

PART I. INTRODUCTION

The *Modelo de Intervención Psicomédica* (MIP) is a comprehensive, individualized behavior change intervention aimed at reducing high risk behaviors for infection and transmission of the Human Immunodeficiency Virus (HIV) and viral hepatitis among active injection drug users (IDUs). It is also aimed at increasing injection drug users' utilization of health care services including drug treatment. MIP was developed by researchers in Puerto Rico, and implemented, evaluated, and proven effective with Latino IDUs. The intervention is participant-centered, theory-driven, and intensive; it consists of seven structured sessions facilitated over a 3-6 month period--five of which are flexible and two that are fixed sessions. All sessions combine individualized counseling with comprehensive case management intended to support positive behavior change.

This implementation manual describes the MIP intervention and is meant to serve as a guide for management teams, including Executive Directors, Program Directors, Managers, Board Members, and fiscal and front-line staff that are considering implementing the MIP intervention. The implementation manual is organized into four parts:

Part I provides an overview of MIP. This section describes the original research that established the effectiveness of the intervention, introduces the theories and models that are the foundation for MIP, and presents the core elements and key characteristics of the intervention. Also included are discussions on the adaptation of MIP for other target populations and the benefits and challenges of implementing the intervention.

Part II is designed to help Program Directors and Supervisors prepare for MIP implementation. This section includes information and guidelines for selecting MIP staff as well as for recruiting and retaining MIP participants. Also discussed are the program resources required to adequately support MIP implementation and the tools necessary to develop a program implementation plan and budget.

Part III details each of the seven sessions that comprise the MIP intervention. Beginning with the Induction Session, the objectives, activities, methods, materials, and required resources for all sessions are described. The worksheets, guides, handouts, and forms used during each session are included at the end of that session.

Part IV explains monitoring and evaluation for MIP. This section presents an overview of the monitoring and evaluation process, outcomes, and data collection instruments with emphasis on how to set up a monitoring and evaluation plan for MIP. Emphasis is placed on monitoring and evaluation strategies that have relevance in community settings.

Overview of MIP

MIP is a cognitive behavioral HIV prevention intervention for active injection drug users that integrates community-based recruitment, individualized counseling, and comprehensive case management. This combination facilitates behavior change that leads to a reduction of HIV risk behaviors and to an overall healthier life-style for participants. MIP incorporates the following strategies: readiness to change, motivational interviewing, building self-efficacy, role induction, and case management.

The intervention is based on research conducted by the Universidad Central del Caribe, School of Medicine, Center for Addiction Studies, Puerto Rico, through support from the National Institute of Drug Abuse (NIDA) (2001). The uniqueness and efficacy of MIP is best captured in its approach, which focuses on the continuous interaction between the participant and the members of the MIP team—the Supervisor, Counselor, and Case Manager/Community Educator. The team works together and in partnership with the participant to address the participant's risk behaviors. MIP team members facilitate his/her integration into the healthcare system, enabling the participant to seek drug abuse treatment and to ultimately establish a family support system and a place in the recovery community.

GOALS:

The goals of MIP are to:

- Reduce HIV/viral hepatitis risk behaviors associated with injection drug use and sex.
- Engage participants in drug treatment and healthcare services.
- Enhance participants' self-efficacy for maintaining behavior change and preventing relapse.

TARGET POPULATION:

The primary target population for MIP is male and female injection drug users 18 years and older recruited from the community. It should be noted, however, that MIP can be adapted for other drug users, such as IDUs participating in methadone maintenance programs for the past year. Organizations interested in using MIP with non-IDUs or with poly drug users should contact their Centers for Disease Control (CDC) project officers to obtain guidance on how to access technical assistance for adapting MIP.

THE INTERVENTION:

The intervention consists of seven structured sessions conducted over a 3-6 month period – one (1) induction session, (5) individualized counseling sessions with a comprehensive case management component, and one (1) booster session that reviews and reinforces the goals accomplished and the challenges encountered throughout the intervention. Sessions activities are guided by the fundamental principles of motivational interviewing, which requires the adoption of a client-centered, non-confrontational, supportive approach to behavior change.

The objective of the intervention is to increase a participant's motivation to change their drug and sex-related HIV risk behavior and to develop a plan to maintain positive behavior changes. MIP is intended to help the participant resolve any ambivalence toward changing high risk behaviors by introducing safer alternative behaviors and increasing the participant's self-efficacy in consistently practicing those behaviors. Several interrelated approaches characterize MIP:

1. Treating the participant with respect and dignity,
2. Fostering autonomy and self-efficacy,
3. Creating a plan for behavior change that includes the actions necessary to achieve the participant's goal, and
4. Helping the participant obtain primary health care, drug treatment, and other supportive services conducive to a healthier and more productive life.

