

How Change Happens: Substance Use Disorders and HIV/AIDS

Trainer Guide



How Change Happens: Substance Use Disorders and HIV/AIDS

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How Change Happens: Substance Use Disorders and HIV/AIDS

Background Information

The purpose of this training is to provide HIV clinicians (including, but not limited to physicians, dentists, nurses, and other allied medical staff, therapists and social workers, and counselors, specialists, and case managers) with an overview of the challenges and strategies for change in working with individuals living with HIV/AIDS and a diagnosis of a substance use disorder. The duration of the training is approximately 2 ½-3 hours, depending on whether the trainer chooses to present all of the slides, or a selection of slides.

This training is a companion to and can be conducted in conjunction with the **“Nature of Addiction and HIV”** training curriculum.

Pre- and post-test questions have been inserted at the beginning and end of the presentation to assess a change in the audience’s level of knowledge after the information has been presented. An answer key is provided in the Trainer’s notes for slides 3-8 and slides 118-122.

Audience Response System can be utilized, if available, when facilitating the pre- and post-test question sessions.

In addition, brief group discussions and a case study have been inserted throughout the presentation to encourage dialogue among the training participants, and to illustrate how the information contained within the presentation can be used clinically

What Does the Training Package Contain?

- PowerPoint Training Slides (with notes)
- Trainer’s Guide with detailed instructions for how to convey the information and conduct the interactive exercises
- Two-page fact sheet entitled, *“How Change Happens: Substance Use Disorders and HIV/AIDS”*

What Does This Trainer's Guide Contain?

- Slide-by-slide notes designed to help the trainer effectively convey the content of the slides themselves
- Supplemental information for select content to enhance the quality of instruction
- Suggestions for facilitating the "Test Your Knowledge" questions and group discussions/case studies

How is This Trainer's Guide Organized?

For this guide, text that is shown in bold italics is a "***Note to the Trainer.***" Text that is shown in normal font relates to the "Trainer's Script" for the slide.

It is important to note that several slides throughout the PowerPoint presentation contain animation, some of which is complicated to navigate. Animations are used to call attention to particular aspects of the information or to present the information in a stepwise fashion to facilitate both the presentation of information and participant understanding. Becoming acquainted with the slides, and practicing delivering the content of the presentation are essential steps for ensuring a successful, live training experience.

General Information about Conducting the Training

The training is designed to be conducted in medium-sized groups (30-50 people). It is possible to use these materials with larger groups, but the trainer may have to adapt the small group exercises/case studies and discussions to ensure that there is adequate time to cover all of the content.







Materials Needed to Conduct the Training

- Computer with PowerPoint software installed (2010 or higher version recommended) and LCD projector to show the PowerPoint training slides.
- When making photocopies of the PowerPoint presentation to provide as a handout to training participants, it is recommended that you print the slides three slides per page with lines for notes. Select “pure black and white” as the color option. This will ensure that all text, graphs, tables, and images print clearly.
- Flip chart paper and easel/white board, and markers/pens to write down relevant information, including key case study discussion points.

Overall Trainer Notes

It is critical that, prior to conducting the actual training, the trainer practice using this guide while showing the slide presentation in Slideshow Mode in order to be prepared to use the slides in the most effective manner.

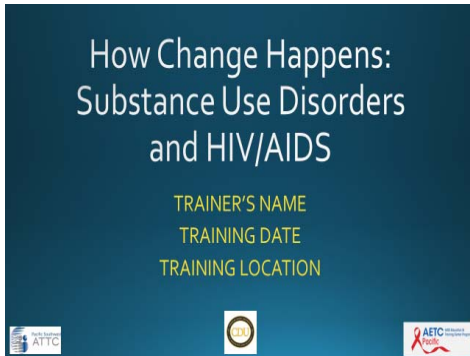
Icon Key

	Note to Trainer		Activity
	References		Audience Response System (ARS)-Compatible Slide
	Image Credit		Video Source

How Change Happens: Substance Use Disorders and HIV/AIDS

Slide-By-Slide Trainer Notes

The notes below contain information that can be presented with each slide. This information is designed as a guidepost and can be adapted to meet the needs of the local training situation. Information can be added or deleted at the discretion of the trainer(s).



Slide 1: Title Slide

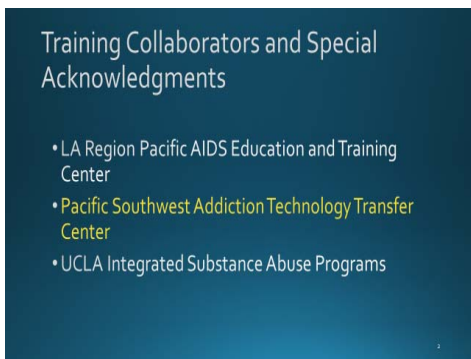


The purpose of this training is to provide HIV clinicians (including, but not limited to physicians, dentists, nurses, and other allied medical staff, therapists and social workers, and counselors, specialists, and case managers) with an overview of the challenges and strategies for change in working with individuals living with HIV/AIDS and a diagnosis of a substance use disorder. The duration of the training is approximately 2 ½-3 hours, depending on whether the trainer chooses to present all of the slides, or a selection of slides.

Pre- and post-test questions have been inserted at the beginning and end of the presentation to assess a change in the audience's level of knowledge after the information has been presented. An answer key is provided in the Trainer's notes in slides 4-8 and slides 118-122.

Audience Response System can be utilized, if available, when facilitating the pre- and post-test question sessions.

(Notes for slide 1, continued)



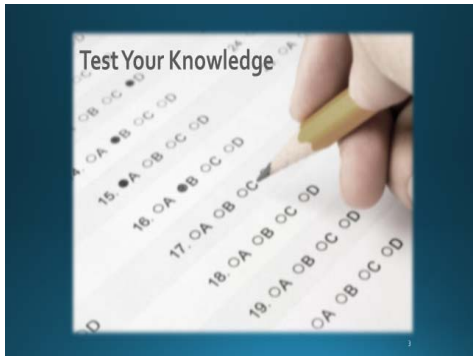
Slide 1: Title Slide



In addition, brief group discussions and a case study have been inserted throughout the presentation to encourage dialogue among the training participants, and to illustrate how the information contained within the presentation can be used clinically.

Slide 2: Training Collaborators and Special Acknowledgments

This PowerPoint presentation, Trainer Guide, and companion fact sheet were developed by Andrew Kurtz, MA, LMFT, Grant Hovik, MA, Beth Rutkowski, MPH (Associate Director of Training of UCLA ISAP) and Thomas E. Freese, PhD (Director of Training of UCLA ISAP and Director of the Pacific Southwest ATTC) through supplemental funding provided by the Pacific AIDS Education and Training Center, based at Charles R. Drew University of Medicine and Science. We wish to acknowledge Phil Meyer, LCSW, Kevin-Paul Johnson, Maya Gil Cantu, MPH, and Thomas Donohoe, MBA, from the LA Region PAETC.



Slide 3: Test Your Knowledge



The purpose of the following five (5) questions is to test the pre-training level of substance use, HIV and obstacles to change knowledge amongst the training participants. The questions are formatted as either multiple choice or true/false questions. Read each question and the possible responses aloud, and give training participants time to jot down their response before moving on to the next question. Do not reveal the answers to the questions until the end of the training session (when you re-administer the questions that appear on slides 118-122).

Pre-Test Question

1. This unaddressed need is associated with lowered CD₄ counts, higher viral load, and stronger medication side effects:
 - A. Legal issues
 - B. Family of origin conflict
 - C. Food insecurity
 - D. Community assaultive violence

Slide 4: Pre-Test Question



Read the question and choices, and review audience responses out loud.



**Audience Response System (ARS)-compatible slide

Answer Key:

#1: Correct response is C (Food insecurity)

Pre-Test Question

2. If current diagnosis rates persist, during their lifetime _____ black MSM will be diagnosed with HIV.

- A. 1 in 100
- B. 1 in 50
- C. 1 in 10
- D. 1 in 2

Pre-Test Question

3. Rates of retention in care based on CDC criteria indicate that ____ of PLWH are successfully retained in treatment.

- A. 86%
- B. 62%
- C. 37%
- D. 13%

Slide 5: Pre-Test Question



Read the question and choices, and review audience responses out loud.



**Audience Response System (ARS)-compatible slide

Answer Key:

#2 – correct response is D (1 in 2)

Slide 6: Pre-Test Question



Read the question and choices, and review audience responses out loud.



**Audience Response System (ARS)-compatible slide

Answer Key:

#3 – correct response is C (37%)

Pre-Test Question

4. PLWH are less likely to disengage from care if they are:
- A. MSM
 - B. Living in poverty and lack environmental resources besides care
 - C. Recent migrants
 - D. Recently diagnosed

Slide 7: Pre-Test Question



Read the question and choices, and review audience responses out loud.



**Audience Response System (ARS)-compatible slide

Answer Key:

#4 – correct response is A (MSM)

Slide 8: Pre-Test Question



Read the question and choices, and review audience responses out loud.



**Audience Response System (ARS)-compatible slide

Answer Key:

#5 – correct response is D (60%)

Pre-Test Question

5. Gay and bisexual men accounted for ___ of all new HIV cases due to injection drug use in 2014.
- A. 5%
 - B. 20%
 - C. 40%
 - D. 60%

Educational Objectives

At the end of this training session, participants will be able to:

1. Describe three basic needs that influence adherence to treatment among PLWHA.
2. Identify at least two factors of intersectionality that maintain inequality of access to services and treatment of HIV/AIDS.
3. Describe the use of at least two strategies to facilitate retention in treatment for PLWHA.
4. Describe one possible action for each of the three stigma reduction strategy categories.

Slide 9: Educational Objectives



Briefly review each of the educational objectives with the audience.

Factors that Promote Change

- Addressing Basic Needs
- Addressing Intersectionality
- Enhancing Engagement and Retention
- Counteracting Stigma
- Interventions that Promote Change



Slide 10: Factors that Promote Change

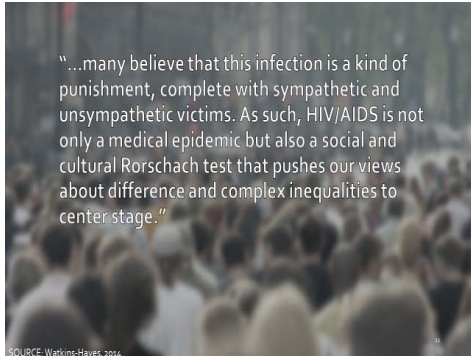


The purpose of this slide is to serve as a “road map” for the trainer to describe to participants the different sections of the training and the focus at each point. The training starts with a description of basic needs to be addressed in treatment and why they are important to focus on in order to enhance change behaviors for individuals diagnosed with a substance use disorder (SUD) or living with HIV/AIDS (PLWH/A). From there, participants will learn about different strategies to enhance engagement and retention and reduce additional barriers such as requiring additional education about relevant topics or reducing stigma.



IMAGE CREDIT:

Fotolia, purchased image, 2016.



"...many believe that this infection is a kind of punishment, complete with sympathetic and unsympathetic victims. As such, HIV/AIDS is not only a medical epidemic but also a social and cultural Rorschach test that pushes our views about difference and complex inequalities to center stage."

Slide 11: No Title



INSTRUCTIONS

Read the quote on the slide out loud and contextualize the importance or understanding that HIV/AIDS is not just viewed as a medical diagnosis but includes history and social/cultural assumptions that can be detrimental in engaging individuals in care or encouraging change behaviors.



REFERENCE:

Watkins-Hayes, C. (2014). Intersectionality and the Sociology of HIV/AIDS: Past, Present, and Future Research Directions. *Annual Review of Sociology, 40*, 431-457.



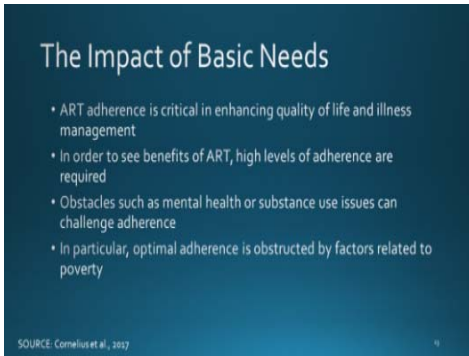
Slide 12: [Transition Slide] Addressing Basic Needs

The next portion of the presentation reviews some of the basic needs that are important to consider in working with individuals diagnosed with a substance use disorder and individuals living with HIV/AIDS. Information will include impacts of basic needs not being met, as well as ways to conceptualize needs when working to motivate individuals towards changes. The section concludes with a discussion of resources for enhancing basic needs getting met.



IMAGE CREDIT:

Fotolia, purchased image, 2017.



Slide 13: The Impact of Basic Needs



Read through each point on the slide, connecting points to one another and highlighting the fact that mental health, substance use, and medication adherence all interact with one another.



REFERENCE:

Cornelius, T., Jones, M., Merly, C., Welles, B., Kalichman, M. O., & Kalichman, S. C. (2017). Impact of food, housing, and transportation insecurity on ART adherence: A hierarchical resources approach. *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV*, 29(4), 449-457.

The Impact of Basic Needs

- Fulfilling basic needs is a starting point for successful achievement of adherence
- Basic resources, interpersonal resources, and personal resources can help or hinder adherence
- PLWH who report food insecurity note obstacles to adherence such as competing costs, stronger medication side effects when hungry, concerns about eating a balanced diet when taking medications
- Food insecurity is associated with
 - Poor ART adherence
 - Poor overall health
 - Lower CD4 count and higher viral load

SOURCE: Cornelius et al., 2017

Slide 14: The Impact of Basic Needs



ANIMATIONS

This slide animates in two parts: The first two bullet points appear initially on the slide; once the slide is advanced, the first two bullet points will gray out as the second two bullet points animate in.

Read through the first two bullet points that identify the importance of fulfilling basic needs and the impact on treatment goals. The second two bullet points identify the impact of a specific basic need, food insecurity, on aspects of an individual's health, including ART adherence and viral load.

The Impact of Basic Needs

- Homelessness and unstable housing disrupt adherence
- When combined with **food insecurity**, **housing insecurity** has a negative relationship with ART adherence
- Some studies have found **no significant link** between ART adherence and unstable housing **when food insecurity is accounted for**
- Lack of transportation is associated with lower ART adherence
- Social support can have a positive impact; yet **individuals living in poverty** often have **underdeveloped social supports**
- Self-efficacy has been consistently demonstrated to predict ART adherence and viral suppression

SOURCE: Cornelius et al., 2017

Slide 15: The Impact of Basic Needs



Read through the bullet points on the slide. Recognize the relationship between different basic needs: that housing only provides a negative link on ART adherence when food insecurity is present. This begins to indicate a hierarchy on intervening around basic needs, starting with food insecurity.



REFERENCE:

Cornelius, T., et al. (2017). Impact of food, housing, and transportation insecurity on ART adherence: A hierarchical resources approach. *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV*, 29(4), 449-457.



Slide 16: Maslow's Hierarchy of Needs



****ANIMATIONS****

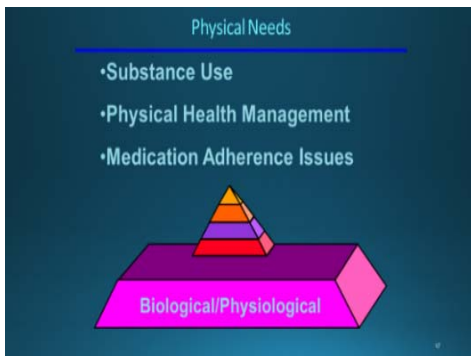
This slide animates in three parts. The first image is of Abraham Maslow. Advancing the slide will cause a triangle to superimpose on the slide. Advancing once more will cause the labels for each level of Maslow's Hierarchy of Needs to appear.

Provide background on Maslow's Hierarchy of Needs when Maslow's picture appears.

Abraham Maslow proposed a hierarchy of needs, or deficiencies including the most basic physiological needs, safety, a sense of community and belonging and self esteem, follow by the growth need, self actualization.

It was thought that in order to move forward, the lower level needs must be met first, and while there is some truth to this, as we are able to successfully attend to aspects of each of these levels, we develop a sense of mastery, and the development of self-esteem. As health care providers we are able to enhance an individuals sense of value and self-worth simply by how we interact with them.

(Notes for slide 16, continued)



Slide 16: Maslow's Hierarchy of Needs

How we observe, reinforce and affirm aspects of their behavior can play an integral role towards the development of a sense of mastery and self-worth.

Abraham Maslow summarized it this way: *"What is necessary to change a person is to change his awareness of himself." We can enhance this awareness by highlighting one's challenges or shortcomings, or we can enhance this awareness by pointing out strengths and highlighting abilities.*

Slide 17: Physical Needs

The base layer of the triangle relates to specific areas of focus in treatment. In particular, the "Biological/Physiological" level must be addressed and stabilized before moving on to the next level. At this level, substance use issues, physical health management/management of symptoms, and medication adherence issues should be prioritized.



Slide 18: Safety & Security

The next layer up of the triangle relates to specific areas of focus in treatment. In particular, the “Safety/Security” level must be addressed and stabilized before moving on to the next level. At this level, mental health management, functional impairments, and legal issues can impact functioning.

Additional information for trainers:

Housing, an important basic need, is not specifically noted in this conceptualization of the hierarchy. It may be useful to describe the importance of addressing housing at this level or even the level previous. Housing may have impacts on an individual’s biological/physiological functioning as well as safety and security.



Slide 19: Love & Belonging Needs

The next layer of the triangle relates to “Love and Belonging.” This level must be addressed and stabilized before moving on to the next level. At this level, social and interpersonal skills, need for affiliation, and relationships are the specific focus. At this level, an individual begins to develop opportunities for community and inclusion. These aspects of functioning are valuable in assisting an individual in the recovery process.



Slide 20: Self-Esteem

The next layer of the triangle relates to “Self-Esteem.” This level must be addressed and stabilized before moving on to the next level. At this level, achievement and mastery, independence/status, and prestige are considered. These concepts tie to an individual’s sense of self. Development of skills and practice of those skills is essential at this level.



Slide 21: Self-Actualization

The top level of this pyramid is “Self-Actualization.” At this level clients will focus on seeking personal potential, self-fulfillment, and personal growth. It is easy to see the way this pyramid acts as a “road-map” for substance use treatment. If an individual is actively using substances or only recently abstinent, it will be difficult to focus specifically on interventions that enhance self-fulfillment; rather initial treatment recommendations will be to stabilize the individual and develop initial coping skills/relapse prevention skills to reinforce stabilization.

