CLEAR:
Choosing Life: Empowerment, Action, Results!

Participant Workbook
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Participant Agenda

DAY ONE

❖ Introductions & Training Overview
❖ Introduction to CRCS
❖ Introduction to CLEAR
❖ Social Action Theory
❖ Cognitive-Behavioral Techniques & CLEAR Core Elements

DAY TWO

❖ Review/Preview
❖ Assessment and Prevention Plan
❖ Core Skill Session 1
❖ Core Skill Session 2
❖ Knowledge, Skills, and Traits of a Counselor

DAY THREE

❖ Review/Preview
❖ Core Skill Session 3
❖ Core Skill Session 4
❖ Core Skill Session 5
❖ Adjourn

DAY FOUR

❖ Review/Preview
❖ Overview of Menu Sessions & Key Concepts
❖ Menu Sessions: A Closer Look
❖ Integrating CLEAR into CRCS
❖ Module 18: Closure and Evaluations
Definition of CRCS

An Introduction to CRCS:

CRCS is intensive, individualized, client-centered counseling for adopting and maintaining HIV risk reduction behaviors. CRCS is designed for HIV-positive and HIV-negative individuals (and even those of unknown serostatus) who are at high risk for acquiring or transmitting HIV and STIs and struggle with issues such as substance use and abuse, physical and mental health, and cultural factors that affect HIV risk. The ultimate goal of the CRCS program is to enact behavior changes or modifications that will reduce the risk of HIV transmission or acquisition.

For people who are HIV-positive, psychosocial challenges such as depression or mental illness, substance use, or homelessness may adversely affect their ability to obtain medical care, adhere to HIV/AIDS treatment, and reduce risk behaviors. Some HIV-negative people also experience challenging life circumstances that leave them unable to prioritize risk reduction. A client with an urgent need for housing, food, or treatment for substance use may find risk reduction difficult.

Often through less intensive prevention interventions, we find that certain clients need more intensive attention to risk reduction challenges. CRCS provides highly individualized, structured, intensive one-on-one risk-reduction counseling and support. Assessment plays a large role in the CRCS process as the primary method for gathering information about risk behavior and factors. This information is used to develop a prevention plan through which the client and counselor work to set behavioral goals and objectives. Their work will allow them to examine behaviors, factors, and contexts. All of these can impact clients’ health and ability to change HIV-related risk-taking behavior.
Who is CRCS’s Priority Population?

“High-risk” is the first priority for identifying appropriate CRCS clients. CRCS is intended for those high-risk clients where other less intensive interventions have not been or are not likely to be successful in supporting risk-reducing behavior change. How an agency defines high risk varies. It may depend on a funder’s definitions, state prioritization or target populations, local epidemiological data, needs assessments, or any of a number of sources. It is important to acknowledge that working one-on-one with a client over an extended period of time often is not expensive. Individuals do not all have the same prevention needs, and since there are many interventions and programs that currently exist, agencies need to be sure that appropriate clients are in the appropriate programs. Therefore, the CRCS counselor should spend time with those clients who are going to benefit the most from the program – those who are high risk, are facing multiple life issues, are having difficulty maintaining or enacting risk reduction, and who have expressed some degree of commitment to participating in ongoing risk-reduction counseling.

For HIV positive people, CRCS may involve the coordination of traditional case management, if those services exist, but should only include providing case management services when the client does not have access to those services elsewhere. Services, such as Ryan White CARE Act case management, are designed to provide direct services around medical care and physical wellness to people living with HIV (and in some cases, their families). CRCS should not duplicate these services; it is focused on risk reduction and behaviors.

It can be easy to think that CRCS is a form of psychotherapy or that it leans to the other end of the spectrum – traditional case management. It is neither. Psychotherapy deals with mental or emotional disorders. If a client exhibits these symptoms, a referral should be made to a mental health professional. It is not the role of the CRCS counselor to solve these deeply rooted psychological issues. They can easily become bogged down in a client’s needs and contextual factors (finding housing, acquiring food, helping with employment, etc.). While these may be important, and may even play a role in a person’s risk-taking behavior, a CRCS counselor should refer these issues and focus his/her time together on aspects of the behavior and the behavior change.
CRCS Core Elements

Core Elements are those parts of an intervention that must be done and cannot be changed. Core Elements are essential and cannot be ignored, added to, or changed.

CRCS for Persons Living with HIV has the following 7 core elements:

1. Develop a client recruitment and engagement strategy.
2. Screen and assess clients to identify those who are at highest risk and appropriate for CRCS.
3. Develop a written, client-centered prevention plan.
5. Actively coordinate services with follow-up. To avoid duplication of services, prevention counselors should not provide case management services to the extent that they are already provided by existing case management systems.
6. Monitor and reassess clients’ needs, risks, and progress and revise prevention plans accordingly.
7. Discharge clients from CRCS once they attain and maintain their risk-reduction goals. Agencies should establish protocols to classify clients as “active,” “inactive,” or “discharged,” and outline the minimum active effort required to retain clients.

CRCS for Uninfected Persons at Very High Risk for HIV has the following 7 core elements:

1. Develop a client recruitment and engagement strategy.
2. Identify clients who are at highest risk and appropriate for CRCS (screening and assessment).
3. Develop a written, client-centered prevention plan.
4. Provide multiple HIV-risk-reduction counseling sessions
5. Actively coordinate services with follow-up.
6. Monitor and reassess clients’ needs, risks, and progress and revise prevention plans accordingly.
7. Discharge clients from CRCS once they attain and maintain their risk-reduction goals. Agencies should establish protocols to classify clients as “active,” “inactive,” or “discharged,” and outline the minimum active effort required to retain clients.
CRCS Procedure Flowchart

Recruitment
  ↓
Engaging
  ↓
Eligibility Screening
  ↓
Not Eligible
  →
Enrollment
  ↓
Assessment
  ↓
Prevention Planning
  ↓
Risk Reduction Counseling
  ↓
Monitoring & Reassessment
  ↓
Discharge
  ↓
Coordination of Services & Referrals
  ↓
Maintenance
  ↓
Referral
  ↓
Not Eligible
  →
Continuum of Cultural Competence

CONTINUUM OF CULTURAL COMPETENCE

Cultural Proficiency

Cultural proficiency involves holding cultural differences and diversity in the highest esteem, pro-activity regarding cultural differences, and promotion of improved cultural relations among diverse groups.

Cultural Competence

Cultural competence involves actively seeking advice and consultation and a commitment to incorporating new knowledge and experiences into a wider range of practice.

Cultural Pre-competence

Cultural pre-competence encourages learning and understanding of new ideas to improve performance or services.

Cultural Blindness

Cultural blindness fosters an assumption that people are all basically alike, so what works with members of one culture should work within all other cultures.

Cultural Incapacity

Cultural incapacity supports the concept of separate but equal; marked by an inability to deal personally with multiple approaches but a willingness to accept their existence elsewhere.

Cultural Destructiveness

Cultural destructiveness acknowledges only one way of being and purposefully denies or outlaws any other cultural approaches.

Core Skill Session 1: Getting to Know Each Other (Assessment)

Core Skill Session 2: Creating a Vision for the Future (Assessment)

Core Skill Session 3: Stressors & SMART Problem-Solving (Assessment)

Core Skill Session 4: Exploring Different Types of Communication (Assessment)

Core Skill Session 5: Putting it all Together (Assessment & Prevention)

Menu Sessions (6 Domains, 21 Sessions)

- Sexual Risk (6 sessions)
- Adherence (3 sessions)
- Substance Use Risk (5 sessions)
- Disclosure (2 sessions)
- Health/Self Care (3 sessions)
- Stigma (2 sessions)

Final Session
Wrap it up! How do I maintain the changes I’ve made?
Client is recruited

Client is screened (preliminary assessment by referral source) and introduced to CLEAR

Yes, Client is eligible

Core Skill Session 1: Getting to Know Each Other (Assessment)
Core Skill Session 2: Creating A Vision For The Future (Assessment)
Core Skill Session 3: Stressors and SMART Problem-Solving (Assessment)
Core Skill Session 4: Exploring Different Types of Communication (Assessment)
Core Skill Session 5: Putting It All Together (Assessment & Prevention Plan)

Menu Sessions Optional (21 Sessions)

Sexual Risk (6 Sessions)
Adherence (3 Sessions)
Substance Use Risk (5 Sessions)
Disclosure (2 Sessions)
Health Care & Self-Care (3 Sessions)
Stigma (2 Sessions)

Final Session: Wrap Up! How Do I Maintain The Changes I’ve Made?

Post Assessment
Tom’s Weight-Loss Plan

Refer to your slides to fill in the blanks.

Tom has done a lot of research on losing weight. So let’s assume that he has adequate _______________ _______________ and _______________.

When he makes his meals at home and has a pretty routine day, he has confidence in his ability to follow through on his plan. But there are some situations where he’s not as confident. (What do we call this? ______-__________.)

Tom recognizes that it’ll be hard to sacrifice some things that he’s used to (e.g., chocolate cake), but if he sticks to his plan, he knows he’ll lose weight. Knowing that he will lose weight is known as what?

____________________________

He’s told all his friends his plans and he’s asked them to support him. He’s noticed that his friends have shown a range of responses to his plans. Some have been very supportive, but others have criticized Tom for being too superficial. In addition, a couple of friends have acted offended, as if Tom is hinting that they should lose weight, too. Depending on the reaction he gets from his friends, Tom is able to approach the subject in different ways and resist pressure to alter his plans. By doing so, he has demonstrated his ______________. _______________.

Tom’s weight loss plan includes daily affirmations to encourage him and a daily weigh-in to stay on track. This is an example of _______-__________ ________.

For every week that he sticks to his plan he has decided to ______________ himself with a special treat.

So, it looks like Tom’s weight-loss plan is off to a good start.
Feeling Thermometer

100  Extremely Uncomfortable
75   Very Uncomfortable
50   Somewhat Uncomfortable
25   Mildly Uncomfortable
0    Not at All Uncomfortable

CLEAR
Choosing Life! Empowerment! Action! Results!
# F-T-D Grid

<table>
<thead>
<tr>
<th>Situation</th>
<th>Thermometer Reading</th>
<th>Physical Sensations</th>
<th>Thoughts</th>
<th>Actions</th>
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Possible Ideal Self Characteristics

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<tr>
<td>Responsible</td>
<td>Calm</td>
<td>Financially Secure</td>
<td>Thoughtful</td>
</tr>
</tbody>
</table>
My Ideal Self

1.

2.

3.

4.

5.
GUIDELINES FOR GOOD WEEKLY GOALS

• Important to you, and you are committed to it.

• Realistic. Not too hard or not too easy.

• Brief, specific and clearly stated.

• Easy to tell when you have accomplished it.
SMART Problem-Solving Steps

S = State the problem.

M = Make a goal.

A = Actions – list the actions you might take.

R = Reach a decision about which actions you could take.

T = Try it and review it.
Life Goals: What is Important to Me!

Under each category, write your goals. You can have more than one goal in each category.

**Education** (ex: Get my GED; Get my B.A. or A.A. degree; Get a training certificate):

**Work** (ex: keep one job for a long time or work as a nurse):

**Relationship with Others:**
- **Partner:** (ex: find a partner who accepts my HIV, be with a partner who does not hit me or verbally put me down):
- **Friends:** (ex: find friends that will support the positive changes I want to make in my life):
- **Family:** (ex: share my HIV status with family members that I think can emotionally support me)
- **Others:** (ex: health care provider):

**Achievements** (ex: learn to drive or play an instrument):

**Feeling Good About Myself** (ex: exercising or keeping a healthy diet):

**Other:**
Goal Log – Core Skill Session 1

Date: ________________________________________________

Short-term Session Goal: __________________________________________
________________________________________________________________
________________________________________________________________

What went well? _________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

What would you have done differently? ______________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

Goal Log – Core Skill Sessions 2-5

Date: _____________________________

Short-term Session Goal: ______________________________________________________
___________________________________________________________________________
___________________________________________________________________________

What went well? _____________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

What would you have done differently? _______________________________________
___________________________________________________________________________
___________________________________________________________________________

My life goal is: _____________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Short-term Session Goal: ____________________________________________________
___________________________________________________________________________
___________________________________________________________________________

What went well? _____________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

What would you have done differently? _______________________________________
___________________________________________________________________________
___________________________________________________________________________
SMART Problem-Solving Guidelines

Step 1: **S** = State the problem

Is the problem stated clearly? (Writing it down will help you define it clearly.)

Is it complete?

What’s your read on the Feeling Thermometer when you think about the problem?

Step 2: **M** = Make a goal

Exactly what do you want to accomplish? What do you want to change from the way it is now?

Is the goal stated clearly?

Is it specific, so you can for sure tell when you have achieved it? (Again, writing it down will help.)

Are you sure this is the goal you want? Can you make a commitment to working on it?

Step 3: **A** = Actions - List the Actions You Might Take To Achieve the Goal

Are these all of the actions you could reasonably take that would achieve your goal?

Is each action stated clearly?

Do the actions specify just one thing to do, as opposed to several things at the same time?

Does each action describe something you will do, as opposed to how you will feel or think? (It’s best to have at least three actions to choose from if possible.)
Step 4: \textbf{R} = Reach a decision about which actions you could take

Have you picked the best course of action, the one with the most pros and the fewest cons?

How will you get the skills that you need, if you don’t have them already?

How will you get the resources that you need, if you don’t have them already?

Are there any additional skills or resources that you will need to be successful? (Anything that is not a skill can be considered a resource. People can be a resource; time can be a resource; money can be a resource; objects and materials can be resources.)

What is going to be your plan for taking the action? What are the specific steps?

What things can get in the way of taking this action and being successful with it? Is there anything you know about for sure that will make it difficult? Is there anything that might go wrong?

What are your plans for dealing with these barriers, so they don’t keep you from taking the action you want to?

Step 5: \textbf{T} = Try it and review it

Did the action work out as you expected?

Were you successful in taking your action? Completely? Partly?

Would you do anything differently if you were starting again?

Did the action you took achieve the goal you wanted to accomplish? Completely? Partly?

Do you need to make a new plan in order to be successful in taking this action?

Do you need to find a new action that will move you forward toward achieving your goal?
Applying SMART Problem-Solving

Step 1: **S** = State the problem

___________________________________________________________________________
___________________________________________________________________________

Step 2: **M** = Make a goal

__________________________________________________________________
__________________________________________________________________

Step 3: **A** = Actions - List the Actions You Might Take To Achieve the Goal

• ___________________________________________________________________
  • ___________________________________________________________________
  • ___________________________________________________________________
  • ___________________________________________________________________

Step 4: **R** = Reach a decision about which actions you could take

• What’s the best course of action, the one with the most pros and the fewest cons?

• Are there any additional skills or resources that you will need to be successful? (Anything that is not a skill can be considered a resource. People can be a resource; time can be a resource; money can be a resource; objects and materials can be resources.)

• What are your plans for dealing with these barriers, so they don’t keep you from taking the action you want to?

Step 5: **T** = Try it and review it

• Did the action work out as you expected?

• Were you successful in taking your action? Completely? Partly?

• Would you do anything differently if you were starting again?
CLEAR
SMART Problem Solving
Client Scenario - Roberto

Roberto is 27 years old. He attends a community college and takes several classes which require a great deal of work. He also has a part-time job at a local youth service organization, which often takes up a lot more time than his required hours. He has very little time to clean or organize his apartment so things are a little messy. Roberto’s life goal is to be healthy and physically fit but he can’t find the time to go to the gym.

He set a goal that he will go to the gym once during the past week. He got to the gym and realized that he did not have his ID card and they would not let him in. His Feeling Thermometer was very high, at an 85, and he stormed out of the gym and went home.
In Session One, Sonya says that she hopes CLEAR will help her take better care of herself and that she will become healthier. She also mentions that she’s tired because she partied the night before.

In Session Two, she shares that her life goals include getting a better doctor and keeping her partner safe.

