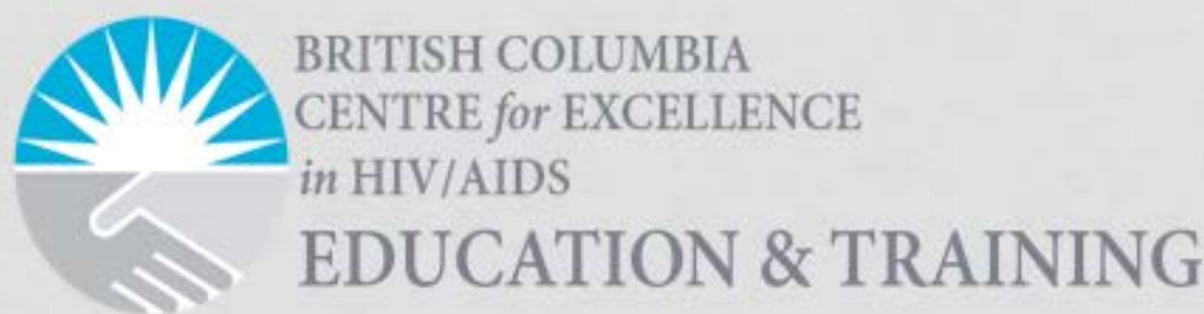

Module 6: Strategies for Risk Reduction in HIV Prevention

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RN, BSc

Faculty Disclosure

- **Faculty:** Liz Kirkpatrick, RN

- **Relationships with commercial interests:**
  - **Grants/Research Support:** none to disclose
  - **Speakers Bureau/Honoraria:** none to disclose
  - **Consulting Fees:** none to disclose
  - **Other:** none to disclose

- Antiretroviral medications are not approved by Health Canada as post-exposure prophylaxis (PEP) for the prevention of HIV. Recommendations for HIV PEP are considered "off-label" use of medications.

Disclosure of Commercial Support

- **This program has not received any financial or in-kind commercial support.**

- **<u>Potential for conflict(s) of interest</u>:**
  - This program has not received any commercial support.

Mitigating Potential Bias

- The content of the presentation is consistent with guidelines developed by the BC-CfE Post-Exposure Prophylaxis (PEP) Committee, a sub-committee of the Committee for Drug Evaluation and Therapy (CDET)
- Generic names of medications are used in place of brand names

Learning Objectives

On completion of this module, participants will develop an understanding of:

- The importance of counselling and communication skills
- Discussing PEP in the context of consensual activities
- Counselling for HIV risk reduction
- Stages of risk

When someone comes to request PEP, the “Panic Button” has been pressed and all they can think of is: “Can I have the medications?” Anxiety levels are often high.

As a healthcare professional, it can often be easy to focus on ascertaining the client’s risk history in order to assess whether they need medication. As a result, there is a potential for the focus of the consult to be medications-driven, and is further exacerbated by anxiety and limited clinic time.
However, it is crucial to consider PEP as only one strategy for preventing HIV infection and must be considered within the broader context of HIV prevention.

Why offer counselling with PEP?

The World Health Organisation (WHO) and the BC-CFE recommend counselling with PEP due to low levels of adherence and follow-up.

When the client presents for PEP, there is often high levels of anxiety. This can be challenging, especially if PEP not appropriate.

Anxiety can:

- Trigger a range of emotion's such as shame, fear, anger and guilt
- Decrease the retention of information which in effect can decrease adherence and follow-up rates
- Create a positive effect. It can create a *unique* window of opportunity for future behavior changes e.g. small to larger steps such as connecting with a family physician for undiagnosed depression or to seek addiction support

When taking a medical history it is helpful to consider any signs of undiagnosed depression, any addiction, or mental health issues. Over-the-counter and herbal medications can also hint at conditions that the client has not disclosed, such as depression.

Why offer counselling with PEP?

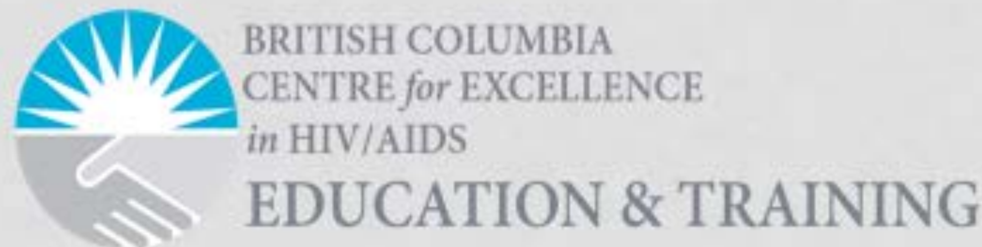
There is a potential for cost effectiveness if the client:

- Knows how to assess their own risk in future; this can decrease unnecessary clinic time and hopefully anxiety, too.
- Adopts one risk reduction strategy, it could potentially reduce future use of PEP.
- Feels comfortable on returning for future PEP or consider PrEP, then we could potentially decrease the acquisition of HIV infections in the future.

PEP counselling is not isolated to the immediate PEP appointment. If all doctors, nurses, pharmacists, peer navigators, community members, & others are all on the same page, then we can all help provide a seamless package of care. We can bridge from community to the PEP clinics and then back to the community, empowering our clients to have positive and healthy sex lives.

