

SAFETY COUNTS

PROGRAM MANUAL

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



Center on AIDS & Community Health



Important Information for Users

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

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

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

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DRAFT

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December 2007

Acknowledgments

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.

Camilla Harshbarger, Jonny Andia, Abu Abdul-Quader, Janet Cleveland, Charles Collins, Nicole Trentacoste, and the members of the *SAFETY COUNTS* Continuous Quality Improvement Team (CQIT) at the Centers for Disease Control and Prevention (CDC), Division of HIV/AIDS Prevention, Intervention Research and Support, gave their support to this project.

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With support from the National Institute of Allergy and Infectious Diseases, Sociometrics Corporation—Josefina J. Card, Ph.D., principal investigator, and John P. Shields, M.S.W., Ph.D., project director—originally packaged the NIDA-funded intervention as *Safety Point*, and their material provided guidance in the development of this manual. This document also benefited from the review of the Sociometrics materials by Sherry Deren of the National Development and Research Institutes, Inc. and Ann Jimerson of AED.

The AED Center on AIDS & Community Health (COACH), in collaboration with CDC, prepared this document under contract to the Centers for Disease Control and Prevention (contract number 200-97-0605, task number 066, and contract number 200-2003-01924, task numbers 003 and 004) to support HIV prevention among injection drug users through technology transfer.

We acknowledge all the clients who participated in the research; without their participation, this intervention could not have been developed. We also acknowledge the valuable feedback provided by the many persons who attended *SAFETY COUNTS* trainings during the time that this manual was being developed.

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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PART I. INTRODUCTION

Organization of This Manual

This manual is divided into four parts. Part I, Introduction, provides an overview of the *SAFETY COUNTS* HIV/hepatitis intervention for drug users and details how *SAFETY COUNTS* directly supports the Centers for Disease Control and Prevention's (CDC's) Advancing HIV Prevention initiative for persons living with and at high risk for HIV infection. This part also explains the theoretical model for the *SAFETY COUNTS* intervention and describes the research that established the effectiveness of the intervention. Finally, the core elements of *SAFETY COUNTS* are identified and explained, together with the key benefits and potential challenges of implementation.

Part II, Preparing for Program Implementation, is designed to help program managers understand how to prepare for the implementation of *SAFETY COUNTS*. This section addresses choosing your *SAFETY COUNTS* intervention team, identifying program resources you will need, partnering with other organizations to accomplish *SAFETY COUNTS* goals, developing an implementation plan, training your intervention team, and estimating the cost of implementing *SAFETY COUNTS*. Part II also addresses the challenging issues of recruiting and retaining drug users in the *SAFETY COUNTS* intervention.

Part III, *SAFETY COUNTS* Session Guide, provides step-by-step instructions for conducting all of the *SAFETY COUNTS* sessions. Beginning with the Program Enrollment Session, each of the different sessions of *SAFETY COUNTS* (Program Enrollment, Group One, Group Two, Individual Counseling, Social Events, and Follow-up Contacts) is explained in careful detail as to content, process, and materials needed. At the beginning of Part III, procedures for integrating HIV and hepatitis testing and counseling referral into all of the sessions are covered. For easy reference, all the worksheets, questionnaires, and forms that are used in each session appear at the end of the instructions for that session. A complete set of these materials for all sessions is contained on the CD ROM provided with this manual at the *SAFETY COUNTS* training and online at www.effectiveinterventions.org. These can be duplicated as required for use during the implementation of *SAFETY COUNTS*.

Part IV, Program Monitoring and Evaluation, presents an overview of evaluation terminology and techniques, including formative, process, and outcome evaluation. Strategies for monitoring the processes and outcomes of *SAFETY COUNTS* activities are discussed. Two instruments that have been developed for use with the *SAFETY COUNTS* program are described – the Program Monitoring Summary and the Risk Reduction Interview – and their use is explained. In particular, procedures for administering a Personal Risk Reduction Interview at program enrollment and again at the end of the program to assess clients' adoption of behavior change strategies are covered in detail.

The Appendices at the end of the manual contain additional materials and resources that are needed for program implementation or that provide background for program managers. Of particular importance are the instructions for creating risk reduction success stories, together with a sample release form and the guidelines for adapting *SAFETY COUNTS*.

Overview of *SAFETY COUNTS*

The *SAFETY COUNTS* program offers a proven intervention for out-of-treatment drug-using persons that will enable them to reduce their risk of becoming infected with or transmitting the human immunodeficiency virus (HIV) and hepatitis viruses such as hepatitis C. The *SAFETY COUNTS* intervention is appropriate for HIV-positive as well as HIV-negative drug users.¹ *SAFETY COUNTS* is based on research that found this intervention to be effective in reducing high-risk sex and drug-use behaviors among both injection and noninjection drug users. As such, it is recommended for implementation by community-based organizations (CBOs) serving drug users.

Through structured group and individual activities, the intervention assists clients in setting personal risk reduction goals and developing specific steps for achieving them. In partnership with behavioral counselors and outreach workers, clients design and manage their personalized goals for reducing their risks of acquiring or transmitting HIV and viral hepatitis. Ongoing support for achieving risk reduction goals is provided through sustained contact with program staff, interactions with peers who are enrolled in the program, and exposure to the personal stories of other drug users in the local community who have been successful in reducing their own risks. Clients participate in the intervention for a period of 4 months.

This client-centered intervention benefits the client and the community. The research showed that the intervention reduced HIV risks by reducing drug use, increasing condom use, and increasing self-reported entry into drug treatment. Clients benefit from the strong outreach component of *SAFETY COUNTS* and from referrals to medical and social services. For HIV-positive clients, *SAFETY COUNTS* may allow them to deal with issues beyond substance use and HIV, such as addressing risk behaviors that can lead to contracting hepatitis and other infections. All clients learn how to make positive changes in their lives through setting specific goals and developing action steps to achieve their goals. These skills empower clients to take charge of their own risk behaviors, thereby benefiting themselves, their partners, their families, and their communities.

The *SAFETY COUNTS* intervention supports abstinence from drug use and encourages entry into drug treatment for persons who demonstrate appropriate readiness. The success of *SAFETY COUNTS* in achieving abstinence goals is indicated by the high percentage of clients who entered or tried to enter drug treatment in the context of their participation in the program. On average who participated in the *SAFETY COUNTS* program reported at follow-up that they had been successful in entering or had tried to enter a formal drug treatment program in the past 6 months. By comparison, only 35% of IDUs and 30% of crack users in the research study who did not

¹ Throughout the text, “drug users” is used to refer to persons who are currently injecting drugs and to noninjection drug users, such as those who use crack or methamphetamine.

participate in the *SAFETY*, 47% of injection drug users (IDUs) and 37% of crack users *COUNTS* program reported such behavior.

According to the Centers for Disease Control and Prevention (CDC)

- Approximately 40,000 people become infected with HIV each year in the United States, and about 10,000 of these are injection drug users (IDUs).²
- IDUs account for more than 60% of new hepatitis C infections in the United States.³
- Within 5 years of their first injection, 50% to 80% of IDUs acquire hepatitis C.⁴
- Of IDUs entering drug treatment facilities, rates of HIV infection range from 2% in Denver and Los Angeles to 37% in New York.⁵
- Continued and intensified HIV prevention efforts focused on men who have sex with men and on IDUs remain critical to prevent further transmission among high-risk populations and to reduce potential expansion to the general population.⁶

The epidemic demands that we implement prevention programs based on what we know works from the evidence of behavioral research. *SAFETY COUNTS* is a research-based intervention that has been shown to be effective with both injection and noninjection drug users. If the *SAFETY COUNTS* intervention is implemented as outlined in this manual, you can expect it to produce positive behavior change among your agency's clients who enroll in the program.

SAFETY COUNTS AND ADVANCING HIV PREVENTION

SAFETY COUNTS supports 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 approach provides

² Centers for Disease Control and Prevention. *CDC HIV/AIDS Update: A Glance at the HIV Epidemic*. 2000 *Statistics*.

³ Centers for Disease Control and Prevention. *Viral Hepatitis and IDUs*, September 2002.

⁴ Centers for Disease Control and Prevention. *Viral Hepatitis and IDUs*, September 2002.

⁵ Centers for Disease Control and Prevention. *CDC HIV Prevalence Trends in Selected Populations in the United States: Results from National Serosurveillance, 1993–1997*.

⁶ Quan et al. HIV Incidence in the United States, 1978–1999. *JAIDS* 2001;31:188–201.

- 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 HIV-infected persons and their partners.** *SAFETY COUNTS* is designed to meet the prevention needs of HIV-infected drug users 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 perinatal 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 to prevent perinatal HIV transmission.

Beyond its role in serving CDC's AHP initiative, *SAFETY COUNTS* can effectively reduce the risk of acquiring or transmitting hepatitis viruses, especially hepatitis C. Among IDUs, the risk for hepatitis C is particularly high because of its primary blood-borne route of transmission. Agencies that implement *SAFETY COUNTS* are encouraged to refer their IDU clients to medical providers for testing for hepatitis C and for vaccination against hepatitis A and B. Safe and effective vaccines are available to prevent infection with both hepatitis A and B. Clients already infected with hepatitis C should be vaccinated against types A and B to prevent additional liver damage.

The *SAFETY COUNTS* Intervention and What Makes It Effective

OBJECTIVES AND THEORETICAL FOUNDATION

SAFETY COUNTS is a cognitive-behavioral intervention, meaning that learning and experiential processes play an important role in developing and maintaining 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 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 hepatitis.
- Determine for themselves what they can reasonably do to reduce their risk for HIV and hepatitis.
- Take ownership of their personal risk reduction goals.
- Develop and manage specific steps for achieving these goals.

The *SAFETY COUNTS* intervention employs a stages-of-change framework, reflecting the model of Prochaska and DiClemente.⁷ The intervention also draws on behavior change principles articulated in the theory of reasoned action (Ajzen and Fishbein),⁸ social cognitive theory (Bandura),⁹ and the health belief model (Rosenstock, Strecher, and Becker).¹⁰

Research Study

The research for *SAFETY COUNTS* was conducted at California State University, Long Beach (CSULB), under a National Institute on Drug Abuse (NIDA) cooperative agreement. The *SAFETY COUNTS* HIV prevention program was developed and evaluated by using a sample of 1,237 crack users and IDUs who were not in drug treatment and who reflected the ethnic diversity of Long

⁷ Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology*, *51*, 390-395. Prochaska, J. O., & DiClemente, C. C. (1986). Toward a comprehensive model of change. In W. R. Miller & N. Heather (Eds.), *Treating Addictive Behaviors: Processes of Change* (pp. 3-27). New York: Plenum Press.

⁸ Ajzen, I., & Fishbein, M. (1980). *Understanding Attitudes and Predicting Social Behavior*. Englewood Cliffs, NJ: Prentice-Hall.

⁹ Bandura, A. (1994). Social cognitive theory and exercise of control over HIV infection. In R. J. DiClemente & J. L. Peterson (Eds.), *Preventing AIDS: Theories and Methods of Behavioral Interventions* (pp. 25-59). New York: Plenum Press.

¹⁰ Rosenstock, I. M., Strecher, V. J., & Becker, M. H. (1994). The health belief model and HIV risk behavior change. In R. J. DiClemente & J. L. Peterson (Eds.), *Preventing AIDS: Theories and Methods of Behavioral Interventions* (pp. 5-24). New York: Plenum Press.

Beach's drug-using population. The principal researcher was Fen Rhodes, Ph.D. The project director was Michele Wood, M.S. A detailed description of the research project and results of the study may be found in Rhodes, F., & Wood, M. (1998), "A Cognitive-Behavioral Intervention to Reduce HIV Risks among Active Drug Users: Efficacy Study," in *Staying Negative in a Positive World: HIV Prevention Strategies That Work* (Proceedings), Sacramento: California Department of Health Services, Office of AIDS. A reprint of this article appears in Appendix A.

The research study compared two behavioral intervention methods: a "standard" intervention and the *SAFETY COUNTS* intervention. The standard intervention consisted of an HIV counseling and testing session protocol developed by NIDA that focused on drug-related risks and provided general HIV/AIDS education. The *SAFETY COUNTS* intervention consisted of seven (or more) sessions of group and individual activities, plus HIV counseling and testing, which were delivered over a 4- to 6-month period. Structured interviews were used for preintervention baseline risk assessment and for a 6-month follow-up assessment. Urine drug tests were also conducted at both the baseline and follow-up time points.

Research Results

The *SAFETY COUNTS* intervention had a positive impact on clients' risk behaviors. Compared with clients in the standard intervention, clients enrolled in *SAFETY COUNTS* were generally about 1.5 times more likely to reduce their drug- and sex-related risks. *SAFETY COUNTS* was equally effective for men and women; young and old participants; and African American, Hispanic, and white participants.

Additional information regarding client outcomes for drug use, drug treatment, and condom use is provided in the accompanying table. Note that measurable behavior change occurred with both the standard and *SAFETY COUNTS* interventions, but *SAFETY COUNTS* resulted in comparatively greater change. In the table, the last column shows that behavior change occurred more frequently in areas that reflected the self-defined personal goals of clients. For example, 87.5% of clients in the *SAFETY COUNTS* intervention who had a personal goal to stop using dirty needles were able to do so compared with 74.3% of all *SAFETY COUNTS* clients and only 67.9% of clients in the standard intervention. So, while positive behavior change generally occurred for many clients in more than one risk area, the greatest change took place in the areas defined by the client's own risk reduction goals.

Magnitude of Behavior Change & Effect of Choosing Own Goal			
Behavior	Standard Intervention	<i>SAFETY COUNTS</i> (All Clients)	<i>SAFETY COUNTS</i> (Clients with Personal Goal Matching Behavioral Area)
Injection drug use (last 30 days):			
Times injected	-14.7	-36.5	-36.5
Days injected	-5.6	-8.2	-10.5
% stopped injecting	21.5	32.9	39.8
% neg. urine test (opiates)	16.4	23.4	29.0
% reduced dirty needles	89.3	85.7	93.8
% stopped dirty needles	67.9	74.3	87.5
Crack use (last 30 days):			
Days used	-8.4	-8.7	-9.3
% stopped using	25.6	28.8	38.8
% neg. urine test (cocaine)	18.6	23.8	27.9
Drug treatment (enter or try):			
% last 6 mos. (IDUs)	35.1	47.0	51.6
% last 6 mos. (crack users)	29.8	37.1	44.0
% last 30 days (IDUs)	15.1	18.5	20.4
% last 30 days (crack users)	8.9	13.2	11.2
Condom use (last 30 days):			
% increased freq.	33.0	49.6	64.1
% used always	15.3	22.5	23.3

Conclusions

The *SAFETY COUNTS* cognitive-behavioral intervention has been found effective in reducing the HIV risks of both injection and noninjection drug users. The individualized approach to setting risk reduction goals increases participant involvement and commitment to behavior change. Assisting participants in developing concrete risk reduction strategies that are realistic and flexible in meeting their personal needs, and allowing them to choose their own goals, enhances the likelihood of successful goal achievement.

SAFETY COUNTS CORE ELEMENTS

Five core elements of the *SAFETY COUNTS* intervention are considered essential to the intervention's success and should not be omitted or modified by local agencies. These core elements, which should be structured as specified in this manual 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

Seven sessions, in addition to a Program Enrollment Session, are required to deliver the core elements of *SAFETY COUNTS*. This number represents a minimum, however, and agencies can provide more individual counseling sessions, social events, and follow-up contacts as they see fit. Research has shown that risk reduction can and does occur by using the seven sessions specified, but providing additional sessions is likely to be more effective. You are encouraged to use this model in a way that works best in your own community. For example, you might decide that an additional individual counseling session or more follow-up contacts are needed with a particular client or with all of your clients. If your organization decides to add extra sessions, it is important to make sure that you follow the order, content, and structure of the core elements.

Within this framework, community-based organizations have flexibility in how they implement the *SAFETY COUNTS* intervention. For example, it may be offered either as a stand-alone intervention or in conjunction with an agency's existing client-service programs. Also, it may be targeted to new agency clients as well as existing clients. The exact context for engaging clients in the *SAFETY COUNTS* intervention will be determined by each agency's particular preferences, needs, and client characteristics.

Specific structured content is prescribed for each session, as summarized below and described in detail in Part III. Because each session builds upon the previous one, the two group sessions need to be provided in sequence; and the client must attend the first group session before attending a social event and both group sessions before participating in an individual counseling session. Follow-up contacts may begin only after an individual counseling session has been completed.

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 persons 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 the second group session, 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 *SAFETY COUNTS* intervention calls for clients to attend a minimum of two social events following their participation in group session one. Experience has demonstrated that 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 socials help to motivate clients to remain engaged in *SAFETY COUNTS* and to complete all components of the intervention.

Follow-up Contacts (Two or More)

Outreach workers conduct at least two supportive follow-up contacts with clients after 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. Their 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.

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.)

INTERNAL LOGIC MODEL

Identifying the impact of particular intervention activities on specific intervention outcomes enhances our understanding of how the intervention works and why the core elements are essential to its success. As described previously, the core elements of *SAFETY COUNTS* are the standardized activities that are conducted with participants over the course of seven or more individual and group encounters. The mechanisms by which these activities influence reductions in risk behavior can be diagrammed in a special flow chart called an internal logic model. An internal logic model of the *SAFETY COUNTS* intervention is shown on the next page.

The logic model for *SAFETY COUNTS* brings together the activities specified as core elements, the determinants of risk behavior (derived from theories of behavior change) focused on by *SAFETY COUNTS* and that the intervention seeks to influence, and the behaviorally related outcomes that lead to adoption of risk reduction behaviors by *SAFETY COUNTS* participants. The following conclusions can be reached from inspection of the logic model:

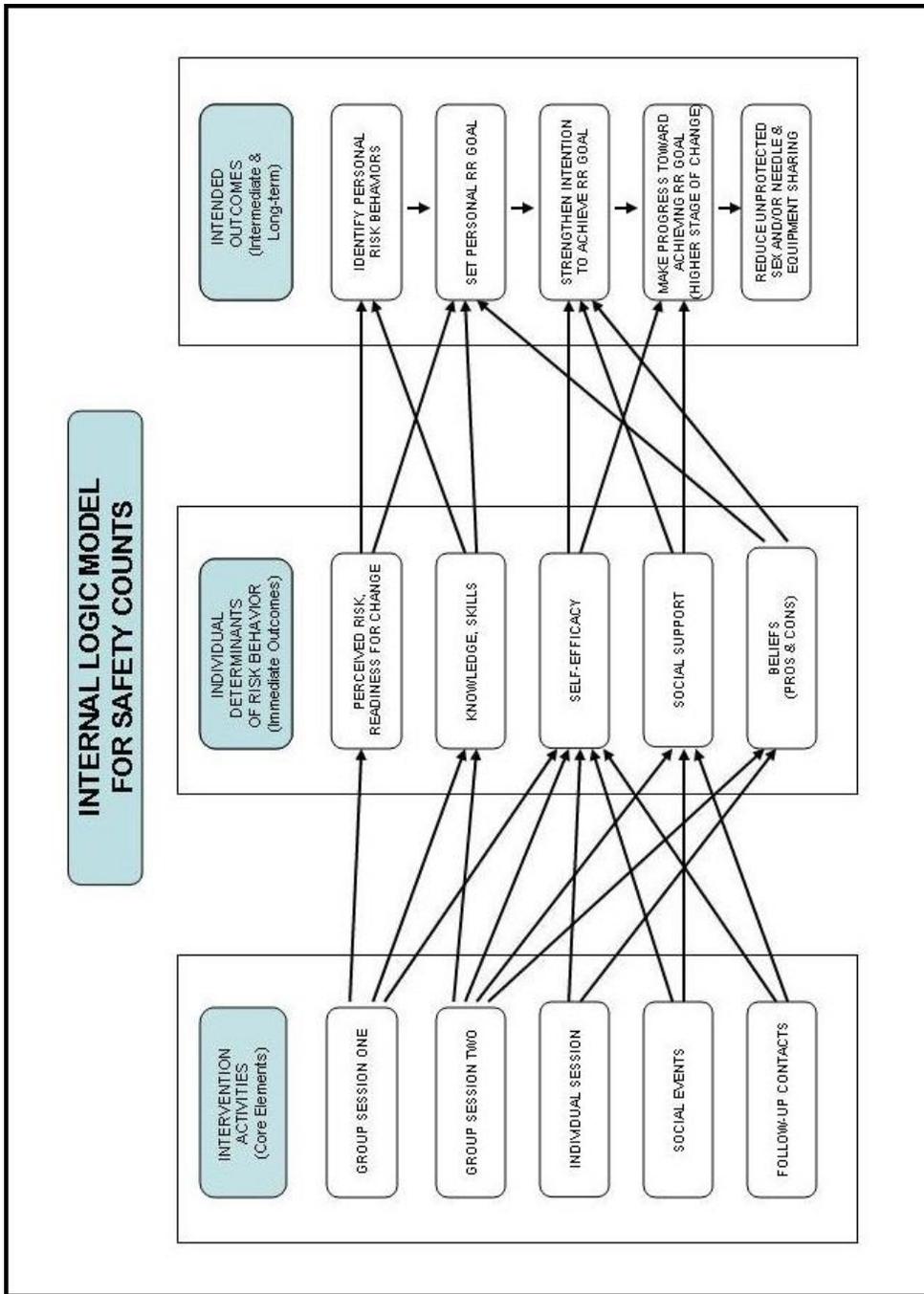
- Self-efficacy is a key determinant of risk behavior that is targeted in every session of *SAFETY COUNTS*.
- Building knowledge and skills and increasing risk awareness are a specific focus only in the first two sessions of *SAFETY COUNTS*.
- Strengthening social support becomes more important as the 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.

For more information about logic models, please see:

United Way. Program outcome model. In: *Measuring program outcomes: a practical approach*. 1996. <http://national.unitedway.org/outcomes/library/pgmomres.cfm>

University of Wisconsin, Cooperative Extension. Logic model: your map and model of action. In: *Section 2 of Evaluating collaboratives*. 1998. pp. 22–30. <http://www.uwex.edu/ces/pdande/evaluation/evaldocs.html>

W.K. Kellogg. W.K. Kellogg Foundation logic model development guide. 2004. <http://www.wkkf.org/Pubs/Tools/Evaluation/Pub3669.pdf>



Please note: *RR* above is an abbreviation for Risk Reduction.

Target Audience

The *SAFETY COUNTS* intervention is intended for persons who are currently using drugs. This includes those who are injecting drugs, such as heroin, speedball, or methamphetamine, and those who are taking drugs they are not injecting, such as methamphetamine or crack cocaine. The drugs individuals may be using are not limited to these examples. In the original research on *SAFETY COUNTS*, participants, at a minimum, either injected drugs or used crack cocaine. In fact, most participants used a variety of substances. In the original research, participants were not currently enrolled in a formal drug treatment program, excluding self-help programs such as Narcotics Anonymous.

In general, *SAFETY COUNTS* is appropriate and may be adapted for all populations of drug users with the following exceptions: (1) persons whose only substance use is alcohol, (2) persons whose only substance use is prescribed methadone, and (3) persons who are currently enrolled in a drug treatment program (not including self-help groups). *SAFETY COUNTS* is not considered to be appropriate for these persons, and the intervention should not be used with these groups.

SAFETY COUNTS has been designed for use with street-based populations who are severely disadvantaged economically and who typically perceive themselves primarily as drug users and secondarily as members of particular ethnic groups or having particular sexual orientations. Working with and/or 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 populations can be problematic in that the incentive structure currently built into *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 incentive substitutes be identified and incorporated into the intervention.

Benefits and Challenges

SAFETY COUNTS provides direct benefits to the clients who participate in the intervention. In addition, *SAFETY COUNTS* provides benefits to the agencies that implement the program. Implementing a new intervention also brings challenges, and these must be confronted and resolved by each agency on an individual basis. Before making a final decision to adopt *SAFETY COUNTS*, the agency's management and staff need to have a clear understanding of the program's benefits to their clients, as well as the benefits and challenges to the agency.

BENEFITS TO THE CLIENT

SAFETY COUNTS provides clients with the opportunity and techniques to begin changing the personal behaviors that are putting them at risk for acquiring or transmitting HIV and viral hepatitis. As a part of the program, clients network with others having similar concerns about their own risks. In this way, they both gain and provide support in their mutual efforts to change risk behaviors. In addition, the intervention offers opportunities for referral to needed services and support, including those related to hepatitis. Clients can be vaccinated against hepatitis A and B and will be protected from future infection regardless of risk behaviors. Clients can be tested for hepatitis C and, if infected, referred for appropriate medical services and substance abuse treatment and counseled on how to protect themselves against additional liver damage.

Clients also benefit from the incentives provided to them in the program. We recommend you provide public transportation coupons or other incentives at each session (if possible) because these incentives will increase the chances that clients will attend all sessions. Clients benefit from food and cash incentives or vouchers for goods at local stores. We recommend you ask clients to identify their preferred form of incentive.

BENEFITS TO THE AGENCY

Offering an effective, proven intervention such as *SAFETY COUNTS* can provide a number of benefits to your agency. As clients begin to change their risk behaviors, they are inclined to seek other services from your agency or from agencies with which you collaborate. This can strengthen community links and build credibility for your agency. The evident effectiveness of *SAFETY COUNTS* can also help to alleviate staff burnout and retention issues as staff members see the tangible results of their work. Documenting client behavior change shows funders that service delivery makes a difference in clients' lives, which could lead to continued or additional funding and strengthened collaborative relationships. Finally, the prestige of implementing a research-based intervention that provides a clear mechanism for monitoring client outcomes can improve the professional standing of your agency with both funders and collaborators.

IMPLEMENTATION CHALLENGES

Implementing a new intervention such as *SAFETY COUNTS* always presents challenges. Staff must take the time and effort to learn a new approach to HIV and viral hepatitis prevention, which may be markedly different from the current program model. Managers have to consider available resources, including funds, staff, and space. Managers must also build and strengthen partnerships with several agencies so they can refer clients to a wide spectrum of services that are reliable and trusted.

Implementation of *SAFETY COUNTS* poses particular challenges due to the structured nature of the intervention. The core content and sequence of sessions must be adhered to exactly, and clients must be engaged to participate in the required minimum number of sessions in order to receive the full benefit of the intervention. To achieve this, special efforts will be needed to recruit drug

users who can benefit from the program and to retain them for the 4-month duration of the intervention. The agency may need to customize the intervention (without changing its core elements) to maximize its appeal and relevance for its local drug-using population. Also, the agency must identify and provide appropriate incentives to clients to encourage their participation in the intervention, which is essential for client retention; and this can be especially challenging for some agencies.

These challenges are by no means insurmountable, but it is important that they be recognized and considered carefully at the time the decision to offer *SAFETY COUNTS* is being made. Ways of meeting these and other challenges are discussed in detail in subsequent sections of this manual.

PART II. PREPARING FOR PROGRAM IMPLEMENTATION

Part II is designed to help program managers understand what you will need to do to prepare for the implementation of *SAFETY COUNTS*. Topics covered in this section include choosing your *SAFETY COUNTS* intervention team, identifying program resources you will need, partnering with other organizations to accomplish *SAFETY COUNTS* goals, developing an implementation plan, training your intervention team, estimating the cost of implementing *SAFETY COUNTS*, recruiting and retaining clients, and conducting a community-level review of program content and materials. With the information provided in this manual, and the expertise found within your own and collaborating organizations, you should be well prepared to implement *SAFETY COUNTS* in your organization.

Choosing Your *SAFETY COUNTS* Team

Like most interventions of its kind, the effectiveness of *SAFETY COUNTS* depends upon the people who implement it. Your team members must be sensitive, skilled, and knowledgeable about the drug-using culture and its various populations. Besides the Executive Director of your agency, you will need at least six team members:

- A Program Manager
- A Program Assistant
- A Behavioral Counselor, who will conduct individual counseling sessions and co-facilitate group sessions and social events
- A Group Facilitator, who will assume lead responsibility for group sessions and social events
- Two Outreach Workers, working as a pair in an outreach team

The behavioral counselor should have prior experience working with drug users and dealing with their personal issues. HIV testing and counseling experience is also helpful. A master's degree in counseling or clinical social work is desirable, but not essential. Individuals whose primary counseling experience has been gained in the context of a drug treatment program should be comfortable with the harm-reduction orientation of *SAFETY COUNTS*.

The group facilitator can be a health educator or other person with prior experience leading groups. This person should possess the skills that will enable him or her to achieve the specific objectives of the intervention in the fluid context of group process. The group facilitator must be able to ensure that all of the sessions of the intervention remain interactive and client-centered.

Outreach workers must be familiar with drug use and the local drug-using culture. The question of whether to use recovering drug users as outreach workers is likely to arise. Common sense dictates that these persons know more about the drug culture and drug use than anyone else. As the program manager, you might want to consider a couple of points before making your decision. Recovering users could run the risk of relapse as they interact once again with drug users and the drug culture in an unsupervised outreach setting. If you plan to employ recovering drug users as outreach workers, you should discuss your concerns openly with them regarding the possibility of relapse and jointly develop a plan for monitoring their situation over time.

It is vital that all your *SAFETY COUNTS* team members possess the appropriate experience, knowledge, skills, and personal characteristics to ensure their success in delivering the intervention. Qualification requirements for specific positions can be found in the Personnel Summary table that appears later in this section. These requirements apply to all intervention staff:

- 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 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 persons of different sexual orientations and genders.

Management of the intervention will be easier if all staff members are responsible to a single organization, but there may be cases in which you want or need to share staff resources with a partnering organization. For example, the *SAFETY COUNTS* behavioral counselor and the group facilitator, who are required only part-time in the *SAFETY COUNTS* intervention, might also be employed by another service agency in the community. More commonly, *SAFETY COUNTS* staff will work on other projects within your own organization. In either case, time management and personnel budgeting will be important topics to address during the planning process.

It is important that all intervention staff members have access to a licensed mental health professional from whom they can seek advice in dealing with difficult client situations or with work-related personal issues. If your organization does not have such a person on staff, it is often

possible to obtain the consulting services of a licensed professional by making an arrangement with another community organization.

Identifying Program Resources

In addition to your intervention team, you will need to identify and obtain the other program resources that are necessary to implement *SAFETY COUNTS* effectively. At a minimum, you will need the following resources:

- **Space for group meetings.** This space should be reliably available when needed. The space should be flexible, i.e., large enough to accommodate group activities such as icebreakers as well as comfortable seating arrangements for large- and small-group activities. Ideally, the group meeting space would come equipped with a VCR player and newsprint easels. If these items don't come with the space, they will need to be obtained elsewhere.
- **Space for private, one-on-one counseling sessions.** This space must be a room with a door. Open cubicles or other venues that are not completely private are not appropriate. The private space should have comfortable seating for counselor and client.
- **Locking file cabinets for storage of confidential client data and/or computer database with password protection.** Remember, identifying information is confidential information, regardless of a client's HIV status.
- **Transportation for clients and outreach workers.** Transportation could include your own organization's van, another organization's van used by agreement, personal cars, and public transportation. In some localities, use of a van to transport many people for other than personal purposes requires that the driver be a licensed chauffeur. Use of personal cars requires the driver to assume liability for any accidents. Adequate and up-to-date insurance is required for all means of transportation (other than public).
- **Outreach materials.** These can include anything you already use in outreach activities to drug users or new materials you develop especially for *SAFETY COUNTS*. The availability of safer sex and safer injection/needle hygiene kits is essential to *SAFETY COUNTS*.
- **Incentives for clients.** These are the perks that will help retain clients in *SAFETY COUNTS* activities. Incentives can include such things as cash, food, transportation vouchers, movie tickets, or door prizes at socials—anything that will keep clients coming back.
- **A referral network in place for client needs that your organization cannot address.** This may be a network already in place or a new network you will need to develop. You will need to make sure that you have specific referral information for clients, e.g., the name of the appropriate staff person at the other agency. You will

also want to be certain that the agency provides high-quality services. Your staff should be prepared to follow up with the client and the other agency about whether action occurred on the referral.

- **Collaborative partnerships with other organizations.** These include partnerships with other organizations to provide component parts of *SAFETY COUNTS* that your organization cannot. These partnerships are discussed further below.

Of course, after the right staff, the most essential resource you will need to implement *SAFETY COUNTS* is adequate funding. A detailed estimate of the costs required to implement *SAFETY COUNTS* is presented later in this section.

Partnering with Other Organizations

Your organization probably already partners with other organizations to access resources and services that you don't provide. Some of these partnerships, such as with drug rehabilitation clinics or agencies that offer HIV testing, are obvious links to *SAFETY COUNTS*.

Some agencies may need reassessment to obtain new services and resources; in some cases, new partnerships will need to be developed to implement *SAFETY COUNTS* effectively. Before partnering with any organization, you will need to determine if the agency will be appropriate for clients enrolled in *SAFETY COUNTS*. Many organizations have restrictions (e.g., abstinence, recovery readiness) and eligibility criteria that may exclude persons who are currently using drugs and do not wish to stop using. Referrals to HIV and viral hepatitis testing are especially important to implementing *SAFETY COUNTS*, since counseling and testing are a core element of the intervention. Your agency must conduct these tests or make referrals to testing in order to implement the intervention with fidelity to the core elements.

After you have identified the resources you need for *SAFETY COUNTS*, take a look at them to determine which resources your organization already possesses and which may require assistance from other organizations. For those resources requiring assistance from others, which other organizations might be interested in helping you with *SAFETY COUNTS*? Do you already have a partnership with such organizations, or do you need to develop a new partnership?

A case in point may be the need for group meeting space. If your organization has limited space for group meetings, a community center a few blocks away may have a facility for these meetings. Or your organization may lack a van, but a faith-based organization you occasionally work with has one. Or the local public transportation authority may be willing to give you free or reduced-fee passes. Another example might have to do with food for socials. Your organization may have no food preparation facilities, but you might be able to find an organization that would let you use these facilities when needed. Or some community organizations (e.g., caterers, fast-food restaurants) may be willing to donate food for socials.

In each of these cases, you will need to work out an agreement with your partner organization. These agreements may be formal (e.g., a Memorandum of Agreement or MOA) or informal (e.g.,

a verbal arrangement). If a particular partnership is essential to the effectiveness of *SAFETY COUNTS*, you will probably want to enter into an MOA with the partner organization. An MOA is a simple document that states what each organization will do. It is most effective if the senior leadership within each organization buys into the agreement. Therefore, no one lower in management responsibilities than a deputy director should sign the MOA, and the agreement should be revisited whenever a change in management staff occurs. A sample MOA is found in Appendix B.

If you are partnering with other organizations to implement *SAFETY COUNTS*, you will want to be sure that their representatives are an integral part of developing an implementation plan and monitoring the intervention's process.

Developing an Implementation Plan

In order to know where you are going to be every step of the way, you will need to develop an implementation plan for *SAFETY COUNTS*. The implementation plan is a straightforward document that outlines exactly what will be done, by whom, when, and how. The plan serves as a checklist for you and your team as you move forward in planning for the implementation of *SAFETY COUNTS*.

The following sample plan illustrates what an implementation plan needs to address. Note that the plan lays out the schedule for pre-implementation activities such as grant-writing and training, as well as specifies the timeline and activities required for the actual implementation of *SAFETY COUNTS*. For the purposes of this sample plan, it is assumed that grant writing for funding begins on May 1 for an application due date of June 15, and funding would commence on October 1.

SAMPLE IMPLEMENTATION PLAN FOR *SAFETY COUNTS*

Task	Steps to Implement	Start Date	Deadline for Task	Person(s) Responsible
PLANNING				
Define job descriptions for program team (funding application task)	Identify tasks for each member and terms of employment	1 May	15 June	Program Manager
Develop budget (funding application task)	Estimate costs for each implementation component	1 May	15 June	Program Manager, CEO

PART II. PREPARING FOR PROGRAM IMPLEMENTATION

Task	Steps to Implement	Start Date	Deadline for Task	Person(s) Responsible
Write and submit grant for funding	Review draft and revise for submission	1 May	15 June	Grant Writer, Program Manager, CEO
Secure funding	Review by funding agency	1 July	1 October	Funding agency
Develop implementation plan	Meet with partner(s), if any; define schedule, tasks	1 October	1 December	Program Manager
Develop monitoring and evaluation plan	Specify process measures, assessment instruments, and monitoring schedule	1 October	1 December	Program Manager
Assign team members internally and/or recruit externally	Post job announcements as required; conduct job interviews	1 October	31 October	Program Manager
TRAINING				
Schedule training sessions; prepare materials	Secure space, equipment; inform team members	1 November	1 December	Program Manager
Train team members; orient new hires to your organization if necessary	Conduct training sessions; if necessary, orient members to paperwork and tax forms	1 November	1 December	Program Manager
PROGRAM IMPLEMENTATION				
Team begins ongoing outreach and recruitment	Recruit and enroll program clients	15 December	Ongoing	Program Manager, Outreach Workers, Counselor (for enrollment)

Task	Steps to Implement	Start Date	Deadline for Task	Person(s) Responsible
Group session one	Conduct group	Every other week, alternating with Group session two	First group session one completed by 31 December	Facilitator, Counselor
Group session two	Conduct group	Every other week, alternating with group session one	First group session two completed by 7 January	Facilitator, Counselor
Individual counseling sessions	Conduct individual sessions		First series completed by 31 January; ongoing thereafter	Facilitator, Counselor
Monthly social events	Conduct socials		First group social completed by 15 January; monthly thereafter	Program Manager, Facilitator, Counselor, Outreach Workers
Follow-up contacts	Conduct structured follow-up contacts		Ongoing after 15 January	Outreach Workers
PROGRAM MONITORING AND EVALUATION				
Implement program monitoring	Program objectives and monitoring indicators provided by funding source	Quarterly and annually (upon receipt of funding)	Ongoing during life of program	Program Manager, Facilitator, Counselor, Outreach Workers

Here are a few points to keep in mind about this sample implementation plan:

- The plan estimates approximately 7 months of planning time, from development of a funding application to implementation of the program. You may find that certain individual tasks take more than the time estimates in the implementation plan. The planning phase overall may actually take less time if your organization possesses all of the resources, including staff, needed to implement *SAFETY COUNTS*. If not, more time may be needed for planning, depending on the local resources that are available to you.
- The plan assumes that a program manager is already available on your staff to implement the planning process from the beginning. This is the ideal, but it may not always be the case.

- The plan projects an optimistic timeline of 5 months for writing and submitting a funding application and obtaining final approval and funding. This may be unrealistic, especially if the grant application is being submitted to an agency requiring a highly detailed proposal and/or lengthy review process. Your agency should start communicating informally with the potential funding agency from the beginning of the grant development process to ensure that your proposal contains all of the content and adequately addresses all of the issues expected by the funder.
- As you well know, all plans need to be flexible. Deadlines shift and unforeseen issues arise along the way. The purpose of the implementation plan is not to lock you into a rigid schedule but rather to give you an idea of the components that you need to consider in planning for a *SAFETY COUNTS* program.

Training Your Intervention Team

Once you have an implementation plan, an intervention team, reliable partnering agencies, and adequate funding in place, the next step is to train your team in the essentials of *SAFETY COUNTS*. A separate training curriculum has been developed to complement this program manual. The curriculum leads you step-by-step through the various components of *SAFETY COUNTS* and allows you to create simple, highly interactive training sessions for your team. One of the most important components of the training curriculum is its focus on the specific procedures for conducting structured intervention sessions.

Staff members who will deliver the *SAFETY COUNTS* intervention (i.e., facilitators, counselors, and outreach workers) must be thoroughly familiar with all sessions of the intervention and completely comfortable with those sessions for which they are directly responsible. Developing the skills required to deliver structured and interactive intervention sessions will require practice. The special role-play exercises that are incorporated into the sessions will help staff to give the intervention a spontaneous look and feel while maintaining the prescribed order and content of the core elements. Even persons with considerable experience in the areas of drug use and HIV and viral hepatitis prevention sometimes report that they are uncomfortable discussing certain personal risk behaviors, or uncomfortable using the language necessary to get points across. Others are uncomfortable with the idea of incremental behavior change, as opposed to immediate and complete change, even though slow progress in small steps characterizes the process of successful behavior change for many people. Finally there is the issue of safety in the field, which can be a valid concern for all program staff. A list of field safety guidelines is provided in Appendix C.

All of these areas of discomfort need to be addressed during the training of your team. The training curriculum focuses directly on these issues at several points, but this may not be adequate for some trainees. Throughout the training, try to find ways to bring to the surface and discuss in a supportive way all of the areas of discomfort or fear that your trainees may be feeling.

Estimating *SAFETY COUNTS* Costs

An important consideration in planning for the implementation of *SAFETY COUNTS* is the level of finances your agency is willing and able to commit to this intervention. In this section, we present a Sample Budget, Personnel Summary, and Non-Personnel Cost Summary (see tables below), with accompanying explanation, to help you estimate a realistic budget for your local area and circumstances. The cost of implementing *SAFETY COUNTS* will vary from place to place based on obvious regional and local differences in salaries, transportation costs, the cost of various goods and services, and other factors. What will not vary, however, are the basic “cost centers,” i.e., the basic areas of cost (personnel, supplies, etc.) that are involved in program implementation.

The purpose of this sample budget is simply to provide an illustration of costs for one representative community-based organization (CBO) implementing *SAFETY COUNTS*. The specifics of your agency may change the costs for you. You may notice that some costs are not included, such as those associated with creating a risk reduction success story (written, audiotape, or video) and with hiring any specialized staff or consultants you may want for program monitoring or evaluation. However, this example provides a useful estimate of the overall cost and resources required to implement the *SAFETY COUNTS* intervention, and can serve as a useful decision-making tool for your agency. Again, it will need to be adapted to fit your local circumstances.

The cost of *SAFETY COUNTS* can be significantly reduced if you are able to obtain donations of supplies (e.g., condoms), services (e.g., food preparation), and incentives (e.g., raffle prizes). Local retailers, caterers, grocers, food banks, restaurants, movie theaters, clothing outlets, drugstores, museums, media outlets, public transportation authorities, taxi companies, and other merchants should all be approached for donations in the preparation phase.

The sample budget makes several assumptions regarding the agency that will implement the intervention. First, the budget assumes that the CBO already has access to drug users through outreach, institutionally, or through some other mechanism. The budget also assumes that the CBO has an appropriate venue to conduct the group sessions, the individual counseling sessions, and the social events. The budget further assumes that the CBO has basic relationships with other HIV service providers in the community, some business relationships with companies that market HIV prevention supplies specific to injection drug users, and some in-house infrastructure to begin the process of grants management. Another assumption is that the CBO is located either in or near the community where the intervention is to be implemented. If your CBO’s circumstances differ from these assumptions, then you will need to consider these factors when you develop your own budget.

