MODELO DE INTERVENCIÓN PSYCOMÉDICA (MIP)

DESCRIPTION

The Modelo de Intervención Psychomédica (MIP) (Psycho-Medical Intervention Model [PIM]) is a holistic behavioral intervention for reducing high-risk behaviors for infection and transmission of HIV among intravenous drug users (IDUs). The intervention is theory-driven and intensive, combining individualized counseling and comprehensive case management over a 3–6-month period. The strategies of motivational counseling (Miller and Rollnick, 1991), self-efficacy (Bandura, 1997; Beck, Wright, Newman, and Liese, 1993), and role induction (Stark and Kane, 1985) are used.

This innovative approach focuses on the continuous interaction between the participant and the members of the MIP team—supervisor, counselor, and case manager. Together, they assess the participant's risk behaviors, and his or her integration into healthcare services, drug abuse treatment, family support system, and the recovery community.

The MIP approach consists of 6 individualized and structured counseling sessions with specific activities, each with a comprehensive case management component, and 1 booster that reviews and reinforces achievements and challenges throughout the intervention. The development of these activities is guided by the fundamental principles of motivational counseling. These principles are 1) expressing empathy, 2) developing discrepancy, 3) avoiding argumentation, 4) not confronting resistance openly (roll with resistance), and 5) supporting self-efficacy. The ultimate objective of motivational counseling is to help the participant explore and resolve the ambivalence related with behavior change. This assumes an increase of the participant's self-efficacy regarding the behaviors that are the focus of the intervention.

Several interrelated approaches that characterize this intervention are 1) treating the participant with respect and dignity, 2) fostering autonomy and self-efficacy; 2) helping the participant envision a more satisfactory life, 3) creating a plan for behavior change that includes the actions necessary to achieve the participant's goal, and 4) helping him or her obtain the primary health care, drug treatment, and other human services necessary to meet basic needs. In addition, the intervention team helps participants to identify and build skills and take the steps required to reduce their drug- and sex-related risk behaviors. These behaviors may result (or may already have resulted) in the participant's contracting and/or transmitting HIV and viral hepatitis.

MIP has been packaged by CDC's Diffusion of Effective Behavioral Interventions Team. Project. Information is available at www.effectiveinterventions.org.

Goals

The goals of MIP are to 1) reduce risk behaviors for infection and transmission of HIV among injection-drug users, 2) engage participants in drug treatment and healthcare

services, and 3) enhance participants' self-efficacy for maintaining behavior change and preventing relapse.

Target Audience

The primary target population is injection-drug users who are 18 years of age and older recruited from the community; however the program can be adapted for other drug users, including IDUs in methadone treatment for the past year. If agencies would like to work with poly-drug users who are currently not injection-drug users, CDC will provide technical assistance for adaptation.

How it Works

The MIP team consists of a case manager, counselor, and supervisor**.** The case manager identifies and recruits the participant in the community, initiates the induction process and serves as an advocate, helping the participant work with all the systems—e.g., health care, drug treatment, legal, and human services—necessary to achieve his or her risk-reduction goals. The case manager remains active with the participant and provides support throughout the intervention, for example, by coordinating appointments and transportation, accompanying the participant, and making other appropriate referrals as necessary.

The counselor meets with the participant and begins conducting formal structured sessions to help the participant achieve the behavior and attitude changes necessary for preventing HIV, reducing injection-drug use, and developing self-efficacy. During one-on-one counseling sessions, the counselor and the participant focus on the participant's motivation to change behavior. They develop a work plan based on what the participant wants to facilitate and maintain behavior change and to prevent relapse. They also focus on strategies participants can use to explain their risk-reduction goals to their peers. These strategies promote the use of clean needles and consistent and correct male and female condom use. HIV and hepatitis C counseling and testing are encouraged and offered throughout the intervention.

The supervisor is constantly involved in the implementation of the services, quality control, and providing feedback and support to other team members. The supervisor is also responsible for identifying resources and creating a guide that will be used by the team and by the participants.

Theories Behind the Intervention

The Transtheoretical Model of Change helps the MIP team understand the participant's level of readiness and commitment to behavior change. This model emphasizes that the stages of change are dynamic, that change happens over time, and that it occurs in stages.