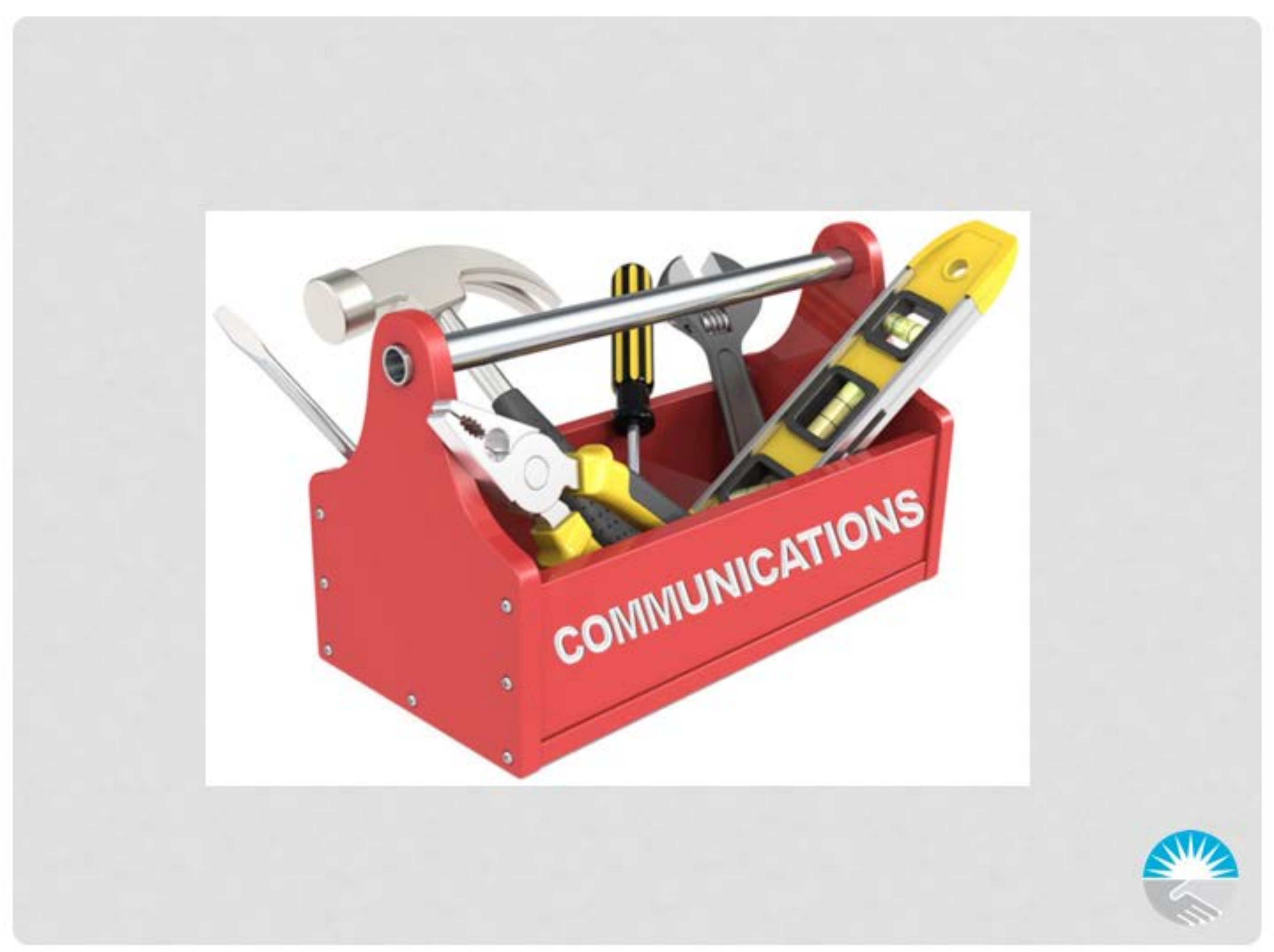
When:
PEP Medication and Counselling = Optimal Care
Each piece of jigsaw = Informed Choices

Lets help give our clients that extra piece of the jigsaw, that extra piece of knowledge and support, so they can make informed choices, not just now, but also in the future.



Before discussing PEP it is important to create a safe space

Counselling is not an extra task but is a way of providing care.



Communication skills is what enables one to share PEP knowledge effectively.
Learning and practising communication skills is a never-ending journey whether we are newly qualified, new in the field, or if one has years of experience.
Proficiency in communication should not be left to chance as it can either generate or erode trust.

Communication Skills (1)

Establish rapport by being non-judgmental and showing sensitivity:

- Be aware of your biases and beliefs. Judging this client may further reinforce shame and stigma.
- Some people may believe that PEP use can significantly increase risky behaviour, however there is little evidence to support this.
- Some people may believe that clients who attend for repeat PEP treatment may not care about their health due to repeatedly putting themselves at risk; it is important to challenge this perception. Clients do care and, as a result, they are accessing one of the risk reduction tools that has been shown to reduce the development of HIV after a potential exposure.
- Clients often state that they feel judged when accessing PEP, even though the risk was not the client's choice, .e.g. the condom was removed without consent

Establishing a rapport with the client is essential in the development of a therapeutic relationship. When clinic time is often limited and the patient's anxiety levels are high, it is often easy to overlook and forget this cornerstone of effective communication.

A therapeutic interpersonal relationship can be defined as one which is perceived by patients to encompass caring and supportive non-judgmental behaviour, embedded in a safe environment during an often stressful period. These relationships can last for a brief moment in time or continue for extended periods. Typically, this type of relationship displays warmth, friendliness, genuine interest, empathy, and the wish to facilitate and support.

Communication Skills (2)

- Communicate at the patient's level of understanding. Avoid using jargon and abbreviations. Explain PEP and HIV-specific jargon that clients may not understand that could impact their level of HIV risk.
  - Examples: HIV viral load, undetectable, less than 40, PrEP, "my partner told me he was clean"
- Location, language, and cultural differences can create barriers to accessing sexual health care, HIV knowledge, and risk reduction.

Communication Skills: Scenario

- A male client presents as having unprotected anal sex with an unknown partner.
- On discussing future risk reduction, the client discloses that he has had an increase in high risk sex over the past 6 months (unprotected anal intercourse with unknown partners).
- He also notes that he has increased his use of crystal meth use while trying to navigate an arranged marriage to a female.
- This case illustrates the importance of discussing risk reduction.

Communication Skills (3)

Be mindful of preferred terminology:

- Do not assume to know how individuals identify themselves. For example, some men who have sex with men (MSM) do not identify themselves as gay or bisexual.
- There may be terminology that is unfamiliar to you (for example, in regards to sexual activity, top means insertive, bottom means receptive). If you do not understand certain language clients use, ask them to explain it further. Use similar language to what the patient uses.
- When a client identifies as trans, it is important to ask the client at the start of the consult how they would prefer to be addressed (for example, he, she, they, or another term). Please write this in the client's chart to show respect in future visits.

