testing Strategies to be evaluated in 3 arm RCT

- Offer on-site HIV rapid testing (via oral fluid) with brief participant-tailored prevention counseling
- Offer on-site HIV rapid testing (via oral fluid) with information only
- Offer referral for HIV testing in the community

### CTN 0032 : 3 Arm RCT

Arm 3 Script for referrals for HIV testing:

*"At this time I would like to offer you referrals to HIV testing sites. Do you accept my offer?"*

(If **YES**, provide study participant with the HIV testing referral sheet)

*"Here is our referral sheet for HIV testing sites in the area."*

*"The sheet lists locations, addresses, hours of operation, types of HIV testing, and any possible fees."*

(If **NO**, simply acknowledge the participant's decision and close the session)

### CTN 0032 : 3 Arm RCT

Arm 2 script for information only with testing:

*"The rapid HIV test requires collecting an oral sample."*

*"Collecting the oral sample consists of you using a flat 'q-tip' like device to swab the front of your mouth between the gums and your upper lip and between the gums and your lower lip. The flat device is then placed into a solution."*

*"The test result will be available in about 20 minutes."*

*"The possible results are non-reactive, which means HIV negative; invalid; or reactive. If your test is invalid or reactive then immediate follow-up testing is needed."*

### CTN 0032 : 3 Arm RCT

- Arm 1 treatment based on CDC's RESPECT 2 counseling model
- RESPECT 2 : a client centered but counselor directed HIV prevention counseling format which aims to:
  - Increase the individual's awareness of personal risk for HIV
  - Increase the individual's concern around risk behavior (to increase motivation to make change)
  - Assist the individual in creating an HIV risk reduction plan with clear goals and specific concrete steps to achieve goals

### Arm 1 Treatment Steps

- Provide an introduction
- Frame the session
- Assess for risk behaviors and factors contributing to risk
- Identify ppt's ambivalence around risk behavior
- Examine previous risk reduction strategies
- Summarize ppt's risks, ambivalence and readiness to change
- Assist in developing a risk reduction plan
- Support participant's risk reduction plan
- Provide general testing information
- Examine readiness to test and provide motivation to be tested
- Provide offer of HIV test change

### Arm 1 Treatment Steps

- Assess for specific risk behaviors and factors contributing to risk:
  - Ask for detailed story of most recent (or recent riskiest) event (who, when, where, how, etc)
  - Discuss factors that contributed to risk: substance use, partner attributes, current stressors, lack of communication around need for condoms or clean needles, etc
  - Identify ppt's ambivalence (concern for risk behavior)

### Arm 1 Treatment

- Examine previous risk reduction strategies:
  - Goal in this portion:
    - To support and reinforce successful attempts to reduce risk
    - Examine obstacles contributing to less successful attempts
    - Brainstorm strategies to overcome obstacles

### Arm 1 Treatment

- Summarize participant's risks, ambivalence, and readiness to change:
  - Put ppt's risk in context of ppt's life
  - Restate various factors contributing to risk
  - Highlight most important or key factors
  - Convey concern over ppt's risk
  - Encourage ppt to address risk issues

### Arm 1 Treatment

- Assist in developing a risk reduction plan:
  - Invite ppt to come up with plan
  - Help tailor plan to participant
  - Ensure plan is realistic
  - Discuss steps to reach plan: who, what, when, where
  - Brainstorm ways to overcome possible obstacles
- Support participant's risk reduction plan:
  - Encourage ppt to write down risk reduction plan
  - Verbally support ppt's plan and ppt's ability to enact plan

### Counselor Training

- Pre-National Training Education
- Train-the-Trainers Meeting
- National Training
- Post National Training
- Post Study Launch Training Efforts

### Ongoing Counselor Training

- Pre-National Training Education
  - HIV 101, counseling overview, review and discussion of counseling role-play DVD
- Train-the-Trainers Meeting
  - Assign training teams, create feedback forms, dry run of role-plays and feedback, review scenarios, adjust national training agenda

### Ongoing Counselor Training

- National Training
  - Introductions, model role-plays with Q & A, small group practice sessions: role-plays and feedback; debrief in larger group. Repeat.
- Post National Training
  - Conducting role-plays over the phone, counselor audio recorded role-plays sent to lead team in SF for review and extensive written feedback
  - Onsite booster trainings with more role-plays!