The Motivational Counseling Model uses a direct client-centered style of counseling. It is a tool that the MIP team uses for the participant to explore and resolve ambivalence about behavior change. It clearly establishes a directive style aimed at helping the MIP team establish collaboration with the client in clarifying and resolving ambivalence. It is considered a client-centered style because the ultimate responsibility to change falls on the participant.

The Social Learning Theory holds that behavior change will occur when the participant learns, via modeling and practice, different information-processing strategies and behavioral responses

to high-risk situations. Role Induction Theory helps the participant understand his or her commitment and expectations within the program. Role induction strategies can increase the participant's perception of the MIP team's credibility, expertise, and empathy.

Role induction is a strategy used throughout the intervention. Role induction, as conceptualized in MIP, entails the evaluation and clarification of the participant's expectations and preconceptions regarding the project and each proposed activity in MIP (Diaz and Perez, 2000).

Research Findings

The MIP intervention study showed that among drug injectors not in treatment, the 6 sessions and 1 booster counseling intervention, using motivational interviewing strategies in conjunction with case management techniques, were effective in helping participants to enter drug treatment, discontinue drug injection, and reduce needle sharing. The intervention was directly associated with discontinuing drug injection. Overall, participants who received the MIP intervention were nearly 2 times more likely to enter drug treatment and half as likely to continue drug injection. For subjects who continued injecting drugs, the MIP intervention enhanced self-efficacy for discontinuing the practices of needle sharing, pooling money to buy drugs, and sharing cotton. The research team stressed that the importance of this study was the success of the two-pronged intervention—the combination of counseling and case management.

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements

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

MIP has the following 7 core elements:

1. Conduct community assessment and outreach to identify sites for potential participant recruitment and enlist the support and cooperation of proven existing community resources.
2. Employ an induction process that covers basic orientation topics and includes an assessment at the beginning of each session of the participant's stage of readiness to seek access to health services and to reduce HIV risk.
3. Use motivational interviewing techniques and apply underlying theories and approach.
4. Use a Self-Assessment Readiness instrument or evaluation tool at each session to affirm and increase the participant's self-efficacy and gauge the participant's readiness to take meaningful action.
5. Counselor and Case Manager interaction and collaboration to identify and intervene on problems related to social support, integration of services and retention.
6. Conduct a minimum of 6 sessions and 1 booster, and provide for additional contacts, if necessary.

7. Conduct a booster session that reviews the participant's achievements, needs, strengths, and outstanding issues and includes an exit plan with specific strategies to maintain healthy behaviors and enhance self-efficacy.

Key Characteristics

Key characteristics are the activities and delivery methods that are critical for conducting an intervention. To meet the needs of the target population and ensure the strategy is culturally appropriate, key characteristics may be adapted for different venues and various at risk-populations.

The MIP intervention has the following key characteristics.

1. **Cultural Competence and Sensitivity.** Conduct whole-staff training to ensure understanding of the culture(s) of the target population(s) and the culture of drug use.
2. **Team Structure and Training**

   -Form an MIP team consisting of a case manager, a counselor, and a supervisor.
   -Ensure that the team is committed to participating in a uniform orientation about the intervention process.
   -Ensure that the team members demonstrate competence in Motivational Interviewing, the Transtheoretical Model of Change, the Social Learning Theory, Role Induction Theory, the bonding process, and developing strategies to ensure participants' access to critical medical and drug treatment resources
   -Ensure that the MIP team has completed a basic HIV/AIDS course and secured HIV counseling and testing certification.

3. Offer counseling and testing and or effective referrals for HIV and viral hepatitis at each contact.

4. **Counseling Team Interaction and the Bonding Process:** Promote close working relationships among members of the MIP team in order to establish a unified approach to the participant's accomplishing his/her goals and ensure the success of MIP.

Procedures

Procedures are detailed descriptions of the above-listed elements and activities. The procedures for MIP are as follows:

Recruiting and Conducting Outreach

Recruitment for MIP is conducted through traditional community outreach, referrals, and social networking. Team members receive training in the techniques of community mapping and in safety procedures. The team maps the community for potential recruitment and intervention sites, e.g., where participants live, congregate, or sell/take drugs. They attempt to establish a positive presence in the community and enlist the support of proven community resources, such as primary health care services, drug treatment programs, HIV testing, detoxification programs, and housing. Community assessment will help the program in developing relationships and memoranda of agreement with these health and social service agencies.