MIP sessions focus on increasing participant readiness to (a) assess the benefits of changing unsafe drug and sex-related behaviors, (b) make a commitment to modify harmful behaviors, and (c) develop a plan to facilitate these changes. **Participants identify risk behaviors they wish to change, build risk reduction skills, and take the steps required to reduce their drug and sex-related HIV risk behaviors.**

ROLE OF THE MIP TEAM

A significant component of the MIP intervention is the relationship between the team members and the participant. Throughout the intervention—both during the structured sessions and by working with the participant in-between sessions—the goal is to develop a constructive, problem-solving relationship with the participant in order to:

- Support the reduction of drug and sex-related HIV risks (e.g., promote the elimination of sharing needles/works, teach condom negotiation skills, and so forth).
- Directly assist participant with obtaining primary and mental health care and other needed social services (case management).
- Assist with entry into and success in drug treatment programs.
- Provide HIV/Sexually Transmitted Infections (STI) counseling and testing and viral hepatitis and TB referrals.
- Help participants identify triggers, practice relapse prevention skills, and identify support systems to maintain behavior change.

The team's responsibility is to help the participant reflect on his/her life and formulate goals in several domains. Although long-term HIV risk reduction and entry into drug treatment are the priorities of MIP, the intervention also requires that attention be placed on the participant's immediate health needs.

What Makes MIP Effective – The Research

MIP is based on research conducted by Dr. Rafaela Robles and her team from the Universidad Central del Caribe, School of Medicine, Center for Addiction Studies, Puerto Rico, with Latino, injection drug users. Funded by the National Institute of Drug Abuse (NIDA, 2001), the goal of the study was to test the effectiveness of a combined counseling and case management behavioral intervention that used behavioral readiness staging and motivational interviewing techniques to engage injection drug users, facilitate their entry into drug treatment and the health care system, and increase their self-efficacy in identifying and modifying drug and sex-related HIV risk behaviors.

Target and Sample Size:

557 study participants comprised of Latino men and women at least 18 years of age and residing in Puerto Rico who had injected drugs during the past 30 days. Women accounted for 11% of the study participants.

Methods:

All participants (n=557) took part in a two-session intervention led by a Counselor. The first session included HIV pretest counseling and testing and discussions about HIV risk behavior, safe needle use, and skills for safer sex. The subsequent session focused on post-test counseling, a review of the first session, referral for drug treatment, and referral for healthcare services as necessary.

The research team then randomly assigned participants to either an experimental (n=285) or control group (n=272). Members of the control group were informed that their participation in the study had come to an end and that a Counselor would contact them in 6 months for a follow-up interview. Participants assigned to the treatment group were invited to participate in a seven session intervention that included individualized counseling and case management assistance to facilitate access to needed health and human services and to help remove barriers for on-going participation in the intervention.

Findings:

At six-month follow up, 440 of the participants (79% from the control group and 79% from the experimental group) were interviewed. Participants in the experimental group were almost twice as likely to have entered drug treatment as those in the control group. Intervention participants were less likely to continue drug injection, independent of whether or not they had entered drug treatment. Participants who continued to inject drugs were less than half as likely to share needles compared to those who continued to inject drugs in the control group, and they were almost twice as likely to have increased self-efficacy in a needle-sharing situation. Those in the intervention group were also found to be less likely to pool money to buy drugs than those in the control group.

Overall, the MIP intervention was shown to be effective in reducing HIV risk behaviors among Latino injection drug users and in facilitating entry into drug treatment. The research team strongly believes that the success of the MIP intervention was due to the following factors:

- The dual approach of the MIP intervention, which combined individualized counseling and case management to address the full scope of participants' psychological, health, and social support needs.
- The supportive interaction between the MIP team and the participant which promoted autonomy and self-efficacy while simultaneously guiding and motivating the participant to change harmful behaviors.
- Flexibility in the implementation of five of the seven structured sessions based on participants' readiness to address a given topic, their stage of change, and their perceived self-efficacy to modify a risky behavior.

Appendix IA on page 19 includes a copy of the published research findings for MIP from a peer-reviewed journal.

Foundations of MIP

MIP is a theory-driven intervention to help injection drug users (IDUs) increase their utilization of health care, including drug treatment; reduce HIV risk behaviors and drug use; and improve health status. As such, the intervention is firmly grounded in the following behavior change theories and models: (1) The Transtheoretical Model of Change (Prochaska & DiClementi), (2) Social Learning Theory (Bandura), (3) Role Induction Theory (Stark & Kane), (4) Motivational Interviewing (Miller and Rollnick), (5) Cognitive Behavioral Approach (Beck), and (6) Comprehensive Case Management.