Communication Skills: Scenario

- A male presents as having unprotected vaginal intercourse with a female sex worker. The client is very anxious. When the client is leaving the room at the end of the appointment, he stops the nurse and informs her that he has had multiple male partners throughout the years. He has never told anyone due to the fear of his family finding out. His knowledge appears to be low and his HIV risk is high.
- This reminds us of the importance of creating a safe space while using terminology that identifies sexual activities versus sexual identity such a heterosexual, men-who-have-sex-with-men.

Communication Skills (4)

- Be mindful of using appropriate non-verbal communication skills. Over half of our communication is non-verbal, such as eye contact and open posture; body language (55%), tone (38%), words (7%) (Mehrabian, 1971).
- Ask open-ended questions (who, what, when, why, how). These questions allow further exploration of the needs of the patient. It allows the client to not only discuss their side-effects, but also how they are dealing with taking their medications day-to-day.
- Open-ended questions gives the client the opportunity to tell their story. This can be an important part of the healing journey.
- Provide factual information verbally, written, or references and online sites to decrease anxiety and misinformation.

Source:
Mehrabian A. Pub. Co.; 1971.

Communication Skills: Scenario

- A client has been started on PEP medications. When the client attends for his day 5 visit, the nurse asks "I see that you are taking your PEP medications for 5 days now. How are you getting on?"
- The client explains that he has a regular male partner with whom he lives. The partner is not aware of the recent HIV risk and PEP medications, therefore the client is trying to work out ways to take the medications at home.
- He is also concerned how he will wear condoms again for the next several weeks when he and his partner have not used condoms in years.
- In this scenario open-ended questions helped facilitate further discussion.

Communication Skills (5)

Bridging Statements

This picture shows a bridge. In this picture the bridge :

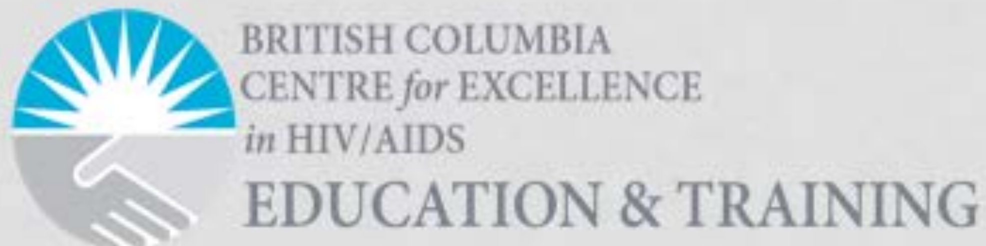
- Is *strong* and *supportive*
- Will *direct* and *guide* the way to a *specific* island

Bridging statements can be compared to a bridge. They are directive statements that *guide* ands *support* clients to a conversation that is specific, detailed, and sensitive.

They are useful for the following reasons:

- It prepares the client for the questions
- It asks permission to discuss their risks
- It explains why we're asking the particular details of their risks

An example of a bridging statement is: So in order to get a better understanding of your risk for HIV, do you mind if I ask you some personal questions?



Discussing PEP

1) Reduce Anxiety

It is important, first and foremost, to develop rapport, reduce anxiety and create a safe space.

When one understands the roots of anxiety, this helps to create empathy.

The following can increase anxiety levels:

- The history of HIV that has created fear and stigma that often continues to exist today
- The level of HIV knowledge can vary from client to client
- The present risk. If a partner refused to test or discuss HIV testing, this leads the client to feel that the partner has something to hide, such as an HIV diagnosis. Other scenarios that increase anxiety includes finding used needles or observing the partner being with multiple other partners shortly after their sexual contact.
- If the client has mental health or addictions history, undiagnosed low moods/depression, these that may impact their coping abilities in high stress periods

1) Reduce Anxiety

- It can be helpful to review the client's present risk to clarify any undisclosed risks
- Reinforce the:
  i. Effectiveness of PEP treatment if taken as advised;
  ii. Continual increase of HIV transmission knowledge and understanding throughout the years.
- Offer on-going support. This can be a weekly visit, phone call, or email (using workplace email policy). Ensure confidentiality by asking the client if it's okay to leave messages.
- Offer appropriate referrals. If a referral is made, check a few weeks later to see whether the client managed to attend this appointment.

Anxiety: Useful Statements

- I *hear* what you're saying and…
- I can *appreciate* that and…
- I completely *understand* and…
- I *see* what you mean and…
- That's a *good question*, let me explain…

Scenario: Sometimes a client may perceive their risk of HIV to be high while the guidelines views the situation as low risk. The client states that they desperately want PEP medications even if their chance of getting HIV is low. They would prefer to "take one month of tablets versus getting HIV for the rest of their lives."

In these situations it is important to maintain the therapeutic relationship. When staff use the above statements, it shows and reflects that we "hear, appreciate, understand and see" their concerns before sharing the reasons why PEP is not recommended.

2) Client Visualizes the PEP Medication

Time	Name of tablet	Reminders
AM	Lamivudine Tenofovir Raltegravir	
PM	Lamivudine Raltegravir	

Often medication regimens can seem simple to staff, however clients often state they feel overwhelmed.
Ensure the client sees the medication on the first visit to reinforce what and when to take their medications.
Give them a pill chart and medication leaflets/resources to refer to when they get home.
Encourage the use of reminders tools such as their phone alarms.

3) Give Clear Advice Regarding PEP

Advice

Call ______________________ if you have any concerns:

- Missed tablets = decreased effectiveness
- Side-effects: Loperamide and dimenhydrinate
- Missed doses
- Seroconversion symptoms (including 12 weeks post-end-of-treatment)
- No sex or use condoms/water-based lubricant

Explain the importance of:

- Adherence and what to do if they experience side-effects and if they miss doses
- What seroconversion symptoms are and how to avoid the potential onward transmission of HIV throughout the PEP period
- Contacting the clinic or pharmacy as soon as possible if they have any concerns.

Overall the main message here is reassurance that they are not alone throughout the following weeks, even though they may not have any further clinic appointments after the day 5 visit.

