Health Promotion and Disease Prevention

The Fenway Guide to LGBT Health
Module 3
Learning Objectives

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

- Explain the challenges and limitations in LGBT health research
- List and describe the health concerns for which LGBT populations are at increased risk
- Discuss key clinical approaches to health promotion and screening when redressing LGBT health disparities
LGBT Health Disparities
LGBT Health Disparities

Institute of Medicine: Lesbian Health: Current Assessment and Directions for the Future (1999)

Findings:

• Growing evidence that lesbians at higher risk for some health problems

• Lesbians experience financial and cultural barriers to accessing optimal healthcare

• More research and population-based data are needed to better understand the health and health status of lesbians
LGBT Health Disparities, cont’d

- Major goal of HP2010: to eliminate health disparities among LGBT populations
- www.healthypeople.gov
- HP2010 LGBT Companion document
- www.lgbthealth.net/side_hp2010.shtml
Limitations in Research on LGBT Health

- Clinical and public health studies on LGBT health are rare:
  - Historically, small convenience samples
  - More recently, larger, population-based studies
  - Lack of funding a major challenge
- Some study designs overestimate pathology (e.g. studies of alcohol use that recruit from bars)
- Inclusion of sexual orientation measures in government surveys is very recent, non-routine, and limited in scope
- Transgender and bisexual-specific research still extremely limited
LGBT Health Concerns

- Cigarette smoking
- Alcohol and recreational drug use and abuse
- Sexually transmitted infections & HIV, viral hepatitis
- Excess weight and obesity (lesbian women), Eating disorders (gay men)
- Mental health disorders:
  - Depression, anxiety, suicide

- Cardiovascular Disease
- Cancers:
  - Anal cancer; HIV-related cancers (gay/bisexual men)
  - Risk factors for breast and reproductive cancers (lesbian/bisexual women)
- Violence and trauma:
  - Hate crimes
  - Domestic violence
  - Sexual assault
Health Promotion in Clinical Practice
Characteristics of Cross-Cultural Care

Respect

Curiosity

Empathy
The Multiple Influences on Health

- Health is not just about the individual (genes and behavior)
- Health is influenced by many external, environmental factors, (McElroy et al, 1988). e.g.:
  - Interpersonal relationships
  - Institutional/organizational factors
  - Community factors
  - Public policies
- As with any person, health status and access to appropriate healthcare can be affected by socioeconomic status, stress, early life experiences, social exclusion, field of work, social support, addiction, nutrition, etc. (Marmot & Wilkinson, 1999)
A Patient-Centered Approach

- LGBT people have same health concerns as general population, as well as some additional risk factors
- Important to treat the whole person, not a collection of risk factors
- Important to understand that LGBT life issues are similar, but also can present unique challenges:
  - Coming out as LGB or T
  - Relationships: marriage/long-term partnership
  - Children: reproduction, adoption
  - Parenting and families
  - Adolescence
  - Aging
  - Legal rights as parents and partners
Guidelines for Health Promotion

- Guidelines developed by many sources, including government sources, professional specialty societies
- Sources not always consistent with each other
- In the United States, the most rigorous evidenced-based analyses, which rate interventions, are published regularly by the US Preventive Services Task Force (USPSTF) of HHS
  - See [http://www.ahrq.gov/clinic/uspstfab.htm](http://www.ahrq.gov/clinic/uspstfab.htm)
USPSTF Evidence Ratings

The USPSTF grades its recommendations based on the strength of evidence and magnitude of net benefit (benefits minus harms).

**Ratings:**

A. The USPSTF strongly recommends that clinicians provide [the service] to eligible patients.

B. The USPSTF recommends that clinicians provide [the service] to eligible patients.

C. The USPSTF makes no recommendation for or against routine provision of [the service].

D. The USPSTF recommends against routinely providing [the service] to asymptomatic patients.

I. The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service].
Health Promotion in Clinical Practice

Primary Care

Public Health

Mental Health
LGBT Clinical Concerns and Recommendations
Tobacco Use

LGB have significantly higher smoking rates compared to heterosexuals.
Tobacco Use: Findings

- LGB adult men and women 2x as likely to smoke as heterosexuals (Tang et al., 2004)

- 38%-59% LGB youth smoke vs. 28-35% hetero youth (Ryan et al, 2001)

- Bisexual-identified people report equal or higher rates of smoking than gays and lesbians (Conron et al., 2008; NM Dept. of Public Health et al., 2006; Dobinson, 2008)

- 30,000 (estimated) LGB people die each year from tobacco-related diseases (American Cancer Society, 2003)
Why are Smoking Rates Higher?