SAFETY COUNTS SAMPLE BUDGET
(Assumes 2,080 Work Hours per Year and 12-Month Budget)

Resource	Unit Cost	Quantity	Total Cost
<i>Personnel Salaries</i>		<i>Hours</i>	
Program Manager (10%)	\$25.00/hr.	208	5,200
Group Facilitator (40%)	\$18.00/hr.	832	14,976
Behavioral Counselor (40%)	\$18.00/hr.	832	14,976
Outreach Workers (75% x 2)	\$13.00/hr.	3120	40,560
Program Assistant (20%)	\$16.50/hr.	416	6,864
Total Salaries			82,576
Employee Benefits (12% of total salaries)			9,909
TOTAL SALARIES & BENEFITS			\$92,485
<i>Non-Personnel Costs and Services</i>			
Supplies (food for groups and socials)			2,400
Outreach Materials (safer injection kits, safe sex kits, etc.)			4,000
Participant Incentives	\$40/month	120 clients	4,800
TOTAL NON-PERSONNEL			\$11,200
SUBTOTAL			\$103,685
Indirect Cost (18% of salaries and benefits)			16,647
GRAND TOTAL			\$120,332

PERSONNEL SUMMARY

[FTE = full time equivalent employee]

Position	Persons @ FTE %	Responsibilities	Skills & Knowledge
Program Manager	1 @ 10%	Assure that intervention fidelity is maintained; oversee evaluation and program monitoring activities; train and supervise staff in delivery of intervention components; assure that supplies are on hand when needed; monitor data collection; request technical assistance; explain intervention to stakeholders; attend social events as needed.	Excellent supervisory skills; strong verbal and written communication skills; experience working with drug users; experience managing HIV prevention programs, preferably for drug users; knowledge of local community; in-depth understanding of intervention core elements and session guidelines.
Group Facilitator	1 @ 40%	Act as lead in co-facilitating group sessions; assist in communicating individual participant goals to outreach staff; maintain confidential records; provide oversight to outreach workers; provide referrals as necessary; coordinate and attend social events.	Prior experience facilitating groups; knowledge of community; comfort and expertise with drug users; strong verbal communication skills; experience delivering HIV prevention programs to drug users; knowledge and understanding of all <i>SAFETY COUNTS</i> components and commitment to <i>SAFETY COUNTS</i> objectives.

Position	Persons @ FTE %	Responsibilities	Skills & Knowledge
Behavioral Counselor	1 @ 40%	Conduct individual counseling sessions with intervention clients; provide referrals for testing and services; maintain confidential client records; assist, train, and monitor outreach workers in planning and conducting follow-up contacts; co-facilitate group sessions; attend and participate in social events.	Professional or para-professional certification of counseling skills; knowledge of community and services; comfort and expertise with drug users; strong verbal communication skills; experience delivering HIV prevention programs to drug users; knowledge and understanding of all <i>SAFETY COUNTS</i> components and commitment to <i>SAFETY COUNTS</i> objectives.
Outreach Workers	2 @ 75%	Make contacts in community; collect evaluation data; recruit program clients; conduct follow-up contacts with clients; provide referrals for testing and services; attend and participate in social events.	Knowledge of community; comfort and expertise with active drug users; strong verbal communication skills; facility with core elements of intervention; experience delivering HIV prevention programs to drug users; general understanding of <i>SAFETY COUNTS</i> components and commitment to <i>SAFETY COUNTS</i> objectives.
Program Assistant	1 @ 20%	Maintain program records; order and follow up on materials and supplies; duplicate intervention materials; enter client and program evaluation data into computer database.	Detail-oriented; good at record keeping & retrieval; can use data-base program of agency; general understanding of <i>SAFETY COUNTS</i> components and objectives.

Note: See *Choosing Your Safety Counts Team* beginning on page 15 for additional information.

NON-PERSONNEL COST SUMMARY

Item	Explanation
Supplies	The budget assumes roughly \$200 per month for food for the social events and group sessions. This figure may be low, but there is also an assumption that a well-connected CBO will be able to elicit other sources of food for these events. These may include local food banks, merchants, or other CBOs. This category also includes copying of intervention materials (i.e., worksheets, goal cards), newsprint pad and easel, handouts, invitations/flyers for social events, etc.
Outreach materials	It is important to remember that <i>SAFETY COUNTS</i> is less about blanketing a target population with intervention materials than it is about providing them with the tools to intentionally change their behaviors. Large CBOs with numerous concurrent grants may be able to virtually eliminate this category and supply materials from other funding streams. Small CBOs will need to budget for an appropriate amount of materials, balancing this budget item with the other components of the intervention. Condoms may be purchased in bulk for less than 10¢ each. Safer injection kits with bleach must be assembled yourself, but still will only cost less than 50¢ each; and once you get started, you can get volunteers to assemble them once a month under staff supervision. Single-use kits (which include a cooker, one cotton ball, and one sterile alcohol pad) may be more effective for this intervention and cost about 25¢ each. Zipper-top bags for packaging all these materials cost a couple of cents each.
Participant incentives	The budget assumes ten 10 clients a month receiving the equivalent of \$40 in incentives over a single year. Note also that, depending on the CBO, there may be other viable options for incentives. Where the CBO has a working relationship with a local food bank or merchants willing to donate food, goods, or services, these may function just as effectively as other types of participant incentives.

Recruiting and Retaining Clients

As a part of your planning process for implementing *SAFETY COUNTS*, we strongly recommend that you give adequate attention to the topics of recruiting clients and retaining them throughout the 4-month course of the intervention. To be successful in conducting *SAFETY COUNTS*, you will have to be successful in recruiting and retaining clients. This section outlines a number of key issues that you might want to consider in planning your recruitment and retention strategies, and provides specific suggestions that can help you to be successful in these critical areas.

Many of the factors that assure success in recruiting persons into *SAFETY COUNTS* are the same ones that keep them in the program once they have been enrolled. But there are also important differences. In recruitment, the objective is to motivate potential intervention clients to take two specific actions: (1) to come into your facility and complete the enrollment process for *SAFETY COUNTS* and (2) to attend group session one. In retention, the objective is to maintain clients' motivation over a longer term once they have been introduced to the intervention. Different factors come into play in achieving these two objectives.

PEER ADVISORY BOARD

For both recruitment and retention planning, a peer advisory board, composed of drug users from the local community, can be a valuable asset. This board can offer guidance regarding where drug users can be accessed, how they are best approached, and how *SAFETY COUNTS* should be pitched to prospective clients. Board members can also offer suggestions about the most effective incentives to use in recruiting clients and retaining them through the course of the intervention.

Having a peer advisory board is a good idea even if your organization already has direct experience working with drug users. If your organization does not have prior experience with drug users, having an advisory board can make a critical difference. We recommend that you form a peer advisory board as early as possible in the planning phase so that you can fully benefit from their advice in developing an effective recruitment and retention strategy. The members of your advisory board should be selected carefully. They all should be drug users themselves, and all should be interested in improving the health of drug users in their community. If you find that you are having difficulty locating appropriate persons to be on your peer advisory board, you might contact other organizations in your community that provide services to drug users. If at all possible, you should arrange to provide a cash honorarium to board members for each meeting they attend. This shows respect for their role and helps in maintaining their involvement.

Since members of your peer advisory board will themselves be eligible to enroll in *SAFETY COUNTS*, many of them will want to do this when the program starts. This does not present a problem. In fact, as time progresses, your advisory board will probably be composed entirely of *SAFETY COUNTS* graduates. We recommend that you keep your peer advisory board active for the duration of your *SAFETY COUNTS* program. As your program becomes stabilized, however, you may wish to reduce the frequency of meetings.

RECRUITMENT

The recruitment process is of primary importance. Without a successful recruitment program, one that provides a continuing stream of eligible drug users who are willing to participate in *SAFETY COUNTS*, your intervention will not have the opportunity to provide its benefits. Your ability to be successful in recruiting persons into *SAFETY COUNTS* depends on your ability to

- Access drug users in the local community.
- Establish a trusting relationship with potential clients and engage them in a brief discussion of *SAFETY COUNTS*.
- Present *SAFETY COUNTS* in a manner that will allow potential clients to appreciate the personal benefits (defined on their own terms) that they will receive from the program.
- Give potential clients the motivational “push” that will get them to participate in a program enrollment session.
- Motivate clients, once enrolled, to attend group session one.

If your organization provides outreach to drug users as a part of its current services, then you already know how to access them. If you do not currently provide services to drug users, you will need to learn the public places in your local community where they can be found. These may include shelters, parks, street corners, parking lots, clinics, and social service organizations. The particular locations in your own community will need to be identified and designated as future outreach sites for recruiting *SAFETY COUNTS* clients.

Contacting and prescreening drug users, explaining the *SAFETY COUNTS* program to them, and arranging for a program enrollment session are the responsibility of the Outreach workers. Once they have identified an individual as a drug user and have successfully established a trusting relationship with that person (which may require several contacts), how they approach the next steps in the recruiting process will make all the difference in determining whether this person becomes an actual client. We suggest that outreach workers role play the recruitment process with other intervention staff at least twice a week for several weeks before doing any real recruitment. During this time, they can be working in the field to locate eligible drug users and spending time with them to establish a trusting relationship.

It will help if outreach workers can offer potential clients some kind of incentive to come to your facility to be interviewed in a program enrollment session. Likewise, once clients have been enrolled in *SAFETY COUNTS*, they will be more likely to attend group session one if they know they will receive a special incentive for doing so. An appointment card bearing a gift coupon provides a tangible reminder to individuals that they will receive a special incentive for taking the next step. These cards can be given by outreach workers and enrollment staff to prospective and newly enrolled clients, and redeemed when they come in for the program enrollment session or group session one.

Once your program is well established, you may want to consider using *SAFETY COUNTS* graduates to assist your outreach staff in recruiting new clients. If you do this, we suggest that you think carefully about how to compensate these persons. One possibility would be to pay them on a per-client-recruited basis. You can ask your peer advisory board how they feel about this option and discuss its pros and cons with them before you make a decision.

RETENTION

Once clients have been enrolled in *SAFETY COUNTS* and have attended group session one, the primary concern becomes keeping them in the program for at least 4 months and motivating them to participate in all of the sessions. Besides the content of the intervention itself and having positive interactions with program staff, providing incentives to clients and making sessions easy for clients to attend will increase their motivation to continue participating in the program.

Client incentives fall into three general categories:

1. **Session participation incentives.** These are cash or noncash items provided to clients at the time they participate in specific *SAFETY COUNTS* sessions.
2. **General program incentives.** These are special services that clients are eligible for and may receive at any time because they are enrolled in the *SAFETY COUNTS* program.
3. **Transportation incentives.** These are tokens, vouchers, or transportation services provided to clients to make it easier for them to attend *SAFETY COUNTS* sessions.

Some of the possible incentives of each type are listed below. These are only examples to consider—you may want to use other incentives in addition to, or instead of, these for your own program.

- Session participation incentives:
 - » Cash
 - » Meals
 - » Lottery prizes
 - » Door prizes
 - » Fast-food coupons
 - » Movie tickets
 - » T-shirts, hats
 - » Personal hygiene or grooming kits
 - » Clothing vouchers

- » Recognition certificates for attending a specified number of sessions
- » Cash or prize for attending a specified number of sessions
- General program incentives:
 - » Food bank
 - » Hot showers
 - » Clothes washing facilities
 - » Free immunizations against hepatitis A and B
 - » On-site testing or active referrals for HIV and hepatitis
 - » Active referrals for social and medical services tailored to drug users' needs
- Transportation incentives:
 - » Client pick-up to and from sessions
 - » Bus or subway tokens
 - » Taxi vouchers

Examples of other factors that can influence retention are listed below. These include the content of the intervention and how it is delivered, the physical environment, and scheduling of sessions.

- Meeting space that is comfortable and inviting.
- Group sessions and social events that are lively, fresh, and interactive, with plenty of opportunities for input from clients.
- Session presentations that foster and communicate caring, trust, respect, and confidentiality on the part of intervention staff.
- A nonjudgmental atmosphere that accepts clients' drug use.
- Free child care during sessions.
- Consistent and convenient scheduling of sessions.

Incentives and other retention strategies are excellent topics for your peer advisory board to consider. As you can see, many factors can potentially influence your clients' willingness to stay involved with *SAFETY COUNTS*. The members of your advisory board can assist you in determining what incentives will be best for motivating your particular clients.

Conducting Community-Level Review

Your agency's *SAFETY COUNTS* program must be reviewed by a Program Review Panel (PRP) established by your health department and representing a cross-section of the local community. The PRP must have at least five members, one of whom is a health department employee.

Your local PRP must review all program materials (pamphlets, brochures, fliers, posters, videos, and questionnaires), as well as the program curriculum, to ensure that they are appropriate for the intended audience in terms of language used and cultural sensitivity.

Your agency is required to ensure that the content of materials to be used in your *SAFETY COUNTS* program is consistent with local community standards of the target audience in terms of language appropriateness and cultural sensitivity.

Complete information concerning the local program review process and content requirements for HIV prevention programs are contained in Appendix D: CDC Content and Review Guidelines for HIV Programs.

PART III. SAFETY COUNTS SESSION GUIDE

This part of the Program Manual provides detailed, step-by-step instructions for conducting the *SAFETY COUNTS* intervention. There are six different types of sessions, as listed below. Note that some of the sessions are delivered more than once to a given client.

- Program Enrollment Session
- Group Session One (one session)
- Group Session Two (one session)
- Individual Counseling Session (one session minimum)
- Social Events (two events minimum)
- Follow-up Contacts (two contacts minimum)

Worksheets and forms that are used in each session are shown at the end of the instructions for that session. For your convenience, a complete set of *SAFETY COUNTS* worksheets and forms suitable for photocopying is included in the intervention kit (see envelope marked “Reproduction Masters”).

Introduction

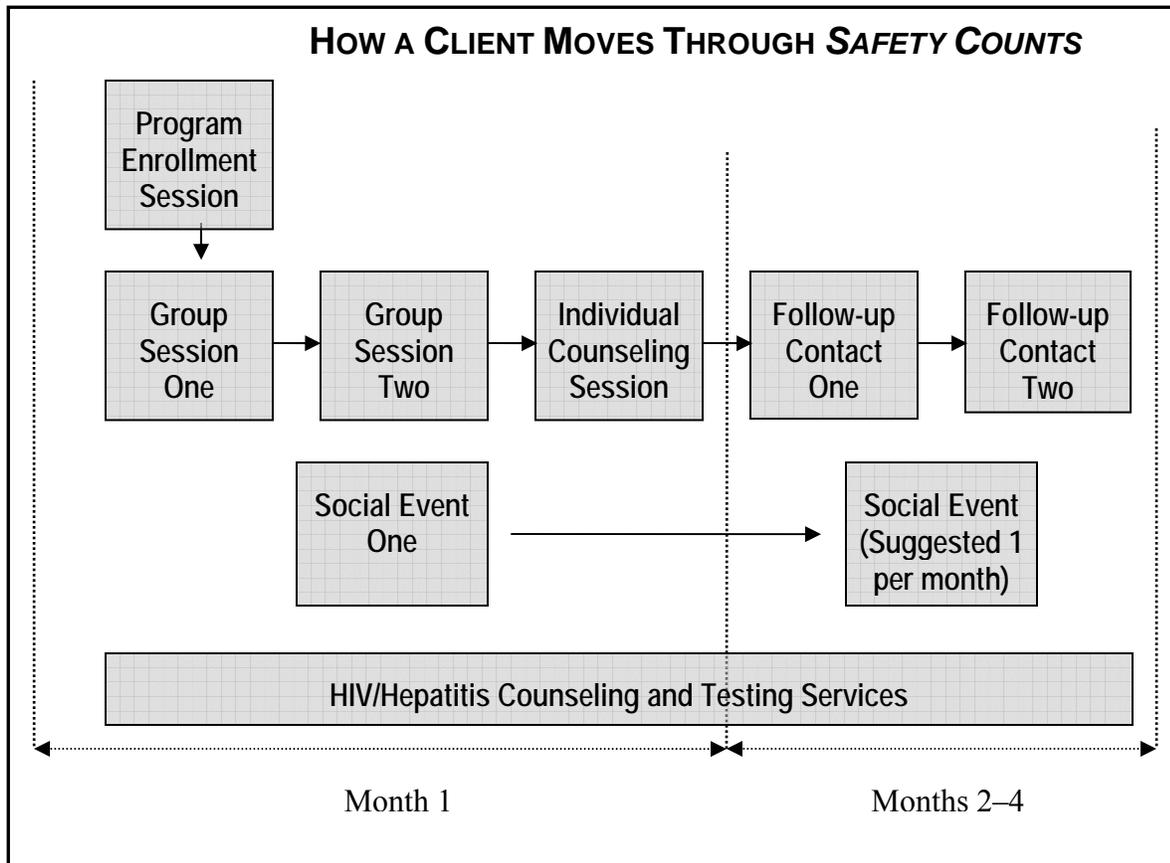
This section begins by describing the sequence and timing of the seven (minimum) *SAFETY COUNTS* sessions. This is followed by discussion of intervention fidelity, and the importance of maintaining the order and content of sessions to ensure fidelity with respect to core elements. Possibilities for adapting and tailoring *SAFETY COUNTS* while maintaining fidelity are also discussed. Next is a description of how the topic of HIV and hepatitis counseling and testing is integrated into and distributed throughout the intervention sessions. Information is also provided on accommodating HIV-positive clients in the intervention. The final two topics covered are confidentiality issues and tips for intervention staff.

SEQUENCE AND TIMING OF SESSIONS

The diagram on the next page shows how clients move through the *SAFETY COUNTS* intervention. During the first month, after an initial program enrollment session, clients receive group sessions one and two, followed by the individual counseling session 1 week later. Clients participate in their first of two or more social events any time after completing group session one. During the next 3 months, clients receive at least two follow-up contacts and attend at least one additional social event. Clients may receive additional, optional individual counseling sessions at any time.

HIV and hepatitis counseling and testing services are offered throughout the 4-month intervention period.

Clients must participate in the group sessions, individual counseling session, and follow-up contacts in the order shown. By adhering to this sequence of sessions, you are ensuring that your clients are building on what they have learned in previous sessions and that they will receive the maximum benefit from the intervention. Once clients have completed group session one, attendance at social events can occur at any time and is not linked to participation in other sessions.



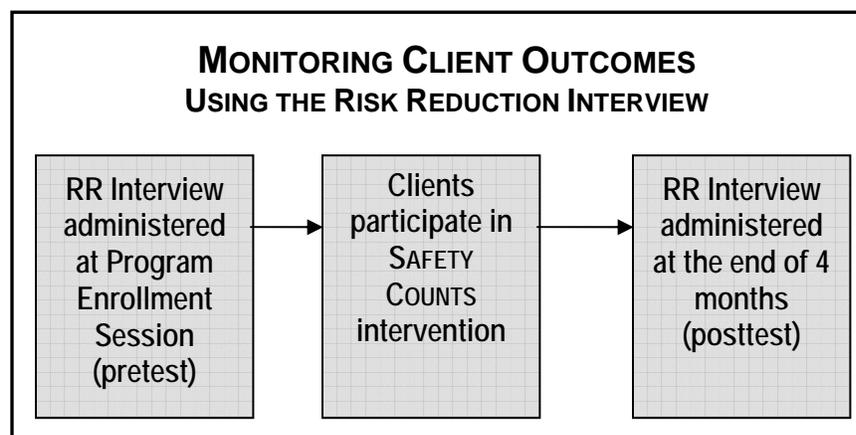
SAFETY COUNTS sessions should be offered on a regular schedule, as shown in the following table. Under this scenario, clients will be enrolled in *SAFETY COUNTS* continuously, as they are recruited. Since group session one is offered every other week, new clients will have to wait no more than 2 weeks to begin their participation in the intervention. If they miss group session two the next week, they can pick it up 2 weeks later. As soon as they have attended group session one, however, they will be eligible to attend the next monthly social event. Following group session two, clients will be reminded to come in for an individual counseling session in 1 week. (A minimum interval of 1 week is required between group session one and the individual counseling session; no minimum time is required between group session one and group session two). Follow-up contacts, which are scheduled on an as-needed basis, can begin 1 week after the

individual counseling session and can take place at any time, so long as they are separated by at least 1 week and do not occur on the same day as a client's social event.

Session	Schedule
Program Enrollment Session	Continuously (as needed)
Group Sessions One and Two	Weekly (alternating Sessions One and Two)
Individual Counseling Session	Continuously (as needed)
Social Events	Monthly (toward the end of each month)
Follow-up Contacts	Continuously (as needed)

SAFETY COUNTS is a 4-month intervention. A client should participate in *SAFETY COUNTS* for at least 4 months, which means that agency staff should keep providing opportunities to attend social events and making follow-up contacts even if the client has attended two socials and had two follow-up contacts. Ideally, after 4 months of participation in *SAFETY COUNTS* (during which time the client will have attended two group sessions, one or more individual sessions, at least two social events, and received at least two follow-up contacts), the client will have achieved his or her personal risk reduction goal and will continue to maintain the new risk reduction behavior after he or she leaves the program.

The diagram below shows how the risk reduction (RR) interview is used to monitor the behavioral outcomes of clients as a result of their participation in *SAFETY COUNTS*. This instrument is administered to clients during the program enrollment session and again at the end of 4 months, following their participation in the intervention. The interview measures a client's status on 15 different risk reduction behaviors using a stages-of-change framework. This allows the client's risk reduction progress to be measured in instances where the client has taken meaningful steps toward reducing his or her risks but has not yet been fully successful in achieving his or her stated goal. Administration and scoring of the risk reduction interview are discussed in detail in Part IV, Program Monitoring and Evaluation.



MAINTAINING INTEGRITY OF THE INTERVENTION

Ensuring Fidelity

Maintaining fidelity to the original intervention design assures that *SAFETY COUNTS* clients will receive the full benefit of the program because they will be receiving the tested intervention, with all core elements faithfully and accurately implemented. *SAFETY COUNTS* has been shown to be effective in reducing risk behaviors when it is delivered as described in this manual. Therefore, to maximize the likelihood your clients will be able to reduce their HIV and viral hepatitis infection risks, you should implement the intervention as it is outlined here. Because *SAFETY COUNTS* is a structured intervention, you need to adhere to the specific content and procedures described in this manual for all sessions. In addition, clients need to participate in *SAFETY COUNTS* sessions—in the order described previously—for at least 4 months.

If the order and content of the sessions are not followed, your program would differ from the *SAFETY COUNTS* intervention that was found to be effective. It would be difficult to determine if a different intervention, which includes only some of the core elements of *SAFETY COUNTS* or misses key content areas, could still be effective at lowering the HIV risks of your clients. Of course, your agency may be delivering *SAFETY COUNTS* with complete fidelity, but some clients may miss one or more sessions. Although these clients are still receiving the intervention, missed sessions could mean that the intervention will be less effective for them.

Adapting and Tailoring

Appendix E provides careful and extensive instructions for adapting *SAFETY COUNTS* for your specific population. This adaptation should be produced in cooperation with your capacity building assistance (CBA) provider, your CDC project officer, and your CDC technical monitor.

Although the order and essential content of *SAFETY COUNTS* sessions must be maintained, the intervention can be adapted in a number of ways and tailored to fit the particular needs of your organization and client base.

“Adaptation” refers to changes in the target audience or venue in which an intervention takes place. Adaptation questions must be answered before tailoring questions. “Tailoring” refers to changes in the health message or activity, how an intervention is delivered or by whom, and the timing of an intervention. When an intervention is adapted or tailored, the integrity of its core elements must be preserved.

Following are some ways in which *SAFETY COUNTS* can be adapted and tailored. The intervention can be offered in conjunction with an existing client service program, rather than as a stand-alone program, with activities of the two programs woven together into a unified whole. In addition, your intervention may be targeted to existing clients of your agency, new clients, or both.

Recruitment and retention strategies may also be tailored to fit your client population. For example, the venue of the program enrollment session can be changed from a private office in

your agency to some other location where confidentiality can be maintained, such as a coffee shop in the community.

With respect to the HIV testing component of *SAFETY COUNTS*, discussed below, your agency may elect to offer on-site testing services, or you may prefer to refer clients to other agencies for HIV testing. (Viral hepatitis testing is typically handled by referral.) *SAFETY COUNTS* can accommodate either approach.

Finally, to a limited extent, the content of sessions can be expanded or enhanced to emphasize specific content areas that you judge to be of special importance. For example, the coverage of HIV and hepatitis facts in group session one may be modified to suit your local needs. Or, you may wish to enhance the discussion of HIV and hepatitis testing in the individual counseling session, or assess clients' service and referral needs in greater depth than described in the session guidelines. You could also add an extra activity to those prescribed for social events if you think your clients would benefit from this—for example, a brief presentation reminding clients of general HIV and viral hepatitis risk factors.

These are all modifications that will allow you to tailor *SAFETY COUNTS* to your population and situation while maintaining intervention integrity.

INTEGRATING COUNSELING AND TESTING INTO SESSIONS

As a core element of *SAFETY COUNTS*, promotion of voluntary counseling and testing for HIV and viral hepatitis (especially hepatitis C) is integrated into all of the sessions of the intervention. Beginning in the program enrollment session and continuing through follow-up contacts in the field, clients are made aware of the benefits of knowing their HIV and hepatitis status and are offered referrals for testing. When and how the topic of HIV and hepatitis counseling and testing might be addressed in each of the sessions is described in the step-by-step session instructions.

This technique of repeating the HIV and hepatitis testing message on multiple occasions throughout the course of the intervention increases the likelihood that clients will come to see the benefits of testing and need for testing services as meaningful on a personal level. More importantly, it increases the chance that they will accept a referral and get tested.

For this approach to work effectively, however, you will need to individualize the testing message for each client, based on your knowledge of the client's personal situation with respect to prior testing experience, HIV status, injection drug use, sexual practices, and viral hepatitis status. The best opportunities for a personalized approach occur in the program enrollment session, the individual counseling session, and the follow-up contacts. In the group sessions and the social events, you may be able to create an opportunity for individual discussion by inviting clients to talk with you at the end of the session if they have any questions or need further information about HIV and hepatitis testing. Clients can also be provided with relevant literature after these sessions have concluded.

When discussing viral hepatitis testing with clients, you need to be aware that injection drug users (IDUs) are at especially high risk of becoming infected with hepatitis C. This is because

hepatitis C is primarily a blood-borne disease, which is transmitted easily among IDUs through sharing dirty needles, cookers, cotton, and water. There is a low risk of transmitting hepatitis C through sexual contact. Hepatitis C is a very high risk for IDUs and a much lesser risk for drug users who do not inject. Hepatitis B, on the other hand, like HIV, can be transmitted by both needle use and sexual contact. Hepatitis A, the other form of viral hepatitis, is contracted through contact with infected feces and not through sexual or blood contact. Effective vaccines are available to protect against both hepatitis types A and B, and it is particularly important to refer clients who are already infected with either HIV or hepatitis C for vaccination to prevent further damage to their bodies.

ACCOMMODATING HIV-POSITIVE CLIENTS

You should assume that some of the people recruited into the intervention may be HIV-positive. An HIV-positive participant doesn't have to reveal his or her status to you or to the group. At all times, you will need to stay away from language that assumes all participants are HIV-negative. For example, you can describe the intervention as helping people who use drugs to reduce their risk of becoming infected with HIV or transmitting it to others. During the individual counseling session, clients can disclose their HIV status if they wish and receive needed referrals for medical treatment and supportive care if they are infected. Just remember, unless a client self-discloses his or her status to you, give equal weight in your discussions to not getting infected and to not infecting others: "Let's talk about how we can protect ourselves and others."

It would be ideal to have a separate intervention track for persons who are living with HIV so that they could discuss their health risks and personal issues in a "safe" setting among persons of like HIV status. Such a setting fosters the development of a mutually supportive environment that is usually not possible in a mixed-status group. If a separate track is established for *SAFETY COUNTS* clients who are living with HIV, it would extend not only to group sessions one and two but also to social events. Thus, you would have two *SAFETY COUNTS* programs operating in parallel with each other—one for self-disclosed HIV-positive clients and a second for HIV-negative and undeclared HIV-positive clients. Whether or not this is possible depends largely on the number of HIV-infected drug users you are able to recruit into your program on an ongoing basis. If you are considering this option, you might want to tell clients at the program enrollment session that, if there is sufficient interest, you will try to form an additional *SAFETY COUNTS* group for persons who are living with HIV.

If you do have separate sessions for clients who are living with HIV, facilitators should acknowledge that HIV-positive clients have health risks that go beyond those faced by HIV-negative clients. For example, for HIV-positive clients, drug use and other behaviors that may contribute to reduced adherence to medication protocols and/or ambivalence toward medical treatment are serious issues. Also, risky behaviors may result in HIV reinfection and/or viral hepatitis infection, which can worsen their existing medical condition. Education about HIV treatments should be realistic and relevant to the specific circumstances and needs of the group participants.

CONFIDENTIALITY

Maintaining the confidentiality of personal information disclosed by clients in your *SAFETY COUNTS* program is absolutely essential. You and other staff members have the responsibility to ensure that personal information provided to you by clients remains private and is not disclosed to unauthorized individuals or agencies. At the time individuals initially join *SAFETY COUNTS*, they are assured the information they provide about themselves, including their name, address, phone number, and contact person, as well as their drug use and sexual activities, will remain confidential (see section titled Program Enrollment Session). Clients have a right to expect that program staff will keep confidential all information they provide about themselves, even information that we may consider trivial.

Listed below are some specific issues and suggested precautions you and your agency will need to consider when dealing with personal client information:

- If a client reveals that he or she is HIV-positive, find out whether this information can be made available to other staff members. If the client does not want you to disclose this information, keep it to yourself.
- Be certain that client files are locked at all times unless a *SAFETY COUNTS* staff member is in the room.
- Treat sign-in lists from social events, and other lists containing names of clients, with the same care that you do primary client records—keep such lists secured in a locked file cabinet.
- If someone calls your agency and asks about a client in the program, do not give out any information about the client, even whether he or she is enrolled in *SAFETY COUNTS*.
- When leaving messages for clients, follow exactly the instructions the client has given on the program enrollment form regarding what to say and not to say.
- When outreach workers are allowed to take client information into the field to conduct follow-up contacts, be sure they take only what is absolutely necessary to locate the client and conduct the follow-up contact. For example, the drug and sex history information on page 2 of the program enrollment form is not needed to conduct follow-up contacts and should not be taken into the field. Never give outreach workers the originals of client records. Be certain any copies of client information are returned and accounted for on the same day they are used; shred copies after you have finished using them.
- Store particularly sensitive client information, such as page 2 of the program enrollment form, in a separate locked space apart from other client data if your funding agency encourages or requires this, or if you believe the extra security may be indicated.

- Obtain a signed release from clients before providing assisted referrals to other agencies where you will need to be communicating about the client to the other agency. Even though a client may give verbal permission, written authorization is preferable because it eliminates the possibility of misunderstanding on your part or the part of the client.

TIPS FOR INTERVENTION STAFF

The topics discussed below are intended to help you and the other members of your intervention team be as effective as possible in delivering the various *SAFETY COUNTS* sessions. The tips that appear below are general in nature and apply to all sessions. Session-specific topics of interest are included with the instructions for each session under the heading, “Tips for Conducting this Session.”

Being Spontaneous and Natural

SAFETY COUNTS is a partially scripted structured intervention. As such, in many places it contains exact dialogue, in quotations, as a suggestion for you and others to use in delivering various parts of the intervention. In other places, we describe only the particular idea we want you to communicate, leaving the actual words for you to generate. In both instances, we are asking you to adhere to a carefully defined structure that has benefited from several years of refinement and has proven to be effective in producing behavior change.

Within this framework, however, there is room for the personal touch. It is essential that you and others who are delivering the *SAFETY COUNTS* sessions be able to appear and feel spontaneous and natural. There is no conflict between delivering a structured presentation and remaining spontaneous and natural. Spontaneity, naturalness, and flexibility can be accommodated within the structure of *SAFETY COUNTS* and are definitely encouraged.

Having specific suggested language is beneficial because it gives you a sense of the feeling as well as the content of the communication. This scripting approach makes it easier for you to understand and appreciate the exact point being made in a given instance. At the start, you can follow this script more or less exactly; then, over time, you can put the ideas into your own words. When making the script your own, be sure that you continue to communicate the full meaning of the original.

Where there is no script but only a description of the idea we want you to communicate, you will need to read carefully what is said in the session guide to be certain that you understand exactly what to do. You will need to generate the words to express the idea. In this situation, since the words are yours from the beginning, it will be relatively easy for you to act spontaneously. The challenge will be not to overlook or misinterpret an important point in the description of what to present.

Another aspect of being spontaneous and natural is being able to respond appropriately to unexpected situations that are not anticipated in the session guidelines. In such instances, you

may adapt the session to accommodate the particular situation, so long as you cover all of the session content. For example, if a client comes into an individual counseling session with a specific question about hepatitis C testing, it would be appropriate to deal with his or her concerns at that point rather than waiting until much later in the session, as is called for in the structured guide. You may want to talk about other referral needs at that time before continuing with the normal session sequence. At any rate, you may adjust the structure as is needed in a particular circumstance, as long as you cover the material eventually.

There is one note of caution: If taking a topic out of sequence would interrupt a progression of ideas and thereby interfere with the clients' comprehension of the session content, you should leave the session sequence intact. In summary, as necessary as it is to adhere to the structure and sequence of the intervention sessions, it is also essential to acknowledge clients' issues and concerns as they come up in the course of the intervention. Use your creativity to turn an unexpected digression into a useful experience, so long as it doesn't derail the session.

Being Interactive

The elements of *SAFETY COUNTS* are intended to be communicated in an interactive manner. This is not a didactic intervention, and you will need to be interactive at all times. Interactive approaches draw people in and help them become involved in what you are saying. To be a good facilitator, you need to be drawn into what clients are saying as well. Being interactive also encourages participants to offer support to one another, which is an objective of the intervention. It may be difficult to be interactive when presenting informational topics, although this is precisely the situation in which interactivity is most important. There are a number of widely recognized techniques for presenting what is essentially lecture material in an interactive manner. One of the best known is asking the audience a series of questions about the material throughout the presentation. You will want to become skilled in these strategies because they will make the difference in whether your clients "tune in" or "tune out" what you have to say.

Duration of Sessions

The total time needed to deliver each session is shown at the beginning of the guide for that session. Estimated times are also provided for the individual session components. The number of minutes indicated for session components represent for the most part "best case" estimates. Thus, overall session times may possibly be greater than those indicated. They will seldom be less than the indicated times. To avoid running over the expected session time, you will want to keep close track of the time you devote to each component as you deliver a session.

Internet Resources

Appendix F provides a comprehensive list of Internet sites with up-to-date information on all aspects of HIV and viral hepatitis, including transmission and prevention, treatment, and statistics. We suggest that you use these resources to supplement the basic information about HIV and viral hepatitis that is provided in this manual.

PROGRAM ENROLLMENT SESSION

SESSION OBJECTIVES

- Determine eligibility and willingness of the prospective client to enroll in the *SAFETY COUNTS* program.
- Obtain demographic and personal contact information from the new client, plus information regarding recent substance use and sex-risk activities.
- Present an overview of *SAFETY COUNTS* to the new client, including information about the intervention's objectives, number of sessions, activities, and expectations for client's participation.
- Obtain baseline information concerning client's intentions and actions related to adopting new behaviors to reduce risk of HIV and hepatitis infection or transmission.

SUMMARY OF SESSION ACTIVITIES

In the program enrollment session, the counselor or facilitator interviews the prospective *SAFETY COUNTS* client to determine his or her eligibility for and interest in the *SAFETY COUNTS* program. As a part of this process, the program enrollment form is completed, and a description and overview of the *SAFETY COUNTS* intervention are provided to the prospective client. The risk reduction interview is administered at the end of the session.

Session time: 1 hour.

The program enrollment session is organized as follows:

1. **Introduction** (5 minutes).
2. **Eligibility Check** (5 minutes). The interviewer conducts a quick assessment of the prospective client's drug-use status to determine basic eligibility for *SAFETY COUNTS*.
3. **Completion of Program Enrollment Form** (10 minutes). Demographic and personal contact information is obtained from the new client, as well as detailed information about recent substance use and sex-risk activities.
4. **Description and Overview of SAFETY COUNTS** (10 minutes). The interviewer provides a brief description and overview of the intervention, including its objectives, number of sessions, activities, duration, and expectations regarding the client's participation.

5. **Completion of Risk Reduction Interview** (15 minutes). The interviewer conducts the risk reduction interview with the new client in order to obtain baseline information concerning the client's intentions, actions, and stage of change related to adopting new behaviors to reduce risk of HIV and hepatitis infection or transmission.
6. **Referral for HIV Testing and Other Needs** (10 minutes). The interviewer determines the new client's need for HIV-antibody or hepatitis testing and other services. As appropriate, a referral is made for on-site or off-site testing, and referrals are made for other services as needed.
7. **Closing** (5 minutes). The interviewer welcomes the new client into *SAFETY COUNTS* and provides information about the time and place of group session one. The incentive is given to the client, who is also offered safer sex and needle hygiene kits.
8. **Participation Documentation**. The counselor completes the client participation record for the new client immediately after the session.

PREPARATION AND SETUP

Who conducts the session? An experienced interviewer, such as the behavioral counselor or group facilitator, should conduct the program enrollment session. This person must be comfortable asking about drug use and sexual behaviors, pay careful attention to details to assure that correct information is recorded, and be non-judgmental about what the client reports. He or she should be able to explain the intervention and answer the client's questions about it.

When does the session occur? The program enrollment session occurs when outreach workers have identified persons they think are eligible and interested in participating in *SAFETY COUNTS*. Your agency may be able to conduct these sessions whenever an eligible client drops in or is brought in by an outreach worker, or it may wish or need to require appointments. Enrollment should take place no more than 1 or 2 weeks before a scheduled group session one, to avoid running the risk of clients losing interest.

Where does it take place? Because of the sensitive and personal nature of the questions asked in the program enrollment session, it must be conducted in a private enclosed room, where confidentiality can be assured and interruptions avoided. A table and two chairs are needed.

How do I prepare? You will need to be completely familiar with the information asked for on the program enrollment form and with the exact procedures for administering the risk reduction interview to avoid fumbling and making errors. You should practice asking the questions with other staff members until you are comfortable with them. You should also be familiar with the materials you will have available in the session—the safer sex and needle hygiene kits, the referral information, and participant incentives.

What should I have ready? You will need the following *SAFETY COUNTS* materials for this session:

- Program Enrollment Form
- Risk Reduction Interview
- Program Activities and Services (display card)
- Invitation Card for Group Session One
- Client Participation Record

In addition, you will need the following materials and supplies:

- Needle hygiene kits (small bottle of bleach, small bottles of water, alcohol pads, and sterile cotton balls)
- Safer sex kits (assorted condoms and tubes of lubricant)
- Local HIV/AIDS and social service resource list for referrals
- Incentives

TIPS FOR CONDUCTING THE SESSION

- The program enrollment session needs to be personalized to reach the participant at a level that is appropriate. The session needs to be thorough and individualized, and to involve the participant in beginning to think about his or her own risk behaviors.
- In most cases, your outreach workers will identify participants for enrollment in *SAFETY COUNTS* and will refer them directly to the staff person responsible for enrollment in your agency. On the street, outreach workers may want to inform drug users that they will be eligible to receive incentives if they join the program. Also, outreach workers may want to provide each prospective client with bus or subway fare to increase the likelihood that recruited persons will show up for their enrollment appointments
- The program enrollment form and the risk reduction interview need to be fully completed before the start of group session one to avoid introducing bias as a result of exposure to the intervention.

STEP-BY-STEP PROCEDURES

1. Introduction (5 minutes)

- A. **Welcome the prospective client** and introduce yourself.
- B. **Confirm that he or she was referred by an outreach worker**, or ask how the individual heard about *SAFETY COUNTS*.
- C. **Review what will happen during the session** and how long it will take.

2. Eligibility Check (5 minutes)

- A. **Confirm that the new prospective client is a drug user** who is eligible for *SAFETY COUNTS*. Make a quick assessment for eligibility purposes only. Do not obtain detailed drug information at this time. Be sure that the prospect has used one or more drugs in the past 90 days, besides alcohol and prescription methadone.
- B. **Confirm that the prospective client understands** that *SAFETY COUNTS* is a structured program with specific expectations for participation.
- C. **Skip to Activity 6: Referral for HIV Testing** if the individual says he or she does not want to be in this kind of program.

3. Completion of Program Enrollment Form (10 minutes)

- A. **Assure the client that all personal information provided will remain confidential:**
You may say something like this:

“Everything you tell me about yourself will remain confidential. Your records will be kept in a locked file, and only staff members of this agency who are a part of the *SAFETY COUNTS* program will have access to your information. From time to time, we are required to make reports about our program to organizations that provide us funding, but your name will not be used and you will not otherwise be personally identified.”
- B. **Obtain the demographic, personal contact, and locator information** asked for on the first page of the program enrollment form.
 - If the new client has a nickname or street name, be sure to record it.
 - Remember to get information about hangouts, which can be important for locating the client for session attendance and follow-up.
 - Obtain the name and phone number, and address if possible, of someone who can be contacted who usually knows how to locate the client. Be sure to find

out whether it will be okay to leave a message with this person and whether it is okay to mention your agency's name.

- Find out where it is okay and not okay for outreach workers to interact with the client for follow-up contacts. For example, the client may not be willing to talk to an outreach worker on the street but would in a coffee shop or a park. Record this information in the "Notes" section of the form (page 2).

C. **Obtain the substance use and sex-risk activity information** asked for on page 2 of the program enrollment form. Check all drugs used in the past 90 days, whether injected or not injected. Circle those drugs that were injected.

- If the client mentions other drugs that are not on the form, record these in the blank spaces provided.
- Obtain information about condom use in the past 90 days for vaginal, anal, and oral sex.
- Ask about the client's sexual orientation and whether the client has traded sex for money or drugs in the past 90 days.

D. **Obtain the HIV testing and hepatitis testing and vaccination information** asked for on page 2 of the program enrollment form.

4. **Description and Overview of *Safety Counts*** (10 minutes)

A. **Provide a brief description and overview of the intervention.**

- Place the Program Activities and Services display card on the table, facing the client.
- Use the display card as a guide to talk through the *SAFETY COUNTS* program.
- State the general objectives of *SAFETY COUNTS*: "To assist drug users in finding and applying ways that they can protect themselves and others from HIV and viral hepatitis, and to assist them in getting medical services, HIV and hepatitis testing services, and other community services they may need."
- Briefly describe each type of session, including social events and follow-up contacts, in very general terms.
- Describe the incentives that clients will receive for participating in the intervention. Use this opportunity to say that clients are expected to stay involved in the program and participate in all of the activities.
- Talk about the kinds of referrals *SAFETY COUNTS* clients can receive. Emphasize that *SAFETY COUNTS* staff will be actively involved in the referral process and won't just hand the client a list of names. Mention drug treatment as one type of referral program staff can make, for those clients who want it.

- Say that *SAFETY COUNTS* is intended to be a 4-month program.
- B. **Obtain the prospective client’s reaction:** “So what do you think about it? Do you have any questions?” Answer questions as completely as possible.
- C. **Obtain commitment:** “Do you think *SAFETY COUNTS* is something you would be interested in?”
- If “Yes,” move on to the risk reduction interview: “We have one more thing to do.”
 - If the client is unsure, suggest not enrolling in the program now: “We don’t have to do this today. You can always join the program whenever you want.”
- Complete Activity 6: Referral for HIV Testing and Other Needs before ending the session.

