Module III: Incorporating Harm Reduction Into Our Work With HIV-Infected Substance Users

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Introduction

Background and Purpose

The content of this module is derived from three training resources: *Harm Reduction 101: The Basics*; *Harm Reduction Skills in Action*; and *Creating Harm Reduction Opportunities in Substance Abuse Treatment*. These resources were developed in 2001 and 2002 by the Statewide Partnership for HIV Education in Recovery Environments (SPHERE), a program of Health Care of Southeastern Massachusetts, Inc., in Brockton, Massachusetts.

This module is designed as a Training of Trainers (ToT) curriculum to provide participants with an overview and working knowledge of harm reduction. There is no universally accepted definition of harm reduction. However, for the purposes of this module, harm reduction may be defined as a collection of strategies and skills for reducing the harms in a person's life. In the context of substance use, harm reduction does not focus on a single aspect of drug use or a single goal, such as abstinence. Instead, harm reduction addresses the continuum of drug use as well as the continuum of activities that may reduce the harm of drug use. An important premise of this module is that harm reduction promotes options for people. Stopping substance use is seen simply as one option for reducing harm. Efforts to reduce the use of particular drugs, to use those drugs more safely, or to switch to less harmful drugs are also seen as valid options for behavior change.

This module describes harm reduction strategies and skills that are uniquely suited to HIV-infected persons who are active substance users or in recent recovery. The activities in this module are designed specifically for providers who support the harm reduction efforts of HIV-infected substance users. To deepen participants' understanding of harm reduction in this population, we will identify the spectrum of harms that are associated with substance use. With modification, this curriculum can be adapted to suit a broader population approach – working with all substance users; not only those infected with HIV.

In addition, we will explore the differences between harm reduction and traditional abstinence-based approaches for behavior change. We will also consider whether the harm-reduction approach is compatible with existing substance abuse treatment programs. Finally, we will ask participants to identify ways in which they already use harm reduction and to look for opportunities to integrate harm reduction more fully into their work. As participants identify concrete ways to incorporate harm reduction into their work, they will develop new skills to support their clients' efforts to live safer, healthier lives.

Resource Materials

- SPHERE's *Facts and Myths About Harm Reduction in Substance Abuse Treatment* Brochure*
- SPHERE's *Stages of Change Wheel**
- SPHERE's *Self-Assessment Ruler**
- Handouts III-1, "Ways We Already Incorporate Harm Reduction" (Page III-13)

- Handout III-2, "Continuum of Drug Use" (Page III-27)
- Handout III-3, "Behavior Change Worksheet" (Print-out slide III-15)
- Handout III-4, "Case Studies" (Page III-34)
- Handout III-5, "ABCDE Decision-Making Model" Worksheet (Page III-51)
- Slides III -1 to III - 41
- Adhering Newsprint and Colored Markers
- Slide Projection Equipment

* Visit www.HCSM.org/sphere.htm to obtain.

Objectives

By the end of this module, participants will be able to:

- Describe harm-reduction approaches and techniques
- List the range of harms created by substance use
- Identify practical harm-reduction skills and tools that are tailored to the needs of HIV-infected substance users
- Consider ways in which participants already incorporate harm reduction into their personal and professional lives
- Integrate the principles of harm reduction into their work with HIV-infected clients
- Use the TOT training experience, including Teach Back sessions*, and the curriculum to create replication trainings. See "Replication Training Suggestions" below.

* When using the module as a Training of Trainers (TOT), it is strongly recommended that the trainees have the opportunity to participate in Teach Backs. Suggested timing of teach back opportunities have been designated, although they have not been factored into the timeframes noted.

Key Facts

- There is no universal definition of harm reduction, nor does it represent a single activity or dynamic.
- Harm reduction focuses on supporting people's efforts to make positive changes in their lives.
- To be effective, harm reduction must be client-centered. Any positive change must be defined and prioritized by the client.
- Harm reduction is based on the premise that each client is the expert on his or her life. This means that clients must play an active role in identifying the behavior change they would like to make and in developing a plan to implement that change.
- The life circumstances of drug users, as well as their reasons for drug use, are varied, diverse, and complex.

Important Note: The term *harm reduction* can provoke intense emotional reactions from medical providers and substance abuse treatment providers. For some providers, these reactions

reflect the belief that a harm reduction approach will undermine their work. For example, certain professionals, many of whom have achieved personal sobriety through abstinence models of recovery, may be staunch advocates of abstinence and view harm reduction as a threat to abstinence. It is important for you as a trainer to bring out and be comfortable in dealing with these perspectives. When you facilitate these sessions, it will be important to acknowledge, manage, and respond to the participants' personal and professional concerns about harm reduction. Be prepared for controversy when you first train on this topic.

Trainer Tips

- It is strongly suggested that you do not attempt to train with these materials for a duration of less than 2.5 hours.
- Offer CEUs for trainings.
- Whenever you are rushed for time, use the slides to present the information, offer your personal story/experience of how you relate to the information being presented, and ask the audience to "brainstorm" on the slide content as a substitute for suggested activities.
- Whenever possible, offer tangible take-a ways to the participants. Suggested items include: local resource lists for client referrals to drug treatment and HIV medical programs, including 12 step meetings, website address lists, hand-outs of printed materials, supply kits (i.e., bags filled with floss, condoms, hand wash, etc.)
- When using the Case Studies, preview and edit them accordingly to ensure relevance to the audience and local conditions.
- Integrate Prevention for Positives messages wherever possible.
- When using the curriculum with an exclusive audience of substance abuse treatment professionals, you may want to consider removing the "HIV-infected" modifier throughout the materials.
- Visit relevant websites for updated information, training materials and tools, and participant handouts. Suggested websites include:

    - **www.anypositivechange.org**
    - **www.motivationalinterview.org**
    - **www.harmreduction.org**
    - **www.treatment.org/Externals/tips.html**
    - **www.HCSM.org/sphere.htm**
    - **www.aidsinfo.net.org/Fact** Sheet Number 155
    - **www.adulted.about.com**
    - **www.trainingdepot.org**

Suggested Training Replications

The module can be offered in two overview segments of 2 – 2.5 hours* as follows:

Sessions 1 – 6; Introduction to Harm Reduction followed by a concluding presentation/activity.

Sessions 7 – 9; Skills Orientation in Harm Reduction preceded by a review activity of previous sessions (1-6).

* The two-segment approach does not allow time for Session 8 skills building activities.

Session 7: What Do People Need to Change Behavior? Can be applied in tandem/integrated with other modules of the Kaleidoscope curriculum.

Session 1: Icebreaker and Introduction

Activity: What Do You Think About Harm Reduction?

Purpose: To introduce the participants and trainer to each other and to give participants the opportunity to state personal beliefs about harm reduction

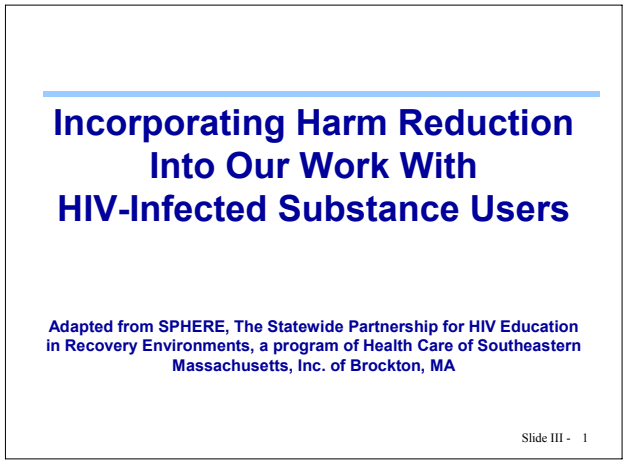
Time: 10 minutes

Materials:

- Newsprint paper and colored markers
- Slide III-1, "Incorporating Harm Reduction Into Our Work With HIV-Infected Substance Users."
- Slide III-2, "What Do You Think About Harm Reduction?"

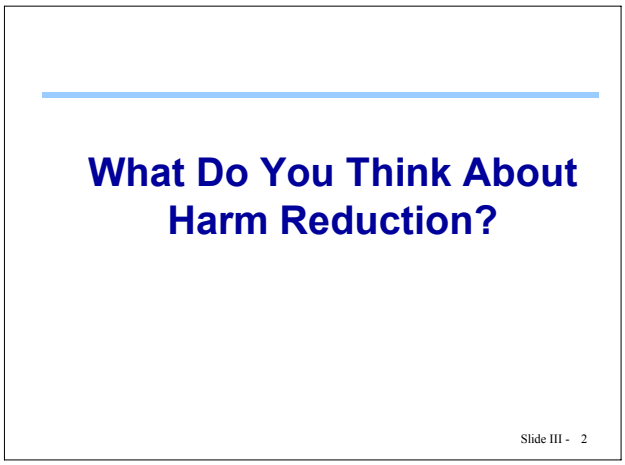
Instructor Notes:

1. Before you begin the training session, display Slide III-1, "Incorporating Harm Reduction Into Our Work With HIV-Infected Substance Users."



2. Before you begin this activity, write "Harm Reduction" at the top of a piece of newsprint paper, and post the paper on a wall or easel.

3. Display Slide III-2, "What Do You Think About Harm Reduction?"



4. Introduce yourself to the group, and then introduce the terms *harm reduction* and *risk reduction*. Tell the participants that these two terms are often used interchangeably.

5. Ask participants to introduce themselves by giving their name, their position (job title), and the type of organization where they work. Also ask them to say the first word or phrase they think of when they hear the words "harm reduction."

6. Record the participants' responses on the "Harm Reduction" newsprint sheet.

7. Once everyone has had a chance to respond, review the list and comment on the range of opinions and ideas reflected there. Identify and comment on which words reflect:
   - **Programs or services**, such as needle- or syringe-exchange programs and services to provide condoms
   - **Skills**, such as client-centered skills
   - **Opinions**, which would include phrases, such as "encourages drug use" or "prevents recovery"
   - **Feelings**, such as "distrust" or "embrace"

8. After you have grouped the participants' responses into these four categories, you will be ready to introduce a fundamental principle of harm reduction: Drug use and its associated activities and behaviors must be viewed on a continuum.