Maslow's Hierarchy and Substance Use Disorders

"If all other needs are unsatisfied, and the organism's attention is dominated by the physiological needs, all other needs may become simply *background* or be pushed into the background. It is then fair to characterize the whole organism by saying simply that it is hungry, for consciousness is almost completely pre-empted by hunger."

Biological/Physiological

SOURCES: Maslow, 1943; Best et al., 2008

Slide 22: Maslow's Hierarchy and Substance Use Disorders



****ANIMATIONS****

Upon click, the "Biological/Physiological" level will separate out from the bottom of the pyramid and text will appear over the remaining pyramid.

Read through the text and note that as substance use disorder progress, the hierarchy and prioritization of different needs changes for individuals using substances. The drive to meet needs becomes consumed by the biological/physiological need to use the substance. This conceptualization highlights a pattern of tolerance and withdrawal that can occur with protracted use. All other needs will be pushed to the background and motivation switches such that the individual is seeking only to fulfill the physiological and neurochemical need for additional administration of the substance of choice.

(Notes for slide 22, continued)

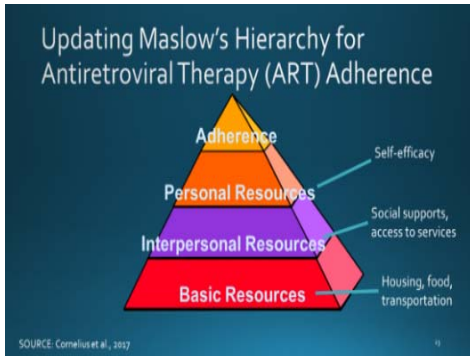
Slide 22: Maslow's Hierarchy and Substance Use Disorders



REFERENCES:

Best, D., Day, E. , McCarthy, T., Darlington, I., & Pinchbeck, K. (2008). The Hierarchy of Needs and care planning in addiction services: What Maslow can tell us about addressing competing priorities? *Addiction Research & Theory*, 16(4), 305-307.

Maslow, A. H. (1943). A theory of human motivation. *Psychological Review*, 50(4), 370-396.



Slide 23: Updating Maslow's Hierarchy for Antiretroviral Therapy (ART) Adherence



****ANIMATIONS****

A new pyramid will appear after one second that displays Maslow's Hierarchy updated with basic conditions for antiretroviral treatment adherence. Upon click, the "Basic Resources" level will be labeled with specific examples of areas for intervention/considerations. The next click will animate in the label for "Interpersonal Resources," and the final advancement of the slide will animate in the examples of "Personal Resources."

While it's easy to see the way that Maslow's Hierarchy of Needs relates to substance use disorders and conceptualizing needs within substance use treatment, researchers have proposed a slightly updated hierarchy for medication adherence – specifically, antiretroviral therapies. Under this conceptualization, there are four different levels of needs that lead up to adherence and can detract from adherence if they are not accounted for or met prior. The first level is "Basic Resources," and this level includes needs such as housing, food and transportation.

(Notes for slide 23, continued)

Slide 23: Updating Maslow's Hierarchy for Antiretroviral Therapy (ART)

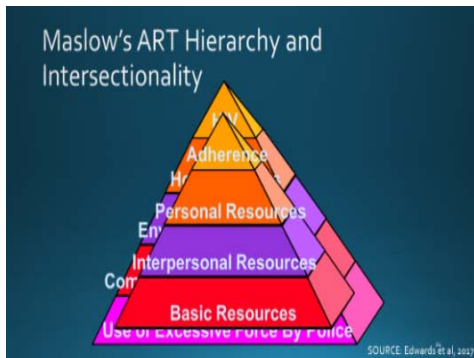
Adherence

While housing and food may fit into the Biological/Physiological level of Maslow's Hierarchy of Needs, transportation is not typically considered as a biological or physiological need. Remember though that transportation can have a significant impact on treatment adherence when considering basic needs. At the Interpersonal Resources level, enhancing social supports and access to services should be the focus of interventions. The next level is Personal Resources which includes enhancing self-efficacy. These conditions can help maintain adherence with clients.



REFERENCE:

Cornelius, T., et al. (2017). Impact of food, housing, and transportation insecurity on ART adherence: A hierarchical resources approach. *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV*, 29(4), 449-457.



Slide 24: Maslow's ART Hierarchy and Intersectionality



****ANIMATIONS****

Upon click, the pyramid on the slide will transition from the "ART Adherence" pyramid on the previous slide to a conceptualization of Maslow's Hierarchy related to Intersectionality.

Maslow's Hierarchy concept can be further extended to describe issues of intersectionality within an individual's community that are prioritized in terms of feelings of safety. The most basic level is identified as Use of Excessive Force by Police and the next Community Assaultive Violence. This is then followed by Environmental Factors and Homelessness. Each of these levels are focuses prior to focusing on HIV for individuals who experience multiple aspects of obstacles based on group identification/affiliation.

(Notes for slide 24, continued)

Slide 24: Maslow's ART Hierarchy and Intersectionality



REFERENCE:

Edwards, L., Lindong, I., Brown, L., Hawkins, A.S., Dennis, S., Fajobi, O., Rowel, R., Braithwaite, R., Syndor, K.D. (2017). None of us will get out of here alive: The intersection of perceived risk of HIV, risk behaviors and survival expectations among African American emerging adults. *Journal of Health Care for the Poor and Underserved, 28*(2), 48-68.

Basic Needs in ART Adherence

- Research finds that housing instability, food insecurity, and limited transportation had a **hierarchical effect** on interpersonal and personal resources
- Lack of access to transportation was the only basic resource that seemed to have a direct, negative effect on ART adherence
- Some of the negative effects were reduced through **home-based care and medication delivery**
- Food, housing, and transportation issues often co-occur for individuals in poverty

SOURCE: Cornelius et al., 2017

Slide 25: Basic Needs in ART Adherence



Read each of the points presented on the slide, focusing on the hierarchical effect of certain needs as described using the conceptualization of Maslow's hierarchy as a framework. Note that some of the solutions that have been identified as effective in reducing the impact of lack of access in ART adherence include outreach at the client's home and the ability to deliver medications to the individual's home. It is also important to consider that while transportation has been identified as the most significant negative factor, all three (transportation, food, and housing) can co-occur and create additional challenges for individuals living in poverty.



REFERENCE:

Cornelius, T., et al. (2017). Impact of food, housing, and transportation insecurity on ART adherence: A hierarchical resources approach. *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV*, 29(4), 449-457.

Addressing Basic Needs

- Interventions providing supplemental food have shown indications of increasing adherence
- Establishing housing is associated with improved functioning and physiological conditions for individuals with HIV
- Additional research on HIV-related stigma as a mediating factor is needed
- **Effective case management** may enhance adherence through reducing instability and unmet needs

SOURCE: Cornelius et al., 2017

Slide 26: Addressing Basic Needs



Read through each point on how to address basic needs. Note that addressing food insecurity by providing supplemental meals and food has been shown to enhance ART adherence. Similarly, establishing housing is associated with improved functioning for people living with HIV. Effective case management is essential in identifying and appropriately managing other unmet needs and establishing some stability.



REFERENCE:

Cornelius, T., et al. (2017). Impact of food, housing, and transportation insecurity on ART adherence: A hierarchical resources approach. *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV*, 29(4), 449-457.

Addressing Basic Needs: Housing First

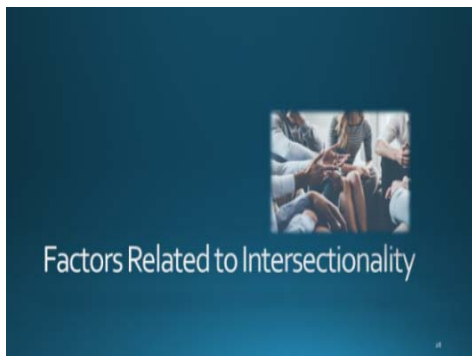
- But isn't providing basic resources cost prohibitive and enabling?
- Costs for HIV-related housing may actually mitigate expenses from emergency room visits and higher level care health costs
- **Housing First** is a national alliance providing assistance to end homelessness
- Does not require prerequisites for accessing housing
- Individuals in Housing First
 - Access housing **faster**
 - Have a housing **retention rate** of up to 98%
 - An **average cost savings** for emergency services of **\$31,545** over two years
 - Cost up to **\$23,000 less to house** compared to shelter programs

Slide 27: Addressing Basic Needs: Housing First



Ask the audience the question that first appears on the slide – a question that is typically asked as a justification for not providing housing to individuals in need. Providing housing is, in fact, not cost prohibitive and investing in housing for individuals in needs significantly reduces some of the expenses that come from exacerbated medical conditions such as HIV. Housing First provides housing to individuals without any prerequisite (such as being in a particular type of treatment). The organization has found that individuals in the Housing First program are able to retain housing and provide an average cost savings every two years of \$31,545. It is also cheaper to provide this kind of longer-term, stable housing than shelter programs.

(Notes for slide 27, continued)



**Slide 27: Addressing Basic Needs:
Housing First**



REFERENCE:

National Alliance to End Homelessness. (2016). *Rapid Re-Housing Fact Sheet: Housing First*. Retrieved from: <http://endhomelessness.org/wp-content/uploads/2016/04/housing-first-fact-sheet.pdf>.

**Slide 28: [TRANSITION SLIDE] Factors
Related to Intersectionality**

The next portion of the presentation describes intersectionality and the impact of multiple stressors due to group affiliation (voluntary or involuntary) on treatment adherence and engaging in change behaviors. It is important to understand this interaction as ignoring the barriers to change prevents a provider from fully engaging with their client.



IMAGE CREDIT:

Fotolia, purchased image, 2017.

Intersectionality of HIV/AIDS

- What is intersectionality?
- A definition initially advanced by Kimberle Crenshaw in 1988 as a method of delineating challenges faced by feminists of color:
- "paradigm of intersectionality challenges single category thinking about identity and group status and emphasizes approaches that interrogate how race, class, gender, sexuality, and other social locations operate simultaneously in social life"

SOURCE: Watkins-Hayes, 2014.

Slide 29: Intersectionality of HIV/AIDS

The definition of intersectionality presented on this slide comes from a conceptualization of intersectionality first identified by Kimberle Crenshaw in describing the challenges faced by feminists of color in 1988. The definition, while not originally specific to substance use or HIV/AIDS, has broad application in its recognition of the way single-category thinking prevents an individual from thoroughly assessing the way complex group statuses operate and interact simultaneously in a patient's life.



REFERENCE:

Watkins-Hayes, C. (2014). Intersectionality and the sociology of HIV/AIDS: Past, present, and future research directions. *The Annual Review of Sociology*, 40, 431-457.

Intersectionality of HIV/AIDS

- Most new infections in the US occur via male-to-male sexual contact
- MSM make up 4% of the US population but account for 78% of all new HIV infections among males
- 25% of new infections are the result of heterosexual contact
- Heterosexual contact is most typically reported in women who report infection (20% of all new cases)
- 8% are the result of intravenous drug use
- Black individuals make up 12% of the US population yet comprise 45% of all people living with HIV/AIDS

SOURCE: Watkins-Hayes, 2014; CDC, 2012

Slide 30: Intersectionality of HIV/AIDS

In considering some of the different group data on individuals living with HIV/AIDS, research indicates that most of the new infections that occur are via male-to-male sexual contact and men who have sex with men (MSM) account for 78% of all new HIV infections among males. MSM make up only 4% of the general population which indicates a significant disparity with the rates of infection. This disproportionality indicates efforts should be focused on targeting this group specifically in any prevention/outreach/education efforts. 25% of all new infections are the result of heterosexual contact and most women report heterosexual contact being the cause of infection. This makes up 20% of all new cases reported. 8% are the result of intravenous drug use. Similar to the disproportionality exhibited in the statistics on MSM, while black individuals make up just 12% of the US population, black individuals account for 45% of all people living with HIV/AIDS.

(Notes for slide 30, continued)

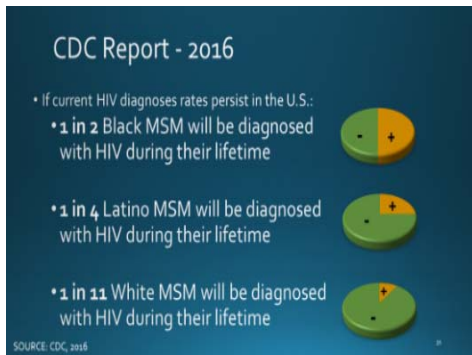
Slide 30: Intersectionality of HIV/AIDS



REFERENCES:

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Diseases Control and Prevention. (2017). *Health Disparities in HIV/AIDS, Viral Hepatitis, STDs, and TB: African American/Blacks*. Retrieved from: <https://www.cdc.gov/nchhstp/healthdisparities/africanamericans.html>.

Watkins-Hayes, C. (2014). Intersectionality and the sociology of HIV/AIDS: Past, present, and future research directions. *The Annual Review of Sociology*, 40, 431-457.



Slide 31: CDC Report 2016



****ANIMATION****

The animations in the slide will start from the bottom to the top with each click, revealing the lowest percentage of risk by ethnicity first.

If current HIV diagnoses rates persist, about 1 in 2 black men who have sex with men (MSM) and 1 in 4 Latino MSM in the United States will be diagnosed with HIV during their lifetime, according to a new analysis by researchers at the Centers for Disease Control and Prevention (CDC). The study, presented at the Conference on Retroviruses and Opportunistic Infections in Boston, provides the first-ever comprehensive national estimates of the lifetime risk of an HIV diagnosis for several key populations at risk and in every state. Gay and bisexual men continue to be most affected by the HIV epidemic in the U.S. At current rates, 1 in 6 MSM will be diagnosed with HIV in their lifetime, including 1 in 2 black MSM, 1 in 4 Latino MSM, and 1 in 11 white MSM. African Americans are by far the most affected racial or ethnic group with a lifetime HIV risk of 1 in 20 for men (compared to 1 in 132 for whites) and 1 in 48 for women (compared to 1 in 880 for whites).

(Notes for slide 31, continued)

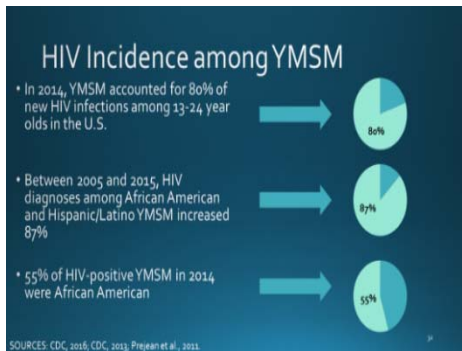
Slide 31: CDC Report 2016

People who inject drugs are at much higher lifetime risk than the general population, and women who inject drugs have a higher risk than men (1 in 23 compared with 1 in 36). People living in the South are more likely to be diagnosed with HIV over the course of their lifetime than other Americans, with the highest risk in Washington, DC (1 in 13), Maryland (1 in 49), Georgia (1 in 51), Florida (1 in 54), and Louisiana (1 in 56).



REFERENCE:

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Diseases Control and Prevention. (2016). *NCHHSTP Newsroom: Lifetime Risk of HIV Diagnosis*. Retrieved from: <http://www.cdc.gov/nchhstp/newsroom/2016/croi-press-release-risk.html>.



Slide 32: HIV Incidence among YMSM

Gay and bisexual men are more severely affected by HIV than any other group in the United States. Among all gay and bisexual men, African American gay and bisexual men bear a disproportionate burden of HIV. An estimated 9,731 youth aged 13 to 24 were diagnosed with HIV in 2014 in the United States. Eighty-one percent (7,868) of diagnoses among youth occurred in persons aged 20 to 24. Among youth aged 13 to 24 diagnosed with HIV in 2014, **80% (7,828) were gay and bisexual males**. Of those newly diagnosed young gay and bisexual males, **55% (4,321) were black**, 23% (1,786) were Hispanic/Latino, and 16% (1,291) were white. From 2005 to 2014, **HIV diagnoses among both black and Hispanic/Latino gay and bisexual men aged 13 to 24 increased about 87%**. Among young white gay and bisexual men, HIV diagnoses increased 56%. However, the most recent 5 years of data (2010-2014) indicate that the diagnoses among black and white gay and bisexual men aged 13 to 24 have stabilized and the increase has slowed to 16% among Hispanic/Latinos. In 2014, an estimated 1,716 youth aged 13 to 24 were diagnosed with AIDS, representing 8% of total AIDS diagnoses that year.

(Notes for slide 32, continued)

Slide 32: HIV Incidence among YMSM



REFERENCES:

Centers for Disease Control & Prevention. (2016). *HIV among youth*, www.cdc.gov/hiv/group/age/youth/index.html (Accessed December 9, 2016).

Centers for Disease Control & Prevention. (2013). Diagnoses of HIV infection in the United States and dependent areas, 2011. *HIV Surveillance Report*, 23.

Prejean, J., Song, R., Hernandez, A., et al. (2011). Estimated HIV incidence in the United States, 2006-2009. *PLoS One*, 6, e17502.

Intersectionality: MSM

- More likely to experience clinical depression and anxiety than other men
- Have elevated rates of childhood sexual abuse relative to US population and heterosexual men
- Latino MSM are 2x more likely to report childhood sexual abuse than non-Latino MSM
- Individuals having experienced childhood sexual abuse are more likely to report sexual encounters
 - that involved drug/alcohol use
 - with non-monogamous partners

SOURCE: Watkins-Hayes, 2014

Slide 33: Intersectionality: MSM

Among all individuals, MSM individuals are more likely to experience clinical depression and anxiety than other men which may also contribute to risk-taking behaviors including substance use and unprotected sexual interactions. Rates of childhood sexual abuse are elevated among MSM compared to the general US population and to heterosexual men; among this group, Latino MSM are two times more likely to report childhood sexual abuse than non-Latino MSM. In consideration of potential risk-taking behaviors, individuals who have experienced childhood sexual abuse are more likely to report using drugs or alcohol during sexual encounters and having sexual encounters with non-monogamous partners.



REFERENCE:

Watkins-Hayes, C. (2014). Intersectionality and the sociology of HIV/AIDS: Past, present, and future research directions. *The Annual Review of Sociology*, 40, 431-457.