These theories provide the conceptual framework for MIP based on the belief that individual behavior change is motivated by three basic needs: autonomy, relatedness, and self-efficacy. Helping a participant meet those needs is the foundation of MIP.

- MIP helps fulfill the participant's need for **autonomy** by encouraging independence and helping the participant develop the ability to make decisions and to act on them.
- MIP helps fulfill the participant's need for **relatedness** by offering the participant the opportunity to build relationships with members of the intervention team and with larger human service and family networks.
- MIP helps fulfill the participant's need for **self-efficacy** by encouraging and reinforcing positive behavior change and healthier behaviors. The participant will persist in changing risky behaviors when he/she is able to value the behavior change not for its own sake, but because the behavior change enhances another aspect of his/her life. For example, a participant may be motivated to stop having unsafe sex not because it is a "good thing to do," but rather because it enables the participant to have a more trusting relationship with a partner.

A brief description of each supporting theory of MIP is summarized below. It should be noted that prior to implementing MIP, organizations should ensure that MIP team members are adequately trained in behavior change theory through the Centers for Disease Control's (CDC) Capacity Building Assistance (CBA) Programs, which offer such training free of charge to CDC and state health department funded organizations.

Transtheoretical Model of Change:

This behavior change model developed by Prochaska & colleagues (1983, 1984, 1994, 1995) suggests that change is dynamic, that change happens over time, and that it occurs in five stages:

The 5 Stages of Change:

1. **Precontemplation:** The person does not recognize a problem with his/her behavior and therefore has no intention to change behavior in the near future. Persons in this stage are viewed as resistant or unmotivated and usually avoid information, discussion, or thought about targeted health behavior. Expressions that typically identify those who are in precontemplation include: "As far as I'm concerned, I don't have problems that need to be resolved," "I believe that I have faults, but there is nothing that I need to change," or "But I don't need to change anything."
2. **Contemplation:** The person is aware that there is a problem and is seriously considering changing a behavior but has not yet committed to making any changes or to taking action. People can be stuck in this stage for long periods of time because they are aware of the benefits of changing a behavior but lack the motivation or self-efficacy to make those changes. A statement characteristic of this stage include: "I know I want to change the way I drink, but I'm not ready to do it."
3. **Preparation:** This stage combines the intention to make a change with the initial steps toward making that change. Participants in this stage are in transition. They intend to change and may have attempted to change but without consistency (>1 month) and/or success. Attempts to change are usually sporadic and inconsistent and, therefore, cannot meet the criteria for "Action". For example, a participant may say "I stopped sharing works with my buddies, but sometimes, I still share needles with my girlfriend when we need that high."
4. **Action:** The person takes action to modify behavior, experiences, and his/her environment in order to overcome challenges in changing risky behavior. The Action Stage involves making overt, observable changes which require a considerable commitment of time and energy so as to reach a specific goal, such as reducing illicit drug use. People in this stage have succeeded in changing a behavior and have performed the new behavior for at least six months. Examples of statements typical of this stage include the following: "I'm working very hard to change," and "Anybody can talk about change, but I am changing."
5. **Maintenance:** The person typically consolidates the benefits of the established behavior change(s) and works to prevent relapse. Maintenance is not the absence of action; it is the continuation of action. Because of this, it is the stage where participants report having the highest levels of self-efficacy. For chronic behavior problems, this stage extends from six months to an undetermined period of time after the first action. The following expressions characterize this stage: "I am here to prevent a relapse in drug use," and "I could need some reinforcements to help me maintain the changes I have achieved so far."

The concept of **relapse** holds great significance in the transtheoretical model of change; relapse is considered a normal part of the behavior change process and can occur during any of the five stages of change.

Social Learning Theory (SLT)

Social Learning Theory (SLT), developed by Bandura (1968), posits that people learn from one another via observation, imitation, and modeling. SLT presumes that when a person observes a powerful role model performing a specific behavior, the person's self-efficacy and the likelihood of the person adopting that behavior increases.

For example, a participant in MIP may be aware of the dangers of needle-sharing and risky sexual behaviors, but that knowledge alone may not be sufficient to motivate the participant to change his/her behavior. SLT asserts that behavior change is more likely to occur and be sustained if other key influencers (for example, a drug-injecting partner) model and practice an alternative behavior, such as insisting on using a clean needle for every injection.

Social Learning Theory explains human behavior as a continuous, reciprocal interaction between cognitive, behavioral, and environmental influences. SLT uses the following dimensions to conceptualize drug use.

