TECHNICAL ASSISTANCE GUIDE

OVERVIEW OF THE SHIELD TECHNICAL ASSISTANCE GUIDE.....1

INTRODUCTION TO THE SHIELD INTERVENTION.....2

CORE ELEMENTS OF THE SHIELD INTERVENTION.....6

FREQUENTLY ASKED QUESTIONS.....7

SHIELD Background.....8

Preparation and Getting Started.....10

Staffing..... .11

SHIELD Participants.....12

Recruitment, Screening and Retention.....15

Implementation Logistics.....18

Facilitation.....21

SHIELD Curriculum and Activities.....24

Adapting SHIELD.....28

Fidelity and Evaluation.....31

SHIELD ADAPTATION GUIDE.....33

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,
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) and
6) Centers for Disease Control and Prevention- IDU and HIV Prevention: Syringe Disinfection for Injection Drug Users

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.

The SHIELD intervention package was developed by a team at the Johns Hopkins Bloomberg School of Public Health:

- Dr. Carl Latkin (PI)
- Dr. Karin Tobin (Co-PI)
- Dr. Melissa Davey-Rothwell (Project Director), and
- Kellie Burns (Project Assistant).

We acknowledge the support provided by the Centers for Disease Control and Prevention (CDC) through cooperative agreement #1H62PS000580-02 for the development of this product and by Dr Carl Latkin in which this product is based. SHIELD is one in a series of products sponsored by CDC's Prevention Research Branch-Replicating Effective Programs (REP). The SHIELD REP project was funded 100 percent by the CDC.

The SHIELD research study was conducted by Dr. Carl Latkin (PI) at the Johns Hopkins Bloomberg School of Public Health. This study was funded by the National Institute on Drug Abuse (1 R01 DA13142). For more information about the outcomes of the study, please refer to:

Latkin, CA, Sherman, S, & Knowlton, A. (2003). HIV prevention among drug users: Outcome of a network-oriented peer outreach intervention. Health Psychology, 22(4), 332-339.

Special thanks to the case study agencies for testing the SHIELD intervention package:

- Recovery in Community (Baltimore, MD)
- Transitioning Lives, Inc. (Baltimore, MD)

Also thanks to the Centers for Disease Control and Prevention (CDC) (Cooperative agreement #1H62PS000580-02) team:

- Dr. Patricia Jones, Prevention Research Branch Project Officer, Centers for Disease Control and Prevention
- Dr. Jonny Andia, Capacity Building Branch, Centers for Disease Control and Prevention
- Carla Galindo, MPH, Capacity Building Branch Training and Development Training Specialist.

Overview of the SHIELD Technical Assistance Guide

The target audience for the SHIELD Technical Assistance (TA) Guide is staff who are involved in the preparation and implementation of the SHIELD intervention including Agency Administrators, Project Managers, Facilitators, and Recruiters.

The TA Guide is designed to be a quick reference for implementing agencies and should be used along with the **SHIELD Project Manager's Guide** and **SHIELD Facilitators Guide**.

This guide is set up in a brief question and answer format. The questions are Frequently Asked Questions (FAQs) that have arisen during preparation and implementation of SHIELD.

Each question is grouped by topic area for easy reference.

Overview of the SHIELD Intervention

The Self-Help in Eliminating Life-threatening Diseases (SHIELD) intervention is a group level HIV prevention intervention that trains current and former drug users to be **Peer Educators**. As a **Peer Educator**, participants learn communication skills to conduct peer outreach to people in their social network. Also, they are taught information about HIV risk and prevention, as well as risk reduction skills.

The SHIELD Intervention has 2 main goals:

1) To train individuals to be **Peer Educators** who conduct outreach with peers by sharing HIV risk reduction information.

As a **Peer Educator**, participants learn risk reduction information and skills. They also learn communication skills (called **PEER** Communication skills) to prepare them for peer outreach. While many people think that peer outreach is done with the community at-large or with strangers, in the SHIELD program, peer outreach is focused on people that the **Peer Educator** knows well or feels very comfortable with such as drug or sex partners, family, friends, support group members, etc. These individuals make up the Peer Educators' "Social Network".

2) To reduce **Peer Educators**' own HIV risk behaviors.

Participants also begin to use the HIV risk reduction information and skills that they learn in the SHIELD sessions to change their own risky behaviors and to maintain credibility as a **Peer Educator**.

These aims are achieved through the following skills-building activities:

SHIELD Skills-Building Activities	
Peer Communication Skills Building Activities	***HIV Risk Reduction Skills Building Activites***
• Facilitator Role-Models • Group Problem-Solving • Role-Plays	• Risk Reduction Ladders • Demonstrations • Games

The SHIELD intervention is delivered through 6 fun and interactive sessions. Each session lasts for 1½ -2 hours and is held in a small group setting (4-12 participants). The small group setting is important for **Peer Educator** training because it facilitates participants' sharing and learning from each others' experiences.

Each SHIELD Group is led by two trained facilitators. Information, referrals, and risk reduction materials are delivered through facilitated discussion, skills building activities, role-plays, and demonstrations. In each session, participants are assigned homework to practice their **Peer Educator** skills outside the group setting.

The topics of the SHIELD intervention sessions are:

Session 1: Introduction to the Peer Educator role and Peer Outreach

Session 2: Peer Educator Communication skills (PEER)

Session 3: Reducing Sexual Risk Behavior-Part 1

Session 4: Reducing Sexual Risk Behavior-Part 2

Session 5: Reducing Injection Drug Use Risk Behavior

Session 6: Graduation and Sustaining Peer Outreach

It is important to emphasize that each of the 6 SHIELD sessions focus on a range of risk reduction options, including abstinence and condom use, that people can practice to prevent HIV. SHIELD is not appropriate for agencies whose sole mission is abstinence from sex or cessation of drug use.

Please refer to the **SHIELD Facilitators Guide** for more detail on the intervention sessions.

Theoretical Foundations of SHIELD

Theoretical foundation refers to the behavior change theory that underlies the SHIELD intervention. The SHIELD intervention was built upon four psychological theories: Social Cognitive Theory, Social Identity Theory, Cognitive Dissonance (or inconsistency) Theory and Social Influence Theory. Each of these theories guides the Peer Educator approach to HIV risk reduction.

Social Cognitive Theory proposes that there are four components necessary for a behavior change to occur: 1) knowledge, 2) development of skills to reduce risk and regulate risk, 3) peer support to reduce risk and 4) self efficacy to reduce risk (belief that one can be successful). In the SHIELD intervention, Peer Educators received psychosocial cognitive skills training to reduce HIV risk behaviors and the opportunity to practice their skills to increase self-efficacy.

Social Identity Theory suggests that individuals classify themselves in terms of group labels. Once an individual begins to identify with a group, they act according to what they perceive other group members are doing. For example, as participants attend each intervention session, they may begin to consider themselves a part of the **Peer Educator** group. In addition, if they perceive that other **Peer Educators** are similar to them, their self-efficacy for conducting peer education may increase. Also, individuals may become motivated to practice HIV risk reduction behavior.

According to ***Cognitive Dissonance Theory***, individuals want their actions to match their words. As **Peer Educators** begin to engage in HIV prevention outreach in their social network, they may change their own risky behaviors in order to make their behaviors and their statements consistent. By talking to their social network members (e.g., partners, friends and family members) about using condoms and not sharing needles, **Peer Educators** may become motivated to adopt these same risk reduction strategies. Furthermore, individuals may begin to adopt safer behaviors to maintain their credibility as **Peer Educators.**

Social Influence Theory proposes that individual behavior is shaped by observing other people in the social environment and modeling the observed behaviors. In addition, an individual is more likely to adopt a given behavior if they feel they are similar to the person they are observing. After learning risk reduction information and skills in the SHIELD intervention sessions, the **Peer Educators** go out into their community to share the information with their social network members. They also model safer behaviors. As social network members observe the safer behaviors of **Peer Educators** (who they perceive as similar to themselves) they may be influenced to change their own risky behaviors.

SHIELD Target Population- Who is SHIELD for?

In the original SHIELD research study, the participants were 94% African American, 61% Male, 85% unemployed, 65% reported less than $500 of income in the past 30 days, and 57% had less than a high-school education. The average age of participants was 39 years.

SHIELD is designed for adults (18 years and older) and may be implemented with men and women as well as individuals who are HIV positive or HIV negative. SHIELD, which has primarily been implemented with heroin and cocaine users, is appropriate for former and current drug users who interact with other drug users. While some participants have been injection drug users, others have been non-injection drug users who interact with injection drug users. Agencies may adapt SHIELD to implement with non-injection drug users or other populations such as methamphetamine users.

In the SHIELD study, many participants were in drug recovery when they went through the **Peer Educator** training. Recovery is a different experience for each individual. Some individuals who are in recovery can interact with other drug users while others may relapse as a result of this interaction trigger. Agencies working with individuals who are in recovery are cautioned to carefully assess if the SHIELD intervention is appropriate for a particular individual. Also, agencies need to decide if a mixed group (i.e., active drug users and individuals in recovery) is appropriate at their agency.

Peer Education requires motivation, social skills, and dedication. Therefore, it is important that a participant has a willingness and interest in conducting Peer Outreach (See Project Managers' Guide).

In addition, participants must have frequent interactions with individuals at risk for HIV such as current drug users in order to conduct their Peer Outreach.

Setting

SHIELD was originally conducted in an urban, community-based research clinic. Although the setting may vary, it is important to hold the intervention in a location that is easily accessible by the target population. It is recommended that agencies offer directions or maps of public transportation routes to the setting. Confidentiality is an important component, therefore sessions should take place in a non-threatening, "safe" place for participants.

Number of Participants

The original SHIELD intervention sessions were held with the number of participants ranging from 4-12. In the Pre-implementation section of this guide, we offer guidance for the number and composition of each SHIELD cycle.

Timing and Frequency of Sessions

The timing of intervention sessions should be convenient and consistent for participants. SHIELD sessions have been implemented in mornings, afternoons, evenings, and weekends. We recommend holding 2 sessions per week and having at least a day in between sessions. For example, hold Session 1 on Monday and Session 2 on Thursday. The following week, hold Session 3 on Monday and Session 4 on Thursday. As a formative activity, agencies should talk to members of the target population to determine ideal times to hold the intervention sessions. Agencies are encouraged to put together a calendar of session dates prior to implementation. (See example calandar in SHIELD Handouts for Participants Folder)

Each set of Sessions 1-6 is considered a SHIELD cycle.