Intersectionality: Social Oppression

- Social networks are essential
- Play a role in shaping sex norms
- Isolation from appropriate networks impacts development of healthy sex norms
- Men who perceive strong support and risk reduction norms among peers are less likely to engage in unprotected sex



SOURCE: Watkins-Hayes, 2014

Slide 34: Intersectionality: Social Oppression

Social oppression additionally contributes to stressors an individual may experience. While intersectionality typically deals with inclusive labels to identify a group, a group may also be identified based on their status as outcasts or on the fringe of social interactions. Social networks are essential in well-being and healthy recovery. In addition to providing useful communities for support, social networks play a large developmental role. Appropriate social interactions and supportive social networks shape sex norms and isolation from appropriate groups will impact the development of healthy behaviors and norms around sex. Men who perceive strong support and a general attitude of adopting risk-reducing behaviors among peer group members are less likely to engage in unprotected sex.



REFERENCE:

Watkins-Hayes, C. (2014). Intersectionality and the sociology of HIV/AIDS: Past, present, and future research directions. *The Annual Review of Sociology*, 40, 431-457.

(Notes for slide 34, continued)

**Slide 34: Intersectionality: Social
Oppression**



IMAGE CREDIT:

Fotolia, purchased image, 2017.

Intersectionality: Social Oppression

- Discrimination and financial impacts are correlated with risky sexual behaviors among gay Latino men
- Systemic homophobia, racism, financial hardship, limited social support are correlated with unprotected anal sex among black and Latino MSM
- Acculturation and migration may act as a protective factor
- Other studies have indicated that immigration may exacerbate risk behaviors

SOURCE: Watkins-Hayes, 2014

Slide 35: Intersectionality: Social Oppression

Continuing from the previous slide, additional aspects of social isolation extend beyond just having appropriate peer groups to regulate development of norms and attitudes. Discrimination and financial difficulties are both correlated with risky sexual behavior among gay Latino men. The systemic discrimination toward both race and sexual orientation are correlated with increased risk behaviors among black and Latino MSM, specifically unprotected anal sex. While race and ethnicity may increase opportunities for stressors and discrimination, acculturation and migration have been found to act as protective factors in some studies while other studies have found that immigration may exacerbate risk-taking behaviors.



REFERENCE:

Watkins-Hayes, C. (2014). Intersectionality and the sociology of HIV/AIDS: Past, present, and future research directions. *The Annual Review of Sociology*, 40, 431-457.

Intersectionality: Heterosexual Sex

- Trends beginning in 2007 indicated that male-to-male and IDU cases were decreasing while heterosexual transmission was increasing
- By the end of 2010, women represented 1 in 4 PLWH
- HIV is more effectively transmitted from men to women than vice versa during unprotected vaginal or anal intercourse
- Challenging the "vulnerability paradigm" to enhance women's power and agency

SOURCE: Watkins-Hayes, 2014

Slide 36: Intersectionality: Heterosexual Sex

The vulnerability paradigm makes assumptions about the role that women play in relationships and in engaging in risk-taking behaviors. It posits that women and not men want to prevent HIV but lack the power to do so. It also states a general preconception that men are more likely than women to bring HIV into the partnership. It also presumes that men more than women will engage in risk behaviors. While these attitudes are based in misconceptions about HIV and/or heteronormative gender roles, the vulnerability paradigm can also mask women's power and agency.



REFERENCE:

Watkins-Hayes, C. (2014). Intersectionality and the sociology of HIV/AIDSs: Past, present, and future research directions. *The Annual Review of Sociology, 40*, 431-457.

Intersectionality: IV Drug Use

- IDU is a significant predictor of delayed or no medical intervention
- Predicts higher mortality rate
- Environmental factors that increase HIV risk:
 - Proximity to shooting galleries
 - Limited neighborhood resources
 - Neighborhood transitions (such as those produced by gentrification)
- New cases of HIV from IDU declined 56% between 2008-2014
- While 5% of all new cases in 2014 resulted from injection drug use, 3% of all new cases were of gay/bisexual men who injected drugs

SOURCE: CDC, 2018

Slide 37: Intersectionality: IV Drug Use

Intravenous drug use plays a significant role as a predictor of delayed or no medical intervention. Because of the delayed or no medical intervention, symptoms exacerbate and outcomes are generally worse, including predicting a higher mortality rate compared to individuals who do not use intravenous drugs. In addition, environmental factors such as limited neighborhood resources or community transitions (like gentrification) can increase HIV risk. While new cases of HIV from intravenous drug use declined 56% from 2008-2014, gay/bisexual men still comprise a disproportionately large number of the new cases of HIV as a result of injection drug use.

Additional information for trainers:

Shooting galleries typically refers to a place where individuals can go to pay money and be “protected” or “safe” while injecting. These areas typically increase the potential transmission of HIV due to needle sharing and other risky behaviors that occur with individuals at the site. Frequent use of “shooting gallery” sites is also tied to increase risk of HIV transmission.

(Notes for slide 37, continued)

Slide 37: Intersectionality: IV Drug Use




REFERENCES:

Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention. (2018). *HIV/AIDS: HIV Among African Americans*. Retrieved from:
<https://www.cdc.gov/hiv/group/racialethnic/africanamericans/index.html>.

Klein, H. & Levy, J.A. (2003). Shooting gallery users and HIV risk. *The Journal of Drug Issues*, 22, 751-768.

Watkins-Hayes, C. (2014). Intersectionality and the sociology of HIV/AIDS: Past, present, and future research directions. *The Annual Review of Sociology*, 40, 431-457.

Intersectionality: Opioid Use



- In 2014, there were 47,055 overdose deaths in the US
- 30,000 were due to opioid overdose
- In 2016, there were 64,000 overdose deaths in the US
- 42,000 were due to opioid overdose
- Among all individuals over 13 diagnosed with HIV, 12% of males and 24% of females were infected via IV drug use
- In January 2015, Scott County in Indiana began investigating 11 new HIV cases
 - The county had 5 new cases between 2004 and 2013
- All 11 reported injecting extended-release oxycodone
- 159 of 181 new cases in a 12-month period reported the same

SOURCE: Bernard et al., 2013; CDC, 2013; CDC, 2015; Peters, 2016

Slide 38: Intersectionality: Opioid Use

Opioid use continues to be a major concern in the US and opioid use contributes to, not only, increase mortality, but also plays a role in the transmission of HIV. In 2014, of the 47,055 overdose deaths in the US, 30,000 were due to opioid use. Two years later, in 2016, there were 64,000 overdose deaths with 42,000 coming from opioid use, an increase of 2%. More females than males report being infected with HIV due to intravenous drug use.

A recent example of how opioid use can expedite transmission is from a case study of Scott County in Indiana which typically has less than one new case of HIV reported per year. Within the first few months of 2015, officials were investigating 11 new cases. All 11 cases reported injecting extended-release oxycodone. Over a 12 month period in Indiana, 159 of 181 new cases of HIV reported the same substance of use.

(Notes for slide 38, continued)

Slide 38: Intersectionality: Opioid Use



REFERENCES:

Bernard, C., Owens, D.K., Goldhaber-Fiebert, J.D., Brandeau, M.L. (2017). Estimation of the cost-effectiveness of HIV prevention portfolios for people who inject drugs in the United States: A model-based analysis. *PLoS Medicine*, 14(5), e1002312.

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention. (2017). *Opioid Overdose*. Retrieved from: <https://www.cdc.gov/drugoverdose/index.html>.

Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention. (2015). *HIV Surveillance Report*. Retrieved from: <https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-2013-vol-25.pdf>.

(Notes for slide 38, continued)

Slide 38: Intersectionality: Opioid Use

Peters, P.J., Pontones, P., Hoover, K.W., Patel, M.R., Galang, R.R., Shields, J., et al. (2016). HIV Infection Linked to Injection Use of Oxymorphone in Indiana, 2014-2015. *New England Journal of Medicine*, 375, 229-239.



IMAGE CREDIT:

Fotolia, purchased image, 2017.

Intersectionality: Space and Place

- Largest number of cases of HIV is in the south
- Largest number of cases per 100,000 people is in the northeast
- Most cases occur in cities with greater than 500,000 people
- CDC identifies poverty as single-biggest factor for HIV infection outside of being a gay/bisexual male
- "Syndemics" are overlapping and mutually reinforcing factors for epidemics:
 - HIV
 - Poverty
 - Substance Use

SOURCE: Watkins-Hayes, 2014

Slide 39: Intersectionality: Space and Place

In considering HIV prevalence based on geographical region, the south has the highest number of cases of HIV. However, the northeast of the United States has the highest number of cases of HIV per 100,000 people. This is largely due to the fact that cities in the northeast tend to be more clustered and densely populated compared to the south. Most cases will occur in cities with greater than 500,000 people and poverty is a major factor in HIV infection. Consider the way in which different factors reinforce each other ("syndemics") as has been discussed up to this point.



REFERENCE:

Watkins-Hayes, C. (2014). Intersectionality and the sociology of HIV/AIDS: Past, present, and future research directions. *The Annual Review of Sociology*, 40, 431-457.

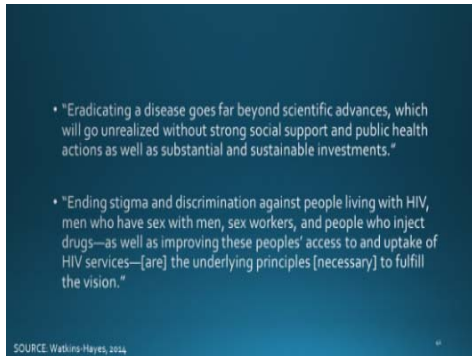
Intersectionality: Factors that Maintain Imbalances in HIV and SUD Care

- Race
- Sexual orientation
- Class
- Gender
- Other categories?

Slide 40: Intersectionality: Factors that Maintain Imbalances in HIV and SUD Care



Engage the audience in a discussion, first identifying the factors that are presented on the slide (Race, Sexual Orientation, Class, Gender) then asking the audience what other categories they would include in this list of intersectionality. Allow for discussion of 5-7 different suggestions and how they see that aspect playing a role in their client's change behaviors.



Slide 41: No Title



Read through each of the quotes that present a conceptualization for how intersectionality and aspects beyond a disease itself can impact health outcomes.



REFERENCE:

Watkins-Hayes, C. (2014). Intersectionality and the sociology of HIV/AIDS: Past, present, and future research directions. *The Annual Review of Sociology, 40*, 431-457.

Path to Addressing Imbalances

- Attend to differences
- Recognize subjectivities/biases
- Awareness of identity categories
- Consider dynamics of dominance sustaining inequalities



SOURCE: Watkins-Hayes, 2014

Slide 42: Path to Addressing Imbalances

This slide begins to summarize the ways that providers can start to address some of the imbalances due to intersectionality and other factors that can impede change in treatment. The first strategy is to consider a mechanism to begin to attend to differences – this requires the provider be aware of his/her own biases and how these may present in the interaction. Part of attending to differences is recognizing that everyone possesses subjectivities and biases and that the goal is not to be free from biases (an impossibility) but rather to notice when they occur so that they do not obstruct engagement. Knowledge of identity categories – both how a provider identifies and what groups patients may identify affiliation with – aid in reducing barriers to change.

(Notes for slide 42, continued)

Slide 42: Path to Addressing Imbalances



REFERENCE:

Watkins-Hayes, C. (2014). Intersectionality and the sociology of HIV/AIDS: Past, present, and future research directions. *The Annual Review of Sociology*, 40, 431-457.



IMAGE CREDIT:

Fotolia, purchased image, 2016.

Intersectionality in Future Approaches

Three main contributions to policy, academic, and programmatic components of HIV/AIDS research and treatment

1. Challenge overemphasis on biomedical and individualized behavioral approaches
2. Enhance intersectional approaches to treatment
3. Focusing research on behaviors that fall outside of the perceived traditional norms

SOURCE: Watkins-Hayes, 2024

Slide 43: Intersectionality in Future Approaches

Three major focuses exist for addressing intersectionality and imbalances in the future. Those approaches focus on more macro level policy, academic, and programmatic components. The first of which is that there should be systemic challenges to the idea that biomedical conceptualizations are the only approach to describing functioning and impacting change – overreliance on a biomedical approach can discount individual resilience, community protective factors, and the importance of spiritual aspects of recovery. Similarly, using an isolated individualized behavioral approach means not integrating all disciplines in recovery effectively. In order to address these treatment imbalances, providers should move towards more integrated, intersectional approaches to treatment, recognizing the overlap between physical health, behavioral health and mental health. Research should also be expanded to focus on issues that may fall outside of the perceived social or traditional norms. For example, research focusing on MSM should be essential when considering HIV prevalence and prevention efforts.

(Notes for slide 43, continued)



Slide 43: Intersectionality in Future Approaches

MSM may fall outside of traditional, established heteronormative social values which, if not focused on in treatment, results in a missed opportunity to enhance practices and reach critical populations.



REFERENCE:

Watkins-Hayes, C. (2014). Intersectionality and the sociology of HIV/AIDS: Past, present, and future research directions. *The Annual Review of Sociology, 40*, 431-457.

Slide 44: [TRANSITION SLIDE] Enhancing Retention

This section will focus on barriers to retention and the importance of retention in initiating change for individuals in substance use treatment or living with HIV/AIDS. The section will also present suggestions for enhancing retention and engagement as a critical component of care.



IMAGE CREDIT:

Fotolia, purchased image, 2017.

Why focus on retention?

- Retention is the "continued engagement in health services, from enrollment in care to discharge or death"
- US Health Resource and Services Administration HIV/AIDS Bureau (HRAS-HAB) defines retention for all Ryan White-funded clinics as two kept appointments at least 90 days apart within a 12 month period
- Individuals retained in care have lower mortality and higher viral suppression
- According to CDC criteria, in 2014, only 66% of PLWH were adequately linked to care and only 37% were retained in care and on ART

SOURCE: Okeke, et al., 2014; Hall et al., 2016

Slide 45: Why Focus on Retention?

It is important to focus on retention as retention results in continued engagement in health services. Retention and engagement should start from the first meeting and continue until "discharge or death." Under the US Health Resource and Services Administration definitions of retention, a patient must keep two appointments within 90 days during a 12 month period. Retention is important as research shows that individuals who are able to be retained in care have lower mortality and high viral suppression. Based on this criteria, the CDC found that, in 2014, only 2/3 of PLWH were appropriately and adequately linked to care with only 37% of individuals retained in care and on ART.



REFERENCES:

Hall, B. J., Sou, K., Beanland, R., Lacky, M., Tso, L. S., Ma, Q., Doherty, M., & Tucker, J. D. (2016). Barriers and facilitators to interventions improving retention in HIV care: A qualitative evidence meta-synthesis. *AIDS and Behavior*, 21(6), 1755-1767.

(Notes for slide 45, continued)

Slide 45: Why Focus on Retention?



REFERENCES:

Okeke, N. L., Ostermann, J., Thielman, N. M., (2014). Enhancing linkage and retention in HIV care: A review of interventions of highly resourced and resource-poor settings. *Current HIV/AIDS Report, 11(4)*, 376-392.

Why focus on retention?

- Remaining in SUD treatment for **at least 90 days** is directly correlated with positive outcomes
- **20.1 million people aged 12 or older** have a substance use disorder
 - 15.1 due to alcohol
 - 7.4 due to illicit drug use
- Only **1.4%** of the individuals who would benefit from substance use treatment received it
 - **17.2 million Americans** needing treatment did not receive it
 - Individuals who would benefit from treatment are likely to never receive any sort of intervention
- Two most common reasons for not obtaining treatment were:
 - Not being ready to discontinue use (38%)
 - No health coverage/could not afford care (26.9%)

SOURCE: NSDUH, 2017

Slide 46: Why Focus on Retention?

Additional evidence of the importance of retention on enhancing substance use treatment outcomes exists. Studies show that remaining in treatment for at least 90 days is directly correlated with positive outcomes. It's important to note that while this provides a measure to treatment success, the types and quality of services and interventions a client receives during the 90 days play a key role.

Recent surveys show that 20.1 million people, 12 and older, have a substance use disorder, with 15.1 million having an alcohol use disorder, and 7.4 having an illicit substance use disorder. However, less than 2% of individuals who would benefit from some form of substance use treatment actually receive any sort of intervention. 17.2 million Americans needed treatment in 2016 but did not receive it. This means that individuals who would potentially benefit from treatment are likely to never receive any sort of intervention. When surveyed, the two most common reasons for not obtaining treatment were not being ready to discontinue use (38% of people identified this as a reason) and not having adequate health coverage (26.9% reported this).

(Notes for slide 46, continued)

Slide 46: Why Focus on Retention?



REFERENCE:

Ahrnsbrak, R., Bose, J., Hedden, S. L., Lipari, R. N., & Park-Lee, E. (2017). *Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health*. Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from <https://www.samhsa.gov/data>.

Factors that affect retention in HIV care

Barriers	Facilitators
<ul style="list-style-type: none"> • Stigma and discrimination • Fear of disclosure • Resources availability • Institutional challenges • High clinician workload • Lack of available pharmacies/medication availability 	<ul style="list-style-type: none"> • Task shifting to lay health workers/peer navigation • Technology-based outreach efforts • Family and friend support • Intensive, strengths-based case management • Relationship with caregivers • Collaborative healthcare decision-making • Patience to answer questions • Being treated with respect

SOURCE: Okelo, et al., 2014; Hallett et al., 2008

Slide 47: Factors that Affect Retention in HIV Care

Multiple factors affect retention in care. Some of the barriers include: stigma and discrimination that may be experienced either in an individual's community or even at a health institution itself. Fear of disclosure of status is relevant to HIV care and substance use and care must be taken in order to ensure privacy is maintained. Institutional challenges such as resource availability and high clinician workload can impact the quality of care and burnout must be considered to ensure effective workforces. Related to previous discussions in the presentation of limited transportation as a basic need, not having access to a pharmacy or needed medications can also act as a significant barrier.

Alternatively, there are a number of facilitators that can guide practice in focusing on enhancing retention. Utilizing lay health workers or individuals with lived experience who can assist in navigating a confusing health system can enhance retention. Using technology to outreach or provide reminders to patients can be a useful tool in improving retention.

(Notes for slide 47, continued)

Slide 47: Factors that Affect Retention in HIV Care

Considerations of engaging family and friends as supports can be useful when appropriate family and friend supports are available, including enhancing relationships with caregivers. When patients are treated with respect and given opportunities to ask questions and get questions answered, the patient is more likely to feel that they are a part of a collaborative treatment team and be more likely to remain in care.