Modeling: People learn through observing the behaviors and attitudes of others and the outcomes of those behaviors. Observational learning and exposure to others successfully performing a behavior and experiencing positive outcomes can motivate behavior change. For example, substance use can be understood as a process of observational, or vicarious, learning.

Self-regulation: This is when the individual has his/her own ideas about what is appropriate or inappropriate behavior and chooses actions accordingly. Alcoholism and addiction are not conditions characterized by the absence of self-regulation. On the contrary, these are ways of self-regulating that are problematic for the individual, the family, and society.

Reciprocal determinism: This concept explains the interaction and relationship between the person, the person's behavior, and the person's environment. Hence, one's environment can influence behavior, but behavior can also influence one's environment. People are capable of re-evaluating their behavior, the impact of that behavior on their environment, and the impact of the environment on them and on their behavior.

Self-efficacy: This describes the perception a person has about his/her capacity to effectively manage a situation. For a person in recovery from substance abuse or attempting to reduce risky behavior, it is the confidence in their ability to cope with stressors that previously led them to engage in those risky behaviors.

Role Induction Theory

The literature indicates that effective results in psychotherapy are related to a participant's expectations and preconceptions at the beginning of an intervention. In the context of MIP, role induction is a process whereby the MIP team explains to the participant the goals of the intervention—to reduce drug and sex-related HIV risk behaviors—and how the program can support the achievement of these goals. It also entails evaluating and clarifying a participant's expectations and preconceptions about MIP, its related activities, and their role and responsibilities in the behavior change process. Role induction has been shown to favorably affect client participation and retention.

Cognitive Behavioral Approach

Cognitive Behavioral Approach is founded on the premise that our thoughts influence our feelings and behaviors, our feelings influence our behaviors and thoughts, and our behaviors influence our feelings and thoughts. These factors are therefore interrelated, and change in one will impact at least one of the others. With this individualized intervention, the participant and the Counselor decide together what behaviors the participant wants to change and at what pace that change will occur. This approach involves the participant as an active partner in the counseling process. If the participant needs to repeat a session or move at a slower pace, the participant and the Counselor will make a decision together and modify the sessions accordingly. Because the participant will be determining his/her personal goals, the likelihood that the intervention will be viewed as relevant is increased. This will therefore motivate the participant to work with the Counselor and Case Manager/Community Educator to reach his/her goals.

Motivational Interviewing (MI)

The motivational interview is a participant-centered style of counseling which recognizes that participants are ultimately responsible for their behavior change. The objective of motivational interviewing is to help the participant explore and resolve his/her ambivalence about behavior change and increase self-efficacy, thus enabling him/her to make positive behavior changes. Motivational interviewing is based on five fundamental principles:

- **Express empathy:** The Counselor uses active and reflective listening skills to understand what the participant is trying to communicate. The attitude is one of acceptance; there is no place for criticism or blaming.
- **Discover discrepancy:** The Counselor actively encourages the participant to explore the gap between his/her goals and his/her present behavior. One of the objectives of motivational interviewing is to emphasize this discrepancy until the participant's desire to change surpasses his/her desire to maintain the present behavior. The participant—rather than the Counselor—should present these arguments for change.
- **Avoid argumentation:** Confrontation and arguing can cause the participant to become resistant and defensive. For example, diagnosing or labeling a participant instead of having the participant describe his/her risk behaviors can cause an argument.

- **Do not confront resistance openly** (“Roll with resistance”): The Counselor’s role is to reduce resistance since it inhibits change. When resistance increases, the Counselor should employ different strategies. The participant is viewed as the primary resource in finding answers and solutions.
- **Support self-efficacy**: For the person recovering from substance abuse and trying to reduce HIV risk behavior, self-efficacy is the belief in his/her ability to change risk behaviors and to cope with the stressors that may have led to engaging in those behaviors.

It should be noted that Self Determination Theory, although not explicit in MIP, is increasingly noted in the literature as being strongly associated with motivational interviewing. In fact, motivational interviewing is viewed as the practical application of Self Determination Theory. Both place a high value on the participant’s right to autonomy and on the individual’s potential for growth and change.

Comprehensive Case Management:

Central to the effectiveness of MIP is comprehensive case management designed to facilitate a participant’s access to health care, drug treatment, and social services. Although there are several approaches to comprehensive case management, the one that most closely aligns with MIP research is the Clinical Rehabilitation Model. This model acknowledges the pivotal role of a counseling relationship combined with case management. In the context of MIP, case management involves building a relationship with the participant, coordinating intervention activities, and advocating on behalf of the participant for a variety of health, human, and social services, including substance abuse treatment.

