TOGETHER LEARNING CHOICES

DESCRIPTION

Together Learning Choices (TLC), formerly Teens Linked to Care,[1–4] is an evidence-based HIV prevention intervention and health promotion intervention for young people (13–29 years of age) living with HIV. Teens may be recruited or referred from HIV treatment programs. TLC was originally called Teens linked to Care because it was designed to target teens and youth (ages 13–24) enrolled in HIV treatment programs. However, the intervention was renamed Together Learning Choices because HIV-infected young people could be linked to a broader range of care that includes emotional and social health as well as medical treatment. The age range was extended because the intervention addresses challenges faced not just by teens but also by young adults who are living with HIV.

NOTE: TLC is still being developed under the Replicating Effective Programs process and will transition into the Diffusion of Effective Behavioral Interventions project in 2006.

Goal

TLC aims to help young people identify ways to increase use of health care, decrease risky sexual behavior and drug and alcohol use, and improve quality of life.

How It Works

TLC is delivered in small groups and uses cognitive-behavioral strategies to change behavior. It provides young people with the tools and skills necessary to live the best life and to be able to make healthy choices. TLC consists of 3 sequential modules, each containing 8 sessions.

- *Staying Healthy* encourages healthy living by focusing on health maintenance and forging effective partnerships with health care providers.

- *Acting Safe* is dedicated to primary and secondary HIV prevention by addressing sex- and substance use-related risk behaviors and reducing new infections and re-infections.

- *Being Together* emphasizes emotional well-being and improving quality of life. This module is optional.

Delivery and scheduling of the sessions are flexible. Clients can enter whenever they wish and are not required to attend every session. Each module is focused on a different behavioral outcome: staying healthy, acting safe, and being together. TLC should be implemented in the order in which it was developed: the Staying Healthy module first, followed by the Acting Safe module. The third module, Being Together, which is optional, can be implemented last.

Theory behind the Intervention

TLC is based on social action theory,[5] which emphasizes how contextual factors influence a person's ability to respond effectively to stressful situations, solve problems, and act effectively to reach goals. This theory was chosen on the basis of results from qualitative studies and other intervention research with disenfranchised young people, mostly people of color.[6–9]

Research Findings

Module 1

Staying Healthy. This module has been shown to increase the number of positive lifestyle behaviors and use of positive action coping styles by young women and use of the social support coping style by young people of both sexes.

Module 2

Acting Safe. Research indicates that young people who attended the intervention reported fewer partners; fewer HIV-negative partners; fewer unprotected sex acts; and significant reductions in a weighted substance use index, use of alcohol or marijuana, and use of illicit drugs.

Module 3

Being Together. Members of a research group reported decreases in feelings of distress, physical symptoms of distress, generalized anxiety, and fear-based anxiety.

A number of important modifications have been made to TLC on the basis of results of packaging and field testing.

First, the number of sessions delivered in Modules 1 and 2 has been reduced to 8 sessions each (from the original 12 and 11, respectively). Implementation of the original version of TLC with HIV-infected youth was challenging in settings other than clinical care. Retention of youth over the required 2–3 months and 12 sessions per module for the complete delivery of the original intervention was determined to be unfeasible for some CBOs and public health programs.

For more than 1 year, CDC's Replicating Effective Programs team collaborated with the original researchers and a Community Advisory Board (CAB) to reduce the number of sessions for Modules 1 and 2 without compromising the integrity of TLC's effective behavior modification model.

This decision to reduce the number of sessions to 8 per module is consistent with the results of the original research on TLC, in which the mean number of sessions participants attended was 7.7 for Staying Healthy and 7.6 for Acting Safe. For Staying Healthy, 70% of participants attended at least 6 sessions, and 73% attended at least 5 sessions of Acting Safe.

The decrease in number of sessions did not result in reduction or change to the content of the intervention. Significant portions of the information have been updated to reflect new developments in the medical management of HIV and a new realization that HIV is a chronic disease. Changes that were made to the original protocol are

- elimination of redundant concepts and activities
- addition of updated information on prevention technology, medical management of HIV, and "club drugs"

- integration of a perspective that treats HIV as a chronic disease, greater emphasis on nonscripted role plays.

Second, TLC now focuses on HIV-infected adolescents and young adults13–29 years old who are receiving HIV-related services in medical clinics or social service agencies. It can be easily be adapted for other settings such as mental health centers.