5. Completion of Risk Reduction Interview (15 minutes)

- A. **Record the client’s name or ID number** at the top of the interview form.
- B. **Introduce the interview**, reading aloud from the interview form.
- Read the first paragraph that is shown in bold type to the client.
 - Read the introduction exactly as it is written. Do not change the wording.
- C. **Ask the four general risk questions** and record a “Yes” or “No” response for each one.
- D. **Ask and obtain responses for the first risk reduction behavior.**
- Follow the exact procedure stated on the interview form.
 - Read the parts shown in bold type aloud to the client.
 - Do not try to memorize the wording. As you become more familiar with the interview, you will be able to read the instructions and risk reduction statements aloud in a completely natural manner.
 - Do not change any of the wording, especially the wording of the nine statements under each risk reduction behavior.
 - Obtain a “Yes,” “Somewhat,” or “No” response for all nine of the statements related to the behavior. If the client hesitates, encourage a response by saying, “It’s okay to give an answer even if you are not completely sure.”
- E. **Check for response inconsistencies** and resolve these with the client if possible.

- Look for obvious inconsistencies in responses, such as saying “No” to “I have tried doing this in the last 30 days” and “Yes” to “I have had 100% success doing this in the last 30 days.”
- Check for other inconsistencies by looking for reversals in the pattern of yes-no responses between earlier and later statements. A reversal is defined as giving a “No” response to a particular statement, followed by a “Yes” response to the next (later) statement.
- Call any response inconsistencies that you have identified to the attention of the client and guide the client in resolving them if possible. (As you become more familiar with the interview, you will be able to identify and resolve inconsistencies “on the fly” as the client responds to the statements.)

F. Administer the additional risk reduction behaviors, paying attention to any behaviors that should be skipped based on responses to the general risk questions.

6. Referral for HIV Testing and Other Needs (10 minutes)

- A. **Ask when the client had his or her last HIV test.** If it was more than 3 months ago, recommend a new test and offer to arrange for a referral (or on-site testing if available).
- B. **If the client is an IDU**, offer a referral for hepatitis C testing.
- C. **Emphasize the importance of knowing your status** and discuss the need for ongoing testing for people who are at risk for HIV or viral hepatitis infection.

7. Closing (5 minutes)

- A. **Welcome the client into the SAFETY COUNTS program.** Say that the client has taken a positive step toward protecting his or her health.
- B. **Give an incentive** for participating in this session.
- C. **Tell the client the time and place of the next group session one** and give him or her an invitation (or appointment) card.
- D. **Offer bus or subway tokens**, if available, for transportation to the group session and home from the program enrollment session.

8. Participation Documentation

Immediately after the client leaves, document the client’s participation in the session on the client participation record. In addition, score the risk reduction interview according to the directions on the form. (The score for any behavior with two or more unresolved response

inconsistencies should be viewed cautiously and considered as potentially invalid.)

FORMS AND WORKSHEETS

PROGRAM ENROLLMENT SESSION

Program Enrollment Form

Display Card: What Does *SAFETY COUNTS* Offer Me?

Risk Reduction Interview

Client Participation Record

SAFETY COUNTS Program Enrollment Form

Date: _____

Client name: _____
First Last MI Nickname

Address: _____
Street Apt. City State Zip

Home phone: _____ Cell: _____ Pager: _____

E-mail: _____

Hangouts: (1) _____ (2) _____

Gender: Male Female Transgender Age: _____ Currently Employed: Yes No

Race/ethnicity: White, not Hispanic Black, not Hispanic Hispanic
 Asian / Pacific Islander American Indian / Alaska Native
 Other: _____

Currently receiving services from this agency? Yes No

Contact name: _____
First Last MI Relationship

Address: _____
Street Apt. City State Zip

Home phone: _____ Cell: _____ Pager: _____

E-mail: _____

OK to leave message? Yes No OK to mention this agency? Yes No

Nonprescribed drugs used in the past 90 days:

- | | | | | |
|------------------------------------|---|--|--|---|
| <input type="checkbox"/> Heroin | <input type="checkbox"/> Cocaine | <input type="checkbox"/> Speedball | <input type="checkbox"/> Methadone | <input type="checkbox"/> Methamphetamine (crank, speed) |
| <input type="checkbox"/> Crack | <input type="checkbox"/> 2CB (bromo, nexus) | <input type="checkbox"/> Ketamine (K, special K) | <input type="checkbox"/> MDMA (ecstasy, X) | <input type="checkbox"/> Amyl/Butyl nitrate (poppers, rush) |
| <input type="checkbox"/> LSD | <input type="checkbox"/> Rohypnol (rufies) | <input type="checkbox"/> Glue, nail polish | <input type="checkbox"/> PCP | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Hormones | <input type="checkbox"/> Demerol | <input type="checkbox"/> Depramine (depo) | <input type="checkbox"/> GHB (G) | <input type="checkbox"/> Benzodiazepine (benzos) |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Vicodin | <input type="checkbox"/> Darvon | <input type="checkbox"/> Percodan | <input type="checkbox"/> Amphetamine (diet pills) |
| <input type="checkbox"/> Valium | <input type="checkbox"/> Xanax | <input type="checkbox"/> Prozac | <input type="checkbox"/> Phenobarbital | <input type="checkbox"/> Seconal |
| <input type="checkbox"/> Marijuana | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Viagra | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Drugs injected in the past 90 days: *(Circle as appropriate in the above list)*

- Shared injection equipment past 90 days? Needles Cookers Cotton Water

- Sexual orientation/identity: Heterosexual Gay, Lesbian Bisexual

- Condom use past 90 days (vaginal sex): None 25% 50% 75% 100% No vaginal sex past 90 days

- Condom use past 90 days (anal sex): None 25% 50% 75% 100% No anal sex past 90 days

- Condom use past 90 days (oral sex): None 25% 50% 75% 100% No oral sex past 90 days

- Traded sex for money or drugs past 90 days? Yes No

Most Recent Date

- | | | | | |
|------------------------------------|------------------------------|-----------------------------|-----------------------------|-------|
| Ever tested for HIV? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | _____ |
| Ever tested for hepatitis C? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | _____ |
| Ever tested for hepatitis A? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | _____ |
| Ever tested for hepatitis B? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | _____ |
| Ever received hepatitis A vaccine? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | _____ |
| Ever received hepatitis B vaccine? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | _____ |

What Does *SAFETY COUNTS* OFFER ME?

- 2 GROUP SESSIONS
- 1 (OR MORE) INDIVIDUAL
COUNSELNG SESSIONS
- 2 (OR MORE) SOCIAL EVENTS
- 2 (OR MORE) FOLLOW-UP
CONTACTS

Client Name or ID _____

Date _____

Risk Reduction Interview

Instructions to Interviewer: This instrument is intended to be administered individually to each client using an interview format. Read each question or statement to the client exactly as it is written. **Do not change the wording of the items.** Text that should be read aloud to the client is shown in bold. Record the client's responses by checking the appropriate box following each question or statement. **Some of the 15 risk reduction behaviors may be skipped, as determined by the client's responses to the four general risk questions that are administered first.**

For each one of the risk reduction behaviors listed, read the behavior aloud to the client (e.g., "using condoms for vaginal sex," then read each of the nine statements below it and mark "Yes," "Somewhat," or "No" for each statement according to the client's response. **Do not let the client fill out the form him or herself.** Be sure that the client responds to all of the statements in each block that is administered. As each block of statements is administered, check for obvious inconsistencies in responding (e.g., saying "No" to "I have tried doing this in the last 90 days," and "Yes" to "I have had 100% success doing this in the last 30 days"), and bring these to the attention of the client. Resolve response inconsistencies as they are encountered.

Interviewer Read Aloud: This is a brief questionnaire to find out where you stand in reducing your personal risks of getting or giving HIV and viral hepatitis. It will take about 15 minutes to complete. I am going to describe some different ways of reducing HIV and hepatitis risk, and then for each way I am going to read aloud a list statements that go along with it. I want you to tell me how much you agree or disagree with each statement by saying "Yes," "Somewhat," or "No" as I read it to you. I'll help you with the first few—you'll see it's really easy once we get going. Before we get started, I need to ask you a few quick questions to get a general idea of your risk situation:

- 1. Have you had vaginal sex in the last 90 days? Yes No
- 2. Have you had anal sex in the last 90 days? Yes No
- 3. Have you had sex of any kind with another person in the last 90 days? Yes No
- 4. Have you used injection drugs in the last 90 days? Yes No

Good, here is the first way of reducing HIV or hepatitis risk. *(Read the risk reduction behavior aloud.)*

Now, tell me how much you agree or disagree with the following statement: *(Read the first opinion statement aloud.)* Say "Yes" if you agree with the statement and believe it is true for you, "No" if you disagree with the statement and believe it is not true for you, and "Somewhat" if your opinion is somewhere in between. So, for the statement I have just read, would you say "Yes," "No," or "Somewhat" so far as *[risk reduction behavior]* is concerned for you?

Now, here is the next statement. Tell me "Yes," "No," or "Somewhat," depending on how you believe it applies to you. *(Read the second opinion statement aloud. Follow the same procedure for the remaining seven statements.)*

Here is another risk reduction behavior. *(Read the second risk reduction behavior aloud.)* After I read it, I'm going to read the same statements again and ask you to tell me "Yes," "No," or "Somewhat" for each one. *(Follow the same procedure for the remaining risk reduction behaviors.)*

1. Using condoms for vaginal sex <i>(Skip if no vaginal sex last 90 days: Q1=No)</i>	Score ____	Yes (2)	Somewhat (1)	No (0)
I believe doing this can keep me from getting or giving HIV or hepatitis.				
Doing this has more positives than negatives in my mind.				
I believe that I am ready to do this.				
I am confident in my ability to do this.				
I have planned how to go about doing this.				
I have tried doing this in the last 30 days.				
I have been able to do this in the last 30 days.				
I have had 100% success doing this in the last 30 days.				
I feel certain I will be able to continue doing this for the next six months.				

2. Using condoms for anal sex <i>(Skip if no anal sex last 90 days: Q2=No)</i> Score ____	Yes (2)	Somewhat (1)	No (0)
I believe doing this can keep me from getting or giving HIV or hepatitis.			
Doing this has more positives than negatives in my mind.			
I believe that I am ready to do this.			
I am confident in my ability to do this.			
I have planned how to go about doing this.			
I have tried doing this in the last 30 days.			
I have been able to do this in the last 30 days.			
I have had 100% success doing this in the last 30 days.			
I feel certain I will be able to continue doing this for the next six months.			

3. Not having vaginal or anal sex <i>(Skip if no vaginal or anal sex last 90 days: Q1 & Q2=No)</i> Score ____	Yes (2)	Somewhat (1)	No (0)
I believe doing this can keep me from getting or giving HIV or hepatitis.			
Doing this has more positives than negatives in my mind.			
I believe that I am ready to do this.			
I am confident in my ability to do this.			
I have planned how to go about doing this.			
I have tried doing this in the last 30 days.			
I have been able to do this in the last 30 days.			
I have had 100% success doing this in the last 30 days.			
I feel certain I will be able to continue doing this for the next six months.			

4. Having fewer sex partners <i>(Skip if no sex partners last 90 days: Q3=No)</i> Score ____	Yes (2)	Somewhat (1)	No (0)
I believe doing this can keep me from getting or giving HIV or hepatitis.			
Doing this has more positives than negatives in my mind.			
I believe that I am ready to do this.			
I am confident in my ability to do this.			
I have planned how to go about doing this.			
I have tried doing this in the last 30 days.			
I have been able to do this in the last 30 days.			
I have had 100% success doing this in the last 30 days.			
I feel certain I will be able to continue doing this for the next six months.			

5. Having fewer sex partners I don't use a condom with <i>(Skip if no sex partners last 90 days: Q3=No)</i> Score ____	Yes (2)	Somewhat (1)	No (0)
I believe doing this can keep me from getting or giving HIV or hepatitis.			
Doing this has more positives than negatives in my mind.			
I believe that I am ready to do this.			
I am confident in my ability to do this.			
I have planned how to go about doing this.			
I have tried doing this in the last 30 days.			
I have been able to do this in the last 30 days.			
I have had 100% success doing this in the last 30 days.			
I feel certain I will be able to continue doing this for the next six months.			

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6. Having sex with only one partner <i>(Skip if no sex partners last 90 days: Q3=No)</i> Score ____	Yes (2)	Somewhat (1)	No (0)
I believe doing this can keep me from getting or giving HIV or hepatitis.			
Doing this has more positives than negatives in my mind.			
I believe that I am ready to do this.			
I am confident in my ability to do this.			
I have planned how to go about doing this.			
I have tried doing this in the last 30 days.			
I have been able to do this in the last 30 days.			
I have had 100% success doing this in the last 30 days.			
I feel certain I will be able to continue doing this for the next six months.			

7. Having protected sex when drunk or high <i>(Skip if no sex partners last 90 days: Q3=No)</i> Score ____	Yes (2)	Somewhat (1)	No (0)
I believe doing this can keep me from getting or giving HIV or hepatitis.			
Doing this has more positives than negatives in my mind.			
I believe that I am ready to do this.			
I am confident in my ability to do this.			
I have planned how to go about doing this.			
I have tried doing this in the last 30 days.			
I have been able to do this in the last 30 days.			
I have had 100% success doing this in the last 30 days.			
I feel certain I will be able to continue doing this for the next six months.			

8. Not sharing needles <i>(Skip if no injection drug use last 90 days: Q4=No)</i> Score ____	Yes (2)	Somewhat (1)	No (0)
I believe doing this can keep me from getting or giving HIV or hepatitis.			
Doing this has more positives than negatives in my mind.			
I believe that I am ready to do this.			
I am confident in my ability to do this.			
I have planned how to go about doing this.			
I have tried doing this in the last 30 days.			
I have been able to do this in the last 30 days.			
I have had 100% success doing this in the last 30 days.			
I feel certain I will be able to continue doing this for the next six months.			

9. Not sharing injection equipment (water, cotton, cookers) <i>(Skip if no injection drug use last 90 days: Q4=No)</i> Score ____	Yes (2)	Somewhat (1)	No (0)
I believe doing this can keep me from getting or giving HIV or hepatitis.			
Doing this has more positives than negatives in my mind.			
I believe that I am ready to do this.			
I am confident in my ability to do this.			
I have planned how to go about doing this.			
I have tried doing this in the last 30 days.			
I have been able to do this in the last 30 days.			
I have had 100% success doing this in the last 30 days.			
I feel certain I will be able to continue doing this for the next six months.			

10. Using a new needle for every drug injection <i>(Skip if no injection drug use last 90 days: Q4=No)</i> Score ____	Yes (2)	Somewhat (1)	No (0)
I believe doing this can keep me from getting or giving HIV or hepatitis.			
Doing this has more positives than negatives in my mind.			
I believe that I am ready to do this.			
I am confident in my ability to do this.			
I have planned how to go about doing this.			
I have tried doing this in the last 30 days.			
I have been able to do this in the last 30 days.			
I have had 100% success doing this in the last 30 days.			
I feel certain I will be able to continue doing this for the next six months.			

11. Bleaching my needle before every use if a new needle is not available <i>(Skip if no injection drug use last 90 days: Q4=No)</i> Score ____	Yes (2)	Somewhat (1)	No (0)
I believe doing this can keep me from getting or giving HIV or hepatitis.			
Doing this has more positives than negatives in my mind.			
I believe that I am ready to do this.			
I am confident in my ability to do this.			
I have planned how to go about doing this.			
I have tried doing this in the last 30 days.			
I have been able to do this in the last 30 days.			
I have had 100% success doing this in the last 30 days.			
I feel certain I will be able to continue doing this for the next six months.			

12. Decreasing or managing my drug use <i>(Ask of everyone)</i> Score ____	Yes (2)	Somewhat (1)	No (0)
I believe doing this can keep me from getting or giving HIV or hepatitis.			
Doing this has more positives than negatives in my mind.			
I believe that I am ready to do this.			
I am confident in my ability to do this.			
I have planned how to go about doing this.			
I have tried doing this in the last 30 days.			
I have been able to do this in the last 30 days.			
I have had 100% success doing this in the last 30 days.			
I feel certain I will be able to continue doing this for the next six months.			

13. Getting into drug treatment <i>(Ask of everyone)</i> Score ____	Yes (2)	Somewhat (1)	No (0)
I believe doing this can keep me from getting or giving HIV or hepatitis.			
Doing this has more positives than negatives in my mind.			
I believe that I am ready to do this.			
I am confident in my ability to do this.			
I have planned how to go about doing this.			
I have tried doing this in the last 30 days.			
I have been able to do this in the last 30 days.			
I have had 100% success doing this in the last 30 days.			
I feel certain I will be able to continue doing this for the next six months.			

14. Using HIV counseling and testing services every 3 months <i>(Ask of everyone)</i> Score ____	Yes (2)	Somewhat (1)	No (0)
I believe doing this can keep me from getting or giving HIV or hepatitis.			
Doing this has more positives than negatives in my mind.			
I believe that I am ready to do this.			
I am confident in my ability to do this.			
I have planned how to go about doing this.			
I have tried doing this in the last 30 days.			
I have been able to do this in the last 30 days.			
I have had 100% success doing this in the last 30 days.			
I feel certain I will be able to continue doing this for the next six months.			

15. Using hepatitis counseling and testing services every 3 months <i>(Ask of everyone)</i> Score ____	Yes (2)	Somewhat (1)	No (0)
I believe doing this can keep me from getting or giving HIV or hepatitis.			
Doing this has more positives than negatives in my mind.			
I believe that I am ready to do this.			
I am confident in my ability to do this.			
I have planned how to go about doing this.			
I have tried doing this in the last 30 days.			
I have been able to do this in the last 30 days.			
I have had 100% success doing this in the last 30 days.			
I feel certain I will be able to continue doing this for the next six months.			

Scoring Instructions: For each risk reduction behavior, compute the total number of points for the nine responses to the statements in that block. Count 2 points for each statement checked “Yes,” 1 point for each statement checked “Somewhat,” and 0 points for each statement checked “No.” Write the score obtained in the blank provided. Each risk reduction behavior should be scored separately. There is a maximum possible score of 18 points for each behavior. (Part IV of the Program Manual provides a scoring example.)

Behavior scores may be interpreted in terms of the five stages of change, as shown below. These ranges are suggestive rather than exact, but they do provide a general indication of the position of an individual on the widely used stages-of-change continuum.

Score	Stage Description	Stage Name
0	Not Considering It	Pre-contemplation
1-8	Planning to Do It	Contemplation
9-14	Taking Steps	Preparation
15-17	Doing It	Action
18	Staying with It	Maintenance

Note: The maintenance stage as measured by this instrument is most accurately described as a “maintenance intention” stage. This is because, strictly speaking, to be in maintenance a person must have actually performed a particular risk reduction behavior for a period of at least six months, as opposed to merely expressing the intention to do so.

SAFETY COUNTS Client Participation Record

Client Name _____

Enrollment Date _____

Sessions Completed:

Program Enrollment:	Date _____	HIV testing referral made _____ Other referrals made _____
Group One:	Date _____	HIV testing referral made _____ Other referrals made _____
Group Two:	Date _____	HIV testing referral made _____ Other referrals made _____
Individual Counseling:	Date _____	HIV testing referral made _____ Other referrals made _____
Social Event 1:	Date _____	HIV testing referral made _____ Other referrals made _____
Social Event 2:	Date _____	HIV testing referral made _____ Other referrals made _____
Follow-up Contact 1:	Date _____	HIV testing referral made _____ Other referrals made _____
Follow-up Contact 2:	Date _____	HIV testing referral made _____ Other referrals made _____

Personal Goal Information:

General Goal:

<input type="checkbox"/> Use condoms for vaginal sex <input type="checkbox"/> Use condoms for anal sex <input type="checkbox"/> Practice alternatives to vaginal/anal sex <input type="checkbox"/> Have fewer sex partners <input type="checkbox"/> Have fewer sex partners I don't use a condom with <input type="checkbox"/> Have sex with only one partner <input type="checkbox"/> Have protected sex when drunk or high <input type="checkbox"/> Don't share needles	<input type="checkbox"/> Don't share injection equipment (water, cotton, cookers) <input type="checkbox"/> Use a new needle for every drug injection <input type="checkbox"/> Always bleach needles if new needles are not available <input type="checkbox"/> Decrease/manage drug use <input type="checkbox"/> Get into drug treatment <input type="checkbox"/> Use HIV counseling/testing services every 3 months <input type="checkbox"/> Use hepatitis counseling/testing services every 3 months
--	---

Personal goal: _____

First step: _____

Barriers and solutions: _____

Client Name _____

Follow-up Contact Information:

Follow-up Contact 1: Date _____ Staff _____ Type: Face-to-face Telephone

Achieved first step? Yes No

Client's view of goal progress to date: Good Fair Poor

Next step (or revised first step):

Barriers and possible solutions:

_____	_____
_____	_____
_____	_____

Follow-up Contact 2: Date _____ Staff _____ Type: Face-to-face Telephone

Achieved first step? Yes No

Client's view of goal progress to date: Good Fair Poor

Next step (or revised first step):

Barriers and possible solutions:

_____	_____
_____	_____
_____	_____

Notes:

GROUP SESSION ONE

SESSION OBJECTIVES

- Make clients aware of their personal risks for acquiring or transmitting HIV and viral hepatitis.
- Identify clients' stages of change for reducing risk with respect to specific drug- and sex-related risk behaviors.
- Motivate and empower clients to reduce their HIV and hepatitis risks by exposing them to stories of successful behavior change by drug-using peers.
- Make clients aware of the importance of having social support for their risk reduction efforts.

SUMMARY OF SESSION ACTIVITIES

Group session one reviews local HIV/AIDS statistics with an emphasis on drug users, helps clients identify their own personal HIV risks, and reviews basic prevention methods.

Session time: 1 hour, 45 minutes.

Group session one is organized as follows:

1. **Introduction** (20 minutes).
2. **Am I at Risk?** (15 minutes). Clients are helped to identify their personal risks for HIV and hepatitis. In this process, Facilitators lead a discussion of HIV and viral hepatitis transmission, risks, and prevention, and clients complete worksheet 1.
3. **Stages of Change—How We Change Our Behavior** (20 minutes). Facilitators lead clients through the stages-of-change model, so that clients may learn how to apply the principles in order to reduce their own risk. Following this discussion, a small group activity allows the clients to select a risk behavior and follow it through the stages of change.
4. **Learning from Risk Reduction Success Stories** (15 minutes). Facilitators present risk reduction success stories reflecting the experiences of drug users in the local community who have successfully made positive changes to reduce their HIV and hepatitis risks. This is followed by an interactive discussion using a stages-of-change framework.
5. **The Importance of Social Support** (10 minutes). Clients are asked to consider the social support portrayed in the risk reduction success stories. They also are asked to

- think of specific individuals in their own lives who have provided support for actions they have taken in the past.
6. **Where Do I Stand in Reducing My Risks?** (15 minutes). Clients complete worksheet 2 and are asked to share where they stand in terms of stage of change on some of the risk behaviors in the worksheet.
 7. **Closing** (10 minutes). The session closes with facilitators encouraging clients to consider learning their HIV and hepatitis status and to share success stories of reducing risky behaviors. They are reminded of future program activities and thanked for their good work in the session.
 8. **Participation Documentation.** Facilitators complete the client participation record for each client immediately after the session.
 9. **Staff Debriefing.** Facilitators meet briefly following the session to discuss and critique the session in overall terms as well as the effectiveness of each of the activities. Issues observed during the session that relate to individual clients also are discussed.

PREPARATION AND SETUP

Who conducts the session? A facilitator and a co-facilitator lead the session. The *SAFETY COUNTS* behavioral counselor usually serves as the co-facilitator. The facilitators should be trained in the intervention and have experience and skill working with drug users.

When does the session occur? This session should be offered on a weekly basis, alternating with group session two. You should have at least three clients in attendance. If a scheduled session falls during the first week of the month, be aware that attendance may be low because this is the time that some people receive benefit checks and food stamps.

Where does it take place? Group session one should take place in a location where clients can talk confidentially and frankly about HIV prevention and their own behavior. Typically, the group sessions are held in a private, comfortable room within the agency.

How do we prepare? Facilitators will want to gather and review all the necessary program materials described below, including safer sex and needle hygiene kits, refreshments, and participant incentives. If you have not conducted this session before with your co-facilitator, practice together and role-play the different discussions contained in the session. Finally, you may want to check out www.cdc.gov/idu for fact sheets and information on viral hepatitis and other issues of concern to IDUs.

What should we have ready? You will need the following *SAFETY COUNTS* materials for this session:

- Worksheet 1: Am I at Risk for HIV and Viral Hepatitis? (one for each client and facilitator).
- Display Cards: The Five Stages of Behavior Change (one set to hold up or post on the wall).
- Worksheet 2: Where Do I Stand in Reducing My Risks for HIV and Viral Hepatitis? (one for each client and facilitator)
- Risk reduction success stories. (The process for creating stories is described in Appendix G: How to Create Risk Reduction Success Stories. Examples of written stories are shown in Appendix H.)
- SAFETY COUNTS* Client Participation Record (originated in the program enrollment session).

In addition, you will also need the following materials, supplies, and equipment:

- Name tags, marker pens
- Light food and refreshments
- Incentives
- Newsprint on easel, markers, and tape
- Local HIV/AIDS statistics
- Brochures giving basic facts about HIV and viral hepatitis
- VCR player and monitor if video used; audiotape player if audiotape is used
- Needle hygiene kits (small bottle of bleach, small bottles of water, alcohol pads, and sterile cotton balls)
- Safer sex kits (assorted condoms and tubes of lubricant)
- Local medical and social service resource list for referrals (including HIV and hepatitis testing)

TIPS FOR CONDUCTING THE SESSION

- Groups should have at least 3 but no more than 12 clients in attendance. An ideal group size is somewhere between 5 and 8 clients.

- As stated earlier, group sessions are preferably scheduled on a weekly basis, with group session one and group session two offered on alternate weeks. Once you set a schedule for the group sessions, we recommend that you adhere to it for the duration of the program. You may cancel a particular group session if you do not have the required minimum of three clients in attendance. When it is necessary to cancel a session, you should provide the regular incentive to any clients who show up for the cancelled group.
- Clients are eligible for group session two anytime after they complete group session one. With the recommended schedule, there will be 1 week between group sessions one and two, but the time may be shorter than this if desired.
- Save the ground rules from this session to see if any of them should be added to the composite list that is used in group session two. The composite is developed from the various sets of ground rules that come out of the different group one sessions that you conduct.
- Worksheet 1 and worksheet 2, which are filled out by clients during the session, contain blanks for the client's name. We suggest that you tell clients it is OK to use first names only. For worksheet 1, a name is not required because this worksheet is kept by the client and not used again. For worksheet 2, a name is necessary because this worksheet is copied and passed out to clients and used again during group session two.

STEP-BY-STEP PROCEDURES

1. Introduction (20 minutes)

A. Welcome and introductions.

- When clients arrive, welcome them and introduce yourself and your co-facilitator. Ask them to fill out a name tag with their first name or nickname.
- Congratulate clients on making a first step toward reducing their risks for HIV infection and on their courage in coming to your session. Let them know that you appreciate their attendance and that they can rely on you and other agency staff to support them in their efforts.
- Talk briefly about the intervention and review what clients can expect. Let them know that there will be:
 - Another group session.
 - An individual counseling session.
 - Social events.

- Follow-up contacts.
- A meeting at the end to fill out evaluation forms.

Remember that clients have already heard a summary of the intervention during the program enrollment session, so this is a review.

Use this opportunity to sell the intervention and get “buy-in” by clients. Stress the benefits that clients will receive by participating:

- Incentives for participation (describe the incentives you are providing).
- Interactive sessions that are fun.
- Food served at each session, with a full meal at the monthly social events.
- Help getting medical services, HIV and hepatitis testing services, and other community services, plus help getting into drug treatment if they want.
- Support and help in finding ways that they can protect themselves and others from HIV and viral hepatitis. (“It’s not about judging, it’s about helping.” “We’re here to help you find a way of lowering your risks that makes sense for you and that really works.” “We can support you in getting there, and we can help you keep on track.”)

B. Ground rules. Now is a good time to set ground rules for the session. Get group “buy-in” by asking the clients about how they would like for the group to work. Record suggested ground rules on newsprint, including the following:

- Confidentiality (“What’s said here stays here.”)
- Respect for other people’s opinions
- Open and honest questions and answers
- No sidebars (private conversations)

C. Introduction icebreaker. Give clients an opportunity to introduce themselves and to get more comfortable with the group. An icebreaker game would work well here. One example is the toilet paper game: Pass a roll of toilet paper and ask participants to tear off as much as they like. Once they have counted the number of squares they have, ask them to tell the group that number of things about themselves.

D. Brief facts about HIV and viral hepatitis. To set the stage for the remainder of the session, talk about some local statistics so that they have a sense of HIV and viral hepatitis in your community. Also, refer to the boxes, “HIV Facts” and “Viral Hepatitis Facts” on the following pages for information about transmission risks.

Note the higher risk of HIV and hepatitis B and C for people who use drugs, due to both needle use (for HIV and hepatitis C) and unprotected sex (for HIV and both B and C). Reinforce the importance of learning about how to prevent HIV and hepatitis B and C, and emphasize that by joining *SAFETY COUNTS* they have taken the first big step to getting involved in their own protection. Describe the ABCs of smart behavior contained in Appendix I

Describe the effectiveness of latex condoms in preventing transmission of HIV, hepatitis, and other sexually transmitted diseases (see Appendix J). Recommend avoidance of nonoxynol-9, as this may increase HIV risk (see Appendix K).

HIV FACTS

How does someone get infected with HIV?

- HIV (the virus that causes AIDS) is found in semen, blood, and vaginal fluid, so you can get HIV from certain sexual and drug use activities. An activity is risky if it involves bodily exchange of blood, semen, or vaginal fluid.

You are at greater risk of getting or giving HIV through sexual acts like...

- Having unprotected sex (sex without a condom): oral, anal, and vaginal intercourse
- Having unprotected sex with more than one partner
- Having unprotected sex when drunk or high
- Having unprotected sex with needle users
- Having unprotected sex with someone who also has other partners
- Having unprotected sex when you or your partner has a sore or lesion that could allow HIV to be transmitted

You are at greater risk of getting or giving HIV through drug practices like...

- Sharing needles
- Sharing other drug injection equipment (water, cotton, cookers)

Also...

- A mother with HIV can give it to her child during pregnancy or giving birth or breast-feeding.

What are ways you don't get HIV? You can't get HIV from...

- Coughing
- Sharing food
- Touching
- Saliva, sweat, tears, urine, or feces
- Clothes, a telephone, or a toilet seat
- A dry kiss
- A mosquito or other insect bites

VIRAL HEPATITIS FACTS

The information about hepatitis in this section is drawn largely from CDC's fact sheet, *Viral Hepatitis and IDUs* [September 2002], which can be downloaded from www.cdc.gov/idu.

Hepatitis is a liver disease. There are three major types of hepatitis, each caused by a virus: the hepatitis A virus (HAV), hepatitis B virus (HBV), and hepatitis C virus (HCV).

- Hepatitis A is primarily transmitted when food or drink that is contaminated by feces from an HAV-infected person is consumed by an uninfected person. The contamination will probably not be visible and may occur anywhere in the production chain from those who harvest the food to those who process it, cook it, or serve it.
- Hepatitis B occurs when blood or body fluids from an HBV-infected person enters the body of an uninfected person. Health-care workers are especially vulnerable because of their frequent exposure to body fluids, as are others exposed to such fluids through shared injection equipment and unprotected sex.
- Hepatitis C occurs when blood (or, to a lesser extent, other body fluids such as semen or vaginal fluid) from an HCV-infected person enters the body of an uninfected person.

Both hepatitis A and B can be prevented through immunization. All injection drug users (IDUs) should be immunized against these unless they have already had the infection. No vaccine to prevent hepatitis C infection is available.

IDUs are at very high risk of getting and giving both hepatitis B and C. Many individuals who become infected with hepatitis B and C develop chronic liver disease that can gradually lead to serious liver damage or to liver cancer.

Many of the risks for hepatitis B and C are the same as the risks for HIV:

- Hepatitis B is transmitted when people share drug solution, syringes, and other drug use equipment that is contaminated with HBV-infected blood. It's also spread through high-risk sexual behaviors, such as unprotected sex with multiple partners.
- Hepatitis C is also transmitted when people share drug solution, syringes, and other drug use equipment that is contaminated with HCV-infected blood. It is also spread through high-risk sexual behaviors, such as unprotected sex with multiple partners, but most HCV infections are due to drug use.
- About 25% of the people living with HIV also have hepatitis C. Most of the people living with both viruses are IDUs.

For each risk listed, there are ways to avoid getting or giving HIV, as well as hepatitis B and C:

- Use a condom for oral, vaginal, and anal sex
- Have protected sex if drunk or high
- Have protected sex with one partner
- Have protected sex if you or your partner has a sore that could be a route of infection
- Practice alternatives to penetrative sex such as mutual masturbation or dry humping
- Don't share needles, rinse water, cotton, or cookers
- Use a new needle for every drug injection
- Bleach a needle before every drug injection if a new needle is not available
- Reduce your drug use or get into drug treatment

In presenting this information, make generous use of newsprint to note key points as you talk. Remember to keep the presentation interactive. It is easy to fall into “lecture mode” for material like this, so be on your guard and don’t let this happen.

- E. **HIV and hepatitis testing.** Make a statement about HIV and hepatitis testing. Acknowledge that some people in the room may have already been tested and know their status (which they don’t need to reveal). “Both positive and negative individuals can benefit from the intervention, and all are welcome.” For those who have not been tested, explain that there are good reasons to do so (e.g., the availability of effective medical treatment and support services) and that you can arrange for on-site testing or give them referrals at the end of the session.

2. Am I At Risk? (15 minutes)

Purpose: The purpose of this activity is to help clients identify their risky behaviors and talk about how they can lower their risks for HIV and viral hepatitis.

- A. **Personal risks for HIV and hepatitis.** Tell the clients it is time to think about their own risks for HIV. Hand out worksheet 1: “Am I at Risk for HIV and Viral Hepatitis?” Lead them through filling out the worksheet by reading each question aloud, and letting them answer the question before moving on to the next one (this process is especially helpful for clients with low literacy levels). Let them know they don't need to share their answers now with the group.
- B. **Review of transmission risks.** After filling out the worksheet, review and discuss general HIV and hepatitis transmission risk. Because viral hepatitis is also a significant problem among IDUs, discussion of HIV risk should also include information about hepatitis. Talk about how you can and cannot get infected. Many of the participants may already know about risk, so you can ask them to tell you. Correct any misperceptions with sensitivity and tact.

3. Stages of Change: How We Change Our Behavior (20 minutes)

Purpose: The purpose of this activity is to develop clients’ understanding of the stages-of-change model so that they can use it as a tool in adopting new behaviors to reduce their health risks. Clients will learn that when they have identified a risk behavior that they want to change, but they do not have a definite plan for starting, they are in stage two. Clients will also learn that when they have a definite plan and are beginning to take steps to change the behavior, they are in stage three.

- A. **Put the five stages-of-change display cards** up on the wall in the front of the room. Be sure the cards are arranged in order, from the lowest to the highest stage of change.
- B. **Select a specific example of behavior change** that is familiar to members of the group and that they may have experienced personally. This behavior will be used as a

real-life example in the explanation and discussion of the stages-of-change process. In talking about stages of change, it is very important to use as an example a behavior that commonly presents difficulties for people and that everybody in the group can identify with. It should also be a “non hot topic,” that is, a behavior that is not emotionally charged for clients. Quitting smoking is usually a good behavior to use as an example because there are typically a number of current or former smokers in the group, many of whom have tried to quit more than once. Examples of other “non hot topics” are going on a diet and starting an exercise program.

- C. **Get clients to identify their past attempts to change behavior.** Assuming you are using quitting smoking as the example behavior, ask how many participants have ever tried to quit smoking or thought about quitting. (If an alternative behavior has been selected, substitute this behavior for smoking cessation throughout this section.)
- D. **Point to the card on the wall for Stage 1: Not Considering It—“I’m not thinking about it now; I’ve got enough to deal with already.”** (Pre-Contemplation Stage)
- “How many of you have ever felt this way about quitting smoking?”
 - After a show of hands, “That’s right, maybe you know you should, but you’re not thinking about it now—maybe later, but not now. And don’t bug me about it!”
 - “Sounds familiar, doesn’t it? Well, that’s where we all start out before we begin something new.”
- E. **Point to the card for Stage 2: Planning to Do It—“I’m thinking it through and I intend to do it, but I’m not sure when.”** (Contemplation Stage)
- “Now we see some kind of progress—you’ve started to think about stopping smoking, you just don’t know when. In other words, you’ve considered it. You are more aware about the benefits of stopping smoking, but you are also very aware of the negatives. This balance between the costs and benefits of changing your behavior can still make you feel unsure about whether to stop smoking. How many of you remember getting to that point?” Ask for a show of hands and acknowledge.
 - “What made you go from not being willing to consider doing it (Stage 1) to start thinking about stopping sometime in the future (Stage 2)?” Encourage participants to tell their individual stories.
 - Identify in each case what it was that moved the participant from not being willing to think about changing his or her behavior (Stage 1) to actively considering it and subsequently developing an intention to change (Stage 2). Highlight these triggers and discuss them with members of the group.

F. **Point to the card for Stage 3: Taking Steps**—"I've made it a goal and taken some steps; I'll be doing it soon." (Preparation Stage)

- "This is the next stage, where we make a definite plan to stop smoking and take concrete steps to prepare to do it. Does that ring a bell for anybody?"
- "There are really two parts to this: The first part is planning how we are going to stop smoking, which usually includes taking some first steps like not buying any more cigarettes. The second part is gearing yourself up to begin for real in the near future, which may or may not include picking a particular date to start."
- "Who can remember what kind of plans you made to stop smoking? What were the first steps you took, before you actually quit? How did you prepare?"
- Encourage participants to describe the plans they made to stop smoking. Ask about the concrete steps they took to prepare to quit smoking before they actually quit smoking. (These are called precursor or "approach" behaviors.)
- "Who set an actual date to stop smoking? Which of you didn't set a specific date but simply knew you were going to stop very soon?"
- Talk through the various scenarios and experiences described by group members. Make the point that you don't have to set a specific date for action; the important thing is to make a commitment, take some concrete steps, and know you are going to start soon.

G. **Point to the card for Stage 4: Doing It**—"I'm really doing it, and I'm taking it 1 day at a time." (Action Stage)

- "I'm sure this has a familiar ring. You've started doing what you planned to do, but you're not 100% you can keep it up without slipping. Keeping with our smoking example, it would probably be better to say you've stopped smoking, and you don't know how on earth you can keep it up without slipping. How many of you can identify with this?"
- "How long did you stay off cigarettes without slipping? If you quit more than one time, how long did you stay off each time?"
- Obtain specific information from each member of the group who has attempted (or succeeded) in giving up cigarettes. Allow group members to describe their experiences in detail.
- Call attention to the variability in the length of time that different people in the group report maintaining their new behavior (staying off cigarettes) without slipping.

- “Just because you slip doesn’t mean you haven’t been a success. It’s normal to slip, and most people do. When you try again, you don’t have to start over from the beginning; usually you just go back one stage.”

H. **Point to the card for Stage 5:** Staying with It (for at least 6 months)—“It’s a part of my life now, and I’m staying on track.” (Maintenance Stage)

- “Now we get to the final stage, the point where the new way of behaving becomes a regular part of your life. After you have been off cigarettes for, say, several months, not smoking starts becoming a normal part of your life. Not smoking isn’t so special any longer, and you don’t have to worry about it the way you used to. Who can identify with this?”
- Give all members of the group an opportunity to describe their personal experiences in maintaining smoking abstinence. If no one in the group has maintained smoking abstinence for more than 2 or 3 months, then ask about people they know who have accomplished this. (Being in the Maintenance Stage is defined in formal terms as successfully performing the new behavior without a slip for 6 months or longer.)
- “The longer you maintain a behavior, the less likely it is you will experience a slip. But if you do, it’s not a failure. It’s just a slip, so it will be easy to get going again.”

I. **Summarize the stages-of-change process,** invite discussion, and establish links to adopting HIV and viral hepatitis risk reduction behaviors.

- Talk through the five stages of change again, pointing to each display card in turn and reading the text of each aloud. In this summary, talk about the process of personal behavior change in general terms rather than by using smoking cessation or any other specific example. Be brief.
- “These five stages describe the steps people go through in adopting any new behavior. As participants in *SAFETY COUNTS*, clients can tell us how to be successful in changing what we do to be safer from getting HIV and viral hepatitis or infecting others.”
- “Let’s think of some specific things people could do—let’s assume they are not doing these things already—that could reduce their risk of getting or giving HIV and viral hepatitis.” Write the group’s suggestions on easel paper.
- Pick a suggested action from the list that will be easy to discuss, e.g., “using condoms.” “Let’s pick using condoms and think about what it might be like for people in the different stages of change.”
- “What do you think it would be like for a person in Stage 1? (Point to display card.) What are some of the things a person at that stage might be thinking or feeling?” Encourage specific suggestions and brief discussion.

- “Let’s say the person is in Stage 3. (Point to display card.) What kinds of things might be happening to a person at this stage?” Encourage specific suggestions and brief discussion.
- J. **Ask for other comments or questions**, then close the segment by saying, “So these are the five stages we go through whenever we change our behavior and start doing something different. Now let’s hear from some real people who have changed their behavior and see how they did it.”

4. Learning from Risk Reduction Success Stories (15 minutes)

Purpose: The purpose of this activity is to empower clients to take steps to reduce their personal HIV and hepatitis risks through hearing the personal stories of peers who have successfully made positive changes in their own lives to reduce their risk of getting or transmitting HIV or viral hepatitis.

Appendix G provides instructions for creating your own risk reduction success stories reflecting the experiences of people in your local community. These may be in the form of videos, audiotapes, or written stories. Samples of written stories appear in Appendix H.

- A. **Select a drug-related success story and a sex-related story** to present at this session out of the four stories that you have developed for *SAFETY COUNTS*. (The other two stories will be used in group session two.)
- B. **Introduce the stories** by explaining that they reflect the experiences of real people in the local community who have been successful in reducing their own risk of getting or transmitting HIV or viral hepatitis. Say that the stories tell how other drug users in the local community have successfully reduced their personal health risks with regard to HIV and viral hepatitis. If your stories do not use real names, let clients know that names have been changed to respect privacy.
- C. **Present the two risk reduction success stories.** If you are using written stories, pass out copies to members of the group and have them follow along while you read the first story aloud. Ask for a volunteer from the group to read the second story aloud. (If no one in your group can read, do the reading aloud yourself. If you are confident in the reading ability of the group, you may ask different volunteers to read each story.)
- D. **Invite brief comments** from the group after the first story, but save full discussion until both stories have been presented.