Possible reasons (Ryan et al, 2001):

- Coping with stress from stigma, discrimination
- Among youth – seeking social acceptance while coping with social isolation, loneliness
- Bars, clubs have historically been primary social outlets for LGBT
- Targeted advertising by tobacco industry
Targeting of LGBT people by the Tobacco Industry
Tobacco Screening and Counseling

Brief provider-initiated screening and counseling is effective (Rating: A)

The 5 A’s

1. Ask if patient smokes: *Do you smoke? How many cigarettes do you smoke per day? Have you ever tried quitting?*
2. Advise patient to quit
3. Assess readiness to quit
4. Assist patient in quitting (if ready)
5. Arrange follow-up visit

More information at:
http://www.surgeongeneral.gov/tobacco/tobaqrg.htm
http://1800quitnow.cancer.gov/
Tobacco Cessation Programs for LGBT

For LGBT-specific interventions, see:

lgbttobacco.org

gaysmokeout.net
Excess Weight and Obesity

- Lesbians have 2x the odds of being overweight or obese (Boehmer et al, 2007; Roberts et al, 2003)
- Eating habits among lesbians may be less healthy (Valanis et al, 2000)
- USPSTF recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults (Rating: B)
Eating / Body Image Disorders

- GB men have higher prevalence of eating disorders compared to heterosexual men (Feldman & Meyer, 2007); higher body dissatisfaction (Kaminski et al, 2005)

- Younger men (18-29) at higher risk (Feldman & Meyer, 2007)

- Data on LB women is mixed
  - same risk as heterosexual women (Feldman & Meyer, 2007)
  - lower risk for lesbians (Siever, 1994)
  - higher risk for bisexual women (Koh & Ross, 2006)

- No official recommendations for screening or counseling

- When caring for GB men, be aware of possible eating disorders; know clinical manifestations
Cardiovascular Disease

- GB men’s risk factors
  - Cigarette smoking
  - Use of club drugs, anabolic steroids (linked to hypertension)
  - HIV-infected individuals’ use of HAART (due to increased incidence of dyslipidemia, insulin resistance, type II diabetes)

- LB women’s risk factors
  - Smoking
  - Obesity/being overweight

- Transgender people’s risk factors
  - Use of estrogen or testosterone may increase risk (Biller 1995), but evidence is indeterminate
Cardiovascular Disease, cont’d

- Hypothesized increase in risk for CVD
  - Stress from concealing sexual orientation or transgender identity (linked to hypertension)
  - Experience of discrimination (elevates blood pressure)

- Screening Recommendations:
  - Screen for all relevant risk factors
  - Follow health promotion guidelines for general population
    - Screen for blood pressure 18+ years (Rating A)
    - Screen for lipid disorders 35+ in men; 45+ in women (Rating A)
    - Treat abnormal lipids in people at increased risk of CVD (Rating A)
Cervical Cancer

- Lesbians get Pap tests less frequently than heterosexuals
  - Fewer Paps in last year (61% vs. 74%, p<.05, Diamant et al, 2000)
  - Fewer annual pap tests (49% vs. 66%, p<.001, Matthews et al, 2004)

- Lesbians are at risk for cervical cancer
  - 77.3% have had sex with men (Diamant et al, 1999)
  - Woman-to-woman HPV transmission occurs (19% in lesbians who have never had sexual contact with men, Marrazzo et al, 1998)

- Recommendation: Follow cervical cancer screening (Rating: A) and HPV vaccination guidelines as for all women; encourage all patients with cervix and under 65 to be screened

- Transgender men (female-to-male/FTM) with cervix should also be screened routinely
Breast Cancer

- LB women less likely to get mammograms
  - Lesbians 4x less likely to undergo mammography (Kerker et al, 2006)
- LB women may have more risk factors for breast cancer
  - Obesity, alcohol use, smoking, lower rates of parity
- Cross-gender hormone therapy used by transgender women (male-to-female/MTF) may increase risk for breast cancer (Schlatterer et al, 1998)
- Transgender men (female-to-male) with intact breast tissue require screening

Recommendation: counsel all patients with breasts to undergo screening mammography according to standard screening guidelines (Rating: B)
Anal Cancer

