Applications of Risk Assessment

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In 1991, 270,000 people in California tested at state-funded sites, and the state spent more than $15 million on counseling, testing, and related outreach. Of those testing through state-funded programs, 17 percent had no identified risk factors, 38 percent were repeat testers, and of repeat testers, more than 90 percent had test results that were the same as they were at previous tests.

In response to these figures, policy makers are questioning whether test counseling is an effective tool in prevention and behavior change efforts, and whether these benefits are balanced by their costs. In addition, they argue that antibody testing was established to detect seropositive people, and not to provide reassurance to uninfected people who repeatedly seek testing or to those whose risk for HIV infection is virtually nonexistent.

Examining these issues presents a valuable opportunity to look at the role of risk assessment as a tool to meet client needs. Such an assessment involves identifying not only direct risk behaviors, but also a broader inventory of factors that can affect risk of infection, either in the past or in the future. This article first presents techniques for assessing client risk. It then discusses the needs of two groups for whom the value of antibody testing is being questioned: so-called “low-risk” clients and people who repeatedly seek testing.

Risk Assessment

Many counselors focus on sexual or injection drug-using history to determine risks of infection among clients. To be effective, however, they must also assess secondary risk factors such as patterns of alcohol consumption, and a much broader variety of factors including attitudes, emotional states, social issues, health status, and economic security. These factors help reveal not only historic risks, but also a person’s likelihood of putting him or herself at risk in the future.

Risk assessment begins as a dialogue between the counselor and client as they establish a counseling relationship. During this time, counselors can clarify the meeting’s focal point—the discussion of the HIV antibody test—and the related topic of the likelihood of HIV exposure. To begin this process, counselors may simply ask, “Why are you seeking testing at this time?”

Listening to and drawing out clients as they speak from their experience will best guide the session and ensure that counselors avoid premature conclusions. For instance, when a client describes a substance abuse pattern, a counselor can learn more about risk by asking about the client’s behaviors, feelings, and thoughts than by concluding that the client is likely to be a seropositive because he or she is an injection drug user. When a female client states that she is heterosexual, a counselor can learn more by asking about her specific sexual behaviors, her sexual partners, the nature of her relationships, and the level of comfort and communication within these relationships, than by assuming that she is at low risk because she is not a gay man or a drug user.

Counselors must continuously “wear their assessment hats” as they define the hierarchy of needs to address with each client. To facilitate the session in general and risk assessment specifically, review the following areas of function, and consider the accompanying questions both in terms of past and present conditions:

- **Cognitive.** Does the client understand what is safe and what is risky, and the concept of safer behaviors? How long has he or she had this understanding?
- **Behavioral.** Which of the client’s behaviors does this understanding affect? Has he or she been able to apply this understanding and change to safer practices? If so, what motivated the change? If not, can he or she suggest what made it difficult?
- **Social.** Does the client have a support system? Who makes up the client’s peer group? Does the client’s peer group support practices that are safe or risky?
- **Economic.** Is the client homeless or at risk for being homeless?

the client need to exchange sex for money to maintain economic survival? Does the client have resources to receive adequate medical care or counseling or to enter a substance abuse program?

- **Emotional.** Does the client report or exhibit signs of depression, anxiety, isolation, low self-esteem, codependency, or other characteristics that might lead to unsafe behavior or that has inhibited initiating behavior change? Does the client report an intention or desire to address unsafe behaviors? Does the client have a history of mental or emotional illness?

- **Values and Beliefs.** Are there rationalizations or reasons based on the values and beliefs of the client that can help or prevent the client from changing behavior or maintain these changes.

Counselors should ask themselves which among these issues must be addressed in the session to assist the client in general, and to help him or her in terms of HIV care and prevention specifically? With information gained from the risk assessment, as well as from a client’s testing history, counselors can better answer this question, offer information about risk reduction, and determine with the client the value of an HIV antibody test.

Low-Risk Clients or Low-Risk Groups?

Misleading assumptions about HIV-related risk often serve as imperfect short-cuts to risk assessment. For example, as stated above, counselors cannot assume that all or even most gay men are currently at risk. Likewise, terms such as “low-risk,” which is being used with increasing frequency, are dangerous because they continue to encourage assumptions based on the average risk of a group rather than the actual risk of an individual.