Third, the behavior modification paradigm was made more accessible and user friendly by incorporating a more explicit and easier to remember "Feel-Think-Do" framework. The Feel-Think-Do framework is a rewording of problem-solving processes intrinsic in social cognitive theories and used in TLC activities.

Fourth, Module 3, Being Together is now optional. The prevention outcomes of Staying Healthy and Acting Safe were most rigorously evaluated and showed significant effect. The Being Together module, however, was less rigorously evaluated due to limited follow-up data; and the outcomes, although significant, were not linked to HIV risk reduction. In addition, the techniques used in the module may require extended training. Being Together can be accessed at http://ucla.chipts.edu. Technical assistance can be obtained from the UCLA Center for Community Health.

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements

Core elements are those parts of an intervention that must be done and cannot be changed. They come from the behavioral theory upon which the intervention or strategy is based; they are thought to be responsible for the intervention's effectiveness. **Core elements are essential and cannot be ignored, added to, or changed.**

TLC has the following 5 core elements:

- Help clients develop awareness and identify feelings, thoughts and actions.
- Teach, model, and practice 4 core skills.
    - Emotional regulation using the Feel/Think/Do framework
    - SMART problem solving (Specific, Measureable, Achievable, Realistic, Time-phased)
    - Goal setting
    - Assertiveness
- Consistently show appreciation and reinforce positive client behavior through the use of thanks tokens.
- Help clients identify their ideal self to help motivate and personalize behavior change.
- Deliver sessions in highly participatory, interactive small groups.

Key Characteristics

Key characteristics are those parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the CBO or target population.

TLC has the following key characteristics:

- Encourage clients to attend all sessions of the intervention, but give them flexibility to drop in for particular sessions on their own schedule.
- Consider use of incentives. Although we recommend using incentives to encourage participants to return to sessions, whether or not to use incentives at all and, if so, what kinds and of what estimated value are up to your agency.
- Modify time intervals. Modify the intervals between sessions to fit the needs and capacity of your agency and population.
- Limit session times. With practice, all sessions can be finished in the time indicated in the Implementation Manual. Agencies may wish to extend the length of their sessions as a result of discussions running longer. It is recommended that the sessions be kept to two hours as much as possible.
- Conduct sessions about once a week. The frequency of the sessions depends on the availability of the facilitators and clients. A rule of thumb is to conduct sessions once a week.
- Let group needs determine facilitators. Although having 2 facilitators of opposite sex may be recommended for purposes of modeling and providing a sex-specific point of view, agency and client circumstances may dictate use of same-sex facilitators or even just 1 facilitator.
- Be flexible about group composition. CBOs may modify TLC with respect to the age, gender, and sexual orientation of clients. For example, if your potential participant population is sufficiently large, you may consider holding separate groups for younger (e.g., under 18) and older clients.
- Start with small groups. We recommend that TLC groups contain from 4 to 8 clients, although slightly larger groups (up to 12) may be workable once your facilitators have sufficient experience to be comfortable with a group of that size.
- Build group cohesion. Clients may disclose personal experiences during TLC sessions, and they need to feel safe and supported as they do so. Building cohesion lays the foundation for building trust, and trust creates the safe and supportive environment necessary for TLC. However, agencies may use different cohesion-building activities.
- Provide food/snacks. CBOs are encouraged to provide refreshments for their participants. This is not a core element but strongly recommended.
- Use visual aids. Visual aids, like the wall charts supplied in the TLC intervention package, can help clients comprehend and retain concepts.
- Consider your location. TLC can be held anywhere there is a private room with enough space to accommodate clients, the role-playing activities, and a refreshment table. The space should be handicapped accessible. For some communities, locations that advertise services for people living with HIV/AIDS are not good places to hold TLC sessions.

Procedures

Procedures are detailed descriptions of some of the above-listed elements and characteristics.

Procedures for TLC are as follows:

Delivering Specific Content

Although the process of change is the same in each session, the content differs between sessions and is based on findings from qualitative research into what young people living with HIV think is important.

Determining Session Format

HIV-infected young people meet regularly in small groups to provide social support, learn and practice new skills, and socialize. Every session in each of the 3 TLC modules establishes a routine to help clients confront a specific attitude or belief, address thoughts and feelings, and change a specific behavior. CBOs that implement TLC must include the following core components in each session:

- Clients review previous goal.
- Facilitator provides engaging activities focused on skill development, problem-solving, attitude formulation, and knowledge acquisition.
- Facilitators help clients reframe negative behavior patterns. A series of fun activities is used. Clients may videotape themselves meeting a new friend, disclosing their HIV status, or brainstorming on how to get angry with a doctor without then receiving poor medical care.
- Facilitators reinforce desired behavior through use of incentives.
- Clients set a new goal.
- Clients are complimented and compliment each other for trying to change their lives.