- E. **Engage group members in an interactive discussion** about the situation portrayed in each story after both stories have been presented. In this discussion, focus on the fact that the behavior changes in the two stories occurred over a period of time—they did not happen overnight. Help participants relate specific aspects of the stories to the different stages of change that the individuals in the stories were going through.
- F. **Address the following questions** as a part of the interactive discussion:
- » “What event triggered the intention to change behavior for each of the individuals? At what point did the individuals make a definite commitment?”
 - » “At what point did each of the individuals in the stories move into the Taking Steps stage?” (Stage 3)
 - » “What problems did the individuals have in trying to perform the new behaviors—that is, what barriers did they encounter?”
 - » “How were these barriers overcome? What other strategies do you think might have worked?”
 - » “What made it easier for them to perform the new behaviors? What helped them out?”
 - » “At what point did each person in the stories move into the Action stage, where they first started being successful in doing what they were trying to do?” (Stage 4)
 - » “What were the individuals doing to maintain their new behaviors? What are some other ways they could maintain change?” (Stage 5)
 - » “Did these people experience any setbacks? Did they fall back to an earlier stage? How were the setbacks dealt with? Do you think that would work for you?”

5. The Importance of Social Support (10 minutes)

Purpose: This activity reinforces for clients the importance of having the support of people around them when they are trying to make a change in their lives.

- A. **Ask clients how important social support was to the individuals** in the risk reduction success stories: “How important was the support of other people like friends and family to the individuals in the stories?”
- B. **Define social support:** “When we have other people who believe in what we are doing, we call that having social support.”

C. Ask clients to identify instances of social support in the stories:

- » “What were some specific examples of social support that occurred in the stories?”
- » “Do you think this made a difference to the individuals who were trying to change their behavior?”

D. Ask clients to think of specific individuals in their own lives who have provided support for them for difficult actions they have taken or when they were in difficult situations:

- » “Who has believed in you and supported you when you were in a difficult situation?”
- » “What was the situation?”
- » “Did this person’s support make a difference?”

Encourage clients to share experiences to reinforce the importance and positive influence of social support.

6. Where Do I Stand in Reducing My Risks? (15 minutes)

Purpose: In this activity, clients learn to apply the stages of change to their own lives and to think about personal change. They use worksheet 2: “Where Do I Stand in Reducing My Risks for HIV and Viral Hepatitis?” to identify what stage of change they are in with regard to several HIV and viral hepatitis risk behaviors. The activity provides clients with an opportunity to identify behaviors they may wish to focus on in establishing a personal risk reduction goal.

- A. **Pass out worksheet 2:** Where Do I Stand in Reducing My Risks for HIV and Viral Hepatitis? Say, “Now let’s take a look at some of the things you might be doing to reduce your risks.”
- B. **Lead clients through filling out the worksheet** one question at a time, as you did with worksheet 1.
- C. **Ask for volunteers to share where they stand** with regard to the behaviors listed in worksheet 2. Describe the worksheet as a list of risk reduction possibilities. Suggest that it can be used by each person as a starting place to tell where and also how to lower his or her personal HIV and viral hepatitis risk.
- D. **Remind clients to bring worksheet 2 with them** when they come to group session two so they use it as a guide in setting a personal risk reduction goal.

7. Closing (10 minutes)

- A. **Remind clients to bring worksheet 2 with them to the next group session.** (Worksheet 1 can be discarded, since it has served its purpose as a tool for raising clients' risk awareness.)

At this time, ask your training partner to make copies of worksheet 2 and return the originals to the clients. Make two copies of each client's worksheet 2, one copy to use in group session two if needed and a second copy for the individual counseling session.

- B. **Remind clients of the importance of knowing their HIV and hepatitis status.** Offer your agency's testing services, or make available referrals to outside agencies for counseling and testing for HIV and viral hepatitis. Pass out brochures on HIV and hepatitis testing for clients to take with them and read later.
- C. **Give a preview of the next group session:** "During the next group session, we'll ask you to think about setting a personal goal for lowering your HIV risk and we'll help you to set up some first steps. This will move you in the right direction. We'll also talk about things that can get in the way and interfere with working toward you goal and suggest ways of getting around them."
- D. **Ask clients for feedback about the session.** Quickly ask clients what they liked about the session and what they would like to see done differently for the next one. Make notes to use in the staff debriefing.
- E. **Praise clients for work well done,** and say again that you are very glad they came to the session. Remind them that next week there will be another group session, and you look forward to seeing them again. Give them the specific day and time and ask each one to commit to attending.
- F. **Give the time and place for the next Social Event.** Pass out invitations, if available, and remind them of the free meal and chance to win prizes.
- G. **Give out participant incentives** and offer needle hygiene kits, safer sex kits, and referral information cards.

8. Participation Documentation

Immediately after the clients leave, document their participation in the session using the client participation record. At this time, check to be sure you have a copy of worksheet 2 for each client to pass out during group session two.

9. Staff Debriefing

After group session one, the facilitators should meet and discuss how they delivered the session and how it was received by the clients. Of interest will be the ease of use of worksheet 1 and worksheet 2, and how successful the stages-of-change session was. Did

clients understand the stages and were they able to apply them to a non-hot topic such as cigarette smoking? You have asked for feedback on group session one, and during the debriefing you can discuss any issues that came up, how to fine-tune group session one for the next time you deliver it, and how to use the information to better prepare for group session two. As you continue to facilitate group sessions, you will become more comfortable and have fun with the intervention.

FORMS AND WORKSHEETS

GROUP SESSION ONE

Worksheet 1: Am I At Risk for HIV and Viral Hepatitis?

Display Cards: The Five Stages of Behavior Change

Worksheet 2: Where Do I Stand in Reducing My Risks
for HIV and Viral Hepatitis?

Client Participation Record
(Originated in Program Enrollment Session)

Name or ID _____

Date _____

SAFETY COUNTS Worksheet 1
Am I at Risk for HIV and Viral Hepatitis?

Instructions: Circle "Yes" or "No" for each question below. Leave any questions blank that do not apply to you. For example, sharing needles does not apply to you if you do not shoot drugs.

In the past three months:		
Have you injected drugs?	Yes	No
Have you used drugs that are not injected?	Yes	No
Have you had sex?	Yes	No
If you inject drugs:		
Do you ever share needles?	Yes	No
Do you ever share rinse water?	Yes	No
Do you ever share cookers or cotton?	Yes	No
If you share needles:		
Do you share with more than one person?	Yes	No
Do you ever use a needle after someone else without first cleaning it with bleach?	Yes	No
If you have sex:		
Have you had more than one sex partner in the past three months?	Yes	No
Have any of your sex partners ever injected drugs as far as you know?	Yes	No
Do any of your sex partners have sex with other people?	Yes	No
Do you ever have sex when you are drunk or high?	Yes	No
Do you ever have sex without a condom?	Yes	No

If you have circled "Yes" for any of these questions, you may be at risk for getting infected with HIV or viral hepatitis, or giving it others. Remember, you can lower your risk by changing your behavior, such as using condoms or not sharing your injection equipment.

THE FIVE STAGES OF BEHAVIOR CHANGE

Display Cards

Not Considering It

"I'm not thinking about it now; I've got enough to deal with already."

1

Planning to Do It

"I'm thinking it through and I intend to do it, but I'm not sure when."

2

Taking Steps

"I've made it a goal and taken some steps; I'll be doing it soon."

3

Doing It

"I'm really doing it, and I'm taking it 1 day at a time."

4

Staying with It (for at least 6 months)

"It's part of my life now, and I'm staying on track."

5

Name or ID _____

Date _____

SAFETY COUNTS Worksheet 2

Where Do I Stand in Reducing My Risks for HIV and Viral Hepatitis?

Instructions: For each way of reducing HIV and viral hepatitis risk shown below, place a check mark in the column that best describes where you currently stand in terms of your own behavior. Check the first (shaded) column if something does not apply to you.

Ways of Reducing Risks	Where I Stand Now in Reducing My Risks					
	Does Not Apply to Me	Not Considering It	Planning to Do It	Taking Steps	Doing It	Staying with It for 6 Months
Using condoms for vaginal sex						
Using condoms for anal sex						
Not having vaginal or anal sex						
Having fewer sex partners						
Having fewer sex partners I don't use a condom with						
Having sex with only one partner						
Having protected sex when drunk or high						
Not sharing needles						
Not sharing injection equipment (water, cotton, cookers)						
Using a new needle for every drug injection						
Bleaching my needle before every drug injection if a new needle is not available						
Decreasing or managing my drug use						
Getting into drug treatment						
Using HIV counseling and testing services every 3 months						
Using hepatitis counseling and testing services every 3 months						

SAFETY COUNTS Client Participation Record

Client Name _____

Enrollment Date _____

Sessions Completed:

Program Enrollment:	Date _____	HIV testing referral made _____ Other referrals made _____
Group One:	Date _____	HIV testing referral made _____ Other referrals made _____
Group Two:	Date _____	HIV testing referral made _____ Other referrals made _____
Individual Counseling:	Date _____	HIV testing referral made _____ Other referrals made _____
Social Event 1:	Date _____	HIV testing referral made _____ Other referrals made _____
Social Event 2:	Date _____	HIV testing referral made _____ Other referrals made _____
Follow-up Contact 1:	Date _____	HIV testing referral made _____ Other referrals made _____
Follow-up Contact 2:	Date _____	HIV testing referral made _____ Other referrals made _____

Personal Goal Information:

General Goal:

<input type="checkbox"/> Use condoms for vaginal sex <input type="checkbox"/> Use condoms for anal sex <input type="checkbox"/> Practice alternatives to vaginal/anal sex <input type="checkbox"/> Have fewer sex partners <input type="checkbox"/> Have fewer sex partners I don't use a condom with <input type="checkbox"/> Have sex with only one partner <input type="checkbox"/> Have protected sex when drunk or high <input type="checkbox"/> Don't share needles	<input type="checkbox"/> Don't share injection equipment (water, cotton, cookers) <input type="checkbox"/> Use a new needle for every drug injection <input type="checkbox"/> Always bleach needles if new needles are not available <input type="checkbox"/> Decrease/manage drug use <input type="checkbox"/> Get into drug treatment <input type="checkbox"/> Use HIV counseling/testing services every 3 months <input type="checkbox"/> Use hepatitis counseling/testing services every 3 months
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Personal goal: _____

First step: _____

Barriers and solutions: _____

Client Name _____

Follow-up Contact Information:

Follow-up Contact 1: Date _____ Staff _____ Type: Face-to-face Telephone

Achieved first step? Yes No

Client's view of goal progress to date: Good Fair Poor

Next step (or revised first step):

Barriers and possible solutions:

_____	_____
_____	_____
_____	_____

Follow-up Contact 2: Date _____ Staff _____ Type: Face-to-face Telephone

Achieved first step? Yes No

Client's view of goal progress to date: Good Fair Poor

Next step (or revised first step):

Barriers and possible solutions:

_____	_____
_____	_____
_____	_____

Notes:

GROUP SESSION TWO

SESSION OBJECTIVES

- Help clients specify a personal goal they would be willing to undertake to reduce their risk of acquiring or transmitting HIV or viral hepatitis.
- Identify first steps towards risk reduction goal achievement.
- Assist clients in identifying barriers to achieving their goals and finding solutions to overcoming those barriers.
- Help clients identify their own sources of social support for accomplishing their risk reduction goal.

SUMMARY OF SESSION ACTIVITIES

In group session two, clients develop their own risk reduction goals and identify the first steps they will take towards accomplishing those goals. Clients also plan how they will address any barriers to the desired change that are likely to come up. Hearing how other drug users have accomplished the changes helps provide ideas, motivation, and encouragement for their own efforts. They also plan how to recruit people from their own lives to provide social support for their risk reduction efforts. The goal cards introduced in this session are an important part of *SAFETY COUNTS* because clients carry the cards with them to remind and encourage them as they move through the stages of change toward achievement of their goals.

Session time: 1 hour, 40 minutes

Group session two is organized as follows:

1. **Introduction** (15 minutes).
2. **Developing Risk Reduction Goals** (20 minutes). Based on the risks identified in group session one and confirmed (or revised) in this session, each client decides on a behavior change goal that he or she can commit to in order to reduce a specific risk.
3. **Identifying First Steps Toward Goals** (15 minutes). Once clients select a goal they wish to commit to, they identify what first steps they can take towards achieving that goal, and write those on their goal cards. The first steps tell clients how to make the change, and may be modified by the client as experience suggests.
4. **Overcoming Barriers to Behavior Change** (15 minutes). Clients discuss and specify the barriers they may encounter in taking those first steps and assist each other in developing strategies to overcome those barriers.

5. **Learning from Risk reduction Success Stories** (15 minutes). Facilitators present risk reduction success stories reflecting the experiences of drug users in the local community who have successfully made positive changes to reduce their HIV and hepatitis risks. This is followed by an interactive discussion focused on goal setting, taking first steps, and social support.
6. **Finding Social Support** (10 minutes). Clients consider the social support portrayed in the risk reduction success stories. They are also asked to identify specific individuals in their own lives whom they could ask for social support for the risk reduction actions they intend to take.
7. **Closing** (10 minutes). Facilitators encourage clients to support each other in their behavior-change attempts. Reminders of the importance of knowing one's status are given, along with referrals and educational information.
8. **Participation Documentation**. Facilitators complete the client participation record for each client immediately after the session.
9. **Staff Debriefing**. Facilitators meet briefly following the session to critique the session in overall terms, as well as the effectiveness of each of the activities. Issues that relate to individual clients and were observed during the session also are discussed.

PREPARATION AND SETUP

Who conducts this session? A facilitator and a co-facilitator lead the session. The *SAFETY COUNTS* behavioral counselor usually serves as the co-facilitator. The facilitators should be trained in the intervention and have experience and skill working with drug users.

When does the session occur? This session should be offered on a weekly basis, alternating with group session one. You should have at least three clients in attendance. If a scheduled session falls during the first week of the month, be aware that attendance may be low, because this is the time that some people receive benefit checks and food stamps.

Where does it take place? Group session two should take place in the same location as group session one. It should be a location where clients can talk confidentially and frankly about HIV prevention and their own behavior. Typically, the group sessions are held in a private, comfortable room within the agency.

How do we prepare? Gather and review all of the materials listed below, including forms and worksheets, safer sex and needle hygiene kits, refreshments, and participant incentives. If you have not conducted this session with your co-facilitator before, practice together well in advance and role-play the different discussions contained in the session.

What should we have ready? You will need the following *SAFETY COUNTS* materials for this session:

- Composite ground rules written on newsprint (developed from previous Group One session).
- Worksheet 2: “Where Do I Stand in Reducing My Risks for HIV and Viral Hepatitis?” (one copy for each client and facilitator).
- Copies of completed worksheet 2 from group session one.
- Display cards: The Five Stages of Behavior Change (used in group session one).
- Goal cards (one for each client).
- Risk reduction success stories. (The process for creating stories and two examples can be found in Appendix G How to Create Risk reduction Success Stories.)
- SAFETY COUNTS* client participation record (originated for each client in the program enrollment session).

In addition, you will also need the following materials, supplies, and equipment:

- Name tags and marker pens
- Light food and refreshments
- Incentives
- Newsprint on easel, markers, and tape
- Brochures giving basic facts about HIV and viral hepatitis
- TV and VCR if video is used; audiotape player if audiotape is used
- Needle hygiene kits: Small bottle of bleach, small bottles of water, alcohol pads, and sterile cotton balls
- Safer sex kits: Assorted condoms and tubes of lubricant
- Local HIV/AIDS and social service resource list for referrals

TIPS FOR CONDUCTING THE SESSION

- Groups should have at least 3 but no more than 12 clients in attendance. An ideal group size is somewhere between 5 and 8 clients.

- As explained earlier, group sessions are preferably scheduled on a weekly basis, with group session one and group session two offered on alternate weeks. Once you set a schedule for the group sessions, we recommend that you adhere to it for the duration of the program. You may cancel a particular group session if you do not have the required minimum of three clients in attendance. When it is necessary to cancel a session, you should provide the regular incentive to any clients who show up for the cancelled session.
- Clients are eligible for group session one anytime after they complete the program enrollment session.
- You will need to make a copy of the completed goal card for each client during the session so that it can be available to the behavioral counselor during the individual counseling session. Many clients forget to bring their card with them. Remember to ask clients to write their first name on the bottom of their goal card. If you are not able to make copies of clients' goal cards, you and your co-facilitator will need to record each client's goal and first step from memory during the post-session debriefing.
- At an appropriate time after conducting group session two, you will want to meet with outreach workers prior to their conducting follow-up contacts to share information about clients and their risk reduction goals.

STEP-BY-STEP PROCEDURES

1. Introduction (15 minutes)

A. Welcome and introductions.

- **Welcome clients** when they arrive and re-introduce yourself. Ask them to fill out a name tag with their first name or nickname.
- **Congratulate them on their continuing interest** in their health and lives and for their courage in returning. Let them know you appreciate their attendance.
- **Briefly review the previous session:** “In the last session, you accomplished several important things:
 - » “You identified your own personal risks related to HIV and hepatitis.”
 - » “You learned how people change their behavior and discovered what stage of change you were in for reducing that risk.”
 - » “You started to think about how other people were reducing similar risks to you.”

Ask if they have any questions from the last session that were not answered, or if they need clarification on anything.

- **Preview the current session:** “During this session, we’re going to carry that further, and make it more personal and relevant to your life. Today you will:”
 - » “Decide on ways you can reduce your personal HIV and hepatitis risk—ways that make sense for you.”
 - » “Single out something concrete that you could do as a first step in reducing your HIV and hepatitis risk.”
 - » “Think about the kinds of things that can get in the way of doing what you want to do, the barriers that you might face.”
 - » “And together, we will find ways of getting around these barriers.”
- B. **Ground Rules.** Quickly review with clients the ground rules outlined on newsprint, representing a composite from previous group one sessions. Get group “buy-in” that these are okay, or get group agreement on any changes they want to make.
- C. **Introduction icebreaker.** Even though you have tried to schedule the group so that at least three clients will know each other, they may not know everyone in the group or may have forgotten the facilitators’ names. Name tags and introductions for everybody (including you) are therefore important. An introduction icebreaker is a good way to do this, and it also provides an opportunity to laugh and relax a bit before the session gets going. One such icebreaker is to have group members pair up and interview each other about the funniest thing that has happened to them, then introduce their interview partner to the group by first name and tell his or her “funniest thing” story.
- D. **Ask if anyone has any questions about HIV or hepatitis,** so you can address them now or find answers for them later.
- E. **Make a statement about HIV and hepatitis testing,** acknowledging that (1) you talked about this in the last group session, and (2) you know that some may have already been tested and know their status. Explain that if they haven’t been tested, there are good reasons to do so (e.g., the availability of effective medical treatment and support services) and that you can arrange for on-site testing or give them referrals at the end of the session.

2. Developing Personal Risk Reduction Goals (20 minutes)

Purpose: The purpose of this activity is for clients to learn how to develop realistic and achievable personal risk reduction goals that they will work toward during the *SAFETY COUNTS* program.

- A. **Introduce the activity:** “Today we are going to talk about developing personal goals for risk reduction and setting up steps for achieving them. We all know what a goal is—it’s something that you work toward and you try to achieve.”

- B. Describe the characteristics of good goals:** “Before we talk about setting goals for ourselves, let’s think for a minute about what makes up a good goal.”
- » Write “Good Goals” as a heading on newsprint.
 - » Say, “There are three things to look for in a good goal.”
 - Realistic (not too hard).
 - Brief, specific, and clear (so you can remember it and know when you’ve achieved it).
 - Near-term (can be accomplished in the next 2 months).
 - » Write the key words on newsprint one at a time, discussing each and getting group input before going on to the next.
 - » At the end, ask, “Did we leave anything out?” Add whatever additional items clients might suggest, such as, “You care about it.”
- C. Revisiting personal risks.** Use worksheet 2: “Where Do I Stand in Reducing My Risks for HIV and Viral Hepatitis?” as a basis for exploring possible risk reduction goals that clients might set for themselves. You will need to give back to clients the worksheet that they completed in group session one (which was copied and retained at the end of group session one). If copies of the completed worksheets are not available, distribute blank worksheets.
- » Ask clients to look at their worksheet and think about which of the 15 risk reduction behaviors on the worksheet might be a good personal goal for them. (For your reference, these 15 behaviors are listed in the box below labeled “General Risk Reduction Goals.”)
 - » Point out that the behaviors they checked as “Considering It” (Stage 2) or “Taking Steps” (Stage 3) would be the best ones to use in setting personal goals.
 - » Explain that anything they checked as “Not Considering It” (Stage 1) means they are probably not ready to make a change in this area. Anything they checked as “Doing it” (Stage 4) or “Staying with It for 6 Months” (Stage 5) is something they do not need a goal for because they are already doing it and achieving it.
- D. Ask clients to circle those risk reduction behaviors on worksheet 2** that they might want to consider as personal goals for themselves.
- E. General goals versus personal goals.** Say that what we want clients to set are personal goals, which means goals that reflect their particular situation. Talk about the difference between personal goals and the general (non-personal) goals (behaviors) shown in worksheet 2. In explaining this, use examples from the table on the next page, “Sample Personal Goals with First Steps.”

- » From the table, give at least two examples of personal goals and how they compare with the general, non-personal goals stated in worksheet 2. Be sure that clients understand that their personal goal will almost never be worded exactly the way it is worded in worksheet 2.
- » Give at least one example from the table of a personal goal that reflects more than one of the general goals in worksheet 2. Explain that it is okay for a personal risk reduction goal to be a combination of two goals from worksheet 2. It doesn't necessarily mean that a personal goal is too broad just because it picks up two of the general risk reduction behaviors.

GENERAL RISK REDUCTION GOALS

- Using condoms for vaginal sex
- Using condoms for anal sex
- Practicing alternatives to vaginal and/or anal sex
- Having fewer sex partners
- Having fewer sex partners I don't use a condom with
- Having sex with only one partner
- Having protected sex when drunk or high
- Not sharing needles
- Not sharing injection equipment (water, cotton, cookers)
- Using a new needle for every drug injection
- Bleaching my needle before every drug injection if new needle is not available
- Decreasing/managing my drug use
- Getting into drug treatment
- Using HIV counseling and testing services every 3 months
- Using hepatitis counseling and testing every 3 months

- F. **Making goals personal.** Show how goals are made personal by developing examples of personal goals from the general risk reduction goals shown in worksheet 2.
- » Start by asking if anyone would be willing to share the risk reduction goal he or she selected from worksheet 2.
 - » Write the client's goal on newsprint and label it "General Goal." (If there are no volunteers, select a goal yourself from worksheet 2 and get the group to join you in developing a personal goal for "John Doe.")

- » Draw a line and write “Personal Goal” on the newsprint. Leave plenty of room on the sheet to develop the wording for the personal goal.
- » Point to the characteristics for “Good Goals” listed earlier on newsprint and ask, “What about the time frame for this goal? Do you think it is something you could accomplish in the next 2 months?”
- » If, after discussion, it appears that the goal is too ambitious, help the client modify it so that it could reasonably be accomplished within a 2-month period.
- » Remind clients that the 2-month time frame is not a deadline: “Remember, 2 months is not a deadline. If you reach your goal earlier than that, good for you. If you take longer, that’s okay too.”

(Most *SAFETY COUNTS* clients will probably spend longer than 2 months getting to the point where they are fully performing their risk reduction goal—Stage 4, Action. Nonetheless, it is important to set the expected time frame for accomplishing goals at 2 months to ensure that their goals will be realistic and manageable, as well as immediate and relevant in clients’ minds.)

- » Next, ask the volunteer to talk about how the goal from worksheet 2 fits into his or her personal life: “Tell us more about what you want to do to reduce your risks. Can you give us some information about your personal situation—how this goal fits into your life? ”
- » From the information the client provides, begin to write out a personal goal for the client on the newsprint. Allow plenty of room so you can change it and add to it as you talk back and forth with the client. Use the “Good Goals” list on newsprint and the “Sample Personal Goals” table to guide you in this process.
- » As the personal goal is being developed, it may become clear that it involves another goal from worksheet 2 in addition to the one that was stated originally. This often happens, and it is okay. Just add the second general goal at the top of the newsprint sheet, and continue. (Examples of personal goals reflecting more than one general goal are shown in the “Sample Personal Goals” table.)
- » Ask for a second volunteer, and repeat the entire process with another goal from worksheet 2: “That was great. Thank you. Now who else will volunteer?”

G. Ask the remaining clients to develop a personal goal for themselves: “Let’s take a few minutes while everybody develops a personal goal for themselves from worksheet 2. I am passing out some goal cards. Everybody please take two or three so it’ll be easy to change your mind as you begin to write your goal down. Don’t bother with the ‘next step’ part; we’ll get to that later.”

Give as much individual help as you can to each of the clients while they are working on their goals. Do not be concerned if the goals are not perfect. They can be refined during the individual counseling session.

SAMPLE PERSONAL GOALS WITH FIRST STEPS		
General Goal(s)	Client's Personal Goal (In the next 2 months . . .)	First Step
Decreasing/managing my drug use.	Cut back on my drug use so I am not high on days I go to the drop-in center or food bank.	Make a list of things I could do to keep me occupied on those days I don't want to get high.
Getting into drug treatment.	Get into a detox program that is gay-friendly.	Talk to my <i>SAFETY COUNTS</i> counselor about what detox programs are available.
Not sharing injection equipment (water, cotton, cookers). Bleaching my needle before every drug injection if a new needle is not available.	Stop sharing water, cotton, and cookers, and clean my needle with bleach if I don't have a new one.	Talk to my drug buddy about not sharing. <i>or</i> Stash needle hygiene kits in places where I will need them.
Using condoms for vaginal sex.	Always use condoms for vaginal sex with my steady girlfriend.	Get brochures to give to my girlfriend that talk about HIV and hepatitis risks from drug injection.
Using condoms for vaginal sex. Having fewer sex partners I don't use a condom with.	Using condoms for vaginal sex with all of my dates.	Talk to my girlfriend to see how she gets her dates to use condoms.
Using condoms for anal sex. Having fewer sex partners I don't use a condom with.	Use condoms with more of the people I have anal sex with.	Make a list of the recent times I used a condom and why I was able to in each of those situations.

3. Identifying First Steps Toward Goals (15 minutes)

Purpose: In this activity, clients will define a concrete first step that they can take in the next week toward achieving their personal goal.

- A. **Introduce the activity:** “Now that each of you has a personal goal, the next thing we need is a way to start working on it. When you have a goal, it’s always a good idea to identify a concrete thing you should do first to get you started.”
- B. **Talk about the taking first step:** “That first step is really important. It shows you are actually doing something toward achieving your goal—it’s a way of telling yourself that you are really making progress and that you can succeed. So, we want to be sure that our first step is something that we can handle and be successful with. The first step can be a small one—that’s okay. It should also be something we think we can do right away, in the next week.”
- C. **Say that the characteristics of good steps are the same as those for good goals** except for the time frame: “What makes a good step is the same as what makes a good goal, except for one thing. Instead of being able to do it in the next 2 months, it is something you can do in the next week. You can start on it right away as soon as you walk out the door.”

Go to the characteristics of good goals previously listed on newsprint and change the title from “Good Goals” to “Good Goals and Steps.” Under “Near-term,” write “2 months—goals” and “1 week—steps.”

- D. **Talk about taking additional steps:** “Once you take the first step, you can take a second step, and then additional steps. All of these steps move you closer and closer to achieving your final goal, and before long you are there. The motto is, ‘One step at a time.’”
- E. **Point to the stages-of-change cards** you have posted on the wall. Remind clients that taking steps toward your goal is Stage 3: “So we are talking about being at the ‘Taking Steps’ stage, and moving toward ‘Doing It.’”
- F. **Work through developing a first step for the personal goals of two clients:** “Now let’s do the same thing we did with personal goals. Let’s develop a first step to go with the personal goal for two people. Who wants to be first?”

Use the following strategy to develop first steps: (1) write each personal goal on newsprint, (2) talk about possible steps, (3) write a ‘draft’ of the first step on the newsprint, and (3) correct and refine the step as necessary. Examples of first steps are shown in table, “Sample Personal Goals with First Steps,” on the previous page.

- G. **Ask everybody to develop a first step to take toward their goal.** Provide individual assistance as necessary, and help clients write their first step on their goal card.

4. Overcoming Barriers to Behavior Change (15 minutes)

Purpose: Clients learn to identify and find ways to overcome possible barriers that would interfere with successfully performing the first step towards their goal.

- A. **Introduce the activity:** “Now we are going to talk about some of the things that can get in the way when we are trying to work toward goals.” Write the word “Barriers” at the top of a newsprint sheet.
- B. **Begin discussing previous barriers** clients have encountered when trying to do something: “Who has ever encountered a barrier or obstacle to something they were trying to accomplish? Something that got in the way and might have kept you from doing it. Can someone tell me about a particular barrier you ran into? And tell us, what were you trying to do—what was your goal?”
- C. **Write the client’s barrier and the goal on newsprint.** Use a very brief phrase to describe the goal—just enough to provide a context for the barrier.
- D. **Ask for other examples of barriers that clients have encountered.** Record three or four examples on the newsprint sheet, along with the relevant goals. The examples do not need to be related to HIV and hepatitis risk reduction, but it is, of course, all right if they are.
- E. **Write the word “Solutions” on another sheet of newsprint.** Go back and ask each of the clients who volunteered how they got around the barrier they described. If they did not get around the obstacle, ask how they possibly could have. Involve other members of the group in talking about possible solutions. Write each solution on newsprint.
- F. **Discuss possible barriers that could be encountered** for clients’ first steps. As above, ask for volunteers to share their first step and to think of barriers that could possibly get in the way of achieving the step. If no one is willing to volunteer, ask for clients to make up some first steps and barriers to talk about. (These will usually turn out to be very close to clients’ real steps and possible barriers.)
- G. **Encourage full discussion of potential barriers and possible solutions.** This will give clients practice in thinking situations through and anticipating possible problems.
- H. **Show clients what to do if they don’t see a way to get around the barrier:** “If you don’t see a way around the barrier, it is okay to modify your step. Just because you can’t do exactly what you had planned doesn’t mean you can’t do something.”

5. Learning from Risk Reduction Success Stories (15 minutes)

Purpose: By viewing and discussing risk reduction success stories, clients will learn how their peers have succeeded at identifying goals, taking first steps, and eventually changing the behaviors that can transmit HIV and viral hepatitis infections.

- A. **Introduce the stories**, explaining that, as those in group session one, they reflect the experiences of real people—other drug users in the local community who have been successful in reducing their own risk of getting or transmitting HIV or viral hepatitis. If your stories do not use real names, remind clients that names have been changed to respect privacy.
- B. **Present the last two risk reduction success stories** of the four that you developed for *SAFETY COUNTS*. One of the stories should deal with drug-related risks and the other with sex-related risks. (The process for creating stories is detailed in Appendix G: How to Create Risk Reduction Success Stories.) These, like those in group session one, may be in the form of videotapes, audiotapes, or written stories. If you are using written stories, pass out copies to members of the group and have them follow along while you read the first story aloud. Ask for a volunteer from the group to read the second story aloud. If someone does not volunteer immediately, read aloud the second story yourself.
- C. **Invite brief comments from the group** after the first story, but save full discussion until both stories have been presented.
- D. **Engage group members in an interactive** discussion about the situation portrayed in each story after the story has been presented. Focus this discussion more narrowly than the discussion that occurred in group session one. Concentrate on those aspects of the stories that relate to the activities in group session two, that is, goal setting, taking first steps, and social support.
- E. **Address the following questions** as a part of the interactive discussion:
 - » “What was the specific behavioral goal of the person in each story?”
 - » “What was the first step for the individuals in the two stories?”
 - » “Did they encounter any barriers in taking this step?” Did they encounter other problems?
 - » “How were these barriers overcome? What other strategies might have worked?”
 - » “What examples of social support did you notice in the stories?”

- » “How do you think this compares with the social support you saw in the stories we talked about last session?”

6. Finding Social Support (10 minutes)

Purpose: The objective of this activity is to assist clients in identifying a person in their own life who will be supportive of their efforts to achieve the risk reduction goal they have set for themselves.

- A. **Remind clients that social support is important** when people are doing something new: “It’s really important to have the support of other people when you are making a change in your life.”
- B. **Talk about the kinds of people** who might serve as sources of support: “It’s good to have somebody who understands what you are going through. This can be a friend, a family member, or a person you hang out with.”
- C. **Ask clients to think about people in their own lives** who could be supportive: “Take a minute and think about the people in your own life who would approve of what you are doing and could be a source of support for you”
- D. **Encourage clients to share their thoughts** about people who might be supportive of their risk reduction efforts: “Who would be willing to share?”
- E. **Ask if there is anybody who can’t think of someone** who could be supportive: “Is there anybody who doesn’t know someone you could talk to and who would be supportive of your personal goal?”
- F. **Ask for group members to help** in identifying social support for any clients who say they can’t think of a person.
 - » Sometimes, other group members can suggest a person in the client’s life who will be supportive.
 - » Often, another client will offer his or her own support.
 - » If neither of these happens, offer support from the group: “Well, you know you always have our support.”

7. Closing (10 minutes)

- A. **Remind clients of the importance of knowing their HIV and hepatitis status.** Offer your agency’s testing services, or make available referrals to outside agencies for counseling and testing for HIV and viral hepatitis. Remind clients that you have educational materials they may take with them. (Have these available in the room.)

- B. **Answer any questions** clients may still have. Let them know that you are happy they came back, and repeat that this is an important step in preventing HIV and in managing their own health. Remind clients there are educational materials they may take with them and read later at their convenience.
- C. **Ask clients what they liked** about the session and what they would like to see done differently if they were to attend it again. Write down their responses. If you have agency evaluation forms that you would like clients to fill out, ask them to do that at this time.
- D. **Remind participants to try to do their first step during the next week**, before they come in for their individual counseling session. Give praise and express confidence that clients will be successful.
- E. **Let them know the next session will be an individual counseling session** where they can talk more privately about issues about their risk reduction, and that there will be monthly social events they will be eligible to attend once they complete this session. Talk about the incentives and other benefits available for their continued participation. Most important, their participation will help them protect themselves and others from HIV and viral hepatitis.
- F. **Praise clients for work well done**, and say again that you are very glad they came to the session. Remind them that next week they will be meeting individually with a counselor, and you look forward to seeing them again. If possible, give each of them a card with a specific day and time, and ask each one to commit to showing up to his or her appointment.
- G. **Give the time and place for the next social event**. Pass out invitations, if possible, and remind them of the free meal and chance to win prizes.
- H. **Give out participant incentives** and offer needle hygiene kits, safer sex kits, and referral information cards.

8. Participation Documentation

Immediately after the clients leave, document their participation in the session using the client participation record. Do not record clients' goals and first steps on the client participation record at this time. They will be refined in the individual counseling session and recorded then.

9. Staff Debriefing

After group session two, facilitators should meet and discuss how they delivered the session and how it was received by the clients. Of interest will be how meaningful the stages-of-change framework was to clients. Also, how comfortable were clients with the concepts of personal goals, first steps, and barriers? How successful were clients in setting personal goals and first

steps for themselves? At this time you can also discuss any feedback you received from clients, issues that came up, and how to fine-tune group session two for the next time you deliver it.

FORMS AND WORKSHEETS

GROUP SESSION TWO

**Worksheet 2: Where Do I Stand in Reducing My Risks
for HIV and Viral Hepatitis?**
(Originated in Group Session One)

Display Cards: The Five Stages of Behavior Change
(Originated in Group Session One)

Goal Card

Client Participation Record
(Originated in Program Enrollment Session)

Name or ID _____

Date _____

SAFETY COUNTS Worksheet 2

Where Do I Stand in Reducing My Risks for HIV and Viral Hepatitis?

Instructions: For each way of reducing HIV and viral hepatitis risk shown below, place a check mark in the column that best describes where you currently stand in terms of your own behavior. Check the first (shaded) column if something does not apply to you.

Ways of Reducing Risks	Where I Stand Now in Reducing My Risks					
	Does Not Apply to Me	Not Considering It	Planning to Do It	Taking Steps	Doing It	Staying with It for 6 Months
Using condoms for vaginal sex						
Using condoms for anal sex						
Not having vaginal or anal sex						
Having fewer sex partners						
Having fewer sex partners I don't use a condom with						
Having sex with only one partner						
Having protected sex when drunk or high						
Not sharing needles						
Not sharing injection equipment (water, cotton, cookers)						
Using a new needle for every drug injection						
Bleaching my needle before every drug injection if a new needle is not available						
Decreasing or managing my drug use						
Getting into drug treatment						
Using HIV counseling and testing services every 3 months						
Using hepatitis counseling and testing services every 3 months						

THE FIVE STAGES OF BEHAVIOR CHANGE

Display Cards

Not Considering It

"I'm not thinking about it now; I've got enough to deal with already."

1

Planning to Do It

"I'm thinking it through and I intend to do it, but I'm not sure when."

2

Taking Steps

"I've made it a goal and taken some steps; I'll be doing it soon."

3

Doing It

"I'm really doing it, and I'm taking it 1 day at a time."

4

Staying with It (for at least 6 months)

"It's part of my life now, and I'm staying on track."

5

SAFETY COUNTS Goal Card

My Goal: _____

My Next Step: _____

Name _____ Date _____

(Actual goal card is wallet-size.)

SAFETY COUNTS Client Participation Record

Client Name _____

Enrollment Date _____

Sessions Completed:

Program Enrollment:	Date _____	HIV testing referral made _____ Other referrals made _____
Group One:	Date _____	HIV testing referral made _____ Other referrals made _____
Group Two:	Date _____	HIV testing referral made _____ Other referrals made _____
Individual Counseling:	Date _____	HIV testing referral made _____ Other referrals made _____
Social Event 1:	Date _____	HIV testing referral made _____ Other referrals made _____
Social Event 2:	Date _____	HIV testing referral made _____ Other referrals made _____
Follow-up Contact 1:	Date _____	HIV testing referral made _____ Other referrals made _____
Follow-up Contact 2:	Date _____	HIV testing referral made _____ Other referrals made _____

Personal Goal Information:

General Goal:

<input type="checkbox"/> Use condoms for vaginal sex <input type="checkbox"/> Use condoms for anal sex <input type="checkbox"/> Practice alternatives to vaginal/anal sex <input type="checkbox"/> Have fewer sex partners <input type="checkbox"/> Have fewer sex partners I don't use a condom with <input type="checkbox"/> Have sex with only one partner <input type="checkbox"/> Have protected sex when drunk or high <input type="checkbox"/> Don't share needles	<input type="checkbox"/> Don't share injection equipment (water, cotton, cookers) <input type="checkbox"/> Use a new needle for every drug injection <input type="checkbox"/> Always bleach needles if new needles are not available <input type="checkbox"/> Decrease/manage drug use <input type="checkbox"/> Get into drug treatment <input type="checkbox"/> Use HIV counseling/testing services every 3 months <input type="checkbox"/> Use hepatitis counseling/testing services every 3 months
--	---

Personal goal: _____

First step: _____

Barriers and solutions: _____

Client Name _____

Follow-up Contact Information:

Follow-up Contact 1: Date _____ Staff _____ Type: Face-to-face Telephone

Achieved first step? Yes No

Client's view of goal progress to date: Good Fair Poor

Next step (or revised first step):

Barriers and possible solutions:

_____	_____
_____	_____
_____	_____

Follow-up Contact 2: Date _____ Staff _____ Type: Face-to-face Telephone

Achieved first step? Yes No

Client's view of goal progress to date: Good Fair Poor

Next step (or revised first step):

Barriers and possible solutions:

_____	_____
_____	_____
_____	_____

Notes:

INDIVIDUAL COUNSELING SESSION

SESSION OBJECTIVES

- Review and refine client's personal risk reduction goal and first step, and modify as indicated.
- Ensure the availability of social support for the client's risk reduction efforts.
- Assess client's HIV, hepatitis, and other referral needs, and provide referrals as indicated.
- Review future *SAFETY COUNTS* program participation and offer praise for client's commitment.

SUMMARY OF SESSION ACTIVITIES

The individual counseling session provides an opportunity for clients to meet one-on-one with the behavioral counselor to discuss personal risk reduction issues in a private setting. It allows counselors to build greater rapport and trust with the client. The goal card is a major focus of the discussion and can be used as a tool to get the session started. Counselors review and work with the client to refine the risk reduction goal as well as the first step toward achievement of that goal. Goals that are not appropriate are redirected. This session is also an opportunity to address prevention, medical and other service needs for HIV-infected, hepatitis-infected, or co-infected clients.

Individual Counseling Session time: 45 minutes

The individual counseling session is organized as follows:

1. **Introduction** (5 minutes). The counselor greets the client and praises him or her for joining the intervention and committing to reduce HIV and viral hepatitis infection risks.
2. **Review and Refine Personal Goal** (10 minutes). The counselor and client review the client's personal risk reduction goal set in group session two and sharpen or modify the goal as indicated.
3. **Review and Refine First Step** (10 minutes). The counselor and client review the client's progress in completing the first step set in group session two. If completed, a second step is established; if not, barriers to achieving the first step are explored. The client's goal and next step are recorded on a new goal card.

4. **Ensure Social Support** (5 minutes). The availability of someone who can be supportive of the client's risk reduction efforts is determined, and the counselor and client explore options for social support as necessary.
5. **Assess Referral Needs and Make Referrals** (5 minutes). The client's needs for HIV and hepatitis services and testing and other community services are assessed, and appropriate referrals are made.
6. **Review Future Program Participation** (5 minutes). The counselor reviews remaining *SAFETY COUNTS* program activities and encourages continued participation by the client.
7. **Closing** (5 minutes). The counselor reminds the client of the importance of the goal card as a symbol of his or her commitment to reduce personal risk and praises the client for participating in the intervention.
8. **Participation Documentation.** The counselor updates the client participation record for the client.

PREPARATION AND SETUP

Who conducts the session? The individual counseling session is conducted by the behavioral counselor. This person also typically serves as the co-facilitator for the group sessions, and this is the preferred arrangement because of the additional information the counselor gains about the clients and their circumstances.

When does it occur? The individual counseling session should be scheduled no earlier than 1 week following the client's completion of group session two. It is important to hold the session as soon as possible after 1 week because follow-up contacts cannot begin until the individual session has been completed.

Where does it occur? The individual counseling session should take place in a location where you and the client can talk confidentially and frankly about HIV and viral hepatitis risks, the client's personal goal to reduce risk, and other personal issues the client may have. Typically, the session will take place at your agency in a private office, where you will need a table and two chairs. You may, however, meet with a client in a private space in the community, possibly a coffee shop or park bench. If you do this, you must be very certain that confidentiality can be maintained.

How do I prepare? You should review the client participation record for the client in question, which documents both group sessions. You should also review the client's goal card to become familiar with the risk reduction goal and the first step that the client selected. Finally, you should review worksheet 2 completed by the client to become familiar with the client's behavioral risk status. If you do not usually attend the group sessions, you should familiarize yourself thoroughly with the activities that take place in those sessions.

