

SAFETY COUNTS

TECHNICAL ASSISTANCE GUIDE

A Cognitive-Behavioral Intervention to Reduce
HIV/Hepatitis Risks Among Drug Users
Who Are Not in Drug Treatment



Center on AIDS & Community Health



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DRAFT

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August 2006

The material in this document is based on the National Institute on Drug Abuse (NIDA)-funded research of Fen Rhodes, Ph.D., principal investigator, and Michele Wood, M.S., project director, at the Center for Behavioral Research and Services at California State University, Long Beach.

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For additional copies of this publication, contact:

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You may also find more information about *SAFETY COUNTS* on the Web at:

www.effectiveinterventions.org

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I. Introduction

A. How to Use this Guide

This guide was developed as a resource for the provision of technical assistance (TA) to agencies that are implementing the *SAFETY COUNTS* intervention. The guide provides a review of key information regarding *SAFETY COUNTS*, including discussion of the core elements, theoretical framework and internal logic model, implementation and planning tasks, and answers to some of the common questions that agencies may have regarding the intervention.

Intended Audience

This guide is a tool for agency staff seeking to implement the *SAFETY COUNTS* intervention in an appropriate and effective manner. This guide is intended to be used as a resource for agencies that are implementing *SAFETY COUNTS* during the planning and implementation process. The material in this guide should be used as a supplement to information provided in the *SAFETY COUNTS* Program Manual and training materials.

TA providers can use this guide to respond to specific questions posed by implementing agencies, or as a guide in a pro-active assessment of and response to overall TA needs.

A further discussion on requesting and receiving technical assistance for *SAFETY COUNTS* is contained in Section II: Technical Assistance for *SAFETY COUNTS*.

B. Content

This guide contains six sections:

- **Section I** (which you are now reading) introduces the guide and discusses the *SAFETY COUNTS* intervention and training program.

- **Section II** reviews some basic information about TA, and discusses how agencies can access and benefit from TA on *SAFETY COUNTS*.
- **Section III** discusses the internal logic model of the intervention and provides a brief overview of the intervention's core elements.
- **Section IV** discusses issues related to agency and staff preparation and planning for the *SAFETY COUNTS* intervention.
- **Section V** provides a practical breakdown of the core elements of the *SAFETY COUNTS* intervention.
- **Section VI** discusses the monitoring and evaluation of the *SAFETY COUNTS* intervention.

Where applicable, questions that training participants and others have asked regarding specific issues of *SAFETY COUNTS* are included at the end of each section.

C. Background on *SAFETY COUNTS*

SAFETY COUNTS is an effective, science-based intervention to prevent HIV and viral hepatitis, designed specifically for persons who are using illicit (not prescribed) drugs and who are not ready or not willing to enroll in drug treatment programs. The intervention is based on a research study funded by the National Institute for Drug Abuse and implemented by Fen Rhodes, Ph.D., principal investigator, and Michele Wood, M.S., project director, at the Center for Behavioral Research and Services at California State University, Long Beach. Researchers found the original intervention effective in reducing high-risk sexual and drug-using behaviors.

SAFETY COUNTS helps clients understand how their drug-use behaviors are related to important influencing risk factors that put them at risk for HIV and hepatitis infection and how to design a plan to reduce these risks. Using structured group and individual activities conducted over a period of 4 months, the intervention helps clients develop personal risk-reduction goals and define specific steps for achieving them. *SAFETY COUNTS* uses a client-centered approach which helps create a partnership based on trust

and understanding between staff and clients. The intervention is appropriate for HIV-infected as well as HIV-negative clients who have used illicit drugs in the past 90 days. Clients may be either injection drug users (IDUs) or drug users who do not inject. CDC has developed Adaptation Guidelines for adapting *SAFETY COUNTS* for several drug using populations. You can find the Adaptation Guidelines as part of the *SAFETY COUNTS* Program Manual and in Section IV of this TA Guide.

The intervention is described in greater detail in the Program Manual and also in Sections III and V of this guide.

SAFETY COUNTS is one of the interventions being nationally diffused by the Centers for Disease Control and Prevention (CDC). Among the TA providers for the *SAFETY COUNTS* intervention are the Capacity Building Assistance (CBA) providers, AED staff and consultants, and the American Psychological Association's (APA) Behavioral and Social Science Volunteers (BSSV). These agencies have extensive experience providing TA for *SAFETY COUNTS*. The CDC-funded Diffusion of Effective Behavioral Interventions (DEBI) project has developed and coordinated a national strategy to provide high quality training and technical assistance on science-based, community- and group-level HIV interventions to state and local HIV prevention agencies. For more information on the DEBI project, visit www.effectiveinterventions.org.

Under the DEBI project, community-based organizations (CBOs) and other agencies with the capacity to implement *SAFETY COUNTS* can receive training on the intervention. The *SAFETY COUNTS* training program is composed of a single two-day session. The course provides a comprehensive overview of the theoretical framework and its internal logic. It describes the relationship between core elements, individual determinants of risk behaviors and intervention outcomes, and the steps for implementing and managing the intervention. The course includes skills building modules and a discussion of resources necessary to maintain the intervention. The course helps participants develop the knowledge and skills necessary to carry out the core elements of *SAFETY COUNTS*.

SAFETY COUNTS supports the CDC's initiative for Advancing HIV Prevention (AHP). The initiative is aimed at reducing barriers to early diagnosis of HIV and increasing access to and utilization of quality medical care, treatment, and ongoing prevention services for persons living with HIV. *SAFETY COUNTS* directly supports all four priority strategies of this initiative, as described below:

- 1. Make voluntary HIV testing a routine part of medical care.** *SAFETY COUNTS* strongly encourages testing for HIV as a precursor to program enrollment. Although being tested is not required for program entry, each of the seven *SAFETY COUNTS* sessions includes a discussion of the importance of testing. This provides multiple opportunities for on-site rapid testing or active referral to testing for clients who need this service.
- 2. Implement new models for diagnosing HIV infections outside medical settings.** As a core element of the intervention, agencies that implement *SAFETY COUNTS* are required to offer testing, including the rapid test, or refer their clients to organizations that can provide testing. Agencies delivering *SAFETY COUNTS* and agencies providing testing work hand-in-hand to recruit clients for *SAFETY COUNTS* and to provide them with needed HIV prevention, medical, and other support services.
- 3. Prevent new infections by working with persons diagnosed with HIV.** *SAFETY COUNTS* is designed to meet the prevention needs of drug users living with HIV in addition to those who are HIV-negative. The intervention uses a behavioral support approach that has been shown to be effective for working with people who have ongoing high-risk behaviors. *SAFETY COUNTS* clients can also be linked to case management prevention programs designed for persons with HIV. Finally, *SAFETY COUNTS* can receive referrals from testing and other programs serving drug users.
- 4. Further decrease prenatal HIV transmission.** *SAFETY COUNTS* works for both men and women, including women with HIV who may be pregnant, to directly address their high-risk behavior and ensure they have access to the

medical and support services they need in order to prevent prenatal HIV transmission.

II. Technical Assistance for *SAFETY COUNTS*

A. Understanding Technical Assistance

Technical assistance (TA) is defined as the provision of direct or indirect services designed to increase the capacity of individuals and organizations to carry out programmatic and management responsibilities. For HIV prevention interventions, TA is aimed at assisting organizations to effectively and appropriately prepare for and implement intervention activities that respond to HIV and related health concerns in their target communities.

Technical assistance for DEBI project interventions, including *SAFETY COUNTS*, can involve helping agencies to: adapt the *SAFETY COUNTS* intervention for specific drug using populations, assess their community's needs; assess and develop their agency's human, financial, and material resources; and develop the agency's level of knowledge and skills to meet their community's needs through programs and services. TA is provided by individuals with experience and expertise in relevant technical and programmatic areas, as well as skills in effectively providing assistance. TA can be provided via email, phone, and in-person consultation.

CDC has established the **CBA Request Information System (CRIS)** to help agencies and health departments obtain technical assistance from the CDC-funded Capacity Building Assistance providers. CRIS offers technical assistance in organizational infrastructure development; intervention implementation and evaluation; structural HIV prevention models; and community planning. CDC directly-funded CBOs and health departments can access CRIS at www.cdc.gov/hiv/cba. An agency funded by its state or local health department should ask the health department to submit a request for them. Agencies should consult with their health department or CDC Project Officer first and let them know they are seeking technical assistance.

Under the DEBI project, organizations have access to TA to complement and build upon training activities. The aim is to further enable agencies to effectively apply knowledge and skills acquired in trainings and to appropriately and successfully implement intervention activities. After participating in a DEBI training such as *SAFETY COUNTS*, organizations may need support and guidance in areas ranging from deciding if the intervention is appropriate for the organization's community, carrying out implementation tasks for the intervention, to assessing the outcome of the intervention. The DEBI project is grounded in the Diffusion of Innovations Theory (E. Rogers) which identifies TA as an important element of diffusion.

B. Requesting and Receiving Technical Assistance for *SAFETY COUNTS*

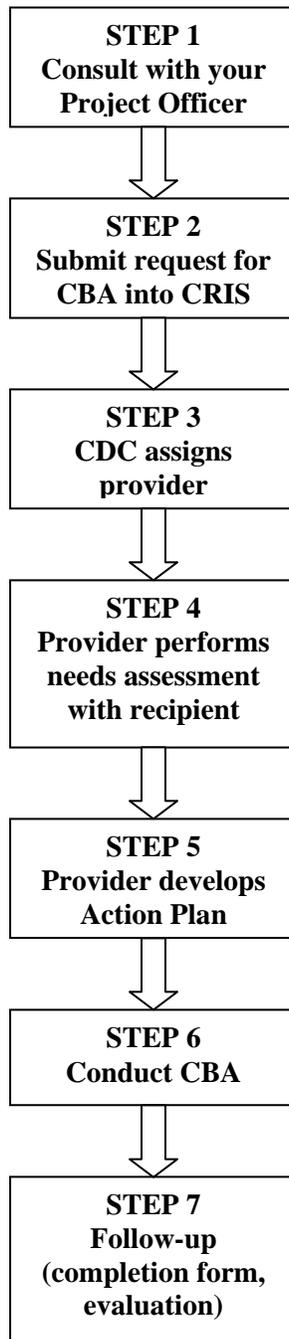
The *SAFETY COUNTS* intervention, both conceptually and programmatically, is somewhat complex and the training program was developed to be comprehensive and intensive. Training participants will likely have questions and concerns about training topics after returning to their agencies. TA provides a valuable opportunity to respond to questions and to guide agencies through their decision making, planning, implementing and evaluating process for *SAFETY COUNTS*. Some of the topics and areas for TA on *SAFETY COUNTS* include:

- Assistance in determining agency ability and readiness to implement *SAFETY COUNTS*.
- Assistance in grant-writing and funding source identification.
- Assessing agency capacity to implement *SAFETY COUNTS* including a resource inventory.
- Assistance in identifying the target population and developing client recruitment and retention strategies.
- Training for staff on specific tasks within the *SAFETY COUNTS* intervention (ex., group facilitation, individual counseling, etc.).
- Assistance in conducting and using process and outcome evaluation data for program improvement and funding source reporting.

The primary providers of TA for *SAFETY COUNTS* are staff of CDC-funded Capacity Building Assistance (CBA) provider agencies and include persons identified as experts in the fields of injection drug use, public health, and CBO administration and management. As with the other DEBI project interventions, the process for requesting and arranging TA for *SAFETY COUNTS* is as follows (see also Figure 1):

1. Agencies access the CRIS system at: www.cdc.gov/hiv/cba. A user ID and password are required to access this CDC-sponsored web application. Agencies not included in the list of eligible users can contact their CDC Project Officer or health department to make a request on their behalf. [CDC strongly recommends that agencies consult with their health department or CDC Project Officer first to let them know they are seeking technical assistance.]
2. The CDC CRIS coordinator contacts the appropriate CBA provider to describe the request and to set up an initial discussion between the implementing agency and the CBA provider.
3. A brief needs assessment with the agency determines the topics and areas in which assistance is needed.
4. The CBA provider and the implementing agency develop a timeline and goals for the TA program and keep CDC updated as to progress and any changes to the agreed upon TA plan.
5. After the action plan is executed and the TA provided, follow-up activities are completed, including an evaluation of the TA.