Successful comprehensive case management rests on three components:

- **Bonding**: A process that strengthens the relationship between the participant and the MIP team. Research shows that participants reporting strong bonds with the MIP team have better results.
- **Goal-setting**: The participant and Counselor agree on the behaviors that the participant wants to change.
- **Tasks**: The participant engages in a series of activities designed to meet his/her needs.

It is important to remember that these theories and models are no substitute for the commitment of MIP team members. Evidence has repeatedly shown that care for the participant and concern for his/her needs is essential to the behavior change process.

Systems Approach of MIP

The MIP model recognizes that participants are connected to a larger network of systems (e.g., family, healthcare, environmental, and other social systems) which may either support or hinder their behavior change efforts. The MIP team should be aware of participants' roles in multiple systems and work with them at both the individual and systems level in order to facilitate and sustain behavior change.

For example, in terms of family systems, the MIP Case Manager/Community Educator should be aware of—and work with the participant to overcome—family disturbances (e.g., childcare) that could impede the participant's involvement in the program. The Case Manager/Community Educator should also help the participant address his/her fears of rejection by family and peers because of roles and behaviors acquired during the intervention. This attention to the participant's environment as well his/her skills and self-efficacy is what defines the holistic nature of the MIP intervention. In MIP, it would not be acceptable to simply provide individualized HIV information and condoms to a homeless IDU participating in high-risk sexual behavior; instead, the system's approach requires that the participant receive assistance to secure basic health and social services, including temporary housing and individualized counseling to help the participant increase self-efficacy on condom use.

The MIP model is not only embedded in effective use of the healthcare system, but it is also closely linked to a relationship with the community where the Case Manager/Community Educator has established a presence and understands the problems and challenges faced by participants. For instance, through community mapping and observation, the Case Manager/Community Educator will be able to identify participants' social, peer, and cultural risk factors. Such information will be used in the process of recruitment and program accessibility and will alert the Case Manager/Community Educator to systems issues that may affect the behavior change process. MIP addresses these systems issues in addition to the participant's behavioral risk reduction goals in order to eliminate environmental barriers, support positive behavioral changes, and ensure an overall higher quality of life for participants.

Core Elements

Core elements are the critical features of an intervention which are thought to be responsible for its effectiveness. The core elements of MIP are derived from the conceptual models, behavioral theories, and the research results on which the intervention is based. They are essential to the implementation of the intervention and cannot be ignored, added to, or changed.

There are seven core elements for MIP:

1. Community Assessment and Outreach

Team members map the community and identify sites for potential participant recruitment (where participants live, hang out, sell and use drugs, and so forth). To accomplish this, team members must receive training in community mapping techniques and in safety procedures.

Additionally, team members must have or develop relationships with proven, existing community resources and establish memoranda of understanding (MOUs) to enlist the support of these resources, thus ensuring that participants can secure services (e.g., primary health care services, drug treatment programs, viral hepatitis testing, detoxification programs, housing, and so forth). Equally important, team members must ensure that participants have health insurance, know how to obtain it if they do not, and know how to access free treatment and care if they qualify to receive it.

2. Induction Process

The first MIP fixed structured session is called “Induction.” The induction process orients a participant to the MIP intervention and session topics, clarifies the participant and MIP team member roles and responsibilities, explains services offered as part of the intervention, secures participant consent, and solicits important demographic and behavioral data from the participant to help inform an individualized behavior modification plan.

Following the “Induction” session, *each* of the remaining six structured sessions in MIP requires a brief “induction” which provides the participant with an overview of the session topic and the activities to follow within that particular session.

3. Motivational Interviewing Technique and Underlying Theories

Motivational interviewing is the principal counseling technique the MIP team uses to help participants move through the stages of change. Using motivational interviewing techniques—both in formal sessions and during contacts in-between sessions—the MIP team helps the participant arrive at the point where he/she is ready to change risky behaviors, enter drug treatment, and obtain health care and human services.

The MIP team must either be competent in, or attend training on motivational interviewing techniques and other theoretical frameworks and models of MIP, including Transtheoretical Model, Social Learning Theory, Role Induction, Cognitive Behavioral Approach, and Comprehensive Case Management.

4. Continuous Stages of Readiness Assessment

The participant and Counselor use a *Behavior Change Self Assessment Instrument* at each session to affirm and reinforce the participant's risk reduction goals and increase participant self efficacy. They evaluate the participant's on-going involvement in the intervention process and assess his/her readiness to take meaningful action, change risk behaviors, enter drug treatment, and obtain health care and social services.

