Providing clients with referrals for prevention services is integral to HIV counseling and testing, and it is especially important when working with high-risk seronegative clients. Counseling sessions by their nature are limited, but appropriate referrals—those that are keyed to the client's concerns, easy to access, and clearly explained—can greatly extend the counseling intervention.

Despite this, a recent study of practices at confidential HIV counseling and testing sites found that most seronegative clients at high risk for HIV infection did not receive referrals. Researchers in this study reviewed risk assessment forms of 5,500 people who received seronegative test results at publicly funded confidential sites in San Francisco in 1995. Nineteen percent of male clients who had sex with men and 48 percent of injection drug-using clients received prevention referrals in either risk assessment or disclosure sessions. Overall, 15 percent of clients who tested seronegative received referrals for prevention services.

Although referral-giving can be important for clients regardless of risk, it is especially crucial to provide referrals to clients at high risk for infection because the test-counseling session may be the last opportunity to offer a primary prevention intervention for these clients. According to the State of California, Department of Health Services, Office of AIDS, more than half of all clients who tested seropositive at state-funded testing programs in 1996 reported having previously tested seronegative. Given the low rates at which some counselors provide referrals, it is likely that a significant number of these clients did not receive prevention services after their previous HIV test counseling sessions.

This issue of the FOCUS Supplement examines factors that may affect HIV test counselors' referral-giving to clients who engage in high-risk behaviors for HIV infection. It also presents strategies for developing resources, assessing clients' referral needs, tailoring referrals to each client, and responding to challenges that can prevent clients from following up on referrals or prevent counselors from offering referrals.

Developing Referral Sources

Clients often have needs that extend beyond the limited scope of the counseling session in terms of both time and focus and the limited training of many test counselors. Appropriate referrals can fill this gap by providing resources specific to a client's particular needs. Supplements to the counseling session can include resources such as sexually transmitted disease (STD) screening, individual counseling and support groups, substance abuse treatment, pregnancy planning, and food and shelter services. In addition, counselors might refer clients to workshops, books, or web sites for information or support.

To effectively provide referrals, counselors must be knowledgeable about resources available in their area. In some parts of the state, counselors have an array of demographic-specific resources. In other areas, only resources of a general nature may be available. Counselors can build and maintain their referral base by learning more about several different resources each month. Counselors should telephone agencies and introduce themselves, speak with staff, and, when possible, visit referral agency sites. It will be important to learn an agency's target population, services, fees, hours, waiting periods, location, accessibility by public transportation, language capabilities, and any idiosyncrasies in the agency's procedures that may affect the ways clients use services. If possible, learn the names of...
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References


Individual service providers—not just agency names—and obtain business cards from these people to give to clients. In addition, network with other HIV counselors to learn their knowledge of resources in the area. Maintain current information about all referrals: check resources for accuracy at least annually and ideally every six months.

Counselors might develop a database for referral-making, including one specifically designed for clients at highest risk. For filing and organizational purposes, think of referrals in terms of categories such as language, race and ethnicity, age, gender, and sexual orientation. For example, an agency that works with runaway youth that is also knowledgeable about HIV can be part of a category called “Youth Services,” an HIV-knowledgeable gynecologist can go under “Women Services,” and a Spanish-speaking counselor may be categorized as “Spanish-Language Services.” Be aware that some agencies separate services based on client HIV status. An agency that provides services for more than one population—for example, young women—might be classified under more than one category—for instance, youth, women, and women who have sex with women.

Assessing Needs, Tailoring Referrals

As a general rule, a referral is the best response for any issue affecting the client’s risk that the test counselor cannot address adequately during the counseling session. When making a referral, it is the counselor’s responsibility to identify any needs or issues based on the circumstances surrounding the client’s risk, help the client understand the connections between these needs or issues and the client’s risk, provide the client with one or more appropriate referrals, and discuss these referrals with the client to see if they need to be changed in order for the client to access them.