Figure 1. Outline of Process for CDC CBA Request Information System (CRIS)



Section III. Review of Core Elements, Theories and Internal Logic Model of *SAFETY COUNTS*

SAFETY COUNTS is a cognitive-behavioral intervention, meaning that learning and experiential processes play an important role in the development and maintenance of HIV and viral hepatitis risk reduction behaviors. *SAFETY COUNTS* allows clients to define their own risk reduction goals and provides supportive reinforcement for their risk reduction efforts. The specific objectives of the *SAFETY COUNTS* intervention are to:

- Introduce methods of reducing HIV and viral hepatitis risk to drug-using clients.
- Assist clients in receiving counseling and testing for HIV and viral hepatitis.
- Motivate and help clients to choose and commit to specific behavioral goals to reduce their risk of transmitting HIV and hepatitis.
- Assist clients in defining concrete steps toward achieving their personal risk reduction goals.
- Provide social support and problem solving in individual and group settings to assist clients in achieving their risk reduction goals.

SAFETY COUNTS allows clients to:

- Recognize how their own behaviors may put them at risk for HIV and viral hepatitis.
- Determine for themselves what they can reasonably do to reduce their risk for HIV and viral hepatitis.
- Take ownership of their personal risk reduction goals.
- Develop and manage specific steps for achieving these goals.

A. Core Elements

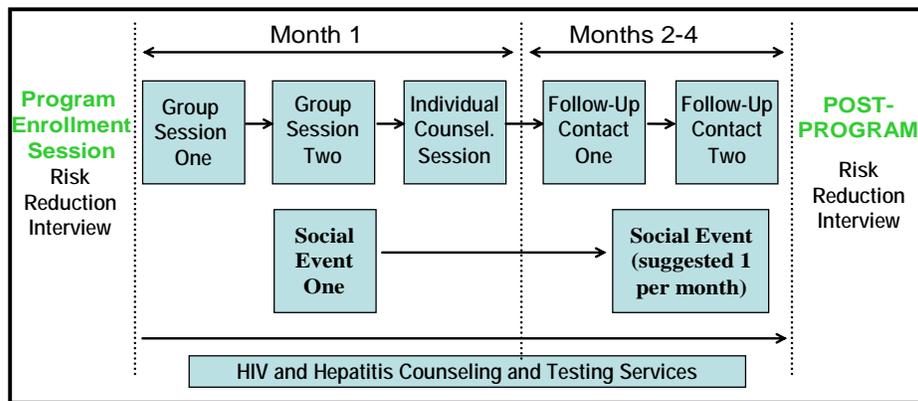
III. REVIEW OF CORE ELEMENTS, THEORIES AND INTERNAL LOGIC MODEL OF *SAFETY COUNTS*

There are five core elements of the *SAFETY COUNTS* intervention that are considered essential to the intervention's success and that should not be omitted or significantly modified by implementing agencies. Figure 2 illustrates the order that these core elements are delivered to the client over the four months. A more in-depth discussion of the core elements can be found in the *SAFETY COUNTS* Program Manual. These core elements, structured as specified and provided to each participant, are:

- Group Sessions One and Two (one session each)
- Individual Counseling Session (one or more)
- Social Events (two or more)
- Follow-up Contacts (two or more)
- HIV/Hepatitis Counseling and Testing

Figure 2. Sequence of the Core Elements

How A Client Moves Through *Safety Counts*



Each client stays in *Safety Counts* for at least four months, and may participate in additional Social Events, Follow-up Contacts, and Individual Counseling Sessions.

Group Sessions One and Two (One Session Each)

The Group Sessions use a Stages of Change framework to help clients identify their current personal stage of change with regard to sexual and drug-related risk behaviors. They provide an opportunity for clients to talk with peers and agency staff about risk behaviors and prevention methods. The sessions establish for clients that personal risk

reduction is relevant, needed, and achievable. Risk reduction stories of individuals in the local community who have successfully reduced their HIV/hepatitis risks are presented as models and motivators for change. Clients identify specific risk behaviors that apply to them and begin a process to reduce a particular risk of their choosing. At the end of Group Session Two, clients set a personal behavioral goal that will reduce this HIV/hepatitis risk and decide on a first step toward meeting that goal.

Individual Counseling Session (One or More)

The Individual Counseling Session, which is conducted after the Group Sessions, gives clients an opportunity to reflect on their personal risk-reduction goals and barriers to goal achievement. Clients work with Counselors to revise their goals if they are unrealistic or too difficult to achieve, and to determine more achievable, smaller steps toward risk reduction. They may also find that the goals they set were easily achievable, and they will be ready to set more challenging goals. In either case, Individual Counseling Sessions allow for the intimacy of discussing risk-taking behavior in more detail in a confidential setting. During this session, the Counselor ensures that the client has identified a person who can provide social support for risk reduction during the course of the intervention. Finally, the Individual Counseling Session is an opportunity for carefully assessing a client's needs for medical, social, and other support services and for providing appropriate referrals.

Social Events (Two or More)

The intervention calls for clients to attend a minimum of two Social Events following their participation in Group Session One. The Social Events, which are usually offered monthly, provide an opportunity to strengthen clients' relationships to the program, to agency staff, and to peers. In a less formal setting, with a meal provided, clients are given support for their progress in achieving personal risk-reduction goals. Clients are also

encouraged to invite friends and family members. These social events help to motivate clients to remain engaged in the intervention and to complete all its components.

Follow-up Contacts (Two or More)

Outreach Workers conduct at least two supportive Follow-up Contacts with clients subsequent to the Individual Counseling Session. These encounters are structured and planned in advance with input from other agency staff who have worked with the client. Follow-up encounters may be conducted in the office, on the street, in the home, or elsewhere in the community. The purpose is to review risk-reduction progress made by the client and to encourage achievement of the client's personal risk-reduction goal. Outreach Workers reinforce the risk-reduction efforts of clients, assess their progress in achieving goals, and offer strategies to overcome reported barriers. At this time, referrals for medical, social, and other support services are again offered as needed.

HIV/Hepatitis Counseling and Testing

Voluntary HIV/Hepatitis Counseling and Testing is the fifth core element of the *SAFETY COUNTS* intervention. This element is integrated into all of the *SAFETY COUNTS* sessions, during each of which the importance of testing for HIV and viral hepatitis is discussed, and on-site testing or active referrals are provided for clients who are interested in being tested. This format provides multiple opportunities for Facilitators, Counselors, and Outreach Workers to discuss the benefits of testing with clients and to encourage them to be tested for HIV and hepatitis. Agencies also refer their IDU clients to medical service providers for vaccination against hepatitis A and B. (Clients already infected with hepatitis C should be vaccinated against types A and B to prevent additional liver damage.)

B. Overview of Behavioral Theories

III. REVIEW OF CORE ELEMENTS, THEORIES AND INTERNAL LOGIC MODEL OF *SAFETY COUNTS*

Behaviors that are directly linked to the transmission of HIV or viral hepatitis include: unprotected sex, sharing needles, and sharing drug preparation equipment.

There are certain factors that influence the likelihood of these behaviors occurring. These are called **Risk Determinants**:

- **Self-efficacy:** One's own self- confidence or a conviction in the ability to perform a new behavior. For example, if you feel confident in your ability to negotiate condoms, you are more likely to try to do so.
- **Skills:** The actual ability we need to do the new behavior. For example, condom negotiation or assertive communication.
- **Knowledge:** Having accurate information. For example, having accurate information on how hepatitis and HIV are transmitted.
- **Social Norms/Support:** Social norms are related to what our friends and other people in our social networks think about a behavior. For example, if our friends think a behavior is right or okay we are more likely to think it is right or okay. Social support is physical and emotional comfort given to us by others.
- **Perception (belief systems and attitudes):** Our beliefs consist of the way we think about something. For example, if a person believes they are not at risk, they are not likely to change their behavior.

If implementing agencies are able to affect an individual's risk determinant, they can cause a change in the risk behavior to which the determinant is linked. For example, if we increase clients' skills around condom use, it is more likely they will use them, thereby reducing the risk behavior of unprotected sex.

SAFETY COUNTS uses various behavioral theories to address and affect these identified risk determinants:

- The **Health Belief Model** proposes that people's motivation to change is affected by their beliefs of their susceptibility to a disease, severity of the disease, and benefits of changing their behavior. So it is affecting the following risk determinants:
 - Their perception (their perceived risk)
 - Their knowledge
 - Their self-efficacy
 - Their skills (they learn skills to make changes in behavior)

- **Social Cognitive Theory** proposes that people learn behaviors by watching and copying other's behaviors (such as peers) as well as behaving the way they think others expect them to behave. Therefore, it is affecting the following risk determinants:
 - Self-efficacy
 - Social norms/support
 - Perception
 - Skills

- **Theory of Reasoned Action** proposes that in order to change a behavior you need to target a very specific behavior and then manipulate the beliefs and/or attitudes around that behavior. So it is affecting the following risk determinants:
 - Perceptions
 - Self-efficacy

SAFETY COUNTS also uses the **Stages of Change Model**, which is extensively addressed with the clients in Group Session One of the intervention.

All of the activities of the intervention have been carefully structured to use these theories to affect the client's risk determinant. That is what makes the program so effective. Everything that is in the intervention was purposefully designed to affect the determinants and the outcome.

C. Internal Logic Model

Every intervention has an internal logic model. The internal logic model is how the intervention works. It is basically looking at the relationships among:

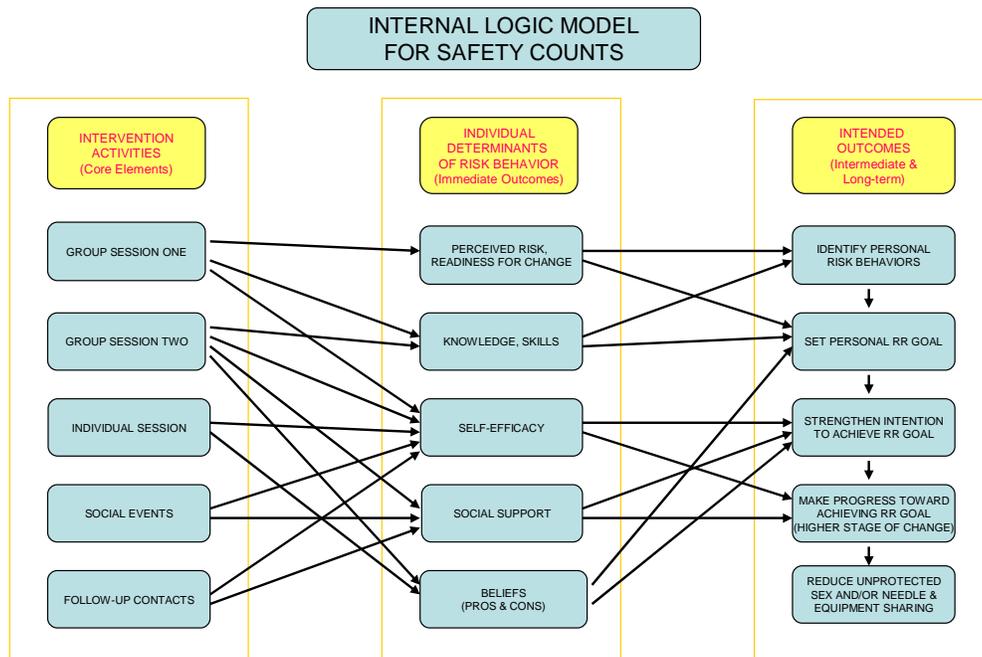
- The intervention activity (core element)
- The determinants of risk
- Intended outcomes

The logic model for *SAFETY COUNTS* shows:

- The particular individual determinants of risk behavior that are influenced by the activities in each *SAFETY COUNTS* session.
- How individual determinants of risk behavior act to influence the intended outcomes of *SAFETY COUNTS*.

III. REVIEW OF CORE ELEMENTS, THEORIES AND INTERNAL LOGIC MODEL OF SAFETY COUNTS

Figure 3. SAFETY COUNTS Internal Logic Model



For example, the Health Belief Model proposes that people’s motivation to change is affected by their beliefs in regards to their susceptibility to that disease. The risk determinants we may look for are perception and knowledge. So, we have intervention activities such as learning about local statistics or information about transmission. Through these activities, we hope to affect their sense of susceptibility. The outcome we are looking for may be more use of condoms or not sharing needles.

Every single piece in this intervention is purposeful. Even the introduction to the sessions, when you congratulate participants for coming into the session, is addressing a risk determinant – their self-efficacy. As the logic model shows:

- Self-efficacy is a key determinant of risk behavior that is targeted in every session of *SAFETY COUNTS*.

III. REVIEW OF CORE ELEMENTS, THEORIES AND INTERNAL LOGIC MODEL OF *SAFETY COUNTS*

- Building knowledge and skills and increasing risk awareness are a specific focus only in the first two sessions.
- Strengthening social support becomes more important as the intervention progresses.
- All of the immediate outcomes of *SAFETY COUNTS* are cognitive in nature.
- Intermediate and long-term outcomes change progressively from cognitive to behavioral.

