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Center for Substance Abuse Treatment

Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases

Treatment Improvement Protocol (TIP) Series

11

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The opinions expressed herein are the views of the consensus panel members and do not reflect the official position of CSAT or any other part of the U.S. Department of Health and Human Services (DHHS). No official support or endorsement of CSAT or DHHS is intended or should be inferred. The guidelines proffered in this document should not be considered as substitutes for individualized patient care and treatment decisions.

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What Is a TIP?

CSAT Treatment Improvement Protocols (TIPs) are prepared by the Quality Assurance and Evaluation Branch to facilitate the transfer of state-of-the-art protocols and guidelines for the treatment of alcohol and other drug (AOD) abuse from acknowledged clinical, research, and administrative experts to the Nation's AOD abuse treatment resources.

The dissemination of a TIP is the last step in a process that begins with the recommendation of an AOD abuse problem area for consideration by a panel of experts. These include clinicians, researchers, and program managers, as well as professionals in such related fields as social services or criminal justice.

Once a topic has been selected, CSAT creates a Federal resource panel, with members from pertinent Federal agencies and national organizations, to review the state of the art in treatment and program management in the area selected. Recommendations from this Federal panel are then transmitted to the members of a second group, which consists of non-Federal experts who are intimately familiar with the topic. This group, known as a non-Federal consensus panel, meets in Washington for 5 days, makes recommendations, defines protocols, and arrives at agreement on protocols. Its members represent AOD abuse treatment programs, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies, and private practitioners. A chair for the panel is charged with responsibility for ensuring that the resulting protocol reflects true group consensus.

The next step is a review of the proposed guidelines and protocol by a third group whose members serve as expert field reviewers. Once their recommendations and responses have been reviewed, the chair approves the document for publication. The result is a TIP reflecting the actual state of the art of AOD abuse treatment in public and private programs recognized for their provision of high quality and innovative AOD abuse treatment.

This TIP, titled *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases*, addresses the twin epidemics of substance abuse and infectious diseases. Service providers from many disciplines and across many systems and agencies are increasingly encountering individuals with AOD abuse problems, which place them at higher risk for acquiring infectious diseases. The TIP presents two screening instruments—one for AOD abuse and one for infectious diseases—that were designed to be able to be rapidly administered by a wide range of providers and relatively simple to score and interpret. The instruments are flexible and applicable to diverse populations. The TIP describes considerations in the development of these instruments and offers guidelines for their use in field tests. Guidelines for training staff in the use of these instruments are also presented, and legal and ethical concerns, especially in the area of confidentiality, are discussed.

This TIP represents another step by CSAT toward its goal of bringing national leadership to bear in the effort to improve AOD abuse treatment.

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Foreword

The Treatment Improvement Protocol Series (TIPs) fulfills CSAT's mission to improve alcohol and other drug (AOD) abuse and dependency treatment by providing best practices guidance to clinicians, program administrators, and payers. This guidance, in the form of a protocol, results from a careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates employs a consensus process to produce the product. This panel's work is reviewed and critiqued by field reviewers as it evolves.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have bridged the gap between the promise of research and the needs of practicing clinicians and administrators. I am grateful to all who have joined with us to contribute to advance our substance abuse treatment field.

Susan L. Becker
Associate Director for State Programs
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Chapter 1—Introduction

Development of this Treatment Improvement Protocol (TIP) was motivated by the Center for Substance Abuse Treatment's (CSAT's) recognition that simple instruments are needed to screen for alcohol and other drug (AOD) abuse problems and infectious diseases. Because these two conditions can occur together with high prevalence in some populations, workers in each of these fields need to be knowledgeable about how to screen their clients for the disorders and problems of the other.

AOD abuse treatment personnel, especially screeners and intake staff, need to be able to recognize risk factors for infectious diseases in the individuals with whom they come into contact. Similarly, outreach workers and other health care personnel working with people at risk for infectious diseases need to be alerted to signs of possible AOD problems in their clientele.

The screening instruments presented in this document were designed for use by AOD and infectious-disease workers to screen for disorders with which they may have limited familiarity. The AOD instrument is intended for use primarily by infectious-disease personnel, whereas the infectious-disease screening instrument is designed for use primarily by AOD workers. The use of these instruments in this manner can enhance the detection of these often comorbid conditions and can promote communication between referral agencies to foster the development of a network of treatment programs and other resources for clients.

Rationale for Concomitant Screening

Many, if not most, of the factors that place an individual at high risk for either substance use disorders or infectious diseases also place them at risk for the other of these two problems. For instance, injecting drug users, in addition to being highly likely to have an addiction problem, are also at high risk for infection with human immunodeficiency virus (HIV) because of the practice of sharing needles that is common among these individuals. Similarly, an individual with sexually transmitted diseases (STDs) may also be likely to have a drug problem, owing to the sexual disinhibition that is often produced by AOD abuse and that may have led to high-risk sexual encounters.

Outreach and other health care personnel who provide services to high-risk individuals, such as the homeless, pregnant adolescents, and criminal offenders, should therefore consider screening for both substance use disorders and infectious diseases because of the relatively high likelihood that an individual being screened for one of these problems also has the other. In addition to identifying more individuals with one or both of these problems, data on the comorbidity of these conditions will also be useful to program planners and managers in developing resources to treat these individuals.

Ultimately, it is hoped that screening for both AOD abuse and infectious diseases concomitantly will facilitate access to health care for at-risk individuals by promoting early identification of these problems. In addition, the appropriateness and specificity of treatment placement can be improved when a comorbid client is accurately screened. For example, individuals with infectious diseases of major health importance can receive appropriate intervention, such as preventive therapy for potential latent tuberculosis (TB) infection in HIV-infected patients, in the AOD abuse treatment center. Another alternative would be to refer these individuals for appropriate treatment of the infectious condition. The risk of illness and spread of disease to other member of the community could thus be reduced.

Scope of the Twin Epidemics

Substance abuse and infectious diseases of public health importance, both of which are preventable causes of illness and death, are two of the 10 leading causes of death in the United States. The prevalence of both problems remains high in certain populations.

Despite indications that AOD abuse is declining in the United States, it is still an integral part of our culture. During any given month in the last 20 years, at least 14 million individuals in the United States consumed some type of illicit drug. A recent report by the Institute of Medicine estimated that on a typical day in 1987–1988, 5.5 million individuals needed treatment for AOD abuse (Institute of Medicine, 1990).

The incidence and prevalence of infectious diseases among AOD abusers, as well as among other high-risk individuals, have increased substantially. The risk for contracting infectious diseases is greater in individuals with AOD abuse problems than in non-AOD users for three major reasons:

- They are more likely to be involved in drug-related activities, such as needle sharing, that place them at risk.
- They may be more likely, because of the sexual disinhibition associated with AOD use, to engage in sexual behaviors that confer an increased risk.
- The social networks of some AOD abusers may overlap with those of individuals with STDs and TB.

People with AOD abuse problems account for a significant proportion of the increasing rate of STDs, HIV infection and acquired immunodeficiency syndrome (AIDS), TB, and hepatitis B and C. In recognition of these factors, AOD treatment programs are becoming sensitized to the medical needs of their clients who are at increased risk for infectious diseases.

Syphilis and gonorrhea occur more frequently in individuals with AOD abuse problems than in the general population. Higher rates of STDs have long been noted in injecting drug users. The syphilis epidemic of the late 1980s, which resulted in the highest rate of syphilis in 40 years, and the increased prevalence of antibiotic-resistant strains of gonorrhea have led to an increased incidence of STDs in persons who abuse drugs. Abuse of cocaine, especially crack, for example, has been associated with sex-for-drugs prostitution, which, in turn, places individuals at increased risk for STDs.

TB has been seen with increased frequency in chronic alcohol abusers and, recently, in injecting drug users as well. Because AOD abusers typically have low compliance with treatment, and because the incidence of both drug-sensitive and multiple-drug-resistant TB is on the rise, the detection of this disease has become a public health imperative. The low socioeconomic status of many individuals with STDs or TB makes it unlikely that they will receive adequate diagnostic and treatment services, contributing to the further transmission of these diseases.

HIV has had a tremendous impact on populations in which AOD abuse and infectious diseases are prevalent. People who abuse drugs are at high risk for contracting HIV infection due to behavioral risk factors, such as needle sharing by injecting drug users and high-risk sexual behaviors resulting from AOD-related sexual disinhibition. The presence of STDs along with the AOD abuse further increases the risk of HIV transmission for physiological as well as behavioral reasons. Studies have shown that the transmission efficiency of HIV is greatly increased in patients with STDs, particularly herpes, syphilis, gonorrhea, and chlamydia (Kirby et al., 1991; Wasserheit, 1992). Conversely, HIV infection lowers an individual's resistance to other infecting organisms, thereby increasing susceptibility to STDs.

In addition, HIV infection alters the clinical course of many diseases, especially TB, increasing both its severity and its potential for transmission. The increase in cases of TB since 1985 has been almost entirely due to the impact of HIV on both the transmissibility of and susceptibility to the disease. TB is much more easily transmitted to others from an individual who also has HIV infection than from someone with TB alone, due to the greatly increased number of bacteria produced per cough by the HIV-infected TB patient. Conversely, being infected with HIV makes a person much more susceptible to TB because of the lowered immune response caused by the virus.

In turn, many individuals treated for infectious diseases also have AOD problems. Left untreated, these substance use disorders may have adverse consequences for the successful treatment of infectious diseases and the prevention of transmitting these diseases to others. AOD abuse often results in behaviors that, in addition to increasing the risks of contracting HIV infection and other infectious diseases, also adversely affect an individual's ability to successfully complete therapy for infectious diseases. These behaviors can also impede the success of interventions intended to change risk-associated behaviors that contribute to the transmission of these diseases.

The relationships between AOD abuse and infectious diseases are becoming clearer. Patients with AOD abuse problems are at higher risk for infectious diseases of all kinds. Conversely, patients with

diagnosed STDs or TB are at higher risk for AOD abuse. Recognition of this potential for comorbidity, and screening for both of these problems, can increase the likelihood of early detection, and, thereby, the success of preventive and rehabilitative measures.

The Screening Process

Screening is a broad term that may be defined as a range of evaluation procedures and techniques. The screening process, however, is distinguishable from comprehensive assessment procedures in several ways. It is important to understand this distinction so that the limitations of the screening instruments are recognized, thereby increasing the likelihood that they will be used appropriately and effectively.

A screening instrument does not enable a clinical diagnosis to be made, but rather merely indicates whether there is a probability that the condition looked for is present. Screening is a preliminary assessment or evaluation that attempts to measure whether key or critical features of the target problem area are present in an individual. A *comprehensive assessment*, on the other hand, is a thorough evaluation whose purpose is to establish definitively the presence or absence of a diagnosable disorder or disease. Accomplishing this goal entails evaluating other problems that may be related to the individual's disorder. A screening procedure typically involves a single event. A comprehensive assessment, in contrast, necessarily encompasses multiple procedures and sources of information.

The options arising from the results of screening should be limited to the following:

- The individual is likely to benefit from a referral for a comprehensive assessment,
- More assessment is not warranted at this time, or
- The screening will be repeated at a later time.

In contrast, the decision options resulting from a comprehensive assessment have to do with the provision of treatment or referral for treatment and for other specialized assessments.

In addition to ascertaining the presence of AOD abuse or infectious disease, a comprehensive assessment is also aimed at identifying problems that may be related to the condition being identified. These ancillary problems include residential or employment instability, physical and mental health problems, and difficulties with interpersonal relationships. On the basis of the information obtained through a comprehensive assessment, a service provider can develop a treatment plan and determine a client's need for additional social services and other health-related referrals.

The Development Process

Goals of Instrument Development

A CSAT-sponsored consensus panel, attended by expert clinicians and researchers, was held in order to conceptualize and develop instruments for screening for AOD abuse and infectious diseases. (See page vii for a list of panel members.) This document describes the considerations and deliberations of the consensus panel and the process used to develop the instruments. The screening instruments themselves, along with guidelines for their use in field tests, are presented in Chapters 2 and 3.

The development of the screening instruments for AOD abuse and infectious diseases was guided by a number of critical goals:

- The instruments must be designed for use in both adolescents and adults.
- The AOD instrument must be designed to address all substances of abuse.
- The instruments must be able to be rapidly administered (in no more than 10–15 minutes); relatively simple to read, administer, score, and interpret; and must be user friendly to a diverse group of outreach workers, paraprofessionals, and professionals in the fields of both AOD abuse and infectious diseases.
- The instruments and related training guidelines and materials must be designed to facilitate their use by AOD abuse and infectious-disease personnel without specific background or training in the field; in other words, the infectious-disease instrument should be easily implemented by AOD service providers, and the AOD abuse instrument should be easily implemented by infectious-disease health care personnel.
- Both screening instruments should be flexible and broadly applicable to diverse populations that vary in ethnic and cultural background, age, gender, socioeconomic status, literacy level, and sexual orientation. They should be designed for use by a wide range of service providers with various skills and backgrounds and to promote collaboration among agencies without compromising objectivity and accuracy.
- The instruments' measurement scope should be limited to screening for potential problems, not establishing a diagnosis. Thus, the clinical decision for individuals who score positive on the instrument would be referral for a more comprehensive assessment or for a complete diagnostic evaluation. Additionally, since screening is not diagnosis, reporting of infectious diseases, which is mandated by local statutes for STDs, TB,

and, in some cases, HIV, is not required when positive results are scored for these items.

- The instruments' validity and practical utility should be evaluated across a wide range of settings, representing diverse clients and problem profiles.

It is expected that appropriate training for interested service providers will occur at the community level and that community agencies serving populations for whom the instruments are intended will strive to use them consistently. Agreement on such issues will help ensure that agencies efficiently and objectively serve the best interests of their clients.

Process Used in the Development of the Instruments

The consensus panel was divided into two smaller workgroups, one of which was charged with developing the AOD instrument, and the other, the infectious-disease instrument. Each of these two workgroups comprised experts in the field represented by the assigned screening instrument: the group responsible for the infectious-disease instrument was made up of infectious-disease clinicians and physicians, and the workgroup developing the AOD instrument was composed of AOD health care professionals. The rationale behind the workgroup assignments was that experts in each field would best understand what questions needed to be asked in order to screen effectively for the problem with which they had familiarity and expertise.

The process of developing the content and format of the screening instruments began with lengthy discussions among members of each workgroup. General decisions about how to organize the content were made. For example, the groups decided to focus on factors reflecting the continuum of abuse and dependence in the AOD instrument and the signs and symptoms of infectious diseases in the infectious-disease instrument. In the latter workgroup, it was decided to focus on behavioral and social risk factors because the infectious diseases being screened for by the instrument are often asymptomatic.

Both groups decided to design the instruments in the form of questions requiring a simple response of either "yes" or "no." It was felt by both groups that this format would facilitate scoring and interpretation and would minimalize subjective interpretation of open-ended questions.

After the preliminary instruments were completed, review of each instrument by the other workgroup provided feedback from the other's perspective that was used subsequently to modify it. In some instances, the wording of a question was changed to simplify it, to make it appropriate for all drugs or all infectious diseases, or to increase its applicability to a diverse population. Each group also developed a glossary of terms pertinent to its screening instrument to aid understanding by workers less familiar with its field of expertise.

AOD Workgroup Process

The AOD workgroup compiled a general list of more than a dozen areas believed to be relevant to the identification of AOD abuse problems. These areas, termed "content domains" (see Chapter 2), were discussed at length and eventually were narrowed and edited for redundancy, resulting in five primary domains.

Noting that the substance abuse field contains many popular and well-researched screening instruments, the AOD workgroup also agreed that no screening tool existed that pertained to all forms of substances of abuse and that was appropriate for both adolescents and adults. The group therefore decided to review well-known screening instruments that were intended for use in adult and adolescent audiences and from which items could be selected to satisfy the need for broader coverage.

Items selected from these existing instruments were then assigned to the relevant content domains that had been decided upon earlier, and the items were placed in a preliminary order. A number of observational items relating to physical signs and symptoms of AOD abuse were also developed to supplement (or replace, in cases in which the resulting instrument would be used with a nonverbal client) the screening questions. These observational items, which are presumed to be relatively specific indicators of drug abuse, appear at the end of the AOD abuse screening instrument (Chapter 2).

Infectious-Disease Workgroup Process

In the infectious-disease workgroup, each member composed a list of questions he or she felt to be the most important and effective in screening for infectious diseases. The questions focused on diseases that are prevalent in AOD-abusing populations. These lists were then combined, and overlapping and redundant areas were eliminated. Discussion of the larger list that resulted eventually led to agreement among the workgroup members as to the questions deemed to be most useful and relevant. The indications, or recommended actions to be taken in response to a positive result, along with the risk factors conferred by a positive result, were then listed for each question.

Because there are far fewer existing screening tools for infectious diseases, the infectious-disease workgroup then devised a brief commentary for each question, explaining the rationale for its inclusion and the implications of an affirmative answer to that question. These notes appear at the end of the screening instrument for infectious diseases (Chapter 3).

Intended Users, Audiences, and Settings

The screening instruments for AOD abuse and infectious diseases were designed for use by a wide variety of service providers in a broad range of populations, service agencies, and settings. These providers may be nurses or nurses practitioners, physicians or physician extenders in treatment clinics (treatment specialists), or mental health workers (psychologists and psychiatrists, case managers, social workers, and paraprofessionals).

Ideally, all agencies and providers that have contact with individuals with AOD abuse problems and/or infectious diseases should be using both instruments with their clients and patients on a routine basis. These groups include, but may not be limited to, the following:

- Outreach workers and screening staff in AOD and infectious-disease facilities
- Public health physicians and nurses
- AOD and medical personnel who have contact with patients in health care institutions
- School nurses
- Criminal justice personnel (police, AOD workers in prisons, and probation officers).

The primary audiences for the screening instruments are populations considered to be at risk for having AOD abuse problems of infectious diseases. Such at-risk populations include the following:

- Individuals who inject illicit drugs
- HIV-infected individuals
- Individuals who engage in unsafe sex practices (including sexually active adolescents, gay and bisexual men, heterosexuals, and sex partners of those at risk for or infected with HIV or STDs)
- Immigrant and migrant populations
- Homeless individuals
- Pregnant women with AOD abuse problems
- People with multiple diagnoses (comorbidities such as AOD abuse, chronic physical or psychological disorders, and/or infectious diseases)
- Sex workers.

Settings in which the instruments can be used include outpatient and inpatient programs for AOD abuse; service organizations and clinics for HIV infection and AIDS, STDs, and TB; and needle-exchange programs. A screening instrument for AOD abuse and infectious diseases that focused only on clients and patients in existing programs for these problems, however, would undoubtedly miss a significant proportion of those at risk. Many individuals who are at risk for both AOD abuse problems and infectious diseases can be found in settings where they are not always perceived to be at risk for these problems.

For example, shelters for battered women or homeless individuals may house people who have AOD problems and who are also at risk for infectious diseases. Because these individuals are usually primarily identified in terms of their needs for shelter, food and clothing, however, the risk or presence of AOD abuse or infectious diseases often goes unrecognized. It is important to identify such "hidden" populations who are at risk for, or who already have, these two problems. Such potential clients may be found in the following settings:

- Primary-care health centers, mental health centers, and mobile health units
- Outreach and health programs for adolescents, and college- and school-based health clinics
- Hospital emergency rooms
- Drop-in community social service centers
- Public housing and transitional living homes
- Senior service and recreational facilities
- Programs and shelters for battered women and the homeless
- Child welfare and child protective agencies
- Family planning programs and clinics
- Rape crisis centers
- Community health centers for medically underserved populations, including illegal aliens, refugees, and migrant workers
- Community-based organizations for homosexual and bisexual men and women
- Job Corps
- Driving-while-intoxicated (DWI) programs
- Criminal justice settings (courts, correctional facilities, detention centers, and probation agencies)
- Parks and street locations where members of target populations congregate.

Limitations of Self-Reporting

Both of the instruments in this document rely on the self-report method, in which results are based on the respondent's answers rather than on direct observation or other objective findings of the person administering the test. The self-report method can be a valid strategy when investigating AOD abuse or risks for infectious diseases, but its limitations are important to consider when using the screening instrument.

Because of the social stigma that has long been attached to substance use disorders and the resulting reluctance by AOD abusers to admit their substance use, the self-report method is notoriously problematic when screening for these disorders. Its limitations are not confined to AOD abuse, however; screening for risk factors for infectious diseases is attended by similar problems. The factors that place a person at risk for these diseases also have to do with behaviors, most notably of sexual habits, that carry similar social stigma.

For example, some people who have AOD problems may give negative responses despite observational evidence of AOD abuse. Others may not admit to behaviors that place them at risk for infectious diseases. In addition, some individuals may answer affirmatively to some of the screening questions for AOD abuse or infectious diseases, such as adverse consequences of substance use or physical symptoms of disease, and yet still deny that they have an AOD problem or that they have engaged in high-risk behaviors. Others may deny that they have an AOD problem or an infectious disease when asked this directly, but will nevertheless answer other, indirect questions affirmatively.

The problems and limitations of self-reporting were taken into account in developing the screening instruments. As a result, most of the questions regarding substance use or risk-taking behaviors are worded indirectly. Screeners need to exercise sensitivity and patience in administering the instruments and to be aware of the possibility that people being screened may deny or minimize their problems.

Epidemiologic Criteria

Sensitivity and Specificity

Recommendations to use results from screening instruments are driven by four epidemiologic criteria. These four criteria are based on the four categories into which test results are divided: two types of positive results (true positives and false positives) and two types of negative results (true negatives and false negatives).

A positive result may be obtained from a test for one of two reasons: 1) either the individual actually has the condition being looked for (a *true-positive* result), or 2) the individual does not actually have the disorder, and the positive result occurred for some other reason, usually having to do with the test itself (a *false-positive* result). The same applies to negative results: a *true-negative* result is one in which the individual actually does not have the disorder, whereas a *false-negative* result is a negative result obtained when the individual is, in reality, positive for the disorder.

Sensitivity is a measure of the percentage of false-negative results that can be expected to be obtained from a test. Looked at another way, measuring a test's sensitivity attempts to determine how many individuals who actually have the disorder in question will be missed by the test. The question attempted to be answered by determining an instrument's sensitivity is: What percentage of individuals who are actually positive will turn up with a negative (that is, a false-negative) result? Sensitivity is defined as follows:

> Positive test results/(true positives + false negatives [i.e., all positives]).

For example, a test that is 99 percent sensitive will be positive for 99 of 100 individuals who are known to have the disease or condition. One of those 100 individuals, who is actually positive for the condition, will be identified as negative (i.e., *false* negative) by such a test.

On the other hand, specificity is a measure of false-positive results. Measuring a test's specificity attempts to determine how many individuals who in reality do *not* have the disorder in question will be identified by the test as having the disorder. Determining the specificity of a test, in other words, is an attempt to answer the question: What percentage of individuals who are actually negative will be identified as positive by the test? Specificity is defined as:

> Negative test results/(true negatives + false positives [i.e., all negatives]).

A test that is 90 percent specific will therefore be negative for 90 of 100 individuals who are known *not* have the disease or condition. Ten of the 100 individuals who are actually negative for the condition will be identified as positive (i.e., *false* positive) by such a test.

