AIDS Education & Training Center

- HIV Risk Assessment & Risk Reduction
Learning Objectives

Review the intersection of trauma with HIV

Understand the association of Mental Health & Substance Use with HIV/AIDS

Review the use of a HIV risk assessment/ HIV risk reduction plan with your patients
Topics

• HIV Risk Assessment
• Trauma & HIV
• Mental Health Issues
• Substance Use
• HIV Risk Reduction
HIV Risk Assessment
Benefits of a Risk Assessment for HIV

• Opens door to discuss risks
  - Patients want information but don’t know how to get it
  - Basis for behavior change discussions
  - Opportunity to start to develop or enhance a relationship with a patient & enhance their understanding of health and healing
Patient Barriers that Hinder HIV assessment & testing

- Perceived lack of confidentiality
- Limited encouragement from social network
- Competing priorities
- Use of substances
- Mental health issues
- Chaotic lifestyle
- Low self confidence
- Trauma survivor
- HIV related stigma
• Perceived or real HIV stigma can hinder successful assessment & referral for HIV testing
• Stigma can hinder perception of risk & promote denial for patient
• Increase secrecy, fear of disclosure for patient
• Increase chance of increasing use of negative coping behaviors (alcohol, drugs, unprotected sex) by patient
• Impact negative beliefs about same-sex relationships by community
• Impact of Trauma
Adverse Childhood Experiences

- **Abuse**
  1. Physical
  2. Sexual
  3. Verbal/Emotional

- **Household Dysfunction**
  4. Mental Illness in the Household
  5. Substance Abuse in the Household
  6. Witnessing Domestic Violence
  7. Separation/Divorce
  8. Household Member in Prison

- **Neglect**
  9. Physical
  10. Emotional
What we know about traumatic childhood experiences

- Identification of one Adverse Childhood Experience (ACE) can mean treatment needed for multiple persons in affected families
- 81% of children from substance abusing families reported at least one additional ACE & the majority experienced 2 or more ACEs
- Koss & associates (2003) found in a ten tribes study 86% of participants experienced one or more ACE categories & 33% reported 4+ categories
- Childhood maltreatment has been found to be associated with long-term changes in brain structure & function
Perception of Self-worth (with History of Trauma)

- A history of complex trauma (*intergenerational trauma-childhood &/or adult abuse*) can significantly:
  - Impair judgment
  - Precipitate lower self-worth & self-efficacy
  - Lower impulse control

- Depression &/or childhood trauma can result in the use of alcohol & drugs as a way to “cope”

Identity within Trauma

- Identity is the crossroad of culture, gender, & ethnicity
- It is changing & not stable
- Trauma frequently has the effect of creating new & difficult-to-comprehend identities for patients (being broken, damaged)
- It is the “I am because of what happened”
- Trauma can interfere with basic human expressions of self, particularly when in a relationship
HIV Risk Factors & Interpersonal Violence

- WHO (2010) “unquestionable link between violence against women & HIV infection”
- CDC (2010) women living with HIV diagnosis and in violent relationships less likely to maintain adherence with antiretroviral medications
- National Congress of American Indians (2006) 1 of every 3 Native women is sexually assaulted in her lifetime
- CDC (2010) “interpersonal violence against Native women highest among any race or ethnicity in the US”
Other Factors associated with HIV Risk

- Unresolved history of complex trauma
- Multiple sexual partners & unprotected sexual activity
- Untreated mental health issues
- Substance abuse (dissinhibition, poor judgment)
Mental Health

• It is estimated that 1 in 4 adult Americans suffer from a diagnosable mental illness during a given year.
• Mental illness carries enormous stigma and remains one of the most challenging barriers for effective patient care.
• General anxiety disorders are estimated to occur in approximately 16% of people living with HIV/AIDS (PLWH), compared with 2.1% of the general population.
• An estimated 20% to 40% of PLWH will suffer from depression during their lifetime, more than twice the rate of the general population.