- Incidence of anal cancer estimated to be 80x higher in gay men than heterosexual men (Knight, 2004)
- Men who have receptive anal intercourse and multiple partners at highest risk (Chin-Hong et al, 2005)
- HIV-infected gay/bi men at increased risk (Friedman et al, 1998)
- Unknown incidence of anal cancer in women who report anal sex
- Recommendation by some specialists (Palefsky, 2006):
  - Anal Pap smears every 1-3 yrs in MSM (annually in HIV+)
- No recommendation from USPSTF or CDC
Mental Health: Research Findings

- Homosexuality is not a mental illness (removed from DSM in 1973)

- LGB people may be at increased risk for:
  - Depression (Cochran et al., 2003)
  - Anxiety and panic attacks (Cochran et al., 2003)
  - Suicidal behavior (especially adolescents) (Silenzio et al, 2007)
  - Eating and body image disorders (men) (Siever, 1994; Kaminski et al, 2005)

- Transgender women (male-to-female) at high risk for:
  - Suicidal thoughts, attempts (Herbst et al, 2008)
Mental Health Concerns

- Why a higher prevalence of mental health disorders?
- Possibly associated with stigma, negative societal attitudes (minority stress theory)
- Internalized homophobia, social learning to reject one's basic personal preferences
- 42% of Americans believe homosexuality should NOT be accepted by society (Pew Research Center, 2003)
- Heterosexuals view bisexuals highly unfavorably (Herek, 2002)
Mental Health: Influencing Factors

- Constant concealment of true identity ("Covering")
- Victimization by (or fear of) verbal or physical attack
- Problems with self-acceptance
- Social isolation; lack of social supports
- Transgender and bisexual-identified people can feel isolated from the gay and lesbian community

- Internalized homophobia associated with eating disorders, high-risk sexual activity, substance abuse, suicide (DiPlacido, 1998; Savin-Williams 1994)
Mental Health: Assessment

In the primary care setting:

- Ask patient about most pressing mental health concerns
- Assess patient’s degree of comfort with sexual orientation and gender identity

Sample questions:

- At what age did you become aware of your sexuality or sexual orientation? How?
- How do you feel about your sexuality or sexual orientation?
- How do you feel about your gender? Is it different from how others view you? How do you describe your gender?
- How “out” are you now? Who knows about your sexuality/gender?
- What were/are the positive aspects of “coming out”?
- What are/were the negative aspects of “coming out”?
Mental Health: Assessment, cont’d

- Assess social factors
  - social isolation
  - social supports (friends, family, role models, mentors)
  - current and historic trauma (e.g. victimization by hate crimes, discriminatory acts)

- Assess coping styles
  - “How do you deal with your problems?”
    - “Do you talk about your problems?”
    - “Are you able to do something to distract yourself during times of stress?”
    - “Are you able to confront the factors that cause you stress?”
Mental Health: Comorbidities and Cofactors

- Gay and bisexual men
  - Methamphetamine use (associated with depression, mania, psychosis)
  - Anabolic steroid use (associated with depression, mania, psychosis)
  - Depression could lead to unsafe sex
  - Depression/anxiety affect HIV treatment adherence

- Lesbian and bisexual women
  - As with heterosexual women: premenstrual dysmorphic disorder
  - Mood disorders related to pregnancy, fertility meds
Mental Health: Treatment

- Biologic/somatic treatment: same as general population

- Psychotherapeutic treatment
  - Refer to APA Guidelines for Psychotherapy with LGB clients (http://www.apa.org/pi/lgbc/guidelines.html)
  - *Gay-affirmative therapy*: affirms rather than pathologizes LGB identity; addresses internalized homophobia; can use in combination with other therapies
  - *Conversion or “Reparative” therapy*: contraindicated; no evidence of efficacy; medical associations advise strongly against

- Community supports
  - Referrals to LGBT-sensitive therapists or LGBT-focused clinics
  - Support groups for LGBT (in person; online)
  - For B & T patients: when possible refer to B- or T- specific support groups (respectively)
Substance Use and Abuse: Findings

- Lesbian/bisexual women

  Compared to heterosexual women:
  - More alcohol-related problems (McKirnan and Peterson, 1989; Wilsnack et al, 2008)
  - Heavier alcohol use (Aaron et al, 2001)
  - Greater lifetime rates of marijuana, cocaine, and other illicit drugs (Skinner, 1994; Skinner and Otis, 1996; Cochran et al, 2004)
  - Bisexual-identified women may have higher rates of use (Conron et al, 2008) and be more likely to use in combination with sex (Koh et al, 2005)
Substance Use and Abuse: Findings, cont’d