Counseling and Testing
As part of the MIP activities, voluntary HIV and hepatitis C counseling and testing are offered to participants.

- **If the CBO already offers counseling and testing,** this intervention fits in well with those services.
- **If the CBO does not offer counseling and testing,** participants should be referred to organizations or agencies that do. This activity must be documented through a memorandum of agreement.

Although participants do not have to be 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.

Conducting the MIP 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 participants' other responsibilities or needs.
- Plan intervention sessions according to participants' time and availability.
- Create an environment of trust, respect, and positive reinforcement (to facilitate the bonding process).
- Maintain strict confidentiality.
- Include the capacity to refer participants to other services (e.g., domestic abuse, rape counseling, mental health services).

Conducting the MIP Sessions (specific)
The MIP intervention consists of 6 sessions and 1 booster session. Each session has the same structured format, although content and implementation may not be linear. This will depend on the needs and readiness of the participant. At the beginning of every session the participant, together with the counselor, assesses the progress he or she has made toward the goals established during the previous session. The participant may also indicate his or her readiness to tackle another topic. If the participant feels he or she has made enough progress in a specific area he or she may skip to another topic. The session topics are as follows:

1. Induction
2. Taking care of your health
3. Readiness for entering drug treatment
4. Relapse prevention
5. Reducing drug-related HIV risk
6. Reducing sex-related HIV risk
7. Booster

Format of Sessions
Each session is approximately 45 minutes to 1 hour long. Case management should be offered and provided after each session. The sessions are designed for individuals and not for groups. In

each session, the participant identifies, with the counselor's help, changes he or she wishes to make based on his or her self-assessment during the previous session and what has happened in the interim (e.g., securing health insurance such Medicaid or other indigent care services, the decision or actual visit to a physician, using condoms, not sharing needles, entering a drug treatment program). The sequence of the sessions is based on the participant's readiness to change.
The location of the sessions is flexible. However, the space used for the sessions must guarantee the safety, privacy, and confidentiality for both the participant and counselor.

It is highly likely that the induction session (first session) may take place in the community, at the location where the participant is first identified by the case manager or another MIP team member. Generally, after the induction session, the following sessions take place at the team's community office, and the counselor or supervisor conducts the sessions. If necessary, the case manager or other team member escorts the participant to and from the session. This time is very valuable because the case manager or other team member can use it to explain MIP, gather information about the participant's progress and challenges, and explore and promote relationships with family and significant others, which the case manager will communicate to the counselor.

Session 1: Induction
The objective of this session is for the participant to accept and continue participating in the intervention, health care, and utilization of services. During a structured session, the case manager and/or counselor explains what MIP is, gives specific information about the intervention, and explains the sessions and the benefits the participant can obtain the case manager and/or counselor clearly states the roles and responsibilities of the MIP team and the participant. This session can be conducted in any community venue—the project site, a treatment program, or any other place in which the environment is favorable.

Once the participant agrees to take part in the intervention, the counselor inquires about critical problems the participant faces and reasons for considering entering into a process to change the behaviors that affect these critical problem areas. Together, the counselor and participant list the problems they will address and create an action plan. The plan details the steps the participant agrees to take to change, those behaviors he or she has identified as being most critical and for which the participant is likely to have the support of significant others within their social network for addressing any obstacles to making the changes. The counselor records action plans targeting the specific behavior addressed in each session.

This session also begins to address the participant's health or human services needs, as identified in the action plan. At this stage, the counselor refers the client to the case manager for assistance in securing health care or other human services. The case manager will make appointments on behalf of the participant and provide escort and transportation services if necessary.

At the end of the session the participant fills out a self-evaluation, and the counselor provides feedback about the participant's readiness to progress to the next stage of change. The counselor

and the participant summarize the issues they discussed, and agree on a plan to address them. They make the next counseling appointment.

Session 2: Taking Care of Your Health
The objective of this session is to get the participant to make an appointment with a physician to take care of his/her health. The participant receives educational information about what constitutes a health examination, and explores the participant's experience with the healthcare system, if any. If the participant is not receiving appropriate health care, the counselor would strongly encourage the participant to explore his or her health care needs and seek appropriate services from a physician, infectious disease clinic, or community-based organization that offers medical care.