Activity: Pocket Your Beliefs About Drug Use and Drug Users

Purpose: To give participants the opportunity first to identify their personal beliefs about drug use and drug users and then to set those beliefs aside during the training session

Time: 10 minutes

Materials: Enough pieces of paper and pens or pencils for each participant

Instructor Notes:

1. Distribute a piece of paper and a pen or pencil to each participant.

2. Ask participants to write a word or phrase that reflects their beliefs about drug use or drug users. For example, their responses might include statements such as the following:

- "Drug use is a chronic disease."
- "Drug use is a sign of weakness."
- "Drug use is caused by society."
- "The only way that drug users can get clean is to abstain completely."

3. Once everyone has finished writing, ask the participants to stand.

4. Give the participants detailed directions for folding their paper into a small square. You might say something like the following: "Fold the paper in half once, again, and then one more time." When all participants have finished folding, ask them to put their papers into their pockets. This action dramatizes the process of putting away their beliefs.

5. Explicitly ask participants to be open-minded and to put aside their opinions about drug use and drug users for the duration of the training session.

6. Acknowledge how harm reduction can challenge our notions about substance use and substance users. Sometimes a person's beliefs about drug use and drug users will lead them to dismiss the harm-reduction approach. For example, adherents to some traditional "risk-elimination" models, such as abstinence, may completely reject risk reduction. It is important to acknowledge that abstinence is included in the harm reduction approach, as one of many options for drug users along a continuum.

7. Note that these preconceptions can undermine our relationships with clients and impede our efforts to support them.

8. **Introduce the following key concept about harm reduction: Harm reduction is a client-centered approach, which means that providers must see things from the client's perspective. By pocketing our personal beliefs about addiction and drug use, we will be in a better position to understand and meet our client's needs.**

Session 2: Describing Harm Reduction

Activity: What Is Harm Reduction?

Purpose: To create a general definition of harm reduction and then tailor this definition to HIV-infected substance users

Time: 25 minutes

Materials:

- Newsprint paper and colored markers
- Slide III-3, "What Is Harm Reduction?"

Instructor Notes:

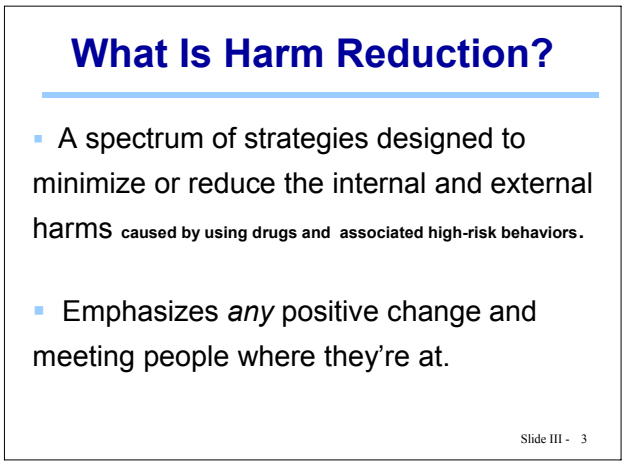
1. Review the newsprint sheet entitled "Harm Reduction," which was completed in the icebreaker activity in Session 1. Ask participants to recall their associations with the words "harm reduction." If most or all of the participants' responses were focused on needle- or syringe-exchange programs, encourage them to think more broadly. You might stimulate discussion by suggesting other possibilities, such as reducing substance use or changing the route of administration. You might point out that harm reduction can also be applied to sexual decision-making.

2. Introduce the following key points about harm reduction:
   - Harm reduction includes a spectrum of techniques and programs that support our work with HIV-infected substance users.
   - We already practice harm reduction in a variety of ways.

3. Ask the group to develop a one- or two-sentence working definition of harm reduction that the group can agree on. The following are examples of some good working definitions:
   - Harm reduction focuses on supporting people as they attempt to make any positive change.
   - Harm reduction must be client-centered, which means that any harm-reduction steps must be defined and prioritized by the client.

4. Record the group's definition of harm reduction on a newsprint sheet and post it.

5. Display and review Slide III-3, "What Is Harm Reduction?" Note that the smaller sized print in the first bulleted definition is specific to the HIV-infected substance-using population. Alternatively, the larger sized print applies to all individuals and a variety of applications.



Ask participants how they would revise or expand the definition of harm reduction for HIV-infected substance users. In other words, what is a more specific definition of harm reduction for persons dealing with both HIV and substance use? To stimulate discussion, you might make suggestions such as the following:

- Strategies to reduce the harm or risk of transmitting HIV or becoming re-infected with HIV when a person is using substances
- Strategies to reduce the risk of more rapid HIV progression as a result of substance use

6. Write the group's adapted definition on a sheet of newsprint paper and then post it.

Session 3: Harm Reduction in Our Lives

Activity: Ways We Already Incorporate Harm Reduction

Purpose: To explore how we already incorporate harm reduction into our lives

Time: 10 minutes

Materials:

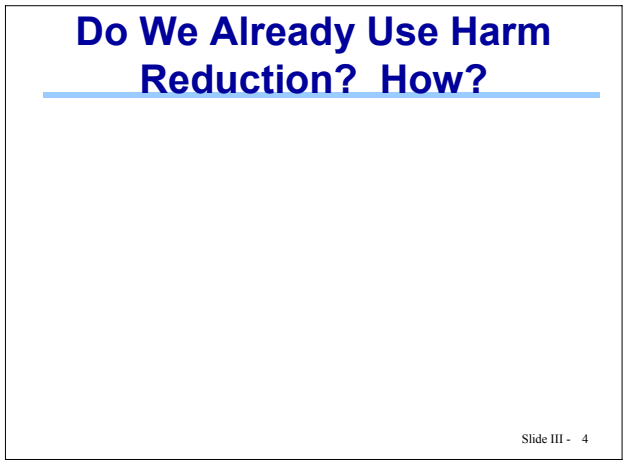
- Newsprint paper and colored markers
- Slide III-4, "Do We Already Use Harm Reduction? How?"
- Handout III-1, "Ways We Already Incorporate Harm Reduction"

Instructor Notes:

1. Before you begin the session, prepare a newsprint sheet with the title "Ways We Already Incorporate Harm Reduction" at the top.

2. Divide participants into small groups of three to five persons.

3. Display Slide III-4, "Do We Already Use Harm Reduction? How?"



4. Give each group Handout III-1 "Ways We Already Incorporate Harm Reduction".

Handout III – 1

Ways We Already Incorporate Harm Reduction

Personal	Professional

5. Ask each small group to come up with a list of ways in which they already integrate harm reduction into their lives – both personal and professional.

6. Ask each small group to share their list with the entire group. Write down their responses on the "Ways We Already Incorporate Harm Reduction" newsprint sheet.

7. Discuss the list, being sure to reinforce the ways in which participants already incorporate harm reduction in their lives and to validate any challenges they have identified.

8. Add the following everyday activities if they are not already on the group's list:

   - Wearing a bicycle helmet
   - Using a seatbelt
   - Flossing teeth
   - Using nicotine patches
   - Placing child locks on cabinets
   - Getting vaccinations
   - Designating a driver who will not drink alcohol at a party or meal

Activity: Reasons to Incorporate Harm Reduction and Reasons Not to Incorporate Harm Reduction

Purpose: To identify participants' concerns about and resistance to the concept of harm reduction

Time: 5 minutes

Materials:

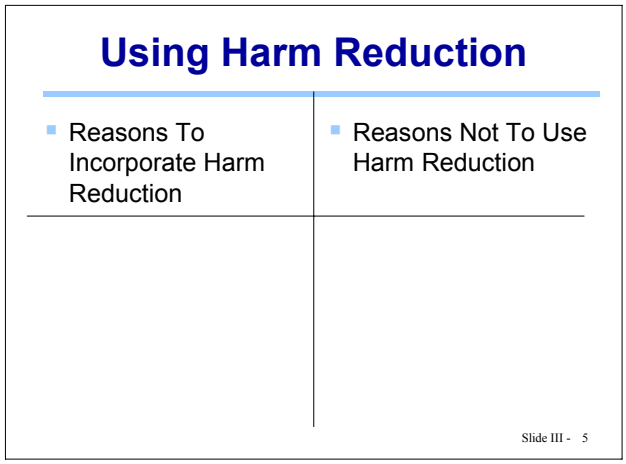
- Newsprint paper and colored markers
- Slide III-5, "Using Harm Reduction"
- SPHERE's *Facts and Myths About Harm Reduction in Substance Abuse Treatment* brochure

Instructor Notes:

1. In preparation for this activity, review SPHERE's *Facts and Myths About Harm Reduction in Substance Abuse Treatment* brochure. Available at www.HCSM.org/sphere.htm

2. Prepare a two-column table on a sheet of newsprint paper. Write "Reasons to Incorporate Harm Reduction" at the top of one column and "Reasons Not to Use Harm Reduction" at the top of the other column.

3. Display Slide III-5, "Using Harm Reduction." Ask participants to share their ideas concerning the reasons why harm reduction should or should not be integrated into their work with clients.



4. Write down the participants' responses in the appropriate columns on the prepared newsprint sheet.

   If the participants have not brought up some of the most important issues about integrating or not integrating harm reduction, then you should suggest additions to the two lists. The following reasons should be added, if needed, to the "Reasons to Incorporate Harm Reduction" column:
   - Challenging populations require many tools to make behavior change.
   - Harm reduction may support a client's behavior change in a nonjudgmental way.
   - Harm reduction is client-centered.
   - Harm reduction keeps clients in care.

   The following concerns should be added, if needed, to the "Reasons Not to Use Harm Reduction" column:
   - Harm reduction gives people permission to use drugs.
   - Harm reduction undermines drug treatment.
   - Harm reduction doesn't really help people.

5. Review the list of reasons and identify which concerns are based on myths. Distribute SPHERE's brochure entitled *Facts and Myths About Harm Reduction in Substance Abuse Treatment*. Clarify and correct any misunderstandings, as needed.

6. Emphasize the following points:

   - Harm reduction involves more than just needle- or syringe-exchange.
   - We each come to the concept of harm reduction with attitudes and judgments. As trainers, we need to be aware of and challenge misconceptions that are presented as facts.

- We each bring preconceived notions about success, challenges, and problems to our understanding of harm reduction. It is important to remind participants of the baggage they may bring to their trainings and to encourage them to identify and challenge their preconceptions.

TEACHBACK OPPORTUNITY

When the curriculum is used, as a Training of Trainers, here is an opportunity to allow for teach back exercises and activities.