IV. Preparing to Implement *SAFETY COUNTS*

In this section, we discuss different aspects involved in the implementation of *SAFETY COUNTS*, including assessing agency readiness and ability to implement *SAFETY COUNTS*, initiating implementation of *SAFETY COUNTS*, considering staffing and other resources required to successfully implement the intervention, and adapting the intervention. This section corresponds to detailed information contained in Part II of the *SAFETY COUNTS* Program Manual.

A. Agency Readiness, Decision Making, and Getting Started

As part of the process to decide whether *SAFETY COUNTS* is a viable option as an intervention for an agency, administrators need to assess the capability of the agency in several areas.

- The ability of the agency to recruit and retain active drug users not currently in drug treatment for a minimum of a seven session intervention which will last four months.
- The ability of the agency to provide a culturally sensitive environment, allowing the staff of the agency or organization to work openly and effectively in cross-cultural situations
- The capacity of the agency to offer HIV and HCV counseling and testing on site or have solid referral contacts for other agencies that are capable of providing this service.
- Personnel available (or who could be hired) to administer the intervention, facilitate a group level intervention, conduct street or institutional outreach, and provide individual level counseling sessions.

- The physical space to conduct group sessions of five to eleven individuals, space where 10 to 50 or more individuals can gather for the social events, and a closed office or area where individual, confidential counseling sessions can occur.
- Sufficient resources to produce targeted outreach materials (safer sex and injection risk reduction kits), provide incentives to intervention participants, to produce either video, audio or written personal risk reduction success stories, and a locking file cabinet.
- Sufficient Memorandum of Understanding and collaborative agreements with other agencies to provide a comprehensive referral network.

If the agency can address the concerns above, the final assessment needed is to find out whether agency culture and philosophy are appropriate for *SAFETY COUNTS*. The *SAFETY COUNTS* intervention treats drug use and high risk sexual behaviors as issues best addressed by public health. The intervention empowers active drug users to make healthy choices regarding their drug use and sexual behaviors within their cultural/social contexts. In many instances, these choices need not, and will not, include discontinuance of drug use. Agencies who maintain a strict abstinence-only outlook when working with drug users will find implementation of *SAFETY COUNTS* to be difficult. Clients who choose abstinence as a risk reduction goal will be encouraged and provided support and referrals necessary for success in that choice.

We suggest that agencies who maintain abstinence-only structures for their clients may consider carefully the possible ramifications of including *SAFETY COUNTS* in their organizational programming. This caveat will also hold for those agencies with which *SAFETY COUNTS* implementers may seek to collaborate. Agencies that are used as possible points of referral for *SAFETY COUNTS* participants, or drug users generally, should be asked as to agency philosophy and culture regarding persons engaged in active drug and

alcohol use. In some instances, these agencies may be inappropriate as referral linkages for this population.

B. Space and Staffing Considerations

Minimally, the *SAFETY COUNTS* intervention requires two, and in some instances three, separate types of meeting space. First, an agency will need a space sufficient for between five and eleven persons to meet comfortably. If sufficiently large, this space can also double as the room where the social events will occur. Social events will be attended by between 10 and possibly 50 or more persons, depending upon agency capacity and number of *SAFETY COUNTS* participants at any given time. The social event space may also be different than the room where the groups will meet. Required also is a space, preferably closed and quiet, where clients can meet and speak confidentially with agency staff for the individual counseling session.

Small community based organizations may find that the space requirements for the social events, or the group sessions, are currently beyond their fiscal ability to access. In these cases a number of possible alternatives exist. First, local governmental or non-governmental agencies may have meeting space that is under-utilized. Municipal, county or state health departments, other AIDS service organizations, churches or synagogues, and local United Way agencies are excellent resources in this instance. Local businesses are also usually amenable to providing meeting space for community based agencies, especially those designated as 501(c)3 organizations (not-for-profit), where donation of meeting space can translate into a tax-deduction at the end of the year.

Staffing for a successful *SAFETY COUNTS* intervention will, in addition to the executive director of the agency, include six positions working at the levels indicated below.

Note: Full-time employee (FTE)

- One program manager (.10 FTE)
- Two outreach workers (2 @ .75 FTE)

IV. PREPARING TO IMPLEMENT *SAFETY COUNTS*

- One behavioral counselor (.40 FTE)
- One group facilitator (.40 FTE)
- One program assistant (.10 FTE)

This is an ideal staffing mix and many agencies will be unable to bring this level of FTE into the *SAFETY COUNTS* implementation. Note that the counselor position may be filled either by a professional (LCSW or MSW) or a paraprofessional. These employees may be working part time on other projects for the agency. Time management and budget considerations are an important aspect of successfully implementing *SAFETY COUNTS*, particularly in smaller CBOs.

Where possible, and as funding allows, some tasks in the *SAFETY COUNTS* intervention can work together with other agency interventions. For example, where only one outreach worker position can be funded for the *SAFETY COUNTS* intervention, it may be possible to include this outreach worker in pre-existing outreach teams. Alternatively, the counselor for *SAFETY COUNTS* may also be providing prevention case management or other individual level intervention services within the agency.

Skills that *SAFETY COUNTS* staff should have include:

- Familiarity with street drugs and drug-use practices.
- Familiarity with injection drug use and safer injecting techniques.
- Familiarity with the drug-using culture and the various subpopulations of drug users.
- Familiarity with HIV and its prevention.
- Familiarity with prevention of hepatitis A, B, and C.
- Good verbal communication skills; active listening skills.

- Personal characteristics that facilitate communication with and acceptance by drug-using clients, including cultural competence, nonjudgmental attitudes, respect for others, friendly and outgoing disposition, and trustworthiness.
- Familiarity with the drug treatment modalities offered in the local community.
- Familiarity with self-help abstinence programs such as Narcotics Anonymous.
- Sensitivity to the needs of individuals of different racial/ethnic backgrounds, sexual orientations and genders.

C. Staff Training and Skills Foundations

Persons employed to implement *SAFETY COUNTS* need to have some background skills specific to their respective roles in the intervention. The necessity of these background skills for *SAFETY COUNTS* staff will become apparent during staff training for the intervention. *SAFETY COUNTS* is a structured intervention where each of the core elements requires specific activities and outcomes for successful implementation.

Outreach Workers

In addition to the skills listed above we recommend that outreach staff for *SAFETY COUNTS* have some previous experience conducting street outreach to drug using populations. Agency staff, and especially outreach workers, must first develop a rapport with the community. Developing rapport requires that the agency give consistent support and are regularly visible in the community. Building trust with the community does not come overnight. It comes from building relationships with target population members one at a time. In this way, the community can observe over time that the organization you represent and the behavior of the staff is caring and helpful. Building trust requires that your outreach workers are consistent – provide same services. It requires that outreach workers and other staff be respectful of the people they are serving and that they can explain their actions and the reasons behind them in a way that the target population

understands. Outreach workers, who generally are accustomed to distributing intervention materials and discussing HIV prevention techniques will need to learn that *SAFETY COUNTS* requires some significantly different outreach activities. When conducting follow-up contacts with *SAFETY COUNTS* participants, outreach workers must discuss:

- Risk reduction goals.
- First steps towards achieving those goals.
- Identifying barriers and providing suggestions to overcome those barriers.

These skills may be very new for some outreach workers and training must take into account these variations in standard outreach practice and procedures.

Group Facilitators

Group facilitators must also be trained specifically for their roles in the *SAFETY COUNTS* intervention. For the individuals conducting the group sessions and the social events, we recommend that they have experience working with group level interventions, preferably involving drug users. It is also suggested that training for persons conducting the groups include:

- In-depth training on presenting the Stages of Change model.
- Assisting clients in identifying risk reduction goals.
- Understanding the potential barriers of any given risk reduction goal.
- Breaking risk reduction goals down into first steps.

Counselors

Similarly, staff providing the individual counseling sessions need to have had some prior experience doing individual level interventions (i.e., prevention case management, risk

reduction counseling, etc.) with drug using populations. Counselors should also be trained on the following:

- Assessing risk reduction goals for appropriateness and attainability,
- Where and when risk reduction goals might be changed,
- Understanding community resources for risk reduction goal referrals.

The *SAFETY COUNTS* Program Manual provides specific direction for staff and should be referred to and utilized when designing staff training curricula. We also recommend that implementers consider a wide range of training options including role playing sessions, instituting quality assurance measures, and debriefing after *SAFETY COUNTS* core elements occur. Lastly, where necessary TA can be excellent resource for staff training on *SAFETY COUNTS*.

D. Adaptation

Interventions to prevent the acquisition and transmission of HIV (interventions directed toward people of negative or unknown serostatus) have received a great deal of attention from researchers and others interested in HIV prevention since transmission routes were identified in the early years of the epidemic. For this reason, the number of evidence-based interventions for this group has grown steadily and interventions are now available for a variety of populations and settings. Interventions to reach individuals of negative or unknown HIV status at high risk for HIV infection can be found on the CDC Replicating Effective Programs (REP) website at www.cdc.gov/hiv/projects/rep/ and the DEBI project website at www.effectiveinterventions.org. As people living with HIV disease (PLWH) have been diagnosed earlier in their infection, and treatment advances have led to greater length and quality of life, the prevention needs of PLWH have begun to receive more attention. Currently, a number of science-based interventions are available to address the strategies of CDC's AHP initiative.

While the investigators who designed these interventions have made every attempt in their research efforts to include the groups that are most impacted by the HIV/AIDS epidemic, no intervention study can be designed to demonstrate efficacy in every group at risk for transmission or acquisition of HIV. However, because the theories of behavior change upon which interventions are based are generalizable across a number of behaviors and populations, the interventions can be adapted to meet the specific needs of groups that were not part of the original research.

As previously discussed, core elements are the critical features that are thought to be responsible for the intervention's effectiveness. In other words, these are the parts of the intervention that are necessary to make it effective. They must be maintained without alteration. Key characteristics are crucial activities and methods for delivering the intervention. These characteristics can be modified to suit your target population.

Although the order and content of *SAFETY COUNTS* must be maintained, there are a number of ways in which the intervention can be adapted to meet the particular needs of your organization and client base. In considering adaptation, you must first have a clear understanding of the internal logic of the intervention. This means you must understand the link between the intervention activities (core elements), the determinants of risk, and the intended outcomes. The internal logic model is discussed in Section III of this guide.

Generally, adaptation involves modification in the following areas:

- **Who:** Modifying the target population. For example, the original *SAFETY COUNTS* was done with crack users and IDUs. If we conduct *SAFETY COUNTS* with crystal meth users, it is an adaptation of *SAFETY COUNTS*.
- **Where:** A modification in the location. So, for example, if you conduct the individual sessions in a van, that is a modification.
- **How:** Delivering it in a different language or changing how you arrange the groups. For example, one suggestion for a modification is to consider having

specific Group Sessions for HIV-positive and HIV negative individuals and/or gender specific so that each member of the group can safely discuss his/her own personal risks. This group dynamic will foster the development of a supportive environment among individuals who might be scrutinized within a discordant group. Of course, if you do have a separate group for HIV positives, it should not be common knowledge that this group is specifically for HIV positives (you do not want to stigmatize the group).

Before considering adaptation, it is very important to do the following:

- **First:** Test the original intervention as is. Very often, people will assume something will not work with their population without trying it.
- **Second:** Develop an understanding of how everything fits into the bigger picture. In other words, review the internal logic model to understand why the intervention was designed to be implemented the original way and how the adaptation affects the internal logic and outcome.

Adapting an intervention must come from an understanding of the population for which the intervention is intended and should take into account both culturally relevant factors for the group being served as well as thorough knowledge of the risk behaviors and risk determinants that place the population at risk for HIV infection. Providers cannot make the assumption that because an intervention will be delivered by a member of the target population, it will be appropriate for that population. Cultural identity does not necessarily lead to cultural competency. Information about risk behaviors and determinants can only be gathered with an appropriate formative evaluation of the target population. Following is a proposed Guideline for Adapting *SAFETY COUNTS* that CBOs should use in considering adapting the intervention for specific drug using populations.

GUIDELINES FOR ADAPTING *SAFETY COUNTS*

The purpose of this segment is to provide guidelines and procedures for community-based organizations (CBOs), in partnership with their designated capacity-based assistance programs (CBAs), to follow in adapting the *SAFETY COUNTS* HIV/hepatitis risk-reduction intervention for delivery to special subgroups of drug users, as defined by type of drug use or specific cultural or personal characteristics such as ethnicity or sexual orientation. These procedures are an extension of those that CBOs are expected to carry out routinely as a part of their preparation for implementing *SAFETY COUNTS* in their own settings. In contrast with the routine procedures for implementing *SAFETY COUNTS* in local drug-using communities, the procedures for adapting *SAFETY COUNTS* for special subgroups of drug users having certain unique characteristics are both broader in scope and more detailed.

