SAFETY COUNTS

DESCRIPTION

Safety Counts is an intervention to prevent HIV and viral hepatitis, designed specifically for persons who are using illicit (not prescribed) drugs and who are not ready or not willing to enroll in drug treatment programs or otherwise stop their drug use. It helps clients understand how their drug-use behaviors are related to important influencing risk factors that put them at risk for HIV infection and design a plan to reduce these risks. Using structured group and individual activities conducted over a period of 4 months, the intervention helps clients develop personal risk-reduction goals and define specific steps for achieving them. An important component of Safety Counts is recruitment, which links clients to counseling, testing, and referral; prevention and treatment services; care; and other support services.

Safety Counts uses a client-centered approach, which helps create a partnership based on trust and understanding between staff and clients. Safety Counts is appropriate for HIV-infected as well as HIV-negative clients who have used illicit drugs in the past 90 days. Clients may be either injection drug users (IDUs) or drug users who do not inject. Examples of specific drugs that individuals may be using, either by injection or by smoking, sniffing, or consuming, are heroin; cocaine; speedball; marijuana; methadone not prescribed by a treatment program; methamphetamine; club drugs such as ketamine, MDMA, 2CB, and benzodiazepine; and pharmaceutical drugs such as Xanax, Vicodin, Demerol, and Percodan.

Safety Counts has been packaged by CDC's Diffusion of Effective Behavioral Interventions project; information on obtaining the intervention training and materials is available at www.effectiveinterventions.org.

Goals

The primary objective of Safety Counts is to reduce HIV transmission among drug users. It also strives to increase understanding of drug-use patterns in relation to HIV infection risk and to monitor HIV seroprevalence among drug users. The program consists of 7 sessions held over 4 months.

How It Works

Clients identify the behaviors that put them at risk, identify and take ownership of personal risk-reduction goals, and develop steps for achieving these goals.

Theories behind the Intervention

Safety Counts uses social modeling, social support, and behavioral contracting (goal setting). Under the guidance of counselors and outreach staff, clients design and manage a personal HIV risk-reduction plan. Clients recognize how their own behaviors may put them at risk for HIV, hepatitis C, and other bloodborne and sexually transmitted diseases; figure out what they can reasonably do to reduce their risk for HIV and hepatitis C; take ownership of their personal risk-reduction goals; and develop and manage plans for achieving those goals. This client-centered

approach helps clients reduce HIV risk behaviors and HIV infection and helps clients and their peers reduce drug use and increase entry into drug treatment. By engaging the client in group and individual sessions, Safety Counts helps form a partnership between clients and CBO staff.

Research Findings

Research showed that participants in the intervention group were more likely than those in the comparison group to report behavior changes at follow-up (5–9 months after enrollment).

- Increased condom use
- Cessation of crack use
- Cessation of drug injection
- Reduced injection drug use

Also, at follow-up fewer crack cocaine users in the intervention group had positive test results for cocaine.[1]

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.**

Safety Counts has the following 5 core elements:

- Conduct 2 group sessions to have clients
    - identify their HIV risks and current stage of change
    - hear risk-reduction success stories
    - set a personal goal
    - identify a first step to reduce HIV risk
- Conduct 1 (or more) individual counseling session to
    - discuss and refine the client's risk-reduction goal
    - assess the client's needs and refer, if needed, to HIV counseling and testing services and to medical and social services
- Hold 2 (or more) group social events to have clients
    - share a meal and socialize
    - participate in planned HIV-related risk-reduction activities
    - receive reinforcement for personal risk reduction
- Conduct 2 (or more) follow-up contacts to
    - review the client's progress in achieving risk-reduction goal
    - discuss barriers encountered
    - identify a next step and possible barriers and solutions
    - refer clients, if needed, to HIV counseling and testing services and to medical and social services
- Conduct or refer to counseling and testing for HIV and hepatitis C.

Each core element of Safety Counts must be implemented as prescribed in the Safety Counts program manual to ensure fidelity to the original intervention. The sessions are to be provided in the order and manner indicated in the program manual, in accordance with the 4-month timeline of the intervention. This required sequence of events is the most efficient way to conduct the Safety Counts intervention. Any deviation from the order outlined in the program manual may result in clients' failure to achieve or adhere to their chosen risk-reduction goal and may ultimately compromise the effectiveness of the Safety Counts intervention.