- Gay and bisexual men

  Compared to heterosexual men:
  - Greater lifetime use rates of cocaine (37%), marijuana (18-37%), MDMA (ecstasy), methamphetamine, poppers (Cochran et al, 2004; Skinner, 1994; Stall et al, 2001)
  - Alcohol use rates similar to heterosexual men (Drabble et al, 2005)

- Transgender women (male-to-female)
  - IDU rates (12%) (Herbst et al, 2008)
  - Other illicit drugs (27%) (Herbst et al, 2008)
Substance Use: Influencing Factors

Alcohol and drugs may be used by LGBT people for various reasons:

- To cope with stress from victimization, homophobic attitudes, “coming out”
- To escape feelings of loneliness, depression
- To help “build courage” to approach potential partners
- Environment: marginalization of LGBT people encourages socializing at bars and clubs (no other social outlets)
  (Trocki et al, 2005; Heffernan, 1998; Barbara, 2002; Rosario et al, 2004; Russell et al, 2002; Amadio, 2006; Ross et al, 2001)
Substance Use and Sexual Risk Behavior

- Alcohol and drug use (poppers, crystal meth) associated with higher sexual risk-taking among GB men and MTF, and consequently with HIV-infection and other STIs (Molitor et al, 1998; Purcell et al, 2005; Wong et al, 2005)

- Increased risk due to:
  - Disinhibitory effects of some substances
  - Prolongation of sexual encounters when on drugs
    - Concurrent recreational use of erectile dysfunction drugs
  - Decreased pain thresholds = increased mucosal trauma
  - Possible immunosuppressive effects of drugs
  - Increased rates of condom failure when on drugs
Substance Use: Subpopulation Considerations

- Gay and Bi men
  - “Party drugs” or “Club drugs:” MDMA (ecstasy), Ketamine, GHB, poppers, crystal meth
  - Circuit parties, raves: High levels of substance use, combining substances
  - Anabolic steroid use

- Lesbians and Bi women
  - Substance use may not decrease with age as much as in general population (Skinner 1994; Hughes et al, 2006)
  - African-American lesbians may be more likely to be heavy drinkers and have drinking problems (Hughes et al, 2006)

- Transgender individuals
  - High rates of injection drug use (Clements et al, 1999)
  - Injection hormones from “black market”
  - Sex work linked to substance use (MTF)
Substance Use and Abuse: Screening and Treatment

- Screening and treatment approaches similar with LGBT as general population
- Many 12-step fellowship programs (AA, NA) have GL or T groups (but no known bisexual groups)
- Some residential and outpatient programs focus on LGBT populations (see Handout 3-A)
Hate Crimes, Sexual Assault, Domestic Violence

- Trauma can be physical or emotional, and can lead to psychological or behavioral problems, such as substance abuse and suicidal behavior.

- Sensitive and effective recognition, intervention, and prevention are key for LGBT victims of trauma.
Hate Crimes: Findings

- 1,472 anti-LGBT hate crimes reported to FBI, 2006
- 2,430 victims reported anti-LGBT violence to National Coalition of Anti-Violence Programs (NCAVP), 2007
- 83% LGB survey respondents fear victimization; 44% threatened with violence (Herek et al, 1997)
Common Reactions to Victimization by Hate Crimes

- Feeling personally targeted
- Crisis of identity
- Self-blame; internalized homo/bi/transphobia
- Loss of trust (including in medical providers)
- Feelings of vulnerability
- Depression, stress, anxiety
- Community members may have trauma responses even if they were not directly targeted
Hate Crimes: Evaluation and Management

- Victims usually present to ER with physical injuries
- Evaluate and treat according to accepted trauma protocols
- Attend to possible sexual victimization
- Patient may fear further victimization and humiliation by perpetrator, or even healthcare providers, family
- Familiarize self with local statutes/ mandatory reporting, and appropriate resources and referrals
Sexual Assault

- Findings on LGBT sexual victimization vary; more information is needed
- LGB lifetime victimization by sexual assault 2-3x higher than non-LGB (Conron et al, 2008)
- LB women report high rates of childhood sexual abuse (Austin et al, 2008)
- 3-10.5% of men experience rape or sexual assault (may be higher)
- GB male victims may underreport because of shame, uncertainty due to belief that it only happens to women
- Male-to-female transgender people who are sex workers at increased risk of sexual assault
Domestic Violence