What should I have ready? You will need the following *SAFETY COUNTS* materials for this session:

- Worksheet 2: Where Do I Stand in Reducing My Risks for HIV and Viral Hepatitis?
- Goal card
- Copies of the goal card and worksheet 2 completed previously by this client
- SAFETY COUNTS* client participation record (originated in the program enrollment session)

In addition, you will also need the following materials and supplies:

- Incentive
- Needle hygiene kit: Small bottle of bleach, small bottles of water, alcohol pads, and sterile cotton balls
- Safer sex kit: Assorted condoms and tubes of lubricant
- Condom demonstration materials: Condoms, lubricant, and penis model
- Needle bleaching demonstration materials: Needle, bleach, and clean water
- HIV test kit (if you are a certified HIV counselor and do on-site testing)
- Local HIV/AIDS and social service resource list for referrals

TIPS FOR CONDUCTING THE SESSION

- The goal card is a good tool to start discussion with the client because it is a symbol of the *SAFETY COUNTS* intervention. It is useful to focus on it heavily and refer to it frequently during the individual counseling session.
- When a client has an appointment, prepare in advance. Review the client participation record and the client's goal card so that you recall any referrals that have been made and what personal goal and first step the client has set.
- Remember to reflect feelings, and "check in" to be sure you understood what the client said ("It sounds like you may be feeling...").
- Listen for any misunderstanding about HIV and viral hepatitis transmission and risk reduction basics. Have needle hygiene and safer sex kits ready, so you can be prepared to demonstrate, if necessary.

- Identify any points that may need reinforcement, and be prepared to help the client find suitable options for safer sex or safer drug use.
- If you are a certified HIV counselor and do on-site testing, you may also want to have an HIV test kit available in case the client expresses a desire to be tested. *SAFETY COUNTS* is a very good vehicle for recommending counseling and testing, which supports CDC's Advancing HIV Prevention initiative.
- The needs of HIV-positive clients for medical treatment and social support services should be addressed during the individual counseling session. This session is your opportunity to link clients to care.
- The individual counseling session is also an ideal opportunity to refer clients to a prevention case management program.
- You must conduct one individual counseling session with a given client, but you may conduct more, depending on the needs and preferences of the client. Additional counseling sessions may, in addition to personal goal issues, focus on medical, social service, or other needs for which referrals can be provided.

STEP-BY-STEP PROCEDURES

1. Introduction (5 minutes)

- A. When the client arrives for the individual counseling session**, promptly greet him or her. Let the receptionist know that you are talking with a client and will not be accepting calls. Invite the client into the counseling area, and make sure you hang a sign on the door indicating that you are not to be disturbed. This emphasizes to the client that she or he is important enough to receive your full attention. Put your pager or cell phone on vibrate or turn it off.
- B. Introduce yourself to the client** if you have not had a chance to meet before. Establish rapport by asking the client how the week went and if any important events or problems occurred. Praise the client for joining the intervention and taking the steps to protect himself or herself and others from HIV and viral hepatitis.
- C. If you are aware, or become aware, that the client has HIV or hepatitis**, reinforce for the client the importance of taking steps to modify the behaviors that place him or her at additional risk for possible re-infection or causing complications to existing medical conditions. If appropriate, praise the client for showing concern about possible transmission of HIV and/or hepatitis to others.

2. Review and Refine Personal Goal (10 minutes)

Purpose: The purpose of this activity is to review and refine the client's personal risk reduction goal, modify it as needed, and reflect any modification on the client's goal card.

- A. **Congratulate the client on setting a personal risk reduction goal.** Ask the client to show you his or her goal card and to discuss the goal shown on it: "Do you have your goal card with you, the one you filled out at the last session? Let's look together at the goal you wrote down. How does that choice feel to you now that you've had a chance to live with it for a week or so?"
 - » If the client does not have the goal card available, ask what the goal was that he or she selected.
- B. **Review the client's goal** and evaluate it in terms of what is desirable in a good goal:
 - » Realistic (not too hard).
 - » Brief, specific, and clear.
 - » Near-term (can be accomplished in the next 2 months).
- C. **Refine and sharpen the client's goal as needed** to make it more personal and less general. This is almost always necessary because the original goal was developed in a group setting with minimal individual guidance.

Make the client's goal as personalized as possible. For example, use names instead of words like "boyfriend" or "girlfriend." Also, be sure that the client does not have more than one goal. "To have fewer sex partners and use a new needle every time I inject drugs," for example, is really two unrelated goals. If a goal is too broad or far-reaching, you might say, "You're right that these issues are very important, but let's just work on this one thing first." Refer to group session two for additional information about developing good goals.
- D. **If the original goal is not appropriate, identify a new goal for the client.** In the process of reviewing the client's goal, it sometimes becomes clear that the original goal does not fit the client's current situation. The client may or may not recognize this, so you must be sensitive in suggesting that a different goal might be substituted for the original one. You may wish to review the risk information provided by the client on worksheet 2 in identifying a new goal.
- E. **Write the client's final goal on the goal card.** It is best to fill out a new goal card for the client rather than trying to modify the one he or she has brought from group session two.

- F. **If the client's goal relates to needle cleaning or using condoms**, a review of correct condom use or the correct procedure for bleaching needles may be needed. Be prepared to demonstrate both.

3. Review and Refine First Step (10 minutes)

Purpose: The purpose of this activity is to review and refine the client's first step, modify it as needed, and reflect any modification on the client's goal card.

- A. **Review the first step that the client developed** in group session two. Ask the client to share any action taken regarding his or her first step since group session two.
- B. **If the client has completed the original first step**, develop a second step toward achieving the client's personal goal. Remember that each step the client sets up should be something that can be accomplished in the very near term—during the next week. (Clients often take longer than 1 week, but the step should be small enough so that it can be done in a week.)
- C. **If the client has not completed the original first step** or has made little progress, consider revising the step to make it more achievable. (See group session two for examples of good steps.)
- D. **In either case, discuss potential barriers to achieving the next step** and develop strategies for overcoming them. Use the discussion about barriers in group session two as a model for doing this.
- E. **Write the client's next step or revised first step on the goal card.** Read both the new step and the refined goal aloud to the client. Ask, "Is this right? Is this something you think you will be able to do?" Suggest that the client carry the goal card with him or her as an immediate reminder of his/her commitment to reduce HIV and hepatitis health risks.
- F. **Express confidence in the client's ability** to complete the new step and achieve the risk reduction goal shown on the goal card.

4. Ensure Social Support (5 minutes)

Purpose: The purpose of this component is to ensure the availability of social support for the client's risk reduction efforts.

- A. **Introduce the topic:** "Let's talk for a minute about something that was mentioned in the last group session. Is there somebody in your life who will be supportive of what you are doing to reduce your risks—somebody who believes the goal you have set for yourself is a good thing?"
- B. **Explore the availability of social support for the client.**

- » If the client has identified a person who can be supportive of his or her risk reduction efforts, stress the great benefit of having such a person. Encourage the client to share feelings and problems about risk reduction with this person.
- » If the client has not identified a support person, review potential sources of support with the client and attempt to identify an individual who might serve this role. Ask the client to name all of the people he/she can think of with whom the client has confided in or could confide in regarding personal problems and issues. List all of these names on a sheet of paper (including any references to God or pets), and then review them with the client to identify one or more persons who might be supportive of the client's goal to reduce HIV/hepatitis risk.
- » If there is no one who can support the client, suggest an outreach worker as an alternative.

C. **Reaffirm the support of SAFETY COUNTS staff:** "I want you to know that all of us here support you. We believe in what you are doing and know that it matters."

5. Assess Referral Needs and Make Referrals (5 minutes)

Purpose: The purpose of this activity is to evaluate the client's HIV- and hepatitis-related service needs, including testing, and other referral needs, and to provide appropriate referrals.

- A. **Assess whether the client is in need of HIV or hepatitis testing services, and hepatitis A and B vaccinations.** Arrange for immediate HIV and/or hepatitis C testing and hepatitis A and B vaccinations if your agency provides these services. If your agency does not provide any of these services and your client needs them, refer the client to an agency that can provide testing or vaccinations. (Help the client to set up appointments if possible.)
- B. **If the client has HIV, hepatitis, or is co-infected,** you want to focus on the risks for non-adherence and/or ambivalence to medical treatments, and reducing risk behaviors that can exacerbate his or her medical condition. If a client is infected with hepatitis C, you want to discuss the importance of receiving additional follow-up with a doctor and getting the hepatitis A and B vaccines.
- C. **Determine whether the client has a need for other services,** and make appropriate referrals.
- D. **Ask the client to contact an Outreach Worker or you directly** if he or she has any future referral needs.

6. Review Future Program Participation (5 minutes)

Purpose: The purpose of this component is to motivate the client to continue his or her involvement in the *SAFETY COUNTS* program.

- A. **After needs are assessed, list the remaining intervention activities**, including the monthly social events and follow-up contacts.
- B. **Give the client the date and time of the next social event**, and encourage the client to bring a guest. Say that the guest should be someone who is supportive of the client's risk reduction commitment and is aware that the client is enrolled in *SAFETY COUNTS*. Give a printed invitation if the client does not have one.
- C. **Let the client know** that the outreach worker will be contacting him or her to follow up on progress made toward the risk reduction goal.
- D. **Encourage the client to seek the outreach worker's assistance** if he or she experiences difficulty in trying to change risk behaviors. Praise the client's outreach worker, reinforcing his or her ability to provide support while the client works toward reducing his or her HIV risks.

7. Closing (5 minutes)

- A. **Remind the client of the importance of the goal card** as a reminder of what he or she is trying to achieve in the program.
- B. **Praise the client again for taking steps** to protect himself or herself and others against HIV. If you are aware that the client is infected with HIV and/or hepatitis, praise the client for taking steps to reduce risk behaviors that can worsen his or her medical condition and can transmit the virus to others.
- C. **Summarize the client's risk reduction goal and agreed-upon next step**. Be certain the client is comfortable with both.
- D. **Give the goal card to the client** to serve as a reminder. Also, review any remaining risk reduction areas relevant to the client.
- E. **Offer an appointment or referral for HIV testing and counseling services**. Offer referrals for hepatitis testing.
- F. **Offer the client safer sex and needle hygiene kits** and a business card. Give the client an incentive—preferably a transportation incentive to make it easy for the client to return to the next session of *SAFETY COUNTS*.

8. Participation Documentation

Document intervention participation on the client participation record. Be sure to record detailed information about the client's personal goal and next step. If the first step defined in group session two was accomplished, make a note of this. It is not necessary to describe specifically how the client's original goal and step were modified in this session unless there is a special reason to do so.

FORMS AND WORKSHEETS

INDIVIDUAL COUNSELING SESSION

Goal Card

(Originated in Group Session Two)

Worksheet 2: Where Do I Stand in Reducing My Risks for HIV and Viral Hepatitis?

(Originated in Group Session One)

Client Participation Record

(Originated in Program Enrollment Session)

SAFETY COUNTS Goal Card

My Goal: _____

My Next Step: _____

Name _____ Date _____

(Actual goal card is wallet-size.)

Name or ID _____

Date _____

SAFETY COUNTS Worksheet 2

Where Do I Stand in Reducing My Risks for HIV and Viral Hepatitis?

Instructions: For each way of reducing HIV and viral hepatitis risk shown below, place a check mark in the column that best describes where you currently stand in terms of your own behavior. Check the first (shaded) column if something does not apply to you.

Ways of Reducing Risks	Where I Stand Now in Reducing My Risks					
	Does Not Apply to Me	Not Considering It	Planning to Do It	Taking Steps	Doing It	Staying with It for 6 Months
Using condoms for vaginal sex						
Using condoms for anal sex						
Not having vaginal or anal sex						
Having fewer sex partners						
Having fewer sex partners I don't use a condom with						
Having sex with only one partner						
Having protected sex when drunk or high						
Not sharing needles						
Not sharing injection equipment (water, cotton, cookers)						
Using a new needle for every drug injection						
Bleaching my needle before every drug injection if a new needle is not available						
Decreasing or managing my drug use						
Getting into drug treatment						
Using HIV counseling and testing services every 3 months						
Using hepatitis counseling and testing services every 3 months						

SAFETY COUNTS Client Participation Record

Client Name _____

Enrollment Date _____

Sessions Completed:

Program Enrollment:	Date _____	HIV testing referral made _____ Other referrals made _____
Group One:	Date _____	HIV testing referral made _____ Other referrals made _____
Group Two:	Date _____	HIV testing referral made _____ Other referrals made _____
Individual Counseling:	Date _____	HIV testing referral made _____ Other referrals made _____
Social Event 1:	Date _____	HIV testing referral made _____ Other referrals made _____
Social Event 2:	Date _____	HIV testing referral made _____ Other referrals made _____
Follow-up Contact 1:	Date _____	HIV testing referral made _____ Other referrals made _____
Follow-up Contact 2:	Date _____	HIV testing referral made _____ Other referrals made _____

Personal Goal Information:

General Goal:

<input type="checkbox"/> Use condoms for vaginal sex <input type="checkbox"/> Use condoms for anal sex <input type="checkbox"/> Practice alternatives to vaginal/anal sex <input type="checkbox"/> Have fewer sex partners <input type="checkbox"/> Have fewer sex partners I don't use a condom with <input type="checkbox"/> Have sex with only one partner <input type="checkbox"/> Have protected sex when drunk or high <input type="checkbox"/> Don't share needles	<input type="checkbox"/> Don't share injection equipment (water, cotton, cookers) <input type="checkbox"/> Use a new needle for every drug injection <input type="checkbox"/> Always bleach needles if new needles are not available <input type="checkbox"/> Decrease/manage drug use <input type="checkbox"/> Get into drug treatment <input type="checkbox"/> Use HIV counseling/testing services every 3 months <input type="checkbox"/> Use hepatitis counseling/testing services every 3 months
--	---

Personal goal: _____

First step: _____

Barriers and solutions: _____

Client Name _____

Follow-up Contact Information:

Follow-up Contact 1: Date _____ Staff _____ Type: Face-to-face Telephone

Achieved first step? Yes No

Client's view of goal progress to date: Good Fair Poor

Next step (or revised first step):

Barriers and possible solutions:

_____	_____
_____	_____
_____	_____

Follow-up Contact 2: Date _____ Staff _____ Type: Face-to-face Telephone

Achieved first step? Yes No

Client's view of goal progress to date: Good Fair Poor

Next step (or revised first step):

Barriers and possible solutions:

_____	_____
_____	_____
_____	_____

Notes:

SOCIAL EVENTS

SESSION OBJECTIVES

- Strengthen clients' connection to *SAFETY COUNTS* and increase the likelihood of continued participation in program activities.
- Provide social support for clients' commitment and efforts to reduce HIV and viral hepatitis risks.
- Provide validation, problem solving, and skills building with respect to achievement of clients' specific risk reduction goals.

SUMMARY OF SESSION ACTIVITIES

The social events provide an opportunity for clients to interact with each other and *SAFETY COUNTS* staff in an informal setting. Social events include entertainment, a meal, a structured risk reduction activity, and a prize drawing.

Session time: 1 hour, 30 minutes

Social events are organized as follows:

1. **Greeting and Introduction** (10 minutes). Clients and guests sign in and receive door prizes and lottery tickets. The master of ceremonies (MC) welcomes attendees, introduces staff, and covers ground rules, and provides a preview of activities.
2. **Program-Related Entertainment Activity** (15 minutes). Clients are entertained with a humorous skit or other activity making fun of some aspect of the *SAFETY COUNTS* program or HIV and hepatitis prevention.
3. **Meal** (25 minutes). A full meal is served.
4. **Goal-Related Risk Reduction Activity** (20 minutes). A structured activity is conducted that focuses on a particular aspect of supporting and facilitating clients' achievement of their personal risk reduction goals.
5. **Drawing for Grand Prize** (5 minutes). A drawing is held for the grand prize.
6. **Dessert and Closing** (15 minutes). Dessert is served, and the MC thanks clients and guests for attending and praises them for their concern in preventing the spread of HIV and viral hepatitis.

7. **Participation Documentation.** The attendance of each client at the social event is documented on the client participation form. The sign-in sheet should be retained because it contains a record of the number of guests who attended.
8. **Staff Debriefing.** A brief meeting of all *SAFETY COUNTS* staff who were in attendance is held immediately following the social event to review the activities and identify strengths and areas needing improvement.

PREPARATION AND SETUP

Who conducts the social events? Primary responsibility for organizing social events is usually assigned to the group facilitator or the behavioral counselor. You will also need to designate an MC for each event, who may be different from either of these individuals. You will want as many staff members as possible to attend, including outreach workers, the program manager, and the program assistant.

When do social events occur? Social events should be held once a month. It is best to avoid the beginning of the month because this is the time when many clients receive benefits payments. Clients are expected to attend a minimum of two social events.

Where do they take place? Appropriate sites include a local community center or other accessible place with room for a meal, group skits, and socializing.

How do we prepare? You will need to make the following preparations at least two weeks in advance of each Social Event.

- Select a time and place.** Find a local community center or other easily accessible location where the social event can be held. In the original intervention, the social events were conducted in community centers located in city parks. It is important to schedule social events that are easily accessible to the participants (located near public transportation and scheduled at convenient times).
- Make arrangement for food.** Meals may be prepared by local businesses, staff, or clients. Staff should try to solicit donations and/or reduced food costs.
- Prepare and distribute invitations.** Give invitations to clients up to two weeks in advance of each event. Invitations should look attractive and include two tickets to the event (client and guest). In the original implementation, including tickets with invitations helped to limit the number of guests brought by each client. Include a brief description of social event activities. Invitations should be greeting-card size and should not be flyers. Distribute them to eligible clients in the field through outreach workers and to clients who participate in the group and individual sessions.

- Plan entertainment and risk reduction activities.** These should be different for each social event and should not be repeated for a period of several months. Suggestions for activities and some sample activities are provided in this manual. Your staff will need to create additional activities according to stated guidelines.

What should we have ready? You will need the following materials, supplies, and equipment for each social event:

- Food (full meal, including dessert)
- Snacks: chips, cookies, hard candy, punch, coffee (in addition to the meal)
- Tables and chairs for participants
- Reception table (near the door) and table for snacks
- Microphone (almost always needed)
- CD or cassette player (for music before and after the event and during the meal)
- Door prizes (personal hygiene kits—toothpaste, soap, shampoo, toothbrush—or other attractive small items)
- Grand prize (\$10 to \$15 in value)
- Lottery tickets
- Name tags
- Room decorations
- Assorted condoms and lubricant
- Safer sex kits (assorted condoms and tubes of lubricant)
- Needle hygiene kits (small bottle of bleach, small bottles of water, alcohol pads, sterile cotton balls)

When should we be ready? Make sure that staff members are present and everything is set up at least 30 minutes before clients and guests are due to arrive.

TIPS FOR CONDUCTING SOCIAL EVENTS

- The two or more social events are important activities because clients discuss their risk reduction goals with each other in a group. In these groups, clients learn from each other, bond, and empower each other through the process of setting risk

- reduction goals and steps—moving through the stages of change. For some of these events, participants may choose to invite a drug using acquaintance, friend, or sex partner. At other events, participants may choose to invite family members to another social event. One reason clients may choose to invite guests to the social event is so guests can learn from the program activities, learn more about how to support the client, and perhaps eventually become *SAFETY COUNTS* participants themselves.
- Since guests can be invited to social events, it is important to structure activities so that clients are not “put on the spot” to disclose personal information about themselves. Although clients are already aware, through the group sessions and the individual counseling session, that they and other clients may invite guests to the social events, it is nonetheless important to be sensitive to the more public nature of social events compared with other *SAFETY COUNTS* activities. If your agency wishes to restrict attendance at the social events to clients only, this is acceptable, but it is not recommended because of the added social support that guests provide for clients.
 - There is no practical way to restrict guests on an event-by-event basis, so it would need to be stated as policy at the time your program begins. A change in policy regarding guests, either to restrict or admit, would be problematic once the program gets going owing to the fact that all current clients would have to be contacted and given adequate notice prior to the next scheduled social event.
 - Clients were encouraged to invite guests to social events in the original implementation of *SAFETY COUNTS*. The nature of the social events was clearly explained to clients, and they only invited guests who were already aware of the clients’ drug use and concerns about HIV. At no time during the original implementation was the presence of guests an issue of concern.
 - Social events are complicated and require extensive coordination and planning. As stated above, one staff member should have overall responsibility for planning the various aspects of each social event. This includes locating and scheduling space, obtaining prizes, arranging for food, producing invitations, and planning entertainment and risk reduction activities. The social event coordinator should prepare a schedule for each monthly social that provides a step-by-step sequence of events, including specific instructions for activities and staff assignments (setup, food service, cleanup, etc).

CONSIDER HAVING A THEME PARTY

Add interest and variety to your social event by having a theme party. Remember to select themes that are culturally appropriate for your audience. Some possible themes for social events are:

- ❖ Holiday themes
- ❖ Seasonal themes
- ❖ Zodiac theme
- ❖ ‘50s theme

STEP-BY-STEP PROCEDURES

1. Greeting and Introduction (5 minutes)

- A. **Distribute door prizes** as clients and their guests arrive. Have safer sex and needle hygiene kits available.
- B. **Ask clients to sign in** at the reception table and give each client and guest name tags and a ticket for the grand prize drawing. Have a space on the sign-in sheet for clients to show the number of guests they have brought with them. (The sign-in sheet will be helpful at the end of the social event when you are documenting client participation.)
- C. **Begin the social event by welcoming clients and their guests.** Praise the clients for taking steps to reduce their risks of coming in contact with HIV and viral hepatitis. You might want to say something like this:

“It’s great to see so many familiar faces. I’d also like to welcome any guests we have with us. As you know, HIV—the virus that causes AIDS—and viral hepatitis have become a real problem in our community, and we are trying to do something about it. These health threats especially affect drug users, so it’s important to do what we can to prevent their spread. On behalf of the whole staff of *SAFETY COUNTS*, I want to congratulate you all for coming out today and for participating in our program. You are doing something important by being here. Today, we have a great program planned and some great food, but first some introductions are in order.”

- D. **Briefly introduce SAFETY COUNTS staff members** and highlight the role of each. It is important that the full *SAFETY COUNTS* team be present at each social event. Pay special attention to the outreach workers when you introduce them.
- E. **List ground rules** for acceptable behavior. These should include not using drugs on the premises and respect for confidentiality of personal disclosures. Let clients know that if anyone is caught breaking the rules, that person will be asked to leave.
- F. **Briefly describe the schedule** of activities for the social event. Be sure to mention the grand prize drawing that will take place before dessert: “You must be present to win.”

2. Program-Related Entertainment Activity (15 minutes)

Purpose: The purpose of this activity is to entertain clients and guests while strengthening their identification with the *SAFETY COUNTS* program and HIV and viral hepatitis prevention.

- A. Introduce the entertainment activity** with a flourish so that the audience understands immediately that what is coming up will be light-hearted. For example, if the activity is a skit or role play, you might say the following: “Ladies and gentlemen, by popular demand we once again proudly present the *SAFETY COUNTS* Players in a stirring drama of our times.” If the entertainment activity is a panel-of-experts game, you might put on a pair of oversized “professor” glasses for the introduction.
- B. Present the entertainment activity.** The activity should be light-hearted, fun, and related to some aspect of the *SAFETY COUNTS* program or to the general area of HIV and viral hepatitis prevention. Entertainment activities that make fun of some aspect of the *SAFETY COUNTS* program are very popular with clients, and these are preferred because they serve to strengthen clients’ identification with *SAFETY COUNTS*. Some possible topics for entertainment activities are shown below. In addition, you may develop your own activities. Whatever activity you choose, always bear in mind that it should respect the sensitivities of your particular audience.

Ideas for Entertainment Activities

- ❖ Mock-serious skit of personal goal setting and determining a first step, using an absurd general goal like “reducing my shopping risk.”
- ❖ Skit spoofing the stages of change model for changing personal behavior, using an unlikely behavior like starting to wear boxer shorts.
- ❖ Skit where a man tries to negotiate condom use with his sex partner, but does it all wrong.
- ❖ Panel-of-experts game, where volunteer panel members take questions from the audience and give ridiculous answers about HIV and viral hepatitis facts, risks, and prevention.

3. Meal (25 minutes)

Purpose: The purpose of the meal is to provide an opportunity for staff to foster a relationship with clients in a non-authoritative setting. Clients will have a chance to speak to staff members in a social environment while eating. In addition, clients can hang out with each other and enjoy a good meal—all part of the rapport-building process that makes for a good program.

- A. Following the warm-up activity, a meal is served to the clients and their guests. After all clients have been served, program staff members should seat themselves among the participants and join in the meal.
- B. At the end of the meal, announce that the prize drawing will take place and dessert will be served in about 20 minutes.

4. Goal-Related Risk Reduction Activity (20 minutes)

Purpose: This activity, which addresses a selected aspect of the risk behavior change process, is intended to support and facilitate clients' achievement of the personal risk reduction goals to which they have committed in *SAFETY COUNTS*.

- A. **Introduce the goal-related risk reduction activity:** “Before we have dessert, let’s spend a few minutes dealing with the main reason we are here today: Protecting ourselves and others from HIV and viral hepatitis. All of us in the *SAFETY COUNTS* program have a personal goal to reduce our risks. We have made a commitment, and we are here to support one another. Support means sharing and helping, and that’s what we would like to do now.”
- B. **Present the goal-related risk reduction activity.** This should be a structured activity dealing with some aspect of the personal risk reduction goals clients have set in *SAFETY COUNTS* and their efforts to achieve them. Presentations about general HIV and hepatitis facts and prevention issues are not appropriate for this activity. This is the “serious” part of the program where clients are expected to “work” for a brief period.

Sample topics for risk reduction activities are shown in the box below. The complete script for a social support story activity can be found in Appendix L. You may wish to develop other activities in addition to those shown below that address goal-achievement issues of particular relevance for your clients. Regardless of the activity you elect to use, remember that it should relate directly to the *SAFETY COUNTS* program and the goal-achievement efforts of your clients.

Some Topics for Risk Reduction Activities

- ❖ Sharing of social support stories (see Appendix E).
- ❖ Breakout groups with assignment to list greatest barriers to making personal changes and greatest facilitators of change in their experience.
- ❖ Presentations by clients who wish to share their progress, challenges, and successes in achieving personal goals.
- ❖ Discussion of triggering events for change and sharing of personal triggers by clients.

5. Drawing for Grand Prize (5 minutes)

- Following the risk reduction exercises, hold a drawing for one prize such as a watch or small radio (\$15 to \$20 in value).
- Ask the winner to come to the front of the room and make a formal presentation of the prize.

6. Dessert and Closing (15 minutes)

- A. After the prize has been given to the winning client, serve dessert.** In the original implementation, ice cream cones were extremely popular and did not require serving dishes or utensils.
- B. During this time, staff can mingle with clients** and begin to clean up the facility.
- C. Make a closing statement that includes mention of HIV and hepatitis testing** while clients and guests are finishing dessert. You might want to say something like:

“Once again, on behalf of the whole staff, I’d like to thank everyone for coming out today. We hope you enjoyed the activities we put together for you. HIV and viral hepatitis have become a problem in our community, but even though these viruses are spreading, there are lots of things people can do to keep themselves safe. That’s what our program is about—protecting yourself and others from HIV and viral hepatitis.

If you haven’t been tested for HIV or hepatitis in the last 3 months, I urge you to consider it—it’s important to know your status. Also, there are educational materials available in the back of the room. Please take them with you to read later at your convenience. If you have any questions or you would like to get tested, talk to one of us and we will be happy to assist. Thanks again for coming and we wish you luck with your risk reduction goals. Let’s give ourselves a round of applause for taking action to stop the spread of HIV and viral hepatitis.”

7. Participation Documentation

After the conclusion of the social event, document clients’ participation in the intervention using the client participation record.

8. Staff Debriefing

We recommend that you debrief with all program staff in attendance to discuss how well you believe the social event was facilitated, what clients gained from it, and the feedback they

gave you. Discuss the entertainment and risk reduction activities that were presented and how they might be improved.

FORMS AND WORKSHEETS

SOCIAL EVENTS

Client Participation Record
(Originated in Program Enrollment Session)

SAFETY COUNTS Client Participation Record

Client Name _____

Enrollment Date _____

Sessions Completed:

Program Enrollment:	Date _____	HIV testing referral made _____ Other referrals made _____
Group One:	Date _____	HIV testing referral made _____ Other referrals made _____
Group Two:	Date _____	HIV testing referral made _____ Other referrals made _____
Individual Counseling:	Date _____	HIV testing referral made _____ Other referrals made _____
Social Event 1:	Date _____	HIV testing referral made _____ Other referrals made _____
Social Event 2:	Date _____	HIV testing referral made _____ Other referrals made _____
Follow-up Contact 1:	Date _____	HIV testing referral made _____ Other referrals made _____
Follow-up Contact 2:	Date _____	HIV testing referral made _____ Other referrals made _____

Personal Goal Information:

General Goal:

<input type="checkbox"/> Use condoms for vaginal sex <input type="checkbox"/> Use condoms for anal sex <input type="checkbox"/> Practice alternatives to vaginal/anal sex <input type="checkbox"/> Have fewer sex partners <input type="checkbox"/> Have fewer sex partners I don't use a condom with <input type="checkbox"/> Have sex with only one partner <input type="checkbox"/> Have protected sex when drunk or high <input type="checkbox"/> Don't share needles	<input type="checkbox"/> Don't share injection equipment (water, cotton, cookers) <input type="checkbox"/> Use a new needle for every drug injection <input type="checkbox"/> Always bleach needles if new needles are not available <input type="checkbox"/> Decrease/manage drug use <input type="checkbox"/> Get into drug treatment <input type="checkbox"/> Use HIV counseling/testing services every 3 months <input type="checkbox"/> Use hepatitis counseling/testing services every 3 months
--	---

Personal goal: _____

First step: _____

Barriers and solutions: _____

Client Name _____

Follow-up Contact Information:

Follow-up Contact 1: Date _____ Staff _____ Type: Face-to-face Telephone

Achieved first step? Yes No

Client's view of goal progress to date: Good Fair Poor

Next step (or revised first step):

Barriers and possible solutions:

_____	_____
_____	_____
_____	_____

Follow-up Contact 2: Date _____ Staff _____ Type: Face-to-face Telephone

Achieved first step? Yes No

Client's view of goal progress to date: Good Fair Poor

Next step (or revised first step):

Barriers and possible solutions:

_____	_____
_____	_____
_____	_____

Notes:

FOLLOW-UP CONTACTS

SESSION OBJECTIVES

- Reinforce client's efforts towards the risk reduction goals identified during previous *SAFETY COUNTS* sessions.
- Assist in refining or developing new next steps towards the client's goal.
- Encourage attendance at *SAFETY COUNTS* social events.
- Remind client of the importance of HIV and hepatitis testing.
- Provide prevention kits and service referrals.

SUMMARY OF SESSION ACTIVITIES

During this session, outreach workers encourage and continue to motivate clients in their efforts toward achieving their previously identified personal risk reduction goal, helping them develop new steps towards that goal if needed. Prevention hygiene kits, informative brochures, and referral information for HIV, hepatitis, and social services are offered. Reminders for social events and an incentive for participating in the planned follow-up contact are given. The outreach workers document the contact and the client's progress on the client participation record after they return to the office.

Session time: 20 minutes

The follow-up contacts are organized as follows:

1. **Approach and greeting** (3 minutes).
2. **Verify and validate client's goal and progress** (4 minutes). The client is praised for making a personal commitment to reduce HIV and hepatitis risks, and the effectiveness of the chosen risk reduction strategy is validated. Progress toward achieving his/her goal is assessed.
3. **Plan the next step** (5 minutes). A next step toward goal achievement is planned with the client. If the current goal has been achieved, a specific action is planned that will help to maintain the goal behavior.
4. **Help client identify and overcome barriers to achieving next step** (4 minutes). Possible problems the client may face in completing the agreed-upon next step are identified and explored, and solutions to these problems are developed with the client.
5. **Social support check-in** (2 minutes). The client is asked whether there is still a person in his or her life who is supportive of the client's efforts to reduce HIV and

- hepatitis risks. If there is no one at present, the outreach worker offers his/her own support.
6. **Closing** (2 minutes). The client is offered risk reduction materials (bleach and/or condom kit), referral information, including information about HIV or hepatitis testing, and the agency's assistance in arranging referrals. The client is reminded of the importance of continued HIV and hepatitis testing. An incentive and invitation to the next social event are given to the client.
 7. **Participation Documentation.** After the conclusion of the follow-up contact, document the client's participation in the intervention using the client participation record.
 8. **Staff Debriefing.** Following the session, outreach workers meet with other program staff to review the session and consider how well session objectives were met. The client's general progress in reducing HIV/hepatitis risk is reviewed and plans for additional follow-up sessions are discussed.

PREPARATION AND SETUP

Who conducts follow-up contacts? Outreach workers trained in *SAFETY COUNTS* (as described earlier) conduct the follow-up contacts after consultation with counselors or facilitators to obtain specific information on the particular clients they are seeking.

When do the follow-up contacts occur? Clients are eligible for planned follow-up contacts a minimum of one week after they have completed the individual counseling session. At least two follow-up contacts (more are desirable) should occur before the end of the fourth month of the client's enrollment in *SAFETY COUNTS*. They should be at least one week apart.

Where do these contacts take place? *SAFETY COUNTS* clients will have been asked in their individual counseling session how and where they prefer to be approached for follow-up contacts, and outreach efforts should be consistent with the client's stated preference. The outreach worker and the counselor or facilitator will jointly review the client information when it is time for the follow-up contact. Together, they will determine where and how to locate the client and conduct the follow-up contact, also taking into consideration any confidentiality concerns expressed by the client. Depending on the client's preference, these contacts may take place on the street, in coffee shops or parks, or similar locations, bearing in mind safety concerns for both staff and client, as well as agency policies. While face-to-face interactions are definitely preferred, contacts may be conducted over the phone if the client requests.

How do we know who is ready for a follow-up contact? The program manager should keep a schedule of clients' progress through the activities and sessions of *SAFETY COUNTS* in such a form that staff can readily identify who is eligible and due for follow-up contacts. It is the responsibility of outreach workers to obtain this

information and meet with the behavioral counselor or facilitator who has worked with the client, before trying to contact the client.

How do we prepare? In the office, review the client's risk reduction interview in order to be familiar with his or her risks, goal, and planned first step. Gather the materials, listed below, that you will need in the field.

What should we have ready? You will need the following *SAFETY COUNTS* materials for each follow-up contact:

- A copy of the program enrollment form for the client (page 1 only)
- An up-to-date copy of the client participation record for the client
- Goal cards (blank)

In addition, you will also need the following materials and supplies:

- Needle hygiene kits: small bottle of bleach, small bottles of water, alcohol pads, and sterile cotton balls.
- Safer sex kits: assorted condoms and tubes of lubricant.
- Local HIV, hepatitis, and social service referral list.
- Brochures on HIV and viral hepatitis testing and risks, overdose prevention, safer sex, and safe injecting.

Should Outreach Workers Take Client Information into the Field?

It will be necessary for outreach workers to have names and contact information for the clients they plan to see, as well as information on each client's personal goal and first step, and the program activities the client has completed. The supervisor should give the outreach worker a copy—never the original—of the program enrollment form (page 1) and the client participation record to carry into the field. Your agency will need to decide on strict procedure to protect client confidentiality, and each outreach worker must be given explicit instructions on how to handle, use, and return forms taken to the field. (For further guidance on confidentiality, see the Introduction to Part III of this manual.)

TIPS FOR CONDUCTING FOLLOW-UP CONTACTS

- Make a point of getting to know and talking to all the clients you can at the social events. This will make it easier for you to recognize the client in the field when you conduct the follow-up contact session. It will also help the client feel more comfortable in talking with you later.
- Prepare for follow-up contacts. With the behavioral counselor or group facilitator, review the client's session participation, personal goals and steps, and preference for being contacted.
- Wait at least one week after a client's participation in the group or individual sessions before conducting a follow-up contact. Wait at least 1 day after social events.
- Remember that two follow-up contacts is the minimum number required for each client during the 4 months of his or her participation in *SAFETY COUNTS*. If it is possible to conduct more than two follow-up contacts during this period, you are encouraged to do so.
- Include in each follow-up contact a reminder of the next social event, including the time and place. Remember that we would like for clients to attend as many social events as they can, not just the minimum of two.
- Review the field safety guidelines contained in Appendix C

STEP-BY-STEP PROCEDURES

1. Approach and Greeting (3 minutes)

- A. **Once you have located the client**, greet him or her, identify yourself by name, and say you are from *SAFETY COUNTS*. Ask if the client has time to talk for 10 or 20 minutes. If the client declines, try to make an appointment for a later time (but soon) when you can meet somewhere convenient for the client. Say that you want to know if the client needs anything and that you are interested in how he/she is doing with his/her personal goal.
- B. **If the client is willing to talk**, continue as below. If not, skip to "closing" and offer information and prevention materials. Do not push strongly for continuing the entire session now if the client is reluctant.

2. Verify and Validate Client's Goal and Progress (4 minutes)

- A. **Validate the client's commitment to reducing HIV and viral hepatitis risk:** "You're smart to be concerned about the risk of HIV and hepatitis, and willing to do something about it."

- B. **Ask the client for the goal card** he or she got at the individual counseling session. If it is not available, say, “That’s okay, I have another one here we can use.” Take out a blank goal card and quickly write in the client’s personal goal and first step taken from the client participation record.
- C. **Validate the specific goal** that the client has chosen: “Using condoms more often makes a lot of sense.”
- D. **Express your personal approval and caring** for the client's risk reduction efforts: “I'm really glad to hear what you are doing—I think it's great.”
- E. **Tell the client that his or her strategy for reducing personal risk is effective:** “Condoms stop the virus. They really work.”
- F. **Assess the client's progress** toward achieving the personal goal: “How's it working out so far? Tell me what you've done.”
- G. **Find out how the client perceives his or her own progress:** ““How do you think you're doing so far?” (You can record "good," "fair," or "poor" on the participation record form.) Find something positive to say even if the client feels discouraged about his or her progress: “I know what you’re saying, but it's great that you’re sticking with the program.”

3. Plan the Next Step (5 minutes)

- A. **Help client to identify a specific action to take next** in working toward his or her personal goal: “What do you think a next step could be?”
- B. **Do not develop a new goal unless the previous goal has become unachievable.** For example, if the client has stopped using injection drugs, needle hygiene is no longer a relevant goal. If the client has broken up with his or her boyfriend, condom use with that boyfriend is beside the point.
- C. **If the client has achieved his or her current goal, congratulate the client** and, in place of a next step, focus on developing a specific action that will help to maintain the goal behavior.
- D. **Review the next step with the client and get commitment to it:** “Let's go over exactly what you're going to do.”

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

- A. **Discuss and identify potential barriers** that might be encountered when taking the client’s next step.
- B. **Discuss barriers that the client has already encountered** in working toward his or her goal.

- C. **Say you understand the barriers** that the client discusses: “I know what you mean; that's a real problem.”
- D. **Suggest specific ways to overcome these barriers.** For example:
 - » “I understand that it can be really hard to wait for a clean needle when you feel sick, but if you practice cleaning you can learn to do it quickly and correctly.”
 - » “I understand that your partner thinks that condoms make sex feel less good. You might tell him that he can put a small amount of lube on the tip of his penis before putting on the condom. This will make it a better experience for him.”
- E. **Enhance the client's belief in his or her ability** to succeed in making personal change: “I know you can make this work for you. You'll be able to do it.”

5. Social Support Check-in (2 minutes)

- A. Ask whether there is still a person in his or her life who is supportive of the client's efforts to reduce HIV and hepatitis risks and who the client can talk to about issues and problems that arise.
- B. If there is no one at the present time, briefly try with the client to identify a new individual who can provide social support.
- C. If a support person cannot be identified, offer your own support.

6. Closing (2 minutes)

- A. **Give the client the date and time of the next social event**, and encourage the client to bring a guest.
- B. **Remind the client about any upcoming or missed appointments** for prevention and care services.
- C. **Remind the client of the importance of HIV and hepatitis testing**, especially if the client has current risks.
- D. **Encourage the client to seek your assistance** if he or she wants to talk about any problems that come up while trying to work toward the client's goal. Praise the client for taking steps to protect himself/herself and others against HIV and hepatitis.
- E. **Offer the client safer sex and needle hygiene kits** and referral information.

7. Participation Documentation

After leaving the client, fill out the follow-up contact information section on your copy of the client participation record. Be sure to provide complete information, particularly about the client's goal progress, next step, and possible barriers. Transfer this information to the original client participation record when you return to the office.

8. Staff Debriefing

As soon as possible after the session, outreach workers should meet with other program staff, including other outreach workers, the group facilitator, and the behavioral counselor, to review the session and consider how well session objectives were met. In doing this, assess (1) how receptive the client was to the follow-up contact, (2) whether the client recalled his or her personal risk reduction goal, (3) how much progress the client had made in achieving his or her goal, and (4) how well the planning of a next step and consideration of barriers went. At this time, any additional follow-up contacts should be planned, with attention to the special needs of this client that should be addressed. Also, for clients who are approaching completion of 4 months of enrollment in *SAFETY COUNTS*, arrangements should be made at this time for a follow-up administration of the risk reduction interview.

FORMS AND WORKSHEETS

FOLLOW-UP CONTACTS

Program Enrollment Form (Page 1)
(Originated in Program Enrollment Session)

Goal Card
(Revised in Individual Counseling Session)

Client Participation Record
(Originated in Program Enrollment Session)

<i>SAFETY COUNTS Goal Card</i>	
My Goal: _____ _____	
My Next Step: _____ _____ _____	
Name _____	Date _____

(Actual goal card is wallet-size.)

SAFETY COUNTS Client Participation Record

Client Name _____

Enrollment Date _____

Sessions Completed:

Program Enrollment:	Date _____	HIV testing referral made _____ Other referrals made _____
Group One:	Date _____	HIV testing referral made _____ Other referrals made _____
Group Two:	Date _____	HIV testing referral made _____ Other referrals made _____
Individual Counseling:	Date _____	HIV testing referral made _____ Other referrals made _____
Social Event 1:	Date _____	HIV testing referral made _____ Other referrals made _____
Social Event 2:	Date _____	HIV testing referral made _____ Other referrals made _____
Follow-up Contact 1:	Date _____	HIV testing referral made _____ Other referrals made _____
Follow-up Contact 2:	Date _____	HIV testing referral made _____ Other referrals made _____

Personal Goal Information:

General Goal:

<input type="checkbox"/> Use condoms for vaginal sex <input type="checkbox"/> Use condoms for anal sex <input type="checkbox"/> Practice alternatives to vaginal/anal sex <input type="checkbox"/> Have fewer sex partners <input type="checkbox"/> Have fewer sex partners I don't use a condom with <input type="checkbox"/> Have sex with only one partner <input type="checkbox"/> Have protected sex when drunk or high <input type="checkbox"/> Don't share needles	<input type="checkbox"/> Don't share injection equipment (water, cotton, cookers) <input type="checkbox"/> Use a new needle for every drug injection <input type="checkbox"/> Always bleach needles if new needles are not available <input type="checkbox"/> Decrease/manage drug use <input type="checkbox"/> Get into drug treatment <input type="checkbox"/> Use HIV counseling/testing services every 3 months <input type="checkbox"/> Use hepatitis counseling/testing services every 3 months
--	---

Personal goal: _____

First step: _____

Barriers and solutions: _____

Client Name _____

Follow-up Contact Information:

Follow-up Contact 1: Date _____ Staff _____ Type: Face-to-face Telephone

Achieved first step? Yes No

Client's view of goal progress to date: Good Fair Poor

Next step (or revised first step):

Barriers and possible solutions:

_____	_____
_____	_____
_____	_____

Follow-up Contact 2: Date _____ Staff _____ Type: Face-to-face Telephone

Achieved first step? Yes No

Client's view of goal progress to date: Good Fair Poor

Next step (or revised first step):

Barriers and possible solutions:

_____	_____
_____	_____
_____	_____

Notes:

PART IV. Program 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 the programs you offer, evaluation has become increasingly important for community-based organizations (CBOs) and agencies. For *SAFETY COUNTS*, it is critical that accurate information be collected regarding the program's ability to meet its objectives to reduce HIV and viral hepatitis risk behaviors. A good evaluation can tell the success story of your organization's implementation of *SAFETY COUNTS*. It can also help you to keep the intervention solidly on track by monitoring key aspects of its implementation and providing ongoing information concerning areas that might need improvement.