The MIP team will follow up on the participant's plan for seeking health care. The counselor meets with the participant to ensure adherence to medical recommendations, including laboratory tests, prescriptions, or referrals to other medical specialist. The counselor uses encouragement and reviews prior action plan agreements from the induction session. The case manager will make appointments on behalf of the participant and provide escort and transportation services if necessary.

At the end of the session the participant fills out a self-evaluation, and the counselor provides feedback about the participant's readiness to progress to the next stage of change. The counselor and the participant summarize the issues they discussed, and agree on a plan to address them. They make the next counseling appointment.

Session 3: Readiness for Entering Drug Treatment
The objective of this session is for the participant to accept a referral to a drug treatment program (detoxification, inpatient and/or outpatient drug treatment including methadone). Then, the counselor and participant develop a history of the participant's drug use and treatment and, using decisional balance strategies (listing the pros and cons), discuss the positive and negative aspects of continuing present patterns of drug use and of entering a detoxification and/or treatment program. By means of role induction, the counselor explains how the intervention can help start the admission process into a drug treatment program. The counselor clarifies the role of MIP in this process, as well as the participant's expectations about what will happen during the visit and/or admission.

The counselor and the participant set goals and develop a plan for this aspect of the intervention. If the participant agrees to enter treatment, the MIP team will ensure that the process of admission is started immediately.

At the end of the session the participant fills out a self-evaluation, and the counselor provides feedback about the participant's readiness to progress to the next stage of change. The counselor and the participant summarize the issues they discussed, and agree on a plan to address them. They make the next counseling appointment.

Note: Session #3 may require multiple contacts for completion of session goals.

Session 4: Relapse Prevention
The objective of this session is to maintain the participant in action stage in relation to the positive changes in risk-reduction behaviors around drug use and to help develop skills to prevent drug use relapse. The session includes examples of situations that precipitate relapse. Counselor and participant develop an individualized profile of high-risk situations for relapse by exploring the participant's last relapse event. It is recommended that they explore three dimensions in the analysis of relapse: feelings, thoughts, and behavior (cognitive behavioral approach). The counselor uses decisional balance (pros and cons) strategies to discuss the positive and negative aspects of preventing relapse.

After the session, the case manager and participant discuss ways in which the case manager could be available to provide support when needed. For example, if the participant needs help to prevent relapse, he or she could contact the case manager, who would help the participant deal with the thoughts or feelings that are placing the participant at risk for relapse.

At the end of the session the participant fills out a self-evaluation, and the counselor provides feedback about the participant's readiness to progress to the next stage of change. The counselor and the participant summarize the issues they discussed, and agree on a plan to address them. They make the next counseling appointment.

Session 5: Reducing Drug-Related HIV Risk
The objective of this session is to start making changes and develop skills for the reduction of high-risk injection behaviors for HIV infection. The counselor reviews with the participant the action plan discussed in the prior sessions and develops a history of the participant's behaviors that place him or her at high-risk for HIV infection. This session involves building the participant's skills for practicing safer injection, including cleansing and sharing of works and paraphernalia and learning about drug-related risks for acquiring or transmitting HIV and hepatitis C. The MIP team provides the participant with safety kits (bleach, cookers, cotton, condoms, lubrication, alcohol pads, water, over-the-counter antibiotic ointment).

Note: Needles may not be distributed at any time using federal funds. Funding for MIP may not be used to support needle exchange services.

The counselor provides a summary and feedback about the issues discussed regarding the participant's risk behaviors. Using decisional balance strategies, the counselor and participant discuss the positive and negative aspects of continuing with present drug injection practices, as well as the pros and cons of making changes in these areas. If necessary, the MIP team transports the participant to other services (e.g., drug treatment program).

At the end of the session the participant fills out a self-evaluation, and the counselor provides feedback about the participant's readiness to progress to the next stage of change. The counselor and the participant summarize the issues they discussed, and agree on a plan to address them. They make the next counseling appointment.

Note: It is recommended that this session is delivered to participants seeking drug treatment prior to admission.