In Session Three, while discussing stressors, she talks about arguments she has with her partner when she mentions condoms.

In Session Four, during the discussion about communication, she shares that she does not feel like her doctor hears what she has to say.

And in Session Five, she tells you that she has been able to quit smoking.
Prevention Goals

Under each category write your goals. You can have more than one goal under a category.

**Sex:**
(examples: I want to lower my discomfort about condoms, I want to refuse unsafe sex)

**Substance Use:**
(examples: I want to stop shooting up, I want to say no to my friends who influence me to use)

**Health Care and Self Care:**
(examples: I want to exercise, I want to eat more healthily, I want to keep all my healthcare appointments, I want to better advocate for my health)

**Adherence:**
(examples: I want to be able to talk to my doctor about my medication side effects, I want to be 100% medication adherent)

**Disclosure:**
(examples: I want to feel more confident about making disclosure decisions, I want to know some tips for making a disclosure in the best possible way)

**Stigma:**
(examples: I want to better cope with HIV stigma, I want to know my rights when it comes to discrimination against persons with HIV)
Individual Prevention Plan

Use one sheet per prevention goal. Make photocopies of this sheet as necessary.

Client Name:__________________________ Client ID#___________________

Long-term Prevention Goal # _______
Date Developed:_____________________

<table>
<thead>
<tr>
<th>Short-Term Weekly Goal Set During Each Session</th>
<th>Goal Accomplished</th>
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Goal Accomplished!

Client’s Signature:______________________________________________________
Date:_____________________________

Prevention Counselor’s Signature:_________________________________________
Date:_____________________________
The Structure of CLEAR

Five Core Skill Sessions
(All CLEAR participants complete these sessions.)

Session 1: Getting to Know Each Other
Session 2: Creating a Vision for the Future
Session 3: Stressors and SMART Problem-Solving
Session 4: Exploring Different Types of Communication
Session 5: Putting it All Together

Other CLEAR Components
(CLEAR participants complete these components as needed.)

Sexual Risk – Multiple sessions on: Why I Have Unsafe Sex, How to Use a Condom, Influencing a Partner to Use a Condom, Safe Sex, Refusing Unsafe Sex, Deciding when to Disclose HIV Status, and How to Tell your Sex Partner.

Substance Use Risk - Multiple sessions on: Setting a Foundation for Change, Discovering your Internal and External Drug and Alcohol Triggers, Reaching your Goals around Injection Drug Use, and the Relationships Between Drugs, Alcohol, and HV.

Health Care and Self Care - Multiple sessions on: Motivating to Stay Healthy, Attending your Health Care Appointments, and Partnering in your Health Care.

Adherence - Multiple sessions on: The Effects of HIV Medications, Challenges to Taking your Medications, and Achieving Perfect Medication Adherence.

Disclosure – Multiple sessions on Disclosure.

Stigma – Multiple sessions on Stigma.

Wrap-Up!
(All CLEAR participants complete this session.)

How Do I Maintain the Changes I Have Made?
Session Observations

Core Elements Taught or Reviewed:

1. Development of emotional awareness through use of a *Feeling Thermometer* and identification of the link between feelings, thoughts, and actions.

2. Identification of one's Ideal Self to help motivate and personalize behavior change.

3. Teaching, modeling, and practicing Short and Long-Term Goal-setting.

4. Teaching, modeling, and practicing SMART Problem-Solving.

5. Teaching, modeling, and practicing Assertive Behavior and Communication.

Cognitive Behavioral Techniques Taught or Reviewed:

CLEAR Thinking:

- Positive Self-Talk
- Reframing
- Arguing against negative thoughts
- Other
## Possible Ideal Self Characteristics

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My Ideal Self

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COUNSELOR RESPONSIBILITIES

Five Key Counselor Responsibilities:

1) Delivering the intervention with fidelity;
2) Creating buy-in from the client;
3) Establishing and maintaining effective boundaries;
4) Understanding assessment and prevention issues, and;
5) Utilizing client-centered skills.

Additional Counselor Responsibilities

a. **Solid understanding of intervention.** Counselors need to become very familiar with the content of the intervention.

b. **Use script as written; Once comfortable, use own words.** Until counselors feel confident with the intervention content, using the script as written is encouraged. Once counselors become comfortable with the intervention, they can summarize the material in their own words, making sure to use language consistent with the target population and including all the main points. Writing session notes on index cards is recommended. However, the use of index cards and summarizing should only be undertaken if counselors have practiced the sessions multiple times and feel very comfortable with the intervention content.

c. **Manage operation of session.** Counselors are responsible for managing the operation of the session. This means:
   a. being familiar with the material beforehand
   b. being on time and staying on time
   c. being prepared and having all materials ready for the session and organized so that they can access them when they need them
   d. communicating enthusiasm, optimism and belief in the intervention
   e. providing the knowledge needed
   f. being a good role model
   g. being empathetic

d. **Teach, model & integrate CLEAR core elements.** Counselors are responsible for teaching, modeling, and integrating the Core Elements of CLEAR which are intended to help clients practice new and healthy ways of thinking, feeling and acting.
e. **Create concern about risky behaviors.** Counselors are responsible for creating concern in clients about unsafe sexual and substance-use behaviors, other forms of unhealthy behavior and lack of adherence to health-promoting behavior, and involvement in risky situations and with risky partners. The key is to do this in a way that is supportive and non-judgmental.

f. **Balancing the needs of client with structure of the sessions.**
Maintaining a balance between engaging the client and establishing realistic expectations is crucial.

g. **Engaging client & establishing realistic expectations.** Assessing client’s expectations and addressing the goals of CLEAR during this initial activity is essential to creating a safe and honest environment where the client and the counselor are both clear on expectations for upcoming sessions.

h. **Creating buy-in from client.** How does CLEAR apply to client’s life? How to make prevention goals meaningful to client’s life.

i. **Clarifying misconceptions about CLEAR.** It is important for counselors to clarify any misconceptions the client may have about CLEAR. Do not assume that the client “knows” what to expect (i.e., some clients may assume that CLEAR is one on one therapy where they can talk about “whatever” is on their mind). This is an opportunity for the counselor to clarify any misconceptions about the client-counselor relationship as well as topics covered during the sessions. For example, the counselor may explain the limitations of the client-counselor relationship (i.e., counselor is not a therapist or a case manager.) In addition, the counselor may emphasize that while the sessions are client-centered, each session contains specific topics that need to be addressed. Therefore, the counselor may take the lead in redirecting the client to the session topics. ‘Client-centered’ means tailoring the intervention to focus on the individual client’s HIV prevention needs, but it does not mean that the client gets to do whatever they want. The CLEAR counselor will guide the sessions so that risk reduction is the primary focus, keeping the client’s particular challenges and needs in mind.
j. **Be client-centered.** Be supportive and non-judgmental. Build on the client’s strengths.

k. **Be comfortable talking about sensitive topics (sex, drug use, sexual orientation)**

l. **Create a safe and welcoming environment.**

m. **Build on client’s strengths.** Affirm participant’s strengths and resiliencies whenever possible.

n. **Don’t have to be an expert and have all the answers.** Counselors don’t have to be an expert and have all the answers. It’s OK to say, “I don’t know.” If this is the case, find the answer (if there is one) and get back to them.

o. **Share limited personal information.** When tempted to share personal information, ask yourself: Is this clearly helpful to the client? Is it directly relevant to the topic or skill being learned? Is there time? Does the content involve material I am comfortable having most people know? If the answer to any one of these questions is “no,” don’t share the information. Even if all answers are “yes,” the counselor should ask him/herself, “Is this about me or the client?” Counselors are recommended to be VERY conservative in their personal disclosures.

p. **Be culturally competent**

q. **Be aware of own comfort level, skills and limits**

r. **Have knowledge of population** (PLWH, at-risk youth, etc.)
Applying SMART Problem-Solving

Step 1: **S** = State the problem

___________________________________________________________________________
___________________________________________________________________________

Step 2: **M** = Make a goal

___________________________________________________________________________

Step 3: **A** = Actions - List the Actions You Might Take To Achieve the Goal

• _________________________________________________________________________
• _________________________________________________________________________
• _________________________________________________________________________
• _________________________________________________________________________

Step 4: **R** = Reach a decision about which actions you could take

• What’s the best course of action, the one with the most pros and the fewest cons?

• Are there any additional skills or resources that you will need to be successful? (Anything that is not a skill can be considered a resource. People can be a resource; time can be a resource; money can be a resource; objects and materials can be resources.)

• What are your plans for dealing with these barriers, so they don’t keep you from taking the action you want to?

Step 5: **T** = Try it and review it

• Did the action work out as you expected?

• Were you successful in taking your action? Completely? Partly?

• Would you do anything differently if you were starting again?
Assertive Communication

My Ideal Feeling Thermometer Range: __________

I. The first component of assertive communication is “What to Say.”
   1. Use “I” statements.
      • Put your comments in terms of “I want” or “I need.”
      • DO NOT use “you should.”
   2. State what you need.
      • Let the other person know what you want them to do.
      • Avoid misunderstandings.
      • Don’t assume another person can read your mind.

II. The second component of assertive communication is “How to Say It.”
   1. Say something positive.
      • It puts people in a better frame of mind.
      • They won’t be defensive.
   2. Listen to the other person and show you understand.
      • It helps when others think you can put yourself in their shoes.
      • It can change your own point of view.
   3. Provide information they need to know.
      • You may know more about what is important to you than they do.
      • Tell them what you think is important and give them the information they want.
   4. State your feelings in a non-hostile way.
      • If a conversation is not going well with another person, name the feeling, communicate it, and explain it.
      • Anger usually comes when you are feeling uncomfortable – more than a reading of 60 on the Feeling Thermometer. Try to communicate the feelings that you may be experiencing, such as frustration, hurt, rejection, fear, or anxiety, when your Feeling Thermometer reading is still low.
      • When a person’s Feeling Thermometer reading is over 60 and he or she is feeling angry, it is common for that person to end up attacking the other person and communicating a blaming message.

Your interactions will go more smoothly if you communicate the feelings before they become too uncomfortable, and before they lead to anger.
Core Skill Session 4: Activity 4 Worksheet

1. What will be the situation in the client's life where they could stand up for their own needs while being respectful and concerned about the needs of the other person?

2. What specific goals does the client have for this situation?

3. What characteristics of the client's Ideal Self should they keep in mind during this situation?

4. Observer Feedback:
Substance Use Weekly Schedule (Example)

- What did you use and how much?
- Where did you use?
- Who were you with when you used?

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:00 Go to work</td>
<td>1:00 Housing application due</td>
<td>10:00 Go to work</td>
<td>9:30 Dr. Greene</td>
<td>10:00 Go to work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7:00 Dinner</td>
<td>3:30 CLEAR</td>
<td>6:30 Work out</td>
<td>10:30 Pick up medications</td>
<td>6:30 Work out</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:30 Meet Chris</td>
<td>5:00 Meet mom for dinner</td>
<td>8:00 Dinner</td>
<td>11:30 Food bank</td>
<td>11:00 M’s party</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:30 Go to bed early</td>
<td>9:00 Go to bed early</td>
<td>1:00 Work out</td>
<td>10:00 Go to work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>6:30 Work out</td>
<td>6:30 Work out</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>11:00 M’s party</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Vodka – 3 shots
  - At home
  - Alone

- Beer – 2 cans
  - At home
  - Alone

- Ecstasy – 2 pills at home with Mike
- Ecstasy – 1 pill at the club with Mike
- Pot – 5 hits at home with Mike
- Pot – 5 hits at the club with Mike

- X
## What are the Pros and Cons of My Substance Use?

<table>
<thead>
<tr>
<th></th>
<th>Pros</th>
<th>Cons</th>
<th>Feeling Thermometer Reading</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often do I use?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Each time I use, how much do I use?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How do I use?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Who do I use with?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Where do I usually use?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What I like about this substance</th>
<th>My concerns and dislikes about this substance</th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

Substance: ________________________________
How often do I use? ________________________________
Each time I use, how much do I use? ________________________________
How do I use? ________________________________
Who do I use with? ________________________________
Where do I usually use? ________________________________
Methods for Recruiting

A constant source or supply of clients is the life blood of a CRCS program. Believe it or not, an agency can run out of clients. Recruitment is a process to assure a constant supply of clients. There are many methods for recruiting potential CRCS clients. Methods vary based upon the agency, the target population, and the available resources. Four potentially valuable resources are:

**Outreach**
Street or community based intervention where peer level, community congruent workers interact with community members for prevention purposes. Workers are trained to locate and build trust with high-risk individuals who are less likely to access services. Outreach workers connect individuals with needed services. They may also provide other interventions such as education, counseling, or testing.

**Social networking**
This is a strategy of using natural social networks and individuals who are members of high-risk populations. Index clients are used to locate and gain access to other members of the same high-risk populations. The index client acts as an envoy. The purpose of social networking is to broaden access to high risk individuals and the areas in which they congregate. The goal is that they will become familiar with and utilize services.

**Disease investigation**
Gaining access to high risk clients by using existing disease tracking systems such as disease surveillance, HIV testing, and partner notification. These systems are capable of identifying who is becoming infected and to whom the disease is spreading. In addition, these systems can pinpoint locales of epidemiological significance. The locales can then become the target areas for outreach purposes.

**Referral systems development**
Developing interagency relationships where clients from one agency are always referred to the partner-agency depending upon the type and nature of needed services. The agencies involved do not provide the same or similar but complimentary services. The agencies together comprise a holistic and support services system. Information is often shared between agencies by formal agreement or contract and in accordance with confidential laws. Many CRCS counselors partner with Ryan White care providers, infectious disease clinics, probation, and courts systems for referrals. They also may partner with local resources, substance abuse treatment centers, mental health services, social services, churches, and shelters for outgoing referrals. In addition, larger agencies can consider what type of intra-agency referrals could serve as referrals for CRCS.
Legal and Ethical Standards

Legal vs. Ethical

How is Law defined?
Law establishes minimum standards of action and behavior based upon custom or practice of a community. Laws proscribe choices or actions and their consequences.

How are Ethics defined?
Ethics typically define the highest or ideal standard of choice or action in response to a set of conditions or circumstances.

Legal vs. Ethical
How you respond to and work with client situations should be based on and influenced by standards and the law. However, the CRCS counselor should not have to rely on his or her individual, personal ethics, or moral interpretations when working with clients. Sometimes difficult decisions must be made.

- Can a person work for an agency whose policies are in opposition? Or should (s)he?
- Can a CRCS counselor support a client in conduct that she sincerely believes is wrong?
- What does the CRCS counselor do when the law and personal or professional ethics are in conflict?

The agency is responsible for providing clear ethical standards by which the CRCS counselor and other prevention workers must govern their behavior and attitudes.

HIV/AIDS is a sexually transmitted infection (STI), but it has been treated very differently than other STIs. The disease brings with it many important ethical dilemmas for professionals working in the field of HIV/AIDS prevention. There is no cure and in some communities it still carries enormous stigma. Ethics in HIV prevention is a subject that is often overlooked.

Even the best guidelines are not always clear. Systems should be in place to resolve ethical dilemmas.
Topics for Legal/Ethical Consideration:

**Confidentiality/Privacy:** Organizations must have well-established policies and procedures for handling and maintaining HIV-related confidential information that conforms to necessary laws, including HIPAA regulations.

**Voluntary and Informed Consent:** A client’s participation must always be voluntary and with the client’s informed consent.

**Cultural Competence:** Organizations must make every effort to uphold a high standard for cultural competence.

**Professional Ethics:** CRCS must be governed by the same general professional ethics that govern most human service fields.

**Discharge Planning:** Organizations must make efforts to ensure that clients have received appropriate referrals and are adequately receiving needed services at time of discharge.

**Duty to Warn:** Organizations must be familiar with necessary procedures/requirements related to cautioning other individuals at risk or in physical danger.