Measuring the sensitivity and specificity of the screening instruments presented in this document is fundamental to determining their accuracy—that is, to finding out how often they accurately identify individuals with AOD abuse problems or infectious diseases and how well they rule out those who do not have these problems. One way of determining the accuracy of the screening instruments would be to determine whether a client who is referred on the basis of screening responses actually has an infectious disease or substance abuse disorder. To accurately determine the sensitivity of these screening instruments, however, they must be tested on large numbers of people known to be at risk for infectious

diseases or AOD abuse. These individuals include those identified through street outreach efforts, interviewed in intake settings, and monitored through followup procedures.

In general, it is desirable for screening instruments to have very high sensitivity, even at the expense of specificity. Therefore, false-positive results are expected to occur and must be addressed through subsequent, more confirmatory tests or assessments. The results obtained from the instruments, therefore, should not be overly relied upon as definitively indicating the presence of AOD problems or infectious diseases in the individuals screened.

Predictive Value

Measurements of sensitivity and specificity are used to determine a test's positive and negative *predictive value*. Positive predictive value is an epidemiologic concept that evaluates the likelihood that a positive test result is truly positive—that the disease or condition is actually present. Negative predictive value is the converse concept—that a negative test truly represents the absence of the disease or condition.

Positive and negative predictive values are determined by a test's sensitivity and specificity, as well as by the prevalence of the condition in the population being evaluated. For example, the predictive value of a positive HIV test is higher in a population of injecting drug users (where HIV seroprevalence is high) than in volunteer blood donors (where HIV seroprevalence is low).

For any screening instrument to be effectively used, an evaluation of its predictive value is critical. Such an evaluation should assess the scope and limitations of the instrument and should be carried out in the same manner as that used with clinical tests. One way to determine an instrument's sensitivity, specificity, effectiveness, and facility of use is through field testing, which should take into account the prevalence of AOD abuse and infectious diseases in the populations being tested. Field testing should also include an assessment of the ease with which clients are referred and can gain access to services.

A formal scoring system for the screening instruments cannot be defined until their accuracy is determined. Until a scoring system for the instruments is defined, workers should use the screening results only as general guidelines.

Organization of This TIP

In addition to this introductory chapter, this TIP has four major chapters. Chapters 2 and 3, *Development of the Simple Screening Instrument for AOD Abuse* and *Development of the Simple Screening Instrument for Infectious Diseases*, describe the procedures used to develop the instruments. The conceptual background that formed the basis on which the workgroup's decisions were based and items were selected is elaborated in these chapters. Also included is a discussion of issues pertaining to administration, scoring, and interpretation of the instruments. Each of these two chapters also contains the instruments constructed by the groups.

Chapter 4, "Training and Implementation," provides a training guide for individual service providers and agencies wishing to implement the screening instruments. Chapter 5, "Ethical and Legal Issues in Screening for AOD Abuse and Infectious Diseases," describes the legal and ethical issues relating to screening for these problems.

Chapter 2—Development of the Simple Screening Instrument For AOD Abuse

Routine screening for alcohol and other drug (AOD) abuse can be used to initiate the process of assessment by identifying a client's possible problems and determining whether he or she needs a comprehensive assessment. Ideally, a screening instrument for AOD abuse should have a high degree of sensitivity: it should be broad in its detection of individuals who have a potential AOD abuse problem, regardless of the specific drug or drugs being abused. The AOD abuse screening instrument presented in this chapter was designed to encompass a broad spectrum of signs and symptoms for substance use disorders. These conditions are characterized by AOD use that leads to negative physical, social, and/or emotional consequences and loss of control over one's pattern and amount of consumption of the substance(s) of abuse.

The view of AOD abuse problems and disorders presented in this chapter and reflected in the screening instrument is consistent with that adopted by the World Health Organization and the American Psychiatric Association. Briefly stated, this view holds that AOD abuse disorders are biopsychosocial disorders, causing impairment and dysfunction in physical, emotional, and social domains. Certain cognitive and behavioral signs and symptoms are also associated with AOD abuse (see the observation checklist at the end of the screening instrument for AOD abuse). Although many of these latter signs and symptoms can be the result of various medical, psychiatric, and social problems, individuals with an AOD abuse disorder generally exhibit several of them.

The screening instrument for AOD abuse was developed by first identifying five primary content domains, which are described in the sections that follow. The screening questions then devised were assigned to one or more of these categories. These screening questions were adapted from existing tools found in the published literature. Because most of these existing tools were designed to screen for alcohol abuse, many items needed to be revised to address other drugs. The sources for the screening items included in the instrument are shown in Exhibit 2-1.

Exhibit 2-1
Sources for Items Included in the AOD Screening Instrument

Question No.	Source Instrument
1	Revised Health Screening Survey (RHSS)
2	Michigan Alcohol Screening Test (MAST)
3	CAGE
4	MAST, CAGE
5	History of Trauma Scale, MAST, CAGE
6	MAST, Drug Abuse Screening Test (DAST)
7	MAST, Problem-Oriented Screening Instrument for Teenagers (POSIT)
8	MAST, DAST
9	MAST, DSM-II-R
10	POSIT, DSM-III-R
11	POSIT
12	POSIT
13	MAST, POSIT, CAGE, RHSS, Alcohol Use Disorders Identification Test (AUDIT), Addiction Severity Index (ASI)

Note: References for these sources appear at the end of this chapter.

Domains Measured by the Instrument

AOD Consumption

A person's consumption pattern—the frequency, length, and amount of use—of AODs is an important marker for evaluating whether he or she has an AOD abuse problem. Questions 1, 10, and 11 in the AOD abuse screening instrument were formulated in order to help delineate an individual's consumption pattern.

Patterns of AOD consumption can vary widely among individuals or even for the same individual. Although substance use disorders often consist of frequent, long-term use of AOD, addiction problems may also be characterized by periodic binges over shorter periods.

Preoccupation and Loss of Control

The symptoms of preoccupation and loss of control are common in persons with substance use disorders. Preoccupation refers to an individual spending inordinate amounts of time concerned with matters pertaining to AOD use. Loss of control is a symptom usually typified by loss of control over one's use of AODs or over one's behavior while using AODs. These symptoms are measured by screening test questions 2, 3, 9, 11, and 12.

The symptom of preoccupation is marked by an individual's tendency to spend a considerable amount of time thinking about, consuming, and recovering from the effects of the substance(s) of abuse. In some cases, the individual's behavior may be noticeably altered by his or her preoccupation with these matters. Such an individual may, for example, lose interest in personal relationships or may become less productive at work as a result of constant preoccupation with obtaining more of the substance of abuse.

Loss of control over AOD use is typified by the consumption of more of the substance(s) of abuse than originally intended. Many persons with an AOD abuse problem feel that they have no direct, conscious control over how much and how often they use AOD. Such an individual may, for example, initially intend to have only one drink but then be unable to keep from drinking more. He or she may find it difficult or impossible to stop drinking once he or she has started. In other instances, a person who originally plans to use a drug for a short period of time may find that he or she is increasingly using it over longer periods than originally intended.

Loss of behavioral control, on the other hand, is typified by loss of inhibitions and by behaviors that are often destructive to oneself or others. In many cases, these behaviors do not occur when the individual is not using AODs. A person with an AOD problem may begin taking unnecessary risks and may act in an impulsive, dangerous manner. Individuals who are intoxicated from AOD abuse may, for example, have sex with someone in whom they ordinarily would not have a sexual interest, or they may start an argument or fight.

Adverse Consequences

Addiction invariably involves adverse consequences in numerous areas of an individual's life, including physical, psychological, and social domains. In the screening instrument for AOD abuse, questions 5–9, 12, and 13 are designed to elicit adverse consequences of AOD abuse.

Examples of adverse physical consequences resulting from AOD abuse include experiencing blackouts, injury and trauma, or withdrawal symptoms or contracting an infectious disease associated with high-risk sexual behaviors. One of the most serious health threats to AOD abusers, particularly those who inject drugs intravenously, is infection with human immunodeficiency virus (HIV), the causative agent of acquired immunodeficiency syndrome (AIDS).

Adverse psychological consequences arising from AOD abuse include depression, anxiety, mood changes, delusions, paranoia, and psychosis. Negative social consequences include involvement in arguments and fights; loss of employment, intimate relationships, and friends; and legal problems such as civil lawsuits or arrests for abuse, possession, or selling of illicit drugs.

As an individual's use continues over time and addiction takes hold, adverse consequences tend to worsen. Thus, people in the very early stages of addiction may have fewer adverse consequences than those in the later stages. Individuals in the early stages of addiction may therefore not make the connection between their AOD abuse and the onset of negative consequences. For this reason, some of the items directed at identifying AOD-related adverse consequences in the screening instrument attempt to obtain this information without making an overt association with AOD abuse.

Problem Recognition

Making a mental link between one's use of AOD and the problems that result from it—such as difficulties in personal relationships or at work—is an important step in recognizing one's AOD abuse problem. Questions 2–4 and 13–16 in the AOD abuse screening

instrument are problem recognition items. Some of these items ask about past contacts with intervention and treatment services, because both research and clinical experience indicate that a history of such contacts can be a valid indicator of AOD abuse problems.

Some individuals who have experienced negative consequences resulting from their AOD abuse will report these problems during a screening assessment. Clients who show insight about the relationship between these negative consequences and their use of AODs, should be encouraged to seek help.

Many, if not most, people who abuse AODs, however, do not consciously recognize that they have a problem. Other reasons why a person may not disclose an AOD abuse problem include denial, lack of insight, and mistrust of the interviewer. These individuals cannot be expected to respond affirmatively to "transparent" problem recognition items—those in the form of direct questions, such as "Do you have an AOD problem?"—during a screening interview. For these individuals, questions must be worded indirectly in order to ascertain whether negative experiences have ensued from the use of AODs.

Tolerance and Withdrawal

AOD abuse, particularly prolonged abuse, can cause a variety of physiological problems that are related to the development of tolerance and withdrawal. Questions 5 and 10 are aimed at determining whether an individual has experienced any of the signs of tolerance and withdrawal.

Tolerance is defined as the need to use increasing amounts of a substance in order to create the same effect. If tolerance has developed and the individual stops using the substance of abuse, it is common for withdrawal effects to emerge.

Withdrawal from stimulants and related drugs often includes symptoms of depression, agitation, and lethargy; withdrawal from depressants (including alcohol) often includes symptoms of anxiety, agitation, insomnia, and panic attacks; and withdrawal from opiates produces agitation, anxiety, and physical symptoms such as abdominal pain, increased heart rate, and sweating.

Administration of the AOD Screening Instrument

Two versions of the AOD screening instrument are presented in this chapter. They have been designed to be administered in the form of either an interview (Exhibit 2-2) or a self-administered test (Exhibit 2-3) to individuals who may be at risk of having an AOD abuse problem.

Use of the screening instrument should be accompanied by a careful explanation of the subject's rights to confidentiality, as well as any limits on confidentiality (see Chapter 5). The interviewer should also be clear about the instrument's purpose and should make it understood that the information elicited from the instrument will be used to benefit, not to punish, the individual being screened.

Ideally, the screening test should be administered in its entirety. Situations may arise, however, in which there is inadequate time to administer the entire test. Street outreach community workers, for example, may have very limited time with an individual.

In such situations, a subset of the screening instrument can be administered. The four boldfaced questions—1, 2, 3, and 16—constitute the short form of the screening instrument. These items were selected because they represent the prominent signs and symptoms covered by the full screening instrument. Although this abbreviated version of the instrument will not identify the variety of dimensions tapped by the full instrument and is more prone to error, it may serve as a starting point for the screening process.

Notes on the Screening Questions

The screening instrument begins with a question about the individual's consumption of AODs (question 1). This question is intended to help the interviewer decide whether to continue with the interview—if the response to this first question is no, continued questioning may be unnecessary.

Questions 2–4 are problem recognition items intended to elicit an individual's assessment of whether too much AODs are being used, whether attempts have been made to stop or control AOD use, and whether previous treatment has been sought. Answers to these questions may help the service provider understand how the individual thinks and feels about his or her use of AODs. People who later report negative consequences as the result of their AOD use but who nevertheless answer "no" to these problem recognition questions may have poor insight about their AOD abuse or may be denying the severity of their AOD problem.

Questions 5–12 were designed to determine whether an individual has experienced any adverse consequences of AOD abuse. These include medical, psychological, social, and legal problems that often are caused by AOD abuse and addiction. Some questions are intended to elicit symptoms of aggression (question 9), physical tolerance (question 10)

Exhibit 2-2
Simple Screening Instrument for AOD Abuse
Interview Form

Note: **Boldfaced questions** constitute a short version of the screening instrument that can be administered in situations that are not conducive to administering the entire test. Such situations may occur because of time limitations or other conditions.

Introductory statement:
"I'm going to ask you a few questions about your use of alcohol and other drugs during the past 6 months. Your answers will be kept private. Based on your answers to these questions, we may advise you to get a more complete assessment. This would be voluntary—it would be your choice whether to have an additional assessment or not."

During the past 6 months...

1. **Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants.)** (yes/no)

2. **Have you felt that you use too much alcohol or other drugs?** (yes/no)

3. **Have you tried to cut down or quit drinking or using drugs?** (yes/no)

4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.) (yes/no)

5. Have you had any of the following?
   - Blackouts or other periods of memory loss
   - Injury to your head after drinking or using drugs
   - Convulsions, or delirium tremens ("DTs")
   - Hepatitis or other liver problems
   - Feeling sick, shaky, or depressed when you stopped drinking or using drugs
   - Feeling "coke bugs," or a crawling feeling under the skin, after you stopped using drugs
   - Injury after drinking or using drugs
   - Using needles to shoot drugs.

6. Has drinking or other drug use caused problems between you and your family or friends? (yes/no)

7. Has your drinking or other drug use caused problems at school or at work? (yes/no)

8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.) (yes/no)

9. Have you lost your temper or gotten into arguments or fights while drinking or using drugs? (yes/no)

10. Are you needing to drink or use drugs more and more to get the effect you want? (yes/no)

11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs? (yes/no)

(Continued on next page)

Exhibit 2-2 (continued):

12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone? (yes/no)

13. Do you feel bad or guilty about your drinking or drug use? (yes/no)

    Now I have some questions that are not limited to the past 6 months.

14. Have you ever had a drinking or other drug problem? (yes/no)

15. Have any of your family members ever had a drinking or drug problem? (yes/no)

16. **Do you feel that you have a drinking or drug problem now?** (yes/no)

- Thanks for answering these questions.
- Do you have any questions for me?
- Is there something I can do to help you?

Notes: _____

Observation Checklist

The following signs and symptoms may indicate an AOD abuse problem in the individual being screened:

- Needle track marks
- Skin abscesses, cigarette burns, or nicotine stains
- Tremors (shaking and twitching of hands and eyelids)
- Unclear speech: slurred, incoherent, or too rapid
- Unsteady gait: staggering, off balance
- Dilated (enlarged) or constricted (pinpoint) pupils
- Scratching
- Swollen hands or feet
- Smell of alcohol or marijuana on breath
- Drug paraphernalia such as pipes, paper, needles, or roach clips
- "Nodding out" (dozing or falling asleep)
- Agitation
- Inability to focus
- Burns on the inside of the lips (from freebasing cocaine)

preoccupation (question 11), and loss of control (question 12). Question 13 is designed to tap feelings of guilt, which may indicate that the individual has some awareness or recognition of an AOD problem; questions 14 and 16 are intended to measure the respondent's awareness of a past or present problem; and question 15 elicits the individual's family history of AOD problems.

Parenthetical words or phrases that accompany some of the screening questions are intended to provide the interviewer with specific examples of what is being looked for or to help the respondent understand the question. For instance, question 1 asks whether an individual has used AOD, and the wording in parentheses prompts the administrator to ask about specific substances of abuse.

Exhibit 2-3
Simple Screening Instrument for AOD Abuse
Self-Administered Form

Directions: The questions that follow are about your use of alcohol and other drugs. Your answers will be kept private. Mark the response that best fits for you. Answer the questions in terms of your experiences in the past 6 months.

During the last 6 months...

1. Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants)
   ___ Yes ___ No

2. Have you felt that you use too much alcohol or other drugs?
   ___ Yes ___ No

3. Have you tried to cut down or quit drinking or using alcohol or other drugs?
   ___ Yes ___ No

4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.)
   ___ Yes ___ No

5. Have you had any health problems? For example, have you:
   ___ Had blackouts or other periods of memory loss?
   ___ Injured your head after drinking or using drugs?
   ___ Had convulsions, delirium tremens ("DTs")?
   ___ Had hepatitis or other liver problems?
   ___ Felt sick, shaky, or depressed when you stopped?
   ___ Felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs?
   ___ Been injured after drinking or using?
   ___ Used needles to shoot drugs?

6. Has drinking or other drug use caused problems between you and your family or friends?
   ___ Yes ___ No

7. Has your drinking or other drug use caused problems at school or at work?
   ___ Yes ___ No

8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.)
   ___ Yes ___ No

9. Have you lost your temper or gotten into arguments or fights while drinking or using other drugs?
   ___ Yes ___ No

10. Are you needing to drink or use drugs more and more to get the effect you want?
    ___ Yes ___ No

(Continued on next page)

Exhibit 2-3 (continued):

11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs?
    ___ Yes ___ No

12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone?
    ___ Yes ___ No

13. Do you feel bad or guilty about your drinking or drug use?
    ___ Yes ___ No

The next questions are about your lifetime experiences.

14. Have you ever had a drinking or other drug problem?
    ___ Yes ___ No

15. Have any of your family members ever had a drinking or drug problem?
    ___ Yes ___ No

16. Do you feel that you have a drinking or drug problem now?
    ___ Yes ___ No

Thanks for filling out this questionnaire.

Exhibit 2-4
Scoring for the AOD Abuse Screening Instrument

Name/ID No.: _____ Date: _____
Place/Location: _____

Items 1 and 15 are not scored. The following items are scored as 1 (yes) or 0 (no):

___ 2	___ 7	___ 12
___ 3	___ 8	___ 13
___ 4	___ 9	___ 14
___ 5 (any items listed)	___ 10	___ 16
___ 6	___ 11	

Total score: ___ Score range: 0–14

Preliminary interpretation of responses:

Score	Degree of Risk for AOD Abuse
0–1	None to low
2–3	Minimal
≥4	Moderate to high: possible need for further assessment

Scoring and Interpretation

A preliminary scoring mechanism for the screening instrument is provided in Exhibit 2-4. Until an empirical evaluation of this scoring protocol is complete, however, it should be considered only as a guideline to interpreting responses to the instrument.

Questions 1 and 15 are not scored, because affirmative responses to these questions may provide important background information about the respondent but are too general for use in scoring. The observational items are also not intended to be scored, but the presence of most of these signs and symptoms may indicate an AOD problem.

It is expected that people with an AOD problem will probably score 4 or more on the screening instrument. A score of less than 4, however, does not necessarily indicate the absence of an AOD problem. A low score may reflect a high degree of denial or lack of truthfulness in the subject's responses. The scoring rules have not yet been validated, and thus the AOD screening instrument needs to be used in conjunction with other established screening tools when making referrals.

Referral Issues

The AOD screening instrument, as a first step in the process of assessment for AOD abuse problems, can help service providers determine whether an individual should be referred for a more thorough assessment. When an individual with a potential AOD problem is identified through the instrument, the interviewer has the further responsibility of linking the individual to resources for further assessment and treatment.

Agencies and providers using the AOD screening instrument should be prepared to make an appropriate referral when the screening identifies a person with a possible AOD problem. A phone number written on a piece of paper is not likely to be effective in linking the individual to the appropriate resource for assessment and treatment. Rather, a thorough familiarity with local community resources is needed on the part of the service provider. The referring provider should take a proactive role in learning about the availability of appointments or treatment slots, costs, transportation needs, and the names of contact people at the agencies to which referrals are made. (See Chapter 5 for a discussion of the legal issues surrounding the referral process.)

Because many individuals identified as having possible AOD problems receive services from more than one agency, it is essential that one agency assume primary responsibility for the client. The ideal model is a case management system. Through personal contacts, case managers can help patients progress through various programs and systems, cut red tape, and remove barriers to access to services.

Providing effective services for AOD abuse requires close cooperation among agencies. Community linkages can help increase the quality of treatment for patients, whereas interagency competition decreases the quality of comprehensive care.

AOD abuse problems should be seen within the larger context of other problems, both current and past, confronted by the individual. Current problems such as instability in housing and employment, homelessness, and hunger often represent immediate needs that are more pressing for the individual than treatment for his or her AOD abuse. Past crises, such as incest, rape, and sexual abuse, can also affect how an individual responds to the screening questions.

Some of the items in the screening instrument may trigger emotional distress or a crisis. Reactions may sometimes include anxiety or depression, which may be accompanied by suicidal thoughts and behaviors. Agencies should therefore develop specific protocols to manage such crises. These protocols should include inhouse management and appropriate referrals and followup.

Glossary for AOD Abuse Screening

Agitation: A restless inability to keep still. Agitation is most often psychomotor agitation, that is, having emotional and physical components. Agitation can be caused by anxiety, overstimulation, or withdrawal from depressants and stimulants.

Blackouts: A type of memory impairment that occurs when a person is conscious but cannot remember the blackout period. In general, blackouts consist of periods of amnesia or memory loss, typically caused by chronic, high-dose AOD abuse. Blackouts are most often caused by sedative-hypnotics, such as alcohol and the benzodiazepines.

CAGE questionnaire: A brief alcoholism screening tool asking subjects about attempts to Cut down on drinking, Annoyance over others' criticism of the subject's drinking, Guilt related to drinking, and use of an alcoholic drink as an Eye opener.

Coke bugs: Tactile hallucinations (also called formications) that feel like bugs crawling on or under the skin. Chronic and high-dose stimulant abuse can cause various types of hallucinations.

Constricted pupils (pinpoint pupils): Pupils that are temporarily narrowed or closed. This is usually a sign of opiate abuse.

