Challenges to Providing Integrated HIV Prevention in Substance Use Treatment Settings: Frontline Staff Perspectives on HIV and Sex-Related, Education, Communication and Stigma

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Challenges to Providing Integrated HIV Prevention in Substance Use Treatment Settings: Frontline Staff Perspectives on HIV and Sex-Related, Education, Communication and Stigma

Jessica Jaiswal, Marybec Griffin, Caleb LoSchiavo, Amanda Cox, Kevin Hascher, Kandyce Dunlap, Suzan Walters, Wanda M. Burton, Benjamin Grini, Mercy Mumba and Ellen Eaton

Abstract

Introduction

Substance use treatment settings can play a critical role in ending the HIV epidemic. Community-based methadone clinics are potentially useful sites to offer biomedical HIV prevention, but little is known about how clinicians and other clinic staff communicate with patients about sexual behavior and HIV-related topics.

Methods

Thirty semi-structured interviews were conducted at two methadone clinics in Northern New Jersey. Participants included medical providers (physicians, RNs, DNPs), methadone counselors, intake coordinators, lab technicians, and other auxiliary staff members. Results: Three major themes were identified: (1) HIV education is primarily provided by external organizations, (2) there is limited staff-patient communication around HIV and sexual behaviors, and (3) HIV stigma is prevalent among staff and patients.

Conclusion

To implement PrEP in methadone treatment settings, clinic staff must be able to engage in non-judgmental communication about HIV and sex with patients. Additionally, federal and state funding for HIV prevention in substance use treatment settings must be prioritized to enable clinics to access the necessary training and resources.

Introduction

Despite decreases among some groups, the rate of new HIV diagnoses in the United States has remained stable for people who inject drugs (PWID) (Centers for Disease Control and Prevention (CDC), 2021b). People who use drugs (PWUD) are vulnerable to HIV acquisition from injection-related behaviors (e.g., syringe/needle sharing), sexual behaviors (e.g., condomless
sex, multiple sexual partners, exchanging sex for money or drugs), and structural drivers of risk (e.g., criminalization, policing, incarceration) (Alpren et al., 2020; Baker et al., 2020; CDC, 2020a, 2021a; Edeza et al., 2020; Flath et al., 2017).

New Jersey (NJ) should be considered a priority area for research on HIV prevention, particularly for PWID. In 2019, rates of new HIV diagnoses in NJ (14.1 per 100,000) surpassed the national and Northeast regional rates of, respectively, 13.2 and 9.4 per 100,000 (CDC, 2020b). Additionally, a significantly higher proportion of people newly diagnosed with HIV in NJ are PWID, representing 22.0% of men and 20.2% of women (AIDSVu, 2021a) compared to the national proportions of 4.7% of men and 15.9% of women (AIDSVu, 2021b). The highest rates of new diagnoses in NJ are seen in Essex County (35.4 per 100,000)—prioritized by the Centers for Disease Control and Prevention (CDC) Ending the HIV Epidemic plan—with over half of the county’s new diagnoses occurring in Newark (CDC, 2021b).

Despite increased HIV acquisition and transmission risk, PWID receives limited HIV prevention services. Among PWID surveyed in the 2018 National HIV Behavioral Surveillance, the most available services were free condoms and injection supplies from syringe service programs and pharmacies (CDC, 2020a). Although HIV pre-exposure pro-phylaxis (PrEP) is an acceptable and effective method of HIV prevention for PWID (Shrestha et al., 2018; Shrestha et al., 2017), providers are often unwilling to prescribe PrEP to PWID (Edelman et al., 2017). Because a majority of PWID report recent use of medications for opioid use disorder (MOUD, e.g., methadone, buprenorphine) (CDC, 2020a), MOUD clinics are potentially effective sites for HIV prevention (Bruce, 2010; Gowing et al., 2006; Karki et al., 2016; Oldfield et al., 2019).