Session 4: Naming Harms

Activity: Naming the Harm

Purpose:

- To increase understanding of the variety of harms caused by substance using behavior
- To demonstrate that providers are promoting public health prevention with positives when they support their clients' efforts to reduce substance use harms
- To increase understanding of the many complex factors that are involved with behavior change
- To help participants more effectively support their clients' efforts to change harmful behaviors

Time: 2-5 minutes

Materials:

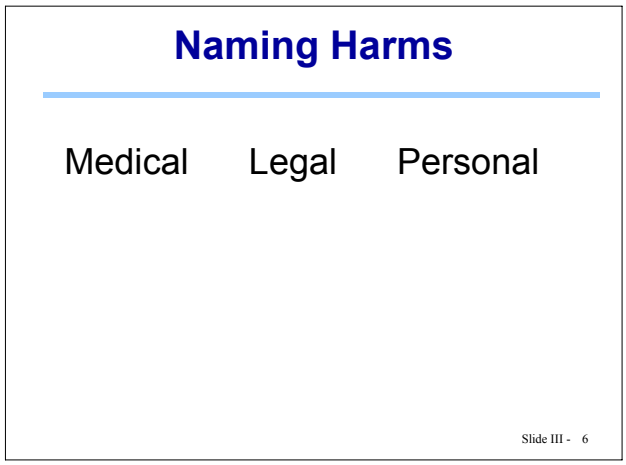
- Newsprint paper and colored markers
- Large index cards
- Slide III-6, "Naming Harms"
- Slide III-7, "Strategies"

Instructor Notes:

1. Before you begin this session, take a sheet of newsprint paper and draw three columns on it. Write "Medical" at the top of the left column, "Legal" at the top of the middle column, and "Personal" at the top of the right column. Do not show the participants this sheet until after they have done their brainstorming work (described in note 3 below).

2. Ask the participants to break into groups of three to five people, and then distribute an index card to each group.

3. Display Slide III-6, "Naming Harms." Ask each group to brainstorm and write down as many drug use related harms as they can in three to five minutes.



4. Show the three-column newsprint sheet to the group.

5. Go around the room, and ask each group to share one item from their list. As each group shares a harm, write it down in the appropriate column.

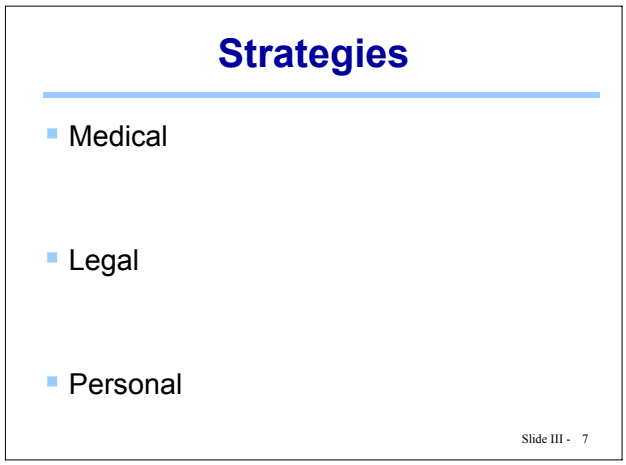
6. When one group mentions a harm, ask the other groups whether they also have that harm on their list. If they do list the same harm, then ask them to cross it off their list. Continue going around the room in this way until the groups have shared all of the different harms on their lists. For example, the medical harms column might include HIV infection, hepatitis, sexually transmitted diseases, overdose, and death. The legal harms column might include incarceration, arrest, stealing, loss of driver's license, and court appearances. The personal harms column might include abandonment by family, loss of children, loss of job, loss of housing, and reduced sexual gratification.

7. Congratulate the group for creating a thorough list as you post the newsprint paper.

8. Expand the list, if necessary, to include the medical, legal, and personal harms listed above in # 6.

9. Emphasize that harms cover a wide range and that each person has a unique set of harms. Consequently, no single strategy should be expected to reduce all harms in all people. Note that reviewing these harms is an important aspect of our work with clients. By reviewing these harms with clients, we can better understand the challenges in their lives and help them focus on changing the behaviors that are most important to them.

10. Display Slide III-7, "Strategies." Ask the participants to discuss strategies for responding to the three types of harm (medical, legal, and personal) listed in the slide. For example, medical harm reduction strategies include the use of bleach kits and condoms, safer sex education, needle-exchange programs, counseling and testing programs, and methadone programs.



Activity: HIV-Infected Substance Users and the Unique Harms They Encounter

Purpose:

- To increase understanding of the unique harms encountered by HIV-infected substance users
- To identify the ways in which personal judgments can become barriers to service

Note: When training an predominant audience of substance abuse treatment professionals, emphasize the word "unique" as a qualifier.

Time: 3-13 minutes

Materials:

- Newsprint paper and colored markers
- Slide III-8, " HIV-Infected Substance User Harms"
- Slide III-9, "Do HIV-Infected Substance Users Have the Right to . . ."
- Newsprint sheet from the previous "Naming the Harm" activity

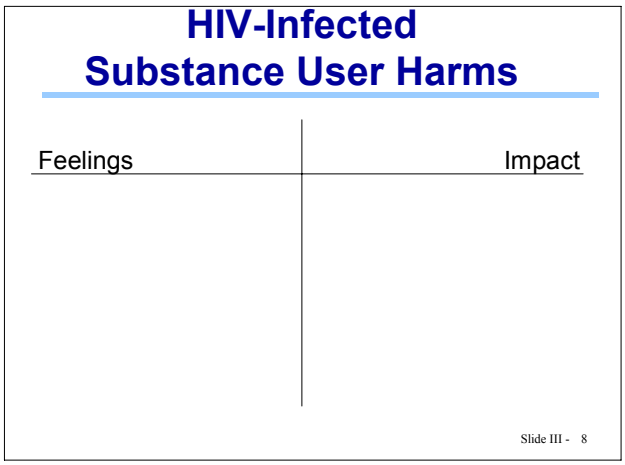
Instructor Notes:

1. Before you begin this session, take a sheet of newsprint paper and use a colored marker to copy Slide III-8, "HIV-Infected Substance User Harms." This sheet will be used later in the session (see notes 4 and 6).

2. Begin the session by acknowledging that our beliefs and feelings about the potential harm of certain sexual and substance-use behaviors may lead us to make judgments about the persons who engage in such behaviors. These judgments may be a barrier to practicing harm reduction.

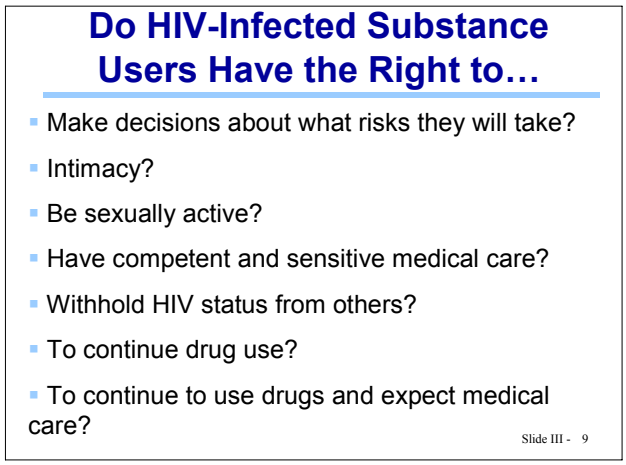
3. Ask participants to think about the unique harms that HIV-infected substance users face. How do these harms differ from the harms faced by uninfected substance users? Be sure to add: risks to personal health (faster progression of HIV disease) and risks to other people's health (through transmission) if these are not already identified.

4. Display Slide III-8, "HIV-Infected Substance User Harms." Ask the participants to share how they feel about HIV-specific harms when they work with HIV-infected substance users. For example, do they feel judgmental, impatient, or frustrated? Do they trust what their clients say and believe that their clients can avoid these HIV-specific harms? What impact do these feelings have on their work? Record both the feelings and the impacts on the sheet of newsprint paper entitled "HIV-Infected Substance User Harms."



5. Encourage participants to distinguish the difference between having an opinion or judgment and allowing that opinion or judgment to impact their work.

6. Display Slide III-9, "Do HIV-Infected Substance Users Have the Right to . . ." This slide contains a series of statements in the form of questions about HIV-infected substance users.



7. Facilitate a discussion about the role that judgments and opinions play in our responses to each of these statements. What impacts do these judgments and opinions have on our work with HIV-infected substance users? Record these impacts on the newsprint sheet entitled "HIV-Infected Substance User Harms".

   Optional: Designate one part of the room as an "Agree" area and another part as a "Disagree" area. Read aloud the statements in the slide one by one. After each statement, ask the participants to go to the part of the room that indicates whether they agree or disagree with it.

8. Ask participants how their judgments and opinions might create barriers in their work with HIV-infected substance users. Then ask the participants to brainstorm on ways to overcome these barriers. Discuss the benefits, from a harm reduction perspective, of addressing the judgments and opinions that undermine our relationships with clients.

Session 5: Harm Reduction Approach with HIV-Infected Substance Users

Presentation: How Does Harm Reduction Take Shape in Service Development and Delivery?

Purpose:

- To review harm reduction and compare and contrast it with approaches used in traditional substance abuse treatment programs

- To explore harm reduction as a model for service delivery

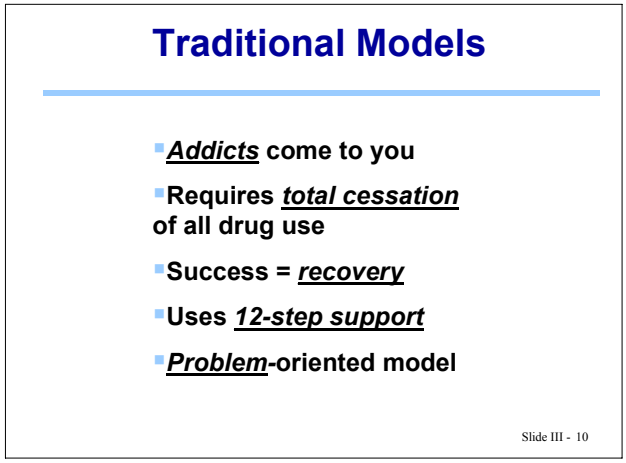
Note: In this presentation, we will review the service components of harm reduction and traditional programs. Some participants may feel strongly that HIV-infected substance users should abstain from all risky behaviors. Be prepared for a lively discussion as this session is designed to bring out the personal values and beliefs of the training audience.