Identifying Mechanisms of Behavior Change

HIV-infected young people identify ways to improve their quality of life within specific areas by setting new habits and daily social routines. Young people set goals around their health, their sexual relationships, drug use, and daily peace. Once goals are set, the group helps each person set realistic ways to meet these goals and helps to solve problems related to reaching the goals.

The steps of problem solving are as follows:

1. Determine what you want.
2. Identify ways to get what you want.
3. Evaluate the best way to get what you want.
4. Practice how to get what you want.
5. Try to get what you want.
6. Review how successful you were in reaching your goal.

Clients not only work on their own goals, but they role-play helping other young people reach their goals (e.g., a change in job, living arrangements, education, or social relationships). At the end of every session, clients agree on the next week's plans to improve their lives. Improving the

quality of life, meditation, and focused attention skills are part of TLC.

ADAPTING

TLC was field tested in 9 clinical care sites in 4 AIDS epicenters (Los Angeles, New York, San Francisco and Miami). Most participants were black and Latino youth. TLC could be adapted for use in other venues and among other racial or ethnic groups.

RESOURCE REQUIREMENTS

Resource needs depend on the number of people living with HIV who are served by the CBO.

People

Program supervisor (at least 1)

- Program supervisors spend 50% of time training, supervising, and coordinating implementation during the first year.
- Program supervisors will need experience in behavioral theories of change and in conducting interventions with persons in small groups.
- Program supervisors need to spend 8 days in training (2 training courses, 4 days each, 1–2 months apart). This training can be spread out over 4 to 8 months. Trained program supervisors may be asked to train all CBO staff.

2 trained facilitators
1 program assistant

Space

TLC can be done anywhere that confidentiality of clients can be assured (for example, a private room) and where a group of young people living with HIV can meet.

Supplies

TLC uses

- special intervention tokens
- a “feeling thermometer”
- condoms
- models for practicing condom use
- standardized program workbooks

RECRUITMENT

The population recruited for TLC is young people living with HIV. They may be recruited from a variety of sites (community venues, AIDS service organizations, medical clinics) using a variety of techniques (word of mouth, print advertisements, flyers).

The Acting Safe module of TLC was designed to reduce sexual risk and substance use behaviors that contribute to increased risk for transmitting HIV. Perinatally infected youth who are not sexually active may not be ideal targets for this component of the intervention. Before implementing TLC organizations should consider screening youth to ascertain extent of risk behaviors and should assign those who are not sexually active into groups with similar ages, backgrounds, and experiences.

Review Recruitment in this document to choose a recruitment strategy that will work in the setting in which the CBO plans to implement TLC.

POLICIES AND STANDARDS

Before a CBO attempts to implement TLC, the following policies and standards should be in place to protect clients, the CBO, and the TLC intervention team:

Confidentiality

A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from the client or his or her legal guardian must be obtained.

Cultural Competence

CBOs must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of their communities. CBOs should hire, promote, and train all staff to be representative of and sensitive to these different cultures. In addition, they should offer materials and services in the preferred language of clients, if possible, or make translation available, if appropriate. CBOs should facilitate community and client involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care,* which should be used as a guide for ensuring cultural competence in programs and services. (Please see Ensuring Cultural Competence in the Introduction of this document for standards for developing culturally and linguistically competent programs and services.)

Data Security

To ensure data security and client confidentiality, data must be collected and reported according to CDC requirements.

Informed Consent
CBOs must have a consent form that carefully and clearly explains (in appropriate language) the CBO's responsibility and the clients' rights. Individual state laws apply to consent procedures for minors; but at a minimum, consent should be obtained from each client and, if appropriate, a legal guardian if the client is a minor or unable to give legal consent. Participation must always be voluntary, and documentation of this informed consent must be maintained in the client's record.

Legal and Ethical Policies
By virtue of participation in TLC, clients will be disclosing their HIV status. CBOs must know their state laws regarding disclosure of HIV status to sex partners and needle-sharing partners; CBOs are obligated to inform clients of the organization's responsibilities and the organization's potential duty to warn. CBOs also must inform clients about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.