HRSA CAREAction (January 2015)
Challenges with Mental Health Diagnosis

- Challenges with diagnoses of depression & anxiety among Native population due to differing tribal cultural meaning of conditions
- Depression is related to family, cultural, community dynamics
- Residing in a highly stressed community requires patient maintenance through ongoing aftercare booster sessions
- Impact of extended family factors upon depression have received limited investigation
- Relationship of culture or spirituality with mental health has met with enormous challenges in operationalization
- Admission of symptoms may be perceived as a sign of weakness
Risks Of Untreated Mental Health Problems

- Poorer adherence to treatment and medication regimens
- Higher hospitalization rates for medical complications
- Greater likelihood of treatment drop-out or being lost to follow-up
- Greater risk of less social support
- Greater risk of suicide or accidental death
Mental Health Issues & HIV Risk

- Unsafe sex or drug practices may occur, due to:
  - Low self-esteem
  - Suicidal rehearsal & attempts
  - Fear of rejection
  - Poor judgment or impaired cognitive functioning
  - Impulsivity
  - Financial problems
  - Transitory or tumultuous relationships
  - Lack of skills or knowledge about safer sex and clean needle use
  - Sexual victimization by others
  - Use of substances (which may be an attempt to self-medicate mental health problem symptoms and may impair judgment)
Survivor Guilt & HIV

• Depression and anxiety can be associated with long-term HIV treatment & care
• Patients may self medicate with substance use
• Emotional distress related to loss of a trusting and safe relationship within a non-safe environment
• Loss of a partner can result in stages of loss—anger, depression, sometimes suicidal ideation, and finally resolution (which can re-occur over lifetime)

• Provide support to patient & if open to counseling assist with referral
Case Example

- 23 year old woman with fatigue, sadness, sexual abuse history
- Today diagnosed with HIV at clinic after moving back to home from southern Cal
- Past history of drugging and drinking
• Medical Clinic

- Assess patient’s coping mechanisms with new HIV dx
- Assess clinic capacity to provide care & treatment
- Assess patient’s interest in seeking further care at clinic or referral for HIV specialty care or primary & specialty care
- If patient agrees to visit with in-house behavioral health provider---assessment could include depression/suicide risk & subsequent mental health/alcohol use
Substance Use (General Population)

• In 2012, **22.2 million** (8.5% of adolescents & 91.5% adults) met criteria for **substance abuse or dependence** (National Survey on Drug Use and Health, 2013)

• **Alcohol** abuse and dependence represents the majority of the 22.2 million (**17.7 million**)  

• Remainder (**4.5 million**) **split** between **drug disorders only** and **combined use** of drugs and alcohol

www.samhsa.gov NSDUH, 2013
Substance Use & HIV

• In U.S. increasing importance of non-injection substance use

• Limited HIV research among women and adolescent substance users

• Growing emphasis on implementation of Evidence Based Practice strategies to improve treatment outcomes

• Limited data to inform efficacy and timing of HIV treatment for active substance users

• Limited integration of substance use into active (HIV Prevention Trials Network) HPTN research protocols
• Amaro (2007) reported that women who participated in trauma treatment intervention remained engaged in substance abuse treatment for a longer period of time.

• Women who decreased substance use demonstrated increased self-efficacy in their relationships & reported more equity in sexual decision-making & more control engaging in HIV protective behaviors (Amaro, 2007). 

• African-American & Latino women were 3 times as likely at 6-month and 5 times as likely at 12-month to engage in non-safe sex than Caucasian women, suggesting a need to add cultural considerations to Evidence Based Practices (Amaro, 2007).

• Native (women & men) had highest percent of estimated diagnoses of HIV infection attributed to injection drug use, compared with all races/ethnicities (CDC, 2015).
Co-occurring Disorders

- Studies have documented rates of combined substance use (meth, alcohol, marijuana...) often used to self-medicate for mental health concerns
- Diagnosis of substance abuse occurs for approximately 45% of patients with serious mental issues
- In 2014, 8.8% of Native men & women ages 18 and older, dx with co-occurring disorder, past-year mental and substance use disorders, while national average was 3.3%
Barriers for Clients Experiencing substance Use and/or Mental Health Problems

• May not be adherent taking their medications & attending appointments (medical and psychiatric)
• May be in recurrent crises
• May be ambivalent about decreasing substance use
• May be disorganized and have difficulty accessing mental health, medical or social service systems
• May lack effective interpersonal skills
HOW CULTURAL BUFFERS CAN DECREASE HARM

• Substance Use History
  - 1. What have you heard about the link between drug and alcohol use and HIV infection?
  - 2. When you have been sexually intimate and used drugs and/or alcohol how often have you or your partner(s) used condoms?
  - 3. If you use injection drugs what do you do with the needles and works?