Research Findings

The SHIELD intervention was effective at producing the following results among **Peer Educators** 6 months after they completed the intervention:

- Increased condom use during vaginal sex with casual sex partners (16% of **Peer Educators** vs 4% of control group);
- Increased condom use during oral sex with casual sex partners (12% of **Peer Educators** vs 3% of control group);
- Reduced needle sharing (69% of **Peer Educators** vs 30% of control group);
- Decreased injection drug use frequency (48% of **Peer Educators** vs 25% of control group); and
- Stopped using injection drugs (44% of **Peer Educators** vs 22% of control group)

Details about the SHIELD research may be found in the following articles:

For information about study design, procedures, and outcomes:

Latkin, CA, Sherman, S, & Knowlton, A. (2003). HIV prevention among drug users: Outcome of a network-oriented peer outreach intervention. Health Psychology, 22(4), 332-339.

For information about Peer Outreach activities:

Latkin, CA, Hua, W, & Davey, MA (2004). Factors associated with peer HIV prevention outreach in drug-using communities.. AIDS Education and Prevention, 16(6), 499-508.

For information about Peer Educator's experience:

Dickson-Gomez, JB, Knowlton, A, & Latkin C. (2004). Values and identity: the meaning of work for injection drug users involved in volunteer HIV prevention outreach. Substance Use & Misuse, 39(8), 1259-1286.

Benefits of Implementing SHIELD

The SHIELD intervention may reach high-risk individuals who are hidden or hard-to-reach. SHIELD is a low cost intervention and requires few resources and minimal technology.

SHIELD participants have reported tangible and intangible benefits from participating in SHIELD.

- Learning new information and getting risk reduction materials that they can use to be safer themselves.
- Gaining pride in being a part of the solution rather than the problem in the fight against HIV in their community.
- Having increased self-esteem; and respect from family and friends.
- Receiving respect from family and friends.

Core Elements of the SHIELD Intervention

The SHIELD intervention has been shown to be effective in changing risky sex and drug behaviors among former and current drug users.

Below is a list of the five Core Elements of the SHIELD intervention and supporting rationale behind each one. Each of these core elements must be maintained to ensure fidelity to the SHIELD intervention. Without each of the core elements, the intervention may not be effective at changing HIV risk behaviors. Refer to the **SHIELD Project Manager's Guide** for detail on the rationale behind each of the core elements.

1) SHIELD is implemented in a small group setting to offer participants an environment that is conducive to sharing experiences and gaining social support from peers.

2) Participants go through the SHIELD Sequence - a series of activities that includes pre-program contact and six intervention sessions in a specified sequence.

3) Each SHIELD intervention session follows a specific structure that includes 5 components.

4) SHIELD sessions aim to build three sets of skills necessary for participants to be a **Peer Educator**. These skills are:
   - Communication skills for conducting effective Peer Outreach (**PEER**)
   - HIV drug-related risk reduction techniques
   - HIV sex-related risk reduction techniques

5) Every session includes interactive **Peer Educator** training activities which build Peer Outreach skills and increase **Peer Educator** self-efficacy. Through increased self-efficacy, participants develop a **Peer Educator** Identity. Activities include:
   - Facilitator Role-models
   - Group Problem-solving activities
   - Role-plays

SHIELD

A PEER-LED PROJECT

SHIELD BACKGROUND

With whom, when and where was the original SHIELD study tested?

SHIELD was funded by the National Institute on Drug Abuse and the Principal Investigator is Carl Latkin, PhD, from the Johns Hopkins Bloomberg School of Public Health. SHIELD was conducted in Baltimore, MD in the late 1990s.

In the original SHIELD research study, the SHIELD participants were 94% African American, 61% Male, 85% unemployed, 65% reported less than $500 of income in the past 30 days, and 57% had less than a high-school education. The average age of participants was 39 years.

What were the results of the original research study?

SHIELD was effective at producing the following results among Peer Educators six months after they completed the intervention:

- Increased condom use during vaginal sex with casual sex partners (16% of **Peer Educators** vs 4% of control group);
- Increased condom use during oral sex with casual sex partners (12% of **Peer Educators** vs 3% of control group);
- Reduced needle sharing (69% of **Peer Educators** vs 30% of control group);
- Decreased injection drug use frequency (48% of **Peer Educators** vs 25% of control group); and
- Stopped using injection drugs (44% of **Peer Educators** vs 22% of control group)

Participants from the original study also reported additional benefits from the SHIELD intervention including:

- Learning new information and getting risk reduction materials that they can use to be safer;
- Gaining pride in being a part of the solution rather than the problem in the fight against HIV in their community; and
- Having increased self-esteem

What is a core element?

Core elements are specific components of the original SHIELD intervention that have been determined to be the underlying basis for behavior change. The SHIELD intervention has 5 core elements. It is essential to adhere to these core elements as you implement SHIELD at your agency. If you do not adhere to all 5 core elements then you will not be doing the SHIELD intervention and may not see the same results in behavior change.

What are the core elements of SHIELD?

1) SHIELD is implemented in a small group setting to offer participants an environment that is conducive to sharing experiences and gaining social support from peers.

2) Participants go through the SHIELD Sequence - a series of activities that includes pre-program contact and six intervention sessions in a specified sequence.

3) Each SHIELD intervention session follows a specific structure that includes 5 components.

4) SHIELD sessions aim to build three sets of skills necessary for participants to be a **Peer Educator**. These skills are:

- Communication skills for conducting effective Peer Outreach (**PEER**)
- HIV drug-related risk reduction techniques
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5) Every session includes interactive **Peer Educator** training activities which build Peer Outreach skills and increase **Peer Educator** self-efficacy. Through increased self-efficacy, participants develop a **Peer Educator** Identity. Activities include:

- Facilitator Role-models
- Group Problem-solving activities
- Role-plays

How is SHIELD different from a support group?

A support group is a group of individuals who share a common problem or challenge, such as addiction or mental health problems. A support group comes together regularly to discuss the challenges and provide social support to each other.

Although participants are encouraged to share experiences and offer social support, the SHIELD group sessions focus on a specific curriculum to teach peer education and risk reduction skills. Clients that are in need of support groups should be referred to other services. Clients may participate in SHIELD and a support group simultaneously.

How is SHIELD different from drug treatment?

The SHIELD intervention is designed for former and current drug users. One of the goals of SHIELD is to decrease HIV risk by changing sex and drug risk behaviors. While some SHIELD participants may decrease or cease their drug use as a result of being in the program, the alternatives that are presented in the SHIELD intervention sessions include various risk reduction options includng cleaning syringes before injecting. Individuals who are seeking drug treatment or recovery services should be referred to other services.

PREPARATION AND GETTING STARTED

How do I obtain "buy-in" from those inside and outside my agency?

It is important to get "buy-in" from all stakeholders before implementing SHIELD. Each agency should identify an intervention *Champion*, someone who will advocate for implementation of the SHIELD intervention. Most importantly, the champion should be someone who is enthusiastic and knowledgeable about the SHIELD intervention. The first step of this process is to hold an introductory meeting with stakeholders. This meeting provides an opportunity for administrators to introduce the SHIELD intervention as well as discuss how the agency and clients will benefit from implementing the program. It is also a chance to get feedback from stakeholders and answer their questions.

Your agency's intervention Champion can use the stakeholder's checklist as a guide (See **SHIELD Project Manager's Guide**). The checklist contains those items the Champion can use to convince the stakeholders that the SHIELD intervention can and should be implemented because it meets the needs of the community your agency serves.

Who are the community stakeholders?

The community stakeholders include any person or organization that has a stake in the successful implementation of the intervention. This group includes clients, agency staff, the Board of Directors/ Executive Board, funding sources, and other community agencies that may be referral sources as well as organizations your agency refers SHIELD participants to.

What materials should my agency review to help us implement SHIELD most effectively?

Prior to implementation, staff should review the **SHIELD Project Manager's Guide**. The **SHIELD Project Manager's Guide** describes the procedures and steps needed to prepare for, implement and maintain the SHIELD intervention.

Agencies should also review the **SHIELD Facilitators Guide**. This guide contains the SHIELD curriculum. Facilitators will use this guide as they deliver the SHIELD sessions. Thus, they need to become familiar with its content and prepare their delivery prior to implementation. Also found in this guide is a section entitled "HIV and Injection 101". We recommend that all facilitators who are new to the field of HIV prevention and injection drug use review this guide in detail as it will provide them with knowledge and confidence in this area. This guide may also be informative to seasoned HIV prevention workers.

Finally, staff should review the original SHIELD articles that describe the behavior changes that occurred among SHIELD **Peer Educators** as well as the peer outreach experiences. Copies of these articles are included in the **SHIELD Project Manager's Guide.**

What resources, other than those included in the package, are necessary in order to implement SHIELD?

In addition to the SHIELD intervention package, there are several materials and resources needed to implement SHIELD and conduct the intervention sessions. The supplies may be used for administrative tasks, recruitment, facilitating intervention sessions, and evaluation. Refer to the **SHIELD Project Manager's Guide** for a detailed list of the recommended resources. Your agency may already have access to many of these items.

For additional questions or technical assistance, adapters should call their funder or the CDC. Another useful website is: **www.effectiveinterventions.org**.

STAFFING

How many staff members are needed to implement SHIELD at my agency?

At a minimum, SHIELD should be implemented with 2 Full-Time Equivalents (FTEs). These staff members will be responsible for recruiting participants, marketing the program, facilitating sessions, and conducting evaluation activities. The following staff breakdown is recommended:

- One Project Manager (50%)
- Two Facilitators (50% each)
- One Recruiter (50%)

This proposed staffing assumes that your agency has additional staff in place such as an administrative assistant, receptionist, and administrator who are responsible for the overall functioning of the organization. Their duties may include answering phone calls, scheduling appointments, ordering supplies, etc.

How should I go about recruiting staff members for SHIELD?

Potential candidates for staff positions can be recruited through posted advertisements in newsletters, online job search engines, and community venues. In addition, networking and talking to people who also work in your field is a great way to recruit staff.

