



CEU MATRIX

THE INSTITUTE FOR ADDICTION & CRIMINAL JUSTICE STUDIES

Presents

***HIV AND OTHER BLOOD-BORNE
INFECTIONS IN DRUG USERS
(Revised 2026) (3 hours)***

Internet Based Coursework

3 hours of educational credit

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HIV and Other Blood – Borne Infections in Drug Users

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This distance learning course package was developed for CEUMatrix by Robert Shearer, Ph.D. It is based on information found in the NIDA Community-Based Outreach Model, A Manual to Reduce the Risk for HIV and Other Blood-Borne Infections in Drug Users.

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HIV and Other Blood – Borne Infections in Drug Users

HIV and Other Blood-Borne Infections in Drug Users

2026 Update

Course Summary

This course is based on a community-based outreach model originally developed by the National Institute on Drug Abuse (NIDA) and has been updated to reflect current evidence, public health guidance, and harm-reduction practices related to HIV, hepatitis B (HBV), and hepatitis C (HCV) prevention. The model is grounded in decades of research on engaging people who use drugs—particularly those not connected to formal treatment—in their natural environments to reduce the transmission of blood-borne and sexually transmitted infections.

The updated course integrates contemporary scientific understanding of HIV, HBV, and HCV transmission, advances in testing and treatment, and current best practices for community-based outreach, syringe services, peer engagement, and linkage to care. The model has been implemented across diverse community settings and populations, including people who inject drugs, people who use non-injection drugs, and individuals involved in drug-using and sexual networks.

Overall, the community-based outreach approach has demonstrated effectiveness across multiracial and multiethnic populations; among men and women; and among individuals who are HIV seropositive, seronegative, or unaware of their status, living in communities with low, medium, and high prevalence of HIV and viral hepatitis. The updated model emphasizes flexibility, cultural responsiveness, harm reduction, and sustained engagement as core elements of effective prevention and public health practice.

Updated Course Objectives

Upon completion of this course, the participant will be able to:

- Understand evidence-based principles of HIV, HBV, and HCV prevention for people who use drugs
- Describe the research foundation and evolution of the community-based outreach model
- Explain the core components of community-based outreach and risk-reduction counseling
- Identify effective strategies for accessing and engaging at-risk populations in community settings
- Apply harm-reduction–informed approaches to personal and behavioral risk assessment
- Describe practical strategies for reducing drug-related and sexual transmission risks
- Recognize methods for reinforcing and supporting sustained risk-reduction behaviors
- Identify key logistical considerations in implementing community-based outreach programs
- Describe the purpose and function of a community field station or outreach base

- Understand best practices for training community-based outreach staff
- Understand supervisory practices that support fidelity, safety, staff wellness, and program effectiveness

Acknowledgements

This updated course is adapted from early HIV prevention research funded by the National Institute on Drug Abuse (NIDA) and incorporates current guidance from the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), and the National Institutes of Health (NIH). All statistics, recommendations, and clinical practices in this edition have been revised to align with the most recent U.S. federal standards for HIV, hepatitis B (HBV), hepatitis C (HCV), and harm-reduction services.

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Preface

The National Institute on Drug Abuse (NIDA) is pleased to provide this manual on a scientifically tested model of community-based outreach to reduce the risk of HIV and other blood-borne infections in drug users.

Since 1985, NIDA has conducted research to determine the most effective ways to reduce the risk of HIV/AIDS transmission in drug users and their sexual partners. Findings from more than 30 studies report that community-based outreach is an effective strategy for reaching drug-using populations and providing them with the means for behavior change.¹ Of those drug users who participated in community-based outreach interventions, a significant number entered treatment for their drug addiction—a primary goal of any HIV prevention effort with drug users. Many others participating in these outreach interventions stopped or at least reduced their frequency of drug injection and their reuse of injection equipment.

The NIDA Community-Based Outreach Model described in this manual is based on more than 15 years of NIDA-funded research.² The Model has been implemented and tested in 52 communities with more than 60,000 injection drug users and with many of their sexpartners.

The Model has also been adapted and tested with nearly 14,000 crack users and tailored to the needs of specific at-risk subgroups, including women who inject drugs, men who use drugs and have sex with men, and drug and sexual risk networks. Overall, the Model has been found

to be effective with multiracial, multiethnic, male and female, HIV seropositive and seronegative, infected and non-infected drug-using populations residing in areas with low, medium, and high HIV prevalence.

This manual contains information that will help community planners, policymakers, programmers, and service providers develop and implement programs to better prevent the spread of HIV and other blood-borne infections. Specifically, the manual provides:

- Research-based principles of HIV prevention for drug-using populations not in drug treatment;
- Background information on community-based HIV prevention, including how it works, why it works, where it works, and for whom it works;
- A discussion of the roles and personal characteristics of effective community-based outreach workers;

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Justice Studies Course Evaluation 107**

Section I: Background Information

- **Chapter 1**
- **Chapter 2**
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Chapter 1: Background

Introduction

This manual provides guidance for community-based HIV, viral hepatitis, and overdose prevention efforts among people who use drugs, particularly those not currently engaged in treatment. The approaches described here are grounded in the latest behavioral science, epidemiological evidence, and harm-reduction frameworks developed by the National Institute on Drug Abuse (NIDA), the Centers for Disease Control and Prevention (CDC), and the Substance Abuse and Mental Health Services Administration (SAMHSA).

Community-based outreach and prevention are core strategies for reducing the transmission of HIV, hepatitis B (HBV), hepatitis C (HCV), and other infectious diseases among people who use drugs. The updated outreach model combines peer-led engagement, education, and linkage to comprehensive health services. It includes risk-reduction counseling integrated with HIV and hepatitis testing, vaccination, overdose prevention, and connections to evidence-based treatment for substance-use and co-occurring disorders.

Outreach specialists and peer educators play a critical role as trusted messengers, providing credible information, distributing harm-reduction supplies (e.g., sterile syringes, safer-use kits, naloxone, fentanyl test strips), and linking participants to testing, treatment, and recovery support. Programs are flexible, meeting individuals where they are—both geographically and in their readiness for change—while emphasizing dignity, autonomy, and cultural responsiveness.

The community-based outreach model is most effective when integrated within a comprehensive network of prevention, treatment, and recovery services. These include syringe services programs (SSPs), medication for opioid use disorder (MOUD), viral hepatitis and HIV testing and treatment, behavioral-health services, and other community health and social supports. Coordination among these service systems reduces duplication, ensures continuity of care, and promotes long-term health outcomes.

Principles of Prevention for People Who Use Drugs

1. **Early and Sustained Prevention:** Early, continuous prevention programming significantly reduces new HIV and hepatitis infections. Sustained outreach and harm-reduction services are necessary to maintain progress, even in areas where transmission has declined.
2. **Harm Reduction and Behavior Change:** Reducing risk behaviors—such as sharing injection equipment or engaging in unprotected sex—is a realistic and evidence-based goal. Prevention should emphasize harm reduction and incremental change rather than requiring abstinence as a precondition for care.

3. **Comprehensive and Integrated Services:** Prevention is most effective when paired with coordinated services, including outreach, testing and counseling, treatment for substance-use and mental-health disorders, sterile syringe access, vaccination, and case management.
4. **Community and Cultural Relevance:** Outreach interventions must reflect local drug-use patterns, cultural norms, and community resources. Continuous community assessment and evaluation ensure that services remain responsive and effective.
5. **Accessibility Across Settings:** Services should be available in diverse settings—health clinics, treatment centers, correctional facilities, mobile vans, and SSPs—to reach people in various stages of use and recovery.
6. **Focus on People Living with HIV or Viral Hepatitis:** Prevention must include those already living with infection to prevent reinfection and onward transmission. Linkage to antiretroviral therapy (ART) or antiviral treatment is a critical prevention strategy.
7. **Network and Community-Level Engagement:** Outreach should target not only individuals but also peer networks and social groups, leveraging community leaders and peer educators to shift norms toward safer behaviors.
8. **Peer and Indigenous Leadership:** Peer outreach workers—individuals with lived experience—remain the most effective messengers for prevention, modeling safer behaviors and connecting participants to care.
9. **Personalized Risk Assessment:** Effective prevention requires tailored risk discussions, addressing barriers to behavior change and setting achievable goals aligned with each person’s circumstances.
10. **Dignity, Respect, and Trauma-Informed Practice:** All interventions must treat people with respect, free of stigma, discrimination, or coercion, and account for trauma and structural inequities that shape health behaviors.
11. **Biomedical and Technological Advances:** Include PrEP, PEP, HCV treatment, and routine testing within outreach. Encourage vaccination for HAV, HBV, influenza, and COVID-19, and integrate overdose-prevention technology (naloxone, drug-checking tools).
12. **Program Evaluation and Cost-Effectiveness:** Ongoing monitoring and data collection ensure that programs remain efficient, responsive, and cost-effective, supporting both public health and fiscal sustainability.

Research Support and Evidence Base

Overview

Since the mid-1980s, the National Institute on Drug Abuse (NIDA) and its federal partners have supported extensive research to prevent HIV, viral hepatitis, and overdose among people who use drugs. Early NIDA demonstration programs—such as the National AIDS Demonstration Research (NADR) and Cooperative Agreement (CA) studies—provided critical evidence that outreach-based prevention could successfully engage people outside of treatment, reduce high-risk behaviors, and link participants to care.

Contemporary research builds upon these foundational programs but now incorporates advances in behavioral science, harm-reduction practice, and biomedical prevention. Evidence consistently shows that community-based, peer-led, and harm-reduction-integrated outreach are some of the most effective strategies for reducing HIV, hepatitis C, and overdose risk among people who inject drugs (PWID).

Evolution of Outreach Research

Over the past three decades, outreach interventions have evolved from short, counseling-based encounters to comprehensive, evidence-based service models that integrate public health, behavioral health, and social support systems. Recent NIH- and CDC-supported research emphasizes:

- **Integration of Services:** Combining harm-reduction outreach with HIV and hepatitis screening, vaccination, and direct linkage to treatment.
- **Peer and Indigenous Outreach Models:** Employing individuals with lived experience to reach participants in trusted community spaces.
- **Behavioral and Biomedical Synergy:** Pairing behavioral risk-reduction counseling with biomedical tools such as PrEP (pre-exposure prophylaxis), PEP (post-exposure prophylaxis), and curative HCV therapies.
- **Overdose Prevention Integration:** Including naloxone distribution, fentanyl test strips, and education on safer-use practices within outreach encounters.
- **Technology-Enabled Engagement:** Using mobile apps, telehealth, and text-based follow-up to maintain ongoing support for participants.

Studies published from 2019–2025 continue to confirm that multi-component outreach programs—combining risk-reduction education, harm-reduction materials, and linkage to treatment—produce measurable declines in syringe sharing, increases in HIV and HCV testing uptake, and improved entry into medication for opioid use disorder (MOUD).

Effectiveness of Contemporary Outreach Programs

Modern evaluations supported by NIDA, SAMHSA, CDC, and HRSA demonstrate that harm-reduction-based outreach achieves significant population-level benefits:

- **Reduced injection-related HIV and HCV transmission:** Expansion of syringe services programs (SSPs) and community-based outreach has been linked to lower community incidence of HIV and viral hepatitis.
- **Increased testing and treatment engagement:** Outreach that includes testing and referral components improves early diagnosis and initiation of ART, HBV vaccination, and HCV curative therapy.
- **Improved linkage to treatment:** Participants in peer-led outreach models are significantly more likely to access MOUD and remain in care.
- **Decreased overdose mortality:** Integration of naloxone distribution into outreach interventions reduces fatal overdose events in communities.

These findings support national strategies such as the HHS Overdose Prevention Strategy and the Ending the HIV Epidemic (EHE) in the U.S. initiative, both of which emphasize outreach and harm-reduction integration as core public-health pillars.

Intervention Philosophy

Current prevention philosophy recognizes that drug use and recovery exist on a continuum. Effective programs do not rely on abstinence as the sole endpoint but rather promote incremental, realistic risk reduction that aligns with each person’s readiness to change.

Role of Outreach

Outreach remains the first point of contact for many people who use drugs. It functions as an accessible entry point into the broader health system. Modern outreach workers—often peers—play multiple roles: educator, advocate, connector, and early-intervention specialist. They provide sterile equipment and harm-reduction materials, distribute naloxone and fentanyl test strips, deliver brief interventions to reduce injection and sexual risks, and link individuals to treatment and recovery supports.

Role of Treatment

Substance-use treatment remains a critical element of HIV and overdose prevention, but outreach efforts now recognize that readiness for treatment varies. For those not yet ready to stop using, harm-reduction and safer-use interventions prevent infection and death while maintaining engagement until treatment is acceptable. Programs promote entry into evidence-based treatment—including MOUD, contingency management, and integrated behavioral therapy—while also supporting those who experience relapse.

Table 1: Hierarchy of Risk-Reduction Strategies for Injection Drug Users

- Stop using and injection drugs.
- Enter and complete evidence-based treatment including relapse prevention
- Take the following steps to reduce personal and public health risks if drug injection continues:
 - Always use a new, sterile syringe every injection.
 - Never reuse or share syringes, water, or drug-preparation equipment.
 - Use only syringes from reliable sources (pharmacy, syringe services program).
 - Prepare drugs with new or disinfected equipment (e.g., cooker, filter, water) and use sterile water when possible.
 - Clean the injection site with a new alcohol swab before injecting.
 - After use, dispose of syringes safely in a puncture-resistant container; do not leave them for reuse.
 - Engage with harm-reduction services such as syringe services programs (SSPs), naloxone distribution, fentanyl/drug-check strips, HIV/HCV testing and linkage to care.

