
Modelo de Intervención Psicomédica

Psycho-Medical Intervention Model



A Cognitive Behavioral Intervention to Reduce HIV, STIs, and Viral Hepatitis Risks among Injection Drug Users utilizing Individualized Counseling and Case Management

IMPLEMENTATION MANUAL

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Important Information for Users

This HIV/STD risk-reduction intervention is intended for use with persons who are at high risk for acquiring or transmitting HIV/STD and who are voluntarily participating in the intervention. The materials in this intervention package are not intended for general audiences.

The intervention package includes implementation manuals, training and technical assistance materials, and other items used in intervention delivery. Also included in the packages are: 1) the Centers for Disease Control and Prevention (CDC) factsheet on male latex condoms, 2) the CDC Statement on Study Results of Products Containing Nonoxynol-9, 3) the Morbidity and Mortality Weekly Report (MMRW) article "Nonoxynol-9, Spermicide Contraception Use—United States, 1999," 4) the ABC's of Smart Behavior, and 5) the CDC guidelines on the content of HIV educational materials prepared or purchased by CDC grantees (Content of AIDS-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions in CDC Assistance Programs).

Before conducting this intervention in your community, all materials must be approved by your community HIV review panel for acceptability in your project area. Once approved, the intervention package materials are to be used by trained facilitators when implementing the intervention.

Acknowledgments

The **Modelo de Intervención Psicomédica (MIP)** is a cognitive behavioral HIV prevention intervention for active injection drug users that integrates community-based recruitment, individualized counseling, and comprehensive case management to reduce drug and sex-related HIV risk behaviors among IDUs.

This intervention 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 and funded through the National Institute of Drug Abuse (NIDA) (2001).

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DRAFT

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.*

DRAFT

PART II. PREPARING FOR PROGRAM IMPLEMENTATION

Organizational Capacity refers to an organization's ability to use its skills and human infrastructure resources to achieve its goals by successfully carrying out its day-to-day activities.

Part II of this manual is designed to help key administrative staff within organizations (e.g., executive directors, program managers/directors, fiscal personnel, evaluators, and so forth) understand the goals and intent of *Modelo de Intervención Psicomédica (MIP)* and the resources needed to prepare for successful MIP implementation. Topics covered in this section include:

- Development of an MIP Implementation Plan and Budget
- Choosing and Training the MIP Team
- Community Assessment and Outreach
- Recruitment and Retention of Participants
- Participants' Rights and Confidentiality
- MIP Materials Review

An MIP Readiness Self-Assessment Survey (2A) and an Organizational Assessment Survey (2B), included in the Appendices at the end of this section, allows an organization to assess MIP's fit into their organizational mission and existing menu of services. The assessment identifies the organization's resource strengths and pinpoints areas that require additional staff/management training and technical assistance to successfully adopt and implement MIP.

Used alongside the expertise of implementing and collaborating organizations, the information and resources provided in this manual are designed to ensure that agencies are well prepared to successfully implement MIP.

Developing an Implementation Plan

An integral step in the planning process for MIP is the development of a program implementation plan. This plan serves as a roadmap for the implementing organization; it describes the tasks to be completed, the team members responsible for those tasks, and the time-frame for accomplishing tasks. Simply put, the implementation plan outlines the "who, what, when, where, why, and how" of MIP and should be used as a guide in planning for MIP.

The following example illustrates important components of an implementation plan for MIP. Implementing organizations should tailor the plans to meet their needs. For example, an organization may wish to add a column titled "Resources Needed" to gauge the human and financial resources required to successfully implement MIP. The sample plan below covers pre-implementation activities such as grant writing and training as well as the activities and timelines required for actual MIP implementation.

When partnering with other organizations, it is recommended that key representatives from all organizations have input in developing the implementation plan. This secures greater buy-in, which, in-turn increases the likelihood that MIP will be implemented as planned.

Note: For the purposes of this sample plan, it is assumed that the grant writing process begins on 1 May for an application due date of 15 June and an award notice to the implementing organization on 1 October.

Table I. Sample Implementation Plan for MIP

Task	Steps to Implement	Start Date	Deadline for Task	Person(s) Responsible
Conduct Organizational Capacity Assessment for MIP.	<p>Read the curriculum and intervention materials.</p> <p>Use the self-assessment instrument to determine organizational readiness for implementing MIP.</p> <p>Make decision to implement MIP.</p>	PRIOR TO APPLYING FOR FUNDING TO SUPPORT MIP		Executive Director and Supervisor with input from other appropriate agency staff and board
Develop objectives that address the funding request. (Funding application task).	Consult with front-line staff to ensure that objectives are reasonable and achievable.	1 May	15 June	Supervisor with input from other appropriate agency staff
Develop budget. (Funding application task).	Work with appropriate agency staff to ensure adequate funding and resources for proposed work-plan objectives.	1 May	15 June	Supervisor with input from other appropriate agency staff
Write and submit grant for funding.	<p>Write proposal.</p> <p>Review and revise as needed.</p> <p>Submit grant application for MIP funding.</p>	1 May	15 June	Executive Director, Supervisor and other appropriate agency staff
Secure funding for MIP.	<p>Proposal review by funding agency.</p> <p>Receive award letter announcing funding for the MIP intervention.</p>	1 August	1 October	Funding agency and implementing agency
Inform agency staff and partner organization of the award and review task commitments.	<p>Meet with partner(s) if any.</p> <p>Define and schedule tasks.</p> <p>Orient agency administrators and staff to the project and to its unique approach.</p>	1 October	1 December	Supervisor, with input from appropriate agency staff and representatives from partnering organizations
Develop monitoring and evaluation plan.	Specify project evaluation process measures, assessment instruments, and monitoring schedule.	1 October	1 December	Supervisor, Evaluator, and/or CBA through CDC

Table I. Sample Implementation Plan for MIP (continued)				
Task	Steps to Implement	Start Date	Deadline for Task	Person(s) Responsible
Recruit and hire MIP team.	<p>Post job announcements.</p> <p>Review job descriptions.</p> <p>Use Interviewing Strategies tool.</p> <p>Conduct interviews.</p> <p>Hire the best.</p>	15 October	15 December	Supervisor
Orient newly hired staff to the organization.	Conduct staff orientation session, and discuss overall organization policies and procedures.	As needed	Ongoing	Supervisor
Train MIP team, other agency staff, administrators, and representatives from partner agencies as needed.	<p>Secure appropriate space and necessary equipment.</p> <p>Inform team members.</p> <p>Attend required training in Motivational Interviewing and Transtheoretical Model of Change.</p> <p>Conduct MIP training sessions.</p>	1 November	Ongoing	Counselor, Case Manager/ Community Educator, and CDC DEBI Trainers
Establish processes and procedures needed to implement MIP.	<p>Develop or modify consent forms for MIP.</p> <p>Establish record keeping processes (forms, data base, and so forth) for MIP.</p>	Ongoing	Ongoing	Counselor, Case Manager/ Community Educator, and Supervisor
Initiate community assessment, outreach, and recruitment.	<p>Use mapping to identify sites where injection drug users congregate.</p> <p>Conduct mapping of services.</p> <p>Publicize the MIP Project.</p> <p>Recruit and enroll participants.</p>	15 December	Ongoing	Case Manager/ Community Educator and Counselor
Secure support from local health and human services and from governmental agencies such as the police department, the public health office, legal services, local churches, food banks, drug treatment centers, needle exchange sites, and so forth.	<p>Review and modify MOUs and Referral Forms (Appendix).</p> <p>Identify partner agencies and refresh or develop new MOUs with community partner agencies.</p> <p>Obtain signed MOUs from key partner agencies.</p>	1 October	31 November	Executive Director and Supervisor

Table I. Sample Implementation Plan for MIP (continued)				
Task	Steps to Implement	Start Date	Deadline for Task	Person(s) Responsible
Establish Peer Advisory Group.	Secure representation from the target population. (For example, MIP Graduate).	1 December	1 February	Counselor and Case Manager/Community Educator.
Establish process and procedures needed to implement MIP.	Develop or modify consent forms for MIP. Establish record keeping processes (forms, data base, and so forth) for MIP.	Ongoing	Ongoing	Supervisor
Implement MIP Intervention and integrate case management into all sessions. Note: Scheduling of sessions needs to be carefully assessed to promote retention of participants. The recommended implementation schedule is one structured session every 1-2 weeks until session six and the booster session 2-4 weeks later.	Conduct Session One Induction Conduct Sessions 2-6 (in the order decided upon by participant & counselor) <ul style="list-style-type: none"> ▪ Session Two: Taking Care of your Health ▪ Session Three: Readiness for Entering Drug Treatment ▪ Session Four: Relapse Prevention ▪ Session Five: Reducing Drug-Related HIV Risk ▪ Session Six: Reducing Sex-Related HIV Risk Conduct Session 7 Booster Session	15 January	15 April	Counselor and Case Manager/Community Educator
Allow for ongoing team case conferencing.	MIP team members consult with each other, discussing MIP participant progress and possible motivators needed to support participants through the behavior change process.	Ongoing	Ongoing	Supervisor, Counselor, and Case Manager/Community Educator
Implement program monitoring.	Follow program objectives and monitoring indicators provided by funding source. Conduct evaluation of MIP using input from participants, team members, and partner organizations.	Quarterly and/or annually (upon receipt of funding)	Ongoing for duration of program	Supervisor, Evaluator

The sample implementation plan estimates approximately seven months of planning time, from the development of a funding application to the implementation of the program. Organizations may find that certain tasks in the planning phase take longer than the time estimated in the sample plan. The planning phase may also take less time if the implementing organization has the capacity and resources—including required staff—to readily implement MIP.

The sample assumes that the Executive Director and Supervisor are already on staff and can facilitate the grant writing and work-plan development process for MIP. It also assumes that there are other staff members performing direct services and administrative functions that contribute to the development of the implementation plan. The sample shows the actual MIP intervention (seven sessions) occurring over a three month period. This is an average. It should be noted that depending on the participant's level of readiness to change risk behavior and his/her commitment to the program, the time frame for the MIP intervention may vary.

Finally, it is important to remember that all plans need to be flexible. Deadlines shift and unforeseen issues arise along the way. The purpose of the implementation plan is not to lock the organization into a rigid schedule, but rather to provide a sketch of the components to be considered in planning for MIP implementation. A Sample Implementation Logic Model (2C) for MIP is included in the Appendices.

Identifying Program Resources

Adequate infrastructure, capability, and resources are vital to the successful implementation of the MIP intervention. Proper planning is essential to understanding the philosophy behind MIP and to assessing resources necessary to execute the intervention. At a minimum, the implementing organization will need to identify and obtain the following resources to implement MIP effectively.

- **Adequate funding.** It goes without saying that the most essential resource needed to implement MIP is adequate funding. A detailed estimate of the costs required to implement MIP is presented later in this section.
- **Collaborative partnerships with other organizations.** Partnerships with organizations that support MIP are needed to ensure a continuum of services to participants.
- **Adequate staffing.** For optimal results, the MIP intervention requires the following staff: Supervisor, Case Manager/Community Educator, and Counselor. The amount of time contributed by each of these team members will be determined by the number of participants targeted, the number of MIP cycles the organization intends to run, and the organization's current staffing plans. The most important factor in putting together the MIP team is securing persons who are highly skilled in their respective occupations, value teamwork, and understand their critical role in the MIP intervention.
- **Space for private, one-on-one counseling sessions.** This space must be an enclosed room that offers privacy. Open cubicles or other venues that are not completely private are not appropriate. The private space should have comfortable seating for the Counselor and/or the Case Manager/Community Educator and the participant.
- **Locked file cabinets for storage of confidential client data and/or computer database with password protection.** All identification information is considered confidential information, regardless of a client's HIV status.

- **Transportation for clients and MIP staff.** Possible methods of transportation include the organization's van, another organization's van secured through agreement (MOU), personal cars, and public transportation. In some localities the use of a van to transport multiple individuals for non-personal purposes requires the driver to obtain a commercial license. Adequate insurance is required for all means of transportation to cover liability in the event of an accident.
- **Risk reduction kits.** These kits can include materials already used for outreach activities to drug users and new materials developed specifically for MIP. The provision of safer sex and safer injection/needle hygiene kits is essential to MIP.
- **Incentives for clients.** Incentives are perks used to retain, reward, and motivate participants taking part in MIP activities. Incentives can include food or food vouchers, transportation vouchers, movie tickets, and other items that will reward participants and keep them interested in the intervention.
- **A referral network to address participants' needs that the implementing organization cannot address.** This may be a network already in place or a new network that needs to be developed. The network should include specific referral information for clients (e.g., the name of appropriate staff members at the collaborating agency) and information about the quality of services offered by the organization. MIP team members should be prepared to track referral from inception to completion by following-up on the participant and on the partner agency.

Estimating the Cost of MIP

An important consideration in planning for MIP implementation is the level of funding organizations are willing and able to commit in order to execute MIP properly. In this section, a sample budget is presented with the estimated cost for implementing MIP. It should be noted that costs will vary depending on the geographic location, funding source, and specific needs and resources of the organization. For example, the cost of MIP can be significantly reduced if an organization has access to donations of supplies (e.g., condoms and snacks); human resources (e.g., the Executive Director's in-kind time); and incentives (e.g., raffle prizes). Local retailers, caterers, grocers, food banks, restaurants, movie theatres, clothing outlets, drugstores, museums, media outlets, public transportation authorities, taxi companies, and other merchants should be approached for donations in support of the MIP program.

The example below provides a realistic estimate of the overall cost and resources required to implement MIP utilizing the standard budgetary guidelines for federally funded programs. This particular budget makes several assumptions regarding the organization that will implement MIP:

- The budget assumes all start up costs for MIP, including a full staffing plan (a Supervisor, Counselor and 2 Case Managers/Community Educators) and other non-personnel costs.
- It is assumed that the implementing organization already has access to injection drug users through outreach, institutionally, or through partnerships with other organizations.
- It is assumed that the implementing organization has an appropriate venue to conduct individual counseling sessions.

- It is assumed that basic relationships exist between the implementing organization and other health and human service providers and businesses in the community.
- It is assumed that the implementing organization is located either in or near the community where the intervention will be implemented so that transportation costs remain reasonable.

If the organization's circumstances differ from the stated assumptions, adjustments should be made to the MIP program budget during its development. Although not included here, a budget justification should be included so that each program expense is clearly explained and justified to support MIP implementation

Modelo de Intervención Psicomédica
SAMPLE FIRST-YEAR 12-MONTH BUDGET
(NORTHEAST REGION)

Note: Costs will vary depending on the implementing organizations' geographic location, funding source and specific needs and resources.

PERSONNEL SALARIES	Annual Salary	% of time FTE	Number of Months	Total Budget
Position Titles/Names				
Supervisor John Smith	\$60,000.	50%	12	\$30,000
1 Counselor <i>To be hired</i>	\$45,000	100%	12	\$45,000
1 Case Manager/Community Educator <i>To be hired</i>	\$35,000	100%	12	\$35,000
1 Case Manager/Community Educator <i>To be hired</i>	\$35,000	100%	12	\$35,000
Total Salaries				\$145,000
Employee Benefits (22% of total salaries)				\$31,900
TOTAL SALARIES & BENEFITS				\$176,900
Non-Personnel Costs and Services				
TRAVEL				
Staff travel for training on MIP prerequisites: 3 trainings x 3days/training x 3 staff = 36 days (Includes airfare, lodging, ground transportation and per-diem)				\$10,395
EQUIPMENT				
3 computers x 3 FTE staff = \$4,800 2 printers x \$500 = 1,000				\$5,800
PROGRAM SUPPLIES				
Non-monetary incentives to support MIP program delivery (snacks, outreach materials, safer injection/sex kits, educational materials, hygiene kits, bus cards /transportation voucher)				\$6,000

CONSULTANTS				
Auditor (Required by CDC & estimated at 1% of program budget)				\$2,580
OTHER DIRECT COSTS				
Printing				\$2,000
Office Supplies				\$1,500
Non-monetary participant incentives (assuming 140 clients/year x \$10 retention vouchers/gift certificate per session x 7 sessions)				\$9,800
Staff conference registration fees 3 staff members x \$500.00				\$1,500
Facility use allowance (Assuming \$20/square foot x 400 sq/ft)				\$8,000
TOTAL NON-PERSONNEL AND SERVICES				\$47,575
TOTAL DIRECT COST (Includes salaries & benefits and non-personnel cost and services)				\$224,475
(Less Equipment)				-\$5,800
Indirect Cost Base				\$218,675
Indirect Cost (18%)				\$39,361
GRAND TOTAL				\$263,837

Choosing and Training the MIP Team

MIP is based on the understanding that the interaction between a drug user and the MIP intervention team creates the context in which behavior change takes place. The success of MIP is largely dependent on the willingness of team members to act as guides, escorts, confidants, and advocates; to help participants overcome obstacles faced when trying to obtain services; and to support them as they progress through each phase of the program. MIP requires team members that are knowledgeable about and skilled in working with drug-use, and sensitive and flexible enough to allow the MIP participant to take control of his/her own health.

At a minimum, the MIP team should comprise of the following staff members:

- 1 Program Supervisor
- 1 Counselor
- 2 Case Manager/Community Educators

The actual staffing pattern for MIP will vary from organization to organization according to program costs and projected number of MIP participants. To the greatest degree possible, MIP team members should reflect the multicultural and multi-linguistic characteristics of the target population.

The ability of the MIP team to work together effectively is critical to the success of MIP. Each team member should have a particular set of experiences, training, and professional competencies that complement and support that of the other team members. Each member will be called upon at different times to address a particular need of the participant. Although each team member performs a specific role within the MIP intervention, it is essential that all team members understand the interdependence of roles in successfully bringing services to the participant and assisting him/her in reducing drug and sex-related HIV risk behaviors.

Example of the MIP Team Working Together

Using the staffing plan in the *Sample Implementation Plan* as a guide, the Program Supervisor leads efforts to secure funding for MIP and has oversight of the program. The Case Manager/Community Educator directs participant outreach and recruitment efforts, establishes program credibility in the drug-using community, and ensures that participants are linked to drug treatment and health and human services, as required. The Counselor facilitates the structured counseling sessions with the participant and motivates him/her to change risky behavior. Then, together, the Counselor, Case Manager/Community Educator and the Supervisor convene for case conferencing to discuss the participant's progress.

The interaction between the Case Manager/Community Educator and the Counselor is a core element of MIP. At each session, the participant must meet with the Case Manager/Community Educator and the Counselor; it is this dual dose of the intervention—ongoing case management combined with counseling—that contributes to the success of the intervention. Team members must work together to ensure that each participant receives access to basic health and human services, remains motivated to progress through the intervention, and obtains the necessary social and family support to fully benefit from MIP.

A summary of the roles and responsibilities of MIP team members is outlined below.

The MIP Team	
Supervisor	
	<ol style="list-style-type: none"> 1. Oversees MIP program activities and ensures that program objectives are met. 2. Develops memoranda of understanding (MOUs) with partner organizations and coordinates collaboration with these agencies. 3. Establishes referral system, program forms, protocols, and procedures for MIP. 4. Facilitates the provision of required training and ongoing education for team members. 5. Implements and monitors quality assurance measures. 6. Develops service mapping documents. 7. Functions as Case Manager/Community Educator or Counselor, as needed. 8. Conducts resource inventory. 9. Maintains regular and updated documentation. 10. Ensures adequate record-keeping to maintain participant confidentiality. 11. Develops relationships with the police department and establishes agreements with police regarding MIP team members carrying drug-using equipment (e.g., needles). 12. Provides and maintains a positive work climate conducive to open team communication and participation, avoiding staff burnout and maximizing service delivery.
Counselor	
	<ol style="list-style-type: none"> 1. Conducts cognitive-behavioral counseling sessions using Motivational Interviewing techniques. 2. Uses MIP materials and protocols to improve participant attitudes and perceptions, identifies stages of change, plan next steps of intervention, and helps the participant develop self-efficacy. 3. Discusses self-evaluation with the participant. 4. Has knowledge of and experience working with substance users and uses the Treatment Improvement Protocols (TIP) from the Center for Substance Abuse and Treatment (CSAT) and the Technical Assistance Publications (TAP) from the Substance Abuse and Mental Health Services Administration (SAMHSA) as guidelines. 5. Is competent in addiction counseling, Motivational Interviewing, and participant staging. 6. Knows community norms and languages and understands the injection drug-use culture. 7. Works with participants to motivate behavior change. 8. Provides risk reduction counseling on drug-use and sexual behaviors. 9. Shares expertise with fellow staff members. 10. Participates in regular formal and informal case conferencing with the Case Manager/Community Educator and with the Supervisor to ensure the participant's needs are met.

The MIP Team
<p>Case Manager/Community Educator</p> <ol style="list-style-type: none"> 1. Leads community mapping efforts to identify sites where potential participants congregate. 2. Establishes positive relationships and credibility within the drug-using communities (including relationships with drug lords, dealers, heads of shooting galleries, and so forth). 3. Knowledgeable about safe and secure outreach strategies. 4. Conducts street and community outreach to recruit potential MIP participants. 5. Enrolls participants into the MIP program. 6. Explains the Case Manager/Community Educator role to participants and to their families. 7. Helps identify local resources and partner organizations that can support MIP implementation. 8. Interacts with participants using Motivational Interviewing. 9. Advocates for and facilitates participant access to drug treatment and other health and social services. 10. Arranges transportation and escorts participants to services. 11. Establishes ties with the recovery community. 12. Provides risk reduction counseling and materials (safety kits, condoms, and so forth). 13. Reviews previous counseling session with participants at each contact. 14. Communicates with the Counselor and Supervisor to move participants through stages of change. 15. Participates in regular formal and informal case conferencing with the Counselor and Supervisor to ensure the participant's needs are met.

Detailed job descriptions for the MIP team (2D) are located in the Appendices at the end of [this section](#).

TRAINING THE INTERVENTION TEAM

Once an implementation plan, an intervention team, reliable partnering agencies, and adequate funding has been secured, the MIP team must be trained in the methods of the MIP intervention.

It is important that the staff members (Supervisor, Counselor, and Case Manager/Community Educator) delivering MIP to participants understand and be comfortable with the highly interactive and participant-centered nature of the intervention. Prior to implementing the MIP intervention, it is imperative that team members receive training in the MIP intervention and other supporting areas:

Training in Motivational Interviewing

- Motivational Interviewing is the strategy used by MIP team members to encourage behavior change among participants. Motivational Interviewing techniques are best learned through practice; hence, the more exposure a staff member has to Motivational Interviewing techniques, the more competent he/she will be at employing them.

Training in Behavior Change Theories, with emphasis on the Transtheoretical Model of Behavior Change

- The MIP intervention is based on several theories, drawing predominantly from the Transtheoretical Model of Behavior Change. The Transtheoretical Model of Behavior Change (also known as the Stages of Change) should be implemented during each contact with participants. Counselors should have the capacity to accurately place participants in the appropriate stage of change so that proper techniques can be identified to support behavior change.

Training in Community Mapping, Assessment, and Outreach

- The MIP intervention relies heavily on the MIP team's efforts to recruit and engage the target population of injection drug users. MIP team members, particularly the Case Manager/Community Educator, must be skilled in mapping, outreach strategies, and safety procedures so as to effectively recruit participants.
- Additionally, all MIP team members should have a working knowledge of substance use, risk reduction strategies, and drug using cultures-- particularly that of injection drug use-- and have basic knowledge of HIV prevention and treatment.

Note: Technical Assistance supporting the implementation of effective behavioral interventions such as MIP is available through CDC's Capacity Building Assistance (CBA) Programs. These programs offer training and technical assistance free of charge to CDC grantees and Health Department funded organizations. Interested organizations should contact their CDC Project Officers or Health Departments for information on how to access capacity building services.

Community Assessment and Outreach

A core element of MIP is community assessment and outreach. Among the first steps required for MIP implementation is the identification and mapping of those social networks used by injection drug users and the recruitment of participants for the MIP intervention by tapping into these networks.

Before recruiting participants for MIP, team members identify and visit locations where potential participants live and congregate to sell, buy, and use drugs and to exchange drugs for sex. These locations may include shooting galleries, homeless shelters, and the street.

Team members must aggressively seek out-of-treatment injection drug users in remote sites and position themselves along main walkways where injection drug users congregate. Forms included in the Appendices to support the community mapping process include: Community Mapping Planning Form (2E); Community Mapping Resource Scan Worksheet (2F); Recruitment Tracking Forms (2G); Service Directory Form (2H); and Field Safety Guidelines (2I).

During outreach visits, it is necessary for MIP team members to establish a positive presence in the community. They can do so by identifying key individuals in the drug-use culture's social networks, informing them about MIP, and developing trusting relationships between them and the MIP team. This process is critical to the team having continued access to potential and enrolled participants and ensures that the team's safety will not be compromised. It is also important for the MIP team to understand the relevance of these social networks for injection drug users: 1) they facilitate drug acquisition; 2) they introduce new drugs and methods of use; and 3) they provide social support. Another MIP team priority entails developing a good working relationship with the local police department to ensure that arrests are not planned while MIP staff is working with the community.

Note: It is essential that team members receive training in community mapping, outreach, and safety procedures prior to going out into the community to ensure the team's safety and successful retention efforts.

Solidifying Partnerships with other Health and Human Service Organizations

The MIP intervention calls for strong and effective ties between the implementing organization and the larger network of drug treatment, health, social, and faith-based service organizations. The quality of the relationships between the MIP team and the staff at local agencies helps determine MIP success. Thus, relationships with local agencies may have to be developed, strengthened, and/or formalized to ensure timely and reasonable access to primary health care, mental health care, drug treatment programs, legal services, religious services, and other health and human services.

As part of the community assessment process, the MIP team identifies the community ties needed to support MIP, first by identifying which resources the implementing organization already has and then by assessing which resources will require assistance from other organizations.

The team then enlists the support and cooperation of existing organizations in the community. In some cases implementing organizations need only formalize the relationship with a partnering organization through MOUs; in other instances, new partnerships will need to be developed to implement MIP effectively.

For example, since counseling and testing are offered and encouraged during every contact with a participant, linkages with drug treatment programs and HIV/STIs, TB, and viral hepatitis testing sites are especially important to the successful implementation of MIP. The implementing organization must ensure that participants can access and receive counseling and testing services upon request. Therefore, it must either directly provide counseling and testing or secure these services through appropriate referrals and collaborative agreements.

Before partnering with any organization it is important to check if the agency is appropriate for participants enrolled in MIP. Partner agencies should be fully aware of MIP's risk reduction approach, as some agencies may have abstinence restrictions in place which exclude individuals currently using drugs from accessing their services. To introduce partnering organizations to MIP, a *Sample Letter of Introduction (2J)* and fact sheet, *Modelo de Intervención Psicomédica (MIP) Fact Sheet (2K)*, are included in the Appendices.

Formal memoranda of understanding (MOU) with partner agencies should explicitly state the terms of the agreement between agencies, including any incentives for participating organizations. Incentives include: increased referrals to and from the partner agency, the opportunity to write collaborative funding proposals, and cross-site training, among others. The development and terms of the memoranda of understanding should be managed by the respective management staff of each organization. A sample Memorandum of Understanding (2L) is included at the end of this section.

In some cases, informal agreements (e.g., a verbal agreement) may be the only option possible for establishing a relationship between the implementing organization and a partnering agency. In such cases, MIP staff should have a solid point of contact for accessing services and follow-up procedures in place to ensure the delivery of services to MIP participants.

Recruiting and Retaining Participants

The most critical, determining factor of successful MIP implementation is the extent to which participants are not only recruited for the intervention, but also retained until the intervention is completed. Thus, implementing organizations must prepare and execute a detailed recruitment and retention plan which realistically considers the organization's needs, abilities, and resources.

The first step in developing a recruitment and retention strategy for the MIP intervention is to clearly understand the intent of both recruitment and retention.

- In recruitment, the objective is to identify, solicit and secure potential participants for MIP.
- In retention, the objective is to maintain participant motivation throughout the course of the intervention so that the participant can successfully complete MIP.

Recruitment

The importance of participant recruitment cannot be overemphasized. Without a successful recruitment strategy that provides a continuous stream of participants willing to enroll in MIP, the benefits of the intervention cannot be realized. Implementing organizations ready to begin recruitment planning should consider CDC's six step approach to developing recruitment strategies.

CDC's Six Step Approach to Developing a Recruitment Strategy

Answer the following questions about the target population:

1. Who is being targeted through recruitment?
2. Where is the appropriate place to recruit clients?
3. When should recruitment be done?
4. What messages should be delivered during recruitment?
5. How should the messages be delivered?
6. Who is the most appropriate person to conduct recruitment?

Once these questions are answered, the organization is ready to begin recruitment. Two suggested recruitment strategies for MIP are:

1. **Targeted recruitment informed by community mapping and outreach**
In targeted recruitment, a team of trained staff identify areas where the target population congregates and conducts outreach in those areas to recruit participants for the MIP intervention.
2. **Peer-to-peer recruitment through drug users' social networks**
In peer-to-peer recruitment, the implementing organization identifies and selects participants of the target community (IDUs) that have successfully completed the MIP program and compensates them for referring or recruiting drug using friends or associates to the MIP intervention.

Targeted Recruitment through Community Mapping and Outreach

The following scenario provides a step-by-step, practice-based description of how targeted participant recruitment occurs through community mapping and outreach.

- First, MIP team members map the locations where drug users live and congregate. These may include street corners, local parks, empty buildings and lots, parking areas outside bars, motels where commercial sex workers take individuals, and so forth.
- The MIP team then visits these sites and attaches informational, colorful posters announcing the MIP program on walls, lamp posts, and visible locations. Team members can distribute risk reduction kits consisting of items such as syringes (where legal), bleach, cookers, condoms, and program brochures. They observe interactions, behavior, language, and communication patterns at these locations and document observations for future use in MIP activities.
- The team returns to the sites multiple times to establish a presence in the community and to begin engaging individuals in brief discussions about MIP. The team establishes relationships with key individuals, learning more about and gaining further access to the designated community.
- Once the team has identified an individual as a drug user and has successfully established a trusting relationship with that individual, continued positive interaction will determine whether or not he/she chooses to become an MIP participant. The team should approach the potential participant for more in-depth discussions about MIP. The team—in the language the participant is most comfortable speaking—explains the approach, philosophy, and potential benefits of the program. Authenticity and trust in the interactions between the drug user and MIP team members are critical as they will contribute significantly to the drug user's ultimate decision as to whether to join the MIP program.
- Once a verbal agreement to participate in MIP has been established, the Case Manager/Community Educator should facilitate the participant's visit to the organization so that he/she can complete the structured sessions with the Counselor. At this point, the Case Manager/Community Educator and Counselor work together to encourage the newly recruited participant to attend the Induction Session.

Peer Driven Recruitment

Peer Driven Recruitment is a structured method of enrollment in which the participant uses his/her social networks to recruit peers for an agency's services or programs. An MIP participant that has successfully completed the intervention is identified by the MIP team and asked to be a peer recruiter. This person's task is to recruit an agreed upon number of drug using associates into the MIP program. The peer is then compensated by the organization, based on the number of persons that sign-up for MIP as a result of their referral.

Research has shown that the peer driven recruitment approach is very effective; sometimes more so than traditional forms of outreach. The two main reasons for the success of this method are: (1) people in the same social network tend to share similar interests and activities, and (2) individuals are more likely to trust and listen to their peers.

Peer recruiters should participate in a volunteer orientation and training session to become fully aware of their significant role in the MIP program and to be capable of explaining the MIP intervention to potential participants. Upon completing training, peer recruiters should be able to:

- Describe their roles and responsibilities as peer recruiters.
- Learn recruitment strategies that can be used with peers.
- Correctly and concisely explain MIP to potential participants.
- Identify dangerous situations and successful ways to avoid these when recruiting in the community.

It is recommended that a member of the MIP team provide on-going supervision to peer recruiters and should:

- Follow up with the peer recruiters weekly, either at the office or in the community.
- Provide support to peer recruiters.
- Issue compensation vouchers to peer recruiters.

Although incorporating a peer recruitment strategy into any program will require an initial investment of time and resources and will require on-going oversight, such strategies have been proven to yield highly positive outcomes, especially when used with populations historically viewed as hard to reach and retain.

Organizations interested in initiating or further expanding their peer recruitment program can access the following document: Successful Strategies for Recruiting, Training, and Utilizing Volunteers—A Guide for Faith and Community-Based Service Providers, at: www.samhsa.gov/FBCI/Volunteer_handbook.pdf

Retention

Keeping participants engaged and committed to a program or service is the main objective of retention strategies. Organizations implementing effective behavioral interventions which call for multiple participant contacts over an extended period of time (such as MIP) need to take steps to ensure that participants remain involved for the duration of the intervention.

Retaining participants—especially active injection drug users—in an HIV behavioral intervention poses a unique set of challenges even for the most experienced organizations. For this reason, a peer advisory group can be of great assistance in providing insight into proven retention strategies. Such strategies should be based on the structure of the intervention, the characteristics of the target population, and the needs, resources and capacity of the organization.

The guiding objectives of an MIP retention strategy should be:

- To uphold the focus and core elements of MIP.
- To provide high quality services to participants.
- To build trusting relationships with participants.
- To consider the characteristics of the target population and to implement and deliver the MIP intervention in a way that is personal, appropriate, and meaningful.
- To identify and distribute incentives that have value to the participants.

In conjunction with the content of MIP and the rapport established between the participant and MIP team members, providing incentives to participants and making sessions easy to attend will increase their motivation to continue participating in MIP. Participant incentives fall into three general categories:

1. Session participation incentives. These are usually non-cash items provided to participants after they complete an MIP counseling or case management session. Examples of these incentives include but are not limited to:

- Meals
- Lottery or door prizes
- Fast-food coupons
- Movie tickets
- T-shirts
- Hats
- Personal hygiene or grooming kits
- Clothing vouchers
- Store Gift Cards (groceries, clothing, restaurant, music etc.)
- Recognition certificates for attending a specific number of sessions
- Phone Cards

2. General program incentives. These are special services that participants are eligible for and may receive at any time because they are enrolled in MIP. Examples of these include but are not limited to:

- Food Bank
- Laundry facilities
- On-site testing or active testing referrals for HIV/ viral hepatitis and other transmittable diseases
- Free immunizations against viral hepatitis
- Active referrals for drug treatment and health and human services tailored to drug users' needs

3. **Transportation incentives.** These are tokens, vouchers, or transportation services provided to participants to facilitate attending MIP sessions. Examples of these include but are not limited to:

- Client pick-up to and from sessions
- Bus or subway cards
- Taxi vouchers

Examples of other factors that can influence retention include: the content and delivery of the intervention, the environment in which the intervention takes place, and the scheduling of sessions. Implementing organizations should optimally aim for:

- A meeting space that is comfortable and inviting.
- Induction session, five flexible sessions and one booster session that is lively, fresh, and interactive with plenty of input from participants.
- Session presentations that foster and communicate the intervention team's commitment to care, trust, respect, and confidentiality.
- A nonjudgmental atmosphere that accepts participants' drug use.
- Free child care during sessions (if appropriate).
- Consistent and convenient scheduling of sessions.

Together, these strategies along with the appropriate incentives will help retain participants in the MIP program. Ultimately, the goal for the MIP team is to graduate participants from the program with the tools necessary to make healthier, safer choices.

Participants' Rights and Confidentiality

As a participant-centered and participant-driven intervention, the *Modelo de Intervención Psicomédica* upholds the rights and confidentiality of participants and espouses that they have a right to:

1. Information
2. Accessible and continuous services
3. Safety, privacy, and confidentiality
4. Respectful and dignified treatment
5. A grievance process
6. The opportunity to determine the most appropriate services
7. The choice to continue or leave the program at any time without penalties or negative outcomes.

Implementing organizations receiving federal, state, or local funding for MIP or for other health care interventions are required to comply with all state confidentiality laws and regulations regarding participant confidentiality. All MIP staff members are required to sign statements that they have read and fully understand the confidentiality laws and requirements upheld by the organization.

Furthermore, implementing organizations should have systems in place that ensure responsible use of participant information. For example, before an implementing organization shares participant information

with another agency to which the participant was referred, the participant must read, sign, and date an informed consent form and the form must be added to the participant's records. A Confidentiality Agreement Form (2M), MIP Participant Consent Form (2N), and Consent to the Use and Disclosure of Health Information Form (2O) are included in the Appendices at the end of this section.

Other forms that can be used to support client rights and confidentiality include a Notice of Privacy Practices and Acknowledgement of Receipt of Privacy Practices Notice (2P), and the Health Insurance Portability and Accountability Act (HIPAA) Acknowledgement Form (2Q).

Ensuring Participant Consent and Confidentiality in MIP

- Eligible participants volunteering to participate in MIP will be fully informed about the program's intent, services, structured counseling and case management sessions, and evaluation component prior to agreeing to participate in the project.
- MIP team members will discuss benefits and possible risks of participating in MIP with potential participants.
- Each participant will be asked to sign an informed consent form prior to engaging in MIP. The form will describe all of the above information and state that participation is voluntary. It will state that a participant may choose not to answer any question at any time, may refrain from any activity at any time, and may drop out of the program at any time, without penalty or harm. Program information and consent forms will be provided in the language the participant is most comfortable reading.
- Team members will complete required documentation after each participant contact and enter this information into the database or case record. A security system will ensure the confidentiality of computer-based records. Files will be saved in password-protected formats. To the extent possible, no personal identifiers will be included in any records that contain detailed information on individual participants.
- All hard copy files containing member information will be stored in locked file cabinets. Only authorized staff members will have access to the files and all file folders will be marked "Confidential."
- Specific informed consent instruments will be written and signed by participants for any information or data that will be shared with, or obtained from, partner agencies.