Referrals
CBOs must be prepared to refer clients as needed. For clients who need additional assistance in decreasing risk behavior, providers must know about referral sources for prevention interventions and counseling, such as comprehensive risk counseling and services, partner counseling and referral services, and other health department and CBO prevention programs for persons living with HIV.

Volunteers
If the CBO uses volunteers to assist with or conduct this intervention, then the CBO should know and disclose how their liability insurance and worker's compensation applies to volunteers. CBOs must ensure that volunteers also receive the same training and are held to the same performance standards as employees. All training should be documented. CBOs must also ensure that volunteers sign and adhere to a confidentiality statement.

QUALITY ASSURANCE

The following quality assurance activities should be in place when implementing TLC:

Facilitators
Training for facilitators should address the following 3 areas:

- Completion of a training workshop, including review of the intervention theory and materials
- Participation in practice sessions
- Observed cofacilitation of groups, including practice of mock intervention sessions

A review mechanism should be in place to assure that all session protocols are followed as written. For quality assurance, key staff and supervisors can review the sessions. They should look for

- adherence to session content

- use of key cognitive behavioral skills techniques
- accessibility and responsiveness to expressed client needs
- important process elements (e.g., time allocation, clarity, use of social rewards)

Selected intervention record reviews should focus on ensuring that consent forms (signed either by the participant, if older than 18 or emancipated, or by a legal guardian) are included for all participants and that session notes are of sufficient detail to ensure that clients are participating actively.

Clients

Clients' satisfaction with the intervention and their comfort should be assessed at the final session of each module. Process monitoring systems should also track the number of sessions each client attends, as well as reasons for not attending.

MONITORING AND EVALUATION

At this time, specific guidance on the collection and reporting of program information, client-level data, and the program performance indicators is under review and will be distributed to agencies after notification of award.

General monitoring and evaluation reporting requirements for the programs listed in the Procedural Guidance will include the collection of standardized process and outcome measures as described in the Program Evaluation and Monitoring System (PEMS). PEMS is a national data reporting system that includes a standardized set of HIV prevention data variables, web-based software for data entry and management, data collection and evaluation guidance and training, and software implementation support services.

Funded agencies will be required to enter, manage, and submit data to CDC using PEMS. Furthermore, agencies may be requested to collaborate with CDC in the implementation of special studies aimed at assessing the effect of HIV prevention activities on at-risk populations.

KEY ARTICLES AND RESOURCES

CDC. Draft CDC Technical Assistance Guidelines for CBO HIV Prevention Program Performance Indicators. Atlanta, Ga: US Department of Health and Human Services, CDC; November 2003.

Rotheram-Borus MJ, Swendeman D, Comulada WS, et al. Prevention for substance-using HIV-positive young people: telephone and in-person delivery. Journal of Acquired Immune Deficiency Syndromes. 2004;37:Supplement 2 (S68–S77).

US Department of Health and Human Services, Office of Minority Health. National standards for culturally and linguistically appropriate services in health care. Washington, DC: US

Department of Health and Human Services; 2001. Available at: http://www.omhrc.gov/omh/programs/2pgprograms/finalreport.pdf.

A complete copy of the TLC intervention is available at: http://chipts.ucla.edu/interventions/manuals/.

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REFERENCES

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

2. Rotheram-Borus MJ, Murphy DA, Wight RG, et al. Improving the quality of life among young people living with HIV. Evaluation and Program Planning. 2001;24:227–237.

3. Rotheram-Borus MJ, Miller S. Secondary prevention for youths living with HIV. AIDS Care. 1998;10:17–34.

4. Swendeman D, Comulada S, Rotheram-Borus MJ. Prevention for young positives: individual, telephone, and group interventions. Presented at: 131st Annual Meeting and Exposition of the American Public Health Association; November 15–19, 2003; San Francisco, Calif.

5. Ewart C. Social action theory for a public health psychology. The American Psychologist. 1991;46:931–946.

6. Luna GC, Rotheram-Borus MJ. Youth living with HIV as peer leaders. American Journal of Community Psychology. 1999;27:1–23.

7. Rotheram-Borus MJ, Miller S. Secondary prevention for youths living with HIV. AIDS Care. 1998;10:17–34.

8. Rotheram-Borus MJ, Luna GC, Marotta T, Kelly H. Going nowhere fast: methamphetamine use and HIV infection: the context of HIV risk among drug users and their sexual partners. Monographs of the National Institute on Drug Abuse. 1994:155–186.

9. Luna GC. Young People Living with HIV: Self-evident Truths. New York, NY: Hayworth: Plenum Press; 1997.