Convulsions: A seizure is a sudden episode of uncontrolled electrical activity in the brain. If the abnormal electrical activity spreads throughout the brain, the result may be a loss of consciousness and a grand mal seizure. One symptom of a seizure is convulsions or twitching and jerking of the limbs. Seizures may occur as the result of head injury, infection, cerebrovascular accidents, withdrawal from sedative-hypnotic drugs, or high doses of stimulants.
Crack: Cocaine (cocaine hydrochloride) that has been chemically modified so that it will become a gas vapor when heated at relatively low temperatures; also called "rock" cocaine.
Dilated pupils: Pupils that have become temporarily enlarged.
Downers: Slang term for drugs that exert a depressant effect on the central nervous system. In general, downers are sedative-hypnotic drugs, such as benzodiazepines and barbiturates.
DTs: Delirium tremens; a state of confusion accompanied by trembling and vivid hallucinations. Symptoms may include restlessness, agitation, trembling, sleeplessness, rapid heartbeat, and possibly convulsions. Delirium tremens often occurs in chronic alcoholics after withdrawal or abstinence from alcohol.
Ecstasy: Slang term for methylenedioxymethamphetamine (MDMA), a member of the amphetamine family (for example, speed). At lower doses, MDMA causes distortions of emotional perceptions. At higher doses, it causes potent stimulation typical of the amphetamines.
Hallucinogens: A broad group of drugs that cause distortions of sensory perception. The prototype hallucinogen is lysergic acid diethylamide (LSD). LSD can cause potent sensory perceptions, such as visual, auditory, and tactile hallucinations. Related hallucinogens include peyote and mescaline.
Hepatitis: An inflammation of the liver, with accompanying liver cell damage and risk of death. Hepatitis may be of limited duration or a chronic condition. It may be caused by viral infection, as well as chronic exposure to poisons, chemicals, or drugs of abuse, such as alcohol.
Ice: Slang term for smokeable methamphetamine. Much as cocaine can be modified into a smokeable state (crack cocaine), methamphetamine can be prepared so that it will produce a gas vapor when heated at relatively low temperatures. When smoked, ice methamphetamine produces an extremely potent and long-lasting euphoria, an extended period of high energy and possible agitation, followed by an extended period of deep depression.
Legal problems: AOD abusers are at a higher risk for engaging in behaviors that are high risk and illegal. These behaviors may result in arrest and other problems with the criminal justice system. Examples of legal problems include driving while intoxicated, writing bad checks to obtain money for drugs, failure to pay bills and credit card debts, being arrested for possession or sale of drugs, evictions, and arrest for drug-related violence.
Marijuana: The dried leaves and flowering tops of the Indian hemp plan cannabis sativa; also called "pot" and "weed." It can be smoked or prepared in a tea or food. Marijuana has two significant effects. In the nontolerant user, marijuana can produce distortions of sensory perception, sometimes including hallucinations. Marijuana also has depressant effects and is partially cross-tolerant with sedative-hypnotic drugs such as alcohol. Hashish (or hash) is a combination of the dried resins and compressed flowers from the female plant.
Needle tracks: Bruising, collapsed veins, or a series of small holes on the surface of the skin caused by chronic injection of drugs into the veins (intravenous injection) or muscle (intramuscular injection) or under the skin (subcutaneous injection).
Nodding out: Slang term for the early stages of depressant-induced sleep. Opioids and sedative-hypnotics induce depression of the central nervous system, causing mental and behavioral activity to become sluggish. As the nervous system becomes profoundly depressed, symptoms may range from sleepiness to coma and death. Typically, "nodding out" refers to fading in and out of a sleepy state.
Opiates: A type of depressant drug that diminishes pain and central nervous system activity. Prescription opiates include morphine, meperidine (Demerol), methadone, codeine, and various opioid drugs for coughing and pain. Illicit opioids include heroin, also called "smack," "horse," and "boy."
Paranoia: A type of delusion, or a false idea, that is unchanged by reasoned argument or proof to the contrary. Clinical paranoia involves the delusion that people or events are in some way specially related to oneself. People who are paranoid may believe that others are talking about them, plotting devious plans about them, or planning to hurt them. Paranoia often occurs during episodes of high-dose chronic stimulant use and may occur during withdrawal from sedative-hypnotics such as alcohol.
Paraphernalia: A broad term that describes objects used during the chemical preparation or use of drugs. These include syringes, syringe needles, roach clips, and marijuana or crack pipes.
Self-help groups: Self-help groups differ from therapy groups in that self-help groups are not led by

professional therapists. Some self-help groups, such as Alcoholics Anonymous, Narcotics Anonymous, and Cocaine Anonymous, are called 12-step programs because they are based on the 12 steps or recommendations for living of Alcoholics Anonymous.
Skin abscesses: A collection of pus formed as a result of bacterial infection. Abscesses close to the skin usually cause inflammation, with redness, increased skin temperature, and tenderness. Abscesses may be caused by injecting drugs and impurities into the body.
Slurred speech: A sign of depressant intoxication. When people consume significant amounts of sedative-hypnotics and opioids, their speech may become garbled, mumbled, and slow.
Tremors: An involuntary and rhythmic movement in the muscles of parts of the body, most often the hands, feet, jaw, tongue, or head. Tremors may be caused by stimulants such as amphetamines and caffeine, as well as by withdrawal from depressants.
Unsteady gait: Unsteady, crooked, meandering, and uncoordinated walk, typical of alcohol-impaired individuals.
Uppers: Slang term used to describe drugs that have a stimulating effect on the central nervous system. Examples include cocaine, caffeine, and amphetamines.

Sources for the AOD Screening Questions

Addiction Severity Index: McLellan, A.T., Luborsky, L., Woody, G.E., and O'Brien, C.P. An improved diagnostic evaluation instrument for substance abuse patients: the Addiction Severity Index. *Journal of Nervous and Mental Disease* 186:26–33, 1980.
AUDIT: Babor, T.F., De La Fuente, J.R., and Saunders, J. AUDIT: Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Health Care. Geneva: World Health Organization, 1989.
CAGE: Mayfield, D., McLeod, G., and Hall, P. The CAGE questionnaire: validation of a new alcoholism screening instrument. *American Journal of Psychiatry* 131:1121–1123, 1974.
DAST: Skinner, H.A. Drug Abuse Screening Test. *Addictive Behavior* 7:363–371, 1982.
DSM-III-R: American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, 3rd Edition, Revised. Washington, D.C.: American Psychiatric Association, 1987.
History of Trauma Scale: Skinner, H.A., Holt, S., Schuller, R., Roy, J., and Israel, Y. Identification of alcohol abuse using laboratory tests and a history of trauma. *Annals of Internal Medicine* 101:847–851, 1984.
MAST: Selzer, M.L. The Michigan Alcohol Screening test: the quest for a new diagnostic instrument. *American Journal of Psychiatry* 127:1653–1658, 1971.
POSIT: Rahdert, E.R. The Adolescent Assessment and Referral System Manual. DHHS pub. no. (ADM) 91-1735. Rockville, Md.: National Institute on Drug Abuse, 1991.
RHSS: Fleming, M.F., and Barry, K.L.: A three-sample test of a masked alcohol screening questionnaire. *Alcohol* 26:81–91, 1991.

Chapter 3—Development of the Simple Screening Instrument for Infectious Diseases

Persons with AOD abuse problems are known to be susceptible to an array of infectious diseases, including tuberculosis (TB), human immunodeficiency virus (HIV) infection, sexually transmitted diseases (STDs), urinary tract infections (which are especially prevalent in women), pneumococcal and other pneumonias, hepatitis B and C, and a number of vaccine-preventable diseases. Because of the high prevalence of such diseases in people with AOD problems, screening for infectious diseases in these individuals can uncover health problems for which referrals for clinical evaluation can be made.

In most individuals who have both AOD problems and infectious diseases, symptoms of infectious diseases are not apparent most of the time. For this reason, it is usually ineffective to attempt to determine whether an individual has any infectious diseases merely by noting the presence of symptoms. Such an approach has poor sensitivity as a method of identifying infectious diseases, because it will miss the great number of individuals who have these diseases but are asymptomatic. The screening instrument presented in this chapter was therefore designed to focus primarily on behavioral and social factors that are known to be associated with an increased risk of infectious diseases.

Unlike screening instruments for alcohol and other drug (AOD) abuse, which are numerous and widely available, very few instruments, especially those based on behavioral risk factors, have been developed to screen for infectious diseases. Currently, there is no single screening instrument available that addresses risk factors for HIV, TB, and STDs in a systematic fashion. Screening instruments for infectious diseases have not been studied and developed to the same degree as have AOD screening instruments, and their utility has not been evaluated.

The screening instrument presented in this chapter represents an attempt to compile information about the known behavioral risk factors for infectious diseases into a simple instrument that can be used by AOD abuse workers in a minimum amount of time and in a variety of settings.

Purpose and Scope

For practical considerations, the screening instrument presented here does not attempt to identify the range of health problems that are common in persons with AOD abuse problems. Rather, it focuses specifically on those infectious diseases that are significant public health problems because of the risk of transmission to others.

That the scope of the screening instrument has been limited in this manner does not negate the importance of the many other health concerns in individuals with AOD abuse problems. Nevertheless, because many individuals with AOD abuse problems have poor access to general health care, any evaluation for STDs and HIV infection in these persons should include an overall assessment of reproductive health, including contraceptive needs, and education about disease prevention, including promotion of condom use.

Like the AOD screening instrument, the screening instrument for infectious diseases cannot, and is not intended to, replace a clinical evaluation. It should not be used as a substitute for laboratory tests or a thorough history and physical examination. Neither should it be used in an attempt to diagnose a particular disease or diseases. Rather, it is designed to identify aspects of an individual's lifestyle and behavior that may place him or her at risk for certain infectious diseases.

The presence of such risk factors, however, does not necessarily indicate that an individual has an infectious disease, just as their absence does not rule out this possibility. When such risks are identified, therefore, the individual should be referred for further assessment and a more thorough clinical evaluation.

A basic standard of care, including assessment for the infectious diseases targeted by specific questions, should be met in all populations being screened.

In settings where certain clinical laboratory tests for infectious diseases are mandated (such as for TB or STDs), however, the purpose of a screening instrument is obviously not to determine which patients should receive those tests. Rather, the goal is to determine the level of risk for particular diseases and to identify those individuals who have active infection and for whom further clinical assessment is indicated.

Administration of the Infectious-Disease Screening Instrument

Two versions of the screening instrument for infectious diseases are presented in this chapter. The field version of the instrument (Exhibit 3-1), which contains only the screening questions themselves, can be used by workers in the field who may be working within time constraints. The annotated version (Exhibit 3-2) provides additional information with which screeners should become familiar before administering the instrument. This version indicates, for each question, the diseases for which an increased risk is present when an affirmative answer is given and the recommended referral actions to be taken. It also contains notes to the interviewer and suggested introductory statements that may be used to explain the purpose of the questions to the interviewee.

Timing of Administration

The point at which the screening instrument is administered will vary depending on individual circumstances and settings. In general, it can be administered after a decision has been made as to whether a client will be accepted into an AOD treatment program. The instrument can also be administered to individuals who are on waiting lists for AOD abuse treatment, provided that referral resources for infectious-disease treatment are immediately available.

If the decision of whether to admit a client into treatment has not yet been made, however, the interviewer should ensure that respondents are not given the sense that their answers will affect whether they will be accepted into a treatment program or referred elsewhere. This is especially important in light of the fact that some of the questions in the instrument deal with highly personal areas, such as sexuality, about which many respondents may find it difficult to give complete information. If respondents believe that their answers may influence the decision of whether the treatment program will accept them, they may be even less inclined to be forthcoming in these areas.

Setting

The infectious-disease screening instrument is designed to be simply and quickly administered in a variety of situations, ranging from a private office to a public street. Whatever the environment, the conditions for screening demand that the interviewer be able to spend at least 5 minutes with the client in some sort of setting in which they cannot be easily overheard.

A street worker, for example, may need to step into an alley or the doorway of a building in order to ensure a modicum of privacy. An interviewer in a correctional setting may be able only to designate a corner of a shared cell as a "private space."

Linkages and Service Integration Models

Clinical linkages between the AOD treatment agency using the screening instrument and the clinical facilities providing diagnostic services for infectious diseases are essential to the effectiveness of any instrument. In the annotated version of the screening instrument (Exhibit 3-2), potential referral sites for infectious-diseases assessment or related care services are identified.

For a screening program for infectious diseases to be successful, a liaison is needed between the organization doing the screening and these facilities. In some cases, screening and clinical laboratory services may be provided in the same location, depending on local practice.

Program managers should periodically review the clinical services needed by clients and should identify providers of those services (see Chapter 4, section on "Referral"). In identifying providers to whom at-risk individuals can be referred, treatment programs should seek out those who are capable of providing prompt evaluations for infectious disease. Examples of provider agencies include:

- Primary-care clinics
- Community health centers
- STD clinics
- TB clinics
- Clinics providing prenatal care, family planning, and child health care
- Clinics providing early intervention for HIV infection

Exhibit 3-1
Simple Screening Instrument for Infectious Diseases
Field Version

1. Have you seen a doctor or other health care provider in the past 3 months? (yes/no)

2. a. Do you live on the street or in a shelter? (yes/no)
   b. Have you ever been in jail? (yes/no)

3. Have you ever been told you have a positive HIV test [test for the AIDS virus]? (yes/no)

4. Women: Have you missed your last two periods? (yes/no)

5. Have you ever had a positive skin test for TB? I mean a test where you got a shot in your forearm, and a few days later a hard bump like a blister appeared. (yes/no)

6. Have you ever been told you have TB? Has anybody you know or have lived with been diagnosed with TB in the past year? (yes/no)

7. a. Within the last 30 days, have you had any of the following symptoms lasting for more than 2 weeks?
   - Fever
   - Drenching night sweats that were so bad you had to change your clothes or the sheets on the bed
   - Productive cough
   - Coughing up blood
   - Shortness of breath
   - Lumps or swollen glands in the neck or armpits
   - Losing weight without meaning to
   - Diarrhea (runs) lasting more than a week

   b. Do you live with someone who has any of the following symptoms?
   - Coughing up blood
   - Drenching night sweats

   c. Do you know or are you close to anyone with these symptoms? (yes/no)

8. Do you use needles to shoot drugs? (yes/no)

9. Do you use coke or crack? (yes/no)

10. In the last 6 months, have you had any VDs [venereal diseases, STDs, sexually transmitted diseases], like syphilis, the clap [gonorrhea], chlamydia, or NGU [nongonococcal urethritis, trichomoniasis, trick]? (yes/no)

11. Have you, or anyone you've had sex with, had any of the following symptoms within the last 30 days?
    a. Sore or ulcer on the penis/vagina ["down there"]?
    b. Rash, spots, or other skin problems, especially on your palms or the soles of your feet?
    Women:
    c. A vaginal discharge that is different from what you usually have?
    d. Pain when you have vaginal sex?
    Men:
    e. Discharge from the penis?

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Exhibit 3-1 (continued):

12. Have you had sex with more than two people—at different times—in the past 6 months? I mean any type of vaginal, rectal, or oral contact, like you went down on your partner or he/she went down on you, with or without a condom. (yes/no)

13. Have you used your rectum for sex? (yes/no) [Use regionally appropriate terminology to indicate penile penetration, as opposed to other types of sexual contact.]

14. In the past 6 months, have you had sex with someone in return for anything, like money, alcohol or other drugs, a place to stay, or just to survive? (yes/no)

15. Have you ever been forced to have sex against your will? (yes/no)

Training Resources

Treatment for AOD abuse and infectious diseases is a dynamic field. Workers in both of these areas must remain updated on the rapidly changing information in these disciplines, as well as the changes and trends in the populations with which they work.

Some resources for training are given here:

- "The Three R's of STDs: Risk, Recognition, and Response" (see Appendix B) is an introductory course offering information on prevalent STDs. Designed to meet the basic needs of outreach workers who deal with populations at risk for STDs and HIV, this course could be expanded and modified for both infectious disease and AOD abuse workers.
- Many health departments operate outreach training efforts for staff involved in STD, HIV, and TB control. Many of these training courses are also open to nonclinical providers.
- "Core Curriculum on Tuberculosis" is available from the American Lung Association as a resource for background information about training.
- To assist in the training of AOD abuse workers, it may be possible in some areas for local infectious-disease workers to visit AOD abuse treatment sites to offer training in how to screen for infectious diseases.

Glossary for Infectious-Disease Screening

Chlamydia: A type of sexually transmitted infection; frequently asymptomatic in women, it can cause infertility, pelvic inflammatory disease, and complications during pregnancy.

Diarrhea lasting >1 week: For the purposes of this screening instrument, this is defined as watery diarrhea, without any formed stool, occurring more than three times a day for a week or more.

Genital sore: An open, infectious sore, or chancre (not warts) on the genitals.

Genitals: The outer sexual or reproductive organs, including the vulva in women and the penis and testicles in men.

Gonorrhea ("the clap"): An STD that causes a discharge from the penis in men and can cause vaginal discharge, pain, infertility, and pelvic inflammatory disease (PID) in women.

NGU (nongonococcal urethritis): A sexually transmitted infection whose symptoms are similar to those of gonorrhea and can be differentiated only on the basis of laboratory tests. NGU is most commonly caused by the same organism that causes chlamydia.

Penile discharge: "Drip"; a discharge (not ejaculation or semen) from the penis, often associated with pain; it can be a symptom of infections such as gonorrhea or NGU.

Period: Menstruation; the time during the menstrual cycle when the lining of the uterus is shed. In most women, periods occur every 23–35 days and may last 3–7 days. A period should be distinguished from "spotting," which refers to small, intermittent amounts of bleeding. A missed period is often the first sign of pregnancy; a woman who has missed two periods in a row should receive a pregnancy test.

Positive HIV test: A blood test that is positive for antibodies to HIV, the virus that causes AIDS.

Positive skin test (Tine test, PPD test): A test for TB in which an injection is made into the skin of the

Exhibit 3-2
Simple Screening Instrument for Infectious Diseases
Annotated Version

All of the questions in the screening instrument are worded so that an answer of "yes" indicates an increased risk for the disease appearing in brackets after the question. Following each question are the indications for what type of referral should be made when an increased risk is identified. Whenever possible, care should be taken to refer to the least number of agencies possible. For example, STD and HIV testing may be available at STD clinics, prenatal care sites, or comprehensive health centers. Also following each question is background information pertaining to the question and the rationale for its inclusion.

Letters refer to the following categories:

A = Needs supporting data based on pilot studies
B = General medical evaluation
C = TB screening
D = STD assessment
E = Prenatal care
F = HIV counseling, testing, referral, and partner notification
G = HIV care/early intervention

Suggested language is incorporated throughout the questionnaire to introduce the screening questions and explain to the respondent why they are being asked. By no means does this wording have to be repeated verbatim to every respondent. The most important goal is to ensure that the concepts expressed by these narrative passages are successfully communicated. The interviewer should always take into account regional and cultural variations in terminology and should use the language that is most comfortable for the person being interviewed. Possible alternative terms are sometimes indicated in quotes within brackets.

Suggested Introductory Statement

A lot of people who use drugs have health problems that they don't even know they have. I want to find out whether you might have any health problems that we can help you with.

Even if you don't feel sick, there could still be something going on with your health that we can do something about before it turns into a bigger problem. To find out, I need to ask you some questions, to get some information from you.

I want you to know that my agency will not give this information to anyone without your permission. [This latter statement can be repeated to the client if a need for referral is identified as a result of the screening; in addition, something like the following statement should also be made when referring a client: I need to ask you to sign this paper so I can tell (the facility to receive the referral) what your answers were. All this paper does is let me tell them why you're going there. I won't do it unless you say it's OK.]

Based on your answers to these questions, we may advise you to get a physical exam. This would be voluntary—it would be your choice whether to have the exam or not. If you do get an exam, there are some diseases that, if you are found to have them, must be reported to the health department.

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Exhibit 3-2 (continued):

Administration of the Screening Instrument

First, I'm going to ask you a couple of general questions about whether you've seen a doctor lately, and about where you live.

1. Have you seen a doctor or other health care provider in the past 3 months? (yes/no)
   [Indication: A]

2. a. Do you live on the street or in a shelter? (yes/no)
      [Risk: TB, HIV]
      [Indications: C, F]

   b. Have you ever been in jail? (yes/no)
      [Risk: TB, possibly HIV]
      [Indications: C, F (depending on locality)]

Now I want to ask you some specific questions about certain kinds of diseases. The reason for these questions is that the diseases we're talking about are better treated if they are caught early.

You've probably heard about the AIDS virus—that you can have it without being sick. That's an example of the kinds of things we're looking for. It's much better to find out about it early, because treatment works better in early cases. [Women: "This is especially important if there is a chance that you could be pregnant, because your baby could get sick or die if you have HIV."]

3. Have you ever been told you have a positive HIV test [test for the AIDS virus]? (yes/no)
   [Risk: HIV]
   [Indication: G]

4. Women: Have you missed your last two periods? (yes/no)
   [Risk: Pregnancy complicated by STDs or HIV]
   [Indications: D, E, F]

5. Have you ever had a positive skin test for TB? I mean a test where they gave you a shot in your forearm, and a few days later a hard bump like a blister appeared. (yes/no)
   [Risk: TB]
   [Indication: C]

6. Have you ever been told you have TB? Has anybody you know or have lived with been diagnosed with TB in the past year? (yes/no)
   [Risk: TB]
   [Indication: C]

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Exhibit 3-2 (continued):

7. a. Within the last 30 days, have you had any of the following symptoms lasting for more than 2 weeks?
   - Fever
   - Drenching night sweats that were so bad you had to change your clothes or the sheets on the bed
   - Coughing up blood
   - Shortness of breath
   - Lumps or swollen glands in the neck or armpits
   - Losing weight without meaning to
   - Diarrhea (runs) lasting more than a week
   - [Risk: TB, possibly HIV-related syndromes]
     [Indications: B, C, F]

   b. Are you now living with someone with any of the following?
   - Coughing up blood
   - Drenching night sweats
   - Active TB
     [Risk: TB, possibly HIV-related syndromes]
     [Indication: C]

Now I need to find out a little bit about what kind of drugs you use. This is because some types of drug use increase your risk of getting certain diseases.

8. Do you use needles to shoot drugs? (yes/no)
   [Risk: HIV]
   [Indication: F]

9. Do you use coke or crack? (yes/no)
   [Risk: Syphilis, HIV]
   [Indications: D, F]

I'm going to ask you these next questions because, as you probably know, there are certain types of infections—like VD—that you can get from having sex with other people. Some of these questions are pretty personal, but you should know that I am not here to judge you. Don't worry about saying "yes" to any of these questions if that's the true answer. The only thing I'm interested in is finding out if you're at risk for a disease that we can treat you for.

10. In the last 6 months, have you had any VDs [venereal diseases, STDs, sexually transmitted diseases], like syphilis, the clap [gonorrhea], chlamydia, or NGU [nongonococcal urethritis, trichomoniasis, trick]? (yes/no)
    [Risk: HIV, STDs]
    [Indication: D, F]

11. Have you, or anyone you've had sex with, had any of the following symptoms within the last 30 days?
    [Risk: STDs, HIV]
    [Indications: D, F]
    a. Sore or ulcer on the penis/vagina ["down there"]
    b. Rash or spots, especially on your palms or on the soles of your feet?
    Women:
    c. A vaginal discharge that is different from what you usually have
    d. Pain when you have vaginal sex
    Men:
    e. Discharge from the penis

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Exhibit 3-2 (continued):

[Questions 12–15 refer to activities that are associated with increased behavioral risk for STDs, especially those that are asymptomatic. They should be asked in a nonjudgmental manner.]