Can former SHIELD participants be hired by an agency?

You may find that after graduation, SHIELD participants want to continue being a part of your organization. It is up to your agency to decide if you want to hire past clients and in what capacity they would function best. One activity that past participants may be highly suited for is recruitment. By sharing their experiences and interacting with former and current drug users, past participants may bring in new, hard-to-reach participants.

Can we hire 1 person to be the Project Manager and a Facilitator?

We do not recommend having one staff member who is the Project Manager and Facilitator. One of the Project Manager's responsibilities is to supervise the Facilitator which includes observing some of the sessions and offering feedback on their facilitation. The Project Manager can serve as a back-up facilitator when an emergency situation arises.

Can we hire 1 person to be the Recruiter and a Facilitator?

One person can play the dual role of recruiter and facilitator as long as they are able to complete all of essential tasks for each position. In this situation, there would be a 100% FTE (50% facilitator & 50% recruiter).

SHIELD PARTICIPANTS

Do we have to target the same population served in the original research study?

SHIELD is designed for adults (18 years and older) and may be implemented with men and women as well as individuals who are HIV positive or HIV negative. SHIELD, which has primarily been implemented with heroin and cocaine users, is appropriate for former and current drug users who interact with other drug users. While some participants have been injection drug users, others have been non-injection drug users who interact with injection drug users. Agencies may adapt SHIELD to implement with non-injection drug users or other populations such as methamphetamine users. Beyond these guidelines, SHIELD can be adapted to suit your agency's needs. The most important thing is that participants are comfortable talking to former & current drug users or people at risk for HIV through their sex behaviors in order to conduct their Peer Outreach.

What is the minimum number of participants for a group session? What is the maximum?

SHIELD has been implemented with 4-12 participants. The ideal group size is 6-8 participants which is easily managed by 2 co-facilitators and allows for optimal group interaction and participation. Groups of less than 6 can be challenging because poor attendance at a session may disrupt group dynamics. Also, groups greater than 8 can be difficult to manage.

Can we deliver the intervention to groups of mixed ages, races or sexual orientations?

Yes, SHIELD has been implemented with mixed groups of men and women who have represented a variety of ages, race/ethnicities, and sexual orientations. In addition, SHIELD has been implemented as a single-gender group.

Are persons living with HIV eligible to participate in SHIELD?

Yes - SHIELD has been implemented with both HIV negative and HIV positive persons.

Can a client be in SHIELD and a support group, such as AA or NA, or other agency program simultaneously?

Yes, it is plausible and even likely that clients will be involved in other programs while they are a SHIELD participant. In these instances your agency simply needs to be upfront about addressing attendance issues, making sure the client can attend all 6 SHIELD sessions without any conflicts. This process begins with the Pre-Program contact where the calendar of sessions is distributed. If a client is unable to attend the sessions, they should be referred to a future SHIELD cycle.

Can a group have both active drug users and individuals in recovery?

This decision is entirely up to your agency. It depends both on the comfort level of your facilitators as well as the comfort of your participants. As noted previously, SHIELD has been conducted with current and former drug users as well as individuals in recovery, all meeting together in the same group.

If your agency does decide to include former drug users or those in recovery, it is important to consider that exposure to information and/or descriptions of scenarios about safer drug injection and drug splitting may trigger someone to relapse, even if they are well into recovery.

To prepare for such triggers, agencies are encouraged to develop a relapse prevention plan to:

- Prepare participants for exposure to the information in the project (e.g. indicating to the group that the next activity will be a demonstration reviewing properly cleaning a needle);
- Accommodate participants who become uncomfortable during an activity (e.g. allowing them to step out of the room during the activity);
- Deal with clients who relapse as a result of exposure to the activity (e.g. providing counseling and/or referrals to drug treatment or support groups); and
- Describe procedures for intervening with the client, staff roles and assignments, referrals, and resources.

What is the best way to deal with a client who is being disruptive to the group?

Facilitators of the SHIELD intervention can expect to encounter difficult or challenging participants from time to time. While we cannot realistically anticipate the wide variety of challenges which may arise, our experience in delivering the intervention does allow us to predict several common types of difficulties and offer some suggestions for overcoming them.

Dealing with a disruptive participant can be challenging. Trying to handle it in front of the group often escalates the situation and may cause embarrassment to the participant, which often makes things worse. Thus, a recommended strategy is for one facilitator to address the disruptive participant in a private setting outside of the group while the other facilitator continues on with the session.

Participants with cognitive problems (that may or may not be related to mental health problems) can also be challenging. They sometimes ask seemingly endless questions or become excessively focused on trivial aspects of an issue or take the discussion into irrelevant areas. It is important that facilitators seek a balance between taking care of the person with the issue and making sure the group is still useful for other participants. One strategy is to tell the participant that their question can be discussed more fully after the end of the session, but that in the interest of covering all the material in that session it is necessary to move on. If the problem is ongoing, facilitators may want to discuss it with their supervisors and decide if the person should continue to participate or not. In addition, the facilitator and supervisor may identify referrals for these participants.

In general, if a problem comes up once it will likely come up again in a different group. For this reason, regular meetings with supervisors, where group facilitation issues are discussed, are an important part of delivering the SHIELD intervention. It is also usually best to address a problem when it first appears, rather than ignore it and hope it will go away. Group members often try to test the boundaries of group rules; facilitators will have an easier time if they enforce the rules firmly, but with humor and good nature.

What should we do if a participant comes to a SHIELD session and they are high or intoxicated?

Since the SHIELD intervention targets drug users, one of the most common problems is participants who come to sessions after using alcohol or drugs. This can create problems in several ways; the participant may be too intoxicated to effectively take part in the group; the intoxicated participant may be disruptive to the activities of the group or the other group members may find the presence of an intoxicated participant disturbing or irritating. It is important to establish a clear expectation about drug use while formulating group rules. We have found that it is not necessary to prohibit participants from coming to the group high: rather, we have emphasized the importance of managing drug use so one is able to participate.

If a participant is nodding out or otherwise appears to be excessively intoxicated, a facilitator should take a moment to talk quietly (or privately, if possible) with the individual and suggest that he or she might like to get a cup of coffee, wash their face, walk around or otherwise seek to freshen up a bit. In general, this will be successful. If not, it is up to the discretion of the facilitator as to whether the participant should be asked to leave or not. If their presence is not causing problems, it is often best to allow them to stay as it is possible they will return to a more normal level of consciousness in a short period of time.

Sometimes intoxicated participants are actively disruptive to group process. This is particularly true if alcohol is involved. In these cases, it is best to ask the participant to settle down and perhaps to step outside for a few moments. The facilitator may want to warn the person that continued disruptive behavior will result in their being asked to leave the session.

Participants who are not using drugs, particularly those who are relatively new to recovery, may find the mere presence of an obviously intoxicated participant disturbing. If the offended participant brings it to the attention of the facilitator privately, the facilitator can handle the issue privately with the participant. If it is brought up publicly in the group, then the facilitator will need to say something with all group members present. Exactly what to say and how to address the issue will depend upon the exact nature of the group, group rules around drug use and the particular individuals involved. In general, it is best if facilitators reflect the concern of the offended individual, but also reiterate that group members are all at different places regarding drug use and that we need to allow people to be part of the group even if they are still using. Often the theme of mutual respect is a good way of bridging the gap; the participant who is excessively high is not respecting the group, but others need to respect participants who are using.

RECRUITMENT, SCREENING AND RETENTION

How and where should SHIELD participants be recruited?

SHIELD participants have been recruited through a variety of strategies including:

1) Advertising during existing programs. For example, at weekly NA or AA meetings, staff can inform clients about the SHIELD program.

2) Street outreach to sites with high levels of drug activity (e.g., street corners).

3) Collaborations with outside agencies that may provide referrals or allow flyers to be posted (e.g., homeless shelters, Social Service agencies, health clinics).

4) Media venues such as local newspapers, radio programs, community newsletters.

5) Word-of-mouth like participants spreading information about the program to others in the community.

During the pre-implementation stage, the Project Manager and recruiter should outline a plan for marketing the SHIELD intervention and recruiting participants. See "Developing a recruitment monitoring system" in the **Project Manager Guide** for more guidance.

My agency is going to pass out flyers to recruit SHIELD participants. What should the flyers say?

Flyers should be simple and appealing to the target population. In addition, agencies should create flyers that do not require a high level of literacy. Input from participants and other stakeholders is useful when designing recruitment materials. These flyers should be passed out as part of street outreach and posted in appropriate locations such as social services agencies, shelters, clinics, etc.

Keep in mind that different flyers may attract different people so we recommend using a wide variety. Each flyer should have a 'catchy' phrase to attract an individual's attention. Some phrases that we have found effective in recruiting **Peer Educators** are:

- Want to make a difference in the community?
- Want to learn how you can fight HIV?
- Do you want to be trained to be a **Peer Educator**?

In addition to a catchphrase, other important information should be listed on the flyer including:

- SHIELD contact person at your agency;
- Hours of operation; and
- Next step that a potential participant should take (e.g., call, walk in) to find out more information.

Is it ok to recruit SHIELD participants who are currently using services at my agency?

Once your agency begins holding SHIELD session, word-of-mouth may spread and existing clients may express interest in participating. Existing clients may participate in SHIELD if they are eligible. As with any potential participants, existing clients should be screened during the Pre-program Contact.

Why do all potential clients need to be screened before being enrolled in SHIELD?

All participants must be screened prior to being enrolled in the intervention. Screening is part of the SHIELD sequence, which in turn is one of the five core elements. As you might recall from training, core elements must be maintained to ensure fidelity to the SHIELD intervention.

Screening is also important because it allows your agency to asses the appropriateness of the SHIELD intervention for each particular client, including their availability to attend all sessions and their willingness and comfort with becoming a Peer Educator. At this time you will also gather contact information, allowing you to get back in touch with the client.

What does "T" stand for on Enrollment form?

This T stands for Transgendered. This categorization can be used by a person whose appearance, personal characteristics, or behaviors differ from cultural stereotypes that determine the roles and identity of men and women.

SHIELD is designed to be an all inclusive intervention and as such it is intended that persons of all genders and sexual orientations may participate. Just as your agency may gather referral information for housing or drug treatment it may also be a good idea to prepare resources that are pertinent to the Lesbian, Gay, Bisexual, and Transgendered (LGBT) community.

