Module II: Strategies for Engagement and Retention in Care

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Introduction

Purpose

This module is designed to provide participants with knowledge and strategies to engage and retain HIV-infected substance users in care. We will examine the environmental, personal, and cultural issues that impact engagement and retention in care. We also will provide a basic orientation to the skills that providers can use to motivate change in HIV-infected substance users and to help them access services that may improve their health. Finally, we will discuss strategies for enhancing provider well being in the workplace. The curriculum targets all persons who provide services to HIV-infected substance users, including medical providers, social workers, substance abuse treatment and mental health providers, outreach workers, and program directors. It is designed as a train-the-trainer (TOT) curriculum so each person can select activities to present and build the knowledge and skills of their audience around engaging HIV-infected substance users in care.

The module has been revised and includes additional options for presenting materials or conducting an activity. Tips for improving your skills as a trainer/presenter have also been added along with a recommended outline for implementing a two-hour training program. We hope you find the materials useful to your work. Enjoy!

Summary of Resource Materials for module

- Handout II-25, "Self-Assessment Tool: Self-Care" (Page 87)
- Handout II-26, "Suggested Replication Trainings" (Page 91)
- Handout II-27, "Resources & References for further learning about Strategies to Engage HIV-Infected Substance Users in Care" (Page 92)
- Slides II-1 to II-29
- Newsprint
- Markers
- Additional References and Resources
- Index Cards
- Nametags
- Colored Post-it Notes
- TV and VCR
- Video: "Motivational Interviewing Tape C: Handling Resistance," recorded in 1998 by William R. Miller and Stephen Rollnick, and directed by Theresa B. Moyers. This videotape can be ordered at the following website: http://www.motivationalinterview.org/training/miorderform.pdf

Objectives

By the end of this module, participants will be able to do the following:

- Describe the environmental, social, personal, and cultural issues that impact an HIV-infected substance user's decision to engage in care and stay engaged
- Develop strategies and practice skills that can be used to build relationships with HIV-infected substance users and that can help them remain engaged in care
- Identify methods for keeping themselves engaged in a challenging environment
- Learn techniques for training and presenting the information to your audience

Session 1: Introduction and Icebreaker (15-20 minutes)

1) Begin the session by introducing yourself. Then go around the room and ask participants to introduce themselves. This will help to establish an effective learning environment so everyone will feel comfortable participating in conversation. Ask each participant to share something with the group. It should be a non-personal item. Suggestions include:

- Where do you work?
- Why you decided to come to this session today?
- How long have you been working with HIV-infected substance users?

2) Start off by doing one of the following two activities to help set the topic for discussion during the day:

- "Top Ten Reasons Why I missed My Dentist Appointment" or
- Engagement is… Retention is….

Top Ten Reasons Why I missed My Dentist Appointment

Purpose: To introduce the major themes of the module

Time: 15 minutes

Materials:

- Name tags
- Flipchart and colored markers
- Index cards

Instructor Notes

1. Break the larger group into smaller working groups of four or five persons each.

2. Give each working group a set of ten index cards and ask them to come up with their "top ten list" of reasons for missing a dentist appointment."

3. Ask each working group to list the reasons in order of most common to least common.

4. Once the working groups have finished listing their reasons, ask them to share their lists with the entire group.

5. Close this introductory activity by drawing out some of the common themes that emerged from each working group. These might include their beliefs, fears, or competing needs or priorities. For example, people might say they are afraid that the dentist will find out they had not been flossing as instructed.

6. Explain to the group that, during the next few hours, they will have the opportunity to explore some of these themes and learn ways to identify the reasons why HIV-infected substance users do or do not receive the care and services they need. Participants will also learn about strategies to bring people into care and keep them in care. The activities and presentations in this module will also help participants cope with the issues and challenges that can impede their capacity to work effectively with HIV-infected substance users.

Engagement Is . . . Retention Is . . .

Purpose: To have participants broadly and creatively define the concepts of engagement and retention as they relate to working with HIV-infected substance users

Time: Five to seven minutes

Materials: Flipchart and colored markers

Instructor Notes

1. In preparation for this activity, review the objective, and reflect on your own responses to the phrases "Engagement is . . ." and "Retention is . . ." as these relate to working with HIV-infected substance users. Consider how *engagement* activities tend to be more provider-initiated, while *retention* activities tend to be more mutual and collaborative.

2. Write the phrase "Engagement is . . ." on a sheet of flipchart paper. Ask participants to brainstorm aloud about what words, ideas, or metaphors come to mind when they respond to this phrase. Urge them to think broadly and creatively without being self-censoring. For example, people might respond in ways similar to the following. Engagement is:
    - An invitation to care
    - A first step toward reducing HIV transmission
    - Being a hospitable presence
    - Like a slow winding river
    - Planting seeds of hope
    - A process of two steps forward, one step backward
    - Like a roller-coaster ride
    - Challenging
    - Fulfilling
    - An exercise in patience

3. Repeat the same exercise with the phrase "Retention is . . ." Participants might respond in ways similar to the following. Retention is:
    - Helping people stay in treatment
    - A predictor of decreased drug use or HIV transmission
    - An obstacle course
    - Like tending a fragile garden
    - Accompanying people on their journey
    - Maintaining CD4 levels
    - A collaborative activity

4. Close the activity by noting the variety of ways we can think about these concepts. The intent of this module is to further explore what is involved in effectively engaging and retaining HIV-infected substance users in care.

Session 2: Being an Effective Trainer
(1 hour)

Objectives of the Session

- Learn techniques for planning and facilitating a training session
- Improve your skills for building a relationship with your audience
- Managing time in your training session/presentation

Materials:

- Handout II-1, "Pre-training Needs Assessment Tool"
- Handout II-2, "Training Planning Form"
- Handout II-3, "Facilitating Learning"
- Handout II-4, "Handling Difficult Decisions"
- Trainers' Tips, Training planning forms and checklists

Instructors Notes:

1) Read the section of Trainers' Tips in the curriculum. Start with a review of the pre-trainer's assessment tool. Talk about an appropriate time frame to begin training. This is usually 2-3 weeks before a training to contact your participants so you can know your audience. Share the Handout: *Training Planning Forms #1 and #2* with your group. Ask for suggestions for other types of information they might want to collect prior to designing the training.

2) Explain the use of the form. For example, this should be filled out as a planning tool for your session. It maybe filled out in partnership with the organization that has hired you for a session. Tell folks at the end of this training program, they will be filling out the form as a way to help plan for their replication session.

3) Review the *Trainers' Checklist*, which has tips for planning, ideas to keep in mind at the training and following the event.

4) Pass out the Handouts: *"Facilitating Learning"* and *"Handling difficult situations"*
Review the points on each handout. If possible, share a personal experience when you had a hard time managing the audience and ways that you tried to connect with the audience. Ask the participants to share examples and brainstorm other ideas to add to the handouts.

Handout II-1:
Pre-Training Needs Assessment Tool
Tool #1

Rationale for conducting pre-training needs assessment:

- For learning to take place, the learner must be actively involved in the experience – engage the learners prior to the actual learning experience.
- Adults relate current learning to what they already know. Trainers benefit from knowing the background of their participants.
- Learners benefit from an opportunity to identify their own learning needs.

To gather this information, conduct a pre-training needs assessment with the intended training participants by simply asking the following questions. Conduct individual interviews (in-person or over the phone with participants or create a form to gather this information via email or hard copy.

How long have you worked in the field of _____?

What is the highest educational level you completed?

What is the title of your job and what are the three most important tasks that you do in your job?

Please rank your interest in the following topic areas (a prepared list).

Not at all interested Somewhat interested Very interested

What do you hope to learn from the training?

What are the ways you learn best? (rank these?)
Seeing _____ Hearing _____ Saying ____ Doing _____

Are there any accommodations that would make a training session most comfortable for you?

Handout II-2

Training Planning Form

Tool #2

After conducting a Pre-Training Needs Assessment of the training participants, this form can be used to establish the objectives and initial planning of a training session. Follow the steps below that lead to implementing a successful training day!

1) **<u>Who is the audience</u>? Compile the Results of Pre-Training Participant Needs Assessment**

2) **Determine the <u>Overall Training Goals</u> by answering the question:**
   As a result of this training, participants will …..

3) **Develop <u>Overall Learning Objectives</u> by answering the following:**
   In order to achieve the previously determined overall training goals; participants will need:
   To do what?
   To know or understand what?
   Possess Attitude(s) of?

4) **What are the specific content areas for the training?**

5) **How will the audience learn the content? What sections of the curriculum do you need and want to use to achieve the goals and objectives?**

6) **What modifications to the curriculum need to be made?**

7) **When is the training to be held? Date, time, and length of session.**

8) **Where will it be held? Describe the location and environment for the session, including room set-up.**

9) **Structure the training? Detail your agenda and training plan with timeframes to include breaks, meals and evaluation.**

10) **What are the training supports, materials, and supplies needed and how will they be arranged for?**

Handout II-3:
Facilitating Learning

- Remember you are responsible to manage the content, keep the group moving forward, and to treat participants as professionals.

- Try to remember people's names and use names when you ask or respond to a question. Nametags can be helpful in this regard.

- Provide pipe cleaners, small toys, or something for kinesthetic learners – people who learn more readily when they have something to do with their hands.

- Interact freely with participants and encourage involvement. Repeat questions so you can understand what is being asked and so all the group can hear. Probe for issues if something is not clear.

- Be responsive to participants. Use participant questions as cues to what they need. Be ready to adjust your presentation as needed. Ask participants for their ideas.

- Try to have resources available for participants who want to continue to learn or access information on the topic. Websites are easy to use and many people have access to the Internet. In advance of the training, prepare a list of websites and written resources with information on your topic to share with participants. Information referrals can increase the potential of training and make a continuing contribution to the lives of the participants.

Handout II-4
Handling difficult situations:

- There will be situations where "talkers" in the group do not listen to others or have their own agenda. Acknowledge their ideas and if they are not relevant to the discussion at hand, reply "that is a good point, but we are focusing on this issue now and perhaps we can address that issue during break or at the end of the session."

- There may be questions that challenge the trainer in emotional ways. Try to be prepared and think through what these questions might be and what might be some responses that help to keep the training on track.

- There may be individuals who do not want to be there. Provide something for the participants such as pads and pens for drawing that can keep these people busy without disrupting the group. If a person is disruptive, give them the choice to leave because no one is forcing a participant to learn.

- If you have a group with widely varied skill levels it can be difficult to design a training that will meet all participant needs. Through interaction and encouraging dialogue among participants everyone can learn from each other. Start the training by acknowledging the ranges of skills and knowledge but establishing ground rules that make clear that all ideas and questions are respected.

- There are times when you may need to step out of the curriculum. An exercise may go wrong or a topic may spur an emotional debate. Try to be able to read your audience and adjust the training to fit the needs of participants.

Session 3: Brief Overview of the Engagement and Retention Module (30 minutes)

Instructor's Notes;

As a train-the-trainer (TOT), remind the participants that Kaleidoscope of Care provides a menu of options for presenting materials to an audience. Review the section on Trainers' tips briefly and then walk participants through the objectives of the module, description of the 3 major sections of the module:

1) What Brings HIV-Infected Substance Users into Care
2) Interpersonal Skills to Enhance Engagement and Retention in Care
3) Keeping Ourselves in Engaged

Review the objectives of each session. Talk about how the module is set up as a menu for each presenter/trainer to pick and choose activities based on the desired learning objectives of the intended audiences. Refer to the reference section and technical resource list for participants to contact for additional information or assistance.

Session 4: Launching the Topics (7 hours)

Without conducting every activity, briefly review the objectives of each section and activity. You may choose to implement some activities with the group. Be sure to review the objectives, handouts, and suggestions for presenting the material to the group.

Section 1: What Brings HIV-Infected Substance Users Into Care?

Objectives of the Session

By the end of the session, participants will be able to:

- Identify some of the reasons why HIV-infected substance users may or may not be in care and the challenges to working with this population
- Name two methods that service providers can use to address the environmental and structural issues in their agencies and thereby enhance engagement and retention in care
- Name at least two or three methods for working effectively in the community to improve access to and use of services

Instructor's Notes:

1) Review the objectives of the section.
2) Describe the menu of activities highlighting information that could be used as part of a presentation to an audience and activities that could be done as small group exercise. Explain the use of the symbols:

 Describes a group exercise for this activity

 Describes material that could be used for a presentation to an audience.

3) For slide presentations, review the content of the slides then give a demonstration on how to use the slides as a teaching tool. Solicit ideas from the audience.
4) Review the references on websites for the audience about where to find information and demonstrations of programs to engage and retain HIV infected substance users in care.

Public Hearing 

Purpose: To identify barriers to health care from the operational, provider, and client points of view

Time: 60 minutes

Materials

- Flipchart paper, colored markers, and tape
- Handout II-5, "Public Hearing Case Study"

Instructor Notes

1. Divide participants into four subgroups:
   - Substance users
   - Care providers (substance abuse treatment providers, counselors, case managers, doctors, nurses, and so forth)
   - Clinic administrative staff
   - Peer advocates

2. Distribute the case study and questions to the participants.

3. Hold the public hearing and have each subgroup give their testimony. You will be responsible for facilitating the meeting, monitoring the time, and keeping everyone on track. All members of each of the subgroups should share in providing the testimony. Allow time for an exchange of questions and answers between those making statements and the rest of the larger group.

4. Conclude the hearing by providing a brief summary of the main themes concerning why HIV-infected substance users may not seek services in this community.
   The list below suggests some highlights to focus on:
   - Structural reasons that may prevent people from accessing medical services
   - Issues concerned with following up on referrals
   - Attitudes that substance users face when they interact with providers and other members of the community
   - Personal barriers or cultural issues that affect the level of services that are given to and received by HIV-infected substance users

After the hearing, write the following words at the top of four blank sheets of flipchart paper: "Attitudes," "Structural/Environmental," "Personal/Cultural," and "Referral/Follow-Up." Group the issues and barriers identified by the participants into the appropriate categories. (Be sure to ask the participants for their opinions about the categories under which their responses should be placed.) These four sheets should be posted in locations where the participants will be able to see them as they complete the other activities in this module.

Handout II-5

Public Hearing Case Study

The county's department of health, which funds many of your clinic services for HIV-infected persons, has asked you to report on your patient retention rate and develop a quality improvement initiative to improve this rate.

Specifically, your funding agency wants to know how many of your current HIV-infected patients have had one visit per quarter in the past year. Your program director or data manager has run the numbers, and they don't look very good. During the last year, one-third of your new patients who came in for their initial intake and blood draws never came back for the results. Of the remaining two-thirds of the new clinic patients, less than half had one visit per quarter. You are involved in other quality improvement activities to look at your performance around providing TB screens, conducting quarterly CD4 tests and viral loads, and prescribing antiretroviral treatment (ART) for eligible patients. On all of these measures, you are doing very well. In fact, you could be considered a model program.

However, the sample for the other quality improvement studies consists of patients who have been engaged in care for the past year. Now you are being asked a different kind of question. Who is coming into care and staying in care? The results are very different, and you clearly need to do something about this. When you take a look at the intakes and demographic profiles, you realize that some of these persons reported injection drug use (IDU) as a risk factor. You also know that other forms of substance abuse are highly prevalent in the community. The problem is, you are so busy seeing the patients who do come in and making sure they are getting the appropriate standard of care that there are few resources available for you to find and engage the people who don't come in.

Your county health department has convened a public hearing to present the results of the countywide and provider-specific data on patient retention and to obtain information and feedback about strategies to improve engagement and retention.

Questions for the Working Groups

Substance users: Address why people don't come back after their first visit, or don't adhere to the standard of one visit per quarter. Here are some specific questions for you to consider:

- What are some of the attitudes you face that prevent you from getting care?
- How does the use of drugs affect your adherence with treatment?
- What aspects of clinic operations help you get care?
- What aspects of clinic operations keep you from getting care?

Care providers: Address why your patients have problems staying in medical care after their first visit. Here are some specific questions for you to consider:

- What policies has your clinic adopted to help substance users access care?
- What clinic policies prevent or hinder access to care?
- Are there interpersonal relationship issues among clinic staff that either promote or hinder access to care?