12. Have you had sex with more than two people—at different times—in the past 6 months? I mean any type of vaginal, rectal, or oral contact, like you went down on your partner or he/she went down on you, with or without a condom. (yes/no)
    [Risk: STDs, HIV]
    [Indications: D, F]

13. Have you used your rectum for sex? (yes/no) [Use regionally appropriate terminology to indicate penile penetration, as opposed to other types of sexual contact.]
    [Risk: HIV]
    [Indication: F]

14. In the past 6 months, have you had sex with someone in return for anything, like money, alcohol or other drugs, a place to stay, or just to survive? (yes/no)
    [Risk: STDs, HIV]
    [Indications: D, F]

15. Have you ever been forced to have sex against your will? (yes/no)
    [Risk: STDs, HIV]
    [Indication: A]

forearm; a positive result is marked by a hard, red swelling at the injection site within 3 days. A PPD test must be interpreted by a nurse or doctor.
Rash (symmetrical): The rash of secondary syphilis. It can take many forms but is most commonly seen on the palms of the hands and the soles of the feet and is often scaly. Any rash affecting large parts of the body should be considered suspicious and should be evaluated. This type of rash should not be confused with track marks or abscesses from skin popping.
Sexual contact: Having sex of any kind: oral, rectal, or vaginal sex between any two people, regardless of their gender.
Sexually transmitted disease (STD): A disease that is spread through sexual contact.
Syphilis: An STD that can cause an ulcer or lesion on the genitals but can also spread to other parts of the body. The most common systemic form of syphilis is marked by a symmetrical rash on the palms of the hands and the soles of the feet. In its advanced stages, syphilis can cause major health problems, including central nervous system disorders, and death.
Tuberculosis (TB): A highly infectious disease that is spread through airborne droplets to people who have had close contact with an infected individual. TB is found most commonly in the lungs but can also be present in other parts of the body. It is characterized by fevers, night sweats, and weight loss, and is more common in HIV-infected and AOD abuse patients.
Vaginal discharge: A discharge of mucus and secretions from the vagina. Many women have a normal vaginal discharge; a "change" in vaginal discharge refers to alterations in quantity or characteristics such as odor, color, or consistency that differ from a woman's usual discharge.

Notes on the Screening Questions

1. This question is a lead-in intended to put the interviewee at ease.

2a. This question is asked because there is an increase in the incidence of TB among homeless individuals that is related to their crowded conditions and limited access to medical care. There have also been TB outbreaks in these settings.

2b. In certain jurisdictions, there is an increased risk of exposure to TB and HIV among individuals who have been incarcerated. This increased risk

is related to crowded conditions (for TB) and to the common occurrence of sexual assault and unprotected sex among prison inmates. A positive response to this question should prompt referral of the individual for HIV testing and counseling in those jurisdictions where HIV is prevalent among prison inmates.

3. HIV-infected persons are at increased risk for TB and STDs. The individual's response to this question should be handled with sensitivity and care. Many HIV-positive individuals have not sought care because of lack of resources, fear of alienation from family and friends, or denial.
4. This question is intended to identify women who may be pregnant and who, in the setting of AOD abuse or infectious-disease outreach, have an increased risk of maternal-fetal transmission of syphilis or HIV.
5. This question is intended to identify individuals with latent TB who are, as a consequence, at risk for active TB. Although most individuals with positive TB skin tests do not have active TB, individuals who are in outreach populations likely to be screened for STDs and AOD abuse and who have positive skin tests should be referred for evaluation to determine whether they have active TB or HIV infection or should receive preventive chemotherapy for TB. Some individuals with a positive skin test may already have been treated for TB prevention; however, it is recommended that a further history be taken by the TB facility to which the individual is referred.
6. This question is intended to identify individuals with TB who are not already in contact, or have fallen out of touch, with their treatment facility. It is also intended to identify individuals who have been in contact with someone who has TB and who thereby have an increased risk of developing latent or active TB. In the non-HIV-infected population, the highest risk of developing active TB occurs within the first year after exposure and infection. In the HIV-infected population, however, development of active disease does not diminish dramatically with subsequent years.

7a. Although the first four symptoms listed in this question (fever, drenching night sweats, coughing up blood, and shortness of breath) are common among individuals with active TB, they are nonspecific and are also consistent with other diagnoses, including bacterial pneumonia, acute bronchitis, lung cancer, and HIV-related lung disease. In the setting of screening performed by AOD and STD service workers, HIV testing should be performed in addition to a general medical evaluation. Other symptoms include lumps or swollen glands in the neck or armpits, which may be present in individuals with extrapulmonary TB or AIDS-related conditions. Unintentional weight loss may identify individuals with latent or active TB or HIV infection; this is a very nonspecific symptom, however, and multiple other diagnoses are possible. Diarrhea lasting more than a week may be a sign of HIV infection but is also nonspecific.

7b. This question is intended to identify individuals who may be in contact with someone who has TB. These symptoms have been selected from those included in 7a. as being somewhat more specific and more likely to indicate a high degree of infectious risk.

8. Injecting drug users are at highest risk for HIV infection, whether or not needle-sharing is acknowledged. In addition, these individuals are at increased epidemiologic risk for other STDs and TB.
9. Cocaine has been linked to the presence of STDs, especially syphilis, and, in some parts of the United States, another genital-ulcer STD, chancroid. These diseases need specific treatment, are not easily diagnosed, and require that sexual contacts also be treated. Both the increased level of sexual activity associated with cocaine use and the presence of other STDs, such as syphilis, increase the risk of HIV infection.
10. A number of well-controlled studies have demonstrated that persons who have had an STD within the past 6 months are at risk for acquiring another STD. This supports the common-sense dictum that changing all aspects of sexual behavior, including increasing condom use, changing sex partner-selection practices, and reducing the number of sexual partners, is difficult.

11a. Genital sores could be symptoms of syphilis, herpes, condyloma, or chancroid, all of which are potentially serious STDs. Persons with genital ulcers also are at risk for HIV infection.

11b. Dermatologic problems are associated with secondary syphilis (especially in the case of a rash on the soles and palms) or HIV infection, which is associated with a large number of skin conditions. It is important to differentiate these skin conditions from chronic skin conditions and from dermatologic manifestations of drug use (e.g., abscesses from skin popping).

11c. Although most STDs in women are asymptomatic, vaginal discharge can be

indicative of gonorrhea, chlamydia, trichomoniasis, or other STDs. It can also, however, be a symptom of a yeast infection that is not an STD.

11d. Painful intercourse, or dyspareunia, especially abdominal pain associated with penetration or orgasm, may be a symptom of early pelvic inflammatory disease. This condition is an inflammation that may involve the fallopian tubes, uterus, and other pelvic structures and, if left untreated, can lead to infertility.

11e. Penile discharge is nearly always a symptom of an STD. The discharge is usually persistent and may be associated, although not necessarily, with painful urination (dysuria). It usually represents either gonococcal urethritis (gonorrhea) or nongonococcal urethritis (NGU), which is often caused by chlamydia.

12. Having multiple sexual partners is associated with an increased risk of STDs and HIV infection.

13. This question is especially important in assessing an individual's risk for HIV infection. Approximately 50 percent of men who have acquired HIV infection via homosexual intercourse admit to this risk factor only after testing positive for HIV. The interviewer may need to talk about a male client's jail experiences in order to determine whether he has had active or recipient anal intercourse. Many men do not think of themselves as having "had sex" if they have been raped by another man or if they have had active anal intercourse (forced or otherwise) with another man in prison. All gay men (whether or not they are also substance abusers) should be targeted for STD education and prevention.

14. These activities are associated with an increased risk of STDs and HIV infection.

15. These activities are associated with an increased risk of STDs and HIV infection.

Chapter 4—Training and Implementation

The instruments in this Treatment Improvement Protocol (TIP) were designed for use by workers in the fields of both alcohol and other drug (AOD) abuse and infectious diseases. This TIP represents one of the first attempts to provide a multidisciplinary approach to these public health problems.

This chapter focuses on the rationale for screening for both of these problems, the purposes and limitations of the instruments, training of staff in conducting screening interviews, and considerations in implementing a screening program for AOD abuse and infectious diseases. The discussions presented here are intended in part to help program staff achieve a basic understanding of, and level of competency in using, the screening instruments presented in this TIP. This chapter can be used as a primary tool for training staff in using the instruments. Trainers should also be familiar with the content of this document.

Understanding the Rationale

One of the basic tenets of understanding the process of screening is the recognition that its goal is not to diagnose a specific problem, but to determine whether an individual needs further, more comprehensive, assessment and evaluation. Several aspects of the screening process should therefore be clarified to personnel who will be administering the screening instruments for AOD abuse and infectious diseases.

- Although the screening process is often used to identify individuals at high risk for a diagnosis, it is never diagnostic in and of itself.
- An individual with a positive screening test must have a clinical assessment before a diagnosis can be made and before clinical management can begin.
- Screening instruments are often intentionally designed to achieve high sensitivity—to identify large numbers of persons with the disease or condition. Therefore, screening tests may have low positive predictive value; in other words, many individuals with a positive screening test will subsequently be found not to have the disorder. Conversely, a negative screening test may not necessarily rule out the possibility that the disorder is present. (See Chapter 1.)

To understand the rationale behind screening for AOD abuse and infectious diseases, workers administering the instruments need to appreciate the magnitude of these problems in the populations with which they come into contact. As discussed in Chapter 1, both AOD abuse and infectious diseases, such as tuberculosis (TB) and sexually transmitted diseases (STDs), are enormous public health problems. Although each of these problems alone has broad public health implications and incurs significant costs, the impact of both together on the acquisition and transmission of human immunodeficiency virus (HIV) has increased their individual importance even further.

Furthermore, the two problems overlap. TB and STDs, for example, are highly prevalent in populations in which AOD abuse is common. It has been estimated that as many as 30 percent of patients admitted to general hospitals have some type of AOD abuse problem (Moore et al., 1989). AOD abuse is associated with behaviors (such as high-risk sexual behavior and needle-sharing practices) that increase the risk for contracting STDs and HIV. It is also linked to social situations (such as those in homeless shelters and jails) where crowding increases the risk for acquiring communicable diseases.

Treatment exists for both AOD abuse and infectious diseases. With the exception of viral diseases such as HIV and herpes infections, which can be treated but not cured, infectious diseases can be treated effectively. Substance abuse treatment, using a variety of modalities, can also be effective, although it requires a more comprehensive and long-term approach. Screening can play an important role in containing these two problems if it is employed as a first step toward assessment and treatment.

The question arises, however, about the usefulness

of screening instruments if they identify clients who need services that are not available because of an already overtaxed treatment system. It is hoped that the use of these instruments will, at the least, serve a valuable information-gathering function that will indicate needs and eventually lead to more funding for treatment resources.

Potential Barriers to Screening

Despite the important reasons to screen for alcohol and other drug problems and infectious diseases, potential barriers also exist that may make service providers apprehensive about implementing the screening process:

- In the absence of an understanding of how the two problems are linked, screening for infectious diseases by AOD workers, and vice versa, may seem irrelevant to the service provider's and agency's goals.
- Service providers may not trust the accuracy of the self-report method (see the section in Chapter 1 on "Limitations of Self-Reporting").
- Existing workloads may overwhelm service providers, who may believe that screening for both AOD abuse and infectious diseases will make their jobs more complicated and difficult.
- If treatment for AOD abuse or infectious diseases is not available, or if clients do not comply with treatment, service providers may feel discouraged about identifying problems for which treatment is unavailable or believed to be ineffective.
- Service providers who have inadequate knowledge of treatment and referral sources for AOD abuse and infectious diseases may believe that screening for these problems is not worthwhile.

Education about the relationship between AOD abuse and infectious diseases is key to overcoming such misconceptions and apprehensions on the part of staff. Workers using these instruments need to understand AOD abuse and infectious diseases as two interrelated problems that must be approached together for interventions to be effective.

It may also help to focus on the benefits that screening can have for patients. Both infectious-disease and AOD agencies have patient care as their primary mission. These instruments can identify problems that affect patients' health and that may also have a direct impact on their ability to complete courses of treatment.

Training for Administration Of the Screening Instruments

As with any screening process that takes the form of an interview, administration of the instruments presented here requires specialized skills on the part of the interviewer in order to establish a rapport with the client. These skills include using good listening techniques and the ability to communicate empathy, support, and understanding and foster an atmosphere of mutual trust and respect.

To employ these skills effectively, workers may need training in order to allow them to be more comfortable with the screening instruments. This may be especially true because of the highly personal and intimate nature of many of the questions, such as those dealing with sexual behavior. Achieving an atmosphere of mutual respect and honesty under the constraints of limited time and privacy poses a significant challenge, requiring the interviewer to be flexible and creative. Training in techniques that can be used to meet this challenge can be helpful in this regard. Exhibit 4-1 shows a suggested curriculum of topics and techniques that should be covered in basic training to administer the screening instruments.

Personnel to Be Trained

Many types of workers can be expected to need or want training in administering the instruments. Chapter 1 ("Intended Users, Audiences, and Settings") gives numerous specific examples of the types of workers to be trained, along with the populations and settings in which screening can be performed. Regardless of the types of professionals being trained, trainers should be familiar with all the populations in which screening will be undertaken.

The Need for Specialized Training

Although many workers providing services for AOD abuse already possess the skills necessary to administer screening instruments, it is anticipated that specialized training will be needed for staff using the instruments presented in this document. A primary reason for the need for specialized training is that the instruments are designed for use by staff who will be working in unfamiliar content areas. AOD workers, for example, may have scant knowledge of the issues surrounding infectious diseases in the individuals with whom they work. Conversely, infectious-disease workers may have little understanding of AOD abuse and dependence.

Moreover, many of the topics addressed in the instruments, such as sexual habits and history, are

Exhibit 4-1
Topics and Techniques for Training Personnel in Administration of the Simple Screening Instruments

Content	Desired Outcome	Appropriate Techniques	Time Needed	Resources Needed
"Why Screen?" (AOD 101 or Infectious Diseases 101)	Knowledge	Lecture, backup reading, visuals, handouts	1 hour for lectures, questions, and discussions	Trainer, reading materials, audiovisual aids
Demonstration of problems encountered through introduction of instrument, and their resolution	Understanding	Problem-solving discussion and feedback	30–40 minutes	Trainer, reading or work materials, interdisciplinary panel
Communication, administering screening instrument to trainees	Skills	Role-playing, critique	1–2 hours	Trainer, work material (instrument), interdisciplinary panel
Legal and ethical issues regarding transfer of patient information	Knowledge and understanding	Lecture, participation cases, skill practice exercise	1 hour	Trainer, guest lecturers, materials
Review of experiences and perspectives on working with AOD and infectious-disease patients	Attitudes	Group process, experience sharing, testimonials, games	30–45 minutes	Trainer, panel or forum of AOD abusers and infectious-disease patients
Development of cultural understanding and sensitivity	Values	Experiential lecture, role-playing, games	45 minutes to 1 hour	Trainer, panel of cultural experts

highly sensitive and personal in nature. AOD and infectious-disease workers may not be comfortable talking with clients about these intimate areas and may need specialized sensitivity training.

Specialized training is also needed because the clients to be screened can be difficult to work with or may be perceived as noncompliant by the workers administering the instruments. Screeners need to develop skills for working with difficult clients. They must be aware of the possibility that clients may deny or minimize problems, give inconsistent answers, or be temporally impaired, all of which can bias the responses. In addition, the settings in which many clients will be found may not be conducive to talking or interviewing. Screeners must learn how to function effectively under suboptimal conditions.

Objectives of Training

Incorporated in a training program for using the screening instruments should be a review of interpersonal skills, including some basic communication and interviewing techniques, and guidelines on how to deal with a range of client reactions. Screeners should be able to administer the instruments in a manner that is casual, friendly, nonthreatening, and nonjudgmental in terms of both verbal and body language.

Screeners should also be familiar and comfortable with local vernacular in describing terms for illness or behavior, as well as with regional and cultural differences in the population being screened. Such differences may relate to terminology or practices that may be prevalent in certain geographical areas. To

enhance the usefulness and effectiveness of the instruments, efforts should be made to educate the target population about the rationale for and uses of the instruments in language they can understand. At the completion of the training, users of the screening instrument should be:

- Able to explain to clients the reasons for screening
- Familiar with the rationale for questions contained in the instruments
- Comfortable in administering the instruments
- Able to interpret the results
- Familiar with the appropriate referral actions that should be taken after identifying a person in need of further assessment.

Interdisciplinary Needs

Training programs should involve the staff of both AOD and infectious-disease agencies, and individuals conducting the training should be selected from a variety of related disciplines. Training programs should be conducted in both AOD and infectious-disease work settings to help workers become familiar with other agencies. AOD and infectious-disease staffs should be supervised by personnel from both disciplines to ensure that referral linkages are operating effectively.

Cross-training of AOD workers by infectious-disease personnel and vice versa will enhance workers' understanding of the issues confronted in unfamiliar disciplines. Allied health professionals, such as physician assistants, AOD abuse counselors, and other paraprofessionals, should also be involved in the training program. The individuals selected should possess characteristics and skills such as acceptance by the target population, credibility, effective communication skills, and an understanding of and ability to maintain confidentiality.

Training for Supervisory Personnel

Supervisors and program managers should also be an integral part of the training process, even if they will not actually be administering the screening instruments. The following are some topics that might be covered for supervisors and managers receiving training:

- Funding and other resources
- Staffing patterns (e.g., integrating screening tasks into existing job descriptions)
- Importance of supporting workers
- Providing opportunities for feedback from staff who are administering the screening instruments
- Allowing release time for employees to receive training
- Providing periodic inservice training
- Ensuring that services exist for clients who score positive on the screening instruments
- Developing memoranda of understanding with referral agencies
- Helping other agencies with mutual problem solving.

Curriculum Content

Training should focus on those areas about which workers have limited knowledge and with which they need more familiarity, particularly the problems and issues confronted in other disciplines. For example, infectious-disease workers may have little awareness or knowledge of the problems faced and the approaches used by AOD workers. Similarly, AOD workers may have little knowledge of the clinical syndromes of infectious diseases or of the public health approaches traditionally used to combat them. Many AOD workers may also feel uncomfortable asking the detailed sexual questions that are integral to the infectious-disease screening instrument and must be asked in a nonjudgmental manner. Similarly, many infectious-disease workers may feel uncomfortable talking about substance abuse with clients.

Some workers may harbor personal and professional biases against the individuals screened. These biases, which may be unconscious, need to be confronted in those receiving training. Biases may be based on cultural and ethnic background or sexual orientation, or may take the form of discrimination against those who abuse AODs or are infected with HIV. Experiential group process activities such as role-playing and focus group strategies, efforts to explore and address expressed concerns, and consciousness-raising can be effective in addressing biases and in promoting more equitable treatment of clients encountered in outreach settings.

Training should also emphasize the responsibility of the screener to explain the consequences of screening and referral to clients. Screeners should develop the necessary skills to anticipate a range of emotional reactions from the client in response to the screening instrument and to reduce clients' anxiety about the screening process. Training must also prepare screeners to face noncompliant clients, in whom denial and resentment may represent a challenge. Clients need to understand that screening is not diagnosis, but a way to assess risk factors, to trigger referral, and to prevent the onset and transmission of disease.

Those who work with people with AOD problems may be particularly frustrated by clients' periods of remission interrupted by relapse, a typical pattern in

individuals with these disorders. Workers who are unfamiliar with AOD abuse disorders need to be educated about the cycle of remission and relapse that is often seen in people with these problems. Understanding that this cycle is often a part of the normal recovery process will help staff work more effectively with these clients.

Basic Information

Staff members who will be screening clients need a basic understanding of the instruments' limitations and purpose. They should understand the distinction between screening and assessment; that the purpose of screening is not to diagnose or treat AOD abuse or infectious diseases, but to identify individuals who are at risk for these problems and who will warrant a more indepth clinical assessment; and that a negative screening result does not necessarily either indicate or rule out the presence of these problems.

Staff should be educated about the legal issues concerning clients' confidentiality and their relation to recordkeeping and public health requirements to report communicable diseases. Screeners should be educated about what kind of client information should be kept and how it should be transferred. These topics are covered in greater detail in Chapter 5 and should be reviewed carefully.

Appendix B presents information about training outreach workers in screening populations for infectious diseases.

Interviewing Techniques

Before administering the instrument, interviewers should talk with the client about the purposes of screening and how the results will be used. Clients may be more willing to be forthcoming in their answers if they understand these points before the screening begins.

The screening instruments should be administered in a setting that is as comfortable as possible. Interviewers should be trained to ask questions straightforwardly, without either verbal or nonverbal signs that may discourage the client from giving an honest answer. Since the questions have only discrete answers of either yes or no, the interviewer must employ the basic counseling skills of probing, listening, and empathy.

Under ideal circumstances, the interviewer should not rush from one question to the next, but should pause between questions, allowing time for discussion when it seems appropriate. In general, it is desirable to adhere to the wording of the questions in the instruments. It is expected, however, that some flexibility in the wording of the questions will be needed.

Sometimes, the interviewer may want to repeat the person's responses, particularly if the client appears to be denying that he or she has any problems. For example, consider question 7 in the AOD abuse screening instrument: "Has your drinking or other drug use caused problems at school or at work?" If a subject answers "no" to this question, the interviewer may want to follow with "So you would say that your drinking or other drug use has never led to problems at school or at work. Is that correct?"

Cultural Competence

Workers and trainers who are culturally competent—who understand the language, culture, and ethnicity of the populations being served—are crucial to the effectiveness of the screening process. Developing cultural competence should be an integral part of the training process, and policies and procedures that promote the recruitment and retention of culturally competent personnel should be developed. Appendix C contains two articles, "Cultural Sensitivity: Treatment for Diversity" and "Self-Instruction to Prevent HIV Infection Among African-American and Hispanic-American Adolescents," that provide insight into some cultural considerations.

The initial and ongoing training of all staff should be designed and implemented to address differences in cultural and ethnic backgrounds, language, gender, sexual orientation, and economic status among the communities being served. It may be helpful to draw trainers from the target populations, such as recovering AOD abusers and HIV-positive individuals.

Interpreting Results and Making Referrals

Workers will also need training in the scoring and interpretation of screening results and appropriate referral actions. Training in these areas can focus on tracking clients for whom a referral was made to ensure that he or she received appropriate followup services.

Safety Issues

It is also essential to address safety issues in training. For example, instruction should be provided concerning how to react to a client who is out of control and how to de-escalate a dangerous or potentially dangerous situation. Basic safety guidelines for interviewers include the following:

- Do not attempt to force someone to respond if they refuse to answer questions.

- Leave if a situation does not feel safe.
- Back up other workers when possible.
- Be alert, particularly when doing street outreach. Physical safety is an issue not only in direct contact with clients, but also because violence may be more likely in some neighborhoods.

Health-related safety issues include possible exposure to TB through airborne transmission and to HIV through needle sticks. Occupational exposure to HIV and even TB, however, can be prevented by following universal precautions for infection control (CDC, 1987; 1990).

Training Approaches

Depending on needs and resources, training programs for administering the screening instruments may range from a few hours of instruction and orientation to a full-day session. At a minimum, however, this TIP should be read and reviewed by staff members who intend to use the instruments.

Joint training by workers from a variety of service agencies will help provide a multidimensional understanding of the screening and referral processes, which will improve assessment and treatment. Whenever possible, training sessions should include personnel from all of the agencies that will be involved in administering the screening instrument.

Training should be supplemented with appropriate visual aids, such as videos, slide presentations, and printed materials. Videos or slides, for example, can be helpful in explaining infectious-disease processes to AOD workers and can help standardize training. State AOD agencies and health departments associated with the screening process should take responsibility for keeping a current list of available resources for assessment and treatment.

Other training techniques include field demonstrations, in which staff can be asked to administer the instruments to actual clients in a "trial run" and the process and results critiqued to identify potential problem areas. Role-playing is especially useful in exploring some of the sensitive areas in the questionnaires, as well as in piloting the instrument itself.

Drawing on existing expertise outside the agency (for example, an AOD community-based organization bringing in infectious-disease workers) can be accomplished in cost-effective ways through brown-bag lunch sessions or an exchange of personnel for training purposes. Unstructured round table discussions are another useful way to explore ideas related to this material. These techniques do not necessarily require additional staff.

