5

Program Components

Program Components

5

Prevention needs of persons with HIV are both similar to and different from prevention needs of HIV negative persons who engage in high-risk behavior. Both may be unable or unwilling to change risky behaviors because of other survival issues more pressing to them than HIV prevention, such as homelessness, poverty, mental illness, abuse, racism, homophobia or addiction. Persons with HIV also face the stigma of HIV/AIDS, which, after more than 20 years, is still pervasive in many communities. In addition, persons with HIV must cope with HIV/AIDS symptoms, treatment side effects and demanding medication regimens. Persons with HIV may struggle with the responsibility of not infecting others and the fear of being rejected by partners and loved ones.

Successful PwP programs must use multiple components that address the specific ethnic, cultural and medical needs of persons of color with HIV. Health and wellness are ongoing needs and require different kinds of activities on an ongoing basis. PwP programs should address not only safer sex and drug use, but should address the needs and strengths of the whole person.

PwP programs can be implemented at different levels: individual, group, community and structural.

- **INDIVIDUAL LEVEL** approaches include working one-on-one with clients through prevention case management, partner notification and referrals/linkages with other services.
- **GROUP LEVEL** approaches include skills building, counseling and support groups.
- **COMMUNITY LEVEL** approaches include social events and media campaigns that address stigma and isolation and increase support.
- **STRUCTURAL LEVEL** approaches include partnering with local and state health jurisdictions and healthcare provider training.

The following sections of this chapter describe components commonly used in PwP programs. These are not intended to stand-alone, but should be mixed and matched according to the specific needs of persons with HIV in your community. This is not a comprehensive list. Many agencies use different and innovative approaches that are not listed here.

The table below highlights the model PwP programs listed in this manual and their multiple components. Use different approaches to best fit your clients' needs.

	MODEL PROGRAMS						
COMPONENTS	E Kuleana Kakou	Mano a Mano	Love Positive	VOICE	Homebase/ Springboard	AIDS Project of the East Bay	CLEAR
Prevention case management	★	★			★		★
Health & wellness	★	★	★	★	★	★	★
Referral	★	★	★	★	★	★	★
Counseling	★			★	★		★
Skills building	★	★	★	★	★	★	★
Support groups	★	★	★	★	★	★	
Social events	★	★	★			★	
Media/ social marketing	★	★	★			★	

Best practices

The following best practices are based on APC's P3 programs' formative research:

Overall wellness

Clients want services that offer an overall wellness model with a focus on staying healthy and looking good, not just HIV/AIDS-related issues.

Integration

Prevention services should be integrated with other HIV and substance use and abuse services. Staff at other services should be made aware of prevention issues and programs.

Social events

Clients want programs that offer social events to help reduce isolation, build a sense of community and meet other persons with HIV for friendship and dating.

Culture

Services need to be culturally appropriate (ethnicity, gender, language and sexual orientation), building on the uniqueness of each community.

COMPONENT: Prevention case management

Prevention case management (PCM) is an individual level, one-on-one, client-centered intervention that uses trained professionals to help clients manage their HIV and other pressing issues such as mental health, drug use, housing and food. The goal of PCM is to help clients with multiple pressing needs incorporate safer sex and drug use practices into their lives. PCM is intended for persons with HIV who have a hard time starting or maintaining HIV prevention practices due to other needs that take precedence, such as drug addiction, sex work, incarceration or mental health concerns. For example, a female sex worker in San Diego, CA, may be addicted to drugs, be an undocumented immigrant and live in an abusive relationship. These factors need to be addressed for her to be able to use condoms consistently and not share needles.

PCM is a bit of a blend between traditional case management and HIV prevention risk reduction counseling. PCM differs from case management in that in addition to following up with patients on adherence to anti-HIV drugs and coordinating referrals to services, PCM includes identifying risk behaviors and the medical and psychosocial needs that stand in the way of a client incorporating safer sex and drug using practices. PCM is an on-going, intensive intervention that requires client trust in order to make a difference.

