Reducing the Risk and Harm of HIV
Goals

- Familiarize HIV prevention service providers with information about behavioral science, effective model of behavior change, and harm reduction;
- Provide opportunities to practice incorporating harm reduction and behavior change theory in which to be more effective with clients.
Module One

HIV Prevention,
Harm Reduction
and Behavioral Science
Module Two - Objectives

Learners will be able to:

- Summarize the definitions of primary, secondary and tertiary prevention.
- Describe a harm reduction approach to HIV prevention.
- State the connection between STDs and HIV.
- State the role social & behavioral science plays in HIV intervention strategies.
Primary Prevention

The reduction or control of causative factors for a health problem; also includes reducing risk factors.

Helping people avoid getting infections or giving it to others.
Primary Prevention

For infectious diseases, this can be further divided into:

- **Primary Acquisition Prevention:** Strategies to help prevent uninfected persons from acquiring an infectious disease;

- **Primary Transmission Prevention:** Strategies to help people avoid transmitting an infectious disease to others.
Secondary Prevention

The promotion of early detection and treatment of a disease in an asymptomatic person to prevent the development of symptomatic disease.

Helping people get diagnosed early and to get into care before symptoms develop.
Tertiary Prevention

- Providing medical and other supportive services to persons with symptomatic disease to minimize complications and maximize quality of life.

*Helping people who develop advanced disease live longer and with an improved quality of life.*
Tanzania Study

- Results showed that early treatment of STDs in a community reduces HIV transmission rates by 40%.
- Secondary prevention of STDs is a primary prevention strategy for HIV.
What is Harm Reduction?

- Philosophy that supports a continuum of change and replaces an all-or-nothing approach to HIV prevention.
- Acknowledgment that small incremental steps are progress and necessary to longer term change.
What is a Harm Reduction Approach?

- identifies a range of risk;
- encourages people to start where they are able in order to protect themselves or their partners;
- to set their own realistic targets; and
- to move at their own pace.
How has Harm Reduction been used in HIV Prevention?

- Traditionally used to reduce HIV risk associated with drug use and needle sharing practices (i.e., Syringe Exchange Programs-SEPs).
- Now being used to address sexual risk as well.
More about Harm Reduction

Provider Goal:
- to recognize the “benefits” clients get from drug use or sexual practices and help clients remain healthy.

Purpose of Intervention:
- to allow the creation of an ongoing dialogue with clients so that safe and open discussions can occur regarding the details and circumstances of their risk behaviors to allow the potential for behavior change.
The STD/HIV Connection

History of STD/ HIV Prevention

- STDs and HIV seen as separate problems
- HIV prevention based on educational models and interventions
The STD/HIV Connection

The STD Epidemic

- The 'Old' STDs - bacterial and curable (such as syphilis and gonorrhea)
- The 'New' STDs - viral and chronic (such as herpes, Hepatitis B & C, and HIV)
- Disproportionate risk for women, adolescents, people of color, and people of lower socioeconomic status (SES)
The STD/HIV Connection

Behaviors

- Same behaviors transmit both (sex and substance use)

Epidemiology

- Same communities have disproportionate risk of both

Immune Effect

- More likely to transmit or get HIV through sex
Why do we need Social/Behavioral Science?

- Many STDs not curable;
- STD/HIV is transmitted by behavior - the actions of people;
- Information/education alone does not result in behavior change;
- Recognition of multiple factors influencing behavior and change;
- Prevention must incorporate behavior change theory;
- Science-based interventions proven effective for HIV prevention.
What is Social/Behavioral Science?


- Seeks to understand the way behaviors are acquired, established, maintained, and how behavior changes over time.
What is Social/Behavioral Science?

Combines Perspectives:
- Epidemiology
- Psychology
- Sociology
- Anthropology

Based on Harm Reduction Philosophy
HIV Prevention - Where Are We Going?

- Increasing STD diagnosis and treatment;
- Harm reduction philosophy;
- Using social/behavioral science-based interventions;
- More focus on primary transmission in addition to acquisition prevention;
- Enhanced STD/HIV program integration;
- Increased access to STD/HIV services at the community level including SEPs and ESAP.
Module Two

Attitudes Toward Sexuality & Substance Use
Module Three - Objectives

The Learner will be able to:

- Explore attitudes around harm reduction strategies for clients.
- Identify how differing values and attitudes may impact the provider/client relationship.
- Develop strategies to address provider/client values conflict.
Reassessing Attitudes About Substance Use

Why do health care providers need to examine their attitudes about sexual behaviors and substance use?