Cultural Competency in MIP

Cultural competency refers to an organization's efforts to respect and incorporate a participant's linguistic and cultural background, beliefs, and values. The MIP program respects diversity and cultural differences among participants.

- Organizations implementing MIP should access a copy of the National Standards for Culturally and Linguistically Appropriate Services in Health Care published by the Office of Minority Health-Dept. of Health and Human Service (www.omhrc.gov). This guide offers strategies for ensuring cultural competence in programs and services. This is especially important when implementing an HIV behavior change intervention such as MIP, where the dominant identity, the drug-use culture, has its own sets of rules, norms, and practices. In order for the MIP team to positively impact the risky behaviors of participants, an understanding of the drug-use culture is essential.

GENDER ISSUES IN MIP

Sensitivity to gender differences is required in order to increase the recruitment and retention of women participants. Research has identified multiple concerns and needs that may be unique to women IDUs. (e.g., family responsibilities, family and partner abuse, rape, and psychiatric disorders). Counselors and Case Managers should recognize this reality accordingly.

Organizations working with women need to be particularly mindful that women are afraid of losing custody of their children if they are identified as drug users. Organizations should have policies in place to address such issues.

MIP Materials Review

Any implementing organizations that chooses to develop program materials supporting the goals and messages of the MIP intervention are strongly encouraged to adhere to the CDC's HIV Program Review Panel Requirements, which can be found at:

http://www.cdc.gov/od/pgofunding/grants/additional_req.shtm#ar5 or in Appendix T.

In summary, all materials (pamphlets, brochures, fliers, posters, videos, and questionnaires) developed by implementing organizations must be reviewed by an HIV Program Review Panel to ensure their consistency with local community standards and their appropriateness in terms of language and cultural sensitivity. Organizations are encouraged to use an existing program review panel such as that created by the state health department's HIV/AIDS Prevention Program.

If an organization chooses to form its own program review panel, at least one member must be an employee (or a designated representative) of a state or local health department. The funding agency will require names of panel members and may request documentation of the materials review process.

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APPENDIX 2A: AGENCY READINESS SELF-ASSESSMENT

The following is a brief self-assessment intended to help organizations determine whether or not they possess or can build the capacity to adopt and implement the *Modelo de Intervención Psicomédica* (MIP) intervention. Please read each item, and place a checkmark (✓) in the appropriate response column.

Capacity and Resources for MIP	Yes, we have the capacity. (1)	We do not presently have this capacity, but we can build the capacity. (2)	No, we do not have access to this capacity. (3)
1. The ability to recruit injecting and/or non-injecting drug users who are currently NOT in drug treatment and to maintain these clients in a 7-session program over 6 months.			
2. Personnel skilled in individual counseling and case management.			
3. Personnel skilled in street-level recruitment of drug users.			
4. The facilities to work with participants in a private area without disrupting other agency services.			
5. The ability to collect, maintain, and process monitoring and outcome data.			
6. Meeting space to conduct seven sessions.			
7. Low-cost incentives for participants (e. g, small stipends, transportation passes, and snacks.)			
8. A means of tracking program activities, including recruitment of clients and sessions delivered.			
9. Agency commitment to participate in the MIP program and evaluation.			

If all of your responses were in column 1 ("Yes, we have this capacity") or in column 2 ("We do not presently have this capacity, but we can build the capacity"), your agency is ready for MIP implementation.

For more information, or to sign up for training, visit: www.effectiveinterventions.org

APPENDIX 2B: ORGANIZATIONAL ASSESSMENT SURVEY

1. Which of the following best describes your organization/agency's current experience with HIV/AIDS prevention programs? Check only one.

<input type="checkbox"/>	We have specific, recent experience providing one or more HIV/AIDS prevention services.
<input type="checkbox"/>	We have some recent experience as providers of HIV/AIDS-related prevention services.
<input type="checkbox"/>	We have little or no experience with HIV-prevention services but have extensive experience in HIV/AIDS treatment services.
<input type="checkbox"/>	HIV/AIDS prevention is/will be a new service area.
<input type="checkbox"/>	Other (Explain):

2. Which of the following best describes your agency's current experience with substance abuse treatment? Check only one.

<input type="checkbox"/>	We have specific, recent experience providing one or more substance abuse treatment services.
<input type="checkbox"/>	We have some recent experience as providers of substance abuse treatment services.
<input type="checkbox"/>	We have little or no experience in HIV/AIDS prevention but have extensive experience in substance abuse treatment.
<input type="checkbox"/>	Substance abuse treatment is/will be a new service area.
<input type="checkbox"/>	Other (Explain):

3. List your organization's two primary services:

a)	
b)	

4. Review the following list of HIV/AIDS and substance abuse treatment programs and:
- Place a check in Column A of each row that lists a specific service or activity that your organization currently provides.
 - If you do not provide a service or an activity or would like to have capacity-building technical assistance (TA) to strengthen the service in order to implement the MIP Program, place a check in the last column of the row that describes the particular service or activity.

SERVICE	(A) YES, WE PROVIDE SERVICE.	(B) YES, WE WANT TO TARGET SERVICE FOR TA.
Individual Level:		
1. HIV counseling and testing		
2. Secondary prevention/case management		
3. Needle exchange		
4. Individual supportive counseling for people in recovery		
4. Individual supportive counseling for HIV patients		
5. Referrals to HIV continuum of care		
6. Referrals to substance abuse treatment		
Group Level:		
7. HIV-prevention workshops		
8. Psycho-educational skills-building groups		
9. Psycho-social/psycho-therapeutic groups		
10. Peer educator training		
11. Training for professionals		
Outreach:		
12. Community mapping/identifying social networks of drug users		
13. Recruiting hard to reach populations (street injection drug users, new immigrants, out of school youth) into interventions		
14. Linkages/continuum of care/referral network development		
15. Linkages/referral network development for drug treatment		
16. Linkages/referral network development for primary health care, housing, and other social services		
17. Linkages/referrals to local CBOs for after-care/recovery support		
Other Services For PLWHAs or Drug Abuse Problems:		
18. Housing for PLWHAS and/or people with drug abuse problems		
19. Food and Clothing Bank		

20. Have or know of a place for participants to take a shower, change clothes, and so forth before going to a physician or to other social services		
CDC Effective Behavioral Interventions (EBIs), such as RAPP, Safety Counts, Holistic Harm Reduction, and so forth)		
21. List EBIs Currently Being Implemented:		

5. Staff Levels
 Three types of services are listed in Columns A, B, and C. Under each column indicate which staff level describes your organization/agency's situation by placing a check under the appropriate program and employment category. Place a check in each row for all 3 programs.

Employment Categories	A. HIV/AIDS Prevention/Treatment		B. Substance Abuse Treatment	
	Yes, we have staff.	We do not have staff.	Yes, we have staff.	We do not have staff.
Upper Management				
Supervisor				
Counselor				
Case Manager/ Community Educator				
Support/Clerical				
Other (Explain):				

6. List specific languages, other than English, in which services and activities are offered.

HIV/AIDS Prevention or Treatment:	
Substance Use Prevention/Treatment	
Other Services (Specify):	

7. How long has your organization offered HIV/AIDS prevention/treatment/activities/services?

Less than one year
 1 year
 2-4 Years
 More than 4 years

8. What percentage of your total annual budget is devoted to HIV/AIDS prevention or treatment services?

_____ %

9. How long has your organization offered substance abuse treatment activities/services?

Less than one year 1 year 2-4 Years More than 4 years

10. What percentage of your total annual budget is devoted to substance abuse treatment services and activities?

_____ %

10a. Does your organization have sufficient funding for HIV-prevention or treatment to contribute to MIP? Check only one.

Yes, we have some funds available.

No, we would have to fundraise for additional resources.

We would need TA to develop new fundraising proposals for this program.

10b. Does your organization have sufficient funding for substance abuse treatment to contribute to MIP? Check only one.

Yes, we have some funds available.

No, we would have to fundraise for additional resources.

We would need TA to develop new fundraising proposals for this program.

11. Using a number scale of 1-10, rate the following activities in order of Technical Assistance priority for implementing MIP. Label the most important activity with a 1 and the least important activity with a 10.

Establish HIV counseling and testing program.

Train staff and supervisors in HIV/AIDS prevention.

Train staff and supervisors in substance abuse prevention and/or treatment.

Train staff and supervisors in theoretical and conceptual approaches and methods of the MIP Program.

Train staff in recruitment and retention.

Train staff in Motivational Interviewing

Develop or strengthen linkages with continuum of care or referral networks.

Develop or strengthen relationships with drug treatment programs.

Develop or strengthen relationships with other services needed by participants in the MIP Program (e.g., primary care, housing, food bank, and so forth).

Other (Specify):

APPENDIX 2C: SAMPLE IMPLEMENTATION LOGIC MODEL FOR MIP

The sample implementation logic model identifies and describes the main activities required to implement MIP and the resources (inputs) that must be secured, developed, and employed in order to execute these activities. The implementation plan also describes the outcomes (outputs) that result when the activities are conducted correctly.

Resources (Inputs)	Activities	Outcomes (Outputs)
Inputs are the resources needed to operate a program and conduct intervention activities.	Activities are the actions conducted to implement an intervention.	Outcomes are the deliverables or products that result when activities are conducted.
PRE-IMPLEMENTATION		
Staff dedicated to MIP - Minimum 3 persons: 1 Supervisor, 1 Counselor, and 2 Case Manager/Community Educators	Recruit and hire team. Train team members in Motivational Interviewing, stages of change, outreach strategies, and MIP.	Fully staffed and trained MIP Team
Office Space	Secure office space.	Safe and confidential office space
Equipment	Purchase/obtain equipment.	Fully equipped office space
Materials and supplies	Purchase materials and supplies for program.	Required materials available to program
Community mapping, community assessment and partnering	Review literature. Conduct key informant interviews. Conduct gatekeeper interviews. Establish focus groups. Conduct observation.	Signed MOUs in place Comprehensive MIP resource directory
Recruitment of participants	Conduct outreach. Conduct social marketing.	Number of contacts made Number of participants recruited Number of individuals who declined services
IMPLEMENTATION		
Session 1: Resources and preparation to conduct Induction Session and offer case management	Perform MIP induction. Discuss roles and responsibilities of both participant and organization.	Number of Induction sessions completed Number of MIP Intake Forms completed Number of Signed Consent Forms completed

	<p>Offer counseling and testing for HIV, STIs, TB, and viral hepatitis.</p> <p>Assess participant readiness for change.</p>	<p>Number of Behavioral Risk Assessments completed</p> <p>Number of the Action Plans completed</p> <p>Number of participants with knowledge of sero-status</p>
<p>Session 2:</p> <p>Resources and preparation to conduct Taking Care of your Health Session and offer case management</p>	<p>Complete Health History Form with participant.</p> <p>Orient participant to health services and arrange a physical examination.</p> <p>Offer counseling and testing for HIV, STIs, TB, and viral hepatitis.</p> <p>Assess participant readiness for change.</p>	<p>Number of participants with completed Health History Forms</p> <p>Number of participants that received case management and referrals</p> <p>Number of participants accessing health care services</p> <p>Number of Action Plans completed</p> <p>Number of participants with knowledge of sero-status</p>
<p>Session 3:</p> <p>Resources and preparation to conduct Readiness for Entering Drug Treatment Session and offer case management</p>	<p>Complete Drug Treatment History and Experience Form with participant .</p> <p>Orient participant to drug treatment services.</p> <p>Offer counseling and testing for HIV, STIs, TB, and viral hepatitis.</p> <p>Assess participant readiness for change.</p>	<p>Number of Drug Treatment History and Experience Forms completed</p> <p>Number of participants entering drug treatment</p> <p>Number of Action Plans completed</p> <p>Number of participants receiving case management and referrals</p> <p>Number of participants with knowledge of sero-status</p>

<p>Session 4:</p> <p>Resources and preparation to conduct Relapse Prevention Session and offer case management</p>	<p>Complete the Guide to Analysis of Most Recent Relapse –Drug Use and Guide to Analysis of Most Recent Relapse – Unprotected Sexual Activity with participant.</p> <p>Analyze last relapse event.</p> <p>Develop skills to decrease risk of relapse.</p> <p>Offer counseling and testing for HIV, STIs, TB, and viral hepatitis.</p>	<p>Number of completed Guide to Analysis of Most Recent Relapse –Drug Use and Guide to Analysis of Most Recent Relapse – Unprotected Sexual Activity forms</p> <p>Number of participants with relapse history</p> <p>Number of Action Plans completed</p> <p>Number of participants receiving case management and referrals</p> <p>Number of participants with knowledge of sero-status</p>
<p>Session 5:</p> <p>Resources and preparation to conduct Reducing Drug-Related HIV Risk Session and offer case management</p>	<p>Explore drug-related risk behavior.</p> <p>Develop skills to decrease drug-related HIV risk.</p> <p>Offer counseling and testing for HIV, STIs, TB, and viral hepatitis.</p>	<p>Number of drug-related risk behaviors identified</p> <p>Number of safe drug-using behaviors reported, such as:</p> <ul style="list-style-type: none"> - not sharing needles - cleaning works - not sharing cookers - not sharing water - using new needles - not pooling money to buy drugs <p>Number of Action Plans completed</p> <p>Number of participants receiving case management and referrals</p> <p>Number of participants with knowledge of sero-status</p>
<p>Session 6:</p> <p>Resources and staff preparation to conduct Reducing Sex-Related HIV Risk Session and offer case</p>	<p>Explore sex-related risk behavior.</p> <p>Develop skills to reduce sex-related HIV risk.</p>	<p>Number of sex-related risk behaviors identified</p> <p>Number of safer sex practices reported, such as use of condoms for vaginal, anal, oral sex</p>

management	Offer counseling and testing for HIV, STIs, TB, and viral hepatitis.	Number of Action Plans completed Number of participants receiving case management and referrals Number of participants with knowledge of sero-status
Booster:	Complete Behavioral Risk Assessment form with participant. Summarize participant goals and accomplishments. Identify gaps and participant needs. Develop a Continuum of Care Action Plan. Offer counseling and testing for HIV, STIs, TB, and viral hepatitis.	Number of completed Behavioral Risk Assessment forms Number of behavioral risk goals achieved Number of Action Plans completed Number of referral services received Number of clients who successfully completed program
Staff supervision and training:	Provide on-going supervision. Conduct periodic evaluation. Provide booster training.	Documentation of case conferences conducted Number of trainings received Number of performance evaluations completed

APPENDIX 2D: SAMPLE JOB DESCRIPTION

POSITION/TITLE: Supervisor
SALARY RANGE: Commensurate with educational and work experience
STATUS: Full-Time - 35 hours per week

Program Description: The MIP program is based on creating trusting and respectful relationship with injection drug users and on enabling them to make healthier choices. This is accomplished using Motivational Interviewing techniques and behavioral readiness staging. The ultimate outcome of MIP is not necessarily abstinence, although the participant may certainly choose this route; the ultimate outcome is increased self-efficacy and choice-making skills among participants. MIP has produced the following outcomes: participants have 1) reduced their HIV risk-related sex and drug practices, 2) entered drug treatment, 3) accessed care for neglected health problems, and 4) created more stable living situations. It is a hands-on program with intensive interaction between the MIP team and participants.

Qualifications: Masters-level professional preferred. Bilingual English/Spanish candidate preferred. Minimum BA/BS with 3-5 years of experience training, supervising, and collaborating with a clinical team required.

Extensive work experience with injection drug users and familiarity with HIV-prevention and harm reduction techniques, including those pertinent to syringe exchange. Knowledge about and experience with people living with HIV/AIDS. Experience working with diverse populations. Knowledge, experience, or the willingness to learn the theories and techniques that underpin the MIP implementation (Stages of Change, Role Induction, Case Management, and Motivational Interviewing) and to use these theories and approaches in staff supervision. Experience with formal mental health diagnoses of patients.

Willingness to work collaboratively with MIP staff (Case Manager/Community Educator and Counselor) in community assessment, participant identification, and participant induction as well as to supervise and participate in a series of intervention sessions for participants. Ability to train staff and injection drug users in safer injecting and overdose prevention and to help participants choose among a variety of drug treatment modalities. Willingness to collaborate with the Case Manager/Community Educator and Counselor to recruit and retain out-of-treatment street injection drug users and to help them increase their ability to make healthier choices by: 1) decreasing their drug and sex related HIV risk practices, 2) obtaining social, health, and other life needs, and 3) considering whether or not to enter a drug treatment program.

Strong organizational and computer skills. Commitment to detail so as to ensure adequate case documentation and confidentiality regarding agency and constituent information.

Function: He/she will be required to provide staff leadership and program vision. He/she will ensure that the program's goals are implemented, that the program maintains its fidelity to the original research, and that the program is in compliance with relevant regulations and CDC and state department standards.

He/she will be required to create and strengthen partnerships with primary care facilities, mental health facilities, drug treatment programs, housing programs, and social and other service providers to ensure immediate patient access to care and services. He/she will then be required to strengthen and maintain these relationships through consistent follow-up with service providers to ensure the execution of protocols.

He/she will be required to oversee community mapping of potential locations where injection drug users congregate (street corners, shooting galleries, homeless shelters, and so forth).

Responsibilities to MIP Staff and Participants:

- Oversee staff use of specific counseling methods prescribed for MIP intervention.
- Build an effective team and resolve and mediate conflicts.
- Accompany team to community sites.
- Counsel participants at various community venues, when appropriate.
- Understand and utilize the harm reduction approach rather than the sobriety-abstinence only approach.
- Supervise and manage the dysfunctional but expected participant behavior changes (relapses, insecurities, anxieties and fears) during the intervention process.

Responsibilities to MIP Program:

- Oversee program and report progress to the Executive Director and other funding services.
- Oversee quality assurance of the program.
- Ensure that program services are conducted in a culturally and linguistically competent manner.
- Ensure programmatic contract and compliance and meet the stated goals and objectives. under program service grants, including timely reporting.
- Assist in fiscal monitoring and maintain program expenses within the program's budget. .
- Maintain updated and accurate documentation of program services.
- Generate and prepare reports for funding sources.

APPENDIX 2D: SAMPLE JOB DESCRIPTION

POSITION/TITLE: Counselor
SALARY RANGE: Commensurate with educational and work experience
STATUS: Full-Time - 35 hours per week

Program Description: The MIP program is based on creating trusting and respectful relationship with injection drug users and on enabling them to make healthier choices. This is accomplished using Motivational Interviewing techniques and consideration of the stages of change. The ultimate outcome of MIP is not necessarily abstinence, although the participant may certainly choose this route; the ultimate outcome is increased self-efficacy and choice-making skills among participants. MIP has produced the following outcomes: participants have 1) reduced their HIV risk-related sex and drug practices, 2) entered drug treatment, 3) accessed care for neglected health problems, and 4) created more stable living situations. It is a hands-on program with intensive interaction between the MIP team and participants.

Qualifications: BA/BS degree in Counseling with 1-3 years experience in the health, mental health, HIV/AIDS prevention or treatment, and/or substance abuse fields preferred. Experience with case management, training, supervising, and collaborating with clinical teams preferred. Candidate with driver's license preferred. Educational requirements may be waived for extensive experience working with injection drug users and HIV/AIDS prevention.

Familiarity with HIV-prevention and harm reduction techniques, including those pertinent to syringe exchange. Knowledge of and experience with people living with HIV/AIDS. Experience working with diverse populations, especially in terms of HIV and substance abuse prevention. Knowledge, experience, or the willingness to learn the theories and techniques that underpin the MIP implementation: Stages of Change, Role Induction, Case Management, and Motivational Interviewing.

Willingness to work with MIP staff (Case Manager/Community Educator and Counselor) in community preparation, participant identification, and participant induction as well as to engage participant in a series of intervention sessions. Ability to train staff and injection drug users in safer injecting and overdose prevention and to help participants choose among a variety of drug treatment modalities. Willingness to collaborate with Supervisor and Case Manager/Community Educator to recruit and retain out-of-treatment street injection drug users and to help them increase their ability to make healthier choices by: 1) decreasing their drug and sex related HIV risk practices, 2) obtaining social, health, and other life needs, and 3) considering whether or not to enter a drug treatment program.

Strong organizational and computer skills and commitment to detail so as to ensure adequate case documentation and confidentiality regarding agency and constituent information, is also required.

Function: He/she will be required to maintain partnerships with primary care facilities, mental health facilities, drug treatment programs, housing programs, and social and other service providers to ensure immediate patient access to care and services.

He/she will be required to partake in community mapping of potential locations where injection drug users congregate (street corners, shooting galleries, homeless shelters, and so forth).

Responsibilities to MIP Team and Participants:

- Train and oversee the Case Manager/Community Educator and ensure his/her use of specific counseling methods prescribed for the MIP intervention.
- Work effectively within a team to resolve and mediate conflicts.
- Accompany team to community sites.
- When necessary, conduct MIP counseling sessions off-site in the community.
- Understand and utilize the harm reduction approach rather than only the sobriety-abstinence approach.
- Develop rapport, trust, and communication with potential and current participants.
- Display non-judgmental attitudes toward and compassion for drug users.
- Document the MIP process (keep records, track participant progress, and so forth).
- Communicate well with people of diverse backgrounds, cultures, and professions (physicians, social service providers, and so forth).
- When necessary, escort participants to various community services and ensure that they are attended. This includes taking a person to a shelter to get a shower and change clothes prior to going to a physician for care.
- Encourage participants to achieve set goals.

APPENDIX 2D: SAMPLE JOB DESCRIPTION

POSITION/TITLE: Case Manager/Community Educator
SALARY RANGE: Commensurate with educational and work experience
STATUS: Full-Time - 35 hours per week

Program Description: The MIP program is based on creating trusting and respectful relationship with injection drug users and on enabling them to make healthier choices. This is accomplished using Motivational Interviewing techniques and consideration of the stages of change. The ultimate outcome of MIP is not necessarily abstinence, although the participant may certainly choose this route; the ultimate outcome is increased self-efficacy and choice-making skills among participants. MIP has produced the following outcomes: participants have 1) reduced their HIV risk-related sex and drug practices, 2) entered drug treatment, 3) accessed care for neglected health problems, and 4) created more stable living situations. It is a hands-on program with intensive interaction between the MIP team and participants.

Qualifications: Minimum 3-5 years working with drug users required. HIV/AIDS medical overview and HIV pre and post-test counseling certificates required.

Individual advocacy skills and cultural sensitivity to different populations. Familiarity with HIV-prevention and harm reduction techniques, including those pertinent to syringe exchange. Knowledge of and experience with people living with HIV/AIDS. Intimate knowledge of the drug-use culture, including its beliefs, norms, patterns of behavior, and so forth. Knowledge, experience, or the willingness to learn the theories and techniques that underpin the MIP implementation: Stages of Change, Role Induction, Case Management, and Motivational Interviewing.

Willingness to work with MIP staff (Supervisor and Counselor) in community preparation, participant identification, and participant induction as well as to engage participant in a series of intervention sessions.

Strong organizational and computer skills. Commitment to detail so as to ensure adequate case documentation and confidentiality regarding agency and constituent information.

Function: He/she will be required to conduct the MIP intervention with out-of-treatment, active injection drug users. He/she will develop and maintain supportive relationships with participants through individualized interventions and team-based case management techniques, empowering participants to evaluate sex and injection drug practices so as to achieve the most appropriate outcome.

He/she will ensure that participants' basic needs are met, including health care, adequate nutrition, housing, and employment. He/she will facilitate and organize participant access to primary health care, mental health care, drug treatment services, and social services, acting as intermediary between individuals and agency officials when necessary.

He/she will be required to partake in community mapping of potential locations where injection drug users congregate (street corners, shooting galleries, homeless shelters, and so forth).

Responsibilities to MIP Team and Participants:

- Initiate case strategies to identify the maximum number of drug users eligible for the MIP program.
- Maintain a caseload of 20-25 participants per program cycle.
- Develop rapport, trust, and communication with potential and current participants.
- Display non-judgmental attitudes toward and compassion for drug users.
- Provide participants with risk-reduction instruction and safety kits (bleach, needles where legal, condoms, and so forth).
- Understand and utilize the harm reduction approach rather than only the sobriety-abstinence approach.
- Produce activity reports and participate in case conferencing with clinical Supervisor and/or Counselor.
- Document the MIP process (keep records, track participant progress, and so forth), maintaining detailed and accurate data on each encounter using program forms.
- Communicate well with people of diverse backgrounds, cultures, and professions (physicians, social service providers, and so forth).
- When necessary, escort participants to various community services and ensure that they are attended. This includes taking a person to a shelter to get a shower and change clothes prior to going to a physician for care.
- When necessary, conduct MIP counseling sessions off-site in the community.
- Encourage participants to achieve set goals.
- Some evening and weekend work.

APPENDIX 2E: COMMUNITY MAPPING PLANNING FORM

In the context of MIP, community mapping is a formative evaluation process designed to gather helpful information for the planning and delivery of the intervention. Community mapping is critical for accessing and understanding the target population and for identifying structural, environmental, behavioral, and psychological factors that can either facilitate or inhibit STD/HIV/viral hepatitis risk-reduction.

Describe your target population:

Example: Injection drug users 18 years and older recruited from the community.

List the sources you will consult in preparation for the community mapping process:

Example: Local health department, state health department, epidemiological data, morbidity and mortality reports,, health and medical journals, and statistical reports.

List the individuals you will consult with in preparation for the community mapping process:

Internal Interviews: Interviews with staff members to assess current knowledge of the target population while developing a list of outside contacts.

Key Informant Interviews: Interviews with those who have regular contact with the target population, such as community-based agencies, the health department, health care providers, the justice system, and other social service providers.

APPENDIX 2F: COMMUNITY MAPPING RESOURCE SCAN WORKSHEET

Directions: Next to the service categories below, list up to two community organizations that provide these services. If you do not know of an organization providing a particular service, indicate this with a “G,” for gap. Provide comments (questions, notes, and so forth) as necessary.

Once you have done this for each service category, you will be able to identify which services providing HIV prevention, care, and treatment are readily available and which are lacking in your community. These are your service gaps—categories where there are no organizations providing the stated service in your community/geographic vicinity.

Note: Resource Scan Worksheet adapted from http://www.caear.org/foundation/pdf/Mod3_Resource_Scan_Worksheet.pdf

Service Category	Agencies offering service	Clients Served/Target Population	Existing Relationship (yes or no)	Comments
Adult/juvenile detention centers				
Back to work programs				
Counseling and testing sites	Example: Peoples Choice Center	ALL	Y	
	Women's Against AIDS	Women and female adolescents	N	Been around for 3 years; affiliated w/ Munroe hosp.
Detoxification centers				

Service Category	Agencies offering service	Clients Served/Target Population	Existing Relationship (yes or no)	Comments
Emergency rooms				
Faith-based services				
Family planning organizations				
Food banks				
Health care centers				
HIV/AIDS service organizations				
HIV/AIDS care and treatment sites				

Service Category	Agencies offering service	Clients Served/Target Population	Existing Relationship (yes or no)	Comments
Homeless shelters/homeless services				
Hospitals				
Immigration/legal services				
Mental health programs				
Migrant health services				
Nutrition counseling				
Social services				

Service Category	Agencies offering service	Clients Served/Target Population	Existing Relationship (yes or no)	Comments
STI clinics				
Substance abuse programs				
Other 1: _____				
Other 2: _____				
Other 3: _____				
Other 4: _____				
Other 5: _____				
Other 6: _____				

APPENDIX 2H: SERVICE DIRECTORY FORM

Name of Organization:

Physical Address:

Mailing Address:

Telephone (s):

Fax:

Email:

Web Page:

Contact (s):

Hours of Operation:

Sun	Mon	Tues	Wed	Thurs	Fri	Sat

Catchments (Geographical Reach):

Mission Statement:

Services Offered:

Admission or Service Requirements:

Documents Required for Admission or Service:

Income Requirement:

Other: *(e.g., service philosophy toward injection drug users)*

APPENDIX 2I: FIELD SAFETY GUIDELINES

- Have a way to check in with the office and with your partner (e.g., calling cards for calling back to the office, two-way radios, pagers, and/or cell phones). Plan communication procedures to keep track of team whereabouts.
- If you are working as a team (which is highly recommended), arrange to meet in a safe place before setting out into the field. Arrive at the area together. Keep each other in view at all times. Don't separate from your partner for long periods of time.
- Have your program identification on you before going out into the field. Make sure it can be easily produced if it is not visible. Identify yourself and tell people what you are doing and why.
- Have plenty of supplies (safe sex and needle hygiene kits) readily available.
- Know the neighborhood. If you are new to the neighborhood in which you are working, accompany other workers who know the neighborhood well and who can teach you about risks and outreach opportunities.
- Do not buy goods or accept gifts, food, or merchandise from street people or clients—it may be stolen. Do not give or lend money to clients.
- Develop a friendly, professional relationship with clients you come into contact with, but do not interact with them socially or romantically.
- Don't make assumptions, judgments, or generalizations about your client population. Behave respectfully toward them, and win their trust and confidence. Avoid any communication, through words, gesture, or posture that conveys arrogance.
- Stay in view of street traffic whenever possible. Do not enter shrubbery, alleys, or other areas where you are not visible unless accompanied by a partner.
- Do not display personalized tags on cars.
- Do not counsel clients outside of the specific requirements of your job.
- Be aware of your surroundings at all times. You can avoid trouble by being observant.
- Do not conduct outreach in the field after dark.
- Dress comfortably and inconspicuously, particularly when working in high-risk areas where drug buys are occurring. Do not dress to impress. Be aware of and avoid gang colors.
- Do not carry a purse or large amounts of money while in the field. Limit jewelry to small costume jewelry items. Do not carry more cash or incentives than you will need that day.

FIELD SAFETY GUIDELINES....*continued.*

- Do not carry weapons.
- Never approach a potential client when he/she is buying drugs.
- Never approach a client when he/she is negotiating with a client or dealing with a pimp.
- Do not enter a crack house or shooting gallery.
- Avoid getting in the middle of the sale of drugs or sex. If a drug or sex deal is conducted near you, leave the area quickly and quietly, without drawing attention to yourself. Never take, touch, or sample any person's drugs or merchandise.
- Consider liability issues of transporting clients in your personal vehicle:
 - Your liability to an injured client if there is an accident.
 - Your vulnerability if the client is carrying drugs.
- Plan escape routes in advance.
- If you find yourself in a dangerous situation, remain calm and try to leave as soon as possible. In case of an emergency, call 911.

APPENDIX 2J: MIP SAMPLE LETTER OF INTRODUCTION

Date

Name of Recipient

Title

Address

City/State/Zip

Dear Sir/Madam:

I am writing to introduce the *Modelo de Intervención Psicomédica* (MIP) Program, an individual behavioral level intervention for reducing high-risk drug and sex-related HIV risk behaviors among intravenous drug users (IDUs).

This intervention recognizes the participant's roles in multiple social systems (e.g., environment system, health care system, family system) and seeks to eliminate barriers that may impede their access and use of healthcare and drug treatment.

The proposed project will target males and females 18 years of age and older and will expand integrated outreach, pre-treatment, and treatment services. It will do so by adding new capacity and enhancing existing outreach, pre-treatment, and treatment services with innovative, culturally competent, and appropriate evidence-based interventions designed to reduce the impact of substance abuse and HIV/AIDS and to improve lives in the targeted community.

The project will demonstrate that culturally appropriate and coordinated outreach, engagement, counseling and case management delivered *simultaneously* decrease morbidity and mortality, improve the quality and length of life, and increase the functional competence of out-of-treatment, substance abusing individuals.

This will increase the participant's ability to complete treatment, decrease the interval between treatment episodes, and strengthen the impact of treatment by upgrading the client's stability through access to housing and vocational preparation.

I would like to meet with you and invite you to partner with us as we embark on this new and exciting initiative. I will be calling to schedule a time to further discuss this project and to answer any questions you may have about the program.

Sincerely,

Name

Title

APPENDIX 2K: *MODELO DE INTERVENCIÓN PSICOMÉDICA (MIP) FACT SHEET*

A cognitive behavior intervention combining individualized counseling and case management to reduce HIV/STI/viral hepatitis risks among injection drug users

Program Overview

MIP is an HIV psycho-medical intervention for out of treatment injection drug users. It is based on Motivational Interviewing techniques, stages of change, social learning, role induction, and cognitive behavioral theories.

Objectives: Participants 1) identify and employ specific ways to reduce drug and sex-related HIV risk; 2) receive assistance obtaining health and other social services; 3) prepare to enter drug treatment programs if they choose to do so; 4) receive HIV counseling and testing and referrals for viral hepatitis and STI testing.; 5) identify relapse triggers and practice relapse prevention skills; 6) create an action plan for maintaining positive behavior changes; and 7) recognize critical support systems for maintaining behavior change.

MIP offers seven one-on-one structured counseling sessions over a 3 month period, and it is conducted by a team of professionals who develop a strong relationship with participants. Motivational Interviewing increases a participants' drive to reduce their drug and sex-related HIV risk.

Core Elements

Original researchers identify 7 core elements:

- Conduct community assessment and outreach
- Employ an induction process
- Use Motivational Interviewing techniques and apply underlying theories and approaches.
- Use a Self-Assessment Readiness instrument or evaluation tool at each session.
- Establish a Counselor and Case Manager collaboration
- Conduct a minimum of 6 sessions and provide for additional contacts if necessary.
- Conduct a booster session (in addition to the 6 sessions).

Target Audience

The primary target population is injection drug users who are 18 years of age and older and recruited from the community; however, the program can be adapted for other drug users, including IDUs in methadone treatment for the past year. If agencies would like to work with poly-drug users who are not currently injection-drug users, CDC will provide Technical Assistance for adaptation.

Robles, R. R., Reyes, J. C., Colon, H. M., Sahai, H., Marrero, C. A., Matos, T. M., Calderon, J. M. & Shepard, E. V. (2004) Effects of combined counseling and case management to reduce HIV risk behaviors among Hispanic drug injectors in Puerto Rico: A randomized controlled study. *Journal of Substance Abuse Treatment* 27, 2, 145-152.

Marrero, C.A., Robles, R.R., Colon, H.M., et al. (2005) Factors associated with drug treatment dropout among injection drug users in Puerto Rico. *Addictive Behaviors*, 30, 397-402

APPENDIX 2L: SAMPLE MEMORANDUM OF UNDERSTANDING

This Memorandum of Understanding (MOU) relates to the proposed collaboration between *Name of Lead Agency* and *Name of Partner Agency* in providing participants enrolled in the MIP Program with the following services:

- Outreach to out of treatment injection drug users.
- HIV/AIDS educational sessions (7).
- HIV counseling, testing, and referral to care.
- Comprehensive case management.
- Assistance with obtaining primary care, mental health treatment, entrance into substance abuse treatment programs, and access to additional social services.

The collaboration is dependent upon an award from CDC to *LEAD AGENCY*. This award allows the *LEAD AGENCY* staff to deliver services to MIP participants either directly or through referrals to our partner, *PARTNER AGENCY*.

This MOU between *LEAD AGENCY* and *PARTNER AGENCY* sets out the collaborative roles and responsibilities as well as the individual roles and responsibilities of *LEAD AGENCY* and those of *PARTNER AGENCY*. This MOU covers the first year of a 5 year project with the intent to renew for Years 2-5 contingent upon additional funding.

Collaborative roles and responsibilities:

- All partners agree that the activities and services of the proposed project are governed by federal laws and regulations that do not permit use of federal and state funds from this project for religious instruction or other religious activities.
- All partners agree to meet with the Project Director, (name), or a designee on a quarterly basis to assess progress in meeting objectives, to make mid-course adjustments if necessary, and to plan for continued service delivery.
- All partners agree that participant information will be considered protected health information between the participant and the program staff only. All material shared with the program staff will be kept confidential and will not be given to anyone or to any agency.
- Partner organizations will share information with the Project Director, including recruitment data, service results, referrals to other programs, treatment progress, health and social concerns, and other information that concerns the quality and quantity of program services rendered.
- Project data that contain participants' names or the names of program staff will be secured as stated by law. Project forms will be coded by number instead of by name and case records will be stored in locked files. Only one staff member—the Project Director or a designee—will hold the key to those files. No names will appear in any reports or papers related to project findings
- Partners agree that project participants are not required to accept any services or information unless they are ready and willing to do so.
- Participation in this project is voluntary. Participants are free to abstain from answering any question they wish. Participants may decide not to take part or to withdraw from the project at any time without penalty. They can still obtain referrals for services if they decide not to participate in the program.

- Responses will be kept private at all times. However, if someone in the study becomes suicidal, threatens to harm others, or reveals a case of child abuse or neglect or elder abuse, the project staff is required by law to report him/her.

Lead Agency's Responsibilities:

MIP staff members will provide the following free services to participants:

- Outreach to engage individuals with drug problems in MIP. Outreach will be conducted in the following cities: (list city, county, state).
- Seven MIP sessions--6 counseling sessions and 1 booster session, all offering HIV counseling and testing, referrals to medical care, comprehensive case management, assessment of service needs, and assistance to obtain services.
- Help accessing medical treatment for pressing health and mental health care needs as well as for entry into drug treatment programs.
- Assistance obtaining other services through partner organizations. These other services may include but are not limited to: temporary housing, employment, parenting resources for children, financial assistance (food stamps, Medicaid), domestic violence shelters, alternative treatments such as acupuncture, meditation, and so forth.
- Assistance gaining entry into drug treatment programs if the participant so wishes.
- Information about HIV and its prevention.
- Referrals for viral hepatitis testing.
- Information about protecting oneself from liver damage and about securing vaccinations against Hepatitis A and B.
- Incentives throughout the intervention, including transportation passes, food vouchers, condoms, and other convenience products.
- Staff escort services, as needed, and staff advocacy.
- Respect of cultural differences and protection from discrimination.
- An understanding of cultural practices, beliefs, and past experiences.
- Follow-up to ensure utilization of services.