4) Give Clear Follow-up Plans

Date:	What to do:
Day 2/3	• Call __________ book an appointment • If relevant, talk to partner about HIV test or HIV viral load
Day 5	Clinic visit: • Get blood results • If relevant, did partner test? • Stop or discontinue medications, if relevant (remaining 23 days)
Week 2	Test for sexually transmitted infections

It is valuable to give the clients a summary of what to expect in regards to their follow-up plan.

4) Give Clear Follow-up Plans

Reinforce the following:

- **Day 2/3:** They need to book their follow-up appointment. It is disappointing if a client walks into a PEP clinic at 7pm to find that the clinic and pharmacy is closed, increasing anxiety levels again.
- **Days 2 – 5:** Encourage the client to talk to their partner regarding testing for HIV or HIV viral load, if possible. Reinforce that the client's information would NOT be shared with the client due to confidentiality and vice-versa.
- **Day 5:** If a client is not appropriate for PEP but has already been started, there is a possibility that the client will be recommended to stop treatment. This can be distressing for clients; it is helpful if the client understands that the Day 5 visit is to review if PEP is recommended to continue.
- **Week 2:** Sexual Health
  - If they have been at risk of HIV, then they would also be at risk of gonorrhea, chlamydia, syphilis, and hepatitis C.
  - It is recommended that client should get tested for STIs; they often need to be directed to services for this.
  - It is also recommended that the client should not have sex, or if they do, they should use latex condoms and lubricant (CfE PEP Guideline, 2017). I always like to check with them if this is something they feel they can do.

Counselling while on PEP: Bloodwork Follow-up

What test: HIV antibody test (4th Generation)
Where: any lab
When to test: as per chart below

Date:	Tests:
Week 3 (dated from the last day of PEP medications) *(same as week 7 from exposure date)*	HIV Antibody Hepatitis C antibody
Week 6 (dated from the last day of PEP medications) *(same as week 10 from exposure date)*	HIV Antibody
Week 12 (dated from the last day of PEP medications) *(same as week 16 from exposure date)*	HIV Antibody Hepatitis C antibody Syphilis

It is important to discuss blood work follow-up, especially since it has a low follow-up rate. Remember the three 'W's:

- **W**hat test: A 4th generation antibody test is recommended. A HIV nucleic acid antibody test (NAAT) is not recommended, as PEP could potentially delay a true positive result.
- **W**here: Explain where the client can get their blood tests done, for example, community labs versus hospital labs or both.
- **W**hen: It is helpful to work out the dates the blood tests are due before the consult for time efficiency. You can then spend time explaining the process to the client instead of working out dates.

Counselling while on PEP: Bloodwork Follow-up

There are **3 places to apply the follow-up dates**:

1. The client's chart, so that it makes it easier for colleagues to work out the timeline when reviewing blood results;
2. On the blood requisitions so clients can refer to these dates;
3. On client's alarm systems (e.g. phone alarms) to remind them to do the blood tests.

Date:	Tests:
Week 3 (dated from the last day of PEP medications) *(same as week 7 from exposure date)*	HIV Antibody Hepatitis C antibody
Week 6 (dated from the last day of PEP medications) *(same as week 10 from exposure date)*	HIV Antibody
Week 12 (dated from the last day of PEP medications) *(same as week 16 from exposure date)*	HIV Antibody Hepatitis C antibody Syphilis

Often clients prefer to combine their HCV blood tests with their HIV tests. This can be done at weeks 3 and 12 post-treatment.

Also discuss with the client a plan for how they will receive their HIV blood results.

Note: One could consider adding a final syphilis test at week 12 so that all risks from the original incident are addressed.

Example of a Patient PEP Plan: Page 1

PEP Patient Plan

Day 2:
- Phone ___________ to book clinic appointment

Day 2-5:
- Discuss HIV antibody or HIV viral load testing with partner, if possible

Day 5:
- Get blood results and discuss partner testing. Discuss continue or stop PEP. If continue, get remaining 23 days of medication.
- Receive blood forms for follow-up
- Week 2: Do sexual health screen

If you have any concerns about the following please call: ___________________________
- Missed tablets = decreased effectiveness ✓
- Side-effects: Loperamide (Diarrhea) and Dimenhydrinate (Nausea) ✓
- Missed doses or want to stop medications ✓

Info given:
- Signs/Symptoms: Seroconversion symptoms) ✓
- No sex or use condoms/water-based lubricant ✓
- Phone alarms ✓
- Medication leaflet, websites ✓

A.M.		P.M:	
	Lamivudine		Lamivudine
	Raltegravir		Raltegravir
	Tenofovir		

Other (support, referrals, resources):

Offering clients a summary of what to expect throughout the PEP process can be valuable. This slide gives an example.

Example of a Patient PEP Plan: Page 2

SURNAME OF CLIENT | FIRST NAME OF CLIENT | LOCUM MSP PRACTITIONER NUMBER

DOB (YYYY MM DD) | SEX: M | PREGNANT? ☐ Yes ☑ No | FASTING?

TELEPHONE NUMBER OF CLIENT

Copy to Physician/MSP Practitioner Number

POSTAL CODE | CITY/TOWN: VANCOUVER | PROVINCE: BC

DIAGNOSIS | CURRENT MEDICATIONS/DATE AND TIME OF LAST DOSE

OTHER TESTS

- ☑ HIV Serology
- ☑ Hepatitis C - Screening (anti-HCV)

Week 3 (end of treatment) = 2nd Nov 2017

Week 6 = 23rd Nov 2017

Week 12 = 4th Jan 2018

SIGNATURE OF REQUESTING PHYSICIAN | DATE SIGNED: 12 Oct 2017

DATE OF COLLECTION | TIME OF COLLECTION | PHLEBOTOMIST | TELEPHONE REQUISITION RECEIVED BY

This slide gives an example of a blood requisition form that clearly states the test and date.

Support Follow-Up

- Check the patient's contact information in case they need to be reached
- Make sure it is okay to leave messages (consider privacy and confidentiality)
- Encourage week 6 and 12 appointment to get HIV test results
  - This can be an opportunity to check ongoing risks and if they have seen any other support, e.g. a counsellor

If the client has any other ongoing issues, they are often encouraged to return weekly for support. They can receive their PEP medications weekly at each visit.
Other methods of support include:

- a clinic visit at week 6 and 12 blood results
- a phone-call
- an email to see if they connected with a referral such as a family physician or counselor. Please refer to your clinic policy in regards to your email policy due to confidentiality.