- *In order to prevent personal concerns from standing in the way of providing treatment and services, providers need to become aware of their values, attitudes and beliefs about drugs and the people who use them.*
Attitudes about Substance Users

- Describe what the typical substance user looks and acts like…
Reality: Data/Statistics

- Heroin and cocaine deaths total 5,000/yr; cigarette and alcohol-related deaths total 600,000/yr.
- Household survey showed that 44,000 whites (non-Hispanic), with income greater than $25,000 have injected drugs.
- 2x as many whites as blacks use crack; 3x as many whites as blacks use powder cocaine.
RACISM, DRUGS AND THE CRIMINAL JUSTICE SYSTEM

- In state prisons, blacks make up nearly 60% of the people serving time on drug offenses although they are only 12% of the general population and 15% of regular drug users.

- Nearly 90% of the people locked up for crack under federal drug laws are black. However, twice as many whites as blacks use crack; three times as many whites as blacks use powder cocaine.
Module Three

Understanding Substance Use
Module Three - Objectives

Learners will be able to:

- Understand the complexities of the etiology and treatment of drug addiction and behavior change;
- Integrate harm reduction model into their approach with substance using clients
Drug Use Continuum

- Experimentation
- Recreation
- Habituation
- Abuse
- Addiction
Drug Use Continuum

- Experimentation
- Recreation
- Habituation
- Addiction
- Abuse
Etiology:
Models of Addiction

Rationale:

- Being familiar with different models and beliefs systems regarding addiction will help the provider assess and work most effectively with the client’s own beliefs to design interventions that are truly client centered.
Etiology / Models of Addiction

- Moral
- Disease
- Self-Medication
- Social Model
- Learning Model
Moral Model

• “Oldest” model
• Purports that addiction is a result of moral “weakness” or lack of will power
• Creates antagonistic relationship between provider and client
• Judgmental and punitive
• Willpower alone is often not an effective solution to addiction
Disease Model

- Addiction is based in genetics
- Substance user is viewed as being ill or unhealthy due to medical condition
- Not punitive or blaming
- Emphasis is on self care vs. self control
- Lacks a component on accountability
Self-Medication Model

- Addiction occurs either as a symptom of another primary mental disorder (ex. depression); or
- As a coping mechanism
- Purports that if you treat mental disorder, addiction will disappear
- Neither punitive or blaming and emphasizes treatment of co-existing mental disorders
Social Model

- Addiction results from environmental, cultural, social, peer or family influences.
- Treatment includes altering social environment and/or coping mechanisms to that environment.
- May play into “blaming” others and/or the user’s environment.
- User may feel victimized.
Learning Model

- Purports that addiction is the result of learning “bad” habits
- Rational Recovery Programs
- “Self control” not always effective response to addiction
Integrative Model: Bio-Psycho-Social
Bio Psycho Social Model

BIO

PSYCHO

SOCIAL

Spiritual Component
The Brain
The Brain

- **Cortex**
  
  Cognitive functions: thought, reasoning, abstraction

- **Limbic**
  
  Emotions: euphoria to depression, reward sites

- **Stem**
  
  Metabolic functions: heart rate, respiration, body temperature
Drug Abuse and the Brain

Part of Brain

▲ Brain Stem

Possible Affect

➔ Speeding or slowing heart rate and breathing

▲ Cerebral Cortex

➔ Slurred speech, loss of balance, memory

▲ Limbic System

➔ Learning and memory of drug “rewards” and pleasures
Barriers to HIV Prevention

- Psychological issues
- Survival needs
- Compulsive behavior
- Incorrect/ineffective prevention messages
- Social and cultural issues and messages
Harm Reduction & Substance Use

- HR theory emerged from community-based intervention designed to support drug users in reducing harm;
- HR providers distinguish themselves from other providers in their willingness to engage with all people;
- Interventions designed to reduce harm to all substance users.
Harm Reduction & Substance Use

- Harm comes from the *circumstances* in which drugs are used rather than the drug itself.