Previous studies have highlighted the need for HIV education in these settings (Sherman et al., 2019), but research and practice are sorely lacking in this area. Few studies have explored
MOUD clinics as sites for implementing HIV prevention, with a greater focus on HIV treatment (Mohd Salleh et al., 2021). Staff and clients in substance use treatment settings have stigmatizing misconceptions about HIV that could be addressed through provider training and patient education (Bazzi et al., 2018; Biello et al., 2018; Shrestha & Copenhaver, 2018). A comprehensive approach to HIV prevention in MOUD settings requires addressing the overlapping ways in which substance use and sexual risk behaviors impact risk for HIV transmission. However, less is known about how patient-provider communication about sexual behavior in MOUD clinic settings impacts HIV prevention. A deeper understanding of the ways in which MOUD clinicians and staff address the interface between substance use disorders, sexual risk behaviors, and HIV prevention could help inform the development of integrated HIV prevention programming in these settings. Thus, this study explores experiences regarding HIV-related education, communication about sexual health, and stigma in MOUD clinics in Essex County, NJ, aiming to better understand implications of PrEP implementation in priority settings for HIV prevention.

**Methods**

**Study design**

Details on the study design and sample are available in previous study publications (Jaiswal et al., 2021, 2022). Briefly, researchers created a list of methadone clinics across two counties in the metropolitan area of Newark, NJ, and contacted each clinic between January–April 2019 to invite them to participate. The final study sample contained 30 participants from two clinics (one public, one private) serving low-income patients. Participants included medical
providers (RNs, DNPs, physicians), methadone counselors, intake coordinators, lab technicians, and other auxiliary staff members. Convenience and snowball sampling were used in these clinics to recruit staff members. All participants provided written informed consent and all activities were approved by the New York University Institutional Review Board.

**Data collection**

Between May–August 2019, 30 interviews were conducted. The average length was about 30 min. The sample represented over 85% of staff at each clinic and saturation was achieved at 26 interviews. Prior to the qualitative interviews, participants completed a brief, interviewer-administered sociodemographic questionnaire. After this questionnaire, two research staff members with training and experience in qualitative data collection conducted semi-structured interviews using an interview guide.

The semi-structured interview guide included questions related to patient populations, treatment models, clinic logistics, HIV risk discernment, and PrEP awareness. The interview guide was developed based on the literature on PrEP in methadone clinic settings, literature on barriers to expanding PrEP services in other clinical settings, and the team’s research and clinical experiences.

**Data analysis**

Interviews were audio-recorded and transcribed by a professional transcription service. To ensure quality control, 20% of the transcripts were randomly selected and reviewed for accuracy. Researchers implemented a multi-step method of recognizing, contextualizing, and examining themes to maintain data integrity. To do this, the team developed a coding scheme, applied it to the data, and used it to determine patterns, major themes, and subcategories. Three
of the authors developed the codebook, participated in coding, and reviewed the analyses to address any differences in the interpretation of themes. In instances of discrepancies, the coders consulted other research team members to discuss and resolve. The authors used multiple techniques throughout the analysis to establish trustworthiness, including credibility and confirmability. For example, the researchers utilized peer debriefing and periodic external audits with researchers not involved in data collection (Lincoln & Guba, 1985). The qualitative data were organized using Atlas.ti.

Finally, to protect participant confidentiality, all participants were assigned pseudonyms. Additionally, because clinics often have a limited number of each staff position, participants’ quotes are presented with their roles categorized into medical and non-medical staff. This categorization was not intended to obscure the critical and diverse roles that staff have in these settings but rather allow us to share participants’ perspectives while protecting them from being publicly identifiable.

**Results**

**Sample characteristics**

Of the 30 participants, the largest proportion were methadone counselors (n = 11). Other staff positions represented included medical providers/clinicians, lab technicians, administrative staff, receptionists, intake coordinators, and security guards. Most participants were women (n = 19). Over 80% of the sample was non-Hispanic Black individuals, followed by Latinx participants. Further characteristics are not provided, to protect participant confidentiality.

**Themes**
Three major themes were identified: (1) HIV education is primarily provided by external organizations and needs to be expanded within the clinics, (2) there is limited staff-patient communication around HIV and sexual behaviors, and (3) HIV stigma is prevalent among staff and patients. Together, these themes demonstrate some of the challenges related to integrating PrEP-related care into substance use treatment settings.