- Same rate as in heterosexual couples
- Can manifest as physical, sexual, or psychological abuse; economic control, social isolation, threats
- Abusive partner attempts to exert power and control – increasingly violent over time
- In same-sex relationships, also can include:
  - Threats of “outing” partner
  - Persuading victim that leaving relationship is akin to admitting same-sex relationships are deviant
  - Asserting women can’t be violent (denying abuse)
  - Asserting men are violent and therefore domestic violence expected
- Male victims may feel ashamed about fearing partner
Sexual Assault: Victim Concerns

- Lesbians and Bi women
  - (if victimized by man) Pregnancy, STIs
  - (if victimized by woman) Law enforcement and healthcare providers may not believe that women can sexually assault

- Gay and Bi men
  - Additional shame because men aren’t typically “victims”
  - Lack of resources specific to men

- Sex workers
  - Fear of legal consequences
  - Concern of not being recognized as sexually assaulted because of nature of sex work

- All LGBT
  - Fear of discrimination when disclose gender of perpetrator or own gender (particularly if date rape, or assault by domestic partner)
  - Lack of response by law enforcement
Domestic Violence: Screening

- There may not be any physical evidence of abuse at time of clinician visit
- Chronic pain, sleep disorders, anxiety, depression all possible effects of domestic violence
- Recommendation: routine inquiry about current and past domestic violence for all patients
  - If you do not know gender of current or past partner(s), use gender-neutral language when asking about partner (e.g., “partner or spouse,” “someone you live with,” “girlfriend or boyfriend”)

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Violence and Trauma: Assessment and Management

- During history, ask routine initial screening question:
  
  At any time, has anyone hit, kicked, choked, threatened, forced him or herself on you sexually, touched you in a sexual way that was unwanted, or otherwise hurt or frightened you?

- Always ask in private, without partner or others present

- Assure victim of violence that he or she is believed, respected, and not responsible or to blame for the abuse

- Help patient assess risk of future victimization

- Initiate discussion of safety needs, referrals
Steps for Recognizing and Treating Victims of Trauma

- Use your **RADAR**
  - **R**emember to ask routinely about violence and victimization in your own practice
  - **A**sk directly about violence. Interview in private always.
  - **D**ocument information about “suspected hate crimes, domestic violence, or sexual assault” in patient’s chart
  - **A**ssess your patient’s safety (Weapons in house? Children safe? Violence escalating?)
  - **R**eview options/Referrals (e.g., LGBT advocacy services, shelters, support groups, legal advocates)
Sexual Health and Function

- Ask about sexual health in an open-ended way, free of judgments and assumptions

- Sexuality, desire, and intimacy should be approached on the patient’s terms, using patient’s vocabulary (see Module 2 for more on this topic)

- Assess patient’s level of satisfaction with how s/he expresses her/himself sexually

- Perform clinical evaluation of sexual function
Sexually Transmitted Infections in MSM

Men who have sex with men (MSM) at risk for:

- Syphilis: 64% of new cases among MSM (Beltrami & Weinstock, 2007)
- HIV/AIDS: ~53% of new cases among MSM (CDC, 2008)
- Gonorrhea: 20-36% of new cases among MSM (Fox et al, 2001; Mark & Gunn, 2004)
- Chlamydia/LGV
- Viral hepatitis (A, B)
- Herpes Simplex Virus
- HPV (urethral, anal)
- MRSA
STI Screening for MSM
(CDC Recommendations)

- Routinely ask sexually active MSM about STI symptoms; maintain a low threshold for diagnostic testing of symptomatic patients.
- Regardless of symptoms or condom use, sexually active MSM should be tested at least annually for:
  - HIV (if HIV negative or not tested within the previous year)
  - Syphilis
  - Hepatitis B
  - Urethral gonorrhea and Chlamydia if had insertive intercourse in past year
  - Rectal gonorrhea and Chlamydia if had receptive anal intercourse in past year
  - Pharyngeal gonorrhea if had receptive oral intercourse in past year
  - Also consider type-specific serologic tests for HSV-2, if infection status is unknown
STI Screening for MSM (CDC Recommendations) cont’d.