- Abstinence from drugs is not necessary for stopping HIV transmission. It is but *one choice* a person might make to avoid HIV infection.
Module Four

HIV Harm Reduction:
Sexual and Substance Use Options
Module Five - Objectives

The Learner will be able to:

- Define harm reduction as it is used in HIV prevention;
- State at least three ways an IVDU client could reduce their risk to HIV infection;
- State at least three different methods a sexually active client could reduce their risk for HIV infection.
Goals of Harm Reduction

- Reduce the risk of HIV and other blood borne infections;
- Reduce or eliminate the negative impact of substance use or sexual behavior;
- Support the empowerment and health of each client.
Syringe Exchange Program

- Proven to reduce HIV transmission (NYC: 50% less likely to become infected)*

- Cost effective ($169,000 annual budget of a SEP vs. $120,000 to treat one person with AIDS)*

- Reduce exposure to contaminated needles which would otherwise be discarded in public places

*MayDay Media, 1995
Syringe Exchange Program

- SEPs do not increase drug use. A reduction in drug use has been shown.
- Reach drug users who fall outside common support structures.
NYS Approved Syringe Exchange Programs (SEPs)

- Exchange used syringes for new ones
- Offer a variety of services to reduce the harm associated with drug use:
  - bleach kits
  - condoms
  - HIV prevention education
  - counseling
  - case management
  - support groups
  - ear-point acupuncture
SEPs continued...

- Serve as a bridge to drug treatment
- Provide referrals to health care, supportive and mental health services
Expanded Syringe Access Demonstration Program (ESAP) in NYC

- Began January 2001
- Access to sterile hypodermic needles can be purchased without a prescription
- Public health measure to prevent blood born diseases, most notably HIV/AIDS and Hepatitis B and C
- Demonstration program based on successful programs in Connecticut and Minnesota
The Connecticut Experience

- 1992 - State law permits pharmacies to sell syringes without a prescription. Evaluation of this study showed:
  - dramatic drop in syringe sharing in a cohort study of HIV+ IDUs
  - no increase in overall drug use
  - decrease in needlesticks to police
  - in neighborhoods with high IDU prevalence, sale of syringes increased 5-fold within one year
The Connecticut Experience (continued)

- In neighborhoods with low IDU prevalence, sale of syringes remained low.
- Data suggests that CT law increased IDU access to sterile syringes.
ESAP: in New York State

- Licensed pharmacies, health care facilities and health care practitioners who can otherwise prescribe hypodermic needles or syringes may register to sell or furnish up to 10 hypodermic needles or syringes to persons 18 years of age or older.

- Persons who are at least 18 may legally obtain and possess hypodermic needles and syringes through ESAP without a medical prescription.
ESAP: in New York State

- Pharmacies may not advertise availability of hypodermic needles or syringes without a prescription and they must keep them in a manner that makes them available only to pharmacy staff (i.e., not openly available to customers)

- Eligible providers must register with the NYS Department of Health
ESAP: in New York State

* Registered providers must cooperate in a program to assure safe disposal of used hypodermic needles or syringes
* Hypodermic needles and syringes provided through ESAP are accompanied by a safety insert explaining proper use, risk of blood borne diseases, proper disposal, dangers of injection drug use, how to access drug treatment as well as information about HIV/AIDS
ESAP: in New York State

- The actual sale or possession of illegal drugs is still a crime. Individuals can still be charged for drug possession if drug residue is found on used syringes in their possession. It is unlawful for individuals to possess syringes with intent to sell or give them to others.
Syringe Disposal

- Health and human services providers can play an important role in educating substance users about proper disposal of syringes.
- Providers should inform their communities that syringes may be disposed by bringing them to any hospital or syringe exchange program.
ESAP: Key Points
for Health and Human Service Providers

- Know the process of obtaining and disposing syringes and walk clients through this process
- Share with clients and community the list of participating ESAP distributions sites (pharmacies, health care facilities and physician offices)
- Share with clients and the community a list of disposal sites for used syringes
ESAP: Key Points
for Health and Human Service Providers

- Incorporate information about availability of sterile syringes into all risk reduction services
- Educate clients and the general community about proper disposal of used syringes
- Address community values and beliefs about syringe availability
ESAP: Key Points
for Health and Human Service Providers

- Network with IDU community and drug treatment community
- Educate on how Syringe Exchange Programs and ESAP compliment each other
Pharmacological Treatments

- Substance use results in both physical and psychological addiction and as such there are medications which treat the illness

Example: Methadone
METHADONE: Treatment Of Heroin Addiction

- Methadone Maintenance has been found to be the most effective treatment for heroin addiction.
- With proper dosage a methadone patient does not get high from methadone.
Methadone

Goals:

- Prevent symptoms of withdrawal
- Prevent craving for heroin
- Block effects of heroin
- Reduce/Eliminate crime associated with obtaining heroin
- Reduce/Eliminate spread of disease associated with the use of syringes
Safety of Methadone Treatment