Time: 30 minutes

Materials: Slide III-10, "Traditional Models"
Slide III -11, "Harm-Reduction Based Models"

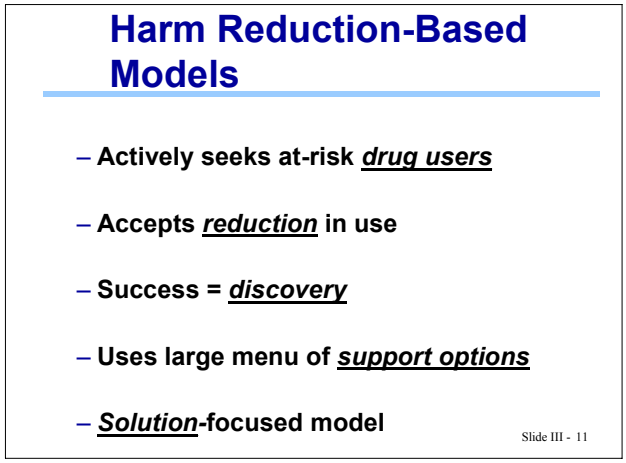
Instructor Notes:

1. Display and review Slide III-10, "Traditional Models" which displays common characteristics of traditionally-based service delivery models, and service components.



2. Note how the language we use can be judgmental, such as referring to substance users as "addicts."

3. Display and review Slide III- 11, "Harm-Reduction-Based Models" displaying the common characteristics of harm-reduction based service delivery models and service components.



4. Note that, by identifying the key service components, we can see how we already incorporate harm reduction into our work.

5. Note the differences between traditional service delivery models and the harm reduction-based models. Talk in more detail about some of these differences. Here are some examples:

   - In the traditional approach, we wait for clients to make and keep appointments. They come to our offices, and sit in our chairs. In contrast, one element of harm reduction is to actively reach out to substance users at locations where they congregate, such as street corners or coffee shops. We might also move our offices or co-locate in these settings.
   - Traditional, abstinence-based drug treatment programs require participants to completely stop all substance use as a precondition for program entry. In contrast, harm reduction does not make abstinence a criterion for service. Harm reduction accepts and supports any reduction in substance use or any attempt to reduce the risks associated with substance use.
   - Traditional programs define success as recovery from substance use. In contrast, in the harm reduction model, any progress toward incorporating harm reduction behaviors into one's life is seen as a success. In the harm reduction model, clients are encouraged to consider the variety of options they have for reducing risk. As they explore different options, clients often make valuable discoveries about their strengths and needs.
   - Traditional programs use 12-step support and counseling, and some also incorporate group work. The harm reduction model offers a broader menu of options, including complementary therapies such as acupuncture.
   - Traditional programs see drugs as the problem and stopping them as the solution. In contrast, from a harm reduction perspective, drug use is seen as just one aspect of a person's life. Harm reduction programs focus on the whole person and personalized approaches for reducing harm.

6. Ask participants whether they can think of other similarities and differences between traditional and harm reduction models. Some aspects of Alcoholics Anonymous (AA) provide examples of how traditional approaches and harm reduction can work together. For example, if someone is high when they show up at an AA meeting, they are allowed to stay and benefit from the program. Ask the participants whether they can think of any other examples that combine traditional and harm reduction approaches.

7. Reinforce the concept of a continuum that incorporates the characteristics of both approaches.

TEACHBACK OPPORTUNITY

When the curriculum is used, as a Training of Trainers, here is an opportunity to allow for teach back exercises and activities.

Session 6: Harm Reduction and Our Notions About Drug Use

Presentation: Thinking About Why People Use and How They Can Change?

Purpose:

- To consider the variety of reasons why people use substances
- To describe substance use on a continuum

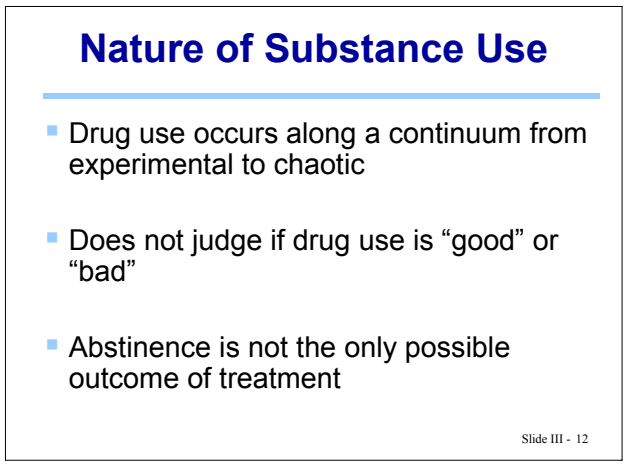
Time: 5 minutes

Materials:

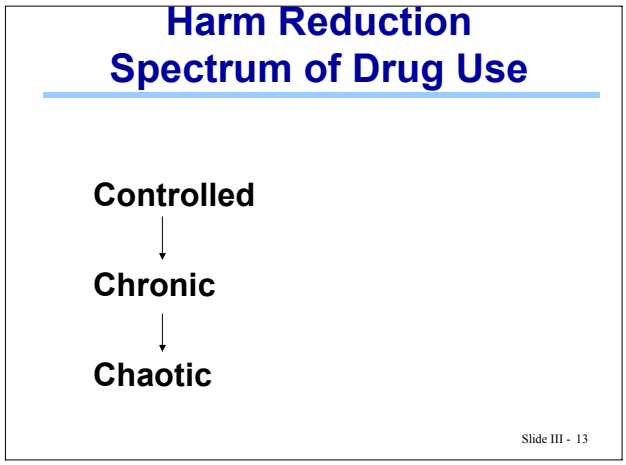
- Slide III-12, "Nature of Substance Use"
- Slide III-13, "Harm Reduction Spectrum of Drug Use"
- Slide III-14, "Being Nonjudgmental"
- Handout III-2, "Continuum of Drug Use"

Instructor Notes:

1. Display Slide III-12, "Nature of Substance Use." Refer back to the activity about drug use and drug users from Session 4. Remind the participants that harm reduction challenges some common notions about drug use by looking at drug-use behaviors in a variety of ways.



2. Display Slide III-13, "Harm Reduction Spectrum of Drug Use." Explain that, in harm reduction, drug use is viewed as a continuum from controlled through chronic to chaotic.



3. Display and review Slide III-14, "Being Nonjudgmental." Note that moral judgments are avoided in the harm reduction model. The nonjudgmental approach of harm reduction allows clients to pursue any of a variety of goals, including abstinence, reduced use, and different or safer use.

4. Distribute Handout III-2, "Continuum of Drug Use" to all participants as a reference.

Handout III-2

Continuum of Drug Use

RECREATIONAL			AT RISK*	
Experimental	**Occasional**	**Regular**	**Heavy**	**Chaotic/Out of Control**

Experimental: Try a drug once or twice or more. 30-70% of all high school students

Occasional: Once a week or now and then. Most Americans use in this way

Regular: Three times a week. At risk of developing physical or psychological dependence

Heavy: Daily or more than once a day. May be addicted or dependent

Chaotic/Out of Control: Compulsive, obsessive, life focused on drugs, loss in other areas of life

* **At Risk: 1.** Addiction **2.** Coping Use, Dependency/Compulsive Use

Session 7: What Do People Need to Change Behavior?

Activity: How Do We Change?

Purpose:

- To identify the variety of supports that people need to change their risk behaviors
- To examine our beliefs about the factors involved in behavior change
- To discuss how we set priorities and make decisions about behavior change
- To provide participants the opportunity to discuss their personal experiences with behavior change.

Time: 20 minutes

Materials:

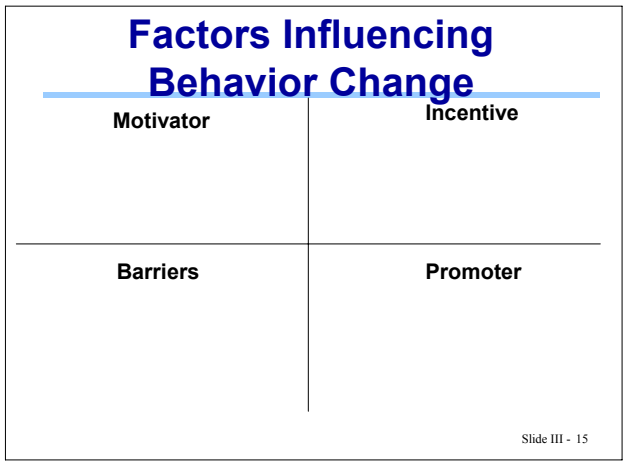
- Newsprint paper and colored markers
- Handout III-3, "Behavior Change Worksheet" for each participant
- Slide III-15, "Factors That Influence Behavior Change: Motivator/Incentive/Barriers/Promoter"

Instructor Notes:

11. Before you begin the session, use a colored maker to copy the contents of the Behavior Change worksheet onto a sheet of newsprint paper. Take another sheet of newsprint paper and write "What People Need to Support Change" across the top.

11. Comment on how common beliefs about behavior change – as represented in drug/alcohol treatment programs, healthcare delivery systems, and other institutions – often lead to an "all-or-nothing" approach to behavior change. The "Just Say No" drug campaign is a perfect example of this "all-or-nothing" approach. Changing behavior is more much complicated than "just saying no."

11. Display Slide III-15, "Factors That Influence Behavior Change." Distribute copy of Slide III-15 as Handout III-3, "Behavior Change Worksheet" to each participant.



11. Share a personal example of an attempt you've made to change your behavior. For example, you might talk about your efforts to eat better, sleep better, or get more exercise. Discuss how the four influences on behavior change listed in Slide III-15 (motivator, incentive, barriers, and promoter) affected you.

11. Ask each participant to consider a health behavior that they have tried to change in the past year, either successfully or not. Assure participants they will not have to reveal the particular behavior they were trying to change. No one will know the behavior unless the participant chooses to disclose it. Instead, they will be asked to share some of the feelings evoked by their effort to change their behavior.

11. Ask the participants to consider the following questions and then write their answers in the appropriate box on the "Behavior Change Worksheet"

    - What was your *motivator* for attempting this change? In other words, what prompted you to think about changing this behavior?
    - What *incentive* kept you working on this behavior change? As you began to change the behavior, what kept you working toward behavior change?
    - What *barriers* did you face as you began to change your behavior? List any obstacles that made your effort more difficult.
    - What *promoter* helped you overcome these barriers? Describe anything that removed some of the barriers.