Theme 1: HIV education and prevention services are primarily sourced from outside the clinic

Participants across clinics reported minimal HIV education and testing. Other than a one-time education session during new patient orientation, HIV resources were predominately external, primarily via testing vans from local community organizations or occasional visits from HIV educators. Only one of the clinics provided on-site testing. While these services provide important services for patients and staff, they were available intermittently.

When asked about the percentage of patients diagnosed with HIV, Ruth stated that she is not sure because of the lack of internal HIV testing:

It’s hard to tell. At my other program, I would be able to tell, but here it’s hard because they don’t have a HIV specialist … We, the program, don’t do the testing. So, it’s kinda hard. The only way that I would know if they were HIV is if the patient disclosed that themselves. … We have HIV education when the patients come here, that’s one of the core orientation groups we have, we offer that, and they have it that first time, and then after that they’re here a year you do it again with them, and then like I was saying sometimes [community organization come here, or [academic medical center] and they offer testing and education. [Ruth, non-medical]
Chris also mentioned mobile testing units, noting that the clinic previously had a visiting HIV specialist:

HIV has been definitely a big issue in this population throughout the years…we used to have the HIV specialist coming here, back before, and this was probably like maybe 10 years ago. And we had a person that would come here just specifically for HIV testing and do that for—I remember they would send in—[the academic] medical center would have their little trucks pull up sometimes, do the free testing. Staff would go there, even the clients. [Chris, non-medical]

When asked if she had heard of PrEP, Janet explained that the health department visited the clinic and offered HIV testing and education, including PrEP information:

They come in on the end of the month of every Tuesday. And they see whoever wants to get tested, whoever wants to come in for the group. We all sit, and we talk about [HIV]. They have mentioned [PrEP] to them. They’ve explained that even though you take the pill, it’s still not a guarantee as of right now that the pill will keep you safe. So, you still have to get tested every three to six months. [Janet, non-medical]

**Theme 2: Limited staff-patient communication around HIV and sexual behaviors**

Staff and providers largely reported infrequent communication with patients about HIV or sexual behaviors, although a few participants described feeling able to communicate about sensitive issues with patients due to their established rapport. Overall, however, dialogue around
HIV and sexual behaviors appeared to be minimal.

**Subtheme 1: Limited discussion around HIV, especially HIV disclosure**

Although the clinics had substantial populations of patients living with HIV, most of the staff did not directly ask patients about their status, opting instead to wait for their patient’s disclosure or to find out from discharge papers or other paperwork. For example, Ruth noted that the intake process offered passive opportunities to learn a patient’s HIV status.

Interviewer: Do patients disclose [if they have HIV]? Do you have a sense if they disclose that?

Ruth: Some of them do. Some of them do, some don’t. Interviewer: How does it come up?

Ruth: For example, during your intake screening you may ask what medications are you on, and they’ll tell you, and you’ll know then, or some of them would say I’ve got HIV meds. That’s the one who could tell. Or some of them might come in with discharge papers from a hospital, another program or whatever, and it may be on there. [Ruth, non-medical]

Several staff members described how patients only sometimes disclosed their HIV status, with some suggesting that shame or denial prevents disclosure. Similarly, Briana noted the high rates of both Hep C and HIV among the patients, and explained that patients often do not want to disclose:

I would say out of 100%, at least 80% [are Hep C positive]. HIV, maybe 30–40%. And that’s another thing, sometimes they don’t wanna tell me. They don’t wanna tell me because they come in the room with me first on a physical, and I sit there, do their vital signs and take a list of their medications, they won’t tell me their HIV medication, but after they go in and see the doctor, and I get the chart back to input into the computer,
I’ll be like, “Oh, they didn’t tell me they were on Truvada,” or whatever the HIV drug is… [Briana, medical]

Furthermore, some staff were hesitant to discuss HIV for fear of alienating their patients. Steven explained that he does not discuss HIV with clients to avoid invoking stigma:

I never bother to, because like I said, people are not so open to talk about that part of their life to an open forum because it’s so stigmatized. So, you’re embarrassed. You’re fearful of people talking about you, so I wouldn’t bring that up. [Steven, non-medical]

Subtheme 2: Limited discussion around sexual behaviors

Although participants agreed that HIV education and prevention were needed, most did not routinely ask about sexual behaviors. Clinicians and counselors, who may need this information to provide appropriate care, either refrained from asking directly about sexual behaviors or noted that disclosure was only possible with strong rapport. As such, there was no consensus on how clinicians and counselors could assess sexual behaviors associated with HIV transmission, which are common in their patient population.