- How has the issue of drug use interfered with your clinic's efforts to engage patients and retain them in care?

Clinic administrative staff: Here are some specific questions for you to consider:

- What are the problems with your clinic?
- Why do you think some people don't come back for care?
- For the people who do return, what factors help them continue to access medical care?

Peer advocates: Here are some specific questions for you to consider:

- What policies or programs help people get the services they need?
- What policies or programs keep people from accessing services?
- Does stigma play a role in keeping people from accessing services?

The Effectiveness of Bringing HIV-Infected Substance Users Into Care

Purpose: To review the evidence of the effectiveness of programs which bring HIV-infected substance users into care

Time: 10 minutes

Materials

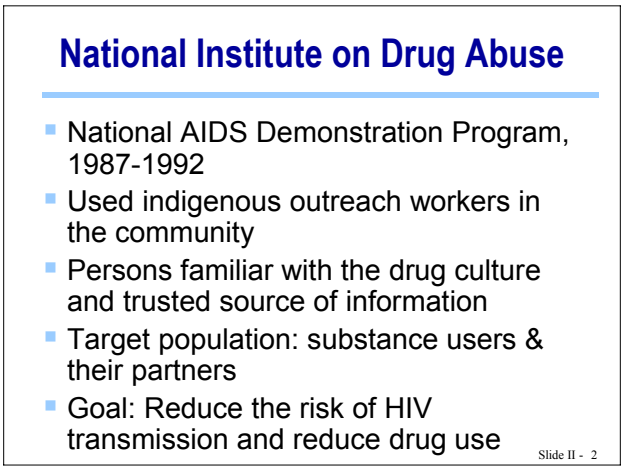
- Slide II-1, "Evidence-Based Success of Bringing HIV-Infected Substance Users Into Care"
- Slide II-2, "National Institute on Drug Abuse"
- Slide II-3, "National AIDS Demonstration Program Interventions"
- Slide II-4, "National AIDS Demonstration Program Results"
- Slide II-5, "Accessing Substance Abuse Treatment Programs"
- Slide II-6, "Accessing Substance Abuse Treatment Programs (continued)"
- Slide II-7, "Accessing Health Care Services"
- Slide II-8, "Accessing Health Care Services (continued)"
- Slide II-9, "Accessing Health Care Services (continued)"
- Slide II-10, "Accessing Health Care Services (continued)"
- Slide II-11, "Accessing Health Care Services (continued)"
- Slide II-12, "Improved Medical Adherence"

Instructor Notes

1. During this presentation, you will review and present Slides II-1 through II-12, which focus on evidence of bringing HIV-infected substance users into medical care and substance use treatment. Read through the slides and instructor notes to familiarize yourself with the material.

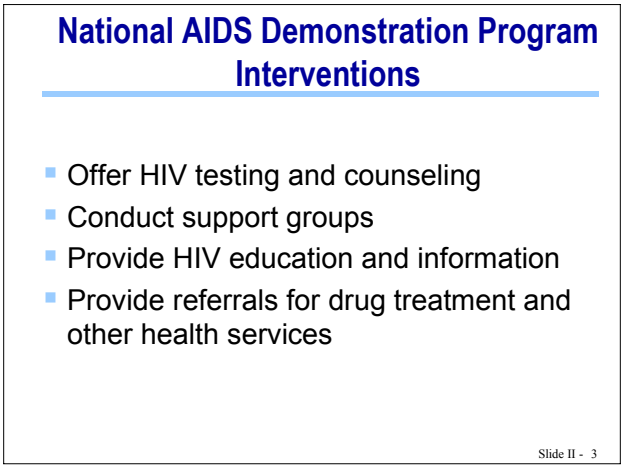
2. Point out that the studies in these slides address some of the key issues raised in the Public Hearing activity in Session 2. The following list has some points you may include:
   - The value of a having a person such as a peer or case manager help clients follow-up with appointments
   - The value of providing ancillary services, such as transportation or child care
   - The importance of frequent communication and contact with clients and their friends or families
   - The value of using peers to address some issues related to attitude and culture
3. Tell participants they may wish to pick and choose slides based on their needs of the audience and the topic of discuss. Also refer them to the resource list at the end of the module for additional resources to help them plan an activity.

4. Display Slide II-2, "National Institute on Drug Abuse."



5. Note that the National Institute on Drug Abuse (NIDA) has supported research to investigate HIV risk reduction among substance users. In 29 community demonstration projects, NIDA examined the effectiveness of community-based interventions for out-of-treatment drug users and their sexual partners.

The model programs selected people from the local community to serve as outreach workers to provide substance users with information and education about changing their behavior. In addition to being from the local community, the outreach workers were familiar with the drug culture and were seen as trusted sources of information.



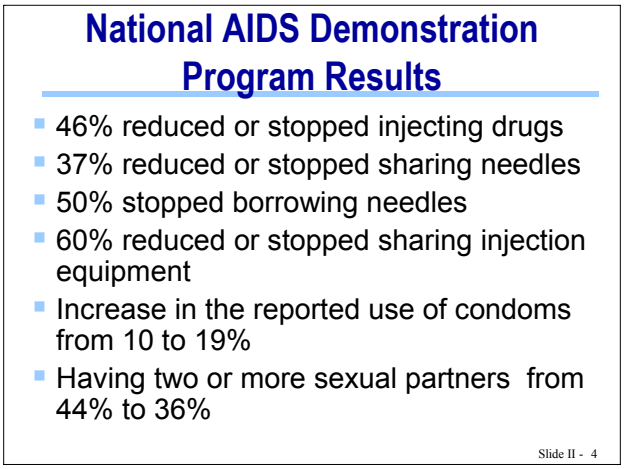
6. Display Slide II-3, "National AIDS Demonstration Program Interventions."

7. Note that the main objective of the study was to provide substance users and their partners with the means to change their risk behaviors and thereby reduce their HIV-related risks.

The services offered to substance users included HIV testing and counseling, and support groups to help people help themselves, share experiences in the drug culture, and reduce the risk of becoming infected with HIV.

Outreach workers also provided peers with information about HIV, its means of transmission, and ways to promote healthy behaviors. Since the outreach workers were seen as trusted sources from the community, they were effective in providing referrals to drug treatment and other health services to current users.

8. Display Slide II-4, "National AIDS Demonstration Program Results."



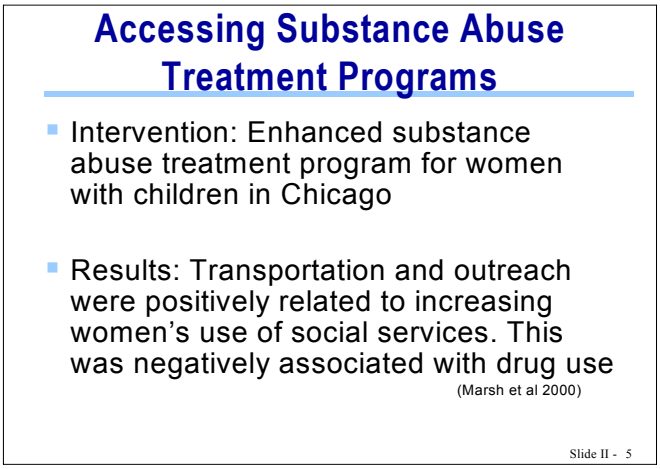
9. Note that the results from the NIDA study demonstrated that community-based programs are effective in reducing HIV-related risks. Here are some of the program highlights:
   - 46% reduced or stopped injecting drugs
   - 37% reduced or stopped sharing needles
   - 50% stopped borrowing needles

- 60% reduced or stopped sharing injection equipment

Although changes in sexual behaviors were less marked than changes in substance use behavior, they still showed improvement.

10. The results of this study led NIDA to develop a community-based outreach model that is currently being implemented with multiethnic, multiracial, male and female HIV-infected and uninfected substance users.

11. Display Slide II-5.

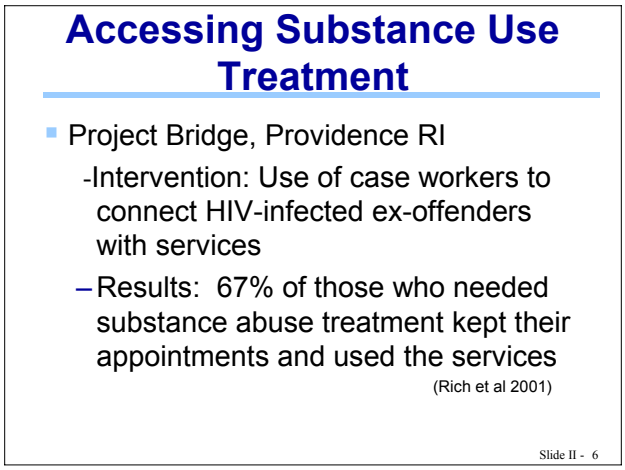


12. This study, conducted by University of Chicago, examined the effectiveness of an enhanced substance abuse treatment program for women with children.

Women with children were enrolled in an enhanced service intervention that included transportation, outreach, and childcare services in addition to substance abuse treatment. The study compared these women with a similar group enrolled in ordinary (non-enhanced) substance abuse treatment programs.

13. The study found that women in the enhanced intervention group were more likely to access services and reduce their drug use.

14. Display Slides II 6-11 and present the points drafted on the slides.



Accessing Health Care Services

- Intervention: Case managers in a HIV outpatient medical program in New Orleans working with HIV-infected women
- Results: Women with 4 or more case management visits per month were more likely to:
  - Take a protease inhibitor
  - Stay engaged in primary medical care

(Magnus et al 2001)

Slide II - 7

Accessing Health Care Services

Nursing LIGHT Program, Detroit, MI

- Intervention: Outreach and intensive case management program
  - Nurses coordinated care and provided support to HIV-infected women with substance use issues
  - Ancillary services, including transportation, support groups, and legal services were also available

(Anderson, 2001)

Slide II - 8

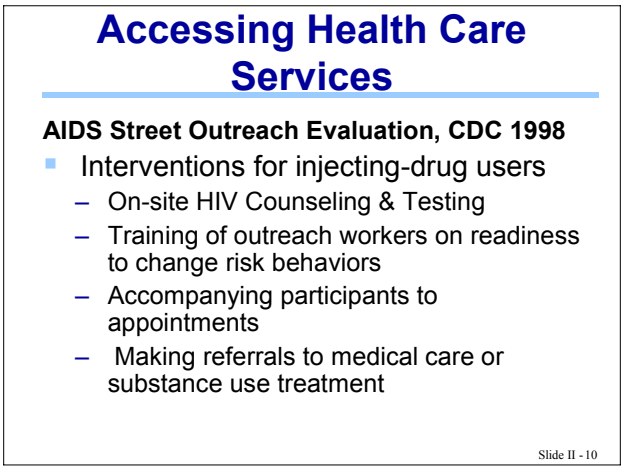
Accessing Health Care Services

Nursing LIGHT Program Detroit, MI

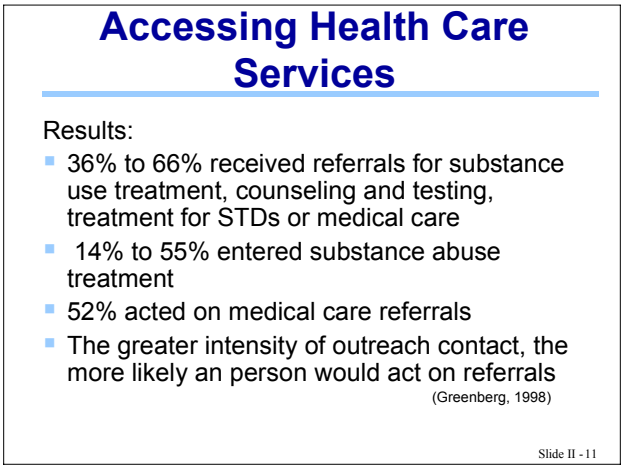
- Results
  - HIV infected women were more likely to follow-up on referrals for medical services and substance use treatment than non-participants in the program

(Anderson, 2001)

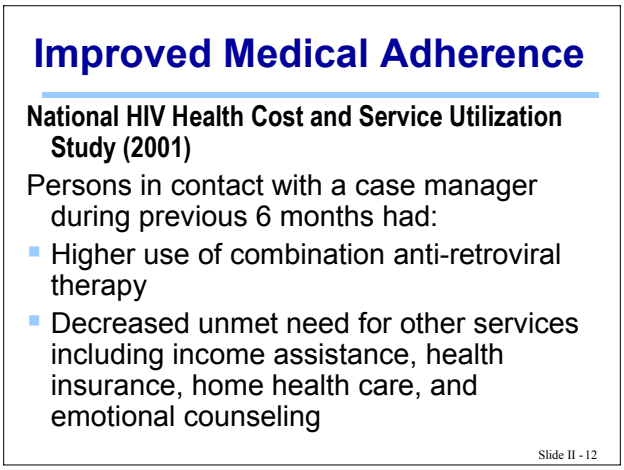
Slide II - 9



15. Note that the CDC AIDS Evaluation of Street Outreach Projects examined the effectiveness of programs in five US cities (Atlanta, Chicago, Los Angeles, New York, and Philadelphia) with outreach and service linkage program to injecting drug-using (IDU) men of color. The enhanced interventions included: on-site HIV counseling & testing, training of outreach workers on readiness to change risk behaviors based on stages of changes, accompanying participants to appointments, and making referrals for medical care and substance use treatment and documenting the use of the services by IDUs. All participants were injecting drug users and HIV infection was unknown.



16. Note that programs that established enhanced referrals systems and training for service providers could help get hard to reach populations such as IDUs to enter medical care and substance abuse treatment.
17. Display Slide II-12, "Improving Medical Adherence."



18. Note that one goal of the National HIV Health Cost and Service Utilization Study (HSUS) was to examine the effect of case management on unmet needs and the use of medical care and medications among HIV-infected persons (Katz, et al., 2001). The survey was conducted among HIV-infected persons who received medical care in hospitals or clinics in the United States. HIV-infected persons who had a case management contact in the previous six months reported higher use of two-drug and three-drug antiretroviral treatment (ART) regimens than those who were not in case management. This group also had less need for substance use treatment. In addition, people receiving sustained case management (that is, contact with a case manager at baseline and a follow-up contact six months later) were more likely to access ART and had a decrease in unmet needs for services, including the following:
    - Income assistance
    - Health Insurance
    - Home health care
    - Emotional counseling

Traditional Versus Nontraditional Settings

Purpose: To compare traditional and nontraditional settings and their differing approaches for engaging HIV-infected substance users in health care

Time: 15 minutes

Materials

- Flipchart paper and colored markers
- Slide II-13: "Traditional Versus Nontraditional Sites"
- Slide II-14: "Suggestions to Improve Traditional Sites"
- Slide II-15: "Suggestions to Improve Traditional Sites (continued)"
- Slide II-16: " Nontraditional Sites"
- Slide II-17: "Benefits of Nontraditional Sites"
- Slide II-18: "Combination of Traditional and Nontraditional Service"
- Slide II-19: "Examples of Promising Approaches to Engage and Retain People"
- Slide II-20: "Examples of Promising Approaches (continued)"

Instructor Notes

1. Describe the differences between traditional and nontraditional settings. Note that traditional sites are community health clinics, drug treatment facilities, hospitals, and community-based organizations that have a permanent or an established location where services are conducted. With nontraditional sites, services are offered in a location where a particular population congregates. The sites are not permanent, but temporary, until the needs of that population are addressed.

2. Present the information in Slides II-13 through II-17.

3. Explain to the participants that this presentation will include suggestions on how to improve services for HIV-infected substance users.

