

HIV RISK ASSESSMENT & HIV RISK REDUCTION

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HIV PROVIDER REFERENCE SERIES

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**HIV RISK ASSESSMENT/HIV RISK REDUCTION
A QUICK REFERENCE GUIDE FOR CARE PROVIDERS
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Marla A. Corwin, LCSW, CAC III

Clinical Education Coordinator, Mountain Plains AETC
Instructor, School of Medicine
Division of Infectious Diseases
University of Colorado Anschutz Medical Campus
Aurora, CO

Lucy Bradley-Springer, PhD, RN, ACRN, FAAN

Principal Investigator and Director, Mountain Plains AETC
Associate Professor, School of Medicine
Division of Infectious Diseases
University of Colorado Anschutz Medical Campus
Aurora, CO

Paul F. Cook, PhD

Associate Professor, College of Nursing
University of Colorado Anschutz Medical Campus
Aurora, CO

OVERVIEW

Preventing new infections with HIV is an important and necessary component of stopping the epidemic and moving toward an “HIV free generation.” Information in this guide, individualized to the patient, can help you determine a patient’s risk for HIV (as well as for other sexually transmitted and blood borne diseases) in order to appropriately individualize risk reduction counseling and better support positive behavior change.

- **Risk assessment** specific to sexually transmitted and blood borne diseases is even more critical in the era of HIV infection.
 - Sexual and drug substance use risks should be determined during a routine health history with every new patient and updated regularly during periodic health care.
 - Risk assessment helps to identify individuals at risk; support recommendations for HIV, STD, and hepatitis screening; and establish risk reduction education topics and strategies.
 - Risk assessment can help people who are already infected access treatment and learn how to avoid transmitting HIV to others.
- **Risk reduction** is the selective application of appropriate techniques and management principles to reduce the likelihood of a risky event and/or the negative consequences of such an event.
 - The goal of risk reduction counseling is to help patients decrease risks to themselves and others, thereby decreasing the number of new HIV infections.
 - Risk reduction helps decrease the rates of HIV infection through targeted prevention efforts.
- **Prevention** techniques include:
 - A comprehensive and effective risk assessment to guide individualized counseling specific to the patient.
 - Risk-reducing prevention methods for people who are at risk of or infected with HIV.
 - Motivational interviewing techniques to engage and motivate patients to change personal risk behaviors.

Key Points

- Begin by assuring confidentiality and explaining why these questions are important. Example: “I am going to ask you some personal questions. I ask them of all of my patients because assessing your drug-use history and sexual health are essential parts of helping you get the best possible care. All of your responses will remain confidential. Do you have any questions before we begin?”
- Start with less threatening topics and move to questions about more sensitive topics.
 - General health and safety questions that are typically asked during a patient history should be raised first.
 - Questions about blood exposure (transfusions, clotting factor, occupational exposure, etc.) should be asked before questions about drug use.
 - Questions about drug use and sex are generally best left until later in the assessment.
 - When addressing drug use, start with legal drugs (tobacco, alcohol, prescription medications) before asking about illicit drugs (heroin, cocaine, methamphetamine, etc.).
 - When asking about sex, start with questions about whether the patient is or ever has been in a sexual relationship before asking about multiple partners, gender of sex partners, and sexual activities.
- Use a variety of questioning methods to gather information. Different people respond to different styles.
 - **Open-ended questions.** These questions invite expansive answers and can provide a lot of information on a topic. “What,” “how,” and “tell me about . . .” questions gather the most information and allow the patient to do most of the talking. Examples:
 - Tell me about your alcohol use.
 - What is your mood usually like?
 - What do you expect from a sexual relationship?
 - How could you be safer when you meet someone you want to have sex with?