5) How can we help people make a change for their future?

Increase Knowledge

- Encourage partner to test for HIV or HIV viral load in order to potentially stop PEP medications safely
- Identify and clarify any myths and misinformation about HIV
- Identify behaviours that have high and low risks of HIV transmission
- Explain what seroconversion symptoms are
  - This is anxiety-reducing relative to the stress associated with searching internet for symptoms
  - www.bccdc.ca/health-info/diseases-conditions/hiv-aids
  - Advise client to seek medical advice if they develop any flu-like symptoms to rule out seroconversion

It is helpful to discuss with the client whether they know the partner and whether they would consider asking them to test for HIV. If this test came back HIV negative, potentially this would mean the client would **not** have to continue PEP treatment as the risk of transmission would be low. Or if the partner is HIV positive and states they have an undetectable viral load, then we would encourage them to ask the partner to share their HIV blood results with our service while being clear that we would not be able to share that partner's information with our immediate client.

Increase Knowledge

- Due to the evolving understanding of HIV throughout the years, it is not uncommon for many peoples' knowledge of HIV to be inaccurate or outdated and surrounded by much fear.
  - It is important to explain that HIV is now seen as a chronic disease that is managed by life-long HIV medications.
- If the client understands what sexual activities are seen as high risk for HIV acquisition, this can allow them to make informed decisions about their sexual activities.
  - Encourage the adoption of one risk reduction step at a time.
  - For example, reducing the number of sexual partners one has, carrying lubricant and condoms, being the insertive versus receptive partner, meeting people through the internet rather than at a bathhouse, or using PrEP.

Understand Risk Taking

Risk can compared to an iceberg

- Often the tip/area above the water is the risk we see

Yet

- Below the water, there are many large factors that are driving the risk

Before we consider helping the client reduce their risk for HIV, it is important for staff to consider why people take risks. Decision making is more complex than a ‘yes’ or ‘no’ action.

Understand Risk Taking

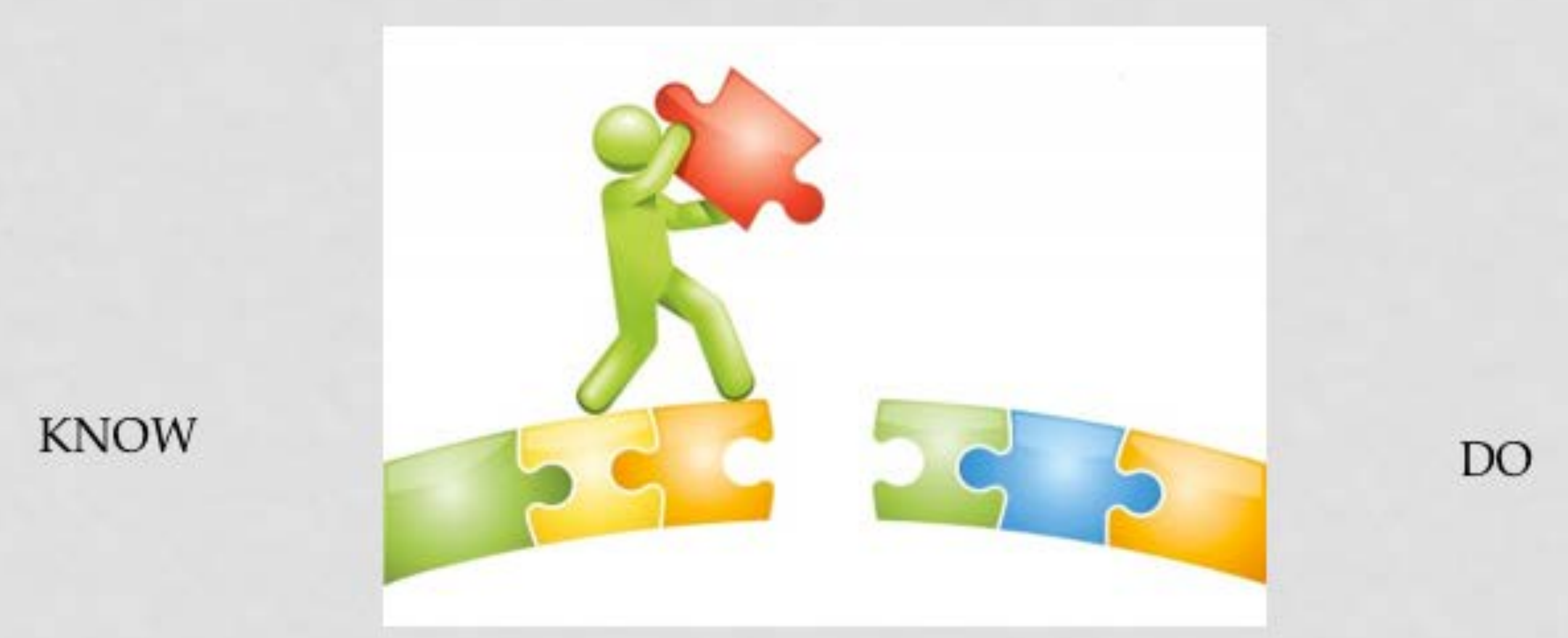
Recognize factors that impact why people take risks. Two models discuss the determinants of health:

1. Social determinants of health, e.g. stigma, culture, and poverty

2. Behavioural determinants of health, e.g. knowledge, attitudes, and skills

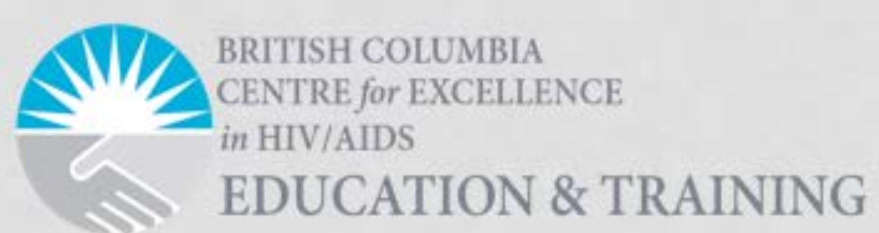
There are two types of barriers noted:
Social: it is important for providers to consider the impact that particular determinants such as stigma, socioeconomic status, cultural identification, and other barriers have on HIV risk, prevalence, and access to services. It is difficult for some of our patients to consider changing their sexual risk behaviors if their housing or livelihood (i.e. commercial sex work or exchanging sex for stable housing) is dependent on these behaviours. When discussing patient behaviour, if factors outside of the patient's control are increasing their risk behaviour, a referral to assist with these factors is strongly encouraged.
Behavioural: knowledge, attitudes, and skills are behavioural determinants of health; these must change before the behaviour can. Are there knowledge deficits? Are there any lack of skills? Are there any negative attitudes, i.e. condom use. Each strategy of risk reduction should be tailored to the client's circumstances.