Do clients need to sign a consent form to participant in the intervention?

A consent form is not required for SHIELD participation. However, some agencies may choose to have participants complete a consent form. Regardless of whether a consent form is used, all staff should talk to participants about confidentiality.

Are non-participants allowed to attend the sessions?

Sometimes there may be people who want to observe a SHIELD session. These observers may be people from one of your funding sources or someone from another agency who is interested in implementing SHIELD themselves. If someone does request to sit in on a group session, it is important to check with participants first to see if anyone objects. If participants object, an observer should not remain in the session. Once participants agree, facilitators should introduce the observer to the group and let clients know the purpose of the observation. We have found that clients are usually receptive to observers, but it is always important to be attentive to clients' comfort levels.

Can a participant bring a friend, spouse, child or anyone else into a group session?

No, participants are not allowed to bring other individuals into a group session. One of the most important qualities of a SHIELD group is the level of comfort that participants feel to share experinces openly and participate without judgment. After a rapport has been built between group members, bringing an outside person into the group will likely disrupt the comfort level for some or all participants.

How can I retain participants during SHIELD?

Retention of participants through the 6-session training is just as important as recruitment. Each session covers new information and provides opportunity to practice Peer Outreach skills.

One strategy to help with retention is to provide reminder calls and letters to SHIELD participants. Prior to Session 1, the facilitators and recruiter should send out letters to participants to remind them of the date, time, and location of the upcoming session. In addition, making reminder calls to participants before each session, including Session 1, is a helpful strategy to keep participants attending the intervention sessions. Simply calling participants and saying "*We look forward to seeing you in the group*" is an effective way to motivate them to continue coming to the program.

Another strategy that has led to successful retention of participants is offering incentives. In the original research study, participants were given $15 for each intervention session that they attended. Other incentives that have been used include gift cards, t-shirts, transportation tokens, and snacks. Another incentive strategy that some agencies have utilized is raffling off prizes after each session. In addition, agencies may offer non-financial incentives. For example, recovery houses or drug treatment centers may offer participants an extra "day pass" for each SHIELD session that they complete.

My agency has a limited budget. Do we have to offer incentives?

No, agencies are not required to offer incentives, but they can help if you are experiencing retention problems. If a limited budget is the main barrier, agencies are encouraged to contact stores and other vendors to find out if they are willing to donate gift cards or items that can be used as incentives. Another option is to offer non-financial incentives (see previous question).

Incentives are most important in the beginning 2-3 sessions, but less important once participants become engaged in the process of becoming a **Peer Educator**. Once participants start buying into the **Peer Educator** approach, they will have internal motivation for coming to the sessions and may not need tangible incentives.

IMPLEMENTATION LOGISTICS

What types of agencies have implemented SHIELD?

SHIELD has been implemented with community-based programs that offer HIV prevention and social services as well as drug treatment and recovery programs. Agencies have implemented SHIELD with clients in different stages of drug use including active drug users, individuals in recovery or treatment, and individuals who are sober.

My agency has an abstinence-only mission. Is SHIELD appropriate for us?

If your agency follows an abstinence-only model, SHIELD is not appropriate for your clients. The SHIELD sessions focus on risk reduction options that people can choose to lower their risk for HIV. Although these options include abstinence, several other options are also included such as condom use and going to a Needle Exchange program. Many of the intervention activities revolve around these options. Thus, implementing agencies need to be open to presenting a range of risk reduction options.

Can SHIELD be implemented by a drug treatment program so that recruitment into drug treatment is one of the outcomes?

Although some participants of the original SHIELD study did report decreased injection drug use or drug use cessation, it is not the main goal of the SHIELD intervention to recruit participants into drug treatment. If an agency would like to measure this outcome, entry into drug treatment, they are certainly able to design their own assessment tools or seek out technical assistance to help with evaluation.

What do we need to consider when selecting a setting or location to hold the SHIELD sessions?

There are several features of a setting/location that make it ideal for holding SHIELD sessions. First, the place should be private and secure so participants are ensured confidentiality. Second, the place needs to be easy to find and access. Third, the place needs one large room that can comfortably hold up to 14 people (i.e. 2 facilitators and 12 participants).

Is it okay to conduct the intervention in a correctional setting, such as a prison, jail, or detention center?

SHIELD has not been tested in a correctional facility. It is likely that conducting the intervention in this type of setting will present unique challenges. For example, it will be difficult for participants to do homework since they interact with a limited number of people. In addition, protocols in correctional settings may prohibit the use of materials such as condoms and syringes that are used in some of the SHIELD activities.

Can the intervention be conducted in a transitional housing facility where most clients are in recovery?

Yes, SHIELD has been implemented in a transitional housing facility. House managers and their supporting agencies will need to assess the appropriateness of SHIELD for their own clients. Because all individuals living in transitional housing are usually expected to stay clean, your agency should fully consider that some activities may serve as triggers for drug use.

What happens in a SHIELD intervention session?

Sessions 2-6 follow a specific curriculum and are led by 2 facilitators. One of the SHIELD Core Elements states that the sessions must follow the SHIELD Session Structure which is a basic outline of all sessions. Session 2-6 follow the same structure which consists of 5 components:

1) Homework Check-in;
2) Presentation of new information;
3) **Peer Educator** Training Activities;
4) Homework assignment and practice; and
5) Summary.

By following this structure, risk reduction and communication skills are reinforced and participants have opportunities to practice their Peer Outreach. Session 1 does not follow the SHIELD structure because the focus is on introducing the concepts of **Peer Educator** and Peer Outreach. Therefore, the primary activity of session 1 is brainstorming and group discussion.

Facilitators follow the scripts and procedures as they proceed through the SHIELD session structure. Many of the activities are interactive so that participants are engaged. During the sessions, both facilitators and participants offer feedback and support to each other.

What time of day should we hold the sessions?

SHIELD has been implemented during the morning, afternoon, and evening. The timing of intervention sessions should be convenient and consistent for participants. During the pre-implementation phase, agencies should talk to potential clients to determine ideal times to hold the intervention sessions. Conflicts to consider include house meetings, curfews and outside programs. Agencies are encouraged to put together a calendar of session dates prior to implementation. (See SHIELD Handouts for Participants Folder for an example of a calendar handout).

How many SHIELD sessions should be held each week?

Holding 1-2 sessions per week is ideal. This schedule will keep the information and skills fresh in participants' minds as well as provide ample time to practice Peer Outreach skills. Based on feedback from past participants, we highly recommend having at least one day in between sessions for **Peer Educators** to practice their Peer Outreach activities.

Does SHIELD have an attendance policy?

Attending each session of the SHIELD intervention, with the same group of participants, is important for participants to be fully trained as **Peer Educators**. Agencies are responsible for developing their own attendance policy. Some agencies may allow participants to miss 1 session while other may require attendance at all 6 sessions.

When determining your attendance policy, keep the following information in mind that we have learned from experience:

- The more sessions a **Peer Educator** attends the more effective their Peer Outreach is and the more likely they are to change their own behaviors.
- New participants should not be introduced to the SHIELD group after Session 1 has been held. Adding an individual who has missed the introduction session may prevent others from opening up and it disrupts group dynamics.
- Once a client starts with 1 group, they should remain in that group. Thus, if a client misses Session 3 they shouldn't make it up with another group. Staying with the same group is important for social support and group bonding.

One of my clients needs to miss a session. Does that mean they can't come anymore?

This decision is up to the discretion of your agency. Some agencies may allow clients to miss a SHIELD session. However, if a client has to miss Session 1, they may not begin a group at Session 2, rather they must wait until the next SHIELD cycle begins. Adding an individual who has missed the introduction session may prevent others from opening up and disrupt group dynamics.

Although a client cannot sit in on a session that they miss, a facilitator may briefly meet with the client before the next session to review the information they missed. Although this brief meeting may help the participant stay up-to-date with the information, the client will miss the social support and feedback of the small-group setting. Thus, a brief 1:1 meeting is not a substitute for a SHIELD session.

Some clients have expressed interest in coming to SHIELD sessions but can't commit to all 6 sessions. What should we do?

It is important to get commitment from potential participants upfront. If there is any hesitation on the clients' part there should be careful consideration of enrolling them in that particular SHIELD cycle. You may have to recommend that they wait for a future cycle when they are more available. In an attempt to avoid participant conflicts, try to choose a schedule that works best for your target population. Consider talking to potential clients before recruitment begins to get a better idea of the optimal time to hold sessions. And again, some scheduling conflicts will be avoided if a calendar of sessions is created prior to recruiting participants. (See **SHIELD Handouts for Participants Folder** for an example calendar template).

FACILITATION

What kind of qualifications do SHIELD facilitators need to have?

SHIELD Facilitators should have the following qualities:

- Experience working with drug-using populations
- Knowledge of HIV risk reduction options
- Good verbal communication skills to engage participants
- Broad familiarity with local community resources
- Awareness of own comfort level and skills
- Ability to think on one's feet (since each set of clients is different)
- Non-judgmental
- Empathetic

Why do we need to have 2 facilitators?

SHIELD intervention sessions contain a lot of material and skills-building activities. Thus, having two facilitators is highly preferred to effectively divide the labor and energy to prepare for and facilitate each session.

What are the benefits of co-facilitation?

There are a number of benefits to co-facilitation including:

- Complimentary styles - each person brings their own style.
- Increased engagement of participants - together facilitators can monitor & foster participation better than either could do alone.
- Dealing with intense situations or disruptive clients - when a group member shares emotionally charged experiences it is always helpful to have one facilitator be able to support that individual while the other facilitator monitors the rest of the group members' reactions.
- Feedback and check-ins - when facilitators work together they can provide each other with important feedback regarding their facilitation skills. They can also check-in with each other when events occur in the group that were difficult or that evoked personal feelings from facilitators.
- Modeling - each facilitator serves as a behavioral model to participants. Co-facilitation allows for two models of individuals coping with their own life situations, but also allows a model of a relationship as demonstrated by how facilitators relate to each other in the groups.
- Shared leadership - participants can become very demanding or argumentative with facilitators. Co-facilitation allows for a sharing of this role and often diffuses these types of problems.
- Pacing - this intervention demands close attention to pacing & time management. Co-facilitating assists each facilitator to pace himself more effectively since facilitators can alternate the role of intervener and observer.
- Source of support - co-facilitators support each other which can help prevent burnout and adds to the experience of the group participants.