Session 6: Reducing Sex-Related HIV Risk
The objective of this session is to get the participant to start making changes and develop skills to reduce sexual practices that place the participant at high risk for HIV, hepatitis C, and STDs. The counselor reviews with the participant the action plan discussed in the prior session and develop a profile of sex behaviors that place the participant at high risk for HIV infection. The MIP team provides the participant with safety kits (bleach, cookers, cotton, condoms, lubrication, alcohol pads, water, over-the-counter antibiotic ointment).

The counselor provides feedback about the issues discussed in relation to the participant's risk behaviors. Using decisional balance strategies, they examine the positive and negative aspects of continuing with present sex behaviors and the pros and cons of changing these behaviors.

At the end of the session the participant fills out a self-evaluation, and the counselor provides feedback about the participant's readiness to progress to the next stage of change. The counselor and the participant summarize the issues they discussed, and agree on a plan to address them. They make the next counseling appointment.

Session 7: Booster
The objective of this session is to maintain the participant in action in relation to the changes obtained during the participation in the intervention. This session reviews achievements and reinforces self-efficacy in relation to the positive changes the participants made in risk-reduction behaviors during the MIP intervention, identifies barriers, and propose possible solutions. This is the closing session. The counselor and the participant summarize the issues discussed by topic, and the counselor uses affirmations to support the participant's success in completing the established plan for each stage. The counselor highlights the achievements and benefits of the intervention and encourages the participant to continue with changes. The counselor and case manager commend the participant for each of the safer behaviors he or she has adopted and other accomplishments achieved.

At the conclusion of this session, the counselor and participant develop an after-care plan that will support the participants' protective behaviors (use of health services, use of drug treatment services, safer sex practices, and safer injection practices).

RESOURCE REQUIREMENTS

People
At a minimum, the MIP intervention requires the following:

- 2 full-time case managers to conduct resource mapping, outreach, and recruitment; collect information on the target population and on follow-up. Case managers must have comprehensive case management skills and knowledge of motivational interviewing, the principal counseling technique used by the MIP to help each participant move through the stages of change. Case managers escort and or arrange transportation to support the participant, advocate for participants and their participant/families, review the previous

session with the participant at each contact, and participate (along with counselor) in the staging of the participant and distribution of safety kits.

- 1 full-time counselor (need not be licensed according to state procedures) to conduct psychoeducational sessions (individual work). Counselors conduct resource mapping, provide and interpret self-evaluation scales, and provide information at each session. They must be trained in and have an excellent grasp of motivational interviewing techniques and stages of change theory; experience working with substance users; Spanish/English addiction counseling competence (according to SAMHSA guidelines); cultural sensitivity regarding diverse populations; and risk reduction experience.
- 1 full-time program supervisor to be responsible for overall administration of the intervention. The supervisor coordinates activities and plans on-going, in-house training and quality assurance. The person functions as counselor or case manager in their absence; develops service mapping, resource inventory, and memoranda of agreement with other service providers and local police; and has experience with motivational interviewing techniques.

Team members must be sensitive, skilled, and knowledgeable about the drug-using culture and its various populations. Case managers for MIP must be completely familiar with the local drug-using community. Community based organizations that do not have much experience with recruitment of 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 on what incentives may be most effective.

Space for Individual Counseling Sessions

Counseling sessions should be held in an office where participant confidentiality can be maintained, preferably not a cubicle. The office must have a door for privacy and comfortable seating for counselor and participant.

Other

- **Funding.** The cost of MIP will vary according to regional and local differences. When implementing MIP, agencies should first consider their own budget and available funds and determine how many participants the agency would like to serve. The original research implemented MIP with about 12 participants per month (144 participants per year) for a 4- year period. A reasonable estimate is to start with 20 participants per cycle every 2 months (approximately 120 participants per year).

  The following example can be used as a general guide: Each participant has a minimum of 7 contacts with your agency (e.g., 120 participants x 7 minimum sessions = 840 contacts). If you have 20 participants per MIP intervention or cycle, you need to consider incentives (usually non-monetary), transportation assistance, and refreshments for all 20, and multiply that amount by 7 (for the 7 sessions). This is the total for one cycle. To obtain a yearly estimate, take that amount and multiply by the number of MIP interventions or cycles you will conduct a year (for example, 6 cycles per year). That is the total cost to fund the intervention alone, not including staffing and overhead.
- **Transportation** for participants and case managers, depending on where MIP sessions and or referral service will be implemented. In metropolitan areas, subway or bus

tokens should be made available to participants, both as an incentive and as insurance that they will attend the activities. In rural areas, consideration should be given to providing funds or vouchers for gasoline. Organizations may also provide transportation services to participants if needed.

