HOLISTIC HEALTH RECOVERY PROGRAM

DESCRIPTION

The Holistic Health Recovery Program (HHRP), formerly Holistic Harm Reduction Program,[1] is a 12-session, manual-guided, group-level program for HIV-infected and HIV-negative injection drug users.

HHRP 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. Two manuals, 1 for HIV-infected and 1 for HIV-negative injection drug users, are available at www.3-s.us/.

Goals

The primary goals of HHRP are harm reduction, health promotion, and improved quality of life. More specific goals are abstinence from illicit drug use or from sexual risk behaviors; reduced drug use; reduced risk for HIV transmission; and improved medical, psychological, and social functioning.

Theories behind the Intervention

HHRP is based on the information-motivation-behavioral skills (IMB) model of HIV prevention behavioral change. According to this model, there are 3 steps to changing behavior: receipt of HIV prevention information, motivation to engage in HIV prevention, and opportunities to practice behavior skills for HIV prevention.

How It Works

HHRP takes a harm-reduction approach to behavior change, in which abstinence from drug use or sexual risk-taking behavior is 1 goal along a continuum of risk-reduction strategies. Clients are not assumed to be abstinent from either drug use or sexual risk behaviors. Risk behaviors are viewed as being sustained by hopelessness in the face of a life-threatening illness (for those who are HIV infected) and high levels of stress, psychiatric disorders, and medical and social problems for those who are HIV infected or HIV negative. The ability to acquire and retain the skills needed for change may be impeded by the effect of HIV status, drug-related cognitive deficits, or both. HHRP enables clients to meet their own harm-reduction goals by presenting materials in a way to minimize the effects of cognitive difficulties and by providing clients with an empathic, directive, nonconfrontational setting in which structure and consistency are emphasized.

Research Findings

Clients in both an Enhanced Methadone Maintenance Program (which includes a 6-session HIV risk-reduction component) and HHRP exhibited significant improvements on measures of addiction severity, harm-reduction behaviors, harm-reduction knowledge, motivation, behavioral skills, and quality of life. HHRP clients had significantly greater improvement in behavioral skills and showed continued decreases in addiction severity and risk behavior after 3 months;

members of the control group did not maintain improvements. In later stages of the project, the HHRP manual for HIV-negative persons was developed as a variation of the HHRP manual for HIV-infected persons to generalize the intervention beyond HIV-infected drug users. It was tested and found to be efficacious in a randomized clinical trial among injection drug users who were either HIV negative or whose status was unknown.

In 2005, HHRP training was field tested by CDC in collaboration with 4 states—New Jersey, Connecticut, Pennsylvania, New York—and the Academy for Educational Development. The findings have been applied to the revisions of this document.

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.**

HHRP has the following 8 core elements:

- Teach skills to reduce harm of injection drug use and unprotected sexual activities.
- Teach negotiation skills to reduce unsafe sexual behaviors with sex partners, and teach skills to heal social relationships.
- Teach decision-making and problem-solving skills using cognitive remediation strategies.
- Teach goal-setting skills and develop action plans to achieve goals.
- Teach skills to manage stress, including relaxation exercises, and help clients understand which aspects of a stressful situation can and cannot be controlled.
- Teach skills to improve health, health care participation, and adherence to medical treatments.
- Teach skills to increase clients' access to their own self-defined spiritual beliefs, in order to increase motivation to engage in harm-reduction behaviors.
- Teach skills to increase awareness of how different senses of self can affect self-efficacy and hopelessness.

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.

HHRP has the following key characteristics:

- **Group sessions.** Hold group sessions at the same time and place each week, and follow the same structured format.
- **Group size.** Have 3 to 15 clients in each group.
- **Facilitators**