- **Closed-ended questions.** These questions can be answered in a few words. The answers don't give a lot of information, but they are specific to the topic and can help direct further questioning. In general, closed-ended questions should be used less often than open-ended questions. Examples:
 - Do you use drugs?
 - If the answer is no, ask: Have you ever used drugs?
 - If the answer is yes, ask an open-ended question to start the conversation: Tell me about the kinds of drugs you use.
 - Are you in a sexual relationship?
 - If the answer is no, ask: Have you ever been in a sexual relationship?
 - If the answer is yes, ask an open-ended question to start the conversation: What does a sexual relationship mean to you?
- **Presumptive questions.** Asking a question as if you assume that the patient has sex or uses drugs will often get a positive response. If the patient doesn't have sex or use drugs, s/he can correct you. Examples:
 - How often do you smoke pot/use drugs/share injection equipment?
 - Tell me about your alcohol use.
 - How do you protect yourself from sexually transmitted diseases when you have sex?
 - When was the last time you had sex with someone you just met?
 - Where do you go to find sex partners?
 - Do you have sex with men or women or both?
- **Direct questions about specific behaviors.** Ask questions that are clearly focused. Examples:
 - What do you know about the people you share your injection equipment with?
 - When is it more difficult to use a condom?
 - How do you ask a new partner about her/his HIV status?

- **Exploratory questions.** When patients are reticent to share information with you, it may be helpful to find out what is happening in their social environments. This can be especially true for adolescents. Examples:
 - How easy is it to get drugs?
 - What do your friends think about using condoms?
- **Normalizing questions.** These questions let the patient know that you understand that the behavior in question is not abnormal or “weird,” and that you are comfortable talking about it. Examples:
 - Some of my patients tell me they share their crack pipes. Have you ever shared a pipe?
 - Sometimes people have anal intercourse. Have you ever had anal intercourse?

Substance Use Risk Assessment

- **Be non-judgmental.**
 - Many patients are reluctant to disclose illicit drug use unless a safe environment has been established.
 - Use words that describe behaviors like “drinking” and “using cocaine” instead of words that describe people such as junkie, crack head, addict, alcoholic, and other pejorative terms.
- **Start with less threatening questions.** Examples:
 - What over-the-counter and prescription medications are you taking?
Do you inject any of those?
 - How often do you use alcohol? tobacco?
 - When was the last time you used a drug from a non-medical source?
- **Do not assume anything.**
 - Drug use occurs in all socioeconomic strata.
 - If a patient says s/he uses or has used drugs, ask about specific drugs (e.g., marijuana, heroin, methamphetamine).
 - Don't forget that people also inject insulin, steroids, and hormones. Sharing injection equipment with these medications can also create the risk of HIV transmission.

- **There is no completely safe way to use drugs.**
 - Alcohol use is highly correlated with unsafe sexual activity and the spread of HIV infection, as well as other sexually transmitted diseases (STDs).
 - Nasal straws and pipes also carry some risk for transmitting blood borne diseases.
 - Any substance (including alcohol) that alters decision-making capabilities can lead to risky sexual behaviors.
 - Any sharing of injection equipment, even one time, can result in exposure to HIV, hepatitis B, or hepatitis C.
 - Illicit drug use sometimes poses threats on the user's physical safety. Drug users are at higher risk of abuse and trauma in a community where using drugs may lead to them being:
 - harassed by law enforcement, peers, or other people in the community;
 - robbed of drugs, money, or personal possessions;
 - sexually assaulted;
 - physically harmed or murdered.
- **Look for other clues in the history and physical.**
 - Antisocial behavior
 - Anxiety, depression, insomnia
 - Post-traumatic stress disorder (PTSD)
 - Signs of physical abuse/violence
 - Recurrent legal problems
 - Needle tracks or other physical evidence of drug use
 - Family, partner, or friend reports of use
- **If there is a positive history of drug use, get more information.** Examples:
 - Tell me about the drugs you have used.
 - How do you use drugs (inject, snort, smoke, etc.)?
 - Have you ever injected a drug?
 - What drugs do/did you inject?
 - How do you know if the equipment you use is clean?
 - Tell me about the last time you had sex when you were high.

Sexual Risk Assessment

- **Use specific terms and neutral language.**

- Use “men who have sex with men” or “women who have sex with women” instead of gay or lesbian.
- Avoid words such as faithful/unfaithful, promiscuous, prostitute, and other value-laden terms.

- **Do not assume anything.**

- Marriage or having children do not always mean an individual (or his/her partner) is monogamous or heterosexual.
 - Monogamy is not guaranteed by marriage: personal, cultural, economic, and other factors can influence a married person to have more than one sex partner.
 - Marriage for same sex couples is legal in a number of states; same sex couples who have been married, are married, even if they are not living in a state where it is legal.
 - People who identify as homosexual may also have sex with people of the opposite gender; people who identify as heterosexual may also have sex with people of the same sex.