The Know-Do Gap



Sometimes clients KNOW what they need to do but find it difficult to DO so. We know that knowledge does not necessary mean one will change their behaviour.

Change needs to come from within the individual.



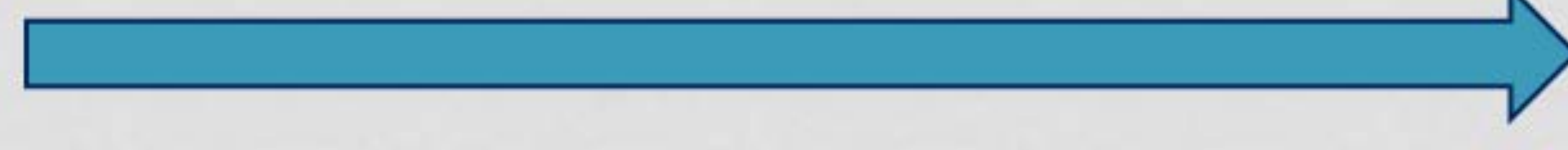
Risk Reduction Tools

There are many approaches to risk reduction. In this module we will discuss 4 specific tools that are often applied in PEP.

Risk reduction and appointment times will vary according to each individual's specific HIV risks, knowledge and experiences/barriers.

Risk Reduction Discussions

There are 3 periods of risk-taking for the client:



Pre-PEP **On PEP** **Post PEP**

When addressing risk reduction, it is important to consider the client's risks before treatment, while on treatment, and future on-going risks.

1) Establish Previous HIV Risks

Pre- HIV risks:

- Has this happened before?
- If so, does it happen regularly OR is it an occasional risk?
- What led to you not wearing condoms this time, i.e. alcohol, drugs, mental health or low moods/depression, gender, culture restrictions, asking to use condoms
- How do you feel afterwards? Are you worried about HIV or HCV?
- MI: What do you like about "X": what do you NOT like about "X"? Summarize with pro's and con's (end with pro's) using client's terms to reflect back what they said
- What are some steps you think you could take to start reducing your risk for HIV/crystal meth use? Can you adopt one risk reduction step?
- Refer to VAMP, AA, family physician, and other support services. Check in with the client a few weeks later
- Empower clients with skills to talk to partners about HIV and potential risk

VAMP, Vancouver Addictions Matrix Program
AA, Alcoholics Anonymous

2) Does the Client want to Reduce their Risk?

Incorporating **Motivational Interviewing (MI)** into our practice.

- Developed in the 1980s as a way to help individuals manage excess alcohol
- It's evidence-based with over 1200 articles published, referring to different health conditions
- It's an effective way of structuring conversations
- Aims to move clients toward achievable risk-reduction goals
- Unlike more coercive methods, motivational interviewing seeks to change behaviour from within the individual
- Often seen as a legitimate, effective, non-intrusive, evidence-based practice
- Motivational interviewing expresses empathy, manages resistance without confrontation, and uses techniques such as reflective listening, summarization, and affirmation to support individuals
- The goal is to motivate individuals to address any ambivalence they may feel. As a result, decisions are made by the individual for the individual rather than by an outside party

After establishing the clients previous on-going risks, it is helpful in establishing if the client is ready to make a change. Motivational Interviewing is a useful tool in determining the level and angle of discussion.
Motivational Interviewing (MI) is a communication strategy that is directive and patient-centered. The goal of MI is to help patients explore and resolve ambivalence in order to change unhealthy or problematic behaviours. The heart of MI is a spirit of empathy, acceptance, respect, honesty, and caring (Moyers, et al., 2005). The "spirit" of MI is like dancing rather than wrestling. It is collaborative, evocative, and honouring of patient autonomy (Mountain Plains AIDS Education and Training Center, 2013).

Source:

Cook PF, et al. Retrieved from: aidsetc.org/sites/default/files/resources_files/etres-441.pdf

Motivational Interviewing (MI): Stages of Change

Stage	Characteristic	Your Goal
Pre-contemplation	No intention to change behavior. Unaware or under-aware of problems	To get patient to consider they have a problem
Contemplation	Aware of the problem & seriously considering a change, but no commitment to take action	To raise awareness of problem by observation of behavior
Preparation	Patient intends to change and makes small behavioral changes	To encourage these steps and support change process; Commit to make change a top priority
Action	Patient decides to take decisive action to change	To make action plan suggestions, reinforce changes, provide support and guidance
Maintenance	Work to prevent relapse and consolidate gains	To support continued change and help with relapse prevention

Bray J, et al. Retrieved from: https://www.bcm.edu/education/programs/sbirt/index.cfm?pmid=25042