    - Have the groups cofacilitated by 2 substance abuse counselors who have experience working with HIV-infected substance abusers and who are comfortable with the concepts of harm reduction in this population.
    - Include 1 male counselor and 1 female counselor, if possible, on the facilitation team.
    - Ensure that at least 1 of the counselors cofacilitating the interventions has a master's degree in a counseling discipline.
- **Group gender or sexual orientation.** Select groups to accommodate the CBO's clientele (e.g., all male, mixed-gender, all gay or lesbian, mixed sexual orientation). During the adaptation process, HHRP may be modified to make sure all relevant issues are addressed for group makeup.
- **Group Structure and Duration.** Schedule HHRP in 1 of several ways.
    - 1 weekly 2-hour session for 12 weeks (e.g., 9:30-11:30 every Wednesday)
    - 2 weekly 1-hour sessions for 12 weeks (e.g., 9:30-10:30 every Tuesday and Thursday)
    - One session (2 hours) alternating with discussion groups weekly for 24 weeks (e.g., Week 1=Group 1, Wednesday, 9:30-11:30; Week 2=Group 1 Discussion, Wednesday, 9:30-11:30)
- **Enrollment.** Choose from 2 enrollment options, each of which has pros and cons. Each organization will decide which enrollment option best meets their requirements.
    - **Open enrollment.** New clients start in any week (this option can be used only if HHRP is offered on an ongoing basis).
    - **Cohort enrollment:** Clients start together and proceed through all 12 groups as a group. If using the cohort recruitment method, to allow for attrition it is recommended that you start with at least 12 clients.
- **Threshold for Discontinuation.** Membership in HHRP requires clients to make a commitment. HHRP members are to attend all group and individual sessions without fail. Members are to be discontinued if they miss 6 sessions. They may start over if the CBO is offering other sessions and if they indicate that they want to participate.
- **Eligibility requirements.** Ensure that clients
    - are of the appropriate HIV status for their HHRP intervention (e.g., HIV infected and HIV negative or unknown HIV status)
    - have recently (within the last 30 days) used or are actively using drugs
    - are either enrolled in a drug treatment program or have expressed a desire to enroll

  Eligibility requirements may be adapted to be made more appropriate for other populations.

Procedures

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

Procedures for HHRP are as follows:

Conducting Sessions

The HHRP manual describes 12 group sessions, each 2 hours long, which can be presented in 1 of the following formats:

- 1 weekly 2-hour session for 12 weeks (recommended)
- 2 weekly 1-hour sessions for 12 weeks
- 1 session (2 hours) alternating weekly with discussion groups for 24 weeks

An individual treatment orientation session can be provided before the client attends group sessions.

Providing Content

Session 1	Setting and Reaching Goals
Session 2	Reducing the Harm of Injection Drug Use
Session 3	Harm Reduction with Latex
Session 4	Negotiating Harm Reduction with Partners
Session 5	Preventing Relapse to Risky Behavior
Session 6	Health Care Participation
Session 7	Healthy Lifestyle Choices
Session 8	Introduction to the 12-Step Program
Session 9	Overcoming Stigma
Session 10	Motivation for Change: Overcoming Helplessness
Session 11	Moving Beyond Grief
Session 12	Healthy Social Relationships

Determining Format

To address the psychiatric and neuropsychological needs that are often present in clients who are dealing with substance abuse issues, the sessions of HHRP use multiple teaching strategies so all persons can learn, regardless of learning style. These strategies are as follows:

- **Multimodal presentation of materials,** including oral (lectures and discussion), visual (slides, videos, charts, and written material), and skill-building (games, practice, role-playing) modalities
    - PowerPoint slide sets are available at www.3-s.us/. They are used to demonstrate a number of harm-reduction skills. To engage all clients (regardless of sex, sexual orientation, or race and ethnicity) in the process of rethinking risk behaviors, images used in HHRP slides should be
        - visually engaging
        - neutral in terms of gender
        - neutral in terms of race and ethnicity
    - Movie clips are used to teach skills and enhance the learning process.
    - Experiential activities provide a nonthreatening context in which HHRP members can practice skills. Immediate feedback during games, role-playing, and exercises can reinforce appropriate behavior and increase self-esteem and self-confidence.
- **Frequent reviews** to facilitate learning and retention
- **Reduction of fatigue and distraction**
    - These factors impede learning and may be particularly problematic for cognitively impaired clients.

    - Frequent breaks, multimodal presentations, and reduction of outside noise and distractions help improve concentration and achieve this goal.
- **Consistency** in meeting times and places, provision of an agenda, and following of the same structured format
- **Assessment and feedback** of knowledge and skills gained
    - This allows members to evaluate the different teaching strategies.
    - This also provides a chance for additional practice of new skills.
- **Generalizability** of information to the life situations of group members
    - **Memory book system** to improve memory for session material and for organizing and remembering activities required for living a healthy lifestyle
    - **Learning by doing** through activities that are appropriate to the group topic and aid in skills acquisition, retention, and self-confidence
    - **Providing immediate feedback** during games, to reinforce appropriate behaviors, discourage less helpful behaviors, and increase self-esteem and self-confidence
    - **Managing stress**
        - Use visualization strategies focused on relaxation and health promotion.
        - Stress can impair concentration, increase cognitive dysfunction (such as memory difficulties or impulsivity), and potentially lead to relapse.
    - **Group treatment**
        - Enable clients to practice and strengthen generalizable social behaviors.
        - Use group treatment to reduce feelings of isolation and provide a sense of interpersonal support from persons with similar life circumstances.