Training Updates

Training updates should include revisions of the content of the training curricula and findings related to the screening results. At the agency level, group debriefing sessions can help workers let off steam, address problems, and keep the process on track.

Implementation of Simple Screening Programs

In implementing a screening program for AOD abuse and infectious diseases, workers and managers should set program objectives with an eye toward what is practically attainable. In an ideal system, referral is smooth, treatment is available on demand, feedback is steady and regular, and information from all involved agencies is processed in a centralized computing system and coordinated by a case manager with an interdisciplinary perspective. Ideally, a comprehensive, computerized directory of services that includes the full scope of intervention modalities is maintained and continually updated. Although these ideals are not always attainable, they should be integrated as much as possible into existing settings, and strategies to use the strengths of local programs and resources should be developed.

Systemwide Collaboration

Implementation of a screening program for AOD abuse and infectious diseases requires collaboration among the agencies and organizations that will be involved in screening efforts. To facilitate this collaboration, the Federal Government can guide the States in providing assistance for local jurisdictions when necessary. At the highest State levels, collaboration is necessary between State AOD agencies and health departments. Such collaboration between experts in AOD abuse and infectious diseases is required for the screening instruments to be widely and successfully used.

In addition, referral and treatment networks that cross traditional agency lines need to be established. An interdisciplinary program will give States the opportunity to lead the way in dealing creatively with the health crises incurred by AOD abuse and infectious diseases.

In light of other State health care responsibilities, it is clear that at least minimal additional resources will be needed to implement the recommendations presented here. Additional Federal resources will also be needed if these recommendations are successful, as they will create new demands for services on a statewide level.

Outreach is an essential component of screening for AOD abuse and infectious diseases and is an important part of any public health effort that addresses these problems. Outreach efforts to screen for these problems should consist not only of connecting with clients on the street who may not be reachable through established systems, but also of proactive attempts within systems and institutions to reach anyone at risk for AOD abuse or infectious diseases.

Equally important is the need to create an environment in which the value of the screening instruments is recognized. There is also a need for collaborative efforts among agencies for the instruments to be used effectively and to be incorporated into existing systems as efficiently as possible.

States can help create the climate for cooperation by sponsoring training sessions bringing together personnel from the various disciplines and departments that need to be familiarized with the screening instruments. These personnel include not only public health workers, clinicians, and outreach workers, but also supervisory personnel, who will supervise outreach staff and must endorse this process if it is to be successful. Community leaders, who can also provide valuable input and support for the effort, also need to be involved.

Finally, on a systemwide level, the screening process should be monitored and evaluated at the agency level to ensure that appropriate numbers of individuals with AOD abuse problems or infectious diseases are identified and successfully referred for appropriate assessment and treatment.

Other Considerations in Implementation

Legal and Ethical Issues

Liability is a legal issue that varies from State to State, or even community to community. It is the responsibility of agency directors and screeners to be aware of the current laws and regulations that apply to them. Of particular importance is the need for administrators of the screening instruments to be knowledgeable about the consent process, including how to prepare and present a consent form. (These issues and the current laws and regulations are discussed in greater detail in Chapter 5.)

In addition to these legal issues, use of the screening instruments can also pose a number of ethical questions, and training should approach these areas openly. In screening for AOD abuse and infectious diseases, the interests of the screening agency, of the client, and of the community may conflict, and seldom is there a "right" answer.

For example, an inherent conflict exists between public health concerns and client autonomy and self-determination when HIV-infected or infectious TB patients fail to take measures to reduce the risk of transmitting their infection to others. Screeners have a responsibility to inform clients with infectious diseases about the implications and potential consequences of having unprotected sex or sharing needles.

Such a discussion, however, may raise clients' concerns that someone will notify their partners about medical risks. This could prevent clients from seeking needed services. Screeners must therefore be clear, both in their own minds and in conversations with clients, about clients' rights to confidentiality and privacy and when these rights may be infringed upon for public health reasons. The use of role-playing can be a helpful training technique to address this issue with program staff.

Another ethical problem may arise if screening identifies problems for which referral and treatment services do not exist. Ideally, the data created by the screening instruments should prompt funding to provide the necessary resources (similar to a needs assessment). Lack of resources emphasizes the need for establishing priorities for treatment and accessibility for competent care. Highlighting gaps in services may encourage programs to determine whether internal changes can promote more efficiency and an enhanced ability to serve more clients.

Recordkeeping

Each agency involved in administering the screening instruments must form its own policies concerning complying with Federal and State confidentiality laws and regulations (see Chapter 5), the recording of results, addressing requirements for interagency reporting, and communicating screening results to clients. Orderly recordkeeping facilitates the documentation of successful client referrals, the implementation of appropriate interventions, and the use of data for epidemiological surveillance purposes.

Because of confidentiality requirements, whenever possible, records should be kept in such a way that the client is not directly identified with or connected specifically to a screening result. Clients may need reassurance that information, especially about sensitive issues such as sexual practices and illegal drug use, will remain confidential. If clients believe their confidentiality will be breached, they will not participate in the program. (See Chapter 5 for a full discussion of recordkeeping in relation to legal requirements to maintain confidentiality.)

Referral Mechanisms

When indicated by the screening results, referral should be made for further assessment. The importance of appropriate referral cannot be overemphasized, but the opportunity for appropriate referral will vary according to local resources.

Effective referral requires more than simply providing the client with a written note. Ideally, a block of time should be set aside to discuss referral options with the client and to answer any questions he or she may have. For some clients, an assessment of sobriety should be done to determine whether he or she understands the referral recommendation.

Ideally, clients should have some input into the referral process. If several equally appropriate options exist, clients may be asked which program they would prefer. This encourages clients to become active participants in the process and to make their own decisions. When possible and appropriate, the screener making the referral should schedule the assessment appointment for the client. The screener should then follow through to ensure that the client gets to the site, or should accompany the client to the referral site. If possible, tokens for cab, bus, or other transportation should be provided. Child care may also be needed.

Incentives can be built into the referral process to encourage client compliance. Incentives may include free medication, priority admission, coupons for treatment, or free transportation (tokens or cab service). It is essential, of course, to ensure that such incentives are actually available before making promises to the client.

Both the agency making the referral and the service provider accepting the referral should be familiar with the screening instrument. This can be facilitated by sending the completed screening questionnaire to the referral program, with the client's consent.

Because of the dynamic nature of the health care system, program managers should periodically review the clinical services needed by the program's clientele and should identify appropriate providers of those services. A mechanism should be established to ensure that these providers are notified in advance of individuals being referred to reduce the chances of clients "slipping through the cracks," and the referring agency can be notified if a client does not appear for a scheduled appointment.

The agency undertaking the screening should identify needs in order to facilitate the referral process. For example, increased availability of appointments or more funds for testing and personnel may be required. Clients' transportation needs also must be met for a referral program to be successful. Wherever possible, collaborations with receiving agencies should be created to maximize the options available to clients and to facilitate their ability to keep appointments.

Case Management

Clients who receive a positive score on a screening instrument should be referred for further assessment, and case management should be an integral part of this process. Early involvement of case managers or social workers can facilitate the referral process. More targeted case management can occur later in treatment for either medical management of disease or supportive social services.

How case management is implemented and integrated into the referral process varies among different organizations and agencies that provide human services. Each agency will need to adapt its own model of case management to fit its functions and goals, but, in general, the services overseen by case management consist of the following components:

- Identification of needs
- Assessment
- Treatment
- Followup and monitoring
- Linkage to appropriate services
- Advocacy.

Community Readiness

Working with the community to promote understanding and acceptance of AOD and infectious-disease problems at the grass-roots level is an important step toward ensuring the success of a screening program. To involve the community, individuals and organizations with an interest in these problems need to be identified. Examples include opinion leaders with proven track records, grass-roots organizations, public health care providers, politicians, nonprofit community-based organizations, schools, and churches. The list may encompass groups as diverse as AIDS service organizations, the Girl Scouts, and the Junior League.

Experts in the fields of AOD abuse and infectious diseases should set up informational sessions on the need for AOD and infectious-disease screening in the community. These sessions need not be dedicated solely to the topics of AOD abuse and infectious diseases but can incorporate other agendas in order to attract a broad range of community representatives. Local television shows and newspapers aimed at specific ethnic groups, especially in larger communities, are also useful ways of disseminating information and promoting understanding of the need for screening.

People who have received services for AOD abuse and/or infectious diseases can also be recruited as volunteers to educate and involve the community. Client testimonies and personal stories are an effective way to capture the interest and commitment of members of the community. Celebrities and athletes are also sometimes interested in publicizing these issues. Organizations providing education, support, and advocacy for gays and lesbians have been very successful in using this avenue of public education about HIV and AIDS.

It is also necessary to anticipate what new programs and future settings will be useful for identifying clients and conducting screening. For example, there will be a great emphasis in the near future on directly observed therapy (DOT) for TB. This is a management strategy designed to address the problem of low medication compliance rates in TB patients, which is an important factor in the spread of multiple-drug-resistant strains of TB. With DOT, short courses of therapy are administered by having patients come into the clinic two to three times a week to receive their medication, or by having field workers administer medication to patients (American Thoracic Society, 1992). Other new service programs and new settings will certainly offer opportunities for screening target populations for AOD abuse and infectious diseases. Communities that conduct ongoing needs assessments will be better prepared to provide a wide array of services to meet future demands.

Model Programs

Ideally, the model AOD program that is focused on public health features the collaboration of a number of agencies and includes interdisciplinary joint training and evaluations. A program that utilizes the screening instruments presented in this TIP optimally would be governed by a strategic planning process that targets the epidemics in the community, taking a broad, public health approach.

The ideal program would be dynamic, so that the focus could change along with the issues surrounding the epidemic. It would consider individual AOD problems as well as public health problems and would use all available indicators to assess the nature and scope of the problem and the populations involved. Input would be obtained from key informants, including personnel working in STD clinics, those providing AOD treatment, and social science workers, and would be used to develop the system and identify the populations that will come into contact with it.

Gaps in services and needs that are not being met must also be identified. Public health authorities need to look at emerging health problems and predict what services will be required. For example, a community with an emerging crack cocaine problem should be aware that an increase in STDs and HIV is likely to follow. The personnel who work with populations in which crack abuse is prevalent need to have access to, and to be able to use, the screening instruments for AOD abuse and infectious diseases in order to identify individuals who are at risk for these problems.

Intervention for identified problems should begin with screening and assessment and move to prevention, early intervention, and treatment. The type of intervention must be determined by the nature of the population; for example, in a community with a low seroprevalence of HIV, prevention could be the strongest component. If an epidemic progresses in a community, however, the intervention should change. Thus, resources should be shifted as epidemics progress and change.

The screening instruments presented here can provide information about the needs in a given community. Screening results are an important form of feedback that should be incorporated into the continuum of care. Decisions about whether capacity should be increased and what levels and types of services are needed can be informed by the information provided by the screening instruments.

The screening instruments may also help to position a community to obtain additional funding for those needs that have been identified. Both screeners and trainers can contribute to the goal of meeting identified needs by developing strategies such as interagency agreements to bring in other human service organizations. In order for these collaborations to take place, however, turf issues must be minimized and cooperation and collaboration emphasized.

Chapter 5—Legal Issues Surrounding Client Confidentiality[1]

Street outreach workers for alcohol and other drug (AOD) abuse and infectious diseases need to be aware of the legal issues that affect the operation of their programs. Of primary concern among these issues is confidentiality: the protection of the client's right to privacy.

Programs that provide street outreach for populations at risk for AOD and infectious diseases typically face questions about how to refer clients for assessment, diagnosis, and possible treatment; how to communicate with collateral sources to gather additional information about clients; and how to communicate with other agencies working with clients. For example, outreach workers are often called upon to assist clients to find and apply for services from appropriate health and social service agencies.

Can outreach staff perform this function and at the same time protect clients' confidentiality? How can outreach workers contact collateral sources for information about a client without violating his or her confidentiality? Are there special rules for outreach workers who assist clients who are minors? What are the rules for reporting child abuse and neglect? This chapter attempts to answer these questions.

Since outreach workers are not engaged in assessment, diagnosis, or treatment of AOD or infectious diseases, they will generally not be responsible for reporting infectious diseases to State health departments, warning others of clients' infectious conditions, or tracing individuals who have had contact with the client and who might therefore be at risk of acquiring communicable diseases. Therefore, these questions are not addressed in this chapter.

This chapter reviews Federal laws and regulations governing the confidentiality of information about persons who seek or receive AOD assessment and treatment services.

Perceived Obstacles to Maintaining Confidentiality

Laws and regulations that govern communication about clients and protect their confidentiality are sometimes viewed as an irritation or a barrier to achieving program goals. For example, some staff may view as burdensome the requirement that a client must sign a consent form before a street outreach worker can make a telephone call to a treatment program on that client's behalf.

The process of obtaining consent, however, can also be seen as a small ceremony that provides a way of making a contract with the client. The worker is about to perform services for the client, and the client should begin to view seriously his or her part of the bargain in following up. Moreover, it is at this point that the outreach worker can let the client know that workers and their agencies, as well as other people helping the client, take his or her privacy very seriously. Indeed, since the outreach worker can make only the most preliminary of determinations about a client, maintaining confidentiality assumes an even greater importance.

Most of the problems that may arise under the laws and regulations that protect clients' confidentiality can easily be avoided through planning ahead. Familiarity with the rules will ease communication and can limit confidentiality-related conflicts among the program, the client, and outside agencies or individuals to a few relatively rare situations.

Federal and State Confidentiality Laws

The primary idea behind protecting confidentiality is to allow the client (rather than the program) to determine when and to whom information about his

or her AOD abuse or infectious diseases will be disclosed. Two sets of laws apply in this area.

First, Federal statutes and regulations guarantee the strict confidentiality of information about all persons applying for or receiving services for AOD abuse prevention, screening, assessment, and treatment. These statutes and regulations apply to any program that holds itself out as providing services for AOD abuse (see "Programs Governed by the Federal Regulations" later in this chapter). (The legal citation for these laws and regulations is 42 U.S.C. §§290dd-3 and ee-3 and 42 C.F.R. Part 2.) Violating the regulations is punishable by a fine of up to $500 for a first offense or up to $5,000 for each subsequent offense (§2.4).[2]

Second, State laws govern the confidentiality of information about human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS), as well as other infectious diseases. Each State has its own rules about how program staff must treat information related to clients' HIV infection and other infectious diseases. (Most States that have laws concerning this information have two separate laws, one for HIV and AIDS and another for other infectious diseases.) Some State laws (particularly those pertaining to HIV- and AIDS-related information) are as strict as the Federal AOD confidentiality law and regulations, whereas others are more lenient.

Information about infectious diseases of clients in AOD programs is protected by both the Federal AOD confidentiality regulations and State confidentiality laws. Information that would identify a client who is part of an outreach program for infectious diseases as an AOD abuser, either directly or by implication, is protected by both State confidentiality laws and the Federal AOD confidentiality regulations (as long as the program holds itself out as providing AOD outreach services and is otherwise subject to the Federal law; see below).

Programs that provide outreach services to populations at risk for AOD and infectious diseases must familiarize their staffs with the requirements of both sets of laws. The impact of State laws, along with the requirements of the Federal law, are discussed here.

Federal Laws and Regulations

The General Rule

Two Federal laws and a set of regulations guarantee the strict confidentiality of information about all persons who seek or receive services for AOD abuse prevention, assessment, and treatment. These individuals include persons whom outreach workers help on the street.

Federal confidentiality laws and regulations protect any information about a client who has applied for or received any services related to AOD abuse from a program that is covered under the law. The services applied for or received by a client may include screening, referral, assessment, diagnosis, individual or group counseling, or treatment.

The restrictions on disclosure of such information apply to any information that would identify the client as an AOD abuser, either directly or by implication. This general rule applies from the time the client makes an appointment or accepts services.[3] It also applies to former clients or patients. The rule still applies when the person making an inquiry about the client already has the information, has other ways of getting it, has some form of official status, is authorized by State law, or has a subpoena or search warrant.

Federal laws and regulations are intended to protect clients' confidentiality in order to attract people into treatment. The regulations tightly restrict communications; unlike in either the physician–patient or the attorney–client privilege, the AOD worker is prohibited from disclosing even the client's name (§2.4).

Programs Governed by the Federal Regulations

Any program that specializes, *in whole or in part,* in providing treatment, counseling, or assessment and referral services for people with AOD problems must comply with the Federal confidentiality regulations (§2.12(3)). This means that programs that provide outreach services for populations at risk for infectious diseases but also provide outreach services for those at risk for AOD problems must comply with the Federal law.

Although the Federal regulations apply only to programs that receive Federal assistance, this includes indirect forms of Federal aid, such as tax-exempt status or State or local government funding received (in whole or in part) from the Federal Government.

Coverage under the Federal regulations does not depend on how a program labels its services. Calling itself a "prevention program," an "outreach program," or a "screening program" does not excuse a program from adhering to the confidentiality rules. It is the kind of services, not the label, that determines whether the program must comply with the Federal confidentiality laws.

State Laws

In the wake of the AIDS epidemic, many States have passed laws protecting HIV-related information about clients. These laws are designed to encourage individuals who are at risk for HIV infection to get tested; to determine their HIV status and, if found to be positive, to begin medical treatment early; and to change risk-associated behaviors. Many State laws have been passed because of the concern that HIV-positive individuals may experience discrimination in employment, medical care, insurance, housing, and other areas if their HIV status becomes known to others. Separate State laws may protect information about other infectious diseases.

Because State laws that protect information about infectious diseases vary in scope, programs providing outreach services to populations at risk for infectious diseases should become familiar with the requirements of their State laws. State health departments should be able to provide information about local laws pertaining to infectious diseases.

Sharing Confidential AOD Information

Information that is protected by the Federal confidentiality regulations may be disclosed after the client has signed a proper consent form. (As explained later in this chapter, some States also require parental consent if the client is a minor.) The regulations also permit disclosure without the client's consent in certain situations, such as medical emergencies, program evaluations, and communications among staff within a program.

The most commonly used exception to the general rule that prohibits disclosure of AOD information is when a program obtains a client's written consent. State laws that protect information about infectious diseases also generally permit disclosure of information if the client signs a consent form. (State laws vary considerably, however, on what language the consent form must contain.)

Consent

Most disclosures of information about an AOD client are permissible if the client has signed a valid consent form that has not expired or been revoked (§2.31).[4] An exception may exist when an AOD client's file contains information about HIV infection or AIDS (see "Use of Consent Forms").

A proper consent form must be in writing and must contain each of the items contained in §2.31 (see sample consent form in Exhibit 5-1), which are:

- The name or general description of the program(s) making the disclosure
- The name or title of the individual or organization that will receive the disclosure
- The name of the client
- The purpose or need for the disclosure
- How much and what kind of information will be disclosed
- A statement that the client may revoke (take back) the consent at any time, except to the extent that the program has already acted on it
- The date, event, or condition on which the consent expires if not previously revoked
- The signature of the client
- The date on which the consent is signed (§2.31(a)).

A general medical release form, or any consent form that does not contain all of the elements listed above, is not acceptable. Some items on this list deserve further explanation and are discussed below.

Purpose of the Disclosure and How Much and What Kind of Information Will Be Disclosed

The purpose of the disclosure, and how much and what kind of information will be disclosed, are closely related. All disclosures, and especially those made pursuant to a consent form, must be limited to information that is necessary to accomplish the need or purpose for the disclosure (§2.13(a)). It would be improper to disclose everything in a client's file if the recipient of the information needs only one specific piece of information.

In completing a consent form, therefore, it is important to determine the purpose or need for the communication of information. Once this need has been identified, it is easier to determine how much and what kind of information will be disclosed, tailoring it to what is essential to accomplish the need or purpose that has been identified.

As an example, suppose an outreach worker is screening a client for AOD services and determines that the client should be assessed more fully by a treatment program. The outreach worker may want to call a treatment program to set up an appointment for the client. The purpose of the disclosure would be "to set up an appointment for an assessment." The disclosure would then be limited to a statement that "Jane Doe (the client) has been screened for AOD abuse." No other information about Jane Doe would be released to the treatment program.

Client's Right to Revoke Consent

The general consent form authorized by the Federal regulations permits the client to revoke consent at any

Exhibit 5-1
Consent for the Release of Confidential Information

I, _____, authorize
(Name of client)
_____ to disclose to
(Name or general designation of program making disclosure)

_____
(Name of person or organization to which disclosure is to be made)

the following information:

_____
_____
(Nature of the information, as limited as possible)

The purpose of the disclosure authorized herein is as follows:

_____
_____
(Purpose of disclosure, as specific as possible)

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____
(Specification of the date, event, or condition upon which consent expires)

Date: _____ _____
(Signature of participant)

_____
(Signature of parent, guardian, or authorized representative, when required)

time, and the consent form must include a statement to this effect. Such revocation need not be in writing. If a program has already made a disclosure prior to the revocation, the program is said to have *acted in reliance on the consent*—in other words, the program was relying on the permission given in the consent form when it made the disclosure. Therefore, the program is not required to try to retrieve the information it has already disclosed.[5]

Expiration of the Consent Form

The consent form must also contain a date, event, or condition on which it will expire if it is not revoked by the client before then. A consent must last "no longer than reasonably necessary to serve the purpose for which it is given" (§2.31(a) (9)).

If the purpose of the disclosure can be expected to be accomplished in 5 or 10 days, for example, it is better to fill in that amount of time rather than a longer period. It is better to think through how much time the consent form should run than to have all consent forms within an agency expire within a standard time, such as 60 or 90 days. When a uniform expiration date is used, an agency can find itself in a situation in which there is a need for a disclosure, but the client's consent form has expired. This means, at the least, that the client must come to the agency again

to sign a consent form. At worst, the client has left or is unavailable (e.g., hospitalized), and the agency will not be able to make the disclosure.

The consent form does not need to contain a specific expiration date, but may instead specify an event or condition. For example, if an AOD client is being referred to an HIV testing site, the consent form should state that it will expire after he or she has "gone for testing," or on the date that the appointment for testing will be made.

If an outreach worker needs to communicate with an outside agency over a longer period, the consent form should be worded accordingly. For example, if the outreach worker is communicating with a child welfare agency about placement of the client's children, then the consent form should expire "after Jane Doe's children are returned."

Signature by Minors and Parental Consent

A minor (defined in most states as persons under age 18) must always sign a consent form for a program to release information, even to his or her parent(s). (*Parent* refers to a parent, guardian, or other person legally responsible for the minor.) The program must obtain the parent's signature in addition to the minor's signature only if the program is required by State law to obtain parental permission before providing treatment to minors (§2.14).

In other words, if State law does not require the program to obtain parental consent to provide services to a minor, then parental consent is not required to make disclosures (§2.14(b)). If State law does require parental consent to provide services to a minor, then parental consent is required to make any disclosures. The program must always obtain the minor's consent for disclosures and cannot rely on the parent's signature alone. Outreach programs should consult with a local lawyer to determine whether they need parental consent to provide services to minors.[6]

Required Notice Against Redisclosure of Protected Information

Once the consent form has been properly completed, one last formal requirement remains. Any disclosure made with the written consent of the client must be accompanied by a written statement that the information disclosed is protected by Federal law and that the person receiving the information cannot make any further disclosure of such information unless permitted by the regulations (§2.32). This statement, not the consent form itself, should be delivered and explained to the recipient at the time of disclosure or earlier (see Exhibit 5-2).