- Ensure vaccination (Hepatitis A/B, influenza, COVID-19) and regular screening for HIV, HBV, HCV; use of biomedical prevention (PrEP, PEP) when eligible; safe sexual practices; avoid use alone; engage in overdose-prevention services.

Integration and Coordination

Modern outreach operates best when integrated with community partners—public health, behavioral-health agencies, and social services—to create seamless linkage from outreach to testing, treatment, and long-term care. Coordination ensures continuity and avoids service duplication.

Inclusion of People Living with HIV and Other Blood-Borne Infections

While the original outreach model primarily focused on individuals unaware of their HIV status, modern prevention strategies recognize that people living with HIV (PLWH) and those with hepatitis B (HBV) or hepatitis C (HCV) are essential partners in disease prevention and community health.

Current federal policy and research emphasize the concept of “treatment as prevention” (TasP) — the scientific evidence that individuals with sustained viral suppression cannot sexually transmit HIV. Outreach and harm-reduction programs now integrate ongoing support for people who know their HIV-positive status, ensuring they remain engaged in medical care, adhere to treatment, and maintain viral suppression.

In this updated model, outreach to people who are already diagnosed serves multiple critical functions:

- **Facilitate linkage and retention in care:** Outreach workers assist clients in connecting to HIV care providers, medication refills, and wraparound services to maintain adherence.
- **Promote viral suppression and overall health:** Access to and adherence with antiretroviral therapy (ART) improves quality of life and prevents onward transmission.
- **Support disclosure and partner services:** Outreach programs provide education and referrals for partner notification, counseling, and testing in a supportive, stigma-free environment.
- **Integrate care for co-occurring conditions:** People living with HIV often face overlapping challenges, including substance-use disorders, hepatitis infection, and housing or behavioral-health needs. Integrated outreach models link clients to comprehensive care addressing all these factors simultaneously.
- **Reinforce harm-reduction and prevention practices:** Outreach continues to offer sterile supplies, naloxone, safer-use tools, and risk-reduction counseling to minimize secondary infections and overdose risks.

By broadening the focus to include both individuals at risk and those already living with infection, the updated community-based outreach model supports the national Ending the HIV Epidemic (EHE) and HHS Overdose Prevention Strategy goals of equitable, person-centered prevention and care.

Chapter 2: Community – Based Outreach and Harm Reduction Framework

Overview of the Community-Based Outreach Approach

Community-based outreach remains a cornerstone of public-health strategies for reducing HIV, hepatitis B (HBV), hepatitis C (HCV), and overdose risks among people who use drugs, especially those who inject. Contemporary outreach models build on NIDA’s original framework but integrate updated behavioral science, harm-reduction principles, and advancements in prevention and treatment.

Modern outreach emphasizes low-barrier, person-centered engagement that connects individuals to comprehensive prevention, testing, and treatment services in environments they trust. Outreach workers—often peers with lived experience—serve as educators, advocates, and navigators, providing accurate information, harm-reduction supplies, and linkage to care.

Outreach is no longer limited to brief, structured counseling sessions. Instead, it now involves multiple, ongoing contacts designed to meet people “where they are,” in community settings such as syringe services programs (SSPs), homeless shelters, mobile clinics, and street outreach sites.

These engagements may include:

- Distribution of sterile syringes, safer-use kits, and naloxone for overdose reversal.
- On-site or referral-based HIV, HBV, and HCV testing and linkage to confirmatory diagnosis and treatment.
- Education on safer injection, safer sex, and prevention of blood-borne infections.
- Distribution of fentanyl test strips and other drug-checking tools.
- Counseling and motivational interviewing to support behavior change and readiness for treatment.
- Linkage to medication for opioid use disorder (MOUD), mental-health and primary-care services, and housing or social supports.
- Promotion of biomedical prevention such as PrEP (pre-exposure prophylaxis) and PEP (post-exposure prophylaxis).

The modern model integrates harm reduction with treatment engagement, acknowledging that relapse and continued use are part of recovery trajectories. Outreach staff are trained to provide non-judgmental support and advocate for health equity and stigma reduction.

Compatibility with Community Programs

The updated community-based approach aligns with current SAMHSA Harm Reduction Framework (2023) and CDC’s national SSP and overdose prevention guidance (2024). It functions best as part of an integrated continuum of services including:

- Syringe services programs (SSPs) offering comprehensive harm-reduction resources.
- Community health centers delivering HIV, HBV, and HCV testing and vaccination.
- Behavioral-health and substance-use treatment providers offering MOUD and counseling.

- Public-health departments coordinating surveillance, linkage, and case management; and
- Peer-led organizations bridging cultural and trust gaps between service providers and communities.

Effective coordination among these partners ensures that people who inject drugs have consistent access to testing, prevention, and treatment without judgment or unnecessary barriers.

Key Elements of Current Outreach Practice

1. **Person-Centered Engagement:** Outreach is tailored to individual readiness, goals, and cultural context.
2. **Evidence-Based Interventions:** Practices include motivational interviewing, trauma-informed care, and harm-reduction education grounded in current evidence.
3. **Integrated Services:** Linkage to comprehensive care—HIV, viral hepatitis, substance-use disorder treatment, and overdose prevention—is central.
4. **Peer Involvement:** Peer outreach workers play critical roles in trust-building and modeling safer behaviors.
5. **Continuous Evaluation:** Programs track engagement, testing, and treatment outcomes to improve service delivery.

Chapter 3: Logistics of the Modern Community – Based Outreach Model

Overview

This section outlines the practical considerations for implementing a community-based outreach and harm-reduction program that aligns with current federal guidance. Successful programs are designed around local epidemiology, patterns of substance use, community culture, and available resources. Flexibility is essential: effective programs tailor activities, messages, and delivery methods to the unique conditions and needs of the populations they serve.

Community and Environmental Factors

Prevention and harm-reduction programs are most effective when grounded in an ongoing assessment of local needs and assets. This includes:

- **Local epidemiology:** Understanding rates of HIV, viral hepatitis, and overdose in the target area.
- **Drug-use patterns:** Monitoring substances used (e.g., fentanyl, methamphetamine, polysubstance combinations) and preferred routes of administration.
- **Structural factors:** Considering housing stability, policing practices, stigma, and access to health services.
- **Resource mapping:** Identifying existing programs—such as syringe services programs (SSPs), substance-use treatment, and community health centers—and determining where gaps exist.

Routine data collection and collaboration with local health departments, hospitals, and community coalitions help programs adapt as new trends emerge (e.g., surges in fentanyl-contaminated stimulants).

Target Populations

Outreach and prevention efforts now reach beyond “out-of-treatment drug users” to engage the broader population of people who use drugs (PWUD)—including those who inject, smoke, snort, or otherwise use substances that increase vulnerability to infectious disease and overdose.

Priority populations typically include:

- People who inject drugs (PWID), including new injectors.
- Individuals recently released from incarceration.
- People experiencing homelessness or housing instability.
- Sex workers and individuals with overlapping sexual and drug-use risks.
- Young adults using fentanyl-contaminated pills or stimulants.
- Racial/ethnic and gender minority groups disproportionately affected by HIV and overdose.

Program planning should be informed by equity and cultural responsiveness, ensuring that materials and ⁱⁱⁱ staffing reflect the communities served.

Appropriate Settings for Program Activities

Modern outreach employs a “**multi-setting**” model that includes fixed, mobile, and virtual components. Effective settings include:

- **Syringe services programs (SSPs):** Core access points for sterile equipment, naloxone, and testing.
- **Mobile outreach units:** Vans or RVs offering on-site testing, vaccination, and linkage to care.
- **Community partners:** Homeless shelters, recovery residences, drop-in centers, and transitional housing.
- **Healthcare settings:** Federally Qualified Health Centers (FQHCs), emergency departments, and urgent-care sites that integrate harm-reduction services.
- **Virtual and telehealth platforms:** Text, chat, or tele-outreach follow-up for education, reminders, and support.

These flexible settings enable outreach workers to maintain contact across environments and time, meeting participants where they live and use substances.

Outreach, Counseling, and Education Sessions

Current best practices no longer restrict counseling to two discrete sessions. Instead, outreach encounters are viewed as **ongoing opportunities for engagement**, tailored to the individual’s readiness and needs.

Core elements include:

- **Risk-reduction counseling:** Personalized conversations addressing injection and sexual risk, overdose prevention, and safer-use practices.
- **Testing and vaccination:** Offering or linking to rapid HIV, HCV, and HBV testing, and ensuring vaccination against HAV/HBV when indicated.
- **PrEP and PEP education:** Integrating biomedical prevention into risk-reduction discussions.
- **Behavioral support:** Using motivational interviewing, harm-reduction goal-setting, and relapse-prevention techniques.
- **Overdose prevention:** Providing naloxone, education on recognizing overdose, and linkage to medication for opioid use disorder (MOUD).

Sessions can occur in outreach settings, clinics, or virtually. Programs should emphasize accessibility, confidentiality, and client choice.

Staffing and Training Considerations

Programs should employ a **multidisciplinary team** that includes:

- **Peer outreach workers** with lived experience who can engage participants credibly and model safer behaviors.
- **Health educators and counselors** trained in trauma-informed, culturally responsive communication.
- **Medical personnel** (e.g., nurses, advanced practice clinicians) to provide testing, vaccination, and linkage to care.

- **Case managers** who coordinate services, follow-up, and referrals.

Training should cover harm-reduction philosophy, infectious-disease prevention, overdose response, stigma reduction, and confidentiality.

Program Design and Flexibility

The outreach model should be **modular and adaptable** to local resources. Programs determine:

- Whether HIV/HCV testing and counseling occur on-site or via referral.
- How education and risk-reduction are integrated into outreach encounters.
- Which staff conduct sessions (e.g., peers, health educators, licensed counselors).
- What follow-up systems (e.g., digital reminders, peer navigation) support long-term engagement.

Integration with local health systems, law enforcement, and community organizations enhances program sustainability.

Table 2

Component	Format	Activities	Staffing	Typical Settings
Initial Outreach Contact	Community-based engagement; brief face-to-face or mobile encounters (5–20 minutes)	<ul style="list-style-type: none"> • Build rapport and assess immediate needs • Provide foundational harm-reduction education (safer injection, safer sex, overdose prevention) • Distribute sterile syringes, safer-use supplies, naloxone, fentanyl test strips • Offer rapid linkage to HIV/HCV testing, vaccination, MOUD, and other services • Schedule follow-up or connect to peer navigator 	Peer outreach workers, harm-reduction specialists, indigenous community leaders	Syringe services programs (SSPs), mobile vans, encampments, shelters, drop-in centers, public spaces

Component	Format	Activities	Staffing	Typical Settings
Session I: Comprehensive Harm-Reduction & Prevention Counseling	Individual session (in person, mobile, or telehealth), ideally shortly after initial outreach (20–30 minutes)	<ul style="list-style-type: none"> • Personalized risk assessment (injection and sexual risk) • Skill-building: safer injection, safer smoking/snorting, overdose response • Education on HIV, HCV, HBV, PrEP, PEP, and vaccination • Motivational interviewing for behavior change and readiness for treatment 	Peer navigators, health educators, counselors, nurses	Mobile outreach units, SSPs, clinics, community health centers, or telehealth
Testing & Health Screening	On-site, mobile, walk-in, or referred testing (10–20 minutes)	<ul style="list-style-type: none"> • Rapid HIV testing or linkage to confirmatory testing • HCV rapid testing or referral for RNA confirmation • HBV/HAV vaccination assessment • STI screening referrals • Overdose risk screening & naloxone training 	Medical staff (nurses, APPs), trained testers, health educators	SSPs, mobile vans, community clinics, FQHCs, shelters, ED triage partnerships
Session II: Follow-Up, Linkage & Reinforcement	Follow-up visit 1–3 weeks after Session I (in person, community-based, or telehealth) (25–30 minutes)	<ul style="list-style-type: none"> • Review risk-reduction progress and challenges • Reinforce safer-use strategies and overdose prevention • Link or re-link to MOUD, HIV care, HCV treatment, mental 	Counselors, health educators, peer navigators	Mobile or fixed SSPs, community clinics, outreach sites, telehealth

Component	Format	Activities	Staffing	Typical Settings
		<p>health, and social services</p> <ul style="list-style-type: none"> • Assist with ART or MOUD adherence support • Provide ongoing supplies and education 		
<p>Ongoing Engagement & Care Navigation</p>	<p>Continuous, flexible contacts via outreach, mobile, or digital communication</p>	<ul style="list-style-type: none"> • Ongoing safer-use support and supply distribution • Appointment reminders and care navigation • Overdose prevention follow-up • Support with insurance, housing, transportation, and case management • Monitoring progress, setbacks, and re-engagement 	<p>Peer navigators, case managers, harm-reduction staff</p>	<p>Community settings, telehealth, text outreach, SSPs, day programs</p>

Section II: Step – by – Step Procedures

- **Chapter 4**
- **Chapter 5**
- **Chapter 6**

Chapter 4: Community-Based Outreach — Accessing and Engaging People at Risk

Overview

Community-based outreach remains a foundational strategy in preventing HIV, viral hepatitis, sexually transmitted infections, and overdose among people who use drugs (PWUD). Modern outreach focuses on meeting people where they are, providing evidence-based harm-reduction services, and building trusting relationships that support health, safety, and autonomy. Engagement occurs in the natural settings where people live, use substances, and access services.