5. Counselor-Case Manager/Community Educator Interaction

This relationship describes the critical role of the dyad—the Counselor and the Case Manager/Community Educator—working together in meaningful ways to encourage and support participants in: behavioral risk reduction goals; problems related to social support and integration into family, healthcare, and drug treatment systems; and successfully completing the MIP program. This interaction requires on-going communication before, during, and after the structured sessions to enable a coordinated effort and to provide a larger dose of the intervention.

6. Minimum Number of Flexible Sessions and Scheduling

A minimum of five (5) flexible sessions and two (2) fixed sessions are required for this intervention. After the Induction Session (a fixed session), the flexible sessions can occur in any order based on the topic the participant identifies as being most important at that particular time. Because the intervention is based on participant decision-making, flexibility in conducting the sessions is crucial. This may entail scheduling additional contacts for a particular structured session if the participant needs more time to process, absorb, and/or take meaningful action in a particular area. The final MIP session—the Booster—is fixed, and can only be conducted after all other sessions have been completed.

7. Booster Session

The last fixed session summarizes and integrates all previous activities by reviewing the participant's achievements, needs, strengths, and outstanding issues. It includes an exit plan with specific strategies to overcome obstacles, maintain healthy behaviors, and enhance self-efficacy.

Key Characteristics

Key characteristics are the activities and delivery methods critical for conducting an intervention. To meet the needs of the target population and to ensure that the strategy is culturally appropriate, key characteristics may be adapted for different agencies and target populations. MIP has the following key characteristics:

- **Cultural Competence and Sensitivity**

Staff training will be conducted to ensure an understanding of the philosophy of MIP, the culture(s) of the target population(s), and the culture of drug use.

- **Team Structure and Training**

Ideally, the MIP team will include a Case Manager/Community Educator, a Counselor, and a Supervisor. The team will participate in a uniform orientation about MIP after which they will have a clear understanding of the underlying theories, core elements, and key characteristics of the intervention. The orientation will require team members to demonstrate competence in motivational interviewing and in developing strategies to ensure participant access to critical health, human, and

drug treatment resources. It is also highly recommended that all MIP team members complete a basic HIV/AIDS course and secure HIV counseling and testing certification.

▪ **Counseling and Testing for HIV/ viral hepatitis and Other Transmittable Diseases**

- Although participants do not have to be tested for HIV/viral hepatitis and other transmittable diseases to participate in MIP, those who have not yet been tested should be encouraged to do so after each contact.
- If the CBO already offers HIV/viral hepatitis counseling and testing, this intervention fits well with those services. Outside referrals for STIs or TB may still be required.
- If the CBO does not offer any counseling and testing services, participants should be referred to organizations or agencies that perform such services and follow-up should occur to ensure access to the referred services. These formal collaborations between agencies must be documented through a memorandum of understanding (MOU).

▪ **Counseling Team Interaction and the Bonding Process**

The MIP team should promote close working relationships among its members in order to establish a unified effort to help participants accomplish their goals and to ultimately ensure the success of MIP. This concept will also serve as a strategy to prevent staff burnout.

Target Audience

The primary target population for MIP is out-of-treatment active injection drug users 18 years and older recruited from community sites where drug users congregate. "Active" injection drug users are defined as individuals who have had at least one substance use experience during the last 90 days.

MIP can be adapted for implementation with other drug users, including IDUs in methadone treatment for the past year. Organizations interested in using MIP with non-IDUs or poly drug users may adapt it using the CDC's adaptation guidelines.

The MIP intervention may not be appropriate for persons whose primary issue is chronic alcohol use.

Modelo de Intervención Psicomédica (MIP) Behavior Change Logic Model

Problem Statement

MIP is designed for adult (18+) male and female Injection Drug Users (IDUs), who are seeking access to and utilization of health related services, including drug treatment. This population is at risk for HIV, Viral Hepatitis, and other STIs due to their drug and sex-related risk behaviors.

Major risk factors for HIV include: Lack of knowledge about HIV related risks and substance use and abuse; low motivation to change behaviors related to HIV risk; low awareness of HIV related risks and benefits of reducing HIV risk; low self-efficacy to achieve behaviors necessary to prevent HIV and gain access to care; lack of skills necessary to understanding, preventing, and managing issues related to HIV risk behaviors and substance use and abuse; lack of social support networks; and lack of access to and utilization of health related and drug treatment services.