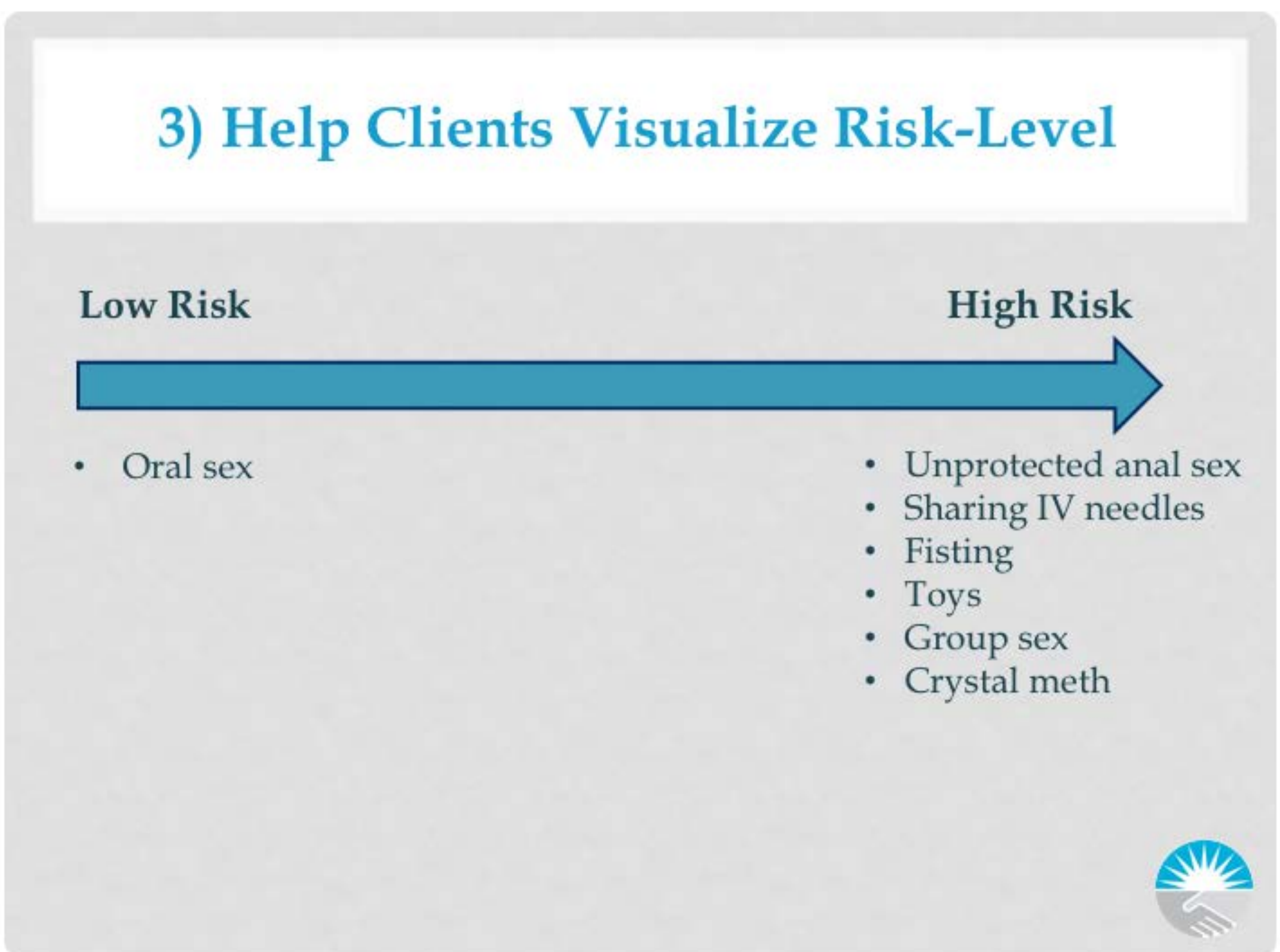
Motivational Interviewing discusses 5 main stages of change; when we look at risk reduction, we should try and identify which stage our client is at. It is useful to determine which stage they are at as this will impact how you would approach your conversation.

Motivational Interviewing (MI): Stages of Change

There are two significant scenarios that one can apply MI in PEP clinics:

1. High levels of anxiety caused by new HIV-risk can often lead someone to move from "contemplation or preparation zone" to "action".
   - The client may decide to address an addiction issue, undiagnosed depression, or perhaps being the insertive versus the receptive partner more often.
2. If a client is returning for their 4th course of PEP treatment, this client may potentially be stuck in the "contemplation zone".
   - Trying to actively move them to the "action" zone in the 1-2 consults maybe not be the most effective method. Perhaps one needs to focus on raising awareness and supporting the change process, as per "Your Goal".

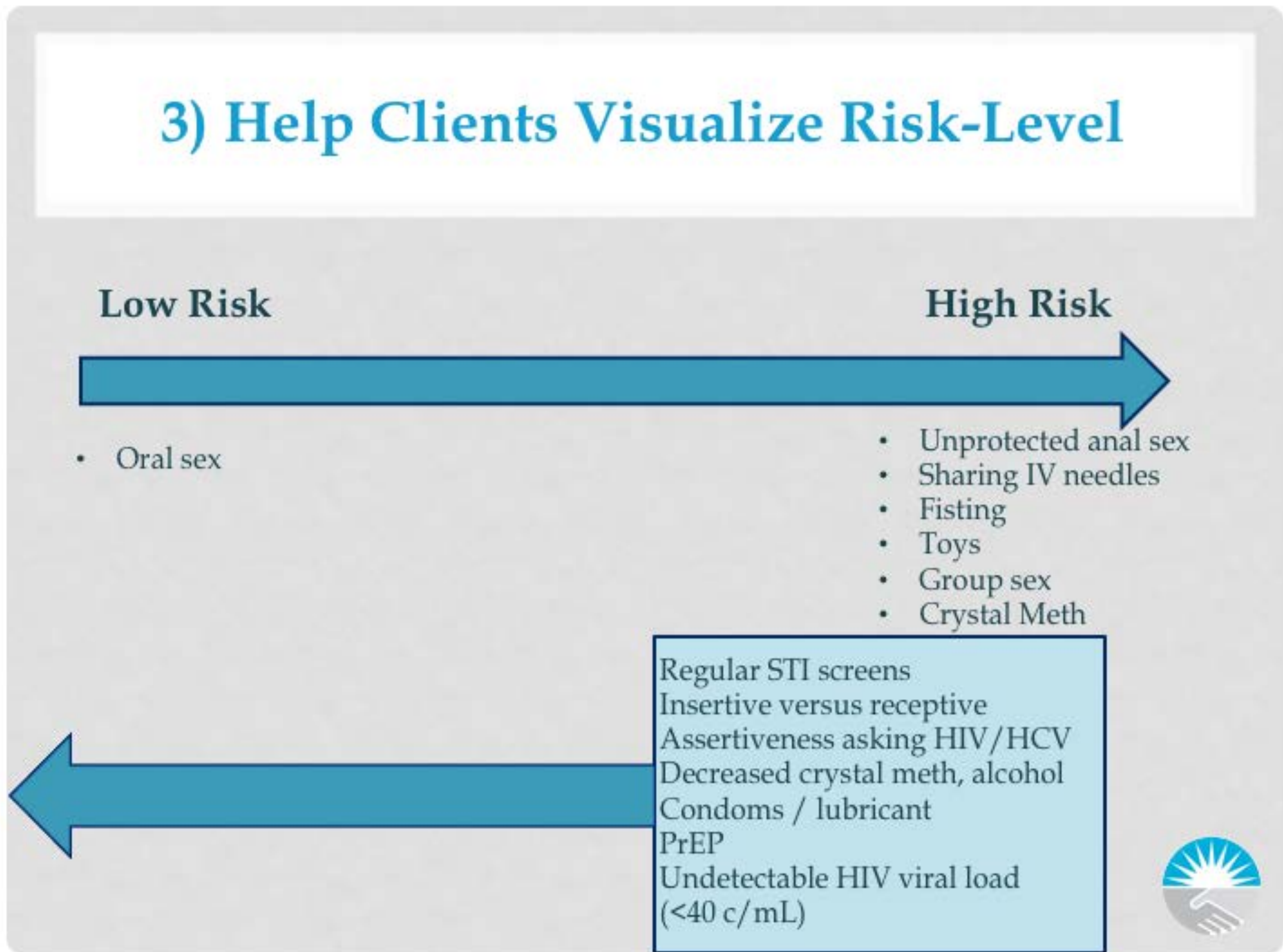
Overall by identifying the client's *stage* of change, this can be a useful tool in guiding one on how to best counsel the client.