Modern Outreach Workforce

Inclusive, Community-Rooted Staffing

Outreach workers should reflect the cultural, racial/ethnic, linguistic, and gender diversity of the communities they serve. Programs are encouraged to intentionally staff teams with:

- Peer workers with lived experience
- Bilingual/bicultural outreach workers
- Harm-reduction specialists
- Health educators and navigators

These team members help deliver prevention messages in accessible language, reduce stigma, and reinforce trust—critical for engaging individuals who experience marginalization, housing instability, or limited access to traditional healthcare.

The Role of Peer Outreach Workers

Federal guidance (SAMHSA, CDC, HRSA) now identifies peer workers as essential, not optional. Peer experience offers advantages such as:

- Enhanced credibility and rapport
- Deep knowledge of local drug-use patterns
- Ability to model safer-use behaviors
- Capacity to recognize emerging risks (e.g., fentanyl contamination, xylazine)
- Skill in navigating community resources
- Trust-building with individuals hesitant to engage with formal services

Peers also help participants access MOUD, HIV/HCV testing, viral hepatitis vaccination, overdose-prevention tools, and social support services.

Skills and Competencies for Modern Outreach Workers

Effective outreach workers demonstrate the following competencies:

1. Trauma-Informed, Non-Stigmatizing Engagement

Workers communicate respect, unconditional positive regard, and cultural sensitivity while recognizing the impacts of trauma, racism, and structural inequities.

2. Harm-Reduction Knowledge and Practice

Workers should be trained to:

- Distribute sterile injection/smoking/snorting supplies
- Provide naloxone and overdose-prevention training
- Offer fentanyl test strips and safer-use strategies
- Conduct HIV/HCV education and linkage to testing
- Explain PrEP/PEP and help connect participants to providers

3. Resource Navigation

Outreach workers must be familiar with:

- SSPs and their legal protections
- Local HIV/HCV testing and treatment sites
- MOUD programs (methadone, buprenorphine, naltrexone)
- Housing, food, and social-service resources
- Behavioral-health and mental-health services

4. Communication and Boundary Management

Workers need skills in:

- Motivational interviewing
- Crisis de-escalation
- Maintaining appropriate professional boundaries
- Protecting confidentiality
- Accurate recordkeeping and documentation

5. Flexibility Across Settings

Modern outreach occurs in:

- Syringe services programs (SSPs)
- Mobile vans, street outreach routes
- Encampments, shelters, drop-in centers
- Emergency departments and urgent-care partnerships
- Tele-outreach or virtual platforms

Workers must adapt to varying levels of privacy, mobility, safety, and participant readiness.

Table 3: Core Personal Characteristics for Effective Community Based Outreach & Harm Reduction Workers.

Category	Modern Personal Characteristics
Foundational Values	<ul style="list-style-type: none"> • Demonstrates unconditional positive regard for people who use drugs (PWUD) • Approaches all interactions free of stigma, judgment, or moralizing • Values harm reduction as a philosophy, not just a service • Respects participant autonomy and self-determination
Cultural & Community Responsiveness	<ul style="list-style-type: none"> • Reflects cultural, racial/ethnic, gender, and linguistic diversity of the community • Demonstrates cultural humility and willingness to learn from participants • Understands structural inequities (racism, poverty, criminalization) affecting health • Able to adapt communication to diverse cultural and community contexts
Trauma-Informed Practice	<ul style="list-style-type: none"> • Recognizes signs of trauma and responds with sensitivity • Maintains a calm, grounding presence during high-stress interactions • Avoids re-traumatizing language or behaviors • Prioritizes emotional safety, confidentiality, and participant choice
Peer & Lived-Experience Attributes (when applicable)	<ul style="list-style-type: none"> • Uses lived experience to build trust and credibility • Understands challenges around behavior change, readiness, relapse, and treatment access • Models safer-use strategies and recovery support without promoting one “right way” to heal • Maintains strong personal boundaries while using experience constructively
Interpersonal & Communication Skills	<ul style="list-style-type: none"> • Effective active listener with nonjudgmental communication style • Skilled in motivational interviewing and strengths-based approaches • Able to deliver complex information in simple, relatable language • Builds rapport quickly in diverse settings and levels of readiness

Professionalism & Boundaries	<ul style="list-style-type: none"> • Maintains clear, consistent boundaries with participants • Protects participant confidentiality and privacy, especially in street settings • Understands ethical considerations in outreach and peer work • Balances empathy with professionalism
Adaptability & Problem-Solving	<ul style="list-style-type: none"> • Able to navigate unpredictable environments (e.g., encampments, shelters) • Comfortably manages rapid changes, crises, or shifting priorities • Able to assess needs quickly and respond with appropriate referrals • Creative, resourceful, and solutions-oriented in low-resource settings
Knowledge & Skill Competencies	<ul style="list-style-type: none"> • Strong understanding of harm-reduction principles and safer-use strategies • Familiarity with HIV/HCV/HBV prevention, testing, and linkage • Knowledge of PrEP, PEP, MOUD, naloxone, and overdose-prevention tools • Awareness of local resources (SSPs, clinics, housing, food, behavioral health)
Collaboration & Community Integration	<ul style="list-style-type: none"> • Works well within multidisciplinary teams (public health, behavioral health, medical providers, SSP staff) • Fosters cross-agency partnerships to support holistic care • Maintains communication and follow-up with participants and providers • Engages community members as partners, not clients
Organizational & Safety Awareness	<ul style="list-style-type: none"> • Demonstrates strong organizational and documentation skills • Practices situational awareness in street-based outreach • Understands how to de-escalate conflict and maintain safety • Recognizes boundaries of personal competence and seeks support appropriately

Community-Based Outreach: Accessing and Engaging People at Risk

Community-based outreach is an evidence-based strategy for engaging people who use drugs (PW_{UD}) in prevention, testing, treatment, and harm-reduction services. The goal is to reach individuals in the

environments where they live, use substances, and socialize, while providing tools and information that improve safety, reduce risk of infection or overdose, and support voluntary entry into care.

Modern outreach emphasizes trust, autonomy, cultural responsiveness, peer leadership, trauma-informed practice, and harm reduction rather than prescriptive behavior change. It is flexible, person-centered, and responsive to the needs and experiences of the individual.

Identifying Outreach Sites and Community Environments

Selecting outreach locations requires a deep understanding of local drug-use patterns, community dynamics, and structural factors affecting health. Today, outreach sites are diverse and include:

- Syringe services programs (SSPs)
- Encampments, street-based locations, parks, and open-air markets
- Mobile outreach routes (vans, RVs, mobile health units)
- Homeless shelters, day shelters, and warming/cooling centers
- Drop-in centers and community hubs
- Emergency departments and urgent-care waiting areas
- Transitional housing, re-entry centers, and probation/parole partnerships
- Online and digital spaces (text outreach, social media groups, virtual check-ins)

Rather than focusing exclusively on “where drugs are purchased or used,” modern outreach prioritizes where people gather, where they feel safe, and where services can be delivered effectively.

Outreach teams gather information from:

- Local PWUD and peer networks
- SSP staff and harm-reduction programs
- Behavioral-health and SUD treatment providers
- Public-health departments and community coalitions
- Street outreach teams, ED navigators, and social-service agencies

Site selection is ongoing. Outreach programs routinely reassess locations as drug markets, patterns of use, and community needs evolve.

Initial Engagement: Conducting the First Outreach Contact

Outreach workers typically make contact with individuals one-on-one or in small groups, approaching them with respect, transparency, and nonjudgmental communication.

Key principles:

- Introduce yourself and the organization without pressure or expectation

- Clarify purpose: safety, support, harm reduction, and voluntary services
- Use plain language and avoid stigmatizing terms
- Allow the participant to guide the conversation
- Prioritize immediate needs (safety, supplies, referrals)
- Avoid engagement with anyone who appears unsafe, distressed, or under threat

Individuals who do not use drugs—or who are already engaged in HIV or HCV care—may still act as connectors, sharing information with peers.

Core Elements of the First Contact

During an initial outreach conversation (which may last 30 seconds or 20 minutes), outreach workers aim to achieve four goals:

1. Explore Risk Behaviors

- Discuss safer injection, safer smoking/snorting, and safer sexual practices
- Address myths, misinformation, and structural barriers (e.g., lack of sterile supplies)
- Assess overdose risk, polysubstance use, and awareness of fentanyl risks

2. Provide Evidence-Based Harm-Reduction Strategies

Instead of bleach kits or abstinence hierarchies, modern strategies include:

- Always use new, sterile syringes and supplies
- Never share syringes, cookers, water, cottons, or smoking/snorting equipment
- Use fentanyl test strips or other drug-checking tools
- Carry and use naloxone; know overdose-response steps
- Practice safer injection techniques (rotate sites, avoid rushing, prepare safely)
- Use condoms or other barrier methods when desired
- Consider PrEP or PEP for HIV prevention
- Test regularly for HIV, HBV, and HCV

3. Provide Supplies and Information

Printed or digital materials should include:

- Safer-use guides
- Overdose prevention materials
- How to use naloxone
- Info on PrEP/PEP, HCV cure, HBV vaccination
- Local service directories (SSPs, clinics, behavioral-health services)

Pictorial materials help communicate effectively with individuals who prefer non-written formats.

4. Offer Referrals and Immediate Linkage

- HIV, HBV, and HCV testing
- HCV treatment (curative therapy)

- Medication for opioid use disorder (MOUD)
- Mental health support and crisis services
- Housing/shelter access
- Primary care and urgent care

Warm handoffs and peer navigation improve follow-through.

Encouraging Participation in Follow-Up Services

After the initial contact, outreach workers may encourage participants to return for:

- Follow-up harm-reduction counseling
- HIV/HCV testing (if not done on-site)
- PrEP/PEP navigation
- HCV treatment initiation
- MOUD intake
- Group or one-on-one education sessions
- Additional harm-reduction supplies

Transparency is essential: outreach workers should clearly describe what to expect, how long sessions last, what services are offered, and the benefits of participation.

The Dynamic, Adaptive Nature of Outreach

Outreach is not a scripted process. It varies according to:

- Time of day
- Physical location
- Presence of law enforcement or community activity
- Individual readiness and mood
- Environmental distractions or safety considerations
- Presence of partners, peers, or other network members

Outreach workers must remain flexible, reflective, and attuned to both individual cues and environmental context.

Repeat Contacts: Building Long-Term Engagement

Meaningful behavior change often emerges through many small interactions over time. Repeated **iii** contacts allow workers to:

- Reinforce harm-reduction strategies
- Build trust and rapport
- Support ART or MOUD adherence
- Respond to crises or emerging risks
- Maintain nonjudgmental presence and support

This long-term engagement is central to modern harm-reduction practice.

Modern Interaction Tools & Techniques

Contemporary outreach incorporates strategies grounded in motivational interviewing, trauma-informed care, and harm reduction, including:

- Open-ended questions
- Active listening
- Exploring goals, strengths, and ambivalence
- Sharing real-life examples when appropriate
- Celebrating small wins
- Identifying barriers and problem-solving collaboratively
- Selective self-disclosure (peer workers)
- Reflective statements
- Summarizing and reinforcing next steps
- Offering choices, not directives
- Maintaining nonjudgmental stance

These tools create a collaborative environment where participants can explore safer behaviors without pressure or shame.

Chapter 5: Session I: Personal Risk Assessment and Strategies for Harm Reduction

Overview of Sessions I and II

Sessions I and II provide personalized education, skills-building, and ongoing support to help individuals reduce risks related to HIV, hepatitis B (HBV), hepatitis C (HCV), other sexually transmitted infections (STIs), and overdose. These sessions build upon information introduced during community-based outreach, offering a more private, structured, and collaborative space for discussing safer-use strategies, sexual health, overdose prevention, and linkage to care.

The format is flexible. While sessions can be conducted in an office or clinic, many programs now use mobile outreach vans, syringe services programs (SSPs), shelters, drop-in centers, or tele-outreach platforms. The goal is to provide person-centered support in settings where participants feel comfortable and safe.

Rather than relying on rigid cue cards, modern practice emphasizes trauma-informed conversation, motivational interviewing, peer engagement, and adaptation to readiness for change. Priority topics should be personalized to the individual's needs, behaviors, and goals.

Topics Covered in Session I

Session I reinforces harm-reduction knowledge and supports participants in identifying practical strategies to stay safer. Topics typically include:

- Basic information about HIV, HBV, HCV, STIs, and overdose risks
- Injection and non-injection drug-use risks and prevention strategies
- Sexual-health risks and safer-sex planning
- Benefits of treatment for substance use and co-occurring conditions
- Information about HIV testing, PrEP, PEP, HBV vaccination, and HCV curative therapy
- Distribution of safer-use supplies
- Linkage to testing, vaccination, PrEP/PEP providers, MOUD programs, and other services

These topics can be covered during a single session, or across multiple shorter interactions, depending on participant preference, environment, and time.