Additional information for presenters: Examining a peer navigation program for a year found that the proportion of patients who attended two clinic visits in a 6-month period increased from 64% to 79%. Another study of 51 women living with HIV reported an increase in the proportion of women who attended all clinic visits over a 6-month period from 10% to 58% with the assistance of a nurse-patient navigation program to enhance engagement. Critical in this program was the inclusion of a transportation resource which helped to reduce barriers to accessing care.

(Notes for slide 47, continued)

Slide 47: Factors that Affect Retention in HIV Care



REFERENCES:

Hall, B. J., Sou, K., Beanland, R., Lacky, M., Tso, L. S., Ma, Q., Doherty, M., & Tucker, J. D. (2016). Barriers and facilitators to interventions improving retention in HIV care: A qualitative evidence meta-synthesis. *AIDS and Behavior, 21*(6), 1755-1767.

Okeke, N. L., Ostermann, J., Thielman, N. M., (2014). Enhancing linkage and retention in HIV care: A review of interventions of highly resourced and resource-poor settings. *Current HIV/AIDS Report, 11*(4), 376-392.

Factors that affect retention in SUD treatment

- Readiness to commit to treatment
- Trust in ability to overcome obstacles/impairments
- Expectation that treatment can be effective
- Potential satisfaction to be gained through treatment
- Perceived and experienced social support
- Clinical profile (ie co-occurring impairments)
- Life purpose/meaning identified by client

SOURCE: Flora & Stalikas, 2013

Slide 48: Factors That Affect Retention in SUD Treatment

When considering the impact of substance use disorders on treatment engagement, providers should consider the individual's readiness to commit to treatment. The more ready an individual is, the more likely the individual is to be retained in treatment. The extent to which a client perceives a provider as having trust in the client's ability to overcome obstacles/impairments can also enhance retention. The client must see the treatment as potentially being effective and that there must be some potential satisfaction that can be gained through treatment. A sense of community or social support enhances engagement and the purpose of the client's life/meaning combine to enhance retention.



REFERENCE:

Flora, K. & Stalikas, A. (2013). Factors affecting substance abuse treatment across different treatment phases. *International Journal of Psychosocial Rehabilitation, 17*(1), 89-104.

A 2014 provider survey conducted by the Department of Behavioral Health and Recovery in Washington found the ten most reported barriers to effective engagement in substance use treatment were:

1. Transportation
2. Lack of safe/sober housing; homelessness
3. Childcare
4. Lack of funding (funding for treatment/co-pays, not eligible for insurance)
5. Lack of motivation
6. Co-Occurring disorders
7. Employment/school commitments; scheduling challenges
8. Lack of family support
9. Clients lack life skills to schedule and attend multiple appointments; need reminders
10. Lack of services (wait times, staff shortage/large case loads, timeliness of appointments)

Slide 49: No Title

One particular survey of identified barriers provided by behavioral health staff was collected by the Department of Behavioral Health and Recovery in Washington State in 2014. They found that there were ten frequently reported barrier to engaging individuals in care. While a number of the items focused on organizational issues such as lack of services and wait times, common barriers discussed up to this point in the training were noted in this survey. These included transportation issues and lack of safe or sober housing.



REFERENCE:

2014 DBHR Washington State Provider Survey. (2015). Retrieved from: <http://adai.uw.edu/retentiontoolkit/survey.htm>.

Activity: Inspiring Coach/Mentor/Teacher

- Think of someone who has helped you accomplish something important
- What characteristics did you most appreciate about them? What made them effective at coaching/guiding you?



Slide 50: Activity



INSTRUCTIONS

- ***Divide audience into 4 groups (or multiples of 4 if larger audience)***
- ***Have each group develop their own list of characteristics***
- ***Debrief: start with one group, have them report their list, trainer writes on flip chart/white board***
- ***“So what’s a common theme among these characteristics?”***

The purpose of this activity is to get participants thinking about characteristics of change agents that help to enhance engagement. Ideally, the trainer would want to identify any aspects of “acceptance” as a transition to the next slide, but participant answers will vary and be valid. Highlighting the common themes (often times “empathy,” “nonjudgmental,” “supportive,” and “believing in me” will come up in discussion) helps to illustrate that there are a set of behaviors that can enhance engagement significantly.

Acceptance

- Willing to accept what someone is bringing to the interaction
- Does not mean you agree with or endorse what they are saying
- How do you show that you accept without judgement?

Slide 51: Acceptance

Acceptance is a critical component of engaging individuals in treatment. Before any change may occur, clients have to feel like they're heard and respected. As noted previously, one major facilitator to engaging individuals in treatment is ensuring that individuals are treated with respect. Acceptance means being willing to tolerate and try to understand what someone is bringing to a particular interaction. This does not mean that you have to agree with what the person does or says or even endorse it, but a component of developing empathy is attempting to display a willingness to tolerate someone else's experience.



Ask the audience in a brief 4-6 minute discussion how they show acceptance without judgment.



Slide 52: Acceptance



****ANIMATION****

Upon click, the image will animate to the right and the shape will shrink, highlighting the point of the star labeled "affirmation."

Discuss with participants what it means to provide an affirmation. Focus on deliberately reinforcing specific strengths. Providing affirmations to clients allows an opportunity to enhance engagement and demonstrate acceptance.



Slide 53: Acceptance



****ANIMATION****

Upon click, the image will animate to the left and the shape will shrink, highlighting the point of the star labeled "autonomy."

Autonomy is offering people "complete freedom to be and to choose." While this seems counterintuitive, the nature of change is such that the more an individual is pushed to change, the less willing that individual becomes to actually make a change. Change originates when an individual is provided an opportunity to consider their own motivations within an atmosphere of compassion and acceptance.



Slide 54: Acceptance



****ANIMATION****

Upon click, the image will animate down and the shape will shrink, highlighting the point of the star labeled “absolute worth.”

The concept of absolute worth is based in respecting that the other person has worth in their own right. It recognizes that people have some expertise in their own lives that providers cannot presume to know. It is important to focus on helping individuals recognize that expertise in situations where they do not see it themselves.

Slide 55: Acceptance



****ANIMATION****

Upon click, the image will animate up and the shape will shrink, highlighting the point of the star labeled “accurate empathy.”

Read through the points on “accurate empathy” and advance to the next slide.



Slide 56: Sympathy



This slide contains a movie clip that will play when the trainer advances the slide. In order for this to work, the connection between the PowerPoint presentation and the video file must be maintained.

When moving the PowerPoint file to another location on your computer, or to another computer, make sure to always move the video file along with it.

If the link becomes broken, the video will need to be reinserted. Delete the image and gray box. From the insert menu in PowerPoint, select "movie." Select the video file "SympathyEmpathy.mp4" that was included for this training. When asked, indicate that the movie should play automatically. It will appear as a black box on the screen. This video should play when the slide show is being viewed when the trainer clicks on the black box.]

The video is an animated clip of Dr. Brene Brown discussing the difference between sympathy and empathy. Play the video and summarize the importance of recognizing the difference between sympathy and empathy in creating acceptance and not inadvertently creating a barrier between provider and client.

(Notes for slide 56, continued)

Activity: Identifying Strengths

You're meeting with a 36 year-old male who was recently diagnosed with HIV. During your assessment, you discover that your client has a two year-old child and is recently estranged from the child's mother. The client states that the child's mother found out that your client was regularly engaging in unprotected sex with men who he would meet at bars and clubs or using hook-up apps.

When asked about the estrangement and potential for risk based on his behaviors, the client states, "She just needs to relax. If she would just do her job and take care of the kid like she's supposed to, everything would be fine." When asked about on-going substance use, the client states that he uses alcohol and marijuana nearly daily and has "on occasion" done cocaine and meth while clubbing and injected heroin "once or twice if someone has it" in the past six months. He feels he doesn't require any health interventions.

Slide 56: Sympathy



VIDEO SOURCE:

<https://www.youtube.com/watch?v=1Ewvgu369Jw>.

Slide 57: Activity: Identifying Strengths



Read through the vignette. Divide the training participants into groups of 2-3. Give them 5-7 minutes to discuss how they might identify strengths of this individual if they were working with him.

Engagement: Barriers to Health Literacy

- Individuals provided with appropriate health education show greater ART adherence
- Health literacy is "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions."
- Health providers face multiple barriers that can impede health education
- Health literacy barriers include:
 - Individual barriers
 - Provider-related barriers
 - System-level barriers

SOURCE: Corless, 2016

Slide 58: Engagement: Barriers to Health Literacy



Read through the bulleted points. Focus on the definition of health literacy and why health literacy and education are important in contributing to changing behavior such as increased medication adherence. Note that health literacy barriers can include individual barriers (motivation or willingness to learn additional information; biases and misconceptions), provider-related barriers (limited training or educational enhancement opportunities), system-level barriers (lack of organizational or macro-level support to provide targeted education to certain groups).



REFERENCE:

Corless, I. B. (2016). Doing what you're told: It's not that simple. *Journal of the Association of Nurses in AIDS Care*, 27(2), 117-120.

Engagement: Overcoming Obstacles

- Use of an integrated team approach – relying on different disciplines with expertise in a coordinated way
- Assess needs and priorities – if housing and food are not addressed, other priorities become less important
- Penalizing patients for noncompliance is counterproductive
- Health care needs should be organized so the patient knows how to access resources during the day and at night
- Give individuals choices in their care
- Establish a program to provide broad HIV-related education
- Develop an activity in which providers and non-providers are tasked with re-writing processes, procedures, worksheets, medication scripts or recommendations to contain less jargon

SOURCE: Corless, 2018

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Slide 59: Engagement: Overcoming Obstacles

The information presented on this slide includes suggestions for overcoming barriers to engagement. Providers should consider using an integrated treatment team approach rather than relying on one particular provider to accomplish all tasks. Thorough assessment and recognition of addressing basic needs helps to appropriately treatment plan. We also recognize that penalizing patients for noncompliance is not consistent with the strategies for engagement discussed up to this point. Collaborative decision making and establishing a program for broad HIV education are components of engaging individuals in treatment – an additional activity would be to involve key stakeholders in identifying jargon in policies and practices to simplify information.

Additional information for trainers:

Individual barriers include: mental health issues, adjustment to recent diagnosis, basic literacy skills, cognitive/organizational impairments, motivational considerations, attempt to self-educate (i.e. ,via the internet).

(Notes for slide 59, continued)

Slide 59: Engagement: Overcoming Obstacles

Additional information for trainers:

Individual barriers include: mental health issues, adjustment to recent diagnosis, basic literacy skills, cognitive/organizational impairments, motivational considerations, attempt to self-educate (i.e., via the internet). System barriers include: manuals, procedures that are too technical and not accessible to varying literacy levels; high co-pays that prevent some individuals from accessing adequate care/resources.



REFERENCE:

Corless, I. B. (2016). Doing what you're told: It's not that simple. *Journal of the Association of Nurses in AIDS Care*, 27(2), 117-120.

REACH: A Mixed Method Approach to Patient Engagement

- HIV stigma and health beliefs are significant barrier to care
- PLWH are less likely to disengage from care if they are:
 - Male
 - Older
 - White
 - MSM
 - initiated on ART
- PLWH are more likely to disengage from care if they:
 - Use intravenous drugs
 - Are migrants
 - Received a recent diagnosis

SOURCE: Howarth et al., 2017

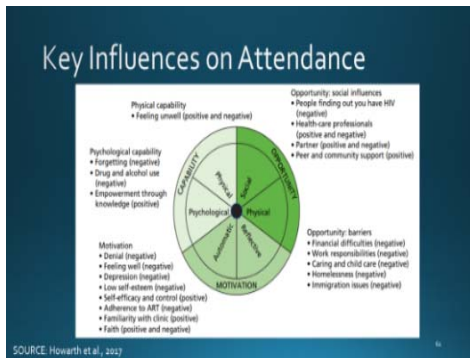
Slide 60: REACH: A Mixed Method Approach to Patient Engagement

The REACH study is a mixed-method study to identify methods for improving HIV care. The study recognized that HIV stigma and health beliefs can significantly impact access to care. Factors that were related to being likely to disengage in care included: being male, older, white, MSM, or initiated on ART. While ART adherence is important, individuals may be likely to disengage once initiated thinking they do not need additional or on-going care. PLWH are more likely to disengage from care if they are using intravenous drugs. Risk factors also include receiving a recent diagnosis as this can cause excessive and unanticipated stress for the individual. An additional consideration would be if the individual is a migrant.



REFERENCE:

Howarth, A., Apea ,V., Michie, S., Morris, S., Sachikonye, M., Mercer, C., Evans, A., Delpech, V., Sabin, C., & Burns, F. (2017) REACH: A mixed-methods study to investigate the measurement, prediction and improvement of retention and engagement in outpatient HIV care. *Health Services and Delivery Research*, 5(13), 1-159.



Slide 61: Key Influences on Attendance



Summarize the main points of the key influences on attendance. Identify that the three aspects of the wheel, “capability,” “opportunity,” and “motivation” all have different components to them. These three aspects could be useful categories to begin to assess an individual’s functioning in order to better understand the potentials barriers (and facilitators) to attending treatment. Note also that each of the three aspects of attendance breaks down into two different components that capture difficulties in that particular component. It is up to the presenter(s) to decide how many of the components they want to discuss, but it is recommended that speakers focus, at minimum, on drawing participants’ attention to the barriers under “Opportunity” as these are specific issues that an organization may want to begin to consider in the hopes of reducing any impact on attendance. These are also some aspects of engagement that have previously been focused on in the presentation, such as “homelessness.”

(Notes for slide 61, continued)

Slide 61: Key Influences on Attendance



REFERENCE:

Howarth, A., Apea ,V., Michie, S., Morris, S., Sachikonye, M., Mercer, C., Evans, A., Delpech, V., Sabin, C., & Burns, F. (2017) REACH: A mixed-methods study to investigate the measurement, prediction and improvement of retention and engagement in outpatient HIV care. *Health Services and Delivery Research*, 5(13).

REACH: Suggestions to Improve Engagement

- Text reminders and online appointments
- Information/welcome packets
- Pill organizers
- Education for providers outside the field of sexual health and HIV
- Clinics aimed at specific groups
- Welcome receptionists and consultation when nonadherence occurs
- Peer support
- Advisors to give practical social support
- Flexible weekend and evening hours
- Transportation for individuals with disabilities

SOURCE: Howarth et al., 2017

Slide 62: REACH: Suggestions to Improve Engagement

This slide presents recommendations from the results of the REACH study on how to improve engagement with individuals coming into care at your facility. One recommendation that is discussed in other parts of the training is to utilize technology in order to provide reminders or give updates on appointments and scheduling. Flexibility in hours and providing some transportation to individuals with difficulty getting to the clinic/organization help to enhance engagement. Peer support, advisors, and consultants dedicated to enhancing education and a welcoming approach are all critical in helping individuals feel valued in clinical interactions but also to receive necessary information in making choices about care.



REFERENCE:

Howarth, A., Apea, V., Michie, S., Morris, S., Sachikonye, M., Mercer, C., Evans, A., Delpech, V., Sabin, C., & Burns, F. (2017) REACH: A mixed-methods study to investigate the measurement, prediction and improvement of retention and engagement in outpatient HIV care. *Health Services and Delivery Research*, 5(13).

NIATx: Reducing Barriers in Substance Use Treatment

- Have regular conversations about barriers
- Consider outreach efforts that are not tied to a physical location
- Utilize motivational interviewing-style scripts for initial interactions with clients
- Develop a system of assisting clients in anticipating and solving logistical problems as part of treatment planning and intervention
 - Transportation
 - Childcare
 - Ability to pay
 - Translation needs
 - Other appointment
 - Criminal justice system
 - Work schedules

Slide 63: NIATx: Reducing Barriers in Substance Use Treatment

Formerly the Network for the Improvement of Addiction Treatment, NIATx provides information to providers about process improvement and organizational change. One aspect of enhancing processes in community health clinics is to address barriers that arise in substance use treatment.

Recommendations from NIATx on how to reduce these barriers include: having conversations regularly about the barriers that are coming up – it will be easier to address specific barriers if they can be incorporated into treatment as an identified symptom of the individual’s substance use or mental health disorder or as an opportunity for case management; using outreach and case management that is not tied to one physical location but can exist within a client’s community; using motivational interviewing and developing scripts around discussions of change can help to enhance engagement and retention; as mentioned when discussing barriers, begin to anticipate the most common logistical problems that clients may encounter, including transportation issues, childcare issues, work schedules, and involvement with the criminal justice system.

(Notes for slide 63, continued)



Slide 63: NIATx: Reducing Barriers in Substance Use Treatment



REFERENCE:

Barriers to Treatment. (March 2018).

Retrieved from

<http://adai.uw.edu/retentiontoolkit/barriers.htm>.

Slide 64: [TRANSITION SLIDE]

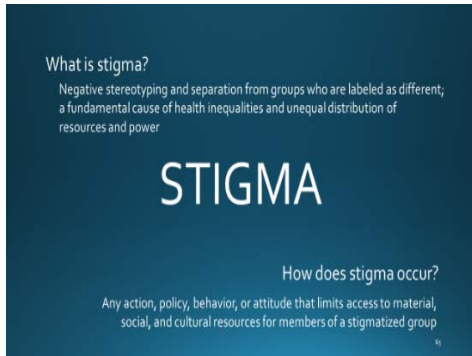
Counteracting Stigma

This section will define stigma and providing examples of ways that providers may (intentionally or unintentionally) perpetuate or contribute to feelings of stigma. The section still also provides suggestions on how to reduce stigma through changing vocabulary and what providers say, as well as discussing stigma with clients.



IMAGE CREDIT:

Fotolia, purchased image, 2017.



Slide 65: What is Stigma

This slide present broad definitions of what stigma is and how it can occur. Stigma is not limited to a particular group or a particular label. Individuals can experience stigma in multiple ways, depending on what groups they identify (or may not choose to identify).