4. Ask participants to share their experiences with services that have worked with HIV-infected substance users.

Traditional versus Nontraditional Sites

- **Traditional**
  - **Established locations for services**
    - **Clinics/Hospitals**
    - **Substance abuse treatment centers**
- **Nontraditional**
  - **Meet people where they are**
  - **Temporary**
    - **Mobile**
    - **Linked with other community services**

Slide II - 13

Suggestions to Improve Traditional Sites

- Change hours of operation to accommodate the lifestyle of substance user
- Offer adult day care
- Establish HIV support groups
- Create an HIV advocate position or establish a formal relationship with an organization that provides advocacy
- Provide training on the importance of medication adherence for consumers and staff

Slide II - 14

Suggestions to Improve Traditional Sites (continued)

- Establish an incentive program where gift certificates, personal hygiene products, food coupons, disposable diapers or money is given to motivate HIV clients
- Offer training in case management on HIV, substance use, or both
- Examine clinic policies to see if barriers to treatment are created
  - Under the influence
  - Bringing children to appointments, etc

Slide II - 15

Nontraditional Sites

- Mobile Outreach
  Sites where mobile medical vehicles or vans are used to bring HIV services to different locations
- Fixed Site Outreach
  Sites where services or clinics are held in locations where people gather (shelters, soup kitchens, hotels and/or single-room occupancy hotels)

Slide II - 16

Benefits of Nontraditional Sites

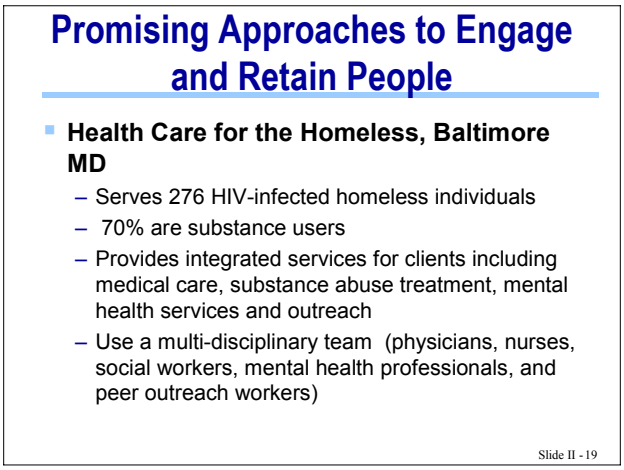
- Bring services to where HIV-infected substance users live and work
- Maintain contact with patients thereby increasing follow-up rates
- Establish a presence or goodwill within the community
- Provide access to services to persons who do not typically use traditional services

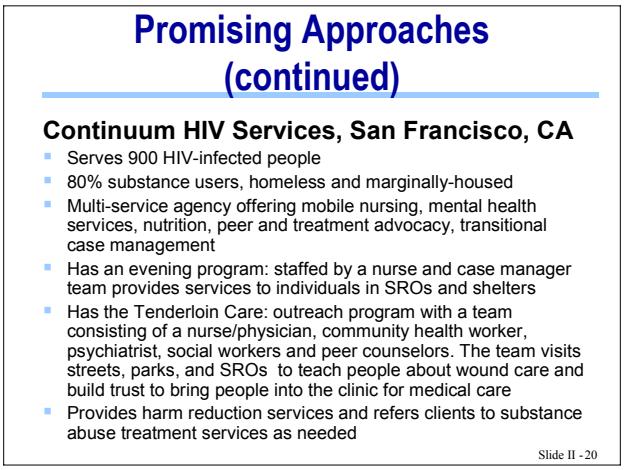
Slide II - 17

Combination of Traditional and Nontraditional Services

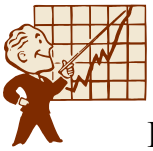
- Outreach workers can refer persons to traditional medical services and bring patients into care
- Medical care facilities can use outreach services to provide follow-up with patients

Slide II - 18





5. Display Slides 19 and 20 on Promising Approaches. Note these are examples of programs that combine both traditional and nontraditional services to engage and retain people in care.
6. Ask participants to describe the type of services provided in their organizations and to share whether they work in traditional or nontraditional programs. Write suggestions on flipchart paper, and note how these are similar to or different from the suggestions provided in the presentation.
7. Refer to comments from the flipchart sheets (Attitudes, Structural/Environmental, Personal/Cultural, and Referral/Follow-Up) developed in the Public Hearing activity in Session 2. Demonstrate how the information presented here is relevant to that earlier discussion.



Building Relationships Within the Community

Purpose: To explore approaches for building relationships within the community as we look for ways to engage HIV-infected substance users in health care

Time: 15 minutes

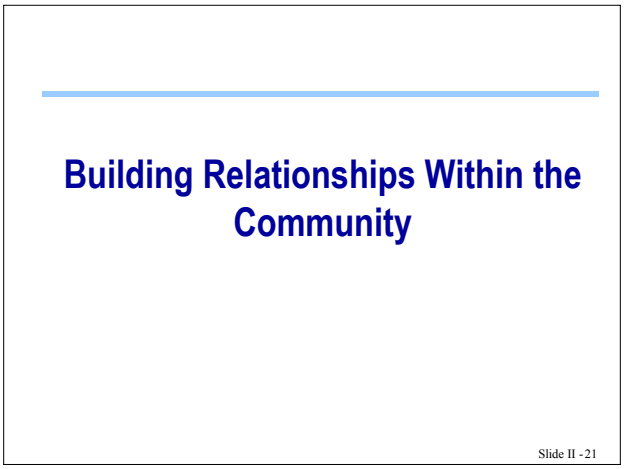
Materials

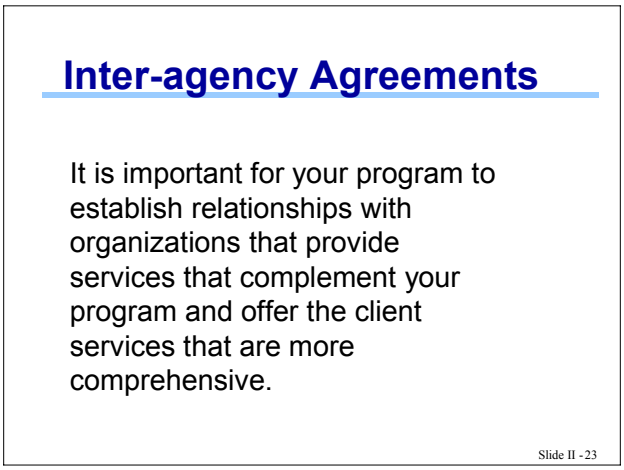
- Slide II-21, "Building Relationships Within the Community"
- Slide II-22, "Community Relations"
- Slide II-23, "Interagency Agreements"
- Slide II-24, "Agencies"

Instructor Notes

1. Ask participants how connected they are to the community and other organizations in the community. What is the nature of their relationships?
2. Who in their agency is responsible for interacting with the community? What are that person's responsibilities? How has this role evolved over time?

3. Present the information in Slides II-21 through II-24.





4. Emphasize the importance of each relationship in providing comprehensive treatment to HIV-infected substance users in traditional and nontraditional programs. Also stress the importance of having a designated contact person, and in the case of other social service agencies, developing an effective referral process.

5. If applicable, refer to comments from the flipchart sheets developed in the Public Hearing Activity in Session 2. Demonstrate how the information presented here is relevant to that earlier discussion. Note how building relationships within the community may have the following benefits:

- Addresses NIMBY (Not In My Backyard) syndrome
- Increases follow-up with clients
- Helps increase understanding of the community culture
- Helps ensure access to more comprehensive services through active referrals
- Clarifies the different job responsibilities of agency staff

Peer Advocacy

Purpose: To introduce and explore the concept of peer advocacy

Time: 15 minutes

Materials

- Slide II-25, "Peer Advocacy"
- Slide II-26, "Who Are Peers?"
- Slide II-27, "What Do Advocates Do?"
- Slide II-28, "Where Do Peer Advocates Come From?"
- Slide II-29, "Giving Back to the Community"

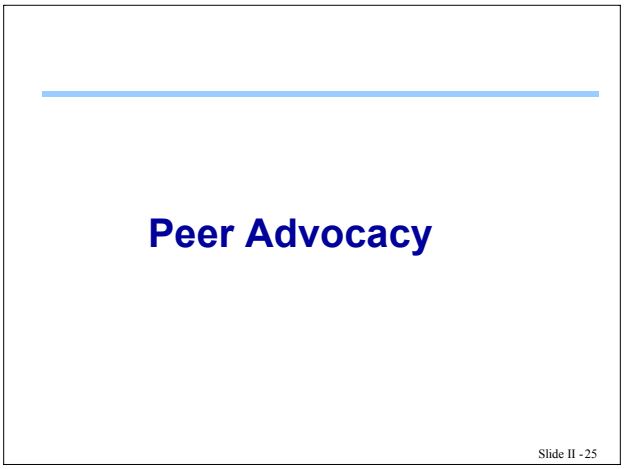
Instructor Notes

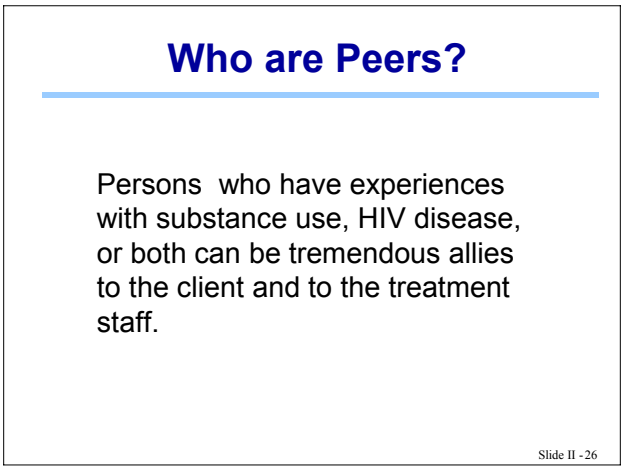
The curriculum offers two options for discussing Peer Advocacy.

Option 1: This section may be presented with slides or you may choose to select a peer that would be comfortable sharing his/her experience with the group. Ask the peer to present their role, the challenges and rewards they find with the work.

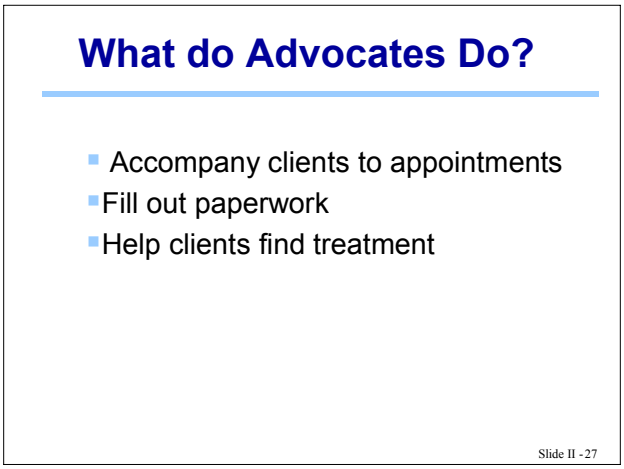
Option 2: Use the slides below to guide a interactive discussion with the group about peer advocacy.

1. Display and present Slides II-25 and II-29.

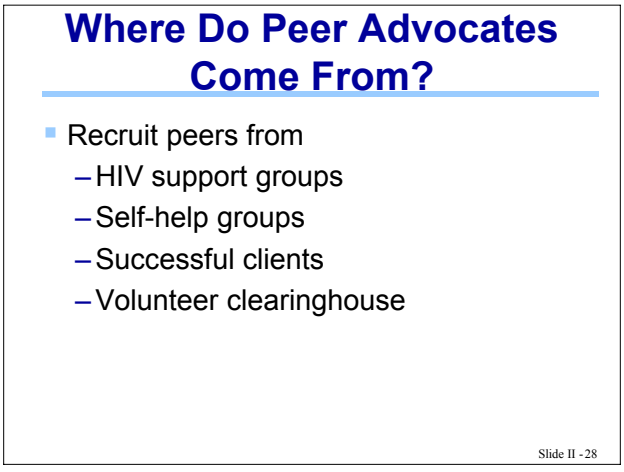


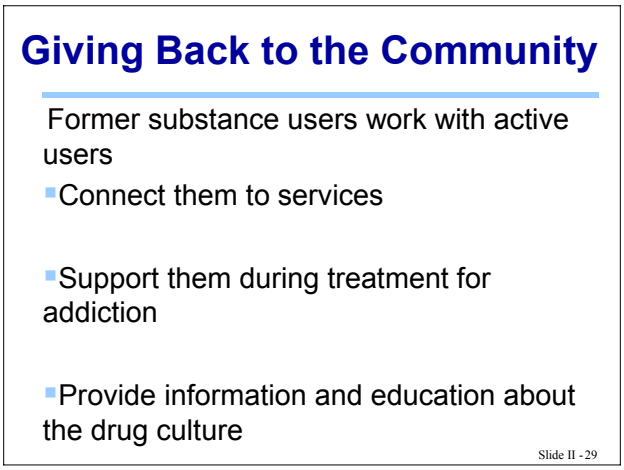


2. Display Slides II-27 "What Do Advocates Do?"



3. Explain that advocacy may be defined as follows: In the context of engaging and retaining clients, advocacy work involves assisting and accompanying clients as they access treatment or other care. Such advocacy work covers a range of activities, including filling out paperwork, taking clients to appointments, and providing other assistance as needed.
4. Display and present Slide II-28 "Where do Peer Advocates Come From?"





5. Display and present Slide II-29 "Giving back to the community." Explain that most substance abuse recovery programs urge their clients to find positive ways to give back to the community. Many clients give back by helping active substance users access and maintain treatment for their addiction and other health-related problems. Clients may also contribute by providing information on the community and drug culture.

6. Ask participants to comment on each slide presented. You might ask the questions below to elicit comments:
   - What do participants think about peer advocacy?
   - Are peer advocates used in their programs and if not, can they be used? What are the potential successes and challenges?

7. If applicable, refer to comments from the flipchart sheets developed in the Public Hearing activity in Session 2. Demonstrate how the information presented here is relevant to that earlier discussion.

8. At the end of this presentation, summarize what the participants have covered and accomplished during Session 2. Use the Session 2 objectives as a guide for your summary. Note, however, that this summary should not be done now if the optional activities described below are added to this session.

In addition to the main activities in Session 2, we are providing two optional activities. Instructors may add these activities to the session if time allows, or they may substitute them for the activities described above. We encourage instructors to conduct a brief needs assessment before starting trainings so they may tailor the activities and messages to their participants.

Cultural Awareness (Part 1)

Purpose

- Understand how to provide culturally sensitive health services
- Explore how people's culturally based beliefs and attitudes may affect their access to and use of services
- Learn how people are conditioned to perceive the world with an "us" versus "them" attitude, and see how random these distinctions are.

Time: 30 minutes

Materials:

- Stickers of various colors

Instructor Notes

1. Ask participants to close their eyes. Explain to the group that you will be walking around the room and placing a sticker on each participant's forehead.

2. Place stickers as follows:
   - Select one individual who will receive a sticker of a color different than that of anyone else in the room.
   - For the rest of the group, make sure that there are at least two but no more than five people who share the same colors.
   - If you'd like, you can vary the size of the groups. For example, you might have one orange, two greens, three or four reds, and five blues.
   - Give one person two stickers of different colors to indicate that he or she is a member of multiple groups.

3. Have the participants open their eyes and, without talking, join with the group to which they feel they belong. Explain that they may help others find their respective groups, but they may not speak.

4. Once everyone has had a chance to join a group, have everyone sit down and discuss the activity. Some of the following points may be used to stimulate the discussion:

- Explore the feelings of those who were the sole person in a "group", as well as the feelings of those who were part of larger groups. Discuss what it feels like to belong to more than one group.
- Point out that you never stated that participants could not welcome others to become a part of their group.
- Ask whether it occurred to anyone to invite a "different" person into his or her group.
- Did anyone want to break off from his or her group to join a different group?
- Try to relate this activity to our everyday interactions with others, both within and outside of our various social groups (family, friends, coworkers, teammates, and so forth).
- Ask how membership in different groups may affect people who work in health services.