Getting Started

Sessions should begin by establishing rapport and clearly explaining the purpose of the meeting. A trauma-informed, nonjudgmental approach helps participants feel safe discussing sensitive issues. ⁱⁱⁱ

Key principles include:

- Introduce yourself and your role clearly
- Explain what the session will cover and how long it will take
- Emphasize confidentiality, participant autonomy, and the voluntary nature of all services
- Encourage questions throughout to increase engagement and ensure clarity

Sessions may take place in private rooms, mobile vans, shaded outdoor spaces, or other accessible environments. The priority is dignity, privacy, and comfort.

Core Content Areas for Session I

1. Basic Information About HIV, HBV, and HCV

Provide concise, accurate information about each condition:

HIV

- Spread primarily through sexual contact, shared injection equipment, or from mother to child during pregnancy/birth.
- Modern HIV treatment allows individuals to achieve an undetectable viral load, meaning they cannot sexually transmit the virus (U=U).
- HIV testing can be rapid and noninvasive (fingerstick or oral swab).
- PrEP and PEP are effective biomedical prevention tools.

HBV

- Easily transmitted through blood and sexual contact.
- A highly effective three-dose vaccine is widely available and recommended for all adults.
- Chronic HBV can be managed with antiviral medications.

HCV

- Most commonly transmitted through sharing injection equipment.
- HCV is curable, usually within 8–12 weeks using oral antiviral medications.
- Regular testing is recommended for people who use drugs.

2. Injection-Related Risks and Modern Prevention Strategies

Modern harm reduction emphasizes access to sterile equipment as the primary strategy for preventing HIV and HCV transmission.

Key safer-injection practices to emphasize:

- Always use new, sterile syringes, cookers, cottons, and sterile water

- Never share any injection supplies (including cookers, cottons, rinse water, tourniquets, ties, or split solutions)
- Prepare drugs in a clean environment with clean hands
- Rotate injection sites and avoid injecting into arteries or damaged veins
- Dispose of used equipment safely in sharps containers
- Access supplies and support at SSPs

Note on bleach cleaning:

Bleach is no longer recommended as a primary prevention strategy. If sterile equipment is completely unavailable, brief discussion may include:

- Bleach may reduce—but does not eliminate—risk
- Only full-strength bleach is effective
- Bleach disinfection is a last-resort option in emergencies

But all modern federal guidance prioritizes sterile equipment through SSPs.

Overdose prevention integration:

Add education on:

- Recognizing overdose
- Using naloxone
- Avoiding mixing substances
- Testing drugs with fentanyl test strips
- Not using alone

This is now standard in outreach sessions.

3. Sexual-Health Risks and Prevention Strategies

Discuss safer-sex strategies, tailored to the participant’s preferences and goals:

- Use condoms or other barrier methods for vaginal and anal sex
- Use external or internal condoms as appropriate
- Use water-based or silicone lubricants
- Encourage open communication with sexual partners
- Offer PrEP and PEP education and referrals
- Discuss the connection between substance use and sexual risk-taking

Demonstrations using anatomical models may help participants understand correct condom use.

4. Benefits of Treatment and Recovery Supports

Explain the role of evidence-based treatment in reducing risks:

- Medication for Opioid Use Disorder (MOUD) reduces overdose risk, injection frequency, and HIV/HCV transmission
- Behavioral health care supports emotional well-being and recovery
- HCV treatment eliminates a major source of harm
- HIV treatment (ART) prevents transmission and improves long-term health
- Programs should assist participants in accessing local treatment options

Treatment is voluntary and should be presented as one of many available options.

5. HIV, HBV, and HCV Testing

Testing is a critical part of prevention and linkage to care.

Participants should be informed:

- Testing can be rapid (results in 20 minutes or less)
- Oral swab and fingerstick options may be available
- Results are confidential
- Testing is voluntary
- Benefits include early detection, treatment access, and reduced transmission

For each virus:

- Explain how tests work
- Clarify what results mean
- Provide referrals or on-site testing when possible
- Offer HBV vaccination if needed
- Connect participants who test positive to treatment

6. Materials and Supplies to Support Risk Reduction

Programs may provide:

Safer-use supplies

- Sterile syringes
- Cookers
- Cotton filters
- Sterile water
- Alcohol pads

- Sharps containers
- Fentanyl test strips
- Naloxone
- Safer-smoking/snorting kits as allowed

Sexual health supplies

- External and internal condoms
- Lubricants
- Instructions for safer-sex practices

Printed or pictorial materials

- Safer-injection guides
- Overdose prevention instructions
- Information about SSPs, MOUD sites, PrEP/PEP providers
- Local service directories

Supplies should be discreetly packaged for participant comfort.

7. Voluntary Testing, Linkage, and Follow-Up

Testing for HIV, HBV, and HCV should be offered on-site when possible. Explain:

- What the tests involve
- The voluntary nature of testing
- Confidentiality protections
- Any required consent forms
- When results will be available

If testing is off-site, provide a warm referral with clear directions, hours of operation, and—when possible—contact info for a supportive staff member.

Chapter 6 Session II: Reinforcement, Post-Test Counseling & Ongoing Harm-Reduction Support

Session II provides an opportunity to review testing outcomes, reinforce harm-reduction strategies, and support individuals in reducing risks related to HIV, hepatitis B (HBV), hepatitis C (HCV), sexually transmitted infections (STIs), and overdose. Regardless of whether a participant completed testing, this session helps build continuity, trust, and linkage to ongoing services.

Session II is ideally delivered within 1–3 weeks after testing or after Session I, though flexibility is important. Sessions may last 20–40 minutes, depending on participant needs and emotional readiness.

Sessions can occur in community settings—including mobile vans, syringe services programs (SSPs), clinics, shelters, outreach sites—or via phone/tele-outreach if preferred.

Topics Covered in Session II

Key components include:

- Delivery and explanation of test results (HIV, HBV, HCV)
- Clarification of result meanings and next steps
- Review of harm-reduction strategies from Session I
- Linkage to medical follow-up and early treatment
- Discussion of optional partner notification resources
- Ongoing support for safer drug use, sexual health, and overdose prevention
- Distribution of safer-use supplies and updated referral information

Participants who declined testing receive the same risk-reduction support as those who tested negative. Individuals who self-report being positive for HIV, HBV, or HCV receive tailored guidance similar to those who test positive on site.

Getting Started

Session II should take place in a private, quiet setting that supports confidentiality and dignity. Begin with:

- A warm introduction
- An explanation of the session's purpose
- Assurance of privacy
- Permission to pause or take breaks
- Sensitive pacing, especially when discussing test results

Trauma-informed engagement is essential, as individuals may experience anxiety, fear, shame, or uncertainty when receiving test results.

Section A: Participants Who Test Seronegative (or Decline Testing)

1. Provision of Test Results –

Explain results clearly and simply. For HIV, clarify:

- A negative result means no HIV was detected today, but recent exposures may not yet appear on the test.
- Rapid 4th-generation tests detect most infections within 2–4 weeks.
- Re-testing may be recommended depending on recent exposures.

For HBV and HCV:

- Negative HBV may indicate non-immunity → Offer HBV vaccination.
- Negative HCV may still require re-testing after recent exposure.

Allow time for questions and emotional processing.

2. Meaning of Test Results & Prevention Counseling

HIV

Explain:

- What “negative” means in the context of the testing window
- Modern prevention tools: PrEP, PEP, condoms, sterile injection supplies
- How substance use may increase vulnerability to sexual or injection-related risk

HBV

- Emphasize the availability of a safe, effective vaccine
- Encourage initiating or completing the HBV vaccine series

HCV

- Clarify the need for repeat testing after recent exposure
- Emphasize that early treatment is highly effective if infection is ever detected

3. Review of Harm-Reduction Strategies

Instead of outdated bleach demos, review modern prevention strategies:

Injection and non-injection drug use

- Always use new, sterile syringes and supplies
- Never share equipment

- Access SSPs regularly
- Test drugs using fentanyl test strips
- Carry and use naloxone
- Avoid using alone when possible
- Rotate injection sites, avoid high-risk veins

Sexual health

- Use external or internal condoms
- Use lube to reduce friction and risk
- Consider PrEP for ongoing HIV risk
- Discuss safer-sex communication strategies

Overdose prevention

- Recognize overdose signs
- Use naloxone
- Avoid mixing substances

4. Materials to Support Prevention

Provide:

- Safer-use kits (sterile syringes, cookers, cottons, sterile water, alcohol wipes, naloxone, fentanyl test strips)
- Condom kits (external/internal condoms, lube)
- Printed or pictorial safer-use guides
- Information on PrEP/PEP, HBV vaccination, and HCV treatment
- Easy-to-read referral cards with hours, addresses, and contact info

Section B: Participants Who Test Seropositive (HIV, HBV, or HCV)

1. Provision of Test Results

Deliver results compassionately and clearly. Allow time for emotional processing. Provide space for anger, fear, confusion, or sadness. Use a calm, supportive tone. Crisis intervention may be needed if an individual becomes overwhelmed.

2. Meaning of Positive Test Results

HIV-Positive Participants

Key points:

- HIV is treatable, and with treatment, people can live long and healthy lives
- Treatment leads to viral suppression, which means U=U (you cannot transmit HIV sexually)
- Early linkage to HIV care is essential
- Encourage starting ART as soon as possible (ideally same day)

Discuss:

- Partner services (optional)
- Protecting injection and sexual partners
- Importance of consistent follow-up

HBV-Positive Participants

- Referral to medical care for evaluation
- Importance of medication monitoring (if needed)
- Avoid alcohol, which accelerates liver damage
- Encourage vaccination of partners

HCV-Positive Participants

- HCV is curable
- Linkage to antiviral therapy
- Discuss reducing risk of reinfection
- Encourage treatment even if asymptomatic

3. Harm Reduction & Overdose Prevention for Seropositive Participants

Reinforce:

- Never share injection equipment
- Continue to use sterile supplies
- Naloxone and fentanyl testing
- Safer-use strategies to prevent coinfection or reinfection

4. Medical Follow-Up & Early Treatment

Provide warm referrals for:

- HIV care
- MOUD for opioid use
- HCV curative therapy
- HBV care and vaccination for partners

- Mental-health services and social supports

Ensure participants understand how to navigate next steps and who they can contact.

5. Partner Notification (Optional & Confidential)

Explain available options:

- Local health department partner services
- Anonymous notification tools
- Voluntary disclosure strategies

Emphasize:

- It is the participant's choice whether and how to notify partners
- Support is available in making that decision

6. Materials & Supplies

Provide:

- Written guidance about their diagnosis
- Information about local HIV/HBV/HCV clinics
- Safer-injection and safer-sex supplies
- Naloxone
- Referral lists (medical, housing, behavioral health, SSPs)

Section III: Implementation Issues

Effective implementation of a community-based outreach and harm-reduction program requires coordinated, person-centered strategies that meet people who use drugs where they are—geographically, emotionally, and medically. The modern model integrates two core components:

1. community-based outreach, and
2. ongoing, flexible harm-reduction counseling and support, including testing and linkage for HIV, hepatitis B (HBV), hepatitis C (HCV), and other health needs.

These components work together to reduce transmission risks, prevent overdose, support safer use, and strengthen connections to care. Successful implementation emphasizes repeated contact, trust-building, and seamless linkage across services such as syringe services programs (SSPs), testing and vaccination sites, medication for opioid use disorder (MOUD), HIV/HCV treatment, and social-service supports.

This section outlines practical considerations for putting the outreach model into action—including staffing, supervision, service coordination, documentation, and safety planning. It provides guidance for designing programs that are responsive to local drug-use trends, culturally relevant, trauma-informed, and aligned with current CDC, SAMHSA, HRSA, and NIDA best practices. The goal is to equip programs to effectively engage individuals at risk of acquiring or transmitting HIV, HBV, HCV, or experiencing overdose, while promoting health, dignity, and autonomy within the communities they serve.

- **Chapter 7**
- **Chapter 8**

Chapter 7 Logistical Considerations for Implementing Community-Based Outreach Programs

Establishing Accessible Program Locations (“Field Stations”)

While community-based outreach can be delivered in many environments, having a consistent, accessible “home base” can enhance program visibility, facilitate safer-use education, provide a location for testing and vaccination, and serve as a hub for care navigation. Modern field stations function as low-barrier drop-in centers, often integrated within broader harm-reduction and health services.

Successful field stations commonly offer:

- HIV, HBV, and HCV testing
- Vaccination (HBV, HAV)
- Naloxone distribution and overdose prevention education
- Safer-use supply distribution
- PrEP and PEP navigation
- Linkage to MOUD
- Peer support groups
- Case management and insurance navigation
- Mental health support
- Access to food, hygiene items, and basic-needs resources
- Digital and tele-outreach options

Possible locations include:

- Syringe Services Programs (SSPs)
- Mobile outreach vans or RV-based health units
- Community health centers or Federally Qualified Health Centers (FQHCs)
- Storefronts in high-traffic areas
- Shared spaces within shelters, day centers, or warming/cooling sites
- Health department facilities
- University or research institutions with community-health partnerships
- Hybrid models combining fixed sites and mobile operations

Field stations should prioritize accessibility, anonymity, cultural responsiveness, safety, and dignity.