It is strongly recommended that prior to conducting any of the Safety Counts core sessions, CBOs conduct a program enrollment session to establish a new client's willingness to participate in the intervention, assess the client's specific risks, gather demographic information, and establish the client's eligibility for the intervention. The agenda of this session should also include acquiring contact information (mail or e-mail address, telephone number, name of a friend or relative, hangouts) that can be used to communicate with the client to remind him or her of upcoming sessions and to locate the client for follow-up.

Group Sessions

To maintain the integrity of the intervention, CBOs must not add additional content to either of the group sessions. In particular, additional HIV/AIDS educational information beyond what is already included should not be added to these sessions. Also, additional sessions or workshops should not be added to the 2 existing group sessions of Safety Counts. CBOs that wish to continue their existing HIV/AIDS or viral hepatitis educational presentations must offer them under a different program name not associated with Safety Counts; attendance should be optional for Safety Counts clients. Although "HIV/AIDS and Hepatitis 101" informational classes can have a number of benefits (e.g., providing an opportunity to make referrals for medical care, mental health care, or other services), they are not a part of Safety Counts and should not be incorporated into the program.

In group sessions 1 and 2, personal risk-reduction success stories are used to empower clients to take steps to reduce their own risks for HIV and hepatitis through experiencing the personal stories of peers who have successfully made such changes in their lives. These stories should reflect the experiences of drug users in your local community and may be in the form of videos, audiotapes, or printed flyers. Each story must conform to a prescribed format and address certain specific topics and questions. Step-by-step guidelines for constructing risk-reduction success stories are contained in Appendix C of the Safety Counts program manual, and these should be followed exactly.

Incentives may be provided to persons whose personal risk-reduction success stories are being developed for use in the intervention. A signed release must be obtained from each person whose personal story will be used (a sample release form is included in the program manual).

Written stories are the easiest to develop, but although quite acceptable, they are not as powerful as video stories. Video stories, on the other hand, are more difficult to develop. However, today's technology can ease the burden considerably. One agency in New York purchased a Sony digital camcorder and, using the editing software supplied with it, produced the required risk-reduction success stories on DVD disks. Total cost for the camera and software was around $700. (Access

to a laptop or other computer with a DVD burner and room to load the editing software was also necessary.) It took staff about a week to become familiar with the camera and learn how to use the editing software. They were able to produce their first risk-reduction success stories for presentation in the group sessions within 2 weeks of purchasing the camera.

If your CBO decides to produce video stories, they must be edited to produce effective stories for use in the intervention. It will not work to shoot raw footage and show it without editing. We recommend that prior to a video recording session, the role model be guided in developing and rehearsing the answers to the questions provided in guidelines (program manual, Appendix C). This ensures that the client understands what is expected and can respond appropriately; it also relieves some of the stress associated with the actual recording of the story. An interviewer then asks these questions of the role model during the recording session, and they are edited out, along with any extraneous comments and digressions on the part of the role-model, after the conclusion of all recording. (This same general approach is also useful in developing audio-recorded stories.)

Individual Counseling Sessions

The 1-on-1, private counseling session should be conducted by someone who has experience with and knows how to talk with drug users. The counselor does not need to be licensed. It is suggested that more than 1 individual counseling session be conducted to ensure that the client fully understands his or her goal and the steps needed to reach that chosen goal. It is also suggested that a final individual counseling session be scheduled so the last risk-reduction checklist can be conducted when the client will be staged for progress in his or her behavior change. This will allow staff an opportunity to congratulate the client for completing Safety Counts and for successfully (or not) changing a risk behavior. In addition, this session will provide time to assess clients' needs for referrals to other prevention services or medical care.

Group Social Events

A key objective of the Safety Counts social events is to provide validation, problem solving, and skills building focused on the specific risk-reduction goals that clients have chosen. Social events require at least 1 staff member to serve as master of ceremonies and small-group facilitator and another staff member to handle food service and general logistics.

A "planned HIV/hepatitis-related risk-reduction activity," following the guidelines set forth in the program manual, must be included as part of every Safety Counts social event. It must be a structured activity that is focused on a particular aspect of supporting and facilitating clients' achievement of their individual risk-reduction goals. Activities that seek to provide only general information about HIV or hepatitis transmission or prevention without engaging clients regarding their personal Safety Counts goals do *not* qualify as planned risk-reduction activities for the purposes of Safety Counts.