According to CDC guidelines, PCM is made up of the following seven parts:

1. Client recruitment and engagement in the process (trust)
2. Screening and assessment (comprehensive assessment of HIV and STD risks, medical and psychosocial service needs including STD evaluation and treatment and substance abuse treatment)
3. Development of a "prevention plan" based on client input and direction
4. Multiple-session HIV risk-reduction counseling
5. Active coordination of medical, mental and social services with follow-up
6. Monitoring and reassessment of clients' needs, risks and progress
7. Discharge from PCM upon attainment and maintenance of risk-reduction goals

Best Practices

PCM is an expensive and time-intensive intervention that requires trained professionals. It also reaches a low number of clients compared to outreach or group activities, but can be more effective because of its focus and intensity. Although little research has been done on the effectiveness of PCM, formative and process research have shown that the following issues help ensure quality PCM:

ENGAGE THE CLIENT

Without buy-in from the client, PCM will not work. PCM must be done with the needs and abilities of the client in mind, without asking for goals that may be impossible to achieve. Active drug use or mental illness, for example, may make it difficult to keep regular appointments.

BE CULTURALLY SENSITIVE

Case managers must have a familiarity with and empathy for their clients, whether they be substance users or abusers, sex workers or gay men. Case managers should be able to understand their life situation without judgment. In Latino and Asian populations, it is also key to have bilingual staff who can speak the client's language.

OFFER SERVICES WHERE THEY'RE NEEDED

PCM should be easily accessible to clients. That may mean offering services in outlying areas or providing "one-stop shopping" so that clients do not have to go to several different sites. If this is not possible, transportation should be provided.

KNOW YOUR REFERRALS

Case managers should keep up to date on and regularly visit the services to which they refer clients. It is especially important to find drug treatment and mental health services that are sensitive to the needs of youth, IDUs, gay men and transgender communities.

STAFF SUPPORT

Program staff understand that behavior change is not easy, yet some may still feel frustration, sadness and even anger with clients. Staff should have paid time to debrief and get support.

RESEARCH In Connecticut, high-risk, drug using HIV- and HIV+ women received an interactive case management intervention to address unmet needs such as social services, drug treatment and medical care. The intervention was most successful in meeting needs for supportive mental health counseling, long-term housing and other basic services.

Thompson AS, Blankenship KM, Selwyn PA, et al. Evaluation of an innovative program to address the health and social service needs of drug-using women with or at risk for HIV infection. *Journal of Community Health.* 1998; 23(6): 419–440.

COMPONENT: Overall health and wellness

One of the differences between prevention programs for HIV+ and HIV- persons is that persons with HIV are dealing with a difficult illness while trying to maintain safe behaviors. HIV is a complicated disease to treat: dosing requirements are strict and complex, adverse reactions can be debilitating and progress needs to be regularly monitored with check-ups and blood tests to determine if the drugs are working.

Prevention concerns may take a back seat when a person with HIV is sick or dealing with adverse reactions to anti-HIV drugs. Maintaining a sense of health and wellness is important for persons with HIV.

Health and wellness components are individual level approaches to prevention that help persons with HIV feel better about themselves and live healthier lives. This can be achieved with an individual educational session, a support group or a social event.

Health and wellness components can address:

- Nutrition (how to shop for healthy foods, eat right, cook nutritious meals)
- HIV treatment education (drug basics, reinfection, alternative therapies)
- Maintaining adherence to treatment
- Exercise (gym memberships or workout buddies)
- Style consultations (make-up, clothing)
- Parenting classes
- Coping and stress reduction
- Employment and job training services

Including health and wellness components in PwP programs shows that agencies are interested in the whole person with HIV, not just their disease. Every model program listed in *Chapter 6* includes health and wellness components.

RESEARCH In Oregon, an HIV prevention program for newly diagnosed persons with HIV had high dropout rates and client dissatisfaction. That program was replaced with a relationship-based Wellness Program that resulted in better attendance and high satisfaction.

Dougherty JA, Monical J, Cassidy DJ. Relationship-Based Secondary HIV Prevention in a Primary Care Setting. Presented at the 1999 National HIV Prevention Conference. Atlanta, GA. Abstract# 600.