Hours of Operation

Outreach programs work best when they align operational hours with the rhythms and realities of the community. Modern guidelines emphasize:

- Flexible, expanded hours: evenings, weekends, and times when PWUD are most active
- Consistency: clear, reliable hours build trust and predictability
- Coverage: when outreach staff work late hours or in high-risk environments, supervisors or clinical support staff should be on call
- Adaptation: programs regularly reassess hours based on local trends, weather, community events, and participant feedback

Hours should reflect the principle that services must be available when and where they are needed, not only within traditional office schedules.

Working in Teams

Modern harm-reduction programs prioritize team-based outreach to increase safety, build capacity, support staff wellness, and improve participant engagement.

Key principles include:

- Outreach teams of two or more for safety and shared decision-making
- Integration of peer workers with lived experience alongside health educators, navigators, or clinicians
- Trauma-informed team communication and debriefing
- Regular, supportive supervision (clinical and operational)
- Attention to burnout, compassion fatigue, and secondary trauma
- Non-punitive, supportive policies around relapse prevention for peer staff

Unlike older models that required “two years of abstinence,” modern federal guidance discourages abstinence-based hiring requirements for peer workers. Instead, programs emphasize:

- Recovery pathway diversity
- Supportive supervision
- Reasonable accommodations
- Clear boundary expectations
- Access to mental health and recovery supports

Peer experience is considered a strength, not a liability.

Maintaining Contact and Continuity With Participants

Because many people served by harm-reduction programs experience homelessness, unstable phone access, stigma, or frequent mobility, maintaining contact requires creative, person-centered approaches.

Programs today use multiple strategies:

Modern contact methods

- Text-based outreach (with consent)
- Prepaid phones or digital communication support
- Social media outreach (private groups, direct messages)
- Peer navigators assigned to participants
- Appointment reminders by text, call, or in-person outreach
- Drop-in hours at field stations
- Regular outreach “routes” based on known gathering points
- Collaboration with shelters, SSPs, and ED linkage teams

Locating participants ethically

A modern “locator form” should gather only the minimum necessary information, and must respect privacy, confidentiality, and consent. Today, systems typically collect:

- Preferred name and pronouns
- Phone numbers (if any), email, or social media contact
- Consent for text or digital communication
- Locations where the participant chooses to meet outreach teams
- Name of a trusted contact person (optional)

Outdated practices like “if you won the lottery, where would you want the check mailed?” are replaced with trauma-informed, autonomy-respecting questions:

“Where do you feel most comfortable connecting with us?”

“If we need to follow up with testing or supplies, what’s the best way to reach you?”

Programs must balance re-engagement efforts with respect for privacy and safety.

Recordkeeping, Documentation, and Accountability

Modern programs emphasize accurate documentation to support:

- Continuity of care
- Service coordination
- Program evaluation
- Funding requirements
- Safety and accountability

Standard documentation includes:

- Brief encounter notes (location, services provided, supplies distributed)
- Testing logs (confidential, compliant with HIPAA/state law)
- Referrals and linkage tracking

- Naloxone distribution records
- SSP supply logs
- Incident reports (e.g., overdose reversal)
- Peer or navigator follow-up notes

Documentation should be:

- Minimalistic, to avoid over-collection of sensitive data
- Secure, using encrypted systems or locked storage
- Participant-centered, avoiding stigmatizing language
- Compliant with state SSP documentation requirements

Modern reporting may include:

- Daily/weekly route summaries
- Hotspot mapping to identify emerging community needs
- Monthly supply distribution data
- HIV/HCV testing and linkage outcomes
- Overdose reversal reports
- Demographic snapshots (anonymous and aggregated)
- Staff check-in/check-out logs for safety

Supervisors should regularly conduct supportive field visits, focusing on staff needs, program quality, and participant safety—not punitive oversight.

Chapter 8 Training and Supervision

Effective community-based outreach programs depend heavily on skilled, knowledgeable, and well-supported staff. Training, supervision, and ongoing professional development ensure consistency, ethical practice, safety, and quality of care. This chapter outlines a modern framework for preparing harm-reduction outreach workers, counselors, and educators to engage people who use drugs (PWUD) in trauma-informed, culturally responsive, evidence-based ways.

Preservice Training & Orientation

All new outreach staff—including peer workers, navigators, educators, and counselors—should receive structured preservice training, job-specific instruction, and supervised field training. Training should be competency-based, trauma-informed, and aligned with federal harm-reduction standards.

Training occurs in two phases:

1. Office-based (classroom) instruction: foundational knowledge, safety protocols, harm-reduction principles, and communication skills.
2. Field-based training: shadowing senior outreach staff, practicing supervised interactions, and learning real-world application.

Foundational Training: HIV, HBV, HCV & Overdose Prevention

All staff must possess a clear understanding of essential concepts related to harm reduction and infectious-disease prevention. Training should include:

- Basics of HIV, HBV, HCV, and STI transmission and prevention
- Updated testing options (e.g., rapid HIV 4th-generation tests, dried blood spot testing, oral swabs)
- HIV prevention tools including PrEP, PEP, and U=U
- HBV vaccination recommendations (ACIP)
- HCV curative treatments and reinfection considerations
- Overdose prevention (naloxone, fentanyl test strips, safer-use strategies)
- Linkage-to-care pathways
- Current local epi trends and prevalence/incidence data
- Health consequences of drug use, polysubstance use, and overdose risks
- Cultural humility and trauma-informed engagement
- Confidentiality, privacy, and informed consent

Staff should also receive education about HBV vaccination, including access points and eligibility, as recommended by CDC and ACIP. ⁱⁱⁱ

Job-Specific Training

After foundational training, staff receive role-specific instruction tailored to outreach, education, and risk-reduction counseling.

Training should cover:

Core Harm-Reduction Strategies

- How to distribute safer-use supplies (sterile syringes, cookers, water, naloxone, condoms, etc.)
- Nonjudgmental communication
- How to explain safer-use practices clearly and respectfully
- Understanding participant autonomy

Outreach Skills

- Identifying and approaching target populations respectfully
- Using trauma-informed verbal and non-verbal communication
- Explaining program goals transparently
- Maintaining personal boundaries
- Navigating high-risk environments safely
- Handling police encounters using established protocols
- Managing requests for money, sex, or substances in an ethical manner
- De-escalation and crisis-intervention basics
- Supporting overdose response and calling EMS safely

Risk Reduction & Education

- Demonstrating safer-injection techniques
- Demonstrating safer-sex practices using anatomical models
- Providing PrEP/PEP navigation
- Discussing HBV vaccination and HCV testing and treatment
- Providing overdose-prevention training
- Using motivational interviewing and strengths-based approaches

Documentation & Logistics

- Recording outreach contacts
- Maintaining confidentiality
- Mandatory reporting requirements
- Referral processes and follow-up

Role-plays, simulations, guided practice, and shadowing are essential components of training.

Field-Based Training

Once staff have mastered core skills in controlled settings, supervised field training begins.

Best practices include:

- Working in teams of two or more for safety
- Spending at least 2 weeks paired with a senior outreach worker
- Supervisors accompanying staff at least weekly
- End-of-day team debriefs
- Practicing interactions with real participants under supervision
- Gradual progression to independent outreach with ongoing supervision

Supervisors should model effective engagement, provide real-time coaching, and reinforce adherence to harm-reduction principles.

Supervisor Responsibilities

Supervisors are central to program consistency, safety, and staff well-being. Their responsibilities include:

- Coaching, mentoring, and supporting outreach staff
- Reinforcing boundaries, confidentiality, and professional ethics
- Conducting field observations
- Leading morning coordination meetings and end-of-day debriefs
- Reviewing documentation for quality and accuracy
- Identifying training needs and competency gaps
- Advocating for staff safety and mental health
- Supporting peer workers with lived experience and reducing stigma
- Ensuring alignment with program protocols and federal best practices

Supervision must be supportive, not punitive. Harm-reduction work is emotionally demanding; supervisors are responsible for creating a safe, affirming environment.

Ongoing Training & Professional Development

Continuing education ensures staff remain current with new evidence, updated guidelines, and emerging risks.

Ongoing training should include:

- Updates on HIV, HBV, HCV, STI screening and treatment
- Emerging drug trends (xylazine, fentanyl analogs, stimulants)
- Overdose prevention and naloxone updates

- Trauma-informed care refreshers
- Self-care, burnout prevention, and secondary trauma support
- Boundary setting and managing dual relationships
- New harm-reduction supplies or technologies
- Community resource mapping
- Anti-stigma and cultural responsiveness training

Training should occur monthly, with annual refreshers and competency evaluations.

Creating a Supportive Work Environment

A healthy outreach program prioritizes staff safety, well-being, and emotional resilience. Supervisors and managers should:

- Promote a culture of safety, respect, and transparency
- Provide emotional support after critical incidents or participant deaths
- Offer access to mental-health support and peer networks
- Identify unsafe environments and authorize immediate withdrawal
- Encourage autonomy while maintaining clear expectations
- Advocate for workers with local partners, including police departments
- Establish clear communication channels and emergency protocols

Effective programs balance structure with flexibility, empowering outreach workers while protecting them from unnecessary risk.

Table 4. Recommendations for Community-Based Outreach Workers

Be Sure To...	Avoid...
<ul style="list-style-type: none"> • Carry program identification and emergency contact information. 	<ul style="list-style-type: none"> • Using substances or being impaired while on duty.
<ul style="list-style-type: none"> • Clearly explain your role, scope, and limits to participants. 	<ul style="list-style-type: none"> • Buying, selling, or accepting drugs or stolen property.
<ul style="list-style-type: none"> • Maintain participant confidentiality and privacy at all times. 	<ul style="list-style-type: none"> • Engaging in sexual activity or accepting sexual favors from participants.
<ul style="list-style-type: none"> • Keep supervisors informed of your route, schedule, and safety concerns. 	<ul style="list-style-type: none"> • Carrying, confiscating, or transporting weapons. <p style="text-align: right;">iii</p>

Be Sure To...	Avoid...
<ul style="list-style-type: none"> • Approach participants with respect, cultural humility, and nonjudgment. 	<ul style="list-style-type: none"> • Violating confidentiality or discussing participant information publicly.
<ul style="list-style-type: none"> • Use trauma-informed communication, especially during crisis situations. 	<ul style="list-style-type: none"> • Asking about drug trafficking information except to locate outreach zones.
<ul style="list-style-type: none"> • Work in teams when possible, for safety and effectiveness. 	<ul style="list-style-type: none"> • Giving money directly to participants.
<ul style="list-style-type: none"> • Follow safety protocols for high-risk environments and emergencies. 	<ul style="list-style-type: none"> • Socializing in environments where active drug use creates safety concerns.
<ul style="list-style-type: none"> • Document encounters accurately and promptly. 	<ul style="list-style-type: none"> • Making promises outside your professional role or capacity.
<ul style="list-style-type: none"> • Build collaborative relationships with police, EMS, shelters, and SSPs. 	<ul style="list-style-type: none"> • Misrepresenting the program or providing inaccurate health information.
<ul style="list-style-type: none"> • Maintain appropriate boundaries and seek supervision when unsure. 	<ul style="list-style-type: none"> • Taking on personal responsibility for participants' choices or outcomes.
<ul style="list-style-type: none"> • Practice self-care, use debriefing opportunities, and seek support. 	<ul style="list-style-type: none"> • Ignoring signs of burnout, stress, or compassion fatigue.

TB in Drug Users

Drug use and injection drug use are important factors in the epidemiology of tuberculosis. The physiological effects of drug use, along with the environment and risk behaviors of drug users, may all contribute to the high prevalence of TB among drug users. A number of studies have demonstrated deleterious effects of drug use on the immune system, with biologic evidence supporting direct impairment by opiates of the cell-mediated immune response. Drug use is frequently associated with a number of epidemiologic factors, including tobacco use, homelessness, alcohol abuse and incarceration, which confer additional risk for TB. Together, these physiological and epidemiological factors may each contribute to observed outcomes, that drug users are more likely to be infectious, take longer to achieve negative culture, and be at increased risk for mortality.

The high prevalence of latent TB (LTBI) and longer periods of infectivity may further contribute to increased rates of TB transmission among drug users. The hallmark of TB control is the effective identification and treatment of cases, and drug users present a unique set of challenges for both. Studies have reported that injection drug users (IDUs) have difficulty completing medical evaluations or adhering to treatment for or TB disease. Even symptomatic IDUs have waited longer to present for treatment after TB symptom onset (“patient delay”), which can increase TB transmission rates or lead to more severe disease. Additionally, a novel hypothesis centers on whether drug users may be less aware of TB symptoms due to opiate suppression of the cough reflex. A recent randomized, controlled trial among 27 patients with chronic cough found that patients taking 5–10 mg morphine sulfate daily experienced a reduction in cough frequency and severity.

TB knowledge and perceptions may further impact care-seeking behavior. In knowledge surveys, most IDUs understood they were at high risk for TB, that HIV infection increases TB risk, and that TB is treatable. However, fewer drug users were aware that TB is spread by coughing or that people could become resistant to medication; confusion between infection and disease is also common. Perceptions that TB can be prevented by condom use or bleaching needles, reported in one study, suggest that HIV/AIDS education messages can

be confused with TB prevention, a problem which itself has led to longer patient delay in some settings.

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Appendix A: Cue Cards for Session 1

Card 1: What is HIV?