This segment describes the general tasks and step-by-step procedures that must be carried out by CBOs, with assistance from CBAs, in order to adapt *SAFETY COUNTS* for use with specific subpopulations of drug users intended to be targeted separately by the intervention. The following topics are covered: (1) population identification, (2) agency resource assessment, (3) formative research and evaluation, (4) adapting intervention activities (5) developing a recruitment and retention plan, and (6) piloting the adapted intervention. Information is presented in a narrative outline format to enhance readability and facilitate later referencing of individual topics. It is assumed that readers of this document are completely familiar with the original *SAFETY COUNTS* intervention and that they have participated in the standard two-day training program for agency staff. In addition they must have a copy of the *SAFETY COUNTS* Program Manual available to use with these guidelines. The guidelines are not meant to replace or reproduce the detail about the intervention already provided in other documentation.

CBOs should make a formal request to their CDC Program Officer and designated CBA prior to initiating any adaptation of *SAFETY COUNTS*. This will ensure that adaptation

activities are properly coordinated and that individual agencies are provided with the level of technical support that they require.

Definition and Limits of Adaptation

Adaptation refers to the process where a behavioral intervention may be customized so that it will recognize or address specific characteristics of individuals or environmental contexts beyond those that were targeted in the original implementation of the intervention. During the adaptation process, it is essential that the core elements of the intervention remain intact. If these are modified significantly, there is the risk that the intervention will no longer be effective in achieving its stated risk reduction objectives.

In *SAFETY COUNTS*, the core elements of the intervention are the structured group sessions, individual counseling session, social events, and follow-up contacts, plus an integrated focus on HIV/hepatitis counseling and testing. The core elements are delivered as described in the Program Manual with respect to number of sessions, sequence, and essential content. Activities within each session are designed to impact specific individual determinants of risk behavior, including perception of risk and readiness for change, knowledge and skills, self-efficacy, social support, and risk reduction pros and cons. Positive changes in these individual determinants in turn cause increases in the adoption and performance of particular risk reduction behaviors by intervention participants. An internal logic model of the *SAFETY COUNTS* intervention is shown in Part IV of the Program Manual. This model diagrams the relationship of sessions and their activities (the core elements of *SAFETY COUNTS*) to individual determinants of risk behavior, and shows their impact on achieving intervention objectives. The model underlines the importance of maintaining the essential structure of *SAFETY COUNTS* sessions in order to preserve the demonstrated effectiveness of the intervention.

In general, *SAFETY COUNTS* is appropriate and may be adapted for all subpopulations of drug users with the following exceptions: (1) individuals whose only substance use is alcohol, (2) individuals whose only substance use is prescribed methadone, and (3) individuals who are currently enrolled in a drug treatment program (not including self-

help groups). *SAFETY COUNTS* is not considered to be appropriate for such individuals, and the intervention should not be employed with these groups.

SAFETY COUNTS has been designed for use with street-based populations, where individuals are severely disadvantaged economically and typically perceive themselves primarily as drug users and secondarily as members of particular ethnic groups or having particular sexual orientations. Adapting *SAFETY COUNTS* for use with non-street-based-populations can be expected to present challenges in terms of recruitment, retention, and, potentially, intervention effectiveness. Such adaptations can be problematic in that the incentive structure currently built into the *SAFETY COUNTS* may not have sufficient power with non-street-based populations to adequately support the recruitment process and maintain the necessary level of participation in the intervention. The current incentive structure consists not only of tangible incentives provided to participants at sessions (such as meals, prizes, coupons, and hygiene kits) but also social incentives including positive personal regard, respect, acceptance, and support by staff, as well as the opportunity to interact with drug-using peers in a cohesive group and experience their affirmation and support. The power of these incentives may be reduced in non-street-based settings, requiring that adequate substitutes for them be identified and incorporated into the intervention.

Detailed Guidelines and Step-by-Step Procedures

A) **Population Identification.** Identify the special subpopulation (group) of drug users that your agency intends to target using *SAFETY COUNTS* and for whom you plan to adapt the intervention. Describe the targeted group in specific terms, especially providing information about the characteristics they have in common. It is the characteristics they have in common that set them apart from other drug users and that define them as a special group for purposes of adapting the intervention. Shared characteristics might include:

- 1) Drug use patterns (drugs used—crack vs. methamphetamine vs. heroin vs. club drugs, or mode of administration—injection vs. non-injection).
- 2) Cultural or personal characteristics (e.g., sexual orientation, gender, age, ethnicity, job status, living situation).
- 3) Describe your rationale for restricting *SAFETY COUNTS* to this particular group of drug users (as opposed to enrolling a broader range of drug users that includes members of this special group). Bear in mind that the original implementation of *SAFETY COUNTS*, which was evaluated in a controlled research study, included participants who differed with respect to the type of drug they used (notably crack, heroin mixed with cocaine, and methamphetamine) and mode of administration (injection and non-injection), their ethnicity (black, white, and Latino), and their gender. Generally speaking, the intervention was found to be effective for all individuals regardless of their specific characteristics. In other words, the intervention has been found to work for a broad range of drug-using individuals in circumstances where the individuals have received the intervention as a single mixed group. It is nonetheless true that in certain instances the effectiveness of *SAFETY COUNTS* might be best maintained, or perhaps enhanced, by focusing the intervention on a particular subgroup of drug users and adapting it specifically for that subgroup.

B) Agency Resource Assessment. As the next step, before initiating the process of adapting *SAFETY COUNTS* for a special population, ensure that your agency has the necessary resources to conduct the intervention as described in the *SAFETY COUNTS* Program Manual as well as to adapt it for the special population of drug users you have identified. In particular, make certain that:

- 1) Your agency has an adequate budget to conduct the intervention.
- 2) You have appropriate staff, both in terms of personal characteristics and skills, to conduct the intervention, and you have an adequate number of staff. Cultural sensitivity of staff with respect to pertinent values and issues of individuals in the subpopulation being targeted is of critical importance.

- 3) All staff members who will be involved in *SAFETY COUNTS* have been fully trained in how to conduct the intervention.
- 4) Your agency possesses sufficient linkages and access to the special group of drug users you intend to target to enable you to recruit an adequate number of participants and to stay in contact with them over a period of time.
- 5) Your agency is able to commit the additional time and staff resources that will be required, beyond those that would be needed for a “standard” implementation of *SAFETY COUNTS*, in order to adapt *SAFETY COUNTS* for a special subgroup of drug users.
- 6) Part II of the *SAFETY COUNTS* Program Manual, “Preparing for Program Implementation,” contains an extended discussion and gives detailed examples of the funding, staffing, and other resources required to implement the *SAFETY COUNTS* intervention. No additional resources should be required when *SAFETY COUNTS* is focused on a specific subpopulation of drug users, once the adapted intervention is up and running.

C) **Formative Research and Evaluation.** Next, begin the process of adapting of adapting *SAFETY COUNTS* for the special population of drug users that you have identified. It will first be necessary to gather detailed information about the special population from a variety of sources. The specific information sources, objectives, and activities required for this effort are outlined below.

- 1) Review whatever literature currently exists (books, journal articles, meeting presentations, Internet websites) concerning the special group of drug users you wish to target with *SAFETY COUNTS*. Pay special attention any information that is available regarding the personal characteristics of group members, general characteristics of the group (e.g., group cohesiveness), and cultural uniqueness of the group compared with other groups of drug users. In addition, obtain detailed information (if available) about the relative frequency of specific HIV and viral hepatitis risk behaviors and the circumstances surrounding their enactment.

- 2) Obtain information from experts in the fields of HIV prevention and drug use. Start by talking with CDC staff members who are familiar with the special population of drug users in which you are interested. Ask for referrals to other experts, including university researchers and staff of selected HIV prevention programs. In addition to obtaining opinions of these expert sources regarding specific issues of the type listed in the section above, request information about additional published literature that might be available.
- 3) Conduct structured interviews and focus groups with local drug users belonging to the special subgroup who will be recruited into *SAFETY COUNTS* and for which you wish to adapt the intervention. (For information about developing and conducting structured interviews and focus groups, see *The Focus Group Kit*, Vols. 1-6, David L Morgan & Richard A Krueger, Sage Publications, 1998 and *Focus Groups: A Practical Guide for Applied Research*, 3rd ed., Richard A Krueger & Mary Anne Casey, Sage Publications, 2000). The number of interviews and focus groups to be conducted will vary depending upon your agency's resources and the degree of consensus that emerges. As a minimum, however, six individual interviews and two focus groups of at least four persons each must be conducted in order to obtain information that will be useful in adapting the intervention. Specific objectives for the structured interviews and focus groups include the following:
 - a) Identify the types and relative frequencies of specific risk behaviors. Also obtain as much information about:
 - (1) Individual determinants of risk behavior (psychological and related personal characteristics of individuals that influence risk behavior and drive behavior change). Examples are knowledge, skills, perceived risk, readiness for change, positive and negative beliefs about consequences, self-efficacy, and social support.
 - (2) Contributing risk factors (incidental behaviors or circumstances that increase the likelihood that a risk behavior will occur). Examples are use

of drugs that increase desire for sexual activity and membership in social networks where consistent use of condoms is discouraged.

- b) Identify specific behaviors that individuals have engaged in themselves or that others they know have engaged in to reduce risks associated with HIV and viral hepatitis. Include all risk reduction behaviors mentioned, even those that may be of questionable efficacy.
- c) Identify specific barriers to risk reduction that have been experienced, ways that these barriers were overcome, or possible ways they could be overcome.
- d) Identify current and past sources of social support reported for risk reduction efforts, as well as suggestions for social support. Identify appropriate strategies for seeking and obtaining social support.
- e) Identify the most appropriate strategies and venues for recruiting members of the special target population into the intervention.
- f) Determine the best incentives to encourage intervention participation.
- g) Determine the best times to schedule intervention activities (e.g., daytime versus evening, weekdays versus weekends).
- h) Identify individuals and content for risk reduction success stories to be produced prior to implementing the adapted intervention:
 - (1) Understand the various risk reduction behaviors that have been successfully adopted by local individuals in the subpopulation of drug users targeted for the intervention.
 - (2) Locate individuals in the local community with appropriate stories who are willing for their stories to be used as a part of the *SAFETY COUNTS* program.

D) Adaptation of Intervention Activities. Use the information obtained from interviews and focus groups, supplemented by information gathered from published literature and experts, to focus and contextualize *SAFETY COUNTS* activities

appropriately in order to adapt them for the local subgroup of drug users your agency intends to target. Specific guidance is provided below.

- 1) It is not necessary to make any changes in the standard forms and worksheets that are used in connection with *SAFETY COUNTS* activities. These were developed to accommodate a variety of potential behaviors and circumstances, and they are intended to provide a common framework for all implementations of the intervention with any drug-using population.
- 2) Carefully review all of the activities in each *SAFETY COUNTS* session to determine which ones to focus on most heavily in adapting the intervention for your subpopulation. Sometimes, adapting activities will consist of nothing more than following the guidelines that already exist and are described in sufficient detail in the Program Manual. In other instances, it will be necessary to go beyond what is explicitly articulated in the Program Manual, focusing and elaborating upon the content of particular activities in order to maximize their relevance for the current target group.
- 3) The different activities in each of the eight *SAFETY COUNTS* sessions are listed below. **Numbering of activities below is consistent with that used in the Program Manual.** Under each activity, there are comments, suggestions, and issues to consider that will assist your agency in adapting the activity for a specific subpopulation. Activities that do not require adaptation or for which adaptation is not relevant, such as Participation Documentation, are labeled as follows: “Adaptation is not applicable to the content of this section.”

Program Enrollment Session

- (1) Introduction:

Adaptation is not applicable to the content of this section.

- (2) Eligibility Check:

Adaptation is not applicable to the content of this section.

- (3) Completion of Program Enrollment Form:

The demographic and other personal information asked for on the Program Enrollment Form ***should not be changed***, as it represents the minimum required for tracking clients in the field and understanding their risk background. If additional information is needed at the time of enrollment, a supplement to the Program Enrollment Form may be developed as indicated. If some of the drugs or sexual activities listed are likely not to apply to clients in the subpopulation being enrolled, a brief statement to this effect prior to completing these parts of the form is sufficient.

(4) Description and Overview of *SAFETY COUNTS*:

Emphasize the particular subgroup you are targeting when you are describing the objectives of *SAFETY COUNTS*. For example, if your program is aimed at African American men who inject drugs and are currently homeless, be specific about saying this. The idea is to communicate to clients that the program is exclusively designed for people just like themselves.