What constitutes a low-risk client is not clear. In practice, the term refers to a wide range of people—from those who do not engage and who seem unlikely to engage in unsafe behavior.
to those who engage in unsafe heterosexual sex with a number of partners. As the debate on testing evolves and as assessment continues to focus less on risk groups and more on specific risk behaviors, it is likely that the definition of low-risk will also evolve. In the midst of this evolution, counselors are left with the task of communicating to clients that low risk still implies some level of risk: in the past, the perception among many people that they were not at risk has resulted in their participation in risky behaviors and ultimately in their infection with HIV.

By performing an appropriate risk assessment, counselors can help clients see beyond dangerous or irrelevant assumptions and understand for themselves the true place of HIV antibody testing in their lives. The reality remains that many clients are not familiar with the purposes of antibody testing. They take the test because their friends have taken it or because they have heard messages that everyone needs to be tested. But messages supporting universal testing has often come from places of authority, clients may distrust counselors who state that not everyone needs to be tested.

Risk assessment can help clients clarify the role and utility of antibody testing, while allowing clients—whether they appear to be at high or low risk—to make their own decisions about taking the test. Even after this process, however, some clients will ask counselors to make this decision for them.

In these cases, attempt to learn the source of the client’s conflict about making the decision. Does the client understand the information presented and his or her HIV-related risks? Is the client dwelling on low-risk behaviors, through which he or she fears infection may have occurred, rather than acknowledging recent high-risk incidents? Is the client feeling anxious about making the decision, and if so, what is the source of this anxiety? Encourage clients to take some more time to think about the issues, and remind them that the decision to test or not to test must be their own. Clients who make a decision about testing based on the advice of counselors or without understanding what they want from testing may be unready to deal with subsequent steps in the HIV prevention or treatment process.

Repeat Clients

Ineffective or incomplete assessment of risks during previous test counseling sessions is often responsible for clients returning for repeat tests. This is true regardless of whether clients have actually engaged in high-risk behaviors or been at risk for transmission since their most recent antibody test.

Despite previous test site visits, these clients may not understand what testing detects, how HIV is transmitted, or how to reduce transmission risk. View the presence of the repeat client as a warning sign for thorough risk assessment, including a review of risk behaviors, and an assessment of psychological or other needs that may be better met by other services.

There are situations when repeat testing is recommended. A second test may be required if a person takes the test during the infection window period—the time up to six months after exposure to HIV but before antibodies to the virus have developed. In addition, a repeat test can be valuable when clients have engaged in high-risk behaviors since a previous test.

Often, however, messages to regularly retest come from health professionals or antibody test counselors who may be well-intentioned, but who may be overlooking the deeper concerns of clients. Instead of offering a repeat test, it may be more valuable to examine these concerns. For example, repeat testers may be confused about the length of the window period. Remind them that reports that the window period may extend for several years have been discredited, and that while it is theoretically possible to seroconvert a year or more after exposure, such an occurrence has not been reported.

Clients may also be suspicious of risk-reduction guidelines and may be using testing to assess the safety of their behaviors. Clients may mistakenly believe that members of “risk groups”—for example, gay men and injection drug users—will continue to engage in risky behaviors. In cases where clients do fail to apply risk reduction strategies, counselors can ask clients, “What if you test negative once again? Or, what if your test is positive? What does the result say about your behavior?”

For some clients, regardless of their behaviors, the result of an antibody test provides only temporary relief for ongoing anxiety about being infected. Many feel relief after receiving their test results, but, over time, their anxiety returns, perhaps when they develop an unrelated illness or learn that a friend is HIV infected. A repeat test is not the answer for these clients; if they continue to avoid risky behaviors, the test will confirm their serostatus without offering them long-term relief from anxiety. Instead, counselors should explore reasons for this anxiety, provide appropriate support, and offer referrals for follow-up counseling.

Conclusion

Public demand for antibody testing will continue bringing to test sites “high-risk” and “low-risk” clients as well as first-time and repeat testers. It will also continue to present fiscal and policy challenges to test site administrators. While it is tempting to view risk assessment only as an approach to respond to these challenges, it is actually a vital tool for serving clients: it ultimately defines the role of the antibody test for each individual, and helps clients make clearer decisions about when and why to test and what additional services to seek.

**For more information on repeat clients, refer to the December 1991 issue of the FOCUS On HIV Antibody Test Counseling, “Repeat Clients.”
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