What Is HIV?

- HIV (Human Immunodeficiency Virus) is a virus that attacks the immune system, specifically the body's CD4 (T-helper) cells that help fight infections.
- HIV is found in blood, semen, vaginal fluids, rectal fluids, and breast milk. It is transmitted through:
 - Sharing injection equipment
 - Unprotected vaginal or anal sex
 - From parent to child during pregnancy, birth, or breastfeeding (without treatment)
 - Rarely, through blood transfusion in countries without screening systems
- Without treatment, HIV can cause severe damage to the immune system and lead to AIDS (Acquired Immunodeficiency Syndrome), the advanced stage of HIV infection where the body is vulnerable to life-threatening infections and cancers.
- HIV is treatable. Today, people who start and stay on HIV medication (antiretroviral therapy, or ART) can live long, healthy lives and prevent sexual transmission to others.
- U=U (Undetectable = Untransmittable): When a person takes HIV medication and achieves an undetectable viral load, they do not transmit HIV through sex.
- In the United States, approximately 1.2 million people are living with HIV. With modern treatment and prevention tools—PrEP, PEP, sterile injection supplies, condoms, and routine testing—HIV transmission is preventable.

Card 2: What is Hepatitis B?

What Is Hepatitis B?

- Hepatitis B (HBV) is a virus that infects the liver. It can cause serious health problems, including chronic liver disease, cirrhosis, liver cancer, and liver failure.
 - HBV is found in blood and sexual fluids of someone who has the infection. It can be passed through:
 - Sharing injection equipment
 - Unprotected sex
 - Sharing items that may have blood on them (razors, toothbrushes)
 - From parent to infant during childbirth
 - Hepatitis B is preventable. A safe and highly effective vaccine is available, and CDC now recommends hepatitis B vaccination for all adults ages 19–59 and for adults 60+ with risk factors.
 - Many people with HBV have no symptoms, but when symptoms occur they may include:
 - Fatigue
 - Nausea or loss of appetite
 - Abdominal discomfort
 - Dark urine
 - Jaundice (yellowing of skin or eyes)
 - Most healthy adults (about 90–95%) who get hepatitis B will clear the virus on their own. Others may develop chronic HBV and need ongoing medical care.
 - Early testing, vaccination, and avoiding sharing injection equipment or personal items that may have blood on them can prevent HBV infection.

Card 3: What is Hepatitis C?

What Is Hepatitis C?

- Hepatitis C (HCV) is a virus that infects the liver. It is found in the blood of a person with the infection and is spread primarily through blood-to-blood contact.
- The highest risk comes from sharing injection equipment—including syringes, cookers, cottons, caps, water, and any items used to prepare or inject drugs.
- HCV is not typically spread through sexual contact, saliva, or casual contact, though transmission can occur during rough sex or when blood is present.
- Many people with hepatitis C do not have symptoms, sometimes for years or even decades. When symptoms occur, they may include:
 - Fatigue
 - Abdominal pain
 - Loss of appetite
 - Nausea or vomiting
 - Dark urine
 - Jaundice (yellowing of skin or eyes)
- Without treatment, HCV can cause liver inflammation, cirrhosis (scarring), liver cancer, or liver failure over time.
- Unlike in the past, hepatitis C is now curable. Modern antiviral medications (called direct-acting antivirals) can cure more than 95% of people, usually in 8–12 weeks.
- Because reinfection can occur, people who inject drugs should receive regular HCV testing and use sterile equipment every time they prepare or inject drugs.

Card 4: Facts About HIV, HBV, and HCV Transmission

Facts About HIV, HBV, and HCV Transmission

- HIV, hepatitis B (HBV), and hepatitis C (HCV) are found in specific body fluids.
 - HIV: blood, semen, vaginal fluids, rectal fluids, breast milk
 - HBV: blood and sexual fluids
 - HCV: blood (this is the primary route of transmission)
- These viruses can be transmitted through:
 - Sharing injection or drug-preparation equipment, including syringes, cookers, cottons, caps, and water
 - Sharing drug solutions or transferring drugs between syringes (frontloading, backloading, or any method involving shared equipment)
 - Unprotected sex, especially when blood is present or when a partner injects drugs or has multiple partners
 - Contaminated blood exposure, though U.S. blood supplies are now screened and this is extremely rare
 - Parent-to-child transmission during pregnancy, birth, or (for HIV and HBV) through breastfeeding when the parent is not in care or treatment
- Hepatitis C (HCV) is not efficiently spread through sexual contact, but the risk increases when blood exposure is more likely (e.g., rough sex, presence of STIs, men who have sex with men, or during menstruation).
- Alcohol and drug use can increase risk because:
 - They can weaken the immune system over time, making it harder to fight infections.
 - They can affect judgment and increase the likelihood of sharing equipment or having unprotected sex.
 - Alcohol use can worsen liver damage for people with HBV or HCV.
- Using new, sterile equipment every time, practicing safer sex, getting vaccinated for hepatitis B, and accessing treatment for HIV/HCV can greatly reduce transmission risk.

Card 5: Facts about HIV, HBV, and HCV That are Often Misunderstood

Facts About HIV, HBV, and HCV That Are Often Misunderstood

- You cannot get HIV, HBV, or HCV from casual contact.
They are not spread by:
 - Sneezing, coughing, hugging, or shaking hands
 - Sharing food, drinks, utensils, or dishes
 - Using the same toilet seat, shower, bedding, or clothing
 - Sharing a phone, computer, or workspace
- You cannot get HIV, HBV, or HCV from kissing, including a dry kiss.
(Very rarely, HBV could be present in blood if both people have open sores—but this is not typical. HIV and HCV are not spread through saliva.)
- You cannot get these infections from insect bites.
Mosquitoes and other insects do not transmit HIV, HBV, or HCV.
- You cannot get HIV, HBV, or HCV from the air, water, or the environment.
These viruses cannot live long outside the body.
- Do not share personal items that may have blood on them, such as:
 - Razors
 - Toothbrushes
 - Nail clippers
 - Items used to trim cuticles or skin
- The main ways these viruses are transmitted are through blood-to-blood contact and unprotected sex—not through everyday activities.

Card 6: Reducing Your Risk of Infection

Reducing Your Risk of Infection

- If you inject drugs, you can get HIV, hepatitis B (HBV), or hepatitis C (HCV) by sharing needles, syringes, or any injection equipment that someone else has used.
- You can also get HIV, HBV, and HCV by sharing cookers, cottons, caps, water, ties, or drug solutions. Even tiny amounts of blood can carry these viruses.
- Rinsing equipment with water—even hot water—does *not* kill HIV, HBV, or HCV. These viruses can survive inside syringes and on other equipment.
- The safest way to reduce your risk:
 - Best method: stop injecting drugs.
 - If you inject, use a new, sterile syringe and all new injection supplies every time.
 - Never use equipment that was used by someone else.
 - Get your supplies from a syringe services program (SSP), pharmacy, mobile van, or community outreach worker.
- If new equipment is *not* available:
 - Avoid injecting with someone else's equipment.
 - Avoid frontloading, backloading, or sharing drug solutions—all can transmit HIV, HBV, and HCV.
 - Bleach disinfection may reduce risk but is not fully protective and should only be used as a last resort when no sterile supplies are available.
- Do not:
 - Put your needle into someone else's rinse water, cooker, or cotton
 - Use drugs drawn up in a syringe someone else has used
 - Share ties, tourniquets, or surfaces used to prepare drugs
- Using new, sterile equipment every time, practicing safer use, and getting tested frequently can greatly reduce your risk of infection.

Card 7: Cleaning Injection Equipment

Cleaning Injection Equipment (If No Sterile Supplies Are Available)

(Bleach is a last resort and may not fully protect you from HIV, HBV, or HCV.)

The safest method is always:

- Use a new, sterile syringe and all-new equipment every time you inject.
- Do not share syringes, cookers, cottons, caps, or water.

If you cannot get new equipment:

Cleaning can lower—but not eliminate—the risk. Follow these steps as carefully as possible:

1. Rinse

- Fill the syringe completely with clean water.
- Shake and squirt it out.
- Repeat until visible blood is gone.

2. Clean with full-strength bleach (last resort)

- Fill the syringe completely with fresh, full-strength household bleach.
- Shake for at least 30 seconds to reach all areas of the barrel and plunger.
- Squirt out the bleach into a sink, toilet, or drain.
- Repeat the bleach step a second time.

3. Rinse Again

- Fill the syringe with clean water to remove the bleach.
- Shake and squirt.
- Repeat a second time.

4. Clean all parts

- If possible, remove the plunger and rinse both the barrel and plunger separately using the same bleach → bleach → water → water steps

5. Clean the cooker and the other equipment

- Wipe or soak the cooker, spoon, or cap in full strength bleach.
- Rinse with clean water.
- Use new cottons whenever possible.

If bleach is not available

These methods reduce risk but do not kill HIV/HBV/HCV reliably:

- Rinse with clean water several times until no blood is visible.
- Boiling metal or glass equipment for 15 minutes can help, but plastic syringes may melt or warp.

Important reminders

- Bleach is not fully effective at killing hepatitis C inside syringes.
- Using new supplies from an SSP or pharmacy is always safer than cleaning.
- Never share water, cookers, cottons, or drug solutions.

Card 8: Reuse of Injection Equipment

Reuse of Injection Equipment

- Direct sharing happens when you use someone else’s syringe after they have injected with it. This is one of the highest-risk ways to get HIV, hepatitis B (HBV), or hepatitis C (HCV).
- Indirect sharing happens when blood from someone else gets into your equipment or drug solution—even if you never pass the same syringe back and forth.
- Common routes of indirect sharing include:
 - Using the same water, cap, cooker, or drug solution as someone else
 - Drawing drugs from a shared cotton filter
 - Using a syringe that someone else used to measure, mix, or divide the drug
 - Putting your syringe into shared rinse water
 - Returning leftover drug solution to a shared cooker, cap, or bottle
 - Using the plunger, barrel, or tip from a previously used syringe to prepare drugs
 - “Beating the cotton” (squeezing out leftover drug from a shared cotton)
 - “Scraping the cooker” (collecting residue from a cooker used by others)
- Even a drop of blood you cannot see can transmit HCV, HBV, or HIV.
- The safest option:
 - Use new, sterile syringes and all new equipment (cookers, cottons, caps, and water) every time you prepare or inject drugs.
 - Never share equipment, water, or containers—*even once*.

Card 9: Benefits of Syringe Services Programs (SSPs)

Benefits of Syringe Services Programs (SSPs)

- Syringe Services Programs (SSPs) provide free, sterile syringes and injection supplies, reducing the risk of HIV, HBV, and HCV.
- SSPs also offer:
 - Safe disposal of used syringes
 - HIV/HCV testing
 - Hepatitis A/B vaccination
 - Naloxone and overdose-prevention tools
 - Fentanyl and xylazine test strips
 - Safer-sex supplies
 - Referrals to treatment, housing, and medical care
- People who use SSPs are more likely to enter substance-use treatment and reduce injection frequency.
- SSPs protect both individual and community health by reducing syringe litter and infectious disease transmission.

Card 10: Sexual Risks Linked to Drug Use

Sexual Risks Linked to Drug Use

- Drug and alcohol use can make it harder to think clearly or make safer choices during sex.
- Some drugs (including methamphetamine, cocaine, and opioids) can increase:
 - Unprotected sex
 - Multiple partners
 - Rougher sex that may cause bleeding
 - Lower ability to negotiate condom use
- If stopping drug use isn't possible, you can still reduce risk by:
 - Using condoms every time
 - Using lube to reduce tearing
 - Getting routine HIV/STI testing
 - Using PrEP if you have ongoing HIV risk
- Drug use can weaken the immune system over time, increasing vulnerability to infections.

Card 11: Using Condoms to Reduce Sexual Transmission

Using Condoms to Reduce Sexual Transmission

- Condoms help prevent HIV, HBV, HCV (when blood is present), and other STIs.
- Use condoms for all vaginal and anal sex.
- Tips for safer use:
 - Check the condom package for damage and expiration date
 - Open carefully to avoid tearing
 - Pinch the tip to leave space
 - Roll the condom down the entire shaft
 - Use water-based or silicone lubricant (no oils—they damage latex)
 - Change condoms between partners and between vaginal/anal/oral sex
 - Remove the condom by holding the base and discarding safely
- Condoms should be stored in a cool, dry place and replaced if damaged or dried out.

Card 12: Using Internal (Female) Condoms

Using Internal (Female) Condoms

- Internal condoms provide protection against HIV, STIs, and pregnancy.
- Benefits:
 - Can be inserted before sex, offering more control
 - Protect more of the external genital area
 - Less likely to break
 - Allow continued intimacy after ejaculation
- Instructions:
 - Check package for damage
 - Squeeze the inner ring and insert like a tampon
 - Ensure the outer ring remains outside the body
 - Guide the partner into the condom to avoid slipping
 - Never use an internal condom with an external condom at the same time
- Internal condoms are single-use only.

Card 13: Talking With Partners About Safer Sex

Talking With Partners About Safer Sex

- Talking about safer sex can feel uncomfortable, but it helps protect both you and your partner.
- Tips for starting the conversation:
 - Be direct and honest about wanting to stay healthy
 - Choose a calm, private moment—*not* during sex
 - Use “I” statements (“I want to feel safe when we’re together...”)
 - Suggest solutions (condoms, lube, PrEP, testing together)
- Remember:
 - Your health and boundaries matter
 - You deserve safe and consensual sex
- Safer-sex conversations can deepen trust and strengthen relationships.