Examples of planned risk-reduction activities include working in small groups to share social support stories, discussing personal triggers for positive behavior change, and sharing successes and challenges in working toward personal risk-reduction goals. Other examples are described in the Safety Counts program manual. CBOs are encouraged to design their own risk-reduction activities rather than limiting themselves to ones suggested in the program manual. Again, all of

these activities must meet the specific criteria outlined above for planned risk-reduction activities.

An entertainment activity is also a part of each social event. This is an opportunity for CBO staff members to express their creativity. Entertainment activities may be oriented around aspects of the Safety Counts program or around factual information about HIV and hepatitis. Clients may be entertained with a humorous skit poking fun at some aspect of the Safety Counts program or HIV and hepatitis prevention Some CBOs have used television game show formats like "Jeopardy" and "Family Feud" to encourage participants to learn more about HIV and hepatitis transmission and prevention. CDC is also pilot testing "Who Wants to Be a Millionaire" for the Safety Counts program.

To maximize involvement and retention of Safety Counts clients, social events should be held no less often than once a month during the 4-month period of the intervention, and clients should be encouraged to attend as many events as possible (a minimum of two are required). This will allow clients maximum opportunity to benefit from social support provided by their peers as well as to develop and strengthen positive social relationships with other Safety Counts participants.

The timing of social events is critical to their success; therefore, it is important for CBOs to determine the best time to hold social events. One CBO in New York has found that mornings, as opposed to evenings or late afternoons, are better in terms of attendance and that the end of the month is best for clients.

To make optimum use of budgeted funds, CBOs are advised to buy food and supplies in bulk for social events. When possible, CBOs should involve clients in organizing and preparing for social events.

Follow-up Contacts

Outreach is 1 of the strong program components of Safety Counts, and the 2 follow-up contacts are core elements and, therefore, must be conducted in order. Outreach workers conduct at least 2 follow-up contacts with clients in the community, on their turf. This contact serves to support clients' behavior change when they are in a setting outside the CBO. During the follow-up contact, the client might need to be reminded of his or her goal, be commended for completing the first step, or create new steps to reach the goal. After the follow-up contact, the client can be referred back to the CBO to attend a social event or have another individual counseling session intended to resolve any misunderstandings or confusion pertaining the steps needed to obtaining the chosen goal.

Outreach workers will have been introduced to clients during the course of the preceding Safety Counts events. Outreach workers will also have been informed of appropriate places and times for contacting clients in the field, this information having been gathered during the enrollment session.

HIV and Hepatitis C Counseling and Testing

Making active referrals for HIV and hepatitis (especially hepatitis C) counseling and testing is a core element of Safety Counts. Referrals for viral hepatitis vaccinations are strongly

recommended. At each Safety Counts activity, information about the benefits of such services must be made available. If your CBO does not provide HIV and hepatitis C testing or viral hepatitis vaccinations, it must collaborate with agencies that do. Clients' needs for HIV and hepatitis C testing and viral hepatitis vaccinations can be assessed at the program enrollment session, during individual counseling sessions, and during follow-up contacts. Social events provide an excellent time to discuss the importance of HIV and hepatitis C testing and viral hepatitis vaccinations and to even have staff members who conduct such services attend to meet potentially interested clients.

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.

Safety Counts has the following key characteristics:

- Help the client identify and access sources of social support for accomplishing a personal risk-reduction goal.
- Use different media (e.g., videotapes) for risk-reduction success stories of local drug users who have reduced their risk for HIV and hepatitis.
- Provide ongoing guidance and reinforcement for each client's step-by-step progress in achieving the risk-reduction goal.

Procedures

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

Procedures for Safety Counts are as follows:

Counseling and Testing

As a result of the activities in Safety Counts, voluntary counseling and testing is offered to clients.

- **If the CBO already offers counseling and testing,** then this intervention fits in well with these services.
- **If the CBO does not offer counseling and testing,** then clients should be referred to organizations or agencies that do.

Although clients are not required to have been tested for HIV before attending the first session, those who have not recently been tested should be encouraged to get tested and learn their HIV status as soon as possible.

Recruiting and Conducting Outreach

In this important component of Safety Counts, clients recruit their peers into the group sessions. A peer who enrolls in the Safety Counts program is encouraged to seek counseling and testing for HIV, hepatitis C, and other infectious diseases as soon as possible, preferably on site. Staff also refer clients to prevention and treatment services; drug treatment services; shelter; and other social, medical, and support services.