Partner Organization Responsibilities:

THIS WILL CHANGE DEPENDING UPON THE SERVICES PROVIDED.

Primary Health Care Service Provider:

- Partner accepts MIP participants for (List the Type of Services Being Offered), regardless of drug-use status.
- Partner provides services to MIP participants in a timely manner, which may mean serving participants who have not made appointments.

- Partner has culturally and linguistically competent staff to provide services to participants.
- Partner treats MIP participants with the same respect and care that it treats all clients.
- Partner is sensitive to the possible trauma experienced by MIP participants and treats participants in the caring manner traumatized individuals require.
- Partner immediately contacts the MIP Case Manager if a participant has difficulty with medical recommendations and/or displays disruptive behavior.
- Partner aids the participant in making decisions about health care and helps the participant make decisions about health care using decisional balance techniques and Motivational Interviewing skills.
- Partner gives its staff members the opportunity to participate in staff training led by *Lead Agency's* capacity building staff. This training will address cultural practices and beliefs, the sensitivities of injection drug users, and the underlying theories of self-determination, stages of change, and Motivational Interviewing.
- Partner allows a project staff member to accompany participants to services.

Drug treatment program that is no longer willing to engage client:

- Partner informs MIP staff if a participant is about to leave drug treatment program, and refers him/her to the *Lead Agency*.
- Partner allows MIP Case Managers and licensed clinical social workers to meet with participants while they are enrolled in drug treatment programs.
- Partner informs MIP staff of a participant's completion of the drug treatment program.

The terms of this Agreement shall be *MM/DD/YY* through *MM/DD/YY*, or the period determined by the grant award, pending funding from the federal CDC.

Therefore, each partner has signed below, indicating their agreement and certifying that the person signing below has the authority to bind the partner to the terms of this Memorandum of Understanding.

Lead Agency, Inc.

Name of Lead Agency's Executive Director

Date

Name of Lead Agency's Director of Clinical Programs

Date

Partner Agency Name

Name of Partner Agency's Executive Director

Date

Name of Partner Agency's Director of xxx Service

Date

APPENDIX 2M: CONFIDENTIALITY AGREEMENT

I, _____, an employee of [*Name of Organization*], agree to abide by the confidentiality laws of the State of [*Name of State*] governing mental health services/practices, the Federal Government's Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law No. 104-191, 110 Stat. 1936-codified as amended in scattered sections of 18, 26, 29, and 42 U.S.C.), and regulations protecting client rights.

Confidentiality refers to the privacy of all clients/participants (e.g., *parents, guardians, caretakers, youth, children, and so forth*) who have had contact with/received services from this organization.

In the course of my work at [*Name of Organization*], I understand that I am bound to confidentiality. I am not to reveal and/or discuss any information pertaining to any client from this organization to any one unless the client/participant signs a written release for this purpose.

Federal laws and regulations protect the confidentiality of client records maintained by this program.

Generally, the program may not disclose an individual's status as a program participant or as an alcohol/drug abuser unless:

1. The client consents in writing.
2. The disclosure is allowed by a court order.
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

By your signature, you are fully consenting to the terms set forth in this agreement. This agreement is not limited to working hours; it is extended to off duty hours as well. In addition, this agreement will remain in effect regardless of employment status (e.g., resignation, termination, leave of absence, and so forth). Violation of this agreement is ground for immediate termination.

Participant Name	Participant Signature	Date

Witness Name	Witness Signature	Date

APPENDIX 2N: MIP PARTICIPANT CONSENT FORM

Explanation of the program: [*Name of the Program*]

Services: You are being invited to participate in a program for out of treatment substance users 18 years of age and older. If you agree to participate in this program, you will have the opportunity to receive the following services:

- Substance abuse treatment services and referrals for methadone, detox, and in and outpatient services.
- Mental health services and/or referrals.
- Free and confidential HIV counseling and testing.
- Individual counseling.
- Relapse prevention education.
- Case management and counseling.
- Referrals to other social service needs.

You will be offered the opportunity to participate in six counseling sessions and one booster session. Case management staff will help you obtain services that you identify, need, and/or want. It is your decision as to which services and educational information you want to receive. You will not be required to accept any services or information unless you are ready and want to accept them.

Process of Service: If you agree to enroll in this program, a staff person will be assigned as your Counselor. He/she will ask you about your background in: drug and alcohol use, mental status, family and housing needs, school, work and income, legal issues and court contacts, and physical health and treatment. He/she will ensure use of services and assess your satisfaction with services using assessment instruments.

Also, the Case Manager will discuss potential referrals for other programs, treatment progress, and health and social needs. All information will be considered protected health information between you and the staff person only.

All information shared with the staff person will be kept confidential and will not be given to anyone or to any agency unless specified by you (the participant).

Program staff will share services data, referrals, treatment progress, and health and social needs with the program evaluator.

Participant Rights:

- Your participation in this project is voluntary.
- You are to abstain from answering any question you wish.
- You may decide to withdraw from the program at any time without any penalty.
- You can still obtain referrals for services if you decide to withdraw from the program.

Benefits:

Participants receive immediate and long-term benefits from this program. Immediate advantages to participants may include:

- Assistance accessing health medical care, both for general and pressing health care needs.
- Mental health services and/or referral to such services.
- Assistance securing health coverage, housing, employment, and so forth.
- Assistance entering drug treatment programs.
- Counseling and testing for HIV and referrals for viral hepatitis and STI testing.
- Incentives throughout the intervention, including transportation, food, safer sex kits, and bleach kits, among others.
- Relapse prevention education through individual sessions.
- Staff escort services to appointments and referrals, when necessary.

Risks:

- You may be asked to disclose personal or stressful information about your situation.
- You may have unpleasant reactions to these questions. If you do not want to answer any question, you may choose not to do so. You may take breaks or stop the interview at any time. We will keep your answers private at all times. However, if someone in the program is in urgent danger of suicide, threatens to harm someone else, reveals a case of child abuse or neglect, or reveals a case of elder abuse, program staff must report these cases.
- You may experience unpleasant emotions. You may ask to speak to a professional about these feelings.

Confidentiality:

Case records will be kept confidential, as stated by law. The only times when the law does not protect confidentiality are listed in the Risk Section of this document. No names will appear in any reports or papers related to the evaluation of this program. Program forms will be coded with a number instead of a name, and case records will be stored in locked files.

Program Evaluation:

Program evaluation data will be used in reports and papers to help influence policies and funding and to improve program services.

By signing this form, you agree to participate in the program described to you both verbally by a staff member and visually in this form. If you have any questions or concerns about your participation in this program, contact [Name and Telephone of Contact].

Participant Name	Participant Signature	Date
Witness Name	Witness Signature	Date

Note: Signed copies of this consent form must be kept on file in participant record, on file with the Program Evaluator, and a copy must be given to the participant.

APPENDIX 2P: NOTICE OF PRIVACY PRACTICES with ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

This notice describes how information can be accessed, used, and disclosed. Please read this notice carefully. If you have any questions about this notice, please speak with your Counselor.

Our Pledge Regarding Information: We understand that information about you and your health is personal. We are committed to maintaining the confidentiality of your personal information. We create a record of the care and services you receive at this agency. We need this record to treat you and to comply with certain legal requirements. This notice applies to all of the records generated by our office, whether made by your personal doctor or by other persons within our office.

This notice advises you of the ways in which we may use and disclose information about you. It also describes your rights to confidentiality and certain obligations we have regarding the use and disclosure of information. As required by Law, we will disclose information about you when required to do so by federal, state, or local law. This includes suspected child abuse or neglect, crime, or threat to commit a crime.

We are required by law to:

- Ensure that medical information and all personal information is kept private.
- Give you this notice of our legal duties and privacy practices with respect to personal information.
- Follow the terms described in this notice.

How We May Use and Disclose information about You: The following categories describe different ways that we may use and disclose your personal information. For each category of uses and disclosures, we will explain what we mean and provide examples. Not every use or disclosure will necessarily be listed below. However, all the ways in which we are permitted to use and disclose information will fall within one of these categories.

Treatment: We may use personal information to provide you with services. We may disclose information about you, with your written consent, to other professionals involved in your treatment.

Treatment Alternatives: We may use and disclose personal information, with your written consent, to recommend possible treatment options.

Individuals involved in Your Treatment: We may release personal information, with your written consent, to a friend or family member involved in your care.

To Avert a Serious Threat to Health or Safety: We may use and disclose personal information when necessary to prevent a serious threat to your health and safety or to the health and safety of another person. Any disclosure, however, would be only to someone able to prevent the threat.

Health Oversight Activities: We may disclose personal information to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor and evaluate programs and to evaluate compliance with civil rights laws

Special Situations: We may use and disclose medical information to medical personnel in a medical emergency,

Your Rights Regarding Information about You: You have the following rights regarding the information we maintain about you:

- **The right to a copy of your record:** You have the right to request a copy of your record. This does not include counseling notes. To request a copy of your record, you must submit the request in writing to your Counselor. If you request a copy of your record, we may charge a fee as permitted by state law for the cost of copying, mailing, and other supplies associated with your request.
- **The right to amend:** If you believe that there is some error in your information or that important information has been omitted, it is your right to request the correction of existing information or the addition of missing information. Your request and the reason for your request must be in writing. We may deny your request for an amendment if it is not in writing or if it does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: was not created by us, is not part of the information kept by the agency, is not part of the information which you would be permitted to inspect, or is accurate and complete.
- **The right to an account of disclosures:** You have the right to request an accounting of disclosures. You must submit your request in writing. Your request must state a time period no longer than six years and not including dates before April 14, 2003. Your request must indicate in what form you want the list, for example on paper or electronically.
- **The right to request restrictions:** You have the right to request a restriction or limitation on the personal information we use or disclose for treatment purposes. You also have the right to request a limit on the personal information we disclose to someone involved in your care, such as a family member. We are not required to agree to your request, however. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing. In your request, you must tell us: (1) what information you want to limit; (2) whether you want to limit our use, our disclosure, or both; and (3) to whom you want the limits to apply (e.g., disclosure to your spouse).
- **The right to request confidential communication:** You have the right to request that we communicate with you about matters in a certain way or at a certain location. For example, you can ask that we only contact you at work, at your home, or by mail. To request confidential communication, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **The right to a paper copy of this notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

Changes to this Notice: We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for information we already have about you as well as for any information we receive in the future. Each time you register at our agency we will offer a copy of the current notice in effect.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with our agency or with the Department of Health. To file a complaint with our agency, you must complete a Client Grievance Procedure. You can ask the receptionist for the form. You will not be penalized for filing a complaint.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health Information (PHI). You have the right to review our notice and to ask questions about our privacy practices. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

I, [Name of Participant], have received a copy of this agency's Notice of Privacy Practices.

Participant Name	Participant Signature	Date

FOR OFFICE USE ONLY

The reason that a standard acknowledgement of the receipt of the Notice of Privacy Practices was not obtained:

- Client refused to sign.
- An emergency situation prevented this office from obtaining it.
- Other (please specify):

**APPENDIX 2Q:
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**

I understand that Federal Laws and Regulations are enforced by this organization and that I have the right to confidential treatment. Any identifying client record information is kept confidential and is protected under Federal Laws and Regulations (42 CFR Part 2). All identifying client information will not be release without written consent from the client. In the event of a court order, the agency may disclose client information if a judge, in accordance with the requirement contained in 42 CFR, issues a subpoena in conjunction with a court order.

Participant Name	Participant Signature	Date
Witness Name	Witness Signature	Date

APPENDIX 2R: CENTERS FOR DISEASE CONTROL AND PREVENTION

REVISED INTERIM HIV CONTENT GUIDELINES FOR AIDS-RELATED WRITTEN MATERIALS, PICTORIALS, AUDIOVISUALS, QUESTIONNAIRES, SURVEY INSTRUMENTS, AND EDUCATIONAL SESSIONS FOR CDC ASSISTANCE PROGRAMS

I. Basic Principles

Controlling the spread of HIV infection and the occurrence of AIDS requires the promotion of individual behaviors that eliminate or reduce the risk of acquiring and spreading the virus. Messages must be provided to the public that emphasize the ways by which individuals can protect themselves from acquiring the virus. These methods include abstinence from illegal use of IV drugs as well as from sexual intercourse except in a mutually monogamous relationship with an uninfected partner.

For those individuals who do not or cannot cease risky behavior, methods of reducing their risk of acquiring or spreading the virus must also be communicated. Such messages are often controversial. The principles contained in this document are intended to provide guidance for the development and use of HIV/AIDS-related educational materials developed or acquired in whole or in part using CDC HIV prevention funds, and to require the establishment of at least one Program Review Panel by state and local health departments, to consider the appropriateness of messages designed to communicate with various groups. State and local health departments may, if they deem it appropriate, establish multiple Program Review Panels to consider the appropriateness of messages designed to communicate with various groups.

A. Written materials (e.g., pamphlets, brochures, curricula, fliers), audiovisual materials (e.g., motion pictures and videotapes), pictorials (e.g., posters and similar educational materials using photographs, slides, drawings, or paintings) and marketing, advertising, Web site-based HIV/AIDS educational materials, questionnaires, or survey instruments should use terms, descriptors, or displays necessary for the intended audience to understand dangerous behaviors and explain practices that eliminate or reduce the risk of HIV transmission.

B. Written materials, audiovisual materials, pictorials, and marketing, advertising, Web site-based HIV/AIDS educational materials, questionnaires, or survey instruments should be reviewed by a Program Review Panel established by a state or local health department, consistent with the provisions of section 2500(b), (c), and (d) of the Public Health Service Act, 42 U.S.C. Section 300ee(b), (c), and (d), as follows:

SEC. 2500. USE OF FUNDS:

(b) Contents of Programs--All programs of education and information receiving funds under this title shall include information about the harmful effects of promiscuous sexual activity and intravenous substance abuse and about the benefits of abstaining from such activities.

(c) Limitation—None of the funds appropriated to carry out this title may be used to provide education or information designed to promote or directly encourage homosexual or heterosexual sexual activity or intravenous substance abuse.

(d) Construction—Subsection (c) may not be construed to restrict the ability of an educational program that includes the information required in subsection (b) to provide accurate information about various means to reduce an individual's risk of exposure to or to transmission of the etiologic agent for acquired immune deficiency syndrome, provided that any informational materials used are not obscene.

C. Educational sessions should not include activities in which attendees participate in sexually suggestive physical contact or actual sexual practices.

D. Program Review Panels must ensure that the title of materials developed and submitted for review reflects the content of the activity or program.

E. When HIV materials include a discussion of condoms, the materials must comply with Section 317P of the Public Health Service Act, 42 U.S.C. Section 247b-17, which states in pertinent part:

"Educational materials that are specifically designed to address STDs shall contain medically accurate information regarding the effectiveness or lack of effectiveness of condoms in preventing the STDs the materials is designed to address."

II. Program Review Panel

Each recipient will be required to identify at least one Program Review Panel established by a state or local health department from the jurisdiction of the recipient. These Program Review Panels will review and approve all written materials, pictorials, audiovisuals, marketing, advertising, and Web site materials, questionnaires, or survey instruments (except questionnaires or survey instruments previously reviewed by an Institutional Review Board—these questionnaires or survey instruments are limited to use in the designated research project). The requirement applies regardless of whether the applicant plans to conduct the total program activities or plans to have part of them conducted through other organization(s) and whether program activities involve creating unique materials or using/distributing modified or intact materials already developed by others. Materials developed by the U.S. Department of Health and Human Services do not need to be reviewed by a panel. Members of a Program Review Panel should understand how HIV is and is not transmitted and understand the epidemiology and extent of the HIV/AIDS problem in the local population and within the specific audiences for which materials are intended.

A. The Program Review Panel will be guided by the CDC Basic Principles (see Section i above) in conducting such reviews. The panel is only authorized to review materials and is not empowered either to evaluate the proposal as a whole or to replace any internal review panel or procedure of the recipient organization or local governmental jurisdiction.

B. Applicants for CDC assistance will be required to include in their applications the following:

1. Identification of at least one panel established by a state or local health department of no less than five persons who represent a reasonable cross-section of the jurisdiction in which the program is based. Since Program Review Panels review materials for many intended audiences, no single intended audience shall dominate the composition of the Program Review Panel, except as provided in subsection D below.

In addition:

a. Panels that review materials intended for a specific audience should draw upon the expertise of individuals who can represent cultural sensitivities and the language of the intended audience, either through representation on the panel or as consultants to the panels.

b. Panels must ensure that the title of materials developed and submitted for review reflect the content of the activity or program.

c. The composition of Program Review Panels must include an employee of a state or local health department with appropriate expertise in the area under consideration who is designated by the health department to represent the department on the panel.

d. Panels reviewing materials intended for racial and ethnic minority populations must comply with the terms of a-c above. However, membership of the Program Review Panel may be drawn predominantly from such racial and ethnic populations.

2. A letter or memorandum to the applicant from the state or local health department which includes:

a. Concurrence with this guidance and assurance that its provisions will be observed.

b. The identity of members of the Program Review Panel, including their names, occupations, and any organizational affiliations that were considered in their selection for the panel.

C. When a cooperative agreement/grant is awarded, and periodically thereafter, the recipient will:

1. Present for the assessment of the appropriately identified Program Review Panel(s) established by a state or local health department copies of written materials, pictorials, audiovisuals, and marketing, advertising, Web site HIV/AIDS educational materials, questionnaires, and surveys proposed to be used. The Program Review Panel shall pay particular attention to ensure that none of the above materials violates the provisions of Sections 2500 and 317P of the Public Health Service Act.

2. Provide for assessment by the appropriately identified Program Review Panel(s) established by a state or local health department, the text, scripts, or detailed descriptions for written materials, pictorials, audiovisuals, and marketing, advertising, and Web site materials that are under development.

3. Prior to expenditure of funds related to the ultimate program use of these materials, assure that its project files contain a statement(s) signed by the chairperson of the appropriately identified Program Review Panel(s) established by a state or local health department, specifying the vote for approval or disapproval for each proposed item submitted to the panel.
4. Include a certification that accountable, state, or local health officials have independently reviewed written materials, pictorials, audiovisuals, and marketing, advertising, and Web site materials for compliance with Section 2500 and 317P of the Public Health Service Act and approved the use of such materials in their jurisdiction for directly and indirectly funded community-based organizations.
5. As required in the notice of grant award, provide to CDC in regular progress reports signed statement(s) of the chairperson of the Program Review Panel(s) specifying the vote for approval or disapproval for each proposed item that is subject to this guidance.

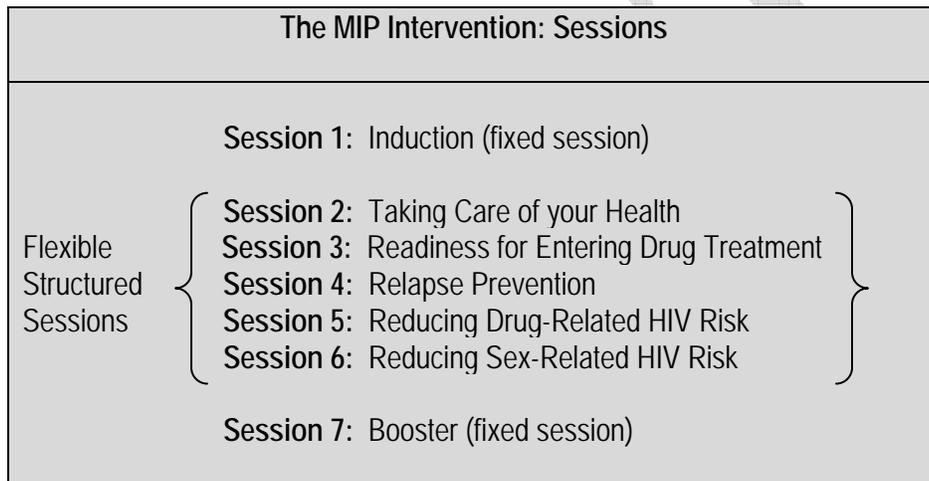
D. CDC-funded organizations, which are national or regional (multi-state) in scope, or that plan to distribute materials as described above to other organizations on a national or regional basis, must identify a single Program Review Panel to fulfill this requirement. Those guidelines identified in Sections I.A. through I.D. and 11.A. through 11.C. outlined above also apply. In addition, such national/regional panels must include, as a member, an employee of a state or local health department.

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PART III. MIP SESSION GUIDE INTRODUCTION

Introduction

This section of the Program Manual provides detailed, step-by-step instructions for conducting MIP sessions. MIP is a *structured intervention* consisting of seven sessions- Induction (Session 1), five Flexible Structured Sessions (Sessions 2-6), and a Booster (Session 7). A structured intervention follows a specific order and covers specific content. Sessions may require more than one contact to ensure that the participant has mastered session materials.



Documentation forms used in a session can be found at the end of that particular session outline.

Summary of the MIP Intervention

The goal of MIP is to increase participants' health awareness and their self-efficacy to reduce HIV risk behaviors. This is done through a combined approach of individualized counseling and case management support. At each session, the MIP team works with the participant to support HIV risk reduction behavior change and to ensure access to needed services.

Sequence of the Structured Sessions

The Induction (Session 1) and the Booster (Session 7) are **fixed** scheduled sessions meaning that they must occur first and last, respectively. Sessions 2 through 6 are **flexible** structured sessions, meaning that they are not necessarily designed to be delivered in a linear sequence. The Counselor and the participant decide on the sequence of the flexible sessions based on participant readiness and individual need.

At the end of each structured session, the participant and the Counselor review the goals that were established for that session and assess progress made toward achieving those goals. If the participant is comfortable with the progress made during that session, the Counselor will help the participant select another structured session topic for the next appointment. If the participant is not ready to progress to another structured session, he/she may request additional contacts to complete the current structured session. The sequencing of five structured sessions is then modified based on the participant's needs.

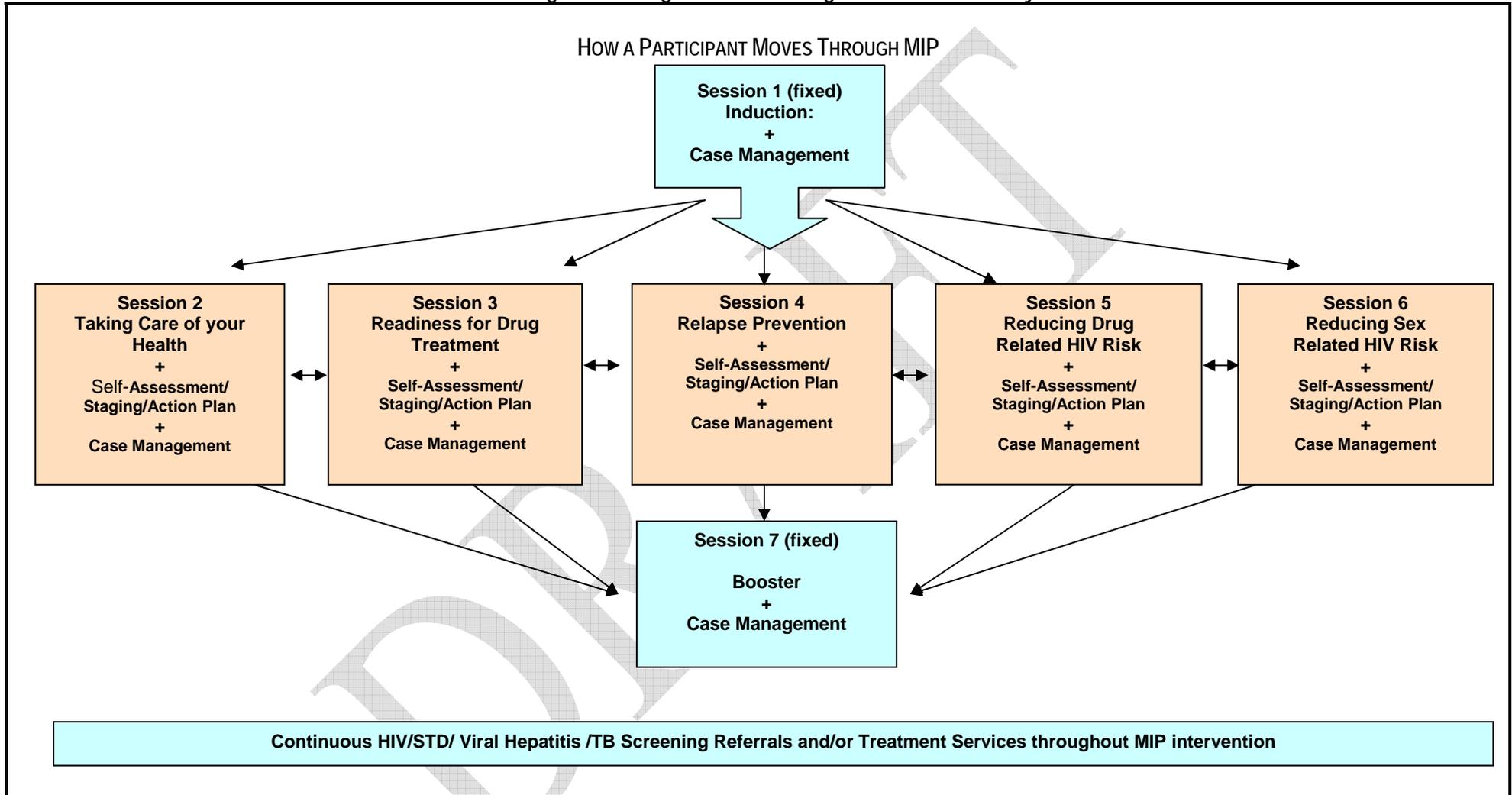
For example, following the Induction Session, a participant may choose to address his/her sex-related HIV risk behaviors. Session 6 (Reducing Sex-Related HIV Risk) would then be selected for the next appointment, rather than Session 2 (Taking Care of your Health). Likewise, a participant may have completed Sessions 2 and 3 with only one contact per structured session but may require multiple contacts to complete Session 5 (Reducing Drug-Related HIV Risk). The sequence and timing of the structured sessions will vary depending on individual participant needs.

What happens when a participant enters a drug treatment program?

If a participant decides to enter a conventional drug treatment program or a methadone maintenance treatment (MMT) program during MIP, the MIP team and the participant will need to decide whether it is appropriate to continue with the intervention. If the participant chooses to continue MIP, the team can change the sequencing of the structured sessions. For example, the Counselor may implement the Relapse Prevention (Session 6) or Reducing Drug-related HIV Risk (Session 5) with the participant in order to prepare him/her for drug treatment, or the Counselor and participant may continue with the other structured sessions and the booster, as appropriate.

For a participant checking into a short-term detoxification in-patient treatment program, it is possible to continue the MIP intervention once the participant leaves. If a participant enters a day treatment program, the Counselor should establish a good working relationship with the treatment staff and should collaboratively assess the participant's ability to continue MIP based on the compatibility of the treatment program with the goals and objectives of MIP.

FIGURE 1: Combining Counseling and Case Management in the Delivery of the MIP Intervention



Note: Induction (Session 1) and Booster (Session 7) represent fixed, structured sessions and must be implemented first and last respectively. Sessions 2-6 are flexible, structured sessions that are administered based on the participant's interest(s) and need(s). Case Management must accompany every structured session.

Timing of the Structured Sessions:

To keep the participant engaged in MIP, weekly contact is recommended. A minimum of one week but no more than two weeks should pass between contacts with a participant. Between sessions, the MIP team should continue to provide case management and follow-up services that support the participant's risk reduction goals.

In the event that a participant is not ready to participate in a structured counseling session during the two week time-frame, the MIP team should continue to provide support and case management services to the participant to encourage on-going participation in MIP. The Booster Session (Session 7) is the final session and should occur only after all six structured sessions have been completed. Counseling, testing, and referrals for HIV/ viral hepatitis and other transmittable diseases are integrated into all seven sessions.

The estimated time frame for completing the MIP intervention is 3-6 months—3 months representing the most motivated participant and 6 months representing participants requiring extensive contacts per structured session. Regardless of a participant's level of motivation and self-efficacy, the MIP team should continue to provide ongoing support. The ideal case would involve a participant attending all seven sessions, completing MIP in 3 months or less, achieving his/her personal risk reduction goals, and maintaining the acquired risk reduction behaviors after he/she leaves the program.

Format of Sessions:

MIP is an individual level intervention. The number of contacts required for each session will vary depending on the individual needs of the participant, the participant's readiness to address certain topics, and the personal goals identified for each session. The Induction Session and Booster Session usually require several contacts, each lasting approximately 45 minutes to 1 hour. Sessions 2 through 6 optimally require one contact lasting approximately 45 minutes to 1 hour.

During each session, the Counselor asks the participant to identify the changes he/she wishes to make regarding a particular behavior (e.g. visiting a physician, using condoms, not sharing needles, entering a drug treatment program, and so forth). The Counselor and the participant engage in an interactive staging process, review participant progress and set new goals as needed. Following each structured session, case management services are provided to ensure that the participant receives the necessary support and referrals to access health and social services. The Counselor integrates the participant's family into the intervention where possible and appropriate.

Location of Sessions:

The location of the sessions is flexible; however, the space used for the sessions must guarantee the safety, privacy, and confidentiality of both the participant and the Counselor. It is highly likely that the first Induction Session contact will take place at the location where the participant is first identified and approached. Generally, all other contacts occur at a site secured by the implementing organization. If necessary, the Case Manager/Community Educator or other team member should escort the participant to and from sessions.

Ensuring Fidelity:

When implementing MIP, it is important to maintain fidelity to the original research. The core elements and key characteristics of the intervention, in addition to Motivational Interviewing strategies and staging techniques, must be retained in order to preserve the integrity and effectiveness of MIP.

Integrating Counseling and Testing into Structured Sessions

A key characteristic of MIP is to offer participants referrals for HIV/STI counseling and testing and for viral hepatitis and TB screening at each contact. If a participant agrees to be tested--either on-site or at a partner agency-- he/she should be accompanied by the Case Manager/Community Educator to the test site either immediately or as soon as possible. If a participant refuses the referral, the structured session continues as intended; however, the MIP team should continue to offer HIV/STI testing and TB and viral hepatitis screening at each contact.

Organizations should consult their local jurisdictions for the laws and regulations regarding HIV testing, credentialing, reporting, and confidentiality.

Guidelines for Implementing the Structured Counseling Sessions

In implementing MIP, there are certain steps that should be taken at each session. These steps are part of the delivery process and are necessary for the intervention's success. At each session, the MIP Intervention Team should:

- Encourage the participant to get tested for HIV/STIs and screened for viral hepatitis, TB, and other transmittable diseases.
- Encourage the participant to take steps to utilize health care services, including drug treatment.
- Ensure a social support network for the participant (e.g., family support, external support groups, and linkages to services).
- Provide referrals to community resources available through MOUs, informal partnerships, and the community resource guide.
- Document all contacts in the participant's file, as required by the funding and implementing organization.
- Utilize Motivational Interviewing techniques throughout the course of the intervention.
- If appropriate and within budget, offer participants incentives and/or refreshments.

Counselor Responsibilities:

- Reinforce participant willingness to continue MIP.
- Maintain a therapeutic relationship with the participant.
- Be punctual.
- Be clear about program expectations.
- Maintain commitments made to participant.
- Check and update participant contact information.
- Establish and review behavior change objectives with participants.
- Assist participants with self-assessment staging.
- Review and check statuses of case management referrals.

Case Manager/Community Educator Responsibilities:

- Assess participant satisfaction with MIP.
- Maintain a therapeutic relationship with the participant.
- Be punctual.
- Be clear about program expectations.
- Maintain commitments made to participant.
- Address participant health, human, social service, and support needs through comprehensive case management.
- Review and check-status of case management referrals.
- Be familiar with community resources available through MOUs, informal partnerships, and the community resource guide.
- Escort the participant to and from sessions and appointments, as necessary and appropriate.

Supervisor Responsibilities:

- Conduct quality assurance checks to ensure the fidelity of MIP.
- Provide supervision of all MIP staff.
- Case conference with the MIP team.
- Perform formal and informal program monitoring and evaluation.

Implementing Organization Responsibilities:

- Ensure a welcoming atmosphere for participants.
- Maintain a referral network
- Secure sufficient funding and donations to maintain MIP.
- Provide appropriate safeguards for confidential information.
- Communicate with MIP team members.
- Advertise whether sessions are available on-demand or if appointments are required for counseling and case management session.

Preparation for every structured session should include the following resources:

- Updated Intake Form
- Completed MIP Behavioral Risk Assessment Form (for reference purposes)

- MIP Self-Assessment/Staging Form
- Behavior Change Self-Assessment Form
- Action Plan Forms
- Incentives for participants (organizations should check with their funding source whether or not monetary incentives are allowed)
- Local HIV/AIDS and social service resource guide (for reference purposes)
- MIP documentation forms (progress notes)

Additionally, it is recommended that organizations have the following supplies to support MIP implementation:

- Refreshments for participants
- Needle hygiene kits (small bottle of bleach/water, alcohol pads, and sterile cotton balls)
- Clean needles (in states where needle exchange is legal)
- Safer sex kits (assorted condoms and tubes of lubricant)
- Personal hygiene kits (soap, shaving cream, toothbrush, toothpaste, and so forth)

Guidelines for Implementing Case Management Sessions

Comprehensive Case Management is an integral part of the MIP intervention and should occur at regular intervals throughout the intervention. It is highly recommended that case management support occur either prior to, or following each structured counseling session or contact. Case Management services ensure that basic health, human, and social service needs are being met, allowing the participant to focus solely on making positive behavior changes. The Counselor and Case Manager/Community Educator work with the participant to identify needs and to ensure services are obtained.

At every case management encounter, the Case Manager/Community Educator should:

- Greet the participant and establish rapport by conversing with him/her.
- Assess participant satisfaction with MIP to facilitate participant retention.
- Work with the Counselor and the participant to identify participant health, human and social support needs.
- Make appropriate referrals to facilitate participant access to needed services.
- Conduct follow-up on referrals.
- Document services successfully accessed by the participant.
- Address barriers preventing successful service access.
- Escort participant to referrals, as needed and appropriate.
- Document case management session activities and outcomes.
- Acknowledge positive steps made toward achieving risk reduction goals.

A sample **Case Management Referral Form (1G)** is included in the appendix at the end of this session.

SESSION ONE: INDUCTION

The primary goal of the Induction Session is to orient the participant to MIP, obtain participant consent, and collect demographic and behavioral data. The Induction Session is the first structured session in MIP and may require one or more contacts in order to explain the intervention, collect baseline data, and ensure the full consent and understanding of the intervention and its requirements.

SESSION OBJECTIVES

- Introduce the MIP intervention to potential participants by explaining the program's objectives and the participant's roles and responsibilities in the intervention;
- Determine a participant's eligibility to enroll in MIP;
- Obtain baseline information concerning the participant's current sex and drug-related HIV risk behaviors;
- Work with the participant to identify and determine his/her most important health, social service, and educational needs;
- Assess the participant's current stage of change and engage the participant in MIP.

SUMMARY OF INDUCTION SESSION

During the Induction Session, the Case Manager/Community Educator or Counselor explains the major components and structure of MIP, informs the participant about the benefits and risks of MIP, discusses the roles and responsibilities of both the MIP team members and the participant, and secures participant consent.

The Induction Session elicits critical information from the participant that will be used throughout the MIP intervention. Part of the Induction process entails conducting a behavioral risk assessment, identifying and discussing behavior change goals, assessing participant readiness for change.

The Counselor refers the participant to the Case Manager/Community Educator for assistance in securing health care and other social services. The Case Manager/Community Educator makes appointments on behalf of the participant and provides escort and transportation services, if necessary.

SESSION TIME: 45-65 minutes (Counseling Session)
Time spent in case management will vary according to participant needs.

Note: The time required to complete the Induction Session will vary according to participant needs

SESSION ACTIVITIES

Session activities can be divided into multiple contacts. These activities assume that the participant has already been recruited from the community and has come in for the first MIP counseling session--the Induction.

	Activity	Responsible Party
1.	Introduction (2 minutes)	Case Manager/ Community Educator
2.	Eligibility Check (3 minutes)	Case Manager/ Community Educator
3.	Description and Overview of MIP (5 minutes)	Case Manager/ Community Educator
4.	Assessment of Participant Interest in MIP (5 minutes)	Case Manager/ Community Educator
5.	Role Induction to MIP (5 minutes)	Counselor
6.	Completion of Participant Consent Form (5 minutes)	Counselor
7.	Completion of Intake Form (5 minutes)	Counselor
8.	Completion of Behavioral Risk Assessment Form (15 minutes)	Counselor
9.	Wrap-up/Staging for Next Session (5 minutes)	Counselor/Participant
10.	Follow-Up Case Management	Case Manager/Community Educator and Counselor
11.	Complete Documentation Forms	Team
12.	Discuss Session Benchmarks with the MIP Team	Team

MATERIALS/RESOURCES NEEDED: (See Session Appendix for referenced forms)

NAME	FORM IN SESSION APPENDIX
Participant Consent Form	Form 1A
Confidentiality Agreement	Form 1B
MIP Intake Form	Form 1C
Behavioral Risk Assessment Form	Form 1D
Behavioral Change Self-Assessment Form	Form 1E
MIP Self Assessment and Staging Form	Form 1F
Case Management Referral Form	Form 1G
Progress Notes	Form 1H
Incentives	

SESSION LOCATION:

Induction Session activities can be conducted in several locations:

- Role Induction can occur in community venues, project sites, treatment programs, or any other location favorable for the intervention.
- Behavioral Risk Assessment, goal identification and action planning can be conducted in a private, enclosed room at the project site.