Card 14: Benefits of Drug Treatment & Recovery Support

Benefits of Drug Treatment & Recovery Support

- Entering treatment can help you reduce or stop drug use at your own pace.
- Treatment options include:
 - Medications for opioid use disorder (MOUD): methadone, buprenorphine, naltrexone
 - Outpatient counseling
 - Residential treatment
 - Peer recovery support
- Benefits of treatment:
 - Reduces HIV, HBV, and HCV risk
 - Reduces overdose risk
 - Improves physical and mental health
 - Increases stability (housing, employment, relationships)
- You don't need to hit "rock bottom" to seek support. Treatment is available even if you're still using.

Card 15: HIV Testing: What to Expect

HIV Testing: What to Expect

- HIV tests check for the virus or antibodies in your blood or saliva.
- Modern 4th-generation HIV tests detect infection earlier than older tests.
- Most people get accurate results 2–4 weeks after exposure; some may need retesting at 6 weeks.
- Rapid tests can return results in 20 minutes.
- Testing is voluntary, confidential, and often free.
- Getting tested helps you know your status and access treatment or prevention options (PrEP/PEP).

Card 16: Hepatitis B Testing: What It Means

Hepatitis B Testing: What It Means

- Hepatitis B tests look for:
 - HBV surface antigen (current infection)
 - HBV antibodies (past infection or immunity)
- A negative test means:
 - You may not be immune and may need HBV vaccination
- A positive test means:
 - You have an HBV infection and should see a medical provider
- HBV can be managed with care, monitoring, and sometimes medication.

Card 17: Hepatitis C Testing: What It Means

Hepatitis C Testing: What It Means

- HCV testing usually involves:
 1. An antibody test (ever infected?)
 2. A viral load test (RNA test) (currently infected?)
- A positive antibody test does not always mean you have active HCV.
- A positive viral load test means you have current infection and can be treated.
- Today, hepatitis C is curable in most people with simple oral medications (8–12 weeks).
- If you inject drugs, regular

Card 18: Staying Healthy if You Have HIV, HBV, or HCV

Staying Healthy if You Have HIV, HBV, or HCV

- Seek medical care as soon as possible:
 - HIV treatment (ART) can suppress the virus and help you stay healthy
 - HBV can be monitored and treated
 - HCV can be cured
- Continue safer injection and safer-sex practices—this protects both you and your partners.
- Do not share injection or drug-preparation equipment.
- Avoid alcohol if you have HBV or HCV—it can damage your liver.
- Eat well, rest, and connect with supportive people or services.
- An undetectable HIV viral load means you cannot transmit HIV sexually (U=U).
- Even after HCV cure, you can get reinfected—stay engaged in prevention and testing.

Appendix B: Cue Cards for Session II

Card 19: Understanding a Negative HIV Test Result

Understanding a Negative HIV Test Result

- Your test result is negative, meaning HIV was *not detected* at this time.
- A negative result does not always mean you are HIV-free — it depends on when you were last exposed.
- Modern 4th-generation HIV tests can detect most infections in 2–4 weeks, but some may take longer.
- If you had a possible exposure within the last 6 weeks, you may need to test again.
- To stay negative:
 - Use condoms for vaginal and anal sex
 - Use sterile syringes and supplies every time
 - Consider PrEP, a medication that prevents HIV
 - Avoid sharing injection equipment
- Keep getting tested if you have ongoing risk.

Card 20: Understanding a Positive HIV Test Result

Understanding a Positive HIV Test Result

- Your test shows you are living with HIV.
- HIV is treatable, and with medication (ART), people live long, healthy lives.
- Starting treatment as soon as possible can:
 - Improve health
 - Reduce viral load
 - Prevent HIV transmission to others
- When your HIV viral load becomes undetectable with treatment, you cannot pass HIV sexually (U=U).
- You should:
 - See a medical provider right away
 - Avoid sharing syringes, cottons, cookers, or water
 - Use condoms during sex until you're linked to care
- Help is available — you are *not* alone, and effective treatment exists.

Card 21: Understanding Negative HBV or HCV Test Results

Understanding Negative HBV or HCV Test Results

- A negative hepatitis B (HBV) test usually means:
 - You are not infected
 - You may not be immune — vaccination is recommended for most adults
- A negative hepatitis C (HCV) antibody or RNA test means:
 - No current infection was found
 - If you had a recent exposure, retesting may be needed in 3–6 months
- If you inject drugs or share equipment, regular HBV/HCV testing is recommended.

Card 22: Understanding Positive HBV or HCV Test Results

Understanding Positive HBV or HCV Test Results

- A positive HBV test means:
 - You have hepatitis B
 - A medical provider can help monitor your liver, provide treatment if needed, and protect your partners
- A positive HCV antibody + positive RNA test means:
 - You currently have hepatitis C
 - HCV is curable with modern medication (usually 8–12 weeks)
- Avoid sharing injection equipment and practice safer sex to protect others.
- Alcohol can worsen liver disease — cutting down or stopping alcohol is strongly recommended.

Card 23: Protecting Your Liver (HBV & HCV)

Protecting Your Liver (HBV & HCV)

- Avoid or reduce alcohol — it speeds up liver damage.
- Talk to a medical provider about monitoring your liver health.
- Get vaccinated for hepatitis A and B (if you are not already immune).
- Eat well, rest, and take medications as prescribed.
- Do not share:
 - Syringes or injection supplies
 - Razors, toothbrushes, nail tools
- If you use drugs:
 - Use new, sterile injection equipment every time
 - Avoid sharing cookers, cottons, caps, or water
 - Get naloxone to prevent overdose
- Cure for hepatitis C is available — treatment can protect your health and reduce transmission.

Card 24: Partner Notification

Partner Notification

- If you test positive for HIV, HBV, or HCV, people you may have exposed could also be at risk.
- You do not have to notify partners alone — there is help:
 - Local health departments offer confidential partner services
 - They can notify partners without using your name
 - They can help connect partners to testing and medical care
- You choose what feels safest. Options include:
 - Telling partners yourself
 - Having a health department worker notify them anonymously
 - Notifying partners by text or phone through secure systems
- Partner notification can protect the people you care about and help stop the spread of infections.

Appendix C: National Partners and Collaborators in HIV, Viral Hepatitis and Harm-Reduction Research

National Partners and Collaborators in HIV, Viral Hepatitis, and Harm-Reduction Research

This intervention model is informed by decades of work across federal agencies, academic institutions, community-based organizations, and national harm-reduction networks. While the original National AIDS Research Consortium is no longer operational, the following organizations represent the current national infrastructure guiding evidence-based HIV, HBV, HCV, and overdose-prevention efforts for people who use drugs.

These entities lead research, surveillance, training, technical assistance, and community engagement across the United States.

Federal Agencies

Centers for Disease Control and Prevention (CDC)

- National Center for HIV, Viral Hepatitis, STD & TB Prevention (NCHHSTP)
- Division of HIV Prevention (DHP)
- Division of Viral Hepatitis (DVH)
- Division of Overdose Prevention (DOP)

Substance Abuse and Mental Health Services Administration (SAMHSA)

- Center for Substance Abuse Treatment (CSAT)
- Center for Substance Abuse Prevention (CSAP)
- Harm Reduction Grants Program
- National Harm Reduction Technical Assistance Center

National Institutes of Health (NIH)

- National Institute on Drug Abuse (NIDA)
- NIDA Clinical Trials Network (CTN)
- Office of AIDS Research (OAR)

Health Resources & Services Administration (HRSA)

- Ryan White HIV/AIDS Program
- Bureau of Primary Health Care
- Community Health Centers & mobile health initiatives

Office of Infectious Disease and HIV/AIDS Policy (OIDP)

- Oversees national Ending the HIV Epidemic (EHE) initiatives
- Integrates policy across HHS agencies

National Research Collaborators

CDC's National HIV Behavioral Surveillance (NHBS) Network

- Provides ongoing data on behaviors among people who inject drugs (PWID)

NIDA HIV & Hepatitis Research Programs

- Harm reduction and treatment access research
- Community-based intervention trials

The HIV Prevention Trials Network (HPTN)

- Biomedical and behavioral prevention research
- Studies involving PWID populations globally

The Hepatitis C Cooperative Research Centers

- Multi-university collaboration on HCV transmission and treatment outcomes

National Harm Reduction & Community Organizations

National Harm Reduction Coalition (NHRC)

- Training, TA, policy, and syringe access best practices

National Alliance of State & Territorial AIDS Directors (NASTAD)

- HIV, hepatitis, and drug user health policy integration
- Oversees many statewide harm-reduction and SSP support systems

The North American Syringe Exchange Network (NASEN)

- Supplies syringe service programs (SSPs) nationwide
- Technical assistance and safer-use materials

The Urban Survivors Union (USU)

- National drug user union focused on rights, policy, and peer leadership

The National Council for Mental Wellbeing

- Integrates harm reduction into BH practice and provider training

Academic Public Health & Research Centers

- Johns Hopkins Bloomberg School of Public Health — Center for Drug Use & HIV Research (CDUHR)
- NYU School of Global Public Health — Center for Opioid Epidemiology and Policy
- Brown University School of Public Health — People, Place & Health Collective
- University of California, San Francisco (UCSF) — HIV & Harm Reduction Research Program
- Yale School of Medicine — Program in Addiction Medicine
- Boston University School of Public Health — Center for Health Law, Ethics & Human Rights

These universities host leading-edge harm-reduction, HIV/HCV, overdose prevention, and community outreach research.

Appendix D: National Partners in Community – Based HIV, Viral Hepatitis, STI, and Harm – Reduction Outreach

National Partners in Community-Based HIV, Viral Hepatitis, STI, and Harm-Reduction Outreach

The original Cooperative Agreement program funded by the National Institute on Drug Abuse (NIDA) brought together multiple U.S. research sites to develop and evaluate early outreach-based HIV interventions.

Although that specific program is no longer active, its legacy continues through a broad network of federal initiatives, research centers, and community-based organizations that support evidence-based outreach, testing, and harm-reduction services for people who use drugs.

The following list reflects the modern 2025 equivalents—organizations that actively shape today’s national outreach efforts, community-based intervention research, and harm-reduction service delivery.

Federal Leadership & National Programs

National Institute on Drug Abuse (NIDA)

- Center for the Clinical Trials Network (CTN)
- NIDA HIV Research Program
- NIDA Hepatitis & Overdose Prevention Initiatives
- Community Outreach & Implementation Science Partnerships

Centers for Disease Control and Prevention (CDC)

- Division of HIV Prevention (DHP)
- Division of Viral Hepatitis (DVH)
- Division of Overdose Prevention (DOP)
- National HIV Behavioral Surveillance System (NHBS)
- Ending the HIV Epidemic (EHE) Jurisdictions

Substance Abuse and Mental Health Services Administration (SAMHSA)

- Center for Substance Abuse Treatment (CSAT)
- Center for Substance Abuse Prevention (CSAP)
- Harm Reduction Grant Program
- National Harm Reduction Technical Assistance Center

Health Resources & Services Administration (HRSA)

- Ryan White HIV/AIDS Program
- Bureau of Primary Health Care (supporting CHCs and mobile units)
- Special Projects of National Significance (SPNS) Initiative

Office of Infectious Disease and HIV/AIDS Policy (OIDP)

- Coordinates national HIV, Hepatitis, and STI strategies
- Supports integration of harm reduction into federal health initiatives

Academic Research Centers Supporting Community-Based Outreach

These universities conduct implementation research, evaluation, and technical assistance similar to the original CA program's mission:

- Johns Hopkins Bloomberg School of Public Health — Center for Drug Use & HIV/HCV Research (CDUHR)
- New York University (NYU) School of Global Public Health — Center for Opioid Epidemiology & Policy
- Brown University School of Public Health — People, Place & Health Collective
- University of California San Francisco (UCSF) — HIV & Harm Reduction Research Program
- Yale School of Medicine — Program in Addiction Medicine
- University of Washington — HIV/STI/Hepatitis Research Network
- Boston University School of Public Health — Center for Health Law, Ethics & Human Rights

National Harm-Reduction & Community-Based Organizations

These organizations now provide the frontline outreach, training, and implementation support that the original CA sites once conducted:

National Harm Reduction Coalition (NHRC)

- Training and technical assistance
- Safer-use education
- National policy advocacy

North American Syringe Exchange Network (NASEN)

- Supplies & logistics for SSPs
- Harm reduction education
- Community-based capacity building

National Alliance of State & Territorial AIDS Directors (NASTAD)

- Drug user health programs
- Syringe service program (SSP) support
- Integration of HIV, hepatitis, and overdose strategies

Urban Survivors Union (USU)

- National drug user union
- Peer-led research and community organizing

AIDS United — Harm Reduction Programs

- Grantmaking
- SSP capacity-building
- Overdose prevention leadership

The National Council for Mental Wellbeing

- Integrates harm reduction and behavioral health
- Supports CHCs and community-based providers

Community-Based Implementation Partners (Representative Examples)

(These reflect the types of organizations—rather than fixed sites—that replicate the role of the original CA program.)