- **No Long-Term Health Risks**
  - does NOT get into the bones or teeth
  - Not harmful to patients with HIV and/or Hepatitis C

- **Side Effects**: Constipation, sweating, dependence
Drawbacks of Methadone Treatment

- Available only in clinics
  - *which are not found in every city and may have waiting lists*

- Regulations are very restrictive, complying with the structure can be very difficult

- Effective only for opioid addiction
  - *not cocaine, alcohol, cigarettes*
Drawbacks of Methadone Treatment

- A treatment, not a cure.
- It is highly stigmatized and there is a lack of factual information about it among patients and providers.
Harm Reduction Options for Substance Use

- Abstinence/Drug Free
- Abstinence/Drug Replacement Therapy
- Obtain New Sterile Syringes
  - SEPs
  - ESAP
- Clean Syringes
  - bleach
  - alcohol
  - boiling
Harm Reduction Options for Substance Use (continued)

- Reduce Consumption
- Consume in Alternative Forms
- Safer Injection Techniques
  - Cleanliness
  - Syringe Choice
  - Injection Techniques
Harm Reduction Options for Sexual Activity

- Abstinence/Delay Onset
- Mutual Masturbation
- Know Partner’s Serostatus and Mutual Monogamy
- For Vaginal Intercourse
  - Male condoms (latex or polyurethane)
  - Female condoms
Harm Reduction Options for Sexual Activity (continued)

- For Oral Intercourse
  - *Latex barrier (ex. non-lubricated condom or dental dam)*

- For Anal Intercourse
  - *Lubricated latex barrier*

- Choice of Activity

- Lubricant
Module 5

Stages of Change and the Transtheoretical Model
Module 5- Objectives

The learner will be able to:

- Describe the Transtheoretical Model (TTM) and readiness for change as applied to STD/HIV risk.
- Practice client staging for readiness for change.
- Identify at least one intervention for each stage of change.
Transtheoretical Model (TTM)

- Clients are in different stages of readiness for making a behavior change
- Change is a process
- Interventions should be matched to each stage of change
- TTM matches interventions to all clients, to all different stages
Transtheoretical Model (TTM)

- Resistance is seen as a measure indicating that a provider has jumped ahead of the client’s readiness for change.
- Relapse is a necessary part of change.
- Essential that providers assess and accept a client’s readiness for change on an ongoing basis.
Stages of Change (SOC)

PRECONTEMPLATIVE

- No intention of changing behavior
- Unaware of risk or feel risk doesn’t apply to them
- Sees no need to change the risky behavior
Stages of Change (SOC)

**CONTEMPLATIVE**

- Acknowledge a need for change but have no specific plans
- View consequences as risky/undesirable
- Ambivalent about making any changes
- Respond with, “Yes, but...”
Stages of Change (SOC)

PREPARATION

- Have plans to change behavior in immediate future
- May have taken some initial steps toward change
Stages of Change (SOC)

**ACTION**

- Have made some changes in their behaviors
- Change is relatively recent
Stages of Change (SOC)

MAINTENANCE

- Consistent behavior change has been maintained for an extended period of time.
- New behavior has become a part of their life.
Stages of Change (SOC)

RELAPSE

- Normal
- Can occur at any stage
- Person is unable to maintain the behavior change
- Necessary part of change
Spiral Model

Stages of Change

Precontemplation
Contemplation
Preparation
Action
Maintenance
Precontemplation
Contemplation
Preparation
Action
Steps to Behavioral Counseling

- Staging the Client
- Selecting Target Behaviors
- Choosing Counseling Strategy
Staging

**Purpose:**
- Determine a starting point
- Understand present and future risk of acquiring STD/HIV
- Guide to assist choosing an effective intervention

**Staging the Client**
- Selecting Target Behaviors
- Choosing Counseling Strategy
**Staging**

▸ Determine client’s present risk by interviewing about:
  - Current Sexual Relationship(s) Status
  - Experience with Safer Sex Practices
  - History of STD/HIV Testing
  - Experience with Drug Use

▸ Determine stage of readiness for change for one (or more) Target Behaviors
Target Behaviors

Staging the Client

Selecting Target Behaviors

Choosing Counseling Strategy

Target Behaviors are:

- Specific sexual and substance use behaviors to reduce STD/HIV risk
- Specifically defined for different client populations
Target Behaviors

Target Behaviors with the **lowest** risk of STD/ HIV:

- Delay or postpone sexual relationship
- Mutually monogamous relationship with an uninfected partner
- Use safer sex consistently
- Be drug free
Target Behaviors (continued)