MIP TEAM MEMBER:

Both the Counselor and Case Manager/Community Educator deliver this session.

- The Case Manager/Community Educator conducts the recruitment and initial introduction to MIP as well as the case management component.
- The Counselor conducts the Intake & Behavioral Risk Assessments and initiates session activities.

PREPARATION

- Become familiar with the **Behavior Risk Assessment Form (1D)**, the **Behavioral Change Self Assessment and Staging Form (1F)**, the **MIP Intake Form (1C)**.
- Become comfortable with the questions on the forms, practice recording participant responses accurately and being nonjudgmental about what the participant reports.
- Practice filling out forms with other staff members so as to avoid fumbling and making errors during form administration.
- Be prepared to provide referrals for HIV/STI counseling and testing and screening for viral hepatitis, TB, and other transmittable diseases.

STEP-BY-STEP PROCEDURES

Note: Session activities for Induction may be divided into multiple contacts with the participant, if necessary. These activities assume that the participant has already been recruited from the community and has come in for the first MIP counseling session. Induction Session activities include:

1. Introduction (2 minutes)

The purpose of the Introduction is to introduce yourself and the implementing organization to the potential participant. Inform the participant that you will be his/her Counselor for the MIP program should he/she decide to commit to the program. The Counselor should thank the participant for coming in and for his/her interest in MIP.

Whenever possible, the Case Manager/Community Educator should escort the participant to the first counseling session and facilitate introductions between the participant and the Counselor. This step further reinforces the team approach to MIP and allows the participant to feel that he/she is in a safe space where difficult issues can be discussed.

2. Eligibility Check (3 minutes)

The Counselor should conduct a quick assessment of the participant's drug-use status for eligibility purposes only. The potential participant must be an out-of-treatment active drug user 18 years or older. He or she must have used drugs (other than methadone and alcohol) within 90 days of joining MIP. Participants who are already in a treatment program are not eligible for MIP; however, they may be eligible for other services within your organization.

3. Description and Overview of MIP (5 minutes)

Provide an overview of the MIP program by briefly describing the seven session intervention structure. Emphasize that MIP is a participant-centered intervention focused on reducing risky drug and sex-related HIV and viral hepatitis risk behaviors through counseling and case management. Explain that the intervention also aims to increase participant access to health and human services through referrals and to increasing participant ability to change harmful behaviors and sustain behavior change efforts.

Mention that a participant must commit to all seven structured counseling sessions and follow-up case management services. Inform the participant that incentives will be provided for active participation in the intervention, and that they are expected to stay actively involved in the MIP program.

4. Assess participant interest in MIP (5 minutes)

Gauge participant interest in and perception of MIP. Pose the following types of open-ended questions:

- "Ask me some questions about MIP?"
- "How do you feel MIP could help you?"
- "What are your feelings about participating in MIP?"

You may also ask the participant how soon he/she wants to start doing something about his/her drug or sex-related HIV risk behaviors. This step helps to assess the participant's readiness for MIP.

If the person agrees to participate in MIP, continue with the rest of the Induction activities. If the individual is not interested or cannot commit to MIP, thank the individual for his/her time and inform him/her that you will be around if he/she decides to participate in MIP at a later time.

5. Role Induction to MIP (5 minutes)

Review the roles and responsibilities of the MIP team members and those of the participant to ensure that the participant knows what the MIP program expects from him/her.

The Counselor should explain the various components of the intervention, including the content areas addressed by MIP: taking care of your health, entering into drug abuse treatment, reducing high risk sex and drug-use behaviors, relapse prevention and a Booster session.

Once an overview of MIP has been provided and questions have been answered, encourage the participant to provide full consent to continue with the intervention.

6. Complete of Participant Consent Form (5 minutes)

Give the participant a copy of the **Participant Consent Form (1A)** and read it with him/her, making sure that he/she is fully aware of what is being agreed upon. Once the participant is comfortable with the information, ask him/her to sign the consent form. Give the participant a copy of the signed consent form.

7. Complete Intake Form (5 minutes)

Complete the **MIP Intake Form (1C)** with the participant. Collect social demographic information and information about places where the participant spends most of his/her time. Record participant nicknames or street names and obtain the name, phone number, and address of someone that will be able to locate the participant if necessary. Determine whether or not the Case Manager/Community Educator can interact with the participant with follow-up contacts.

For example, the participant may not be willing to talk to a Case Manager/Community Educator on the street but would do so in a coffee shop or a park. Record this information on the **MIP Intake Form (1C)**. Assure the participant that all personal information he/she has provided will remain completely confidential.

8. Complete Behavioral Risk Assessment (15 minutes)

The **Behavioral Risk Assessment Form (1D)** is to be administered by the Counselor. It is to be used as a reference tool throughout the intervention. It only takes approximately 20 minutes to complete.

This form is used as an assessment and evaluation tool to examine participant progress during each structured session. By reviewing baseline information on participant risk behaviors, the Counselor can help the participant set risk reduction goals.

It is important to remember that the participant should not fill this form out on his/her own. The tool is to be administered as an interview. The **Behavioral Risk Assessment Form (1D)** asks sensitive questions related to health conditions, family support systems, sources of income, drug use, sexual behavior, mental health, and so forth. Therefore, staff members implementing MIP must become acquainted with the form prior to administering it. The more you use it, the easier it will be to administer this tool.

9. Wrap-up/Staging for Next Session (5 minutes)

Summarize the main benchmarks of the current session, including discussions and planned action steps. Inform the participant that he/she has successfully completed the Induction Session and will be deciding on the focus of next session for MIP. Provide the participant with a list of remaining session topics. These topics are:

- Taking Care of your Health
- Readiness for Entering Drug-Treatment
- Relapse Prevention
- Reducing Drug-Related HIV Risk
- Reducing Sex-Related HIV Risk

Ask the participant which topic he/she is ready to work on and document in your progress notes.

- Give the participant the **Behavioral Change Self Assessment Form (1E)** and ask him/her to identify the stage where he/she is now. If necessary, the Counselor reads the staging options for the chosen session to the participant and documents his/her responses. This information allows you (the Counselor) to determine and prepare for the next structured session. Record the participant's responses on the **MIP Self Assessment and Staging Form (1F)**.

Thank the participant for his/her time and reinforce the fact that he/she has taken positive steps toward protecting his or her health.

Give the appropriate incentive for participating in this session and an appointment card with the time and place of the next session.

10. Follow-Up Case Management

After concluding the counseling session, accompany the participant to the Case Manager/Community Educator to initiate case management services.

At each case management session, the Case Manager/Community Educator should assess the participant's satisfaction with MIP and address any issues that could hinder participant retention.

Additionally, the Case Manager/Community Educator should:

- Address participant health and social service needs.
- Offer a referral for HIV/STI testing and counseling services. Offer referrals for TB and viral hepatitis screening and vaccination.
- Make appropriate referrals for services the implementing organization cannot provide. A **Case Management Referral Form (1G)** is in the session appendix.
- Follow-up on participant when possible and appropriate and escort participant to referred agencies.
- Ensure that participants have transportation to access services.
- Provide bus or subway tokens, if available and necessary.

11. Documentation

MIP Staff must check the **MIP Intake Form (1C)**, **Behavioral Risk Assessment Form (1D)**, for accuracy, missing information or errors. In addition, complete the **MIP Self Assessment and Staging Form (1F)**, indicating both the participant's perception of their stage of change and the Counselor's perception of the participant's stage of change. Check for signature and date on the **Participant Consent Form (1A)**.

Document session milestones in **Progress Notes (1H)**, including changes in the participant's stage of change, MIP team perspectives, attended appointments, and any materials, incentives, and resources given to the participant.

12. Discuss Session Benchmarks with the MIP Team

The MIP team meets to discuss the intervention plan for the participant. Information is shared about the participant's goals for behavior change and his/her health and human service needs to ensure a comprehensive and seamless approach to providing services.

DRAFT

STRUCTURED SESSION 1- FORMS:

- A. Participant Consent Form
- B. Confidentiality Agreement
- C. MIP Intake Form
- D. Behavioral Risk Assessment Form
- E. Behavior Change Self-Assessment Form
- F. MIP Self-Assessment and Staging Form
- G. Case Management Referral Form
- H. Progress Notes

DRAFT

STRUCTURED SESSION 1A PARTICIPANT CONSENT FORM

Explanation of the Program: [*Name of the Program*]

Services: You are being invited to participate in a program for out of treatment substance users 18 years of age and older. If you agree to participate in this program, you will have the opportunity to receive the following services:

- Substance abuse treatment services and referrals for methadone, detox, and in and out-patient services.
- Mental health services and/or referrals.
- Free and confidential HIV counseling and testing.
- Individual counseling.
- Relapse prevention education.
- Case management and counseling.
- Referrals to other social service needs,

You will be offered the opportunity to participate in six individual sessions and one booster session. Case management staff will help you obtain services that you identify, need, and/or want. It is your decision as to which services and educational information you want to receive. You will not be required to accept any services or information unless you are ready and want to accept them.

Process of Service: If you agree to partake in this program, a culturally competent staff person will be assigned as your Counselor. He/she will ask you about your background: drug and alcohol use, mental status, family and housing needs, school, work and income, legal issues and court contacts, and physical health and treatment. He/she will ensure use of services and assess your satisfaction with services using assessment instruments.

Also, the staff person will discuss potential referrals for other programs, treatment progress, and health and social needs. All information will be considered protected health information between you and the staff person only.

All material shared with the staff person will be kept confidential and will not be given to anyone or to any agency unless specified by you (the participant).

Program staff will share services data, referrals, treatment progress, and health and social needs with the program evaluator.

Participant Rights:

- Your participation in this project is voluntary.
- You can abstain from answering any question you wish.
- You may decide not to take part or to withdraw from this project at any time without any penalty.
- You can still obtain referrals for services if you decide not to participate in this program.

Benefits:

Participants receive immediate and long-term benefits from this program. Immediate advantages to participants may include:

- Assistance accessing health care services, both for general and pressing health care needs.
- Mental health services and/or referral to such services.
- Assistance securing health coverage, temporary and permanent housing, employment, and so forth.
- Assistance entering drug treatment programs.

Risks:

- You may be asked to disclose stressful or displeasing information about your situation and experiences.
- You may have unpleasant reactions to these questions. If you do not want to answer any question, you may choose not to do so. You may take breaks or stop the interview at any time. We will keep your answers private at all times. However, if someone in the program is in urgent danger of suicide, threatens harm to someone else, reveals a case of child abuse or neglect, or reveals a case of elder abuse, program staff must report these cases.
- You may experience unpleasant feelings as a result of participating in this program. You may ask to speak to a professional about these feelings.

Confidentiality:

Case records will be kept confidential, as stated by law. The only times when the law does not protect confidentiality are listed in the risk section of this document. No names will appear in any reports or papers related to the evaluation of this program. Program forms will be coded with a number instead of a name, and case records will be stored in locked files.

Program Evaluation:

Program evaluation data will be used in reports and papers to help influence policies and funding and to improve program services.

By signing this form, you agree to participate in the program described to you both verbally by a staff member and visually in this form. If you have any questions or concerns about your participation in this program; contact **[Name and Telephone of Contact]**.

Participant Name	Participant Signature	Date
Witness Name	Witness Signature	Date

Note: Signed copies of this consent form must be kept on file in participant record, on file with the Program Evaluator, and a copy must be given to the participant.

NOTE: This document is subject to local HIV/STI surveillance laws HIV/STI laws and surveillance

STRUCTURED SESSION 1B CONFIDENTIALITY AGREEMENT

I, _____, an employee of [*Name of Organization*], agree to abide by the confidentiality laws of the State of [*Name of State*] governing mental health services/practices, the Federal Government's Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law No. 104-191, 110 Stat. 1936-codified as amended in scattered sections of 18, 26, 29, and 42 U.S.C.), and regulations protecting client rights.

Confidentiality refers to the privacy of all clients/participants (e.g., *parents, guardians, caretakers, youth, children, and so forth*) who have had contact with/received services from this organization.

In the course of my work at [*Name of Organization*], I understand that I am bound to confidentiality. I am not to reveal and/or discuss any information pertaining to any client from this organization to any one, unless the client/participant signs a written release for this purpose.

Federal law and regulations protect the confidentiality of client records maintained by this program.

Generally, the program may not disclose an individual's status as a program participant or as an alcohol/drug abuser unless:

1. The client consents in writing.
2. The disclosure is allowed by a court order.
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

By your signature, you are fully consenting to the terms set forth in this agreement. This agreement is not limited to working hours; it is extended to off duty hours as well. In addition, this agreement will remain in effect regardless of employment status (e.g., resignation, termination, leave of absence, and so forth). Violation of this agreement is ground for immediate termination.

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Participant Name

Participant Signature

Date

--	--	--

Witness Name

Witness Signature

Date

STRUCTURED SESSION 1C MIP INTAKE FORM

Please answer all questions. The information on this form will be held in strictest confidence. Some programs offered by our organization require proof of identity and/or citizenship.

Name:		Date:	
Date of Birth:		Social Security #: - -	
Age: <input type="checkbox"/> < 13 <input type="checkbox"/> 13-18 <input type="checkbox"/> 19-24 <input type="checkbox"/> 25-34 <input type="checkbox"/> 35-44 <input type="checkbox"/> 45 >			
Address:			
City:		State:	Zip Code:
Telephone:		Email:	
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender		Country of Origin:	
Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non Hispanic/Latino		Languages Spoken: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other	
Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian		<input type="checkbox"/> Black/African American	
<input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White			
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Cohabitation			
Head of Household: <input type="checkbox"/> Yes <input type="checkbox"/> No		Total Numbers of Household:	
Living Arrangement: <input type="checkbox"/> Rent <input type="checkbox"/> Own <input type="checkbox"/> Homeless		Amount of Rent/Mortgage: \$	
Last Grade Completed:		Occupation:	
Source of Income: <input type="checkbox"/> Temporary AID Needy Families <input type="checkbox"/> SSI <input type="checkbox"/> SS <input type="checkbox"/> Food Stamps <input type="checkbox"/> Child Support <input type="checkbox"/> Other			
If Other:		Income Level: \$	
Health Insurance: <input type="checkbox"/> Private <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> None		HIV Status: <input type="checkbox"/> Positive <input type="checkbox"/> Negative/Unknown	
Transmission Risk: <input type="checkbox"/> Sexual contact involving transgender and unsafe injection drug practices			
<input type="checkbox"/> Male to male sexual contact and unsafe injection drug practices		<input type="checkbox"/> Sexual contact involving transgender	
<input type="checkbox"/> Male to male sexual contact <input type="checkbox"/> Unsafe injection drug practices		<input type="checkbox"/> Heterosexual contact <input type="checkbox"/> Other	
Emergency Contact #1	Name:		
Address:			
Telephone:		Relationship:	
Emergency Contact #2	Name:		
Address:			
Telephone:		Relationship:	
Hangouts:			
Indicate Service(s) Desired: (1)		(2)	
Referred By:			

STRUCTURED SESSION 1D BEHAVIORAL RISK ASSESSMENT

Description: The MIP Behavioral Risk Assessment is designed to assess the participant's current drug and sex-related HIV/STI/viral hepatitis risk behaviors. The assessment also captures the participant's family, health, and social support needs.

Administration:

This instrument should be administered to each participant at the time of enrollment in MIP as part of the Induction Session (Session 1). The MIP team uses this information to work with the participant in developing personal drug and sex-related HIV risk reduction goals. This information is also useful in building social support systems that encourage positive behavior change. The MIP Behavioral Risk Assessment is to be administered again during the Booster Session (Session 7). The Counselor and Case Manager/Community Educator fill out Section G in preparation for implementing the Booster Session.

The Behavioral Risk Assessment measures individual progress made in achieving the identified risk reduction goals. Individuals who have not completed the expected number of sessions should also be administered the MIP Behavioral Risk Assessment. This Behavioral Risk Assessment should not be administered during the delivery of MIP intervention activities.

Instructions to Interviewer: This assessment is intended to be completed using an interview format.

- Familiarize yourself with the document, and read each question or statement to the participant exactly as it is written.
- Explain that you will be asking a series of questions about family support, drug and alcohol use, and sexual practices. Relay that this information will only be used to help the participant establish risk reduction goals that foster a healthier lifestyle. Tell the participant that they do not have to answer any question that they are uncomfortable with and that they can choose to skip any question they wish. Tell the participant that they should answer the questions honestly and provide accurate information so that the MIP team can better help him/her. Inform the participant that the interview will take about 15 minutes to complete.
- Record the client's responses by checking the appropriate box following each question or statement. It is unacceptable for the participant to fill out the form by him/herself.
- Check for obvious inconsistencies in the participant's responses and bring these to the attention of the participant. Resolve inconsistencies as they are encountered.
- Refer to and use the baseline data acquired in the Behavioral Risk Assessment for each structured session to help set HIV risk reduction goals.

A. RECORD MANAGEMENT

Date Completed: _____

Client ID: _____

B. EDUCATION AND EMPLOYMENT

1. Are you currently enrolled in school or in a job training program?

NOT ENROLLED

ENROLLED, FULL TIME

ENROLLED, PART TIME

OTHER (SPECIFY)

REFUSED

DON'T KNOW

Program Name: _____

Program Name: _____

2. Are you currently employed?

EMPLOYED FULL TIME (35+ HOURS PER WEEK)

EMPLOYED PART TIME

UNEMPLOYED, LOOKING FOR WORK

UNEMPLOYED, DISABLED

UNEMPLOYED, VOLUNTEER WORK

UNEMPLOYED, RETIRED

UNEMPLOYED, NOT LOOKING FOR WORK

OTHER (SPECIFY) _____

REFUSED

DON'T KNOW

2b. How do you spend most of your time during the day? _____

C. FAMILY/SOCIAL CONNECTEDNESS

1. In the past 30 days, what has been your main housing situation?

SHELTER (SAFE HAVENS, TRANSITIONAL LIVING CENTER [TLC], LOW DEMAND FACILITIES, RECEPTION CENTERS, OTHER TEMPORARY DAY OR EVENING FACILITY)

STREET/OUTDOORS (SIDEWALK, DOORWAY, PARK, PUBLIC OR ABANDONED BUILDING)

INSTITUTION (HOSPITAL, NURSING HOME, JAIL/PRISON)

HOUSED [IF HOUSED, CHECK APPROPRIATE SUBCATEGORY]

OWN/RENT APARTMENT, ROOM, OR HOUSE

SOMEONE ELSE'S APARTMENT, ROOM, OR HOUSE

HALFWAY HOUSE

RESIDENTIAL TREATMENT

OTHER HOUSING (SPECIFY)

REFUSED

DON'T KNOW

2. [IF FEMALE] Are you currently pregnant?

- YES
- NO
- REFUSED
- DON'T KNOW

3. Do you have children?

- YES
- NO
- REFUSED
- DON'T KNOW

a. How many children do you have?

|_|_|_| REFUSED DON'T KNOW

b. Are any of your children living with someone else due to a child protection court order?

- YES
- NO
- REFUSED
- DON'T KNOW

c. If yes, how many of your children are living with someone else due to a child protection court order?

|_|_|_| REFUSED DON'T KNOW

d. For how many of your children have you lost parental rights?

|_|_|_| REFUSED DON'T KNOW

4. In the past 30 days, have you attended any voluntary self-help groups not affiliated with a religious or faith-based organization? In other words, did you participate in a non-professional, peer-operated organization devoted to helping individuals who have addiction related problems. Some such organizations can include: Alcoholics Anonymous, Narcotics Anonymous, Oxford House, Secular Organization for Sobriety, Women for Sobriety, and so forth.

- YES [SPECIFY HOW MANY TIMES] _____
- NO
- REFUSED
- DON'T KNOW

5. In the past 30 days, did you attend any religious/faith-based voluntary self-help groups?

- YES [SPECIFY HOW MANY TIMES] _____
- NO
- REFUSED
- DON'T KNOW

6. In the past 30 days, did you attend meetings that support recovery other than those of the organizations described above?

- YES [SPECIFY HOW MANY TIMES] _____
- NO
- REFUSED
- DON'T KNOW

7. In the past 30 days, did you have interaction with family and/or friends that are supportive of your recovery?

- YES [SPECIFY HOW MANY TIMES] _____
- NO
- REFUSED
- DON'T KNOW

8. To whom do you turn when you are having trouble?

- NO ONE
- CLERGY MEMBER
- FAMILY MEMBER
- FRIENDS
- REFUSED
- DON'T KNOW
- OTHER (SPECIFY): _____

D. DRUG AND ALCOHOL USE

	Number of Days	REFUSED	DON'T KNOW
1. During the past 90 days how many times have you used the following:			
a. Alcohol to intoxication	_ _	0	0
b. Both alcohol and drugs (on the same day)	_ _	0	0
2. During the past 90 days, how many times have you used the following:			
a. Cocaine/Crack	_ _	0	0
b. Marijuana/Hashish (Pot, Joints, Blunts, Chronic, Weed, Mary Jane)	_ _	0	0
c. Opiates:	_ _	0	0
▪ Heroin, Morphine, Demerol, Percocet, Codeine, Oxycotin/Oxycodone, non-prescription methodone)			
d. Hallucinogens/psychedelics, PCP	_ _	0	0

- Angel Dust, Ozone, Wade, Rocket Fuel)
MDMA (Ecstasy, XTC, X, Adam), LSD
(Acid, Boomers, Yellow Sunshine),
Mushrooms or Mescaline)

e. Methamphetamine or other amphetamines 0 0
 ▪ Uppers, Speed, Ice, Chalk, Crystal, Glass, Fire, Crack

f. Sedatives/Downers/Tranquilizers 0 0
 ▪ Benzodiazepines: Diazepam (Valium),
Alprazolam (Xanax), Triazolam (Halcion),
and Estazolam (Prosoin and Rohypnol-also
known as roofies, roche, and cope);
 ▪ Barbiturates: Mephobarbital (Mebacut) and
pentobarbital sodium (Nembutal);
 ▪ Non-prescription: Grievous Bodily Harm,
Liquid Ecstasy, and Georgia Home Boy;

g. Inhalants (Poppers, Snappers, Rush, Whippets) 0 0
 ▪ Ketamine: (known as Special K or Vitamin K)

h. Other illegal drugs (Specify): 0 0

3. In the past 90 days have you injected drugs?

- YES
- NO
- REFUSED
- DON'T KNOW

4. In the past 90 days, how often did you use: (Check the appropriate response for each behavior)

	a syringe/needle	a cooker	cotton	water
Always				
More than half the time				
Half the time				
Less than half the time				
Never				
REFUSED				
DON'T KNOW				

E. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY

1. How would you rate your overall health right now?

- Excellent
- Very good
- Good
- Fair
- Poor
- REFUSED
- DON'T KNOW

2. During the past 30 days, did you receive:

a. In-patient treatment for:

_____ YES (for how many nights) _____ NO

- i. Physical complaint _____ nights
- ii. Mental or emotional difficulties _____ nights
- iii. Alcohol or substance abuse _____ nights

b. Out-patient treatment for:

_____ YES (for how many nights) _____ NO

- i. Physical complaint _____ nights
- ii. Mental or emotional difficulties _____ nights
- iii. Alcohol or substance abuse _____ nights

c. Emergency Room treatment for:

_____ YES (for how many nights) _____ NO

- i. Physical complaint _____ nights
- ii. Mental or emotional difficulties _____ nights
- iii. Alcohol or substance abuse _____ nights

Results:

3. Have you been tested for:

- a. HIV Y N Positive Negative Unknown
- b. Viral hepatitis Y N Positive Negative Unknown
- c. STIs Y N Positive Negative Unknown
- d. TB Y N Positive Negative Unknown

4. In the past 30 days, not due to your use of drugs or alcohol, how many days have you:

- | | Days |
|---|------|
| a. Experienced serious depression | _ _ |
| b. Experienced serious anxiety or tension | _ _ |
| c. Experienced hallucinations | _ _ |
| d. Experienced trouble understanding, concentrating, or remembering | _ _ |
| e. Experienced trouble controlling violent behavior | _ _ |
| f. Attempted suicide | _ _ |
| g. Been prescribed medication for psychological/emotional program | _ _ |

5. How much have you been bothered by these psychological or emotional problems in the past 30 days?

- Not at all
- REUSED
- DON'T KNOW
- Considerably
- Slightly
- Moderately

F. SEXUAL ACTIVITY

1. During the past 30 days, did you engage in sexual activity?

- Yes [How many times] |__|__|
- No
- NOT PERMITTED TO ASK
- REFUSED
- DON'T KNOW

If yes, how many:

Contacts

a. Sexual partners (vaginal, oral, anal) did you have
How many of those partners did you practice safe sex?

b. Unprotected sexual contacts did you have

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c. Unprotected sexual contacts were with an individual who is
or was:

- 1. HIV positive or has AIDS
- 2. An injection drug user
- 3. High on some substance

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2. During the past 30 days, have you used condoms for vaginal sex?

- Did not have vaginal sex in the past 30 days
- Yes [How many times?] |__|__|
- No
- REFUSED
- DON'T KNOW

3. During the past 30 days, have you used condoms for anal sex?

- Did not have anal sex in the past 30 days
- Yes [How many times?] |__|__|
- No
- REFUSED
- DON'T KNOW

4. During the past 30 days, have you had sex while you were drunk or high?

- Did not have sex in the past 30 days
- Yes [How many times?] |__|__|
- No
- REFUSED
- DON'T KNOW

4a. If you had sex while high or drunk, how many times did you use condoms?

- Always
- More than half the time
- Half the time
- Less than half the time
- Never
- REFUSED
- DON'T KNOW

NOTE: For the Booster Session (Session 7), complete section G of this form on the next page.

DRAFT

G. EVALUATION OF SERVICES RECEIVED

[TO BE COMPLETED BY MIP PROGRAM STAFF AT BOOSTER SESSION (Session 7)]

Date Completed: _____

Identify the number of days services were provided to the participant during the MIP intervention. [ENTER ZERO IF NO SERVICES PROVIDED]

Modality	Days
1. Case Management	_ _ _
2. Day Treatment	_ _ _
3. Inpatient/Hospital (Other than detox)	_ _ _
4. Outpatient	_ _ _
5. Outreach	_ _ _
6. Intensive Outpatient	_ _ _
7. Methadone	_ _ _
8. Residential/Rehabilitation	_ _ _
9. Detoxification (Select Only One)	
A. Hospital Inpatient	_ _ _
B. Free Standing Residential	_ _ _
C. Ambulatory Detoxification	_ _ _
10. After Care	_ _ _
11. Recovery Support	_ _ _
12. Other (Specify) _____	_ _ _

Case Management Services

1. Family Services (Marriage Education, Parenting, Child Development Services)	Y	N
2. Child Care	Y	N
3. Family Planning	Y	N
4. Male or Female Condoms	Y	N
5. Employment Service	Y	N
6. Pre-Employment	Y	N
7. Employment Coaching	Y	N
8. Individual Services Coordination	Y	N
9. Transportation	Y	N
10. HIV/AIDS Service	Y	N
11. Domestic Violence	Y	N
12. Utility Assistance	Y	N
13. Food voucher	Y	N
14. Supportive Transitional Drug-Free Housing Services	Y	N
15. Other (Specify) _____	Y	N

Identify the number of sessions provided to the participant during the MIP Intervention. [ENTER ZERO IF NO SERVICES PROVIDED.]

Treatment Services

[PROVIDE AN ANSWER FOR AT LEAST ONE TREATMENT SERVICE NUMERED 1 THOROUGH 4.]

Treatment Services	Sessions
1. Screening	_ _ _
2. Brief Intervention	_ _ _
3. Brief Treatment	_ _ _
4. Referral to Treatment	_ _ _
5. Assessment	_ _ _
6. Treatment/Recovery Planning	_ _ _
7. Individual Counseling	_ _ _
8. Group Counseling	_ _ _
9. Family/Marriage Counseling	_ _ _
10. Co-Occurring Treatment/ Recovery Services	_ _ _
11. Pharmacological Interventions	_ _ _
12. HIV/AIDS Counseling	_ _ _

Medical Services

Medical Services	Sessions
1. Medical Care	_ _ _
2. Alcohol/Drug Testing	_ _ _
3. HIV/AIDS Medical Support & Testing	_ _ _
4. Other Medical Services (Specify) _____	_ _ _

After Care Services

After Care Services	Sessions
1. Continuing Care	_ _ _
2. Relapse Prevention	_ _ _
3. Recovery Coaching	_ _ _
4. Self-Help and Support Groups	_ _ _
5. Spiritual Support	_ _ _
6. Other After Care Services (Specify) _____	_ _ _

Education Services

Education Services	Sessions
1. Substance Abuse Education	_ _ _
2. HIV/AIDS Education	_ _ _
3. Other Medical Services (Specify) _____	_ _ _

Peer-To-Peer Recovery Support Services

Peer-To-Peer Recovery Support Services	Sessions
1. Peer Coaching or Mentoring	_ _ _
2. Housing Support	_ _ _
3. Alcohol and Drug Free Social Activities	_ _ _
4. Information and Referral	_ _ _
5. Other Peer-to-Peer Recovery Support Services (Specify) _____	_ _ _

STRUCTURED SESSION 1E
Behavior Change Self-Assessment Form

The purpose of this form is to learn how you presently perceive your primary health, drug (detox) treatment, sexual risk reduction and drug-related risk reduction needs. Read from the bottom to the top for each category and select the statement that you most agree with.

HIV RISK			
Health Services	Drug Treatment	Sexual Conduct	Drug Injection Conduct
I have been taking care of my health for over six (6) months.	I have been without using drugs over six (6) months.	It has been more than six (6) months that when I have sexual relations I project myself against HIV.	It has been more than six (6) months that when I inject drugs, I avoid getting infected with HIV.
I am presently taking care of my health.	I am presently in treatment (detox or outpatient).	I presently protect myself against HIV when I have sexual relations.	I presently protect myself against HIV when I inject
Next month, I am planning to see a doctor.	I am planning to request detox admission very soon (next month).	Very soon (next month), I am thinking about making safe decisions regarding my sexual behavior to avoid getting infected with HIV.	Maybe I should be more careful when I inject to avoid getting infected with HIV.
Maybe I should see a doctor.	Maybe my drug use is a problem and I should seek treatment (detox).	Maybe I should be more careful with my sexual activities to avoid getting infected with HIV.	Very soon (next month) I am planning to inject drugs in a safer way to avoid getting infected with HIV
I do not have any health problems that I need to take care of.	My drug use is not a problem.	My sexual practices do not place me at risk of HIV infection.	When I inject drugs, it doesn't concern me that I might get infected with HIV.

STRUCTURED SESSION 1F
MIP SELF ASSESSMENT & STAGING FORM

This form is to be used by the Counselor to record the Participant's stage of change					
Participant		Date			
Staff		Location			
Session No		Contact No			
<input type="checkbox"/> Face to Face	<input type="checkbox"/> Telephone Contact	<input type="checkbox"/> Session Completed	*Dosage_____		
<input type="checkbox"/> Safer Sex Kits	<input type="checkbox"/> Bleach Kits	<input type="checkbox"/> Incentive	<input type="checkbox"/> Referral		
TAKING CARE OF YOUR HEALTH					
Role Induction		Decisional Balance			
Affirmations		Information/Options			
Reflective Listening		Goal Setting			
Support Self-Efficacy		Action Plan			
Stage	Pre	Contemplation	Preparation	Action	Maintenance
Staff	1	2	3	4	5
Participant	1	2	3	4	5
PREPARING TO ENTER DRUG TREATMENT					
Role Induction		Decisional Balance			
Affirmations		Information/Options			
Reflective Listening		Goal Setting			
Support Self-Efficacy		Action Plan			
Stage	Pre	Contemplation	Preparation	Action	Maintenance
Staff	1	2	3	4	5
Participant	1	2	3	4	5
REDUCING DRUG-RELATED HIV RISK					
Role Induction		Decisional Balance			
Affirmations		Information/Options			
Reflective Listening		Goal Setting			
Support Self-Efficacy		Action Plan			
Stage	Pre	Contemplation	Preparation	Action	Maintenance
Staff	1	2	3	4	5
Participant	1	2	3	4	5
REDUCING SEX-RELATED HIV RISK					
Role Induction		Decisional Balance			
Affirmations		Information/Options			
Reflective Listening		Goal Setting			
Support Self-Efficacy		Action Plan			
Stage	Pre	Contemplation	Preparation	Action	Maintenance
Staff	1	2	3	4	5
Participant	1	2	3	4	5

**STRUCTURED SESSION 1G
CASE MANAGEMENT REFERRAL FORM**

The Form is to be used by the MIP Counselor and/or Case Manager/Community Educator to refer the participant for health, human, and support services not currently offered by the implementing organization.

Participant's Full Name: _____ Telephone Number: _____

Participant's Address: _____

Date of Birth: _____ Age: _____

Referred to: _____ Contact: _____

Address: _____

Date of Appointment: _____ Time: _____

Reason for Referral

- | | |
|--|---|
| <input type="checkbox"/> Mental Health Service | <input type="checkbox"/> Primary Health Services |
| <input type="checkbox"/> Opiate Addiction/Abuse | <input type="checkbox"/> Parenting Skills Program |
| <input type="checkbox"/> Cocaine Addiction/Abuse | <input type="checkbox"/> Domestic Violence/Anger Management |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Food Voucher |
| <input type="checkbox"/> Poly-Substance Abuse | <input type="checkbox"/> Counseling |
| <input type="checkbox"/> Rental/Housing Assistance | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Utility Assistance | <input type="checkbox"/> Family Planning |
| <input type="checkbox"/> Other: _____ | |

Comments

For more information, contact _____ at ()

Counselor/Case Manager

Date

**STRUCTURED SESSION 1H
PROGRESS NOTES**

		Case Manager Notes	Counselor Notes
DATE:	END TIME:		
	START TIME:		
DATE:	END TIME:	_____ Signature of MIP Team Member	_____ Signature of MIP Team Member
	START TIME:		
DATE:	END TIME:	_____ Signature of MIP Team Member	_____ Signature of MIP Team Member
	START TIME:		
DATE:	END TIME:	_____ Signature of MIP Team Member	_____ Signature of MIP Team Member
	START TIME:		

SESSION TWO: TAKING CARE OF YOUR HEALTH

Session 2 should be scheduled no earlier than one week following the Induction sessions or another structured session that the participant chose to cover prior to covering this session. Structured sessions should be scheduled within a two-week period to maintain participant interest in MIP. The **Taking Care of Your Health Session** may require one or more contacts depending on the participant's individual goals and needs.

SESSION OBJECTIVES

- Increase participant readiness to take care of his/her health.
- Obtain participant health history.
- Assist participants with obtaining care, support, and treatment for his/her health problems.
- Provide active referral and follow-up. This includes making appointments to increase participant access to healthcare services.
- Ensure the availability of social support networks for the participant's health-related goals.

SUMMARY OF TAKING CARE OF YOUR HEALTH SESSION

In this session, the MIP team encourages the participant to take control of his/her health, primarily by making an appointment with a physician. The participant receives information about what a physical examination entails and shares his/her experience with the health care system. Through role induction and motivational interviewing skills, the participant is able to identify his/her health care needs while increasing his/her ability to make decisions, take action, and obtain necessary medical care and testing.

The participant's **Behavioral Risk Assessment Form (1D)** is reviewed by the MIP team. Using this information, the Counselor and participant set new goals and the MIP team encourages the participant to comply with medical recommendations, including lab tests, prescriptions, and/or referrals and offers transportation services, if necessary.

At the end of the session, the participant fills out a self-evaluation. The Counselor provides feedback about the session, about the participant's willingness to take action. The Counselor and the participant summarize the issues they discussed, agree on a plan to address them, and make the next counseling appointment.

SESSION TIME: 45-60 minutes (Counseling Session)
Time spent in case management will vary according to participant needs.

Note: The time required to complete Session 2 will vary according to participant needs.

SESSION ACTIVITIES

	Activity	Responsible Party
1.	Introduction (5 minutes)	Counselor
2.	Role Induction (10 minutes)	Counselor
3.	Participant Health History (Health History Form) (20 minutes)	Counselor
4.	Determine Participant Willingness to Utilize Health Care & Decisional Balance (10 minutes)	Counselor
5.	Develop Action Plan (5 minutes)	Counselor
6.	Ensure Social Support Networks (5 minutes).	Counselor
7.	Wrap-up/Staging for Next Session (5 minutes)	Counselor
8.	Follow-Up Case Management	Case Manager/ Community Educator and Counselor
9.	Complete Documentation Forms	Team
10.	Discuss Session Benchmarks with the MIP Team	Team

MATERIALS/RESOURCES NEEDED (See Session 2 Appendix for referenced forms):

NAME	FORM in SESSION APPENDIX
Completed MIP Intake Form (1C), Behavioral Risk Assessment Form (1D)	From Induction Session (Session 1)
Health History Form	Form 2A
Medical Examination Guide	Form 2B
Decisional Balance Form	Form 2C
Action Plan Form	Form 2D
Behavioral Change Self-Assessment	Form 2E
MIP Self-Assessment and Staging Form	Form 2F
Case Management Referral Form	Form 2G
Progress Notes	Form 2H
Health care resource guide including list of physician, infectious disease clinics, drug treatment programs, and community-based medical services	Local Resource
HIV/STI, TB, and viral hepatitis counseling and testing resource guide	Local Resource
Incentives	

SESSION LOCATION:

Due to the sensitive and personal nature of the questions asked during this session, Session 2 must be conducted in a private, enclosed room, where confidentiality can be assured and interruptions avoided.

