

# RESPECT

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## DESCRIPTION

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RESPECT is a 2-session, individual-level intervention for HIV-negative women and men. This client-focused counseling model was designed to assess clients' risk for HIV, enhance clients' perception of personal risk and work with clients to develop a risk reduction plan. The researchers also believe that the RESPECT model can be effective for persons living with HIV to assist in reducing transmission to others. RESPECT can be used as a stand-alone intervention or integrated into other HIV prevention interventions such as HIV Counseling, Testing, and Referral (CTR) or Comprehensive Risk Counseling and Services (CRCS).

RESPECT has been packaged by CDC's Diffusion of Effective Behavioral Interventions (DEBI) project. Information on training and related materials on the intervention is available at [www.effectiveinterventions.org](http://www.effectiveinterventions.org).

### Goals

RESPECT aims to reduce clients' high-risk behaviors and prevent HIV (and STD) acquisition and transmission.

### How It Works

RESPECT is intended to 1) heighten clients' awareness of their personal risk for HIV through the use of "teachable moments," and 2) support clients in developing a realistic and achievable plan to reduce their risk behaviors. Teachable moments are situations or circumstances that can create an opportunity for behavior change. During the sessions, counselors may discover that there is inconsistency between a client's beliefs and behaviors. When pointed out, this inconsistency may result in an internal conflict (i.e., emotional discomfort), which is also called cognitive dissonance. The RESPECT model relies heavily on these concepts.

Using a structured protocol, the counselor engages in an interactive, one-on-one conversation with the client. In the first session, the counselor conducts a risk assessment, asks questions to better understand the context of the client's high-risk behaviors, addresses contradictions between the client's beliefs and behaviors, guides the client in developing a risk-reduction strategy, and offers referrals for services to support the client in attaining his/her risk-reduction goal. In the second session, the counselor delivers the HIV test result (if a test was given, such as in a CTR setting), follows up with the client to gauge progress toward meeting their risk-reduction objective, works with the client on developing a long-term risk-reduction plan, and provides additional referrals (as needed). Although the original RESPECT model was used with standard HIV-testing, RESPECT can also be used with rapid testing.

### Theory behind the Intervention

Two theories undergird RESPECT—the Health Belief Model and Social Cognitive Theory. However, the Theory of Reasoned Action and the Transtheoretical Model also play important roles in this intervention.

The ***Health Belief Model*** is a framework that explains and predicts health behaviors by focusing on the extent to which individuals perceive themselves to be at risk for a particular condition or disease. According to this model, behavior is guided by individuals' perceived susceptibility of acquiring a health condition, perceived severity of the health condition, perceived benefits of engaging in risk-reduction activities, and perceived barriers to engaging in risk-reduction activities. Individuals will be motivated to change their behaviors if they believe that the benefits of doing so outweigh the consequences of not changing their behavior. The Health Belief Model is used in RESPECT to increase a client's perception of his/her personal risk for HIV and encourage risk-reduction behaviors through the development of a realistic risk-reduction plan, followed by incremental steps to achieve it.

***Social Cognitive Theory*** posits that behavior is acquired and maintained through a reciprocal relationship between personal factors (e.g., cognitions and emotions), the environment, and aspects of the behavior itself. Key tenets of this theory are 1) that individuals will be more likely to change their behavior if they foresee positive outcomes resulting from the change, 2) that behavior change can occur via vicarious learning (i.e., observing the behavior of others), and 3) that in order to change behavior, individuals need to believe in their ability to do so (i.e., self-efficacy). Drawing on Social Cognitive Theory, RESPECT counselors help clients build the skills and self-confidence to implement a risk-reduction strategy. In addition, this theory can be used to help the client explore friends' and family members' beliefs and determine who in their life would be supportive of their plan.

According to the ***Theory of Reasoned Action***, behavior change is influenced by one's individual beliefs, attitudes, and intentions to engage in a behavior. During the two RESPECT sessions, the counselor explores with clients how their decisions to engage in risk behaviors are influenced by their attitudes and beliefs. Because a person's intention to engage in a behavior is believed to be a key determinant in whether the person will ultimately change the behavior, the RESPECT counselor gets a commitment from the client to take the first step toward a larger risk-reduction plan in the first session. The plan is written on an appointment card so that the client has a written reminder of a return appointment as well as the plan he or she has developed and agreed to attempt. This theory also addresses the influence of one's peers on an individual's behavior, so RESPECT counselors gauge the client's perceptions of what his/her peers believe and do.