**Questions to consider:**
- What is the standard for confidentiality at your agency?
- Who is responsible for maintaining confidentiality?
- How is confidentiality maintained at your agency?
- What are the specific requirements of confidentiality?
- How are records kept?
- What do your laws say about confidentiality?
- What is your agency’s policy for obtaining consent to treatment?
- What is the meaning of “informed consent”?
- What information must be given to a client before consenting to treatment?
- Under what circumstances will client information be released to legal officials or courts?
- What client situations or circumstances are you obligated to report to law enforcement?
- To whom are you legally obligated to report?
- What does your professional, ethical standards or licensing say about reporting?
- What do your laws say about voluntary and informed consent?
- From your agency’s viewpoint, how important is offering services that consider and support cultural differences to your clients?
- Can you ethically offer services to clients whose cultural needs are different from your agency’s?
• How culturally competent is your agency?
• How culturally competent are you?
• What attitudes and behaviors must you assume in order to deliver ethical services?
• When should you discuss discharge with the client?
• Under what conditions should discharge occur?
• What is “duty to warn”?
• Who has duty to warn?
• What is your agency’s policy regarding duty to warn?

Other questions and comments regarding ethics:
• When a “red flag” appears, look to your agency policy and procedures and consider your ethical stance.
• Where do you go with your questions regarding…?
• Where is your policy?
• How will you deal with the tough situations?
Quality Assurance

What is Quality Assurance?

Quality assurance is the collective term for all of the activities that are conducted to ensure that the CRCS program is delivered in a consistent and effective manner and in accordance with established standards. Having a supervisor observe the program to make sure that the core elements are present in the CRCS intervention is an example of a quality assurance measure.

Each agency should develop a tailored protocol describing their plan for implementation of CRCS. Your CRCS program should have written quality assurance protocols that are included in protocol manuals. In addition, your CRCS program should routinely use client feedback as a factor in assessing the quality of CRCS services.

Quality assurance activities or goals should include the following:

- Compliance with appropriate standards for certification of CRCS counselors.
- Small client caseloads – 12-20 clients per counselor; larger caseloads may be appropriate for CRCS counselors who are not providing case management services.
- Tailored implementation manual to ensure effective delivery of CRCS services and minimum standards of service delivery.
- Examples of quality assurance mechanisms include the following:
  - Written protocols
    - Descriptions of specific prevention counseling related activities, including client engagement, screening, risk-reduction counseling, etc.
  - Training
    - List of needed trainings for CRCS counselors, supervisors, and managers, along with the particular skills the staff will need to fulfill their job descriptions.
• **Supervision**
  - Regular review of each staff member’s performance, effectiveness in implementing CRCS, and quality of services. This should include direct observation when feasible.

• **Chart reviews**
  - At least quarterly reviews by a supervisor of each client’s case files (risk behavior and needs assessment, prevention plan, and progress notes) to monitor effectiveness of counseling and appropriate documentation.

• **Case conferencing and presentations**
  - Regular presentations of cases (case conferences), especially those that are complex or difficult, by CRCS counselors to peers, others who provide services to CRCS clients, and supervisors in order to invite suggestions and share experiences.

• **Client satisfaction surveys or interviews**
  - Routine feedback from clients about their satisfaction with the service and ideas for improvement.
Clinical Supervision

What Is It & Why Have It?

Supervision is the relationship between the supervisor and supervisee which promotes the development of responsibility, skill, knowledge, and ethical standards in the practice of social work. Supervision is a source of knowledge, expertise, and more advanced skills to the person being supervised. The nature of this relationship depends on the respective skills of the two professionals involved, the client population and/or the specific client being served. It is usually ongoing, required and hierarchical in nature. Clinical supervision occurs when there is close ongoing review and direction of a supervisee’s clinical practice. The reason for supervision is to ensure best practices with clients. It is a CRCS counselor’s most important professional relationship. It is a complex and skillful process that can be learned.

Reasons for Supervision

- For Professional growth, development and provide personal support. (This support should never turn into therapy for the supervisee)
- For quality assurance, quality improvement, and risk management.
- For statutory, administrative, or credentialing requirements.
- To ensure that the worker is clear about roles and responsibilities.
- To assist in identifying and managing stress in the worker’s professional role.
- To consider the resources the worker has available to do their job and manage issues arising where they are inadequate.

When the supervisor is contracted from outside of the agency, the supervisor should understand the agency’s mission, policies and procedures. The extent of responsibility of the supervisor for the supervisee needs to be clearly defined and delineated with agency personnel and the supervisee. It is suggested that not only a written agreement be in place but the agency should also have a clinical supervision policy. This reveals whether an agency or organization is serious or not about supervision. It also establishes and provides for the context and organizational culture to the supervision that is undertaken within. Such letters should include a statement of the purpose of clinical supervision, the format (individual, small group, face to face, direct observation, etc.), length, frequency and duration of the supervision. That client is informed of the name and how to contact the supervisor and the nature of the information being shared. The agreement should also include that records of documentation of the supervisory activities be kept, the fee agreement, ethical and practice standards principles be followed and information about the required reporting of unethical or illegal professional behavior as well as circumstances for discontinuing supervision.
Responsibilities of the CRCS Counselor

- Inform the supervisor of all contacts with clients in sufficient detail including what the client said and what the supervisee said.
- Discuss his/her cognitive, emotional, and behavioral reactions to clients and sessions.
- Keep records of dates and the content of the supervision, to include any direction given by the supervisor.
- Maintain records which document the reason for risk-reduction and other counseling, the plan for intervention, the progress made in risk reduction counseling, and the risk assessments and referrals or collaborations.
- Provide client consent and mandatory disclosure forms signed by client.
- On a regular basis provide feedback about the quality of the work provided by the supervisor.
- Inform the supervisor of any complaints or actions made against him/her.
- Maintain the highest standards of practice and ethical conduct.

Responsibilities of Supervisor

- To understand the agency’s mission, policy and procedures.
- Assure that it is the practice of any supervisee to provide the mandatory disclosure statement.
- Keep records that document supervision to meet the generally accepted standards of practice.
- Assure that clients are informed of change of supervisory relationship and that an adequate termination with both the supervisee and his/her clients is undertaken.
- Monitoring the supervisee’s activities to verify she/he is providing services that meet minimal standards.
- Assist the supervisee in becoming aware of and adhering to all legal, ethical, and professional responsibilities.
- Assuring that no conflicting relationship exists between the client and the CRCS counselor, the supervisor and supervisee, and supervisor and client.
- Have experience, training, and competence adequate to perform and direct services provided by the supervisee as well as appropriate knowledge, skills, and expertise in supervision.
Ethical and Legal Aspects of Supervision

No conflicting dual role relationships. Law and standards of practice prohibit one from supervising one’s own relatives, spouse, or domestic partner. This is for protection of the client based on a potential conflict of interest for the supervisor and between the supervisee and client.

The comprehensive risk counselor and the supervisor must protect the confidentiality of the client. So the supervisor has an ethical and legal responsibility to handle supervisory material in a confidential manner. Based upon good ethical standards it should be the supervisor’s practice to protect the privacy of the supervisee and to limit revelations about the supervisee to official business and with full knowledge of the supervisee.

The duty to report to the appropriate authorities: The supervisor has an ethical and legal responsibility to report direct knowledge of unethical or illegal conduct by a supervisee with attention to the confidentiality rights of the client.

Supervisees are held to the same standards of care and skill as their supervisors.

Liability occurs when harm is caused by the erroneous actions or omissions of the supervisor or supervisee in the planning, course or outcome of the work of the supervisee. The supervisee’s work must meet minimum expected standards of care, even if the supervisee is a student.

Qualifications of a Supervisor

- Should be more clinically advanced than the supervisee.
- Be a licensed mental health professional.
- Have at least three years post-masters direct service experience, and preferably five years post masters experience.
- Have experience with the supervisee’s client population, and methods of treatment.
- Have some formalized training in supervision, such as continuing education, reading, and/or consultation.
- Be affiliated with professional organizations, so that the supervisor is grounded in the field and the ethical standards of the profession.
- Participate in ongoing professional development, through reading, attending or presenting at professional workshops or seminars, participating in peer education/consultation groups, or writing of professional articles.
Components of CRCS, CLEAR and CRCS/CLEAR combined

CRCS + CLEAR
- Provide Case Management (linked with risk reduction)
- Provide 5 CLEAR core sessions
- (Optional: Provide 1 or more CLEAR menus)
- Provide CLEAR Wrap Up session

CLEAR only
- Provide 5 CLEAR core sessions
- (Optional: Provide 1 or more CLEAR menus)
- Provide CLEAR Wrap Up session

CRCS only
- Provide Case Management (linked with risk reduction)
- Provide Risk Reduction Counseling
Traditional case management services (housing, job, mental health, substance abuse, etc.) linked with risk reduction. For HIV+ Clients coordinate with Ryan White Case Manager.

Assessment (Formal)
- Core Session One
- Core Session Two
- Core Session Three
- Core Session Four
- Core Session Five (Prevention Plan)

No Menu selection
- Risk Reduction Counseling related to Prevention Plan and Core Sessions
- Risk Reduction Counseling

Menu Sessions
- Sexual Risk
- Substance Use
- Health Care & Self Care
- Adherence
- Disclosure
- Stigma

Wrap Up
- Maintenance
- Discharge

CRCS Only
- Prevention Plan
- Case Management, Referrals, Monitoring and Reassessment

Referral
- Not Eligible
- Eligible
CLEAR, CRCS or CLEAR/CRCS?

Please read the following scenarios and make the appropriate selection of services as well as the reason(s):

**Services Choices:**
- CLEAR
- CRCS
- CLEAR/CRCS
- Referral to Ryan White Case Mgmt
- None of these

**Scenario 1**
Carlos is HIV+ and homeless. During assessment, he states that he needs housing and linkage to care. During conversation he states that he is not interested in attending regular sessions.

*Answer:*
*Reason:*

**Scenario 2**
Bella is homeless and frequently “crashes” at a friend’s house. She tells you that in exchange for a place to stay, she often has to have unprotected sex with her friend. She is willing to attend regular sessions and to discuss a prevention plan.

*Answer:*
*Reason:*

**Scenario 3**
Victoria is a transgender M-F who is a commercial sex worker. She will have unprotected sex whenever a client is willing to pay more. She uses meth and cocaine during the weekend. She is willing to get help for her drug use and is willing to get risk reduction counseling. However, when you mention the five Core Skill Sessions, she tells you that you are crazy - there’s no way that she is willing to “talk” that much. However, she will do “something that is less structured.”

*Answer:*
*Reason:*

During one of the sessions with her CRCS case manager, Victoria states that she realizes that her drug use may be related to depression. She has accepted that perhaps her decision-making skills have not always been the best. She says that “Maybe those five Core Skill Sessions might not be so bad after all.”

*Answer:*
*Reason:*

Scenario 4: Malcolm is a MSM who is not “out” to his family. He loves to go to clubs and frequently takes home dates with whom he will have unprotected sex, if they ask. Malcolm wants to live a more “open” life but he also wants to be live to an old age. During assessment, it doesn’t appear that Malcolm has other risk factors and/or other emerging needs. He is agreeable to attending regular sessions and working on a prevention plan for reducing his sexual risk.

Answer:
Reason:

During Core Skills Session 3, Malcolm tells you he lost his job. He is asking for help with housing because he cannot pay his rent.

Answer:
Reason:

During Core Skill Session 4, Malcolm tells you that he has tested positive for HIV. He is very concerned about his health and asks you for help in finding a medical provider.

Answer:
Reason:

Summary:

A client may have a variety of needs that change over time. Even though a client may not be ready for CLEAR, he/she could benefit from enrolling in CRCS. Later, the client may be ready for CLEAR’s more structured sessions, or be ready to address issues of substance use, sexual risk, disclosure, etc. The most important thing is to work with the clients on issues that he/she determines are most important. You may also have a case in which client is enrolled in CLEAR/CRCS, but he/she tells you that he/she has tested positive for HIV. In that situation you keep the client with the CLEAR services, remove him/her from CRCS and make a referral to Ryan White Case Management.
Prevention for Substance-Using HIV-Positive Young People

Telephone and In-Person Delivery

Mary Jane Rotheram-Borus, PhD, Dallas Swendeman, MPH, W. Scott Comulada, MS, Robert E. Weiss, PhD, Martha Lee, PhD, and Marguerita Lightfoot, PhD

Summary: HIV risky behaviors and health practices were examined among young people living with HIV (YPLH) in Los Angeles, San Francisco, and New York over 15 months in response to receiving a preventive intervention. YPLH aged 16 to 29 years (n = 175; 26% black and 42% Latino; 69% gay men) were randomly assigned to a 3-module intervention totaling 18 sessions delivered by telephone, in person, or a delayed-intervention condition. Intention-to-treat analyses found that the in-person intervention resulted in a significantly higher proportion of sexual acts protected by condoms overall and with HIV-seronegative partners. Pre- and postanalyses of YPLH in the delayed-intervention condition alone found that YPLH tended to have fewer sexual partners, used fewer drugs, reported less emotional distress, and decreased their use of antiretroviral therapies. Prevention programs can be delivered in alternative formats while retaining efficacy. When YPLH are using hard drugs, drug treatment may be needed before delivery of preventive interventions.

Key Words: adolescents, intervention, HIV, HIV prevention, young people living with HIV

(J Acquir Immune Defic Syndr 2004;37:S68–S77)

Young people represent approximately 50% of all HIV infections worldwide and 18% of reported HIV cases in the United States. Nationally, approximately 110,000 young adults less than 23 years of age are living with HIV and 23% of HIV-infected persons are less than 30 years of age. Because the number of sexual partners and sexual activity is highest in late adolescence and early adulthood, it is critical to ensure that transmission acts are reduced among young people living with HIV (YPLH). The goal of this article is to examine the efficacy of an intervention to reduce transmission acts.

YPLH who do not change their sexual risk acts or injection drug use may infect others and become reinfected with new viral strains. Previous research with persons living with HIV indicates that at least one third of YPLH are likely to continue their transmission behaviors after learning their serostatus. The primary motivation to reduce transmission risk acts is altruism, although self-preservation may motivate some youth to avoid acquiring other sexually transmitted infections or to avoid becoming reinfected with drug-resistant strains of HIV. To motivate YPLH to reduce transmission for the public good, it is necessary to address the young people’s need to improve their physical health and mental health, especially their adherence to health regimens. Adherence to medical regimens is likely to extend the quality and length of life for YPLH. With an extended lifespan, there is also a greater likelihood that YPLH may relapse into transmission behaviors. Thus, to reduce sexual and substance use transmission acts of YPLH, an intervention that addressed the needs of the YPLH (receiving and adhering to medications and health regimens and improving mental health) and society (reducing sexual and substance use transmission acts) was evaluated.

We previously demonstrated that attending a 3-module intervention delivered in small groups, Teens Linked to Care, reduced unprotected sexual acts and drug use and improved physical health and mental health outcomes among YPLH—the same goals as the intervention in this study. For example, YPLH in the intervention condition reported 82% fewer unprotected sexual acts, 45% fewer sexual partners, 50% fewer HIV-negative sexual partners, and a 31% reduction in substance use compared with YPLH in a delayed condition. Health-related coping skills improved for young women living with HIV, and mental health symptoms were significantly reduced in the intervention compared with the delayed condition. The intervention was cost-effective in reducing new infections (Lee MB, Leibowitz H, Rotheram-Borus MJ, unpublished data).

After demonstrating that an intervention is efficacious, researchers typically replicate the same intervention design and content and often demand fidelity to the initial intervention delivery. The strategy of replication with fidelity does not allow us to develop guidelines for when and how to tailor the intervention to different market segments or to improve on the initial intervention. This study deviated from the traditional...
replication strategy. Three types of adaptations were made in the current trial.