Case Management services can take place at community venues, project community sites, treatment programs, or any other place with a favorable environment for the intervention.

PREPARATION

- The following forms from the Induction Session need to be reviewed before initiating this session: the **MIP Intake Form (1C)**, the **Behavioral Risk Assessment Form (1D)**.
- Become familiar with the **Health History Form (2A)**.
- Staff members should review these forms to become familiar with the participant's history and risk reduction goals and to be prepared to follow-up on any referrals that have been made.
- Become familiar with the resource guides, the referral processes, and the contents in the safer sex and needle hygiene kits.
- Be prepared to provide on-site HIV/STI, TB, and viral hepatitis testing or to make an appropriate referral if the participant desires to be tested.

STEP-BY-STEP PROCEDURES

1. Introduction (5 minutes)

At the beginning of the session, greet and introduce yourself to the participant if you have not met before, and establish rapport by making conversation with the participant.

2. Role Induction (10 minutes)

Review the roles and responsibilities of the MIP team members and those of the participant to ensure that the participant knows what the MIP program expects from him/her.

Explain that the purpose of Session 2 is to help the participant take care of his/her health care needs. Discuss the activities that will take place during the session—including a description of what occurs during a medical examination—and review the respective roles and responsibilities of both the MIP team members and of the participant.

Remind the participant of agreements made during the Induction Session with regard to health status. Use data from the **Behavioral Risk Assessment Form (1D)**, if necessary.

3. Participant Health History (20 minutes)

The main focus of this session is to obtain a detailed history of the participants' health in order to motivate the participant to access health services. Obtaining a detailed health history helps facilitate the process and can also motivate the participant towards behavior change.

The Counselor does this using the **Health History Form (2A)**. This form assesses a participant's knowledge and experience with the health care system. The Counselor also provides information about health examinations using the **Medical Examination Guide (2B)**. The Counselor then provides feedback about what has been discussed in relation to the participant's health.

If the participant is not receiving appropriate healthcare, the Counselor strongly encourages the participant to address his/her health care needs and to seek medical attention through a physician, an infectious disease clinic, or a community-based organization that offers medical care.

If available, the participant should be given a local resource guide with a list of community services.

4. Determine Participant Willingness to Utilize Health Care (10 minutes)

The Counselor determines the participant's willingness to access and utilize health care and psycho-medical services, including primary health care, drug treatment, emergency care, infectious diseases services, and community based medical care.

If necessary, the Counselor should complete the **Decisional Balance Form (2C)** as an exercise to help the participant identify the positive and negative aspects of continuing present patterns of health neglect, as well as the pros and cons of consulting a physician for a physical examination.

The Decisional Balance strategy is usually conducted with a participant when there is ambivalence about changing a risk behavior. Ambivalence is usually expressed when the participant is in the pre-contemplation or contemplation stage of change. The goal of the Decisional Balance exercise is to work with the participant until the advantages of changing a risk behavior clearly outweigh maintaining the participant's current risk behavior.

Another strategy used in every MIP structured session is to gauge the participants' willingness to take action on specific issues--which in this case, is accessing health care services. Determining the participants' willingness to take action is a quick and simple step that provides the Counselor with the information he/she needs in order to create the session action plan and inform follow-up case management services. For example, after taking the participants' health history, the Counselor may ask the participant how soon he/she wants to start doing something to take charge of his/her health.

- Which health issues do you want to address now?
- Are you ready to go to a doctor today? I can accompany you if you wish.
- If not today, then how about next week?
- If not next week, when?

This information is noted in the progress notes for that session and used to identify session goals and used to complete an **Action Plan Form (2D)** in the next activity.

5. Develop Action Plan

Based on information obtained during the health history and on the participant's willingness to take action, establish/verify the participant's behavior change goals as it relates to taking care of his/her health. To do this:

- Verify and write down the new goals using the **Action Plan Form (2D)**.
- The Case Manager/Community Educator will work with the participant to make an appointment with a primary care physician, if the participant wishes to do so.
- Provide participants with a local resource guide listing services in the community.

6. Ensure Social Support (5 minutes)

As with every session in the MIP intervention, the Counselor reinforces positive social support networks for the participant.

If the participant has identified a person who is supportive of his/her risk reduction efforts, stress the benefit of having such a person.

If the participant has not identified such a person, review potential support networks with the participant and attempt to identify an individual who might serve this role. If there is no one to support the participant, suggest an MIP team member as an alternative. Do this by reaffirming MIP staff support, perhaps saying, "I want you to know that we all support you. We believe in what you are doing and know that it matters."

7. Wrap-up/Staging for Next Session (5 minutes)

The Counselor should:

- Summarize the main benchmarks of the current session, including established goals and planned action steps.
- Inform the participant that he/she has successfully completed this session and will be deciding on the focus of next session for MIP.
- Provide the participant with a list of remaining session topics;
- Ask the participant which topic he/she is ready to work on and document in your progress notes. Discuss the participant's selection closest to action.
 - Give the participant the **Behavioral Change Self-Assessment (2E)** and ask him/her to identify their current stage of change, the Counselor reads the staging options to the participant and documents his/her responses. Both discuss the stage closest to action---an indication of the participant's readiness to make changes. Record the participant's response on the **MIP Self Assessment and Staging Form (2F)**.
- Thank the participant for his/her time and reinforce the fact that he/she has taken positive steps toward protecting his or her health.
- Give the appropriate incentive for participating in this session.
- Give them an appointment card with the time and place of the next session.

8. Follow-Up Case Management Contact

After concluding the counseling session, the Counselor should accompany the participant to the Case Manager/Community Educator to initiate case management services. The Counselor shares the **Action Plan Form (2D)** with the Case Manager/Community Educator so that appropriate referrals to health, support and other human services can be made.

At each case management session, the Case Manager/Community Educator should assess the participant's satisfaction with MIP and address any issues that could hinder participant retention. Additionally, the Case Manager/Community Educator should:

- Address participant health and social service needs.
- Offer a referral for HIV/STI testing and counseling services. Offer referrals for TB and viral hepatitis screening and vaccination.
- Make appropriate referrals for services the implementing organization cannot provide. A **Case Management Referral Form (2G)** is included in the session appendix.
- Follow-up on participant when possible and appropriate and escort participant to referred agencies.
- Ensure that participants have transportation and access to services.
- Provide bus or subway tokens, if available and necessary.

9. Complete Documentation Forms

Check for accuracy on the **Health History Form (2A)** and **Action Plan Form (2D)**. In addition complete the **MIP Self Assessment and Staging Form (2F)**, indicating both the participant's perception of their stage of change and the Counselor's perception of the participant's stage of change.

Document session milestones in **Progress Notes(2H)**, including changes in participant's stage of change, MIP team perspectives, attended appointments, and any materials, incentives, and so forth given to the participant.

10. Discuss Session Benchmarks with the MIP Team

The MIP team meets to discuss the intervention plan for the participant. Information is shared about the participant's goals for behavior change and his/her health and human service needs to ensure a comprehensive and seamless approach to providing services.

SESSION II FORMS:

- A. Health History Form
- B. Medical Examination Guide
- C. Decisional Balance Form
- D. Action Plan Form
- E. Behavior Change Self-assessment
- F. MIP Self-Assessment and Staging Form
- G. Case Management Referral Form
- H. Progress Notes

DRAFT

STRUCTURED SESSION 2A HEALTH HISTORY FORM

Name of Participant: _____
 Number: _____
 Date of Birth: _____
 Sex: _____
 Location of Session: _____
 Date of Session: _____

Note: This information is confidential and will not be shared with any other agency or unit within this organization unless a written consent is provided by the participant to do so.

1. What health problems, if any, do you currently have?

2. Do you have a primary health care physician? ____Y ____N
 - Would you like me to help you get medical care from a doctor or a nurse practitioner?

3. Place a check in the box next to your current conditions.

Anemia	<input type="checkbox"/>	Epilepsy, seizures	<input type="checkbox"/>	Mental health (depression, bipolar, schizophrenia, other: _____)	<input type="checkbox"/>
Asthma, bronchitis	<input type="checkbox"/>	Fibroid, tumor	<input type="checkbox"/>	Pulmonary embolus	<input type="checkbox"/>
Bleeding (vaginal, anal)	<input type="checkbox"/>	Gonorrhea	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>
Blood clot in veins	<input type="checkbox"/>	Headaches (frequent and severe)	<input type="checkbox"/>	Sickle cell anemia	<input type="checkbox"/>
Breast lump, tumor	<input type="checkbox"/>	Heart disease/murmurs	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Hepatitis, liver disease	<input type="checkbox"/>	Stomach ulcer	<input type="checkbox"/>
Chlamydia	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	Syphilis	<input type="checkbox"/>
Chest pain (severe)	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Infection of uterus, ovaries (PID)	<input type="checkbox"/>	Trichomonas	<input type="checkbox"/>
Discharge (vaginal)	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	TB	<input type="checkbox"/>
Dizzy or fainting spells (recurring)	<input type="checkbox"/>	Ovarian cysts	<input type="checkbox"/>	Varicose veins/phlebitis	<input type="checkbox"/>
Dental problems	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>
Injuries	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>
Sexual Abuse/Rape	<input type="checkbox"/>		<input type="checkbox"/>	Other: _____	<input type="checkbox"/>

STRUCTURED SESSION 2B

Medical Examination Guide

Note: This form is to be used by the Counselor to explain the medical examination process to the participant during Activity 3 of the Taking Care of Your Health session.

Physical Examination

Physical Examination is conducted to evaluate health status and review risk factors; is performed by a certified physician; it takes place at the physician's office; it does no harm or hurt; and lasts around 40 minutes. **The physical examination consists of three parts: Medical History, General Physical Examination and Clinical Analysis.**

1. Medical History: To obtain information about: prior conditions or illnesses; family medical history; medications presently being used; and habits or behaviors that affect health.

2. General Physical Examination: Conducted in an examination room. Clothing must be unbuttoned or taken off in order to facilitate the medical evaluation. Most of the time, you will be asked to change into a comfortable garment that facilitates the medical evaluation. You will be weighed; your vital signs will be taken (pulse, blood pressure, respiration and temperature). The doctor will also examine eyes, ears, nose and throat; palpate the trunk and the pelvis; evaluate the reflexes by lightly tapping the joints and listen to your chest (heart and lungs) and abdomen (intestinal sounds) with a stethoscope.

Optional Exams:

Women (performed by the Obstetrician and/or Gynecologist)

Papanicolaou or Pap smear: The purpose of this annual examination is to collect samples of vagina and cervix cells to detect cancerous growths.

Procedure: While lying on the examination table and with legs lifted to the side, a medical instrument (a speculum) is introduced into the vaginal canal. Stay relaxed. Through the speculum, a cotton swap is smeared over the walls of the vagina and around the cervix. It may cause discomfort, but not pain.

Pelvic Exam: The purpose is to palpate the uterus and the ovaries.

Procedure: A glove covered finger is introduced inside the vagina while the other hand is placed over the abdomen with light pressure applied.

Breast Exam: The purpose is to palpate the breasts to detect any tumors.

Procedure: A physician palpates breasts in circular form to detect any abnormal growth or lumps.

Men (performed by a general practitioner or primary care physician)

Testicular Exam: The purpose is to palpate the testicles to detect abnormal growths and/or inflamed or tender areas.

Procedure: In standing position, upper body bent forward and relaxed, a physician palpates the testicles and prostate.

Prostate Exam: The purpose of this test is to palpate the prostate to detect abnormal growth or tenderness.

Procedure: Consists of a glove-covered finger introduced inside of the anal cavity while the upper body is bent forward and relaxed. The physician palpates the prostate to detect abnormal growth or tenderness. It may cause discomfort, but not pain and is recommended annually.

3. Clinical Analysis: a series of tests to detect alterations of blood and urine components.

Samples Ordered:

CBC: complete blood count of red and white cells- the CBC test.

SMA20: chemical test that measures the functions of kidney, liver, pancreas, and other organs.

Urinalysis: Analysis to detect sugar, protein, bacteria, and blood levels in urine.

Urinary Toxicology Test: Detoxification Exam that detects recent psycho-active substance use.

STRUCTURED SESSION 2C DECISIONAL BALANCE FORM

Note: Decisional Balance is a strategy to use for participants in the pre-contemplation/ contemplation stages. The following are the procedures for completing the Decisional Balance Strategy:

1. Place an action-oriented goal at the top of the blank Decisional Balance Strategy Chart.
2. Ask the participant to tell you the cons (reasons for not changing a behavior) of making the behavior change.
3. When he/she has completed the list of cons, ask him/her to tell you the pros (reasons for changing a behavior) of making a behavior change.
4. When the participant has listed all the possible pros and cons, explain that not all reasons carry the same weight. For example, even if he/she has a long list cons, the reasons on the list may be less significant than the reasons on a shorter list of pros.

This is an example of using Decisional Balance to assess participant interest in visiting a primary care physician.

Sample Decisional Balance Chart: Decision to Visit a Health Care Provider	
PROS	CONS
I cannot get help for this pain unless I see a doctor.	I am worried about what the doctor might find out about me.
I want to live in a healthier way than I do now.	I do not like having to get undressed.
I now have support when I go to the clinic.	I am worried that they will treat me poorly.
I know my Counselor won't let me be treated badly.	I am worried that they might criticize me for using drugs or have me arrested.
I am worried that I am getting sicker.	I am worried that I might get sicker.
My friends and family will be relieved that I am getting help.	I am like my grandfather, and he lived to be 95 without seeing a doctor.

DECISIONAL BALANCE FORM

Problem Statement	
Pros "Benefits"	Cons "Consequences"
DRAFT	

STRUCTURED SESSION 2D ACTION PLAN FORM

Once the participant decides to begin a session, the Counselor inquires about critical problems the participant faces and his/her reasons for deciding to change behaviors that affect those problems. Together, the Counselor and participant develop goals and objectives to address these issues. This action plan documents the steps the participant agrees to take to change those behaviors he/she has identified as being most critical and for which he/she is most likely to have the support of significant others within his/her social network.

<input type="checkbox"/> Induction Session	<input type="checkbox"/> Reducing Drug-Related HIV Risk
<input type="checkbox"/> Taking Care of Your Health	<input type="checkbox"/> Reducing Sex-Related HIV Risk
<input type="checkbox"/> Readiness for Entering Drug Treatment	<input type="checkbox"/> Booster
<input type="checkbox"/> Relapse Prevention	<input type="checkbox"/> Other

Problem: _____

Goal: _____

Objectives: _____

Interventions/Activities: _____

--	--	--

Participant Name

Participant Signature

Date

--	--	--

Counselor Name

Counselor Signature

Date

STRUCTURED SESSION 2E
Behavior Change Self-Assessment Form

The purpose of this form is to learn how you presently perceive your primary health, drug (detox) treatment, sexual risk reduction and drug-related risk reduction needs. Read from the bottom to the top for each category and select the statement that you most agree with.

HIV RISK

Health Services	Drug Treatment	Sexual Conduct	Drug Injection Conduct
I have been taking care of my health for over six (6) months.	I have been without using drugs over six (6) months.	It has been more than six (6) months that when I have sexual relations I project myself against HIV.	It has been more than six (6) months that when I inject drugs, I avoid getting infected with HIV.
I am presently taking care of my health.	I am presently in treatment (detox or outpatient).	I presently protect myself against HIV when I have sexual relations.	I presently protect myself against HIV when I inject
Next month, I am planning to see a doctor.	I am planning to request detox admission very soon (next month).	Very soon (next month), I am thinking about making safe decisions regarding my sexual behavior to avoid getting infected with HIV.	Maybe I should be more careful when I inject to avoid getting infected with HIV.
Maybe I should see a doctor.	Maybe my drug use is a problem and I should seek treatment (detox).	Maybe I should be more careful with my sexual activities to avoid getting infected with HIV.	Very soon (next month) I am planning to inject drugs in a safer way to avoid getting infected with HIV
I do not have any health problems that I need to take care of.	My drug use is not a problem.	My sexual practices do not place me at risk of HIV infection.	When I inject drugs, it doesn't concern me that I might get infected with HIV.

**STRUCTURED SESSION 2F
MIP SELF ASSESSMENT & STAGING FORM**

This form is to be used by the Counselor to record the Participant's stage of change

Participant		Date	
Staff		Location	
Session No		Contact No	
<input type="checkbox"/> Face to Face	<input type="checkbox"/> Telephone Contact	<input type="checkbox"/> Session Completed	*Dosage _____
<input type="checkbox"/> Safer Sex Kits	<input type="checkbox"/> Bleach Kits	<input type="checkbox"/> Incentive	<input type="checkbox"/> Referral

TAKING CARE OF YOUR HEALTH

Role Induction		Decisional Balance			
Affirmations		Information/Options			
Reflective Listening		Goal Setting			
Support Self-Efficacy		Action Plan			
Stage	Pre	Contemplation	Preparation	Action	Maintenance
Staff	1	2	3	4	5
Participant	1	2	3	4	5

PREPARING TO ENTER DRUG TREATMENT

Role Induction		Decisional Balance			
Affirmations		Information/Options			
Reflective Listening		Goal Setting			
Support Self-Efficacy		Action Plan			
Stage	Pre	Contemplation	Preparation	Action	Maintenance
Staff	1	2	3	4	5
Participant	1	2	3	4	5

REDUCING DRUG-RELATED HIV RISK

Role Induction		Decisional Balance			
Affirmations		Information/Options			
Reflective Listening		Goal Setting			
Support Self-Efficacy		Action Plan			
Stage	Pre	Contemplation	Preparation	Action	Maintenance
Staff	1	2	3	4	5
Participant	1	2	3	4	5

REDUCING SEX-RELATED HIV RISK

Role Induction		Decisional Balance			
Affirmations		Information/Options			
Reflective Listening		Goal Setting			
Support Self-Efficacy		Action Plan			
Stage	Pre	Contemplation	Preparation	Action	Maintenance
Staff	1	2	3	4	5
Participant	1	2	3	4	5

**STRUCTURED SESSION 2G
CASE MANAGEMENT REFERRAL FORM**

The objective of this session is for the participant to accept and continue participating in the intervention and in utilizing case management services.

PARTICIPANT'S FULL NAME: _____ PHONE #: _____

PARTICIPANT'S ADDRESS: _____

D.O.B.: _____ Age: _____

REFERRED TO: _____ TO SEE: _____

ADDRESS: _____

DATE OF APPOINTMENT: _____ TIME: _____

REASON FOR REFERRAL:

- | | |
|--|--|
| <input type="checkbox"/> Mental Health Services | <input type="checkbox"/> Primary Health Services |
| <input type="checkbox"/> Opiate Addiction/Abuse | <input type="checkbox"/> Parenting Skills Program |
| <input type="checkbox"/> Cocaine Addiction/Abuse | <input type="checkbox"/> Domestic Violence/ Anger Management |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Food Voucher |
| <input type="checkbox"/> Poly-Substance Abuse | <input type="checkbox"/> Counseling |
| <input type="checkbox"/> Rental/Housing Assistance | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Utility Assistance | <input type="checkbox"/> Other |
| <input type="checkbox"/> Family Planning | |

COMMENTS: _____

IF YOU HAVE ANY QUESTIONS, YOU MAY CONTACT ME AT: _____

SINCERELY,

Counselor/Case Manager

Date

**STRUCTURED SESSION 2H
PROGRESS NOTES**

		Case Manager Notes	Counselor Notes
DATE:	END TIME:		
	START TIME:		
DATE:	END TIME:		
	START TIME:		
DATE:	END TIME:		
	START TIME:		

SESSION THREE: READINESS FOR ENTERING DRUG TREATMENT

Session 3 should be scheduled no earlier than one week and no later than two weeks following a previous MIP Session. The Readiness for Entering Drug Treatment Session may require more than one contact depending on the participant's individual goals and needs. The participant should have knowledge of HIV risk reduction skills and relapse prevention information prior to entering drug treatment to increase their chances for success. If a participant decides to go into drug treatment, it is highly recommended that the participant still complete Session 4 (Relapse Prevention), and Session 5 (Reducing Drug-related HIV Risk).

SESSION OBJECTIVES

- Raise participant awareness about HIV and other health risks associated with injection drug use.
- Assess participant knowledge and experience with drug treatment services.
- Increase participant readiness to enter drug treatment.

SUMMARY OF READINESS FOR ENTERING DRUG TREATMENT SESSION

The goal of Session 3 is to encourage participants to consider drug treatment (detoxification, in-patient, or out-patient drug treatment). The Counselor conducts a history of the participant's drug use and treatment. Through program content and motivational interviewing skills, participants are engaged in a decisional balance process that enables them to explore and identify the positive and negative aspects of entering a detoxification and/or treatment program.

By means of role induction, the Counselor encourages the participant to enroll in a drug treatment program. The Counselor and the participant discuss various drug treatment options and the Counselor and the participant set goals and develop a plan for entering drug treatment. If the participant agrees to enter treatment and these services are available, the MIP team will ensure that the admission process is initiated immediately.

At the end of the session, the participant fills out a self-evaluation. The Counselor provides feedback about the session and about the participant's readiness to change. The Counselor and the participant summarize the issues they discussed, agree on a plan to address them, and make the next counseling appointment.

SESSION TIME: 45-60 minutes (Counseling Session)
Time spent in case management will vary according to participant needs.

Note: The time required to complete Session 3 will vary according to participant needs.

SESSION ACTIVITIES

	Activity	Responsible Party
1.	Introduction (5 minutes)	Counselor
2.	Role Induction (10 minutes)	Counselor
3.	Assess Knowledge and Experience with Drug Treatment Services (15 minutes).	
4.	Willingness to Entering Drug Treatment (5 minutes)	Counselor
5.	Develop Action Plan (5 minutes)	Counselor
6.	Ensure Social Support Networks (5 minutes).	Counselor
7.	Wrap-up/Staging for Next Session (5 minutes)	Counselor
8.	Follow-Up Case Management	Case Manager/ Community Educator and Counselor
9.	Complete Documentation Forms	Team
10.	Discuss Session Benchmarks with the MIP Team	Team

MATERIALS/RESOURCES NEEDED (See Session Appendix for referenced forms):

NAME	FORM in SESSION APPENDIX
Completed MIP Intake Form (1C), Behavioral Risk Assessment Form (1D) - for review	From Induction Session (Session 1)
Drug Treatment History and Experience Form	Form 3A
Decisional Balance Form	Form 3B
Action Plan Form	Form 3C
Behavioral Change Self-Assessment	Form 3D
MIP Self-Assessment and Staging Form	Form 3E
Case Management Referral Form	Form 3F
Progress Notes	Form 3G
Drug treatment resource guide including detoxification, in-patient, out-patient, and methadone treatment services	Local Resource
HIV/STI, TB, and viral hepatitis counseling and testing resource guide	Local Resource
Local HIV/AIDS services and social services resource list	Local Resources
Incentives	

SESSION LOCATION:

Due to the sensitive and personal nature of the questions asked during this session, Session 3 must be conducted in a private, enclosed room, where confidentiality can be assured and interruptions avoided.

Case Management services can take place at community venues, project community sites, treatment programs, or any other place with a favorable environment for the intervention.

PREPARATION

- The following forms from the Induction Session need to be fully completed and reviewed prior to initiating this session: **MIP Intake Form (1C)**, the **Behavioral Risk Assessment Form (1D)**
- Review and become familiar with the **Drug Treatment History and Experience Form (3A)**.
- Staff members should review these forms to become familiar with the participant's history and risk reduction goals and to be prepared to follow-up on any referrals that have been made.
- Become familiar with the resource guides, the referral processes, and the contents in the safer sex and needle hygiene kits.
- Be prepared to provide on-site HIV/STI, TB, and viral hepatitis testing or to make an appropriate referral if the participant desires to be tested.

STEP-BY-STEP PROCEDURES

1. Introduction (5 minutes)

At the beginning of the session, greet and introduce yourself to the participant if you have not met before, and establish rapport by making conversation with the participant.

2. Role Induction (10 minutes)

Review the roles and responsibilities of the MIP team members and those of the participant to ensure that the participant knows what the MIP program expects from him/her.

Introduce Session 3, by explaining that the purpose of the session is to discuss drug treatment and to assess whether the participant is ready to go into drug treatment.

Discuss admission to a detoxification program, in-patient, and out-patient drug treatment. Utilize a drug abuse services resource guide to inform the participant of his/her drug treatment options, and review the program criteria for admission.

Remind the participant of agreements made during the Induction Session with regard to health status, including drug use and/or risk reduction goals. Use data from Behavioral Risk Assessment, if necessary.

3. Develop Drug History (10 minutes)

Develop health history utilizing the **Drug Treatment History and Experience Form (3A)**. The Counselor provides feedback about the participant's drug treatment history.

4. Assess Knowledge and Experience with Drug Treatment Services. (20 minutes)

The focus of this session is to provide information about drug treatment services, including: detoxification, in-patient, and out-patient drug treatment. The Counselor should discuss the different philosophies, eligibility criteria, and admission processes for various drug treatment modalities.

Using the **Drug Treatment History and Experience Form (3A)** to help facilitate the discussion, the Counselor should explore the participant's experience with the drug treatment services, if any, and document the participant's responses on the form.

The Counselor should encourage the participant to explore his/her drug treatment needs and consider treatment. If the participant is ambivalent about drug treatment services, complete the **Decisional Balance Form (3B)** to identify the positive and negative aspects of continuing present patterns of drug use and the pros and cons of accepting drug treatment services. The Counselor encourages the participant to explore his/her drug treatment needs and consider treatment.

If the participant is prepared to enter treatment, the MIP team must follow-up immediately to identify treatment programs with their respective eligibility requirements and current capacity. Upon confirmed availability, arrangements should be made immediately to get the participant into the drug treatment program; even if it may mean escorting him/her to the program site.

4. Participant Willingness to Enter Drug Treatment Services (5 minutes)

The Counselor should gauge the participants' willingness to take action on entering drug treatment in order to develop an appropriate action plan for that session. For example, after taking the participants' drug treatment history, the Counselor may ask the participant how soon he/she wants to access drug treatment services.

You may ask:

- How ready are you to go into a drug treatment program?
- Are you ready to go into a drug treatment program today? I can accompany you if you wish. If you ask this question, make sure on-demand treatment is an option.
- If not today, then how about next week?
- If not next week, when?

The participants' response is noted in the progress notes for that session and used to identify session goals and develop the Action Plan specific to the goals of that session.

5. Develop Action Plan

Based on information obtained during drug treatment history and on the participant's willingness to take action, establish/verify the participant's behavior change goals. To do this:

- Develop new goals using the **Action Plan Form (3C)**.

- The Case Manager/Community Educator will work with the participant to access drug treatment and other services, as appropriate.
- Participants should be provided with a local resource guide listing services in the community.

Together, the Counselor and participant discuss drug-use risk reduction goals and develop an **Action Plan Form (3C)** mapping out strategies to prepare the participant for entering drug treatment.

6. Ensure Social Support (5 minutes)

As with every session in the MIP intervention, the Counselor reinforces positive social support networks for the participant. If the participant has identified a person who is supportive of his/her risk reduction efforts, stress benefit of having such a person.

If the participant has not identified such a person, review potential support networks with the participant and attempt to identify an individual who might serve this role. If there is no one to support the participant, suggest an MIP team member as an alternative. Do this by reaffirming MIP staff support, perhaps saying, "I want you to know that we all support you. We believe in what you are doing and know that it matters."

7. Wrap-up/Staging for Next Session (5 minutes)

In this activity, the Counselor will:

- Summarize the main benchmarks of the current session, including what was discussed and the planned action steps.
- Inform the participant that he/she has successfully completed the "Readiness for Entering Drug Treatment" Session and will be deciding on the focus of next session for MIP.
- Provide the participant with a list of remaining session topics;
- Ask the participant which topic he/she is ready to work on and document in progress notes.
- Give the participant the **Behavioral Change Self Assessment Form (3D)** and ask him/her to identify the stage where he/she is now. If necessary, the Counselor reads the staging options to the participant and documents his/her responses. Both discuss the stage closest to action---an indication of the participant's readiness to make changes. Record the participant's responses on the **MIP Self Assessment and Staging Form (3E)**.
- If the participant is willing to go to treatment, explain to him/her the program's willingness to deliver the Relapse Prevention Session prior to his/her admission to treatment. The Counselor also offers to deliver the Reducing Drug and/or Relapse prevention sessions if the participant so chooses. These sessions provide knowledge and skills that support self-efficacy and relapse-prevention. Delivering these sessions prior to treatment will prevent exposing the participant to paraphernalia and potential triggers after treatment.
- Thank the participant for his/her time and reinforce the fact that he/she has taken positive steps toward protecting his or her health.
- Give the appropriate incentive for participating in this session.
- Give them an appointment card with the time and place of the next session.

8. Follow-Up Case Management Contact

After concluding the counseling session, accompany the participant to the Case Manager/Community Educator to initiate case management services. The Counselor shares the **Action Plan Form (3C)** with the Case Manager/Community Educator so that appropriate referrals to health, support and other human services can be made.

Additionally, the Case Manager/Community Educator should:

- Address participant health and social service needs.
- Offer a referral for HIV/STI testing and counseling services. Offer referrals for TB and viral hepatitis screening and vaccination.
- Make appropriate referrals for services the implementing organization cannot provide. A **Case Management Referral Form (3F)** is included in the session appendix.
- Follow-up on participant when possible and appropriate and escort participant to referred agencies.
- Ensure that participants have transportation and access to services.
- Provide bus or subway tokens, if available and necessary.

9. Complete Documentation Forms

Check for accuracy on the **Drug Treatment History and Experience Form (3A)** and the **Action Plan Form (3C)**. In addition, complete the **MIP Self Assessment and Staging Form (3E)**, indicating both the participant's perception of their stage of change and the Counselor's perception of the participant's stage of change.

Document session milestones in **Progress Notes (3G)**, including changes in participant's stage of change, MIP team perspectives, attended appointments, and any materials, incentives, and so forth given to the participant.

10. Discuss Session Benchmarks with the MIP Team

The MIP team meets to discuss the intervention plan for the participant. Information is shared about the participant's goals for behavior change and his/her health and human service needs to ensure a comprehensive and seamless approach to providing services.

Ensure that MIP team members have access to participant intake data, behavioral risk data, and case management action plans.

STRUCTURED SESSION III FORMS:

- A. Drug Treatment History and Experience form
- B. Decisional Balance Form
- C. Action Plan Form
- D. Behavior Change Self-Assessment
- E. MIP Self-Assessment and Staging Form
- F. Sample Case Management Referral Form
- G. Progress Notes

DRAFT

STRUCTURED SESSION 3A DRUG TREATMENT HISTORY AND EXPERIENCE FORM

Note: This form is to be used with the behavioral risk assessment and the drug/alcohol history.

This information is confidential and will not be shared with any other agency or unit within this organization, unless a written consent is provided by you the participant to do so. This form should be used in collaboration with the information in the behavioral risk assessment drug/alcohol history. EACH IMPLEMENTING ORGANIZATION MUST PREPARE A LIST OF AVAILABLE TREATMENT OPTIONS IN THEIR SPECIFIC COMMUNITY.

Participant Name: _____ Client ID: _____ Date of Birth: _____
 Gender: _____ Location of Session: _____ Date of Session: _____

Treatment Modality	Experienced	Completed	Repeated
Outpatient	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Treatment Modality	Experienced	Completed	Repeated
Intensive Outpatient (At least 9 hours per week)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Treatment Modality	Experienced	Completed	Repeated
Partial Hospitalization	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Treatment Modality	Experienced	Completed	Repeated
Residential Inpatient (Non Hospital)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Treatment Modality	Experienced	Completed	Repeated
Detox	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Treatment Modality	Experienced	Completed	Repeated
Inpatient Hospitalization	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Treatment Modality	Experienced	Completed	Repeated
Other (Specify) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

STRUCTURED SESSION 3B DECISIONAL BALANCE FORM

Note: Decisional Balance is a strategy to use for participants in the pre-contemplation/ contemplation stages. The following are the procedures for completing the Decisional Balance Strategy:

1. Place an action-oriented goal at the top of the blank Decisional Balance Strategy Chart.
2. Ask the participant to tell you the cons (reasons for not changing a behavior) of making the behavior change.
3. When he/she has completed the list of cons, ask him/her to tell you the pros (reasons for changing a behavior) of making a behavior change.
4. When the participant has listed all the possible pros and cons, explain that not all reasons carry the same weight. For example, even if he/she has a long list cons, the reasons on the list may be less significant than the reasons on a shorter list of pros.

This is an example of using Decisional Balance to assess participant interest in seeking drug treatment.

Sample Decisional Balance Chart Access Drug Treatment

Pros	Cons
I want to do more for my children.	I like using drugs because it makes me feel good.
I want my family to respect me.	I like using drugs with my friends.
I want to be able to pay my bills.	I do not know what I would do without drugs.
I want to stay healthy and not get HIV.	I like using drugs because I do not feel sad when I do so.
I don't want to lose my children.	I don't believe I will succeed.
The treatment facility will help me stop using drugs.	I don't like to be told what to do.
There are out-patient treatment programs.	I don't like to be locked up in a treatment program.

DECISIONAL BALANCE FORM

Problem Statement	
Pros "Benefits"	Cons "Consequences"
DRAFT	

STRUCTURED SESSION 3C ACTION PLAN FORM

Once the participant decides to begin a session, the Counselor inquires about critical problems the participant faces and his/her reasons for deciding to change behaviors that affect those problems. Together, the Counselor and participant develop goals and objectives to address these issues. This action plan documents the steps the participant agrees to take to change those behaviors he/she has identified as being most critical and for which he/she is most likely to have the support of significant others within his/her social network.

<input type="checkbox"/> Induction Session	<input type="checkbox"/> Reducing Drug-Related HIV Risk
<input type="checkbox"/> Taking Care of Your Health	<input type="checkbox"/> Reducing Sex-Related HIV Risk
<input type="checkbox"/> Readiness for Entering Drug Treatment	<input type="checkbox"/> Booster
<input type="checkbox"/> Relapse Prevention	<input type="checkbox"/> Other

Problem: _____

Goal: _____

Objectives: _____

Interventions/Activities: _____

--	--	--

Participant Name

Participant Signature

Date

--	--	--

Counselor Name

Counselor Signature

Date

STRUCTURED SESSION 3D
Behavior Change Self-Assessment Form

The purpose of this form is to learn how you presently perceive your primary health, drug (detox) treatment, sexual risk reduction and drug-related risk reduction needs. Read from the bottom to the top for each category and select the statement that you most agree with.

HIV RISK

Health Services	Drug Treatment	Sexual Conduct	Drug Injection Conduct
I have been taking care of my health for over six (6) months.	I have been without using drugs over six (6) months.	It has been more than six (6) months that when I have sexual relations I project myself against HIV.	It has been more than six (6) months that when I inject drugs, I avoid getting infected with HIV.
I am presently taking care of my health.	I am presently in treatment (detox or outpatient).	I presently protect myself against HIV when I have sexual relations.	I presently protect myself against HIV when I inject
Next month, I am planning to see a doctor.	I am planning to request detox admission very soon (next month).	Very soon (next month), I am thinking about making safe decisions regarding my sexual behavior to avoid getting infected with HIV.	Maybe I should be more careful when I inject to avoid getting infected with HIV.
Maybe I should see a doctor.	Maybe my drug use is a problem and I should seek treatment (detox).	Maybe I should be more careful with my sexual activities to avoid getting infected with HIV.	Very soon (next month) I am planning to inject drugs in a safer way to avoid getting infected with HIV
I do not have any health problems that I need to take care of.	My drug use is not a problem.	My sexual practices do not place me at risk of HIV infection.	When I inject drugs, it doesn't concern me that I might get infected with HIV.

STRUCTURED SESSION 3E
MIP SELF ASSESSMENT & STAGING FORM

This form is to be used by the Counselor to record the Participant's stage of change

Participant		Date	
Staff		Location	
Session No		Contact No	
<input type="checkbox"/> Face to Face	<input type="checkbox"/> Telephone Contact	<input type="checkbox"/> Session Completed	*Dosage _____
<input type="checkbox"/> Safer Sex Kits	<input type="checkbox"/> Bleach Kits	<input type="checkbox"/> Incentive	<input type="checkbox"/> Referral

TAKING CARE OF YOUR HEALTH

Role Induction		Decisional Balance			
Affirmations		Information/Options			
Reflective Listening		Goal Setting			
Support Self-Efficacy		Action Plan			
Stage	Pre	Contemplation	Preparation	Action	Maintenance
Staff	1	2	3	4	5
Participant	1	2	3	4	5

PREPARING TO ENTER DRUG TREATMENT

Role Induction		Decisional Balance			
Affirmations		Information/Options			
Reflective Listening		Goal Setting			
Support Self-Efficacy		Action Plan			
Stage	Pre	Contemplation	Preparation	Action	Maintenance
Staff	1	2	3	4	5
Participant	1	2	3	4	5

REDUCING DRUG-RELATED HIV RISK

Role Induction		Decisional Balance			
Affirmations		Information/Options			
Reflective Listening		Goal Setting			
Support Self-Efficacy		Action Plan			
Stage	Pre	Contemplation	Preparation	Action	Maintenance
Staff	1	2	3	4	5
Participant	1	2	3	4	5

REDUCING SEX-RELATED HIV RISK

Role Induction		Decisional Balance			
Affirmations		Information/Options			
Reflective Listening		Goal Setting			
Support Self-Efficacy		Action Plan			
Stage	Pre	Contemplation	Preparation	Action	Maintenance
Staff	1	2	3	4	5
Participant	1	2	3	4	5

**STRUCTURED SESSION 3F
CASE MANAGEMENT REFERRAL FORM**

The objective of this session is for the participant to accept and continue participating in the intervention and in utilizing case management services.