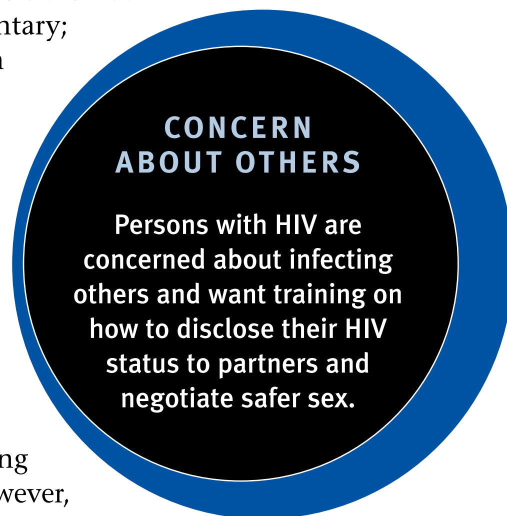
COMPONENT: Partner counseling and referral services

Partner counseling and referral services (PCRS), also called partner notification, helps persons with HIV and their sex and needle-sharing partners disclose or discover their HIV status. Partners are notified so that they can make an effort to avoid becoming infected in the future or, if they're already infected, to avoid infecting others. It is important that PCRS not be just a means of disclosure to partners, but also a means of providing referrals to partners so they have early access to medical evaluation, treatment and other services.

PCRS is an individual level approach and proceeds in stages. First, the client with HIV decides which partner's name(s) to provide and who will notify them. Second, each partner is notified and encouraged to come in for HIV testing and counseling. Third, if the partner arrives for testing, she is counseled on safer sex and drug use. If the partner tests positive, she is provided with relevant referrals for care and social services.

Confidentiality

Notification must be confidential; that is, partners are not told who gave their name. It must also be voluntary; the person with HIV is allowed to decide which names, if any, they wish to report. PCRS can be approached three different ways: by the person with HIV, by that person's healthcare provider or by trained health department or local agency staff.



Who notifies?

Some persons with HIV prefer to notify their partners themselves. In this case, they need handouts or brochures describing HIV counseling and testing services to give to their partners. However, disclosure is often more difficult than anticipated (most PwP programs offer skills building sessions on disclosure). Some agencies and health departments offer contact referrals. In this case, the client is given a certain amount of time, agreed upon by the client; if the client has not disclosed within this period, the health department will provide PCRS.

Healthcare providers may also offer PCRS to patients, but most often it is referred out to health departments or agencies. Health departments often have staff who are trained to interview patients, locate partners and conduct partner notification. Occasionally there

is a possibility of domestic violence or abuse by the partner. Health departments and agencies must be sensitive to this and have appropriate strategies and referrals in place.

Legal concerns

Most states and some cities have laws around partner notification. In some areas, healthcare providers may be required by law to report the names of any known partners, even if their patient has refused to do so.

RESEARCH A study in North Carolina found that partner notification by public health counselors was much more effective than partner notification by the patient.

Landis SE, Schoenbach VJ, Weber DJ, et al. Results of a randomized trial of partner notification in cases of HIV infection in North Carolina. *New England Journal of Medicine*. 1992; 326: 101–106.

COMPONENT: Referrals and linkages

Many persons of color with HIV are struggling with multiple concerns and may have other issues besides HIV infection to contend with. Most PwP programs cannot do everything for everyone. All of the model programs listed in *Chapter 6* provide referrals. Referrals are most often used for:

- HIV care and treatment
- STD screening and treatment
- Substance use and abuse treatment
- Syringe exchange programs
- Partner counseling and referral services
- Mental health treatment
- Housing
- Couples counseling
- Employment & job training services

Giving referrals is not simply about handing someone a phone number. In order for referrals to be effective, PwP programs should build bridges between agencies. Many agencies have put cooperative agreements in place with service providers and provide an up-to-date resource guide so that immediate referrals can be made to services. In lieu of a printed or online resource guide, providers can call other agencies to check on availability of services. Having a relationship in place with the referral agency will make this process much smoother. Some guidelines:

- **ENSURE SENSITIVITY:** Many agencies are not experienced in dealing with certain populations such as gay men, transgenders, IDUs or youth. Look for an agency where clients will feel comfortable. Offering training for agencies on harm reduction or cultural issues can be helpful.

- **CHECK LOCATION:** Persons with HIV often complain that services are not easily accessible to them. Other times, a client may want to go out of his neighborhood to ensure confidentiality. If necessary, provide bus tokens or taxi fare to make sure clients can reach the referred agency.