If one of the facilitators can't come to a session, should we reschedule the session or only have 1 facilitator?

Just as it is important for participants to commit to the 6 sessions, it is also important for facilitators to be available for all sessions. That being said, sometimes unforeseen events will prevent a facilitator from attending a session. If the size of the group is small (i.e. less than 6 participants) the session can be held with the remaining facilitator. Another strategy is to have a back-up facilitator who can stand in for the facilitator during the session.

My agency is going to have a back-up facilitator, who should that be?

The back-up facilitator should be someone that has attended the Training of the Facilitators (TOF) and is available on the days when SHIELD sessions are held. Some agencies may plan to have the Project Manager or Recruiter trained as a back-up since this person should stay up to date with the SHIELD program anyway. Agencies should consider introducing the back-up facilitators during Session 1. That way, if they are called to stand in, it will be a familiar face for participants.

What if a session needs to be cancelled, but the participants still want to meet?

It is up to your agency to decide if participants are allowed to gather at your location for something other than a SHIELD session. If participants continue to meet, your agency should consider having a staff member around who can monitor the group. Also, clients should be informed that this gathering is not a replacement for a SHIELD session. The session that was missed will need to be made up before the group can move on to the next session.

Do facilitators have to attend the TOF?

Yes, attending the Training of Facilitators (TOF) is important for all potential facilitators who will facilitate SHIELD sessions. The TOF training devotes a lot of time for skills-building, asking questions and addressing agency specific issues. In-house trainings are not sufficient to prepare someone to facilitate the SHIELD intervention because they often do not include enough skills-building activities and guidance on conducting the sessions.

Since there needs to be 2 facilitators who will conduct the intervention, agencies should consider sending 3 or 4 staff persons to the TOF so that additional staff members can be trained as back-up facilitators.

Do facilitators have to memorize all of the scripts?

No, it is not intended that facilitators memorize the SHIELD scripts. During the first few SHIELD cycles, facilitators should use the scripts until they are familiar with the material. Eventually, facilitators will become comfortable and familiar with the SHIELD content and take home points so that they can convey the message in their own words, which often results in a more powerful delivery. However, as facilitators practice and prepare to deliver the session we do encourage that they read the scripts. Facilitators should not be discouraged if they need to follow the scripts closely for their first few cycles.

Do the facilitators who conduct the intervention need to be the same race and ethnicity as the clients? Same gender?

No, this is not a core element of the SHIELD intervention. However, given part of the theoretical foundation of SHIELD, which says that an individual is more likely to adopt a given behavior if they feel they are similar to the person they are observing, agencies should assess their ideal characteristics for a facilitator during pre-implementation.

Since SHIELD is for former and current drug users, does a facilitator have to be a former drug user?

Former or current drug use is not a prerequisite for facilitators. However, we recommend having someone who has experience working with drug-using populations. By having this experience, facilitators will be better informed about drug use behaviors and terminology and will be able to handle any challenges that arise.

How should we handle facilitator turnover? Can new facilitators be oriented and trained?

The best way to prepare for facilitator turnover is to have back-up facilitators trained and available. As we mentioned before, for someone to facilitate a SHIELD group they need to have attended the TOF. This is why we recommend sending more than 2 facilitators to the initial training.

May a former SHIELD participant serve as a co-facilitator in future groups?

It is up to your agency to decide if a former SHIELD participant has the adequate group facilitation skills to be a co-facilitator. When considering former participants, keep in mind all of the essential qualities that a SHIELD facilitator should possess. In addition, keep in mind that this person also needs to attend the TOF prior to conducting any of the SHIELD groups.

How much preparation time is needed before each session?

Preparation is important for each session and includes a variety of activities such as: 1) walking through the procedures and scripts with co-facilitators; 2) conducting “mock” sessions; 3) writing posters; 4) arranging the room; 5) printing or copying handouts, etc. The amount of time needed for preparation will vary by session. In the **SHIELD Facilitators Guide**, there is a list of preparation tasks that should be done before each session. Facilitators should review this list and complete each activity at least one day before the session will be held.

What should I do if I don’t know the answer to a participant’s question?

Participants may ask questions that facilitators do not know the answers to. The best thing to do is to tell the participant that you are unsure of the answer, but will research it and bring an answer to the next session. It is better to be upfront with the participants and say “I don’t know” rather than guessing or making up an answer. This response also demonstrates to participants what they can do when a question comes up during their Peer Outreach that they are unsure of how to answer.

SHIELD CURRICULUM AND ACTIVITIES

Some of the scenarios in the SHIELD session are not relevant to our clients? Are we allowed to change them?

The scenarios in the package should be used as guides. However, agencies may adapt them to make the situation more relevant to their clients. When adapting a scenario, it is important to make it realistic and not too complicated. You may even choose to use a real-life situation that your client brings up.

Can SHIELD graduates go to a session and share their experience?

Yes, it can be very positive for SHIELD graduates to share their experience with new participants. Testimonials may encourage and motivate **Peer Educators** to trust in their ability to do outreach work. Session 1 or 2 is an ideal time to arrange this activity as this is the time when **Peer Educators** may have the most apprehension.

What is a risk ladder and how do we use it?

A risk ladder is an intervention prop used to show participants that sex and drug behaviors have varying levels of risk associated with them. The ladder is designed so that the risky behaviors are at the top and as you move down the ladder, one moves to safer behaviors. There are 3 risk ladders used in the SHIELD intervention sessions: 1) Safer Sex (Session 3); 2) Safer Injection (Session 5); and 3) Safer Drug Splitting (Session 5).

How should facilitators describe the risk ladders?

Facilitators should start at the top and work their way down the ladder because as you move through the ladder, you are presenting safer options to participants.

Can we add behaviors to the risk ladder?

Behaviors should not be added to the risk ladder unless there is firm evidence that supports placement of the behavior on the ladder. The behaviors that are included are common and their risk levels have been established.

How are role-plays conducted?

This activity can be conducted between two clients or a facilitator and a client depending on the group members' comfort level. The aim of this activity is to have participants practice using their **Peer Educator** skills in a supportive environment and gain feedback. Participants who participate in the role-play will also have the opportunity to receive suggestions for improving their skills. The procedures for conducting role-plays include:

- Facilitators ask for volunteers for the role-play; one to play the **Peer Educator** and one as the peer. If no one volunteers, or feels comfortable, then the facilitator can play the **Peer Educator** and encourage another client to play the peer or vice versa.
- Facilitators pick a scenario provided in the curriculum and read the scenario to the group to "set the scene". [Facilitators may also ask the volunteers/group if they have a scenario that they would like role-played.]
- Facilitators remind the group of who is playing each role, **Peer Educator** and Peer.
- Conduct the role-play.
- After the role-play, facilitators acknowledge both volunteers.
- Facilitators debrief how the role-play was with the **Peer Educator** using their skills and solicit feed back from the group.

Facilitators may find it useful to "freeze" the role-play so that they can engage the group in problem-solving and discussing how the **Peer Educator** can handle the situation or give the **Peer Educator** suggestions. The "freeze" is not intended to distract the group from the skills practice but to clarify and enhance the practice. To "freeze" the role-play a facilitator can say "time-out" or "freeze".

What is a debriefing session? When is it conducted and who attends?

Debriefing sessions take place after a SHIELD session. At the end of each intervention session, facilitators should briefly meet with the Project Manager to discuss how the session went. The debriefing gives facilitators a chance to reflect on each session and problem-solve solutions when challenges arise. Many topics may be covered in the debriefing such as a description of participants, problems with the curriculum, examples of successful Peer Outreach, etc. The **SHIELD Facilitators Guide** and **SHIELD Project Manager's Guide** contain a list of suggested facilitator debriefing questions.

Who should Peer Educators do their Peer Outreach with?

While many people think that Peer Outreach is done with the community at-large or with strangers, in the SHIELD program, Peer Outreach is focused on people that the **Peer Educator** knows or feels comfortable with such as drug or sex partners, family, friends, support group members, etc.

Who should be the Homework Buddy?

SHIELD participants may choose anyone that they know to be a Homework Buddy. However, facilitators should offer the following guidelines to assist participants in choosing this person:

- Someone who could benefit from the HIV prevention information being presented in SHIELD;
- Someone who is supportive to the participant and will be willing to commit to doing homework assignments for the 6 sessions; and
- Someone who the participant sees at least weekly.

The homework assignment should be a positive and rewarding experience. So if a client says they want to do the homework with someone with whom they also have a lot of conflict, facilitator should encourage them to pick a more supportive person.

Does a participant have to do the homework assignment with the same person each time?

Peer Educators should be encouraged to do their homework assignments with the same person throughout the duration of the SHIELD program. By doing the assignment with the same person, **Peer Educators** will build self-efficacy for Peer Outreach.

Can homework be done over the phone or does it have to be face-to-face?

Ultimately, facilitators should encourage a majority of face-to-face contact with a Homework Buddy. Occasional phone use is okay as long as they are also interacting with their Homework Buddy in person. The biggest emphasis for homework should be placed on a client's effort to do their homework. If telephone is the only way for a participant to contact their Homework Buddy than they should be commended for doing the best job they could as a **Peer Educator.**

Can clients have more than 1 Homework Buddy?

Yes, clients can certainly have more than one Homework Buddy. The more practice a client can get during the intervention the higher their self-efficacy will be for taking on the **Peer Educator** identity. However, please keep in mind that it is best if Homework Buddies stay consistent throughout the intervention. For example, it is okay if a client has 2 Homework Buddies that he or she does the homework with every week, however, participants should not switch around Homework Buddies (i.e. do homework with Buddy A for Sessions 1, 3, & 5 and homework with Buddy B for Sessions, 2, 4, & 6).

What should I do if a participant does not do their homework assignment?

Facilitators should stress that the homework assignments are important for **Peer Educators** to practice their peer outreach skills. There will be instances where your participants do not do the homework assignments. During the homework check-in facilitators should ask participants their reason for not doing the homework. Once the participant offers a reason, the facilitator and other group members can problem-solve and develop solutions to motivate participants to do their next homework assignment.