Part IV presents an overview of standard evaluation terminology and techniques, with emphasis on those strategies that have relevance in community settings. How to set up a monitoring and evaluation program for *SAFETY COUNTS* is discussed in specific terms. A logic model for *SAFETY COUNTS* is presented, which can assist you by providing a helpful framework for developing your evaluation plan. A sample monitoring and evaluation plan for *SAFETY COUNTS* is also included, which can be tailored as required to suit your particular needs. Two instruments for evaluating *SAFETY COUNTS* are included at the end of Part IV, one for process monitoring and a second for outcome monitoring. How and when these instruments are used with the *SAFETY COUNTS* intervention are explained in full.

The Importance of Evaluation

Evaluation can be defined as “the systematic collection of information about the activities, characteristics, and outcomes of programs to make judgments about the program, improve program effectiveness, and/or inform decisions about future programming” (Patton, 1997). It can also be described as “collecting, analyzing, interpreting and communicating information about the effectiveness of social programs undertaken for the purpose of improving social conditions” (Rossi et al, 1999).

There are three basic reasons for evaluating a “proven” intervention such as *SAFETY COUNTS*:

1. Accounting to the various stakeholders in the intervention.
2. Assuring program fidelity and program improvement.
3. Developing knowledge for planning future programs.

There are many different stakeholders that will benefit from the kinds of information produced by a *SAFETY COUNTS* evaluation. Some may require that evaluation information be provided as a condition for continued funding. These stakeholders are

- The staff who are implementing the intervention.

- The clients who are participating in the intervention.
- The community partners that have joined in supporting the intervention.
- The funding agency that is providing financial support for the intervention.
- The prevention planning group that has made recommendations to the funding agency.
- The political body that may decide the fate of future funding for interventions such as *SAFETY COUNTS*.

Your employees who are working on the intervention will want the assurance that their work on *SAFETY COUNTS* is making a difference for the people they are serving. Equally important are the drug users who are enrolled in *SAFETY COUNTS*, who will want to be confident that your intervention is appropriate and effective in promoting their health and safety. Also interested will be the community partners that have assisted in making *SAFETY COUNTS* a success by either referring new clients or serving clients referred by you. Other community partners that will be interested are those that may have provided various incentives to encourage continued participation of clients in *SAFETY COUNTS*. In addition, it is likely that residents of the broader community will want to know that you are implementing an intervention that will have beneficial outcomes for their community as a whole. Finally, there is the funding agency itself and its adjuncts, which will want specific, ongoing assurance that you have implemented *SAFETY COUNTS* as intended, and that the intervention is making a positive difference in terms of reducing the HIV and hepatitis risks of the drug users who participate in it.

As a “proven” effective intervention, *SAFETY COUNTS* is already understood to be effective in achieving behavior change among drug users. The evaluation your organization conducts can show that you maintained fidelity to the core elements of *SAFETY COUNTS*, and that you helped the clients enrolled in *SAFETY COUNTS* to change their behavior and reduce their risk of transmitting HIV and viral hepatitis. Evaluation can also identify any needs that may exist for strengthening your implementation activities and suggest methods for accomplishing this, thus leading to an increase in the effectiveness of your program.

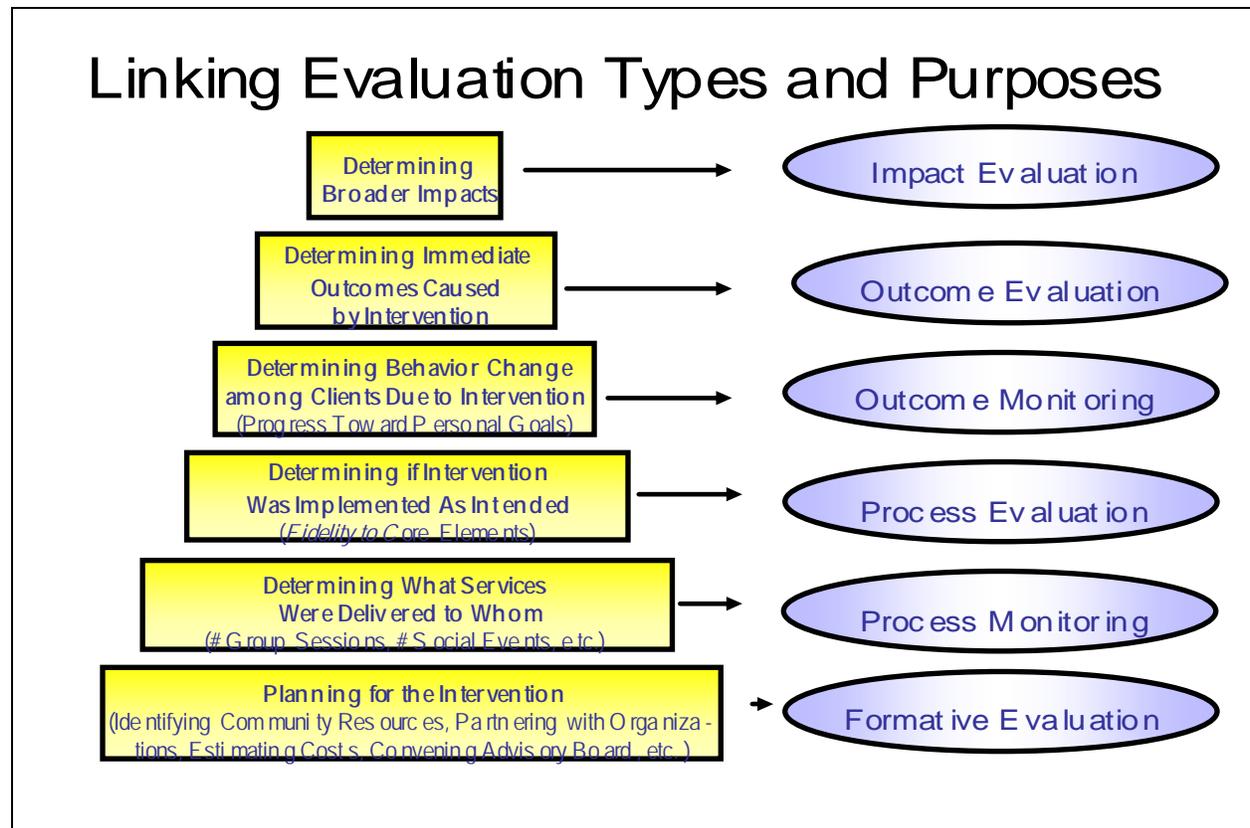
Types of Evaluation

There are various schools of thought concerning the distinctions among different types and techniques of evaluation. In this manual, the following names will be used to describe the different types of evaluation: (1) formative evaluation, (2) process monitoring, (3) process evaluation, (4) outcome monitoring, (5) outcome evaluation, and (6) impact evaluation. (The terms “evaluation” and “monitoring,” while distinctive in terms of the different processes they describe, are often collectively referred to as different types of “evaluation.”) These six types of evaluation are described briefly below and are also illustrated in the accompanying figure, “Linking Evaluation Types and Purposes.”

1. Formative evaluation collects information 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. Formative evaluation can answer questions such as: “How should the intervention be designed or modified to address population needs?” “What can we learn from pre-testing our approach?” “Are the materials we are going to use appropriate?”
2. Process monitoring collects data describing the characteristics of the population served, the types and frequency of services provided, and the resources used to deliver those services. It assists with making changes and improvements during the implementation process, and can answer questions such as: “What services were delivered?” “How and where were those services delivered?” “What population was served?” “What resources were used?”
3. 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 by persons it is intended to serve. It can answer questions such as: “Was the intervention implemented as intended, with fidelity to the core elements?” “Did the intervention reach the intended audience?” “Did individuals experience barriers in accessing the intervention, and what were these?”
4. Outcome monitoring collects data about client outcomes before and after the intervention, such as knowledge, attitudes, skills, behaviors, and intentions for behavior change. It can answer the question: “Did the expected outcomes occur and to what degree?” Ideally, outcome monitoring should be conducted only after process evaluation has shown that the intervention is being delivered as intended, but in practice outcome and process monitoring are often carried out concurrently.
5. Outcome evaluation collects data about outcomes or results of the intervention, as well as other comparison groups that did not participate in the intervention being evaluated. It can answer the question: “Did the expected outcomes occur as a result of the intervention?”
6. Impact evaluation collects similar data to outcome evaluation, in conjunction with data about the incidence of new HIV and hepatitis infections and other indicators at the jurisdictional, regional, and national levels, over a longer time frame. It can answer the questions: “What long-term effects did the intervention have on HIV and hepatitis infection?” “Were the initial outcomes sustained over an extended time frame?”

Below is a list of evaluation resources you may wish to review:

- Handbook: Strategies for Implementing the Evaluation Guidance for CDC-Funded HIV Prevention Programs, Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention. www.cdc.gov/hiv/aboutdhap/perb/guidance.htm



Adapted from ORC MACRO

- HIV Prevention Program Evaluation Materials Database, Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention. (www.cdcnpin.org/scripts/dhap/selection.asp)
- Centers for Disease Control and Prevention, MMWR, Framework for program evaluation in public health, September 17, 1999/Vol.48/No.RR-11. (www.cdc.gov/mmwr/preview/mmwrhtml/rr4811a1.htm)

Evaluating *SAFETY COUNTS*

The original research phase of *SAFETY COUNTS*, described in Part I of this manual, employed all of these evaluation strategies, including outcome evaluation but excluding impact evaluation. **It is not expected or advised that your organization conduct either outcome or impact evaluation for *SAFETY COUNTS*.** Outcome evaluation and impact evaluation require a high level of technical expertise and resources. The original researchers have already established that *SAFETY COUNTS* is an effective intervention in terms of its positive outcomes, and you do not need to repeat this. For the purposes of implementing *SAFETY COUNTS*, you should, however, conduct formative evaluation, process monitoring, process evaluation, and outcome monitoring.

It is important to develop an overall plan for evaluating your *SAFETY COUNTS* program prior to starting any evaluation activities. For each of the different types of evaluation you will be conducting (formative and process evaluation, process and outcome monitoring), you will want to prepare a concrete plan that includes: (1) what information will be provided by the evaluation strategy, (2) how it will be used, (3) what instruments and techniques will be used to collect the data, and (4) who will collect the data. In addition, you should identify who will be responsible for analyzing, summarizing, and communicating the data that have been collected to ensure that information from the evaluation is appropriately and fully utilized. An example of how a plan for process monitoring and evaluation might look is shown in the table on page 152.

An implementation model or plan is a practical set of concrete activities. It is related to the logic planning and sequence of the different components that the intervention needs in order to work. On the other hand, the internal logic model (see Part I) is a more theoretical set of assumptions linked with the core elements/activities of the intervention and the intervention output. The implementation model is a tool that can greatly assist you in developing a complete evaluation plan. An implementation model identifies and categorizes the individual components of an intervention and presents them in a time-sequenced flow diagram. The implementation model identifies intervention inputs, activities, outputs, short-term outcomes, intermediate-term outcomes, and long-term impacts. An implementation model will help you to identify the activities your intervention is conducting to alter the specific behaviors you are working to change and the particular outcomes you expect to see as a result of your intervention. Your process monitoring and process evaluation efforts will focus on the activities and outputs on the intervention. Your outcome monitoring efforts will focus on short-term outcomes of the intervention.

The sample implementation model on the next page assumes that the formative evaluation process has already been completed for your intervention. You want to conduct a formative evaluation process prior to implementing your *SAFETY COUNTS* intervention, however; formative evaluation should be conducted continuously throughout the intervention.

SAMPLE IMPLEMENTATION MODEL FOR SAFETY COUNTS INTERVENTION

Inputs →	Activities →	Outputs →	Short-Term Outcomes →	Intermediate-Term Outcomes →	Long-Term Impact
<ul style="list-style-type: none"> • Full-time and part-time staff. • Program manual, training manual, and TA guide. • Risk reduction supplies and incentives. • Office space. • Funding. • In-kind support. 	<ul style="list-style-type: none"> • Conduct outreach to recruit clients. • Enroll clients; complete Program Enrollment Form and Personal Risk Reduction Checklist. • Produce risk reduction success stories. • Conduct Group Session One (ongoing). • Conduct Group Session Two (ongoing). • Conduct Individual Counseling Session (ongoing). • Conduct monthly Social Events (ongoing). • Conduct Follow-up Contacts (ongoing). • Package/distribute safer sex, needle hygiene, and personal hygiene kits. 	<ul style="list-style-type: none"> • Number and characteristics of clients enrolled. • Number and types of behavioral goals selected by clients to reduce their risks for HIV and viral hepatitis. • Number (%) of clients attending Group Session One and/or Two. • Number (%) of clients attending Individual Counseling Session. • Number (%) of clients attending 1 and/or 2+ Social Events. • Number (%) of clients receiving 1 and/or 2+ Follow-up Contacts. • Number and types of materials distributed. 	<ul style="list-style-type: none"> • Increased percent of target population who commit to specific behavioral goals to reduce personal risks for HIV and viral hepatitis. • Increased percent of target population who make progress toward achieving their risk reduction goal. • Increased percent of target population who progress to a higher stage of change. 	<ul style="list-style-type: none"> • Increased percent of target population who change their behavior to reduce risk of HIV and viral hepatitis. • Increased percent of target population who maintain lower-risk behaviors. 	<ul style="list-style-type: none"> • Reduced incidence/prevalence of HIV and viral hepatitis in the community.

The following paragraphs give more detail about each type of evaluation and provide specific guidance for planning and conducting local evaluation activities for *SAFETY COUNTS* programs.

FORMATIVE EVALUATION

Formative evaluation is an essential first step in conducting a comprehensive evaluation of your *SAFETY COUNTS* program. Essentially, formative evaluation is the front end of your implementation planning process, in that formative evaluation identifies and provides detailed information

about the important factors influencing implementation of *SAFETY COUNTS* in your setting. Identifying these factors will help your organization in implementing *SAFETY COUNTS*; others will represent challenges and barriers to be overcome. A good formative evaluation process lays out all of these issues in detail, thereby setting the stage for you to develop a realistic implementation plan that both recognizes the assets of your organization and provides solutions to identified challenges.

Below is a list of issues you will want to address in conducting your formative evaluation. Many of these are discussed in detail in Part II, “Preparing for Program Implementation.”

- Staffing requirements and availability.
- Needs and opportunities for partnering with other organizations.
- Program costs.
- Funding sources.
- Client access and recruitment issues.
- Client retention issues.
- Definition and availability of appropriate client incentives.
- Estimated number of drug users in your local community who may be recruited into *SAFETY COUNTS*.
- Perceptions of *SAFETY COUNTS* among members of the general community.
- Attitudes of local law enforcement toward drug users, and police perceptions of *SAFETY COUNTS*.
- Drug terminology and paraphernalia employed by drug users in your community.

Because formative evaluation is a part of the implementation planning process, it must be conducted prior to actual program implementation, and consequently it is usually thought of as not continuing into the intervention implementation phase. This is not always the case, however. If you decide to convene a client advisory committee with your first few *SAFETY COUNTS* clients, as recommended in Part II of this manual, then the process of working with them to develop effective client recruitment and retention strategies will be a type of formative evaluation.

PROCESS MONITORING AND PROCESS EVALUATION

Process monitoring and process evaluation are highly related to one another. Both rely on information gathered about the conduct of program activities and delivery of services, both are ongoing in nature, and the results of both are fed back into the intervention to improve its functioning. They differ, however, in terms of the questions they answer. Process monitoring answers the question, “What intervention activities were conducted and with what frequency?”

Process evaluation answers the question, “Were intervention activities conducted in the intended manner?” Process evaluation thus speaks to the issue of intervention fidelity (core elements), while process monitoring does not. Put another way, process monitoring tells you if the intervention is being implemented efficiently, while process evaluation tells you if it is being implemented effectively. Because process monitoring and process evaluation share much of the same data, we will refer to the two techniques collectively as “process monitoring and evaluation.”

In planning your process monitoring and evaluation activities for *SAFETY COUNTS*, you will want to consider carefully what data about the intervention you will need to collect. As stated earlier, you want to be sure that you will be collecting all of the information that is necessary to guide you in managing the intervention program. On the other hand, you do not want to collect information that you will not be using, because this places an added burden on the intervention staff. Since process monitoring and evaluation are ongoing and continue throughout the life of the intervention program, it is important to plan thoughtfully.

Developing a systematic plan for process monitoring and evaluation of your *SAFETY COUNTS* program that recognizes the realities and constraints of your particular situation can be very helpful. An example of such a plan is shown on the next page. Among other elements, the plan specifies all of the data collection methods that will be used in conducting process monitoring and evaluation for *SAFETY COUNTS*, including forms, questionnaires, and other techniques. In the sample plan, the names of the specific *SAFETY COUNTS* instruments that will be used are listed, along with two unstructured techniques: observation and audio tape recording.

It is strongly recommended that some means of monitoring the completeness and quality of intervention sessions be included in your plan. Observation by a nonparticipating staff member is an effective means of accomplishing this for the group sessions, social events, and follow-up contacts. Likewise, making tape recordings of selected individual counseling sessions, with the explicit consent of clients at the time the sessions are conducted, is an effective means of monitoring these activities. You may be surprised that most clients will probably not object to being tape recorded once the purpose is explained. Both of these strategies were employed in the original research program, and they are commonly used as a monitoring tool in programs of this type. If you do not wish to consider audio tape recording, there are two other options for monitoring the delivery of individual counseling sessions. The first is to include an observer as a part of selected sessions, again with the consent of the client. The second is an indirect method, which involves conducting periodic role plays with the counselor, with one staff member taking the part of the client and another person acting as observer.

In addition to identifying the data collection methods that will be used, the sample process monitoring and evaluation plan specifies for each method (1) when and by whom the data will be collected, (2) exactly what information it will provide, and (3) how that information will be used in managing and improving the *SAFETY COUNTS* program. When describing the information that will be provided by a particular method, it is generally best to be as exact and complete as possible—without having so much detail that it obscures the purpose of the plan. The examples shown in the sample plan are somewhat abbreviated in the interest of conserving space and would benefit from additional detail in some instances.

For example, “number and types of materials distributed” might list the various types of materials, such as safer-sex kits, needle hygiene kits, referral cards, personal hygiene kits, etc. As another example, “number of referrals made, by type and session” might be broken down into specific types of referrals, such as HIV testing, viral hepatitis testing, hepatitis A/B vaccination, food and shelter, HIV case management services, etc.

The last column of the sample plan describes how the information that is collected by the various methods will be used in managing and improving the *SAFETY COUNTS* program. In some instances, it is important that you be very explicit in describing how information will be used, especially if the suggested use is not an obvious one. In other instances, a more general description will communicate adequately.

As a concrete example of how process data can pinpoint problem areas in an intervention, which in turn can lead to development of appropriate solutions, let us consider the following hypothetical situation. Suppose that you have noticed a recent drop-off in the number of clients who are completing the intervention. The source of the problem is not clear, because new clients are still going through the group sessions and the individual counseling session at more or less the same pace as always. Outreach staff are as busy as ever with follow-up contacts, and attendance has not dropped off at the monthly social events. However, when you look carefully at the process data you have collected, it becomes clear that the problem lies with the social events.

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/ viral hepatitis.
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.

Although general attendance at the social events continues to be good, relatively few of your new clients are coming to them. This leads to a brainstorming session with intervention staff, during which it is concluded that a recent change in procedure regarding how clients are invited to social events might be the source of the difficulty. Two months ago, in order to save staff time, the old procedure that was followed for new clients of delivering personal printed invitations to the first social event was discontinued in favor of a phone reminder. At the suggestion of intervention staff, clients who are “old hands” are interviewed, and they confirm that the printed invitations made a real difference in motivating them to attend the social events initially. You decide to reinstitute the old procedure, and attendance of new clients improves. This is just one example of how you can directly link evaluation activities to intervention improvements.

Process Monitoring and Evaluation Tools

As the sample evaluation plan suggests, there are a number of forms and instruments that can serve as a source of information for your process monitoring and evaluation of *SAFETY COUNTS*. One of these, the program monitoring summary, is specifically designed for this purpose. Other forms and instruments include the program enrollment form, the client participation record, and the risk reduction interview. The latter, while primarily an outcome monitoring tool, can also provide baseline information regarding clients’ specific risk behaviors—information that can be used to ensure that the relative emphasis placed on sex versus drug risks in your *SAFETY COUNTS* intervention is consistent with the general risk profile of your clients. Reference copies of these tools appear in Part III at the end of the sessions in which they are used. In addition, copies of the program monitoring summary and the risk reduction interview appear at the end of this section.

Program Monitoring Summary

The program monitoring summary provides a convenient means of summarizing much of the process data that you will need for monitoring and evaluating your *SAFETY COUNTS* intervention. Raw data for the summary is taken from client participation records and your organization’s log of risk reduction and other materials distributed through *SAFETY COUNTS*. Managers may find the program monitoring summary useful in compiling some of the statistics for reporting to funding agencies.

Within the framework of CDC's evaluation guidance, *SAFETY COUNTS* group sessions and social events can be considered as group-level interventions (GLIs) and the individual counseling sessions and follow-up contacts can be considered as individual-level interventions (ILIs). The program monitoring summary cannot be used for reporting client-level data. You must use the client participation record for this purpose. Please refer to Volume 1, Chapter 4 of the evaluation guidance for a complete description of CDC's data reporting requirements for process monitoring (www.cdc.gov/hiv/aboutdhap/perb/hdg.htm).

The program monitoring summary suggests the kinds of activities that an agency might collect data on for process monitoring and evaluation and for reporting about the intervention to the funding agency. You may want to add more information to the summary, such as the demographic data about participants that is collected on the program enrollment form. Feel free to use

this summary as a starting point to create a form that best meets the particular needs of your agency.

OUTCOME MONITORING

Outcome monitoring for *SAFETY COUNTS* determines what changes have occurred in HIV/viral hepatitis risk behaviors among the clients with whom you have been working. Specifically, have there been changes in sexual risk behaviors and/or drug-related risk behaviors? Were these changes in a positive direction, that is, did they reduce clients' risk of HIV/viral hepatitis transmission? How large were the changes? Have clients progressed on the stages-of-change scale for the behaviors reflecting their personal goals?

These questions can be answered by administering the Risk Reduction Interview, which was designed to use with *SAFETY COUNTS*, at the time clients enter *SAFETY COUNTS* and again after they have completed the program. Comparison of before and after responses for each client provides information about immediate outcomes of *SAFETY COUNTS*.

Risk Reduction Interview

Description and Administration. The risk reduction interview is a means for rapidly assessing the current status of intervention participants' adoption of behavioral strategies to reduce the risk of acquiring or transmitting HIV and viral hepatitis. Seven sexual risk reduction behaviors, six drug-related risk reduction behaviors, and two counseling and testing behaviors are included in the interview. These behaviors are consistent with the individualized risk reduction goals set by participants during group session two and the individual counseling session. The risk reduction interview usually takes around 15 minutes to complete.

This instrument should be administered to each participant at the time of enrollment in *SAFETY COUNTS*, before the first group session. It is recommended that it be administered a second time four months following enrollment, after participants have completed all program sessions and activities. Participants who have not completed the expected number of sessions and activities by the end of four months —i.e., the two group sessions and one individual counseling session, plus a minimum of two social events and two follow-up contacts—should also be administered the risk reduction interview. This risk reduction interview should *not* be administered during the delivery of *SAFETY COUNTS* intervention activities, including social events and follow-up contacts. It should be administered by itself, preferably on a different day from any intervention activities.

The risk reduction interview is used to measure the progress made by individuals in achieving the personal risk reduction goals they have identified for themselves, as well as risk reduction progress they may have made in non-goal areas. Current risk reduction status in each of the 15 areas assessed is expressed numerically on a scale from 0 to 18. Lower numbers indicate earlier stages of behavioral adoption and higher numbers reflect later stages. The later stages, especially action and maintenance, reflect greater success in adopting a specific risk reduction behavior.

This structured interview must be conducted on an individual basis with each client. The risk reduction interview cannot be used in a group setting, and it is unsuitable for self-administration by clients. The one-on-one interview format enables the interviewer to assess the internal consistency of the client's responses and provide corrective guidance as needed. Instructions for conducting the risk reduction interview are provided on the interview form (reproduced at the end of this section). Additional details are given in the program enrollment session guide (Part III of this manual).

This risk reduction interview is the primary outcome monitoring instrument provided for *SAFETY COUNTS*. It can be used to demonstrate the success of the program to your funders. Depending on your agency's needs and the requirements from your funding source, you may choose to use this instrument as a pre- and post-test evaluation to monitor the progress of clients. As explained above, the risk reduction interview is administered at the time of enrollment, before any intervention activities, as a pre-test. Then, at the end of four months, after the client has participated in group sessions one and two, at least one individual counseling session, two social events, and two follow-up contacts, the instrument may be administered a second time as a post-test. The two completed interviews can be scored (see table below) and compared to assess whether the client has moved from one stage to a higher stage during the individual's time in *SAFETY COUNTS*. While persons who participate in *SAFETY COUNTS* tend to show positive changes in more than one area of risk, the greatest changes usually occur in the area of their personal risk reduction goal.

Scoring. Each of the 15 risk reduction behaviors is scored separately. To do this, find the total number of points earned in each block (behavior) by adding together the numerical scores for the statements in that block. Ignore any statements that do not have check marks. Count 2 points for each statement checked "Yes," 1 point for each "Somewhat," and 0 points for each "No." There is a maximum possible score of 18 points for each risk reduction behavior.

Scores may be interpreted in relation to the five stages of change as shown in the following table. The score ranges are suggestive rather than exact, but they do provide a general indication of the position of individuals on the widely used stages-of-change continuum.

Score	Stage Description	Stage Name
0	Not Considering It	Pre-contemplation
1-8	Planning to Do It	Contemplation
9-14	Taking Steps	Preparation
15-17	Doing It	Action
18	Staying with It	Maintenance

NOTE: The maintenance stage as measured by this instrument is most accurately described as a "maintenance intention" stage. This is because, strictly speaking, to be in maintenance a person must have actually been performing the risk reduction behavior for at least six months, not just have the intention to do so.

Sample Responses and Scoring Example for One Behavior

(X's Indicate Client's Responses Obtained during the Risk Reduction Interview)

8. Not sharing needles (Skip if no injection drug use last 90 days: Q4=No)	Score _____	Yes (2)	Somewhat (1)	No (0)
I believe doing this can keep me from getting or giving HIV or hepatitis.		X		
Doing this has more positives than negatives in my mind.		X		
I believe that I am ready to do this.		X		
I am confident in my ability to do this.		X		
I have planned how to go about doing this.			X	
I have tried doing this in the last 30 days.		X		
I have been able to do this in the last 30 days.		X		
I have had 100% success doing this in the last 30 days.			X	
I feel certain I will be able to continue doing this for the next six months.				X

Calculation of score for this risk reduction behavior:

6 "Yes" responses	@ 2 points each	= 12 points
2 "Somewhat" responses	@ 1 point each	= 2 points
1 "No" response	@ 0 points each	= <u>0</u> points
Total Score		14 points

Response consistency check:

The client's responses show a satisfactory degree of consistency in that there are no reversals in the pattern of yes-no responses going from Statement 1 ("I believe doing this can keep me from getting HIV...") to Statement 9 ("I feel certain I will be able to continue doing this..."). In other words, there are no instances where a "No" response on an earlier statement is followed by a "Yes" response on a later statement. The "Somewhat" response, instead of a "Yes," that is checked for Statement 5 ("I have planned how to go about doing this") is considered a minor deviation from the ideal pattern.

Stage of change:

Using the scoring table at the end of the Risk Reduction Interview, a score of 14 points places the client at the high end of Stage 3, "Taking Steps" (Preparation).

FORMS

PROGRAM MONITORING AND EVALUATION

Program Monitoring Summary

Risk Reduction Interview

SAFETY COUNTS PROGRAM MONITORING SUMMARY

Period: _____ to _____

GLI = Group Level Intervention
 ILI = Individual Level Intervention

Number of Clients Enrolled:

Total clients enrolled during period _____
 Number having sex-related personal goals _____
 Number having drug-related personal goals _____

Number of Clients Completing Program¹ _____

Number of Clients Attending Intervention Sessions:¹

Group Session One (GLI) _____
 Group Session Two (GLI) _____
 Individual Counseling Session (ILI) _____
 One or more Social Events (GLI)..... _____
 Two or more Social Events (GLI) _____
 One or more Follow-up Contacts (ILI) _____
 Two or more Follow-up Contacts (ILI) _____
 Group Sessions One and Two (GLI) _____
 Group Sessions One & Two (GLI) and Individual Counseling Session (ILI) _____
 All required sessions²..... _____

Number of Intervention Sessions Conducted:

Group Session 1 (GLI)..... _____
 Group Session 2 (GLI)..... _____
 Individual Counseling Session (ILI)..... _____
 Social Events (GLI)..... _____
 Average attendance _____
 Follow-up Contacts (ILI)..... _____

Number of Referrals Provided/Used:¹

Referrals for HIV testing provided..... _____
 Referrals for HIV testing used _____
 Referrals for hepatitis testing/immunization provided _____
 Referrals for hepatitis testing/immunization used _____

Quantity of Materials Distributed:

Safer sex kits _____
 Needle hygiene kits _____
 Brochures _____
 Incentives (_____) _____
 Other (_____) _____

¹Includes all current clients—whether enrolled during this period or enrolled earlier.
²Group Sessions One & Two, Individual Counseling Session, 2+ Social Events, and 2+ Follow-up Contacts.

Client Name or ID _____

Date _____

Risk Reduction Interview

Instructions to Interviewer: This instrument is intended to be administered individually to each client using an interview format. Read each question or statement to the client exactly as it is written. **Do not change the wording of the items.** Text that should be read aloud to the client is shown in bold. Record the client's responses by checking the appropriate box following each question or statement. Some of the 15 risk reduction behaviors may be skipped, as determined by the client's responses to the four general risk questions that are administered first.

For each one of the risk reduction behaviors listed, read the behavior aloud to the client (e.g., "using condoms for vaginal sex," then read each of the nine statements below it and mark "Yes," "Somewhat," or "No" for each statement according to the client's response. **Do not let the client fill out the form him or herself.** Be sure that the client responds to all of the statements in each block that is administered. As each block of statements is administered, check for obvious inconsistencies in responding (e.g., saying "No" to "I have tried doing this in the last 90 days," and "Yes" to "I have had 100% success doing this in the last 30 days"), and bring these to the attention of the client. Resolve response inconsistencies as they are encountered.

Interviewer Read Aloud: This is a brief questionnaire to find out where you stand in reducing your personal risks of getting or giving HIV and viral hepatitis. It will take about 15 minutes to complete. I am going to describe some different ways of reducing HIV and hepatitis risk, and then for each way I am going to read aloud a list statements that go along with it. I want you to tell me how much you agree or disagree with each statement by saying "Yes," "Somewhat," or "No" as I read it to you. I'll help you with the first few—you'll see it's really easy once we get going. Before we get started, I need to ask you a few quick questions to get a general idea of your risk situation:

- 1. Have you had vaginal sex in the last 90 days? Yes No
- 2. Have you had anal sex in the last 90 days? Yes No
- 3. Have you had sex of any kind with another person in the last 90 days? Yes No
- 4. Have you used injection drugs in the last 90 days? Yes No

Good, here is the first way of reducing HIV or hepatitis risk. *(Read the risk reduction behavior aloud.)*

Now, tell me how much you agree or disagree with the following statement: *(Read the first opinion statement aloud.)* Say "Yes" if you agree with the statement and believe it is true for you, "No" if you disagree with the statement and believe it is not true for you, and "Somewhat" if your opinion is somewhere in between. So, for the statement I have just read, would you say "Yes," "No," or "Somewhat" so far as *[risk reduction behavior]* is concerned for you?

Now, here is the next statement. Tell me "Yes," "No," or "Somewhat," depending on how you believe it applies to you. *(Read the second opinion statement aloud. Follow the same procedure for the remaining seven statements.)*

Here is another risk reduction behavior. *(Read the second risk reduction behavior aloud.)* After I read it, I'm going to read the same statements again and ask you to tell me "Yes," "No," or "Somewhat" for each one. *(Follow the same procedure for the remaining risk reduction behaviors.)*

1. Using condoms for vaginal sex <i>(Skip if no vaginal sex last 90 days: Q1=No)</i>	Score ____	Yes (2)	Somewhat (1)	No (0)
I believe doing this can keep me from getting or giving HIV or hepatitis.				
Doing this has more positives than negatives in my mind.				
I believe that I am ready to do this.				
I am confident in my ability to do this.				
I have planned how to go about doing this.				
I have tried doing this in the last 30 days.				
I have been able to do this in the last 30 days.				
I have had 100% success doing this in the last 30 days.				
I feel certain I will be able to continue doing this for the next six months.				

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2. Using condoms for anal sex <i>(Skip if no anal sex last 90 days: Q2=No)</i> Score ____	Yes (2)	Somewhat (1)	No (0)
I believe doing this can keep me from getting or giving HIV or hepatitis.			
Doing this has more positives than negatives in my mind.			
I believe that I am ready to do this.			
I am confident in my ability to do this.			
I have planned how to go about doing this.			
I have tried doing this in the last 30 days.			
I have been able to do this in the last 30 days.			
I have had 100% success doing this in the last 30 days.			
I feel certain I will be able to continue doing this for the next six months.			

3. Not having vaginal or anal sex <i>(Skip if no vaginal or anal sex last 90 days: Q1 & Q2=No)</i> Score ____	Yes (2)	Somewhat (1)	No (0)
I believe doing this can keep me from getting or giving HIV or hepatitis.			
Doing this has more positives than negatives in my mind.			
I believe that I am ready to do this.			
I am confident in my ability to do this.			
I have planned how to go about doing this.			
I have tried doing this in the last 30 days.			
I have been able to do this in the last 30 days.			
I have had 100% success doing this in the last 30 days.			
I feel certain I will be able to continue doing this for the next six months.			

4. Having fewer sex partners <i>(Skip if no sex partners last 90 days: Q3=No)</i> Score ____	Yes (2)	Somewhat (1)	No (0)
I believe doing this can keep me from getting or giving HIV or hepatitis.			
Doing this has more positives than negatives in my mind.			
I believe that I am ready to do this.			
I am confident in my ability to do this.			
I have planned how to go about doing this.			
I have tried doing this in the last 30 days.			
I have been able to do this in the last 30 days.			
I have had 100% success doing this in the last 30 days.			
I feel certain I will be able to continue doing this for the next six months.			

5. Having fewer sex partners I don't use a condom with <i>(Skip if no sex partners last 90 days: Q3=No)</i> Score ____	Yes (2)	Somewhat (1)	No (0)
I believe doing this can keep me from getting or giving HIV or hepatitis.			
Doing this has more positives than negatives in my mind.			
I believe that I am ready to do this.			
I am confident in my ability to do this.			
I have planned how to go about doing this.			
I have tried doing this in the last 30 days.			
I have been able to do this in the last 30 days.			
I have had 100% success doing this in the last 30 days.			
I feel certain I will be able to continue doing this for the next six months.			

SAFETY COUNTS

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6. Having sex with only one partner <i>(Skip if no sex partners last 90 days: Q3=No)</i> Score ____	Yes (2)	Somewhat (1)	No (0)
I believe doing this can keep me from getting or giving HIV or hepatitis.			
Doing this has more positives than negatives in my mind.			
I believe that I am ready to do this.			
I am confident in my ability to do this.			
I have planned how to go about doing this.			
I have tried doing this in the last 30 days.			
I have been able to do this in the last 30 days.			
I have had 100% success doing this in the last 30 days.			
I feel certain I will be able to continue doing this for the next six months.			

7. Having protected sex when drunk or high <i>(Skip if no sex partners last 90 days: Q3=No)</i> Score ____	Yes (2)	Somewhat (1)	No (0)
I believe doing this can keep me from getting or giving HIV or hepatitis.			
Doing this has more positives than negatives in my mind.			
I believe that I am ready to do this.			
I am confident in my ability to do this.			
I have planned how to go about doing this.			
I have tried doing this in the last 30 days.			
I have been able to do this in the last 30 days.			
I have had 100% success doing this in the last 30 days.			
I feel certain I will be able to continue doing this for the next six months.			

8. Not sharing needles <i>(Skip if no injection drug use last 90 days: Q4=No)</i> Score ____	Yes (2)	Somewhat (1)	No (0)
I believe doing this can keep me from getting or giving HIV or hepatitis.			
Doing this has more positives than negatives in my mind.			
I believe that I am ready to do this.			
I am confident in my ability to do this.			
I have planned how to go about doing this.			
I have tried doing this in the last 30 days.			
I have been able to do this in the last 30 days.			
I have had 100% success doing this in the last 30 days.			
I feel certain I will be able to continue doing this for the next six months.			

9. Not sharing injection equipment (water, cotton, cookers) <i>(Skip if no injection drug use last 90 days: Q4=No)</i> Score ____	Yes (2)	Somewhat (1)	No (0)
I believe doing this can keep me from getting or giving HIV or hepatitis.			
Doing this has more positives than negatives in my mind.			
I believe that I am ready to do this.			
I am confident in my ability to do this.			
I have planned how to go about doing this.			
I have tried doing this in the last 30 days.			
I have been able to do this in the last 30 days.			
I have had 100% success doing this in the last 30 days.			
I feel certain I will be able to continue doing this for the next six months.			

10. Using a new needle for every drug injection <i>(Skip if no injection drug use last 90 days: Q4=No)</i> Score ____	Yes (2)	Somewhat (1)	No (0)
I believe doing this can keep me from getting or giving HIV or hepatitis.			
Doing this has more positives than negatives in my mind.			
I believe that I am ready to do this.			
I am confident in my ability to do this.			
I have planned how to go about doing this.			
I have tried doing this in the last 30 days.			
I have been able to do this in the last 30 days.			
I have had 100% success doing this in the last 30 days.			
I feel certain I will be able to continue doing this for the next six months.			

11. Bleaching my needle before every use if a new needle is not available <i>(Skip if no injection drug use last 90 days: Q4=No)</i> Score ____	Yes (2)	Somewhat (1)	No (0)
I believe doing this can keep me from getting or giving HIV or hepatitis.			
Doing this has more positives than negatives in my mind.			
I believe that I am ready to do this.			
I am confident in my ability to do this.			
I have planned how to go about doing this.			
I have tried doing this in the last 30 days.			
I have been able to do this in the last 30 days.			
I have had 100% success doing this in the last 30 days.			
I feel certain I will be able to continue doing this for the next six months.			

12. Decreasing or managing my drug use <i>(Ask of everyone)</i> Score ____	Yes (2)	Somewhat (1)	No (0)
I believe doing this can keep me from getting or giving HIV or hepatitis.			
Doing this has more positives than negatives in my mind.			
I believe that I am ready to do this.			
I am confident in my ability to do this.			
I have planned how to go about doing this.			
I have tried doing this in the last 30 days.			
I have been able to do this in the last 30 days.			
I have had 100% success doing this in the last 30 days.			
I feel certain I will be able to continue doing this for the next six months.			

13. Getting into drug treatment <i>(Ask of everyone)</i> Score ____	Yes (2)	Somewhat (1)	No (0)
I believe doing this can keep me from getting or giving HIV or hepatitis.			
Doing this has more positives than negatives in my mind.			
I believe that I am ready to do this.			
I am confident in my ability to do this.			
I have planned how to go about doing this.			
I have tried doing this in the last 30 days.			
I have been able to do this in the last 30 days.			
I have had 100% success doing this in the last 30 days.			
I feel certain I will be able to continue doing this for the next six months.			

SAFETY COUNTS

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14. Using HIV counseling and testing services every 3 months (Ask of everyone) Score ____	Yes (2)	Somewhat (1)	No (0)
I believe doing this can keep me from getting or giving HIV or hepatitis.			
Doing this has more positives than negatives in my mind.			
I believe that I am ready to do this.			
I am confident in my ability to do this.			
I have planned how to go about doing this.			
I have tried doing this in the last 30 days.			
I have been able to do this in the last 30 days.			
I have had 100% success doing this in the last 30 days.			
I feel certain I will be able to continue doing this for the next six months.			

15. Using hepatitis counseling and testing services every 3 months (Ask of everyone) Score ____	Yes (2)	Somewhat (1)	No (0)
I believe doing this can keep me from getting or giving HIV or hepatitis.			
Doing this has more positives than negatives in my mind.			
I believe that I am ready to do this.			
I am confident in my ability to do this.			
I have planned how to go about doing this.			
I have tried doing this in the last 30 days.			
I have been able to do this in the last 30 days.			
I have had 100% success doing this in the last 30 days.			
I feel certain I will be able to continue doing this for the next six months.			

Scoring Instructions: For each risk reduction behavior, compute the total number of points for the nine responses to the statements in that block. Count 2 points for each statement checked “Yes,” 1 point for each statement checked “Somewhat,” and 0 points for each statement checked “No.” Write the score obtained in the blank provided. Each risk reduction behavior should be scored separately. There is a maximum possible score of 18 points for each behavior. (Part IV of the Program Manual provides a scoring example.)

Behavior scores may be interpreted in terms of the five stages of change, as shown below. These ranges are suggestive rather than exact, but they do provide a general indication of the position of an individual on the widely used stages-of-change continuum.

Score	Stage Description	Stage Name
0	Not Considering It	Pre-contemplation
1-8	Planning to Do It	Contemplation
9-14	Taking Steps	Preparation
15-17	Doing It	Action
18	Staying with It	Maintenance

Note: The maintenance stage as measured by this instrument is most accurately described as a “maintenance intention” stage. This is because, strictly speaking, to be in maintenance a person must have actually performed a particular risk reduction behavior for a period of at least six months, as opposed to merely expressing the intention to do so.

APPENDICES

- A. Reprint: “Staying Negative in a Positive World—
Strategies that Work”**
- B. Sample Memorandum of Agreement**
- C. Field Safety Guidelines**
- D. CDC Content and Review Guidelines for HIV
Programs**
- E. Guidelines for Adapting Safety Counts**
- F. Internet Resources**
- G. How to Create Risk Reduction Success Stories**
- H. Sample Risk Reduction Success Stories**
- I. The ABCs of Smart Behavior**
- J. Male Latex Condoms and Sexually Transmitted
Diseases**
- K. Nonoxynol-9 Spermicide Contraception Use**
- L. Social Event Risk Reduction Activity— Sharing Social
Support Stories**

APPENDIX A

Reprint: “Staying Negative in a Positive World: Strategies that Work”

Staying Negative in a Positive World: HIV Prevention Strategies That Work

Proceedings from:

**Staying Negative in a Positive World:
HIV Prevention Strategies That Work
Symposium for HIV Prevention Professionals
Los Angeles, CA
April 8-9, 1998**

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*California Department
of Health Services*



Office of AIDS

SYMPOSIUM PRESENTATIONS

A Cognitive-Behavioral Intervention to Reduce HIV Risks Among Active Drug Users: Efficacy Study

Fen Rhodes, Ph.D.