11. Once everyone has completed the worksheet, ask participants to identify and place an asterisk (*) next to the most significant motivator, incentive, barrier, and promoter listed on their worksheet. Ask participants to share these critical influences on their behavior. Write down the participants' responses on the newsprint sheet entitled "Factors that Influence Behavior Change."

11. Acknowledge that the lists represent the variety of feelings that people have about making changes, as well as the diverse tactics, barriers, and supports that participants encountered. These four contributing factors – motivator, incentive, barriers, and promoter – are unique for each person.

11. Summarize the key concepts about behavior change by focusing on the range of supports that people need. Simply reading a brochure or hearing a piece of information is seldom enough to change a person's behavior. Note that we all change in different ways, so no single approach will work for everyone. Some people make changes quickly, some change slowly, and others change only when they feel in control of a situation. In some cases, personal reasons are the primary motivator for change. In other cases, external conditions are the primary motivator. For example, a person may exercise to enhance their appearance (a personal reason) or because their job requires a certain level of fitness (an external reason).

11. Ask participants to think and talk about attitudes and beliefs that support behavior change. Record their responses on the sheet of newsprint paper entitled "What People Need to Support Change." The list should include the following:

- Focusing on things that are "doable"
- Recognizing that change often occurs slowly and gradually
- Building one's confidence to make a change
- Recognizing that changes often involve losses as well as benefits
- Emphasizing strengths
- Identifying barriers and approaches for overcoming them

11. Note that a person's feeling of vulnerability is often a key factor in their decision to change. Their sense of internal power is often a key factor in their efforts to make a change. Developing skills, using tools, and gaining the support of others can also help a person make a change.

Optional Activity: What Do Substance Users Need for Change?

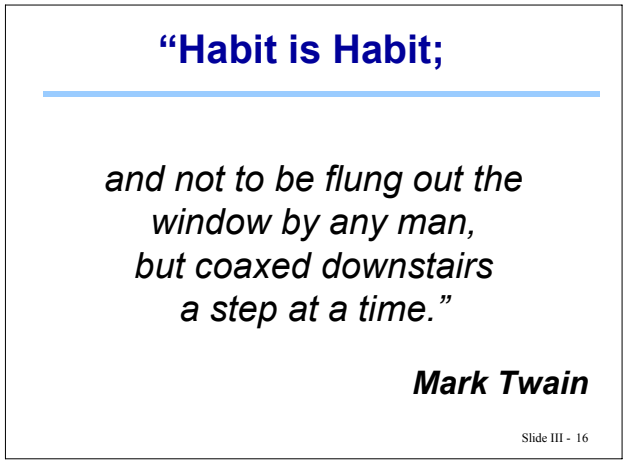
Purpose: To examine in greater detail what HIV-infected substance users need to adopt risk-reducing behaviors

Time: 5 minutes

Materials: Slide III-16, "Habit Is Habit"

Instructor Notes:

1. Display Slide III-16, "Habit Is Habit." Read it aloud for participants.



2. Ask participants whether they think that substance users can change their risk behaviors. What do they think substance users need in order to change? What do providers find frustrating when trying to help their clients change?

Activity: Stages of Change and Harm Reduction

Purpose:

- To review the Stages of Change model and its relevance to harm reduction
- To explore the harm reduction premise that the client is the expert and is responsible for choosing the type and timing of behavior change
- To apply the Stages of Change model as a way of "locating" clients along the continuum of change
- To use the Stages of Change model to support clients as they progress from one stage of change to another, regardless of where they are on the continuum
- To recognize strategies for each stage of change
- To understand the relevance of ambivalence to behavior change and to recognize the cues that ambivalence can offer the provider

Time: 20 minutes

Materials:

- Newsprint paper and colored markers
- SPHERE's *Stages of Change Wheel* for each participant
- Handout III-4, "Case Studies"
- Slide III-17, "Stages of Change"
- Slide III-18, "What Is Ambivalence, and What Is Its Role in Behavior Change?"
- Slide III-19, "Meeting People Where They're At"
- Slide III-20, "Meeting People Where They're At (continued)"
- Slide III-21, "Beliefs About Behavior Change"
- Slide III-22, "Stages of Change – Good for Providers because"
- Optional Handout II-11; GRACE: Five Principles of Motivational Interviewing in Kaleidoscope Curriculum Module – Strategies for Engagement & Retention in Care.

Instructor Notes:

1. Distribute and introduce SPHERE's *Stages of Change Wheel*, and show participants how to use it. The wheel not only defines the stages of change but also provides a means for clients to "hear" the stages. The wheel also offers some suggestions for supporting people as they

move between the stages, including relapse. Providers can use the wheel to share both the theory and language of the Stages of Change model with their clients.

2. Show the participants how they can use the wheel to explain the different stages of change to their clients. When working with a client on a particular change, a provider can ask the client to think about where they fall on the wheel and to identify factors that might help them progress to the next stage.

3. Divide participants into small groups of mixed disciplines (e.g., medical and substance abuse treatment providers).

4. Provide one Handout III-4, “Case Studies” to each small group.

Handout III-4
Case Studies

Melissa

Melissa is a 25-year-old woman living with HIV. She is a heroin user, has never been in a methadone maintenance program, has been incarcerated intermittently, and smokes about a pack of cigarettes each day. She works in the commercial sex industry, and lives with roommates in a small apartment. Only one of her roommates is aware of her HIV status. She uses heroin three to four times a day. Melissa receives her HIV care from a local community health center, and goes to the doctor at least every three months when she's is not in jail. Most of her visits to the doctor are prompted by symptoms consistent with either sexually transmitted diseases (STDs) or upper respiratory infections. Melissa has health insurance coverage through the state's Medicaid program.

Melissa's most recent CD4 count was 480/mm^3 and her viral load was 45,000 copies/Ml. Her current health problems include genital herpes and recurrent upper respiratory infections. Melissa has been on and off antibiotics for the past year during episodes of pneumonia, and she takes acyclovir to manage the herpes infection. Melissa is also on combination therapy. She comes to meet with you and states that she wants to stop taking her meds because of the side effects.

Raymond

Raymond is a 50-year-old man living with HIV and Hepatitis C (HCV). He works full time as a corporate manager, and is married with two teenage children. His family is aware of his HIV status. Raymond is an alcoholic and occasionally uses cocaine. He was first diagnosed with HCV in 1990, when it was referred to as non-A non-B Hepatitis. Raymond first tested positive for HIV in 1995, while in drug treatment. Raymond has excellent health insurance through his employer. No one at work is aware of his HIV or HCV status.

Raymond is prone to relapse, especially during periods of stress at home or work. When relapsing, he often drops out of contact for days at a time. Sober from alcohol and cocaine for the last six months, at Raymond's last appointment, his doctor suggested he begin antiretroviral therapy since his numbers were "taking a turn for the worse." Raymond's CD4 count was 350/mm^3 and his viral load was 85,000 copies/Ml. His liver function tests remained stable.

Anxious to stay healthy for his wife and kids, Raymond wants to start antiretroviral therapy. He is concerned that he won't be able to stick with a regimen. He comes to you asking if you think he can handle it and mentions that he has been feeling "very vulnerable lately and really wants to drink."

Krista

Krista is a 35-year-old woman living with HIV. She is currently homeless and typically stays on the street in "crack houses" or "wet" shelters. Krista sometimes stays with her mother. She is only allowed to stay with her mother when she is sober. Krista uses crack cocaine and is an alcoholic. She drinks whatever she can get her hands on and typically uses crack in the evenings when she is bored, lonely, and "hits the streets."

Although she considers herself a "loner", she has connected with a local street outreach program that provides free lunches and day services in the winter. At one point she was also connected with the local Department of Mental Health. She was diagnosed with manic depression, but never followed up on the suggested mental health supports.

Krista receives her HIV care from the public health clinic at an urban medical center. She goes to the doctor's office often because her doctor is very kind, she likes the center staff, and she appreciates being able to hang out in the waiting room and watch TV. Krista informs you that her AIDS is "under control" and she is feeling very depressed.

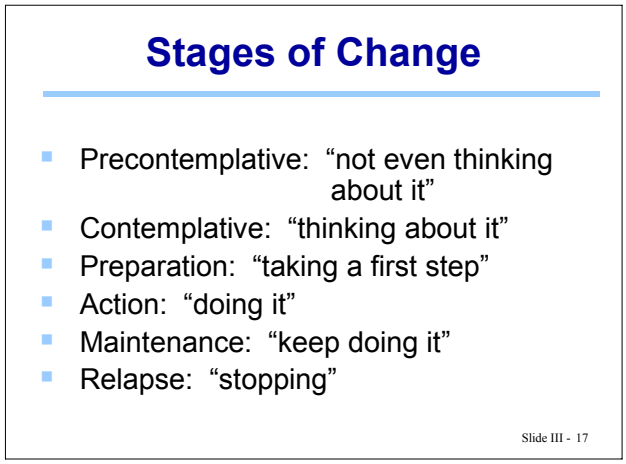
Marlon

Marlon is a 21-year-old man who has unprotected sex with other men and is living with HIV. He works for a landscaping company and often takes on construction work as well. Marlon likes to attend circuit parties because they make him feel that his life is "normal". He also likes to have anonymous sex, and uses recreational drugs only at the parties.

Marlon has a steady boyfriend who is also HIV-infected. They live together in a studio apartment. Neither feels that they need to use condoms when they have sex since they are both HIV-infected. They use condoms most of the time when they have anonymous sex with others.

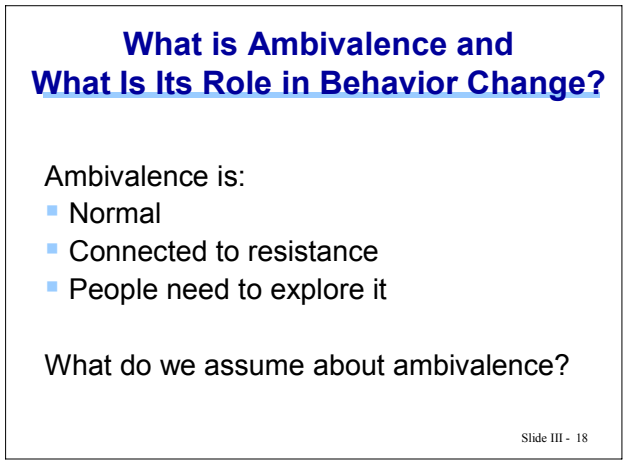
Marlon was diagnosed with HIV four years ago. At that time, he had a CD4 count of 180/mm^3 and a viral load of 80,000 copies/Ml. His doctor started him on therapy immediately. Until recently, his treatment has been very successful. Marlon's viral load has been climbing over his past few appointments. His most recent viral load was 90,000 copies/Ml and his CD4 count is at 300/mm^3. His doctor performs a genotype test indicating he is in fact resistant to some of his HIV meds. He asks for your advice on what he should do.