- **Important questions to ask in a sexual history.**

- How old were you when you started having sex?
- Have you ever had an STD? If so, when? How was it treated?
- Have you ever been frightened or hurt in a sexual interaction?
- Have you ever been tested for HIV?
 - If so, tell me about that.
 - If not, have you ever been offered an HIV test and decided not to have it? Tell me about that.

- **Ask for an explanation.** It is appropriate to solicit reasons for a patient’s behavior, but avoid asking “Why?” which puts people in a defensive position and can stop a conversation. It is better to use questions such as:

- How did you come to that decision?
- When you say you had sex, what exactly do you mean?
- Tell me what you mean when you say you are always “the top.”

- How do you bring up the topic of condom use with your partner(s)?
- What did you mean when you said you had “the drip”?
- **Direct and non-judgmental questions are the best.**
 - Do you have oral sex? vaginal sex? anal sex?
 - What do you know about your partner(s)’ past sexual activities?
 - What do you do when you think you have an STD?
 - When do you use condoms?
 - Are there situations where it is easier to protect yourself?
 - Have you ever had sex with someone you didn’t know or just met?

Clinical Risk Assessment

- In addition to obtaining the history of risk factors, a basic medical history to identify symptoms of early HIV infection is appropriate.
- Assess for symptoms of acute and chronic HIV infection:
 - Headaches
 - Fever, chills, night sweats
 - Diarrhea
 - Skin lesions/rashes
 - Fatigue
 - Weight loss when not trying to lose weight
 - Shingles
 - Oral thrush
 - Frequent and hard to treat vaginal candidiasis
 - History of STD, hepatitis, or TB
 - Generalized lymphadenopathy
 - History of opportunistic infection
- When you see any of the above symptoms, especially in the context of a history of risk behaviors, include HIV in your differential diagnosis.
- People with HIV infection often have a history of unresolved trauma, violence, and/or abuse. Trauma can occur through physical or emotional harm and/or through neglect.

- Past traumas can have a lasting effect on an individual's ability to act safely and protect the self in the present.
- Current and continuing traumas can lead to high-risk behaviors and problems with treatment for HIV infection.
- Assess for trauma and abuse in all patients with or at risk for HIV infection:
 - Tell me about the family and environment you lived in as a child.
 - Have you experienced violence or trauma in your life? Can you tell me what happened?
 - Have you ever been forced to have sex against your will? How do you think that experience has affected your current relationships?
 - How safe do you currently feel in your relationships?
 - What makes you feel safe/unsafe in a sexual relationship?
- If a patient seems distressed or expresses concerns for safety, immediately set up an appointment with a social worker or mental health provider.

HIV Testing

- All patients between the ages of 13 and 65, regardless of identified risk, should be screened for HIV.
- Patients at increased risk for HIV infection (as established by risk assessment) should be tested as soon as possible, whenever symptoms occur, and annually.
- HIV testing should be offered whenever a patient is diagnosed with another STD, hepatitis B, hepatitis C, or tuberculosis.
- In the context of helping women and/or couples think about having children:
 - HIV testing should be offered to every woman who discusses planning for pregnancy or presents for a first pre-natal appointment.
 - Don't leave men out of reproduction discussions; they should also be offered HIV testing when planning for pregnancy.
 - If a woman is found to have HIV and is interested in pregnancy, she should be counseled:
 - If already pregnant, she needs to learn about ways to maintain her own health and decrease the risk for mother-to-child transmission of HIV; this means entering into HIV care under the supervision of an experienced clinician and starting antiretroviral therapy. She may also want to discuss pregnancy termination.

- If planning a pregnancy, she needs to learn about treatment for her own infection and counseled about ways to decrease the risk of HIV transmission to her male partner during insemination as well as ways to decrease the risk of mother-to-child transmission of HIV.
- If the male partner in a relationship planning for pregnancy is found to be infected with HIV, the couple needs counseling about decreasing the risk of HIV to the partner and the array of ways to continue with pregnancy plans, including pre-exposure prophylaxis (PrEP).