It is taking me longer/shorter to complete the session than is suggested in the SHIELD Facilitators Guide? What are some possible reasons for this?

Each of the activities of the SHIELD sessions has a recommended time frame. Sometimes an activity may go longer or shorter. One reason for a longer session may be the size of the group. Larger groups (i.e. 10-12 participants) may take longer so that each participant has time to practice their skills and engage in activities. Another common reason for a longer session (which may or may not be attributed to the group size) is a lot of discussion or questions by group members. Questions will arise and facilitators should try to answer all participants' questions. However, facilitators should also keep track of time to make sure that the questions and discussions do not take too long.

If you find that you are unable to complete the session within the 90 minute time frame, you might need to invest in more preparation time, which will allow you to be more concise without omitting any important components.

There are several common reasons for shorter sessions. First, just as larger groups may take up more time, smaller groups may take up less time. Another reason for a shorter session is that a component is inadvertently skipped. Facilitators should make sure that they follow each of the procedures outlined in the session.

Ninety minutes seems like a long time for a session. What can the facilitators do to prevent the participants from getting bored?

Facilitators and participants may be surprised at how quickly the 90 minutes goes by. The sessions are designed to be fun, educational, and interactive to prevent boredom. The majority of activities engage participants either through games, discussions, or skills-building activities. If facilitators sense that some of the participants are bored, they should try to engage these participants and get them involved in the activities. In addition, each session has a built in "break" so that participants can have a short breather, use the restroom, grab a snack, or smoke a cigarette.

Some of our clients have low literacy levels. What should we do?

There are two areas where literacy levels may be a concern, but both can be overcome using simple alternative methods.

One area to consider is the use of visual aids and handouts during the SHIELD sessions. Many of these visuals contain wording to describe a particular topic. To accommodate those with low literacy levels, facilitators should always read materials out loud. Reading aloud will actually assist the entire group in absorbing information.

Another area to consider is completing evaluation forms. Although these forms can be completed alone by the client, it is also plausible for a facilitator to read the evaluation questions aloud and mark the client's responses.

ADAPTING SHIELD

Can we add a session or two to cover more information?

One of the Core Elements is the SHIELD Sequence which consists of: 1) Pre-program contact; 2) Sessions 1-6. Although a session may not be added (such as Session 7) to the cycle, agencies may choose to offer booster sessions. Booster sessions are an opportunity to reinforce Peer Outreach skills as well as present new information. Thus, if an agency wants to cover more detailed information about a topic such as Hepatitis, a booster session could be held. If booster sessions are held, facilitators should follow the booster session outline in the **SHIELD Facilitators Guide.**

Can we change material or an activity that does not apply to our target population?

Refer to the Adaptation Guide for information for changing material or an activity.

Can we delete material or an activity that does not apply to our target population?

Refer to the Adaptation Guide for information on deleting material or an activity.

Most SHIELD sessions are designed to last about 90 minutes; can certain elements be consolidated or eliminated so that the session can be done in a shorter amount of time?

The most important thing to think about when considering an adaptation to the SHIELD intervention is fidelity to the core elements. With this in mind, it would be difficult to consolidate or cut out certain parts of the session without compromising the session structure, which is a core element. It is this structure which gives sufficient time for acquisition of knowledge, skills-building, and review and explanation of homework.

If a session is supposed to last a certain amount of time, can the session be made longer if clients want to stay?

Sometimes sessions may run over the allotted time and this is okay as long as everyone in the group is in agreement that they want to continue the session. It is important to be respectful of every person's schedule and to allow them the opportunity to leave at the scheduled time. Facilitators should check in with the group when they realize that they may run over time or someone suggests staying longer.

If you are running over time consistently, keep in mind the attention level and fatigue of your participants. If the group seems less controllable or more lethargic as time goes on it is not a good idea to extend the sessions.

Can the order of sessions be changed?

No, the order of the SHIELD sessions may not be changed. Changing the order would violate the core element which outlines the SHIELD sequence. The intervention is designed so that each session builds upon the one before it and they are arranged in a particular order that is most conducive to client learning and acquisition of Peer Outreach and risk reduction skills.

Is it okay to combine sessions in order to decrease the total number of times the group has to meet? For example, can we hold 2 sessions back-to-back or hold them all as a full-day program?

No, each session should be held on a different day. In addition, there should be at least one day in between sessions. The reasoning for this schedule is two-fold. First, each session contains a lot of information and skills that participants need to retain. By holding one session at a time, participants will not experience information overload and will be able to absorb the new information. Second, at the end of each session, participants are assigned homework so that they can practice their Peer Outreach skills. By having at least one day in between sessions, participants have time to complete their homework assignments.

My agency is not allowed to pass out condoms or safer injection materials. What can we do?

Although distribution of risk reduction materials is encouraged, some agencies may be prohibited from doing so. The best way to handle this obstacle is to distribute a list of local places where these materials can be picked up for free or relatively cheap.

Can we distribute information to participants if the information is not officially part of the intervention (e.g., Materials such as locations for HIV testing and counseling or brochures on HIV and STDs)?

Yes, it is highly encouraged that facilitators are prepared with various community resources in the event that your participants express a need that is outside the scope of the SHIELD package. While the package does contain generic materials, you may need to tailor the information for your own community.

Additionally, **Peer Educators** are meant to act as resources in the community which does not end with HIV and injection outreach. If participants express the desire to pass along the information you provide to them, you should not hesitate to help them do so.

How can we integrate HIV, STD and/or Hepatitis screening into the SHIELD Intervention?

Although HIV and STD screening is not part of the SHIELD intervention, it is possible for your agency to coordinate testing for participants. If your agency already conducts testing this might be a relatively simple process, while it may require more in depth logistical planning for those agencies who do not provide this service. If your agency needs to work with an outside testing facility, you should consider how SHIELD participants would travel to this off-site location. Ideally, a representative would be able to come to your agency to conduct testing. It should also be considered how participants might respond to mandatory vs voluntary testing.

Can a facilitator make referrals to other services such as mental health or substance abuse programs?

Yes they can. During the pre-implementation stage, agencies should identify community resources. The purpose of this activity is two-fold. First, **Peer Educators** will disseminate information about local resources, so facilitators need to pass this information on to **Peer Educators**. Second, facilitators may need to make referrals for SHIELD participants themselves.

FIDELITY AND EVALUATION

How can we ensure fidelity to SHIELD?

By adhering to the 5 core elements, your agency can ensure fidelity to the SHIELD intervention. These elements are so important because if followed, they give your agency the opportunity to experience a similar level of success that the original SHIELD study produced.

Another thing facilitators can do to ensure fidelity is to follow the procedures and scripts outlined in the **SHIELD Facilitators Guide.**

Does my agency have to do an evaluation?

No, your agency is not required to conduct an evaluation. However, evaluation tools are provided in the **SHIELD Project Manager's Guide** in the event your agency would like to do an evaluation. You may decide evaluation is important to validate the successfulness of SHIELD at your agency or your funding agency may require you to provide them with progress reports. Keep in mind that SHIELD was evaluated at the scientific level and is proven to be successful at changing behaviors if the five core elements are maintained.

If my agency implements SHIELD, do we have to use all of the evaluation tools included in the package?

These tools are only recommendations, they are not required materials. It is acceptable for agencies to pick and choose those evaluation tools which work best for their needs. Given the variety of tools provided, we are confident that you should be able to find one that is useful to your agency.

What is purpose of the pre and post test assessments?

The pre and post test assessments are used to assess client outcomes before and after participating in the SHIELD intervention. The pre-test is a baseline assessment of participants' behaviors and attitudes. After going through the intervention, the post-test, which includes the same questions as the pre-test, can be given to see if their participation led to changes in their behaviors and attitudes.

ADAPTATION GUIDE

INTRODUCTION **36**

DEFINITION AND LIMITS OF ADAPTATION **36**

DETAILED GUIDELINES AND STEP-BY-STEP PROCEDURES **37**

COMMON ADAPTATIONS **39**

SHIELD population 39

Definition of Peer Educator AND Peer communication skills 40

Order of SHIELD sessions 40

Omitting information 40

Scenarios 41

Risk Ladders 41

Homework assignments 41

Revising Session 5 (Safer injection skills) 42

Adding information or sessions 42

Booster 43

Hepatitis C Booster Session 44

Overdose Prevention Booster Session 48

INTRODUCTION

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 SHIELD intervention for former and current drug users. This document is intended to complement the Technical Assistance Guide in the intervention package.

We discuss detailed steps to take in order to successfully adapt SHIELD which includes (1) population identification, (2) formative research and evaluation, and (3) piloting the adapted intervention.

In addition, we describe some common adaptations. 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 SHIELD intervention and that they have participated in the standard two-and-a-half-day training program for agency staff. In addition they must have a copy of the SHIELD Project Managers Guide and SHIELD Facilitators Guide 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 SHIELD. 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.

The SHIELD intervention has 5 core elements:

1) SHIELD is implemented in a small group setting to offer participants an environment that is conducive to sharing experiences and gaining social support from peers.

2) Participants go through the SHIELD Sequence- a series of activities that includes pre-program contact and six intervention sessions and optional booster sessions in a specified sequence.

3) Each SHIELD intervention session follows a specific structure that includes 5 components. These components are:

- Homework check-in
- Presentation of new information
- Peer Educator training activities (i.e. group problem-solving and role-plays)
- Homework assignment and practice
- Summary

4) SHIELD sessions aim to build three sets of skills necessary for participants to be a Peer Educator. These skills are:

- Communication skills for conducting effective peer outreach (PEER)
- HIV drug-related risk reduction techniques
- HIV sex-related risk reduction techniques

5) Every session includes interactive Peer Educator training activities which build Peer Outreach skills and increase Peer Educator self-efficacy. Through increased self-efficacy, participants develop a Peer Educator Identity. Activities include:

- Facilitator Role-models
- Group Problem-solving activities
- Role-plays

For more detail on the rationale behind each core element, please refer to the Project Manager's Guide.

DETAILED GUIDELINES AND STEP-BY-STEP PROCEDURES

A) Population Identification.

1) Identify the special subpopulation (group) of drug users that your agency intends to target using SHIELD and for whom you plan to adapt the intervention.