First, although there were significant improvements associated with Teens Linked to Care, 30% of YPLH did not attend even 1 intervention session. There were several significant barriers to attending groups delivered in a small group setting. First, when arriving at a group meeting for HIV-positive persons, one’s serostatus is disclosed to 8 to 10 unfamiliar persons simultaneously. Fears may arise about disclosure. Second, the low rate of HIV detection among YPLH often led to a delay of several months organizing a group, even in urban AIDS epicenters. Third, there were so few YPLH that young gay men, women, and heterosexual men were combined within 1 group; yet, the issues were significantly different for each subpopulation. Finally, anticipating challenges related to efficacious interventions, we realized it would be necessary to tailor the delivery modalities so that persons in different life situations (ie, different market segments) would have an intervention acceptable to them. Therefore, we adapted our previous intervention to be delivered in modalities that are consistent with the existing case management models being implemented nationally with funding from the Ryan White CARE Act and Centers for Disease Control and Prevention.

Most existing prevention case management services are delivered in individual 1-on-1 counseling sessions. For persons who are too ill, live in rural settings, or are homeless, telephone interventions are seen as a viable alternative delivery format. Therefore, the Teens Linked to Care intervention, designed for small groups, was adapted to be delivered in individual sessions and on the telephone. The goals were the same (reducing sexual and substance use risk acts, improving physical health behaviors, and improving mental health), but the delivery format shifted.

Second, Teens Linked to Care was delivered in 10 to 12 sessions for each of 3 modules, reflecting each of the intervention’s goals (reducing transmission, improving physical health, and improving mental health). To be more feasible for replication, we reduced the number of sessions per module from 10 to 12 to 6 sessions per module.

Third, because drug use has been consistently associated with sexual risk acts, we focused this study on drug-using youth. Only YPLH who had engaged in drug use at least 5 times during the previous 3 months were eligible for enrollment (criteria were set from inspection of rates of substance use in our previous trial). Behavioral changes are achieved when the desired goals are clear, consumers are motivated to change, the situations that elicit risk acts are identified, and patterns of coping with future risk situations are planned and rehearsed to proceed in a different way. Building on an extensive qualitative study of YPLH and our earlier interventions, the situations that YPLH typically encounter were identified; these situations were different for young gay men, women, young adults, and adolescents, methamphetamine users, and injecting drug users. The in-person and telephone formats allowed us to tailor the situational contexts addressed in the intervention to the YPLH’s life challenges. The intervention then focused on helping YPLH to set goals; to become and remain motivated to change; and to plan and rehearse how to cope more effectively with situational challenges in sexual and substance use risk situations and medical care delivery settings and when using medications and experiencing negative emotional states. Situations in each domain were addressed for 6 sessions within each module, allowing rehearsal and planning several times in each domain.

To compare the cost-effectiveness of the in-person and telephone delivery formats with that of our previous study with YPLH in small groups, we monitored the costs of delivering each module of the intervention.

METHODS

Participants

Although it is estimated that there are 110,000 YPLH in the United States, fewer than 10% of these YPLH have been identified through HIV testing, and it is estimated that only 10% of the identified YPLH are linked to care. Therefore, recruitment is a challenge nationally for YPLH. The first strategy to recruit YPLH was via the major adolescent AIDS clinics in Los Angeles (Children’s Hospital and Los Angeles Gay and Lesbian Center) and New York (Montefiore Medical Center and Kings County Medical Center). When insufficient numbers of YPLH were enrolled, we expanded to a broad range of community-based sites (eg, Los Angeles Youth Network, Gay Men’s Health Crises) and sites in San Francisco, with some sites securing institutional review board approval and the remaining agreeing to comply with the University of California at Los Angeles’ Institutional Review Board requirements. We then expanded recruitment procedures to include solicitation in newspapers, conferences, and community events that were likely to be attended or read by YPLH. YPLH were currently receiving medical care at the recruitment site or were linked to ongoing care at the time of enrollment into the study.

From 1999 to 2002, 253 YPLH aged 16 to 29 (median = 23) years were recruited with voluntary informed consent in Los Angeles, San Francisco, and New York. Across cities, YPLH were recruited from 17 medical providers (n = 66), 21 social service agencies (n = 121), 2 needle exchange programs (n = 6), 1 drug treatment center (n = 4), 4 other research studies (n = 5), or outreach on the street or at special events (n = 15) as well as through newspaper advertisements (n = 12) and referrals from friends (n = 19). Ten young people contacted the study from unknown sources. Many young people attended more than 1 service site concurrently, and others moved to new service sites over the course of the study; therefore, there is not only 1 site identified for each participant. Although many
youth were part of a convenience sample, a consecutive series of youth were approached from each of the medical provider sites and social service treatment settings, allowing us to document 23 refusals. There were too few youth from any 1 site to make meaningful comparisons of youth recruited from different sites.

Parental consent was obtained for nonemancipated YPLH less than 18 years of age. All YPLH received an incentive of $20 to $25 per assessment.

In the previous intervention trial, significant numbers of YPLH did not engage in substance use at the assessment interview or over time. Because this study aimed at reducing transmission acts among substance users, we had an eligibility criterion of using illicit drugs at least 5 times in the last 3 months. A validity study of potential screening instruments to identify HIV-seropositive persons who engaged in risky acts demonstrated low reliability and validity; thus, a full 45-minute extended interview was the criterion to identify a valid response on sexual and substance use risk acts. Given these findings, each potential participant was initially recruited with voluntary consent for a baseline interview so as to assess eligibility. On the basis of the interview, YPLH were recruited for the intervention trial.

Eligibility rates varied across cities. In Los Angeles, 118 YPLH were recruited for the baseline assessment and 74% (n = 87) were eligible for participation. In New York, 68% (n = 68 of 100) of YPLH assessed were eligible, and 83% (n = 29 of 35) of YPLH were eligible in San Francisco. Fewer YPLH were recruited in San Francisco because this site was added a year later than the other cities. Of the 253 YPLH initially recruited, 72% (184 of 253) were eligible and 95% (176 of 184) were randomized into the trial. One baseline interview file was damaged, resulting in 175 participants.

Intervention

Similar across intervention delivery format (in-person or telephone sessions), 3 modules of 6 sessions each focused on a different target behavior: improving physical health, reducing sexual and substance use acts, and improving mental health. Module 1 focused on improving one’s physical health regimen, particularly utilization and adherence to antiretrovirals (ARVs). In addition, the module addressed coping with learning one’s serostatus, implementing new daily routines to stay healthy, issues of disclosure, and participation in health care decisions. Health care was addressed first to address the needs of the YPLH before asking for altruistic behaviors with sexual and drug-using partners.

Module 2 aimed to reduce unprotected sexual acts and substance use by asking YPLH to identify situations that are likely to elicit risky acts and to modify their patterns of substance use as well as increase their skills in condom use self-efficacy and negotiation skills. Disclosure of serostatus was not endorsed by the intervention; we were concerned that disclosing one’s serostatus transferred responsibility to the informed partner to protect himself or herself. Regardless of the desire of the partner, YPLH were encouraged to use condoms if engaging in sexual acts.

Module 3 aimed to reduce emotional distress and to improve the quality of life of YPLH. The module focused on helping YPLH to anticipate situations that would raise negative emotions (eg, anxiety, depression, fear, anger). YPLH were taught a “Feeling Thermometer” to identify their affective states across difficult situations and then to self-control negative emotions through the use of relaxation, self-instruction, and meditation. Module 3 focused on helping YPLH to identify long-term life goals.

The format of each session was similar across each session and each module. Each session started with recognizing personal successes during the previous week, recognizing success in completing goals targeted during the previous session, introduction of new material (eg, strategies for remembering ARVs, proper use of condoms), rehearsal and planning for challenging situations that might arise in the next week and the future, review of the session’s progress, and goal setting for the next week.

A detailed manual (available online at http://chipts.ucla.edu/) guided the 3 intervention modules totaling 18 sessions of 2 hours each. Each participant received $10 for each session attended.

The in-person sessions were delivered 1-on-1 in private rooms available at collaborating sites or other community agencies. When these spaces were not available in locations accessible to a participant, arrangements were made to deliver sessions in the participant’s home (if it was judged to be safe and private) or, on rare occasions, in a nearby park or coffee shop.

Telephone sessions were delivered 1-on-1 at times convenient for participants. YPLH were provided with workbooks to supplement and provide concrete prompts to complete the session content. The original design called for small group meetings in a telephone chat-room. Slower than anticipated recruitment, coupled with challenges in coordinating mutually agreeable group schedules and poor initial adherence, caused us to revise the protocol to 1-on-1 delivery during the first telephone group attempted. Follow-up and recontact efforts consisted of weekly written letters or e-mail, followed by telephone calls. Three weekly attempts were made before shifting to monthly follow-up.

Intervention facilitators held masters degrees and were licensed therapists or clinical social workers or had completed their clinical training and were accumulating hours toward licensure. Most facilitators were female. Spanish-speaking facilitators were available for monolingual Spanish-speaking participants (approximately 3% of the sample).

The facilitators were supervised biweekly and received intensive 3-day training for each module from teams of expe-
rienced cognitive-behavioral intervention researchers. The training included review of the study’s theoretic orientation, the intervention manual, and videotapes of model sessions as well as practice in conducting each session of the intervention.

Quality assurance ratings were conducted from randomly selected videotapes and audiotapes of sessions. Ratings for more than 80% of the sessions exceeded criteria for content and process measures of fidelity.

Across modules, 78% (n = 94 of 120) of young people participated in at least 1 session: 87% (n = 53) attended at least 1 individual session and 69% (n = 41) participated in at least 1 session in the telephone intervention (attendees). Fewer young people completed all 18 sessions (35%): 41% of those receiving individual sessions and 29% of those receiving the telephone interventions. The mean number of sessions was 10.0 in the individual sessions and 7.5 in the telephone sessions. Attendees (n = 94) and nonattendees (n = 26) were compared on each baseline characteristic listed in Table 1. No significant differences were found between YPLH in either condition. After the 15-month assessment, young people in the delayed condition received the intervention; 56% attended the in-person intervention.

Assessments

Retention was high and similar across sites and intervention conditions as YPLH were assessed at 3 months (86%), 6 months (78%), 9 months (86%), and 15 months (82%). Young people were individually interviewed at a site convenient to them. An ethnically diverse team of trained interviewers assisted by collecting data using computerized assessments. Quality assurance ratings were conducted on 20% of interviews through audiotape reviews, and 93% met criteria on ratings of completeness, positive tone, and crisis referrals. For all assessment domains, activities reported for the previous 3 months are defined as “recent” behaviors.

The following measures were evaluated at each assessment period:

1. HIV risky behaviors
   A. Sexual risk acts. Using a structured interview protocol, youth reported the total number of partners and sexual acts, specific sexual acts with each partner, and whether condoms were used during each of these sexual acts. A sexual partner was defined as a male or female partner with whom the youth engaged in vaginal or anal sex. A sexual act was defined as a single session of receptive or insertive vaginal or anal sex. Oral sex was reported but omitted in all calculations of risk because of its low association with HIV transmission. Based on extensive sexual history data obtained, we derived the following indices: (1) no recent sexual risk (abstinence or 100% condom use over the last 3 months); (2) the number of HIV-negative sexual partners or partners of unknown status; (3) the number of seroconcordant sexual partners; and (4) the proportion of vaginal and anal sex acts protected by condoms with all partners, seroconcordant partners, and HIV-negative partners (or partners of unknown status). Disclosure of serostatus before sexual intercourse was assessed for each sexual partner. The percentage of partners YPLH disclosed was calculated for seroconcordant and HIV-negative partners or partners of unknown status.

2. Health-related outcomes
   A. Medication adherence. At the time this study began, ARV medications were recommended for all persons living with HIV. We assessed lifetime and recent ARV utilization and adherence, classified as present (1) or not (0). ARV adherence was based on an adapted measure. YPLH reported the specific ARV medications they were taking; the number of times per day each medication was supposed to be taken; and how many times a dose was missed or skipped yesterday, 2 days ago, and 3 days ago. Adherence was defined as adhering to at least 90% of ARV medications that were supposed to be taken over the 3 days before the interview.

   B. Health behaviors. We assessed an index of medical adherence as the number of medical appointments missed.
In addition, we used a measure of positive health behaviors\(^7\) to document the frequency of engaging in 12 behaviors used to maintain health at least once a week on average: yes (1) or no (0) (eg, balanced diet, exercise, vitamins, adequate sleep).

C. Self-report health status. YPLH reported: (1) T-cell count, (2) viral load count, (3) knowledge of T-cell count, (4) whether or not symptoms of HIV had been experienced, and (5) whether or not AIDS had been diagnosed. Self-reported CD4 and viral load counts were compared with counts from medical charts for 38 randomly chosen YPLH. Self-reported counts that
matched the most recent medical chart information were used when possible. Self-reported and medical chart information that differed by more than 6 months was not used, resulting in 33 cases being used to analyze CD4 counts and 29 cases being used to analyze viral load counts. The Pearson correlation between self-report and medical chart information was 0.80 for CD4 counts and 0.69 for viral load counts (both \( P < 0.0001 \)).

3. Mental health outcome. The Brief Symptom Inventory (BSI), a 53-item reliable index of global severity of mental health symptoms, was administered (\( \alpha = 0.97 \) at baseline). Participants rated the level of severity for each symptom during the previous week on a scale from 0 (not at all) to 4 (extremely). Scores are reported as the mean response of the 53 items. The logarithm of the score is used in analyses.

Cost Data

Research staff, supervisors, and university budget ledgers were monitored to calculate the resources expended for delivery of each intervention modality, including personnel, transportation, materials, food costs, overhead, and participants’ opportunity costs as well as training the session facilitators. The resources were inventoried at the time that the intervention was conducted in 1999 through 2002. Monetary incentives were given for participation to reimburse participants for their time. In-person intervention and telephone intervention were assessed separately. We also excluded resources associated with the scientific evaluation of the study, for example, the assessment.

Data Analysis

Intent-to-treat analyses were conducted examining measures from the baseline assessment until 15 months. Mixed-effect regression models were used to evaluate the impact of the intervention condition on transmission-, physical health-, and mental health-related outcomes. Covariates included time since baseline assessment (months), intervention condition, ethnicity, gender, recruitment city, and time by intervention condition interaction. A covariate for having traded sex during the lifetime of YPLH was included in models for sexual behavior outcomes, and a covariate for the amount of time since ARV initiation was included in the model for the ARV adherence outcome.

An autoregressive moving average (ARMA) covariance structure provided the best fit of several covariance structures we tested and was used in all longitudinal analyses. The ARMA covariance structure suggests that the correlation of outcomes between time points is dependent on the average correlation across time points and the proximity of time points. Outcomes measured closer together are more highly correlated.

Missing observations did not contribute to the fit of the model at time points where they were missing or affect how nonmissing observations were used in analyses. For the analysis of 2 outcomes composed of fractions, the fraction of protected sex acts and adherence to ARVs, the analyses excluded observations with 0 denominators. For example, in the analysis of adherence, observations for participants who were not using ARVs recently were excluded.

Results are presented using relative effect size (RES) at 15 months, defined as \( 100 \times \left( \frac{\text{outcome T1} - \text{outcome T2}}{\text{outcome T1}} \right) \). F-statistics (F), t-statistic absolute value (t), and corresponding degrees of freedom (\( df \)) are presented for intervention condition comparisons.

Baseline intervention condition differences of recent outcomes were tested by examining F-statistics for intervention main effects in the mixed-effect regression models; differences for demographics and other measures were tested using ANOVA; logistic regression; and Poisson regression for continuous, dichotomous, and count measures, respectively. Baseline intervention condition differences of recent outcomes were adjusted for by including an intervention condition covariate in all mixed-effect regression models.

To assess changes among YPLH in the delayed-intervention condition over time independently, we compared participants in the delayed condition on baseline and 15-month outcomes, performing a paired t test, McNemar test, and logistic regression, including a random effect for each pair, on continuous outcomes, dichotomous outcomes, and outcomes represented as a fraction, respectively.

All analyses were performed using SAS software, version 8.01 (SAS Institute, Cary, NC). Dichotomous and count (eg, number of protected acts) outcome measures were modeled using logistic and Poisson mixed-effect regressions, respectively, in the GLIMMIX macro, and continuous outcome measures were fit using linear mixed-effect regressions in the PROC MIXED procedure.