Conducting the Intervention (general)

- Provide a meeting space that is comfortable and inviting.
- Plan interventions at the same time and place, which should be convenient and should not conflict with clients' other responsibilities or needs.
- Plan intervention sessions (especially socials) that are lively and developed with plenty of input from clients.
- Create an environment of trust and respect.
- Maintain strict confidentiality.
- Include the capacity to refer clients to other services (domestic abuse agencies, rape counseling, and mental health).

Conducting Sessions (specific)

Group Sessions 1 and 2. The group sessions help clients identify their personal stage of change. These sessions give clients an opportunity to talk with peers and CBO staff about risk behaviors and prevention methods. They also enable clients to view videos about risk reduction. The video provided in the Safety Counts kit is a copy of the video used in the original intervention, showing how local drug users were able to successfully adopt sex- and drug-related risk-reduction strategies. To increase the authenticity of the stories, CBOs are strongly encouraged to make their own videos using persons from their local communities. Alternatively, CBOs may choose to produce audiotapes or written stories or to arrange for live testimonials describing personal risk-reduction successes. Live testimonials, however, are the least desirable mechanism because of their uncontrolled nature. The group sessions help clients understand that personal risk reduction is relevant, needed, and achievable. During the group sessions, clients think about how risk behaviors apply to them, set a personal goal for reducing HIV risk, and decide on a first step toward meeting that goal.

Individual counseling. The individual counseling session, which is conducted after the group sessions, focuses on behavior. It gives clients an opportunity to reflect on their personal risk-reduction goals and barriers to achieving those goals.

- **If the goals were unrealistic or too difficult,** clients work with counselors to revise them and come up with smaller, more achievable steps toward risk reduction.
- **If the goals were easily achievable,** clients and counselors set more challenging goals.

The individual session allows for the intimacy and confidentiality of discussing risk-taking behavior in detail. This session also provides an opportunity to build rapport between the counselor—who acts as a supporter—and the client. Finally, the individual session is an opportunity for assessing a client's needs and referring the client to medical and support services, if needed.

Social events. After participating in the group session, clients attend at least 2 social events. The events must have a planned HIV-related risk-reduction activity such as a game, workshop, or presentation. Typically offered monthly, the social events provide an opportunity to strengthen clients' relationships with the program, CBO staff, and peers. The social events offer a less formal setting, usually with a meal provided, where clients are given support for their progress in achieving personal risk-reduction goals. Clients are encouraged to invite friends and family

members. These social events can help motivate clients to complete the full 7-session intervention.

Follow-up contacts. Outreach workers contact their clients at least 2 times after the individual counseling session. These follow-up contacts are structured and planned in advance with input from other CBO staff members who have worked with the client. However, outreach workers are encouraged to attend group sessions and social events so they are well acquainted with clients. Follow-up contacts may be conducted in the CBO, on the street, in the home, or elsewhere in the community. Their purpose is to review clients' progress toward achieving their risk-reduction goals, offer strategies to overcome reported barriers, and offer encouragement to continue toward the goals. Referrals are offered for social, medical, drug treatment, shelter, and other support services, as needed.

RESOURCE REQUIREMENTS

People

At the minimum, Safety Counts requires the following:

- 1 dedicated full-time outreach worker to conduct follow-ups, cofacilitate group sessions 1 and 2, and help with setting up and coordinating the social events
- 1 full-time behavioral counselor (need not be licensed) to conduct individual counseling sessions, facilitate group sessions 1 and 2, and conduct all social events
- 1 part-time (35%) program director to be responsible for overall administration of the intervention, supervise, and help with social events

Ideally, you would want a full-time outreach worker, counselor, group facilitator, and program director. The outreach worker will eventually be so busy conducting follow-ups that he or she might not be available to cofacilitate groups and help with social events.

Team members must be sensitive, skilled, and knowledgeable about the drug-using culture and its various populations. Ideally (for easier management), they should all be from the same agency, but it may be necessary to share human resources with other agencies.

Outreach workers for Safety Counts must be completely familiar with the local drug-using community; it is preferable that they be recovering drug users. CBOs that do not have a lot of experience with outreach to active drug users are encouraged to form a peer advisory panel composed of indigenous current drug users, former drug users, or both. This panel can guide initial recruitment efforts and advise as to what incentives may be most effective.

Space

Safety Counts needs space for group meetings and individual counseling sessions.