The prohibition on redisclosure is clear and strict. Those who receive the notice are prohibited from rereleasing information except as permitted by the regulations. A client may, however, sign a consent form authorizing such a redisclosure.

Use of Consent Forms

The fact that a client has signed a proper consent form authorizing the release of information does not force a program to make the proposed disclosure unless the program has also received a subpoena or court order (§§2.3(b); 2.61(a) (b)).[7] The program's only obligation is to refuse to honor a consent that is expired, deficient, or otherwise known to be revoked, false, or invalid (§2.31(c)). A program cannot be forced to disclose information, even by a subpoena, if a client has not given consent; however, a program can be forced to disclose by a subpoena if the client has given consent.

In most cases, the decision of whether to make a disclosure pursuant to a consent form is within the discretion of the program, unless State law requires or prohibits disclosure once consent is given. In general, it is best to follow this rule: Disclose only what is necessary, for only as long as is necessary, keeping in mind the purpose of the communication.

The above rules apply to any program that specializes, in whole or in part, in providing treatment, counseling, and/or assessment and referral services for people with AOD abuse problems. State laws control how programs may release information about infectious diseases. Many States that protect information about HIV infection and AIDS prohibit the release of information without the consent of the client and have strict requirements about the form the client must sign.

What happens when a client signs a proper consent form permitting disclosure of information about AOD abuse, and his or her file also contains information about HIV infection or AIDS? Can the program release the AOD information? The answer depends on the law of the State in which the program is located. Even if a client has signed a consent form permitting disclosure of information about his or her AOD abuse, the program may not release information about HIV infection or AIDS unless it has complied with State law governing the release of such information.

Suppose a client's file contains information about both AOD abuse and HIV infection, and the client wants to allow the program to disclose the AOD information, but not the HIV information, to an outside agency. There are a number of ways to handle such a situation.

Exhibit 5-2
Prohibition on Redisclosing Information Concerning Clients Receiving Treatment for AOD Abuse

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

- The consent form can be drafted in a way that includes all (or relevant parts of) the AOD information but excludes all the HIV information. The consent form must contain a statement of the purpose of the disclosure and how much and what kind of information will be disclosed. The program can restrict access to the HIV information in the client's file by having the client sign a consent form that has as its purpose, for example, "referral for outpatient AOD treatment." How much and what kind of information will be disclosed would then be "results of AOD screening and assessment."
- The program can maintain a filing system that separates AOD- and HIV-related information into two different files, such as "treatment" and "medical," and disclose only information from the treatment (AOD) file. (This solution can be used regardless of whether State law protects information about HIV infection and AIDS.)
- The program can send the client's file without the HIV-related information to the outside agency and place the following notice on the disclosure: *This file, which is being provided to [name of the referral agency] with the client's consent, does not contain any information protected by section [number] of [State] law. The fact that this notice accompanies these records is NOT an indication that the client's file that is maintained by [name of the referring agency] contains any information protected by section [number].*

If this approach is used, the notice should be attached to all clients' files, regardless of whether they contain any HIV-related information, when referrals are made so that those who do have such information are not singled out and identified by implication.

If the client wants information about his or her HIV infection to be disclosed to an outside agency, the program must ensure that it is complying with the requirements of State law before it releases any such information.

Communication With Others

Now that the rules regarding consent are clear, we can turn to the questions that were introduced at the beginning of this chapter:

- How can outreach workers make referrals for further assessment without violating clients' confidentiality rights?
- How can outreach workers and programs seek information from collateral sources about clients whom they are screening?
- How can multiple agencies effectively communicate without violating the Federal rules or State laws?
- Can outreach workers and programs report child abuse?

The following sections address these questions. In all such cases, it is important to bear in mind the requirements of the Federal regulations concerning AOD information, as well as any State laws that govern the confidentiality of information about infectious diseases (including HIV infection). In all cases, any program that wishes to communicate with collateral sources about a client's infectious diseases must check State laws to determine whether the client's consent is required before such contacts are made.

Making Referrals for AOD Assessment

When a street outreach worker makes an appointment for a client to receive assessment or treatment for AOD abuse, is the worker making a disclosure that is covered by the Federal AOD regulations? The answer is yes.

When a program that screens clients for AOD abuse makes contact with an AOD assessment or treatment agency to set up an appointment for a client, it is making a *client-identifying disclosure* that the client has sought or received its services. In other words, when

the outreach worker makes a telephone call to an AOD program, the worker is, in effect, telling the AOD program that the client has asked for or received AOD services. The Federal AOD regulations generally prohibit this kind of disclosure unless the client gives consent or the disclosure falls under one of the other exceptions to the general rule. (See "Other Exceptions to the General Rule" later in this chapter.)

How, then, is an outreach worker to proceed? The easiest way is to obtain the client's written consent to call the assessment or treatment program.[8] Another possibility is for the outreach worker to accompany the client to the assessment or referral program and allow the client to make all disclosures.

If the outreach worker uses a consent form, it must be one that meets the requirements of the regulations, not a general medical release form. If the outreach worker is part of the program to which the client will be referred, then a consent form may not be necessary under the Federal rules, since there is an exception for information disclosed to staff within the same program (see "Internal Program Communications" later in this chapter).

If the outreach worker is making a referral for the client to receive services for HIV infection or AIDS, the worker must check State laws to find out whether the client's consent is required before contact is made with an outside agency. Programs that provide outreach services for both HIV/AIDS and AOD abuse must comply with both sets of laws. Thus, an AOD program that makes a referral for HIV testing must comply with both Federal and State HIV/AIDS confidentiality laws. An HIV/AIDS outreach program that is screening for AOD abuse must also comply with both sets of laws when it makes a referral for AOD abuse.

Seeking Information From Collateral Sources

Programs that screen clients may at times need to ask a collateral source, such as a family member, employer, physician, or mental health professional, to verify information obtained from the client. To communicate with others in this way, however, is to make a client-identifying disclosure. In other words, when program staff seek information from these sources, they are letting those sources know that the client has asked for AOD services. The Federal AOD regulations generally prohibit this kind of disclosure unless the client consents to it.

To address this problem, a program may obtain the client's consent to contact the specific individual or agency from which information is being sought. Another approach is to ask the client to sign a consent form that permits disclosure to any one of a number of entities or persons listed on the consent form itself. The form used in this latter method must include "the name or title of the individual or the name of the organization" for each collateral source the program may contact. With either of these two methods, the consent form required by the Federal regulations, not a general medical release form, must be used.

Programs that screen for infectious diseases (including HIV infection) and wish to obtain information from collateral sources must check State laws to determine whether the client's consent is required to contact those sources. For example, an HIV/AIDS outreach worker wishing to communicate with a client's AOD treatment program must first determine whether the client's consent is required, as well as what other State law requirements must be met. The drug treatment program, in turn, must obtain a signed consent form from the client before releasing any information to the outreach worker.

Ongoing Communications Among Diverse Agencies

Programs to which referrals are made for treatment often wish to review the results of screening procedures, as well as any other information that the referring agency has about a client. To get this information, the AOD treatment program must obtain the client's consent to receive screening results from the referring agency.

Outreach agencies, however, often need to communicate with a treatment or other program over an ongoing period. In these cases, the agency making the referral and the program receiving it both must have the client sign a consent form permitting each to communicate with and release information to the other. Every conversation about a client between two programs that are covered by the Federal regulations must be authorized by such written consent, unless some other exception to the general rule applies (see "Other Exceptions to the General Rule" later in this chapter).

All communications by the outreach agency with outside persons or entities must be dealt with on an individual basis, either by the client's consent or by ensuring that the proposed disclosure falls within one of the narrow exceptions permitted by the Federal regulations. (These exceptions are explained later in this chapter.) As with other types of communications described in this section, outreach agencies that need to communicate with other programs about clients' HIV or AIDS information must comply with the requirements of State law.

Reporting Child Abuse and Neglect

All 50 States and the District of Columbia have statutes that require reporting when there is reasonable cause to believe or suspect child abuse or neglect. Although many of these State statutes are similar, each has different rules about what kinds of conditions must be reported, who must report them, and when and how reports must be made.

Most States require not only physicians but also educators and social service workers to report suspected child abuse. Most States require an immediate oral (usually telephone) report, and many now have toll-free numbers to facilitate reporting. (Half of the States require both oral and written reports to be made.) All States extend immunity from prosecution to persons who report child abuse and neglect, meaning that a person who reports child abuse or neglect cannot be brought into court. Most States provide for penalties for failure to report.

The Federal confidentiality regulations permit programs to comply with State laws that require the reporting of child abuse and neglect. Thus, if a client reveals to program staff that he or she has neglected or abused children—or is a neglected or abused child—that fact may have to be reported to State authorities.

However, this exception to the general rule prohibiting disclosure of any information about a client applies only to initial reports of child abuse or neglect. Programs may not respond to followup requests for information, or even subpoenas for additional information—even if the records are sought for use in civil or criminal proceedings resulting from the program's initial report—unless the client gives consent or the appropriate court issues an order under subpart E of the regulations. This means that child protection authorities cannot have access to clinical records without the client's consent or a court order.

Because State laws vary, programs should consult an attorney who is familiar with State laws to ensure that their reporting practices are in compliance with those laws and that any report of child abuse that reveals infectious disease information about a client is made in accordance with them.

Other Exceptions to the General Rule

Communications Not Disclosing Client-Identifying Information

The Federal regulations permit programs to disclose information about a client if the program reveals no *client-identifying information.* This is information that identifies someone as an AOD abuser. Thus, a program may disclose information about a client if that information does not identify him or her as an AOD abuser or support anyone else's identification of the client as an AOD abuser. There are two ways in which this may be accomplished.

First, a program can report aggregate data about all or a portion of its client population (i.e., summarizing information that gives an overview of the clients served in the program). Thus, for example, a program may tell a news agency that in the last 6 months, it screened 43 clients—10 female and 33 male.

Second, a program can communicate information about a client in a way that does not reveal the client's status as an AOD abuse patient (§2.12(a) (i)). For example, a program that provides services to clients with other problems or illnesses in addition to AOD abuse may disclose information about a particular client as long as it does not reveal that the client has an AOD problem or is receiving services for AOD abuse. A program that is part of a general hospital, for instance, may contact the police about a threat made by a client, as long as it does not reveal that the client has an AOD abuse problem or is a client of the treatment program.

Programs that provide only AOD services, however, may not be able to use this latter approach, since letting someone know that one is calling from a drug outreach program will necessarily identify the client as someone receiving services from the program. A free-standing program, however, can sometimes make anonymous disclosures—that is, disclosures in which the client's name or status as an AOD client is not mentioned. Programs using this exception to disclose information related to HIV infection or other infectious diseases must also consult State laws to determine whether a disclosure is permitted.

Internal Program Communications

The Federal regulations permit some AOD information to be shared among workers within the same program. Staff who have access to clients' records because of the nature of their responsibilities, including full- or part-time employees and unpaid

volunteers, may consult among themselves or otherwise share information about clients if their work so requires (§2.12(c) (3)).

A question that often arises is whether this exception allows a program that provides AOD services as part of a larger entity—such as a health department or mental health agency—to share confidential information with others who are not part of the AOD program itself. The answer is among the most complicated in this area. In brief, such disclosures are permitted under certain circumstances, but it is essential that an expert be consulted before these communications are made. Programs should consult an attorney who is familiar with State law to learn whether it similarly restricts staff within an infectious-disease program in regard to HIV-related information about clients.

Qualified Service Organization Agreements

Programs often need to share information about clients with outside agencies that provide services to the program. Examples of such an outside agency is a laboratory performing AOD analyses or a company providing data processing. When communication needs to take place on a routine basis with such an outside agency, the program can enter into a qualified service organization agreement (QSOA).

A QSOA is a written agreement between a program and a person providing services to the program, in which that person:

> (1) *Acknowledges that in receiving, storing, processing or otherwise dealing with any patient records from the program, he or she is fully bound by [the Federal confidentiality] regulations; and*
> (2) *Promises that, if necessary, he or she will resist in judicial proceedings any efforts to obtain access to patient records except as permitted by these regulations* (§§2.11, 2.12(c) (4)).

A QSOA should be used only when an agency or official outside of the program is providing a service to the program itself. It is not a substitute for obtaining individual consent in other situations.

Disclosures that are made under a QSOA must be limited to information that is needed by the outside agency so that it can perform its services for the program and so that the program can function effectively. QSOAs may not be used between two programs that provide AOD abuse services.

Programs that share information with outside agencies by using QSOAs must take care that, if any information related to infectious diseases (including HIV infection) is to be transmitted, it is done in accordance with State law.

Medical Emergencies

A program may make disclosures to public or private medical personnel "who have a need for information about a client for the purpose of treating a condition which poses an immediate threat to the health" of the client or any other individual. The regulations define a medical emergency as a situation that poses an immediate threat to health and requires immediate medical intervention (§2.51).

The exception concerning medical emergencies permits disclosure only to medical personnel. This means that it cannot be used as the basis for a disclosure to family or the police or other nonmedical personnel.

Whenever a disclosure is made to cope with a medical emergency, the program must document the following information in the client's records:

- The name and affiliation of the recipient of the information
- The name of the individual making the disclosure
- The date and time of the disclosure
- The nature of the emergency.

Programs using the medical-emergency exception to disclose information about clients in relation to infectious diseases, including HIV infection and AIDS, must also consult State laws to determine whether a disclosure is permitted.

Crimes on Program Premises or Against Program Personnel

If a client has committed or threatened to commit a crime on program premises or against program personnel, the regulations permit the program to report the crime or threat to a law enforcement agency or to seek its assistance. In such a situation, without any special authorization, the program can disclose the circumstances of the incident, including the suspect's name, address, last known whereabouts, and status as a client at the program (§2.12(c)5)). Programs should consult a local lawyer to determine how to report a crime on program premises or against program personnel if the report will reveal information about a client's HIV infection or AIDS.

Court-Ordered Disclosures

A State or Federal court may issue an order that will permit a program to make a disclosure about a client that would otherwise be forbidden. A court may issue such an authorizing order, however, only after it follows certain special procedures and makes particular determinations required by the regulations. A subpoena, search warrant, or arrest warrant, even

when signed by a judge, is not sufficient, standing alone, to require or even to permit a program to disclose information (§2.61).

Before a court can issue an order authorizing a disclosure about a client, the program and any clients whose records are sought must be given notice of the application for the order and an opportunity to make an oral or written statement to the court.[9] Generally, the application and any court order must use fictitious names for any known client, and all court proceedings in connection with the application must remain confidential unless the client requests otherwise (§§2.64(a), (b), 2.65, 2.66).

Before issuing an authorizing order, a court must find that there is "good cause" for the disclosure. A court can find good cause only if it determines that the public interest and the need for disclosure outweigh any negative effect that the disclosure will have on the client, the relationship between the client and his or her physician or counselor, and the effectiveness of the program's treatment services. Before it may issue an order, the court must also find that other ways of obtaining the information are not available or would be ineffective (§2.64(d)).[10]

Programs using the court order exception to disclose information relating to HIV infection or other infectious diseases must also consult State law to determine whether such a disclosure is permitted.

Research, Audit, or Evaluation

The confidentiality regulations also permit programs to disclose client-identifying information to researchers, auditors, and evaluators without client consent, provided that certain safeguards are met (§§2.52, 2.53).[11] State law must be consulted to ensure that any audit that inspects information about a client's HIV status is done in accordance with State law.

Other Rules About Confidentiality

Client Notice and Access to Records

The Federal AOD confidentiality regulations require a program to notify a client of his or her right to confidentiality and to give him or her a written summary of the regulations' requirements. The notice and summary should be handed to clients when they begin participating in the program or soon thereafter (§2.22(a)). The regulations also contain a sample notice.

Programs can use their own judgment to decide when to permit clients to view or obtain copies of their records, unless State law grants clients the right of access to records. The Federal regulations do not require programs to obtain written consent from clients before permitting them to see their own records.

Security of Records

The Federal regulations require programs to keep written records in a secure room, a locked file cabinet, a safe, or other similarly secure location. This requirement can pose a particular challenge to street outreach workers, who sometimes carry clients' records with them. Workers may be concerned that if their possessions are stolen on the street, clients' names will be disclosed.

Two precautions may be taken by programs to deal with this problem. First, clients' records should be transferred to a secure room as often as possible, preferably at the end of each day. Second, workers could use coded forms to record client information and keep clients' names in a separate location, such as in a small notebook kept in a breast pocket. This will reduce the risk that if a worker's bag is stolen, client-identifying information will be disclosed. Each day, the list of clients seen should be torn out of the notebook and placed in a secure room or locked file cabinet.

The program should establish written procedures that regulate access to and use of clients' records. Either the program director or a single staff person should be designated to process inquiries and requests for information (§2.16).

A Final Note

State laws govern many issues of concern to outreach programs. All outreach programs should try to find a lawyer who is familiar with State laws affecting their programs. A local practitioner is the best source for advice on such issues, particularly since many areas of the law are still developing.

Endnotes

1. This chapter was written for the consensus panel by Margaret K. Brooks, Esq.
2. Citations in the form "§2..." refer to specific sections of 42 C.F.R. Part 2.
3. Only clients who have "applied for or received" services from a program are protected. If a client has not yet been assessed or counseled by a program and has not sought help from the program, the program is free to discuss the client's AOD problems with others. However, from the

time the client applies for or receives services, or the program first conducts an assessment or begins to counsel the client, the Federal regulations govern.

4. Note, however, that no information obtained from a program (even if a client consents) may be used in a criminal investigation or prosecution of a client unless a court order has been issued under the special circumstances set forth in §2.65 (42 U.S.C. §§290dd-3(c); 42 C.F.R. §2.12(a), (d)).
5. The regulations state that "acting in reliance" includes services that were provided while the program was relying on the consent form to permit disclosures to a third-party payer. (Third-party payers are health insurance companies, Medicaid, or any party, other than the patient's family or the treatment agency, that pays the bills.) Thus, a program can bill the third-party payer for past services that were provided before the consent was revoked. However, a program that continues to provide services after a client has revoked a consent authorizing disclosure to a third-party payer does so at its own financial risk.
6. It seems unlikely that State law will require parental consent for outreach programs to provide services to minors. Outreach programs should know, however, that the Federal AOD regulations contain an exception permitting a program director to communicate with a minor's parents, even when the minor does not consent, when *both* of the following two conditions are met:
   (1) The program director believes that a minor who is applying for services, because of extreme AOD use or a medical condition, does not have the capacity to decide rationally whether to consent to the notification of his or her parents or guardian, and
   (2) The program director believes that the disclosure is necessary to cope with a substantial threat to the life or well-being of the minor or of someone else.

   Thus, if a minor applies for services in a State where parental consent is required to provide services, but the minor refuses to consent to the program's notification of his or her parent or guardian, the regulations permit the program to contact a parent without the minor's consent *only* if these two conditions are met. Otherwise, the program must explain to the minor that, although he or she has the right to refuse to consent to any communication with a parent, the program cannot provide any services without such communication and parental consent [§2.14(d)].
7. For an explanation of how to handle subpoenas and search and arrest warrants, see *Confidentiality: A Guide to the Federal Laws and Regulations*, published in 1990 by the Legal Action Center, 153 Waverly Place, New York, NY 10014.
8. Note that if the client is a minor and State law requires the outreach program to obtain parental consent in order to provide services, then parental consent is required to disclose information about the minor. Programs providing outreach services should determine whether State law requires that they obtain parental consent to offer services to minors.
9. However, if the information is being sought to investigate or prosecute a client for a crime, only the program need be notified (§2.65). If the information is sought to investigate or prosecute the program, no prior notice at all is required (§2.66).
10. If the purpose of seeking the court order is to obtain authorization to disclose information in order to investigate or prosecute a client for a crime, the court must also find, in addition to these two criteria, that the crime involved is extremely serious (such as an act causing or threatening to cause death or serious injury) and that the records sought are likely to contain information of significance to the investigation or prosecution. When law enforcement personnel seek the order, the court must also find that the program had an opportunity to be represented by independent counsel. (If the program is a governmental entity, it *must* be represented by counsel.) (§2.65(d))
11. For a more complete explanation of the requirements of §§2.52 and 2.53, see *Confidentiality: A Guide to the Federal Laws and Regulations* (cited in note 6).

Appendix A—References

American Thoracic Society. Control of tuberculosis in the United States. *American Review of Respiratory Diseases* 146:1623–1633, 1992.

Centers for Disease Control. Public Health Service statement on management of occupational exposure to human immunodeficiency virus, including considerations regarding zidovudine postexposure use. *Morbidity and Mortality Weekly Report* 39(RR1):1–14, 1990.

Centers for Disease Control. Recommendations for prevention of HIV transmission in health-care settings. *Morbidity and Mortality Weekly Report* 36(2S):1s–18s, 1987.

Institute of Medicine. *Broadening the Base of Treatment for Alcohol Problems.* Washington, D.C.: National Academy Press, 1990.

Kirby P.K., Munyao, T., Kreiss, J., and Holmes, K.K. The challenge of limiting the spread of HIV by controlling other STDs. *Archives of Dermatology* 127:237–242, 1991.

Moore, R.D., Bone, L.R., Geller, G., Mamon, J.A., Stokes, E.J., and Levine, D.M. Prevalence, detection, and treatment of alcoholism in hospitalized patients. *Journal of the American Medical Association* 261:403–407, 1989.

Wasserheit, J.N. Epidemiological synergy. *Journal of Sexually Transmitted* Diseases 19:61-67, 1992.

Appendix B—Sample Curriculum for Outreach Workers

The Training and Education Branch of the Division of STD/HIV Prevention at the Centers for Disease Control (CDC) has developed a curriculum for use in training outreach workers and HIV educators. Since 1991, the CDC has used the curriculum at trainings in several states and has been refining it for use with varied audiences.

An Approach to STD Prevention Education

The "Three R's of STD" (3Rs) is a versatile approach designed to meet a wide range contemporary needs for STD prevention education, while also reinforcing HIV prevention efforts. The 3Rs is a distillation of key facts and prevention behaviors related to dozens of different STDs and syndromes; these key facts and concepts are condensed for communication through nearly every conceivable medium.

The 3Rs approach works to influence health-seeking behavior among persons who eventually experience STD symptoms. The aim is both to halt further spread and more quickly treat infected others, especially women, who may not experience symptoms. The strategy is to saturate community areas where populations are at increased risk of STDs with 3Rs messages so that the contents of the training gradually become internalized and reflected in the actual behavior of infected persons.

The 3Rs of STD

- **Risk:** Risk increases with unprotected sex and sex with different partners. Reduce risk by limiting partners and using condoms properly (from start to finish during sex).
- **Recognition:** Know the signs of STDs:
  Sore(s), mainly on or around sexual organs
  Rash, mainly on the palms and soles of the feet
  Discharge from sexual organs.
- **Response:** **If** STD signs appear, or
  If STD exposure is suspected (some people don't experience sores, rash, or discharge), or
  If a public health representative confidentially notifies you of an exposure to STD:
  - **Stop having sex at once**; avoid spreading infection.
  - **Talk to recent partner(s)**; take them with you to see a doctor.
  - **Don't try self-treatment**; see your doctor or an STD clinic immediately!