- Syringe service programs (SSPs)
- Mobile outreach and mobile health units
- Federally Qualified Health Centers (FQHCs)
- LGBTQ+ community health centers
- Homeless health programs
- Street outreach teams and peer networks
- Medication for Opioid Use Disorder (MOUD) providers
- HIV/HCV community testing organizations
- Overdose prevention outreach teams
- County and municipal health departments

Appendix A: Post Test and Evaluation for HIV and Other Blood-Borne Infections in Drug Users

Directions: To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEU Matrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions. Then, submit your test to us for processing. This can be done in the following manner: Submit your test via the Internet. All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions found at the end of this appendix. Then, return to your browser and go to the Student Center located at:

<http://www.ceumatrix.com/studentcenter>

Once there, log in as a Returning Customer using your Email Address and Password. Then click on ‘View Lesson Quiz’ and you will be presented with the electronic exam.

To take the exam, simply select from the choices of "a" through "e" for each multiple-choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded, and you will receive your results immediately. If your score is 80% or greater, you will receive a link to the course evaluation. You will also receive a link to the Certificate of Completion. This is the final step in the process, and you may save and / or print your Certificate of Completion.

If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

NOTE: THE EXAM QUESTIONS AND /OR ANSWERS MAY BE IN A DIFFERENT ORDER IN THE ONLINE EXAM

Answer the following questions by selecting the most appropriate response.

Chapter 1

1. Community-based HIV risk-reduction efforts target _____ drug users.
 - a. in-treatment
 - b. pre-treatment
 - c. out-of-treatment
 - d. outpatient treatment
 - e. post-treatment

2. Intervention activities draw on principles of HIV prevention, communications theory, and _____ theory.
 - a. cognitive behavior
 - b. health transaction
 - c. psychosocial
 - d. ABCD
 - e. health behavior

3. Appropriately designed preventive programs can reduce not only HIV transmission, but also hepatitis _____ and _____.
 - a. B, C
 - b. A, B
 - c. C, D
 - d. D, E
 - e. A, C

4. _____ outreach workers have been shown to be particularly effective agents of behavior change.
 - a. In-culture
 - b. Indigent
 - c. Ingenuous
 - d. Indigenous
 - e. Ingenious

5. Risk-reduction information is _____ to achieve and maintain behavior change.
 - a. necessary but not efficient
 - b. necessary and sufficient
 - c. necessary but not sufficient
 - d. not necessary and not sufficient
 - e. sufficient but not necessary

6. The _____ program was implemented and designed to further advance knowledge gained in the _____ program.
- RADR, ACA
 - CA, NADR
 - ACC I, ACC II
 - AC, NODR
 - CCR, COR
7. The distribution of materials to facilitate risk reduction includes _____ kits.
- CPR
 - testing
 - UA
 - first aid
 - bleach
8. Drug users may be difficult to reach because illegal drug use is a highly _____ activity.
- stereotyped
 - invisible
 - romanticized
 - cultish
 - stigmatized
9. Drug addiction is a chronic disorder and _____ occurs frequently.
- death
 - relapse
 - a miracle
 - recovery
 - stonewalling
10. The hierarchy of risk-reduction strategies for injection drug users has _____ strategies or levels.
- 6
 - 5
 - 4
 - 3
 - 2

Chapter 2

11. The two interrelated components of the community-based outreach model includes _____ sessions of counseling in the second component.
- 6
 - 5
 - 4
 - 3
 - 2
12. The counseling sessions are designed to occur _____ HIV testing.
- before
 - after
 - away from
 - during
 - before and after
13. The community-based outreach program is designed to _____.
- complement other strategies
 - offer referrals for HIV testing
 - offer referrals for HIV prevention
 - offer referrals for access to sterile syringes
 - all of the above

Chapter 3

14. The specific out-of-treatment populations to whom preventive efforts are directed vary on the basis of _____ seroprevalence.
- HIV/AIDS
 - HBV
 - HCV
 - all of the above
 - none of the above
15. The major drawback of conducting sessions in office-based settings is the needed effort to maintain _____.
- access
 - confidentiality
 - ethics
 - safety
 - noise levels

16. The outreach model features _____sessions.
- a. large group
 - b. small group
 - c. individual
 - d. family
 - e. couples

Chapter 4

17. Personal experience with drug use by outreach staff is _____.
- a. prohibited
 - b. helpful but not required
 - c. not helpful and not required
 - d. required
 - e. risky
18. Members of the local community many times are uniquely qualified to recognize _____barriers.
- a. psychic
 - b. outcome
 - c. process
 - d. content
 - e. contextual
19. One of the abilities needed for outreach workers is the ability to recognize and maintain personal _____.
- a. wellness
 - b. safety
 - c. contacts
 - d. hygiene
 - e. boundaries
20. There are _____desirable characteristics of community-based outreach workers.
- a. 10
 - b. 9
 - c. 8
 - d. 7
 - e. 6

21. The ability to adhere to guidelines or a program is the personal characteristic of _____.
- discipleship
 - conformity
 - discipline
 - integrity
 - concreteness
22. Outreach workers often work _____.
- alone
 - undercover
 - in pairs
 - in groups of three
 - teams of four
23. The community-based outreach model includes _____ core activities workers seek to accomplish during an initial contact.
- 7
 - 6
 - 5
 - 4
 - 3
24. Next to abstinence, the next safest method for reducing sexual risk is avoiding _____ sex.
- group
 - same sex partner
 - cyber
 - penetrative
 - non-penetrative
25. Add-on services might include:
- couples counseling
 - syringe exchange
 - community events
 - all of the above
 - none of the above

26. It is highly desirable for community-based outreach workers to engage at-risk drug users in _____ conversations.
- clandestine
 - multiple
 - two way
 - one way
 - probing
27. Which of the following is not a tool for maximizing the impact of interactions with individuals at risk?
- role-playing
 - praise
 - confrontation
 - reflecting
 - summarizing

Chapter 5

28. A set of _____ cue cards is provided to guide Sessions I and II.
- 10
 - 24
 - 12
 - 18
 - 16
29. Which of the following materials is not needed to conduct Session I ?
- condom
 - lubricant
 - needle hygiene kit
 - demonstration syringe
 - tourniquet
30. Card 3 provides basic information about _____.
- HBV
 - HIV
 - HCV
 - proper techniques for cleaning equipment
 - none of the above
31. To be effective, all contaminated surfaces must be exposed _____ to full-strength bleach for at least _____ each time.
- three times, 60 seconds
 - twice, 30 seconds
 - twice, two minutes
 - once, 45 seconds

e. once, 2 minutes

32. Used injection equipment should be considered as _____.
- a. biochemical byproduct
 - b. harmless waste
 - c. trash
 - d. hazardous waste
 - e. biodegradable

33. The hierarchy for understanding sexual risk should be explained in terms of _____ risk.
- relative
 - absolute
 - total
 - minimal
 - varying
34. Card 12 introduces _____.
- the male condom
 - the use of lubricant
 - suggestions for talking about safer sex with partners
 - cutting condoms
 - the female condom
35. Card 13 introduces _____.
- the male condom
 - the use of lubricant
 - suggestions for talking about safer sex with partners
 - cutting condoms
 - the female condom
36. Despite the benefits, the interventionist must assure the participants that antibody testing is _____.
- flawed
 - dangerous
 - involuntary
 - risky
 - voluntary
37. If referred for testing, the participant should be notified that he or she may be required to sign (a)an _____ form.
- NIDA-A
 - NADR
 - HIV Disclaimer
 - informed consent
 - notification of next of kin

Chapter 6

38. Session II should be held within _____ after the scheduled HIV, HBV, or HCV test.
- 12 weeks
 - 10 weeks
 - 6 weeks
 - 8 weeks
 - 9 months
39. Which of the following would not be included in the materials for Session II ?
- cup with clean rinse water
 - empty cup
 - demonstration syringe
 - lubricant
 - container with full-strength alcohol
40. Card 23 contains recommendations for minimizing _____ damage.
- liver
 - kidney
 - heart
 - colon
 - lung
41. _____ may be needed when a participant has been informed that he or she has tested positive.
- Valium
 - CPR
 - Crisis intervention
 - Police
 - Restraints
42. The number of possible combinations of results from HIV, HBV, and HCV testing is _____.
- 8
 - 7
 - 6
 - 5
 - 4

43. There is a window of about _____ months before a test registers positive because of the slow development of antibodies after infection.

- a. 6
- b. 3
- c. 10
- d. 8
- e. 12

44. Card 24 presents issues concerning _____ notification.

- a. doctor
- b. partner
- c. minister
- d. probation officer
- e. court

Chapter 7

45. _____ community-based outreach takes place is just as important as _____ is conducted .

- a. What, what
- b. Why, why it
- c. When, why it
- d. When, where it
- e. What, why it

46. If former drug users are hired, it is considered prudent to require a minimum _____ year period of abstinence.

- a. 6
- b. 5
- c. 4
- d. 3
- e. 2

47. _____ forms can be helpful for monitoring community-based outreach activities.

- a. Contact
- b. Death
- c. Incarceration
- d. Funeral
- e. Homeless shelter

Chapter 8

48. Outreach training typically includes _____ phases.
- a. 6
 - b. 5
 - c. 4
 - d. 3
 - e. 2
49. Community outreach workers should spend at least _____ weeks in designated sites with a senior outreach person.
- a. 2
 - b. 3
 - c. 4
 - d. 5
 - e. 6
50. Using the same personnel for outreach activities and counseling/education is _____.
- a. mildly discouraged
 - b. strongly recommended
 - c. strongly discouraged
 - d. mildly recommended
 - e. uncharted territory

CEU Matrix – The Institute for Addiction and Criminal Justice Studies Course Evaluation

The final step in the process required to obtain your course certificate is to complete this course evaluation. These evaluations are used to assist us in making sure that the course content meets the needs and expectations of our students. Please fill in the information completely and include any comments in the spaces provided. If you submit your evaluation online, you do not need to return this form.

NAME:

COURSE TITLE:

DATE:

<u>COURSE CONTENT</u>		
Information presented met the goals and objectives stated for this course	<input type="checkbox"/> Start Over <input type="checkbox"/> Good <input type="checkbox"/> Excellent	<input type="checkbox"/> Needs work <input type="checkbox"/> Very Good
Information was relevant	<input type="checkbox"/> Start Over <input type="checkbox"/> Good <input type="checkbox"/> Excellent	<input type="checkbox"/> Needs work <input type="checkbox"/> Very Good
Information was interesting	<input type="checkbox"/> Start Over <input type="checkbox"/> Good <input type="checkbox"/> Excellent	<input type="checkbox"/> Needs work <input type="checkbox"/> Very Good
Information will be useful in my work	<input type="checkbox"/> Start Over <input type="checkbox"/> Good <input type="checkbox"/> Excellent	<input type="checkbox"/> Needs work <input type="checkbox"/> Very Good

Format of course was clear	<input type="checkbox"/> Start Over <input type="checkbox"/> Good <input type="checkbox"/> Excellent	<input type="checkbox"/> Needs work <input type="checkbox"/> Very Good
POST TEST		
Questions covered course materials	<input type="checkbox"/> Start Over <input type="checkbox"/> Good <input type="checkbox"/> Excellent	<input type="checkbox"/> Needs work <input type="checkbox"/> Very Good
Questions were clear	<input type="checkbox"/> Start Over <input type="checkbox"/> Good <input type="checkbox"/> Excellent	<input type="checkbox"/> Needs work <input type="checkbox"/> Very Good
Answer sheet was easy to use	<input type="checkbox"/> Start Over <input type="checkbox"/> Good <input type="checkbox"/> Excellent	<input type="checkbox"/> Needs work <input type="checkbox"/> Very Good
COURSE MECHANICS		
Course materials were well organized	<input type="checkbox"/> Start Over <input type="checkbox"/> Good <input type="checkbox"/> Excellent	<input type="checkbox"/> Needs work <input type="checkbox"/> Very Good
Materials were received in a timely manner	<input type="checkbox"/> Start Over <input type="checkbox"/> Good <input type="checkbox"/> Excellent	<input type="checkbox"/> Needs work <input type="checkbox"/> Very Good
Cost of course was reasonable	<input type="checkbox"/> Start Over <input type="checkbox"/> Good <input type="checkbox"/> Excellent	<input type="checkbox"/> Needs work <input type="checkbox"/> Very Good
OVERALL RATING		

<p>I give this distance learning course an overall rating of:</p>	<input type="checkbox"/> Start Over <input type="checkbox"/> Needs work <input type="checkbox"/> Good <input type="checkbox"/> Very Good <input type="checkbox"/> Excellent
<p>FEEDBACK</p>	
<p>How did you hear about CEU Matrix?</p>	<input type="checkbox"/> Web Search Engine <input type="checkbox"/> Mailing <input type="checkbox"/> Telephone Contact <input type="checkbox"/> E-mail posting <input type="checkbox"/> Other Linkage <input type="checkbox"/> FMS Advertisement <input type="checkbox"/> Other: .
<p>What I liked BEST about this course:</p>	
<p>I would suggest the following IMPROVEMENTS:</p>	
<p>Please tell us how long it took you to complete the course, post-test and evaluation:</p>	<p># of minutes were spent on this course.</p>
<p>Other COMMENTS:</p>	