RESULTS

Sample

Table 1 gives characteristics of YPLH measured at baseline (n = 175). Most YPLH were male, gay or bisexual male (69%), and of ethnic minority heritage. About half of the YPLH were currently on ARVs and had experienced symptoms of HIV; most had used ARVs during their lifetime, had served time in jail, and had graduated from high school or received a GED certificate. Over their lifetime, YPLH had a median of 50 sexual partners; 2 YPLH reported being sexually abstinent, and 21 YPLH reported having 1000 or more sexual partners. Disclosure of serostatus and condom-protected sex seems to be higher among seroconcordant (HIV-positive) partners than among HIV-negative partners or partners of unknown status. As part of an eligibility criterion to be in the study, all YPLH had received substances 5 or more times. Most (78%) had used hard drugs over their lifetime.

Randomization successfully resulted in similar groups across demographic and most outcome measures, but we did
find differences at recruitment across intervention conditions for the proportion of protected sex acts across all sexual partners (F = 9.49, df = 2, 155; P < 0.01), among HIV-positive sexual partners (F = 3.13, df = 2, 94; P = 0.05), and among HIV-negative sexual partners (F = 10.46, df = 2, 141; P < 0.01). The in-person intervention condition had a higher proportion of protected acts across all sexual partners, among HIV-positive sexual partners, and among HIV-negative sexual partners compared with the delayed-intervention condition (P < 0.05). The telephone intervention condition had a higher proportion of protected acts across all sexual partners and among HIV-negative sexual partners compared with the delayed-intervention condition (P < 0.05). The telephone intervention condition also had a higher proportion of protected acts across all sexual partners and among HIV-negative sexual partners compared with the in-person intervention condition (P < 0.05).

**Intent-to-Treat Analyses**

Table 2 summarizes the estimated outcomes at the baseline and 15-month assessments for each intervention condition as well as for the RES. Each outcome measure reflected a linear trend over time; therefore, we have not included the mean on each measure for the intermediate time points. Significant differences for time by intervention condition effects are indicated. There was a significant difference in the proportion of protected acts between intervention conditions over time across all partners (F = 3.38, df = 2, 380; P = 0.03) and among HIV-negative partners (F = 5.18, df = 2, 264; P < 0.01) but not among HIV-positive partners. YPLH in the in-person intervention increased their proportion of protected sexual acts across all sexual partners compared with YPLH in the delayed intervention over time (t = 2.57, df = 380; P < 0.01). The proportion of protected sexual acts in the telephone condition was not significantly different from that in the delayed intervention or in the in-person intervention over time. YPLH in the telephone group had a significant decrease in the proportion of protected acts among HIV-negative partners compared with YPLH in the in-person intervention over time (t = 2.65, df = 264; P < 0.01). The number of sexual partners and disclosure of serostatus to partners were similar over time across intervention conditions.

The proportion of YPLH using hard drugs, the proportion of injecting drug users, the proportion of YPLH with symptoms of dependency, and the number of different drugs used were similar among intervention conditions over time.

The proportion of ARV use and adherence to ARV medication were similar among intervention conditions over time. The proportion of those who changed their health behaviors (eg, exercised, ate a healthy diet, took supplements and vitamins) was similar between intervention conditions over time. On average, logs of the overall score for emotional distress on the BSI were similar between intervention conditions over time.

### TABLE 2. Intervention Condition Estimated Outcomes at Baseline and 15 Months for Intent-to-Treat Analyses

<table>
<thead>
<tr>
<th>Recent Outcome Measures</th>
<th>Telephone (n = 59)</th>
<th>In Person (n = 61)</th>
<th>Delayed (n = 55)</th>
<th>Relative Effect Size*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sexual behavior</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of HIV-negative partners</td>
<td>5.0</td>
<td>4.6</td>
<td>4.0</td>
<td>1.4</td>
</tr>
<tr>
<td>Percent of protected acts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All partners</td>
<td>59%</td>
<td>59%</td>
<td>45%</td>
<td>58%†</td>
</tr>
<tr>
<td>HIV-negative partners</td>
<td>75%</td>
<td>65%†</td>
<td>53%</td>
<td>73%§</td>
</tr>
<tr>
<td>100% condom use or abstinent</td>
<td>57%</td>
<td>50%</td>
<td>57%</td>
<td>58%</td>
</tr>
<tr>
<td><strong>Substance use</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 or more symptoms of dependency</td>
<td>52%</td>
<td>43%</td>
<td>52%</td>
<td>40%</td>
</tr>
<tr>
<td>Used hard drugs</td>
<td>66%</td>
<td>47%</td>
<td>48%</td>
<td>48%</td>
</tr>
<tr>
<td>Injected drugs</td>
<td>15%</td>
<td>15%</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>Number of different drugs</td>
<td>1.9</td>
<td>1.4</td>
<td>1.7</td>
<td>1.5</td>
</tr>
<tr>
<td>Use ARVs</td>
<td>50%</td>
<td>36%</td>
<td>55%</td>
<td>43%</td>
</tr>
<tr>
<td>Adherent to ARV regimen</td>
<td>60%</td>
<td>54%</td>
<td>62%</td>
<td>70%</td>
</tr>
<tr>
<td>Number missed appointments</td>
<td>1.1</td>
<td>0.9</td>
<td>0.8</td>
<td>0.7</td>
</tr>
<tr>
<td>Log emotional distress</td>
<td>1.0</td>
<td>0.8</td>
<td>1.0</td>
<td>0.9</td>
</tr>
</tbody>
</table>

*Relative effect size = 100 × (u1 − u2)/u2, where u1 and u2 are estimated outcomes at 15 months.
†Telephone vs. in-person; P < 0.01 for time by intervention comparison.
‡In-person vs. delayed; P < 0.05 for time by intervention comparison.
§In-person vs. delayed; P < 0.01 for time by intervention comparison.
Changes in the Delayed Condition Over Time

Participants at 15 months in the delayed condition showed a trend toward having fewer sexual partners (mean decrease = 3.7, t-statistic = 1.97, df = 42; P = 0.06), using fewer different drugs (mean decrease = 0.42, t-statistic = 2.03, df = 42; P = 0.05), and having a lower mean global BSI score (mean decrease = 0.26, t-statistic = 2.06, df = 42; P = 0.05) compared with the participants at baseline. At 15 months, YPLH were also less likely to be using highly active antiretroviral therapy (HAART) compared with baseline ([McNemar test] df = 1; P = 0.06). Of YPLH using HAART at baseline, 50% (10 of 20) of participants were not using HAART at 15 months. Of participants not using HAART at baseline, 13% (n = 3 of 23) were using HAART at 15 months.

Cost Analysis

The total cost of the in-person intervention for the 3 modules was $3500 per participant (approximately $1167 per module), which was higher than the cost of $2692 per participant for the telephone intervention (approximately $897 per module). The excess cost of traveling time and expenses for in-person sessions accounted for this difference. Personnel accounted for most of the total costs: 65% for in-person sessions and 60% for telephone sessions. Overhead costs averaged 25% and material and instrumental costs averaged 12% of total costs across intervention conditions.

DISCUSSION

This trial aimed to test the limits of the process of tailoring and adapting an efficacious intervention. Could we change the delivery format and reduce the number of sessions and retain efficacy with drug users? Because community providers typically adapt the intervention for delivery in their particular setting and for somewhat different populations, this is a key debate in the field of prevention today. This replication of an intervention for YPLH suggests some of the pitfalls in such adaptations.

We adapted a 3-module intervention delivered in a small group setting and examined individually delivered telephone and in-person sessions as alternative formats for preventing transmission and improving physical health and mental health outcomes for YPLH. These delivery modalities are consistent with the prevention case management models for persons living with HIV. We also reduced the number of sessions by 50% to examine the influence of less lengthy interventions with YPLH.

The proportion of protected sexual risk acts, especially with seronegative partners, was significantly higher among youth randomized to the in-person intervention condition delivered in individual sessions. This is consistent with the findings of our previous intervention trial.7 There were significant reductions in sexual risk when YPLH were randomized to individual sessions focused on encouraging reductions in sexual transmission acts, at a cost of $1167 per person for module 2. This finding is particularly impressive, because there was a significant difference across intervention conditions at recruitment. There was less opportunity for improvement among youth randomly assigned to the in-person condition; yet, the youth in the in-person group significantly increased their condom use compared with other groups.

Also similar to the previous intervention, approximately two thirds of YPLH attended interventions delivered in a small group format and in a telephone format in this study. At least 1 individual session was attended by 87% of youth, suggesting that a prevention case management approach may be an acceptable delivery modality for YPLH. In addition, we would anticipate that case management offers the potential to deliver the intervention over an extended period as YPLH work with their case managers. Small groups result in a lower per person cost per module ($547 vs. $1167) even with double the number of sessions. Yet, individual sessions have fewer concerns regarding disclosure of serostatus, and the interventions could be used in rural settings. Based on the results of this trial, an efficacious intervention for reducing sexual transmission among YPLH can be delivered in small group or in individual sessions.

One of the important implications of this trial is the need for screening among YPLH before service delivery. In reviews of a substantial number of studies with persons living with HIV33 and in our last 2 intervention trials,7,12,16 we found that more than half of persons living with HIV do not demonstrate any sexual risk transmission acts over the course of the trial. Substantial resources and diminished effect sizes occur when we include those not engaging in transmission acts for delivery of preventive interventions. In this trial, we screened on substance use risk acts, which we expected to be associated with inconsistent sexual risk practices. Unlike previous researchers’ findings4,6 and our own results in the previous intervention trial,7 however, hard drug users were not more likely to have unprotected sexual risk acts. Similarly, not all YPLH are in need of interventions to increase adherence to medical regimens or to improve mental health. More than half were on ARVs and adhering to more than 90% of their medication doses. Screening seems to be a key strategy for selecting YPLH in need of intervention.

The YPLH in the delayed-control condition improved over time on many outcome measures with only repeated assessments. The pre- and postanalyses among participants in the delayed condition indicated that most YPLH reduced their sexual and drug use behaviors over time, without interventions, but with repeated assessments of risk behaviors over time. Almost all participants in the control condition of every intervention trial have improved substantially.34-37 The consistent improvements associated with repeated assessments in the control conditions have led our research team to examine...
repeated assessments as a cost-effective intervention strategy for persons living with HIV; this strategy is currently being evaluated (M. Lightfoot, PhD, study in progress). The benefits of repeated assessments as a strategy for improving health-related HIV behaviors may significantly reduce the costs of intervention delivery.

Reducing illicit substance use was also a primary goal of this intervention, and all youth had used drugs at least 5 times in the previous 3 months to be eligible for the trial. The effect sizes for reductions in substance use among the in-person and telephone conditions compared with the delayed condition were relatively large yet did not reach significance. Retrospective analysis suggests that we were underpowered to observe significant results within the intervention and control conditions given the substantial reductions in substance use among YPLH in the control conditions. To show a significant difference in hard drug use in the immediate intervention groups compared with the delayed-intervention group over time, we would have needed 5.4 times more participants to show significance.* Future trials with YPLH must anticipate loss of power with abstinence.

Sexual risk outcomes seem to be robust; sexual risk behaviors are significantly reduced with efficacy in in-person delivery formats despite the number of reduced sessions. The other positive outcomes were not retained, however, including improvements in mental health, adherence to medical regimens (particularly ARVs), and improvements in healthy lifestyle behaviors. It may be important to note that YPLH reported 20 positive health behaviors (eg, exercise regularly) at recruitment and emotional distress scores in the normative range. In addition to tailoring interventions to those who have deficits in a specific area, interventions for YPLH may require a greater dose of an intervention to achieve positive outcomes in medical adherence and mental health outcomes for YPLH, similar to the number of sessions in our earlier intervention. The case management services being offered and the ongoing medical care provided to persons living with HIV offer important ongoing opportunities to deliver sufficient doses of interventions in highly accessible settings. These alternatives are currently being examined.

ACKNOWLEDGMENTS

The authors thank Jeffrey Chen, Hsin-Hsin Foo, Danny Jenkins, Mark Kuklinski, Kris Langabeer, Linda Levin, Kathryn Mattes, Mabel Mendez, Peggy O’Hara, and Brian Ramos for their assistance. This study was approved by the University of California at Los Angeles Human Subjects Protection Committee.

*This calculation is equal to \((t\text{-statistic for an } \alpha\text{-level of 0.05/observed } t\text{-statistic})^2 = (1.96/0.84)^2\), where 0.84 is the t-statistic for the time by intervention interaction parameter estimate in a mixed-effect regression model for the hard drug use outcome. The telephone and in-person interventions were combined into 1 group.

REFERENCES


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Introductions

- Name
- Agency/Organization
- Jobs and relationship to CLEAR
- Expectation for the training
- Counseling Experience

Welcome to CLEAR

Training Objectives

- Describe the goals of CLEAR
- Describe and demonstrate the application of CLEAR core elements
- Demonstrate specific skills, techniques and tips relevant to implementing CLEAR

Agenda - Day One

- Module 1: Introductions and Training Overview
- Module 2: The National HIV/AIDS Strategy (NHAS) and High Impact Prevention (HIP)
- Module 3: Introduction to CLEAR
- Module 4: Social Action Theory
- Module 5: Cognitive-Behavioral Techniques and CLEAR Core Elements
- Module 6: Assessment and Prevention Plan
- Wrap-up and Adjourn

Housekeeping

- Restrooms
- Training schedule, breaks
- Room temperature
- Vending machines
- Smoking area

Course Materials

- Implementation Manual
  - Comprehensive
  - Step-by-step
- Participant workbook
- Handouts
Module 2

The National HIV/AIDS Strategy and High Impact Prevention:

Relevance and Importance

National HIV/AIDS Strategy (NHAS)

THE VISION:
The U.S. will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socioeconomic circumstance, will have unfettered access to high quality, life extending care, free from stigma and discrimination.

Goals

- Reduce new HIV infections
- Increase access to care and improve health outcomes for people living with HIV
- Reduce HIV-related health disparities
- Achieve a more coordinated national response to the HIV epidemic

CDC’s Overall Prevention Strategy

Treatment is Prevention....

- Identify/Screen
- Test
- Engage in care
- Adhere to treatment
- Retain in care

High Impact Prevention

CDC’s Approach:

Using combinations of scientifically proven, cost-effective, and scalable interventions targeted to high risk populations in the high prevalence geographical areas to increase the impact of HIV prevention efforts.

Enhancing Prevention

High Impact Prevention in Practice (Fenton, CDC, 2012)

- HIV Testing
  - Testing in health care and non-health care settings
  - Testing of pregnant women
  - Ensure linkage to care and prevention services
- HIV Prevention with Positives
  - ART and adherence interventions
  - STD screening and treatment
  - Partner services
  - Behavioral interventions for HIV-positive persons
  - Retention and re-engagement in care
- Condom Distribution
  - Focus on people with HIV and at high risk
- Structural and Policy Initiatives
  - Create enabling environment for optimal HIV prevention and care through policies, regulations, and practice
In the U.S. there are 1.2 million people living with HIV

For every 100 people living with HIV:
- 80 are aware of their infection (testing)
- 62 are linked to HIV care (linkage)
- 41 stay in HIV care (retention)
- 36 get antiretroviral therapy (access)
- 28 have undetectable levels of virus (adherence).

What Strategies do you have in place at your agencies to provide prevention services with persons living with HIV/AIDS?

What are the challenges of providing prevention services with persons living with HIV/AIDS?

A range of client-centered services that include the provision of advice, education, and assistance in obtaining medical, housing, substance abuse, mental health, social, community, legal, financial, and other needed support services.

What is case management?

What is referral?

The process by which person’s needs for care and supportive services are assessed and persons are provided with assistance, including necessary follow-up efforts, to facilitate initial contact with appropriate service providers.

What is Navigation?