Facilitating

The 2 counselors work as a team to facilitate all aspects of the groups. One is primarily responsible for ensuring that all material is presented in accordance with the manual, and the other is primarily responsible for the experiences had by members of the group. Counselors must establish group structure, provide a consistent model of behavior and behavior change, and use a consistent and nonjudgmental therapeutic style to help each client reach his or her own harm-reduction goals. HHRP counselors should receive ongoing supervision from a clinically trained professional with experience in harm reduction.

Understanding Mechanisms of Behavior Change

HHRP takes a harm-reduction approach to behavior change; abstinence from drug use or sexual risk-taking behavior is 1 goal along a continuum of risk-reduction strategies. Clients are not assumed to be abstinent from either drug use or sexual risk behaviors. Risk behaviors are viewed as being sustained by hopelessness in the face of a life-threatening illness, high levels of stress, psychiatric disorders, and medical and social problems. In addition, the ability to acquire and retain the skills needed for change is impeded by HIV- and drug-related cognitive deficits. By presenting materials in such a way as to minimize the effects of cognitive difficulties and by providing clients with an empathic, directive, nonconfrontational setting in which structure and consistency are emphasized, the HHRP intervention allows clients to meet their own harm reduction goals.

ADAPTING

HHRP's risk-reduction approach is sufficiently broad that the intervention could be adapted for those who use noninjection drugs. HHRP can also be translated (e.g., into Spanish) or have some of the language paraphrased for clients who have literacy challenges or to make it appropriate for those who use noninjection drugs.

RESOURCE REQUIREMENTS

People

HHRP needs a project coordinator and 2 substance abuse counselors, at least 1 of whom should be a masters' level clinician with experience. It is recommended that each counselor team have 1 man and 1 woman.

Space

HHRP is best done at a facility that treats clients with substance abuse or dependence issues; for example, a methadone maintenance clinic, other drug treatment facility, or CBO serving a high number of HIV-infected clients who use drugs. The sessions must be done in a space that is private and secure so that confidentiality can be assured. It is crucial that the sessions not be interrupted by people coming and going and by outside noise.

Supplies

HHRP needs

- access to audiovisual equipment
    - a slide projector or computer projector and screen
    - a TV and VCR with remote control
    - an easel, easel chart paper, and markers
- money for incentives (food or small prizes) to give out at each group session

The HHRP counselor manual was designed to be highly user-friendly and contains relevant background and theoretical material. This manual minimizes the need for extensive prior training. The manual includes all the other materials needed to run the program, such as

- detailed scripts for each group session
- all necessary visual aids (slides or PowerPoint format)
- learning activities
- quizzes

Resources (e.g., sample implementation plan, CBO readiness checklist) for CBOs considering implementing HHRP are available at www.effectiveinterventions.org.
Intervention materials (including background and research information manuals, and instructional materials for individual and group sessions) are available at www.3-s.us/.

Other

For the program to be effectively and safely implemented, CBOs must

- maintain 2 group facilitators

- maintain a program manager/director
- maintain an administrative manager/interviewer
- provide individual sessions (Orientation and Closing)
- provide and adhere to all 12 of the manual-guided group sessions of HHRP
- have preexisting counseling and referral capabilities

RECRUITMENT

Although the original HHRP intervention was offered to clients in a methadone maintenance clinic, it can be adapted to reach clients in any drug treatment program or in a CBO serving a high percentage of persons living with HIV who have substance abuse and dependence issues.

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

POLICIES AND STANDARDS

Before a CBO attempts to implement HHRP, the following policies and standards should be in place to protect clients, the CBO, and the HHRP program 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 HHRP, 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, poviders 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.

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 HHRP:

Facilitators

Training

The HHRP manual is comprehensive and contains detailed scripts for each session. Additional training required for facilitators will depend upon the facilitator's level of expertise but could include

- completion of a training workshop, including review of the intervention theory and materials
- participation in practice sessions
- observed cofacilitation of groups, including practice with mock intervention sessions

Session Review
CBOs should have in place a mechanism to ensure that all session protocols are followed as written. Quality assurance activities can include observation and review of sessions by key staff and supervisors involved with the activity. This review should focus on

- adherence to session content
- multimodal presentation of material
- use of role-playing
- use of behavioral games as teaching aids
- comfort with the nonjudgmental, nonconfrontational approach to treatment

Weekly supervision should ensure that treatment is provided in accordance with the HHRP manual, that ways to adapt the manual are discussed, and that counselor concerns are shared.

Record Review
Selected intervention record reviews should focus on assuring that consent forms (signed either by the client, 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 each session.

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

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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.

Intervention materials including background information, and research, as well as manuals and instructional materials, for individual and group sessions are available at www.3-s.us.

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REFERENCES

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