Marcus described his hesitancy to ask about patients’ sexual behaviors for fear of making patients feel judged:

Interviewer: Do you think anyone in particular would benefit from PrEP?

Marcus: Well, I don’t know their sexual histories. Some of them don’t disclose that to us. I do ask once in a while, but some people are very reluctant to come up with it. Some people don’t tell you the truth. They say, “I’m not doing any- thing,” when they are. And I have not seen anybody that says “I’m having sex for cash”, or “I have sex with people for money or for other benefits”… if you talk like that, you’re closing the door for further conversation.
Interviewer: So, you wouldn’t necessarily say, “Are you selling sex for money?”

Marcus: If you do that, you close the door completely… if it’s somebody doing it, it will be maybe 1 out of 50 might say yes. But they are ashamed. They have mental conditions, and they are not proud of it. So, if I’m not proud of something, you don’t expect me to voluntarily give it up, do you? And we talk about it and I become uneasy, and I become less comfortable to talk to you. I might see it as judgmental, and I might duck away. [Marcus, medical]

When asked if patients trade sex for drugs or money, Steven responded that, although sex work was common, patients—especially men who sold or traded sex with men—would likely not disclose:

Some [trade sex], but it’s—that must not be something that would be proud to tell you. Maybe years later, after they’re clean, they’ll say, "Yeah, I used to do that," but not when they first come in, though. They wouldn’t reveal that, not if they’re straight, a heterosexual person, male…But they do—some be defeated to that point, where they have no other way to make money. [Steven, non-medical]

Although many participants seemed to avoid questions that might alienate patients, some staff expressed that sex could be more openly discussed if trust was established. For example, Helen explained that patients were often hesitant to disclose potentially stigmatized behaviors, with disclosure facilitated by counselors’ communication skills and rapport with the patient:

I don’t think they perceive [being at risk for HIV]…a lot of the time they’re not forthcoming that they may be shooters. Or they won’t want to admit that they are sexually active… a lot of these people are pretty closed on their full background. They don’t want to admit. And that’s some of the addiction problem. Because they’re self-medicating to forget what they did. Their bad choices… And it’s open admission. So, that’s the bond that you have to get and be able to address through the open-ended
questions. But it’s the skill of the counselor and how they—how strong a bond is. And how they feel about their confidentiality. If it’s available and they feel that it’s not going to go all across country. [Helen, non-medical]

Maria expressed similar sentiments, stating that patients may be willing to discuss sensitive topics and PrEP openly because “over time” patients become more trusting. She also noted that patients would likely feel more comfortable accessing this type of healthcare at their substance use treatment clinic rather than going somewhere “randomly”:

I think if [PrEP] was offered at a methadone clinic, I think [patients] would be more open because honestly, when they come in and over time, we gather information from them. And over time, they do inform us or notify us of their truth. And I think if someone comes in here and speaks with them or if someone gives them information here related to anything that can affect them based off them being a part of this sub-group, I think it would be more effective as opposed to me going into a medical doctor’s office and also me going to my gynecologist…I think if it’s offered on-site in a place where most persons already feel safe and comfortable being honest about their behaviors related to their addiction, I think it would be more effective as opposed to me randomly going into a clinic where I don’t really know anyone and now having to tell my story all over again. I think that this type of setting or addiction recovery program would create an environment where it’s easier for the person to be more open and honest about those things because this is the one place where they do share that information because we’ve done Hep-C testing. [Maria, non-medical]

Theme 3: HIV stigma is prevalent among staff and patients and in the clinic setting

Staff described the presence of HIV stigma in the clinic context, with some expressing stigmatizing attitudes toward people living with HIV. Overall, staff perceived, and in some cases
personally experienced, HIV-related stigma to be common and a likely barrier to HIV prevention. Many participants noted the need for increased HIV education in the clinic to address HIV-related stigma, though that stigma might prevent patients and staff from engaging in that education.