Target Behaviors with the **lowest** risk of STD/ HIV:

- Attend a treatment program offering drug replacement therapy
- Stop **shooting** drugs
- Obtain new syringes (SEPs & ESAP) and don’t share “works”
- Clean “works”
Selecting Target Behaviors

❖ Discuss client’s feelings/perceptions of Target Behaviors relative to present and future risk
❖ Determine client’s stage of readiness for change for each Target Behavior
❖ Build client’s self-efficacy by choosing a Target Behavior the client is willing to work toward
Harm Reduction and the TTM

Practicing harm reduction is an important step in helping clients move along the stages of change (by building self-efficacy), as well as move from high-risk behaviors toward risk elimination.
Harm Reduction Options

For Precontemplative or Contemplative Clients

Clients who are precontemplative or contemplative about their risk behaviors are those who may have ruled out options that eliminate their risk.

▲Providers should work closely with their clients to identify options that reduce their risk while considering the client’s unique needs and circumstances.
Target Behaviors for Precontemplative or Contemplative Clients

For Sexual Activity

- Abstinence/Delay Onset
- Mutual Masturbation
- Know Partner’s Serostatus and Mutual Monogamy

- Vaginal Intercourse
  - Male condoms (latex or polyurethane)
  - Female condoms

- Oral Intercourse
  - Latex barrier (ex. non-lubricated condom or dental dam)
Target Behaviors for Precontemplative or Contemplative Clients

For Sexual Activity (continued)

- Anal Intercourse
  - *Lubricated latex barrier*

- Choice of Activity

- Lubricant
Target Behaviors for Precontemplative or Contemplative Clients

For Substance Use

- Abstinence/Drug Free
- Abstinence/Drug Replacement Therapy
- Obtain New Sterile Syringes
- Clean Syringes
- Reduce Consumption
- Consume in Alternative Forms
- Safer Injection Techniques
Verbal Communication Elements

- Open-Ended Questions
- Prompts
- Paraphrasing and Reflection
- Summarizing
Counseling Strategies

- Precontemplative
- Information Giving
- Story Telling
- Impact of Behavior
Counseling Strategies

- **Precontemplative**
  - Information Giving
  - Story Telling
  - Impact of Behavior

- **Contemplative**
  - Explore Ambivalence
  - Behavior & Self Image
Counseling Strategies

- **Precontemplative**
  - Information Giving
  - Story Telling
  - Impact of Behavior
  - Explore Ambivalence
  - Behavior & Self Image

- **Contemplative**

- **Ready for Action**
  - Develop a Plan
Counseling Strategies

- Precontemplative
  - Information Giving
  - Story Telling
  - Impact of Behavior
- Contemplative
  - Explore Ambivalence
  - Behavior & Self Image
  - Develop a Plan
- Ready for Action
- Action & Maintenance
  - Identify Rewards
  - Identify Supports
  - Find Substitutes
  - Avoid Cues
  - Role Model
Counseling Strategies

- Precontemplative
  - Information Giving
  - Story Telling
  - Impact of Behavior

- Contemplative
  - Explore Ambivalence
  - Behavior & Self Image

- Ready for Action
  - Develop a Plan

- Action & Maintenance
  - Identify Rewards
  - Identify Supports
  - Find Substitutes
  - Avoid Cues
  - Role Model
Working with Ambivalence

- Strongest obstacle to lasting change
- Not a personality trait
- Normal
Strategies for Ambivalence

- Acknowledge Ambivalence
- Explore Ambivalence
- Have Client Articulate Reasons for Change
- Add to the Pros for Change
- Offer Alternatives/Substitutes
Working with Resistance

Common forms of resistance:

- Rebellion
- Rationalization
- Reluctance
- Resignation
Working with Resistance

- Rebellion
- Reinforce client’s need for and perception of control
- Offer options for consideration and discussion
Working with Resistance

- Rebellion
- Rationalization

- Listen empathetically
- Use active listening skills
- Acknowledge what they say
- Avoid arguing
- Try to get at feelings
- Offer discussion: theory vs. reality
Working with Resistance

- Rebellion
- Rationalization
- Reluctance/Ambivalence

- Utilize active listening to understand reluctance
- Provide feedback in sensitive manner
- Acknowledge the difficulty of change
- Offer substitutes
Working with Resistance

- Rebellion
- Rationalization
- Reluctance/Ambivalence
- Resignation

- Instill hope and build confidence
- Explore challenges that the client has experienced before
- Help client to identify their barriers for change including pros and cons