- **Supplies.** For example, TV, easels with paper and markers, safer-sex and needle-hygiene kits, photocopier, VCR, and video camera [optional].
- **Partnerships** with other organizations, if needed.
- **Memoranda of Agreement** with other service providers.
- **Incentives.** Participants should receive non-monetary incentives for each session they successfully complete. CBOs must budget for incentives if appropriate. It is recommended that cash equivalents (gift coupons to grocery stores or department stores) be alternatives to cash incentives as appropriate by funding guidelines. It is recommended that participants of the target population be asked what type of incentives they would like.
- **Referral Networks.** If the CBO cannot provide a service, especially HIV and hepatitis C counseling and testing, these services should be secured through a Memorandum of Agreement with a local provider.

RECRUITMENT

The population recruited for MIP is active IDUs who are not in a formal or informal drug treatment program. MIP may be appropriate for current injectors who, in addition to injecting, use other drugs (poly-drug users) and are currently in methadone treatment programs.

Since the etiology of alcohol use and abuse may be different from that of drug use, this intervention may not effectively meet the needs of persons whose primary problem is chronic alcohol use.

MIP recruitment and outreach is contingent upon the CBO's ability to work within existing drug-user networks. Recruitment can occur numerous ways: through targeted recruitment contacts, by enrolling participants who access the CBO's other services, or by using the drug users' social networks (peer-driven recruitment). The social network technique uses current drug-using participants as recruiters. Participants can be given incentives for successfully recruiting new participants eligible for MIP and for successfully helping retain peers in the program. Many will ask their primary drug-using partner or primary sex partner to enroll in the program. MIP requires that persons who wish to enroll through social network techniques be screened to confirm they are current drug users. Social network recruiters should be trained in recruitment methodology and the importance of confidentiality.

During the recruitment process, case managers/community educators should not only promote the MIP program, but they should also briefly assess potential participants' individual needs for medical and social services (including HIV counseling and testing and drug treatment). They should effectively communicate to potential participants the advantages of getting into this program to work on meeting those needs. The needs assessment and outreach presence of MIP in

the community are key benefits of the program. Fold-over handout cards describing the MIP program and services in the local area are highly recommended.

It is also recommended that CBOs prepare business cards, letterhead, and appointment cards to remind participants of upcoming sessions.

POLICIES AND STANDARDS

Before a CBO attempts to implement MIP, the following policies and standards should be in place to protect participants 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 participant is referred, signed informed consent from the participant 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 profiles 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 participants, if possible, or make translation services available, if appropriate. CBOs should facilitate community and participant 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 participant confidentiality, data must be collected, reported, and stored according to CDC requirements.

Linkage of Services

As part of recruitment, health education, and risk-reduction, MIP staff must link participants whose HIV status is unknown to counseling, testing, and treatment 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 are completed.

Personnel Policies

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

Safety
CBO policies must exist for maintaining the safety of workers and participants. 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, the CBO should know and disclose how their liability and workers' compensation insurance applies to volunteers. CBOs must ensure that volunteers 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

CBOs should adhere to the following quality assurance standards when implementing MIP:

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

Implementation Plan
A strong component of quality assurance is preparing a plan to implement MIP. 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 MIP.

Fidelity to Core Elements
CBOs must ensure that staff members are maintaining fidelity to all core elements.

Participants and Staff

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

MONITORING AND EVALUATION

At this time, specific guidance on the collection and reporting of program information, participant-level data, and program performance indicators are 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, 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 asked 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

Robles R, Reyes J, Colon H, Sahai H, Marrero A, Matos T, Calderon J, Shepard E. Effects of combined counseling and case management to reduce HIV risk behaviors among Hispanic drug injectors in Puerto Rico: A randomized controlled study. Journal of Substance Abuse Treatment. 2004;27:145–152.

Marrero, CA, Robles RR, Colon HM, Reyes JC, Matos TM, Sahai H., et al. Factors associated with drug treatment dropout among injection drug users in Puerto Rico. Addictive Behaviors. 2005; 30:397-402.

For more information on technical assistance or training for this intervention, please go to www.effectiveinterventions.org.