Stigma and Health

- Stigma affects health through many, multidirectional pathways
- Perceived discrimination can affect health directly and indirectly through stress response
- Individuals experiencing devaluation and discrimination may cope with risky behaviors such as substance use
- Stigmatizing ideas motivate and justify discriminatory treatment
- Healthcare providers who hold stigmatizing beliefs are more likely to provide unequal care
- Education and employment stigmatization can lead to health disparities as well

SOURCE: Clair et al., 2016

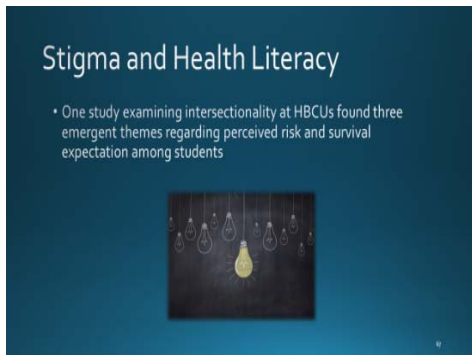
Slide 66: Stigma and Health

Stigma is a complex and confounding aspect of treatment in that, even if the practitioner is careful not to perpetuate stigma, it may still affect the engagement and willingness of the client to participate as fully as the practitioner may want. Stigma also impacts the experience of stress and can affect an individual's health either directly by preventing an individual from access care at a certain location; or indirectly through the stress response produced by having to confront devaluation. This stress response can push individuals in the direction of riskier coping mechanisms such as substance use. Education and employment stigmatization can lead to health disparities as well as limited opportunities in these areas can exacerbate devaluation or, more practically, deny the individual access to needed resources related to healthcare and well-being.



REFERENCE:

Clair, M., Daniel, C., & Lamont, M. (2016). Destigmatization and health: Cultural considerations and the long-term reduction of stigma. *Social, Science and Medicine*, 165, 223-232.



Slide 67: Stigma and Health Literacy

Among minority emerging adults, limited knowledge about the risk and impact of HIV is prevalent. This leads to a high rate of new diagnoses among this particular age group. The Get SMART Project aimed to gather information about the perspective of safe sex practices and substance use among young adults, particularly African-American youth between the age of 18-24 – 46% of 824 interviewed students at Historically Black Colleges and Universities (HBCUs) reported not using a condom during their last sexual intercourse. The researchers identified academic institutions as being a critical access point in on-going partnership to provide education around risk reduction to youth.



REFERENCES:

Bcheraoui, E., Sutton, M.Y., Hardnett, F.P., & Jones, S.B. (2013). Patterns of condom use among students at historically Black colleges and universities: Implications for HIV prevention efforts among college-age young adults. *AIDS Care, 25*(2), 186-193.

(Notes for slide 67, continued)

Slide 67: Stigma and Health Literacy



REFERENCES:

Edwards, L.V., Lindong, I., Brown, L., Hawkins, A.S., Dennis, S., Fajobi, O., Rowel, R., Braithwaite, R., & Sydnor, K.D. (2017). None of us will get out of here alive: The intersection of perceived risk for HIV, risk behaviors and survival expectations among African American emerging adults. *Journal of Health care for the Poor and Underserved, 28*(2), 48-68.

Theme 1: Stigma, Secrets and Satisfaction

- Knowledge of HIV status is critical for appropriate care and lowering likelihood of transmission
- Only 35% of young people 18-24 have ever had an HIV test
- Only 25% of sexually experienced youth have ever had an HIV test
- The combination of lack of perceived purpose to testing and not seeing oneself as at risk contributes to risky behaviors

SOURCE: Edwards et al., 2017

Slide 68: Theme 1: Stigma, Secrets and Satisfaction

The first emergent theme that researchers found revolved around stigma, secrets, and satisfaction. In particular, it is essential that individuals have knowledge of why understanding HIV status is critical and how knowledge of status can reduce likelihood of transmission with appropriate care. Only about one in three young people 18-24 have ever had an HIV test and only one in four sexually experienced youth have had an HIV test. Education should focus on reducing the perceived lack of purpose in testing. Not seeing oneself as being at risk also increased the potential for risky behavior.



Additional information for trainers:
This slide includes two quotes from the study specifically related to Theme 1. These quotes are incorporated into a handout (see page 154 of trainer guide) given to participants and referenced on Slide 71 to discuss how a provider might approach dispelling myths in conversation with clients.

(Notes for slide 68, continued)

Slide 68: Theme 1: Stigma, Secrets and Satisfaction

Quote 1: *“I prefer not know my HIV status. I am satisfied not knowing and life is easier that way. What you don’t know can’t hurt you. If a person doesn’t look right, I won’t have sex with them unless I am smoking weed or maybe high. Some of the main reason why people don’t get tested is because they don’t want to know if they have HIV. Plus, we don’t see ourselves at risk. The people I hang out with are okay. They are clean. HIV ain’t that big of a problem. Don’t they have pills that will take care of it anyways? This is information that I really don’t need to know.”*

Quote 2: *“Getting tested for HIV is my business. Nobody needs to know that information but me and who I am having sex with at the moment, if I chose to tell them. These people are nosey and all up in your business!! All you need is for someone to find out your HIV status and it’s all over the news. Hell no, I am not taking that chance. Whatever my HIV status is my secret and I will tell only when I feel like it. More people should be like me. Just have sex, get high, smoke a little and have some juice, enjoy yourself, and live life. If I were positive, I don’t think I would tell. And, that’s really easy and all I have to say about it.”*

(Notes for slide 68, continued)

Slide 68: Theme 1: Stigma, Secrets and Satisfaction



REFERENCE:

Edwards, L.V., Lindong, I., Brown, L., Hawkins, A.S., Dennis, S., Fajobi, O., Rowel, R., Braithwaite, R., & Sydnor, K.D. (2017). None of us will get out of here alive: The intersection of perceived risk for HIV, risk behaviors and survival expectations among African American emerging adults. *Journal of Health care for the Poor and Underserved, 28*(2), 48-68.

Theme 2: Living in the Moment

- Uncertain survival expectations are emerging as an indicator of adolescent pessimism, particularly among African-American youth
- This is contrary to the belief that young individuals see themselves as invincible and living forever
- Survival expectations have been linked to problem behaviors such as weapon use, unsafe sexual behaviors, substance use, HIV transmission and fast food consumption

SOURCE: Edwards et al., 2017

Slide 69: Theme 2: Living in the Moment

The second theme that researchers noted in talking with youth about HIV risk was “Living in the Moment.” This spoke to uncertain survival expectations as an emerging indicator of adolescent pessimism, particularly among African-American youth. This seems to run contrary to the belief that young people see themselves as invincible and living forever. This survival expectation and foreshortened sense of future has been linked to additional impulsive and problematic behaviors such as unsafe sexual behaviors, substance use, HIV transmission and unhealthy diet. Consider the way in which this perspective is related to the shifted Maslow’s Hierarchy of Needs on Slide 24 and aspect of community safety.



Additional information for trainers:

This slide includes two quotes from the study specifically related to Theme 1.

These quotes are incorporated into a handout (see page 154 of trainer guide) given to participants and referenced on Slide 71 to discuss how a provider might approach dispelling myths in conversation with clients.

(Notes for slide 69, continued)

Slide 69: Theme 2: Living in the Moment

Quote 3: *"I know people living with HIV and they look okay to me. I like having sex and I like it with different girls and sometimes I don't have condoms on me. Condom use or lack of condom use communicates different message to people, you know what I mean. I live for this moment and if I get offered sex, I am taking it and probably without a condom. I just don't see myself at risk for HIV anyways. I can't worry about something that may never happen. You have to get what you can whenever you can. Life is short. And, I just want to have a good time."*

Quote 4: *"I have the desire for immediate gratification and to get what I can right now!!! I don't care about anything except what I want. I know that sounds selfish! It's dope when you can live life the way you want while you're here. I know too many friends that are gone. They are dead!! Almost every week, every day, somebody gets killed or hurt real bad in a fight or something. I need to get mine now!! Sex helps you get through the day and deal with stress. If I have a condom, I may or may not use it. It really depends but if I am high, I might forget to practice safe sex."*

(Notes for slide 69, continued)

Slide 69: Theme 2: Living in the Moment



REFERENCE:

Edwards, L.V., Lindong, I., Brown, L., Hawkins, A.S., Dennis, S., Fajobi, O., Rowel, R., Braithwaite, R., & Sydnor, K.D. (2017). None of us will get out of here alive: The intersection of perceived risk for HIV, risk behaviors and survival expectations among African American emerging adults. *Journal of Health care for the Poor and Underserved, 28*(2), 48-68.

Theme 3: Millennial Melancholy

- Homelessness and fear of community or police violence is an emergent theme
- Hopelessness was associated with inconsistent condom use, multiple sex partners, and increase alcohol and substance use
- Long term goals are replaced by short-term, immediate gratification focuses
- Immediate needs become emergent and planning for the future becomes a lower priority

SOURCE: Edwards et al., 2017

Slide 70: Theme 3: Millennial Melancholy

The last theme that emerged from the study focused on “Millennial Melancholy,” specifically related to aspects of the modified Maslow’s Hierarchy of Needs on Slide 24. Issues related to housing and homelessness and fear of community or police violence were noted frequently. The hopelessness that resulted from this anxiety was associated with increased risky sexual behaviors and substance use. The focus was less on planning for the future and immediate gratification became the driving force in decision making.



Additional information for trainers:
This slide includes two quotes from the study specifically related to Theme 3. These quotes are incorporated into a handout (see page 154 of trainer guide) given to participants and referenced on Slide 71 to discuss how a provider might approach dispelling myths in conversation with clients.

(Notes for slide 70, continued)

Slide 70: Theme 3: Millennial Melancholy

Quote 5: *“My father is responsible for paying our rent. Sometimes he pays and sometimes he may miss a month or two. I never know how things are going to be around here. Therefore, I take it one day at time. We have come so close to being evicted and one day I know it’s going to happen. That’s a fear I that I am often faced with. I have to think about what I have right here and right now and that’s just the way it is. Sometimes, I can understand why people trade sex for different things. At least they may hook up with someone and have a nice place to stay. I know of people who trade sex for different things (e.g., money, food, clothes, and gifts) but I don’t want to do that. I want more for my life.”*

Quote 6: *“Last year my cousin was shot in the leg while coming home from a party. He didn’t know the guy but the guy just shot him for no reason. People out here are crazy and tripping. You never know when you may catch a bullet, fist, stick, or knife. This is crazy and I am supposed to worry about an STD or HIV?”*

(Notes for slide 70, continued)

Slide 70: Theme 3: Millennial Melancholy



REFERENCE:

Edwards, L.V., Lindong, I., Brown, L., Hawkins, A.S., Dennis, S., Fajobi, O., Rowel, R., Braithwaite, R., & Sydnor, K.D. (2017). None of us will get out of here alive: The intersection of perceived risk for HIV, risk behaviors and survival expectations among African American emerging adults. *Journal of Health care for the Poor and Underserved, 28*(2), 48-68.

Activity

- Choosing one of the six quotes presented above, how would you initiate a conversation with this individual to try to correct misinformation and highlight the importance of safe sexual and substance use practices?

Slide 71: Activity



Referring to the handout (see page 154 of the trainer guide) with the six quotes from the previous slides, ask participants to get into groups of 4-6 and discuss one of the quotes (consider assigning quotes to groups rather than letting groups choose, depending on the size of the training). Once they've discussed the quote, ask them to consider how they might initiate a conversation with this individual to try to engage them in treatment by reducing misinformation around risky behaviors in a way that could enhance engagement. This activity lasts 5-10 minutes, depending on number of participants.

Counteracting stigma

- Stigma occurs when someone holds a negative opinion or attitude toward others; in this case, PLWHA, someone with a mental illness and or substance use
- Stigma is a complicated problem with no easy solutions
- One way to counteract stigma is to provide education and getting to know someone who has a particular illness
- Stigma can create additional obstacles and stressors in the general public

Slide 72: Counteracting Stigma

The recommendations for counteracting stigma begin with a recognition that stigma can occur whenever someone holds a negative opinion or attitude towards others. For the purposes of this presentation, we are focusing specifically on people living with HIV/AIDS, someone with a mental illness or someone using substances. One way to begin to counteract stigma is to provide education to others about what it means to live with a particular illness. Without the opportunity for education and getting to know someone living with a particular illness, misinformation is perpetuated that can have detrimental impacts on individuals in the general public.

Counteracting stigma

- Become educated about HIV, substance use, and mental illness; the symptoms, course of illness, and treatment options
- Possible to correct misinformation by providing information about a personal experience of working with or living with HIV, a mental illness, or substance use
- Disclose information to counteract stigma selectively
- Become aware of legal rights and advocacy support

Slide 73: Counteracting Stigma



Read through each of the suggestions listed for counteracting stigma. Emphasize the importance of education and, for healthcare staff in particular, training.

Conditions for Stigma Reduction

1. The credibility of new constructions – that is, the apparent “truthfulness” of new information and the perception of the individuals distributing the information (status and visibility)
2. The interaction of new constructions with existing ideologies
3. The inherent linkage between the stigmatized group and the dominant group – a common drive or “fate”

SOURCE: Claret et al., 2016

Slide 74: Conditions for Stigma Reduction

Three conditions have to be present in order to begin to reduce stigma. These are conditions that can be adopted within an organization or broader as a community.

The first of these is the status and visibility of new conceptualizations regarding expectations of what it means to be living with HIV/AIDS or a substance use disorder.

Who is distributing the information and are they a trustworthy source of information? If the individual is credible, the information they are presenting is more likely to be adopted and take root in the general public. For example, to the general public in the 90s, the highest profile individual living with HIV was Magic Johnson. Since that time, he has come to be identified publically not by his diagnosis but for the number of public initiatives he has worked on in and around Los Angeles. This type of “good will” towards an identified figure living with a particular illness can help to integrate new information to destigmatize misinformation in the general public.

The second of the conditions is the interaction of new constructions with existing ideologies. Meaning, how do new conceptualizations that are presented fit with existing ideologies held by the targeted audience.

(Notes for slide 74, continued)

Slide 74: Conditions for Stigma Reduction

Ease of integration will indicate whether or not the new constructions will be easily adopted. Early in the development of rights laws related to individuals living with AIDS, policy makers and supporters of equal rights had to frame the right to equal treatment within existing frameworks of other, previously established marginalized groups with disabilities.

The last is the ability to tie the stigmatized group and the dominant group together to begin to reduce the ostracizing that a stigmatized group may experience. The “common fate” may also help to normalize individuals diagnosed with a particular illness as not being inherently different from other (“majority”) group in public. For example, public health initiatives and messaging that clarify the narrative of HIV/AIDS as a viral condition, not as a “gay condition” tied fates together in the general public.



REFERENCE:

Clair, M., Daniel, C., & Lamont, M. (2016). Destigmatization and health: Cultural considerations and the long-term reduction of stigma. *Social, Science and Medicine*, 165, 223-232.

Stigma Reduction Strategies

1. Change cultural constructions by using social actors to enhance equivalencies between PLWH and general population (accomplished by counselors, doctors, lawyers, policy makers, journalists, media, etc.)
2. Enhance awareness of basic rights with materials that specifically include HIV-specific education; engage family and community support to implement policy-driven interventions that increase normative responses and grassroots actions
3. Address inequities within healthcare settings and institutional culture, examining factors that perpetuate stigma at individual, environmental, and societal levels

SOURCE: Clair et al., 2016

Slide 75: Stigma Reduction Strategies

Based on these conditions for reducing stigma, three actions are presented to guide stigma reduction as a social level.

The first of which is to use identified social actors that have high visibility and high credibility in a particular community. The second is to enhance awareness of basic rights from a grassroots action standpoint that seeks to engage families and community members in understanding HIV-specific issues. The last is the address healthcare inequities through institutional policies and culture; ensuring that any actions are consistent with the expectations of the overall organization and reduce stigma towards patients.



REFERENCES:

Chambers, L., Rueda, S., Baker, D. N., Wilson, M., Deutsch, R., Raeifar, E., Rourke, S., & The Stigma Review Team. (2015). Stigma, HIV, and health: A qualitative synthesis. *BMC Public Health*, *15*(848), 1-17.

Clair, M., Daniel, C., & Lamont, M. (2016). Destigmatization and health: Cultural considerations and the long-term reduction of stigma. *Social, Science and Medicine*, *165*, 223-232.

(Notes for slide 75, continued)



Slide 75: Stigma Reduction Strategies



REFERENCES:

Thapa, S., Hannes, K., Cargo, M., Buve, A., & Mathei, C. (2015). Effect of stigma reduction intervention strategies on HIV test uptake in low and middle-income countries: A realist review protocol. *Systematic Reviews, 4*, 142.

Slide 76: [TRANSITION SLIDE]

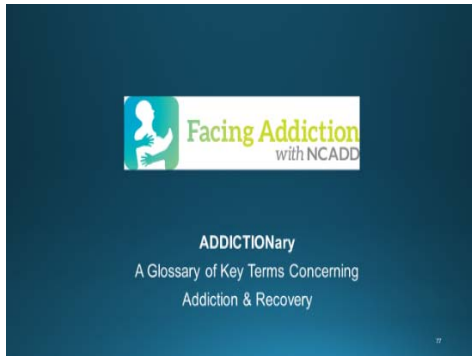
Counteracting Stigma

This section will provide recommendations to providers on how to counteract stigma using language that is person-centered.



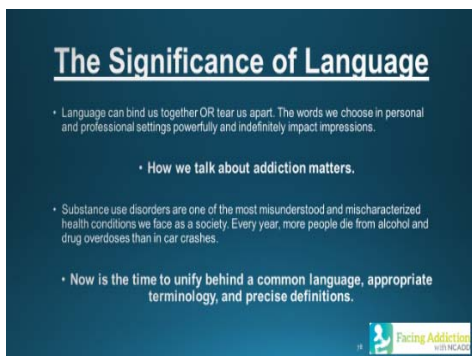
IMAGE CREDIT:

Fotolia, purchased image, 2017.



Slide 77: Facing Addiction

The “ADDICTIONary” is a presentation developed by the National Council on Alcoholism and Drug Dependence, designed to describe the way language changes and current terms that are used in substance use treatment to reduce stigma between providers and clients. Terms are constantly evolving, so it is important that providers approach interactions with an open-mind and continue to educate themselves.



Slide 78: The Significance of Language

Recognizing the significance of language is critical in being able to reduce stigma and engage individuals in treatment. Words matter – this is true regardless of the presenting problems someone describes when coming to treatment. Substance use, like HIV/AIDS, is one of the more misunderstood and mischaracterized health conditions. Using person-centered and unified language helps to clarify misconceptions and reduce misinformation.

SOURCE CREDIT:

Facing Addiction with the National Council on Alcoholism and Drug Dependence, 2018.