PARTICIPANT'S FULL NAME: _____ PHONE #: _____

PARTICIPANT'S ADDRESS: _____

D.O.B.: _____

Age: _____

REFERRED TO: _____ TO SEE: _____

ADDRESS: _____

DATE OF APPOINTMENT: _____ TIME: _____

REASON FOR REFERRAL:

- | | |
|--|--|
| <input type="checkbox"/> Mental Health Services | <input type="checkbox"/> Primary Health Services |
| <input type="checkbox"/> Opiate Addiction/Abuse | <input type="checkbox"/> Parenting Skills Program |
| <input type="checkbox"/> Cocaine Addiction/Abuse | <input type="checkbox"/> Domestic Violence/ Anger Management |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Food Voucher |
| <input type="checkbox"/> Poly-Substance Abuse | <input type="checkbox"/> Counseling |
| <input type="checkbox"/> Rental/Housing Assistance | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Utility Assistance | <input type="checkbox"/> Other |
| <input type="checkbox"/> Family Planning | |

COMMENTS: _____

IF YOU HAVE ANY QUESTIONS, YOU MAY CONTACT ME AT: _____

SINCERELY,

Counselor/Case Manager

Date

**STRUCTURED SESSION 3G
PROGRESS NOTES**

		Case Manager Notes	Counselor Notes
DATE:	END TIME:		
	START TIME:		
DATE:	END TIME:	_____ Signature of MIP Team Member	_____ Signature of MIP Team Member
	START TIME:		
DATE:	END TIME:	_____ Signature of MIP Team Member	_____ Signature of MIP Team Member
	START TIME:		
DATE:	END TIME:	_____ Signature of MIP Team Member	_____ Signature of MIP Team Member
	START TIME:		

SESSION FOUR: RELAPSE PREVENTION

It is recommended that the Relapse Prevention Session (Session 4) be administered prior to, in conjunction with, or after any of the following sessions.

- Readiness for Entering Drug Treatment
- Reducing Drug-related HIV risk
- Reducing Sex-related HIV risk

The Relapse Prevention Session may require more than one contact depending on the participant's individual goals and needs.

SESSION OBJECTIVES

- Discuss the process and procedures of the Relapse Prevention Session (Session 4);
- Assess the participants' relapse experiences with drug use and unsafe sex practices;
- Assist the participant in developing skills to prevent relapse.

SUMMARY OF RELAPSE PREVENTION SESSION

The objective of the Relapse Prevention Session is to maintain the drug and sex-related risk reduction practices that the participant has incorporated into his/her life and help the participant prevent relapse by developing greater self-efficacy in risk reduction behaviors. This session often is negotiated with the MIP participant in order to further support drug and sex risk reduction practices and drug treatment.

This session includes examples of situations that precipitate relapse. The Counselor and the participant explore the participant's last relapse event (and the feelings, thoughts, and behaviors associated with that event) to develop an individualized profile of high-risk situations for relapse and identify strategies that can be used to avoid a relapse episode.

At the end of the session the participant conducts a self-evaluation and sets relapse prevention goals. The Counselor and the participant summarize the issues they discussed, agree on a plan to address them, and make the next counseling appointment.

SESSION TIME: 45-60 minutes (Counseling Session)
Time spent in case management will vary according to participant needs.

Note: The time required to complete Session 4 will vary according to participant needs.

SESSION ACTIVITIES

	Activity	Responsible Party
1.	Introduction (5 minutes)	Counselor
2	Role Induction (10 minutes)	Counselor
3.	Assess Participant Experiences with Relapse (15 minutes).	Counselor
4.	Determine Participant Willingness to Learn Relapse Prevention Strategies(5 minutes)	Counselor
5.	Develop Action Plan (5 minutes)	Counselor
6.	Ensure Social Support Networks (5 minutes).	Counselor
7.	Wrap-up/Staging for Next Session (5 minutes)	Counselor
8.	Follow-Up Case Management	Case Manager/ Community Educator and Counselor
9.	Complete Documentation Forms	Team
10.	Discuss Session Benchmarks with the MIP Team	Team

MATERIALS/RESOURCES NEEDED (See Session Appendix for referenced forms):

NAME	FORM in SESSION APPENDIX
Completed MIP Intake Form(1C), Behavioral Risk Assessment Form(1D), (for review)	From Induction Session (Session 1)
Guide for the Analysis of the Most Recent Relapse—Drug Use	Form 4A
Guide for the Analysis of the Most Recent Relapse—Unprotected Sexual Activity	Form 4B
Decisional Balance Form	Form 4C
Action Plan Form	Form 4D
Behavioral Change Self-Assessment	Form 4E
MIP Self-Assessment and Staging Form	Form 4F
Case Management Referral Form	Form 4G
Progress Notes	Form 4H
HIV/STI, TB, and viral hepatitis counseling and testing resource guide	Local Resource
Local HIV/AIDS and social service resource list for referrals	Local Resources
Incentives	

SESSION LOCATION

Due to the sensitive and personal nature of the questions asked during this session, Session 4 must be conducted in a private, enclosed room, where confidentiality can be assured and interruptions avoided.

Case Management services can take place at community venues, project community sites, treatment programs, or any other place with a favorable environment for the intervention.

PREPARATION

- The following forms from the Induction Session need to be fully completed and reviewed prior to initiating this session: **the MIP Intake Form (1C), and the Behavioral Risk Assessment Form (1D).**
- Review the **Guide to Analysis of Most Recent Relapse –Drug Use (4A) and Unprotected Sexual Activity (4B).**
- Staff members should review these forms to become familiar with the participant's history and risk reduction goals and to be prepared to follow-up on any referrals that have been made.
- Become familiar with the resource guides, the referral processes, and the contents in the safer sex and needle hygiene kits.
- Be prepared to provide on-site HIV/STI, TB, and viral hepatitis testing or to make an appropriate referral if the participant desires to be tested.

STEP-BY-STEP PROCEDURES

1. Introduction (5 minutes)

At the beginning of the session, greet and introduce yourself to the participant if you have not met before, and establish rapport by making conversation with the participant. Make sure to give the participant your full attention.

2. Session Induction (10 minutes)

Introduce the Relapse Prevention Session by explaining that the purpose of the session is to increase the participant's ability to recognize and avoid relapse triggers that lead to resuming risky behaviors. Explain that session activities will include a discussion of relapse episodes, the strategies and techniques to prevent relapse, and skills-building exercises to help prevent relapse.

Review respective roles of both the MIP team members and of the participant in accomplishing this task.

Remind the participant of agreements made during the Induction Session with regard to sexual risk taking, drug use, and risk reduction goals.

3. Assess Participant Experiences with Relapse (20 minutes)

Following the **Guide for the Analysis of Most Recent Relapse in Drug Use (4A)** and **Sexual Risk Taking (4B)** the Counselor and the participant explore the participant's last relapse episode to develop a profile of high risk situations for relapse. Together, they analyze thoughts, feelings, and behaviors that led to relapse. The Counselor should ask open-ended questions such as:

- What was taking place when you decided to resume risky behaviors?
- What thoughts and feelings did you experience before engaging in risky behavior?
- How could the relapse have been avoided?
- What things would you change about that situation?
- What could you have done differently?
- What are some alternate behaviors to what you did?
- Who could have helped you through the situation that led to your relapse?

Based on the information the participant provides about his/her most recent relapse, the Counselor identifies healthy behaviors that can be substituted for risky ones in order to prevent relapse.

The Counselor should remain nonjudgmental during this discussion. He/she should stress to the participant that a relapse episode offers the opportunity to learn about the individualized process of recovery. It can also help the participant develop new strategies and skills to avoid future relapse episodes by answering the following questions pertaining to recovery: What works? What doesn't work? Who can help? What are the triggers?

The Counselor provides feedback about the issues discussed and asks the participant to identify the risk behaviors he/she wishes to work on to prevent relapse. The Counselor should complete the **Decisional Balance Form (4C)** for those participants ambivalent about changing the behaviors associated with relapse. For participants that are prepared to act, the Counselor should continue with goal setting and action planning for that session.

4. Determine Participant Willingness to Learn Relapse Strategies (5 minutes)

The Counselor should gauge the participants' willingness to take action to avoid relapse in order to develop an appropriate action plan.

For example, after conducting an analysis of the participants' last relapse episode, the Counselor may ask the participant how soon he/she wants to take action to prevent a (drug-use or unprotected sexual activity) relapse. For example,

- When would you like to work on relapse prevention strategies?
- Are you ready to work with me now to explore your relapse triggers and identify strategies to avoid relapse?

The participants' response is noted in the progress notes for that session and used to identify session goals and develop the **Action Plan Form (4D)** specific to the goals of that session.

5. Develop Action Plan

Based on information obtained during the recent relapse analysis and on the participant's willingness to take action, establish/verify the participant's behavior change goals. To do this:

- Refer to the information from the Induction Session action plan and verify new goals using the **Action Plan Form (4D)**.
- The Case Manager/Community Educator will work with the participant to make necessary referrals.
- Provide participants with a local resource guide listing services in the community.

6. Ensure Social Support (5 minutes)

As with every session in the MIP intervention, the Counselor reinforces positive social support networks for the participant. If the participant has identified a person who is supportive of his/her risk reduction efforts, stress benefit of having such a person.

If the participant has not identified such a person, review potential support networks with the participant and attempt to identify an individual who might serve this role. If there is no one to support the participant, suggest an MIP team member as an alternative. Do this by reaffirming MIP staff support, perhaps saying, "I want you to know that we all support you. We believe in what you are doing and know that it matters."

7. Wrap-up/Staging for Next Session (5 minutes)

In this activity, the Counselor will:

- Summarize the main benchmarks of the current session, including what was discussed and the planned action steps.
- Inform the participant that he/she has successfully completed the "Relapse Prevention" Session and will be deciding on the focus of next session for MIP.
- Provide the participant with a list of remaining session topics;
- Ask the participant which topic he/she is ready to work on and document in your progress notes.
 - Give the participant the **Behavioral Change Self Assessment Form (4E)** and ask him/her to identify the stage where he/she is now. If necessary, the Counselor reads the staging options for the chosen session to the participant and documents his/her selected response. This information allows you (the Counselor) to determine and prepare for the next structured session. Record the participant's responses on the **MIP Self Assessment and Staging Form (4F)**.
- Thank the participant for his/her time and reinforce the fact that he/she has taken positive steps toward protecting his or her health.
- Give the appropriate incentive for participating in this session.
- Give them an appointment card with the time and place of the next session

8. Follow-Up Case Management

After concluding the counseling session, accompany the participant to the Case Manager/Community Educator to initiate case management services. The Counselor shares the **Action Plan Form (4D)** with the Case Manager/Community Educator so that appropriate referrals to health, support and other human services can be made.

Additionally, the Case Manager/Community Educator should:

- Address participant health and social service needs.
- Offer a referral for HIV/STI testing and counseling services. Offer referrals for TB and viral hepatitis screening and vaccination.
- Make appropriate referrals for services the implementing organization cannot provide. A **Case Management Referral Form (4G)** is included in the session appendix.
- Follow-up on participant when possible and appropriate and escort participant to referred agencies.
- Ensure that participants have transportation and access to services.
- Provide bus or subway tokens, if available and necessary.

9. Participation Documentation

Check for accuracy on all forms completed during the session. In addition complete the **MIP Self Assessment and Staging Form (4F)**, indicating both the participant's perception of their stage of change and the Counselor's perception of the participant's stage of change.

Document session milestones in **Progress Notes (4H)**, including changes in participant's stage of change, MIP team perspectives, attended appointments, and any materials, incentives, and so forth given to the participant.

10. Discuss Session Benchmarks with the MIP Team

The MIP team meets to discuss the intervention plan for the participant. Information is shared about the participant's goals for behavior change and his/her health and human service needs to ensure a comprehensive and seamless approach to providing services.

SESSION IV FORMS:

- A. Guide for Analysis of Most Recent Relapse- Drug Use and Sex
- B. Guide for Analysis of Most Recent Relapse- Unprotected Sexual Activity
- C. Decisional Balance Form
- D. Action Plan Form
- E. Behavior Change Self-Assessment
- F. MIP Self-Assessment and Staging Form
- G. Case Management Referral Form
- H. Progress Notes

DRAFT

STRUCTURED SESSION 4A

Guide for Analysis of Most Recent Relapse—DRUG USE

This guide is to be used by the Counselor in discussions with participants on possible triggers of relapse and how to cope with them. Explore with the participant their most recent drug relapse experience and analyze thoughts, feelings and behaviors.

What can be done?

What are the alternate and healthy behaviors?

Relapse offers the opportunity to learn about the individualized process of recovery. It can help develop new strategies and skills to avoid future relapse episodes by answering the following questions pertaining to recovery: What works? What doesn't work? Who can help? What are the triggers? Consider the following questions while analyzing the most recent relapse in unprotected sexual activity.

- When did the most recent relapse episode occur? (Think about that day and the time it happened).
- Where were you when you used drugs? (Think on the specific place)
- Think about the specific activity you were doing at that moment. (For example, were you drinking?)
- Who was with you at the moment relapse occurred? What were the other persons doing?
- How did you obtain the drug? (Think about all the specific activities you had to do in order to obtain the drug).
- What do you think triggered your relapse?
- How did you feel when this use episode ended?
- What is the probability that this situation may be repeated?

1. Probes of activities, actions and behaviors that triggered relapse:

- | | |
|---|--|
| <input type="checkbox"/> Passing by a drug selling point or shooting gallery. | <input type="checkbox"/> Getting money |
| <input type="checkbox"/> Meeting someone with whom you can buy, use and /or share drugs | <input type="checkbox"/> Finding a job |
| <input type="checkbox"/> Having a fight or discussion with a close member of the family | <input type="checkbox"/> Not being able to find a job |
| <input type="checkbox"/> Loosing your children | <input type="checkbox"/> Talking to someone about drug use |
| <input type="checkbox"/> Seeing related paraphernalia | <input type="checkbox"/> Coming out of jail/prison |
| <input type="checkbox"/> Using drugs after being drug-free for sometime | <input type="checkbox"/> Being at a party |
| <input type="checkbox"/> Using other types of drugs (Alcohol, Cigarettes) | |
| <input type="checkbox"/> Other (Participant Describes) _____ | |

2. Probe for feelings:

- | | | | | |
|--|---|---|--|--|
| <input type="checkbox"/> Feeling bored | <input type="checkbox"/> Feeling happy | <input type="checkbox"/> Feeling sad/frustrated | <input type="checkbox"/> Feeling angry | <input type="checkbox"/> Feeling guilty |
| <input type="checkbox"/> Feeling tired | <input type="checkbox"/> Feeling rejected | <input type="checkbox"/> Feeling afraid | <input type="checkbox"/> Feeling excited | <input type="checkbox"/> Feeling in love |
| <input type="checkbox"/> Feeling alone | <input type="checkbox"/> Other (Describe) _____ | | | |

3. Probes for thoughts:

- | | |
|---|---|
| <input type="checkbox"/> To remember the last time you used drugs. | <input type="checkbox"/> To remember a dream about drugs. |
| <input type="checkbox"/> To think that you will feel better if you use drugs. | <input type="checkbox"/> To think that drugs help you to forget. |
| <input type="checkbox"/> To think that you cannot live without drugs. | <input type="checkbox"/> To think that you cannot function without drugs. |
| <input type="checkbox"/> To think that you cannot come out of using drugs. | <input type="checkbox"/> To think that you are not important to anybody. |
| <input type="checkbox"/> To think that you don't have alternatives. | <input type="checkbox"/> To think that nobody wants to help |

4. Other:

- Other (Describe) _____
- Other (Describe) _____

DRAFT

STRUCTURED SESSION 4B

Guide for Analysis of Most Recent Relapse—UNPROTECTED SEXUAL ACTIVITY

This guide is to be used by the Counselor in discussions with participants on possible triggers of relapse and how to cope with them. Explore with the participant their most recent unprotected sexual experience and analyze thoughts, feelings and behaviors.

What can be done?

What are the alternate and healthy behaviors?

Relapse offers the opportunity to learn about the individualized process of behavior change. It can help develop new strategies and skills to avoid future relapse episodes by answering the following questions: What works? What doesn't work? Who can help? What are the triggers? Consider the following questions while analyzing the most recent relapse in unprotected sexual activity.

- When did the most recent relapse episode occur? Think about the specific day and time.
- Where were you when the relapse episode occurred? Think of the specific place.
- What were you doing when the relapse episode occurred? Think about the specific activity.
- Who was with you when the relapse episode occurred? What was he/she doing?
- Did you anticipate having unprotected sex in this situation?
- What do you think triggered your relapse?
- How did you feel after the relapse episode?
- What is the probability that this will happen again?

1. Probes of activities, actions and behaviors that triggered relapse:

- | | |
|--|---|
| <input type="checkbox"/> Getting together with someone you had previously had unprotected sex with | <input type="checkbox"/> Getting money |
| <input type="checkbox"/> Not carrying condoms with you | <input type="checkbox"/> Finding a job |
| <input type="checkbox"/> Meeting someone with whom you can buy, use and /or share drugs | <input type="checkbox"/> Not being able to find a job |
| <input type="checkbox"/> Having a fight or discussion with a close member of the family | <input type="checkbox"/> Talking to someone about sex |
| <input type="checkbox"/> Loosing your children | <input type="checkbox"/> Being at a party |
| <input type="checkbox"/> Coming out of jail/prison | |
| <input type="checkbox"/> Using drugs after being drug-free for sometime | |
| <input type="checkbox"/> Other (Participant Describes) _____ | |

2. Probe for feelings:

- Feeling bored Feeling happy Feeling sad/frustrated Feeling angry Feeling guilty
 Feeling rejected Feeling afraid Feeling excited Feeling in love Feeling alone
 Other (Describe) _____

3. Probes for thoughts:

- To remember the last time you had unprotected sex.
 To think that you will feel better if you had unprotected sex.
 To think that sex helps you to forget.
 To think that you cannot live without unprotected sex.
 To think that you are not important to anybody.
 To think that you don't have alternatives.

4. Other:

- Other (Describe) _____
 Other (Describe) _____
 Other (Describe) _____

STRUCTURED SESSION 4C DECISIONAL BALANCE

Note: Decisional Balance is a strategy to use for participants in the pre-contemplation/ contemplation stages. The following are the procedures for completing the Decisional Balance Strategy:

1. Place an action-oriented goal at the top of the blank Decisional Balance Strategy Chart.
2. Ask the participant to tell you the cons (reasons for not changing a behavior) of making the behavior change.
3. When he/she has completed the list of cons, ask him/her to tell you the pros (reasons for changing a behavior) of making a behavior change.
4. When the participant has listed all the possible pros and cons, explain that not all reasons carry the same weight. For example, even if he/she has a long list of cons, the reasons on the list may be less significant than the reasons on a shorter list of pros.

This is an example of using Decisional Balance to assess participant interest in maintaining positive behavior changes.

**Sample Decisional Balance Chart:
Preventing Relapse**

PROS	CONS
I want to address my drug or sex-related HIV risk behavior.	My risk for HIV/STIs, viral hepatitis, and other transmittable diseases will increase if I cannot prevent relapse.
I want to live in a healthier way than I do now.	I would always have to be conscious about my behavior if I want to prevent relapse.
I want to improve myself.	I will feel like a failure if I cannot prevent relapse.
My friends and family will be proud of me.	My family will be unhappy and isolate me if I cannot prevent relapse.

DECISIONAL BALANCE

Problem Statement	
Pros "Benefits"	Cons "Consequences"
DRAFT	

STRUCTURED SESSION 4D ACTION PLAN FORM

Once the participant decides to begin a session, the Counselor inquires about critical problems the participant faces and his/her reasons for deciding to change behaviors that affect those problems. Together, the Counselor and participant develop goals and objectives to address these issues. This action plan documents the steps the participant agrees to take to change those behaviors he/she has identified as being most critical and for which he/she is most likely to have the support of significant others within his/her social network.

<input type="checkbox"/> Induction Session	<input type="checkbox"/> Reducing Drug-Related HIV Risk
<input type="checkbox"/> Taking Care of Your Health	<input type="checkbox"/> Reducing Sex-Related HIV Risk
<input type="checkbox"/> Readiness for Entering Drug Treatment	<input type="checkbox"/> Booster
<input type="checkbox"/> Relapse Prevention	<input type="checkbox"/> Other

Problem: _____

Goal: _____

Objectives: _____

Interventions/Activities: _____

--	--	--

Participant Name

Participant Signature

Date

--	--	--

Counselor Name

Counselor Signature

Date

STRUCTURED SESSION 4E
Behavior Change Self-Assessment Form

The purpose of this form is to learn how you presently perceive your primary health, drug (detox) treatment, sexual risk reduction and drug-related risk reduction needs. Read from the bottom to the top for each category and select the statement that you most agree with.

HIV RISK

Health Services	Drug Treatment	Sexual Conduct	Drug Injection Conduct
I have been taking care of my health for over six (6) months.	I have been without using drugs over six (6) months.	It has been more than six (6) months that when I have sexual relations I project myself against HIV.	It has been more than six (6) months that when I inject drugs, I avoid getting infected with HIV.
I am presently taking care of my health.	I am presently in treatment (detox or outpatient).	I presently protect myself against HIV when I have sexual relations.	I presently protect myself against HIV when I inject
Next month, I am planning to see a doctor.	I am planning to request detox admission very soon (next month).	Very soon (next month), I am thinking about making safe decisions regarding my sexual behavior to avoid getting infected with HIV.	Maybe I should be more careful when I inject to avoid getting infected with HIV.
Maybe I should see a doctor.	Maybe my drug use is a problem and I should seek treatment (detox).	Maybe I should be more careful with my sexual activities to avoid getting infected with HIV.	Very soon (next month) I am planning to inject drugs in a safer way to avoid getting infected with HIV
I do not have any health problems that I need to take care of.	My drug use is not a problem.	My sexual practices do not place me at risk of HIV infection.	When I inject drugs, it doesn't concern me that I might get infected with HIV.

STRUCTURED SESSION 4F
MIP SELF ASSESSMENT & STAGING FORM

This form is to be used by the Counselor to record the Participant's stage of change

Participant		Date	
Staff		Location	
Session No		Contact No	
<input type="checkbox"/> Face to Face	<input type="checkbox"/> Telephone Contact	<input type="checkbox"/> Session Completed	*Dosage_____
<input type="checkbox"/> Safer Sex Kits	<input type="checkbox"/> Bleach Kits	<input type="checkbox"/> Incentive	<input type="checkbox"/> Referral

TAKING CARE OF YOUR HEALTH

Role Induction		Decisional Balance			
Affirmations		Information/Options			
Reflective Listening		Goal Setting			
Support Self-Efficacy		Action Plan			
Stage	Pre	Contemplation	Preparation	Action	Maintenance
Staff	1	2	3	4	5
Participant	1	2	3	4	5

PREPARING TO ENTER DRUG TREATMENT

Role Induction		Decisional Balance			
Affirmations		Information/Options			
Reflective Listening		Goal Setting			
Support Self-Efficacy		Action Plan			
Stage	Pre	Contemplation	Preparation	Action	Maintenance
Staff	1	2	3	4	5
Participant	1	2	3	4	5

REDUCING DRUG-RELATED HIV RISK

Role Induction		Decisional Balance			
Affirmations		Information/Options			
Reflective Listening		Goal Setting			
Support Self-Efficacy		Action Plan			
Stage	Pre	Contemplation	Preparation	Action	Maintenance
Staff	1	2	3	4	5
Participant	1	2	3	4	5

REDUCING SEX-RELATED HIV RISK

Role Induction		Decisional Balance			
Affirmations		Information/Options			
Reflective Listening		Goal Setting			
Support Self-Efficacy		Action Plan			
Stage	Pre	Contemplation	Preparation	Action	Maintenance
Staff	1	2	3	4	5
Participant	1	2	3	4	5

**STRUCTURED SESSION 4G
CASE MANAGEMENT REFERRAL FORM**

The objective of this session is for the participant to accept and continue participating in the intervention and in utilizing case management services.

PARTICIPANT'S FULL NAME: _____ PHONE #: _____

PARTICIPANT'S ADDRESS: _____

D.O.B.: _____

Age: _____

REFERRED TO: _____ TO SEE: _____

ADDRESS: _____

DATE OF APPOINTMENT: _____ TIME: _____

REASON FOR REFERRAL:

- | | |
|--|--|
| <input type="checkbox"/> Mental Health Services | <input type="checkbox"/> Primary Health Services |
| <input type="checkbox"/> Opiate Addiction/Abuse | <input type="checkbox"/> Parenting Skills Program |
| <input type="checkbox"/> Cocaine Addiction/Abuse | <input type="checkbox"/> Domestic Violence/ Anger Management |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Food Voucher |
| <input type="checkbox"/> Poly-Substance Abuse | <input type="checkbox"/> Counseling |
| <input type="checkbox"/> Rental/Housing Assistance | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Utility Assistance | <input type="checkbox"/> Other |
| <input type="checkbox"/> Family Planning | |

COMMENTS: _____

IF YOU HAVE ANY QUESTIONS, YOU MAY CONTACT ME AT: _____

SINCERELY,

Counselor/Case Manager

Date

**STRUCTURED SESSION 4H
PROGRESS NOTES**

		Case Manager Notes	Counselor Notes
DATE:	END TIME:		
	START TIME:		
DATE:	END TIME:	_____ Signature of MIP Team Member	_____ Signature of MIP Team Member
	START TIME:		
DATE:	END TIME:	_____ Signature of MIP Team Member	_____ Signature of MIP Team Member
	START TIME:		
DATE:	END TIME:	_____ Signature of MIP Team Member	_____ Signature of MIP Team Member
	START TIME:		

SESSION FIVE: REDUCING DRUG-RELATED HIV RISK

Session 5 should be scheduled no earlier than one week and no later than two weeks following a previous MIP session. The Reducing Drug-Related HIV Risk Session may require more than one contact depending on the participant's individual goals and needs. It is also recommended that this session be administered prior to a participant entering drug treatment in order to increase their chances for success.

SESSION OBJECTIVES

- Increase participant readiness to reduce drug-related HIV risks.
- Provide information regarding drug-related HIV risk behaviors.
- Strengthen participant skills in reducing drug-related HIV risk behaviors.
- Motivate the participant to make changes that reduce high risk injection behaviors.

SUMMARY OF REDUCING DRUG-RELATED HIV RISK SESSION

The goal of Session 5 is to help the participant initiate behavioral changes by developing skills for safer injection drug use. These behavioral changes include cleaning works and paraphernalia and learning about drug-related risks for acquiring or transmitting HIV and viral hepatitis.

The MIP team provides participant with drug and sex safety kits consisting of bleach, cookers, cotton, condoms, lubrication, alcohol pads, water, and over the counter topical antibiotic ointment. Where legal and available, clean syringes may also be distributed.

By means of Decisional Balance, the Counselor and the participant discuss the positive and negative aspects of continuing with present drug injection practices, as well as the pros and cons of changing these practices.

The participant and the Counselor or Case Manager/ Community Educator establish drug-related risk reduction goals and work on skills-building to accomplish these goals. The participant is then accompanied to the Case Manager/Community Educator for case management services.

Note: Needles may not be distributed at any time using federal funds. Federal funding for MIP may not be used to support needle exchange services.

SESSION TIME: 45-60 minutes (Counseling Session)
Time spent in case management will vary according to participant needs.

Note: The time required to complete Session 5 will vary according to participant needs.

SESSION ACTIVITIES

	Activity	Responsible Party
1.	Introduction (5 minutes)	Counselor
2.	Role Induction (10 minutes)	Counselor
3.	Assess Knowledge and Experience Reducing Drug-Related HIV Risk (15 minutes)	Counselor
4.	Skills-Building Activities to Reduce HIV Risk- Safer Works (15 minutes)	Counselor
5.	Determine Participant Willingness to Reduce Drug-Related HIV Risk (5 minutes)	Counselor
6.	Develop Action Plan (5 minutes)	Counselor
7.	Ensure Social Support Networks (5 minutes).	Counselor
8.	Wrap-up/Staging for Next Session	Counselor
9.	Follow-Up Case Management	Case Manager/ Community Educator and Counselor
10.	Complete Documentation Forms	Team
11.	Discuss Session Benchmarks with the MIP Team	Team

MATERIALS/RESOURCES NEEDED (See Session Appendix for referenced forms):

NAME	FORM in SESSION APPENDIX
Completed MIP Intake Form (1C), Behavioral Risk Assessment Form (1D) - for review	From Induction Session (Session 1)
Injection Drugs Orientation Guide	Form 5A
Decisional Balance Form	Form 5B
Action Plan Form	Form 5C
Behavioral Change Self-Assessment	Form 5D
MIP Self-Assessment and Staging Form	Form 5E
Case Management Referral Form	Form 5F
Progress Notes	Form 5G
"Safer Works- Steps to Cleaning Syringes "- Handout	Form 5H
HIV/STI, TB, and viral hepatitis counseling and testing resource guide	Local Resource
Local HIV/AIDS and social service resource list for referrals	Local Resources
Needle hygiene/drug use safety kits (small bottle of bleach/water, alcohol pads, and sterile cotton balls)	
Clean needles (only in states where needle exchange is legal)	
Incentives	

SESSION LOCATION

Due to the sensitive and personal nature of the questions asked during this session, Session 5 must be conducted in a private, enclosed room, where confidentiality can be assured and interruptions avoided.

Case Management services can take place at community venues, project community sites, treatment programs, or any other place with a favorable environment for the intervention.

PREPARATION

- The following forms from the Induction Session need to be fully completed before initiating this session: the **MIP Intake Form (1C)**, and the **Behavioral Risk Assessment Form (1D)**
- Staff members should review and become familiar with the **Injection Drugs Orientation Guide (5A)** and **Safer Works-Steps to Cleaning Syringes Handout (5H)**.
- Become familiar with the resource guides, the referral processes, and the contents in the safer sex and needle hygiene kits.
- Be prepared to provide on-site HIV/STI, TB, and viral hepatitis testing or to make an appropriate referral if the participant desires to be tested.

STEP-BY-STEP PROCEDURES

1. Introduction (5 minutes)

At the beginning of the session, greet and introduce yourself to the participant if you have not met before, and establish rapport by making conversation with the participant. Make sure to give the participant your full attention.

2. Role Induction (5 minutes)

Review the respective roles and responsibilities of both the MIP team members and of the participant and explain that the purpose of this session is to increase participant knowledge about drug-related HIV and viral hepatitis risks and to encourage participants to develop skills to minimize those risks. Inform the participant that he/she will learn about drug-related risks for acquiring or transmitting HIV and viral hepatitis. He/she will also have an opportunity to practice steps for safer injection drug use, such as cleaning works and paraphernalia.

At the end of the session the participant conducts a self-evaluation and with the help of the Counselor, sets risk reduction goals for drug use. The Counselor may use information from the Behavioral Risk Assessment and Induction Session Action Plan, if necessary, to help with goal setting. The Counselor and the participant summarize the issues they discussed, agree on a plan to address them, and make the next counseling appointment. The participant is then accompanied to the Case Manager/Community Educator to access case management services in support of these and other MIP-related goals.

3. Assess Knowledge and Experience Reducing Drug-Related HIV Risk (15 minutes)

The Counselor provides information about drug-related HIV risk reduction behaviors and explores the participant's experience with drug-related HIV risk behaviors. If the participant has no past experience with reducing drug-related HIV risk behaviors, the Counselor strongly encourages the participant to explore his/her drug-related HIV risks and learn about risk reduction strategies.

Following the **Injection Drugs Orientation Guide (5A)**, the Counselor and the participant discuss drug-using HIV risk behaviors that the participant may have engaged in the past. The Counselor then provides feedback about the participant's past HIV risk behaviors.

If the participant has no past experience with attempting to reduce drug-related HIV risk behaviors, the Counselor strongly encourages the participant to learn about risk reduction strategies.

The following is an example of Counselor feedback: "You've mentioned a number of behaviors that put you at risk for becoming infected with HIV. These behaviors can also place your partners (and possibly others) at risk. You mentioned that you have shared either needles, cookers, spoons, rinsing water, or cotton. You said that on more than one occasion, you have used unsterilized equipment found on the street. This puts you at risk for HIV, viral hepatitis, and other infections."

If the participant is ambivalent about reducing drug-related HIV risk behavior, complete the **Decisional Balance Form (5B)** to identify the positive and negative aspects of continuing present risky behaviors. For participants who are prepared to act, the Counselor should follow with the skills-building, staging, goal setting, and action planning activities.

4. Skills-Building Activities to Reduce HIV Risk (15 minutes)

Once the Counselor has evaluated the participants' drug-related HIV risk, the counselor should discuss risk-reduction behaviors and demonstrate protective behaviors through simulation, for example cleaning works and safely using injection equipment.

The Counselor should provide information on safer drug-injection practices and local syringe exchange programs, where available. The **Safer Works- Steps to Cleaning Syringes Handout (5H)** found in the Appendix at the end of this section can be used as a guide to explain safer injection drug use to participants. Video clips that demonstrate how to clean ones works can be found at the Harm Reduction site: www.harmreduction.org or <http://www.anypositivechange.org/menu.html>. This site provides an excellent visual of "cleaning works" that can be used as a teaching tool to introduce and/or reinforce safer drug-injection practices.

Finally, the Counselor should provide participant with a safer injection drug use kit.

5. Determine Participant Willingness to Reduce Drug-Related HIV Risk

The Counselor should gauge the participants' willingness to take action to reduce drug-related HIV risk in order to develop an appropriate action plan. For example, after conducting an analysis of the participants' current and past risky drug-use behaviors, the Counselor may ask the participant how soon he/she wants to start reducing their drug related HIV risk. For example, ask:

- How ready are you to make changes with regard to sharing needles?

- Do you want to learn how to clean your works now? If not, when?

The participant's response is noted in the progress notes for that session and used to identify session goals and complete the **Action Plan Form (5C)** specific to the goals of this session.

6. Develop/Modify Action Plan

Based on information obtained from the evaluation of the participant's drug-use HIV risk behaviors and his/her willingness to take action, establish/verify the participant's behavior change goals as it relates to reducing drug-related HIV risk. To do this:

- Verify and write down new goals using the **Action Plan Form (5C)**.
- The MIP team will work with the participant to achieve session goals.

7. Ensure Social Support (5 minutes)

As with every session in the MIP intervention, the Counselor reinforces positive social support networks for the participant.

If the participant has identified a person who is supportive of his/her risk reduction efforts, stress benefit of having such a person.

If the participant has not identified such a person, review potential support networks with the participant and attempt to identify an individual who might serve this role. If there is no one to support the participant, suggest an MIP team member as an alternative. Do this by reaffirming MIP staff support, perhaps saying, "I want you to know that we all support you. We believe in what you are doing and know that it matters."

8. Wrap-up/Staging for Next Session (5 minutes)

In this activity, the Counselor will summarize the main benchmarks of the current session, including what was discussed and the planned action steps.

- Inform the participant that he/she has successfully completed the "Reducing Drug-Related HIV Risk" Session and will be deciding on the focus of next session for MIP.
- Provide the participant with a list of remaining session topics;
- Ask the participant which topic he/she is ready to work on and document in your progress notes.
- Give the participant the **Behavioral Change Self Assessment Form (5D)** and ask him/her to identify the stage where he/she is now. The Counselor reads the staging options for the chosen session to the participant and documents his/her responses. This information allows you (the Counselor) to determine and prepare for the next structured session. Record the participant's responses on the **MIP Self Assessment and Staging Form (5E)**.
- Thank the participant for his/her time and reinforce the fact that he/she has taken positive steps toward protecting his or her health.
- Give the appropriate incentive for participating in this session.
- Give them an appointment card with the time and place of the next session.

9. Follow-Up Case Management

After concluding the counseling session, accompany the participant to the Case Manager/Community Educator to initiate case management services. The Counselor shares the **Action Plan Form (5C)** with the Case Manager/Community Educator so that appropriate referrals to health, support and other human services can be made.

Additionally, the Case Manager/Community Educator should:

- Address participant health and social service needs.
- Offer a referral for HIV/STI testing and counseling services. Offer referrals for TB and viral hepatitis screening and vaccination.
- Make appropriate referrals for services the implementing organization cannot provide. A **Case Management Referral Form (5F)** is included in the session appendix.
- Follow-up on participant when possible and appropriate and escort participant to referred agencies.
- Ensure that participants have transportation and access to services.
- Provide bus or subway tokens, if available and necessary.

10. Complete Documentation Forms

Check for accuracy on the required forms in this session. In addition complete the **MIP Self Assessment and Staging Form (5E)**, indicating both the participant's perception of their stage of change and the Counselor's perception of the participant's stage of change.

Document session milestones in **Progress Notes (5G)**, including changes in participant's stage of change, MIP team perspectives, attended appointments, and any materials, incentives, and so forth given to the participant.

11. Discuss Session Benchmarks with the MIP Team

The MIP team meets to discuss the intervention plan for the participant. Information is shared about the participant's goals for behavior change and his/her health and human service needs to ensure a comprehensive and seamless approach to providing services.

Ensure that MIP team members have access to participant intake data, behavioral risk data, and case management action plans.

SESSION V FORMS:

- A. Injection Drugs Orientation Guide
- B. Decisional Balance Form
- C. Action Plan Form
- D. Behavioral Change Self-Assessment
- E. MIP Self-Assessment and Staging Form
- F. Sample Case Management Referral Form
- G. Progress Notes
- H. Safer Works- Steps to Cleaning Syringes - Handout

DRAFT

STRUCTURED SESSION 5A

Injection Drugs Orientation Guide

Note: This form is to be used by the Counselor and the participant to explore drug-related HIV risk behaviors and to analyze the strategies and techniques used to reduce risk behaviors.