Cultural Awareness (Part 2)

Purpose

- Understand how to provide culturally sensitive health services
- Explore how a person's culturally based beliefs and attitudes may affect his or her access to and use of services
- Discover that there are different ways to define the term "culture" and discuss how each of these definitions influences the ways that services are delivered

Time: 30 minutes

Materials

- Flipchart paper, colored markers, and tape
- Pens or pencils
- Handout II-6, "Cultural Awareness and Health Education: Personal Pledge"
- Handout II-7, "Cultural Awareness and Health Education: Personal Pledge"

Instructor Notes

1. Tape a few pieces of flipchart paper to a wall with the heading, "Elements of Culture." Lead a group discussion in which the participants develop a comprehensive list of the elements of culture. Address any questions or concerns that people may have about the list. Once the participants have finished adding items to the list, check to see whether the items below have been included. If not, suggest that these items be added:
   - Race
   - Ethnicity
   - Gender
   - Sexual orientation
   - Disease status (for example, infected with HIV)
   - Age
   - Religion

- Family

2. Divide the participants into small working groups of three to five people, and provide each working group with flipchart paper and a colored marker. Using the list as a guide, ask each group to develop a one- to two-sentence definition of culture.

3. Ask for volunteer from each working group to read and post his or her group's definition.

4. Emphasize the variety of thoughts, ideas, and definitions surrounding the word "culture."

5. Pass out pencils, pens, papers, and Handout II-6, "Cultural Awareness and Health Education Personal Pledge." Show Slide II-30, which has the same title as the handout. Have several participants read the pledge aloud so that it can be heard in different voices.

6. Discuss the main points of the pledge and ask for feedback. Review the role of health providers as you review the pledge. Ask the participants if they would like to sign the pledge as a personal commitment. Pledges need not be handed in.

Handout II-6

Cultural Awareness and Health Education
Personal Pledge

My Personal Commitment

Cultural background shapes a person's values, beliefs, and actions in many different ways.

Health services work best when health professionals are aware of how family, community, and culture have shaped values, beliefs, and actions about sexuality and substance use.

Effective health services are able to show a genuine sense of openness, acceptance, and respect for the cultures of all persons who participate in their program.
Personal awareness of how my cultural, ethnic, racial, and regional background has shaped my values, beliefs, and actions is an important step in becoming more aware of others.

Knowing my own biases and limits concerning other cultures will help strengthen my ability to be an effective health professional.

I embrace the statements made above and will do all that I can to promote an understanding of health and personal well-being among all people, regardless of their cultural, ethnic, racial, and regional background.

_____ _____
Signature Date

Wrap-Up

Purpose: To summarize the ideas generated regarding effective strategies to engage HIV-infected substance users in care, and provide additional resources to learn about new programs.

Time: 10 minutes

Materials

- Flipcharts
- Markers
- Handout: Resources & References

Instructor's Notes

1) On a Flipchart, ask participants to brainstorm new ways they have learned to bring people in HIV medical care.
2) Ask them to identify ways that may be feasible to adopt at their workplace.
3) Have them write down one concrete action that they can take to implement suggestions at their workplace. For example, it could be to share what they learned at this training with other staff members at a meeting, organize a support group of HIV-infected peers, or set a meeting with another agency that you would like to link your services.
4) Share the Handout 27: "Resources & References" with the group. Review the web sites and ask if there are other suggestions to add to the list. Provide your email/contact information to the group in case future questions or issues arise.
5) Thank the group for their participation and wish them luck with their work!

Section 2: Interpersonal Skills to Enhance Engagement And Retention

Objectives for the Entire Session
By the end of the session participants will be able to:

- Identify common dilemmas encountered in engagement and retention efforts, and review professional and ethical guidelines relevant to those dilemmas
- Name and describe the four stages of the Relational Model of Engagement and Retention
- Discuss three conceptual frameworks that inform the process of engagement and retention in care
- Understand the basic principles of motivational interviewing and the use of techniques specifically designed to motivate HIV-infected substance users to make positive behavioral change
- Describe at least three ways to make more effective referrals
- Model a training session with one or two of the activities for the group

Suggested Review Time for the Section: 3 hours

What Would You Do If . . . ?

"Sometimes it feels like we're trying to do brain surgery
with an axe, a screwdriver, and a cell phone."

Heather Barr, public health nurse

Purpose: To identify common dilemmas encountered in engagement and retention efforts and to review professional and ethical guidelines relevant to these dilemmas

Time: 30 minutes

Materials

- Flipchart and colored markers
- Handout II-3, "Professional and Ethical Guidelines for Care Providers"

Instructor Notes

1. Providers inevitably face situations in their work that present moral, ethical, or practical dilemmas. Identifying some of these dilemmas in advance can help to avoid being caught off guard when they arise. In addition, the relevant professional and ethical guidelines for one's work provide important guidance to providers.

2. Throughout the activity, remind participants to be aware of their reactions to the issues that come up and of the importance of consistently discussing these "sticky issues" with their peers and supervisors at work.

3. Introduce the activity by acknowledging that working with HIV-infected substance users can be challenging. Providers often encounter unique and complex situations to which the proper response is not always evident. Practical and ethical dilemmas inevitably arise. Providers sometimes feel compelled to "bend" certain rules or at least to adapt the rules to their normal way of practicing. This may leave providers with a feeling of uncertainty about whether they are doing the right thing in a given situation. This activity is designed to acknowledge these real-life concerns and to offer some basic guidelines that can help ground and give direction to providers.

4. Ask participants to brainstorm about some of the "sticky issues" and dilemmas regarding engagement and retention they have faced or might face in the course of their work. Examples might include the following:
   - Assisting a person who engages in high-risk survival sex and refuses to use protection
   - Helping a person who desperately wants to get into methadone treatment but can't because there is none is available
   - Working with a person whose active substance use interferes with his or her ability to adhere to an HIV treatment regimen.
   - Helping injection drug users who aren't ready to stop using be able to gain access to sterile needles and syringes in a location where there is no needle exchange program

5. Break into small working groups of four to six people. Explain that each working group is going to do an exercise called "What would you do if…?"

6. Ask half the people in each working group to come up with some real life dilemmas that they have encountered or could expect to encounter in the course of their work. Ask the other half of each working group to assume the role of an expert panel on a radio talk show. Ask the persons with dilemmas to take turns "calling in" to the expert panel, which will be asked, "What would you do if . . . (this particular scenario occurred)?"

7. The task of the expert panel is to discuss among themselves the relevant questions and issues raised by the case and to provide advice about the steps the caller might take. Everyone on the panel should have the opportunity to speak. Encourage a lively interchange between the callers and the panel members.

8. Have the caller and expert subgroups switch roles so that each person in each working group has an opportunity to present at least one dilemma and have a response given to it.

9. Reconvene the large group and ask several participants to comment on what came up for them during this exercise.

10. Distribute Handout II-7, "Professional and Ethical Guidelines for Care Providers." Review the guidelines with the group and invite comments about any of them, especially those that might "raise an eyebrow or two." Ask if anyone has other ideas for guidelines that were not included on the handout.

11. Conclude the activity by emphasizing the importance of consistently consulting with peers and supervisors when dilemmas arise in the course of work. Encourage regular review of these ethical guidelines or similar professional and agency guidance.

Handout II-7

Professional and Ethical Guidelines for Care Providers

"Ethics . . . are nothing but reverence for life."
Albert Schweitzer

The overriding philosophy of these guidelines is to treat other people as you yourself would want to be treated or, at the very least, to do no harm. This applies not only to interactions with the persons to whom we reach out and provide care, but also to our interactions with coworkers, supervisors, staff from other agencies, policy-makers, and others. The expectation is that providers will consistently be respectful of others and provide competent and compassionate care in whatever forms that may take.

Providers should try to anticipate and identify the ethical dilemmas that may arise in their work and to discuss these issues with supervisors and peers. Some of the guidelines below are designed to prompt such discussions and thereby increase understanding about what it means to provide care within proper boundaries. The recommendations compiled in these guidelines may be used to complement the specific codes of ethics and policies that have been developed for and accepted by various professional disciplines and organizations.

- Commit yourself to being well prepared physically, intellectually, emotionally, and spiritually for doing this work.
- Learn about the culture of the people to whom you provide care. Understand the influence that culture has on people's health beliefs and their access to health care.
- Develop an awareness of the causes, experience, patterns, and politics of HIV and substance use.
- Address the person's HIV and substance use issues as well as his or her emotional and social service needs.
- Understand the codes of ethics and relevant policies that are specific to your professional discipline and the organization in which you work.
- Be genuine and hospitable in your interactions with people.
- Strive to remain objective in your attitudes and actions. Avoid being judgmental.
- Be respectful of others' desire for privacy and their wish to keep some personal information to themselves.
- Adhere to the rules of confidentiality required in your work.

- Keep your word. Be trustworthy and reliable. Promise only what you can deliver.
- Respect people as ends, not means. Never exploit clients for personal or agency gain.
- Promote behaviors that enhance health and wellness and decrease risk or harm to self or others.
- Work within the limits of your competency, skill, and training.
- Seek supervision as soon as possible in crisis situations.
- Avoid intervening in situations in which you are not trained or competent.
- Refrain from imposing your moral or religious beliefs on others.
- Never engage in sexual activity with anyone to whom you are providing care.
- Do not accept cash gifts from clients. Accept other gifts only when it is culturally appropriate.
- Refrain from giving cash or personal gifts to clients except as may be culturally acceptable.
- Never carry weapons (with the possible exception of pepper spray).
- Never use alcohol or illegal drugs on the job.
- Take time to use your knowledge and experience to inform public planning and policy making.
- Develop practices of self-care and renewal within and outside the work setting.

Relational Model of Engagement and Retention

Purpose: To explore the four stages outlined in the Relational Model of Engagement and Retention for the care of HIV-infected substance users

Time: 20 minutes

Materials

- Flipchart and colored markers
- Handout II-8, "Relational Model of Engagement and Retention"
- Handout II-9, "Steps Along the Engagement and Retention Continuum"
- Handout II-10, "Case Study: Maria"

Instructor Notes

1. Distribute Handouts II-8 and II-9. Write the four stages of the relational model on a flipchart:
    - Making a connection
    - Developing the relationship
    - Educating and linking to services
    - Supporting wellness and stability

2. Introduce the model by noting that developing trusting relationships with HIV-infected substance users is essential if we are to successfully engage and retain them in our care. HIV-infected substance users often have difficulty accessing the services and care they need because of stigma, fear, lack of awareness, ambivalence, hopelessness, and the significant barriers presented by the health and social service system itself. One of the provider's most vital roles is to help HIV-infected substance users overcome these personal and systemic barriers. It is simply not enough to provide information and education. Establishing an ongoing, supportive relationship with a provider is often the first step people take to move in the direction of positive change.

3. Explain that the relational model is based on provider experience and the literature about effective outreach and engagement methods. It is intended to inform the process of engaging and retaining individuals in care for providers of all disciplines.

4. The stages described in the model are not necessarily discreet, nor do the stages always progress in a smooth, linear fashion. Instead, the model simply attempts to illustrate the different developmental phases of the helping relationship and the tasks common to each phase. It is important to note that some helping relationships never make it beyond the initial "making a connection" stage, and relatively few make it all the way to the fourth stage of "supporting wellness and stability." In addition, a person's movement along the relational

continuum might take a short or very long time, depending on his or her readiness and the availability of appropriate resources.

5. Distribute Handout II-10, which is entitled "Case Study: Maria." To illustrate the model, refer to the case example of Maria in Handout II-6. Ask four volunteers to read aloud one of the four sections in the case example. Invite questions and comments. Encourage participants to think about which specific activities in each stage would be most relevant in their own work situation and role.

6. Conclude the activity by encouraging participants to think about what stage(s) of relationship they are in with the various HIV-infected substance users with whom they work.

Handout II-8

Relational Model of Engagement and Retention

An important aspect of engagement and retention is the process of building and maintaining a safe, supportive relationship with someone who is HIV-infected and uses substances. The goal of this process is to help persons address their various health and social service needs and to provide them with the information needed to decrease their harm to self and others. Care providers "share a part of the journey" with the persons they serve, while providing material assistance, information, medical care, counsel, and advocacy. These efforts are designed to help persons move toward improved health and stability and prevent further transmission of HIV. This relationship generally follows a progression through the following four relational phases:

- Making a connection
- Developing the relationship
- Educating and linking to services
- Supporting wellness and stability

Making a Connection

This phase is particularly applicable to working with harder-to-reach individuals. It begins with observing a person in his or her environment followed by making some form of introduction. It is helpful, whenever possible, to spend time simply watching to see how a person acts, how he or she relate to others, what kind of space he or she needs, and how he or she seems to be experiencing their environment and responding to the world.

Careful observation helps the provider determine an appropriate way to introduce himself or herself. If the contact is occurring outside of a clinic setting such as on the street, one might simply pass by with a nod or greeting – offering a basic acknowledgment of the other person's presence. In a clinic setting, it may involve providing a warm greeting or engaging in a brief, casual conversation with someone. As trust develops, the provider moves from making a more general introduction as a neighbor/member of the community/someone who cares to introducing oneself more specifically as an outreach worker/nurse/doctor.

Developing the Relationship

Simply put, developing the relationship involves providing a caring, trustworthy presence and sharing a small part of someone's journey. This requires being able to spend time with the person. The provider creates the space for trust to grow by listening carefully and respectfully to the client's story and becoming attuned to his or her current situation, how he or she sees themselves, his or her perceptions of the world around them, and his or her ability to meet his or her personal needs. A trusting relationship is based on collaborating with a client, not by making demands. The provider must be truthful and dependable, making sure to follow through with promises made.

Educating and Linking to Services

This phase of the relationship focuses on providing education and information tailored to the client and his or her readiness to accept help. As the relationship develops, the provider links the client to other resources and clinical providers at the appropriate time. By partnering with others – case managers, medical providers, substance abuse treatment providers, social

service programs, and family members – the provider helps create a widening circle of care that the client can rely on for assistance in the various aspects of life. The provider plays an integral role during this phase by helping to coordinate care, accompanying the client as needed, resolving problems, supporting the client's follow-through with treatment plans, and continuing to enhance the client's motivation.

Supporting Health and Stability
The relationship moves into this phase when the client has established a regular pattern of using resources and services in the community and has achieved relative stability. In this stage of the relationship, there is an increased emphasis on seeing the provider and client as fellow citizens and community members. The provider's care giving role diminishes as the client becomes increasingly integrated into the life of the community. Some clients decide to reach out to others to provide similar assistance to what they once received. In time, the provider and client recognize that their relationship has met its goals and they agree to bring the formal relationship to an end.

This handout was adapted from *Relational Outreach and Engagement Model* by Craig Rennebohm, Mental Health Chaplaincy, Seattle, WA.

Handout II-9

Steps Along the Engagement and Retention Continuum

This handout was developed in particular for providers involved in engaging difficult to reach individuals in nontraditional settings. However, many of these steps can readily be adapted for providers working in clinic settings.

Making a Connection

- Observe the person: Watch the person to learn about his or her behavior, basic needs, and level of functioning. Survey the surrounding environment (when outside a traditional clinic setting) to assess for safety concerns for the provider and individual. Determine how best to make an approach that is likely to be within the person's comfort level and appropriate to the environment.

- Greet the person: Briefly greet the person with something like a nod or a "hello," but don't engage in additional conversation.

- Introduce yourself: Approach the person and introduce yourself by name, recognizing that the person may or may not respond. At first, you may choose to identify yourself in general terms – for example, as a neighbor or a person involved in reaching out to the community.

- Initiate casual conversation: Speak informally with the person about a topic or topics not specifically related to services or needs. The goal of this step is to build a relationship and increase the person's comfort level.

- Identify yourself in your specific role: Let the person know your discipline or title, and describe how you work for a local program that provides services to people with concerns related to HIV and substance abuse. In the engagement and retention model, this step is seen as a significant transitional point to the next phase, which is the development of the provider-client relationship.

Developing the Relationship

- Hear the client's story: Listen to the client's concerns, wishes, history, perceptions, feelings, and so forth. Use interviewing skills, such as asking open-ended questions, affirming strengths, listening reflectively, and summarizing.

- Do an activity together: Do something together, such as having a cup of coffee, going for a walk, eating a meal, or some other relationship-building activity.

- Identify the client's perceived needs: Find out about the client's perceived needs and determine whether or not these needs are related to HIV status or substance use.

- Provide material assistance: Give the client something tangible, such as a meal ticket, a blanket, condoms, bleach kit, or hygiene kit.

- Accompany the client when accessing short-term and survival services: Go with them to an appointment or to obtain services, such as food, shelter, or clothing**.**

- Provide information and referrals to short-term and survival services: Give information and referrals to help improve the client's immediate situation.