(5) Completion of Risk Reduction Interview:

Like the Program Enrollment Form, the Risk Reduction Interview ***should not be changed***. The 15 risk reduction behaviors that are presented in the interview cover all of the behavioral categories for reducing HIV and hepatitis transmission risks. The four general risk questions that are asked at the beginning of the interview enable the interviewer to identify any risk reduction behaviors that do not apply to a particular client and should therefore be skipped. The Risk Reduction Interview, in its original form, thus accommodates itself to the particular risk profiles of special subgroups.

(6) Referral for HIV Testing and Other Needs:

In addition to providing referrals for HIV and viral hepatitis testing, this is an opportunity to show new clients that your agency is linked to resources in the community that can provide them with services relevant to their

particular needs. By demonstrating that your agency understands their group's unique issues, you can strengthen their commitment to participate in *SAFETY COUNTS*.

(7) Closing:

Adaptation is not applicable to the content of this section.

(8) Participation Documentation:

Adaptation is not applicable to the content of this section.

Group Session 1

(1) Introduction:

The sequence and basic content of the five topics covered in the Introduction ***should not be changed***. The presentation, however, should be focused in such a way that participants are encouraged to perceive *SAFETY COUNTS* as a program that speaks to the unique needs and issues of their particular subgroup. This will encourage group cohesiveness and strengthen participants' identification with *SAFETY COUNTS*. Adaptation efforts should be concentrated in two areas: the Welcome (where the objectives and activities of *SAFETY COUNTS* should be summarized in a way that maximizes relevance for targeted participants) and Brief Facts about HIV and Viral Hepatitis (which should be modified to focus on the current participant group).

(2) Am I at Risk?

Worksheet 1 (Am I at Risk for HIV and Viral Hepatitis?) may be modified by adding additional questions that reflect variations in risk behaviors and contributing risk factors that are unique to the current target group. Such additional items should be added in the last three sections of the worksheet ("If you inject drugs," etc.). The content of the first section ("In the past three months:") ***should not be changed***. In addition ***none of the current questions should be deleted***. Note that Worksheet 1 is suitable for use "as

is” with any group of drug users. Adapting the worksheet to make it a closer fit to the special group your agency is targeting is a worthwhile effort, but it is not necessary in order for the intervention to work.

(3) Stages of Change—How We Change Our Behavior:

The current instructions in the Program Manual for conducting this activity incorporate procedures that adapt the presentation to fit the personal characteristics and experiences of specific group participants. No additional adaptation is required for this component to be effective with special target groups. Note that the major portion of this segment is intentionally not related to HIV/hepatitis risk behaviors or to drug use. At the very end of the presentation, where a linkage is made between stages of change and HIV/hepatitis risk reduction, participants are asked to suggest some potential risk reduction behaviors, which are then listed on easel paper by the facilitator. Since these come from participants themselves, they do not need to be adapted to ensure relevance.

(4) Learning from Risk Reduction Success Stories:

The risk reduction success stories are a key component of the intervention, and they must be developed locally by each agency according to the instructions provided if they are to be effective in motivating risk behavior change. Closely follow the specified procedures for creating risk reduction success stories described in the Program Manual (Appendix C). If this is done, no additional adaptation is required to use this component with special groups. Risk reduction success stories are drawn from the local population of drug users being targeted by the intervention, and they will as a matter of course incorporate and reflect the special circumstances and behaviors of the subgroup of drug users who will be enrolled. Ensuring that risk reduction success stories reflect the personal experiences of real people in the local community who possess the same core characteristics as individuals who will receive the intervention will ensure that the stories have maximum relevance when they are presented.

(5) The Importance of Social Support:

The current instructions in the Program Manual for conducting this activity incorporate procedures that adapt the presentation to fit the personal characteristics and experiences of specific group participants. No additional adaptation is required for this component to be effective with special target groups. This first part of this activity consists of a guided critique of the risk reduction success stories during which participants identify instances of social support that were observed in each of the stories. For properly constructed stories, the social support instances they contain will be perceived by participants as realistic and potentially relevant for them on a personal level. In the second part of the activity, participants are asked to think of specific individuals in their own lives who have provided social support for them previously in problem situations. For both parts, the current procedures assure maximum relevance of content for special groups.

(6) Where Do I Stand in Reducing My Risks?

Worksheet 2 (Where Do I Stand in Reducing My Risks for HIV and Viral Hepatitis?) is employed in this activity to provide participants with an opportunity to evaluate their current risk reduction efforts using the stages-of-change framework. Although the content of this worksheet ***should not be changed***, it is suggested that the facilitator talk through the questions on the worksheet prior to asking participants to fill it out. As each question is read aloud, the facilitator should elaborate with specific examples of the general behavior that are relevant for the subgroup of drug users being targeted. For example, “Practicing alternatives to vaginal and/or anal sex” would be followed by examples of specific alternatives likely to be practiced by these participants. “Decreasing/managing my drug use” would be followed by examples of possible ways this might be accomplished for specific drugs and situations familiar to the participants. This same approach should be applied to all or most of the 15 risk reduction

behaviors listed, so that participants will understand them in the context of their own lives and will appreciate that each of the general behaviors listed represents more than one, and usually several, specific ways of reducing disease risk.

(7) Closing:

Adaptation is not applicable to the content of this section.

(8) Participation Documentation:

Adaptation is not applicable to the content of this section.

(9) Staff Debriefing:

Adaptation is not applicable to the content of this section.

Group Session 2

(1) Introduction:

As with the Introduction in Group Session 1, the sequence and basic content of the topics outlined in the Program Manual ***should not be changed***. It may be possible to adapt the icebreaker to focus it on a shared characteristic or experience of group members that will bring them closer together and that they can laugh about together (sensitive topics should, of course, be avoided). Focusing the icebreaker in this manner can reinforce for participants the message that *SAFETY COUNTS* is a program designed for people like themselves with their special background and special needs.

(2) Developing Risk Reduction Goals:

The current instructions in the Program Manual for conducting this activity incorporate procedures that adapt the presentation to fit the personal characteristics and experiences of specific group participants. No additional adaptation is required for this component to be effective with special target groups. It is recommended, however, that facilitators review the information obtained from target group members during the

exploratory structured interviews conducted prior to intervention implementation to familiarize themselves with the range of specific risk reduction activities mentioned.

(3) Identifying First Steps Toward Goals:

The current instructions in the Program Manual for conducting this activity incorporate procedures that adapt the presentation to fit the personal characteristics and experiences of specific group participants. No additional adaptation is required for this component to be effective with special target groups. However, information from previously conducted structured interviews may be useful in a general way in informing facilitators' understanding of plausible first steps toward achieving specific personal risk reduction goals.

(4) Overcoming Barriers to Behavior Change:

The current instructions in the Program Manual for conducting this activity incorporate procedures that adapt the presentation to fit the personal characteristics and experiences of specific group participants. No additional adaptation is required for this component to be effective with special target groups. As above, however, it is possible that information from preliminary structured interviews may be informative in terms of understanding any special barriers to risk reduction barriers faced by target group members.

(5) Learning from Risk Reduction Success Stories:

The current instructions in the Program Manual for conducting this activity incorporate procedures that adapt the presentation to fit the personal characteristics and experiences of specific group participants. No additional adaptation is required for this component to be effective with special target groups. (See comments for Activity 4, Group Session 1, above.)

(6) Finding Social Support:

The current instructions in the Program Manual for conducting this activity incorporate procedures that adapt the presentation to fit the personal characteristics and experiences of specific group participants. No additional adaptation is required for this component to be effective with special target groups. This activity is a continuation of the social support activity in Group Session 1 (see Activity 4 above). In the current activity, participants are guided to identify one or more people in their own lives who could be supportive of their personal HIV/hepatitis risk reduction efforts. Information obtained from the structured interviews conducted with target group members prior to implementing the intervention may be helpful to facilitators in understanding the various social support possibilities for his group of participants.

(7) Closing:

Adaptation is not applicable to the content of this section.

(8) Participation Documentation

Adaptation is not applicable to the content of this section.

(9) Staff Debriefing

Adaptation is not applicable to the content of this section.

Individual Counseling Session (1 minimum)

(1) Introduction:

The sequence and basic content of the three topics covered in the Introduction *should not be changed*. However, in addition to the instructions provided in the Program Manual for building rapport with participants, the behavioral counselor should acknowledge the special drug user group to which the participant belongs and make positive

reference to the participant's and the group's concern with HIV and viral hepatitis.

(2) Review and Refine Personal Goal Card:

The current instructions in the Program Manual for conducting this activity incorporate procedures that adapt the presentation to fit the personal characteristics and experiences of specific group participants. No additional adaptation is required for this component to be effective with special target groups. (See Group Session 2, Activity 2.)

(3) Review and Refine First Step:

The current instructions in the Program Manual for conducting this activity incorporate procedures that adapt the presentation to fit the personal characteristics and experiences of specific group participants. No additional adaptation is required for this component to be effective with special target groups. (See Group Session 2, Activities 3 and 4.)

(4) Ensure Social Support:

The current instructions in the Program Manual for conducting this activity incorporate procedures that adapt the presentation to fit the personal characteristics and experiences of specific group participants. No additional adaptation is required for this component to be effective with special target groups. This activity is a follow-up to the social support identification activity that was conducted during Group Session 2 (Activity 6).

(5) Assess Referral Needs and Make Referrals:

As in the Program Enrollment Session (Activity 6), this is an opportunity to provide a valuable service to participants and to demonstrate that your agency has linkages to resources in the local community that are relevant to the needs of their particular subgroup of drug users.

(6) Review Future Program Participation:

Adaptation is not applicable to the content of this section.

(7) Closing:

Adaptation is not applicable to the content of this section.

(8) Participation Documentation:

Adaptation is not applicable to the content of this section.

Social Events (2 minimum)

(1) Greeting and Introduction:

As in the welcome for Group Session 1 (Activity 1), the greeting speech for social events should be personalized for the special group being targeted. This can be accomplished by recognizing the special challenges or obstacles group members face together as they confront health threats like HIV and viral hepatitis. The various housekeeping topics should be covered listed in the Program Manual.

(2) Program-Related Entertainment Activity:

As described for the icebreaker in Group Session 2 (Activity 1), it is beneficial if the content of the entertainment can reflect the shared characteristics and experiences of the target group for which the intervention is being adapted. Having fun together around topics that celebrate participants' shared uniqueness will strengthen their bonds with one other as well as with *SAFETY COUNTS*.

(3) Meal:

Adaptation is not applicable to the content of this section.

(4) Risk Reduction Activity:

The current instructions in the Program Manual for conducting this activity incorporate procedures that adapt the presentation to fit the personal characteristics and experiences of specific group participants. No

additional adaptation is required for this component to be effective with special target groups.

(5) Drawing for Grand Prize:

Adaptation is not applicable to the content of this section.

(6) Dessert and Closing:

In the closing statement, the facilitator should identify the special subgroup targeted by the intervention and call attention to specific positive attributes possessed by its members. This should be woven into a general theme of “people helping themselves to stay safe in our community.”

(7) Participation Documentation:

Adaptation is not applicable to the content of this section.

(8) Staff Debriefing:

Adaptation is not applicable to the content of this section.

Follow-up Contacts (2 minimum)

(1) Approach and Greeting:

Follow the instructions in the Program Manual regarding how to approach participants. It is expected in *SAFETY COUNTS* that all follow-up contacts will take place in the field (out of the office setting) on the participant’s “turf.” This is one more reason that outreach workers should, if at all possible, be similar to the participants they interact with in terms of ethnicity and other salient characteristics, including community of origin. They should also be familiar with the drug use patterns of individuals in the special target population for which *SAFETY COUNTS* is being adapted. (Issues related to hiring former drug users as outreach workers are discussed in the Program Manual, Part II.)

(2) Verify and Validate Client's Goal and Progress:

Adaptation is not applicable to the content of this section.

(3) Plan the Next Step:

The current instructions in the Program Manual for conducting this activity incorporate procedures that adapt the presentation to fit the personal characteristics and experiences of specific group participants. No additional adaptation is required for this component to be effective with special target groups. As mentioned earlier (Group Session 2, Activity 3), information from previously conducted structured interviews may be useful in a general way in informing the understanding of outreach workers regarding reasonable concrete steps that might be taken toward achieving specific personal risk reduction goals.