Because each client is unique, counselors must tailor referrals to the needs of the individual. For example, during a risk assessment session, a gay male client in his late thirties may reveal that he does not know any gay men his age who are uninfected. Appropriately, the counselor would explore the client’s thoughts and feelings and how these might affect his motivation to remain at low risk for infection. The astute counselor would also assess this client’s support system. An appropriate referral could be a support group for HIV-negative gay men. If there is no such group in the client’s area, there may be a more generalized support group where he can feel comfortable sharing with other gay men his feelings about being the only uninfected man in his peer group. Other possible referrals could be a grief support group, an on-line support group, or individual counseling. Accepting his or her “limited role,” the test-site counselor in this scenario provides a referral that offers on-going care, addresses the client’s need for support, and bolsters his motivation to stay uninfected.

In tailoring referrals, be familiar with the five-stage model of behavior change and consider each client’s stage of change. Problems may arise if the counselor tries to make a referral for behavior change when the client is not ready to change. For instance, rather than giving a referral for treatment for an injection drug user who is not interested in stopping her drug use, it may be more useful to give referrals for a needle exchange program and for services where the client can receive education about the relationship between injection drug use and HIV infection.

A client in the “pre-contemplation” stage who has not considered changing behavior may be open to informational referrals. A copy of an article that addresses the client’s risk-related issue, an information hotline, or a public forum on the topic are appropriate referrals for someone at this stage. For example, a recently divorced heterosexual woman who is new to dating and who for many years had sex only with her husband, may not be ready to use condoms or to negotiate condom use with partners. She may, however, be willing to learn more about condoms, including the Reality brand female condom. In addition, she may be willing to consider talking with friends about how they protect themselves from HIV infection.

For clients in the “contemplation” stage of change, referrals that help to explore ambivalence about changing behaviors are often effective, especially referrals for brief counseling sessions in which clients can better explore and sort through thoughts or feelings about the benefits and drawbacks of change. Action-oriented referrals are often helpful for clients in
the “ready for action,” or preparation, stage of change. Effective resources may include workshops and self-help books that can help the client develop a plan for taking action or that consider alternatives to high-risk behaviors.

A client in the “action” stage would likely benefit from resources that provide support for behavior change already made. Appropriate referrals may include support groups, self-help groups, and 12-step meetings. These referrals are also appropriate for clients in the “maintenance” stage. The counselor’s aim at this stage is to provide referrals that offer the ongoing support that may help a client avoid a return to risk behaviors.

Challenges for Clients

There are various reasons a high-risk client may not pursue a referral. Following up on a referral may be a physical or emotional challenge, it can be time-consuming, and a client may have a history of not receiving adequate services when pursuing referrals. Disclosing one’s risk in an environment beyond the counseling session can be a frightening experience that may involve examining and changing behaviors that are important in a client’s life. In addition, clients may interpret receiving a referral as the counselor’s way of dismissing them because of disinterest or the complexity of their concerns.

Lack of resources may also prevent a client from accessing a referral. A client willing to enter a drug treatment program, for example, may have to wait several months before being admitted because of limited availability and may change his or her mind during this time. If there are no other options, explain the situation so that the client understands the limitations of the referral. When available, offer clients temporary solutions while they wait for other resources. For example, while waiting to get into a drug treatment program, a client may enter a 12-step program; or, while waiting for a support group, a client may attend a drop-in group.

To make it easier for the client to contact a referral source, discuss each detail of a referral, including the specific person the client can contact, and what this person’s role is related to providing a service. Ask the client if any of these details pose a challenge, or if he or she suspects they might in the future, and explore ways of dealing with potential challenges.

Barriers to Offering Referrals

Counselors may experience numerous challenges of their own that affect whether and how they present referrals. These challenges relate to the counselor’s relationship with clients and the counselor’s perception of him or herself and professional role.