• Sexual History
  - 1. Within the last 3 months have you had more than one sexual partner?
  - 2. What do you know about the sexual activity of your partner(s) in the past?
  - 4. In the last year how many male partners and female partners have you had?
HIV Risk Reduction Planning
Harm Reduction & HIV Risk Reduction

- Public health approach for intervention with behaviors that harm individuals & their communities
- Focus on improving the health of the public & the individual as well as decreasing the harmful behavior of the individual
- The focus is on one behavior at a time
- It requires checking in with a patient regarding their “change” goal at each patient visit
To Use Harm Reduction requires

- Pragmatism
- Focus on a behavior
- Target a goal
- Provide education about targeted risk
- Explore intervention options
- Ask the patient about the plan at next appointment
Behavior to Change:

Steps:

1.

2.

3.

Where I can get support for change:
Readiness to Change

- So how do we improve our communication with patients?
- Assess patient readiness to change
- Use specific communication & problem solving skills based on patient readiness to change
## Stages of Change/Readiness to Change

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<th>Stage</th>
<th>Description</th>
<th>Actions</th>
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| Pre-contemplative            | Patient sees no need to change behavior                                      | • Raise risk awareness  
                             | “What problem?”                                                                 | • Discuss impact of behavior on others                                      |
| Contemplative                | Sees the need to change behavior, but has barriers                           | • Discuss pros & cons, ambivalence/barriers                                |
| “Yes but...”                 |                                                                             |                                                                         |
| Ready for Action             | Is ready to change behavior and may have already taken some steps            | • Assist with goals  
                             | “Let’s do it”                                                               | • Teach Skills  
                             |                                                                          | • Develop a plan                                                      |
| Action Changing              | Has changed behavior for a short period of time                              | • Reinforce goals  
                             |                                                                             | • Reinforce skills                                                      |
| Maintenance                  | Has changed behavior for a long period of time                                | • Praise success  
                             | Live it                                                                    | • Promote self-efficacy                                                  |

*Source: Prochaska and DiClemente, 1983*
Three Steps

1. Use patient’s risk assessment responses
   - (Identify patient’s *personal perception* of risk)

2. Work with patient to select a safer goal behavior
   - Identify patient’s level of readiness for change
   - Assess supports & obstacles

3. Develop a personalized action plan
   - *Negotiate small, realistic risk-reduction steps*
   - Refer to specialized services, if needed
Steps 1 & 2--HIV Risk Screening/Select Behavior

- Use HIV Risk Assessment tool to identify behavior to change

Risk Behavior?

Safer Goal Behavior?
Step 3
Develop a Realistic, Simple Plan

• **Work with one behavior**
  - Help select one behavior

• **The Steps**
  • Help patient select & review possible steps (mood is important)

• **Social support**
  - Have patient select one person to talk to about the plan
Review & Summarize Patient Risk Reduction Plan

First
- Summarize all safe behaviors

Then
- Summarize all risky behaviors

Finally
- Talk about possibility of referral
Providing Reassurance

- We all have regular ups & downs
- The goal is to have patients realize the occurrence of these ups & downs
- HOW TO?
  - Increase awareness that emotions are like “passing weather”
  - Increase awareness that negative emotions may last for a few minutes, a day, and often flit from one emotion and thought to the next
  - Use examples or metaphors
  - Encourage patient to decrease judgment of their emotions or thoughts

Focus on breath for 30 seconds
Subsequent client contact

**Ask about risk-reduction plan at next meeting.**

- Review
- Change or add to plan
- Encourage patient to keep trying
- Reinforce their change
- Provide support

*Remember: behavior takes time to change*
References


• Herman, Judith Lewis (1992). Trauma and recovery: The aftermath of violence from domestic abuse to political terror. Basic Books: New York


Questions