- Respond to emergency situations: Contact appropriate emergency services when the client's life, health, or safety is at risk.

- Client initiates contact with provider: In this step, the client contacts the care provider in person or makes contact by phoning or leaving a message.

- Meet in a public venue: When the client is ready, meet in a setting with some structure, such as a drop-in center, restaurant, or office. This step is seen as a transitional point to the next phase.

Educating and Linking to Services

- Identify mutual longer-term goals: Work together with the client to identify mutually agreeable goals, such as accessing health care, addressing substance use, reducing risk, returning to work, or accessing mental health services, income or entitlement programs, housing, or educational opportunities.

- Enhance motivation toward positive change: Assess the client's readiness to change, and use motivational enhancement skills to explore ambivalence, information and support needs, and so forth.

- Plan for meeting longer-term goals: Work together to develop a plan to achieve goals in various areas.

- Provide education: Offer the client relevant information about HIV and substance use, and educate about risk reduction practices and related topics.

- Provide information about services: Give the client information about other care providers and services that might help the client reach his or her goals.

- Connect with other longer-term services: Meet together with the client and other service providers to work on an action plan to achieve goals.

Supporting Wellness and Stability

- The HIV-infected client meets with other service providers when you are not present: Adjust your helping role as the client is able to establish working relationships with other care and service providers.

- Make outside referrals, arrange appointments, and negotiate services: Provide support to the client and facilitate his or her access to services.

- Advocate for the client within new support systems: Advocate on behalf of the client and act as bridge between the client and the long-term service system.

- Meet together to review the client's work with other long-term providers: This involves activities such as remaining in a supportive role, listening to the client's concerns, focusing on the client's stated goals, and addressing adherence issues.

- Monitor the client's progress: Remain in periodic contact with the client and his or her other service providers as needed. Help the client maintain stability.

- Terminate the formal provider-client relationship: This final step occurs when both parties agree that the client's care has been successfully transitioned to other providers. Celebrate progress the client has made, and express gratitude and grief when saying goodbye. Wish one another well in the ongoing journey.

This handout was adapted from the "Outreach and Engagement Checklist" form, published in 1996 by Northwest Resource Associates, Seattle, Washington.

Handout II-10

Case Study: Maria

The Better Health Alliance Group (BH) is a community-based clinic located on the south side of Metro City. It serves a culturally diverse and predominantly lower-income and working-class neighborhood. The clinic offers a variety of health services including pediatric, ob-gyn, general medicine, and sexually transmitted disease care. When heroin use began increasing in the community about ten years ago, BH opened a methadone clinic and began an extensive community outreach program for HIV counseling and basic medical care. Every day, BH sends a mobile van to two major parks in the area with a nurse named Angela, a physician named Pete, and an HIV and substance abuse treatment counselor named John.

Making a Connection

During the past few weeks, John has noticed a woman who occasionally sits on a bench near where the van is parked. She appears very thin and seems rather guarded. John walks by her one day and simply nods and says hello. The next day he offers her a cup of coffee but she refuses and looks away. During the next week, John continues to say hello, and one day she asks if she can now have a cup of coffee. John says "sure," and gives her a cup. He then asks if he can sit with her on the bench for a while. Over time, they start to talk, and she begins to tell John bits and pieces of her story. He learns that her name is Maria and that she's 27 years old. She's lived in the area for the past five years.

Developing the Relationship

Maria eventually tells John that she once held a steady job and that things were going well in her life until she started using heroin after her mother died. She lost her housing several months ago because most of her money went for heroin use. During the past month, Maria has been living with her 3 year-old daughter in one of the shelters in the community, but her time is limited there. She says that the people at the shelter are willing to help her find a job and a place of her own, but they say she needs to get clean first. Another resident at the shelter told her that the people in the BH van might be able to help her get clean.

Maria admits she's ambivalent about giving up heroin, because she likes the way she feels on it. However, she realizes that, for her own sake and for the sake of her daughter, she can't continue living this way. John discloses that he is a substance abuse treatment counselor and talks with Maria about some possible treatment options and the pros and cons of each. He tells her that there is unfortunately no in patient treatment program available in the Metro City area that would allow her to have her daughter with her. After considering the different options, Maria says she'd like to check out a methadone program. John describes how the methadone program works at the BH clinic. John asks Maria whether she would like to go there to arrange for a screening interview on her own or whether she would like him to go with her. Maria says she can go there on her own, provided that John makes a map for her with directions, which he does.

After two weeks of not seeing Maria, John spots her one-day sitting on the bench near the van. He knows that she never made it to the clinic. John approaches Maria and asks how she's doing. John also says that he's noticed she hasn't made it to the clinic yet. Maria says she tried to access the clinic but started using heroin heavily again after learning there was a long waiting list to get into the program.

Educating and Linking to Services
John and Maria agree to continue meeting. John follows a patient and persistent approach in which he provides Maria with information and uses his skills to help increase her motivation to get treatment. As a result of their mutual efforts, John is eventually able to help Maria complete the steps needed to start methadone treatment.

Some time later Maria shows up at the outreach van with her daughter, who has a bad cough and is not sleeping. Maria had taken her daughter to the emergency room at the local hospital during the previous weekend but decided to leave after waiting two hours without seeing anyone. John asks whether Maria would like her daughter to see a nurse named Angela in the van. After Maria agrees, Angela examines Maria's daughter and recommends that Maria take her to a pediatric clinic across town for a more thorough examination. Angela sets up a walk-in appointment for Maria at the clinic. Maria tells Angela that she doesn't have any transportation to get to the clinic and is unsure how to reach it.

John agrees to accompany Maria and her daughter to the pediatric clinic. He gives Maria his telephone extension and suggests that she ask the pediatric nurse to call him after their appointment. Maria does this, and the pediatric nurse calls John after the appointment. John later sits with Maria and asks her about her daughter's appointment. Maria says the appointment went fine, but she confides that she is worried that her daughter may be sicker than people realize. Maria tells him that she learned one year ago that she was infected with HIV, and she is afraid her daughter may also be infected. She didn't want to tell the pediatrician because she was afraid the authorities would try to take her daughter away from her. John reassures Maria that there are people at the BH clinic that can help her, and he tells her about the HIV and STD clinic services there. John says that he works with one of the case managers, Julie, and he suggests that they all meet together to set up a plan. John calls Julie and arranges for a meeting the next day.

John and Julie meet with Maria and ask what she would like to accomplish in the next few months. Maria says that she would like to find a stable place to live and perhaps find a job so she can start supporting her daughter. John also asks Maria how she learned about her HIV infection and if she has seen a doctor for it. Maria mentions that she did go to see a doctor a few months after learning she was infected with HIV. However, since she felt fine at the time, Maria didn't think she needed to return until she got sick. Now that her daughter is sick, Maria is also worried about her own HIV infection. Julie makes arrangements for both Maria and her daughter to meet with the HIV doctor in their clinic.

Supporting Wellness and Stability
It is now one year later. Maria and her daughter are both receiving the medical care they need. Maria continues on methadone treatment, and they are living in subsidized, low-income public housing. She receives some minimal case management assistance. Maria has been able to get some part-time work to supplement the public assistance she receives. Although Maria is still facing a number of challenges, she is feeling much better about her overall situation. Maria hopes someday to complete methadone treatment, go back to school, and eventually get a better-paying job so she can support herself and her daughter.

Questions for Discussion

- What are some examples of how the BH team made a connection with Maria?
- What are some examples of John and Julie's concrete actions that helped build a relationship with Maria?
- What are some of the reasons why Maria was reluctant to engage in BH services?
- How did the BH staff address some of these concerns and support Maria's stability and good health?

Frameworks of Engagement

Purpose: To explore several conceptual perspectives to enhance engagement and retention efforts

Time: 20 minutes

Materials

- Handout II-11, "Hospitality – Creating Space for the Stranger"
- Handout II-12, "Story as a Framework for Engagement"
- Handout II-13, "What Does It Mean to Care?"

Instructor Notes

1. In preparation for this activity, read each of the handouts and the related questions for discussion. Think about your own responses to the questions.

2. Write the word "Hospitality" on a sheet of flipchart paper and ask participants to briefly brainstorm about the images or ideas that word immediately evokes for them. Write down their responses. Then do a similar brief brainstorm for the word "Story" and then again with the word "Care."

3. Divide the participants into at least three small working groups with four to six participants each. Have each working group choose one of the three frameworks of engagement (hospitality, story, or care) for discussion, using the corresponding handouts to guide their discussions. If there are more than three working groups, some groups will examine the same framework of engagement.

4. Ask that someone in each working group read their handout aloud to the rest of the working group. Tell them that, once the handout has been read, each working group should discuss their responses to the questions in the handout.

5. After ten minutes, have a representative from each working group report back to the entire group on one or more key insights or examples from their discussion. The group representatives will describe how the concepts of hospitality, story, or care may be used to enhance engagement and retention activities in work with HIV-infected substance users. In this way, each participant will be exposed to each of the three frameworks of engagement.

6. Conclude the activity by asking the participants whether they know about any other helpful frameworks of engagement that might inform their work.

Handout II-11

Hospitality – Creating Space for the Stranger

Persons who are infected with HIV and are actively using substances often feel like outcasts. They are stigmatized as a result of judgmental attitudes and punitive social policies. They might also become estranged from their past relationships and activities, and may lack a sense of place and purpose in the world. Literally, they become strangers.

"Offering the gift of hospitality" is a useful approach for care providers to think about overcoming this estrangement. In his book *Reaching Out,* Henri Nouwen defines hospitality as "creating free and friendly space for the stranger." This definition goes far beyond images of tea and sandwiches being shared in a pristine setting. Instead, it points us toward new and deeper relationships in our lives.

Hospitality offered to a stranger is an invitation to enter into a relationship – a relationship that provides a welcoming face and presence and that creates a sense of refuge from an often impersonal, hostile world. Hence, a person can have a taste of what it is like to be "at home" in the context of a safe, friendly relationship.

A hospitable relationship comes with no strings attached. It does not pass judgment and does not make demands. Instead, it provides a space in which a person can freely explore his or her needs, abilities, and hopes. Such a relationship becomes both a resting place and a guiding light. It provides a place of self-reflection and restoration. It instills and renews hope.

The power of hospitality lies not in coercion but in careful listening, reflection, information-sharing, and kindly persuasion. It encourages, but does not force. It is built upon the trustworthiness, competency, and integrity of the provider.

When we think of our own experiences of being graced with the hospitable presence of another, we remember it as calming, orienting, and renewing. It is like remembering who we are – returning to our true home – so that we can once again move ahead more confidently in our lives. The absence of such a hospitable presence often leads to isolation, disorientation, confusion, and despair. Like all of us, people who are infected with HIV and using substances need hospitable relationships in their lives.

Hospitality is offered in many ways – sometimes by a simple gesture of acknowledgement, a warm smile, or a cup of coffee. Hospitality may also involve listening patiently without interrupting, offering information and a word of encouragement, or simply being present with the other person in silence. Offering hospitality requires time, patience, and kindly persistence. It cannot be rushed. It sees the "big picture" rather than seeking a quick fix.

As trust within the relationship builds, a sense of companionship develops. The provider and client spend time together on a more predictable basis. The client shares more and more of his or her story. Small tasks are shared. The client begins to ask about other resources. In time, hospitality leads to increasing the circle of care to help the client access needed resources and services. In this way, the client's medical, housing, financial, counseling, and other treatment and social service needs are met.

Over time, the client progresses toward greater wellness and stability. The relationship is no longer one-sided, moving instead into a phase of increasing mutuality. Once a stranger, the client has now become more a neighbor and friend. We discover that our stories are interwoven and that we are bonded by our common humanity. In this phase, the client and provider recognize each other for the strengths and gifts that they bring to the relationship as well as to the larger community.

In the end, hospitality that is given becomes a gift of hospitality received.

Ken Kraybill

Questions for Discussion

- What other phrases might be used to describe the idea of "providing hospitality" besides those mentioned in the handout (such as creating space and providing a welcoming face)?
- How is the concept of providing hospitality similar to and distinctive from the idea of providing service?
- In what circumstances have you been a "stranger" who was offered the gift of hospitality by someone else? What was that experience like?
- What are some specific ways you might offer hospitality to an HIV-infected substance user in your work? Consider a particular person you know.
- How could your team or organization improve upon the ways it provides "free and friendly space for the stranger?"

Handout II-12

Story as a Framework for Engagement

Everyone has a story. Sharing our stories creates a common ground on which we can meet each other as human beings. Our stories are neither right nor wrong. They are simply our stories.

Some of us can tell our stories with an unclouded memory for our past, clarity about our present situation, and a realistic understanding of where our journey is heading in life. Some of us find telling our story extremely difficult. Our past may be painful and deeply hidden from memory. We may never have had much support in putting together any real, coherent sense of ourselves in relationship to others. The current stresses in our lives may be upsetting or confusing the sense of who we are, where we have been, and where we are going.

Mental illness, intoxication, developmental disability, neurological disorders, and brain injuries can deprive persons of the capacity to tell their story and locate themselves with others and the world. In the midst of illness, a person's story may take on bizarre dimensions. Difficulty in sharing a coherent story, or the presentation of a very disjointed or strange story, may be an indication that a person is suffering from a disabling condition. A person who presents in this manner may require specialized care.

Inviting another person to share his or her story can be a non-threatening way to build mutual trust and to develop a more detailed picture of the person's situation and needs. If we are also willing to share a little of our own story, we can expand the common ground.

We end, in a sense where we began. As we share our stories over time, we are both enriched. We have walked a little way on the journey together. At best, I have been able to add a little something to another person's story – some hope, some concrete help, some encouragement. In turn, they have added something to mine – their courage, their humanness, and their experience.

Every encounter we have is a small piece of the larger story. Every encounter is an opportunity to listen and share, and to help move our stories along with care and compassion.

Craig Rennebohm

Questions for Discussion

- What is the significance of "story" in relation to engagement and retention?
- How can you elicit a person's story in the context of your work?
- What are some reasons why a person might have difficulty remembering all or part of his or her story?
- What are some reasons why HIV-infected substance users might be reluctant or fearful to tell their stories?
- Who do you ask to share their stories?
- How do you define and determine the "truth" of someone's story? To what extent is this truth dependent on factual accuracy?
- When do you suggest that a client might benefit from other professional help?

Handout II-13

What Does It Mean To Care?

The word care has become a very ambiguous word. When someone says, "I will take care of you!" it is more likely an announcement of an impending attack than an expression of tender compassion. In addition to this ambiguity**,** the word care is commonly used in a negative way. For example, in response to the question, "Do you want coffee or tea?" you might say "I don't care."

Real care is not ambiguous. Real care excludes indifference and is the opposite of apathy. The word "care" finds its roots in the Gothic "kara" which means "lament." So the root meaning of care is "to grieve, to experience sorrow, to cry out with." I am very much struck by this background of the word care, because in common usage, we tend to look at caring as an attitude of the strong toward the weak, of the powerful toward the powerless, of the haves toward the have-nots. And, in fact we feel quite uncomfortable with an invitation to enter into someone's pain before doing something about it.

Still, when we honestly ask ourselves which persons in our lives mean the most to us, we often find that they are the persons who, instead of giving much advice, solutions, or "cures," have chosen instead to share our pain and touch our wounds with a gentle and tender hand. The friend who can be silent with us in a moment of despair or confusion, which can stay with us in an hour of grief and bereavement, who can tolerate not-knowing, not-curing, and not-healing, and who can face with us the reality of our powerlessness – that is the friend who cares.

Our tendency is to run away from the painful realities or to try to change them as soon as possible. But attempting to cure without care makes us into rulers, controllers, and manipulators, and prevents a real community from taking shape. Cure without care makes us preoccupied with quick changes, impatient and unwilling to share each other's burden. And so cure can often become offending instead of liberating.

It is therefore not so strange that cure is often refused by people in need. The phenomenon of refusing help that is offered without care is not limited to individuals. Indeed, oppressed minorities have resisted support and suffering nations have declined medicine and food when they decided that it was better to suffer than to lose self-respect by accepting a gift from a non-caring hand.