Space for group meetings must

- be available when needed
- be large enough for groups (group sessions of 8–10 people, social events of up to 30 people)

- have comfortable seating arrangements for small- and large-group activities

Space for individual counseling sessions should be an office, preferably not a cubicle, where client confidentiality can be maintained. It must have a door for privacy and comfortable seating for counselor and client.

Other

- **Money.** The cost of Safety Counts will vary according to regional and local differences; however, cost can be significantly reduced if supplies, services, and incentives are donated rather than purchased. When implementing Safety Counts, it is best to start with your budget first. Look at the amount of money you have, and then think about how many clients you would like to serve. The Safety Counts program manual suggests 8 to 10 clients per group, which means 8 to 10 per 4-month intervention cycle. Some agencies have implemented Safety Counts using 6 to 8 clients per group. You can consider having ten 4-month Safety Counts interventions a year, recruiting and starting a new 4-month intervention cycle approximately each month, or you can have three 4-month interventions a year. It all depends on your budget. The following example can be used as a general guide. If you have 10 clients per Safety Counts intervention, you need to consider cash or other incentives for all 10 and transportation assistance for all 10, then multiply that by 7 for each intervention activity (core element). That is just transportation assistance and incentives. For refreshments, calculate the cost for food and drink for all 10 at group sessions 1 and 2, and for the social events for the 10 and their guests. Once that is done, take your total (for transportation assistance, incentives, and food) and multiply that by the number of Safety Counts interventions you will conduct a year. That is the total cost to fund just the intervention.
- **Transportation** for clients and outreach workers, depending on where Safety Counts is implemented. In metropolitan areas, subway or bus tokens should be made available to clients, both as an incentive and as insurance that they will attend the intervention activities. In rural areas, consideration should be given to providing funds or vouchers for gasoline. CBOs may also consider asking clients to share rides to Safety Counts events.
- **Supplies** (TV, easels with paper and markers, safer-sex and needle-hygiene kits, photocopier, audiotape recorder/player, VCR, and video camera [optional])
- **Partnerships** with other organizations, if needed
- **Incentives.** Clients should receive an incentive for each and every core element that they successfully complete. Some CBOs will have budgeted for these incentives; some will not have. It is recommended that if cash or cash equivalents (gift coupons to grocery stores or department stores) cannot be distributed, alternatives be found to this type of incentive. It is recommended that members of the target population be asked (either individually or in a focus group) as to what type of incentives they would appreciate for Safety Counts participation. In addition, those CBOs that have no funds for incentives should seek donations from local merchants in order to provide the requested incentives.
- **Referral network** (for needs the CBO cannot meet, especially HIV counseling and testing)

RECRUITMENT

The population recruited for Safety Counts is active drug users. Safety Counts activities are based on the assumption that clients are currently using drugs. Safety Counts is *not* appropriate for, and should not include, persons who are currently enrolled in a formal drug treatment program (including methadone treatment) because it could undermine their treatment plans and the paths they have already chosen. It is appropriate for drug treatment staff to refer persons to the Safety Counts program if they have started using drugs again and do not wish to continue receiving treatment.

In addition, the Safety Counts intervention should *not* be conducted with correctional facility inmates, although information about Safety Counts may be provided at the time they are released. Discharge planners can refer to Safety Counts persons who may have continued or initiated drug use while incarcerated and who indicate a lack of interest in entering an abstinence-based treatment program upon release.

Finally, Safety Counts is *not* appropriate for persons who report alcohol as the only or primary substance they have used in the past 90 days. Although many drug users drink alcohol at the same time that they are using other drugs, those whose substance use is largely limited to alcohol should not be enrolled in this intervention. The Safety Counts program cannot effectively meet the needs of persons whose primary issue is chronic alcohol use or abuse.

Recruitment is an important component of Safety Counts. Safety Counts recruitment and outreach is contingent upon the CBO's ability to work within existing drug-user networks. Recruitment can occur numerous ways: through outreach worker contacts, by enrolling clients accessing the CBO's other services, or by using the drug users' social networks. The social network technique uses current drug-using clients as recruiters. Clients can be given incentives for successfully recruiting new clients eligible for Safety Counts. Many will ask their primary drug-using partner or primary sex partner to enroll in the program. Safety Counts requires that persons who wish to enroll are screened to confirm they are current drug users.