RISK REDUCTION COUNSELING

Methods to Reduce Risk

- Substance use risks can be decreased by:
 - Stopping use of drugs or alcohol.
 - Accessing substance use treatment, which remains the most effective form of risk reduction for substance users.
 - Not injecting; injecting is the most risky way to use substances.
 - Not sharing injection equipment or other drug using paraphernalia.
 - If sharing equipment, appropriately bleaching and cleaning drug-using equipment.
 - Changing route of delivery (e.g., smoking or snorting rather than injecting).
 - Using drugs and/or drinking alcohol less frequently and/or in smaller quantities.
 - Not having sex when under the influence of drugs/alcohol.
- Sexual risks may be decreased by:
 - Abstaining from sexual activity.
 - Having sex only in a mutually monogamous relationship.
 - Engaging only in sexual activities that do not involve insertive vaginal, anal, or oral sex.
 - Using condoms consistently and correctly.
 - Avoiding high risk sexual behaviors (unprotected anal or vaginal intercourse).
 - Limiting the number of sexual partners.

- Not having sex with unknown/anonymous partners.
- Not having sexual relations while intoxicated, high, or otherwise impaired.
- Thoroughly cleaning sex “toys” or paraphernalia
- Remember: for many people, sex and drugs are inextricably linked. For instance,
 - Stimulants make sex more exciting so that users report that sex is “boring” in the absence of cocaine or amphetamines. Stimulants also increase sex drive, pleasure, and risky sexual behaviors.
 - Alcohol is commonly associated with all forms of substance use and high-risk sexual behaviors. It is often used to make sex less frightening or painful for those who have been sexually hurt or abused.

MOTIVATIONAL INTERVIEWING

Overview

- Motivation is a person’s level of readiness to enter into, continue, and maintain a specific behavior change.
- Your responsibility is not simply to dispense advice but to also motivate the patient to change.
- Use Motivational Interviewing techniques to:
 - identify perceptions of personal risk;
 - support change;
 - focus on small, achievable steps; and
 - encourage incremental changes that can lead to bigger, long-term changes in risk reduction behaviors.

The Spirit of Motivational Interviewing

- The Spirit of Motivational Interviewing is found in the principles of acceptance, collaboration, and empathy, which are sometimes referred to as ACE.
- Discussing prevention using the following principles has been shown to be an effective way to motivate a patient to change.

- The patient is the expert on his/her life.
- The patient is responsible for his/her own behavior. The patient gets to make choices about his or her own life. You are not able to force anyone to change, and need to give up the idea that any patient “must” change.
- The patient functions within a unique social context that influences her/his personal choices for change, change methods, and the ability to change. Be curious about that context and seek to understand it by asking questions and engaging in conversations.
- Helping patients feel in control is essential for change. So is a supportive relationship with health care providers and other support people.
- You have knowledge and skills related to prevention, risk reduction, and counseling. Share that knowledge in an open and honest way, not a coercive or threatening one.
- You can be supportive and persuasive in encouraging change.
- You need to communicate in a way that simultaneously says, “I care about you and want to see you make healthy choices” as well as “I respect you and know that you need to make your own decisions about your health.”
- This combination of caring and respect – neither one without the other – is what makes motivational interviewing work.
- Everyone is ambivalent about making behavior change:
 - Although a patient’s current behavior may have costs, it also has some benefits; otherwise the patient wouldn’t be doing it in the first place.
 - Although you can’t change the patient’s behavior, you can help the patient work through ambivalence and make a choice about future behavior.

General Guidelines for Motivational Interviewing:

- **Express empathy.** Use active, reflective listening.
 - True empathy requires meeting the person where s/he is with warmth and genuineness.
 - You need to maintain a stance of non-identification with the patient. Identifying with a patient clouds judgment and inhibits unbiased work.
 - You can access empathy for difficult patients by reminding yourself, “The person in front of me is struggling.”