- **SPEAK THEIR LANGUAGE:** Even if someone is bilingual, they may feel more comfortable speaking in their native tongue. Make sure the referral agencies have counselors who speak appropriate languages or can provide translators if necessary.

- **FOLLOW UP:** Keep in touch with clients and follow up to make sure appointments are kept. If they haven't been, find out why and work to reduce barriers whenever possible.

Finally, referrals and linkages are not a one-way street. Just as prevention programs can refer to substance use and abuse treatment, these programs can also make referrals to the PwP agency. Good relationships with other agencies can help build clientele and reach persons with HIV PwP programs might not have reached otherwise.

COMPONENT: Counseling

Counseling consists of individual or group level sessions led by a trained counselor where members discuss issues and the counselor gives guidance and support. Sessions can occur at the counselor's office or clinic, or counselors can have office hours at an agency. Counseling usually implies a longer-term relationship with clients to work on issues that are more difficult or complex than can be addressed in a support group.

Counseling as part of an HIV prevention program for persons with HIV often focuses on a specific risk-related issue and emphasizes practical and achievable steps toward behavior change. In addition to HIV risk reduction, other issues that are best addressed in counseling sessions include:

- Depression
- Stress from family, finances, work
- Childhood sexual and physical abuse
- Sexual compulsivity/addiction
- Internalized homophobia
- Drug or alcohol addiction

Counseling interventions can incorporate personalized plans that list easily achievable goals for clients. Plans are based on the client's needs, abilities and readiness to change. For example, a plan for stress reduction might include, first, noting situations that evoke stress; second, understanding which situations can or can't be changed; and last, brainstorming alternate reactions to the situation.

RESEARCH In Wisconsin, men and women with HIV attended multiple sessions of supportive-expressive group therapy to improve quality of life and promote health-enhancing behavior. This model of support group was found to reduce distress and traumatic stress symptoms.

Koopman C, Gore-Felton C, Marouf F, et al. Relationships between stress and attachment, social support, and coping among HIV-positive persons. *AIDS Care*. 2000;12:663-672.

RESEARCH Incorporating HIV Prevention into the Medical Care of Persons Living with HIV. Recommendations of CDC, the Health Resources and Services Administration, the National Institutes of Health and the HIV Medicine Association of the Infectious Diseases Society of America. **www.cdc.gov/mmwr/PDF/rr/rr5212.pdf**

COMPONENT: Skills building

It is often assumed that once someone acquires HIV, they will immediately start using condoms and stop sharing needles. But if someone didn't have the knowledge, skills, confidence or resources to do this before they were infected, how are they going to do it after becoming positive? Skills building activities are an integral group level component of PwP programs. All of the model programs listed in *Chapter 6* contain a skills building component.

Skills building activities are interactive exercises that promote and reinforce safe behavior. Skills building activities are a part of risk reduction, which may also include education and counseling. They provide an opportunity for clients to learn new skills, practice old ones, discuss barriers and gain confidence in their ability to use those skills on a daily basis.

What kinds of skills can be learned? For persons with HIV, there are many possibilities:

- **SAFER SEX:** using condoms, saying no to unwanted sex, eroticizing safer sex, learning alternative sexual activities to penetration or oral sex, reducing number of sex partners.
- **SAFER DRUG USE:** cleaning injection equipment, not sharing needles, not using syringes to share drugs, resisting peer pressure, using needle exchange.
- **INTERPERSONAL:** dating, maintaining intimacy in relationships (especially serodiscordant relationships), developing communication skills such as negotiating safer sex with partners.
- **DISCLOSURE:** telling or not telling partners, family, co-workers, healthcare practitioners about HIV status and understanding potential positive and negative consequences, learning legal rights to privacy and non-discrimination. This also applies to drug use or sex work status.
- **GENERAL WELLNESS:** dealing with stress, coping with illness, adhering to medication, learning new life or job skills.
- **EMPOWERMENT:** communicating with healthcare workers, asking for help, taking responsibility for one's actions.

INCENTIVES

Incentives are integral to starting a PwP program, keeping attendance high and letting clients know their time is valued. Cash, bus tokens, phone cards, food, hot meals and t-shirts are all valuable.

Skills building activities can use videos, safer sex games, role plays, small group discussions and homework assignments to build and reinforce these skills.