During the recruitment process, outreach workers should not only promote the Safety Counts program, but they should briefly assess potential clients' individual needs for medical and social services (including HIV counseling and testing and drug treatment) and make specific referrals as needed. The needs assessment and referral component of recruitment for Safety Counts is a key benefit of the program. Fold-over handout cards describing services in the local area are highly recommended.

It is also recommended that CBOs prepare business cards, letters, and appointment cards to remind clients of upcoming groups and events. Alternatively, the program can be printed on the back of clients' goal cards. As has been found by CBOs currently implementing Safety Counts, attrition rates can be significant without a system in place to consistently remind clients of Safety Counts events and appointments for individual counseling sessions.

POLICIES AND STANDARDS

Before a CBO attempts to implement Safety Counts, the following policies and standards should be in place to protect clients and the CBO:

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, reported, and stored according to CDC requirements.

Linkage of Services

Recruitment and health education and risk reduction must link clients whose HIV status is unknown to counseling, testing, and referral services and persons living with HIV to care and prevention services. CBOs must develop ways to assess whether and how frequently the referrals made by their staff members were completed.

Personnel Policies

CBOs conducting recruitment, outreach, and health education and risk reduction must establish a code of conduct. This code should include, but not be limited to, the following: do not use drugs or alcohol, do use appropriate behavior with clients, and do not loan or borrow money.

Safety

CBO policies must exist for maintaining safety of workers and clients. Plans for dealing with medical or psychological emergencies must be documented.

Selection of Target Populations

CBOs must establish criteria for, and justify the selection of, the target populations. Selection of target populations must be based on epidemiologic data, behavioral and clinical surveillance

data, and the state or local HIV prevention plan created with input from state or local community planning groups.

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 Safety Counts:

CBOs

Attributes of Team Members

- Familiarity with the process and logistics of drug use
- Familiarity with the drug-using culture and its various populations
- Familiarity with HIV and its prevention
- Good oral communication skills
- Personal characteristics that facilitate communication (e.g., nonjudgmental attitudes; active listening skills; friendly, outgoing, and trustworthy personality)

Implementation Plan

A strong component of quality assurance is preparing a plan to implement Safety Counts. A comprehensive implementation plan will facilitate understanding and buy-in from staff and increase the likelihood that the intervention will run smoothly.

Leadership and Guidance

Someone from the CBO should provide hands-on leadership and guidance for the intervention, from planning through implementation. In addition, a decision maker from the CBO should provide higher level support, including securing resources and advocating for Safety Counts.

Fidelity to Core Elements

It is necessary to determine whether staff members are maintaining fidelity to the 5 core elements.

Clients and Staff

It is necessary to ensure that the intervention is meeting the needs of CBO clients and staff. Staff who are implementing Safety Counts can develop their own quality assurance checklist to help staff identify, discuss, and solve problems.

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

Rhodes F, Humfleet GL. Using goal-oriented counseling and peer support to reduce HIV/AIDS risk among drug users not in treatment. Drugs & Society. 1993;(3/4):185–204.

Rhodes F, Humfleet GL, Mowrey-Wood MM, Corby NH. The Behavioral Counseling Model for Injection Drug Users: Intervention Manual. Rockville, Md: National Institute on Drug Abuse; 1993. NIH Publication 93-3597.

Rhodes F, Malotte CK. HIV risk interventions for active drug users: experience and prospects. In: Oskamp S, Thompson S, eds. Understanding and Preventing HIV Risk Behavior: Safer Sex and Drug Use. Thousand Oaks, Calif: Sage Publications; 1996:207–236.

Rhodes F, Wood MM, Booth RE. Efficacy and effectiveness issues in the NIDA Cooperative Agreement interventions for out-of-treatment drug users. Journal of Psychoactive Drugs. 1998; 30:261–268.

Rhodes F, Wood MM, Hershberger S. A cognitive-behavioral intervention to reduce HIV risks among active drug users. In: Staying Negative in a Positive World: HIV Prevention Strategies that Work. Sacramento, Calif: California Department of Heath Services, Office of AIDS; 2000:113–124.

Wood, MM, Rhodes F. A cognitive-behavioral intervention to reduce HIV risks among active drug users: implementation issues. Paper presented at: Staying Negative in a Positive World: HIV Prevention Strategies That Work; April 1998; Los Angeles, Calif.

For more information on technical assistance or training for this intervention or to get your name on a list for a future training, please go to www.effectiveinterventions.org.