The Negative Power of Stigma

- One can argue that no other medical condition is shrouded in stigma like that of substance use disorders. This harmful stigma affects those who are suffering, their loved ones, and often numerous others connected to the individual.
- Sadly, it is often due to this stigma that those in need of treatment do not seek medical attention.
- The language we all use can play a significant role in stigma reduction – but too often, inappropriate use of language unintentionally strengthens the harmful effects of the disorder.



Slide 79: The Negative Power of Stigma

Building upon previously discussed aspects of stigma, is it easy to understand that if an individual were to come to treatment and be confronted with judgement and blaming language, they would be less likely to engage with the provider in that interaction and unlikely to ever return for follow-up. This has relevance for the way we advertise and describe our services before someone even comes in for treatment. If they feel that they won't be granted privacy or experience shame even considering approaching a treatment facility, it will be difficult to get that individual engaged in services.

SOURCE CREDIT:

Facing Addiction with the National Council on Alcoholism and Drug Dependence, 2018.

 **The Real Stigma of Substance Use Disorders**

In a study by the Recovery Research Institute, participants were asked how they felt about two people "actively using drugs and alcohol."

One person was referred to as a "substance abuser"



The other person as "having a substance use disorder"



No further information was given about these hypothetical individuals.

THE STUDY DISCOVERED THAT PARTICIPANTS FELT THE "SUBSTANCE ABUSER" WAS:

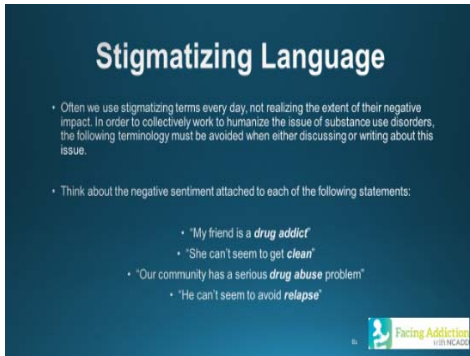
- less likely to benefit from treatment
- more likely to benefit from punishment
- more likely to be socially threatening
- more likely to be blamed for their substance related difficulties and less likely that their problem was the result of an innate dysfunction over which they had no control
- they were more able to control their substance use without help

Slide 80: The Real Stigma of Substance Use Disorders

While it is intuitive that providers should use person-centered language in talking with individuals, research has actually demonstrated the detrimental impact of not using person-centered language. In a study, one individual was referred to as a "substance abuser" while the other was referred to as "having a substance use disorder." In gathering feedback about the two individuals, participants demonstrated biases based on these descriptors alone. The "substance abuser" was viewed as being less likely to benefit from treatment, more likely to benefit from punishment, more likely to be threatening, more likely to be blamed for substance-related difficulties, and more able to control their substance use without help. If each of these biases were held (consciously or unconsciously by a provider), they could impact treatment and engagement in significant ways.

SOURCE CREDIT:

Facing Addiction with the National Council on Alcoholism and Drug Dependence, 2018.



Slide 81: Stigmatizing Language

Consider the way that we might use stigmatizing language in everyday conversation without realizing it due to the term being commonplace in social interactions. However, there could easily be a perceived negative sentiment or judgement attached to those terms.

Consider that in each of the phrases on the slide. For example, "My friend is a drug addict" is a very stigmatizing term that will instantly lead individuals to perceive the friend in an overwhelmingly negative way while giving no real substantive diagnostic information about the individual's functioning.

SOURCE CREDIT:

Facing Addiction with the National Council on Alcoholism and Drug Dependence, 2018.

Correcting our Language

STIGMATIZING	CORRECTED
ABUSER, ADDICT, ALCOHOLIC	A PERSON WITH A SUBSTANCE USE DISORDER
CLEAN	A STATE OF A PERSON IN ABSTINENCE OR IN RECOVERY, NEGATIVE URINE SCREENS
DIRTY	A STATE OF NON-ABSTINENCE OR A PERSON NOT YET IN RECOVERY, POSITIVE URINE SCREENS
SUBSTANCE ABUSE	SUBSTANCE USE DISORDER
RELAPSE, LAPSE	A RECURRENT OF SYMPTOMS
DRUG REPLACEMENT THERAPY	MEDICATION FOR



Slide 82: Correcting our Language



Read through the slide, noting the stigmatizing language on the left and the corrected, less stigmatizing term on the right.

Additional information for trainers:

The term “substance abuse” may still be used if a study was done using the DSM-IV-TR criteria for diagnosis and that aspect of the study is specifically noted. However, current terminology indicates a range of “substance use disorders” without the inclusion of the outdated “abuse” or “dependence” identifiers.

SOURCE CREDIT:

Facing Addiction with the National Council on Alcoholism and Drug Dependence, 2018.

	STOP	GO	WHY	
<i>Let's Stop HIV Together</i>	These words and phrases can cause people to experience stigma, may lead to discrimination, and may be incorrect.	Use these words and phrases when talking about HIV. They are correct and nonstigmatizing.	Be aware of why these words or phrases are problematic. Get the facts.	
<i>A Guide to Talking About HIV</i>	X Body fluids	<ul style="list-style-type: none"> ✓ Blood ✓ Amniotic fluid ✓ Semen 	<ul style="list-style-type: none"> ✓ Pre-ejaculate ✓ Breast milk ✓ Vaginal fluids 	Only some body fluids transmit HIV. "Body fluids" covers all fluids coming from the body and not just those involved in HIV transmission. Be specific if you can.
	X To battle HIV and/or AIDS X War against HIV/AIDS	<ul style="list-style-type: none"> ✓ Response to HIV and AIDS 	These terms may be considered militaristic and may lead others to think that people living with HIV have to be "fought" or eliminated.	
	X High(risk) groups) X Groups with high-risk behavior	<ul style="list-style-type: none"> ✓ High-risk behavior (condomless sex, sharing needles, etc.) ✓ Highly-affected communities ✓ Key populations ✓ Key populations at higher risk 	These terms imply that membership in a particular group can result in an HIV-positive diagnosis. They may also provide a false sense of security to those who do not self-identify with one of these groups.	
	X AIDS (when referring to the virus, HIV)	<ul style="list-style-type: none"> ✓ HIV ✓ HIV and AIDS (when referring to both) 	AIDS itself is not a condition. It is a range of conditions, or a syndrome, that occurs when a person's immune system is weakened by the HIV infection.	

Slide 83: Let's Stop HIV Together



****ANIMATION****

Upon click, the image will animate to reveal the second part of this chart with additional recommendations for modifying language.

While NCADD had developed a guide to talking about substance use issues using less stigmatizing language, the CDC has also developed a guide for using less stigmatizing language when talking about HIV and AIDS. In addition to more accessible terms, the guide provides context in the "WHY" column as to why the shift has occurred in order for providers to educate themselves and provide some context for education to clients if applicable.



REFERENCE:

A Guide To Talking About HIV. Center for Disease control and Prevention. Retrieved from:
<http://www.cdc.gov/actagainstaids/pdf/campaigns/lsht/cdc-hiv-togetherstigmalinguageguide.pdf>



Slide 84: [TRANSITION SLIDE]

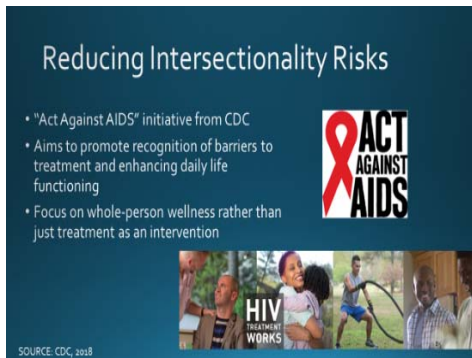
Interventions to Promote Change

This section will begin to discuss recommendations for promoting behavior change among individuals coming in to HIV care. While this section is primarily focused on HIV care, substance use treatment resources may be embedded in programs and practice recommendations.



IMAGE CREDIT:

Fotolia, purchased image, 2017.



Slide 85: Reducing Intersectionality Risks

In considering the impact of intersectionality described previously, the CDC has a publicly-available, comprehensive initiative called “Act Against AIDS” that is designed to promote awareness, identification, and access to individuals around HIV and AIDS. The focus is on shifting towards whole-person wellness rather than just treatment as an intervention.



REFERENCE:

HIV Treatment Works. 2018. Center for Disease Control and Prevention. Retrieved from:

<http://www.cdc.gov/actagainstaids/campaigns/hivtreatmentworks/index.html>.



IMAGE CREDIT:

<https://www.cdc.gov/hiv/library/infographics/index.html>, 2018.



Slide 86: HIV Treatment Works Video



****ANIMATION****

Upon click, the first video will play full-screen. Once the video has played all the way through, click again to advance the slide and play the second video. This slide contains a movie clip that will play when the trainer advances the slide. In order for this to work, the connection between the PowerPoint presentation and the video file must be maintained. When moving the PowerPoint file to another location on your computer, or to another computer, make sure to always move the video file along with it.

If the link becomes broken, the video will need to be reinserted. Delete the image and gray box. From the insert menu in PowerPoint, select "movie." Select the video file that was included for this training. When asked, indicate that the movie should play automatically. It will appear as a black box on the screen. This video should play when the slide show is being viewed when the trainer clicks on the black box.

(Notes for slide 86, continued)

Slide 86: HIV Treatment Works Video

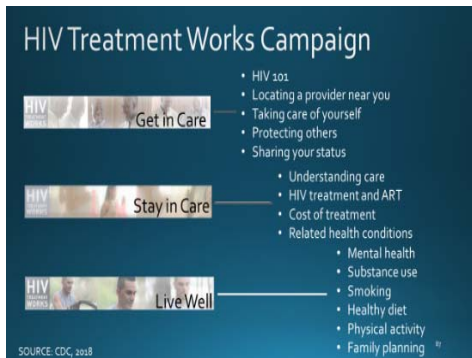
The first video is a short clip on promoting health behaviors for the whole person. The second clip incorporates patient testimonial about the importance of care and how care can be effective. It is important to note that while these are useful tools to increase awareness, these may not be the typical experiences of every client a participant has worked with.



VIDEO SOURCE:

HIV Treatment Works. 2018. Center for Disease Control and Prevention. Retrieved from:

<http://www.cdc.gov/actagainststids/campaigns/hivtreatmentworks/index.html>.



Slide 87: HIV Treatment Works Campaign



****ANIMATION****

Upon click, the items related to “Get in Care” will animate in and a line connecting the box to the bulleted points will appear. Advancing again will cause that section to gray out while the next box and bulleted items animate in. This continues for the third box upon advancing.

Within the HIV Treatment Works compendium, there are a number of resources for providers. They are broken into multiple categories, three of which are presented on this slide. The program provides recommendations to providers and potential clients on how to understand the need for care, how to stay in care and other aspects related to wellness.



REFERENCE:

HIV Treatment Works. 2018. Center for Disease Control and Prevention. Retrieved from:

<http://www.cdc.gov/actagainstaids/campaigns/hivtreatmentworks/index.html>.

HIV Treatment Works: Other Components

- Resources
 - How to find a doctor
 - Finding support services
 - Hotlines
 - Paying for Care
 - Older Adults
 - US Epidemic
- Resources for Providers
 - Co-occurring issues (co-infections, substance use, mental health, etc.)
 - Prevention, Testing, and Treatment Campaigns

SOURCE: CDC, 2018

Slide 88: HIV Treatment Works: Other Components

Other aspects related to care include utilizing resources. Finding a doctor or getting additional supports are aspects of engagement that have previously been discussed in this training as contributing to better engagement and retention. Utilizing the website may be useful for providers to orient themselves to available resources in their community and how to encourage clients to access them.



REFERENCE:

HIV Treatment Works. 2018. Center for Disease Control and Prevention. Retrieved from:

<http://www.cdc.gov/actagainststids/campaigns/hivtreatmentworks/index.html>.



Slide 89: HIV Treatment Works: Campaigns



****ANIMATION****

Upon click, the banners will animate in from left to right. This slide present examples of available web banners and print posters to use in enhancing awareness or advertising treatment.

Identifying Best Practices in HIV Care

- CDC conducted meta analysis of over 12,000 reports on engagement strategies, identifying five evidence-based interventions (EBIs) for engagement in care
- Criteria was to identify best practice for linkage to, retention, or re-engagement in HIV care (LRC)
- Examined a set of evidence-informed interventions that were not as rigorously evidence-based as the EBI condition
- None of the studies identified a re-engagement component

SOURCE: Higa, et al., 2016

Slide 90: Identifying Best Practices in HIV Care

The CDC has identified a number of best practice recommendations from a meta-analysis on over 12,000 reports of engagement strategies. From this meta-analysis, a recommendation for the five best evidence-based interventions (EBIs) emerged to engage individuals in HIV care. The study also identified a set of evidence-informed interventions that are promising and could yield enhance engagement, but the studies themselves were not as rigorously evaluated as the EBI conditions. It is also important to note that none of the studies included re-engagement following loss of contact or discontinuation as a component of engagement.



REFERENCE:

Higa, D.H., Crepaz, N., Mullins, M.M., & The Prevention Research Synthesis Project. (2016). Identifying best practices for increasing linkage to, retention, and re-engagement in HIV medical care: Findings from a systematic review, 1996-2014. *AIDS and Behavior*, 20, 951-996.

Identifying Best Practices in HIV Care

- ARTAS: focus on building rapport, establishing a linkage coordinator who: encourages recognition of strengths to link to care, coordinates links between patient and community resources, advocates for medical care
 - Timeline: 5 sessions in 90 days or until individual is linked
- Retention through enhanced personal contacts: an interventionist meets clients at medical visits; calls between visits to provide encouragement and answer questions about medical visits; build skills in personal organization; develops plan to address unmet needs; helps client use personal strengths to accomplish goals
 - Timeline: brief face-to-face meeting and phone calls over 1 year

SOURCE: Higa et al., 2015

Slide 91: Identifying Best Practices in HIV Care

The first of the best practices in HIV care recommended by the CDC is ATRAS – anti-retroviral treatment and access to services. This intervention is focused specifically on building rapport and establishing linkage through a linkage coordinator. This individual encourages recognition of strengths and is able to link the individual, following assessment, to community resources that will assist in enhancing access to medical services. The typical timeline for this intervention is 5 sessions over a period of 90 days or until the individual is successfully linked.

The second recommended practice is designed to focus on retention through enhancing personal contacts between an interventionist and a client who meet during medical visits and talk on the phone between sessions. This individual will assist in any linkage issues, including case management around planning and organization to attend critical sessions. This intervention also uses a strengths-based focus for engagement and identification of goals. The timeline for this intervention is one year.

(Notes for slide 91, continued)

Slide 91: Identifying Best Practices in HIV Care



REFERENCE:

Higa, D.H., Crepaz, N., Mullins, M.M., & The Prevention Research Synthesis Project. (2016). Identifying best practices for increasing linkage to, retention, and re-engagement in HIV medical care: Findings from a systematic review, 1996-2014. *AIDS and Behavior*, 20, 951-996.

Identifying Best Practices in HIV Care

- Buprenorphine treatment: physician and nurse with substance use training provide buprenorphine treatment within an HIV clinic, offering doses and providing counseling; conduct regular drug testing
 - Timeline: step down from induction (daily) to on-going weekly or monthly sessions
- Extended counseling: trained counselor or community support worker provides counseling in HIV disclosure, healthy living, importance of medical care, home visits to enhance motivation for medical care
 - Timeline: one HIV post-test session and monthly 2-hour counseling sessions

SOURCE: Higa et al., 2016

Slide 92: Identifying Best Practices in HIV Care

Buprenorphine will be discussed later in the training as well, but the use of this medicine is useful in enhancing engagement with a nurse or physician in an HIV clinic in which an individual can receive doses and counseling with regular drug testing. The timeline for this intervention varies with initial daily administration to on-going weekly or monthly sessions.

Extended counseling is an intervention that involves a trained counselor providing on-going HIV-related care and focusing on aspects of healthy living and motivation for medical care. The timeline is monthly 2-hour long sessions.



REFERENCE:

Higa, D.H., Crepaz, N., Mullins, M.M., & The Prevention Research Synthesis Project. (2016). Identifying best practices for increasing linkage to, retention, and re-engagement in HIV medical care: Findings from a systematic review, 1996-2014. *AIDS and Behavior*, 20, 951-996.

Identifying Best Practices in HIV Care

- Virology fasttrack: Clinical decision support system generates interactive alerts in health care provider's EHR to notify provider of missed appointments and new laboratory toxicities; allows providers to easily schedule follow-up appointments and tests
 - Timeline: on-going

SOURCE: Higa et al., 2016

Slide 93: Identifying Best Practices in HIV Care

Virology fasttrack utilizes electronic health records in order to provide regular updates to providers regarding relevant laboratories, follow-up appointments, and needed tests. Integration with notification systems in an existing electronic health record automates the alerts to free up other organizational resources. The timeline is on-going.



REFERENCE:

Higa, D.H., Crepaz, N., Mullins, M.M., & The Prevention Research Synthesis Project. (2016). Identifying best practices for increasing linkage to, retention, and re-engagement in HIV medical care: Findings from a systematic review, 1996-2014. *AIDS and Behavior*, 20, 951-996.

The ACCEPT Model

- Group-based intervention targeted to early intervention with newly diagnosed, gender-specific youth
- In 2013, only 78% of youth diagnosed with HIV were linked to care within three months of diagnosis
- Only 52% were retained in care
- The goal of ACCEPT was to enhance engagement and retention for a vulnerable population

SOURCE: Hosek et al., 2018

Slide 94: The ACCEPT Model

One additional recommendation for intervention is the ACCEPT Model. The ACCEPT Model is a group-based intervention that is specifically targeted towards newly diagnosed, gender-specific youth. ACCEPT grew out of recognition that in 2013, only 78% of youth diagnosed with HIV were actually linked to care and only 52% were retained in care. The intent of the group format was to enhance engagement and retention for this particular vulnerable population.



REFERENCE:

Hosek, S.G., Harper, G.W., Lemos, D., Burke-Miller, J., Lee, S., Friedman, L., & Martinez, J. (2018). Project ACCEPT: Evaluation of a group-based intervention to improve engagement in care for youth newly diagnosed with HIV. *AIDS and Behavior*, doi: 10.1007/s10461-018-2034-4. [Epub ahead of print]. Retrieved from: <http://link.springer.com/content/pdf/10.1007%2Fs10461-018-2034-4.pdf>.