(4) Help Client Identify and Overcome Barriers to Achieving Next Step:

The current instructions in the Program Manual for conducting this activity incorporate procedures that adapt the presentation to fit the personal characteristics and experiences of specific group participants. No additional adaptation is required for this component to be effective with special target groups. As with the activity above, information from structured interviews may be helpful to outreach workers in gaining a fuller understanding of possible barriers participants in the special target population can face (see Group Session 2, Activity 4).

(5) Social Support Check-In:

The current instructions in the Program Manual for conducting this activity incorporate procedures that adapt the presentation to fit the personal characteristics and experiences of specific group participants. No additional adaptation is required for this component to be effective with special target groups. This activity is a follow-on to the social support

check-in that was conducted during the Individual Counseling Session (Activity 4).

(6) Closing:

Adaptation is not applicable to the content of this section.

(7) Participation Documentation:

Adaptation is not applicable to the content of this section.

(8) Staff Debriefing:

Adaptation is not applicable to the content of this section.

E) **Developing a Recruitment and Retention Plan.** Develop a recruitment plan for the adapted intervention and a plan to ensure retention of participants. Successful recruitment and retention are dependent upon the intervention's having an adequate incentive structure. This includes both physical and social incentives. Issues, strategies, and specific suggestions for recruiting and retaining *SAFETY COUNTS* clients are contained in Part II of the Program Manual. In addition, a general discussion of recruitment planning and procedures is contained in the CDC document, Procedural Guidance for Recruitment. This document is available on the CDC website (http://www.cdc.gov/hiv/topics/prev_prog/AHP/resources/guidelines/pro_guidance_recruitment.pdf). The degree to which recruitment and retention strategies developed for the adapted intervention will differ from those outlined in the *SAFETY COUNTS* Program Manual will depend upon a variety of factors. Primary among these is the extent to which the subpopulation being targeted by the adapted intervention may be characterized as street-based.

F) **Piloting the Adapted Intervention.** Pilot the newly adapted version of *SAFETY COUNTS* to identify problems and issues that need to be addressed before the intervention is actually implemented within the special target population. The piloting process can be relatively simple, involving trying out selected activities or segments from individual sessions, or it can be more complicated, involving the presentation of

one or more complete sessions. The individuals selected to serve as participants for piloting should be recruited from the subpopulation of drug users who will be targeted by the adapted intervention.

E. Target Population and Recruitment

The *SAFETY COUNTS* intervention is designed to be used with individuals who have used illicit drugs in the past 90 days and who are not in drug treatment programs. This includes injecting drug users (IDUs) and non-injecting drug users, as well as individuals who misuse prescribed medications, combine alcohol with other illicit substances, and illicit use of methadone.

Injection drug users (IDUs) include those who inject heroin, crack, hormones, cocaine, ketamine, speedballs, methamphetamines, and crystal methamphetamine. Non-injecting drug users may be sniffing or consuming heroin, pharmaceutical drugs including Xanax, Vicodin, Demerol and Percodan (see *SAFETY COUNTS* Program Enrollment Form). These drug users may frequently drink alcohol while simultaneously using these drugs.

SAFETY COUNTS is not to be implemented with people who indicate that alcohol is their primary drug of choice, or with alcoholics. *SAFETY COUNTS* is not to be conducted, or to be used with people who are enrolled in methadone treatment programs, correctional institutions, or any other type of drug treatment program. However, information about *SAFETY COUNTS* can be provided to individuals being released from such facilities. It is problematic to recruit from drug treatment or correctional settings. *SAFETY COUNTS* eligibility criteria require current drug use and this could undermine the treatment plan and path the individual has already chosen. Discharge planners and other treatment providers may refer individuals to *SAFETY COUNTS* when clients disclose that drug use had been reinitiated and they are no longer interested in participating in abstinence-based HIV/HCV prevention or drug treatment services.

One component of *SAFETY COUNTS* that should be addressed prior to implementation is the issue of client recruitment into the intervention. The primary goals of a successful recruitment component include:

- Gaining access to drug users in the community.
- Establishing trusting relationships with potential participants and engaging them in brief discussions about *SAFETY COUNTS*.
- Presenting *SAFETY COUNTS* in a manner that will allow potential participants to appreciate the benefits that they may receive from the program.
- Giving potential participants the motivational "push" that will get them into your facility for Group Session One.
- Identify – through formative research – potential barriers for recruitment, retention and implementation.

CDC recommends developing a recruitment and retention plan prior to implementing the intervention. Taking the time to make a plan in the beginning can really help to successfully recruit and retain clients and implement *SAFETY COUNTS* effectively.

A few key recommended areas to include in this plan are:

1. **Decide what the target number is.** Develop goals for number of cycles of *SAFETY COUNTS* per year, number of people starting each cycle, and number of people completing each cycle.
2. **Develop a plan for learning about your target population** including where they hang out, what their needs are, drug culture (related to particular drugs), social network patterns, etc. This can be done through formative evaluation. All of this information can help you when you are thinking about your recruitment and retention plan.
3. **Develop a written plan for multi-method recruitment strategies.** Do not just depend on one strategy. Take a look at all of the options that people have

- discussed here. Have a written plan that incorporates as many different strategies as possible. This plan should include methods to be used, who will be targeted with each method, locations where they will be targeted, what messages will be used, and who will carry out the activities related to each recruitment method.
4. **Develop a written plan to monitor the process and effectiveness of your recruitment strategies.** You want some means of keeping track of what is working and what is not. This could include log forms where outreach workers keep track of where they are recruiting and asking people during the enrollment session how they came to the program.
 5. **Develop a written plan for client retention strategies.** Again, do not get stuck on one strategy. For example, you can have various types of incentives. You may send reminder cards of when the groups are being held. Your outreach workers can always carry Social Event invitation cards with them. Even if they are not scheduled to see a client, they could give him/her an invite if they see him/her on the street. One thing to keep in mind if you are having problems with retention is to explore what is going on in the sessions. Often, retention is closely related to facilitation of the sessions.

Many community-based organizations will be familiar with the process of street or institutional outreach and hence should require only minimal time to strategize where and how to recruit people into *SAFETY COUNTS*. Agencies that are unfamiliar with outreach, however, should examine closely their ability to recruit persons into *SAFETY COUNTS* and possible strategies to maintain a steady flow of clients throughout the life of the intervention. In some instances, this assessment will require that the agency conduct a formative evaluation (see above section on Adaptation, and also Section VI. Monitoring and Evaluating *SAFETY COUNTS*), to identify when and where street outreach should be conducted to intercept persons likely to be eligible for the intervention. The formative evaluation process will also identify business venues and service agencies frequented by the target population and how individuals may be recruited by these agencies into *SAFETY*

COUNTS. In some instances, and particularly with many hidden populations, outreach may be conducted by placing recruitment advertisements in tabloids and magazines read by potential clients. Formative evaluation will also provide insight into how to utilize word-of-mouth or social network peer referrals. The social networks approach is a recruitment strategy based on the concept that individuals are linked together to form large social networks. For instance, the Responding Driven Sampling (RDS) technique is a robust social network recruitment effort that penetrates the networks of hard-to-reach populations – injection drug users, migrant workers who use drugs, young MSM who use methamphetamine, etc. – providing modest rewards to existing program clients for bringing close friends and associates from their networks into the program.

Implementing organizations that operate concurrent, alternative interventions for members of *SAFETY COUNTS* target populations should also be aware that cross-recruitment from intervention to intervention within the agency is a cost-effective and efficacious way to maintain a client base. Such a strategy, however, is of course dependent on both (or all) interventions being intended for identical target populations.

As mentioned in the *SAFETY COUNTS* Program Manual, the overriding concern regarding street outreach is the need to maintain the safety of the outreach workers. The process of formative evaluation should also provide implementing agencies with strategies and mechanisms to ensure the safety of their outreach workers.

Finally, the key to effective outreach is flexibility. Drug using populations are forced by circumstance to respond quickly to changes in the environment. A drug copping area one day may be overrun with police the next. It is important for community-based organizations to respond quickly to information provided by clients so as to optimize their outreach efforts.

F. Frequently Asked Questions

Staffing and Resources

Q. What do you think about hiring co-facilitators from a former client pool or essentially former drug users?

A. This will depend largely upon agency policy regarding hiring former users or former clients. So long as individuals have the requisite skills to accomplish the role for which they have been employed there does not appear to be any reason not to hire former users or clients.

Q. Should you have two facilitators for the group sessions?

A. Per the *SAFETY COUNTS* Program Manual, two persons should facilitate the group sessions.

Q. Can you use the same staff person that facilitated the group sessions for the follow-up contact? Can one person fill more than one role?

A. Yes, one person can fulfill more than one role. An implementing agency in New Jersey has successfully implemented *SAFETY COUNTS* with just two employees, who share between them all the roles for the intervention.

Q. Should we designate a specific staff member to be responsible for data collection and quality control?

A. This will depend on funding and agency priorities. Where possible it is always convenient to have a single staff member responsible for data collection, data entry and quality control. In most agencies, these tasks are distributed between administrative personnel and intervention staff.

Q. Most of the staff at my agency do individual level counseling, and no one has a lot of experience with running groups. Should we hire someone to deliver the *SAFETY COUNTS* group sessions?

A. In the absence of an individual with some background facilitating groups and if funding is sufficient it would be advisable to hire another person with experience to fill this role. Alternatively, a request for technical assistance for training regarding group facilitation may be an option for the agency. See discussion in Section II regarding how to request TA.

Q. Most of our staff have experience running groups. Do they need to attend formal training, or can they get what they need from the *SAFETY COUNTS* Program Manual?

A. The *SAFETY COUNTS* Program Manual should provide, to experienced facilitators, enough information to successfully run Group Sessions One and Two and the Social Events. Agencies interested in having staff attend *SAFETY COUNTS* trainings should contact GEMS at the website listed in Section II of this guide for information on attendance at trainings.

Q. What is the ideal staffing plan to implement *SAFETY COUNTS*?

A. Ideally staffing should include a Program Manager at .10 FTE, a Group Facilitator at .40 FTE, a Behavioral Counselor at .40 FTE, two Outreach Workers at .75 FTE, and a Program Assistant at .20 FTE.

Q. What are the bottom-line resources we need to effectively use the *SAFETY COUNTS* intervention?

A. At a minimum, sufficient funding for the following: wages for staff, intervention supplies, and incentives for participants. In addition, meeting space for the groups and social events, an office for the individual counseling sessions, a filing cabinet (preferably

with a lock) to hold records, the capability to produce materials for outreach, and a business phone for messages.

Fidelity

Q. How can I change the *SAFETY COUNTS* intervention without sacrificing effectiveness?

A. The sessions may be changed to reflect the culture and perhaps some specific risks of the target population. For example, sexual risks may be emphasized with crack smokers or speed injectors. Language may also be changed so that the target population is comfortable and understands the intervention, such as by using street slang or colloquialisms in place of obscure medical terminology. For example, ‘chiva’ versus heroin or crystal versus methamphetamine. In addition translation into other languages is wholly appropriate and should be done when working with populations for whom English is not the first language learned or used. See the discussion above regarding adaptation and tailoring.

Q. Some barriers just can’t be changed, like culture. What do we do then?

A. As stated in the section above on adaptation, *SAFETY COUNTS* can be modified as to which types of populations can be served (adaptation) and when it is delivered, as well as what is addressed and how the message is conveyed. Given these parameters it should be possible to “fit” *SAFETY COUNTS* to a wide variety of at-risk populations and cultural milieus.

Q. In what ways do you see *SAFETY COUNTS* supplementing or strengthening existing interventions and services within an agency?

A. *SAFETY COUNTS* can complement a variety of pre-existing interventions in an agency. For example it can be used as an intake device to bring high-risk or HIV positive individuals into further services such as prevention case management or HIV care services. It can also be used as a referral program where persons identified as high risk at

a needle exchange or during outreach can be recruited into *SAFETY COUNTS* and then further introduced to the other services of the agency.

Q. If we are offering some of these core elements, but not all core elements, is it still *SAFETY COUNTS*?

A. No, *SAFETY COUNTS* is *SAFETY COUNTS* only when all the core elements are being implemented.

Q. We don't conduct testing for HIV or HCV. Can we still implement *SAFETY COUNTS* and adhere to the core elements with fidelity?

A. Yes. It is, however, essential that your agency have in place a referral system where persons are referred to alternate agencies for HIV and HCV counseling and testing, and assured of appropriate access to and, where possible, priority placement for these services. Your agency should also have in place a mechanism to verify that persons referred to HIV and HCV counseling and testing services have in fact taken advantage of them.

V. Implementing *SAFETY COUNTS*

This section presents the various specific requirements of the core elements for *SAFETY COUNTS*. These requirements include preparatory work to be accomplished and the activities involved in each element. Specific details on the content of the elements are presented in the Program Manual, including a complete listing of the required materials for each session.