- **Develop discrepancy.** Help the patient see a difference between current behavior and broader goals.
 - Highlight the patient’s experience of ambivalence to help clarify goals and support reasons for change.
 - Help the patient see his or her situation more objectively. For example, ask what the patient might tell a friend to do in the same situation.
 - Discrepancy can be pointed out by helping patients explore extremes and confront fears. Try some of these motivational interviewing techniques:
 - What is the best/worst thing that might happen if you continue as you are?
 - What is the best/worst thing that might happen if you change?
 - What is the most likely outcome? Where does it fall between the extremes?
 - What concerns you the most?
- **Avoid arguing.** Arguing leads to resistance.
 - The more you tell someone, “You can’t,” the more they internally respond, “I can” or “I will.”
 - Also, in the process of arguing people tend to remember their own reasoning over that of the other person.
- **Roll with resistance.** Resistance is not a problem; it is a signal to change tactics.
 - If the patient is arguing, you are likely trying too hard to persuade and not hard enough to listen and understand.
 - Ask fewer questions. Instead, repeat back what the patient says to communicate that you heard it.
 - Offer information but do not impose goals. Turn problems and questions back to the patient; s/he must actively participate in problem solving.
- **Support self-efficacy.** Demonstrate your belief in the patient’s ability to change.
 - Help the patient develop a menu of options.
 - Ask about other times the patient has been capable and successful in the past.
 - The patient is responsible for choosing and carrying out necessary actions, but may need your support in starting to believe that s/he can be successful.

Motivational Interviewing Techniques Include:

- **Define goals clearly.** Help the patient verbalize specific goals that can be used to measure progress at future meetings. Example: If the patient says, “I want to have sex only with my primary partner,” ask how realistic the goal is, how likely the patient is to achieve it, what things might get in the way, and how the patient might overcome them.
- **Be interactive.** Format discussions that actively engage the patient in the conversation. Open-ended questions are best for this. Examples:
 - What do you think about your doctor’s suggestion that you stop using drugs?
 - How important do you think that goal is? How confident are you that you could achieve it?
 - What have you tried in the past, and what ideas do you have at this point in time?
- **Reflect back what the patient said.** Restate what the patient said to see if what you heard is what the patient meant.
 - Example: “Your family is concerned about your new partner, but you do not think it is a problem. Is that correct?”
 - You can reflect back either what the patient said or the way in which they said it. For example, “You looked concerned when you talked about your partner just now.”
- **Don’t interrupt.** Interrupting can kill a conversation; allowing the patient sufficient time to finish his/her thoughts and sentences helps to gather more information, avoid misunderstanding, and enhance the provider-patient relationship.
- **Be comfortable with silence.** Patients often need time to think about a question in order to formulate a response. Allow at least 10 seconds before offering prompts or your input. Try silently counting to 10 to decrease your own discomfort with silence.
- **Respond to patient questions.** This provides the patient with helpful information for overcoming ambivalence and making behavior changes. It also lets the patient know you are actively listening. Example: “You wonder if you need to use condoms when your viral load is undetectable. Here is some information about that . . .”

- **Communicate at the patient’s level of understanding.** This may involve using non-medical terms and using terms about drug use and sex behaviors that the patient uses.
 - It’s not just about communicating at a certain level of understanding, but also about communicating that you value the patient and can understand and use his/her language.
 - Let the patient lead the way. Listen to the language the patient uses and incorporate it into your discussions. Examples:
 - How does it feel when you are tweaking?
 - What happens when you use Vitamin K?
 - How can you protect yourself when you are the bottom with a partner?
 - Limits:
 - Sometimes patients use terms, such as “fuck” and “screw,” that may be uncomfortable for you or that you do not want to use in a professional setting. In these instances, it is appropriate to say, “The clinical term for that is sexual intercourse. If you don’t mind, that is the term I will use when we are talking about having sex, and I’m OK with you using whatever terms you are most comfortable with.”
 - Sometimes patients use terms that you don’t understand. This is when it is important to ask clarifying questions: “I heard you refer to booty bumping. I don’t know that term. Will you tell me what it means?”
- **Use affirming statements.** Statements of appreciation and understanding help support the patient during the counseling process.
 - Example: I know how hard it is to talk to your partner about decreasing your sexual risk, so I admire the efforts you have made to have that conversation. You are moving forward to meet your goal.
 - When using affirming statements, be as specific as possible about what the patient did successfully – sometimes people aren’t aware of their own strengths, and you can be of service by pointing them out.
 - You can affirm effort or intention as well as behavior. Example: You have made a good start on using condoms more often by planning to carry them with you when you have a date.