Best Practices

KNOW YOUR CLIENTS

Always begin sessions with an assessment of the needs of your clients. In a condom use session, for example, clients may know where to buy them, what kinds there are and when to use them, but may not know the correct technique for actually putting on condoms.

CELEBRATE SMALL CHANGES

Behavior change is a slow and difficult process. While the ultimate goal might be to stay healthy and reduce the risk of transmission, other markers for change are also important. Getting a job, reconnecting with family members or discussing sexual needs with a partner are all successes to celebrate.

RESEARCH Project TLC, a skills building intervention for youth with HIV, helped youth improve coping and support and reduce risky sexual and drug using behaviors. Compared to youth who did not participate in the project, Project TLC youth reported 45% fewer sex partners and 50% fewer HIV negative partners. They also reported a decrease of 6% in marijuana use and 22% in hard drug use.

Rotheram-Borus MJ, Lee MB, Murphy DA, et al. Efficacy of a preventive intervention for youths living with HIV. *American Journal of Public Health.* 2001;91:400–405.

COMPONENT: Support groups

Support groups are a group level intervention where persons with HIV get together on a one-time or regular basis with like-minded people to discuss what's going on in their lives and offer support. Groups can incorporate skills building, social events and overall health and wellness. In fact, often other program interventions turn into support groups; for example, after a six-session skills building program, some participants may decide to continue meeting with program staff as a support group.

Support groups are usually formed around common topics, such as serodiscordancy, speed use or language barriers. Support groups for persons of color with HIV are also good places to discuss social, cultural and structural factors that affect HIV risk behaviors such as poverty, racism, sexism, homophobia, religion and stigma.

Groups can be open-ended (members can drop in when they like) or close-ended (with limited membership and specified duration).

- **OPEN-ENDED GROUPS** can work well for clients who have a hard time keeping schedules, or who may need only periodic support.

- **CLOSE-ENDED GROUPS** allow members to build trust and make progress on issues over time. These work well for groups with specific goals, such as behavior change support groups.

Having a trained facilitator is key. Facilitators can be peers, professionals or both, but they should understand the members' world and be empathetic to it. Facilitators should also speak their language: bilingual members may feel more comfortable discussing certain topics in their native tongue. Facilitators should be excellent listeners and observers. Non-verbal cues such as body language, sighs or facial expressions are often as important as members' spoken contributions.

Best Practices

ENSURE CONFIDENTIALITY

Support groups should set ground rules for confidentiality at the beginning of each session. Groups often discuss intimate issues, so trust in the members and facilitator is key. This is especially true for smaller, tight-knit communities where a group member may know another member's partners, friends or family.

OFFER INCENTIVES

It is often difficult to keep members coming to support groups. Providing food, snacks or bus tokens helps. Close-ended groups can offer incremental incentives, such as a phone card after two sessions, a T-shirt after four, or a group retreat if a member attends all sessions.

COMPONENT: Social events

Social events are an integral part of PwP programs due to the stigma and isolation faced by many persons with HIV. They should be geared to a specific group, such as Latino men who have sex with men (MSM) and gay men, African American women or street youth with HIV. Social events are a community level intervention and are often the easiest and most popular way to attract clients into a program. They also can be a reward for attendance; for example, if a client attends a certain number of skills building sessions, they can then attend a weekend retreat.

Social events can take many forms: large parties, retreats, support groups, small tailored events such as potluck dinners or mingling time set aside at the beginning or end of each intervention session.

The goals of social events are to:

- Increase the sense of community among persons with HIV
- Provide HIV prevention education including learning safer behaviors
- Offer a chance to meet other persons with HIV for dating or friendship
- Allow persons with HIV to relax and take a break from disease
- Recruit participants for future, more formalized prevention programs

Social events can incorporate HIV prevention and wellness messages in different ways such as: providing educational posters, brochures, free condoms and lubricant or even on-site HIV testing. Education can be interactive and fun, using safer sex games, videos, plays and skits. The most important aspect, however, is for people to build community and reduce isolation in a fun, relaxing way.

RESEARCH Bay Men is an HIV prevention intervention for MSM with HIV. Bay Men integrates social time, fun, food and serious discussions into their prevention program. The program has been successful in recruiting a diverse sample of men, and participants report great satisfaction with the program.