- More frequent STI screening (i.e., at 3–6 month intervals) is indicated for MSM who have multiple or anonymous partners, have sex in conjunction with illicit drug use, use methamphetamine, or whose sex partners participate in these activities.
- Vaccination against hepatitis A and B is recommended for all MSM in whom previous infection or immunization cannot be documented.
- HPV vaccine in men being evaluated.
- NOTE: USPSTF takes a more conservative view of STI screening.
# STI Testing in MSM

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<thead>
<tr>
<th>STI</th>
<th>Site</th>
<th>FDA Approved Tests</th>
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<tbody>
<tr>
<td>HIV</td>
<td>Blood</td>
<td>EIA; confirm reactives with Western Blot</td>
</tr>
<tr>
<td>HIV</td>
<td>Blood</td>
<td>Rapid test; confirm reactives with WB or IFA</td>
</tr>
<tr>
<td>HIV</td>
<td>Oral Fluid</td>
<td>Rapid test; confirm reactives with WB or IFA</td>
</tr>
<tr>
<td>Syphilis</td>
<td>Blood</td>
<td>RPR or VDRL; confirm reactive with FTA-ABS, TPPA, or MHA-TP</td>
</tr>
<tr>
<td>Gonorrhea</td>
<td>Urethra</td>
<td>Culture or NAAT (urine or urethral swab)</td>
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<td></td>
<td>Pharynx</td>
<td>Culture</td>
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<td></td>
<td>Anus</td>
<td>Culture</td>
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<tr>
<td>Chlamydia</td>
<td>Urethra</td>
<td>NAAT (urine or urethral swab)</td>
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<tr>
<td></td>
<td>Pharynx</td>
<td>Culture (but testing not routinely recommended)</td>
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<tr>
<td></td>
<td>Anus</td>
<td>Culture</td>
</tr>
</tbody>
</table>
STIs among WSW

- Research on STIs and behavioral risk factors among women who have sex with women (WSW) is limited
- Female-to-female sexual contact can transmit:
  - Bacterial vaginosis
  - Chlamydia
  - HSV-1
  - HPV
  - Trichomonas

(Bailey et al, 2004; Pinto et al, 2005; Marrazzo et al, 1998; Bauer and Welles, 2001; Singh et al, 2008)
STIs among WSW, cont’d

- Significant numbers of WSW have (or have a history of) sex with men (Diamant et al., 1999)
- Women who have sex with women and men may be at higher risk for HIV and other STIs compared to women who exclusively have sex with men or women (Cochran and Mays 2007; Diamant et al, 2000; Fethers et al, 2000)
- Take a thorough sexual history and screen accordingly
- Perform Pap tests on all women
STIs: Transgender Findings

- Research on STIs and behavioral risk factors among transgender populations is limited
- Recent review (29 studies) on HIV risk (Herbst 2008):
  - Avg. prevalence of HIV infection among transgender male-to-females (MTF) -- 27.7%
  - Higher among African American MTF -- 56.3%
  - Many MTF did not know HIV-infected status
  - Avg. prevalence of prior STI diagnosis among MTF -- 21%
  - Studies of female-to-male transgender people very rare
Routine HIV Testing: New CDC Guidelines

Changes to previous recommendations include:

- Routine HIV testing for all patients (13-64), regardless of risk
- Patient should be notified that testing will occur; patient can decline (opt-out)
- Separate written consent for HIV testing should not be required; general informed consent is sufficient
- Pre-test prevention counseling should not be required
- Persons at high risk for HIV should be screened at least annually

Note: many states still do not allow testing without counseling and specific informed consent
Implementation of New Guidelines

- Aside from local laws and regulations...
- What are barriers?
- What are opportunities?
- What existing or new resources will need to be utilized?
Prevention Counseling, Programs, and Interventions
Risk-Reduction Counseling / Behavioral Change

- Patient-centered approaches are best
- Assess the patient’s “stage of change” (Prochaska et al, 1992): (precontemplation, contemplation, preparation, action, maintenance, relapse)
- Tailor the therapeutic relationship and treatment intervention to the stage (Prochaska & Norcross, 2001)
- Use Motivational Interviewing: “a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.” (Miller & Rollnick, 2002) See: http://www.motivationalinterview.org
Prevention Interventions

- **Guide to Community Preventive Services**
  - Provides systematic reviews of interventions for tobacco, alcohol, cancer, obesity, sexual risk behavior, violence, and more
  - [http://www.thecommunityguide.org](http://www.thecommunityguide.org)

- **Put Prevention Into Practice (PPIP)**
  - Recommends formal systems to implement clinical preventive services

- **Diffusion of Effective Behavioral Interventions (DEBI)**
  - Provides interventions, training and technical assistance on evidence-based HIV/STI/Viral Hepatitis prevention programs
  - [http://www.effectiveinterventions.org](http://www.effectiveinterventions.org)

- **National Cancer Institute Research-Tested Intervention Programs**
  - Provides access to cancer intervention programs and products
Further Learning

- See Handout 3-A for Resources
- See Handout 3-B for References