MIP Behavior Change Logic Model

Behavioral Determinants Corresponds to risk or contextual factors	Activities To address behavioral determinants Note: All listed activities are used in multiple areas of the intervention	Outcomes Expected changes as a result of activities targeting behavioral determinants	
		Immediate Outcomes	Intermediate Outcomes
<ul style="list-style-type: none"> Lack of knowledge about HIV related risks and substance use and abuse. Low motivation to change behaviors related to HIV risk. Low awareness of HIV related risks and benefits of reducing HIV risk. Low self-efficacy to achieve behaviors necessary to prevent HIV and to gain access to care. Lack of skills to understand, prevent, and manage issues related to HIV risk behaviors and substance use and abuse. Lack of social support networks. Lack of access to and utilization of health related and drug treatment services. 	<ul style="list-style-type: none"> At counseling sessions, participants learn about the HIV/STI risks related to injection drug use. At every contact with clients, express empathy, develop discrepancy, avoid argumentation, and support self-efficacy to improve motivation to reduce risk behaviors. Conduct role induction at each session to clarify roles and responsibilities of participants and program staff. Assess clients' stages of change with regard to changing HIV risk behaviors. Offer counseling and testing for HIV/STIs/TB and viral hepatitis. At each contact, MIP staff provides referrals to health services, drug treatment programs, and other needed social services. At each session, teach and role-play effective risk reduction behaviors to improve participants' confidence in preventing HIV and accessing health care services. At counseling sessions participants learn and model proper HIV/STI risk reduction techniques and skills (injection related, sex related, and relapse prevention related). In all sessions, the MIP team works with participants to ensure adequate social support networks. 	<ul style="list-style-type: none"> Increase knowledge of HIV risk behaviors and substance use and abuse. Increase motivation to reduce risk behaviors. Increase understanding and commitment to the program and to its objectives. Increase self-efficacy for reducing HIV risk behaviors. Increase participant knowledge of sero-status. Increase access and utilization of healthcare services Increase participant self-efficacy in reducing HIV risk behaviors through safer sex and injection practices and through drug treatment. Increase knowledge and skills to prevent, understand, and manage potential issues related to HIV risk behaviors and substance use and abuse. Increase social support networks. 	<ul style="list-style-type: none"> Increase and maintain knowledge of HIV risk behaviors and substance use and abuse. Increase and maintain motivation to reduce high risk behaviors. Increase and maintain awareness of the benefits of reducing HIV risk. Increase and maintain utilization of health related services, including drug treatment programs. Increase and maintain confidence in practicing safer injection and sex related behaviors Increase and maintain knowledge and skills to prevent, understand, and manage potential issues related to HIV risk behaviors and substance use and abuse. Ensure and maintain social support networks.

Adaptation of MIP

Adaptation is defined in the literature as “the process of modifying an intervention without competing with or contradicting its core elements or internal logic” (McKelroy et al., 2006).

This definition is meant to capture the process by which organizations take an effective behavioral intervention in its packaged form and modify or adjust various components of the model in order to adapt the intervention to a different population or to a different setting. During the adaptation process, it is essential that the core elements of MIP remain intact. If these are modified significantly, there is a chance that the intervention will no longer be effective in achieving its stated risk reduction objectives.

Because MIP is a structured intervention, any modification to the key characteristics, recommended content, or delivery mechanisms would be considered an adaptation and therefore subject to variability in outcomes for participants. Although the core elements and content of MIP sessions must be maintained, there are a number of ways in which the intervention can be adapted to fit the particular needs of the implementing organization. For example, session content can be expanded or enhanced to emphasize specific content areas that the Counselor or participant judges to be of special importance.

Adapting an effective behavioral intervention such as MIP is a process that requires careful consideration and planning. Organizations interested in adapting the MIP intervention for special subgroups of drug users (e.g., poly drug users or non-IDUs), for certain intervention settings, or for populations with specific cultural and personal characteristics should obtain assistance in doing so through the CDC Capacity Building Assistance (CBA) program or via their Project Officer or Technical Monitor.

Benefits and Challenges

MIP's innovative approach to working with injection drug users—a population categorized as among the most difficult to reach with behavior change interventions—provides multiple benefits to both the implementing organization and the participants. Likewise, there are challenges in the adoption and implementation of MIP that impact both the organization and the participant.

Benefits to the Participant

MIP participants receive immediate and long-term benefits from this intervention. Immediate advantages to participants may include access to medical treatment for pressing healthcare needs, food, temporary housing, drug treatment programs, and other human services.