Steven described the nature of HIV stigma in the clinic setting:

There’s still a lot of stigma about HIV. You get the bone and cross if you got it, a sign on your forehead… It’s nobody’s business what’s yours. It’s not something you go broadcasting unless it’s to the person that you’re about to have sex with. But other than that, I don’t think it’s anybody else’s business. [Steven, non-medical]

While many staff were concerned about the impact of HIV stigma on disclosure, others used stigmatizing (and seemingly HIPAA-noncompliant) language to talk about people with HIV:

This is just something that happened to me in the lobby, I was sitting there, and this real fine woman walked by, but everybody knew she had HIV. So, my client is catcalling, so I’m like, “Man, you know she got HIV.” He says to me he’ll just put on three condoms [laughs]. [David, non-medical]

Like participants above who expressed the need for more education, Debra felt that more programming must be developed to address the lack of HIV prevention service offerings, noting stigma as a barrier to implementation:

We have to expand our program here to address [more HIV education]. But I think at first you couldn’t do it because [of] the stigma. [Debra, non-medical]

Similarly, when asked whether HIV was on “patients’ radar”, Cassandra explained that shame was common and that stigma needed to be addressed by education:

It’s on their minds but I see a lot of them try to keep it hid-den. Ashamed—being ashamed or being like they’re gonna be looked at, judged, shunned, and all that. Some of them, they will share about it. But I think that needs to be more implemented in all programs. Them trucks need to continuously keep coming
Sheila, informed by her experience living with HIV, felt stigma was a persistent problem. However, she did not perceive HIV stigma as a barrier to PrEP uptake for people with partners living with HIV:

Sheila: Being an HIV [positive] person, one day—one time I shared it in a women’s ministry, and I got a lot of—I felt judged and I said, “Oops, I shouldn’t have shared that.” But because people, they just weren’t educated, that’s all. It’s still a stigma. It’s still a stigma.

Interviewer: Do you think the fact that there’s still stigma out there, do you think that would make people hesitate about PrEP?

Sheila: Not the participant. The participant probably would want to take PrEP to prevent from getting it if their—they knew their partner was positive. I think the stigma would come from people outside looking in…They may make comments, “Watch that person. They have HIV.” Or they may talk about them or judge them because they don’t—they’re uneducated about what PrEP is”…So, I think it needs to be more information. I mean you hear about it on T.V., but it doesn’t give you a lot of information over the television…So, I think providers, like health providers, need to start educating people, patients, all patients, just like they do STDs. [Sheila, non-medical]

Latandra explains that education may help with the widespread problem of stigma, which patients are accustomed to dealing with, and posits that it would not necessarily be a barrier to PrEP uptake:

We have seen this disease transform from a terminal illness to a chronic illness. We’ve seen it in our lifetime. It didn’t take 100 years to do that. So, that’s part of the education. And when people see that, but clearly there is still some stigma associated with HIV. [But]…the people that we serve already have plenty of stigmas, so they’ll be able to deal with that, I believe. The information and the knowledge and the fact that that’s a support for living life on life’s terms, they’ll be able to deal with that. Stigma—nobody knows what
medicines you take; we’re talking to each other, I don’t know what medicines you take, you don’t know what I take. And whether we did or not, should it change the conversation? No. [Latandra, medical]