Participants should receive an incentive for each and every core element that they successfully complete. Some agencies will have budgeted for these incentives, some will not. It is recommended that if cash or cash equivalents (gift coupons to grocery stores or department stores) cannot be distributed that alternatives be found to this type of incentive.

It is recommended that members of the target population be asked (either individually or in a focus group) as to what type of incentives that they would appreciate for *SAFETY COUNTS* participation. In addition, those agencies that have no funds for incentives should seek donations from local merchants in order to provide the requested incentives.

A. Program Enrollment Session

In the Program Enrollment Session, an agency staff member conducts an interview with a prospective *SAFETY COUNTS* client to determine his/her eligibility for and interest in participating in the *SAFETY COUNTS* program. As a part of this process, the Program Enrollment Form and the Risk Reduction Interview are completed. The agency staff member will also provide the prospective client with an overview and description of the *SAFETY COUNTS* intervention including number and length of sessions, incentives, and confidentiality guarantees (where applicable). This session should also include acquiring contact information sufficient for communication (mail, email or telephonic) to remind clients of upcoming events and to contact these persons in the field for follow-up. It is recommended that agencies prepare and pilot-test media (business cards, letters and

appointment cards) to remind clients of upcoming groups and events. As has been found by agencies currently implementing *SAFETY COUNTS*, attrition rates can be significant without a system in place to consistently remind participants of *SAFETY COUNTS* events and appointments for Individual Counseling Sessions. In most cases, it should be possible to conduct this program enrollment session in the office or perhaps in a café or restaurant.

To improve retention, it is important for agencies to review the process of screening clients. Who is more likely to complete the program? Does the client understand that the program takes four months of commitment? Recognize whether the client is high (on drugs) at intake, or seriously disoriented (visible mental problems or socially unstable). Most importantly, analyze the Risk Reduction Interview and verify for risk behavior contradictions. For instance, if the client does not have any significant risk behavior, then the client should not be enrolled in *SAFETY COUNTS*.

B. Group Session One

Preparatory work for Group Session One includes having invited and received confirmation of attendance from at least 10 participants. Potential participants will have attended a program enrollment session and will have filled out a Program Enrollment Form. The room or setting where the group is to occur has been identified, reserved and prepared. Copies of all written materials have been made, the supplies listed above have been assembled and checked, particularly the TV/VCR/DVD or audiotape player, to ensure that they are working and that the facilitators understand their operation.

It is required that Personal Risk Reduction Success Stories be used in Group Session One and Group Session Two. The *SAFETY COUNTS* Program Manual lists components that should be included in each story. Incentives can be provided to facilitate client cooperation in filming the risk reduction stories. Prior to filming any risk reduction success story, clients must sign a release form provided by the agency. Recording DVDs can be a useful inexpensive option, and many of today's computers have software to edit video, or the software can be purchased at relatively low cost. Some cameras come with

software that can be downloaded for editing purposes. An implementing agency in New York has purchased a Sony Digital Video camcorder and has recorded and produced personal risk reduction success stories using this technology. The camcorder comes with editing software which is easily downloaded onto a computer. It took this agency about a week to learn the camera and editing software and they had produced their first personal risk reduction success stories for presentation within ten working days of having purchased the system. Total price for the camera and software was around \$700.

It is recommended that prior to filming or audio recording the Risk Reduction Success Story that participants rehearse the answers to the questions provided in Appendix C of the Program Manual. This ensures that the client understands and can answer the questions appropriately and also relieves some of the stress associated with the actual recording of the interview.

Upon completion of Group Session One, staff needs to fill out *SAFETY COUNTS* Participation Records for all attendees and file all materials that may have locator or other confidential information (Worksheet 2 and *SAFETY COUNTS* Participation Record). Staff should debrief regarding the session, how the presentation flowed, how the clients interacted with each other and anything that might impact client participation in other *SAFETY COUNTS* core elements. Where necessary, report attendance and other documentation to appropriate funding source; it is recommended that this be done the day of the group so as not to lose any relevant information.

C. Group Session Two

Preparatory work for Group Session Two includes reminding participants, when and where possible, to attend the group. Facilitators will have debriefed from Group Session One and discussed any problems or conflicts within the group and developed strategies to address these potential issues. Facilitators will have reviewed and discussed the Worksheet 2 input from the group and extracted pertinent information. The room or setting where the group is to occur has been identified, and where indicated, reserved.

Copies of all written materials have been made, the supplies listed above have been assembled and checked, particularly the TV/VCR/DVD or audiotape player, to ensure that they are working and that the facilitators understand their operation.

Upon completion of Group Session Two, facilitators will fill out *SAFETY COUNTS* Participation Record for all attendees, and file all materials that may have locator or other confidential information (Worksheet 2 and *SAFETY COUNTS* Participation Record). Where necessary report attendance and other documentation to appropriate funding source, it is recommended that this be done the day of the group so as not to lose any relevant information.

D. Individual Counseling Session

Preparation for the Individual Counseling Session includes debriefing with facilitators and outreach workers regarding the participants risk reduction goal and circumstances that may cause barriers to the participant achieving his/her goals. It is important that the participant's Worksheet 2 has also be reviewed and discussed with pertinent program staff. If specific referrals are to be made for the participant, for example prevention case management or other health/social services, these referrals should be prepared and where possible collaborating agencies notified of the possibility of a referral from the *SAFETY COUNTS* intervention.

Upon completion of the Individual Counseling Session, the counselor will fill out the *SAFETY COUNTS* Participation Record for the participant, and file all materials that may have locator or other confidential information (Worksheet 2, and *SAFETY COUNTS* Participation Record). Where necessary, report attendance and other documentation to appropriate funding source. It is recommended that this be done the day of the session so as not to lose any relevant information.

E. Social Events

Preparation for the Social Events can be extensive. A proper venue with sufficient space for upwards of 50 persons needs to be secured. A meal needs to be prepared, purchased, or solicited. The quantity of food needs to be sufficient for all persons attending the Social Event. Invitations need to be printed and distributed and ongoing reminders to participants where possible need to occur. The physical space needs to be prepared with tables set for dining and food service, a podium or raised platform for a stage area needs to be set up. All the employees of the organization should attend this function. In order to ensure that attendance at the Social Event is properly logged, an employee familiar with *SAFETY COUNTS* participants should be designated to sign in clients. Where possible, child care should be provided so that participants are free to take full advantage of the learning opportunities provided during the Social Event. Outreach materials need to be prepared in the event that future *SAFETY COUNTS* participants could be recruited during the course of the event.

A planned risk reduction activity is required for the Social Event. This is an opportunity for agency staff to express their creativity. Agencies have used television game shows such as Jeopardy and Family Feud – interactive games that allow participants to learn about HIV and hepatitis prevention.

Other planned risk reduction activities include working in small groups to share social support stories, discussing personal triggers for behavior change, or sharing progress and challenges in achieving personal risk reduction goals. This type of social event requires one facilitator for the small group and one event coordinator to keep food and logistics organized.

To ensure *SAFETY COUNTS* retention, Social Events should be conducted once a month. This will allow clients to develop and strengthen their social support skills during the four months required for intervention completion.

Upon completion of the Social Event, it will be necessary to fill out the *SAFETY COUNTS* Participation Record for the participants. If individuals are recruited into new *SAFETY COUNTS* cohorts during the Social Event, their names and other information need to be recorded for further contacts. Where necessary, report attendance and other documentation to appropriate funding source. It is recommended that this be done the day of the session so as not to lose any relevant information.

F. Follow-up Contacts

Preparation for the Follow-up Contact includes a review by the outreach workers of Worksheet 2 and the *SAFETY COUNTS* Participation Record. The outreach workers will also want to discuss specific issues regarding appropriate times and places to meet with the participant. Outreach workers should also review available resources and have the ability in the field to make referrals to other HIV and social service agencies.

Outreach workers conduct at least two Follow-up Contacts with program participants in the community, on their turf. This contact serves to support the client's behavior change when they are in a setting outside the office. During the Follow-up Contact the client might need to be reminded of their goal, be commended for completing their first step or create new steps to reach their goal. Upon completion of the Follow-up Contact the client can be referred back to the agency to attend a Social Event or have another Individual Counseling Session intended to resolve any misunderstandings or confusion pertaining to the steps needed to obtain the chosen goal.

Upon completion of the Follow-up Contact, it will be necessary for the outreach workers to fill out the *SAFETY COUNTS* Participation Record for the participants. Outreach workers may also debrief relevant program staff regarding client risk reduction goal progress and to ascertain further suggestions for the participant when re-encountered. Where necessary, report attendance and other documentation to appropriate funding source. It is recommended that this be done the day of the session so as not to lose any relevant

information. Note: since this is a structured contact, informal encounters with client in the field are not considered part of a Follow-up Contact.

G. HIV and HCV Counseling and Testing

Voluntary HIV/viral hepatitis Counseling and Testing/Vaccination is integrated into all of the *SAFETY COUNTS* sessions, during each session the importance of testing for HIV and viral hepatitis is discussed, and on-site testing or active referrals are provided for clients who are interested in being tested. The sessions listed above provide multiple opportunities for facilitators, counselors, and outreach workers to discuss the benefits of testing with clients and to encourage them to be tested for HIV and viral hepatitis. Where available, agencies should also refer their IDU clients to medical service providers for vaccination against Hepatitis A and B. If the implementing agency does not provide HIV/HCV testing or viral hepatitis vaccinations, collaborations with agencies that do provide these services are required.

H. Frequently Asked Questions

Core Element Sequence

Q. I start with a group of 25 enrolled in Group Session One. By the time I get to the Follow-up Contacts, factor out the ones who go to jail, who die, by the time I get to the final contact, I may have 10 people. Can I add people on while the intervention is running, perhaps in Group Session Two?

A. No, *SAFETY COUNTS* is a structured and sequenced intervention. In the instance where attrition has reached a point where it makes little sense to go ahead with Group Session Two (less than two participants) it may become necessary for the agency to evaluate their retention strategies and revise them as appropriate. In the event that such a situation continues, a request for TA may be an option for the agency to consider.

Q. If somebody does not attend *SAFETY COUNTS* activities for more than three months do they go back to Group Session One?

A. Yes, and three months is the dividing line. Persons who are lost to the program for less than three months can continue with the sequenced flow of the intervention. Those persons who are gone longer than 3 months need to re-start the entire sequence with an assessment interview followed by Group Session One.

Q. How long does it take a client to complete *SAFETY COUNTS*?

A. Assuming the client has made every scheduled Group Session, Social Event, Individual Counseling Session and Follow-up Contact with no lapses about four months.

Q. How many goals should be achieved before a client completes the intervention?

A. One goal should have been accomplished, however, the participant may achieve the first step towards a goal by the end of the intervention. Again a small success can be very important to the participant and provide enough motivation to continue working towards larger, more potentially substantial behavior change.

Q. Do people in different phases of *SAFETY COUNTS* attend the same Social Event?

A. Yes, so long as they have attended Group Session One, participants may attend the Social Events.

Q. What do clients get out of Social Events?

A. The Social Events provide an opportunity to strengthen a client's relationship to the program, to agency staff and to their peers. In a casual setting, with a meal provided, clients are given support for their progress in achieving personal risk-reduction goals.

Q. Can we add educational sessions to the intervention?

A. In order to maintain the integrity of the intervention, program implementers are not allowed to add any extra educational sessions to the intervention. Program Directors should continue to offer HIV and viral hepatitis educational sessions at different times, under a different program name or different schedule other than *SAFETY COUNTS*. HIV 101 workshops can provide a great opportunity to make referrals to mental health counseling, medical care and other services.

Q. Is it okay to do more than the minimum? For example, have a participant receive several Follow-up Contacts or attend more than two Social Events?

A. Yes, it is okay to do more than the minimum. Where possible we recommended that clients attend more than two Social Events and receive more than two Follow-up Contacts. Increased contact between staff and clients provides for enhanced support, encouragement, and resources for the participant to continue the process of behavior change.

Q. When do you offer HIV, HBV and HCV testing?

A. HIV testing should be offered in an appropriate manner throughout the intervention. In Group Sessions One and Two, knowledge of serostatus should be emphasized as a way to understand and potentially reduce risk. A similar message can be expressed in the Individual Counseling Session and during the Follow-up Contacts. Information on HIV testing and a discussion of where to go, who to see and what taking the HIV test is like may also form a part of the agenda of the Social Events. Hepatitis C testing should also be discussed as appropriate throughout the intervention. Hepatitis A and Hepatitis B vaccinations should also be offered, where available, and discussed with program participants perhaps near the end of the groups or after the groups have ended. Information on vaccinations and Hepatitis C testing should also be made available during the Individual Counseling Session and during Follow-up Contacts.