The ***Transtheoretical Model*** (also known as Stages of Change) presents five stages of behavior change: precontemplation, contemplation, preparation, action, maintenance. Although some individuals go through the five stages in a linear fashion, it is expected that some individuals will relapse before being able to maintain their new behavior successfully. The Transtheoretical Model plays a smaller, but important,

role in RESPECT, and it is used to assess the readiness of a client to commit to risk-reduction behaviors. Since not all clients are ready or willing to develop a risk-reduction plan, counselors should ensure that they assess where their clients are on the continuum before proceeding with the development of a plan.

### **Research Findings**

The efficacy of RESPECT was assessed in a multicenter randomized controlled trial with 5,758 HIV-negative heterosexual persons aged 14 and older who visited an STD clinic.<sup>1</sup>

Three interventions were compared in the Project RESPECT study:

1. Brief RESPECT counseling consisting of 2 sessions that totaled 40 minutes;
2. Enhanced RESPECT counseling consisting of 4 sessions that totaled 200 minutes; and
3. Brief educational messages consisting of 2 sessions that totaled 10 minutes, which was the standard practice at the time.

Compared with participants in the educational messages intervention, participants in the 2- and 4-session RESPECT interventions had lower STD incidences and higher self-reported 100% condom use up to 12 months after participating in the interventions. Because research demonstrated that participants in the 2-session RESPECT counseling model achieved similar results as those in the 4-session model, CDC has packaged the 2-session model as a DEBI to make it more feasible for agencies to implement this intervention.

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## **CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES**

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### **Core Elements**

Core elements are critical components of an intervention's conceptualization and design that are believed to be responsible for the intervention's effectiveness. These core elements are derived from the behavioral theories upon which the intervention is based.

**Core elements are essential and cannot be ignored, added to, or changed, in order to maintain intervention fidelity and intent.**

RESPECT has the following 5 core elements:

- Conduct one-on-one counseling, using the RESPECT protocol prompts.
- Utilize a “teachable moment” to motivate clients to change risk-taking behaviors.
- Explore circumstances and context of a recent risk behavior to increase perception of susceptibility.
- Negotiate an achievable step that supports the larger risk-reduction goal.
- Implement and maintain quality assurance procedures.

### **Key Characteristics**

Key characteristics are those parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the CBO or target population.

RESPECT has the following key characteristics:

- Conduct sessions using open-ended questions, prompting the client to engage actively in the discussion.
- Allow the *client* to identify an achievable risk-reduction step.
- Engage in role-plays with the client to increase the client's self-efficacy to engage in risk-reduction behaviors.
- Provide referrals based on the client's self-identified needs.
- Modify the time needed to complete all of the protocol components, taking cues from client needs and agency requirements.
- Provide on-site conventional HIV testing, which will allow the client to attempt to implement the risk-reduction step between sessions. When implemented in non-HIV testing settings, it is recommended that a second session be scheduled for purposes of following up on the attempt to implement a plan.

## **Procedures**

Procedures are detailed descriptions of some of the above-listed elements and characteristics. Procedures for RESPECT are as follows:

### **Engaging in client-focused counseling**

Many clients are knowledgeable about the ways in which HIV can be transmitted, but they do not perceive their own behaviors as risky. Therefore, during client-focused counseling, it is important to focus specifically on what places the client at risk, rather than provide general HIV education. Using the protocol guides or counselor cards, the counselor should engage in an interactive conversation with the client to 1) determine what behaviors place the client at risk for HIV (or STDs), 2) use a "teachable moment" to increase the client's concern about his/her personal HIV risk, and 3) develop a strategy to reduce identified risks.

***Note:** Client-focused HIV prevention counseling should not be confused with Carl Rogers' client-centered approach to counseling, which allows the client to guide the direction of the counseling session. In RESPECT, the counselor guides the flow of the session using a structured protocol with open-ended questions and other counseling techniques to ensure active engagement of the client.*

The following components should be addressed in each of the RESPECT sessions:

### **Session 1 Stages**

- Stage 1: Introduce and orient the client to the session.
- Stage 2: Enhance the client's sense of self-risk.
- Stage 3: Explore the specifics of the most recent risk incidence.
- Stage 4: Review previous risk-reduction experiences.
- Stage 5: Summarize the risk incident and risk patterns.
- Stage 6: Negotiate a risk-reduction step.
- Stage 7: Identify sources of support and provide referrals.
- Stage 8: Close the session.

## **Session 2 Stages**

Stage 1: Frame the session and orient client.

Stage 2: (Give result)

Stage 3: Review the risk-reduction step.