2) Describe the targeted group in specific terms, especially providing information about the characteristics they have in common. It is the characteristics that the subgroup has 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:

a) Drug use patterns (drugs used—crack vs. methamphetamine vs. marijuana vs. club drugs, or mode of administration—injection vs. non-injection).

b) Cultural or personal characteristics (e.g., sexual orientation, gender, age, ethnicity, job status, living situation).

3) Describe your rationale for restricting SHIELD 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 SHIELD, which was evaluated in a controlled research study, included participants who differed with respect to the type of drug they used (notably crack, heroin and cocaine) 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 SHIELD 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) Formative Research and Evaluation.

1) Before adapting SHIELD, it is important 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.

2) Review whatever literature currently exists (books, journal articles, meeting presentations, Internet websites, etc.) concerning the special group of drug users you wish to target with SHIELD. 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.

3) 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.

4) Conduct structured interviews and focus groups with local drug users belonging to the special subgroup who will be recruited into SHIELD 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).

C) Piloting the Adapted Intervention.

1) Pilot the newly adapted version of SHIELD to identify problems and issues that need to be addressed before the intervention is actually implemented within the special target population.

2) The piloting process should involved trying out the adapted activities or segments to identify problems with content or flow.

3) During the pilot, it is helpful to solicit feedback from participants about the activities and materials. The participants in the pilot activities should be representative of the SHIELD target population- former and current drug users.

The remainder of this guide is designed to discuss some of the common adaptations that agencies have proposed or implemented.

COMMON ADAPTATIONS

1) SHIELD population

SHIELD is designed for adults (18 years and older) and may be implemented with men and women as well as individuals who are HIV positive or HIV negative. SHIELD, which has primarily been implemented with heroin and cocaine users, is appropriate for former and current drug users who interact with other drug users. While some participants have been injection drug users, others have been non-injection drug users who interact with injection drug users. Agencies may adapt SHIELD to implement with non-injection drug users or other populations such as methamphetamine users.

In order to implement SHIELD with other types of drug users (i.e. methamphetamine users, crack smokers, etc), agencies are encouraged to conduct formative research to determine their population's interest in becoming Peer Educators. In addition, it is important to remember that SHIELD is not solely for injection drug users. SHIELD is intended also for people who interact with drug users and may share drug-related risk reduction information and resources during peer outreach. Thus, agencies are cautioned from omitting all reference to injection drug use.

Specific adaptations that may occur include changing:

1) Scenarios
2) Homework assignments (Session 2)
3) Information in the HIV 101 game
4) Risk Ladders
5) Presenting New information (Component 2)

2) Definition of Peer Educator AND Peer communication skills

The goal of SHIELD is to train individuals to be Peer Educators. A SHIELD Peer Educator is someone who conducts outreach to their peers by sharing HIV risk reduction information and resources so that they can be safer. This outreach is guided by the 4 PEER communication skills. The definition of Peer Educator and the PEER communication skills are central to the SHIELD intervention and may not be adapted.

3) Order of SHIELD sessions

One of the core elements in the SHIELD sequence states that participants go through SHIELD from the Pre-program contact and Sessions 1-6. Some agencies may be interested in changing the order of sessions. Each of these sessions is important and builds upon the previous one. Thus, re-ordering sessions is a violation of a Core Element.

For guidance to adding sessions, please refer to section on "Adding information or sessions".

4) Omitting information

Some agencies may be interested in solely focusing on safer sex OR safer drug behaviors. As a result, they may wish to delete some of the sessions. Deletion of any of the sessions is not allowed for two reasons. First, SHIELD focuses 3 sets of skills- 1) safer sex, 2) safer drug behaviors, and 3) communication skills. Second, the SHIELD sequence which includes Sessions 1 through 6. Omission of any of the sessions would be a violation of both of these core elements.

For more information on revising Session 5 for non-injection drug use see section "Revising Session 5"

5) Scenarios

In each session, scenarios are presented as group problem-solving activities and role-plays. Suggested scenarios are provided. Agencies may adapt these scenarios to best fit their participants' needs. When adapting a scenario, agencies should follow these guidelines:

- Do not make it complicated. When scenarios are complicated, some participants may consider them unrealistic and disengage from the activity. For example adding unnecessary details about a character in the scenario, outside of the risk behavior may distract and complicate the scenario.
- Focus on one key risk behavior so that discussion of risk reduction options is centered on one type of practice.
- Some agencies have used participants' real-world experiences or challenges as scenarios. If your agency chooses to do this, be sure to ask for approval from the participant so they do not feel on the spot.
- Scenario discussions should be structured around the PEER communication skills. For example, participants should identify the risky behavior (evaluate the situation), explore safer options, and discuss resources and referrals that they can offer to their peers in the scenario.
- When providing feedback to participants, Facilitators should always start with positive comments. Then, offer constructive feedback as needed.

6) Risk Ladders

In Session 3 and Session 5, risk ladders are presented to participants. Each risk ladder comes with a set of behavior cards. Each behavior occupies a different level of risk. The goal of these visual materials is to show participants that there is a range of behaviors that put people at risk for HIV and that there are options for lowering this risk.

Behaviors may be added to the risk ladders as long as there is evidence about the placement of risk level of the behavior.

We caution agencies to be selective about adding too many behavior cards to the ladders The key message that participants should hear with the ladder activities is that there are different levels of risk with different behaviors and therefore different options that are available to reduce risk. Adding too many behavior cards may distract from this message and may make Peer Outreach challenging because Peer Educators may not have the time or ability to describe all of the cards.

7) Homework assignments

At the end of each session, participants are given a homework assignment. The goal of the homework assignment is to provide Peer Educators with the opportunity to share new information and practice their peer outreach skills by sharing information learned in the session with a social network member. Homework assignments may not be omitted. If participants have challenges completing the homework or are resistant to doing it, facilitators should problem-solve with them solutions to the challenges.

Agencies may adapt the homework assignments. However, homework is essential so that participants have time to practice their skills. Thus, homework assignments may not be omitted. Appendix II of the

SHIELD Facilitators describes the aims of each of the homework assignment. If assignments are changed, it is important to ensure that the adapted assignment still meets the suggested aim.

Homework is conducted with a "homework buddy". This term was chosen based on feedback from participants in the SHIELD study as well as agencies that field-tested the intervention package. If participants are resistant to this term, agencies may change the term. For example, "practice assignment" and "peer" can be used.

8) Revising Session 5 (Safer injection skills)

Some agencies may be interested in revising or omitting Session 5 which focuses on injection risk reduction. Prior to omitting the session, agencies should remember that participants who are not injectors themselves may share this information with members of their social network. Thus, agencies should conduct some formative work to determine if members of their target population interact with injection drug users who would benefit from learning the information.

An ideal strategy is to reduce some of the injection material, such as omitting the safer splitting and cleaning equipment demonstrating, and adding information on non-injection drug use information.

Some specific elements that would be adapted for non-injection drug using populations include:

1) Scenarios
2) Homework assignments
3) Risk Ladder

Please note the injection and splitting risk ladders were developed based on evidence that some behaviors have a higher risk for HIV than others. See section on "Adapting Risk Ladders" for guidance on adapting risk ladders in this session.

In all drug-related sessions, the following information should be emphasized:

o Limiting the number of times that drug equipment is shared is a way to lower one's risk.

o Cleaning drug equipment (i.e. needles, cookers, pipes, rubber tips, and straws) with multiple washes of water greatly lowers one's risk for HIV.

o Using brand new or sterile equipment whenever possible is a safe strategy.

For additional assistance with adapting the curriculum for non-injection drug users, request Technical Assistance from a CBA provider.

9) Adding information or sessions

The SHIELD intervention provides detailed information about HIV and risk behaviors. Component #2 of each session focuses on presenting new information about a HIV-related topic. Some agencies may be interested in adding new information about other health concerns that affect the target population such as

hepatitis, needle exchange programs, overdose prevention, and sexually transmitted infections. We encourage staff to stay updated on new information and adding new information is appropriate. However, the addition of new information should be balanced with the amount of time for each session. 90 minutes is the target session length.

Some places where new information may be presented include: HIV 101 game (Session 2, Component 3); integrated into scenarios; and Booster sessions.

10) Boosters

Booster sessions are a wonderful opportunity to stay in touch with Peer Educators and present new information. In this guide, we have provided 3 examples of booster sessions. One session focuses on Hepatitis and two sessions focus on Overdose prevention.

The structure for the booster sessions are: 1) Welcome, 2) Peer Educator Check-In and group problem solving peer outreach barriers, 3) Skills Refresher Activity and 4) Closing. We have included in this adaptation guide content that can be used in Component 3: Skills Refresher Activity. However, when implementing the booster session, it is important to allow time for all components.

Hepatitis and Overdose are significant public health issues for drug-using populations. While the majority of the booster maybe spent on providing the Peer Educators with factual information about these topics, it is important that the focus of the booster is on how Peer Educators can use their PEER communication skills to talk with their networks about these topics. Accordingly the information that is being presented can be framed as important so that Peer Educators can evaluate their networks situation (e.g. risk) and explore safer options and provide resources and referrals.

The hepatitis booster example includes curriculum to review transmission risk behaviors, prevention and care for those living with hepatitis C. One of the main objectives of this booster is to emphasize how infectious (easily transmitted) hepatitis C is for all types of drug users.

The overdose booster is written in two parts: one focusing on risks and prevention and one focusing on signs and symptoms and responses. These can be combined – however depending on the group size or the types of questions and discussion a combined booster may be too much.

With all of the booster sessions, it is important to have all of the risk reduction ladders posted to reinforce the concept of options to lower risk.