Discussion

This study provides insight into potential barriers and opportunities for integrating PrEP services into methadone clinic settings. The findings presented here reflect some of the ongoing challenges related to treating substance use disorder while simultaneously addressing the ways in which unmanaged substance use disorder impacts the risk for HIV. Although participants were aware of the interface between drug use, structurally driven higher-risk behaviors, and HIV risk, there was no established method of consistently inquiring about such behaviors. Although some staff were able to broach these topics, most described difficulty communicating about these topics. Despite these challenges, some staff described ways in which MOUD treatment settings may present unique opportunities for comprehensive HIV prevention. Several participants described how methadone counselor relationships created the opportunity for long-term relationships with staff built on trust and disclosure. Related, clinic staff reported that most of the HIV-related education and testing was done via community organizations (e.g., mobile van), suggesting that more on-site infrastructure support for HIV services would help facilitate the integration of PrEP services. Finally, HIV-related stigma was a salient theme, as participants reported concern about HIV stigma as a potential barrier to discussing sex and HIV with patients, in addition to some staff expressing stigmatizing ideas about HIV and people living with HIV. Together, these themes suggest that while some HIV-related education and communication barriers exist, there is also potential for overcoming these challenges to provide integrated HIV prevention services in MOUD treatment settings.
Communication around HIV and sexual behaviors

The provision of HIV-related services, including PrEP, cannot be successfully integrated into substance use treatment settings if staff are not comfortable discussing HIV and sexual behaviors in a clear and consistent manner. Many staff members noted that HIV and sexual behaviors were insufficiently discussed, with a subset reporting that this was possible when rapport was established. Studies have shown that disclosure is essential to providing quality patient-centered care (Griffin et al., 2020) and ensuring that services meet patients’ needs (Guise et al., 2017; Marchand et al., 2020). Staff should both encourage disclosure and routinely ask patients about HIV status and sexual behaviors as part of ongoing care.

The Centers for Disease Control and Prevention’s Five P’s model provides a framework for comprehensive sexual history-taking (CDC, 2015). To engage patients in this discussion, clinicians should remember the Five P’s: (1) Partners; (2) Practices; (3) Protection from STIs; (4) Past History of STIs; and (5) Pregnancy intention. Without strong training in how to take a comprehensive sexual history, providers and patients miss opportunities to discuss HIV prevention. Moreover, routine discussion about sexual behavior and HIV will also help normalize talking openly about these topics, which decreases stigma over time (Hussein & Ferguson, 2019). It is critical that MOUD staff and clinicians understand the unique ways in which substance use disorder impacts risk for HIV and are able to tailor sexual health discussions to this setting. MOUD providers must be comfortable asking about stigmatized behaviors (e.g., transactional sex) in an open and non-judgmental way so that they can assess risk for HIV, counsel patients appropriately, and offer PrEP.

Infrastructure support for training and HIV testing
As noted by the participants, most HIV-related services are delivered by external providers due to limited funding, resources, and trained staff. To support integrated HIV-related services, methadone clinics will require significant infrastructure support to train medical and non-medical staff, focused on non-judgmental approaches to discussing biomedical and behavioral HIV prevention, and to consistently provide on-site HIV testing services, which is a requirement of ongoing PrEP use (Behrends et al., 2021). However, many substance use treatment settings, especially those that serve low-income and/or uninsured patients, are often underfunded and financially constrained. Additionally, previous research has found that substance use treatment providers may view HIV prevention as too far outside the scope of substance use-related clinical care (Jaiswal et al., 2021). This may be related to financial constraints and federal guidelines that functionally prevent methadone clinic settings from expanding services (NASAM 2020, ASAM 2021). These same federal guidelines have also fragmented methadone clinics from other sites where medical care is provided, creating another structural barrier to incorporating HIV prevention into methadone clinics.

Advocates and researchers have called for increased federal and state funding to address the severe treatment disparities that exist throughout the United States (Stewart et al., 2021). The national focus on the opioid overdose epidemic is largely recent, following a shift toward impacting White people rather than Black and brown communities (Hart & Hart, 2019). This further illuminates the inequities within the healthcare system that have disproportionately harmed minoritized populations. Some have argued that the federal guidelines restricting methadone prescribing to siloed DEA-regulated clinics where patients must present daily for their medication is itself a manifestation of systemic racism that leads to pseudo-criminalization of people of color with substance use disorder. Thus, interrelated forces of systemic racism, classism,
and stigma are structural factors that must be addressed to increase access to substance use treatment and PrEP for communities most in need of HIV prevention. Addressing these interrelated forces is crucial for integrating biomedical HIV prevention services into substance use treatment settings, as reducing the siloing of care requires not only significant resource allocation but also a clear commitment to providing holistic, comprehensive low-barrier care for all people with substance use disorder. Advocates should simultaneously seek to increase funding for existing services while also exploring opportunities to modify the dated regulatory framework that guides how methadone is prescribed for OUD.