Stage 4: Revise the risk-reduction step.

Stage 5: Identify sources of support.

Stage 6: Provide referral.

Stage 7: Close the session.

The main elements of Session 2 will be the same regardless of setting. The primary difference in a test setting will be providing the result at the beginning of the session.

## **Developing a risk-reduction plan**

One of the main objectives of the first session is to enhance the client's perception of his/her risk. Once the client views himself/herself at risk, the counselor works with the client to develop a risk-reduction step that the client can attempt before the next session. Ultimately, this step will lead to a larger behavioral goal. It is important that the counselor allow the client to identify the behavior to change rather than choosing the behavior for the client. This will allow the client to have ownership over the risk-reduction plan and will increase the likelihood that the new behavior will be adopted.

Some clients may choose an unrealistic goal that may be beyond their reach. The counselor should break the long-term goal into smaller steps and work with the client to select one of the incremental steps. Together, the client and counselor should anticipate and problem-solve any potential barriers that may arise so that the client can readily overcome these obstacles. In addition, skills and strengths identified from previous risk-reduction attempts are acknowledged and built upon to facilitate future attempts. The counselor should make sure that the client is committed to trying the step and feels confident in his/her ability to implement the step before leaving the session. Finally, the counselor should write the step down on paper for the client to refer to after the session. In subsequent sessions, the client builds on his/her initial risk-reduction step to develop a long-term plan of behavior change.

**Making referrals.** During the RESPECT sessions, counselors may discover that clients need additional support in initiating and maintaining their behavior change. Counselors may recognize areas of concern to which the client is not attuned. The counselor should make sure that the client is amenable to the referrals, prioritizing them according to the needs most expressed by the client. In addition, the counselor should be cognizant of not overwhelming the client with too many referrals. Examples of appropriate referrals include the following:

- Alcohol and drug treatment programs
- Crisis intervention hotlines
- Emergency food sources
- Family planning clinics
- Financial assistance sources

- Free health care clinics (for persons without insurance)
- HIV treatment specialists
- Housing programs
- Legal aid sources
- Mental health professionals
- Services for sexually or physically abused persons
- Support groups and intensive HIV prevention intervention organizations
- Transportation programs

Counselors should not assume that clients will be able to access these services on their own. Therefore, they should provide as much information and assistance as possible to ensure that clients will follow-through on the referral (often called an *active* referral). It may be helpful for the counselor to phone the service provider for the client. If possible, the counselor should provide the following information about the referral agency:

- Name of the provider or agency
- Range of services provided
- Target population(s)
- Service area(s)
- Contact name, telephone and fax numbers, street address, e-mail address, and web site
- Directions, transportation information, and accessibility to public transportation
- Hours of operation
- Cost for services
- Eligibility criteria
- Application materials
- Admission policies and procedures
- Competence in providing services appropriate to the client's culture, language, gender, sexual orientation, age, and developmental level
- Previous clients' satisfaction with services

### **Delivering the HIV test result (if applicable)**

Before the session, the counselor should confirm that the HIV test result belongs to the client. In addition, the counselor should be emotionally prepared to handle the potential emotions or reactions that could arise during the session, especially if the result is positive. After welcoming the client back, the counselor should state the result in a clear and simple manner. It is important to provide the result at the beginning of the session so as not to prolong any anxiety that the client may be experiencing.

If the result is negative, the counselor should explain that the result means that the client was not infected as of 3 months ago, but that the test would not cover all recent risk exposures. It may identify some but not all new infections. The counselor should work with the client on developing a long-term risk-reduction plan that builds on the risk-reduction step selected in the first session. The counselor should also explore the client's reaction to the result, determine whether the client needs to be retested based on recent risk behavior, and provide any necessary referrals.

If the result is positive, the counselor should allow the client time to process the meaning of the result. In a supportive manner, the counselor should note how the client is coping with the news and address any questions the client may have. It is important that the counselor assess the client's wellness strategy (for both emotional and physical health) and access to health care. If the client is emotionally ready to explore risk-reduction issues, the counselor should help the client to devise a plan to reduce the risk of transmission to current and future partners. Regardless, it is important for the counselor to validate the client's feelings and make sure that the client is ready to end the session. The counselor should ask the client what his/her next steps are, while at the same time not pressuring the client to make any major decisions that are not urgent. It may be helpful to the client to discuss who he/she will be seeing in the near future and how he/she will handle the situation. Finally, the counselor should summarize the key issues that were discussed in the session and encourage the client to call if he/she has any questions or concerns. The counselor might ask the client for contact information so that he/she can follow up in the next few days. The counselor should end the session by exploring what services the client might need and providing the appropriate referrals.