Several features of the 3Rs approach make it practical for state, local, or community HIV or STD prevention programs.

- **Clearly linkable with training approaches for HIV and complements rather than competes with such approaches.** STD infection is an established cofactor in HIV transmission, and common methods are promoted to prevent sexual transmission. The messages of 3Rs also remind those who deny their risk for HIV that the incidence of STDs make that a foolhardy decision.
- **Versatile.** The 3Rs is straightforward and condensed to allow its presentation in multiple ways; e.g., formal presentation, "street" delivery, counseling session, school curricula, fliers, posters, pamphlets, radio, television, etc.
- **Focused on behaviors that will prevent infection.** Treating even a small portion of persons before they spread infection could reverse some STD trends; treating partners early, especially women, can prevent costly, life-threatening complications.
- **Can be evaluated.** Public STD clinics can track the health-seeking and referral behaviors of symptomatic males to measure impact of a sustained 3Rs campaign.
- **Easy learning curve for staff.** Education staff with no STD background can absorb and begin using the 3Rs approach with nothing more than a half-day inservice training.
- **High confidence level for staff (easy to get and stay enthusiastic about).** Experience has shown that the "user friendly" approach, combined with a clear purpose and complementary linkage to HIV, has produced wide acceptance.
- **Simple to present.** The 3Rs approach is straightforward and does not require even low level expertise in STDs; technical disease questions are referred to a clinic.
- **"Catchy" and memorable.** This feature of the 3Rs title makes it a hook on which to hand the prevention messages and to promote recall if STD symptoms appear.
- **Usable messages by persons receiving the education.** The 3Rs messages are practical, yet not overwhelming in either number or complexity.

Course Description

Title. The "Three R's of STD: Risk, Recognition, and Response" is an introductory course that offers information on prevalent sexually transmitted diseases and is designed to meet the basic training needs of health care outreach workers who work with persons at risk for HIV infection.

The 3Rs concept is designed to be taught in other health settings and used in media campaigns so that the "risk ,recognition, response" message is effective through repetition.

Eligibility. New community HIV prevention outreach workers, HIV test counselors, and health educators or those whose job descriptions include triaging STD questions of their clientele (for example, drug users, prostitutes) may apply for this course.

Class size. Variable, 10 to 50 students.

Class time. 16 hours (2 days).

Content summary. This course covers disease risk behaviors, common STD manifestations, prevention behaviors including condom use, STD clinic orientation, laboratory test principles, communication skills, and integrating STD and HIV prevention messages.

Format. Lectures, role play exercises, and class discussion. All students are required to participate in the role play exercises.

Didactics. All lectures must utilize and promote CDC's *Sexually Transmitted Diseases Clinical Practice Guidelines, 1991* and *Sexually Transmitted Diseases Treatment Guidelines, 1989.* The following STD topics, program management topics, and role play should be incorporated:

- STD topics (2 hours each topic)
  - Risk/unsafe behaviors
  - Recognize common manifestations (sores, rash, discharge)
  - Disease complications/sequelae
  - Respond: discussion of five STD prevention behavior messages
  - Substance abuse and STDs
- Program management topics (1/2 to 1 hour each topic)
  - STD clinic orientation
  - Laboratory test principles
  - Disease intervention/test counseling overview
  - Case management
  - Integration into HIV prevention programs
  - Communication skills
  - Learning theory
  - STD/HIV and the law

Objectives. All didactics must include specific content and activities that enhance the learning outcome.

Participants will:

- Better understand why STDs must be included when conducting HIV educational outreach activities.
- State the key risk factors associated with sexually transmitted diseases.
- Know the symptoms that categorize most STDs.

- Know the five STD prevention behavior messages that are important to address in HIV educational activities.
- Describe appropriate ways for clients to respond to a suspected STD.

Evaluation. Participants must complete a course and training evaluation.

Certificate. All participants who successfully complete the course will receive a certificate of attendance that includes the number of CEUs earned.

The Three R's of STD
Agenda

Time	Topic	Method
DAY 1		
30 minutes	Introduction/agenda review	Participation
30 minutes	Pretest	Test
2 hours	Risk: (1) STD transmission, (2) Unsafe behaviors, (3) Similarity to HIV	Lecture Discussion Flipchart
2 hours	Recognize: Common STD manifestations	Lecture Participation Overheads
30 minutes	Recognize: Disease complications & sequelae	Lecture Slides CDC publications
2 hours	Respond: Clinical care resource 5 STD prevention behavior messages	Lecture Overheads
30 minutes	Integration of "3Rs" into HIV prevention programs	Discussion
DAY 2		
1 hour	STD intervention overview HIV test counseling overview HIV case management	Lecture Overheads Handouts
1 hour	STD clinic orientation (tour optional)	Lecture (Field trip)
1 hour	Laboratory test issues	Lecture Slides
1 hour	Substance abuse and STD	Lecture
1 hour	Communication skills	Lecture Overhead
2 hours	Role play: Integrating the "3Rs" into HIV outreach educational activities (counselor, patient, observer).	Groups of 3 Observer feedback
30 minutes	STD and the law	Lecture Discussion

Appendix C—Cultural Competence

Two articles on cultural competence are included here. The first article, "Cultural Sensitivity: Treatment for Diversity," was published in the July/August 1992 issue of *The Counselor*, a publication of the National Association of Alcoholism and Drug Abuse Counselors. For the article, the association invited several treatment professionals to share their views on prejudice and cultural sensitivity.

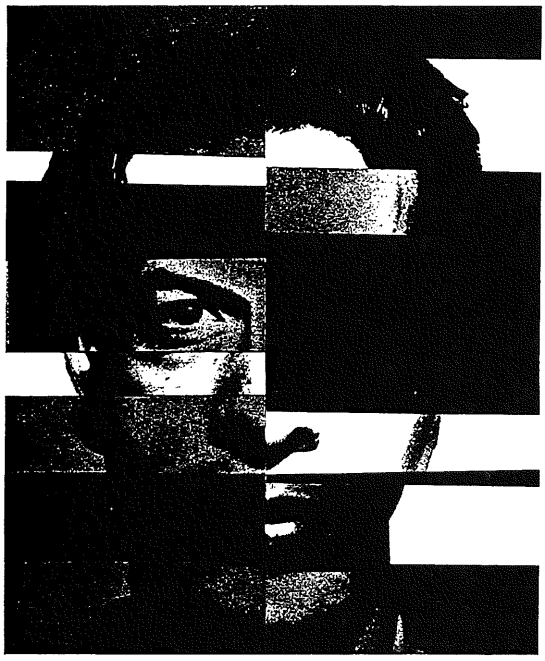
The second article, "Self-Instruction to Prevent HIV Infection Among African-American and Hispanic-American Adolescents," was published in 1990 (vol. 58, no. 4) in the *Journal of Consulting and Clinical Psychology*, a publication of the American Psychological Association. The authors report the results of a study in which different interventions were used to instruct adolescents about avoiding behavioral risks for HIV infection.

Both articles are reprinted with permission.

CULTURAL SENSITIVITY: TREATMENT FOR DIVERSITY

The days when the traditional client in treatment was a middle class, middle aged, white male are over. In cities, suburbs or rural communities, counselors face a client population that is representative of the demographic realities of our society. America's complexion today is multi-ethnic, multicultural, and varied in terms of age, lifestyle and physical abilities.

Treatment programs and professionals need to understand, acknowledge and appreciate the diversity in their clients in order to respond to their needs. To shed some light on the current situation, ***The Counselor*** *magazine asked the following group of professionals to share their perspectives on the differences between prejudice and cultural sensitivity and their impact on treatment.*



Bart Aoki

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Asian American Recovery Center

San Francisco, California

Aoki: Prejudice is inherent to individual functioning as it influences all of our decisions from what we have for dinner to how we judge the potential for change in a counseling client. Prejudice is irrational, implying a lack of introspection and a closed and rigid stance while cultural sensitivity is based on awareness, both of the self and others, and implies flexibility and openness to diversity. Cultural sensitivity is a developed skill, consistent with ethical and professional treatment and woven through all organizational and counseling processes. Cultural sensitivity should be the foundation of treatment, and along with prejudice, should demand accountability.

Within the Asian American population, counselors must understand and respect the diversity among the multiple racial and ethnic groups that comprise our community. That Asian Americans will vary in their experience, behaviors, problems, and world views depending upon their generational status in the United States is a given. For counselors to concentrate on these factors does not betray a prejudice. In order to effectively facilitate change, an appreciation, or cultural sensitivity, of these differences is as much a given as is effective communication and analytic skills.

For the Asian American client, prejudice comes into play at a number of levels. It is expressed in a setting's adherence to a particular program design or treatment approach, regardless of evidence of its lack of relevance to certain client groups. Prejudice is also betrayed by the specific location and level of accessibility of a program to different groups as well as by the lack of diversity in its staffing. The covert message that is conveyed to clients from diverse ethnic backgrounds is that this program is closed to their unique and different needs.

A recognition of the impact of racism upon different Asian groups and its interaction with culturally preferred coping styles is essential to an accurate assessment of an Asian client. Asian ethnic groups differ in their experiences and perceptions of stressors, distress, helpers, and health care.

At the counselor's level, prejudices are expressed in preferences for particular types of clients and in reactions to the individual relationship with the client. For example, prejudice is expressed when counselors advocate the expression of self assertive behavior to Asian American clients who may not accept self-assertion. It is also seen in a system's or counselor's rigid and potentially false belief that Asian Americans experience fewer problems and thus are in lesser need of treatment.

Because prejudice is present at

many levels in treatment settings, it must be addressed in a systematic way by understanding and predicting the mechanisms that should be incorporated for accountability. This can take the form of staff discussions and training at all organizational levels. Most importantly, counselors and program supervisors must examine and address prejudice continually.

Melvin Delgado

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Boston University

School of Social Work

Massachusetts

Member of the Editorial Board of the Hispanic Journal of Behavioral Sciences *and co-author of* Hispanic Adolescents and Substance Abuse *(1989) for the Office of Substance Abuse Prevention.*

Delgado: Because there are many different Hispanic subgroups in the United States representing every Spanish-speaking country in the world, a major challenge facing those who want to be culturally sensitive lies in the understanding that Hispanic people are not a homogenous group. The tendency to group all Hispanic people together does a prodigious disservice to this group. Mexican Americans, Puerto Ricans and Cubans represent the greatest concentration of Hispanics in the Nation, each with their own differences which can affect treatment issues. For example, urban-rural differences can manifest themselves in various ways when Hispanics seek treatment. If an individual is born and raised in a rural part of Puerto Rico and then moves to a large urban setting in the United States, not only does the client have to adjust to American life but he/she must also contend with the stresses of living in a city and speaking a different language.

Prejudice is the result of personal experience or minimal contact which has produced an inherent dislike. On the other hand, cultural sensitivity is a state of mind that acknowledges the differences between groups which should be celebrated rather than feared and disliked. Yet the differences within and between these subgroups can make cultural awareness and sensitivity difficult to achieve.

Prejudice towards Hispanics is covertly reflected in the lack of awareness of how culture plays a role in the development of delivery of services. Culturally sensitive counseling with Hispanics requires professionals to be aware that as a group, we define family differently than is usually the practice in the United States. Our definition of family is one that has permeable boundaries with strong influences, encompassing blood relatives, relatives by marriage, and close family friends and neighbors who are treated "just like family." Additional support systems exist, involving folk healers, religion, and community institutions such as grocery stores, botanical shops, and social clubs. This rich array of cultural resources must be taken into account in the development of any culturally sensitive intervention. If these differences are reacted to as "abnormal, primitive and different," prejudice will result, hindering treatment.

Since lack of communication can result in an isolated prejudice, materials describing the rehabilitation program and services must be translated into the Spanish-dialect of the Hispanic subgroups. Professionals must be willing to examine its structure, staffing and service delivery. Failure to do so will seriously limit the effectiveness of the program in meeting the needs of a population that is growing in numbers, needs, and complexities.

On the administrative side, prejudice is manifested by how willing the treatment facility is to have an Hispanic presence throughout all levels of the organization. Unfortunately, treatment programs are reluctant to hire more than one Hispanic on staff and this is done only after all efforts to meet the needs of the community have failed. Hiring Hispanic treatment professionals is seen as a last resort. Hispanic treatment staff are expected to work far beyond what is expected of others. When Hispanic counselors are hired, they must perform a wide range of duties, many of which are not part of their job descriptions, i. e. interpreting for other staff who are non-bilingual, translating English written letters and documents into Spanish, and representing the agency at community-related functions and coalitions. When in-service education is offered, it rarely meets the needs of Hispanic staff since the treatment facility may not feel it should learn about the community since there is an Hispanic person on staff to handle this dimension of service delivery.

Efforts must be made to make the treatment facility hospitable to a wide range of ethnic themes, including involving Hispanic families and natural support systems in the delivery of services.

John de Miranda

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Peninsula Health Concepts

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Director of the California Alcohol, Drug and Disability Study (1989).

de Miranda: Since prejudice is based on false perceptions, a special kind of prejudice is created when relating with disabled persons. Most people tend to view individuals with disabilities as either sad and to be pitied, or heroic and courageous, the

so-called "super-cripple" phenomenon. These people suffer from a frame of mind I call, "disabilophobia," characterized by an irrational avoidance of people with serious, visible, disabling conditions and by feelings of discomfort and awkwardness when forced to interact with disabled persons. These are feelings to which no one is immune.

During a recent clinical study of five severely disabled individuals who are also in recovery, I, the team leader and a disabled person, was anxious that I would say the wrong thing and cause emotional harm. Because I also had to act as personal care attendant, I was scared that I might cause physical harm or discomfort. What I learned from this experience is that this form of prejudice can strike anyone, including someone like myself who has dual disabilities. This kind of prejudice is not only patronizing, but it also assumes that clients are incapable of making their needs known. Despite my prejudice towards the participants, each story of recovery was similar to my own and those of non-disabled persons in recovery.

Sensitivity is developed by learning to value and appreciate differences between disabled persons. It does not come easily, especially when the presumptive attitude of people is so ingrained. It is, however, the sine qua non without which there can be no true helping relationship.

When dealing with addicted individuals with disabilities, professionals have been accused of being rigid, insensitive, and over-controlling. Many clients have been denied quality care because professionals would not treat someone who required medications for life-threatening conditions. Professionals who are unwilling to be flexible in their psychoactive medication policy are discriminating against a class of disabled individuals who require such medications. Such overt practices are clearly outlawed by Section 504 of the Rehabilitation Act of 1973 which governs all alcohol and drug programs receiving federal funds. Despite the fact that AA's position of tolerance regarding "life sustaining" medications is presented in its literature, many professionals are still antagonistic to the use of psychoactive medications, even for people with serious life-threatening conditions.

Treatment professionals must also realize that many disabled addicts may have been exposed to large quantities of pain management medications from an early age. Since this knowledge may change certain treatment issues, ignorance and lack of access to appropriate treatment creates a special prejudice in the treatment setting.

Professionals who are otherwise sensitive to special populations may not know the first thing about "disability culture" or how to talk with someone about their disabling condition. As part of treatment, many newly recovering persons with disabilities must re-experience major developmental issues in their lives, including renegotiating and reaccepting the reality of the disability. Yet, if the counselor working with the client doesn't understand the special treatment issues, then prejudice hinders treatment. A counselor must be aware that addiction may be a coping mechanism for the client to deal with the life-long isolation of having a disability. The impact of the disability on family members must also be examined. Counselors must realize that a family's emotional and interpersonal dynamics may have been so constrained in response to the stress of raising a disabled child that there may be little support in reserve when addiction treatment is necessary.

In my experience of providing disability-related training to alcohol and drug treatment professionals, I am frequently surprised by the field's lack of understanding and knowledge about disability issues. Yet these same professionals are eager to gain this information and broaden their understanding. This paradox is the result of prejudice, a fear of the unknown and a widespread, yet silent, consensus that treatment programs are not responsive to people with disabilities.

Rosie Hatchett

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NAADAC's Counselor of the Year for 1990, and named by the National Council of Negro Women as one of the top hundred Outstanding Black Women in Indiana.

Hatchett: It is obvious that prejudice towards African Americans exists in the lack of available treatment. Although facts indicate that alcoholism and drug abuse are the top health problems among African Americans, many treatment programs have only 5-10% of African American clients on any given day.

When someone takes away my rights because of the color of my skin, texture of my hair, size of my lips and the kind of clothes I wear, then prejudice has determined my acceptance in society. Prejudice has classified African Americans as a subgroup within a subgroup instead of being accepted into a general sociocultural environment.

Through cultural sensitivity, African Americans are seen as unique and their needs are based on the vast structure of language, behavior, customs, knowledge, symbols, ideas, values, matter and mind. For example, a general hospital in the South 28 years ago had 35 beds, two of which were for "colored folk." Today, that hospital has eight beds

for African Americans. Did this change take place because the administration became sensitive to the needs of the African American client? Or were African Americans singled out and patronized?

The most powerful benefit of cultural sensitivity for African Americans makes it unnecessary for us to "cross the tracks" to get our core human needs met in a white societal context. Cultural sensitivity allows me to say "I am somebody" with great meaning. Cultural sensitivity is respecting others who have ways of living different than my own.

Many facilities providing treatment are located in predominantly white communities with white counselors. Many African Americans view this as a hostile and unsafe environment which can effect the attitudes of both counselor and client towards treatment. It is hard to deal with our racial pain during treatment with the person who is viewed as the source of the pain. This is not to say that African Americans work better in treatment with African American counselors. Any counselor who is culturally liberated can produce most positive outcomes in treatment and develop empathy and trust through shared life experiences.

In addition, the belief that African Americans are seen as failures in treatment, which makes them enter treatment later, is another form of prejudice. There are many counselors who are consciously aware of their dislike for African Americans and who know that these attitudes are inappropriate in a counselor-client relationship. But that same counselor will try to hide his/her true feelings, not realizing that the prejudice will be evident. The therapeutic interaction itself will betray the counselor's true feelings through a lack of empathy for the client. Counselors who act out deep seated prejudices towards African Americans will dehumanize and humiliate the client, resulting in overt racism and hostility. Counselors should ask for help from someone who may have more experience in working with African American clients to address issues relating to culture or they should not work with this population at all.

Counselors must be able to identify the interpersonal styles of the African American client

Treatment can be developed to allow a client to talk about racial identity issues and cultural differences. Counselors must be able to identify the interpersonal styles of the African American client and recognize this population as being culturally immersed, traditional, acculturated and bi-cultural. This is a must in order to provide effective treatment with effective results. Until treatment professionals are willing to admit that different cultures require different modes of treatment, we will continue to see fewer ethnic groups getting appropriate care.

Edward Magiste

NCAC II

Counselor at Serenity Hall,

St. John & West Shore Hospital

Westlake, Ohio

Magiste: Prejudice is more difficult to recognize towards gays, lesbians and bisexuals than it is for the ethnic and disabled groups because it is based on sexism rather than racism. Rather than disliking one's skin color, ethnic origin or physical limitations, prejudice toward gay people is based on personal sexual orientation that is condoned rather than condemned by society.

The essence of prejudice lies in the fact that gays, lesbians and bisexuals are perceived to be wrong for being themselves. *The Big Book of AA* explains prejudice as "contempt prior to investigation," and this population is subjected to this in many ways. Two examples are gay individuals who are afraid to put pictures of their life partner on their desks because of the adverse reactions of staff or who must lie about who is next of kin on insurance forms because no one recognizes the gay life partner as that. Gays, lesbians and bisexuals must constantly justify friends and lifestyle.

Cultural sensitivity can create an atmosphere of acceptance through recognition that there are distinct differences between gay men and women and straight men and women. It means knowing that a gay person seeks a long term committed relationship with someone of the same sex; that AIDS is not an exclusive membership criteria for the gay community; and knowing that they socialize with a lot of people of the same gender but are not sexual with them. Gay people must struggle for acceptance within every ethnic group.

There are three distinct examples of prejudice toward the gay/bisexual population in the treatment setting. The literature and research conducted in the field does not take into account alternative lifestyles and expression, leaving gays, lesbians and bisexuals to look for validation and support in a group that asserts heterosexual values and male dominance. Professionals must ask that more be done in studying and understanding gays, lesbians and bisexuals other than just make occasional references to "significant others." Every treatment center should have at least one person on staff who is

sensitive about the issues of gays, lesbians and bisexuals. This person should be aware of the different expressions of personhood of this population so that these clients may receive not only sympathy and understanding for their addiction, but also empathy and insight for their recovery.

A second example is found in the assumption that all gays, lesbians and bisexuals are comfortable with their sexual orientation. Whether they have been acting it out or not, many gays, lesbians and bisexuals are overwhelmed by the coming out process. Although the gay client has the same degree of shame that any other addicted person has entering treatment, no amount of education on the disease concept of treatment will address the years of shame felt for having erotic feelings towards members of one's own gender. The converse of this is also true. There is an assumption that being gay, lesbian or bisexual immediately predisposes one to being maladapted. Counselors need to find out from the client where they are with their sexual orientation. And, as with all personal expressions of self, there is no "normal."

The third kind of prejudice comes in the form of exclusion. Many counselors and treatment centers, for whatever reason, ignore the client's sexual orientation. Some use the line of thinking that says "we treat addiction, not orientation." Albeit a true statement, all too often orientation isn't even mentioned. This leaves the client with a discounted feeling, and this kind of prejudice says to the gay, lesbian and bisexual client that who you are is not important.

Counselors and treatment centers must respect sexual orientation and treat addicts accordingly. Programs should be designed to enhance, not retard, the gay person's recovery, and the treatment facility should be the place where individual uniqueness is sacred.

Kay Mattingly-Langlois

MA, NCAC II, President

The Center for Creative Change

Indianapolis, IN

Immediate Past President of NAADAC.

Mattingly-Langlois: It is a mistake to assume that because a few women have risen to top positions in business and industry, and earned recognition in non-traditional arenas such as the armed forces, sports, the space program and politics, that women today enjoy equal opportunity in our society.

That is an illusion. Sexism in our country is pervasive and contributes to lower wages, fewer employment opportunities, and lack of day care. In addition, many women are the victims of domestic violence and crime.

Prejudice and cultural insensitivity also impact women in the treatment setting where their needs and special demands are placed second to male counterparts.

From our clients' perspectives, females have different issues in treatment than males but rarely are these addressed. Most of the treatment modalities in the United States are based on the white male treatment needs. So by mixing male and female clients together in group therapy, the needs of the females may go unnoticed and untreated.

Research has shown that females are more likely to be more sensitive and put the feelings of others ahead of their own. Women are typically going to listen to the men and do less talking, an important trait that treatment programs should recognize. Women need to be in their own groups where they take care of their own needs.

Sexism also crops up in insidious ways. It has been my experience that in staff meetings, for example, a female counselor can make a statement regarding appropriate treatment for a client. Even though her expertise is acknowledged, the input is generally more accepted if a male counselor makes the same statement.

Another example comes through behavior and attitude. Once I worked with a male counterpart who touched me every time we talked. He did not touch other males. His attitude was that because I was a woman, it was all right to take such liberties. And taken another step, we know from recent events how women suffer from sexual harassment.