- All participants have access to counseling and testing for HIV/viral hepatitis and other transmittable diseases (e.g., STIs and TB). If participants test positive for transmittable diseases, team members help participants obtain appropriate care, treatment, and referrals. Participants also receive information on protecting themselves against liver damage and acquiring vaccinations for viral hepatitis.
- All participants receive risk reduction kits and information on safer injection and sex practices. The MIP team offers this information in a way that helps the participant clarify what he/she wants to do about the consequences of unsafe drug and sex practices. Where legal, the risk reduction kits should include condoms, sterile needles, bleach, isopropyl alcohol, a bottle of water, cotton, over-the-counter topical antibiotics, and other materials required for cleaning drug injection equipment.
- All participants receive information on drug treatment and alternative programs. If a participant wants to enroll in a program, the MIP team will facilitate entry into that program and will continue to offer follow-up support to the participant.
- Participants may receive a number of incentives during the intervention, including transportation passes and food vouchers, for successful completion of each session. Several studies in the literature suggest that incentives facilitate recruitment and retention.

Benefits to the Organization

The agency receives many benefits by offering an effective, evidence-based intervention such as MIP. The intervention provides a unique opportunity for agencies to recruit participants who have historically been reluctant to become involved with health and human service programs and to deliver a life-altering intervention aimed at reducing drug and sex-related HIV risk behaviors.

- MIP offers opportunities for staff members to acquire new knowledge and practical skills, which can boost morale, increase job satisfaction, and act as an incentive for staff members to remain with the agency. The agency can offer training in the theories, core elements, and methods of MIP for

all management and staff. In this way, MIP may enable the entire staff to work more effectively with agency clients, whether or not they use or are affected by drugs.

- MIP helps expand the relationships between the organization and primary care, drug treatment, mental health, and other health and human services--bringing greater program visibility and facilitating stronger community linkages.
- CDC will not only provide free Technical Assistance to directly funded agencies, but it will also offer training in organizational development to organizations implementing behavioral interventions such as MIP. Capacity building may include staff training, human resource development, and program development, adaptation, and evaluation. Such assistance will strengthen both the agency's overall capacity and the MIP program.
- Implementing the MIP risk-reduction program may make the agency more competitive when seeking grants from funding sources that support harm reduction models (e.g., needle exchange programs). Data collected about participants' behavior changes can increase the agency's credibility with funders as it demonstrates that the agency's programs are evidence-based and outcome-oriented.

Implementation Challenges

Implementing a new intervention such as MIP presents unique challenges. Prior to deciding to adopt MIP, the management team and organization staff must understand its theoretical foundations, core elements, and methods. Most importantly, the implementing organization must accept and commit to the participant-centered and behavioral risk reduction underpinnings of MIP. This is particularly important for organizations that use an abstinence-only model. To implement MIP properly, an organization must be flexible enough to change its focus from abstinence to reduced risk. Staff members must be made aware that risk reduction and abstinence are not in opposition to each other; however, MIP is a risk reduction model and does not consider abstinence the only indicator of success.

The intervention's comprehensive approach requires a preliminary assessment of organizational and staff capacities, including the organization's relationships with local healthcare, housing, and legal services; drug treatment programs; and other human service agencies. It is critical that these relationships are built, sustained, and kept reliable as they are essential to facilitating a participant's access to services.

Organizations preparing to implement MIP should consider the following:

MIP program staff members need to be competent in the principles of motivational interviewing, behavior change theories, and recruitment and retention strategies.

- Both the organization and the MIP program staff must accept the risk reduction approach utilized by MIP for addressing drug and sex-related HIV risk behaviors.
- Both the organization and the MIP program staff must be committed to the supportive interaction between the participant and MIP team members.
- The organization requires emergency policies and procedures specifically related to the MIP, such as those regarding participants' rights, safety within and outside the organization, obtaining informed consent from the participant, and responsible use of information by organization staff.

- The organization must ensure that MIP program staff members are well supported with ongoing supervision.
- The organization has prepared and budgeted adequate resources to support MIP implementation.

Minimal level of resources needed to support MIP implementation:

- Leadership and guidance from key agency personnel from the planning through the implementation stages of MIP.
- A dedicated, well-trained MIP team consisting of at least one of each the following members: Case Manager/Community Educator, Counselor and Supervisor.
- A site that is located in the community and conducive to intervention sessions (e.g. a storefront office).
- Formal partnerships via MOUs with local agencies willing to provide primary health care, mental health care, housing, drug treatment, and other human services.
- Incentives for participants attending/completing MIP sessions.
- Risk reduction kits with information and support materials aimed at reducing drug and sex-related HIV/viral hepatitis risk.
- A safe waiting area accessible to participants' children while participants are attending sessions. Any childcare provided must be in a designated place with staff supervision.

PART I: APPENDIX IA

A. Original published research on MIP: *Effects of Combined Counseling and Case Management to Reduce HIV Risk Behaviors among Hispanic Drug Injectors in Puerto Rico: A Randomized Control Study.*

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