*Note: The above process will be different when using RESPECT in conjunction with rapid testing because Sessions 1 and 2 will be conducted on the same day. Therefore, the client will likely not be able to practice the risk-reduction step that was agreed upon in Session 1.*

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## ADAPTING

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RESPECT can be used in various settings where individuals are at high behavioral risk for HIV. In the original study, RESPECT was found to be effective with HIV-negative heterosexual women and men whose main risk for HIV was through sexual transmission. However, the intervention can be used with populations who have other risk factors such as injection drug use. RESPECT can also be used with HIV-positive persons to prevent transmission of HIV or acquisition of an STD. In addition, RESPECT was found to be highly effective with younger persons, so an agency might adapt RESPECT for use with adolescents. Finally, although the original RESPECT model was used with standard HIV-testing, RESPECT can also be used with rapid testing, although researchers found that the latter might be slightly less effective with men.<sup>2</sup>

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## RESOURCE REQUIREMENTS

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### People

RESPECT requires paid or volunteer staff members or experienced mental health professionals who are trained in the RESPECT counseling model, general counseling principles, fundamentals of HIV prevention counseling, and their local organizational requirements for HIV CTR and related interventions. The number of RESPECT counselors depends on the demand for counseling and testing in the agency. However, because RESPECT is an individual-level intervention, only one counselor is needed per

session. In addition, at least one supervisor who is trained and skilled in the RESPECT counseling model and is able to provide ongoing support, guidance and quality assurance is required.

### **Space**

RESPECT needs space that is private and secure so that confidentiality can be assured.

### **Supplies**

The RESPECT package includes the implementation manual, counselor cards, protocol script cards, risk-reduction step forms, a training video, and quality assurance recommendations and forms. In addition to these materials, RESPECT also requires a referral resource guide that should be compiled by the agency implementing RESPECT.

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## **RECRUITMENT**

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RESPECT originally targeted persons who visited a public STD clinic. Often individuals self-refer for counseling and testing because they are concerned about their risk for HIV (or STDs). The following are additional recruitment strategies that can be used to reach clients for RESPECT:

- Recruit HIV-positive and high-risk HIV-negative persons to encourage people in their social networks to participate in RESPECT.
- Recruit from other agencies that serve high-risk populations, such as substance abuse treatment facilities or homeless shelters.
- Recruit from, or integrate into, other HIV prevention services such as CRCS.
- Recruit high-risk adolescents who are receiving services through other agencies.

Review the Recruitment section of the Procedural Guidance document to choose a recruitment strategy that will work in the setting in which the CBO plans to implement RESPECT.

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## **POLICIES AND STANDARDS**

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Before a CBO attempts to implement RESPECT, the following policies and standards should be in place to protect clients, the CBO, and the RESPECT intervention team:

### **Confidentiality**

A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from the client or his or her legal guardian must be obtained.

### **Cultural Competence**

CBOs must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of their communities. CBOs should

hire, promote, and train all staff to be representative of and sensitive to these different cultures. In addition, they should offer materials and services in the preferred language of clients, if possible, or make translation available, if appropriate. CBOs should facilitate community and client involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, which should be used as a guide for ensuring cultural competence in programs and services. (Please see Ensuring Cultural Competence in the Introduction of these guidelines for standards for developing culturally and linguistically competent programs and services.)

### **Data Security**

To ensure data security and client confidentiality, data must be collected and reported according to CDC requirements.

### **Informed Consent**

CBOs must have a consent form that carefully and clearly explains (in appropriate language) the CBO's responsibility and the client's rights. Individual state laws apply to consent procedures for minors; but at a minimum, consent should be obtained from each client and, if appropriate, a legal guardian if the client is a minor or unable to give legal consent. Participation must always be voluntary, and documentation of this informed consent must be maintained in the client's record.

### **Legal and Ethical Policies**

If agencies offer HIV testing with RESPECT, clients will learn their HIV status when they return for their test results. CBOs must know their state laws regarding disclosure of HIV status to sex partners and needle-sharing partners. CBOs are obligated to inform clients of the organization's responsibilities if a client receives a positive HIV test result and the organization's potential duty to warn. CBOs also must inform clients about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.

### **Referrals**

CBOs must be prepared to refer clients as needed. For clients who need additional assistance in decreasing risk behavior, providers must know about referral sources for prevention interventions and counseling, such as comprehensive risk counseling and services, partner counseling and referral services, and other health department and CBO prevention programs.