5. Display Slide III-17, "Stages of Change." Ask each group to review their case study and decide what stage they believe the person is in. What strategies could be used to support this person? Ask the groups to identify the local resources of organizations and agencies that can and will support persons in each of the stages?



6. Ask each small group to share their findings and strategies. Then ask the entire group whether they can suggest any additional strategies that might be helpful to the individual in their case study. Note for the participants that they will be coming back together as a case study group later in the module and will need to refer to their group assigned case study.

7. Display Slide III-18, "What Is Ambivalence, and What Is Its Role in Behavior Change?"



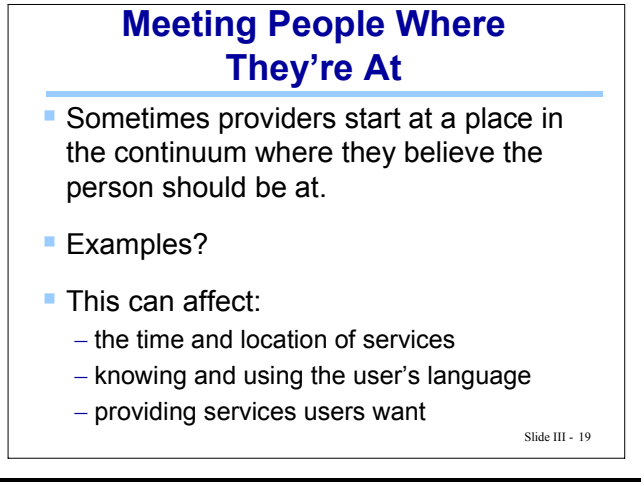
8. Ask participants to share their knowledge and assumptions about the role of ambivalence in behavior change. Are ambivalence and resistance the same? Ask participants whether they think ambivalence means that a person does not want to change. Does it indicate that something is wrong with the person? Does it mean that the person is in denial?

9. Suggest that, in a harm reduction framework, resistance and ambivalence are signals that the provider may need to change his/her strategy. Ambivalence may mean that the client no longer feels in control of the agenda or the timeframe. The client may no longer feel invested in making the change, or he/she may feel that they are being rushed to complete it. When a provider encounters ambivalence or resistance, he/she should reassess their role and closely examine the approaches and support being offered to the client. The provider can then work with the client to modify the goals and the timetable for change.

10. Recap the essentials of behavior change by displaying and reviewing the following slides:

    - Slide III-19, "Meeting People Where They're At"
    - Slide III-20, "Meeting People Where They're At (continued)"
    - Slide III-21, "Beliefs About Behavior Change"
    - Slide III-22, "Stages of Change"

11. Optional Handout: Distribute Handout II – 11; GRACE: Five Principles of Motivational Interviewing from Kaleidoscope curriculum.



Meeting People Where They're At

- Harm reduction lets the patient/client say where s/he is at – providers discover this through open conversation.
- Understanding the Stages of Change can be helpful in "finding" the patient/client and helping the person talk about where they're at.

Slide III - 20

Beliefs About Behavior Change

- Behavior change is slow
- Incremental change is measured
- "Stages of Change" model is used
- Success around change celebrates small changes

Slide III - 21

Stages of Change

Good for providers because:

- Tailored interventions
- Evaluates by measuring a patient's/client's progress from stage to stage
- Change is GRADUAL
- Patient/Client controls timing

Slide III - 22

TEACHBACK OPPORTUNITY

When the curriculum is used as a Training of Trainers, here is an opportunity to allow for teach back exercises and activities.

Session 8: Redefining the Provider-Client Relationship

Activity: Harm Reduction and Provider-Client Relationships

Purpose:

- To review the ways in which harm reduction may affect provider-client relationships
- To identify ways that providers can incorporate harm reduction skills into their relationships with clients

Time: 10 minutes

Note: This session can be shortened and conducted as an overview rather than a skills building training. To do so, only use the Activity: Harm Reduction Provider and Client Relationships followed by a review of the two presentations: Harm Reduction Skills and Tools and Self-Assessment Scales.

Materials:

- Newsprint paper and colored markers
- Slide III-23, "Redefining the Relationship"
- Slide III-24, "Harm Reduction Relationships"
- Slide III-25, "Harm Reduction Relationships (continued)"
- Slide III-26, "Harm Reduction Equation"

Instructor Notes:

1. Before you begin this session, prepare a newsprint sheet with the title "Skills We Use" at the top.

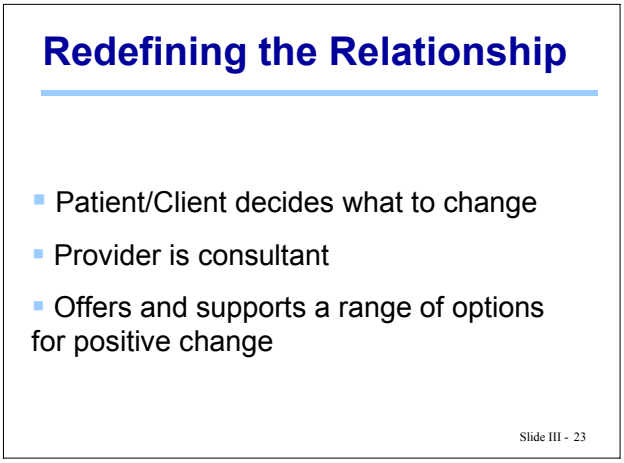
2. Ask participants to name some of the effective skills they already use with clients. Write down their responses on the prepared newsprint sheet entitled " Skills We Use."

3. Review the list and add any important skills that the participants have not mentioned. The following skills should be included on the final list:
   - Creating and supporting options
   - Asking open-ended questions
   - Assessing the pros and cons of making a change
   - Reaching and supporting clients "where they're at"
   - Using motivational interviewing techniques

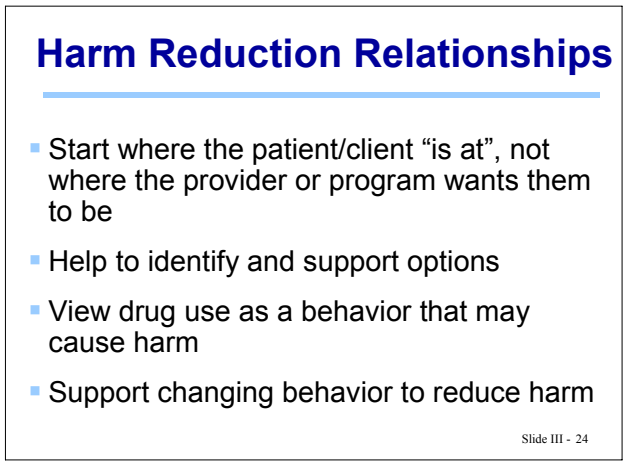
4. Remind the participants that harm reduction involves the use of a diverse collection of strategies and skills to help people reduce the harms in their lives.

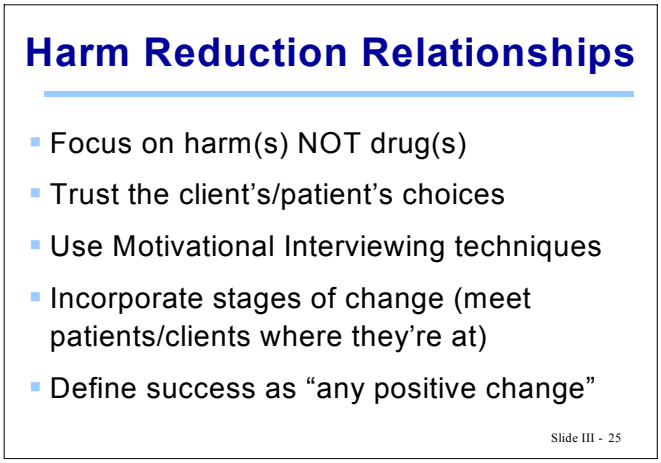
5. At this point, it will be useful to introduce the motivational interviewing (MI) technique. MI is a collection of counseling techniques specifically designed to support a client's desire for change. People often attend weeklong trainings to acquire MI skills. Since we have a very limited amount of time, we will simply describe the basic MI techniques and discuss how these techniques can help create a climate for change. However, before we try out some of these techniques, we will review how the roles of providers and clients in the harm reduction model and the ways in which these roles differ from those in traditional models.

6. Display Slide III-23, "Redefining the Relationship". Explain that there are three key aspects to harm reduction relationships. Acknowledge that some participants may have already fully integrated the harm reduction approach into their relationships with clients, while others may have incorporated some aspects of model. In the harm reduction relationship, the provider is not seen as the client's surrogate parent or boss. Instead, the provider is viewed as a consultant who can clarify information for the client and offer alternatives and options. The client, rather than the provider, is seen as responsible for the success of harm reduction efforts.

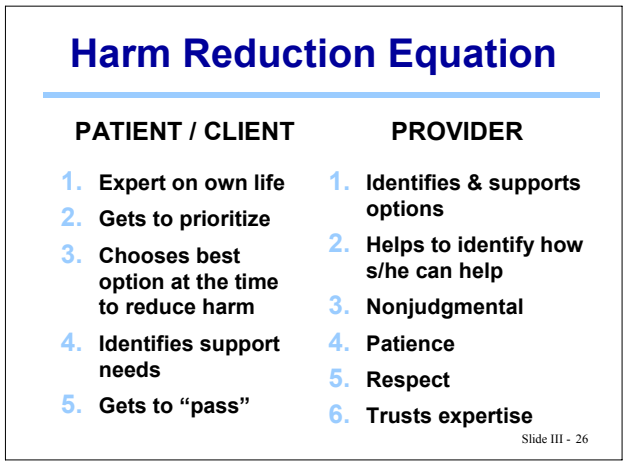


7. Display and review Slides III-24, and III-25, "Harm Reduction Relationships". Ask participants to consider whether they already incorporate the harm reduction approach into their relationships with clients.





8. Display Slide III-26, "Harm Reduction Equation." Note that, in harm reduction, the provider-client relationship is seen as a collaboration. The provider and the client work together to assess the harms or behaviors that the client wants to change. Slide III-26 summarizes the expertise that the client and provider each bring to this collaborative relationship.