Henri Nouwen

Questions for Discussion

- Why does the author say that "care" has become an ambiguous word in common usage?
- What is the root meaning of the word "care," based on its origins in the Gothic word "kara"? Does this surprise you in any way?
- The author suggests that the root meaning of care challenges the common view of caring for others as an "attitude of the strong toward the weak, the powerful toward the powerless, of the haves toward the have-nots." How does this relate to our engagement and retention efforts?

- What is meant by the phrase “cure without care?” What are some examples in your work situation that might illustrate an approach of cure without care?
- How might you work with other professionals to improve the care of an HIV-infected substance user?

Enhancing Motivation Toward Positive Change

Purpose: To develop core skills to help HIV-infected substance users increase motivation toward positive change

Time: 40-60 minutes

Materials

- Flipchart and colored markers
- Handout II-14, "Stages of Change"
- Handout II-15, "Four Principles of Motivational Interviewing"
- Handout II-16, "OARS+E: The Basic Skills of Motivational Interviewing"
- Handout II-17, "Open-Ended Questions and Affirmations"
- Handout II-18, "Reflective Listening"
- Handout II-19, "Summarizing"
- Handout II-20, "Eliciting Change Talk"
- TV and VCR
- "Motivational Interviewing Tape C: Handling Resistance," recorded in 1998 by William R. Miller and Stephen Rollnick, and directed by Theresa B. Moyers. This videotape can be ordered at the following website: http://www.motivationalinterview.org/training/miorderform.pdf

Instructor Notes

1. Preview all or part of the videotape cited above. To find the segment of the tape to be shown during this activity, fast-forward approximately 32 minutes into the tape to a 15-minute section entitled: "Case Example: Responding to Resistance." In this part of the tape, the interviewer (woman sitting on the right) effectively demonstrates the use of basic motivational interviewing skills with a client who is reluctant to address his substance use problem (middle-aged man wearing vertically striped shirt).

2. Distribute Handout II-14, "Stages of Change." Summarize the five stages: precontemplation, contemplation, preparation, action, and maintenance. Also comment on the concept of relapse. Include the following key points:
   - Behavior change can involve starting, ending, increasing, decreasing, or altering a particular behavior. Behavior is defined broadly, not only referring to physical behaviors, but also to thoughts, attitudes, and beliefs.
   - The process of change is not necessarily linear. It is often more like a spiral than a straight line. Sometimes it is "two steps forward, one step backward."
   - The stages are not totally distinct from one another.
   - It is common to be at different stages of change for various behaviors in one's life.
   - In general, stages cannot be skipped. A person must move through each stage eventually.

- People move through the stages according to their own pace and timing. For example, some people linger for years in one or more of the precontemplative, contemplative, or preparation stages. Others move very quickly through them into the action phase.
- Relapse is expected and accepted.
- Each stage (and relapse) requires a different stance and response by the care provider.

3. Distribute the Handout II-15, "Four Principles of Motivational Interviewing." Describe each of these four principles by using the talking points on the handout. Invite clarifying questions and comments from participants.

4. Distribute the following five handouts:

   - Handout II-16, "OARS +E: The Basic Skills of Motivational Interviewing"
   - Handout II-17, "Open-Ended Questions and Affirmations"
   - Handout II-18, "Reflective Listening"
   - Handout II-19, "Summarizing"
   - Handout II-20, "Eliciting Change Talk"

5. Describe these five key skills one at a time, and then review the examples provided on the handouts. Note that first four skills are focused on a client-centered approach, and the critical fifth, "Eliciting Change Talk", describes the directive nature of motivational interviewing. Spend as much time as is needed to ensure that participants are thoroughly familiar with them. Reinforce how these skills, along with the four principles of motivational interviewing, may be used to diminish resistance and promote motivation to change.

   Important: Be sure to note that, although these are the foundational skills, they are not the only skills used to enhance motivation. It is also appropriate at times to ask closed-ended questions, change the focus, provide information, state an opinion, give advice when requested, and so forth.

6. Show the motivational interviewing video segment described above. After the participants have viewed it, facilitate a discussion by asking the following questions:
   - Drawing on the principles of motivational interviewing, what types of things did the interviewer do? For example, participants might say that she generated a gap, rolled with resistance, expressed empathy, and so forth..
   - What things did the interviewer *not* do, based on the principles of motivational interviewing? For example, participants might say that she didn't pass judgment, didn't give advice, didn't argue, and so forth.
   - What examples did you observe of the interviewer using the skills: open-ended questions, affirmations, reflective listening, summarizing, and eliciting change talk?

Handout II-14

Stages of Change

Precontemplation
In the precontemplation stage, a person has no intention to change behavior in the foreseeable future. Many people in this stage are unaware or barely aware of their problems. Others might wish to change, but are not seriously considering changing within the next six months.

Contemplation
In the contemplation stage, a person is aware that a problem exists and is seriously thinking about addressing it, but is not yet committed to preparing for and taking action. People in this stage are experiencing ambivalence, weighing the pros and cons. They can remain stuck in this phase for long periods of time.

Preparation
In the preparation stage, a person is committed to taking action soon and is making concrete steps to do so. People in this stage often report small, positive behavioral changes. Although ambivalence may still be present, it is diminishing.

Action
In the action stage, a person is actively changing his or her behavior, relationships, or environment to overcome the problem. Their commitment is clear, and they are willing to devote the considerable time and energy required in this stage. Action is a critical part of behavior change, but it should not to be confused with behavior change itself, which is a broader process encompassing all of the stages of change

Maintenance
In the maintenance stage, a person continues to work at stabilizing behavioral change and consolidating the gains made during the action phase. The maintenance stage is not static, but is, in fact, very active. It often requires a great deal of hard work and perseverance. It is also a time to enjoy the rewards resulting from the change.

(Relapse)
Although relapse is not considered a stage of change, it is often part of the change process. Relapse occurs when a person reverts to the problem behavior. This may happen one or more times at any point along the change pathway. The duration of relapse may be very brief or lengthy. Relapse is viewed as a temporary loss of motivation and is regarded as a learning opportunity.

This handout was adapted from *Changing for Good* by James Prochaska, John Norcross, and Carlo DiClemente, published in 1994 by William Morrow and Company, Inc., New York; and *Motivational Interviewing* (2nd edition) by William Miller and Stephen Rollnick, published in 2002 by Guilford Publications, New York.

Handout II-15

Four Principles of Motivational Interviewing

Express Empathy

- Create atmosphere in which client can safely explore conflicts and face difficult realities
- Acceptance facilitates change, pressure to change tends to immobilize it
- Accurate, skillful reflective listening is fundamental – seeks to understand the client's feelings and perspectives without judging, criticizing, or blaming
- Ambivalence is normal, not pathological

Develop Discrepancy

- When one's own behavior is seen as conflicting with important personal goals such as health status, living situation, self-image, change is more likely to occur
- Counselor uses and amplifies discrepancy *within* the person to explore *importance* of change for him or her
- Goal is to have client, not the counselor, present reasons for change – consistent with self-perception theory – essentially that we come to know what we believe by hearing ourselves say it.
- Motivational interviewing designed to elicit and reinforce change statements. These statements include recognition of the problem, expression of concern, intention to change, and optimism for this change.

Roll with Resistance

- Avoid arguing for change.
- Resistance is not to be directly opposed. Opposing resistance generally strengthens it.
- Resistance is a signal to respond differently.
- Offer new perspectives but don't impose them.
- The client is a primary resource in finding answers and solutions.
- Client resistance is significantly influenced by the counselor's behavior.

Support Self-Efficacy

- Goal is to enhance the client's confidence in his or her capability to cope with obstacles and to succeed in change
- Assumes the client, not the counselor, is responsible for choosing and carrying out change
- Self-efficacy is a key element for motivating change and a reasonably good predictor of the treatment outcome
- The counselor's own belief in the person's ability to change can have a powerful effect on the outcome – often becomes a self-fulfilling prophecy

This handout was adapted from *Motivational Interviewing* (2nd edition) by William Miller and Stephen Rollnick, published in 2002 by Guilford Publications, New York

Handout II-16

OARS+E: The Basic Skills of Motivational Interviewing

The motivational interviewing approach is often referred to as more *a way of being with clients* than as *a series of techniques*. As such, it is not only what you do, but how you do it that is important. Motivational interviewing is not a prescriptive approach for working with people. However, certain methods are required to employ this particular approach.

There are five specific methods that are useful throughout the process of motivational interviewing. The first four, summarized by the acronym OARS (Open questions, Affirmations, Reflective listening, and Summarizing), are derived largely from client-centered counseling. In motivational interviewing they are used to explore ambivalence and clarify reasons for change.

The fifth method, Eliciting change talk (+E), is more clearly directive and is specific to motivational interviewing. It integrates and guides the use of the other four methods.

Although these five methods appear simple, they are not necessarily easy to use. They require considerable practice. Providers must consciously incorporate them into their practice. The reward for doing so is that these methods can effectively help others move in the direction of positive change.

This handout was adapted from *Motivational Interviewing* (2nd edition) by William Miller and Stephen Rollnick, published in 2002 by Guilford Publications, New York.

Handout II-17

Open-Ended Questions and Affirmations

Open-Ended Questions

Open-ended questions encourage people to talk about whatever is important to them. They help providers build rapport, gather information, and increase understanding. Open-ended questions are the opposite of closed-ended questions, which require only a limited response, such as "yes" or "no."

Open-ended questions invite people to tell their own stories in their own words from their own points of view. Their answers reveal a richness of content that goes far beyond mere facts and allows the listener to hear "what makes the person tick." Open-ended questions should be used frequently, though not exclusively, in conversation with clients.

The example below shows the contrast between an open-ended and a closed-ended question. Notice that, although the questions focus on the same topic, the second question is more likely to elicit a detailed response.

- Did you have a good relationship with your parents?
- What was your relationship with your parents like?

Here are a few more examples of open-ended questions:

- Would you tell me more about . . . ?
- Would you help me understand . . . ?
- How would you like things to be different?
- What are the positive things and what are the less good things about . . . ?
- What do you think you will lose if you give up . . . ?
- What have you tried before?
- What do you want to do next?

Affirmations

Affirmations are statements and gestures that recognize a people's strengths and acknowledge behaviors that lead in the direction of positive change, no matter how big or small. Affirmations help to build people's confidence in their ability to change. To be effective, affirmations must always be genuine and congruent.

Examples of affirmations:

- I am really impressed with the way you . . .
- That's great how you've reached your goal of cutting back on your drug use.
- Using protection shows that you have real respect for yourself and your partners.
- I was hoping I would have the opportunity to meet with you again.
- You have a quite a gift for . . .

This handout was adapted from motivational interviewing materials developed by David B. Rosengren, and from *Motivational Interviewing* (2nd edition) by William Miller and Stephen Rollnick, published in 2002 by Guilford Publications, New York.

Handout II-18

Reflective Listening

"Listening looks easy, but it's not simple. Every head is a world."
Cuban proverb

Reflective listening is a primary skill in outreach. It is a pathway for engaging others in relationship, building trust, and fostering motivation to change. Reflective listening appears deceptively easy, but it takes hard work and skill to do well.

Sometimes the approaches we use in working with individuals do not exemplify reflective listening, but instead serve as roadblocks to effective communication. Examples include misinterpreting what is said or assuming what a person needs.

To listen reflectively, it is vital to learn to *think* reflectively. This way of thinking, which accompanies good reflective listening, includes interest in what people say and respect for their inner wisdom. Hypothesis testing is a key element of reflective thinking and listening. What you think the person means may not be what they really mean. Listening may break down in any of the three ways listed below:

- The speaker does not say what is meant.
- The listener does not hear correctly.
- The listener gives a different interpretation to what the words mean.

Reflective listening is meant to close the loop in communication to ensure that breakdowns don't occur. The listener's voice turns down at the end of a reflective listening statement. This may feel presumptuous when you do it, yet it leads to clarification and greater exploration. In contrast, asking additional questions tends to interrupt the client's flow. Some people find it helpful to use some standard phrases like the following:

- "So you feel . . ."
- "It sounds like you . . ."
- "You're wondering if . . ."

There are three basic levels of reflective listening that may deepen or increase the level of intimacy and thereby change the affective tone of an interaction. In general, the depth of intimacy should match the situation. Examples of the three levels are given below:

- Repeating or rephrasing: The listener repeats or substitutes synonyms or phrases, staying close to what the speaker has said.
- Paraphrasing: The listener makes a major restatement in which the speaker's meaning is inferred.
- Reflecting feeling: The listener emphasizes emotional aspects of communication through statements that express feelings; this is the deepest form of listening.

Varying the levels of reflection is an effective approach in reflective listening. At times, there are also benefits to overstating or understating a reflection. An overstatement (that is, an amplified reflection) may cause a person to back away from a position, while an understatement may help to continue and deepen the feeling intensity.

This handout was adapted from motivational interviewing materials developed by David B. Rosengren, and from *Motivational Interviewing* (2nd edition) by William Miller and Stephen Rollnick, published in 2002 by Guilford Publications, New York.

Handout II-19

Summarizing

Summaries are special applications of reflective listening. Although they can be used throughout a conversation, they are particularly helpful at transition points. For example, summaries are often helpful after someone has finished speaking about a particular topic or recounted a personal experience, or when the encounter is nearing an end. Summarizing helps to ensure that there is clear communication between the speaker and listener. It can also provide a stepping-stone toward change.

Structure of Summaries

Begin with a statement indicating that you are making a summary. For example:

- "Let me see if I understand so far . . ."
- "Here is what I've heard. Tell me if I've missed anything . . ."

Give special attention to what are known as "change statements." These are statements that a person makes that point toward a willingness to change. There are four types of change statements, all of which overlap:

- Problem recognition: "My use has gotten a little out of hand at times."
- Concern: "If I don't stop, something bad is going to happen."
- Intent to change: "I'm going to do something, I'm just not sure what it is yet."
- Optimism: "I know I can get a handle on this problem."

If the person expresses ambivalence, it is useful to express both sides of their ambivalence in the summary statement. For example, "On the one hand, it seems that . . . while on the other hand, it sounds like . . ."

It is acceptable to include information in summary statements from other sources, such as your clinical knowledge, research, courts, or family.

Be concise.

End summary statements with an invitation. For example:

- "Did I miss anything?"
- "If that's accurate, what other points are there to consider?"
- "Is there anything you want to add or correct?"

Depending on the person's response to your summary statement, it may lead naturally to planning for or taking concrete steps toward the change goal.

This handout was adapted from motivational interviewing materials developed by David B. Rosengren, and from *Motivational Interviewing* (2nd edition) by William Miller and Stephen Rollnick, published in 2002 by Guilford Publications, New York.

Handout II-20

Eliciting Change Talk

Eliciting change talk is the consciously directive strategy on the part of the counselor for resolving ambivalence. If open questions, affirmations, reflective listening, and summarizing were the only skills used by the counselor, it would be quite possible for the client to remain stuck in ambivalence. Instead of the counselor advocating for change, which often puts the client in the position of defending against it, motivational interviewing takes a different tact. The idea is to have the counselor facilitate the client's expression of change talk, that is, for the client to present the arguments for change.

Four Categories of Change Talk

- Recognizing disadvantages of the status quo
  "I guess this is more serious that I thought."
- Recognizing advantages of change
  "I'd probably feel a lot better."
- Expressing optimism about change
  "I think I could probably do that if I decided to."
- Expressing intention to change
  "I've got do something."

Methods for Evoking Change Talk

- Asking evocative questions
  "What worries you about your current situation?"
- Using the *importance* ruler (also use regarding client's *confidence* to change)
  "How important would you say it is for you to_____? On a scale of 0 to 10, where 0 is not at all important and 10 is extremely important, where would you say you are?"

0	1	2	3	4	5	6	7	8	9	10
Not at all important									Extremely important	

- Exploring the decisional balance
  "What do you like about your present pattern?" "What concerns you about it?"
- Elaborating
  "What else?" Ask for clarification, an example, or to describe the last time this occurred.
- Querying extremes
  "What concerns you most about? What are the best results you could imagine if you made a change?"
- Looking back
  "What were things like before you? What has changed?"
- Looking forward
  "How would you like things to be different a year/three years from now?"
- Exploring goals and values
  "What things are most important to you?"