### Ongoing Counselor Training

- Roleplay Scenario Examples:

You are a 30 year old heterosexual woman not sure that you want to test today. You have not been sexual for 18 months because you've been incarcerated for the past year and a half. You have a history of substance use including needle use. You have been clean and sober for four months—the same period of time you have lived at the half-way house. While in prison you shared needles with several women, one of whom you suspect may have HIV. You are torn between testing and getting your results and just not knowing.

You are a 59 year old male who is fine with getting tested as you are happy to receive the study stipend. You have been on methadone maintenance for 10+ years. You had always used new or clean needles. You have no primary female partner but have several female casual sexual partners you have met through the methadone program. Condom use is only at sex partner's request.

### Written Feedback

- Included quotes from ppts and counselors in audio recorded session and covered:
  - Overall Counseling Skills: use of non-judgmental language, open-ended questions, active listening
  - Risk Assessment: explore riskiest events & factors contributing to risk, heighten ppt's awareness and concern for risk, explore previous safer sex strategies
  - Risk Reduction Plan: Offer options if needed, establish concrete steps, discuss roadblocks, secure support for plan

### Examples of Written Feedback

Turning a :

- Leading question:

*"You have a good marriage, right?"* into an open ended question:  
*"How committed are you to your wife?"*

- Closed-ended question :

*"Does your drinking increase your unprotected sex?"* into an open ended question: *"How might your drinking impact your sexual risk behavior?"*

- Judgmental statement:

*"Your risk reduction plan is good because you will stop your bad behavior"* into a non judgmental statement: *"Your risk reduction plan seems reasonable and doable and will reduce your risk for HIV and other STIs."*

### Examples of Written Feedback

#### ■ Exploring contributing factors to risk behavior:

Counselor: "How often do you drink?"

Ppt: "Not that often, I don't get drunk. I drink every other night."

Counselor: "So, most of the time you are looking up you are sober, or just a little buzzed, right?"

Feedback provided to counselor:

Before making such a summary statement we need to know a lot more about his drinking. He may actually drink 5 or 6 beers per night but too him, he is not drunk. He may be having alcohol every time he has sex.

To assess further, consider asking additional open ended questions:

"How many drinks do you have on an average night?"

"What is the most you drink?"

"How often do you drink that much?"

"How often do you have sex when you have been drinking?"

"How does your drinking impact your sexual risk behavior?"

### Examples of Written Feedback

#### ■ Increasing ppt's concern for risk behavior and ambivalence:

Scenario: married male having sex with co-worker. Feedback to counselor:

You did a nice job of increasing his awareness and concern around his risk by asking him things like:

"How do you feel about your risk taking?" and

"You tell me you aren't using condoms with your co-worker yet you really don't want any STDs and really don't want to pass anything to your wife. Can you explain that for me?"

When your ppt stated that he loved his wife and did not want to bring anything home, an appropriate question to ask would be :

"So tell me, what would it be like if your wife did get an STD?"

Getting him to spend some time thinking about the very real consequences of bringing home an STD might get him that much more motivated to make a change.

### Ongoing Counselor Training

#### ■ Post Study Launch Training Efforts:

- Weekly counselor calls (cases and QA trends)
- Real time fidelity monitoring with immediate written feedback
- Counselor requested consultation

### Specific Counseling Issues in CTN 0032

- Ppt brings 9 year old daughter into Arm 1 counseling session
- Ppt bolts after receiving counseling but before receiving test results
- Low(er) risk ppt receives reactive test result
- Arm 1 (counseling arm) ppt refuses counseling
- Arm 2 (test info only arm) ppt insists on counseling
- Study ppt in drug treatment facility) discloses thoughts of self harm: study records vs. medical/clinic records?
- Study ppt is Study counselor's drug treatment client

### Other Counseling/Testing Considerations

- Limited role of HIV test counselor
- Counselor self care
- Level or amount of risk behavior not always predictive of who will test reactive at any one testing event
- The extent of actual risk behavior may never be shared
- HIV risk behaviors may increase due to life circumstances
- If no counseling then difficult to prepare client (and staff) for possible reactive result
- Different rapid HIV tests and processing times may influence who gets tested, when, and how
- Clinic population may determine risk reduction counseling needs