Risk Behavior	Modes of Infection	Prevention or Risk Reduction
1. Sharing needles or injection equipment.	1. Needles and injection equipment are contaminated with HIV-infected blood.	<ul style="list-style-type: none"> -Use new needles each time you inject drugs. -Carry your own syringe and another to share. -Clean equipment with chlorine and water. -Do not lend equipment; do not use another person's equipment. -Do not share syringes. -Verify that the syringe has the tip covered. -Participate in a needle exchange program.
2. Sharing cookers or spoons.	2. Cookers or spoons are contaminated with HIV-infected blood.	<ul style="list-style-type: none"> -Do not share cookers or spoons. -Clean cookers with 1part bleach & 9 parts water. -Use your own cooker. -Obtain new cookers.
3. Sharing rinsing water.	3. Water contaminated with HIV-infected blood.	<ul style="list-style-type: none"> -Do not share rinsing water. -Use clean water each time you clean equipment. -Throw away rinsing water after using it. -Do not collect water from the street, with your hands, or in dirty or moldy containers.
4. Re-using and/or sharing cotton	4. Cotton contaminated with HIV-infected blood.	<ul style="list-style-type: none"> -Do not share cotton. -Do not re-use cotton. -Use new, clean cotton each time you inject. -Do not make balls with threads of dirty clothing.
5. Consequences of contributing in the purchase and use of drugs also known as "pooling money for drugs"; frontloading or back loading	5. Injection equipment contaminated with HIV-infected blood.	<ul style="list-style-type: none"> -Use a new syringe to measure diluted drug. -Cooker should be new or clean. -Each participant has a new (preferable) or clean syringe. -Use new cotton. -Order of participation: those with new syringes go first, those with clean syringes go next, and those with used syringes go last.
6. Using equipment found in a garbage can or on the street.	6. Equipment contaminated with HIV-infected blood.	<ul style="list-style-type: none"> -Do not pick up equipment from garbage cans or from the street. -If it is to be used, clean it with chlorine and water before using it.

STRUCTURED SESSION 5B Decisional Balance Strategies

Note: Decisional Balance is a strategy to use for participants in the pre-contemplation/ contemplation stages. The following are the procedures for completing the Decisional Balance Strategy:

1. Place an action-oriented goal at the top of the blank Decisional Balance Strategy Chart.
2. Ask the participant to tell you the cons (reasons for not changing a behavior) of making the behavior change.
3. When he/she has completed the list of cons, ask him/her to tell you the pros (reasons for changing a behavior) of making a behavior change.
4. When the participant has listed all the possible pros and cons, explain that not all reasons carry the same weight. For example, even if he/she has a long list of cons, the reasons on the list may be less significant than the reasons on a shorter list of pros.

This is an example of using Decisional Balance to assess participant interest in reducing risky drug- use behavior.

Sample Decisional Balance Strategies Reduce Drug Use and Risky Drug-Use Behaviors	
Pros	Cons
I could get HIV or viral hepatitis if I do not end risky drug-use behaviors	My girl/boyfirend shoots up with me.
My family will respect me more if I use drugs less.	I could loose credibility with my peers.
I can avoid overdosing.	I can overdose
I will protect my partner and children from HIV and viral hepatitis.	I'm addicted – when I need drugs I need them immediately; I don't have time to think about clean needles.
I can save money because I won't have to use drugs as often.	I have to worry about finding clean needles.
I won't need drugs all the time.	I'll lose my contacts and won't be able to get drugs when I need them.

Decisional Balance Form

Problem Statement	
Pros "Benefits"	Cons "Consequences"
DRAFT	

STRUCTURED SESSION 5C ACTION PLAN FORM

Once the participant decides to begin a session, the Counselor inquires about critical problems the participant faces and his/her reasons for deciding to change behaviors that affect those problems. Together, the Counselor and participant develop goals and objectives to address these issues. This action plan documents the steps the participant agrees to take to change those behaviors he/she has identified as being most critical and for which he/she is most likely to have the support of significant others within his/her social network.

<input type="checkbox"/> Induction Session	<input type="checkbox"/> Reducing Drug-Related HIV Risk
<input type="checkbox"/> Taking Care of Your Health	<input type="checkbox"/> Reducing Sex-Related HIV Risk
<input type="checkbox"/> Readiness for Entering Drug Treatment	<input type="checkbox"/> Booster
<input type="checkbox"/> Relapse Prevention	<input type="checkbox"/> Other

Problem: _____

Goal: _____

Objectives: _____

Interventions/Activities: _____

--	--	--

Participant Name

Participant Signature

Date

--	--	--

Counselor Name

Counselor Signature

Date

STRUCTURED SESSION 5D
Behavior Change Self-Assessment Form

The purpose of this form is to learn how you presently perceive your primary health, drug (detox) treatment, sexual risk reduction and drug-related risk reduction needs. Read from the bottom to the top for each category and select the statement that you most agree with.

HIV RISK

Health Services	Drug Treatment	Sexual Conduct	Drug Injection Conduct
I have been taking care of my health for over six (6) months.	I have been without using drugs over six (6) months.	It has been more than six (6) months that when I have sexual relations I project myself against HIV.	It has been more than six (6) months that when I inject drugs, I avoid getting infected with HIV.
I am presently taking care of my health.	I am presently in treatment (detox or outpatient).	I presently protect myself against HIV when I have sexual relations.	I presently protect myself against HIV when I inject
Next month, I am planning to see a doctor.	I am planning to request detox admission very soon (next month).	Very soon (next month), I am thinking about making safe decisions regarding my sexual behavior to avoid getting infected with HIV.	Maybe I should be more careful when I inject to avoid getting infected with HIV.
Maybe I should see a doctor.	Maybe my drug use is a problem and I should seek treatment (detox).	Maybe I should be more careful with my sexual activities to avoid getting infected with HIV.	Very soon (next month) I am planning to inject drugs in a safer way to avoid getting infected with HIV
I do not have any health problems that I need to take care of.	My drug use is not a problem.	My sexual practices do not place me at risk of HIV infection.	When I inject drugs, it doesn't concern me that I might get infected with HIV.

STRUCTURED SESSION 5E
MIP SELF ASSESSMENT & STAGING FORM

This form is to be used by the Counselor to record the Participant's stage of change

Participant		Date	
Staff		Location	
Session No		Contact No	
<input type="checkbox"/> Face to Face	<input type="checkbox"/> Telephone Contact	<input type="checkbox"/> Session Completed	*Dosage_____
<input type="checkbox"/> Safer Sex Kits	<input type="checkbox"/> Bleach Kits	<input type="checkbox"/> Incentive	<input type="checkbox"/> Referral

TAKING CARE OF YOUR HEALTH

Role Induction		Decisional Balance			
Affirmations		Information/Options			
Reflective Listening		Goal Setting			
Support Self-Efficacy		Action Plan			
Stage	Pre	Contemplation	Preparation	Action	Maintenance
Staff	1	2	3	4	5
Participant	1	2	3	4	5

PREPARING TO ENTER DRUG TREATMENT

Role Induction		Decisional Balance			
Affirmations		Information/Options			
Reflective Listening		Goal Setting			
Support Self-Efficacy		Action Plan			
Stage	Pre	Contemplation	Preparation	Action	Maintenance
Staff	1	2	3	4	5
Participant	1	2	3	4	5

REDUCING DRUG-RELATED HIV RISK

Role Induction		Decisional Balance			
Affirmations		Information/Options			
Reflective Listening		Goal Setting			
Support Self-Efficacy		Action Plan			
Stage	Pre	Contemplation	Preparation	Action	Maintenance
Staff	1	2	3	4	5
Participant	1	2	3	4	5

REDUCING SEX-RELATED HIV RISK

Role Induction		Decisional Balance			
Affirmations		Information/Options			
Reflective Listening		Goal Setting			
Support Self-Efficacy		Action Plan			
Stage	Pre	Contemplation	Preparation	Action	Maintenance
Staff	1	2	3	4	5
Participant	1	2	3	4	5

**STRUCTURED SESSION 5F
CASE MANAGEMENT REFERRAL FORM**

The objective of this session is for the participant to accept and continue participating in the intervention and in utilizing case management services.

PARTICIPANT'S FULL NAME: _____ PHONE #: _____

PARTICIPANT'S ADDRESS: _____

D.O.B.: _____

Age: _____

REFERRED TO: _____ TO SEE: _____

ADDRESS: _____

DATE OF APPOINTMENT: _____ TIME: _____

REASON FOR REFERRAL:

- | | |
|--|--|
| <input type="checkbox"/> Mental Health Services | <input type="checkbox"/> Primary Health Services |
| <input type="checkbox"/> Opiate Addiction/Abuse | <input type="checkbox"/> Parenting Skills Program |
| <input type="checkbox"/> Cocaine Addiction/Abuse | <input type="checkbox"/> Domestic Violence/ Anger Management |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Food Voucher |
| <input type="checkbox"/> Poly-Substance Abuse | <input type="checkbox"/> Counseling |
| <input type="checkbox"/> Rental/Housing Assistance | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Utility Assistance | <input type="checkbox"/> Other |
| <input type="checkbox"/> Family Planning | |

COMMENTS: _____

IF YOU HAVE ANY QUESTIONS, YOU MAY CONTACT ME AT: _____

SINCERELY,

Counselor/Case Manager

Date

**STRUCTURED SESSION 5G
PROGRESS NOTES**

		Case Manager Notes	Counselor Notes
DATE:	END TIME:		
	START TIME:		
DATE:	END TIME:	_____ Signature of MIP Team Member	_____ Signature of MIP Team Member
	START TIME:		
DATE:	END TIME:	_____ Signature of MIP Team Member	_____ Signature of MIP Team Member
	START TIME:		
DATE:	END TIME:	_____ Signature of MIP Team Member	_____ Signature of MIP Team Member
	START TIME:		

STRUCTURED SESSION 5H SAFER WORKS - STEPS TO CLEANING SYRINGES

These are the correct steps to cleaning syringes.

- 1 Pour water into two cups
- 2 Pour some bleach into a cup
- 3 Draw water into the syringe the first time
- 4 Pour out the first cup of water
- 5 Shoot water out the first time
- 6 Draw bleach into the syringe
- 7 Shoot the bleach out.
- 8 Draw water into the syringe the second time
- 9 Shoot water out the second time
- 10 Dump out bleach and final cup of water

SESSION SIX: REDUCING SEX -RELATED HIV RISK

Session 6 should be scheduled no earlier than one week and no later than two weeks following an MIP session. The Reducing Sex-Related HIV Risk Session may require more than one contact depending on the participant's individual goals and needs.

SESSION OBJECTIVES

- Increase participant readiness to reduce HIV/STI sex-related risks.
- Provide information about sex-related HIV risks.
- Strengthen participant ability to practice safer sex.
- Motivate the participant to make positive behavior changes to reduce HIV/STI sex-related risks

SUMMARY OF REDUCING SEX-RELATED HIV RISK SESSION

The goal of Session 6 is to increase the participant's knowledge and skills regarding safer sex practices. The Counselor or Case Manager/ Community Educator develop a profile of the participant's high HIV risk sex-related behaviors. He/she will discuss risk reduction practices that address those risks. The participant will be provided with a safer sex kit consisting of male and female condoms, literature on condom use, lubrication, dental dams, and so forth. The participant and the Counselor or Case Manager/ Community Educator will set new or review existing sexual risk reduction goals and build skills to accomplish these goals.

SESSION TIME: 45 - 60 minutes

Note: The time required to complete Session 6 will vary according to participant needs.

SESSION ACTIVITIES

	Activity	Responsible Party
1.	Introduction (5 minutes)	Counselor
2	Role Induction (10 minutes)	Counselor
3.	Assess Participant Knowledge & Experience with Reducing Sex-Related HIV Risk (15 minutes)	Counselor
4	Safer-Sex Skills-Building Activities to Reduce HIV Risk (15 minutes)	Counselor

5.	Determine Participant Willingness to Reduce Sex-Related HIV Risk (5 minutes)	Counselor
6.	Develop/Modify Action Plan (5 minutes)	Counselor
7.	Ensure Social Support (5 minutes)	Counselor
8.	Summary/Staging for Next Session (5 minutes)	Counselor
9.	Follow-Up Case Management	Case Manager/ Community Educator and Counselor
10.	Complete Documentation Forms	Team
11.	Discuss Session Benchmarks with the MIP Team	Team

MATERIALS/RESOURCES NEEDED (See Session Appendix for referenced forms):

NAME	FORM in SESSION APPENDIX
Completed MIP Intake Form (1C), Behavioral Risk Assessment Form(1D) (for review)	From Induction Session (Session 1)
Sexual Activity Orientation Guide	Form 6A
Decisional Balance Form	Form 6B
Using Condoms Handout	Form 6C
Action Plan Form	Form 6D
Behavioral Change Self-Assessment	Form 6E
MIP Self-Assessment and Staging Form	Form 6F
Case Management Referral Form	Form 6G
Progress Notes	Form 6H
HIV/STI, TB, and viral hepatitis counseling and testing resource guide	Local Resource
Local HIV/AIDS and social service resource list for referrals	Local Resources
Safer Sex kits (male and female condoms, lubrication, safer sex brochure, dental dams, and so forth)	
Incentives	

SESSION LOCATION:

Due to the sensitive and personal nature of the questions asked during this session, Session 5 must be conducted in a private, enclosed room, where confidentiality can be assured and interruptions avoided.

Case Management services can take place at community venues, project community sites, treatment programs, or any other place with a favorable environment for the intervention

PREPARATION

- The following forms from the Induction Session need to be fully completed before initiating this session: the **MIP Intake Form (1C)**, and the **Behavioral Risk Assessment Form (1D)**.
- Staff members should review and be familiar with the **Sexual Activity Orientation Guide (6A)** and the **Using Condoms Handout (6C)**.
- Become familiar with the resource guides, the referral processes, and the contents in the safer sex and needle hygiene kits.
- Be prepared to provide on-site HIV/STI, TB, and viral hepatitis testing or to make an appropriate referral if the participant desires to be tested.

STEP-BY-STEP PROCEDURES

1. Introduction (5 minutes)

At the beginning of the session, greet and introduce yourself to the participant if you have not met before, and establish rapport by making conversation with the participant. Make sure to give the participant your full attention.

2. Role Induction (10 minutes)

Review the roles and responsibilities of the MIP team members and those of the participant to ensure that the participant knows what the MIP program expects from him/her.

The goal of Session 6- Reducing Sex-Related HIV Risk- is to help the participant initiate safer sexual practices. These behavioral changes include putting on a male and/or female condom, negotiating safer sex, practicing lower risk sexual activities, and learning about sex-related risks for acquiring or transmitting HIV and viral hepatitis.

In this session, the Counselor or Case Manager/ Community Educator develop a profile of the participant's high HIV risk sex-related behaviors and discuss risk reduction practices that address those risks. If there is ambivalence about changing high risk sexual practices the Counselor and participant, by means of Decisional Balance, discuss the positive and negative aspects of continuing with high risk sexual behaviors, and the pros and cons of changing these practices.

The participant is provided with a safer sex kit consisting of male and female condoms, literature on condom use, lubrication, dental dams, and so forth. The participant and the Counselor or Case Manager/ Community Educator set new sexual risk reduction goals and build skills to accomplish these goals. The participant is then accompanied to the Case Manager/Community Educator for case management services.

3. Assess Participant Knowledge and Experience with Reducing Sex-Related HIV Risk (15 minutes)

The Counselor provides information about sex-related HIV risk and explores the participant's sex-related HIV risk behaviors. If the participant has limited experience with safer sex practices, the Counselor strongly encourages the participant to learn about sex-related HIV risk reduction strategies.

Using the **Sexual Activity Orientation Guide (6A)** the Counselor or Case Manager/Community Educator and the participant discuss the participant's sex-related HIV risk behaviors and propose safer-sex risk reduction strategies.

The Counselor provides feedback about the participants' past or current sex-related HIV risk behaviors.

If the participant is ambivalent about changing high risk sex behaviors, the Counselor should complete the **Decisional Balance Form (6B)** to identify the positive and negative aspects of continuing present risky behaviors. For participants who are prepared to act, the Counselor should follow with the skills-building, staging, goal setting, and action planning activities.

4. Safer-Sex Skills Building (15 minutes)

Once the Counselor has evaluated the participant's sex-related HIV risk, the counselor should discuss risk-reduction behaviors and demonstrate protective behaviors through simulations. The Counselor should then ask the participant to do the same. For example, practice correct use of male and/or female condoms, negotiating condom use, using dental dams, and so forth. The Counselor should provide the participant with a safer sex kit and use the **Using Condoms Handout (6C)** to ensure that a participants' correct use of condoms.

5. Determine Participant Willingness to Reduce Sex-Related HIV Risk (5 minutes)

The Counselor should gauge the participants' willingness to take action to reduce sex-related HIV risk in order to develop an appropriate action plan.

For example, after conducting an analysis of the participants' current and past sexual risk-taking behaviors, the Counselor may ask the participant how soon he/she wants to start practicing safer sex. For example, you may ask:

- Are you ready to learn how to use a female condom?
- When will you be ready to show me how to correctly put on a condom?
- Are you ready now to role-play safer-sex negotiation? If not, when?

The participants' response is noted in the progress notes for that session and used to identify session goals and develop the Action Plan specific to the goals of that session.

6. Develop/Modify Action Plan (5minutes)

Based on information obtained from the evaluation of the participant's sex-related HIV risk behaviors and his/her willingness to take action, establish/verify the participant's behavior change goals as it relates to reducing sex-related HIV risk. To do this:

- Verify and write down new goals using the **Action Plan Form (6D)**.
- The MIP team will work with the participant to achieve session goals.

7. Ensure Social Support (5 minutes)

As with every session in the MIP intervention, the Counselor reinforces positive social support networks for the participant.

If the participant has identified a person who is supportive of his/her risk reduction efforts, stress benefit of having such a person.

If the participant has not identified such a person, review potential support networks with the participant and attempt to identify an individual who might serve this role. If there is no one to support the participant, suggest an MIP team member as an alternative. Do this by reaffirming MIP staff support, perhaps saying, "I want you to know that we all support you. We believe in what you are doing and know that it matters."

8. Wrap-up/Staging for Next Session (5 minutes)

Summarize the main benchmarks of the current session, including what was discussed and the planned action steps and inform the participant that he/she has successfully completed this session and will be deciding on the focus of next session for MIP.

- Provide the participant with a list of remaining session topics. The Counselor should only list the structured session topics that the participant has not yet completed;
- Ask the participant which topic he/she is ready to work on and document in your progress notes. Discuss the participant's selection closest to action to
- Give the participant the **Behavioral Change Self Assessment Form (6E)** and ask him/her to identify the stage where he/she is now. If necessary, the Counselor reads the staging options to the participant and documents his/her responses. Both discuss the stage closest to action--an indication of the participant's readiness to make changes. This information allows you (the Counselor) to determine and prepare for the next structured session. Record the participant's responses on the **MIP Self Assessment and Staging (6F)**.
- Thank the participant for his/her time and reinforce the fact that he/she has taken positive steps toward protecting his or her health.
- Give the appropriate incentive for participating in this session and an appointment card with the time and place of the next session.

9. Follow-Up Case Management

After concluding the counseling session, accompany the participant to the Case Manager/Community Educator to initiate case management services. The Counselor shares the **Action Plan Form (6D)** with the Case Manager/Community Educator so that appropriate referrals to health, support and other human services can be made

At each case management session, the Case Manager/Community Educator should assess the participant's satisfaction with MIP and address any issues that could hinder participant retention.

Additionally, the Case Manager/Community Educator should:

- Address participant health and social service needs.
- Make appropriate referrals for services the implementing organization cannot provide. A **Case Management Referral Form (6G)** is included in the session appendix.

- Follow-up with participant on referrals and when possible and appropriate, escort participant to referred agencies.
- Assess the participant's transportation needs to access services and their next MIP appointment, and provide bus or subway tokens, if available.

10. Complete Documentation Forms

Check for accuracy on all required forms in this session. In addition complete the **MIP Self Assessment and Staging Form (6F)**, indicating both the participants perception of their stage of change and the Counselors perception of the participant's stage of change.

Document session milestones in progress notes, including changes in participant's stage of change, MIP team perspectives, attended appointments, and any materials, incentives, and so forth given to the participant.

11. Discuss Session Benchmarks with the MIP Team

The MIP team meets to discuss the intervention plan for the participant. Information is shared about the participant's goals for behavior change and his/her health and human service needs to ensure a comprehensive and seamless approach to providing services.

Ensure that MIP team members have access to all MIP documentation.

SESSION VI FORMS:

- A. Sexual Activity Orientation Guide
- B. Decisional Balance Form
- C. Using Condoms Handout
- D. Action Plan Form
- E. Behavioral Change Self-Assessment
- F. Self-Assessment/Staging Form
- G. Sample Case Management Referral Form
- H. Progress Notes

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STRUCTURED SESSION 6A Sexual Activity Orientation Guide

This form is used by the counselor to explore with the participant the HIV risk behaviors related to sexual activity and the strategies and techniques that can be used to reduce risk taking or re-infection.

Risk Behavior	Modes of Infection	Prevention or Risk Reduction
<p>Multiple sexual partners.</p> <p>To have sexual relations without protection.</p> <p>Use condom incorrectly.</p> <p>To have sexual relations with men who have sex with men without protection.</p> <p>To have sexual relations with women who have sex with women without protection.</p> <p>To have sexual relations HIV+ partners.</p> <p>To have unprotected sex in exchange for money or drugs.</p> <p>To have unprotected sexual relations with an injection drug user.</p> <p>To have unprotected sexual relations under the effects of drugs.</p>	<p>Body fluid exchange (blood, semen, vaginal secretions, and maternal milk) from an HIV infected person to another person.</p>	<p>Practice safer sex measures:</p> <p>Correct condom use: never use petroleum based oils or jelly; correct placement.</p> <p>If you practice oral sex, use condom without lubrication or spermicide.</p> <p>For vaginal/anal sex use latex condoms with lubricant.</p> <p>Avoid using two condoms at the same time.</p> <p>Reduce the number of sexual partners.</p> <p>Know the partner's HIV <i>status</i>.</p> <p>Orient and/or request your partner to have a HIV test.</p> <p>Always have condoms available that are in good condition and check the expiration date.</p> <p>Never have sex without protection.</p> <p>Avoid body fluid exchange with HIV infected persons.</p> <p>Utilize low risk techniques: Mutual Masturbation, Rubbing genitalia with protection, and Dry kisses.</p> <p>Use other protection barriers as dental dams or plastic wrap (not microwave type).</p>

STRUCTURED SESSION 6B DECISIONAL BALANCE

Note: Decisional Balance is a strategy to use for participants in the pre-contemplation/ contemplation stages. The following are the procedures for completing the Decisional Balance Strategy:

1. Place an action-oriented goal at the top of the blank Decisional Balance Strategy Chart.
2. Ask the participant to tell you the cons (reasons for not changing a behavior) of making the behavior change.
3. When he/she has completed the list of cons, ask him/her to tell you the pros (reasons for changing a behavior) of making a behavior change.
4. When the participant has listed all the possible pros and cons, explain that not all reasons carry the same weight. For example, even if he/she has a long list cons, the reasons on the list may be less significant than the reasons on a shorter list of pros.

This is an example of using Decisional Balance to assess participant interest in reducing risky drug- use behavior.

SAMPLE DECISIONAL BALANCE FORM FOR SEXUAL RISK BEHAVIORS

Sample Decisional Balance Strategies Begin Practicing Safer Sex	
PROS	CONS
I don't have to worry about getting infected with HIV/STIs and viral hepatitis.	I like to have sex with lots of different people.
I don't have to worry about infecting someone I care about.	My partner will think I do not trust him/her.
I can have a close relationship without the fear of HIV.	Condoms take the excitement out of sex.
I am told that there are ways of having good sex and still using a condom.	I like having sex without condoms.
Some of my friends will respect my decision.	Some of my friends will think I am stupid.

Decisional Balance Form

Problem Statement	
Pros "Benefits"	Cons "Consequences"
DRAFT	

STRUCTURED SESSION 6C USING CONDOMS

- Distribute Condom Demonstration Kits
- **Condom Exploration**
 1. Distribute condom packets and lubricant.
 2. Encourage the participant to become familiar with the condoms and the lubricant by stretching them, blowing them up, and so forth to see how strong the condoms are and to reduce discomfort.
 3. Explain that even before ejaculating, the penis releases small amounts of fluid that can contain sperm and HIV. Therefore, males must wear a latex condom from the beginning to the end of your sexual contact.
 4. Inform the participant that when using condoms, there are several easy steps to remember. These steps are listed below.

How to Put a Condom On:

- Step 1:** Talk to your partner about using a condom.
- Step 2:** Buy condoms, check expiration date and check condoms for damage to packaging.
- Step 3:** Man becomes hard.
- Step 4:** Open package carefully. **(DO NOT USE YOUR TEETH TO OPEN THE CONDOM PACKAGE)**
- Step 5:** Add lubricant to condom if necessary
- Step 6:** Pinch tip of condom to remove air (pinch an inch and twist)
- Step 7:** Unroll condom down to base of penis.
- Step 8:** Have sexual intercourse and man ejaculates.
- Step 9:** Male holds the base of the condom as he pulls out to keep the condom from slipping off.
- Step 10:** Remove the condom carefully to keep contents from spilling.
- Step 11:** Throw the used condom away **(NEVER USE A CONDOM TWICE)**

CONDOM DEMONSTRATION GUIDE

1. Explain the steps for using a condom.
2. As you explain the steps, encourage participants to ask questions.
3. Talk about the different kinds of condoms and what to look for on the packaging.
4. Open up a few different types of condoms, and let participants examine the reservoir tip, the difference between lubricated and non-lubricated, and so forth.
5. Explain that latex condoms are the only kind of condoms that prevent HIV infection.
6. Explain that some condoms are lubricated with spermicide to provide an extra layer of protection against pregnancy.
7. Specify not to buy condoms with non-oxynonol-9 lubricant.
8. Use a phallic proxy to demonstrate condom use.
9. Tell participants to be careful opening the package; fingernails can tear condoms.
10. Allow participants to touch the condoms without inhibitions and demonstrate how big and strong condoms are. Stretch out the condom by pulling it gently, but firmly, at both ends like you would prior to blowing up a balloon. Have people stretch the condom over different body parts (e.g., head, arm, foot, and leg). Whoever succeeds in stretching the condom over the largest area without popping it, wins an extra incentive.
11. Next, blow up a condom and tie it off.
12. Rub Vaseline on one spot. After about three minutes, the condom will break.
13. Inform women participants of the importance of using a water-based lubricant, like K-Y Jelly.
14. Unroll a condom using the proxy, making sure it is unrolling the right way.
To UNROLL THE CONDOM:
 - Pinch the tip of the condom, leaving enough space at the tip of the condom for semen.
 - While pinching the tip, unroll the condom all the way down to the base of the phallic proxy.
 - Smooth out any air bubbles that may be trapped inside.
 - Add more lubricant.
 - Remove the condom. Emphasize that: After having sex, it is essential to pull away gently while holding the base of the condom so that it does not slip off; Do not to spill contents when taking the condom off; Always throw away used condoms.
15. Allow participants to practice putting on and taking off condoms using their phallic proxies.
16. Give participants some female condoms and explain how to use them. Many sex workers have found that male clients are more willing to have sex using a female condom instead of a male condom.

Warnings:

**DO NOT USE CONDOMS THAT CONTAIN NON-OXYNOL- 9!
THIS CAN ACT AS AN IRRITANT IN THE VAGINA OR THE ANUS AND CAN CAUSE CUTS IN THE
MEMBRANES, THUS ALLOWING HIV TO ENTER INTO THE BLOODSTREAM.**

Latex Condoms should not be used by people who are allergic to them because it can cause the same type of irritation as non-oxynol-9 condoms.

NEVER USE THE SAME CONDOM TWICE!

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STRUCTURED SESSION 6D ACTION PLAN FORM

Once the participant decides to begin a session, the Counselor inquires about critical problems the participant faces and his/her reasons for deciding to change behaviors that affect those problems. Together, the Counselor and participant develop goals and objectives to address these issues. This action plan documents the steps the participant agrees to take to change those behaviors he/she has identified as being most critical and for which he/she is most likely to have the support of significant others within his/her social network.

<input type="checkbox"/> Induction Session	<input type="checkbox"/> Reducing Drug-Related HIV Risk
<input type="checkbox"/> Taking Care of Your Health	<input type="checkbox"/> Reducing Sex-Related HIV Risk
<input type="checkbox"/> Readiness for Entering Drug Treatment	<input type="checkbox"/> Booster
<input type="checkbox"/> Relapse Prevention	<input type="checkbox"/> Other

Problem: _____

Goal: _____

Objectives: _____

Interventions/Activities: _____

--	--	--

Participant Name

Participant Signature

Date

--	--	--

Counselor Name

Counselor Signature

Date

STRUCTURED SESSION 6E
Behavior Change Self-Assessment Form

The purpose of this form is to learn how you presently perceive your primary health, drug (detox) treatment, sexual risk reduction and drug-related risk reduction needs. Read from the bottom to the top for each category and select the statement that you most agree with.

HIV RISK

Health Services	Drug Treatment	Sexual Conduct	Drug Injection Conduct
I have been taking care of my health for over six (6) months.	I have been without using drugs over six (6) months.	It has been more than six (6) months that when I have sexual relations I project myself against HIV.	It has been more than six (6) months that when I inject drugs, I avoid getting infected with HIV.
I am presently taking care of my health.	I am presently in treatment (detox or outpatient).	I presently protect myself against HIV when I have sexual relations.	I presently protect myself against HIV when I inject
Next month, I am planning to see a doctor.	I am planning to request detox admission very soon (next month).	Very soon (next month), I am thinking about making safe decisions regarding my sexual behavior to avoid getting infected with HIV.	Maybe I should be more careful when I inject to avoid getting infected with HIV.
Maybe I should see a doctor.	Maybe my drug use is a problem and I should seek treatment (detox).	Maybe I should be more careful with my sexual activities to avoid getting infected with HIV.	Very soon (next month) I am planning to inject drugs in a safer way to avoid getting infected with HIV
I do not have any health problems that I need to take care of.	My drug use is not a problem.	My sexual practices do not place me at risk of HIV infection.	When I inject drugs, it doesn't concern me that I might get infected with HIV.

**STRUCTURED SESSION 6F
MIP SELF ASSESSMENT & STAGING FORM**

This form is to be used by the Counselor to record the Participant's stage of change

Participant		Date	
Staff		Location	
Session No		Contact No	
<input type="checkbox"/> Face to Face	<input type="checkbox"/> Telephone Contact	<input type="checkbox"/> Session Completed	*Dosage _____
<input type="checkbox"/> Safer Sex Kits	<input type="checkbox"/> Bleach Kits	<input type="checkbox"/> Incentive	<input type="checkbox"/> Referral

TAKING CARE OF YOUR HEALTH

Role Induction		Decisional Balance			
Affirmations		Information/Options			
Reflective Listening		Goal Setting			
Support Self-Efficacy		Action Plan			
Stage	Pre	Contemplation	Preparation	Action	Maintenance
Staff	1	2	3	4	5
Participant	1	2	3	4	5

PREPARING TO ENTER DRUG TREATMENT

Role Induction		Decisional Balance			
Affirmations		Information/Options			
Reflective Listening		Goal Setting			
Support Self-Efficacy		Action Plan			
Stage	Pre	Contemplation	Preparation	Action	Maintenance
Staff	1	2	3	4	5
Participant	1	2	3	4	5

REDUCING DRUG-RELATED HIV RISK

Role Induction		Decisional Balance			
Affirmations		Information/Options			
Reflective Listening		Goal Setting			
Support Self-Efficacy		Action Plan			
Stage	Pre	Contemplation	Preparation	Action	Maintenance
Staff	1	2	3	4	5
Participant	1	2	3	4	5

REDUCING SEX-RELATED HIV RISK

Role Induction		Decisional Balance			
Affirmations		Information/Options			
Reflective Listening		Goal Setting			
Support Self-Efficacy		Action Plan			
Stage	Pre	Contemplation	Preparation	Action	Maintenance
Staff	1	2	3	4	5
Participant	1	2	3	4	5

**STRUCTURED SESSION 6G
CASE MANAGEMENT REFERRAL FORM**

The objective of this session is for the participant to accept and continue participating in the intervention and in utilizing case management services.

PARTICIPANT'S FULL NAME: _____ PHONE #: _____

PARTICIPANT'S ADDRESS: _____

D.O.B.: _____ Age: _____

REFERRED TO: _____ TO SEE: _____

ADDRESS: _____

DATE OF APPOINTMENT: _____ TIME: _____

REASON FOR REFERRAL:

- | | |
|--|--|
| <input type="checkbox"/> Mental Health Services | <input type="checkbox"/> Primary Health Services |
| <input type="checkbox"/> Opiate Addiction/Abuse | <input type="checkbox"/> Parenting Skills Program |
| <input type="checkbox"/> Cocaine Addiction/Abuse | <input type="checkbox"/> Domestic Violence/ Anger Management |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Food Voucher |
| <input type="checkbox"/> Poly-Substance Abuse | <input type="checkbox"/> Counseling |
| <input type="checkbox"/> Rental/Housing Assistance | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Utility Assistance | <input type="checkbox"/> Other |
| <input type="checkbox"/> Family Planning | |

COMMENTS: _____

IF YOU HAVE ANY QUESTIONS, YOU MAY CONTACT ME AT: _____
SINCERELY,

Counselor/Case Manager

Date

**STRUCTURED SESSION 6H
PROGRESS NOTES**

		Case Manager Notes	Counselor Notes
DATE:	END TIME:		
	START TIME:		
DATE:	END TIME:	_____ Signature of MIP Team Member	_____ Signature of MIP Team Member
	START TIME:		
DATE:	END TIME:	_____ Signature of MIP Team Member	_____ Signature of MIP Team Member
	START TIME:		
DATE:	END TIME:	_____ Signature of MIP Team Member	_____ Signature of MIP Team Member
	START TIME:		

SESSION SEVEN: BOOSTER

Note: The Booster Session marks the completion of the MIP Program and should be the last of the seven sessions conducted. It should be conducted no sooner than two weeks after completing the last of the six structured sessions. The Booster Session will require more than one contact in order to review and reinforce participant risk reduction accomplishments. The Booster also ensures that the participant has support systems in place to help maintain positive behavior change. The MIP staff should schedule follow-up contacts as needed.

SESSION OBJECTIVES

- Review and evaluate participant behavior change goals and accomplishments.
- Affirm positive steps taken by the participant during MIP.
- Develop a plan to maintain positive behavioral changes.
- Ensure that the participant is linked to mental health services and social support networks that encourage and sustain risk reduction efforts.

SUMMARY OF SESSION ACTIVITIES

The Booster Session marks the completion of the MIP Program and should be the last of the seven sessions conducted.

The goal of the Booster is to ensure maintenance of positive behavioral changes and skills developed during MIP. This session reviews the participant's achievements in the program, reinforces self-efficacy in risk reduction behaviors, identifies the barriers for unmet goals, and seeks possible solutions to resolve challenges.

The Booster session requires that the Counselor and Case Manager/Community Educator work together to prepare for the Booster and run the session. Both MIP team members commend the participant for adopting risk-reduction behaviors, and for accessing and utilizing case management services, including healthcare and drug treatment (if applicable).

At the conclusion of the session, the Counselor and the participant develop a continuum of care action plan to support the participant's protective behaviors (utilization of health services, utilization of drug treatment services, and safer sex and injection practices). The participant is given a copy of his/her continuum of care plan, asked about additional case management needs, and informed that he/she has successfully completed MIP.

SESSION TIME: 45 - 60 minutes, however, multiple contacts may be necessary
Note: The time required to complete Session 7 will vary according to participant needs.

SESSION ACTIVITIES

Booster Session activities follow a slightly different order than that of the other structured sessions. This is because the Booster requires the Counselor or Case Manager/Community Educator to collect post-intervention data from the participant by re-administering the **MIP Behavioral Risk Assessment (7A)**.

The MIP staff then review and compare the MIP Behavioral Risk Assessment data taken at Induction to the assessment data from the Booster. Additionally, the MIP team will review the participant's case record, case management action plans, and progress notes to capture all major accomplishments. Team members will then develop a continuum of care action plan which reflects the on-going health, social service, and support needs of the participant.

	Activity	Responsible Party
1.	Preparation for Booster Session and a continuum of care action plan (time will vary depending on the individual participants' case)	MIP team
2.	Introduction (5 minutes)	Counselor
3.	Role Induction (10 minutes)	Counselor
4.	Conduct Behavioral Risk Assessment and Booster Forms (20 minutes)	Counselor <u>and</u> Case Manager/Community Educator
5.	Summarize Participant Goals and Accomplishments in MIP (20 minutes)	Counselor <u>and</u> Case Manager/Community Educator
6.	Develop a Continuum of Care Action Plan to Sustain Behavior Change (15 minutes)	Counselor <u>and</u> Case Manager/Community Educator
7.	Ensure support and referral (5 minutes)	Counselor <u>and</u> Case Manager/Community Educator
8.	Next Steps/Closing the Counseling Session (5 minutes)	Counselor <u>and</u> Case Manager/Community Educator
9.	Follow-Up Case Management Contact	Case Manager/Community Educator
10.	Complete Documentation Forms	Team
11.	Discussion and case closeout with the MIP Team	Team

MATERIALS/RESOURCES NEEDED: (Forms can be found in the session appendix)

NAME	FORM in SESSION APPENDIX
Completed Intake Form, Behavioral Risk Assessment, and Action Plan forms (for review)	From Induction and structured sessions (Session 1-6)
Behavioral Risk Assessment	Form 7A
Booster Development Guide	Form 7B
Continuum of Care Action Plan Form	Form 7C
Case Management Referral Form	Form 7D
Progress Notes	Form 7E
Local HIV/AIDS and social service resource list for referrals	Local Resources
HIV/STI, TB, and viral hepatitis counseling and testing resource guide	Local Resources
Incentives	

SESSION LOCATION:

Due to the sensitive and personal nature of the questions asked during this session, the Booster Session must be conducted in a private, enclosed room, where confidentiality can be assured and interruptions avoided.