Another subtle instance lies in the language between men and women. Most of us would not consider calling a male boss a "boy" yet many male employees will call a female boss a "girl." While it is considered a compliment by young society to call a woman a "girl," this term implies that a "girl" is more attractive than a woman and that age makes females less attractive. In addition, this assignation automatically slots females in a lower position in the hierarchy. Females are just as guilty as males in this respect.

Professionals should be aware of not only the terms that are used, but also what is said and how it is said. This shouldn't be applied to only male or female interactions. It can also be applied to ethnic populations, gay populations, any group of people with whom counselors interact.

I don't think that there are many counselors who are malicious in many areas because there is a basic caring about people that draws them into this profession. "Counselor, know thyself" should be every professional's motto.

But counselors who know they have a bias should learn as much as they can about the population to overcome their feelings. Otherwise, they should not work with that population.

Leo Whiteford

CAC, Counselor

Puyallup Tribal Treatment Center

Takoma, Washington

Whiteford is a Chippewa-Cree Indian and a member of the Northwest Indian Alcohol-Drug Specialist Certification Board.

Whiteford: Those who work within the Native American population are perhaps more conscious about the differences between prejudice and cultural sensitivity. Since we, as Native Americans, have been forced to live in a bi-cultural environment, the historical experiences of being forced to attend boarding schools, forced not to speak our native tongue and living under the watchful eyes of a paternalistic government has raised the awareness of prejudice and cultural sensitivity within our people. It is apparent to the Native American today that not everyone in the United States cares to understand the meaning or have a definition for prejudice or cultural sensitivity, making it difficult for any person in any workplace **not** to have some form of prejudice. Because of cultural ignorance and lack of education necessary for everyone to sensitize themselves to the wide diversity of cultures that exist today, professionals will consistently be overt and covert in their dealings with minorities, especially Native American people.

Prejudice can be overt when individuals from Anglo treatment settings state, "Oh, just another drunken Indian again." As a result, the Native American is presented in a condescending manner. In addition, during assessments, a pre-existing bias on the part of the counselor can tip an evaluation in a way that reflects prejudice and undermines treatment.

Native Americans themselves can display a prejudicial attitude towards their counterparts which presents itself in verbal or non-verbal communication. The statement, "He is an apple" (red on the outside and white on the inside) is common between Native American clients.

Not knowing the differences in cultural traditions also adds incidences of prejudice. A client, who wishes to attend a local spiritual activity which is based on cultural heritage, may be refused by the treatment staff who don't understand the significance of the ceremony. As a result, it has taught us that Native American counselors understand how best to treat our own tribal members. A Native American client will be more comfortable in a treatment program with Native American counselors.

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Self-Instruction to Prevent HIV Infection Among African-American and Hispanic-American Adolescents

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This study tested the efficacy of self-instruction intervention to reduce avoidable risks for HIV infection associated with drug use and unsafe sexual activity among African-American and Hispanic adolescents ($N = 60$). After completing pretests, adolescent participants in the study were randomly divided into three conditions. Participants in one condition received a self-instructional guide about AIDS and its transmission along with group instruction in using the guide. Adolescents in another condition received the guide without group instruction. Participants in the third condition received neither the guide nor group instruction. Outcome findings indicate that participants in the two self-instruction conditions improved more between pretest and posttest assessments on measures of HIV infection risk compared with adolescents in the control condition.

Behavioral risks associated with human immunodeficiency virus (HIV) infection—intravenous drug use and unsafe sexual practices—are preventable (Centers for Disease Control, 1988a, 1988b; Day, Houston-Hamilton, Deslondes, & Nelson, 1988). Even though much is known about preventing HIV infection, tested interventions do not exist for youth at highest risk for AIDS (Brooks-Gunn, Boyer, & Hein, 1988; DiClemente, Boyer, & Morales, 1988; Flora & Thoresen, 1988). These youths are disproportionately African-American and Hispanic adolescents. In the present study, an intervention to prevent HIV infection was developed specifically for and tested among a sample of these high-risk youths.

African-Americans and Hispanics combined account for 70% of all cases of AIDS among heterosexual men, 70% of all AIDS cases among women, and 75% of all pediatric AIDS cases (Selik, Castro, & Pappaioanou, 1988). Separately, African-Americans represent 26% of all adult AIDS cases and 58% of all pediatric AIDS cases (Heyward & Curran, 1988; Morgan & Curran, 1986). Hispanic-Americans account for 14% and 22% of all adult and pediatric AIDS cases, respectively. African-Americans and Hispanics represent 51% and 30%, respectively, of all AIDS cases associated with intravenous drug abuse (Mascola et al., 1989).

Interventions to help African-American and Hispanic adolescents prevent HIV infection by reducing their risks for drug use and unsafe sexual activity are justified. Among the most promising interventions are those grounded in learning theory and based on youths' preferred culture- and age-specific styles of learning (Bobo, Snow, Gilchrist, & Schinke, 1985; Schinke, Moncher & Holden, 1989; Schinke et al., in press). One such intervention using self-instruction and cognitive-behavioral principles of problem solving was developed and tested in the present study.

Support for this research was provided by National Institute on Drug Abuse Grant DA 05321.

The authors thank Victoria Cusare and Carl Cecora for their assistance with field operations of this study and Catherine Bowman for her editorial assistance.

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Method

Subjects

Participants were 60 adolescents enrolled in an urban job-training program. The 34 female subjects (56.7%) and 26 male subjects (43.3%) had a mean age of 16.01 years. Primarily, participants were from African-American (36.7%), Hispanic (26.6%), and Caribbean-Black (15%) backgrounds, with the remaining participants from other minority groups (11.7%) and nonminority groups (10%). Youths were invited to participate in the study as an adjunct to job-training program activities. In an initial session, youths learned about study procedures and risks. Then participants and their parents were given passive consent forms. No youths or parents passively declined study participation.

Measurement

Participants completed a pretest battery coded to ensure confidentiality and to enhance the accuracy of self-reports (Murray, O'Connell, Schmid, & Perry, 1987). Pilot-tested and refined with a prior sample of African-American and Hispanic adolescents, the battery contained scales on demographic items, drug use and sexual activity, and HIV infection knowledge, attitudes, and risks. Overall, alpha reliability for the self-report battery was .89. Test–retest reliabilities for the measure from responses to expectedly stable questions over two assessment occasions averaged .97.

Procedure

Before they left the pretest measurement session, participants received an informational sheet on AIDS and its prevention. Participants

were then scheduled for a posttest measurement session, 1 month later. Posttest measures employed the same battery used at pretest. Randomly, participants were divided into three conditions: guide plus group instruction, guide only, and control.

Guide plus group instruction. Participants in this condition met with research staff for three 1-hr sessions during the 1-month interval between measurements. During each session, intervention leaders described the rationale and use of the self-instructional guide. Leaders devoted the first half hour of each session to information about AIDS, drug use, and unsafe sexual activity; the second half hour was devoted to describing and explaining five steps to cognitive problem solving.

Guide only. Participants in this condition received the self-instructional guide after completing the pretests. Encouraged to read the guide and to complete its exercises, participants were not otherwise instructed in the guide's use. Participants discussed their experiences with the self-instructional guide after completing posttest measures.

Control. Participants in this condition received no intervention other than the aforementioned AIDS fact sheet.

Intervention

The self-instructional guide was written in a comic book format that relied heavily on graphics with brief passages of text. Written in rap music verse, the guide informed participants about AIDS risks, myths, and prevention strategies. Rap music is a popular form characterized by improvised and rhymed lyrics. Lyrics were presented by a cartoon character drawn to mirror participants' age and ethnic–racial backgrounds. Throughout the guide, the character described how adolescents can contract AIDS and how they can avoid it through behavior change.

The guide devoted attention to risks associated with intravenous drug use, including needle sharing, sexual contact with partners who inject drugs, and decisions and steps that could lead to intravenous drug use. An example of the guide's instructional tone and textual material is this rhyme that accompanied an unflattering cartoon of a person injecting drugs: "Dopers get it from sharin' the spike. . . . Share needles—share AIDS and take the permanent hike."

After explaining the behavioral risks of AIDS and ways to avoid the risks, the guide introduced participants to a cognitive problem-solving sequence. The sequence used a game format that required youths to make hypothetical decisions about drug use and AIDS risks. The sequence included four steps, the initials of which form the acronym SODA. ("This game is called SODA; but you don't exactly drink it. . . . In order to play it you gotta *think* it!")

The first step in the sequence was *Stop.* In this step, participants learned that they should pause and give themselves time to consider their choices and the consequences of those choices when facing drug use and other risk-taking situations. ("Really stop and *think* what these choices could *really* mean for you, today, tomorrow . . . for *years* to follow.")

The second step, *Options,* reminded participants that problems have many solutions. To graphically show participants how to consider their options, the guide depicted a scale on which various outcomes from decisions were weighed. ("The *best* way to choose your option is to think of a scale that measures how much you gain and how much you would fail.")

For the *Decide* step, the guide showed participants how to choose the best solution from their options. Emphasizing that appropriate responses vary depending on the problem, the guide recommended that participants base their decisions on an assessment of problem situations. The guide told participants to consider especially whether the solution to a problem situation would involve danger, rejection, or risk taking. Participants then noted the decision that was best for them.

In the *Action* step, participants reviewed five types of verbal responses to peer pressure situations: I statements ("I don't use *that* kind of stuff"); Delay statements ("I can't tell you my answer now. Let me get back to you later"); Refusals ("I can't go with you today, so I'll see y'all later on"); Blunt and Blur statements ("You're right, man, I am a drag; but the price of a free high is *more* than I can afford"); and Alternative suggestions ("I don't get high, pal, but you know who does, so check 'em out").

Next, participants were presented with five problem situations and told to record their responses referring to the problem-solving paradigm. The problem situations in the guide were referred to as puzzles. ("Now move on to my puzzles. Let me see how you do. You heard enough from me. I wanna hear from *you*!") For each puzzle, participants were asked to solve the problem situation for a cartoon character.

Problem situations in the puzzles included the following: Should the cartoon character use a borrowed needle to inject drugs; should the character work as a prostitute; should the character talk to her teacher because she is worried about getting AIDS from her drug-using boyfriend; should the character take drugs after listening to an older teenager argue in favor of drug use; and should the character strive to emulate the life-style of a high-status drug dealer? At the end of each problem-solving situation puzzle, participants were reinforced for work just completed and were encouraged to progress to the next problem ("Good answer! Now you've got the hang of it, so keep on goin.' Try the next one on your own").

Results

Pretest Findings

Across conditions, study participants did not differ on measured demographic variables, according to one-way analysis of variance (ANOVA) and chi-square tests (Table 1). Additional one-way ANOVA comparisons at pretest showed that participants were also similar among the three conditions on variables associated with future problem-behavior risk. These variables are represented by age–grade discrepancy and by school truancy, suspensions, and grade failure—the last four entries in Table 1.

Intervention Integrity

To determine whether self-instructional intervention was delivered consistently within conditions and whether it was perceived as equally effective by participants, manipulation checks were performed. Manipulation check data were collected from participants through open-ended and Likert-scaled items on anonymous feedback sheets. Analyses of manipulation check data revealed no within-condition differences on any variables, including how much participants perceived that they learned, $F(4, 109) = <1$, and on how much participants enjoyed intervention sessions, $F(4, 104) = 1.65$, *n.s.*

On an anonymous, open-ended evaluation form completed after posttesting, the majority of participants in the intervention conditions were positive about intervention. Of all the participants, 59.8% stated that they liked everything about intervention. Only 6.1% of participants reported they already knew intervention content. Using open-ended responses, 21.4% of participants expressed a desire to learn more about AIDS and related risk factors.

Outcome Findings

Outcome differences at posttest among the three conditions were analyzed univariately. Univariate tests, rather than multi-

Table 1
Demographic Risk Characteristics of Participants

Variable	Guide + group (n = 18)			Guide only (n = 19)			Control (n = 23)		
	M	*SD*	%	*M*	*SD*	%	*M*	*SD*	%
Age (years)	15.69	1.03		16.03	1.63		16.23	1.61	
Female			56			68			48
African-American			22			58			30
Caribbean Black			11			11			17
Hispanic-American			33			21			26
Other minority			17			5			13
Nonminority			17			5			9
Highest grade (years)	9.06	0.99		9.39	0.92		9.30	1.22	
Truant past year[a]	1.66	1.35		1.28	1.60		1.74	3.31	
School suspensions[b]	0.39	0.61		0.21	0.54		0.18	0.50	
Held back in school[b]	0.33	0.49		0.53	0.77		0.70	0.93	

Note. Guide + group = self-instructional guide plus group intervention; Guide only = self-instructional guide given after pretesting; Control = no intervention.
[a] Number of occasions. [b]Lifetime prevalence, number of occasions.

variate tests, were performed because the study's small sample sizes and missing responses from participants vitiated the sensitivity of multivariate tests to find among-conditions differences. One-way analysis of covariance (ANCOVA) on posttest scores, using pretest scores as covariates, revealed several differences among the three conditions (Table 2). After intervention, participants reported changes in their perceptions about the value of AIDS education, $F(2, 54) = 4.59$, $p < .014$. Within-condition differences on this variable were found by dependent t tests. Those tests showed pretest to posttest change for participants in the self-instruction-only condition, $t(18) = 2.54$, $p < .021$. No changes for participants in the other two conditions were shown by dependent t tests.

ANCOVA on pretest to posttest differences indicated that after intervention, study participants changed their responses about the transmission of the AIDS virus through casual contact, $F(2, 53) = 3.38$, $p < .042$. Dependent t tests revealed no within-condition differences on this variable. Analyses of participants' responses between pretest to posttest on a scale regarding their fear of AIDS failed to reach significance, $F(2, 55) = 2.04$, $p < .139$, as did changes in participants' responses regarding their approval of casual drug use, $F(2, 55) = 2.05$, $p < .138$.

According to ANCOVA, pretest to posttest scores on a measure of participants' approval of intravenous (IV) drug use were significant among the three conditions, $F(2, 55) = 5.35$, $p < .008$. Within-group t tests for changes on this variable indicated that participants who received the self-instructional guide plus small group intervention nonsignificantly decreased their permissiveness toward IV drug use, $t(17) = 1.72$, $p < .102$, whereas participants in the control condition nonsignificantly increased their permissiveness toward IV drug use, $t(22) = 1.70$, $p < .103$.

Responses on scales of participants' willingness to discuss drugs, $F(2, 54) = 2.12$, $p < .13$, and sex, $F(2, 56) = 2.06$, $p < .14$, with their families did not differ among conditions between the two measurement occasions. Regarding their willingness to talk with friends about sex, participants' responses changed between pretest and posttest measurements, $F(2, 56) = 5.68$, $p < .006$. Comparisons within conditions on this variable showed that participants in the self-instruction plus group intervention condition were more likely to talk with friends about sexual matters after intervention than before intervention, $t(17) = 3.06$, $p < .007$. On scores from a scale of participants' intentions to use condoms as a protection against the transmission of HIV infection, ANCOVA revealed no differences between measurements, $F(2, 56) = 2.1$, $p < .132$.

Discussion

Experiences and data from this study allow four conclusions about interventions for AIDS prevention among African-American and Hispanic adolescents. First, the study demonstrated how issues of HIV infection, drug use, and unsafe sexual activity are addressed through a self-instructional format aimed at high-risk youth from ethnic–racial minority backgrounds. Second, based on intervention manipulation checks, the study indicated that self-instructional intervention for preventing HIV infection among African-American and Hispanic adolescents is acceptable, replicable, and engaging.

Third, outcome findings from the study modestly suggest that self-instructional intervention can help African-American and Hispanic adolescents reduce their behavioral risks for AIDS and HIV infection. On outcome measures of youths' willingness to talk with friends about sexual matters, participants in the self-instruction plus group intervention condition improved more between pretest and posttest assessments than participants in the self-instruction only condition and participants in the information-only control condition.

Participants in the self-instruction only condition, moreover, improved more from pretest to posttest on their ratings of the value of AIDS education, relative to participants in the other two conditions. Albeit nonsignificant, postintervention differences favored participants in both self-instruction conditions

Table 2
Pretest and Posttest Results for Each Condition

Variable	Guide + group instruction (n = 18)		Guide only (n = 19)		Control (n = 23)	
	M	*SD*	*M*	*SD*	*M*	*SD*
AIDS education valuable[a]						
Pretest	3.11	0.90	3.32	0.82	3.52	0.51
Posttest	3.39	0.61	3.84	0.38	3.52	0.51
AIDS not from casual contact[a]						
Pretest	2.33	1.03	2.72	1.23	3.00	0.82
Posttest	2.28	1.07	3.12	0.79	2.91	0.83
Fear of AIDS[b]						
Pretest	1.22	0.73	1.05	0.23	1.05	0.21
Posttest	1.39	0.79	1.21	0.63	1.00	0.00
Approve casual drug use[a]						
Pretest	1.28	0.57	1.11	0.32	1.26	0.45
Posttest	1.22	0.43	1.06	0.23	1.35	0.49
Approve IV drug use[a]						
Pretest	1.28	0.46	1.06	0.24	1.13	0.34
Posttest	1.06	0.24	1.01	0.22	1.30	0.47
Talk with family about drugs[c]						
Pretest	4.33	1.08	4.11	1.33	4.00	1.38
Posttest	3.67	1.33	4.06	1.11	4.14	1.18
Talk with family about sex[c]						
Pretest	2.61	1.04	2.84	1.12	2.87	0.97
Posttest	2.44	1.10	3.11	1.05	2.87	1.14
Talk with friends about sex[c]						
Pretest	3.61	0.50	3.63	0.50	3.57	0.79
Posttest	3.81	0.71	3.74	0.45	3.48	0.79
Would not use condoms[a]						
Pretest	3.56	0.62	3.79	0.42	3.48	0.51
Posttest	3.39	0.78	3.79	0.42	3.65	0.49

Note. Guide + group = self-instructional guide plus group intervention; Guide only = self-instructional guide given after pretesting; Control = no intervention, IV = intravenous.
[a] Four-point scale: 1 (*strongly disagree*), 4 (*strongly agree*). [b] Four-point scale: 1 (*very afraid*), 4 (*not at all afraid*). [c] Four-point scale: 1 (*never*), 4 (*always*).

on a measure of intravenous drug approval, when compared with control condition participants.

The study's fourth conclusion concerns the participant sample involved in the research. From demographic and risk assessment data, the sample represented an ideal target population for AIDS prevention efforts. Study participants were at risk for school problems; many had stopped regularly attending school. The study and its interventions appeared to reach and interest African-American and Hispanic youths, who have much to gain from preventive interventions aimed at behavioral correlates of HIV infection.

Among the study's notable limitations were its small sample size, reliance on self-report measures, lack of follow-up assessments, and large variances on outcome measurements. Possibly these large variances accounted for the few significant differences among study conditions.

The study's limitations notwithstanding, experiences and findings from the research suggest that self-instruction holds promise as a means for delivering AIDS prevention content and skills to African-American and Hispanic adolescents. Obviating handicaps placed on interventions delivered through schools and by pedagogical means that are unresponsive to disenfranchised youth, self-instructional intervention can respond to the everyday realities and risks faced by youth in a personalized manner (De La Cancela, 1989; DiClemente, 1989).

More work lies ahead for research on HIV infection risks among African-American and Hispanic youth. That work can take several courses. Few data are available on the mechanisms of risk taking, on the accurate and reliable measurement of HIV infection risks, and on gender and ethnic–racial differences in adolescents' acquisition and application of knowledge and attitudes about HIV infection (Jaffe & Wortman, 1988; Sandberg, Rotheram-Borus, Bradley, & Martin, 1988). Most important, aggressive and innovative efforts to reduce the risks of HIV infection among African-American and Hispanic adolescents deserve further research.

References

Bobo, J. K., Snow, W. H., Gilchrist, L. D., & Schinke, S. P. (1985). Assessment of refusal skill in minority youth. *Psychological Reports, 57*, 1187–1191.

Brooks-Gunn, J., Boyer, C. B., & Hein, K. (1988). Preventing HIV infection and AIDS in children and adolescents: Behavioral research and intervention strategies. *American Psychologist, 43*, 958–964.

Centers for Disease Control. (1988a). HIV-related beliefs knowledge and behaviors among high school students. *Morbidity and Mortality Weekly Report, 37,* 717–721.

Centers for Disease Control. (1988b). Number of sex partners and potential risk of sexual exposure to human immunodeficiency virus. *Morbidity and Mortality Weekly Report, 37,* 566–568.

Day, N. A., Houston-Hamilton, A., Deslondes, J., & Nelson M. (1988). Potential for HIV Dissemination by a cohort of Black intravenous drug users. *Journal of Psychoactive Drugs, 20,* 179–182.

De La Cancela, V. (1989). Minority AIDS prevention: Moving beyond cultural perspectives towards sociopolitical empowerment. *AIDS Education and Prevention, 1,* 141–153.

DiClemente, R. J. (1989). Prevention of human immunodeficiency virus infection among adolescents. *AIDS Education and Prevention, 1,* 70–78.

DiClemente, R. J., Boyer, C. B., & Morales, E. S. (1988). Minorities and AIDS: Knowledge attitudes and misconceptions among Black and Latino adolescents. *American Journal of Public Health, 78,* 55–57.

Flora, J. A., & Thoresen, C. E. (1988). Reducing the risk of AIDS in adolescents. *American Psychologist, 43,* 965–970.

Heyward, W. L., & Curran, J. W. (1988). The epidemiology of AIDS in the U.S. *Scientific American, 259,* 72–81.

Jaffe, L. R., & Wortman, R. N. (1988). The fear of AIDS: Guidelines for the counseling and HTLV-III antibody screening of adolescents. *Journal of Adolescent Health Care, 9,* 84–86.

Mascola, L., Lieb, L., Iwakoshi, K. A., McAllister, D., Siminowski, T., Giles, M., Run, G., Fannin, S. L., & Strantz, I. H. (1989). HIV seroprevalence in intravenous drug users: Los Angeles, California 1986. *American Journal of Public Health, 79,* 81–82.

Morgan, W. M., & Curran, J. W. (1986). Acquired immunodeficiency syndrome: Current and future trends. *Public Health Reports, 101,* 459–465.

Murray, D. M., O'Connell, C. M., Schmid, L. A., & Perry, C. L. (1987). The validity of smoking self-reports by adolescents: A reexamination of the bogus pipeline procedure. *Addictive Behaviors, 12,* 7–15.

Sandberg, D. E., Rotheram-Borus, M. J., Bradley, J., & Martin, J. (1988). Methodological issues in assessing AIDS prevention programs. *Journal of Adolescent Research, 3,* 413–418.

Schinke, S. P., Botvin, G. J., Orlandi, M. A., Palleja, J., Zayas, L. H., Moncher, M. S., & Bebel, M. Y. (in press). Preventing AIDS among Hispanic adolescents: Sociocultural strategies for risk reduction. *Journal of Adolescent Research.*

Schinke, S. P., Moncher, M. S., & Holden, G. W. (1989). Preventing HIV infection among Black and Hispanic adolescents. *Journal of Social Work and Human Sexuality, 8,* 63–73.

Selik, R. M., Castro, K. G., & Pappaioanou, M. (1988). Racial/ethnic differences in the risk of AIDS in the United States. *American Journal of Public Health, 78,* 1539–1545.

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