### **Volunteers**

If the CBO uses volunteers to assist with or conduct this intervention, the CBO should know and disclose how their liability insurance and workers' compensation applies to volunteers. CBOs must ensure that volunteers also receive the same training and are held to the same performance standards as employees. All training should be documented. CBOs must also ensure that volunteers sign and adhere to a confidentiality statement.

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## QUALITY ASSURANCE

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Quality assurance is an ongoing process that ensures that counselors maintain fidelity to the core elements of the intervention.<sup>3</sup> The following quality assurance activities should be in place when implementing RESPECT:

### **Counselors and Supervisors**

#### **Training**

Both counselors and supervisors should participate in training and continuing education to ensure that they have the requisite skills to implement RESPECT successfully. In addition to training on RESPECT, training on the following topics is recommended:

- Assuring Quality Assurance of HIV Prevention Counseling
- Counseling, Testing, and Referral
- Fundamentals of HIV Prevention Counseling
- HIV 101

Information about RESPECT training can be found at [www.effectiveinterventions.org](http://www.effectiveinterventions.org). Information on other training offered by CDC and our partners can be found on the Training Events Calendar at [www.cdc.gov/hiv/topics/cba/index.htm](http://www.cdc.gov/hiv/topics/cba/index.htm).

#### **Session Observation**

The supervisor should observe the counseling sessions to ensure that counselors are consistently adhering to the RESPECT protocol and are providing high-quality counseling. These observations may be done in person, or the counselor might video- or audiotape the session for later review by the supervisor or peer-review groups. Before observing the session, the counselor must obtain the consent of the client.

It is recommended that a new counselor be observed by a supervisor once a week. As counselors become more experienced in using RESPECT, the frequency of observations can decrease. A counselor with 6–12 months' experience might be observed once a month, whereas a counselor with 1 year of experience might be observed once every 6 months. The counselor and supervisor should debrief after each observation.

#### **Record Review**

Records should be reviewed regularly to ensure that counseling sessions are documented consistently and correctly. The following information might be documented:

- Process and outcome data requirements
- Main risks and circumstances related to client's most recent risk incident
- Date of most recent risk incident
- Risk-reduction step
- Referrals and rationale for the referrals

#### **Case Conferences**

Case conferences are an ideal opportunity for counselors and supervisors to obtain support from and provide constructive feedback to other staff in the agency. During case conferences, the counselors and supervisors can present challenging sessions, practice using the RESPECT materials, and discuss strategies for better serving their clients. Peer role-playing can be a useful strategy during these meetings.

### **Clients**

RESPECT staff should administer client satisfaction surveys to clients at each session. These anonymous surveys can be used to assess clients' satisfaction with the overall counseling experience, session components (e.g., negotiating a risk-reduction step), and counselor characteristics (e.g., display of empathy). Clients should also be given the opportunity to offer suggestions on how to improve the sessions.

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## **MONITORING AND EVALUATION**

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Specific guidance on the collection and reporting of program information, client-level data, and the program performance indicators will be distributed to agencies after notification of award.

General monitoring and evaluation reporting requirements for the programs listed in the procedural guidance will include the collection of standardized process and outcome measures. Specific data reporting requirements will be provided to agencies after notification of award. For their convenience, grantees may utilize PEMS software for data management and reporting. PEMS is a national data reporting system that includes a standardized set of HIV prevention data variables, web-based software for data entry and management. CDC will also provide data collection and evaluation guidance and training and PEMS implementation support services.

Funded agencies will be required to enter, manage, and submit data to CDC by using PEMS or other software that transmits data to CDC according to data requirements. Furthermore, agencies may be requested to collaborate with CDC in the implementation of special studies designed to assess the effect of HIV prevention activities on at-risk populations.

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## **KEY ARTICLES AND RESOURCES**

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2. Metcalf CA, Douglas JM, Malotte CK, Cross H, Dillon BA, Paul SM, Padilla SM, Brookes LC, Lindsey CA, Byers RH, Peterman TA, for the RESPECT-2 Study Group. Relative efficacy of prevention counseling with rapid and standard HIV testing: A randomized, controlled trial (RESPECT-2). *Sexually Transmitted Diseases*. 2005;32:130–138.
3. Kamb ML, Dillon BA, Fishbein M, Willis KL, for the Project RESPECT Study Group. Quality assurance of HIV prevention counseling in a multi-center randomized controlled trial. *Public Health Reports* 1996;111:99–107.