**Addressing HIV-related stigma**

The data revealed stigmatizing attitudes around HIV among staff and patients, as well as staff’s concerns about HIV-related stigma as a barrier to HIV prevention efforts. HIV stigma in substance use treatment settings may be particularly concerning due to the already intense levels of stigma experienced by patients with substance use disorders. Pervasive substance use stigma in the U.S. has characterized people who use drugs are as undeserving of dignity and care, inhibiting treatment availability and accessibility (Wakeman & Rich, 2018). Structural and interpersonal stigma within clinic settings also affects the potential rollout of PrEP among MOUD patients. Often, OUD treatment service uptake is perceived as an admission of criminalized and stigmatized behaviors (e.g., sex work, injection drug use, buying and/or selling criminalized substances) (Nieweglowski et al., 2018). The regulatory structure of methadone clinics, in which patients must present daily for directly observed treatment, reinforces this stigma (Harris & McElrath, 2012). In addition to stigma related to substance use (Guise et al., 2017), stigma around HIV, sexual orientation, and sexual behaviors persists due to entrenched homophobia among clinicians (Guise et al., 2017; Jaiswal et al., 2021) and in clinical education (Herling, 2021).
To reduce stigma, it is essential to improve the availability of clinical education around both substance use (Lindsay et al., 2017) and HIV and sexual behaviors. However, providing continuing education for staff requires funding and prioritization of this training for all medical and non-medical staff, which is difficult to obtain in an increasingly stressed funding environment. In addition, ongoing staff education around HIV and implicit bias should be part of continuing education for clinicians as well as staff (Jaiswal et al., 2021). While essential, providing continuing education for staff requires funding and prioritization of this training for all clinic and frontline staff, which is often difficult to obtain in an increasingly stressed funding environment.

**Limitations**

Although transferability may be limited, Northern New Jersey was intentionally selected as an area with low resources for and high need for OUD treatment and HIV prevention. While generalizability is not an explicit goal of qualitative methods, the findings presented here may be cautiously applicable in some settings, including medium and large-sized methadone clinics in urban settings where public health infrastructure is underfunded. The brevity of staff interviews is another limitation. Although staff participants spent as much time as possible given their job requirements, more time for additional probing would have been helpful.

**Conclusion**

The inclusion of HIV prevention in methadone treatment settings could profoundly benefit this population, as integrated care environments connect patients to necessary services. Increasing on-site HIV education and improving staff-patient communication around HIV and sexual behaviors requires substantial resources, necessitating funding in a financially limited
setting. Future education and training should address multiple types of stigma and focus on the influence of rapport and trust building on staff-patient communication and disclosure of stigmatized behaviors.

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<tr>
<th>Gaps</th>
<th>Recommendations</th>
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<tbody>
<tr>
<td>HiV education and prevention services are primarily sourced from outside the clinic</td>
<td>• On-site infrastructure support for HiV services, including HiV testing (a requirement of ongoing PreP use).</td>
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<tr>
<td>Limited staff-patient communication around HiV and sexual behaviors</td>
<td>• Improve the availability of clinical education around HiV and sexual behaviors.</td>
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<td>• Staff should both encourage disclosure and routinely ask patients about HiV status and sexual behaviors as part of ongoing care.</td>
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<td>• CDC’s Five P’s model provides a framework for comprehensive sexual history-taking: (1) Partners; (2) Practices; (3) Protection from Stis; (4) Past History of Stis; and (5) Pregnancy intention.</td>
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<tr>
<td>HiV stigma is prevalent among staff and patients and in the clinic setting</td>
<td>• Anti-stigma training would benefit all clinic staff regardless of role.</td>
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<td>• Staff must be comfortable asking about stigmatized behaviors (e.g., transactional sex) in an open and non-judgmental way so that they can assess risk for HiV, counsel patients, and offer PreP if appropriate.</td>
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No potential conflict of interest was reported by the authors.

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