Woods B, Gomez C. Bay Men: Fun and Effective Prevention for HIV+ MSM. Presented at the 3rd Annual CAPS HIV Prevention Conference. April 2003. **www.caps.ucsf.edu/2003Workshops.html**

RESEARCH An intervention for depressed gay men with HIV compared two eight-session small groups: one behavioral group and one social support group. Both groups resulted in lower levels of depression and hostility. However, the social support group members had lower levels of overall psychiatric problems and anxiety as well as reduced frequency of unprotected receptive anal intercourse.

Kelly JA, Murphy DA, Bahr GR, et al. Outcome of cognitive-behavioral and support group brief therapies for depressed HIV-infected persons. *American Journal of Psychiatry.* 1993;150:1679-1686.

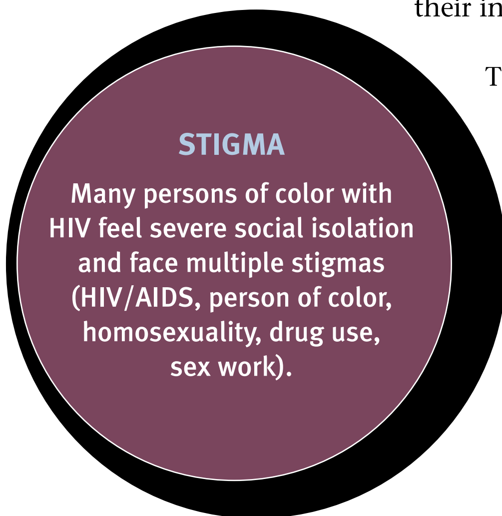
COMPONENT: Media and social marketing

Media and social marketing components can address a large population of the public and can be effective in addressing stigma and isolation for persons of color with HIV. Campaigns can reach not just persons with HIV, but also their friends and family, the community affected by HIV and the general public. They have a wider range than individual or group components, but are not meant for skills building or behavior change. Media and social marketing components should be used in conjunction with individual or group components to enhance and build upon skills. They may not have easily measured results.

Media and social marketing campaigns can help:

- Raise awareness that HIV exists in a community
- Increase knowledge of safer behaviors
- Influence attitudes and social norms
- Dispute myths or misconceptions
- Recruit clients into a program
- Give a voice to persons with HIV
- Start conversations about prevention

It is important to pre-test campaigns and messages to make sure they don't accidentally add to stigma and stereotypes. Recently, the HIV community complained about drug company campaigns that presented healthy, happy persons with HIV and downplayed the severe side effects of HIV medication. Pre-testing can ensure that you've crafted the right message and that the locations and channels will actually reach their intended audience.



There are many channels to choose from for media and social marketing campaigns. If at all possible, it is best to use several channels to expand the reach of your campaign. For example, bus shelter posters can be reinforced with flyers or palm cards placed in key venues.

The various media are:

- **LARGE SCALE:** Radio, television, internet, local newspapers and magazines, billboards, bus shelters

- **MEDIUM SCALE:** Community events, schools, churches/religious institutions, social venues (such as bars, barbershops or malls)

- **SMALL SCALE:** Hotlines, other service agencies, friends, parents, healthcare workers, palm cards

RESEARCH *HIV Stops with Me* is a media campaign designed to decrease HIV transmission and increase a sense of community for persons with HIV. Outlets include television commercials, a web site and print advertising. The program has had high reach in communities of persons with HIV and has been shown to increase disclosure, condom use and a sense of responsibility for HIV transmission.

HIV Stops with Me, Year Three Evaluation Results 2002.
www.hivstopswithme.org/sf/images/sf_2002eval.pdf

COMPONENT: Provider training

As the number of persons with HIV increases and their treatment, care, mental health, substance use and abuse and other needs increase, more and more healthcare and social service providers are going to be providing services to persons with HIV. And as HIV prevention and treatment begin to integrate through PwP programs, healthcare providers will be expected to incorporate prevention into their clinical care. Yet providers may be ill equipped to address these new issues.

Provider training is a structural level intervention that trains and prepares healthcare and social service providers to understand prevention issues or provide HIV prevention services. Provider training targets providers at non-HIV related agencies who may have patients with HIV as well as healthcare providers who work with patients with HIV but have little knowledge of prevention.