Patient/client navigation seeks to support and help patients address barriers standing in the way of their HIV care and treatment. Patient navigation services include linking persons to health care systems, assisting with health insurance and transportation, identifying and reducing barriers to care and tailoring health education to patients.

Case management, referrals, linkage to care, and health education are part of the navigation activities.
Navigation services may be sustained across the continuum of HIV care and treatment.

Key Functions of Navigators:
- Locate, engage and motivate HIV infected individuals to participate fully in HIV treatment
- Build a relationship of trust with the client
- Periodically monitor patient engagement and assess needs and barriers
- Participate in case conferences to determine courses of action with specific patients
- Address individual barriers to care
- Educate the client about health and treatment services, including benefits of early ART

Key Functions of Navigators cont.
- Provide positive reinforcement as the patient experiences success in accessing the health care system
- Provide appointment reminders and other logistic and attendance support like accompaniment
- Provide adherence support
- Use directories of services to link patients to needed services
- Refer and ensure linkage and access of the client to other services (mental health, substance use, housing, health insurance, etc.) as needed to support engagement in care

What is CLEAR?
- An evidence-based HIV prevention and health promotion intervention:
  - Appropriate for HIV+ people and people at high-risk for acquiring HIV, ages 16 and older
  - Delivered in multiple, weekly, one-hour and one-on-one sessions
  - Uses cognitive-behavioral techniques
  - Client-centered intervention

CLEAR Intervention Trial:
Study Participants
- 1999-2002
- 175 YPLH in Los Angeles, New York City and San Francisco
- Ages 16-29 (mean of 23)
- Most participants were
  - Latino (42%) and Black (26%)
  - Males (78%)
  - Gay, bisexual or question (70%) and,
  - High-school graduates (55%)

Intervention Outcomes

<table>
<thead>
<tr>
<th>At the 15 Month Follow-up</th>
<th>Used Condoms with all Partners</th>
<th>Engaged in Protected Sexual Acts with HIV Negative Partners</th>
<th>Number of HIV Negative Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants in In-person Intervention</td>
<td>58%</td>
<td>73%</td>
<td>1.4</td>
</tr>
<tr>
<td>Participants in Control Conditions</td>
<td>22%</td>
<td>32%</td>
<td>2.5</td>
</tr>
</tbody>
</table>
CLEAR Intervention Trial: Intervention Content

• Three modules, six sessions each:
  • Staying Healthy - Health care utilization and treatment adherence
  • Acting Safe - Sexual risk behaviors and link to substance use
  • Being Together - Emotional well-being and quality of life
• First six session did not focus on HIV risk behaviors or condom use

Modifications to Original Intervention

• Reduced required number of sessions from 18 to 5
  • 5 Core Skill Sessions
  • 21 Menu Sessions (six different domains)
  • Wrap-up Session
• Eliminated redundant concepts
• Updated information (prevention technology, medical management of HIV, “club drugs”)
• Integrated perspective that treats HIV as a chronic disease
• Incorporated Feel-Think-Do Framework
  • Highlights the underlying theory
  • Link between feelings, thoughts, and actions

Goals of CLEAR

• The overall goal of CLEAR is to help clients maintain health, reduce transmission and acquisition of HIV and other STIs and improve their quality of life.
• Specifically, CLEAR strives to increase or enhance behaviors that promote:
  • Healthy living
  • Effectively facing the challenges of daily living
  • Positive feelings, thoughts, and actions
  • Developing daily routines to stay healthy
• The intervention enhances these behaviors via application of the core elements.

Core Elements

• Core elements are critical features of an intervention’s intent and design that are believed to be responsible for the intervention’s effectiveness.
  • Derived from the behavioral theories upon which the intervention is based.
  • Must be maintained without alteration, in order to maintain intervention fidelity.

CLEAR Core Elements

1. Development of emotional awareness through use of a Feeling Thermometer and identification of the link among feelings, thoughts and actions (F-T-D Framework)
2. Identification of one’s Ideal Self to help motivate and personalize behavior change
3. Teaching, modeling and practicing Short- and Long-Term Goal Setting
4. Teaching, modeling and practicing SMART Problem-Solving
5. Teaching, modeling and practicing Assertive Behavior and Communication

CLEAR Core Elements

1. Feeling Thermometer
2. Ideal Self
3. Short- and Long-Term Goal Setting
4. SMART Problem Solving
5. Assertive Behavior and Communication
Overview of CLEAR Sessions

• During the Five Core Skill Session:
  • Core elements are introduced and essential cognitive-behavioral techniques are taught (repeated through the Menu Sessions)
  • A personal life goal and an individual prevention plan are developed

• Menu Sessions
  • Divided into six domains
  • Provide opportunities for client to learn, practice and internalize the cognitive-behavioral techniques

Client Eligibility

• A client may be eligible for CLEAR if he/she is:
  • 16 years old or older
  • HIV+ or high-risk HIV-
  • Willing to complete all 5 core skill sessions

• Ultimately, it is up to each agency to decide who is eligible for CLEAR and the following should be considered:
  • Client must be willing to create a prevention plan (identify and be willing to address at least one prevention goal) and prioritize items as appropriate
  • Client should have the desire to change HIV risk behavior

CLEAR: More than your typical HIV intervention

<table>
<thead>
<tr>
<th>Typical</th>
<th>Everything in Typical, plus</th>
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<tbody>
<tr>
<td>• Prevention goals</td>
<td></td>
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<tr>
<td>• Risk behaviors</td>
<td></td>
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<tr>
<td>• Sexual behaviors</td>
<td></td>
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<tr>
<td>• Substance use</td>
<td></td>
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<tr>
<td>• Disclosure</td>
<td></td>
</tr>
<tr>
<td>• Adherence</td>
<td></td>
</tr>
<tr>
<td>• Relationship with health care providers</td>
<td></td>
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<tr>
<td>• Stigma</td>
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<tr>
<td><em>Emotional regulation</em></td>
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<td><em>Relaxation</em></td>
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<tr>
<td><em>Ideal self</em></td>
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<td><em>Life goals</em></td>
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<td><em>Life stressors</em></td>
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<td><em>Coping with stressors</em></td>
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<tr>
<td><em>Problem solving</em></td>
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<tr>
<td><em>Communication/ Assertiveness</em></td>
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</tbody>
</table>

The first five Core Skill Sessions do not focus on HIV prevention issues!

CLEAR: More than your typical HIV intervention

• How do you think most clients would respond when they find out that CLEAR includes these additional elements?
  • Strength-based intervention
  • Focus on positive attributes
    • Ideal Self
    • Quality of Life
  • Future focus
  • Promotes healthy behaviors
  • Find it refreshing that they are not expected to talk about HIV and risk behaviors from the very beginning
CLEAR: More than your typical HIV intervention

- Core Skill Sessions focus on positive attributes:
  - Life and the future
  - Ideal Self - the kind of person you’d like to be
  - Long-term goals for the future
  - Setting weekly goals towards achieving life goal
  - Other life skills: problem solving, communication, emotional regulation, relaxation and coping skills

CLEAR

...engages the whole person, not just the “HIV positive person” or the person at “high-risk” for HIV!

Why General Life Sessions are Held Before Prevention Sessions

- Less threatening - reduces resistance and increases rapport
- Life context influences risk behaviors
- Life context influences prevention plan
- Prevention goals may be identified within the context of life goals
- Motivates behavior change and commitment to prevention plan
- Strength-based model

Importance of Theory...

Why is it important to understand the theory behind an intervention?

CLEAR

is based on the Social Action Theory

What do you know about Social Action Theory?

Social Action Theory

- Asserts that a person’s ability to change behaviors that endanger his/her health are influenced by:
  - The individual’s self-change process
  - Contextual factors
**Scripts**

- Social Action Theory describes a dynamic, reciprocal relationship between the individual and his/her life context
- As a result of this interplay, life habits develop
- These habits are often referred to as “scripts”
- Scripts are automatic or subconscious patterns of feeling, thinking, and doing

One of the goals of CLEAR is to help individuals replace unhealthy scripts with healthier ones. In time, the new scripts will become automatic.

**Define Cognitive-Behavioral Techniques**

- Cognitive-behavioral techniques combine the goals of cognitive therapy and behavioral therapy
  - Cognitive therapy assumes that maladaptive behaviors and disturbed mood or emotions are the result of inappropriate or irrational thinking patterns and aims to change behaviors by changing thought patterns.
  - Behavioral therapy trains individuals to replace undesirable behaviors with healthier behavioral patterns.

**Cognitive-Behavioral Techniques (CBT)**

- The provider works with the client to:
  - Identify thoughts and behaviors that are causing distress
  - Change those thoughts in order to re-adjust the behavior
- Some cognitive-behavioral techniques include:
  - **Emotional regulation**: having control over one’s emotional and consequent actions
  - **Reframing**: thinking about a situation from a different perspective more positive in nature
  - **Self-talk**: telling ourselves more positive things

**Core Elements**

- Core elements are critical features of an intervention’s intent and design that are believed to be responsible for the interventions effectiveness.
  - These core elements are derived from the behavioral theories upon which the intervention is based.
  - They must be maintained without alteration, in order to maintain intervention fidelity.

**Core Element #1**

- Development of *emotional awareness* through:
  - Use of a **Feeling Thermometer**
    - A tool that helps clients assess and discuss their feelings of discomfort
  - Use of the **F-T-D Framework** to identify the link among feelings, thoughts, and actions
    - A tool used to connect an individual’s feelings, thoughts, and actions

**Feel-Think-Do Framework**

- Feeling Thermometer
- Body Sensation
- Relaxation

- Clear thinking
- Cognitive Techniques (reframing, positive self-talk, etc.)

- Goal-Setting
- SMART Problem Solving
- Assertive Communication
**Feel-Think-Do Framework**

**Feel:** Discomfort

**Think:** “I’ll never be able to resist cake”

**Do:** Eat cake

---

**Feel:** More comfortable

**Think:** “I want the cake but I can live without it”

**Do:** Eat celery

---

**Feeling Thermometer**

- Establishes a hierarchy of comfortable vs. uncomfortable events
- Promotes awareness of escalating discomfort by linking our comfort level to body reactions
- Establishes a rate of optimal performance where you can clearly think and act
- Slows down the F-T-D process
- Acts as a counseling tool

---

**CLEAR Thinking**

- Related to F-T-D Framework
- Controls or counters self-defeating thoughts
- Cognitive techniques used to support CLEAR thinking
  - Positive self talk
    - Cope with unchangeable situation by what we say to ourselves
  - Reframing
    - Re-describes the experience in positive terms (e.g. framed as opportunities to grow and learn instead of disasters)
  - Arguing against negative thoughts
    - Interrupt or argue against a negative thought - challenge it by thinking or saying, “Stop!”

---

**“DO”**

- In the F-T-D Framework, “do” refers to:
  - Reactions to an event (i.e., problem solving, relaxation, etc.)
  - Helps clients understand the link between their feelings, thoughts, and actions
  - Links with Feeling Thermometer and thoughts
  - The actions we take are a result of our feelings and thoughts

---

**F-T-D Framework**

- Allows the client to explore and understand the relationship among Feelings, Thoughts and Actions
- Our actions are influenced by our thoughts and feelings
- Feel-Think-Do is a simple way of understanding cognitive-behavioral theory
- The process can begin at any point (actions influence the way we think and feel, and feelings and thoughts influence our actions.)
How do you think explaining the F-T-D cycle helps clients?
• Feelings are linked to thoughts which are linked to actions
• Often subconscious - like a script
• Although automatic, there are opportunities to change
• Possible to self regulate actions to situations
• Key concept - help clients self regulate around self-protective behaviors
• Overall goal is to make self-protective behaviors routine

Understanding F-T-D Helps the Client:
• Understand why unwanted habits may be hard to change
• See there are opportunities for change
• Become aware/conscious of scripts
• Integrate new action scripts into existing ones
• Make the new scripts automatic and routine

F-T-D Grid

<table>
<thead>
<tr>
<th>Situation</th>
<th>Thermometer Reading</th>
<th>Physical Sensations</th>
<th>Thoughts</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Used during the CLEAR sessions to help clients understand the link between feelings, thoughts and actions

Feel-Think-Do Framework

Core Element #2

• Identification of one’s Ideal Self to help motivate and personalize behavior change
• Image of who we strive to be
• Our positive values and strengths
• How we would like to behave
• Creates framework for behavioral decision making

Activity: My Ideal Self

• In Session 2, clients are asked to review a list of possible Ideal Self characteristics and then they are asked to identify their own Ideal Self characteristics
  • Your Ideal Self consists of the characteristics that are especially important to you and reflect your standards
  • Your Ideal Self can include traits you already have
  • Write five words that best describe your Ideal Self (use your own words, or use the words listed on the hand out)
What are the Characteristics of your Ideal Self?

- Strong
- Caring
- Wise
- Courageous
- Responsible
- Physically fit/Healthy
- Forgiving
- Self loving
- Honest
- Calm
- Giving
- Loving
- Focused
- Financially secure
- Fair
- Spiritual
- Friendly
- Loyal

Ideal Self

- Ideal Self and the F-T-D Framework
  - How would my Ideal Self want to feel, think and behave in a response to this situation?
  - Where would I need to be on the Feeling Thermometer to think and behave based on my Ideal Self?
  - After the Ideal Self is articulated by the client, it can be used as a benchmark for the way the clients want to feel, think and act.
  - Ideal Self and the Prevention Plan
    • Prevention Plan must contain goals that are consistent with the Ideal Self

Feel-Think-Do Framework

Think: Distorted, Unhealthy thoughts

Feel: Uncomfortable
High Feeling Thermometer

Do: Unhealthy Actions

“I already have HIV, so who cares if I don’t use a condom” or “One time without a condom won’t kill me,” and subsequently not use a condom.

Feel-Think-Do Framework

Same Client Operating from the Ideal Self

Think: Healthy Thoughts

Feel: More comfortable
Lower Feeling Thermometer

Do: Healthy Actions

“I should use a condom to keep myself safe and subsequently, use a condom.

Core Element #3

- Teaching, modeling, and practicing short- and long-term goal setting
  - Goal setting is crucial to behavior change
  - The client needs to know where he/she is going and needs to achieve small steps along the way in order to make change.
  - Setting goals and reviewing the client’s progress with the counselor can serve as a motivator to help the client achieve goals and continue with the intervention.

Types of Goals used in CLEAR

- Short-term weekly goals
- Long-term goals
  • Life goals
  • Prevention goals
Short-Term Goals

- Set at the conclusion of every session, starting with Core Skill Session One
- Related to session content
- Often broken down into steps
- Written on a goal card and the weekly goal log
- Reviewed at the beginning of each session, starting with Core Skill Session Two
- Increments on the way to achieving long-term goals

Long-Term Goals

Life Goals
- Introduced in Session 2
- Influenced by Ideal Self
- Integrated into weekly goals
- Inspire commitment to prevention plan
- Goal/Dreams for the future

Prevention goals
- Established in Session 5
- Influenced by Ideal Self
- Integrated into weekly goals
- Guides the Menu Session selection

Guidelines for Goal Setting

- Goals should be
  - Important to you
  - Something you are committed to
  - Realistic - not too hard and not too easy
  - Brief, specific and clearly stated
  - Easy to tell when they are accomplished

Activity: Ideal Self and a Life Goal

- Based on one of the characteristics of your Ideal Self, write one life goal for yourself
- Make sure that it is a life goal that you would not mind sharing with another person and that your goal fits within the guidelines for a good goal.
- Develop a short-term goal that can be accomplished within a week.
- Make sure that it is a step towards your life goal.