Case Management services can take place at community venues, project community sites, treatment programs, or any other place with a favorable environment for the intervention.

MIP TEAM MEMBER:

The Counselor and Case Manager/Community Educator deliver this session. It is recommended that both staff members participate in the preparation and implementation of the Booster Session since counseling data as well as case management information will be required to summarize accomplishments and develop a continuum of care action plan for the participant.

If the Counselor and Case Manager/Community Educator cannot both be present for the Booster session, as with the other sessions, the Counselor conducts most of the activities outlined in the structured session; however, the Case Manager/Community Educator must provide detailed information to the Counselor on services accessed or pending. A follow-up case management episode may also be necessary.

STEP-BY-STEP PROCEDURES

1. Preparation for Booster

It is highly recommended that the MIP team work together to prepare for the Booster Session and that the Counselor and Case Manager/Community Educator conduct the Booster session together. This provides dual support and closure for the participant.

- Become familiar with the **Booster Development Guide (7B)**.
- Review the participant's utilization of case management services, including access to drug treatment.

- Be prepared to provide on-site HIV/STI, TB, and viral hepatitis testing or to make an appropriate referral if the participant desires to be tested

In preparation for the session, the Counselor and Case Manager/Community Educator should meet to review the participant's file. Documents for review include:

- MIP Behavioral Risk Assessment (From Induction)
- Action Plan Forms
- Case Management Referral Forms
- Self-Assessment and Staging Forms
- Progress Notes
- Continuum of Care Action Plan Form

Based on the document review, the Counselor and Case Manager/Community Educator should:

- Summarize the participant's accomplishments in MIP.
- Identify the participant's current and past stage of change for each risk behavior addressed.
- Summarize case management services accessed by the participant.
- Identify gaps that require additional counseling and/or case management services.
- Document accomplishments, gaps, and additional participant needs in order to facilitate the Booster session and develop an appropriate continuum of care action plan.

2. Introduction (5 minutes)

Greet the participant and establish rapport by making conversation with the participant. Give the participant your full attention.

3. Role Induction (10 minutes)

Review the roles and responsibilities of the MIP team members and those of the participant to ensure that the participant knows what to expect from this session

Inform the participant that he/she has officially completed six of the seven MIP sessions and that this session- the Booster- is the final session in MIP. Explain that the purpose of the session is to review the goals and accomplishments from previous structured session sand establish any areas that need further improvement.

Explain that during this contact, you will need to administer the **Behavioral Risk Assessment Form (7A)** once again to get a sense of what has been accomplished thus far and of how you can support positive behavior maintenance.

Inform the participant that you will summarize his/her goals and accomplishments, identify gaps, and work with him/her to develop a Continuum of Care Action Plan Form that sustains positive behavior change.

Clarify that although this is the final contact for the MIP Intervention, he/she can contact any MIP team member for additional counseling, case management, and support services, as needed.

4. Administer the MIP Behavioral Risk Assessment (20 minutes)

The **Behavioral Risk Assessment Form (7A)** is to be administered by the Counselor. The Counselor obtains updated and current information on participant demographics, social and family networks, mental health, and physical health, including experience with drug treatment services. Information about current substance use and sexual behaviors is also collected. The Counselor then asks the participant about the case management services he/she has utilized as part of the MIP Intervention in **Section G** of the **Behavioral Risk Assessment Form (7A)**.

The Counselor and Case Manager/Community Educator should both be involved in the review of the Behavioral Risk Assessment Forms (at Induction, and again, during the Booster). Positive behavior changes should be noted, as well as outstanding goals that still need to be accomplished.

While the Counselor and Case Manager/Community Educator work, the team should ensure that the participant is remains occupied by offering a meal, or another incentive.

5. Summarize Participant Goals, Accomplishments in MIP (20 minutes)

Using the **Booster Development Guide (7B)** the Counselor, participant and Case Manager/Community Educator review the goals that were developed during the intervention. They validate the participant's achievements in reaching or working toward reaching those goals.

MIP team members and the participant summarize the issues discussed within each structured session and use affirmations to support the participants' successes in achieving his/her goals for each structured session. MIP team members highlight the benefits of the intervention and encourage the participant to continue making positive changes.

If appropriate, MIP team members should commend positive behavior changes that were not identified as goals, but which were observed during the intervention.

Team members also discuss any new or unmet goals with the participant and recommend strategies to achieve those goals in the Continuum of Care Action Plan Form.

6. Develop a Continuum of Care Action Plan to Sustain Behavior Change (15 minutes)

The MIP team asks the participant to work out an action plan to help maintain the behavioral changes made in MIP and to achieve unmet goals identified during the review of accomplishments.

MIP team members, working with the participant, should complete the **Continuum of Care Action Plan Form (7C)**. The participant identifies all the challenges he/she feels will face in maintaining behavioral changes.

If it appears useful, the Counselor or Case Manager/Community Educator should return to the relapse prevention session, reviewing triggers and identifying support systems.

7. Ensure Social Support and Referral (5 minutes)

Explore the participant's social support options.

If the participant has no one to support him/her, link the participant to counseling services or support groups.

8. Closing the Counseling Session (5 minutes)

The commitment to a Continuum of Care Action Plan Form completes the MIP cycle. Inform the participant that you would like to follow-up with him/her in 3 months to see how he/she is doing. Put a note in the participant file to contact him/her and ask about HIV test results and reduction of risk behaviors.

Say good-bye to participant and tell him/her to stop by whenever he/she feels it is necessary or wishes to see you. Wish the participant good luck, and praise the participant for taking positive steps toward protecting his/her health.

Give the participant a copy of his/her Continuum of Care Action Plan and provide an incentive for participating in this session.

9. Follow-Up Case Management Contact

As a follow-up to the Continuum of Care Action Plan Form, address any final case management needs identified during the counseling session that will help the participant maintain his/her behavior change accomplishments. A **Case Management Referral Form (7D)** can be found in the appendix.

Check the status of any previous referrals, and note whether or not there has been follow-up. Ask the participant whether he/she has additional health and social service needs. Make appropriate referral/linkages to services.

Congratulate the participant for taking positive steps toward improving his/her health and Inform the participant that he/she has successfully and formally completed the MIP Intervention. Invite him/her to contact you if in need of additional case management services.

10. Complete Documentation Forms

Document the last session's milestones in **Progress Notes (7E)**.

Write a summary report.

11. Discuss Intervention Benchmarks with the MIP Team

The MIP team meet to close-out the intervention and to complete the final report.

SESSION VII FORMS:

- A. Behavioral Risk Assessment Form
- B. Booster Development Guide
- C. Continuum of Care Action Plan Form
- D. Case Management Referral Form
- E. Progress Notes

DRAFT

STRUCTURED SESSION 7A BEHAVIORAL RISK ASSESSMENT

Description: The MIP Behavioral Risk Assessment is designed to assess the participant's current drug and sex-related HIV/STI/viral hepatitis risk behaviors. The assessment also captures the participant's family, health, and social support needs.

Administration:

This instrument should be administered to each participant at the time of enrollment in MIP as part of the Induction Session (Session 1). The MIP team uses this information to work with the participant in developing personal drug and sex-related HIV risk reduction goals. This information is also useful in building social support systems that encourage positive behavior change. The MIP Behavioral Risk Assessment is to be administered again during the Booster Session (Session 7). The Counselor and Case Manager/Community Educator fill out Section G in preparation for implementing the Booster Session.

The Behavioral Risk Assessment measures individual progress made in achieving the identified risk reduction goals. Individuals who have not completed the expected number of sessions should also be administered the MIP Behavioral Risk Assessment. This Behavioral Risk Assessment should not be administered during the delivery of MIP intervention activities.

Instructions to Interviewer: This assessment is intended to be completed using an interview format.

- Familiarize yourself with the document, and read each question or statement to the participant exactly as it is written.
- Explain that you will be asking a series of questions about family support, drug and alcohol use, and sexual practices. Relay that this information will only be used to help the participant establish risk reduction goals that foster a healthier lifestyle. Tell the participant that they do not have to answer any question that they are uncomfortable with and that they can choose to skip any question they wish. Tell the participant that they should answer the questions honestly and provide accurate information so that the MIP team can better help him/her. Inform the participant that the interview will take about 15 minutes to complete.
- Record the client's responses by checking the appropriate box following each question or statement. It is unacceptable for the participant to fill out the form by him/herself.
- Check for obvious inconsistencies in the participant's responses and bring these to the attention of the participant. Resolve inconsistencies as they are encountered.
- Refer to and use the baseline data acquired in the Behavioral Risk Assessment for each structured session to help set HIV risk reduction goals.

A. RECORD MANAGEMENT

Date Completed: _____

Client ID: _____

B. EDUCATION AND EMPLOYMENT

1. Are you currently enrolled in school or in a job training program?

- NOT ENROLLED
- ENROLLED, FULL TIME
- ENROLLED, PART TIME
- OTHER (SPECIFY)
- REFUSED
- DON'T KNOW

Program Name: _____

Program Name: _____

2. Are you currently employed?

- EMPLOYED FULL TIME (35+ HOURS PER WEEK)
- EMPLOYED PART TIME
- UNEMPLOYED, LOOKING FOR WORK
- UNEMPLOYED, DISABLED
- UNEMPLOYED, VOLUNTEER WORK
- UNEMPLOYED, RETIRED
- UNEMPLOYED, NOT LOOKING FOR WORK
- OTHER (SPECIFY) _____
- REFUSED
- DON'T KNOW

2b. How do you spend most of your time during the day? _____

C. FAMILY/SOCIAL CONNECTEDNESS

1. In the past 30 days, what has been your main housing situation?

- SHELTER (SAFE HAVENS, TRANSITIONAL LIVING CENTER [TLC], LOW DEMAND FACILITIES, RECEPTION CENTERS, OTHER TEMPORARY DAY OR EVENING FACILITY)
- STREET/OUTDOORS (SIDEWALK, DOORWAY, PARK, PUBLIC OR ABANDONED BUILDING)
- INSTITUTION (HOSPITAL, NURSING HOME, JAIL/PRISON)
- HOUSED [IF HOUSED, CHECK APPROPRIATE SUBCATEGORY:]
 - OWN/RENT APARTMENT, ROOM, OR HOUSE
 - SOMEONE ELSE'S APARTMENT, ROOM, OR HOUSE
 - HALFWAY HOUSE
 - RESIDENTIAL TREATMENT
 - OTHER HOUSING (SPECIFY)
- REFUSED

DON'T KNOW

2. [IF NOT MALE] Are you currently pregnant?

- YES
- NO
- REFUSED
- DON'T KNOW

3. Do you have children?

- YES
- NO
- REFUSED
- DON'T KNOW

a. How many children do you have?

|_|_|_| REFUSED DON'T KNOW

b. Are any of your children living with someone else due to a child protection court order?

- YES
- NO
- REFUSED
- DON'T KNOW

c. If yes, how many of your children are living with someone else due to a child protection court order?

|_|_|_| REFUSED DON'T KNOW

d. For how many of your children have you lost parental rights?

|_|_|_| REFUSED DON'T KNOW

4. In the past 30 days, have you attended any voluntary self-help groups not affiliated with a religious or faith-based organization? In other words, did you participate in a non-professional, peer-operated organization devoted to helping individuals who have addiction related problems. Some such organizations can include: Alcoholics Anonymous, Narcotics Anonymous, Oxford House, Secular Organization for Sobriety, Women for Sobriety, and so forth.

- YES [SPECIFY HOW MANY TIMES] _____
- NO
- REFUSED
- DON'T KNOW

5. In the past 30 days, did you attend any religious/faith-based voluntary self-help groups?

- YES [SPECIFY HOW MANY TIMES] _____
- NO
- REFUSED
- DON'T KNOW

6. In the past 30 days, did you attend meetings that support recovery other than those of the organizations described above?

- YES [SPECIFY HOW MANY TIMES] _____
- NO
- REFUSED
- DON'T KNOW

7. In the past 30 days, did you have interaction with family and/or friends that are supportive of your recovery?

- YES [SPECIFY HOW MANY TIMES] _____
- NO
- REFUSED
- DON'T KNOW

8. To whom do you turn when you are having trouble?

- NO ONE
- CLERGY MEMBER
- FAMILY MEMBER
- FRIENDS
- REFUSED
- DON'T KNOW
- OTHER (SPECIFY): _____

D. DRUG AND ALCOHOL USE

	Number of Days	REFUSED	DON'T KNOW
1. During the past 30 days how many times have you used the following:			
a. Alcohol to intoxication	_ _	0	0
b. Both alcohol and drugs (on the same day)	_ _	0	0
2. During the past 30 days, how many times have you used the following:			
a. Cocaine/Crack	_ _	0	0
b. Marijuana/Hashish (Pot, Joints, Blunts, Chronic, Weed, Mary Jane)	_ _	0	0
c. Opiates:	_ _	0	0
▪ Heroin, Morphine, Demerol, Percocet, Codeine, Oxycotin/Oxycodone, non-prescription methodone)			

- | | | | |
|--|-----|---|---|
| d. Hallucinogens/psychedelics, PCP
▪ Angel Dust, Ozone, Wade, Rocket Fuel)
MDMA (Ecstasy, XTC, X, Adam), LSD
(Acid, Boomers, Yellow Sunshine),
Mushrooms or Mescaline) | _ _ | 0 | 0 |
| e. Methamphetamine or other amphetamines
▪ Uppers, Speed, Ice, Chalk, Crystal, Glass, Fire, Crack | _ _ | 0 | 0 |
| f. Sedatives/Downers/Tranquilizers
▪ Benzodiazepines: Diazepam (Valium),
Alprazolam (Xanax), Triazolam (Halcion),
and Estazolam (Prosoin and Rohypnol-also
known as roofies, roche, and cope);
▪ Barbiturates: Mephobarbital (Mebacut) and
pentobarbital sodium (Nembutal);
▪ Non-prescription: Grievous Bodily Harm,
Liquid Ecstasy, and Georgia Home Boy;
▪ Ketamine: (known as Special K or Vitamin K) | _ _ | 0 | 0 |
| g. Inhalants (Poppers, Snappers, Rush, Whippets) | _ _ | 0 | 0 |
| h. Other illegal drugs (Specify): | _ _ | 0 | 0 |

3. In the past 30 days have you injected drugs?

- YES
- NO
- REFUSED
- DON'T KNOW

4. In the past 30 days, how often did you use: (Check the appropriate response for each behavior)

a syringe/needle a cooker cotton water

Always

More than half the time

Half the time

Less than half the time

Never

REFUSED

DON'T KNOW

E. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY

1. How would you rate your overall health right now?

- Excellent
- Very good
- Good
- Fair
- Poor
- REFUSED
- DON'T KNOW

2. During the past 30 days, did you receive:

a. In-patient treatment for:

___ YES (for how many nights) ___ NO

- i. Physical complaint ___ nights
- ii. Mental or emotional difficulties ___ nights
- iii. Alcohol or substance abuse ___ nights

b. Out-patient treatment for:

___ YES (for how many nights) ___ NO

- i. Physical complaint ___ nights
- ii. Mental or emotional difficulties ___ nights
- iii. Alcohol or substance abuse ___ nights

c. Emergency Room treatment for:

___ YES (for how many nights) ___ NO

- i. Physical complaint ___ nights
- ii. Mental or emotional difficulties ___ nights
- iii. Alcohol or substance abuse ___ nights

Results:

3. Have you been tested for:

- a. HIV Y N Positive Negative Unknown
- b. Viral hepatitis Y N Positive Negative Unknown
- c. STIs Y N Positive Negative Unknown
- d. TB Y N Positive Negative Unknown

4. In the past 30 days, not due to your use of drugs or alcohol, how many days have you:

- | | |
|---|-------------|
| | Days |
| a. Experienced serious depression | _ _ |
| b. Experienced serious anxiety or tension | _ _ |
| c. Experienced hallucinations | _ _ |
| d. Experienced trouble understanding, concentrating, or remembering | _ _ |
| e. Experienced trouble controlling violent behavior | _ _ |
| f. Attempted suicide | _ _ |
| g. Been prescribed medication for psychological/emotional program | _ _ |

5. How much have you been bothered by these psychological or emotional problems in the past 30 days?

- Not at all
- REUSED
- DON'T KNOW
- Considerably
- Slightly
- Moderately

G. SEXUAL ACTIVITY

1. During the past 30 days, did you engage in sexual activity?

- Yes [How many times] |__|__|
- No
- NOT PERMITTED TO ASK
- REFUSED
- DON'T KNOW

If yes, how many:

a. Sexual partners (vaginal, oral, anal) did you have
How many of those partners did you use condoms with

Contacts

b. Unprotected sexual contacts did you have

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c. Unprotected sexual contacts were with an individual who is or was:

- 1. HIV positive or has AIDS
- 2. An injection drug user
- 3. High on some substance

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2. During the past 30 days, have you used condoms for vaginal sex?

- Did not have vaginal sex in the past 30 days
- Yes [How many times?] |__|__|
- No
- REFUSED
- DON'T KNOW

3. During the past 30 days, have you used condoms for anal sex?

- Did not have anal sex in the past 30 days
- Yes [How many times?] |__|__|
- No
- REFUSED
- DON'T KNOW

4. During the past 30 days, have you had sex while you were drunk or high?

- Did not have sex in the past 30 days
- Yes [How many times?] |__|__|
- No
- REFUSED
- DON'T KNOW

4a. If you had sex while high or drunk, how many times did you use condoms?

- Always
- More than half the time
- Half the time
- Less than half the time
- Never
- REFUSED
- DON'T KNOW

SEE NEXT PAGE—PART G—FOR BOOSTER (SESSION 7)

DRAFT

G. EVALUATION OF SERVICES RECEIVED

[TO BE COMPLETED BY MIP PROGRAM STAFF AT BOOSTER SESSION ONLY (Session 7)]

Date Completed: _____

Identify the number of days services were provided to the participant during the MIP intervention. [ENTER ZERO IF NO SERVICES PROVIDED]

Modality	Days
1. Case Management	_ _ _
2. Day Treatment	_ _ _
3. Inpatient/Hospital (Other than detox)	_ _ _
4. Outpatient	_ _ _
5. Outreach	_ _ _
6. Intensive Outpatient	_ _ _
7. Methadone	_ _ _
8. Residential/Rehabilitation	_ _ _
9. Detoxification (Select Only One)	
A. Hospital Inpatient	_ _ _
B. Free Standing Residential	_ _ _
C. Ambulatory Detoxification	_ _ _
10. After Care	_ _ _
11. Recovery Support	_ _ _
12. Other (Specify) _____	_ _ _

Case Management Services	Y	N
1. Family Services (Marriage Education, Parenting, Child Development Services)	Y	N
2. Child Care	Y	N
3. Family Planning	Y	N
4. Male or Female Condoms	Y	N
5. Employment Service	Y	N
6. Pre-Employment	Y	N
7. Employment Coaching	Y	N
8. Individual Services Coordination	Y	N
9. Transportation	Y	N
10. HIV/AIDS Service	Y	N
11. Domestic Violence	Y	N
12. Utility Assistance	Y	N
13. Food voucher	Y	N
14. Supportive Transitional Drug-Free Housing Services	Y	N
15. Other (Specify) _____	Y	N

Identify the number of sessions provided to the participant during the MIP Intervention. [ENTER ZERO IF NO SERVICES PROVIDED.]

Treatment Services <i>[PROVIDE AN ANSWER FOR AT LEAST ONE TREATMENT SERVICE NUMERED 1 THORUGH 4.]</i>	Sessions
1. Screening	_ _ _
2. Brief Intervention	_ _ _
3. Brief Treatment	_ _ _
4. Referral to Treatment	_ _ _
5. Assessment	_ _ _
6. Treatment/Recovery Planning	_ _ _
7. Individual Counseling	_ _ _
8. Group Counseling	_ _ _
9. Family/Marriage Counseling	_ _ _
10. Co-Occurring Treatment/ Recovery Services	_ _ _
11. Pharmacological Interventions	_ _ _
12. HIV/AIDS Counseling	_ _ _
13. Other Clinical Services (Specify) _____	_ _ _

After Care Services	Sessions
1. Continuing Care	_ _ _
2. Relapse Prevention	_ _ _
3. Recovery Coaching	_ _ _
4. Self-Help and Support Groups	_ _ _
5. Spiritual Support	_ _ _
6. Other After Care Services (Specify) _____	_ _ _

Education Services	Sessions
1. Substance Abuse Education	_ _ _
2. HIV/AIDS Education	_ _ _
3. Other Medical Services (Specify) _____	_ _ _

Peer-To-Peer Recovery Support Services	Sessions
1. Peer Coaching or Mentoring	_ _ _
2. Housing Support	_ _ _
3. Alcohol and Drug Free Social Activities	_ _ _
4. Information and Referral	_ _ _
5. Other Peer-to-Peer Recovery Support Services (Specify) _____	_ _ _

Medical Services	Sessions
1. Medical Care	_ _ _
2. Alcohol/Drug Testing	_ _ _
3. HIV/AIDS Medical Support & Testing	_ _ _
4. Other Medical Services (Specify) _____	_ _ _

STRUCTURED SESSION 7B

Booster Development Guide

This instrument is administered to participants upon completing the intervention. It assesses a participant's perspective on various risk reduction behaviors using a stages-of-change framework. This allows the participant's risk reduction progress to be measured in instances where the participant has taken meaningful steps toward reducing his/her risks but has not yet fully achieved his/her stated goal.

After the Case Manager/Community Educator and the Counselor review the participant's record and identify achievements, strengths, and areas that need improvement, the following steps should be taken:

1. Engage the participant in a discussion about what motivated him/her to begin and continue MIP.
2. Discuss the achievements and benefits of participating in the project, emphasizing the importance of maintaining positive behavior changes. Begin the discussion by asking the participant to answer the following questions:
 - What were some of the benefits of participating in MIP? What were some of your most meaningful achievements?
 - Where do you still have room for improvement in relation to topics covered in the intervention sessions?
3. After the participant identifies achievements and the areas to be improved, the Case Manager/Community Educator and the Counselor will add positive behavior changes that took place without being identified during an exercise. These behavior changes should be noticeable through case records and personal interaction.

The facilitator will validate participant achievements, beginning with participant identified goals that were reached during the intervention. Assess the positive impact of behavior changes in the participant's family, work, and social life. Illustrate the Stage of Change process to help the participant better understand his/her progress.

Booster Development Guide*continued*

1. What positive behavior changes have you achieved in the program?
2. How do you plan to maintain positive behavior changes?
3. Do you foresee any problems maintaining positive behavior changes?
4. How can the MIP team help you address these problems?
5. Is there anything else you want to change related to health, drug and sex-related risk behaviors, or family?
6. What are some reasons to make those changes (e.g., personal, children, and so forth)?
7. Who can support you in making further positive behavior changes (e.g., family members, counselors, and so forth)?
8. What counselor or professional can you call if you feel you have a problem maintaining behavior change?

STRUCTURED SESSION 7C CONTINUUM OF CARE ACTION PLAN FORM

Once the participant decides to begin a session, the Counselor inquires about critical problems the participant faces and his/her reasons for deciding to change behaviors that affect those problems. Together, the Counselor and participant develop goals and objectives to address these issues. This action plan documents the steps the participant agrees to take to change those behaviors he/she has identified as being most critical and for which he/she is most likely to have the support of significant others within his/her social network.

<input type="checkbox"/> Induction Session	<input type="checkbox"/> Reducing Drug-Related HIV Risk
<input type="checkbox"/> Taking Care of Your Health	<input type="checkbox"/> Reducing Sex-Related HIV Risk
<input type="checkbox"/> Readiness for Entering Drug Treatment	<input type="checkbox"/> Booster
<input type="checkbox"/> Relapse Prevention	<input type="checkbox"/> Other

Problem: _____

Goal: _____

Objectives: _____

Interventions/Activities: _____

Participant Name	Participant Signature	Date

Counselor Name	Counselor Signature	Date

**STRUCTURED SESSION 7C
CONTINUUM OF CARE ACTION PLAN FORM**

AREA OF FOCUS	GOALS	OBJECTIVES	INTERVENTION/ACTIVITIES
Health			
Drug Treatment			
Reducing Drug-Related HIV Risk			
Reducing Sex-Related HIV Risk			

**STRUCTURED SESSION 7D
CASE MANAGEMENT REFERRAL FORM**

The objective of this session is for the participant to accept and continue participating in the intervention and in utilizing case management services.

PARTICIPANT'S FULL NAME: _____ PHONE #: _____

PARTICIPANT'S ADDRESS: _____

D.O.B.: _____ Age: _____

REFERRED TO: _____ TO SEE: _____

ADDRESS: _____

DATE OF APPOINTMENT: _____ TIME: _____

REASON FOR REFERRAL:

- | | |
|--|--|
| <input type="checkbox"/> Mental Health Services | <input type="checkbox"/> Primary Health Services |
| <input type="checkbox"/> Opiate Addiction/Abuse | <input type="checkbox"/> Parenting Skills Program |
| <input type="checkbox"/> Cocaine Addiction/Abuse | <input type="checkbox"/> Domestic Violence/ Anger Management |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Food Voucher |
| <input type="checkbox"/> Poly-Substance Abuse | <input type="checkbox"/> Counseling |
| <input type="checkbox"/> Rental/Housing Assistance | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Utility Assistance | <input type="checkbox"/> Other |
| <input type="checkbox"/> Family Planning | |

COMMENTS: _____

IF YOU HAVE ANY QUESTIONS, YOU MAY CONTACT ME AT: _____
SINCERELY,

Counselor/Case Manager

Date

**STRUCTURED SESSION 7E
PROGRESS NOTES**

		Case Manager Notes	Counselor Notes
DATE:	END TIME:	<hr/> Signature of MIP Team Member	<hr/> Signature of MIP Team Member
	START TIME:		
DATE:	END TIME:	<hr/> Signature of MIP Team Member	<hr/> Signature of MIP Team Member
	START TIME:		
DATE:	END TIME:	<hr/> Signature of MIP Team Member	<hr/> Signature of MIP Team Member
	START TIME:		

PART IV. PROGRAM MONITORING AND EVALUATION

Part IV – Program Monitoring and Evaluation presents an overview of standard evaluation terminology and techniques with emphasis on those strategies that have relevance in community settings. Part IV discusses how to set up a monitoring and evaluation plan for MIP. MIP data collection forms that support program monitoring and evaluation activities are displayed in Table 1 at the end of this section. Implementing agencies should use these forms to help guide their process and outcome monitoring activities.

The Importance of Evaluation

There are three reasons for evaluating a proven intervention such as MIP:

1. Accountability to the various stakeholders of the intervention.
 - **Example:** Were you able to serve 200 participants as you proposed in your funding application? If not, why?
2. Assuring program fidelity and program improvement.
 - **Example:** Did the MIP team conduct all seven sessions as intended, or were changes made? If so, what were those changes and are they documented?
3. Developing knowledge for planning future programs.
 - **Example:** What types of incentives seemed to work best?

As a proven intervention, MIP is understood to be effective in achieving behavior change among drug users. In conducting evaluations, implementing organizations should demonstrate that they have maintained fidelity to the MIP core elements and helped participants reduce their HIV/STI-related risk, including drug use. The evaluation process identifies ways of strengthening MIP activities and, in turn, strengthening the overall effectiveness of the MIP intervention.

Types of Evaluation

Program monitoring and evaluation ensures accountability to the various stakeholders, confirms program fidelity, facilitates program improvement, and provides reliable information for program planning.

Some stakeholders may require evaluation information as a condition for continued funding. Stakeholders include:

- Staff members implementing the intervention.
- Clients participating in the intervention.
- Community partners that support the intervention.
- The funding agency providing financial support for the intervention.
- The prevention planning group that has made recommendations to the funding agency.
- Political actors who make funding decisions about the intervention.

There are several types of monitoring and evaluation processes that can be used to provide stakeholders with the necessary information about the MIP program. These include: Formative Evaluation (Community Needs Assessment), Process Monitoring, Process Evaluation, Outcomes Monitoring, and Outcomes Evaluation.

Formative Evaluation (Community Needs Assessment): Community assessment and outreach is a core element of MIP. Community Needs Assessment is the process of gathering information about target population members and about the community they inhabit so as to better understand their needs. This is done through community mapping, a process that involves talking with staff, gatekeepers (individuals capable of providing insight and access to the community), and community members. In this way, Community Needs Assessment facilitates an understanding of the specific risk behaviors and challenges faced by members of the target population and of the population's culture. This leads to the creation of more effective risk reduction messages and to the building of relationships with community members.

Process Monitoring: Process monitoring is used to make changes and improvements to the implementation process. It addresses questions such as: "What services were delivered?", "How and where were those services delivered?", "What population was served?", and "What resources were used?" It does so by collecting data that describes target population characteristics, the types of services provided, the frequency of those services, and the resources used to deliver those services.

Process Evaluation: Process evaluation focuses on how the intervention was delivered. It assesses planned versus actual program implementation by compiling data that describes the differences between the intended target population and the population served. It addresses questions such as: "Did the intervention reach the intended audience?", "Did individuals experience barriers accessing services?", and "Was the intervention implemented with fidelity to the core elements?"

Outcome Monitoring: Outcome monitoring determines the extent to which program goals and objectives were met. It demands routine documentation and review of program-associated outcomes. These outcomes include: individual-level knowledge, attitudes, skills, and behaviors; access to services; service delivery; and community factors.

Outcome Evaluation: Outcome evaluation assesses the impact of MIP on individual participants and on the communities in which they reside. It ultimately answers the question, "Did the expected outcomes occur and to what degree?" Ideally, outcome evaluation should be conducted after process evaluation has shown that the intervention is being delivered properly, but in practice, outcome and process evaluation are often performed concurrently.

Implementing and Evaluating MIP

In order for the implementing organization to experience similar outcomes to those documented in the original research, the MIP intervention must be implemented with a high degree of fidelity and adherence to the core elements of the intervention.

The monitoring and evaluation objectives of MIP are to:

1. Monitor program implementation, including the identification of factors contributing to/or constraining effective program implementation.
2. Track individual and group performance measures in the following domains: HIV/viral hepatitis status; entry to and retention in substance abuse treatment (SA); and access to health and social services.
3. Measure individual participant behavior change regarding: recovery from substance abuse, reduction or elimination of drug-related risk behaviors, and reduction or elimination of sex-related risk behaviors.
4. Produce reports with accurate and reliable information for funders and Program Supervisors.
5. Provide data to modify and strengthen the program and to develop new funding proposals to sustain the intervention.

Three steps to implementing MIP monitoring and evaluation activities include:

- **Step One: Develop a Monitoring and Evaluation Plan**
- **Step Two: Conduct a Community Needs Assessment**
- **Step Three: Conduct Process and Outcomes Monitoring and Evaluation**

STEP ONE: Develop a Monitoring and Evaluation Plan

Implementing organizations should develop a monitoring and evaluation plan prior to implementing MIP. The plan should outline: data sources, monitoring and evaluation activities, the individuals responsible for each activity, and a timeframe for each activity. It is also necessary to develop a strategy for keeping collected data both confidential and easily accessible to the Program Supervisor or to a designated staff member for monitoring and reporting purposes. The monitoring and evaluation plan should also discuss evaluation products, and monitoring and evaluation forms required by funding agencies as well as the implementing organization.

Finally, the monitoring and evaluation plan should specify how the data will be stored. For example, implementing organizations may choose to store information on paper, in a Word document, in an Excel spreadsheet, or in an Access database. Be specific about where data will be stored, who will document it, and what the expectations are for reporting evaluation findings.

Data security should be considered as it ensures client confidentiality. Regardless of storage methods, measures should be taken to protect sensitive participant data. Security measures may include: password protected files, locked file cabinets, specialized coding to protect participant identity, separate server, and other measures deemed appropriate by a data securities expert.

STEP TWO: Conduct a Community Needs Assessment

Community mapping is a process used to gather information helpful to service planning and delivery. In the context of MIP, community mapping identifies structural, environmental, behavioral, and psychological factors that can facilitate or act as barriers to STD/HIV/viral hepatitis risk-reduction. The community mapping process involves interviewing internal staff members, talking to key informants and gatekeepers, conducting focus groups, and directly observing community dynamics. Key informants should be chosen based on their knowledge of the target population and of the community. These may be current or former members of the target population and service providers working closely with the target population. Likewise, focus groups may be composed of current or former members of the target population and services providers. **Section II Appendices 2E – 2H** contain sample forms that can be used to facilitate the community-mapping process. These forms can be adapted as necessary.

In the past, programs implemented without input from members of the target population have either failed or have had negative, unintended consequences. The success of such social programs is compromised by a lack of understanding of the target population's perspectives and culture. Therefore, a critical first step in any STD/HIV/viral hepatitis prevention program is to become familiar with the target population. It is understood that a program's effectiveness depends on its ability to tailor services to the specific population being targeted. This requires an understanding of the population's risk behaviors, the significance these behaviors hold for population members, and the context in which these behaviors occur. A clear understanding of general population characteristics as well as individual population member characteristics is essential.

STEP THREE: Conduct Process and Outcomes Monitoring and Evaluation

Upon determining what information will be collected, who will collect it, and at what intervals it will be collected, ensure that the appropriate forms have been completed.

Forms designed for staff use should have clear instructions, include enough room to make notes, and clearly indicate when the forms should be used, how often the forms should be used, and to whom the forms should be sent. Forms designed for participant use should include clear instructions and should be sensitive to the participant's reading level. These forms should be available in other languages as appropriate.

Data collection forms for MIP process and outcome monitoring and evaluation are listed below.

- *Community Mapping Planning Form*
- *Community Mapping Resource Scan Worksheet*

- *MIP Agency Readiness Self-Assessment*
- *The MIP Intake Form*
- *The Self-Assessment and Staging Form*
- *The Behavioral Risk Assessment Form*
- *The Action Plan Form*
- *The Case Management Referral Form*
- *Progress Notes*

These forms are used and updated on an on-going basis throughout the MIP intervention. Combined, they provide a rich source of data for all MIP program monitoring and evaluation needs.

Table 1 below, **MIP Data Sources by Evaluation Type**, explains the types of forms used in the implementation of MIP that can provide information for the MIP monitoring and evaluation activities.

Table 1: MIP Data Sources by Evaluation Type			
Type of evaluation	Data Source	Timeline	Person responsible
Formative Pre-implementation (Community needs assessment, specific risk behaviors, culture of community, build relationships with community members and stake holders).	Community Mapping Planning Form	4 – 6 weeks Prior to implementation	Community Educator/ Case Manager
	Community Mapping Resource Scan Work sheet		
	Service Directory Form		
	MOUs with Collaborating agencies Organizational Assessment Survey	4 – 6 weeks Prior to implementation	Supervisor
	Agency Readiness Self-Assessment	Immediately	Supervisor
	Review agency Documents: Budgets, reports	Immediately and ongoing	Supervisor

Type of evaluation	Data Source	Timeline	Person responsible
Process Monitoring Implementation (Data collection of characteristics of population served and types and frequency of services provided. Types of resources used to deliver services).	MIP Intake Form Behavioral Risk Assessment Form Self Assessment and Staging Form Action Plan Form Case Management Referral Form Progress Notes	During each MIP session	Counselor or Community Educator
Process Evaluation Implementation (Detailed data collection of how intervention was delivered, population intended and population served, individuals that accessed the intervention).	Recruitment Tracking Record Self-Assessment and Staging Form Behavior Change Self-Assessment Form Action Plan form Case Management Referral Form Progress Notes	During each MIP session	Counselor or Community Educator
Outcome Monitoring Implementation (Extent to which program goals and objectives were met e.g.: individual-level knowledge attitudes, skills and behaviors).	MIP Intake Form Behavioral Risk Assessment Form Self-Assessment and Staging form Behavior Change Self-Assessment Form Action Plan Form Case Management Referral Form Behavioral Risk Assessment Form	MIP sessions Induction Booster Session	Counselor or Community Educator

Process Monitoring Implementation (Program implementation, track individual and group performances, measure participant behavior, produce reports with accurate information, produce data to modify and strengthen program).	MIP Intake Form Behavioral Risk Assessment Form Self Assessment and Staging Form Action Plan Form Case Management Referral Form Progress Notes	Ongoing during each MIP session	Counselor or Community Educator or Case Manager
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The community mapping forms can be found in **Part II, Appendices E-H**. The MIP Intake Form, Self-Assessment and Staging Form, Behavioral Risk Assessment Form, Action Plan Form, and Case Management Referral Forms can be found at the **end of the structured sessions in Part III** of this manual. These forms suggest the kinds of activities that agencies should conduct to collect data for monitoring and evaluation.

These forms are only meant to be a starting point. Implementing organizations should feel free to create forms that best meet their specific needs, either adding information to the forms or using only the components that are relevant.

Note: For some CDC and other federally funded HIV prevention programs, there will be an evaluation process specified by the funder. In the case of CDC, a system called Program Evaluation and Monitoring Systems (PEMS) is required. Technical Assistance may be requested to implement PEMS.