(Miller and Rollnick, Motivational Interviewing, 2nd edition, 2002, The Guilford Press)

Practicing With OARS +E

Purpose: To practice using the five methods involved in enhancing motivation

Time: 30 minutes

Materials: Handout II-21, "Scenarios"

Instructor Notes

1. In preparation for the activity, review the scenarios in Handout II-20 and separate each one. Then fold and place the scenarios in a box for the training session. Write the discussion questions on newsprint:
    - *For the client:* how it felt to be interviewed with these techniques. Did they feel heard? What techniques worked best for them? What techniques didn't work as well?
    - *For the observer*: What examples of the four principles and the methods did the provider use during the interview?
    - *For the provider*: Which techniques worked best for them? What was the most challenging aspect of the micro-skills approach?

2. Divide the participants into small working groups of three persons each. Assign a specific role to each person in the working groups. The three roles are the provider who is conducting the interview, the client being interviewed, and an observer. The people in the role of providers should handle their interviews from the stance of someone in their clinical discipline or position – for example, as a physician, a mid-level nurse, or an outreach worker.

3. Ask the people who are in the role of interviewed clients to select a scenario from the box and read it. They should not reveal the scenario ahead of time to the persons in either the provider or observer roles.

4. The persons in the provider role begin by asking an open-ended question, such as "How might I be of help?" or "What brings you here today?" The person in the client role should create a personal story around the scenario. The provider's goal is to use the micro-skills to understand the client's situation, thoughts, and feelings. The provider should try to use each of the four techniques as often as possible during the interview. Allow about eight to ten minutes for each interview.

5. The job of persons in the observer role is to jot down examples of the provider's use of the five techniques – open-ended questions, affirmations, reflective listening at various levels, summarizing, and eliciting change talk.

6. After each role-play, the three participants should debrief for about five minutes around the discussion questions listed in instructor note #1.

7. If possible, ask each working group to repeat the role-play twice more using different scenarios so that each participant has an opportunity to play all three roles.

8. At the end of the activity, thank the group for their willingness to practice these skills. Encourage them to learn more about approaches to enhance motivation and to continue practicing these core skills in their work.

Handout II-20

Scenarios

You are a 17-year-old, homeless Caucasian youth who has tested positive for HIV. To survive, you make money by having sex, usually unprotected, with various regular customers.

You are a young Latino woman who is in early pregnancy and is infected with HIV. You are afraid to see your doctor, because you are ashamed of your HIV status.

You are a 50-year-old African American man who is infected with HIV. You have remained drug-free for the three months since you successfully completed a long-term residential treatment program for your heroin addiction. You report that you've recently been having intense cravings to use again.

You are an immigrant man in your thirties from West Africa. You recently tested positive for HIV. You don't believe that you could possibly be infected, and you refuse to discuss it with anyone.

You are a formerly homeless Native American woman in your early forties living with HIV. You've recently found permanent housing, but it seems to be more of a problem than a solution. You report that you feel walled in, that you don't like being alone, and that people are constantly knocking on your door trying to sell you drugs that threaten your recovery. You report feeling more and more depressed and are considering moving out. You say you were happier living on the streets.

You are a 29-year-old Caucasia***n*** woman who is infected with HIV. You are trying to regain custody of your two young children. You recently moved into clean-and-sober transitional housing after successfully completing in-patient treatment for polysubstance use. You tell your provider in confidence that you've been drinking and using crack occasionally, but you are not doing any of that "other stuff." You report that you only use on the weekends when you are away from the transitional housing facility.

You are a man in your thirties who is infected with HIV. A few months ago you were released from prison after serving a lengthy sentence for multiple drug-related offenses. You are currently on parole with the requirement that you not use drugs. For the first month after release you went back to smoking crack almost every day, but now report feeling very proud that you've been able to cut back to smoking crack only on weekends.

You are a 28-year-old Latino male who has tested positive for HIV. You probably contracted the virus by having anonymous unprotected sex with men at gay sex clubs. You are married with a child and do not consider yourself to be homosexual. You are afraid to disclose your HIV status to your family.

You are a 25-year-old woman who is involved in a long-term abusive relationship with a partner who is infected with HIV and uses injection drugs. You are quite concerned that you might also test positive for HIV, but your partner refuses to let you get tested or seek medical help. Your partner says in a dismissing manner, "What you don't know won't hurt you."

Effective Referral and Linking

Purpose: To highlight the necessary elements for making successful referrals

Time: 20 minutes

Materials: Handout II-21, "Checklist for Making Successful Referrals"

Instructor Notes

1. In preparation for this activity, familiarize yourself with Handout II-21 and the activity instructions, and be prepared to facilitate a group discussion.

2. Introduce the activity by noting that effective referrals require more than giving someone a name and phone number and then wishing them good luck. There are many personal and systemic barriers that may hinder HIV-infected substance users' attempts to access the help they need. As needed, ask participants to name some of these barriers.

3. Refer participants to Handout II-21, "Checklist for Making Successful Referrals." This checklist presents the issues that providers should consider when making referrals. Review these items, and invite participants to make comments and ask questions.

4. Have participants break into pairs. Ask each person to think about an HIV-infected substance user to whom they are currently providing care. Ask them to identify a particular need (such as medical care, substance use treatment, public assistance, shelter, or housing) for which a referral will likely be needed. Instruct each participant to talk with their partner about the likely success of this referral with this client using the checklist and the questions below as a guide:
   - If I were to make this referral today, how successful would it probably be?
   - How ready are the client, the system, and I (as the provider) to ensure that this referral will work out? (Be sure to factor in the client's inner motivation to pursue the referral.)
   - What still needs to be learned or negotiated to prepare for a successful referral for this client?

5. Close the activity by facilitating a discussion with the large group by raising some or all of the following questions:
   - What new insights do you have about making successful referrals?
   - Are there any issues that should be considered that are not on the checklist?
   - What specific strategies can you use to ensure that clients make it to their first appointment and keep follow-up appointments?

- Do you have any thoughts about how to use the checklist as a visual reminder in the office?

Handout II-21

Checklist for Making Successful Referrals

- I have an adequate understanding of the individual's situation and perceived needs.
- The client and I have talked about how to prioritize these needs and what options exist to help address them.
- The client is willing and ready to be referred.
- We have discussed what issues might make it difficult for the individual to follow through with the referral.
- I am familiar with the agency to which I am referring the individual, including its eligibility requirements and services.
- The agency has the *capacity* and *willingness* to serve HIV-infected substance users in a respectful, culturally competent, and knowledgeable manner.
- I have a working relationship with at least one of this agency's staff persons who can provide useful information and help advocate for the individual.
- I have considered whether or not to accompany the client to this agency. My decision was based on the following qualities and capacities of the person:
  - Ability to negotiate complex social situations
  - Ability to provide and receive information
  - Ability to tolerate waiting
  - Level of ambivalence about seeking help
  - Interpersonal style (passive to argumentative)
- If the client is going alone, I have provided sufficient information and "coaching" to help make the referral successful.
- I have made a plan to follow-up with the individual to see how things went and to determine next steps.
- I have a backup plan if this referral fails to work out for any reason.

Section 3: Keeping Ourselves Engaged

This section provides a menu of activities that can be used to introduce and promote self-care activities for staff members working with HIV-infected substance users.

Objectives for the Entire Session: By the end of the session, participants will be able to:

- Describe at least three guidelines and specific practices to promote personal and collective well being in the work environment.
- Model one or two self-care activities that they can use with their own programs. Two activities that are highly encouraged to demonstrate include: the River of Life activity and the Great Care Debate

Suggested Review Time: 1 hour

Materials:
Handout II-22, "This work…"

Instructor's Notes:

1) Introduce this section by explaining the rewards and challenges in working on a daily basis with providing care to HIV-infected substance users. Use the poem in Handout II-22 to illustrate. If applicable, draw upon some of the lessons learned from earlier activities such as the Public Hearing. Taking care of ourselves and fellow colleagues to balance the demands of work and our personal lives is important if we are to be effective in our work.

2) Explain this section outlines activities that each person can do with fellow staff members or by themselves to find ways to promote a healthier work environment as well as a healthier self.

3) Encourage the group to include an exercise in their follow-up training activities and/or reference in their presentations around Strategies to engage and retain HIV-infected substance users in care. Remind them if we ourselves are not engaged in our work, it will be a challenge to engage others in care.

Handout II-22

This work…

exhilarating
and exhausting

drives me up a wall
and opens doors I never imagined

lays bare a wide range of emotions
yet leaves me feeling numb beyond belief

provides tremendous satisfaction
and leaves me feeling profoundly helpless

evokes genuine empathy
and provokes a fearsome intolerance within me

puts me in touch with deep suffering
and points me toward greater wholeness

brings me face to face with many poverties
and enriches me encounter by encounter

renews my hope
and leaves me grasping for faith

enables me to envision a future
but with no ability to control it

breaks me apart emotionally
and breaks me open spiritually

leaves me wounded
and heals me

Ken Kraybill

Promoting Well-being in the Work Environment

Purpose: To identify policies and practices which keep staff engaged in the work and motivate HIV-infected substance users to keep coming back for care

Time: 40 minutes

Materials: Flipchart and colored markers

Instructor Notes

1. Read the activity instructions below and prepare accordingly.

2. Ask the group to brainstorm about elements of the work environment that are necessary both to keep staff engaged and to motivate clients to keep coming back for care. Examples of these key elements of agency culture might include its organizational structure, policies, philosophy of care, supervision, decision-making, communications, operating procedures, cultural sensitivity, building features, aesthetics, safety, attitudes, activities, and support of personal wellness. Write down the participants' ideas on a sheet of flipchart paper.

3. Break the large group into smaller working groups of four to six participants.

4. Ask the participants to imagine that they are at a retreat that includes all agency staff, Board members, and some people who receive care from the agency. The focus of the retreat is to create and maintain a healthy work environment that promotes the well being of everyone who works for the agency and is served by it. Each working group is charged with identifying some specific ideas for policies, practices, and activities that would improve the work environment for staff and for those who receive services. Encourage the working groups to be imaginative and to come up with ideas that could be realistically implemented in the workplace. Ideas may be either big or small.

The following list has some examples of policies, practices, and activities that might be implemented:

- Personal check-ins at the beginning of staff meetings
- Regular staff potlucks
- Redesigned workspace to improve safety and aesthetics
- Regular visits from a massage therapist
- Ways to improve communication
- In-service training on "creating a respectful workplace"
- Special recognition of birthdays and work anniversaries
- Retreats to nature
- Policies that promote personal wellness

- Formation of staff softball, volleyball, and soccer teams
- Allocation of time and space for meditation or yoga
- Designation of a "De-stress the Workplace Month"
- Diverse activities in job descriptions
- Opportunities and permission to become involved in advocacy
- Flexible work schedules

5. Give working groups about 10 to 15 minutes both to brainstorm ideas and to prepare a presentation for the larger group about their recommendations. Direct the working groups to follow the guidelines below in making their presentations:
   - All members of the group must participate in the presentation in some way.
   - Presentations must take five minutes or less.
   - The presentation should include three to five specific and workable recommendations for implementation.
   - These recommendations are to be presented in an interesting and creative way – no dry, didactic speeches are permitted! The performance of skits, songs, and pantomime, and the use of props, limericks, haiku, role plays, and so forth is highly encouraged.

6. Have the small groups make their presentations. Consider giving prizes for the most creative, clever, or humorous ones.

7. Conclude the activity by discussing the most workable ideas that were raised, and challenge participants to consider ways to implement them in their own work settings.

In addition to the main activities in Section 3, we are providing five optional activities. Instructors may add these activities to the session if time allows, or they may substitute them for the activity described above.

River of Life

Purpose: To have participants reflect on the personal experiences and influences that have motivated them to become involved in this work

Time: 30 minutes

Materials: One blank piece of paper and pen for each participant

Instructor Notes

1. Familiarize yourself with the activity. In preparing for it, draw your own "river of life," as described below. Do this exercise with someone else if possible and share your experiences.

2. Acknowledge that this exercise, particularly the aspect of reflecting on the "rough waters" in our lives, may provoke unwelcome thoughts or memories for some participants. Comment on this when introducing the "River of Life" exercise and give participants permission to excuse themselves from doing the exercise if they choose.

3. Explain that a river is a meaningful symbol in many cultures and that most people find it quite natural and stimulating to think of their own lives in terms of a river. In this activity, participants are invited to use the symbol of a river to reflect on their personal lives. You may also acknowledge that many people prefer to view their lives as a pathway or roadway rather than a river. As the instructor, it is important to be flexible and to allow people to use whichever metaphor works best for them. In addition, some participants may not feel comfortable drawing. Ask those persons to write out their river of life rather than draw it. Note that the remaining notes refer only to the River of Life metaphor.

4. Write the following words on a sheet of flipchart paper:
   - River currents
   - Tributaries or streams
   - Rough waters

5. Invite each person to take a piece of blank paper and a pen and to draw a simple river. Along the course of the river, have them identify particular strengths, gifts, and passions (river currents) they possess and bring to their work. Next, they are to draw and identify "tributaries or streams" flowing into the river that correspond to the key influences in their lives. Examples might include specific people, education, books, experiences, and events. Ask the

participants to focus especially on influences that have contributed directly or indirectly to becoming involved in this work. Finally, ask the participants to draw and identify "rough waters" in the river that represent particularly challenging times that have influenced them in a significant way or have been the source of valuable learning relevant to this work.

6. Encourage participants to be as self-disclosing in this exercise as they are comfortable doing. Explain that they will be asked to share some of their experiences in small working groups of two or three people. Allow six to eight minutes for drawing the river, tributaries, and rough waters.

7. Form groups of two or three people each and invite participants to share with each other their experience of drawing the river. Allow sufficient time for this part of the activity, at least ten minutes per person. You may prompt them with questions, such as the following:
   - What did this exercise stir in you?
   - Did you have any particular insights?
   - What are some of the gifts, passions, and values that connect you to your work?

8. To provide closure to the activity, invite a few participants to share with the entire group any discoveries or insights they have gleaned from this river excursion.

This activity was adapted from the "River of Life" exercise in the *Community Organizing Curriculum* (3rd edition), published in 1994 by the New Mexico Department of Health, Public Health Division, Santa Fe, New Mexico.

Worker Safety and Precautions: What Are the Risks?

Purpose: To increase awareness of the health and safety risks in outreach and to promote prevention efforts and guidelines for intervention

Time: 10 minutes

Materials
- Flipchart and colored markers

Instructor Notes
1. The outreach setting is a unique and ever-changing environment. Taking services to "where people are" presents intriguing possibilities and may also present certain risks for the provider's health and safety. Employers need to fully inform their outreach workers about these risks, and workers need to take these matters seriously. Outreach workers must make a commitment to abide by agency policies, maintain awareness of their environment, and to take steps to reduce work-related risks to a minimum.

2. Familiarize yourself with the activity as outlined below. The approach described is an effective way to help groups brainstorm creatively and then begin to define the issues in more measurable terms.

3. Ask participants to name the various specific health and safety risks they might encounter in their work. Encourage them to think broadly about the nature of these risks. Remind them to define health risks not only in physical terms, but in relation to their psychological, emotional, and spiritual health as well.

4. After completing this brainstorm, consider grouping the ideas into general risk categories. These categories will likely include the following:
   - Exposure to diseases
   - Accidents
   - Physical violence
   - Harassment
   - Verbal and emotional abuse
   - Emotional or psychological symptoms
   - Stress
   - Burnout

5. Encourage participants to discuss with their co-workers specific ways to reduce the risks that they encounter in their work.

Safety Guidelines for Street Outreach

Purpose: To identify and generate discussion about safety guidelines for street outreach

Time: 15 to 20 minutes

Materials: Handout II-23, "Safety Guidelines for Street Outreach"

Instructor Notes

1. In preparation for this activity, review the guidelines noted on Handout II-23, "Safety Guidelines for Street Outreach." Pay special attention to the opening statement: "These safety guidelines for street outreach are adapted from guidelines developed by outreach workers in the downtown skid row area of Los Angeles. They are designed solely to assist staff in avoiding trouble on the street. They do not address how to handle difficulties once they arise. The strength of these guidelines is that they address the needs of street outreach workers who operate in a very different work environment from staff who are agency-based. The guidelines are intended as only one part of an agency's overall safety policies and procedures."