Q. What does HCV prevention have to do with the *SAFETY COUNTS* intervention?

A. Virtually all needle use risk reduction activities as outlined in the *SAFETY COUNTS* intervention materials are effective in reducing the risk of transmission and acquisition of HCV. In most localities HCV infection rates far outstrip HIV seroprevalence among IDUs. Therefore, statistics regarding HCV infection and its impact on IDUs can be presented during Group Session One to personalize issues of risk.

Q. What does Hepatitis A and Hepatitis B have to do with HIV prevention for injecting and non-injecting drug users?

A. Hepatitis B (HBV), like HCV and HIV is a blood-borne pathogen, hence any needle use risk reduction activity that is effective in reducing the risk of HIV and HCV also reduces the risk of HBV. In addition, vaccines exist for both HBV and HAV. Persons who are identified as being drug users (both injection and non-injection) should be provided the opportunity to be vaccinated against these diseases. Co-morbidity of HIV and any of the hepatitis viruses, or co-morbidity between the hepatitis viruses can be lethal and should be perceived by providers working with this population to be a top priority for prevention and care.

Programmatic Considerations

Q. What is the time frame to implement the intervention?

A. This will depend upon the agency. Assuming an agency has a reasonable amount of infrastructure, concurrent contact with the proposed target population, and the physical resources to implement, between four and six months should be required to put all the core elements in place, hire and train staff, and begin the intervention.

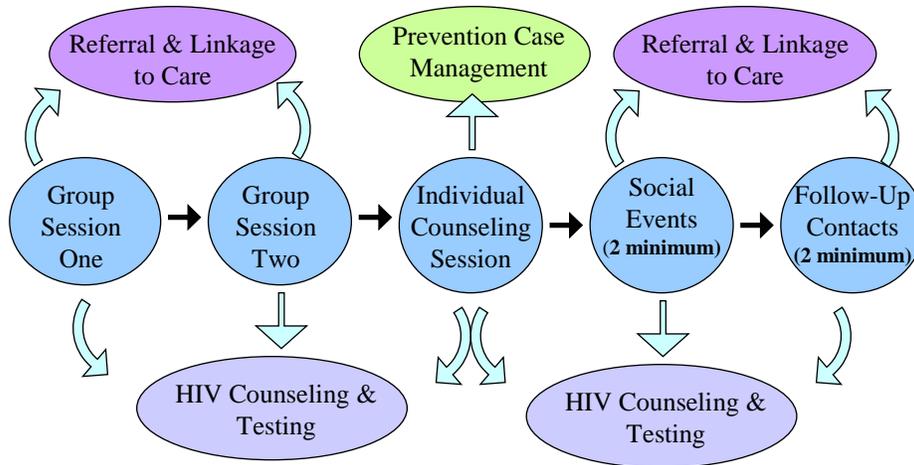
Q. What is the relationship between CDC’s new Advancing HIV Prevention initiative and this intervention?

A. Clearly this intervention has a number of intersections with the HIV prevention initiative from CDC. These include the emphasis that can be placed upon knowledge of serostatus to encourage persons at risk to test for HIV. *SAFETY COUNTS* may also be used for persons who are HIV-positive. An agency may even consider running parallel cohorts of participants who are both HIV-negative and HIV-positive given the possibility of disparate concerns and issues regarding prevention and transmission of the virus.

CDC’s Advancing HIV Prevention (AHP) Initiative



How *Safety Counts* Incorporates CDC's AHP Initiative



Q. Do the personal risk reduction success stories have to go through the review committee process?

A. Yes, assuming they were produced with federal funds, or will be distributed with federal funding, they need to be reviewed.

Q. How do we maintain confidentiality regarding the various *SAFETY COUNTS* worksheets?

A. We recommend that where locator information or names or drug use behaviors are collected from participants that these records be stored in a locking file cabinet. In some instances agencies may choose to develop unique identifiers for participants and this may be sufficient to maintain confidentiality even when the records are stored in unlocked filing cabinets. The basic rule of thumb is that when information that can identify a person and link that identification with drug use those records must be kept confidentially.

Q. Where does *SAFETY COUNTS* stand on abstinence from drug use?

A. The intervention identifies abstinence from drugs as an effective method for reducing risk for HIV infection. Clients who identify abstinence as their personal risk reduction goal are encouraged and supported by staff to be successful. Agencies implementing *SAFETY COUNTS* should have sufficient contact and referral relationships with drug treatment providers to be of assistance in finding appropriate opportunities for clients to realize the goal of abstinence.

Q. We are implementing *SAFETY COUNTS* in a rural area. Where should we go to do outreach for recruitment of clients into the intervention?

A. There are a number of options for outreach in rural areas. First, posting flyers in social service agencies, outpatient drug treatment counseling venues and other institutions and areas that are frequented by drug users should prove effective. Second, making contact with the population in local jails or through criminal justice agencies is another option for recruitment. Note that such contact should be prefaced by meetings with representatives of responsible agencies so that the purpose and general outline of *SAFETY COUNTS* strategies can be explained. Finally, once contact has been established with drug users in an area, information from these individuals can be used to identify and contact other potential clients as well as establishing other venues for outreach.

Q. Can we hold the Social Events in a park?

A. No. It would be difficult to maintain confidentiality in such a public venue. The ability for the participants to focus on the risk reduction activity might also be compromised in a park setting.

Q. During the Program Enrollment Session we are finding it difficult for the intake counselor to complete the Personal Risk Reduction Interview with the client. What can we do?

A. First, in order to familiarize program staff with the Program Enrollment Session and the intake forms, it is a good idea to have the intake counselor practice administering the Personal Risk Reduction Interview with other staff members in role playing sessions. Other options include providing for a break during the Program Enrollment Session so that the client can rest. Alternatively, scheduling two sessions on two separate days for Program Enrollment should leave ample time to complete the Personal Risk Reduction Interview in a less time constrained manner.

VI. Monitoring and Evaluating *SAFETY COUNTS*

A. Types of Monitoring and Evaluation

Program monitoring and evaluation of *SAFETY COUNTS*, or of any other behavioral intervention, is an important program management tool. With limited resources and increased pressures to "prove the effectiveness" of your programs, evaluation becomes more important. It is critical that accurate information is collected regarding the program's ability to meet its objectives and reduce HIV and viral hepatitis risk behavior. A good evaluation can tell the story of your agency's implementation of *SAFETY COUNTS* and can help re-direct and improve the intervention.

This section presents an overview of evaluation terminology and techniques. It also provides some basic forms – the Program Activity Summary Worksheet and the Personal Risk-Reduction Interview – to assist you in conducting the monitoring and evaluation of the process and outcome of implementing *SAFETY COUNTS* in your agency. This section corresponds to detailed information contained in the *SAFETY COUNTS* Program Manual.

There are three reasons to evaluate STD/HIV prevention interventions, such as *SAFETY COUNTS*:

Accountability: Accountability may be to the funder, the staff, the clients, and the community

Program Improvement: Evaluation helps us to improve existing programs

Knowledge Development: Evaluation helps us to plan future programs

For the purposes of this guide, four types of evaluation will be presented: Formative Evaluation, Process Monitoring, Process Evaluation, and Outcome Monitoring. These evaluation types are briefly described below.

Formative Evaluation collects data describing the needs of the population and the factors that put them at risk as well as factors that can help them reduce their risk and protect their health.

Process Monitoring collects data describing the characteristics of the population served, the types of services provided and at what frequency, and the resources used to deliver those services. It assists with making changes and improvements during the implementation process.

Process Evaluation collects more detailed data about how the intervention was delivered, differences between the intended population and the population served, and access to the intervention.

Outcome Monitoring collects data about client outcomes before and after the intervention, such as knowledge, attitudes, skills, behaviors, or intentions for behavior change.

B. Recommendations for Monitoring and Evaluating *SAFETY COUNTS*

It is recommended that implementing agencies evaluate *SAFETY COUNTS* by conducting process monitoring, process evaluation, and outcome monitoring. The table below lists these selected evaluations of the *SAFETY COUNTS* intervention including some sample indicators, methods and sample tools. Note that the sample tools listed are contained in the *SAFETY COUNTS* Program Manual.

Sample Process Monitoring and Evaluation Plan for *SAFETY COUNTS*

Data Collection Method	When and by Whom	Information Provided	How Used
Program Enrollment Form	At Enrollment Session, by Counselor or Facilitator	<ul style="list-style-type: none"> ▪ Demographic characteristics of clients (age, gender, ethnicity, etc.) ▪ Injection and non-injection drugs used by clients at intake ▪ Sexual activities and condom use at intake 	Ensure client demographics are representative of target population. Ensure intervention is reaching drug users at high risk of HIV/HCV.
Personal Risk Reduction Interview	At Enrollment Session, by Counselor or Facilitator	<ul style="list-style-type: none"> ▪ Specific drug-related risk behaviors of clients at intake ▪ Specific sex-related risk behaviors at intake 	Ensure emphasis placed on sex vs. drug risks in prog. is consistent with general client risks.
Client Participation Record	At the end of each session, by staff delivering the session	<ul style="list-style-type: none"> ▪ # of clients enrolled ▪ % completing all sessions ▪ % completing some sessions, by session ▪ % completing no sessions ▪ # referrals made, by type and session 	Assess retention of clients in intervention; identify sessions where participation is problematic. Ensure adequacy of referrals (# and types). Ensure % of telephone Follow-up Contacts is not excessive. Track materials distributed for procurement planning.
Program Monitoring Summary	Monthly and quarterly	<ul style="list-style-type: none"> ▪ % telephone Follow-up Contact(s) ▪ # and types of materials distributed ▪ # Group Sessions and Social Events held, and average attendance 	
Observation	Selected Groups and Follow-up Contacts, by Program Manager or Counselor	<ul style="list-style-type: none"> ▪ Assessment of each session element ▪ Assessment of personal style 	Ensure adherence to intervention guidelines in terms of content and procedure.
Audio tape recording	Selected Individual Sessions, by Counselor	<ul style="list-style-type: none"> ▪ Assessment of each session element ▪ Assessment of personal style 	Ensure adherence to intervention guidelines in terms of content and

			procedure.
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C. Frequently Asked Questions

Q. We have to label our interventions. Is *SAFETY COUNTS* a group level intervention (GLI) or an individual level intervention (ILI)?

A. The definition for individual level and group level interventions varies from state to state and this should be taken into account when reporting statistics to state or local health departments. Generally, *SAFETY COUNTS* would include both a group level intervention component, and individual component and a street outreach component. These may be reported separately without losing either process data or continuity with other interventions that the agency may be implementing concurrently.

Q. We’d like to develop a client satisfaction survey for our intervention participants. How should we begin?

A. There a number of ways to develop client satisfaction surveys. Many agencies already have such surveys and would likely be able to provide you with copies of them. Checking with a local or state health department first may save a lot of time and effort. If you choose to develop a survey, the best thing to do is ask what types of satisfaction with your programs you want to measure. Then develop questions that effectively elicit the measures and types of satisfaction that clients have with the intervention. It would also be a good idea to check with TA providers for help and guidance in this area.

Q. How can my agency create an evaluation plan?

A. The Program Manual has a number of excellent suggestions and resources to help agencies develop implementation plans. Referring to that document and then seeing what type of resources are available to the agency to implement an evaluation plan should provide a background as to what the agency might do and how much staff time and

resources may be brought to bear on the implementation. Again if agencies are having difficulty with evaluation they should obtain TA through the CRIS system

Q. How can the Personal Risk Reduction Interview be used for outcome monitoring?

A. The Personal Risk Reduction Interview is an excellent tool for describing how a participant has moved through the stages of change regarding HIV risk behaviors. With the data from this instrument it should be possible to show what type of effect the intervention has had in terms of participants reaching their risk reduction goals and changing risk behaviors.

Q. Can the questions used for the Personal Risk Reduction Interview be modified to be more specific to the client base?

A. In general, all the worksheets provided to agencies can be modified (see adaptation above) within certain limits. To change a tool that may be used for any type of evaluation can have potentially immense (and unintended) effects on how and what is being measured. In this instance, the Personal Risk Reduction Interview is specifically designed to be a general measure of where a person is in regards to certain risk reduction behaviors. The Personal Risk Reduction Interview is meant to be as exhaustive as possible in describing all the general risk reduction categories that an individual may choose to lower risk in regards to HIV infection and transmission. More specific behaviors will be developed as the individual addresses his/her individual risk reduction goals and seeks to achieve these goals. In the event an agency should still choose to change or alter the Personal Risk Reduction Interview, consultation with *SAFETY COUNTS* TA providers is recommended.