Visualisation of risks can be helpful in determining previous risks and motivation to change any factors in the future.

One method of helping clients talk about their risks is provided below:

- Staff: draw a sliding scale from high to low risk
- Ask the client what activities they normally do that put them at risk of HIV
- Ask the client to place the activities on the arrow
- Ask the client are there are any activities that increase trauma such as fisting, toys



- Ask client if there is anything they could do to reduce their on-going risk?
- Is there one risk reduction activity (from the blue box) that they could adopt, that is realistic for them?
- Explain that risk reduction can be viewed in two ways:

Preventing all risks by stopping all activities that have a risk for HIV

Or

Reducing some risks that are realistic to implement

Refer to other services, if appropriate.

4) Give Client Resources / Tools for the Future

Assessing your own risk	Finding a sexual health clinic	HIV / Sexual health information
Action Canada for Sexual Health & Rights	SMARTSEX RESOURCE	CATIE Canada's source for HIV and hepatitis C information
HIV Risk Reduction Tool Beta Version CDC	Get tested on-line: GETCHECKED ONLINE A SERVICE PROVIDED BY THE BC CENTRE FOR DISEASE CONTROL	SMARTSEX RESOURCE

Lastly, it is important to give clients tools for future self-care. Clients should:

- Know how and where to assess their own risk
- How to find sexual health clinics
- Where they can have discreet screening for sexually transmitted infections, e.g. GETCHECKEDONLINE
- Know where to find sexual health care information
- Know where to access PrEP

It can be helpful to mark these websites on your computer so you can open it quickly to share and reinforce these sources of information.

Summary

- Counselling is NOT an extra job: it's just how you do a consult
- Creating a space safe and developing a therapeutic relationship is the cornerstone of the care we provide
- Remember PEP is not solely about this one incident – it's about that client's future risk too
- Risk reduction is considering social and behavioural determinants of health; use Motivational Interviewing
- Each consult should be tailored to the individual's circumstances, incorporating reducing anxiety, discussing adherence, providing clear follow-up plans and discussing risk reduction for the future
- Let's support our clients to have healthy sex lives
- Ensure we provide an environment of inclusiveness and respect

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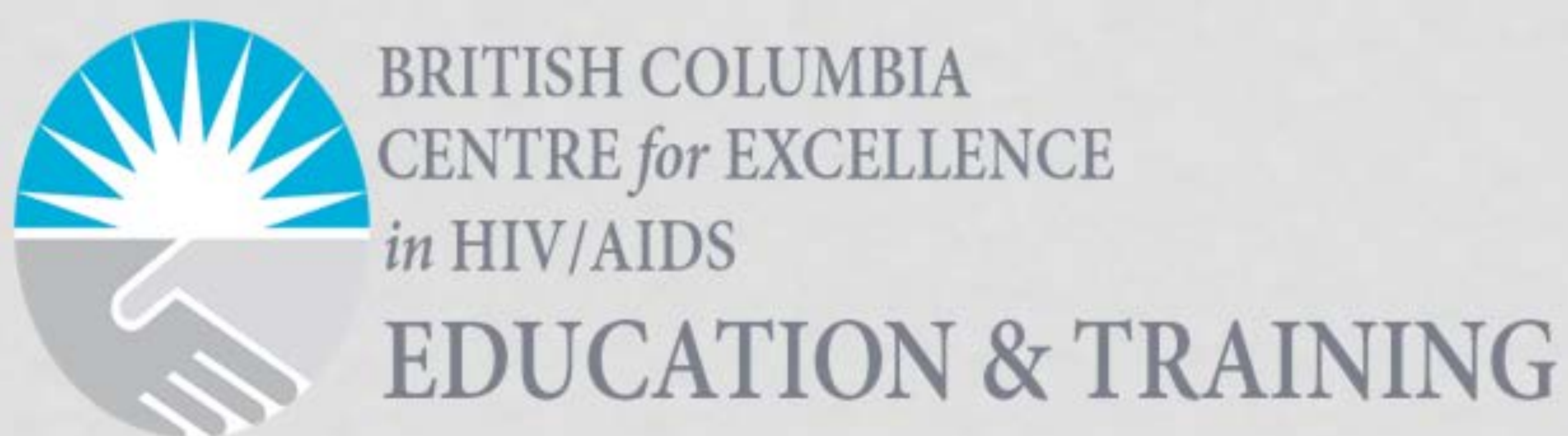

End of Module 6