They may be:

- Doctors, nurses and other healthcare workers at HIV clinics
- Clinic or agency administrative staff
- Case managers and social workers
- Substance use and abuse providers
- Mental health providers
- Prison or juvenile detention staff
- Housing providers

Persons of color with HIV may have various competing concerns such as substance use and abuse, housing or counseling needs which take precedence over prevention concerns. It makes sense, therefore, to help these other service providers understand prevention. Provider training for social service providers does just that by highlighting issues such as ambiguous information, shame, disclosure concerns and fear that persons with HIV may face and that may affect their ability to comply with risk reduction goals.

Likewise, healthcare providers whose clients have HIV may need coaching in theories of prevention and how to deliver prevention messages. Provider training can address issues of confidentiality, motivational interviewing, reasonable risk reduction goals and comfort discussing intimate relationships. Training can also point out other clinical services that can help with prevention, such as adherence support, STD screening and treatment and partner notification.

For provider training to be most effective, it is important to assess providers' preparedness to address prevention issues, provide training as necessary and ensure that the prevention-related services that they provide are appropriate to their role in their agency. Training may be needed in the following areas:

- **TAKING SEXUAL AND DRUG USE HISTORY.** A key element here is using extensive role plays and videotapes for clinicians to develop comfort discussing intimate relationships. Often training programs give providers checklists for discussing risk behaviors. Remember that many providers do not have the time to conduct comprehensive risk assessment. Delivering the right message and including referrals where needed is key.

- **REFERRING TO OTHER SERVICES**
  Providers should know about and have access to each other's services so that they know where to send clients for substance use and abuse or mental health treatment, and vice versa. Case managers can help ease these linkages.

- **UNDERSTANDING HARM REDUCTION APPROACHES**
  Many providers are trained to cure or stop behaviors. Harm reduction strategies often go against the abstinence goals of substance treatment or incarceration, for example. Providers may need understanding of and training in specific harm reduction strategies such as needle exchange.

- **REFLECTING ON CHALLENGES**
  Providers are often faced with many competing concerns and challenges on a structural and personal level. Training should allow time to discuss personal values and feelings, how their relationships with clients are affected and the challenges they may have faced integrating prevention into their jobs.

- **ADDRESSING CONFIDENTIALITY ISSUES**
  Providers may be concerned about the ramifications of discussing illicit activities, such as illegal drug use or knowingly putting partners at risk for HIV. Providers may feel torn between maintaining a trusting relationship with the client and their duty to warn partners or other providers.

DUTY TO WARN

Are doctors, nurses and counselors bound by a "duty to warn" when their clients put others or themselves at risk? Can they remain non-judgmental if a patient tells them about unprotected sex or syringe sharing?

Best Practices

ACKNOWLEDGE TIME PRESSURES

Most providers are already feeling squeezed for time and may feel they can't even address their own specialty adequately, much less address HIV prevention. Training programs should be short and directed. Providing tools for providers to use — such as checklists and "prescription" pads — can be helpful.

USE THE CULTURE OF CLINICIANS

Healthcare providers are fairly high tech compared to many prevention providers, and are not as used to casually chatting with peers. Therefore, it is best to write notes on charts or use beepers and e-mail to contact providers rather than stop them in the hallway for face-to-face discussions or try to get them on the phone. Also, clinicians are used to taking continuing medical education (CME) courses, so offering credit and providing trainings or refreshers online can be helpful.

RESEARCH In Connecticut, healthcare providers at an HIV clinic were trained to use motivational interviewing to assess patients' risk behaviors, elicit strategies for change and negotiate behavior change goals. Incorporating the motivational interviewing within the clinic visit appeared to be a feasible and practical option.

Cornman DH, Amico KR, Fisher JD, et al. The Options Project: A healthcare provider-initiated risk reduction intervention for HIV-infected individuals in clinical care settings. Presented at the International Conference on AIDS, Barcelona, Spain. July 2002. Abstract no. WePeF6734.

See also: *Incorporating HIV Prevention into the Medical Care of Persons Living with HIV.* Recommendations of CDC, the Health Resources and Services Administration, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. **www.cdc.gov/mmwr/PDF/rr/rr5212.pdf**