Counselor Tips Related to Goal Setting

- Adhere to goal-setting guidelines
- Reward any progress toward achieving goals
- Integrate core elements in goal setting:
  - FTD Framework
  - Feeling Thermometer
  - Ideal Self
Core Element #4

- Teaching, modeling and practicing SMART Problem Solving
  - Introduced in Core Skill Session Three
  - Slows down “automatic” decision making
  - SMART (not your usual SMART):

<table>
<thead>
<tr>
<th>S</th>
<th>State the problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>Make a goal</td>
</tr>
<tr>
<td>A</td>
<td>Achieve a list of all possible actions</td>
</tr>
<tr>
<td>R</td>
<td>Reach a decision</td>
</tr>
<tr>
<td>T</td>
<td>Try it and review it</td>
</tr>
</tbody>
</table>

How is SMART Problem Solving Introduced in Core Skills Session Three?

- The client identifies a list of current stressors
- SMART Problem Solving is introduced as a skill to cope with stressors
- Clients are given a copy of the SMART Problem Solving Guidelines
- The steps are applied to one of the client’s current stressors

SMART Problem Solving Counselor Tips

- The client, not the counselor should generate options
- List every option the client comes up with and evaluate later
- Be cognizant of counselor verbal and non-verbal communication
- Remember goal setting and problem solving are related

Core Element #5

- Teaching, modeling and practicing assertive behavior and communication
  - Introduced in Core Skill Session Four
  - Practiced in Role Plays
  - Verbal and non-verbal assertiveness related to:
    - Everyday interactions
    - Provider relationships
    - Condom and safer sex negotiation

Assertive Behavior and Communication

- Assertiveness standing up for your needs while being concerned and respectful about the needs of others
- Differentiate between passive, assertive, and aggressive communication
- Relates to Ideal Self and FTD Framework
  - How would your Ideal Self communicate?
  - Assertive behavior is an example of the “do” in FTD

Feel-Think-Do Framework

- Feel-Thermometer
  - Body Sensation
  - Relaxation
- Think
  - Clear thinking
  - Cognitive Techniques (reframing, positive self talk, etc.)
- Do
  - Goal-Setting
  - SMART Problem Solving
  - Assertive Communication
Overview of Core Skill Session Activities & Core Elements

<table>
<thead>
<tr>
<th>CORE SKILL SESSION 1</th>
<th>CORE SKILL SESSION 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Introduce Feel-Think-Do</td>
<td>• Introduce the Ideal Self</td>
</tr>
<tr>
<td>• Introduce and practice Feeling Thermometer</td>
<td>• Introduce Ideal Self Characteristics</td>
</tr>
<tr>
<td>• Use example to illustrate Feel-Think-Do</td>
<td>• Link between F-T-D and Ideal Self</td>
</tr>
<tr>
<td>• Feeling Thermometer linked with aspects of living with HIV</td>
<td>• Introduce and identify Life Goals</td>
</tr>
<tr>
<td>• Introduce Goal-Setting</td>
<td>• Relaxation</td>
</tr>
<tr>
<td></td>
<td>• Goal-Setting</td>
</tr>
<tr>
<td>CORE SKILL SESSION 3</td>
<td>CORE SKILL SESSION 4</td>
</tr>
<tr>
<td>• Identify current stressors and link to Feeling Thermometer</td>
<td>• Identify characteristics of different types of communication</td>
</tr>
<tr>
<td>• Introduce and practice CLEAR talking</td>
<td>• Introduce Assertive Communication</td>
</tr>
<tr>
<td>• Link between CLEAR talking, Feeling Thermometer and Ideal Self</td>
<td>• Practice Assertiveness</td>
</tr>
<tr>
<td>• Introduce and practice SMART Problem Solving</td>
<td>• Relaxation</td>
</tr>
<tr>
<td>• Goal-Setting</td>
<td>• Goal-Setting</td>
</tr>
</tbody>
</table>

CORE SKILL SESSION 5
• Identify prevention steps already taken
• Identify Ideal Self Characteristics and Life Goals with health promotion steps taken
• Complete Prevention Goals worksheet
• Identify a Prevention Goal as the first long-term goal for the Prevention Plan
• Goal-Setting

Assessment

In HIV prevention - often a structure set of questions is asked during the initial meeting with a client

In CLEAR - assessment is an ongoing process which begins with any information that you get from referral sources and continues throughout the sessions

Sonya’s Profile

Session 1: hopes CLEAR will help her take better care of herself and that she will become healthier; mentions that she’s tired because she partied the night before
Session 2: shares that her life goals include getting a better doctor and keeping her partner safe
Session 3: while discussing stressors, talks about arguments she has with her partner when she mentions condoms
Session 4: during the discussion about communication, share that she does not feel like her doctor hears what she has to say
Session 5: tells you that she has been able to quit smoking

Activity: Sonya’s Client Profile

What assessment can you make about Sonya’s needs and issues related to HIV risk?
What concerns might you want to follow up on?
What strengths do you see in Sonya?
Focus on client-centered, strength-based approach

Assessment: Getting to Know You

• What is important to you?
• What kind of person do you want to be?
• What’s been going well?
• What prevention strategies have you already taken?
• What has been challenging?
• What would you want to improve upon?
• How do you cope with stressors?
• How well do you communicate and get your needs met?
• What affects your prevention behavior?
• What are your thoughts about HIV and STDs?
• How can CLEAR be meaningful to you?
• Tell me about successes you’ve had in the past.

Prevention Plan

What is a prevention plan?
Goals that promote emotional and physical health
As a result, prevent re-infection or transmission of HIV
Formally takes place during Core Skill Session 5
First 4 Core Skill Session set the stage by
Continuously assessing strengths and risk behaviors
Development of life goal
Life Goals: What is Important to Me!
Under each category, write your goals. You can have more than one goal in each category.

Education (ex: Get my GED; Get my B.A. or A.A. degree; Get a training certificate):

Work (ex: keep one job for a long time or work as a nurse):

Relationship with Others:
- Partner: (ex: find a partner who accepts my HIV, be with a partner who does not hit me or verbally put me down):
- Friends: (ex: find friends that will support the positive changes I want to make in my life):
- Family: (ex: share my HIV status with family members that I think can emotionally support me)
- Others: (ex: health care provider):

Achievements (ex: learn to drive or play an instrument):

Feeling Good About Myself (ex: exercising or keeping a healthy diet):

Other:

Prevention Goals
Under each category, write your goals. You can have more than one goal under a category.

Sex (ex: I want to lower my discomfort about condoms, I want to refuse unsafe sex):

Substance Use (ex: I want to stop shooting up, I want to say no to my friends who influence me to use):

Health Care and Self-Care (ex: I want to exercise, I want to eat more healthy, I want to keep all my healthcare appointments, I want to better advocate for my health):

Adherence (ex: I want to be able to talk to my doctor about my medication side effects, I want to be 100% medication adherent):

Disclosure (ex: I want to feel more confident about making disclosure decisions, I want to know some tips for making a disclosure in the best possible way):

Stigma (ex: I want to better cope with HIV stigma, I want to know my rights when it comes to discrimination against persons living with HIV):

Guidelines for Goal Setting
- Goals should be
  - Important to you
  - Something you are committed to
  - Realistic - not too hard and not too easy
  - Brief, specific and clearly stated
  - Easy to tell when they are accomplished
Training Agenda: Day Two

- Review/Preview
- Module 8: Core Skill Session 1
- Module 9: Core Skill Session 2
- Knowledge, Skills, and Traits of a Counselor

Structure of Skills Practice: Core Skill Session 1

- Overview of Activity Aims
  - Activity 1: What Can CLEAR Do for Me?
    - Watch clip
    - Group discussion
  - Activity 2: What is Our Commitment?
    - Increase rapport
    - Encourage appropriate boundaries
  - Activity 3: How Do I Feel About Living with HIV?
    - Introduce the Feeling Thermometer
    - Discuss the experience of living with HIV
  - Activity 4: What are Good Goals?
    - Reinforce client and counselor expectations and commitment

Structure of Skills Practice/Feedback Format

- Counselor
  - What did you do well?
  - What might you do differently?
- Client and Observer (provide the counselor with feedback)
  - What did he/she do well?
  - What might he/she do differently?
- Focus on implementation activity, not counseling skills
  - Did the counselor:
    - Follow the Implementation Manual?
    - Discuss/teach the core elements?
    - Discuss/teach cognitive-behavioral techniques?

Core Skill Session One: Activity Aims

- Activity 1: What Can CLEAR Do For Me?
  - Explore expectations and clarify misconceptions
  - Provide basic overview of CLEAR
- Activity 2: What is Our Commitment?
  - Introduce the Feeling Thermometer
  - Discuss the experience of living with HIV
- Activity 3: How Do I Feel About Living with HIV?
  - Introduce the Feeling Thermometer
  - Discuss the experience of living with HIV
- Activity 4: What are Good Goals?
  - Reinforce client and counselor expectations and commitment
  - Introduce goal setting and set a goal for next week

Core Skill Session One
Activity 1: Counselor Tips

- Give clear and concise information
- Only disclose the personal information outlined in the script
- Stick to the Script!
- If client expresses an expectation that will not be met, inform client that it will not be met
- Use information about client’s expectations later to guide the assessment and development of the prevention plan in Core Skill Session Five

Core Skill Session One
Activity 3: Counselor Tips

- Try to model the use of the Feeling Thermometer for clients
- Continually apply the Feeling Thermometer throughout the activity, even if it’s not in the script to help clients practice using it
Counseling Tips for Activity 4

• Make goals concrete and guidelines for goal setting clear - help set client up for success
• Maintain a balance between increasing buy in and developing rapport - be honest about what CLEAR is and what the client can expect
• Affirm and emphasize client’s strengths to increase self efficacy - don’t point out weaknesses
• Assess clients in an informal manner and build rapport through conversation
• Take notes throughout the sessions, noting things that the counselor can link to the core elements and to future menu sessions

Core Skill Session 2: Activity Aims

• Activity 1: Check In
  • Set a positive tone and shape positive behavior
  • Outline the purpose of this session
• Activity 2: What is My Ideal Self?
  • Introduce the concept of the Ideal Self
  • Have the client identify his/her values as they relate to the Ideal Self
• Activity 3: How Can I Create a Vision for My Future?
  • Identify and discuss life goals
  • Draw and discuss a picture of client’s ideal future
• Activity 4: How Can I Relax?
  • Reduce tension and negative thoughts
  • Introduce the concept of lowering the FT through relaxation and Ideal Self
• Activity 5: What’s Next?
  • Reinforce today’s learning
  • Set weekly goals
  • Motivate client to return to the next session

Core Skill Session Two
Activity 2: Counselor Tips

• Counselors should link as many topics covered in the activity as possible with the F-T-D grid
• Emphasize to the client that when our behaviors are in line with our Ideal Self, we are more comfortable and our FT level is low
• When we are not behaving in line with our Ideal Self, we are less comfortable and our FT level is higher. This is why we use the F-T-D grid to define the characteristics of our Ideal Self

Core Skills Session Two
Activity 3: Counselor Tips

• Remind participants of guidelines for good goals
• Sometimes clients may hesitate to make goals. In such cases, counselor should explore the client’s understanding of a goal.
• If the client does not want to set a life goal, counselor may focus on a short-term goal, “What would you like to do for yourself between now and the next time we meet?”

Core Skill Session 2
Activity 4: Counselor Tips

• Counselors can adapt this activity by using various types of relaxation exercises. However, it is important to understand that it cannot be removed or omitted.
• Counselors can use relaxation exercises throughout the sessions (even when it is not written in) as needed.

Core Skill Session 2
Activity 5: Counselor Tips

• Sometimes a client’s weekly goal may seem unrelated to his/her life goal or the session content.
• The counselor should explore the goal and reframe it to enable the client to see the connection between the goal, his/her life goals, Ideal Self and/or session content.
• In assisting a client in developing weekly goals, counselors need to keep in mind that CLEAR is client centered. Remain client centered at all times.
Group Activity

- Knowledge, Skills, and Traits of a Counselor

Key Counselor Responsibilities

- Delivering the intervention with fidelity
- Creating buy in from the client
- Establishing and maintaining effective boundaries
- Utilizing client-centered skills

Core Skill session 2 Activity 4

- How Can I Relax?

Day 2 Wrap up & Adjourn

Welcome to Day 3

Training Agenda: Day 3

- Module 10: Review/Preview
- Module 11: Core Skill Session 3
- Module 12: Core Skill Session 4
- Module 13: Core Skill Session 5
- Adjourn
Core Skill Session 3 Activity Aims

- Activity 1: Check in
- Activity 2: What are my Current Stressors
  - Identify client’s life stressors
  - Identify client’s comfort level associated with each stressor
  - Identify several ways to think about and respond to each stressor
- Activity 3: What is CLEAR Thinking?
  - Introduce CLEAR Thinking
  - Teach the client to replace unhelpful thoughts with CLEAR thoughts
  - Discuss how CLEAR thoughts can help client reach his/her goals
- Activity 4: What is SMART Problem Solving
  - Introduce SMART Problem Solving method
  - Use client’s problem to illustrate method
  - Discuss the importance of thinking before acting
- Activity 5: How Can I Relax?
- Activity 6: What’s Next?

Core Skills Session 3 Activity 3: Counselor Tips

- It’s easy to get confused about when to use SMART Problem Solving and CLEAR Thinking addressing stressors.
  - Use SMART Problem Solving to address controllable stressors
  - Use CLEAR Thinking to address uncontrollable stressors

Core Skill Session 3 Activity 4: Counselor Tips

- Remain non-judgmental about the options the client comes up with during SMART problem solving.
  - Identify the pros and cons of every option
  - Problems should be SPECIFIC, well-defined and that it’s only one problem, not multiple problems
  - SMART problem solving process might take awhile - slow down the F-T-D process

Core Skill Session 4 Activity Aims

- Activity 1: Check in
- Activity 2: How is Communication Related to F-T-D?
  - To discuss how F-T-D impacts assertive communication
- Activity 3: What are the Different Types of Communication?
  - To differentiate between aggressive, assertive and passive communication
  - To illustrate assertive communication through a role play
  - To identify the FT rating that client identifies with effective communication
- Activity 4: How Can I Apply Assertive Communication in My Life?
  - Identify a situation where client would like to apply assertive communication skills
  - Allow the client to practice these skills
- Activity 5: How Can I Relax?
- Activity 6: What’s Next?

Core Skill Session 4 Activity 2: How is Communication Related to F-T-D?

- Key Points:
  - Relate the client’s recent communications to F-T-D
  - Use the F-T-D grid to write down the client’s thoughts, feelings and action
  - Use the grid to show how an event is made of multiple, escalating steps
  - Counselor is responsible for making the link clear

Three Types of Communication

- Aggressive
  - Disrespectful of other people, stand up for your rights but violate the rights of others
- Passive
  - Put the rights of others before your own, minimizing your own self worth
- Assertive
  - Stand up for your own needs while being concerned and respectful about the needs of others
Core Skills Session 5 Activity Aims

- Activity 1: Check in
- Activity 2: Prevention Steps
  - Assess the client’s motivation to prevent HIV
  - Identify the client’s areas of strength
  - Relate prevention steps to client’s Ideal Self and long-term goals
- Activity 3: What Prevention Goals do I Want to Start Working on as a Part of My Prevention Plan?
  - Identify client’s prevention goals
  - Select one goal as the beginning of client’s individual prevention plan
  - Use Ideal Self and long-term goals to identify a series of prevention goals
- Activity 4: What’s Next?