2. Review the guidelines together as a large group. Comment on selected guidelines as you see fit, and provide examples from your experience. It may be helpful to give examples of

situations in which workers did not adhere to guidelines or agency policies and experienced negative consequences as a result.

3. Review the list of risks identified in the previous activity. Ask participants how these guidelines address the risks identified earlier by the group. Invite participants to ask questions and share their own examples.

4. Even when the truth of a guideline seems self-evident, ask the participants why it was included on the list. Play the role of devil's advocate periodically to urge the group to think more deeply about these guidelines.

5. After reviewing the guidelines on the handout, ask the group to suggest other guidelines they would add to the list. Some workers who do outreach in specific settings or with specific populations will generate guidelines that may be unique to their situation.

Handout II-23

Safety Guidelines for Street Outreach

These safety guidelines for street outreach are adapted from guidelines developed by outreach workers in the downtown skid row area of Los Angeles. They are designed solely to assist staff in avoiding trouble on the street. They do not address how to handle difficulties once they arise. The strength of these guidelines is that they address the needs of the street outreach workers who operate in a very different work environment from staff who are agency-based. The guidelines are intended as only one part of an agency's overall safety policies and procedures.

1. Your supervisor needs to know where you will be at all times.

2. Learn as much as possible about the situation before setting out to do outreach.

3. Do not plan outreach in areas which you have good reason to believe are inherently dangerous.

4. Be aware of gang areas and gang colors. Avoid wearing gang colors when doing outreach in those areas.

5. Always carry business cards and identification with you.

6. Inform collaborating agencies of your presence.

7. Introduce yourself and inform people about what you are doing and why.

8. Do not argue with someone who does not agree with what you are doing.

9. Outreach is preferably conducted in two-person teams. No team member should conduct outreach activities alone unless he or she receives prior approval from the supervisor.

10. Do not approach those who are showing signs that they do not want to be bothered.

11. Do not criticize your partner in public while conducting outreach. Always present yourselves as a team.

12. Wear comfortable clothes and shoes. Do not overdress.

13. Do not carry valuables or other personal possessions, such as jewelry, large amounts of money, radios, and laptops. If you are carrying incentives, make arrangements to hold these in a secure place.

14. Do not remain in a spot where you are privy to a drug deal that is either in process or is being set up to "go down." Leave the area immediately without drawing attention to yourself or others.

15. Do not linger with a person who you know is holding illegal drugs.

16. Do not interrupt the sale of sex or drugs for money. Leave the area immediately without drawing attention to yourself or others.

17. Do not counsel or play the role of a social worker on the streets.

18. Maintain confidentiality with all clients you meet.

19. Do not accept gifts or food from clients or buy any merchandise from them.

20. Do not give or lend money to clients.

21. Do not accept or hold any type of controlled substance.

22. Never enter any clients' cars or homes or any enclosed area.

23. Tell clients approximately when you will be back and where you can be reached. Provide clients with a business card.

24. Work with your partner and supervisor to develop a contingency plan for worst-case scenarios or dangerous situations.

25. Keep your supervisor informed about any unusual developments.

26. In case of an emergency, call 911 or have another person call that number. Do not separate from your partner unless you feel that staying together would increase your danger.

Employee Statement
I acknowledge that I have received a copy of the safety guidelines for performing outreach. I certify that I have read and understand these guidelines, and I agree to comply with agency guidelines related to this issue to the best of my ability.

Print Name: _____

Signed: _____ Date: _____

Supervisor Signature: _____ Date: _____

Self-Care: The Great Debate

Purpose: To acknowledge the mixed messages we often hear about self-care in our lives and work settings

Time: 15 minutes

Materials: Handout II-23, "Self-Care: The Great Debate"

Instructor Notes

1. In preparation for this activity, make two copies of the Handout II-24, "Self-Care: The Great Debate." If you wish, supply some props for the two characters mentioned in the handout – the Voice of Self-Care Wisdom and the Voice of Work.

2. Ask for two volunteers to take part in a short skit. Give each volunteer a copy of the handout. Then assign one person to play the Voice of Self-Care Wisdom and the other to play the Voice of the Work.

3. Explain that the Voice of Self-Care Wisdom is leading a burnout prevention workshop for the group. The skit begins with the Voice of Self-Care Wisdom welcoming the group to the workshop and then beginning to offer sage advice (from the handout) to participants in an engaging, somewhat lilting voice. For example, "Stop denying. Listen to the wisdom of your body."

4. The Voice of the Work character is positioned at the back of the room and intones responses in a distant, disembodied manner. The Voice of Work says things such as, "*Work until the physical pain forces you into unconsciousness*." The two voices continue back and forth as the role players read the advice and corresponding responses.

5. When the skit has ended, invite participants to comment on their own experience of being caught in the middle of these different messages.

6. Close this activity by commenting that these messages can come from personal attitudes and beliefs as well as from external sources. Either way, it is important to acknowledge that providers and organizations have legitimate needs that are sometimes at odds. Providers will need to find a healthy balance between these competing needs and to be aware that this balance may shift at different times. Work colleagues can help monitor this balance for one another.

Handout II-24

Self-Care: The Great Debate

Voice of Self-Care Wisdom versus Voice of the Work

Wisdom: Stop denying. Listen to the wisdom of your body. Freely admit the stresses and pressures that reveal themselves physically, mentally, and emotionally.

> ***Work****: Work until the physical pain forces you into unconsciousness.*

Wisdom: Avoid isolation. Don't do everything alone! Develop or renew relationships with friends and loved ones. Closeness not only brings new insights, but also can be an antidote for agitation and depression.

> ***Work:*** *Shut your office door and lock it from the inside so no one will distract you. They are just trying to keep you from catching up on your paperwork.*

Wisdom: Change your circumstances. If your job, your relationship, a situation, or a person is dragging you under, try to change your circumstances or leave, if necessary.

> ***Work****: If you feel something is dragging you down, suppress those thoughts. Try drinking stronger coffee.*

Wisdom: Pinpoint the areas that are creating difficulties for you, and work towards alleviating that pressure.

> ***Work****: Increase intensity. Work harder. The harder you work, the more people you can help! If you find yourself working at a relaxed pace and enjoying your work, you probably need closer supervision.*

Wisdom: Stop over-nurturing. If you routinely take on other people's problems and responsibilities, learn to gracefully disengage. Try to get some nurturing for yourself.

> ***Work****: Make an effort to be everything to all people. You exist to solve other people's problems. Perhaps you haven't read your job description thoroughly.*

Wisdom: Learn to say "No." Speaking up for yourself will help diminish stress. This means refusing additional requests or demands on your time or emotions.

> ***Work****: Never say no to anything. It shows weakness and makes you look like a slacker. Never put off until tomorrow what you can do by working late today.*

Wisdom: Begin to back off and detach. Learn to delegate, not only at work, but also at home and with friends. In this case, detachment means rescuing yourself for yourself.

> ***Work****: Delegating is a bad idea. If you want it done right, do it yourself.*

Wisdom: Reassess your values. Try to sort out the meaningful values from the temporary and fleeting, the essential from the nonessential. You'll conserve energy and time, and you'll begin to feel more centered.

> ***Work**: Reflecting on such things is not only selfish but a waste of time. We will send you a memo explaining how to prioritize your values. Until then, if someone questions your priorities, tell them you are not able to comment and refer them to the Personnel Department. It will be taken care of.*

Wisdom: Learn to pace yourself. Try to take life in moderation. You only have so much energy available. Decide on what is wanted and needed in your life, then begin to balance work with love, pleasure, and relaxation.

> ***Work**: A balanced life is a myth perpetuated by so-called self-care experts trying to make a buck! They're just trying to undermine your commitment to your work. Don't be fooled by this.*

Wisdom: Pay attention to your body. Exercise regularly and take care of yourself nutritionally. Don't skip meals, disregard your need for sleep, or break your medical appointments.

> ***Work**: Yeah, whatever! Your body serves your mind; your mind serves the agency. Push the mind, and the body will follow. Drink Mountain Dew.*

Wisdom: Diminish worry and anxiety. Try to keep worrying to a minimum – it changes nothing. You'll have a better grip on your situation if you spend less time worrying and more time taking care of your real needs.

> ***Work**: If you're not worrying about work, you must not be very committed to it. We may have to find someone else who is.*

Wisdom: Keep your sense of humor. Begin to bring joy and happy moments into your life. Very few people suffer burnout when they're having fun.

> ***Work**: So, you think your work is funny? We'll discuss this with you at a special meeting on Friday at 6:00 p.m. Be there!*

This handout was adapted from a document on the Massachusetts Institute of Technology web site at http://web.mit.edu/afs/athena.mit.edu/user/w/c/wchuang/News/college/MIT-views.html

Self-Assessment Tool: Self-Care

Purpose: To use a self-assessment tool to rate yourself in the areas of physical, psychological, emotional, spiritual, and workplace self-care

Time: 15 minutes

Materials: Handout II-25, "Self-Assessment Tool: Self-Care"

Instructor Notes

1. In preparation for this activity, complete the self-assessment tool (Handout II-20) yourself and think about your responses to the follow-up questions listed below. Alternatively, do this exercise with another person or a small group, and then discuss it among yourselves.

2. Make sure that you have enough copies of the tool for each participant.

3. Distribute a copy of the self-assessment tool to each participant and request that everyone takes about five to seven minutes to complete it. Emphasize that this is representative list of self-care activities, not an all-inclusive list. In addition, note that the participants should not infer that anyone should be doing all of the things mentioned on the list. This tool simply provides a snapshot of a person's current attention to personal wellness.

4. Once participants have completed the self-assessment, ask them to discuss the ideas and issues it raised. You can ask participants to discuss this in pairs, in small groups, or in the entire group. If you wish, you may prompt the participants with questions such as the following:
   - Were there any surprises? Did the assessment present any new ideas that you hadn't thought of before?
   - Which activity ideas seem like they would be more of a burden than a benefit to you?
   - What are you already doing to practice self-care in the physical, psychological, emotional, spiritual, and workplace realms?
   - Of the activities you are not doing now, which particularly spark your interest? How might you incorporate them into your life sometime in the future?
   - What is one activity or practice you would like to "try on for size" starting now or as soon as possible?

Handout II-25

Self-Assessment Tool: Self-Care

Rate yourself, using the numerical scale below, to fill in the empty boxes:
5 = Frequently, 4 = Occasionally, 3 =Sometimes, 2 = Never, 1 = It never even occurred to me

How often do you do the following activities?

Physical Self-Care

☐ Eat regularly (that is, breakfast, lunch, and dinner)
☐ Eat healthfully
☐ Exercise or go to the gym
☐ Lift weights
☐ Practice martial arts
☐ Get regular medical care for prevention
☐ Get medical care when needed
☐ Take time off when you're sick
☐ Get massages or other body work
☐ Do physical activity that is fun for you
☐ Take time to be sexual
☐ Get enough sleep
☐ Wear clothes you like
☐ Take vacations
☐ Take day trips or mini-vacations
☐ Get away from stressful technology such as pagers, faxes, telephones, and e-mail
☐ Other:_____

Psychological Self-Care

☐ Make time for self-reflection
☐ Go to see a psychotherapist or counselor
☐ Write in a journal
☐ Read literature unrelated to work
☐ Do something at which you are a beginner
☐ Take a step to decrease stress in your life
☐ Notice your inner experience – your dreams, thoughts, imagery, and feelings
☐ Let others know different aspects of you
☐ Engage your intelligence in a new area – go to an art museum, performance, sports event, exhibit, or other cultural event
☐ Practice receiving from others
☐ Be curious
☐ Say no to extra responsibilities sometimes
☐ Spend time outdoors
☐ Other:_____

Emotional Self-Care

- ☐ Spend time with others whose company you enjoy
- ☐ Stay in contact with important people in your life
- ☐ Treat yourself kindly (for example, by using supportive inner dialogue or self-talk)
- ☐ Feel proud of yourself
- ☐ Reread favorite books and see favorite movies again
- ☐ Identify comforting activities, objects, people, relationships, and places, and seek them out
- ☐ Allow yourself to cry
- ☐ Find things that make you laugh
- ☐ Express your outrage in a constructive way
- ☐ Play with children
- ☐ Other:_____

Spiritual Self-Care

- ☐ Make time for prayer, meditation, and reflection
- ☐ Spend time in nature
- ☐ Participate in a spiritual gathering, community, or group
- ☐ Be open to inspiration
- ☐ Cherish your optimism and hope
- ☐ Be aware of nontangible (nonmaterial) aspects of life
- ☐ Be open to mystery and not-knowing
- ☐ Identify what is meaningful to you and notice its place in your life
- ☐ Sing
- ☐ Express gratitude
- ☐ Celebrate milestones with rituals that are meaningful to you
- ☐ Remember and memorialize loved ones who are dead
- ☐ Nurture others
- ☐ Have awe-ful experiences
- ☐ Contribute to or participate in the causes you believe in
- ☐ Read inspirational literature
- ☐ Listen to inspiring music
- ☐ Other:_____

Workplace/Professional Self-Care

- ☐ Take time to eat lunch with co-workers
- ☐ Take time to chat with coworkers
- ☐ Make time to complete tasks
- ☐ Identity projects or tasks that are exciting, growth-promoting, and rewarding for you
- ☐ Set limits with clients and colleagues
- ☐ Balance your caseload so that no particular day is 'too much!"
- ☐ Arrange your workspace to make it comfortable and comforting
- ☐ Get regular supervision or consultation
- ☐ Negotiate for your needs, such as benefits and pay raises
- ☐ Have a peer support group
- ☐ Other: _____

This handout was adapted from *Transforming the Pain: A Workbook on Vicarious Traumatization* by Karen Saakvitne and Laurie Anne Pearlman, published in 1996 by TSI Staff.

Session 5: Wrap-Up

What Will You Do When . ..

Purpose: To identify and summarize the ideas and insights which participants have gleaned during this module and will take back to their work settings

Time: 30 minutes

Materials:

- Handout II-26, "Suggested Replication Trainings"
- Flipchart
- Colored marker

Instructor Notes

1. Hand out the training planning assessment forms and give participants 20 minutes to fill out their suggested topics for a training on Engaging and Retaining HIV-Infected Substance Users in Care. If the group is large have them work in pairs.

2. Invite several participants to share with the group their proposed outline and how they plan to incorporate it into their work.

3. Share the Handout II-26 outlining ideas for two-hour replication training. Ask for feedback for other activities that could be done at their sites.

5. Inform the participants about the optional activities that there was not enough time to do. Ask participants whether they have any ideas for other related activities or resources. Share Handout II- 27 "Resources & References for further learning about Strategies to Engage HIV-Infected Substance Users in Care." Ask people if they have other ideas for resources to share with the group. Note the suggestions on the flip charts.

6. Conclude by thanking people for their participation and wish them well in their ongoing work.

Handout II-26:
Suggested Replication Trainings

Time: 2 hours

Session I: Introduction, Icebreaker, Objectives (15 minutes)

Session II: Framework for Engagement: (30 minutes)

a. Hospitality
b. Story

Session III: Practicing OARS

b. Review Handouts (20 minutes)
c. Practice methods in groups (40 minutes)

Session IV: Close out (15 minutes)

a. End with one of the self-care activities, such as "The Great Debate" or the Outreach poem

Handout II-27:

Resources & References for further learning about
Strategies to Engage HIV-Infected Substance Users in Care

Websites:

Please note: These websites have rich sources of information. To expedite your search, it is suggested to use key words such as: "HIV/AIDS", "Outreach", Access to care for people living with HIV/AIDS, substance abuse and HIV, behavior change strategies.

1) Health Resources & Services Administration: www.hrsa.gov

2) Substance Abuse and Mental Health Services Administration: www. Samsha.gov

3) National Health Care for the Homeless Council: www.nhchc.org

4) National Minority AIDS Council: www.nmac.org

5) Centers for Disease Control: www.cdc.org

6) Harm Reduction Coalition: www.harmreduction.org

7) New Mexico AIDS Information Network: www.aidsinfonet.org/

8) University of California at San Francisco: http://hivinsite.ucsf.edu

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