- **Elicit self-motivating statements.** Ask questions and reflect answers in ways that motivate the patient to make arguments for personal behavior change. The acronym **DARN CAT** can help you remember what to ask. Examples:
 - **D**esire for Change: Tell me how you decided that you needed to make this change.
 - **A**bility to Change: What makes you think that you could make a change right now, if you wanted to?
 - **R**easons for Change: What do you think would improve in your life if you decided to make this change?
 - **N**eed for Change: What things make you feel a change is needed right now?
 - **C**ommitment to Change: What makes you so sure a change is the right thing?
 - **A**ctivation for Change: What attitudes or other personal characteristics will help you to make this change?
 - **T**aking Steps for Change: What strategies have worked for you in the past, and what are you trying right now?
- **Clarify the discrepancy between the patient's goals and behaviors.** Create and strengthen inconsistency between the patient's current behavior and long-term objectives. Examples:
 - How does your current substance use impact your goal to be in a long-term relationship?
 - I understand you are afraid your sex partners will think poorly of you if you carry condoms (affirming), but how does not using condoms impact your goal of not giving HIV to your partners and protecting yourself from STDs?
 - I hear you saying that you would like to cut back on drinking, but you're also telling me it's the only thing that helps you cope. It sounds like you feel stuck.
- **Reframe defeatist statements.** This approach acknowledges the validity of the patient's statements with a new meaning or interpretation.
 - In reframing, it helps to use the word "and" in place of the word "but."
 - Example: If the patient says, "I've tried to quit using drugs but I always go back to using. I'm hopeless," consider responding with, "You've tried to quit and not been successful. I think all those past efforts show how much you want to change and I admire you for that (affirming). One way

to think about it is that each of those attempts was practice for the day you make the change permanent. What do you think about that perspective?”

- **Emphasize personal choice.** This reminds the patient about alternatives, increases her/his sense of control, and helps him/her generate options to the current behavior. Example: “You’re the one who will decide what to do. I can tell you about some strategies that have worked for other people. Would you like to hear them?”
- **Use Elicit-Provide-Elicit to provide education.** Rather than telling the patient new information right away, use this method to:
 - find out what they know about the topic (elicit),
 - then fill in any missing pieces (provide), and
 - finally, ask for the patient’s reaction to the new information (elicit).For example, “What strategies do you use to protect yourself from HIV?” (elicit knowledge). “... Yes, abstinence is definitely the safest option, but it’s not the only one. You could also use condoms. That doesn’t eliminate all risk, but it definitely provides more protection than what you are doing now” (provide). “What do you think about that?” (elicit patient’s response).
- **Summarize the patient’s statements.** Review the information and provide clarification.
 - This helps create a transition for inviting more information.
 - Example: “It sounds like you are torn. Stimulants make sex more exciting but they can raise your viral load. This is difficult for you. Anything else?”

You *can* help your patients reduce risky behaviors but you can’t make those choices for them. You will be most helpful if you offer a combination of encouragement and challenge, empathy and respect. Give your patients new information and then find out what they want to do with it. The patients you see are resilient; they are capable of affecting their environments and not simply responding to them. Help your patients see their own strengths and exercise their own control over their lives. Build sincere, safe, and nonjudgmental relationships, offering encouragement and hope. And always remember that behavior change happens in small steps, over time – today is just one step on the road. Offering a combination of caring, together with choices, is the best way to help your patients make changes to be healthier, safer, and less risky.

RESOURCES

Mountain Plains AIDS Education and Training Center

<http://www.mpaetc.org/>

AETC National Resource Center

<http://aidsetc.org>

AIDS Infonet

<http://www.aidsinfonet.org/>

CDC Recommendations and Guidelines

<http://www.nccc.ucsf.edu/>

HRSA Target Center

<https://careacttarget.org/>

National HIV/AIDS Clinicians' Consultation Center

<http://www.nccc.ucsf.edu/>









MountainPlains
AIDS EDUCATION AND TRAINING CENTER

Mountain Plains AIDS Education and Training Center
University of Colorado • Anschutz Medical Campus
303.724.0867
www.mpaetc.org