The ACCEPT Model

- Consists of six group sessions and three total individual pre- and post-group sessions
- Outcomes focused on:
 - Influence engagement in care
 - Adherence to treatment
 - Decreased psychosocial barriers
 - Enhance HIV awareness of stigma, knowledge, and social support
- When compared to a general health and wellness intervention, ACCEPT participants
 - were 2.3x more likely to take HIV medications over a 12-month period
 - demonstrated earlier viral load decline and improvement in CD4
 - were equally likely to indicate decreases in psychosocial distress

SOURCE: Hosek et al., 2018

Slide 95: The ACCEPT Model

The ACCEPT Model consisted of six group sessions and three individual sessions (pre and post). The groups were identified as being gender-specific to focus on engagement and opportunities to identify gender-specific health issues. The outcomes of the groups were focused on enhancing engagement and adherence to treatment, decreasing barriers, and improving education about stigma and social supports. In general, outcomes showed that ACCEPT participants were 2.3 times more likely to take HIV medication over a 12-month period. These participants also demonstrated earlier viral load decline. The participants were equally likely to indicate decreases in overall psychosocial distress ratings.



REFERENCE:

Hosek, S.G., Harper, G.W., Lemos, D., Burke-Miller, J., Lee, S., Friedman, L., & Martinez, J. (2018). Project ACCEPT: Evaluation of a group-based intervention to improve engagement in care for youth newly diagnosed with HIV. *AIDS and Behavior*, doi: 10.1007/s10461-018-2034-4. [Epub ahead of print]. Retrieved from: <http://link.springer.com/content/pdf/10.1007%2Fs10461-018-2034-4.pdf>.

The ACCEPT Model

- Individual session 1 (pre-group): identification of support; meeting with medical provide to ask questions
- Individual session 2 (pre-group): review of medical provider meeting; prep for group experience; meet with peer facilitator
- Group Session 1: HIV overview
- Group Session 2: disclosure and stigma
- Group Session 3: preparing for medical intervention/adherence
- Group Session 4: health living and substance use
- Group Session 5: HIV-positive sexuality and reproduction (gender-specific)
- Group Session 6: goal setting and self-esteem
- Individual session 3 (post-group): discussion of experience, road map for future, facilitate referrals, identify social support

SOURCE: Hosek et al., 2018

Slide 96: The ACCEPT Model

The format of the ACCEPT model broke down into two individual pre-group sessions that focused on introducing the purpose of the group and giving participants opportunities to ask questions. The first group session provided an overview of HIV, the second on disclosure and stigma, and the third on medical intervention and adherence. Session four, five, and six enhance aspects of healthy living, including substance use issues, positive sexuality, and self-esteem. The final session was an individual session post-group that summarized experiences in group and developed a future plan for on-going support.



REFERENCE:

Hosek, S.G., Harper, G.W., Lemos, D., Burke-Miller, J., Lee, S., Friedman, L., & Martinez, J. (2018). Project ACCEPT: Evaluation of a group-based intervention to improve engagement in care for youth newly diagnosed with HIV. *AIDS and Behavior*, doi: 10.1007/s10461-018-2034-4. [Epub ahead of print]. Retrieved from: <http://link.springer.com/content/pdf/10.1007%2Fs10461-018-2034-4.pdf>.



Slide 97: [TRANSITION SLIDE] Interventions to Promote Change

This section will begin to discuss recommendations for promoting behavior change among individuals seeking substance use disorder treatment. While this section is primarily focused on substance use disorder treatment, HIV treatment resources may be embedded in programs and practice recommendations.



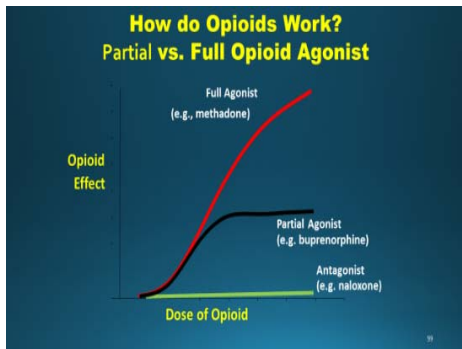
IMAGE CREDIT:

Fotolia, purchased image, 2017.



Slide 98: Approved Medications for Treatment

This slide presents two different categories of medications that can be used to treat alcohol use disorders and opioid use disorders. The medications for alcohol use disorder are acamprosate, naltrexone, disulfiram, and extended-release naltrexone. The medications approved for opioid use disorders are naltrexone, methadone, buprenorphine, and buprenorphine/naloxone combinations. While these medications have different physiological and neurochemical effects, all have been thoroughly researched and demonstrated efficacy in managing symptoms and improving functioning.



Slide 99: How do Opioids Work?

This slide graphically depicts the different types of opioids (whether they are prescribed medications such as Vicodin or methadone, or an illicit substance, like heroin).



Move forward to reveal first line (full agonist)

Full agonists (e.g., heroin, opium, Vicodin, methadone, etc.) fully activate the receptors so that the more you use, the more effect you experience. If someone continues to use, they will eventually experience overdose and, possibly, death.



The following metaphor may be helpful in explaining the differences between the types of opioids:

Opioid agonists work like having the right key to a door. You put the key in the lock, the lock turns and the door opens completely.

(Notes for slide 99, continued)

Slide 99: How do Opioids Work?



Move forward to reveal the next line (antagonists)

Opioid antagonists (e.g., naltrexone, naloxone) fill the receptors and block the action of other opioids. If the person has used an opioid agonist, the antagonist will replace it on the receptor and the person will experience withdrawal. If the person is stable on an antagonist, and uses another opioid, the antagonist will block the effects, preventing the user from experiencing the high.



The door metaphor continued:

Opioid antagonists work like having the wrong key to a door. You put the key in the lock; the door remains locked and will not open. Additionally, since the key is in the lock, no other key can be put in the lock (even if it is the right key for that door) until the wrong key is removed.

(Notes for slide 99, continued)

Slide 99: How do Opioids Work?



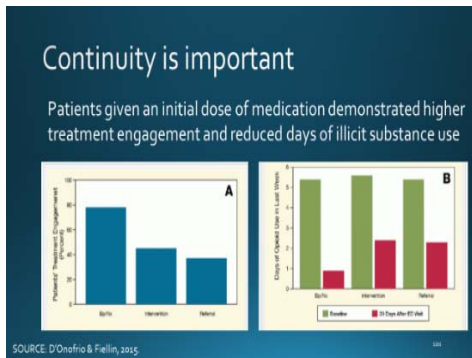
***Move forward to reveal the last line
(partial agonists)***

Opioid partial agonists (e.g., buprenorphine) are in the middle. At lower doses, they work just like agonists, filling the receptor and preventing withdrawal symptoms. However, as the dose increases, a ceiling effect occurs so that if more is used, no more effect is achieved. This ceiling effect applies both to opioid euphoria (they don't feel high), and to the respiratory suppression (making overdose less likely).



The door metaphor continued:

Opioid partial agonists work like having the right key to a door, but the chain is on the door. The key goes in and opens the door, but it will only open so far.



Slide 100: Continuity is Important

The main point of this slide is that individuals who were provided with medication-assisted treatment for substance use issues at intake showed a greater reduction in substance use and improved treatment engagement compared to individuals who just received an intervention or referral. Important to consider is that if we can effectively engage individuals using medicines that reduce unpleasant symptoms, they are more likely to be engaged and treatment compliant.

Additional information for trainers:

Drs. Gail D'Onofrio, David Fiellin, and colleagues at the Yale School of Medicine and School of Public Health screened 71,000 patients who presented for emergency care at a large urban hospital. Of 329 who met the researchers' study criteria and were found to be addicted to opioids, one-third (34 percent) came to the ED seeking treatment for their opioid addiction, and another 8.8 percent were experiencing opioid overdoses. The rest were identified through screening after presenting with various other emergencies. Most (75.1 percent) used heroin, and the remainder reported misusing prescription opioids exclusively.

(Notes for slide 100, continued)

Slide 100: Continuity is Important

Use or misuse of other addictive drugs was highly prevalent, including cigarettes (88 percent), cocaine (55 percent), marijuana (53 percent), and sedatives (47 percent).

The researchers assigned each patient addicted to opioids to one of three protocols:

1. Referral for treatment via a handout with information on local treatment centers offering inpatient and outpatient care, and how to contact them
2. A 10-to-15 minute motivational and informational discussion addressing drug use, addiction, and treatment, using the manualized Brief Negotiation Interview (BNI) modified for opioid users; plus active connection to local service providers, securing of insurance approval, and transportation arrangements
3. The BNI and a sufficient take-home supply of Bp/Nx (preceded by an onsite initial dose of Bp/Nx for patients in withdrawal) to last until an initial scheduled appointment for office-based follow-up care within 3 days

(Notes for slide 100, continued)

Slide 100: Continuity is Important

They found that 30 days after their ED visits, 78 percent of patients who were given Bp/Nx were engaged in addiction treatment, compared with 45 percent of those in the referral and brief intervention group, and 37 percent in the referral-only group (see Figure). The average number of days per week of self-reported opioid use, which was 5.4 in all groups at the time of their ED visit, had fallen to 0.9 in the Bp/Nx group, 2.4 in the interview plus referral group, and 2.3 in the referral-only group.

Among the patients who were engaged in treatment at follow-up, fewer of those who had initiated Bp/Nx in the ED were enrolled in costly inpatient care (11 percent versus 35 to 37 percent in the other groups). Patients in all three groups exhibited similar reductions of about one-third in behaviors that increase the risk for contracting or transmitting HIV.

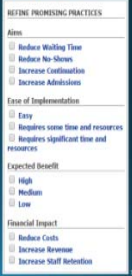


REFERENCE:

D'Onofrio, G., O'Connor, P.G., Pantalon, M.V., Chawarski, M.C., Busch, S.H. et al. (2015). Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial. *JAMA*, 313(16), 1636-1644.

NIATx's Promising Practices Database

- Provides a list of over 30 evidence-supported interventions that enhance retention and engagement
- Interventions focus on motivational enhancement activities, office-based process-improvement, assessment of risk of leave, levels of care, and collaborative approaches to care
- Users can sort and search based on ease of use and desired outcome



The screenshot shows a sidebar with the following filter categories and options:

- Aims:**
 - Reduce Waiting Time
 - Reduce No-Shows
 - Increase Continuation
 - Increase Adherence
- Ease of Implementation:**
 - Easy
 - Requires some time and resources
 - Requires significant time and resources
- Expected Benefit:**
 - High
 - Medium
 - Low
- Financial Impact:**
 - Reduce Costs
 - Increase Revenue
 - Increase Staff Retention

Slide 101: NIATx's Promising Practices Database

Additional promising practices can be found via the NIATx database. This database provides a comprehensive list of over thirty evidence-based interventions that are focused on enhancing retention and engagement. The recommendations focus on a number of potential interventions including utilizing motivational enhancement activities, office-based process-improvement, and collaborative methods to integrate care. The database is able to be sorted and searched based on focus and desired outcome.



Interventions to Promote Change Integrating HIV and SUD

Slide 102: [TRANSITION SLIDE] Interventions to Promote Change: Integrating HIV and SUD

This section will discuss recommendations for integrating HIV and substance use treatment.



IMAGE CREDIT:

Fotolia, purchased image, 2017.

CDC Compendium of Evidence-Based Interventions for HIV Prevention

- CDC has identified and compiled a list of behavioral interventions for individuals who are using illicit drugs
- Interventions have been demonstrated to reduce the risk of acquiring HIV or other STDs
- The Compendium is broken into three chapters
- *Linkage to, Retention in, and Re-engagement in HIV Care* contains 14 best practices
- *Medication Adherence* contains 14 evidence-based interventions
- *Risk Reduction* contains 61 evidence-based interventions

SOURCE: CDC, 2017

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Slide 103: CDC Compendium of Evidence-Based Interventions for HIV Prevention

The Centers for Disease Control Compendium for Evidence-Based Interventions for HIV Prevention is a list of behavioral interventions for individuals who are using illicit drugs. This compendium of interventions has demonstrated efficacy in reducing the risk of acquiring HIV or other STDs. The resource is divided into three chapters that focus on different practice areas: Linkage to, Retention in, and Re-engagement in Care; Medication Adherence; and Risk Reduction. The section focused on Linkage contains 14 different recommended practices. The Medication component contains 14 interventions. The Risk Reduction component contains 61 different evidence-based interventions.



REFERENCE:

Compendium of Evidence-Based Interventions and Best Practices in HIV Prevention. 2017. Center for Disease Control and Prevention. Retrieved from: <http://www.cdc.gov/hiv/research/interventionresearch/compendium/index.html>.

Identifying Best Practices in Integrated HIV/SUD Care

- Prevention and Treatment
 - Utilization of standardized screening and brief intervention in primary care settings (such as SBIRT)
 - CBT
 - MI
 - Community reinforcement approaches such as CM

SOURCE: Belani et al., 2011

Slide 104: Identifying Best Practices in Integrated HIV/SUD Care

Under the prevention and treatment category, the recommended interventions focus on standardized screening mechanisms that lead to brief intervention in primary care settings, such as SBIRT (Screening, Brief Intervention, and Referral to Treatment). Cognitive-Behavioral Treatment and Motivational Interviewing are evidenced-based treatments that have substantial bodies of evidenced supporting their efficacy in treating substance use issues, as well as physical health impairments. Any opportunity for involvement of community reinforcement helps to enhance interventions. Contingency management is a useful intervention that provides behavioral reinforcement to clients.

(Notes for slide 104, continued)

**Slide 104: Identifying Best Practices in
Integrated HIV/SUD Care**



REFERENCE:

Belani, H., Chorba, T., Fletcher, F., Hennessey, K., Kroeger, K., Lansky, A., et al. (2012). Integrated prevention services for HIV infection, viral hepatitis, sexually transmitted diseases, and tuberculosis for persons who use drugs illicitly: Summary guidance from CDC and the U.S. Department of Health and Human Services. *Morbidity and Mortality Weekly Report*, 61, 1-40.

Identifying Best Practices in Integrated HIV/SUD Care

- Outreach Programs
 - Peer educator outreach
 - In locales where individuals congregate, on the streets, or in mobile vans/clinics
 - Provide education on drug- and sex-related risk-reduction
 - Provide risk reduction supplies such as condoms, sterile needles/syringes, naloxone
 - Refer to prevention programs
 - Help build trust in treatment services and healthcare providers

SOURCE: Belani et al., 2022

Slide 105: Identifying Best Practices in Integrated HIV/SUD Care

The use of outreach programs allows provider organizations to reach clients in their community. One of the recommendations for being able to successfully engage individuals in their community is to utilize peer educators to engage clients or potential clients. As discussed previously, the ability to meet potential clients where they are reduces the impact of transportation as a barrier to engagement. On-going education and risk reduction supplies can be provided in communities directly. The use of naloxone, an opioid antagonist, can assist in preventing overdose death. This type of outreach allows providers to provide referral resources and build linkage and trust in existing healthcare programs.

(Notes for slide 105, continued)

**Slide 105: Identifying Best Practices in
Integrated HIV/SUD Care**



REFERENCE:

Belani, H., Chorba, T., Fletcher, F., Hennessey, K., Kroeger, K., Lansky, A., et al. (2012). Integrated prevention services for HIV infection, viral hepatitis, sexually transmitted diseases, and tuberculosis for persons who use drugs illicitly: Summary guidance from CDC and the U.S. Department of Health and Human Services. *Morbidity and Mortality Weekly Report*, 61, 1-40.

Identifying Best Practices in Integrated HIV/SUD Care

- Vaccination
 - Hepatitis A and B for individuals using illicit drugs
 - Pre-vaccination testing for Hepatitis B is recommended for all individuals who share a household with, have had sexual contact with, or have shared needles with someone with Hepatitis B and for individuals living with HIV
- Prevention of Mother-to-Child Transmission
 - Pregnant women with HIV have cited illicit drug use as a major barrier to care
 - All pregnant women should be screened for Hepatitis B
 - Pregnant women who use illicit drugs are at greater risk for all sexually transmitted infections

SOURCE: Belani et al., 2012

Slide 106: Identifying Best Practices in Integrated HIV/SUD Care

Vaccination of Hepatitis A and B is recommended for individuals using illicit drugs. Pre-vaccination testing for Hepatitis B should be standard practice for all individuals who may have been exposed to Hepatitis B. Currently, there is no vaccine for Hepatitis C.

The vertical transmission of HIV from mother to child should be a focus for on-going care with considerations of substance use and Hepatitis B treatment as well. Pregnant women with HIV cite illicit drug use as a major barrier to care and women who use illicit drugs are at greater risk for sexually transmitted infections.



REFERENCE:

Belani, H., Chorba, T., Fletcher, F., Hennessey, K., Kroeger, K., Lansky, A., et al. (2012). Integrated prevention services for HIV infection, viral hepatitis, sexually transmitted diseases, and tuberculosis for persons who use drugs illicitly: Summary guidance from CDC and the U.S. Department of Health and Human Services. *Morbidity and Mortality Weekly Report*, 61, 1-40.

Identifying Best Practices in Integrated HIV/SUD Care

- Risk Reduction and Messaging
 - Four strategies reduce risk behaviors:
 - Risk-reduction programs and messages
 - Treatment of substance use and mental disorders
 - Access to sterile injection and drug preparation equipment
 - Interventions to increase condom availability
 - Messaging should include information about:
 - Preventing the transmission of infectious diseases, assessment of personal risk, training on proper condom use, addressing emotional or practical issues related to safe sex, safer sex negotiation training, HIV testing, STD screening and treatment, referral to substance use treatment and housing, training in overdose prevention (naloxone)

SOURCE: Belani et al., 2012

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Slide 107: Identifying Best Practices in Integrated HIV/SUD Care

Four strategies to reduce risk behaviors should focus on reduction programs and messages. Treatment should integrate substance use and mental health disorders. The use of sterile injection and drug preparation equipment reduces the potential for overdose, and these sites allow for opportunities to deliver interventions that increase condom availability. Messaging related to risk should specifically focus on education and assessment, as well as screening and referral to treatment as appropriate.



REFERENCE:

Belani, H., Chorba, T., Fletcher, F., Hennessey, K., Kroeger, K., Lansky, A., et al. (2012). Integrated prevention services for HIV infection, viral hepatitis, sexually transmitted diseases, and tuberculosis for persons who use drugs illicitly: Summary guidance from CDC and the U.S. Department of Health and Human Services. *Morbidity and Mortality Weekly Report*, 61, 1-40.