Michelle Wood, M.S.

One of the organizations focused on HIV prevention risk reduction services to high-risk individuals is the Center for Behavioral Research and Services at California State University, Long Beach (CSULB). Dr. Fen Rhodes, director of the Center and a professor of psychology, has developed a prevention program for the Offices of AIDS. He has a long history of involvement in HIV risk reduction programs, particularly to injection drug users, and has been a principle investigator on major studies such as *Project Respect* in Long Beach. *Project Respect* demonstrated the effectiveness of HIV counseling and the increased effectiveness of enhanced HIV counseling. Dr. Fen Rhodes and his colleague Michelle Wood presented their prevention program developed at the CSULB for crack cocaine and injection drug users. Their prevention strategy is called a *cognitive behavioral intervention* to reduce HIV risk among active drug users; these are drug users out of treatment. Dr. Rhodes presented an overview of the study and basic results of the study including the statistical findings. Michelle Wood discussed implementation of the intervention and discussed implementation issues. Michelle Wood is a research associate at the CSULB, was the program coordinator for the outreach program, and has been involved in HIV prevention research for about 10 years.

Study Overview

The objectives of their cognitive behavioral intervention study were two fold. The first objective was to design an intensive enhanced theory-based HIV risk reduction intervention for active intravenous drug users (IDUs) and crack users who are not in treatment. The subjects were accessed largely through street outreach. In addition, the program also intended to evaluate and compare this enhanced intervention with what has come to be called the National Institute on Drug Abuse (NIDA) standard HIV counseling and testing intervention for drug users.

The study was one of the twenty-three cooperative agreement studies under the NIDA Cooperative Agreement for AIDS Community-Based Outreach/Intervention Research Program. The study ran from 1992 to 1996 -- some of the cooperative agreement studies are still running currently. The cooperative agreement studies were an outgrowth of the National AIDS Demonstration Research Project (NADR) that went from 1987 to 1991. All twenty-three cooperative agreement sites employed the same NIDA standard HIV counseling and testing intervention specially developed and oriented toward drug users. All the sites employed the same baseline and follow-up questionnaires. However, each particular site was responsible for developing its own enhanced HIV intervention, which will be compared to the HIV counseling and testing intervention of NIDA.

The study compared the NIDA standard HIV counseling and testing (C&T) with the NIDA standard HIV C&T plus an enhanced HIV behavioral intervention. All participants attended two NIDA standard sessions of risk reduction counseling with optional testing (95% participating in

HIV testing). Individuals in the study had to self-report injection or crack cocaine use in the past 30 days. In addition, participants had to display some evidence of recent drug use either from track marks and/or urine tests for opiates/cocaine.

The recruitment and assignment of subjects was a quasi-experimental design. The study was a crossover design with two geographic areas in Long Beach, which were closely matched in terms of HIV risk distribution. At any point in time everybody in one geographic area was being recruited into the enhanced study condition, and everybody in the other geographic area was being recruited into the NIDA standard condition. Half way through the study the conditions were switched and subjects participated in the other condition. There were two pairs of three “hang-out” zip codes for each geographic location hang-out zip code. The “hang-out” zip code, not the zip code of residence, was the basis for the recruitment. Usually the resident zip code was the same as their “hang-out” zip, but not always. A quota sampling ensured a sufficient representation of race/ethnicity for analysis.

A standard baseline risk assessment inventory was given to subjects and a matching follow-up was given from five to nine months after study enrollment. The actual intervention took approximately four months. The intervention was an extended series of contacts with individuals. During the follow-up there was a minimum of one month between the most recent intervention contact and the follow-up interview to minimize response bias. There were urine tests for opiates and cocaine, both at baseline and at follow-up.

There were two kinds of incentives for participants: monetary and non-monetary. Incentives are very, very important for this type of population in facilitating participation activities. Non-monetary incentives included food coupons, bus tokens, and personal hygiene kits that were provided at intervention sessions. Other non-monetary incentives included drug user socials with meals, snacks at the intervention workshops, and drawings with prizes. Monetary incentives were primarily associated with data collection. Ten dollars was given for the baseline interview, \$10.00 for a supplementary interview that occurred at the post-test counseling (second session of the standard), and \$20.00 for a follow-up interview.

The intervention elements consisted of two sessions of NIDA standard HIV counseling and testing, incorporating drug-focused prevention education. In addition, there were two enhanced cognitive-behavioral group interventions employing a stages-of-change framework. The enhanced interventions were added to the NIDA standard intervention and consisted of a minimum of seven additional activities. The additional activities were planned activities with three office based and four field based. Initially the counselor identified the client’s risk and identified the personal stages-of-change for adopting specific HIV risk- reduction behaviors (see Table 1-1).

Table 1-1
Intervention Elements

- A standard HIV counseling and testing incorporating drug-focused prevention education (2 sessions).
- Cognitive-behavioral group workshops employing stages-of-change framework (2 sessions).
- Individual counseling to refine client's personal risk-reduction plan, strengthen commitment to personal goal, and ensure availability of social support for risk reduction (1 session).
- Planned supportive contacts by outreach workers to encourage achievement of clients' personal risk-reduction goals (2 minimum).
- Monthly social events for clients, support buddies, and staff, with lunch and planned risk-reduction activities (2 minimum).

During these two group sessions, videos were shown of role models who depicted people who had successfully achieved some of the risk-reduced goals and sample risk-reduction goals that were particularly relevant for the population. Then through discussion and some workshop activities, the researchers focused individuals on their own HIV risk and encouraged them to elect or choose a particular or specific behavior to work on during the period of intervention. It is fairly critical to the intervention that the individual commits to a particular behavior essentially of his or her own choosing. This turned out to have a substantial impact on the size of the intervention effect. Intervention effect was larger and there was more change for behaviors that were consistent with the goals people had selected, and there was less change for those same people in risk-reduction areas that were not of their own choosing. The intervention was not the researcher's perception of individuals' needs, but the perception of the client's needs, interests, and areas that were practical for them to work on.

During the next stage of the intervention the researchers tried to begin to define some initial steps to work on toward goal attainment. This is backed up with a third office-based individual counseling session. During the session, the client's personal risk-reduction goal was refined to make it more achievable with a greater possibility of success. This was one single session. The rest of the sessions were all out of the office.

There were some planned supported contacts with a minimum of two during the four-month period and in some cases up to four or five contacts. After completion of the three office-based sessions, an outreach worker trained in this kind of process went out on a field visit to contact the client and worked with the client towards achievement of his or her particular goal. In addition, monthly socials at recreation centers provided an indirect focus on the partners of drug users. There was the direct focus of the intervention on the drug users and then there was an indirect focus on the partners of users through socials, risk-reduction buddies, and/or support persons.

Essentially the participant characteristics were pretty much matched in the standard and enhanced interventions (see Table 1-2). Forty-five percent of participants considered themselves to be homeless. That does not mean that they were all sleeping on the street. This was in answer to the question: "Do you consider yourself to be homeless?" About 7-1/2 % of the participants were in jail at some time during the past month. In the analyses of the study,

participants who at baseline or at follow-up had been in jail for more than five days during the month were set aside. This was done because those participants would distort the report of the risk reduction behaviors to too great a degree.

Table 1- 2			
Participant Characteristics (n = 1,237)			
	Standard	Enhanced	p
Gender (%):			
<i>Male</i>	69.3	66.4	.301
<i>Female</i>	30.7	33.6	
Race/ethnicity (%):			
<i>African-American</i>	43.0	44.1	.145
<i>White</i>	29.9	30.7	
<i>Latino</i>	22.3	18.3	
<i>Other</i>	4.7	6.9	
Age (mean)	37.8	37.9	.862
Employment status (%):			
<i>Unemployed</i>	89.5	86.3	.217
<i>Employed (part-time)</i>	8.9	11.8	
<i>Employed (full-time)</i>	1.6	1.9	
Homelessness (%)	45.9	42.1	.207
In jail past month (%)	7.0	8.1	.518
Drug use (%):			
Injection only	29.3	28.1	.898
Crack only	34.1	34.9	
Both	36.6	37.0	
HIV status (% positive)	3.5	4.8	.312

Injection drug use was almost universally through the use of speedball (heroin and cocaine). The group was largely a heterosexual group. About 4% of participants were HIV positive. The intervention was appropriate for both HIV positive and negative individuals. This gives you a feel of where people were and what the participants' status was at the time of the start of the intervention. The standard and enhanced interventions are in separate columns, so you could see they were pretty much matched. Needle hygiene is the percentage of time dirty needles were used. Dirty needles represents a combination of sharing needles, if you use a non-new needle, and cleaning. So you would be at zero if you shared needles but cleaned needles 100%

of time and zero if you do not share at all and then cleaning is irrelevant. So dirty needles reflect the composite of these two behaviors. Almost nobody used condoms with about 67% and 64% of people reporting no condom use for sexual activity including anal, oral, and vaginal sex during the past 30 days (see Table 1-3).

Table 1-3			
Baseline HIV Risks (Past 30 Days)			
	Standard	Enhanced	<i>p</i>
Drug use (%):			
<i>Days injected (IDUs)</i>	23.0	22.9	.781
<i>Times injected (IDUs)</i>	48.7	48.5	.927
<i>Days used crack (CUs)</i>	17.4	18.4	.200
Needle hygiene IDUs (%):			.
<i>Times used dirty needle</i>	11.7	10.8	.761
<i>IDUs used dirty needle</i>	27.6	26.6	.811
<i>Times dirty (subset)</i>	42.3	40.5	.761
Sexual activity: ¹ (%)			
<i>Encounters unprotected</i>	77.7	78.3	.693
<i>Persons no condom use</i>	67.0	64.2	.394
¹ Excludes those individuals (28%) reporting no sex in past 30 days.			

There were 1237 out-of-treatment IDU and crack user participants who were assigned to the standard and enhanced conditions. There was substantial participation in the enhanced intervention with a little more than half of participants who completed all three office based sessions and at least two of the other four sessions (see Table 1-4). Eighty percent of participants completed the follow-up interview five to nine months after the study enrollment with 82% in the standard intervention and 79% in the enhanced intervention. Thirty-three percent of unfollowed participants could not be accessed because of incarceration.

Table 1-4**Enhanced Intervention Participation**

- **All enhanced participants completed two sessions of NIDA standard counseling and testing.**
- **88% completed at least on additional session:**
 - ◆ **68%, all 3 formal enhanced sessions.**
 - ◆ **60%, one or more planned outreach contacts.**
 - ◆ **61%, one or more social events.**
 - ◆ **58%, at least 5 enhanced sessions (3 formal sessions plus at least 2 outreach contacts and/or socials).**
 - ◆ **37%, all 7 enhanced sessions (beyond NIDA standard counseling and testing).**

Dr. Rhodes presented a logistic regression so all of the variables could be seen that are taken into account. The point of showing this is to take a look at the bold p -values, those are the things that are significant here. And every one of the behavioral variables was analyzed in this way, taking into account gender, age, race/ethnicity, and in some cases the type of drugs used. Baseline condom use, whether you used condoms at all or not in the prior 30 days when you enrolled in the study, mattered a whole lot in whether you used more condoms later. It stands to reason, but you have to have the data to show it, to be able to assert it. The odds ratio 2.78 means that people were about two and three-quarters times more likely to increase their condom use if they were in the enhanced condition than if they got the standard intervention alone. All of the comparisons are enhanced, plus the standard alone. What this analysis says for race/ethnicity is that the effectiveness of the intervention effect on this variable of condom use was no different across race/ethnicity or age or gender. (see Table 1-5).

Table 1-5		
Logistic Regression ¹		
Baseline/Follow-up Change: % Time Used Condoms Standard vs. Enhanced Intervention (n=242)		
Variable	Odds Ratio	<i>p</i>
Intervention condition (enhanced)	2.78	.011
Baseline condom use (>0)	5.61	.000
Type of drug use:		
<i>Injection</i>	.85	.725
<i>Crack</i>	1.67	.151
Gender (female)	1.13	.694
Age (older)	.91	.757
Race/ethnicity		
<i>African-American</i>	.61	.45
<i>White</i>	.42	.23
<i>Latino</i>	.30	.13
¹ Based on self-report, prior 30-days. Interviews rated as invalid by interviewers were excluded from analysis. Participants incarcerated for more than 5 days in the month prior to interview were also excluded. Enhanced intervention participants reflect those completing 3 formal sessions in addition to the NIDA standard intervention plus 2 or more outreach encounters and/or socials. Analysis of condom use is based on individuals reporting less than 100% condom use at baseline and whose behavioral goal focused on decreasing sexual risk.		

The next table (Table 1-6) shows a summary of the rest of the variables with all of the extraneous variables eliminated and only the main measures shown. Look at the *p*-values that are in bold -- these are significant findings. Enhanced intervention participants were significantly more likely to (1) reduce the number of times they injected, (2) reduce the number of days they injected, (3) stop injecting altogether, (4) have a negative urine test (for either opiates or cocaine) at follow-up, (5) stop using crack, and (6) have entered or tried to enter drug treatment for injection-injecting drug use or crack use within the six months prior to follow-up. No significant differences were found for the likelihood of reducing or stopping the use of dirty needles, for reducing the number of days crack was used, or for entering or trying to enter drug treatment for injection drug use or crack use in the 30 days prior to follow-up.

The drug treatment variable was combined whether people actually got into treatment, with a composite of whether they entered and/or tried to get into treatment. This is a more powerful variable combined together than separate. Over the last six months (since the baseline interview), people in enhanced intervention were more likely to report having entered or tried to enter drug treatment than people who were in the standard condition. So, there were a number of real effects as a consequence.

Table 1-6 Logistic Regressions ¹ Baseline/Follow-up Change: Drug Use Variables Standard vs. Enhanced Intervention		
Variable	Odds Ratio	p
Injection drug use:		
<i>Reduced times injected</i>	2.87	.000
<i>Reduced days injected</i>	2.49	.001
<i>Stopped injecting</i>	3.20	.000
<i>Negative urine test (opiates)</i>	2.16	.034
<i>Reduced use of dirty needles</i>	1.63	.679
<i>Stopped use of dirty needles</i>	3.78	.112
Crack use:		
<i>Reduced days used</i>	1.51	.110
<i>Stopped using</i>	2.10	.003
<i>Negative urine test (cocaine)</i>	1.77	.030
Drug treatment:		
<i>Entered/trying past 6 mos. (IDUs)</i>	2.01	.005
<i>Entered/trying past 6 mos. (CUs)</i>	1.82	.009
<i>Entered/trying past 30 days (IDUs)</i>	1.44	.242
<i>Entered/trying past 30 days (CUs)</i>	1.30	.470
¹ Analyses controlled for gender, age, race/ethnicity, and baseline frequency of drug use. Enhanced intervention participants selected for 5 sessions beyond NIDA standard and drug-related risk-reduction goal.		

The next table (see Table 1-7) is the one that is the most interesting and tells the tale the most. Here, without statistical tests, are just some percentages and in a couple of cases a few days and times. This compares the standard intervention to the enhanced intervention for *any* personal risk reduction goal and the enhanced intervention for people where the risk reduction goal matched the particular behavior being reported. In other words, *enhanced same goal* for times injected means that we reduced the number of times injected in the enhanced intervention over the standard by 36 days. It was 36 days shorter for people who had a goal of reducing their injection drug use. It was also 36 days in that case for people who had any goal, whether it was a sex goal or a drug-related goal or not.

If you look down through all of the rest of these variables, you can see the general pattern. However, the risk reduction effect is stronger, the behavior change is greater, and there is more of a difference when the personal goal matched the behavior being measured. So people changed more in the number of days injected compared for *any goal* versus *same goal*. The standard is always the least with a pretty consistent pattern.

There is a big difference in condom use. Based on self-report in the last 30 days, in the standard condition 33% of the people reported an increase in condom use over base line. For enhanced people, regardless of their goal, 49.6% reported increased frequency of condom use compared to 22.5% in the standard. But still better than that was the enhanced condition for

those people who had a condom use goal with 64.1% of those people reporting an increase in condom use.

Table 1-7			
Extent of Behavior Change & Effect of Personal Goal Choice			
Variable	Standard	Enhanced Any Goal	Enhanced Same Goal
Injection drug use:			
<i>Times injected</i>	-14.7	-36.5	-36.5
<i>Days injected</i>	-5.6	-8.2	-10.5
<i>% stopped injecting</i>	21.5	32.9	39.8
<i>% neg. urine test (opiates)</i>	16.4	23.4	29.0
<i>% reduced dirty needles</i>	89.3	85.7	93.8
<i>% stopped dirty needles</i>	67.9	74.3	87.5
Crack use:			
<i>Days used</i>	-8.4	-8.7	-9.3
<i>% stopped using</i>	25.6	28.8	38.8
<i>% neg. urine test (cocaine)</i>	18.6	23.8	27.9
Drug treatment (enter/try):			
<i>% last 6 mos. (IDUs)</i>	35.1	47.0	51.6
<i>% last 6 mos. (CUs)</i>	29.8	37.1	44.0
<i>% last 30 days (IDUs)</i>	15.1	18.5	20.4
<i>% last 30 days (CUs)</i>	8.9	13.2	11.2
Condom use:			
<i>% increased freq.</i>	33.0	49.6	64.1
<i>% used always</i>	15.3	22.5	23.3

The enhanced intervention was generally superior to the NIDA standard counseling and testing intervention. The interventions were equally effective regardless of participants' gender, age, and race/ethnicity. This was true for both drug-related and sex-related behaviors. There was greater behavior change when the personal risk reduction goal matched the behavior. Participants experienced greater behavior change in areas that reflected the personal risk - reduction goals they had chosen for themselves at the beginning of the program.

Finally, a cautionary note, the research design really does not allow us to single out which particular elements in the intervention are the most important. Dr. Rhodes stated that we really can not formally conclude which ones of these elements are the most powerful. Within this research design, it is not possible to assess the relative effectiveness of individual components of the enhanced intervention. In Dr. Rhodes personal opinion, one of the most important things running through the intervention was simply the maintenance of an extended engagement with clients, an extended engagement that was focused on reducing personal risk in an area of their own choosing.

Implementation Issues

The starting place for this intervention was the NIDA standard HIV counseling and testing. The testing was optional with more than 95% of the participants who elected to be tested. This health education model allowed people to participate in the education regardless of whether or not they had been tested. The sessions took place in the researcher's storefront office, and also out in a outreach vehicle. The sessions used a set of counseling discussion cards developed by NIDA and various researchers. For the first session, the pre-test NIDA standard counseling session, there were nine cards used (see Table 1-8).

What is AIDS?	What about cocaine and crack?
How does someone get infected?	The benefits of drug treatment.
What behavior puts you at risk?	The HIV antibody test.
Why use condoms?	
Why clean needles and syringes?	If you are infected with HIV.

During session two, there were three cards plus a review of the cards that were covered in the first session. People who had tested negative or who had elected not to be tested got a separate set of cards than the people who tested positive. Folks who tested positive were also invited to come back to an additional counseling session where they could get some active referrals and go over the stuff that was discussed at a different point in time. The cards were developed by NIDA and used at all of the sites that participated in this study. The counselors tended to put the cards out on the table and read them, and then they would use different languages to explain them or perhaps come up with some examples or re-state what was said in order to make sure it was really understood.

For example, one card draws your attention to the point about how to reduce injection drug risk. The counselor described risk in a hierarchy. For example the counselor would say "the safest thing you could do to reduce your injection risk, of course, would be to stop using drugs; if you couldn't do that the next safest thing would be to stop using needles. If you're not going to do that, then you could stop sharing needles. And the next safest thing would be to clean your works." So the counselor goes through each card and covers the points.

There was demonstration and rehearsal for both needle cleaning and condom use with the counselor demonstrating and the client rehearsing. Crack users also participated in the needle cleaning demonstration and rehearsal. The counselor asked crack users to participate in the needle cleaning demonstration because they might know somebody who asks them how to clean a needle. This is an important point because a third of our participants used both crack and injection drugs.

Following the pretest and posttest sessions, the researchers conducted the first workshop. This was usually conducted the day of the posttest results or within the next two days. These sessions were about an hour and a half long and took place in the storefront facility or in the outreach van. Most sessions took place in the storefront facility because the van was rather cramped making it somewhat difficult to have a real comfortable group, especially in the heat.

The activities during the workshop included the identification of the personal *stages-of-change* for adopting specific HIV risk reduction behaviors. The counselor helped clients pick a goal to focus on while they were participating in the intervention. Role model videos were shown depicting peers who had successfully achieved risk reduction. The counselor helped the client's figure out what the first step was in reaching an HIV risk reduction goal. Counselors helped people establish what would be the first step, and worked with them from there.

In addition, counselors helped participants in these workshops to identify risk reduction personal support buddies. Counselors helped participants to identify an individual in their life who they would turn to and look to for support in making behavioral changes. People tended to pick sex partners or drug using partners who also had some vested interest in that individual's safety. So sex partners either were or were not drug users, but cared about the individual's safety. If some individuals did not have people that they really wanted to trust to be a buddy, an outreach worker was available to serve in that role.

The role model videos that were shown during the group workshops were developed using people who have successfully made behavioral changes. An interviewer asked the questions and the individual who was serving as the role model answered. The interviewers were cut out so what was shown ended up with just a person telling their story. These were individuals who had successfully completed behavior changes during the pre-testing of the intervention. The individual role models had successfully made behavioral changes and were actual clients who had adopted some risk reduction behavior. Four videos describing four different goals were used and include: getting off of drugs, using condoms, not sharing works, and cleaning works. Two videos were shown at each session.

The individual role models started out by sharing their name and how long they have lived in the city, what drugs they had used, and their drug use history. They described what their risks had been that is the tales of all the things they did to put themselves at risk. Then they described the steps they had taken to protect themselves. They talked about their reasons for deciding to change their behavior. And this was kind of their rationale, what motivated them to make this change, what was the triggering event or the turning point. Then they described the process of what making the changes was like, what kind of barriers they encounter when they were trying to adopt using condoms or always clean their needles or to get off of drugs.

The individual role models also described what facilitators they had available, what helped make them successful and the different reactions of their peers. More specifically how their peers reacted when they decided they wanted to always clean their works or quit sharing or get off crack. Then they discussed maintaining behavior change, how long it had been, what kinds of temptations they had faced, if they had any experiences with relapse, and if so how did they get back on track, and how their peers reacted to their maintaining change over time. And then they described what they thought the benefits and costs of behavior change were - how their life improved, what was better, and what were the sacrifices if they perceived any. And these were very well received.

The videos were a real high point. The videos demonstrated how the stages-of-change model would be employed because the role models talked about their process and the counselor pointed out the various components of the stages-of-change model. The *Stages-of-Change Worksheet* was not a handout that was given out to people. The counselors did not say go fill this out, like an assignment. That really clearly would never work. The worksheet was used more like a counseling guide, and it was used in the two workshop sessions. The worksheet was used again in the individual counseling session, and was completed as a group. All of the participants had a copy, but they did not necessarily have to fill it out if they were not able to read or if they did not have good enough glasses to be able to read. It was talked through, and you can see down the column on the left the various goals that people might have chosen, and then across the top you can see the five stages of behavior change

The *Stages-of-Change Worksheet* was used to help people identify what point in the change process they were at for various risk behaviors. This in turn was used to help decide what would be an appropriate goal for this individual. The worksheet helped the counselor and the client hone in on what are the risks, where they stand, and what would be the appropriate next steps. The emphasis was always moving towards a higher stages-of-change and moving more towards maintenance.

The worksheet just listed the five stages and was used as a metaphor in the various sessions. Laminated cards were made up of the different stages and hung up on the wall. When the cards were introduced, the counselor talked about the different stages, how somebody who was, for example, trying to quit smoking could use the various stages in their change process. Counselors continued with different activities that focused on this, looking at change in this way. Counselors let the participants in the workshops pick a goal, and then demonstrated how a person might walk through these stages in trying to make the change. For selecting goals, counselors tried to encourage people not to pick a goal where they were already in the maintenance stage, where they had been already practicing that behavior for a good bit of time because that would be fruitless, that is no behavior change, that is behavior maintenance. For someone who was in stage one (pre-contemplation), not really considering it, that was not really a good goal to select because the person probably was not going to be very committed to making that change.

The next session following the group workshop occurred two weeks later. Clients had two weeks to take those first steps that were outlined in the group session and start making changes. This session was an individual counseling session, one-on-one, so it allowed people a chance to talk to a counselor and perhaps share and discuss things that they may not have been comfortable talking about in a group. The session also allowed the counselor to have time to reflect with the client about what had happened when they tried to start making changes. These were held in the office and in the van, and the first step was to review and refine the client's personal risk reduction plan.

Sometimes the clients needed help picking a goal. The counselors did not say "This is a bad goal you've chosen, I think you should change it to this." That would not work. It was a discussion and conversation back and forth. The counselors attempted to lead the participants in selecting a goal where they could really be committed, had a chance at being successful, and were able to make a change. The counselors reviewed the client's goal and what happened when the client tried their first steps. Barriers encountered were then discussed, and solutions to overcoming those barriers were also reviewed. An effort was made to strengthen client's commitment to the goal that was chosen, and the counselor tried to ensure the availability of social support for risk reduction. For example, the counselor might ask "Have you talked to your support buddy" or "How have they been able to help you?", and maybe if it did not sound like it was going well, "Who else would be a better person, can you think of someone who could really get behind you and be there for you?"

Below is a list of the HIV risk reduction goals used in this study (see Table 1-9). Items such as *not sharing needles, not having sex when drunk, and high and not having penetrative sex* describe the ultimate goal or the end point. The interviewers attempted to help clients reduce the occurrence of these behaviors or make progress towards eliminating them. The *Stages of Behavior Change* table (Table 1-10) was presented throughout the entire intervention. The emphasis was on always using condoms during vaginal or anal sex. The most popular goal, 53% of the people, was reducing or getting off drugs, either by themselves or through a treatment program. About 20% chose shooting more safely either by not sharing or by cleaning their works. About 25% of the people chose a condom use goal. The remaining few individuals chose some other sex goal like reducing the number of people they have sex with. There were a

small number of sex workers in the sample who engaged mostly in oral sex. Sex workers' goals were mainly using condoms for oral sex.

Table 1-9 Sample HIV Risk Reduction Goals	
Cleaning needles with bleach.	Getting into drug treatment.
Not sharing needles.	Always using condoms during sex.
Not sharing rinse water.	Not having sex while drunk or high.
Not sharing cookers or cottons.	Not having penetrative sex.
Getting off drugs that are injected.	Having fewer sex partners.
Getting off crack.	Having sex only with non-IDUs.
Decreasing drug use.	

Table 1-10 The Five Stages of Behavior Change
Stage 1 (Precontemplation) Not Considering It <i>"I've got enough to deal with already."</i>
Stage 2 (Contemplation) Planning To Do It <i>"I'm definitely gong to do it, but now's not the time."</i>
Stage 3 (Preparation) Ready For Action <i>"I've taken some steps already, and I'm set to go."</i>
Stage 4 (Action) Doing It <i>"I'm making it happen, but it hasn't been long."</i>
Stage 5 (Maintenance) Staying With It <i>"It's part of my life now, and it's working out fine."</i>

When clients picked a goal at their second group, health educators helped clients fill out a goal card to take home (see Table 1-11). Some of them admitted that they thought it was a little hokey, but when they found it in their pocket it made them focus on their goal and what they had committed to do. The *Goal Card* outlined the first step that would be taken. Clients picked a real discreet act that they could complete over that two-week period.. For example, if a client's goal

were using condoms with their partner, the first step would be going home Tuesday night and talk to their partner about using condoms.

Table 1-11 Goal Card
<p>WHAT I WILL DO TO REDUCE AIDS RISK</p> <p><i>My Goal:</i></p> <hr/> <hr/> <hr/> <hr/> <p><i>My First Step:</i></p> <hr/> <hr/> <hr/> <hr/>

Monthly social events were held each month for participants and their support buddies in city-owned recreation centers and was attended by all outreach and intervention staff. Social events were very fun to implement. At first, the staff was very suspicious of this element of the intervention, the idea of having 20 to 35 active drug users in one place with lots of food and refreshments and fun scared some of them. It took a lot to convince them to get behind it at first. The staff was overwhelmingly supportive of the social events after the first event. Participants were eligible and allowed to participate in as many of the social events as they wanted to while they were enrolled, they just simply had to finish the three formal sessions, two groups, and the individual session. Clients were allowed to bring their support buddy who was usually a sex partner or a drug-using partner. Clients felt more comfortable at the social events with someone they knew very well.

Events were held at city-owned recreation centers where the researchers were able to get discounts on the fee. Fees could usually be waived if a funding agent ran the place where events were held. The purpose of the monthly social events were to:

- ◆ Strengthen the participant’s relationship to the program, staff, and support buddies.
- ◆ Reinforce participants’ commitment to reducing personal risks, including level of drug use.
- ◆ Provide social support for progress in achieving personal risk- reduction goal.

- ◆ Encourage a sense of community and to affirm personal self worth.

Outreach staff delivered printed invitations individually to participants. Invitations were made elegant, inviting, and warm on the most affordable paper. This was not just a flyer for a program activity; the invitations really tried to make it special.

Many activities took place during these monthly social events. Personal grooming hygiene kits, bleaching kits, and condom kits were distributed. Personal grooming hygiene kit materials were donated from local shops and a food bank. Outreach workers and health educators performed skits that incorporated risk reduction themes as an icebreaker. All of the outreach workers and most of the counselors had former drug use experience, so they were able to really play the role of a drug user effectively and to help provide content. An example of a skit would be a party scene with somebody wanting to use bleach to clean their works or somebody wanting to use condoms with a partner. A lot of humor was used and the skits were very authentic to the client's life experiences. Testing and testing positive were also topics that came up in these skits. Hot meals were provided, bearing in mind cost. Some of the local delis donated food, which helped promote the program and gain support for it.

Structured risk reduction activities (e.g., panel of peer role models, small-group discussion, role-play) at every social event were very well received to a surprising degree. Participants coming back said that the risk reduction activities were the most useful thing they have seen in a long time. One of the most successful activities and well received was a panel of peers who had successfully made behavior changes. Outreach workers and former clients who were willing to share their stories of getting off drugs or some other behavior change talked about their process of change. The panel of peer role models was like a live role model video that allowed the audience an opportunity to ask questions. Outreach workers were typically considered real stars because they had not only gotten off drugs, but they had jobs and were out helping people. Outreach workers were seen as real community leaders, and having them in these panels sharing their stories was real moving. This provided team building for the staff because it gave everyone a real good appreciation for some of the life experience that people brought to the program.

Another successful activity was small-group discussions based on a risk reduction goal or a stage-of-change. Breaking up into groups by risk reduction goals was most effective. A health educator or an outreach worker led each group in discussing what barriers people were facing on their journey in reducing their risk. The group talked about what solutions they had come up with. If somebody was facing one type of barrier, another person in the group could say, "You know, I was dealing with that, this is what I came up with that really worked." The responses and the suggestions came from the peer group. The small-groups collapsed into a big group to summarize the activity --this was very popular.

Staff members performed skill-building role-plays on negotiating condom use on stage. Participants from the audience provided suggestions then staff members would have participants come up and demonstrate their suggestions. Prize drawings such as cheap watches, radios, and movie tickets were given away at the end to encourage people to stay. Socialization and desserts at the end also encourage participants to stay.

Field- based planned supportive contacts took place after the individuals session and the two group sessions. An outreach worker went out into the field to engage the client and help encourage achievement of their personal risk reduction goals (minimum of two). The outreach worker and the counselor sat down together to discuss strategies for each individual client before contacting the client. This was useful because sometimes the client shared slightly different or emphasized different aspects of their life. The outreach worker and the counselor looked at the client's chosen goal, the first step towards the goal, and special circumstances in that person's life. They developed a plan for the outreach worker that included the next steps

towards the client's goal and barriers the client might encounter then the outreach worker went out to talk to the client. The outreach worker validated the client's chosen goal, reinforced their efforts, assessed their progress, discussed barriers and solutions, discussed strategies for overcoming the barriers, and helped the client to identify a realistic next step based on their discussion.

It is helpful to have staff with connections with local drug treatment programs when working with drug users. Look for balanced individuals who are non-judgmental and have street shrewdness. Tape-recorded selected sessions with the client's permission were used for training. Real examples were used in the training sessions including challenging questions that clients asked, ways clients may respond, or examples of outreach workers dealing with a difficult issue. Outreach workers also role played clients and had the counselor trainees bring them into a group. Outreach workers would wait in the lobby, the receptionist would call them in, and the counselor trainee would see them. The outreach workers gave feedback about the counselors. Some of the questions asked about the counselor include:

- ◆ Did they shake your hand?
- ◆ How do they greet you?
- ◆ Did they talk to you as they walk down the hall or did they just leaving you behind in a trail of dust
- ◆ Did they use complicated and overly technical terms?

This exercise validated the expertise of the outreach staff, provided real good feedback to the counselors, and helped the outreach workers have a real clear picture of what the intervention was like from the client's perspective.

The important features of this intervention include ongoing engagement of clients over time, food bank services, monthly social events, and the use of role model videos. Clients who were eligible for food bank services received a bag of groceries every other week and at every session. This communicated a concern for their general wellbeing beyond just HIV. The monthly social events were both fun and helpful and allowed clients and their buddies to participate in the whole intervention process. The role model videos were also a great success. One former client who got off of drugs and eventually became an outreach worker was used in the role model video. She became known among the clients as the movie star. Clients were very taken with her and impressed with seeing, through the video, her whole process of change, it made it real for them that getting off drugs and changing behavior was something they could do.

Maintaining the correct tone for skits was challenging. The participants told us they wanted the skit stories to be gory, realistic, real life with all the language and all the real activities. There was a balancing act between being real life and keeping the tone appropriate without glorifying drug use. Talking about and promoting condom use was sometimes a barrier. Some of the staff had not personally committed to using condoms, and it was more difficult for them to really communicate that message in a believable way. Other staff members were not comfortable talking about the explicit details of condom use, such as losing an erection and other details of that nature. Some staff members felt uncomfortable using slang to talk about sex and anatomy even when appropriate. There was a lot of training required, more than expected, to get outreach workers to be able to do the field based intervention. Some people did not want the intervention to end and were disappointed. These people came back and were on the role model panels at the socials and helped recruit people.

The researchers would enhance and expand the buddy component making it more central to the intervention if they had to do it all over again. They would include a greater number of structured activities in which the buddy could participate. In addition, they would increase staff interactions with the buddy to draw them more into the intervention. They would also strengthen the field-base component of the intervention by teaming the counselor and the outreach worker

to go out in the field together. They would have also tried to provide more training to the outreach staff to help them develop their counseling skills. In conclusion, Ms. Wood thanked all the different staff members and the participants who were a part of this intervention over the four years that it was implemented because they were the ones who helped to make it successful.

Question & Answer Session

QUESTION: We like the idea of non-monetary incentives that are not necessarily related to HIV (e.g. clothing, hygiene kits, toothbrushes, soap, lotion, etc.) to develop rapport. Many counties do not have funding for monetary incentives. Could you tell us more about non-monetary incentives that you used?

ANSWER: Clothing has been very popular and successful as a non-monetary incentive. We received clothes through donations and it was fairly easy to do that. We gave out groceries and hygiene items that were obtained through donations and at the Long Beach Food Bank. We can put together a bag of groceries and hygiene items that costs about \$35 in the grocery store for about 45 cents from the food bank. We also put snacks in the lobby that we obtained through the food bank.

QUESTION: Our county health department basically told us that there would be no problems with us handing out condoms in public places, but they would not support our efforts if we started passing out bleach because they think it is condoning drug use. We can not even talk about a needle exchange program. This is a barrier to using a harm reduction type of strategy. How can we get beyond that barrier?

ANSWER: On the topic of community resistance to harm reduction, basically you have to educate individuals, like the Board of Supervisor members and the community. Supervisors are afraid that their constituents will not approve, so if they get some comments from the community that it is okay, then they will take a risk. You can educate the community that you are not the buddy of druggies, you are not just helping them out to make a buy, but that you're trying to reduce the harm to the community as well as the individuals. This is especially true in rural communities, where you get a lot of resistance to harm reduction. This is a slow solution, but that is really the only way to make any progress. And even baby steps really have good outcome.

QUESTION: We have not seen a move in prevention efforts among other drug users who are not injection drug users. We thought that there should be more of a focus on outreach in the club and bar scene among those individuals who are not IDU and may not be MSM. I think that the same methods can be used in different areas where individuals are not IDUs.

ANSWER: The particular program that we described was for injection drug users and crack users specifically. About one third of the people to whom the program was delivered and for whom it was effective were crack-only users at the time of enrollment. And another third were crack users who also simultaneously injected. So, two thirds of the people in the program were crack users. We developed a program that would simultaneously be effective to address the issues of IDUs and crack users. And as you have pointed out, the issues for crack users are different because they have

only sexual risks. IDUs have sexual risks and also drug-related risks. I agree with you completely, it is very important to go beyond drug injectors and this program goes one step in that direction. This same model can be effective in touching the entire substance abuse arena.

QUESTION: To your knowledge, are the prevention protocols still being used even though the formal study has ended?

ANSWER: Our own health department is funding an individual counseling program that is stages-of-change oriented and is linked to a food bank program. In addition, the California Food Bank Program for active drug users also includes the social event component of the prevention. We regularly have a group of about 30 people who will come to an event, they look forward to it and tell other people about it.

What we have done is to take individual pieces of the prevention and use them in specific context. The prevention program exists in the context of other services that are perceived to be of direct value to keep the client coming back. It either has to exist in that context or you have to have very significant meaningful participation incentives of one sort or another, including monetary, if you can.

Unless you have something that has high intrinsic interest, you will have nobody there. The socials apparently meet that criterion of having high intrinsic interest, but without some external beating of the bushes, they are probably a selected segment of your group.

QUESTION: Were clients case managed or how were they referred out to services? What kind of services were they able to access through your program?

ANSWER: An individual outreach worker recruited participants. The outreach worker functioned similarly to a case manager, a type of relationship where one outreach worker was responsible for a group of clients. We had a team of four outreach staff so they did not share clients. Another outreach worker could work with that person, but only one person maintained responsibility for nurturing and encouraging the participation of their caseload. If a client said "I'm really interested in getting off of drugs", the outreach worker would talk to that person and also connect them with a health educator who would go through local resources to get them connected. The outreach worker would transport them to drug treatment if that was something the client wanted to do. Types of services that we typically got people connected with were HIV treatment services, drug treatment, housing, and food services.

QUESTION: What was the attrition rate in the study? And were they eligible to re-enroll later on? How was that handled in terms of your recruitment?

ANSWER: The intervention was an ongoing process and a client could leave the program and return later. For example, a client could land in jail or have a serious binge then come back and decide they wanted to get back involved. There was an eight months period where clients could participate. We delivered this intervention to active drug users (crack users, injection drug users, speed users) and found about 60% - 65% participated in a minimum of six sessions with very little outreach effort. This included the counseling and food bank where the individual session was combined with the social event component.

QUESTION: One of the sample risk reduction goals you mentioned was not sharing needles. Your results indicate reduced times and days of drug injection but not reduced use of dirty needles. One of the barriers that we talked about was a needle exchange program or the lack thereof. Did any of the participants say it would be easier for them to reach their goal if needle exchange were available? Did you get any sense of that from the clients you worked with?

ANSWER: Participants certainly said that they wanted needle exchange. I agree that we ought to have it, and we do not. Bleach has been distributed in Long Beach for years, and the message about bleaching has really been out there. People are generally able to get needles from sources such as pharmacies and diabetics. The folks who have trouble getting needles on a regular basis are folks who are living out in the parks and on the beaches. They tend to use needles and then have to store them in public places. Information about cleaning is more important for these folks because they are using needles that many other people have used. We really wish we could do a needle exchange program ourselves.

QUESTION: You had the ability of developing a really comprehensive program based on a lot of funding that was available to you, and now that that funding has ended you have been able to continue specific components of that program. How can communities create a program like this? What components of this program do you feel are the most important in implementing?

ANSWER: Implementing for us means obtaining funding for one or more of these components. Submitting proposals to the Office of AIDS or to county sources are the two main sources of money. I suggest the socials, *stages-of-change* based individual counseling or groups, or the plan outreach contacts. The plan outreach contacts are really a version of case management so you would need to apply the context that the funding agency would favor for case management. You would point to the successful prior implementation of that element in a program like ours, and then think through how you can manage the resource issue.

Socials are very practical, manageable, and do-able resource-wise approach to prevention. As we noted before, they are intrinsically interesting and so you are not going to have to have a huge outreach support staff to get people to attend. You do not have to work too hard to sell group sessions to a funding source, those are perceived as being cost effective. Selling individual counseling, one person at a time individually, is a difficult sell and probably one of the last things that you would approach a funding agency about. These components, except perhaps for the individual counseling component, are readily interpretable in your local yearly proposals for HIV prevention funds. I do not think that getting any of these things started in a community is a huge trick, even the socials. In my view, the biggest trick is organizing. You have to have in place some ongoing training capability and somebody in the agency has to have a vision of the way it is supposed to look and then continually work with front line staff to get closer and closer to that vision. Because the information we were presenting is fairly highly structured, it loses its essence very quickly without continual nurturing it. That is the hardest part of all of it.

QUESTION: Did clients give you feedback on parts were most valuable for them?

ANSWER: I think that different people liked different things better. Some people were not very good in social groups and they really gravitated to the one-on-one contacts with

outreach workers and the individual counseling sessions. Other people really liked the social groups. The social events were very popular among a very large group of people.

QUESTION: Did you find a lack of drug treatment options to be a barrier for some people in terms of goal setting?

ANSWER: Treatment works well when you can get someone into treatment when they want to go. The main activity of the counseling staff in terms of working with clients in the enhanced intervention was trying to make treatment available when they wanted it. It was hard to do and we could not always do it. Client's who were HIV positive could get in the same day - it is not easy unless you are HIV positive. In Long Beach, there are waiting lists and a lot of fee-for-services agencies making treatment options difficult.

Our program was focused on HIV risk harm reduction. We wanted to remain engaged with the people and did not want to *tell* clients to get drug treatment or give up drugs or reduce drug use. We were very sensitive to that issue, extremely sensitive, and so worked very hard not to present an image of being the drug treatment police. The success of working with folks is not to present your own agenda to them. However, drug treatment was one HIV risk reduction options that people could choose to talk about and we helped clients work towards that goal. Two-thirds of the people chose drug reduction related goals. A large percentage of active drug users at any moment in time are very interested in reducing or stopping their own drug use.

QUESTION: Is it possible to take some of the workable parts of this program and condense it into a version that could be utilized in county jails?