Presentation: Harm-Reduction Skills and Tools

Purpose: To offer tools and strategies for incorporating harm reduction into our work

Time: 5 minutes

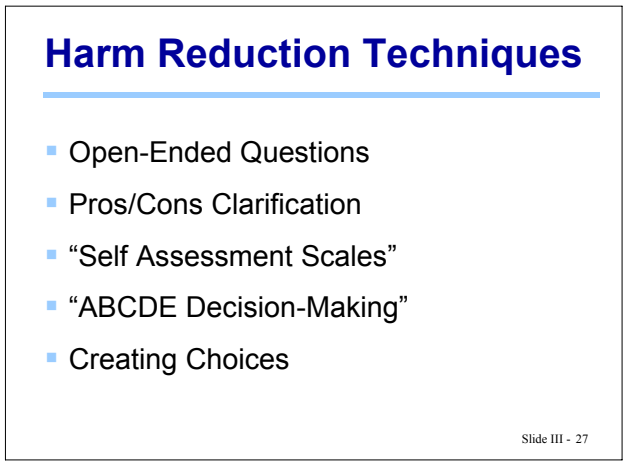
Materials:

- Slide III-27, "Harm Reduction Techniques"

Instructor Notes:

1. Acknowledge the wealth and diversity of experience in the room.

2. Display and review Slide III-27, "Harm Reduction Techniques".



3. Tell the participants that they will learn about and have the opportunity to practice the harm reduction techniques listed in Slide III-27 later in this session.

Activity: Open-Ended Questions

Purpose:

- To emphasize the importance of asking open-ended questions
- To give participants the opportunity to practice this interviewing technique

Time: 20 minutes

Materials

- Newsprint paper and colored markers
- Slide III-28, "What Is an Open-Ended Question?"
- Slide III-29, "Developing Open-Ended Questions"

Instructor Notes:

1. Display and review Slide III-28, "What Is an Open-Ended Question?"

What Is an Open-Ended Question?

- Prompts patients/clients to respond with answers other than "yes" or "no"
- Questions start with "why" or "how"
- Benefits:
  - Responses help you understand
    - Don't ask a question that invites a negative response
    - Ask questions that demonstrate no value judgments

Slide III - 28

2. Divide the participants into small groups of three to five people.

3. Give one piece of newsprint paper and one colored marker to each small group.

4. Display Slide III-29, "Developing Open-Ended Questions" and assign each group one topic from the slide.

Developing Open-Ended Questions

TOPICS:

- Hepatitis
- Sexually Transmitted Diseases
- Sexual History
- Sexual Risk Reduction
- Drug and Alcohol Use
- Needle Use
- Experience with Risk Reduction

Slide III - 29

5. Ask each group to develop as many open-ended questions as they can for their topic. Strongly encourage them to practice asking open-ended questions. Note the difficulty of asking open-ended questions, especially in the environments that we all work in where closed-ended questions are promoted (i.e., reporting formats)

6. When the small groups have completed this task, ask the participants about the process of developing open-ended questions. Ask one person from each group to select and read one opened-ended question from their assigned topic. If the question presented is not open-ended, ask all of the participants how they might change the question to be open-ended.

Activity: Pros and Cons – Decisional Balance Questions

Purpose:

- To review the usefulness of developing pro and con questions
- To introduce decisional balance questions and the ABCDE model for decision-making

Time: 15 minutes

Materials:

- Newsprint paper and colored markers
- Slide III-30, "Pros and Cons of Making a Change"

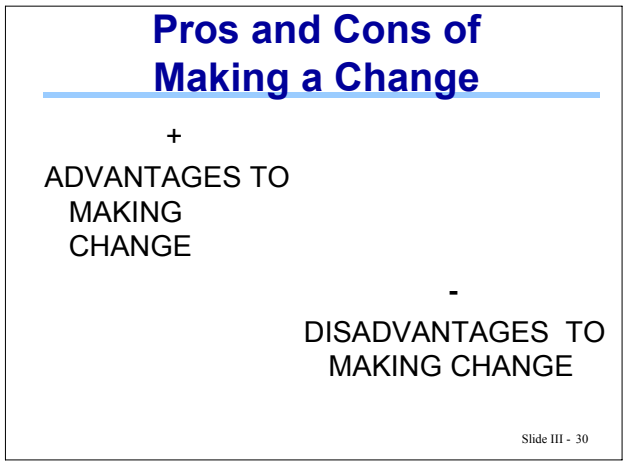
Instructor Notes:

1. Before you begin the session, prepare a newsprint sheet with a two-column table. Write "To Use" at the top of the left column and "Not to Use" at the top of the right column.

2. Ask participants to identify the benefits of using pro and con questions when working with clients. Tell participants that these types of questions help clients:
   - Consider the advantages and disadvantages of a particular course of action
   - Determine the barriers to a course of action
   - Identify what they need to support behavior change
   - Begin to develop strategies that either create supports or overcome barriers

3. Discuss the value of asking questions as clients progress through the stages of change. Well-worded questions can help clients sort out the pros and cons of particular behaviors. These directed questions also give clients the opportunity to identify and express any ambivalence they may be feeling about a behavior change. The Stages of Change model described in Session 7 calls these kinds of questions "decisional balance questions." Decisional balance questions are particularly useful when someone is expressing ambivalence. Responding to these questions can help clients clarify their needs and help them make a more informed decision about their next steps.

4. Display Slide III-30, "Pros and Cons of Making a Change".



5. Refer to and briefly review the newsprint sheet created in Session 3 – "Reasons to Incorporate Harm Reduction" and "Reasons Not to Use."

6. Now post the new newsprint sheet with the "To Use" and "Not to Use" columns. Ask participants the question, "What are the reasons to use condoms during sexual activity, and what are the reasons not to use condoms?"

7. Note: If you prefer, you can substitute other decisional balance questions for the condom use example in note 6. Here are a few possibilities:
   - What are the reasons to tell/not to tell a sexual partner or family member that you're infected with HIV?
   - What are the reasons to reduce/not to reduce your drug use?
   - What are the reasons to visit/not to visit a doctor?

8. Write down the participants' responses in the appropriate columns on the newsprint sheet. Providers can use similar decisional balance questions when talking with their clients about behavior change. When clients articulate their reasons for making or not making a change, their providers may gain a deeper understanding of their point of view. In the process, providers will have the opportunity to offer information, dispel myths, and provide support and referrals.

Presentation: Self-Assessment Scales

Purpose:

- To review the role of self-assessment scales in our interactions with clients

- To review how we measure success and how our evaluation of success can reflect and support behavior change

Time: 15 minutes

Materials:

- Slide III-31, "Self-Assessment Scales"
- SPHERE'S *Self-Assessment Ruler*
- Slide III-32, "Outcome Measures"
- Slide III-33, "Outcome Measures (continued)"

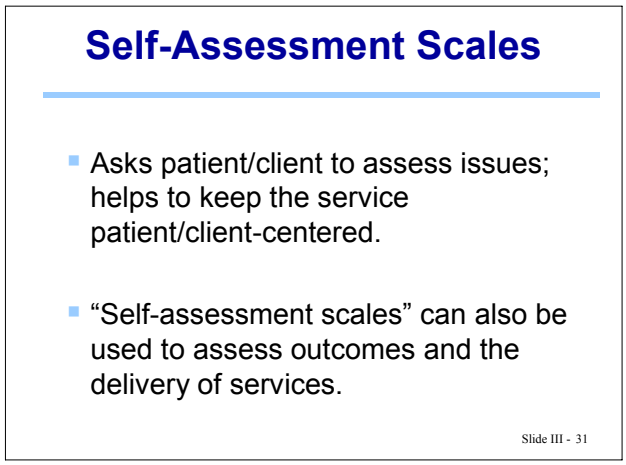
Instructor Notes:

1. Remind participants that the way we measure success is often different in a harm reduction model compared to traditional models.

2. Ask participants how they currently measure success in their work. Their responses might include statements like the following:
   - Client gets sober
   - Provider sets goal
   - Client takes all their medicine
   - Client abstains from all substance use

3. Explain that, in a harm reduction model, the outcomes and the ways we measure them are client-centered and take into account the slow and gradual nature of behavior change. In addition, a concerted effort is made to identify the ways in which clients have been successful and to celebrate the strengths they have demonstrated. Continued engagement with the client is considered a "success."

4. Display Slide III-31, "Self-Assessment Scales". Note that the use of self-assessment scales can be important tools for measuring success in a client-centered way. These evaluation tools allow clients to measure their success subjectively. Self-assessment scales can also help clients clarify where they want to be – their "goals."



5. Note that providers don't always check in with clients about their concerns, beliefs, attitudes, and goals in behavior change. Self-assessment scales offer clients this opportunity. These scales also yield valuable information that providers can use when discussing change with clients identifying ways to more effectively support their clients efforts to implement behavior change.

6. Exhibit SPHERE'S *Self-Assessment Ruler* as an example of a self-assessment scale.

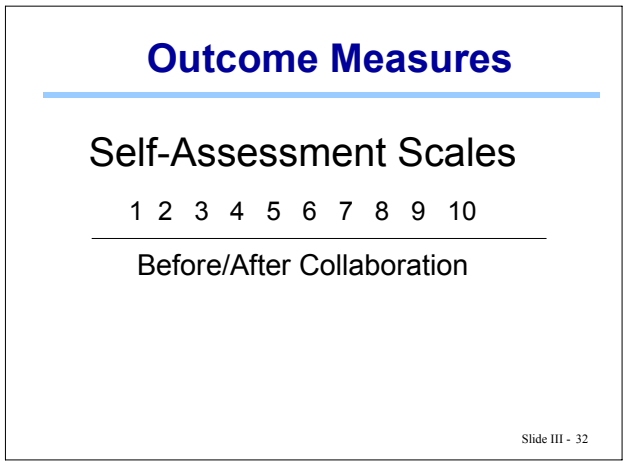
7. Identify some questions providers can ask clients or clients can ask themselves. Describe how questions can be used to:
   - Identify where clients are at and where they want to be

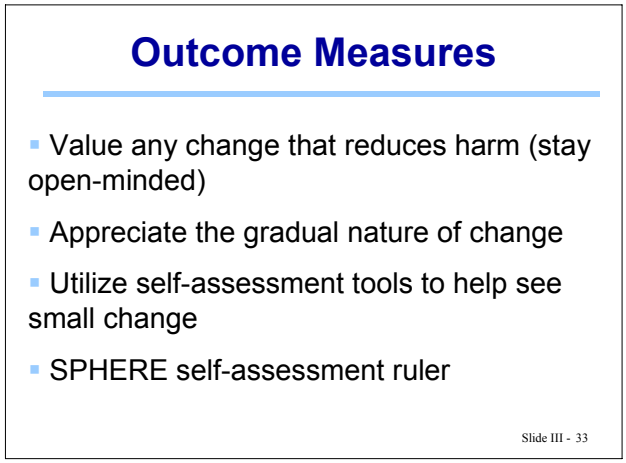
   Help clients prioritize the behaviors they want to change
   Identify supports that clients need to make the change
   Create an agenda for the provider

8. Explain how self-assessment scales can be used to measure success and remind clients of how far they have come.

9. You can also use self-assessment scale questions to help your clients "measure" their efforts. Keep a record of where clients place themselves on the scales. Refer to these numbers in subsequent conversations when you use the scales again. For example, if a client reports that a problem has decreased in size, you can support his/her efforts to reduce that problem. If a client reports that the problem has increased, you can work with the client to develop strategies for decreasing the problem and discuss ways to better support his/her efforts. These are some of the ways in which self-assessment scales can serve as client-centered evaluation tools.