12-Step Participation

- A wealth of research demonstrates the efficacy of supplementing treatment with 12-step participation
- A clinician's willingness to adopt proactive and positive attitudes toward 12-step referral and integration are significant in 12-step engagement
- While 12-step meeting participation is a significant predictor of abstinence self-efficacy in substance use, complications due to intersectionality can arise
- HIV-risk sexual behavior showed greater variance with abstinence self-efficacy even when combined with 12-step attendance

SOURCE: Dennis & Davis, 2015; Majer et al., 2015

Slide 108: 12-Step Participation

Participation in 12-step groups has been shown to be beneficial in reducing impairment as a result of substance use. Clinicians should educate themselves and be willing to consider referral to 12-step groups as appropriate. 12-step group participation also predicts abstinence self-efficacy though complications due to intersectionality can impact sexual risk behaviors even with 12-step group attendance.



REFERENCES:

Dennis, C. & Davis, T. (2015). Enhancing the referral-making process to 12-step programs: Strategies for social workers. *Research on Social Work Practice, 27*(4), 423-433.

Majer, J.M., Glanzman, O., Palmer, J.S., & Jason, L.A. (2015). Predictors of abstinence self-efficacy: Examining the role of HIV-risk sexual behavior. *Journal of Social Service Research, 41*(1), 39-48.

Contingency Management

- Contingency management (CM) provides tangible incentives for specific targeted behaviors
- Has been shown to enhance treatment retention
- Increases abstinence relative to 12-step for PLWH receiving treatment at an HIV clinic
- Study examining CM for cocaine use in an outpatient clinic found no difference in efficacy for PLWH versus individuals who were not diagnosed with HIV

SOURCE: Burch et al., 2017

Slide 109: Contingency Management

Contingency management is a behavioral reinforcement-based intervention to provide incentives for specific targeted behaviors. This intervention has been shown to enhance treatment retention and increase abstinence when compared to a 12-step group for individuals living with HIV. Contingency management was found to be as efficacious for individuals living with HIV who were using cocaine as it was for individuals who were not diagnosed with HIV indicating that the intervention is effective for more complex, co-occurring health needs.



REFERENCE:

Burch, A.E., Rash, C.J., & Petry, N.M. (2017). Cocaine-using substance abuse treatment patients with and without HIV respond well to contingency management treatment. *Journal of Substance Abuse Treatment, 77*, 21-25.

Motivational Interviewing to Address Intersectionality Risk

- Motivational interviewing has demonstrated efficacy for medication adherence as well as improvement in functioning for long-term disability/chronic illness
- Meta-analysis demonstrates that MI is effective alone and (preferably) in combination with other treatment interventions
 - Positive outcomes regardless of interventionist
 - Universality of efficacy – across genders, ages (16+), SES and race/ethnicity
- While effects decrease post-delivery, eight sessions of MI has been shown to be effective in improving CD4 counts and medication adherence in co-occurring alcohol use populations

SOURCES: Parsons et al., 2007; Dillard et al., 2016

Slide 110: Motivational Interviewing to Address Intersectionality Risk

A significant takeaway from this and the next MI slide are the follow-up to “Continuity is Important” – while there are demonstrated results to application of MI, lack of maintenance plans and regular fidelity monitoring impact adherence rates. Motivational interviewing (MI) is an accessible intervention that can be delivered by a range of professional staff. It has demonstrated efficacy for a number of targeted health behaviors, including medication adherence and improvements in reducing risk behaviors associated with long-term or chronic illnesses including substance use disorders and HIV. The recommended practice is to integrate MI with other evidence-based practices, but MI has been shown to be effective as a standalone intervention in promoting behavior change independent of gender, age (above 15) and across socioeconomic statuses or race/ethnicities. Specifically, MI has demonstrated improvements in CD4 counts and medication adherence among co-occurring alcohol use population in as little as eight sessions. A word of caution though: the effects tend to decrease after the delivery of the intervention so on-going support, contact, and potentially booster sessions are indicated.

(Notes for slide 110, continued)

Slide 110: Motivational Interviewing to Address Intersectionality Risk



REFERENCES:

Dillard, P.K., Zuniga, J.A., & Holstad, M.M. (2016). An integrative review of the efficacy of motivational interviewing in HIV management. *Patient Education and Counseling, 100*, 636-646.

Palacio, A., Garay, D., Langer, B., Taylor, J., Wood, B.A., & Tamariz, L. (2016). Motivational interviewing improved medication adherence: A systematic review and meta-analysis. *The Journal of General Internal Medicine, 31*(8), 929-940.

Parsons, J.T., Golub, S.A., Rosof, E., & Holder, C. (2007). Motivational interviewing and cognitive-behavioral intervention to improve HIV medication adherence among hazardous drinkers: A randomized control trial. *Journal of Acquired Immune Deficiency Syndromes, 46*(4), 443-450.

Motivation-Based Interventions

- Brief MI is useful but must be supplemented with on-going intervention/repeated contact
- Four sessions of Motivational Interviewing has been shown to reduce substance use and unprotected sex in young gay and bisexual men (YGBM) better than education alone
- Homophobia and racism decrease motivation for accessing HIV prevention services
- The empathetic, non-judgmental approach resonates with these groups disproportionately affected by bullying, depression, stigma –YGBM of color

SOURCES Aharonovitch et al., 2016; Parsons, et al., 2014

Slide 111: Motivation-Based Interventions

In considering a brief intervention similar to SBIRT, brief MI is useful but must be supplemented with on-going follow-up. Case management and on-going linkage are key in ensuring continued engagement. Aspects related to intersectionality such as homophobia or racism decrease motivation for accessing preventative services. The best approach for a practitioner is to continue to utilize MI beyond education alone and to remain empathetic and non-judgmental as previously discussed in this training.



REFERENCES:

Aharonovitch, E., Sarvet, A., Stohol, M., DesJarlais, D., Tross, S., Hurst, T., Urbina, A., & Hasin, D. (2017). Reducing non-injection drug use in HIV primary care: A randomized trial of brief motivational interviewing, with and without HealthCall, a technology-based enhancement. *Journal of Substance Abuse Treatment, 74*, 71-79.

(Notes for slide 111, continued)

Slide 111: Motivation-Based Interventions



REFERENCES:

Parsons, J.T., Lelutiu-Weinberger, C., Botsko, M. & Golub, S.A. (2014). A randomized controlled trial utilizing motivational interviewing to reduce HIV risk and drug use in young gay and bisexual men. *Journal of Clinical Psychology, 82*(1), 9-18.

Effective Treatment for SUD and HIV

- There are limited studies that examine appropriate interventions focused on internalized HIV stigma and internalized SUD stigma
- The relationship is clear: individuals with internalized HIV stigma were significantly more likely to experience depression if they identified internalized SUD stigma as well
- Acceptance and Commitment Therapy may be one consideration for further evaluation in reducing barriers related to stigma

SOURCE: Earnshaw et al., 2013

Slide 112: Effective Treatment for SUD and HIV

While the previous slides provide recommendations to providers about effective ways to integrate HIV and SUD care, there are limited studies that focus on the impact of internalized stigma resulting from the intersectionality of HIV and substance use disorders. There is a clear relationship that internalizing the stigma associated with HIV or SUD results in increases in depression. One possible intervention may be the use of Acceptance and Commitment Therapy (ACT) as an opportunity to assist clients in integrating aspects of self that are incorrectly identified by others within their community as negative or undesirable.



Additional information for the trainer(s):

ACT is an evidence-supported intervention that uses mindfulness and acceptance-based techniques to integrate on-going events into the actions of the whole organism and various current and historically based contexts. This conceptualization can be particularly useful for aspects of intersectionality that are based on those contexts and manifest in different forms of social narrative or discrimination.

(Notes for slide 112, continued)

Slide 112: Effective Treatment for SUD and HIV



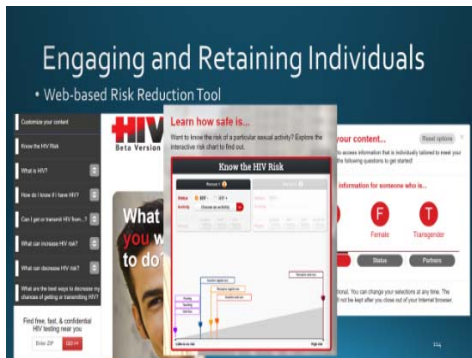
REFERENCE:

Earnshaw, V.A., Smith, L.R., Cunningham, C.O., & Copenhaver, M.M. (2013). Intersectionality of internalized HIV stigma and internalized substance use stigma: Implications for depressive symptoms. *Journal of Health Psychology, 20*(8), 1083-1089.

Slide 113: [TRANSITION SLIDE] Additional Tips for Providers

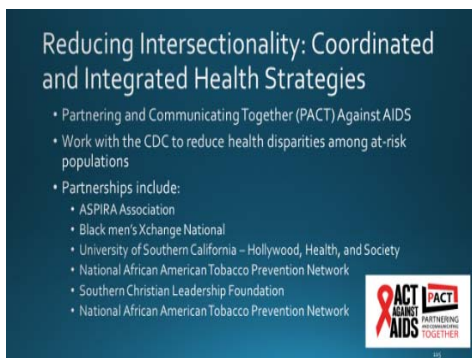
This last section summarizes some additional tips for providers and recommendations for on-going care/education.





Slide 114: Engaging and Retaining Individuals

This slide presents a sample of screenshots from a web-based tool developed as part of the CDC’s “HIV Treatment Works” campaign. The web-based Risk Reduction Tool provides potential clients with an opportunity to learn about their risk and also seek additional opportunities for education or find providers in their area to talk to.



Slide 115: Reducing Intersectionality: Coordinated and Integrated Health Strategies

It is of great importance for providers to focus on integrated care and building partnerships with organizations that supplement care that is being provided at a particular site. A coordinated effort to develop these community partnerships involves organizations that are part of the CDC’s Partnering and Communicating Together Against AIDS program. Consider if any existing partnerships are in areas that you work in and discuss the potential for linking with/building additional relationships and connections.

Final Thoughts/Things to Remember

- Recognize that intersectionality is complex and essential to understanding an individual comprehensively
- Find opportunities to reduce stigma and enhance engagement such as educating key stakeholders through community relationship building
- Ensure that we approach all clients without judgement – language matters!
- Utilize a motivational approach to engage individuals and have conversations with genuine interest and empathy

SOURCE: Glass, 2015

Slide 116: Final Thoughts/Things to Remember

Some final thoughts to consider as the training ends: a lot of discussion has focused on intersectionality and the way in which recognizing intersectionality can be a useful assessment and engagement intervention. This opportunity to understand and individual comprehensively without prior judgement allows for more genuine interaction and trust. An additional way to build trust is to adopt Person-First Language with a focus on enhancing strengths and reducing stigma at every interaction. Involve key stakeholders and community partners in this endeavor to continue to reduce barriers to engagement.



REFERENCE:

Glass, J.E. (2015). Challenges ahead in developing and testing referral to treatment interventions. *Addiction*, 110(9), 1419-1420.

Final Thoughts/Things to Remember

- Identify barriers AND facilitators
- Repeated contact is key
- Integrated case management consistent with readiness to change is essential
- Complex cases make referral and continuity more difficult: higher risk patients with co-occurring anxiety/depression, SUD, and HIV are less likely to receive follow-up contact
- BUT when providers are able to adequately engage these individuals, their retention in care is the same as PLWH who do not have behavioral/mental health issues

SOURCE: Glass, 2015; Gardner et al., 2015

Slide 117: Final Thoughts/Things to Remember

Key takeaways in considering for on-going work include focusing specifically on how to improve and enhance linkage between different providers and organizations.

Identifying strengths that an organization already possesses and building on those can be useful. Integrating case management and establishing health navigators that can initiate repeated outreach and contact is essential.

Complex cases that involve SUD, HIV, and mental health issues create additional difficulty for providers. These clients are less likely to engage in follow-up contact or receive the benefit of treatment services. However, when providers are able to utilize effective engagement strategies with these clients, their retention in care despite the challenges presented by co-occurring health issues is no different than people living with HIV who do not have a co-occurring mental health or behavioral health issue.

(Notes for slide 117, continued)

Slide 117: Final Thoughts/Things to Remember



REFERENCES:

Gardner, L.I., Marks, G., Shahani, L., Giordano, T.P., Wilson, T.E., Drainoni, M., et al. (2016). Assessing efficacy of a retention-in-care intervention among HIV patients with depression, anxiety, heavy alcohol consumption and illicit drug use. *AIDS*, 30(7), 111-119.

Glass, J.E. (2015). Challenges ahead in developing and testing referral to treatment interventions. *Addiction*, 110(9), 1419-1420.

Slide 118: Post-Test Question



Read the question and choices, and review audience responses out loud.



**Audience Response System (ARS)-compatible slide

Answer Key:

#1 – correct response is C (Food insecurity)

Post-Test Question

1. This unaddressed need is associated with lowered CD4 counts, higher viral load, and stronger medication side effects:
 - A. Legal issues
 - B. Family of origin conflict
 - C. Food insecurity
 - D. Community assaultive violence

Post-Test Question

2. If current diagnosis rates persist, during their lifetime _____ black MSM will be diagnosed with HIV.

- A. 1 in 100
- B. 1 in 50
- C. 1 in 10
- D. 1 in 2

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Post-Test Question

3. Rates of retention in care based on CDC criteria indicate that ____ of PLWH are successfully retained in treatment.

- A. 86%
- B. 62%
- C. 37%
- D. 13%

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Slide 119: Post-Test Question



Read the question and choices, and review audience responses out loud.



**Audience Response System (ARS)-compatible slide

Answer Key:

#2 – correct response is D (1 in 2)

Slide 120: Post-Test Question



Read the question and choices, and review audience responses out loud.



**Audience Response System (ARS)-compatible slide

Answer Key:

#3 – correct response is C (37%)

Post-Test Question

4. PLWH are less likely to disengage from care if they are:
- A. MSM
 - B. Living in poverty and lack environmental resources besides care
 - C. Are recent migrants
 - D. Recently diagnosed

Slide 121: Post-Test Question



Read the question and choices, and review audience responses out loud.



**Audience Response System (ARS)-compatible slide

Answer Key:

#4 – correct response is A (MSM)

Slide 122: Post-Test Question



Read the question and choices, and review audience responses out loud.



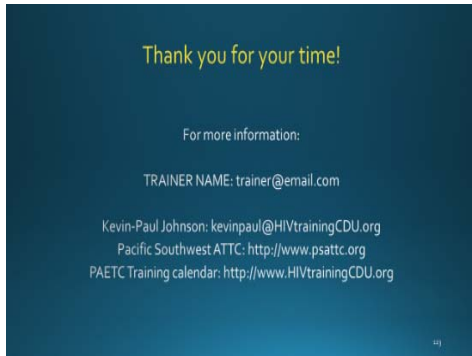
**Audience Response System (ARS)-compatible slide

Answer Key:

#5 – correct response is D (60%)

Post-Test Question

5. Gay and bisexual men accounted for ___ of all new HIV cases due to injection drug use in 2014.
- A. 5%
 - B. 20%
 - C. 40%
 - D. 60%



Slide 123: Final Slide

ADD TRAINER(S) NAMES AND CONTACT INFORMATION AND REPLACE IMAGES FOR TRAINER'S ORGANIZATION



This concludes the presentation. Thank the participants for their time and address any last-minute questions about the content. Encourage participants to reach out to the Pacific Southwest ATTC or the LA Region PAETC, should they have questions or concerns following the training session.

Acknowledgments

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APPENDIX 1:
ACTIVITY HANDOUT

Activity: Choosing one of the six case scenarios, how would you initiate a conversation about the importance of treatment and care?

Scenario 1: “I prefer not know my HIV status. I am satisfied not knowing and life is easier that way. What you don’t know can’t hurt you. If a person doesn’t look right, I won’t have sex with them unless I am smoking weed or maybe high. Some of the main reason why people don’t get tested is because they don’t want to know if they have HIV. Plus, we don’t see ourselves at risk. The people I hang out with are okay. They are clean. HIV ain’t that big of a problem. Don’t they have pills that will take care of it anyways? This is information that I really don’t need to know.”

Scenario 2: “Getting tested for HIV is my business. Nobody needs to know that information but me and who I am having sex with at the moment, if I chose to tell them. These people are nosey and all up in your business!! All you need is for someone to find out your HIV status and it’s all over the news. Hell no, I am not taking that chance. Whatever my HIV status is my secret and I will tell only when I feel like it. More people should be like me. Just have sex, get high, smoke a little and have some juice, enjoy yourself, and live life. If I were positive, I don’t think I would tell. And, that’s really easy and all I have to say about it.”

Scenario 3: “I know people living with HIV and they look okay to me. I like having sex and I like it with different girls and sometimes I don’t have condoms on me. Condom use or lack of condom use communicates different message to people, you know what I mean. I live for this moment and if I get offered sex, I am taking it and probably without a condom. I just don’t see myself at risk for HIV anyways. I can’t worry about something that may never happen. You have to get what you can whenever you can. Life is short. And, I just want to have a good time.”

Scenario 4: “I have the desire for immediate gratification and to get what I can right now!!! I don’t care about anything except what I want. I know that sounds selfish! It’s dope when you can live life the way you want while you’re here. I know too many friends that are gone. They are dead!! Almost every week, every day, somebody gets killed or hurt real bad in a fight or something. I need to get mine now!! Sex helps you get through the day and deal with stress. If I have a condom, I may or may not use it. It really depends but if I am high, I might forget to practice safe sex.”

Scenario 5: “My father is responsible for paying our rent. Sometimes he pays and sometimes he may miss a month or two. I never know how things are going to be around here. Therefore, I take it oneday at time. We have come so close to being evicted and one day I know it’s going to happen. That’s a fear I that I am often faced with. I have to think about what I have right here and right now and that’s just the way it is. Sometimes, I can understand why people trade sex for different things. At least they may hook up with someone and have a nice place to stay. I know of people who trade sex for different things (e.g., money, food, clothes, and gifts) but I don’t want to do that. I want more for my life.”

Scenario 6: “Last year my cousin was shot in the leg while coming home from a party. He didn’t know the guy but the guy just shot him for no reason. People out here are crazy and tripping. You never know when you may catch a bullet, fist, stick, or knife. This is crazy and I am supposed to worry about an STD or HIV?”