Day 3 Wrap up & Adjourn

Training Agenda: Day Four

- Module 14: Review/Preview
- Module 15: Overview of Menu Sessions and Key Concepts
- Module 16: Menu Sessions - a Closer Look
- Module 17: CLEAR (Planning and Implementation)
- Module 18: Closure and Evaluation
- Adjourn

Core Skill Sessions at a Glance (Debrief)

<table>
<thead>
<tr>
<th>#</th>
<th>CSS1</th>
<th>CSS2</th>
<th>CSS3</th>
<th>CSS4</th>
<th>CSS5</th>
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<td>Check-In</td>
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<td>Check-In</td>
<td>Check-In</td>
<td>Check-In</td>
</tr>
<tr>
<td>2</td>
<td>What is our commitment?</td>
<td>What is my Ideal Self?</td>
<td>What are my current stressors?</td>
<td>How is communication related to FTD?</td>
<td>What Prevention Steps have I already taken?</td>
</tr>
<tr>
<td>3</td>
<td>How do I feel about LWH?</td>
<td>How can I create a vision for my future?</td>
<td>What is CLEAR thinking?</td>
<td>What are the different types of communication?</td>
<td>What prevention goals do I want to start working on . . . ?</td>
</tr>
<tr>
<td>4</td>
<td>What are good goals?</td>
<td>How can I relax?</td>
<td>What is SMART Problem-solving?</td>
<td>How can I apply assertive communication in my life?</td>
<td>What’s next?</td>
</tr>
<tr>
<td>5</td>
<td>What’s next?</td>
<td>How can I relax?</td>
<td>How can I relax?</td>
<td>How can I relax?</td>
<td>How can I relax?</td>
</tr>
</tbody>
</table>
How are the Menu Sessions Selected in CLEAR?

- Counselor works with client to identify prevention goals
- Six domains that represent the Six Menu Sessions
- Counselor assesses client’s risk throughout all five Core Skills Sessions
- Session in each domain must be implemented in order, unless a specific Menu Session does not pertain to the client’s life context/expressed need
- When a Menu Session is completed, the client may choose a second prevention goal.

Progress in completing the prevention goals is monitored through completion of weekly goals.

SEXUAL RISK (6 Sessions)
- SMART Problem-Solving
- F-T-D linked to condom use
- Correct use of male and female condoms
- Assertive Communication
- Sex-related risks
- Role play of safe sex negotiation
- Role play of triggers

SUBSTANCE USE (5 Sessions)
- Assess substance use
- Weekly schedule
- Triggers
- CLEAR Thinking
- SMART Problem-Solving
- Injection drug-related risks
- Substance use and HIV issues
- Communicating substance use to HCP
- Substance use as a barrier to adherence

ADHERENCE (3 Sessions)
- Information on HIV treatment
- F-T-D linked to adherence
- CLEAR Thinking
- SMART Problem-Solving
- Injection drug-related risks
- Substance use and HIV issues
- Communicating substance use to HCP
- Substance use as a barrier to adherence

HEALTH CARE (3 Sessions)
- Outline current health habits
- HIV care-related rights and responsibilities
- Barriers to keeping appointments
- SMART Problem-Solving
- Role play anti-event with HCP
- Guidelines for being a partner in care

STIGMA (2 Sessions)
- Positive characteristics and accomplishments
- F-T-D linked to stigma
- Identify internal stigma
- Identify external stigma
- CLEAR Thinking
- Q&A for housing, employment, and sex issues

DISCLOSURE (2 Sessions)
- Assess previous disclosure experiences
- Assess difficulty & importance of disclosure
- Disclosure tips
- Role play disclosure

Dealing with External Triggers

- SMART Problem Solving
  - Avoidance
  - Removal
  - Neutralizing
  - Take yourself away from the trigger (leave the scene)
  - Changes some aspect of the trigger
  - Takes the power away from the trigger
  - Applies mostly to situations with other people

How Does CLEAR Help Clients Deal with Triggers?

- Feel-Think-Do helps participants learn about sex and substance use patterns
- CLEAR teaches participants to:
  - Control triggers
  - Stop thoughts before they become craving

<table>
<thead>
<tr>
<th>Type of Trigger</th>
<th>Examples</th>
<th>How does CLEAR help clients deal with the trigger?</th>
</tr>
</thead>
<tbody>
<tr>
<td>External Trigger</td>
<td>People, places, situations, things</td>
<td>SMART Problem-Solving: -Avoidance -Removal -Neutralizing</td>
</tr>
<tr>
<td>Internal Trigger</td>
<td>Emotions and feelings (e.g. anger, happiness)</td>
<td>CLEAR Thinking: -Positive self-talk -Reframing -Countering</td>
</tr>
</tbody>
</table>
Dealing with Internal Triggers

- CLEAR Thinking:
  - Positive self talk
  - Cope with unchanged situation by what we say to ourselves
  - Reframing
  - Re-describes the experience in positive terms
  - Changes the way in which the problem is understood
  - Problems framed as disasters vs. opportunities to grow and learn
  - Countering/Arguing against negative thoughts
    - “Stop”
    - Rubber band

Substance Use Weekly Schedule

- If the client has a prevention goal related to substance use, they will be introduced to the Substance Use Weekly Schedule.
- This is a tool that tracks the client’s progress related to his/her long-term substance use prevention goal and reveals drug and alcohol use patterns.
- Once introduced, this tool is used throughout the CLEAR program.

### Subsection: Dealing with Internal Triggers

- CLEAR Thinking:
  - Positive self talk
  - Cope with unchanged situation by what we say to ourselves
  - Reframing
  - Re-describes the experience in positive terms
  - Changes the way in which the problem is understood
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### Subsection: Substance Use Weekly Schedule

- If the client has a prevention goal related to substance use, they will be introduced to the Substance Use Weekly Schedule.
- This is a tool that tracks the client’s progress related to his/her long-term substance use prevention goal and reveals drug and alcohol use patterns.
- Once introduced, this tool is used throughout the CLEAR program.

### Table: Substance Use Weekly Schedule (Example)

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 AM</td>
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<td>2:00 PM</td>
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<td>10:00 PM</td>
</tr>
</tbody>
</table>

Counselor helps the client fill out this schedule and should verbally discuss it.

### Table: Overview of Sexual Risk Menu Sessions & Activities

<table>
<thead>
<tr>
<th>SESSION 1</th>
<th>SESSION 2</th>
<th>SESSION 3</th>
<th>SESSION 4</th>
<th>SESSION 5</th>
<th>SESSION 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Check In</td>
<td>• Check In</td>
<td>• Check In</td>
<td>• Check In</td>
<td>• Check In</td>
<td>• Check In</td>
</tr>
<tr>
<td>• What Leads Me to Have Unsafe Sex?</td>
<td>• What are My Thoughts About Condoms?</td>
<td>• I Use a Female Condom?</td>
<td>• What’s Safe?</td>
<td>• What do People Living with HIV Need to be Aware of?</td>
<td>• How do I Feel About Disclosure?</td>
</tr>
<tr>
<td>• How do I Handle My Unsafe Sex Triggers?</td>
<td>• How do I Use a Female Condom?</td>
<td>• What’s Next?</td>
<td>• What’s Next?</td>
<td>• When it Comes to Substance Use?</td>
<td>• The Pros and Cons About Sharing My Status</td>
</tr>
<tr>
<td>• What’s Next?</td>
<td>• What’s Next?</td>
<td>• What’s Next?</td>
<td>• How do I Communicate My Safer Sex Desires to My Partner?</td>
<td>• How Can I Handle My External Triggers?</td>
<td>• How do I Tell a Partner I am HIV Positive?</td>
</tr>
<tr>
<td>• What’s Next?</td>
<td>• What’s Next?</td>
<td>• What’s Next?</td>
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<td>• Check In</td>
<td>• Check In</td>
</tr>
<tr>
<td>• What Are the Pros and Cons of My Substance Use?</td>
<td>• What Keeps My Drug &amp; Alcohol Use Going?</td>
<td>• What Are My Internal Triggers for Drug &amp; Alcohol Use?</td>
<td>• What Do I Think About Changing My Injection Drug Use Behaviors?</td>
<td>• What is My Injection Drug Use Triggers?</td>
<td>• What’s Next?</td>
</tr>
<tr>
<td>• How Comfortable am I with the Cons of My Substance Use?</td>
<td>• What are My External Triggers for Drug &amp; Alcohol Use?</td>
<td>• How Can I Tell a Partner I am HIV Positive?</td>
<td>• How Do I Handle My Injection Drug Use Triggers?</td>
<td>• What’s Harmful About Injecting Drugs?</td>
<td>• What’s Next?</td>
</tr>
<tr>
<td>• Keeping Track of Progress</td>
<td>• What Do I Think About Changing My Injection Drug Use Behaviors?</td>
<td>• What’s Next?</td>
<td>• What Are My Injection Drug Use Triggers?</td>
<td>• How Do I Feel About Disclosure?</td>
<td>• What’s Next?</td>
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<tr>
<td>• What’s Next?</td>
<td>• What Are My Internal Triggers for Drug &amp; Alcohol Use?</td>
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<td>• How do I Feel About Disclosure?</td>
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<td>• How Can I Handle My External Triggers?</td>
<td>• What’s Next?</td>
</tr>
<tr>
<td>• What’s Next?</td>
<td>• The Pros and Cons About Sharing My Status</td>
<td>• How do I Tell a Partner I am HIV Positive?</td>
<td>• How do I Feel About Disclosure?</td>
<td>• The Pros and Cons About Sharing My Status</td>
<td>• What’s Next?</td>
</tr>
</tbody>
</table>
Overview of the Health/Self-Care Menu Sessions & Activities

SESSION 1
• Check-In
• Why Should I Stay Healthy?
• What Does It Mean to Stay Healthy?
• What Are My Barriers to Staying Healthy and How Can I Cope with Them?
• What’s Next?

SESSION 2
• Check-In
• What Weighs on My Decision to Keep or Skip Appointments?
• Attending Medical Appointments: Breaking Down Barriers
• What’s Next?

SESSION 3
• Check-In
• How Do I Communicate What I Need to My Health Care Provider?
• How Can I Promote a Productive Relationship with My HCP?
• What Are My Rights and Responsibilities?
• What’s Next?

Overview of Adherence Menu Sessions & Activities

SESSION 1
• Check-In
• What Is My Current Medication Regimen?
• How Is My Adherence?
• What Affects the Way I Take My Meds?
• How Can I Use CLEAR Thinking to Improve My Adherence?
• What’s Next?

SESSION 2
• Check-In
• What Are My HIV Medications All About?
• How Can I Use SMART Problem-Solving to Improve Adherence?
• How Can I Plan to Achieve My Adherence Goals?
• What’s Next?

SESSION 3
• Check-In
• How Should I Talk to My HCP About My Meds?
• What Are the Barriers to Discussing My Meds with My HCP?
• Practice Discussing My Meds with My HCP
• What’s Next?

Overview of Stigma Menu Sessions & Activities

SESSION 1
• Check-In
• Who Am I?
• How Do I Feel About Stigma?
• CLEAR Thinking
• What’s Next?

SESSION 2
• Check-In
• How Can I Use CLEAR Thinking to Handle External HIV Stigma?
• What Are My Rights as a Person Living with HIV or AIDS?
• What’s Next?

Overview of Disclosure Menu Sessions & Activities

SESSION 1
• Check-In
• How Do I Feel About HIV Disclosure?
• Disclosure: Advantages and Disadvantages
• Who Needs to Know?
• What’s Next?

SESSION 2
• Check-In
• Review of “Whether to Disclose Your Status” Session
• Practicing Disclosure
• Relaxation
• What’s Next?
Wrap-Up Session: Activity Aims

- Activity 1: Check in
- Activity 2: How Do I Feel and Think About Maintaining the Changes I’ve Made?
  - Assess the client’s thoughts and feelings about maintaining behavior change
  - Reframe defeating thoughts with CLEAR thoughts
- Activity 3: How Do I Maintain the Changes I’ve Made?
  - Develop strategies to maintain new behaviors for the long term
- Activity 4: Closure
  - To bring closure to the CLEAR sessions
  - Give the client his/her workbook
  - Allow client to express thoughts and feeling about the CLEAR experience

Client’s Workbook

- Strategies for maintaining behavior change
- Opportunity for client to express with CLEAR has meant in his/her life
- Tangible account of the hard work completed
- Resource to remind the client of how each skill and technique is used

CLEAR

- Planning and Implementation

Legal & Ethical Considerations

- How are ethics defined?
  - Ethics typically define the highest or ideal standard of choice or action in response to a set of conditions or circumstances.
- How is law defined?
  - Law established minimum standards of action and behavior based upon custom or practice of a community. Laws proscribe choices or actions and their consequences.

Legal & Ethical Policies

- The agency is responsible for:
  - Providing clear ethical standards by which counselors/providers and other prevention workers must govern their behavior and attitudes.
  - Updating codes of ethics agency protocol
  - Provide training to counselors when agency policies or laws change
Topics for Legal/Ethical Consideration

- Confidentiality/Privacy
- Voluntary informed consent
- Cultural competence
- Professional ethics
- Discharge planning
- Duty to warn
- Others
  - Staff qualifications
  - QA
  - Coordination of services

Quality Assurance

- Should develop and adhere to established standards to ensure program is delivered in a consistent manner
- Tailored manual describing the agency’s plan for implementation
- Written quality assurance protocols
- Evaluation

Clinical Supervision in CLEAR

Planning for implementation of CLEAR

Needs assessment activities

- Identifying and analyzing epidemiological reports
- Exploring factors that influence risk behaviors
- Examining the local or state comprehensive HIV prevention plan
- Consulting with science providers, members of the target population and other community stakeholders who possess key knowledge through focus groups or structured interventions

CLEAR Recruitment

1. What recruitment strategies have you been using at your agencies for CLEAR?
Retention

• How can your agency retain clients in the CLEAR intervention?

CLEAR retention strategies

• Phone calls, emails and or text messages (periodically between sessions). (confidentiality)
• Giving monetary or other incentives.
• Ground rule in the first session: The client agrees to come back “One more time” and repeating that at each session.
• Providing positive feedback to clients for committing to attend the sessions.
• Providing consistent validation and reinforcement to clients.

What should we do about clients who quit attending sessions but later ask to come back?

• This should be addressed in the policies and procedures set up by the agency.

• Agencies also may want to give Counselors some leeway in how they handle the situation.

How do you know if your agency has the capacity to implement CLEAR?

• It is important to examine not only the budget, but also a number of other capacity issues
• Does you agency have/can hire counselors and a clinical supervisor with appropriate background, skills and experience for CLEAR?
• Do you have the capacity to recruit members of the target population for the CLEAR intervention?
• Does your agency has adequate space to implement CLEAR?
• Can your agency develop policies needed to implement CLEAR?

What techniques can I use to keep clients involved in the sessions?

How do you know if your agency has the capacity to implement CLEAR? Cont..

• What type of organizational changes need will need to occur to ensure that CLEAR is implemented successfully?
• Will implementing CLEAR change your agency’s relationship with other prevention and/or services agencies? Is your agency ready to make those changes?
• Is your staff culturally competent to implement CLEAR with your target population?
• Can your organization successfully adapt CLEAR to meet its needs and those of its target population?
Opportunities for adaptation of CLEAR

- Key word here is assessment
- It is important to consider how comfortable your clients will be with CLEAR materials or sections of the script
- If clients do not feel comfortable with a particular piece of the intervention, ask how they might prefer such information to be presented
- Check on language and literacy issues
- Pre test the new materials or script with members of the target population and adjust as need it

CLEAR Monitoring and Evaluation

<table>
<thead>
<tr>
<th>For more information on:</th>
<th>See the CLEAR Implementation Manual</th>
<th>See the CLEAR Evaluation Field Guide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluating CLEAR</td>
<td>Page 35</td>
<td>Entire Document</td>
</tr>
<tr>
<td>Process Monitoring</td>
<td>Page 35</td>
<td>Pages 19-20</td>
</tr>
<tr>
<td>Process Evaluation</td>
<td>Page 35</td>
<td>Pages 21-22</td>
</tr>
<tr>
<td>Outcome Monitoring</td>
<td>Page 36</td>
<td>Pages 22-24</td>
</tr>
</tbody>
</table>

CLEAR training and Technical Assistance (TA)

For Technical assistance and training request:
- CDC direct funded agencies should contact their project officer and submit a CRIS request
- Indirect funded (funded through local/state health department) should contact their health department program officer to request TA and or training. The health department program officer will submit the CRIS request

For training request can also go to: www.effectiveinterventions.cdc.gov

How to Access CLEAR Forms

www.effectiveinterventions.cdc.gov

Wrap Up!

Final Questions and Answers

- Evaluations
- Thank you!!!