ANSWER: Unfortunately, in a prison setting, access to condoms is not an open issue and drug use is underground. The sex that occurs is in a different context. We would have to take this program apart and rework it. The part of this program that has to do with developing personal commitment to achieve certain goals could be adapted. But, the practical work of developing a next step to achieve a goal requires a setting where you can experience the activity and be a participant. That is very difficult in an incarcerated setting. There are some of these same issues in a treatment setting. I think that there would have to be considerable adaptation and some of the goals would need to be modified.

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APPENDIX B

Sample Memorandum of Agreement

SAMPLE MEMORANDUM OF AGREEMENT

This document is a Memorandum of Agreement (MOA) between [your organization] and [collaborating organization]. The MOA is in effect as of the date specified below and will remain in effect until the end-date specified below or until one or both parties to the agreement request in writing to terminate it.

Purpose of Agreement. The purpose of this MOA is to create a means of sharing resources between [your organization] and [collaborating organization] in order to implement the *SAFETY COUNTS* program more effectively.

Scope of Agreement. This MOA pertains only to the goods and/or services specified and does not bind either party to any other action or agreement.

Timeline of Agreement. This MOA will be in effect from [beginning date] until [end-date].

Agreement. [Collaborating organization] agrees to make available to [your organization] the large meeting space located at [address] on Wednesday evenings at 6:00 p.m. until 8:00 p.m. throughout the timeline of this MOA. [Collaborating organization] understands and agrees that [your organization] will conduct group meetings and serve meals at this place and time. [Collaborating organization] also agrees to make available at this place and time a television monitor and VCR. [Your organization] agrees to provide all food and materials associated with meals served at this place and time and to clean the meeting space thoroughly following the event. [Your organization] also agrees to pay to [collaborating organization] the equivalent of four hours of janitorial wages, or \$40, per month during the timeline of this MOA. [Collaborating organization] agrees to invoice [your organization] on a quarterly basis for this amount.

Our signatures below signify agreement to this MOA.

Date: _____

Date: _____

APPENDIX C

Field Safety Guidelines

FIELD SAFETY GUIDELINES

- **Always be sure you have a way to check in** with the office and your partner (e.g., calling cards or petty cash for calling back to the office, two-way radios, pagers, and/or cell phones). Plan communications procedures for team members to keep track of each other's whereabouts.
- **If you are working as a team** (and we would suggest that you do), arrange to meet in a safe place before setting out into the field. Arrive at the area together. Keep each other in view at all times. Don't separate from your partner for long periods of time.
- **Have your program identification** on you before going out into the field. Make sure it can be easily produced if it is not visible. Identify yourself and tell people what you are doing and why.
- **Have plenty of supplies** (safe sex and needle hygiene kits) readily available.
- **Know the neighborhood.** If you are new to the neighborhood in which you are working, accompany other workers who know the neighborhood well and can teach you about risks and outreach opportunities.
- **Do not buy goods or accept gifts,** food, or merchandise from street people or clients—it may be stolen. Do not give or lend money to clients.
- **Develop a friendly, professional relationship** with clients you come into contact with, but do not interact with them socially or romantically.
- **Don't make assumptions,** judgments, or generalizations about your client population. Behave respectfully towards them and win their trust and confidence. Avoid any communication, through words or gesture or posture, that conveys arrogance or an "attitude."
- **Stay in view of street traffic** whenever possible. Do not enter shrubbery, alleys, or other areas where you are not visible unless accompanied by a partner.
- **Do not display** personalized tags on cars.
- **Do not counsel clients** outside of the specific requirements of your job.

- **Be aware of your surroundings** at all times. You can avoid trouble by being observant.
- **Do not conduct outreach in the field after dark.**
- **Dress comfortably and inconspicuously**, particularly when working in high-risk areas where drug buys are occurring. Do not dress to impress. Be aware of gangs and their colors, and avoid both.
- **Do not carry a purse** or a large amount of money while in the field. Limit jewelry to small costume jewelry items. Do not carry more cash or incentives than you will need *that day*.
- **Do not carry weapons.**
- **Never approach** a potential client when she or he is buying drugs.
- **Never approach** a client if he or she is negotiating with a client (john or trick or date) or dealing with a pimp.
- **Do not enter a crack house** or shooting gallery without first building a relationship with the person in charge.
- **Avoid getting in the middle** of the sale of drugs or sex. If a drug or sex deal is conducted near you, leave the area quickly and quietly, without drawing attention to yourself. Never take, touch, or sample any person's drugs or merchandise on the street.
- **Consider liability** issues of transporting clients in your personal vehicle:
 - Your liability to an injured client if there is an accident.
 - Your vulnerability if the client is carrying drugs.
- **Plan escape routes** in advance in case a situation goes badly.
- **If you find yourself in a dangerous situation**, remain calm and try to leave as soon as possible. In case of an emergency, call 911.

APPENDIX D

CDC Content and Review Guidelines for HIV Programs

CENTERS FOR DISEASE CONTROL AND PREVENTION

Revised Interim HIV Content Guidelines for AIDS-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions for CDC Assistance Programs

I. Basic Principles

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

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

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

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

SEC. 2500. USE OF FUNDS.

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

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

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

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

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

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

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

II. Program Review Panel

Each recipient will be required to identify at least one Program Review Panel, established by a state or local health department from the jurisdiction of the recipient. These Program Review Panels will review and approve all written materials, pictorials, audiovisuals, marketing, advertising, and Web site materials, questionnaires or survey instruments (except questionnaires or survey instruments previously reviewed by an Institutional Review Board--these questionnaires or survey instruments are limited to use in the designated research project). The requirement applies regardless of whether the applicant plans to conduct the total program activities or plans to have part of them conducted through other organization(s) and whether program activities involve creating unique materials or using/distributing modified or intact materials already developed by others.

Materials developed by the U.S. Department of Health and Human Services do not need to be reviewed by a panel. Members of a Program Review Panel should understand how HIV is and is not transmitted and understand the epidemiology and extent of the HIV/AIDS problem in the local population and the specific audiences for which materials are intended.

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

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

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

In addition:

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

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

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

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

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

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

b. The identity of members of the Program Review Panel, including

their names, occupations, and any organizational affiliations that were considered in their selection for the panel.

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

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

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

3. Prior to expenditure of funds related to the ultimate program use of these materials, assure that its project files contain a statement(s) signed by the chairperson of the appropriately identified Program Review Panel(s) established by a state or local health department, specifying the vote for approval or disapproval for each proposed item submitted to the panel.

4. Include a certification that accountable state or local health officials have independently reviewed written materials, pictorials, audiovisuals, and marketing, advertising, and Web site materials for compliance with Section 2500 and 317P of the Public Health Service Act and approved the use of such materials in their jurisdiction for directly and indirectly funded community-based organizations.

5. As required in the notice of grant award, provide to CDC in regular progress reports, signed statement(s) of the chairperson of the Program Review Panel(s) specifying the vote for approval or disapproval for each proposed item that is subject to this guidance.

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

[Federal Register Doc. 04-13553, Filed 6-15-04, 8:45 am]

APPENDIX E

Guidelines for Adapting Safety Counts

GUIDELINES FOR ADAPTING SAFETY COUNTS

The purpose of this document 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 document 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.
 - (1) The different activities in each of the eight Safety Counts sessions are listed below. Numbering of activities 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.”

b) Program Enrollment Session

(1) Introduction:

- (a) Adaptation is not applicable to the content of this section.

(2) Eligibility Check:

- (a) Adaptation is not applicable to the content of this section.

(3) Completion of Program Enrollment Form:

- (a) 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:

- (a) 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:

- (a) 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:

- (a) 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:

- (a) Adaptation is not applicable to the content of this section.

(8) Participation Documentation:

- (a) Adaptation is not applicable to the content of this section.

c) Group Session 1

(1) Introduction:

- (a) 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?

- (a) 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:

- (a) 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:

- (a) 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:

- (a) 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?

- (a) 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:

(a) Adaptation is not applicable to the content of this section.

(8) Participation Documentation:

(a) Adaptation is not applicable to the content of this section.

(9) Staff Debriefing:

(a) Adaptation is not applicable to the content of this section.

d) Group Session 2

(1) Introduction:

(a) As with the Introduction in group session one, 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:

(a) 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:

(a) 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:

- (a) 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:
- (a) 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:
- (a) 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:
- (a) Adaptation is not applicable to the content of this section.
- (8) Participation Documentation
- (a) Adaptation is not applicable to the content of this section.
- (9) Staff Debriefing
- (a) Adaptation is not applicable to the content of this section.
- e) **Individual Counseling Session** (1 minimum)
- (1) Introduction:
- (a) 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:

- (a) 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:

- (a) 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:

- (a) 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:

- (a) 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:

- (a) Adaptation is not applicable to the content of this section.

(7) Closing:

- (a) Adaptation is not applicable to the content of this section.

(8) Participation Documentation:

- (a) Adaptation is not applicable to the content of this section.

f) **Social Events** (2 minimum)

(1) Greeting and Introduction:

- (a) 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:

- (a) 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:

- (a) Adaptation is not applicable to the content of this section.

(4) Risk Reduction Activity:

- (a) 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:

- (a) Adaptation is not applicable to the content of this section.

(6) Dessert and Closing:

- (a) 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:

- (a) Adaptation is not applicable to the content of this section.

(8) Staff Debriefing:

- (a) Adaptation is not applicable to the content of this section.

g) **Follow-up Contacts** (2 minimum)

(1) Approach and Greeting:

- (a) 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:

- (a) Adaptation is not applicable to the content of this section.

(3) Plan the Next Step:

- (a) 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:

- (a) 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:

- (a) 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:

- (a) Adaptation is not applicable to the content of this section.

(7) Participation Documentation:

- (a) Adaptation is not applicable to the content of this section.

(8) Staff Debriefing:

- (a) 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.

APPENDIX F

Internet Resources

HIV AND HEPATITIS INTERNET RESOURCES

Internet Site	Transmission & Prevention	Safer Sex	IDU & Other Drug Use	Hepatitis & HIV Co-infection	Treatment & Side Effects	Statistics
AVERTing HIV and AIDS www.avert.org/statindx.htm This site has global and regional statistics and trends for HIV/AIDS.						X
Centers for Disease Control and Prevention http://www.cdc.gov/hiv/dhap.htm	X	X	X	X	X	X
CDC Prevention Among Injection Drug Users www.cdc.gov/idu This site contains access to materials and resources developed to assist HIV prevention providers working with IDUs and their sex partners.	X		X	X		
CDC Viral Hepatitis and Injection Drug Users www.cdc.gov/hepatitis and www.cdc.gov/idu/hepatitis This site contains fact sheets on hepatitis and injection drug use.	X		X	X	X	
Center on AIDS and Community Health www.coach.aed.org and www.hivaidsta.org These sites contain technical assistance materials and fact sheets on IDU HIV prevention, hepatitis, and substance abuse.	X		X	X		X
HepNet, the Hepatitis Information Network www.hepnet.com/pres/present.html This site provides links to publications, papers, and additional websites regarding hepatitis.	X			X	X	X
HIVpositive.com www.hivpositive.com This site is a resource for HIV-positive people and their caregivers and loved ones.						X

Internet Site	Transmission & Prevention	Safer Sex	IDU & Other Drug Use	Hepatitis & HIV Co-infection	Treatment & Side Effects	Statistics
<p>Managing Desire: HIV Prevention Strategies for the 21st Century www.managingdesire.org This site contains resources for training counselors and educators.</p>	X	X				
<p>National Academies Press www.nap.edu This site provides links to books on HIV prevention and other issues.</p>	X					
<p>National Center for Infectious Disease Viral Hepatitis www.cdc.gov/ncidod/diseases/hepatitis This website contains information on viral hepatitis.</p>	X			X	X	
<p>National Development and Research Institutes www.ndri.org NDRI is a center for the sociobehavioral study of drug use and HIV in the United States. This site includes a street-based prevention intervention targeting active injection drug users.</p>	X		X			
<p>National Foundation for Infectious Disease www.nfid.org/factsheets/ This site contains fact sheets with information on hepatitis B and hepatitis C.</p>	X			X	X	X
<p>National Institute on Drug Abuse www.hiv.drugabuse.gov This site contains extensive information about drug users and HIV.</p>	X		X			X

Internet Site	Transmission & Prevention	Safer Sex	IDU & Other Drug Use	Hepatitis & HIV Co-infection	Treatment & Side Effects	Statistics
<p>National Institutes of Health: National Institute of Allergy and Infectious Diseases, Division of Acquired Immunodeficiency Syndrome http://www3.niaid.nih.gov/healthscience/healthtopics/HIVAIDS/default.htm This site contains information about HIV prevention, treatment, and vaccines.</p>	X				X	
<p>San Francisco AIDS Foundation www.sfaf.org This site contains information about prevention, treatment, and policy surrounding HIV/AIDS.</p>	X	X			X	X
<p>Statistics www.statistics.com This site contains a variety of statistics on HIV/AIDS.</p>						X
<p>Substance Abuse and Mental Health Services Administration www.samhsa.gov This government site contains information regarding substance abuse.</p>			X			X
<p>The Body www.thebody.com This site is a comprehensive resource for treatment, prevention, testing, safer sex, and other basic information regarding HIV/AIDS.</p>	X	X			X	
<p>University of California at San Francisco: Center for AIDS Prevention Studies (CAPS) www.caps.ucsf.edu This site contains printable fact sheets and brochures for groups at high risk.</p>	X	X				

Internet Site	Transmission & Prevention	Safer Sex	IDU & Other Drug Use	Hepatitis & HIV Co-infection	Treatment & Side Effects	Statistics
<p>Walnet www.walnet.org This Commercial Sex Information Service of this site contains information produced by and for commercial sex workers.</p>		X				

APPENDIX G

How to Create Risk Reduction Success Stories

HOW TO CREATE RISK REDUCTION SUCCESS STORIES

This section describes the step-by-step procedure for creating the four risk reduction success stories that are used in group sessions one and two. As explained earlier, these stories may be produced in the form of videos, audiotapes, or written stories. Which option you choose depends upon the resources that are available to your agency. Videotaped stories are perhaps the most powerful, and these are what were used in the original intervention. However, they are the most difficult to produce and require the most resources. Audiotaped stories require less in the way of specialized facilities and equipment, but like video stories, they must be edited extensively to produce an acceptable final product. Written stories, on the other hand, require few special resources to produce, and the final content can be easily controlled. Written risk reduction stories have been used successfully in other behavioral interventions and are recommended as the most practical option for many agencies.

Identify Role-Model Individuals

- Identify 6-8 drug-using individuals in the local community who have been successful in reducing their HIV or hepatitis C risk by achieving one of the behavioral goals specified in the Risk Reduction Interview. Make sure individuals have been performing the risk reduction behaviors in question for a sufficient period of time (at least 3-6 months). Because risk reduction success stories must be produced prior to *SAFETY COUNTS* startup, you will need to rely on your agency's existing outreach staff and connections to the local drug-using community to identify persons who are considered suitable prospects. Although only four stories are required for *SAFETY COUNTS*, it will almost always be necessary to conduct interviews with more than four people to obtain four good stories.
- Remember that two of the final stories should portray successful reduction of drug-related risks, and two should portray reduction of sex-related risks.
- Obtain a signed release from each person for a video or audio-recorded personal interview and the use of his or her story in the *SAFETY COUNTS* intervention. If possible, obtain permission to use the person's real first name. Be certain that all understand clearly that they are being asked to share their story of successful behavior change with other drug users who are also trying to reduce their risks of HIV and hepatitis.

Conduct Interviews

- Conduct and record (videotape or audiotape) a personal interview to obtain the risk reduction success story of each individual. When videotaping interviews, the interviewer should remain off-camera. (*Note: An audiotape recording is required for creation of written risk reduction stories.*)
- Ensure that interviews include sufficient detail to allow creation of useful risk reduction success stories. "Raw" interviews should be at least 20-30 minutes in length.
- Guide the interview process to ensure that the following topics and questions are addressed:

- General background information—first name (or pseudonym), length of time in local area, living situation, current drug use pattern.
- Specific behavior change made to reduce HIV or viral hepatitis risk.
- What made the individual first decide to start performing this particular risk reduction behavior? What led up to his or her decision (commitment)? How long ago was this?
- What initial difficulties (barriers) did the individual encounter in trying to trying to perform the new risk reduction behavior?
- How did he or she solve these problems?
- What problems were encountered in trying to perform the behavior consistently?
- How were these problems resolved?
- What made performing the new behavior easier (facilitators)?
- How many times did setbacks (falling back to earlier stage) occur from the time the individual first started trying to perform the risk reduction behavior until it became a consistent part of his or her life (if not already answered from the questions above)? What were the particulars of each setback?
- For how long has the person been successfully (consistently, fully) performing the risk reduction behavior?
- How important was the support of friends, family, or other people in achieving success? How did they help? How important is their support now?
- How confident is the individual that he or she will be able to continue performing this risk reduction behavior in the future?

Edit Stories

- Using material from each recorded interview, produce a brief final story that clearly portrays how the individual first tried and finally succeeded in making this particular risk reduction behavior a part of his or her daily life.
- In each story, show how the individual has moved through the five stages of change—from precontemplation to contemplation to preparation to action to maintenance.
- **For video and audio stories**, edit the raw interview to retain those segments that best portray the individual's personal journey in achieving risk reduction success.
 - Ensure that the edited story has a logical flow and is easy for viewers or listeners to follow. (This usually requires rearranging the original interview material.)
 - Eliminate repetitious material and material that is tangential to the story.

- Do not include the interviewer's voice in the final story.
- Keep the length of the final videotape or audiotape to a maximum of 5-8 minutes.
- **For written stories**, use the raw interview to compose a story that fully captures the individual's personal efforts and realistically portrays his or her progression in achieving risk reduction success.
 - Begin by producing an unedited transcript of the full interview. Use the written transcript as your guide in writing the story.
 - Write stories in the first person ("I").
 - Use some of the actual words and phrases spoken by the person whenever possible.
 - Incorporate some local color, such as references to local hangouts, to reinforce the perception that this is a real individual from the local community.
 - Show what caused the person to commit to making this particular change to reduce his/her HIV risk.
 - Describe in as much detail as possible the barriers that were encountered and setbacks that occurred. Describe how the individual resolved these problems to enable eventual success in achieving his or her goal.
 - End the story on a positive but realistic note in terms of expectations for the future.
 - Limit the story to no more than 1-1¼ single-spaced pages.

RELEASE TO USE PERSONAL STORY

I hereby assign all rights to the sound and/or video recording made of me this date to the agency named below. I authorize without limitation the reproduction, editing, adaptation, copyright, exhibition, broadcast, and/or distribution of this material for nonprofit educational purposes in the format or formats specified below.

Name of agency to which rights are assigned: _____

Media format approved: Sound recording Video recording Printed material

I approve the use of my real name (first name only) in these materials: Yes No

I certify that I understand that this material will be used solely for the purpose of educating others about the risks and dangers of HIV and/or hepatitis C infection, and that I am being portrayed as a person who has successfully made changes in personal behavior in order to decrease my risk of acquiring or transmitting HIV or hepatitis C.

Client name (print) _____ Staff signature _____

Client signature _____ Date _____

APPENDIX H

Sample Risk Reduction Success Stories

JOLEEN'S STORY

My name's Joleen, and they've asked me to tell about how I started using condoms. I don't use them every time I have sex, but I do try to use them for sure if I'm high or I've had some beers. That's because I'm sometimes not too careful who I go with when I've been doing drugs and stuff, and the condoms keep me from catching HIV or something else.

Anyway, here's what happened. Time was, I'd let guys do me, and I didn't worry about condoms or anything else. I'd heard talk about how you could get HIV and other stuff, but I'd never been sick, and I didn't know anybody who'd got HIV or AIDS. Then one day I saw my best girlfriend, Lori, and, man, did she look down. She told me her boyfriend, the one she had been with for almost two years, had got himself tested at the health department because outreach worker said he'd better. Then she says, "They told him he has the HIV/AIDS thing. Probably got it from the needle." Well, I just couldn't believe it, but it was true. So I said, "What about you girl, are you OK?" Lori comes back, "I got tested too—thank God we'd been using condoms, and it turns out I'm OK."

Well, you can believe me when I tell you I was worried then. Here's my very best friend since I can't remember when, and her very own boyfriend turns up with HIV. And he didn't even look sick at all—I just saw him last month. The way I looked at it, if *he* had HIV, and Lori didn't know it even though she was *living* with him, what about these guys I've just been *partying* with? If Lori's guy could have HIV, my guys could have it in spades—that's the way I thought. I said to myself, "I could give up sex, but I don't see that happening." What I finally figured is this: If Lori could use condoms with her steady guy, I could use them with my party guys. At least I could try.

The thing was, I didn't know how to start. To be honest, I didn't even know if I could do it. So I went back to Lori. She had been using condoms with her steady, she said, so I would ask her advice. And, after all, she was my very best friend in the whole world.

When I saw Lori, she told me right off, "Girl, I am so glad you are going to start looking out after yourself." Then I told her my worries and how I wasn't sure I could do it. Lori came right back, "We'll figure it out, and we'll make a plan." And that's what we did.

Right off, we decided I would carry plenty of condoms with me all of the time. Then no need to worry when I might be partying. Well, I found out pretty fast that just having a condom around didn't mean the guy was gonna put it on. I got a lot of back talk, and I have to admit I didn't stand my ground.

Again, Lori to the rescue. She told me how you could you could sweet talk a guy so he would use a condom. If that didn't work, she told me how she put her foot down with her boyfriend so he learned what's what. I was worried some of the guys would cut me out because of the condom thing—I usually get a taste of their stuff whenever I want. Lori said that won't happen—that the guys would accept the condoms once they got the picture. "Anyway," she said, "they'll hear when you tell how those condoms will protect them too. They won't say it, but you can believe they're listening."

To tell the truth, it wasn't that easy, especially at first. And if it wasn't for Lori, I don't think I could have done it. It took a lot of trying, and I guess for a while I didn't do that good. But Lori stuck with me, and she helped me figure out what to do every time a new problem came up. In the end, she was right—the guys did go along with the condom thing, and now I feel safe.

RANDY'S STORY

My name is Randy, and I'll tell you straight I'm proud of what I've done. I'd been wanting to clean up for a long time—at least a part of me did—but do something about it was something else. Anyway, getting myself in a treatment program, with all the stuff you had, to do just wasn't happening. At least that's what it was like before the outreach worker who comes around got involved. One day I just sort of casual asked him how easy it was to get in a program if you wanted to. The worker was kind of cool about it; he just said there was a good program downtown he knew about, and he could talk to me more about in it whenever I wanted. I said, "OK, maybe sometime," and let it drop. A couple of months later, as it turned out, I actually did get in that drug program, and so far I'm staying with it. Like I said, I'm kind of proud of myself because, if you want to know the truth, it wasn't all that easy and it didn't happen overnight.

Here's how it happened: One day I confess I was feeling pretty bad when the outreach worker came by handing out the usual—you know, condoms, bleach kits, and those little cards that show where you can get food and stuff. I was pretty strung because I hadn't scored at all that day, and I guess it showed. The worker told me I really could get in that drug program downtown if I wanted to, and he said he would help me. "Like get real," I thought, "Now, what are *you* gonna do to help me?" So I said, "If you mean giving me another one of those stupid cards with some address on it, don't bother." Well, long story short, the worker said he really could help me get in the program, but it would take a couple of weeks to get in. So I said, "OK, let's go." It wasn't like I really believed him or anything, but the way I felt so sick not scoring, it was easier to shine him on.

As it turned out, it was no joke, him helping me out. The next day, the worker was back again and started telling me more about getting in that drug program. I wasn't sick by then, and I felt pretty mellow, so I was cool with listening. Also, my girlfriend had been on me like forever about getting in a program, and I guess that had something to do with it too. Anyway, the worker set up this plan with me, sort of step by step—exactly what I needed to do and making sure I wouldn't slip up. First thing, I had to call in on the phone, and I had to set a time for when I was going to do it. After that, we took it one step at a time and figured out exactly what I had to do each day.

During the next couple of weeks, the worker kept asking me how I was doing, was I still on track to get in the program, and talked about making sure I could stay with the plan. He said he really believed I was going to get accepted in the treatment program. Also, I was hearing a lot of positive stuff from my girlfriend—how it was so great I was finally doing this treatment thing. So, bottom line, I started feeling pretty good about doing this thing. And I started trying harder to do all the stuff I was supposed to do to get in the program, like checking in with the treatment guys every day. Let me be straight—it wasn't a piece of cake; I had to start over from scratch a couple of times. But once I got going, it was like, "I can do this." So I finally got in the program, and it looks like the start of something good.

So what I'm saying is this. At first, I just sort of half wanted to get in a treatment program, and I didn't believe deep down I really could anyway. But things started changing once I got going, and I know that outreach worker helped me do it.

APPENDIX I

The ABCs of Smart Behavior

THE ABCS OF SMART BEHAVIOR

To Avoid or Reduce the Risk for HIV and Viral Hepatitis

- A** Stands for abstinence.
- B** Stands for being faithful to a single sexual partner.
- C** Stands for using condoms consistently and correctly.

APPENDIX J

Male Latex Condoms and Sexually Transmitted Diseases



For more information:
 CDC's National Prevention Information Network
 (800) 458-5231 or www.cdcnpin.org

CDC National STD/HIV Hotline
 (800) 227-8922 or (800) 342-2437
 En Espanol (800) 344-7432
www.cdc.gov/std

Fact Sheet for Public Health Personnel:

Male Latex Condoms and Sexually Transmitted Diseases

In June 2000, the National Institutes of Health (NIH), in collaboration with the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), and the United States Agency for International Development (USAID), convened a workshop to evaluate the published evidence establishing the effectiveness of latex male condoms in preventing STDs, including HIV. A summary report from that workshop was completed in July 2001 (<http://www.niaid.nih.gov/dmid/stds/condomreport.pdf>). This fact sheet is based on the NIH workshop report and additional studies that were not reviewed in that report or were published subsequent to the workshop (see "[Condom Effectiveness](#)" for additional references). Most epidemiologic studies comparing rates of STD transmission between condom users and non-users focus on penile-vaginal intercourse.

Recommendations concerning the male latex condom and the prevention of sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV), are based on information about how different STDs are transmitted, the physical properties of condoms, the anatomic coverage or protection that condoms provide, and epidemiologic studies of condom use and STD risk.

The surest way to avoid transmission of sexually transmitted diseases is to abstain from sexual intercourse, or to be in a long-term mutually monogamous relationship with a partner who has been tested and you know is uninfected.

For persons whose sexual behaviors place them at risk for STDs, correct and consistent use of the male latex condom can reduce the risk of STD transmission. However, no protective method is 100 percent effective, and condom use cannot guarantee absolute protection against any STD. Furthermore, condoms lubricated with spermicides are no more effective than other lubricated condoms in protecting against the transmission of HIV and other STDs. In order to achieve the protective effect of condoms, they must be used correctly and consistently. Incorrect use can lead to condom slippage or breakage, thus diminishing their protective effect. Inconsistent use, e.g., failure to use condoms with every act of

intercourse, can lead to **STD** transmission because transmission can occur with a single act of intercourse.

While condom use has been associated with a lower risk of cervical cancer, the use of condoms should not be a substitute for routine screening with Pap smears to detect and prevent cervical cancer.

Sexually Transmitted Diseases, Including HIV

Sexually transmitted diseases, including HIV

Latex condoms, when used consistently and correctly, are highly effective in preventing transmission of HIV, the virus that causes AIDS. In addition, correct and consistent use of latex condoms can reduce the risk of other sexually transmitted diseases (STDs), including discharge and genital ulcer diseases. While the effect of condoms in preventing human papillomavirus (HPV) infection is unknown, condom use has been associated with a lower rate of cervical cancer, an HPV-associated disease.

There are two primary ways that STDs can be transmitted. Human immunodeficiency virus (HIV), as well as gonorrhea, chlamydia, and trichomoniasis – the discharge diseases – are transmitted when infected semen or vaginal fluids contact mucosal surfaces (e.g., the male urethra, the vagina or cervix). In contrast, genital ulcer diseases – genital herpes, syphilis, and chancroid – and human papillomavirus are primarily transmitted through contact with infected skin or mucosal surfaces.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical basis for protection. Condoms can be expected to provide different levels of protection for various sexually transmitted diseases, depending on differences in how the diseases are transmitted. Because condoms block the discharge of semen or protect the male urethra against exposure to vaginal secretions, a greater level of protection is provided for the discharge diseases. A lesser degree of protection is provided for the genital ulcer diseases or HPV because these infections may be transmitted by exposure to areas, e.g., infected skin or mucosal surfaces, that are not covered or protected by the condom.

Epidemiologic studies seek to measure the protective effect of condoms by comparing rates of STDs between condom users and nonusers in real-life settings. Developing such measures of condom effectiveness is challenging. Because these studies involve private behaviors that investigators cannot observe directly, it is difficult to determine

accurately whether an individual is a condom user or whether condoms are used consistently and correctly. Likewise, it can be difficult to determine the level of exposure to STDs among study participants. These problems are often compounded in studies that employ a “retrospective” design, e.g., studies that measure behaviors and risks in the past.

As a result, observed measures of condom effectiveness may be inaccurate. Most epidemiologic studies of STDs, other than HIV, are characterized by these methodological limitations, and thus, the results across them vary widely--ranging from demonstrating no protection to demonstrating substantial protection associated with condom use. This inconclusiveness of epidemiologic data about condom effectiveness indicates that more research is needed--not that latex condoms do not work. For HIV infection, unlike other STDs, a number of carefully conducted studies, employing more rigorous methods and measures, have demonstrated that consistent condom use is a highly effective means of preventing HIV transmission.

Another type of epidemiologic study involves examination of STD rates in populations rather than individuals. Such studies have demonstrated that when condom use increases within population groups, rates of STDs decline in these groups. Other studies have examined the relationship between condom use and the complications of sexually transmitted infections. For example, condom use has been associated with a decreased risk of cervical cancer – an HPV associated disease.

The following includes specific information for HIV, discharge diseases, genital ulcer diseases and human papillomavirus, including information on laboratory studies, the theoretical basis for protection and epidemiologic studies.

HIV / AIDS

HIV, the virus that causes AIDS

Latex condoms, when used consistently and correctly, are highly effective in preventing the sexual transmission of HIV, the virus that causes AIDS.

AIDS is, by far, the most deadly sexually transmitted disease, and considerably more scientific evidence exists regarding condom effectiveness for prevention of HIV infection than for other STDs. The body of research on the effectiveness of latex condoms in preventing sexual transmission of HIV is both comprehensive and conclusive. In fact, the ability of latex condoms to prevent transmission of HIV has been scientifically established in “real-life” studies of sexually active couples as well as in laboratory studies.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical basis for protection. Latex condoms cover the penis and provide an effective barrier to exposure to secretions such as semen and vaginal fluids, blocking the pathway of sexual transmission of HIV infection.

Epidemiologic studies that are conducted in real-life settings, where one partner is infected with HIV and the other partner is not, demonstrate conclusively that the consistent use of latex condoms provides a high degree of protection.

Discharge Diseases, Including Gonorrhea, Chlamydia, and Trichomoniasis

Discharge diseases, other than HIV

Latex condoms, when used consistently and correctly, can reduce the risk of transmission of gonorrhea, chlamydia, and trichomoniasis.

Gonorrhea, chlamydia, and trichomoniasis are termed discharge diseases because they are sexually transmitted by genital secretions, such as semen or vaginal fluids. HIV is also transmitted by genital secretions.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical basis for protection. The physical properties of latex condoms protect against discharge diseases such as gonorrhea, chlamydia, and trichomoniasis, by providing a barrier to the genital secretions that transmit STD-causing organisms.

Epidemiologic studies that compare infection rates among condom users and nonusers provide evidence that latex condoms can protect against the transmission of chlamydia, gonorrhea and trichomoniasis. However, some other epidemiologic studies show little or no protection against these infections. Many of the available epidemiologic studies were not designed or conducted in ways that allow for accurate measurement of condom effectiveness against the discharge diseases. More research is needed to assess the degree of protection latex condoms provide for discharge diseases, other than HIV.

Genital Ulcer Diseases and Human Papillomavirus

Genital ulcer diseases and HPV infections

Genital ulcer diseases and HPV infections can occur in both male or female genital areas that are covered or protected by a latex condom, as well as in areas that are not covered. Correct and consistent use of latex condoms can reduce the risk of genital herpes, syphilis, and chancroid only when the infected area or site of potential exposure is protected. While the effect of condoms in preventing human papillomavirus infection is unknown, condom use has been associated with a lower rate of cervical cancer, an HPV-associated disease.

Genital ulcer diseases include genital herpes, syphilis, and chancroid. These diseases are transmitted primarily through "skin-to-skin" contact from sores/ulcers or infected skin that looks normal. HPV infections are transmitted through contact with infected genital skin or mucosal surfaces/fluids. Genital ulcer diseases and HPV infection can occur in male or female genital areas that are, or are not, covered (protected by the condom).

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical basis for protection. Protection against genital ulcer diseases and HPV depends on the site of the sore/ulcer or infection. Latex condoms can only protect against transmission when the ulcers or infections are in genital areas that are covered or protected by the condom. Thus, consistent and correct use of latex condoms would be expected to protect against transmission of genital ulcer diseases and HPV in some, but not all, instances.

Epidemiologic studies that compare infection rates among condom users and nonusers provide evidence that latex condoms can protect against the transmission of syphilis and genital herpes. However, some other epidemiologic studies show little or no protection. Many of the available epidemiologic studies were not designed or conducted in ways that allow for accurate measurement of condom effectiveness against the genital ulcer diseases. No conclusive studies have specifically addressed the transmission of chancroid and condom use, although several studies have documented a reduced risk of genital ulcers in settings where chancroid is a leading cause of genital ulcers. More research is needed to assess the degree of protection latex condoms provide for the genital ulcer diseases.

While some epidemiologic studies have demonstrated lower rates of HPV infection among condom users, most have not. It is particularly difficult to study the relationship between condom use and HPV infection because HPV infection is often intermittently detectable and because it is difficult to assess the frequency of either existing or new

infections. Many of the available epidemiologic studies were not designed or conducted in ways that allow for accurate measurement of condom effectiveness against HPV infection.

A number of studies, however, do show an association between condom use and a reduced risk of HPV-associated diseases, including genital warts, cervical dysplasia and cervical cancer. The reason for lower rates of cervical cancer among condom users observed in some studies is unknown. HPV infection is believed to be required, but not by itself sufficient, for cervical cancer to occur. Co-infections with other STDs may be a factor in increasing the likelihood that HPV infection will lead to cervical cancer. More research is needed to assess the degree of protection latex condoms provide for both HPV infection and HPV-associated disease, such as cervical cancer.

Department of Health and Human Services

For additional information on condom effectiveness, contact
CDC's National Prevention Information Network
(800) 458-5231 or www.cdcnpin.org

APPENDIX K

Nonoxynol-9 Spermicide Contraception Use

Nonoxynol-9 Spermicide Contraception Use—United States, 1999

MMWR, May 10, 2002 (Vol. 51, No. 18).

Most women in the United States with human immunodeficiency virus (HIV) become infected through sexual transmission, and a woman's choice of contraception can affect her risk for HIV transmission during sexual contact with an infected partner. Most contraceptives do not protect against transmission of HIV and other sexually transmitted diseases (STDs) (1), and the use of some contraceptives containing nonoxynol-9 (N-9) might increase the risk for HIV sexual transmission. Three randomized, controlled trials of the use of N-9 contraceptives by commercial sex workers (CSWs) in Africa failed to demonstrate any protection against HIV infection (2--4); one trial showed an increased risk (3). N-9 contraceptives also failed to protect against infection with *Neisseria gonorrhoeae* and *Chlamydia trachomatis* in two randomized trials (5,6), one among African CSWs and one among U.S. women recruited from an STD clinic. Because most women in the African studies had frequent sexual activity, had high-level exposure to N-9, and probably were exposed to a population of men with a high prevalence of HIV/STDs, the implications of these studies for U.S. women are uncertain. To determine the extent of N-9 contraceptive use among U.S. women, CDC assessed data provided by U.S. family planning clinics for 1999. This report summarizes the results of that assessment, which indicate that some U.S. women are using N-9 contraceptives. Sexually active women should consider their individual HIV/STD infection risk when choosing a method of contraception. Providers of family planning services should inform women at risk for HIV/STDs that N-9 contraceptives do not protect against these infections.

CDC collected information on types of N-9 contraceptives purchased and family planning program (FPP) guidelines for N-9 contraceptive use. The national FPP, authorized by Title X of the Public Health Service Act, serves approximately 4.5 million predominantly low-income women each year. Program data for 1999 were obtained from all 10 U.S. Department of Health and Human Services (HHS) regions on the number of female clients and the number of female clients who reported use of N-9 contraceptives or condoms as their primary method of contraception. CDC obtained limited purchase data for 1999 for specific N-9 contraceptives and program guidelines from eight state/territorial FPPs within six HHS regions. State health departments, family planning grantees, and family planning councils were contacted to request assistance in collecting data on purchasing patterns of the 91 Title X grantees; of the 12 FPPs that responded, eight provided sufficient data for analysis.

In 1999, a total of 7%--18% of women attending Title X clinics reported using condoms as their primary method of contraception. Data on the percentage of condoms lubricated with N-9 were not available. A total of 1%--5% of all women attending Title X clinics reported using N-9 contraceptives (other than condoms) as their primary method of contraception ([Table 1](#)). Among the eight FPPs that provided purchase data, most (87%) condoms were N-9--lubricated ([Table 2](#)). All eight FPPs purchased N-9 contraceptives (i.e., vaginal films and suppositories, jellies, creams, and foams) to be used either alone or in combination with diaphragms or other contraceptive products. Four of the eight clinics had protocols or program guidance stating that

N-9--containing foam should be dispensed routinely with condoms; two additional programs reported that despite the absence of a clinic protocol, the practice was common. Data for the other two programs were not available.

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Editorial Note:

The findings in this report indicate that in 1999, before the release of recent publications on N-9 and HIV/STDs (4,6,7), Title X family planning clinics in the U.S. purchased and distributed N-9 contraceptives. Among at least eight family planning clinics, most of the condoms purchased were N-9--lubricated; this is consistent with trends in condom purchases among the general public (8). The 2002 STD treatment guidelines state that condoms lubricated with spermicides are no more effective than other lubricated condoms in protecting against the transmission of HIV infection and other STDs (7). CDC recommends that previously purchased condoms lubricated with N-9 spermicide continue to be distributed provided the condoms have not passed their expiration date. The amount of N-9 on a spermicide-lubricated condom is small relative to the doses tested in the studies in Africa and the use of N-9--lubricated condoms is preferable to using no condom at all. In the future, purchase of condoms lubricated with N-9 is not recommended because of their increased cost, shorter shelf life, association with urinary tract infections in young women, and lack of apparent benefit compared with other lubricated condoms (7).

Spermicidal gel is used in conjunction with diaphragms (1); only diaphragms combined with the use of spermicide are approved as contraceptives. The respective contributions of the physical barrier (diaphragm) and chemical barrier (spermicide) are unknown, but the combined use prevents approximately 460,000 pregnancies in the United States each year (1).

The findings in this report are subject to at least two limitations. First, data on specific products and patterns of contraceptive use were limited; CDC used a nonrepresentative sample of regions and states that voluntarily provided data, and specific use patterns of the contraceptives could not be extrapolated from these data. Second, data correlating use of N-9 contraceptives with individual HIV risk were not available.

Prevention of both unintended pregnancy and HIV/STD infection among U.S. women is needed. In 1994, a total of 49% of all pregnancies were unintended (9). Furthermore, 26% of women experience an unintended pregnancy during the first year of typical use of spermicide products (1). In 1999, a total of 10,780 AIDS cases, 537,003 chlamydia cases, and 179,534 gonorrhea cases were reported among U.S. women. Contraceptive options should provide both effective fertility control and protection from HIV/STDs; however, the optimal choice is probably not the same for every woman.

N-9 alone is not an effective means to prevent infection with HIV or cervical gonorrhea and chlamydia (2,7). Sexually active women and their health-care providers should consider risk for infection with HIV and other STDs and risk for unintended pregnancy when considering contraceptive options. Providers of family planning services should inform women at risk for HIV/STDs that N-9 contraceptives do not protect against these infections. In addition, women seeking a family planning method should be informed that latex condoms, when used consistently and correctly, are effective in preventing transmission of HIV and can reduce the risk for other STDs.

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APPENEDIX L

Social Event Risk Reduction Activity: Sharing Social Support Stories

SOCIAL EVENT RISK REDUCTION ACTIVITY

Sharing Social Support Stories (20 Minutes)

Objectives:

- To elicit stories from clients about people who provided them with social support and encouragement as they worked toward their personal risk reduction goal.
- To identify unmet needs for social support.
- To articulate means for obtaining unmet needs.

Facilitator's Script:

Let's take a few minutes to talk about something important. It's about the people who have helped us.

What I would like for us to think about are the people who have helped us with the special goals we have set for ourselves to reduce our risk of HIV and viral hepatitis.

Everybody in *SAFETY COUNTS* has a personal goal. All of you have been working on your goals, and it isn't always easy.

Who in your life has helped you with your goal? Who has given you some support and encouragement about working on your goal when you needed it? How many people have had somebody help them like that?

Ask for a show of hands. (If there are no hands, ask how many clients would like to have someone who would support them. In such a situation, reframe the remainder of the activity to focus on obtaining stories from clients about desired social support.)

Who will share with us?

Call on a volunteer to tell his or her support story. Ask questions to draw out the client if needed. Guide the client as necessary to ensure that the story stays focused on social support that was provided for the client's risk reduction goal, not social support in general.

Who helped you with your goal, and what kind of help did they give?

Thank you.

Give applause.

Who else will share?

Call on a second volunteer to share his or her support story. (If there is sufficient time, you may ask for a third volunteer.)

Thank you all for sharing. Those were great stories!

Give applause.

It really does help to have somebody who is in your corner—somebody with a sympathetic ear. When you're trying to do something new, it's a lot easier if there's somebody who believes in you and knows you can do it.

Now let's shift gears a bit. I'd like to ask some of you who didn't raise your hands: What kind of support from others would you like to have for your risk reduction goal? What is your personal support wish list? Would you rather have support from one special person, or from several people?

Who would be willing to share their wish list?

Call on a volunteer. Write the client's main points on easel paper. Try to keep the client's wish list focused on social support for achieving risk reduction goals.

Thank you for sharing.

Give applause.

Who else has a wish list for personal support they would like to share?

Call on a second volunteer. Write the client's main points on easel paper.

Thank you both for sharing. That was great!

Give applause.

Now, how do you think you could go about getting the personal support you don't already have? What are some things you could do to get what you need?

Write suggestions on easel paper. Try to get as many clients as possible involved in making suggestions, not just the two clients who shared their wish lists.

Looking at this list, there are a lot of different things we can do to get the support we need from other people.

Review the main themes in the list of suggestions recorded on the easel paper.

So, there are things we can do to get the personal support we need.

From what we've heard today, we can see that personal support from other people can really mean a lot when you need it. If you have support from somebody, it helps you stay on track and helps you meet your goal. Now that we know some ways to go about getting that support, we don't just have to wait for it to happen.

THE END