Difficulty in establishing rapport with a client may inhibit the referral-making process. For example, a client might express resentment toward having to test because his girlfriend insisted that he test. Instead of focusing on the reasons for the client to test, the counselor might more effectively establish rapport by exploring the client’s thoughts and feelings around the idea that he “has to” test.

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tance to provide a referral with a statement such as, “I want to give you a referral because I see that you are having trouble lowering your risk, and I feel strongly that the referral can help you stay uninfected. But, my sense is that you won’t use the referral. Can we talk about this?” Doing this, the counselor may gain information for tailoring the referral to what the client may or may not be willing or able to do.

Ask this client what it might be like for him to inform his wife that she may be infected because of his sexual behaviors with other people. Ask him what he can do to lower the risk of infection to himself, his wife, and other partners. Depending on the client’s responses, the counselor can provide a referral to drug treatment or, more likely, to a resource where the client can learn about HIV risks related to crack cocaine use.

Sometimes a counselor may feel that he or she has already pushed the client too far and that giving a referral would overwhelm the client and negate work already accomplished during the session. One way to introduce a referral in such a situation is by saying, “You’ve done a lot of good work in this session. We’ve talked about your drug use and its connection to unprotected sex with multiple partners. I’d like to take this a step further and talk with you about a referral that can help you stay uninfected, but I’m afraid you might have reached your saturation point. Can we continue for another five minutes?”

Conclusion

An HIV test counseling session is a unique opportunity to provide individually tailored prevention interventions to high-risk clients, and making referrals is vital to achieving this goal. An array of obstacles may impede clients from accessing referral resources or prevent counselors from providing referrals. In both cases, the counselor can overcome these barriers. By preparing for these situations, counselors can reverse the current trend of allowing high-risk clients to leave sessions without referrals.

Case Example:
Beyond the Counseling Session

Bobby is a 32-year-old gay man who tests for HIV annually. For many years, his primary risk has been occasions of unprotected receptive oral sex in which partners ejaculated in his mouth. These episodes occurred when Bobby had smoked marijuana and “wanted it to happen.” In the past year, he has also engaged in receptive anal sex on numerous occasions, including two times in which his partner did not use a condom and both had used crystal methamphetamine.

Invite Bobby to talk about his thoughts and feelings related to his desire to receive semen or to have another man’s penis inside him. If this is a difficult issue for Bobby, acknowledge the possibility that it also may be a meaningful subject for him. Reframe his sexual desires as healthy. Encourage discussion about what circumstances would make these practices safer for him and about Bobby’s drug use. Ask open-ended questions that help Bobby look at what drug use does for him, both in positive and negative ways.

Identifying Resources

Let Bobby know that there are referrals that can help him with what he has discussed. Give him a referral for a book on gay men’s sexuality that has a good chapter on the “how-to’s” and the “do not’s” of anal sex. Tell him where he can find such a book, including the public library. Ask him if he knows where to get condoms and lubricant. If he does not, offer this information.

Assess the extent to which he values talking about his concerns, and whether he has people in his life with whom he can talk about these things. Explain that there are places where he can talk in greater detail about his feelings related to his sexual desires, his drug use, being gay, and HIV. If it exists in the area, describe a local gay men’s support group and a local gay-sensitive counselor, and ask if he would be comfortable going to either or both of these.

If Bobby says, “Not at this time,” it may be helpful to reflect back again the probable connections between his sexual desires, his drug use, and his HIV risk. Ask Bobby what he thinks would keep him from pursuing these referrals, and help him trouble-shoot obstacles. Restate concerns about his behavior and explain how the referrals can provide an important venue for him to talk openly and brainstorm how to negotiate condom use with a partner. Finally, give Bobby a referral where he can learn more about methamphetamine use.

Ask again whether Bobby foresees any challenges in accessing these referrals and learn what these are. Brainstorm with him to find solutions and make changes in the referrals to better suit his situation.
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