HEPATITIS C BOOSTER SESSION

Hepatitis C Booster	
Component 3	
PROCEDURES	SUGGESTED SCRIPTS
Introduce topic of hepatitis C	Hepatitis C is another virus that is very common in the injector community partly because it is much more infectious compared to HIV. Hepatitis C is also transmitted through blood and causes the liver to become inflamed and can cause cirrhosis (scarring) and in some people Hepatitis C can cause liver cancer. Hepatitis C can live for a long time outside of the body. Unlike HIV, Hepatitis C does not die in the air and can even live in dried up blood. This is why it is very important to know about what puts you at risk and prevention.
Present information about risk behaviors	Behaviors that place you at risk for getting infected with Hepatitis C are any behaviors where blood may be present such as: • Sharing needles/cookers/cotton/rinse water • Tattoo and piercing needles • Sharing razors/nail clippers • Sharing toothbrushes • Sharing stems • Sharing straws for sniffing
Knowledge review activity	Knowledge review activity Let's do a quick knowledge game so that you can learn more about Hepatitis C risk factors and prevention strategies. **Question 1: Hep C can be spread by shaking hands, hugging, or drinking out of the same cup as someone who has HepC.** [Answer 1: FALSE] Facilitator note: the HepC virus is spread by blood to blood contact.] Bonus: How do people catch the HepC virus? • Sharing needles/cookers/cotton/rinse water • Tattoo and piercing needles • Sharing razors/nail clippers • Sharing toothbrushes • Sex (not as easy but can be possible)

Knowledge review activity (continued)	
PROCEDURES	SUGGESTED SCRIPTS
	Question 2: People with HepC don't always have symptoms. [Answer 2: TRUE] Facilitator note: not many people-with HepC show symptoms when they are first infected. Bonus: What are symptoms that people with HepC may have? • Jaundice • Abdominal pain (right upper abdomen) • Fatigue • Nausea and vomiting • Dark urine **Question 3: Hep C damages the kidneys?** [Answer 3: FALSE, HepC attacks and damages the liver.] Bonus: How does HepC hurt the liver? • HepC causes the liver to become inflamed. • HepC can cause cirrhosis(scarring) of the liver • In some people HepC can cause liver cancer **Question 4: People who have HepC don't have to worry about sharing injection equipment because they are already infected.** [Answer 4: FALSE] Facilitator note: You can get more Hep C virus, HIV, or other blood-borne viruses. Bonus: How can you prevent spreading Hep C to drug buddies? • Clean surfaces when preparing drugs • Don't share cookers/rinse water/cotton/needles • Don't share straws

Knowledge review activity (continued)	
PROCEDURES	SUGGESTED SCRIPTS
	Question 5: Breast milk transmits Hep C [Answer 5: FALSE]. Facilitator note: Only blood transmits Hep C. Bonus: What body fluids spread HIV that do not spread Hep C? • Breast Milk • Semen • Vaginal secretions
Review Hep C care strategies	With hepatitis being so common among injection drug users – it is important to be able to talk to our peers about how to take care of yourself if you have Hep C. The first steps are things we can do on your own to take better care of your liver. The later steps require the assistance of a medical care provider. One of the best things that we can do for our livers is to cut down on alcohol. Alcohol is really bad for your liver even if you don't have hepatitis. HepC and alcohol cause serious liver damage. Try to cut back or if possible stop drinking. This includes beer. Drinking water helps your liver function better. Try to drink at least eight glasses a day. Another thing that you can do to help your liver is to cut down on eating foods that have a lot of sugar and fat in them. Try to eat more fresh fruits and vegetables instead. These are three fairly easy things that we can do to keep our health up if you have Hep C. If you can get a doctor, working with them can help you learn what your treatment options are. Your doctor can also run a liver function test can help keep track of the health of your liver.

Review Hep C care strategies (continued)	
PROCEDURES	SUGGESTED SCRIPTS
	There are vaccines available for Hep A and B. People with Hep C should get vaccinated for Hep A and B. Getting infected with Hep A or B if you already have HepC or HIV can be very serious, even life threatening. Talk to your provider about whether the medications may be a good choice for you. The meds they have right now work for about 60% of the people who take them, but there may be serious side effects for many people. You need to think carefully about a lot of issues before you decide to take these meds.
Peer Educator Training Activity	Now that we have talked about the different risk factors that increase heroin overdose and the safer options, let's practice using our PEER Communication skills to talk about overdose with our peers. P: When would be good times and places to talk about heroin overdose risk? What are some things that you would say to your peers to help them explore safer options? What resources and referrals could you provide?

OVERDOSE PREVENTION BOOSTER SESSION

Overdose Prevention Booster Session	
Component 3	
PROCEDURES	SUGGESTED SCRIPTS
Introduce topic of heroin overdose	As Peer Educators, another way that we can help our networks is by talking with them about the risk factors for heroin overdose.
Present information about the risk factors for Heroin Overdose	There are three main categories of risk factors that can increase our chances of overdosing on HEROIN (point to poster – see example below): If your Tolerance for heroin has dropped you have a much greater chance of overdosing. What are some reasons that our tolerance can drop? (Make sure the following have been mentioned: been incarcerated, in detox, chose to cut down on own, been sick/lost weight, depression). Dose is another risk factor. Shooting too much and/or too quick can increase your risk of overdose. Mixing drugs with heroin, especially other depressants like alcohol, benzodiazepines, and other opiates are a big risk factor for HEROIN overdose. If you have been drinking alcohol or had taken other pills, it is that much more important to taste your dope and inject slowly. Also, some pills last longer than others, for example, methadone, which is an opiate, lasts for 24 hours and Oxycotin lasts for 12. So if you inject heroin within a few hours of using these other drugs you are much more likely to overdose. A lot of people are confused about the role that methadone plays with overdose. Most people don't realize that you can overdose on methadone. When you use methadone it fills up the same receptor in the brain that heroin uses. The difference between methadone and heroin is that methadone blocks the euphoric effects (the high) of opiates (like morphine and heroin). So if you use too much methadone or use heroin on top of methadone, you are putting a lot of opiates into your system, which can cause you to overdose.

Review prevention strategies	One of the easiest things to do is to control the pace. Injecting slowly and tasting your drugs is one way that you can control your high. If your tolerance is low or dropped for whatever reason, we recommend that you taste your dope before you shoot the entire dose. If you are not hitting yourself, tell your "doctor" not to slam it…but to take it slow. We also recommend that you avoid getting high alone. Many people prefer to get high alone as a way to lower risk of HIV or hepatitis infection. However, your risk of dying from an overdose is greater if there is no one to help you if you go out. Even if our buddies want privacy, as Peer Educators we can check on them to make sure that they have not overdose.
Peer Educator Training Activity	Now that we have talked about the different risk factors that increase heroin overdose and the safer options, let's practice using our PEER Communication skills to talk about overdose with our peers. P: When would be good times and places to talk about heroin overdose risk? What are some things that you would say to your peers to help them explore safer options? What resources and referrals could you provide?

Example of Risk Factors Poster	
Risk Factors for Opiate Overdose E: Evaluate the situation	Prevention for Opiate Overdose E: Explore safe options
Decreased Tolerance • Recent incarceration or hospitalization • Poor health (recent illness, weight loss) • Recent drug detox	• Inject slowly • Partner up
Dose • Using too much • Using too quickly	• Pace yourself, inject slowly (taste the drugs) • If using a street doctor ask them not to slam it.
Mixing Depressants • Heroin and alcohol • Heroin and methadone • Xanex, Klonopin, Dilaudud, Percocet, and Oxycotin and heroin	• Poor health (recent illness, weight loss) • Recent drug detox
	• Stop using drugs

Overdose Booster II: Signs and Symptoms and Responding	
PROCEDURES	SUGGESTED SCRIPTS
Introduce topic of heroin overdose	As Peer Educators, another way that we can help our networks is by talking with them about how to recognize heroin overdose and what to do during a drug overdose.
Introduce topic of heroin overdose	Most of the signs that people recognize easily happen in later stages of overdose. During the later stages overdose people often aren't getting oxygen to their brain which can cause them to die. If you recognize these late signs, it is important to get medical help and the person breathing as soon as possible. Harder to recognize signs of heroin overdose are: Slowed breathing and heartbeat, choking or gurgling sounds, and throwing up. If you notice these signs this means that you have more time to help the person. Our goal is for you is to realize that there are symptoms of overdose that occur before someone turns blue so that you can intervene sooner than later. Did you know that it can take up to two hours before someone actually dies from a heroin overdose? That's a long time for you to be able to intervene. (People die from a heroin overdose because they go into respiratory arrest, they stop breathing and the brain eventually shuts down.) Heroin Overdoses do not have to be fatal. The sooner you act, the better chances of them surviving and having less serious health problems later.
Present Signs and Symptoms poster	This poster shows the different signs of heroin overdose in the early stages versus later stages. [Facilitator read poster]
Transition to responding	Now that you all are familiar with the different signs and symptoms of heroin overdose, let's talk about different ways we can respond to help someone who is overdosing.

Review common street responses	What are some of the different things you have seen or heard that people do to try to get someone out of an overdose? [Facilitator allow group to discuss and then show street remedies poster and summarize using the script]. We realize that these remedies often do work to revive an overdose victim because they are methods of stimulating a person. What we want you to understand is that a lot of the times these street remedies can actually cause harm to the victim too. For example, if you use a lot of ice on a victim or leave them in a tub of ice for a while this can lead to hypothermia. Hypothermia is a condition where the core body temperature drops and the body is unable to heat itself. This condition can be life-threatening. Another way that an overdose victim can become hypothermic is if you left them outside in weather like this to “wake up”. [Facilitator review the rest of the Street Responses and Medical Consequences chart]: The following is information that participants may ask about: Hypertension can occur if you inject a person with salt water. This can increase the pressure in the veins and you can risk a stroke or heart attack. Neuropathy is when you lose sensation in your limbs. If you leave someone laying in the same position their circulation can be cut off]. Our point is to show you that using these street remedies can be dangerous to the victim. While they may work to stimulate the person they can cause some long-term damage.
If applicable: review different options for appropriate responses to overdose including rescue breathing, call EMS and using naloxone.	

Poster of Signs and Symptoms	
Signs that occur Early during a Heroin OD	Signs that occur late in overdose
• Heartbeat is slow • Breathing is slow • Choking or gurgling sounds • Throwing up	• Falling out (passing out) • Unresponsive • Eyes roll up in the head • Lips turn blue • Stopped breathing

Poster of Street Remedies and Medical Consequences	
Street Remedy	Medical Consequence
Using ice	Too much can lead to hypothermia
Putting in the shower or tub	Victim could drown
Injecting with salt water	Hypertension
Pour milk down their throat	Could drown
Hitting, slapping	Bruises, broken bones
Leaving them	Neuropathy, crush syndrome
Placing them on their back	Drown in vomit