10. Display and review Slides III-32,"Outcome Measures" and III-33, "Outcome Measures (continued)" as a recap.





11. Summarize as follows: when we accept the client's view of the problem we can use it to guide his/her efforts for behavior change. Providers can ask the following questions:
    - How much do you think your substance use is a problem?
    - How much do you think using a condom is a problem?
    - How much of a problem is it for you to follow your medication regimen?
    - How much of a problem is it to clean your "works"?
    - How much of a problem is your nutritional health?
    - How much of a risk is your substance use?
    - How much of a risk is sharing your works?
    - What's your risk for transmitting HIV through sex?

Activity: ABCDE Model for Decision-Making

Purpose: To review the ABCDE decision-making model, emphasizing how this model can be used to identify a person's options

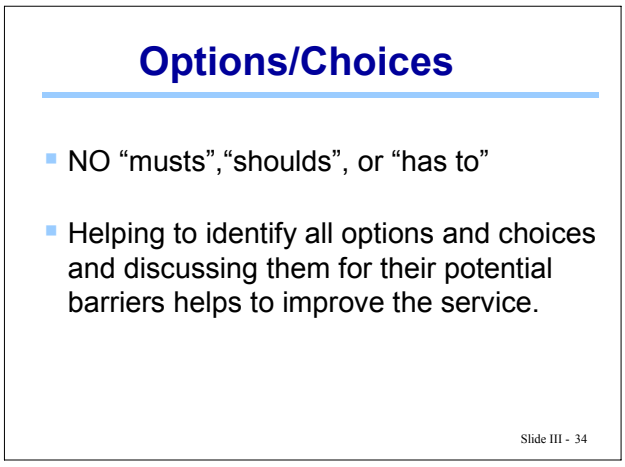
Time: 30 minutes

Materials:

- Newsprint paper and colored markers
- Slide III-34, "Options/Choices"
- Handout III-5, "ABCDE Decision-Making Model" Worksheet
- Slide III-35, "Options/Choices – ABCDE Model: **A**ssess"
- Slide III-36, "Options/Choices – ABCDE Model: **B**rainstorm"
- Slide III-37, "Options/Choices – ABCDE Model: **C**onsider and **D**ecide"
- Slide III-38, "Options/Choices – ABCDE Model: **E**valuate"
- Handout III-4, "Case Study"

Instructor Notes:

1. Display Slide III-34, "Options/Choices". Reinforce that helping clients consider options is a key harm reduction skill. By considering their options in detail, clients are better able to prioritize the changes they wish to make. They can decide which behaviors to change first, how they want to make the changes, and when to start.



2. Distribute Handout III-5, "ABCDE Decision-Making Model" Worksheet. Draw a copy of the model on a sheet of newsprint paper. Tell the participants that they will complete the model as a group. You will record their responses on the newsprint sheet and track how the decision-making process unfolds.

Handout III-5

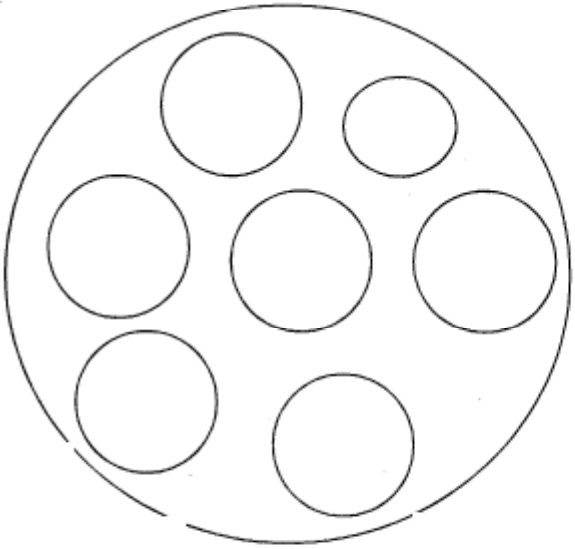
"ABCDE Decision-Making Model" Worksheet

Assess

A- Assess
B- Brainstorm
C- Consider
D- Decide
E- Evaluate

Write harm to be addressed in box

Brainstorm Write possible options to reduce harm in small circles.



Consider- Cross out options you think would not be a good idea.

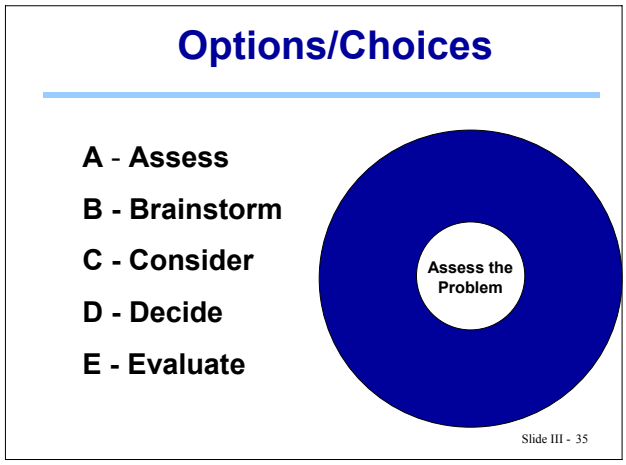
Decide- Place a star on your best option

Evaluate- Evaluate your decision. Is this the best decision I can make?

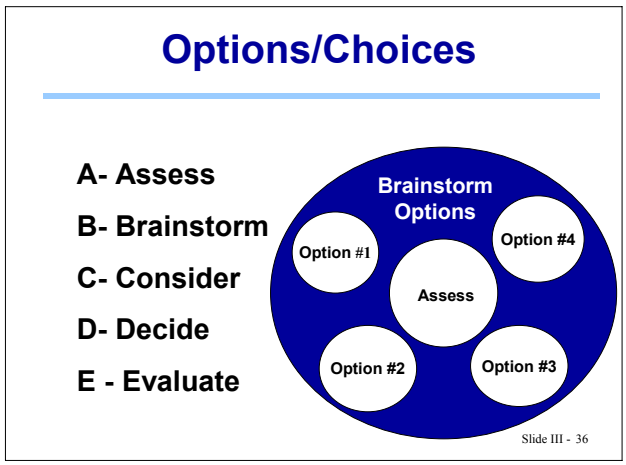
ABCDE Model adapted by SPHERE, The Statewide Partnership for HIV Education in Recovery Environments
A program of Health Care of Southeastern Massachusetts, Inc.
1-800-530-2770 extension 224

3. Ask participants to regroup into the previous case study groups they were in for the Stages of Change exercise.

4. Display Slide III-35, "Options/Choices: **A**ssess." Ask each of the groups to identify (**A**ssess) a harm for reduction from their respective Case Study.

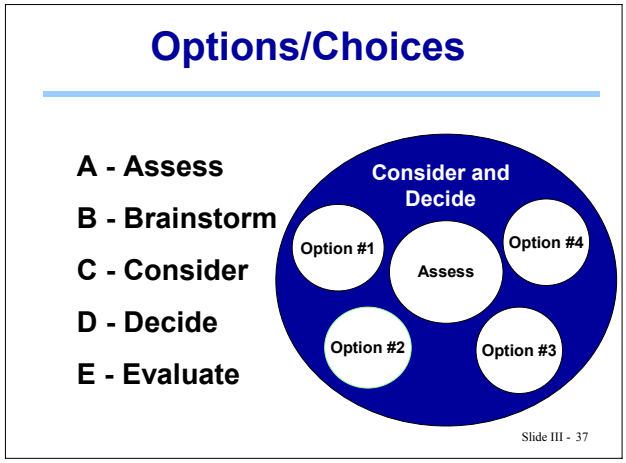


5. Display Slide III-36, "Options/Choices: **B**rainstorm." Ask participants to brainstorm all ideas to reduce the harm, remembering not to make judgments about the client. Write each of these ideas in its own small circle as shown in the slide.



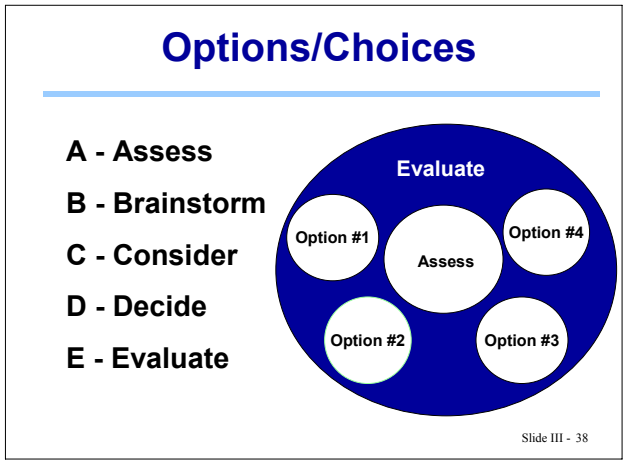
6. Display Slide III-37, "Options/Choices: **C**onsider and **D**ecide." Ask the group to consider each of the circled options for change that they identified during the brainstorm. The following questions can help the group screen the different options:
    - How effective would this option be in reducing the harm they've chosen?
    - Is the person likely to try this approach?
    - Does the person have the capacity to use this approach?

Place an "X" through all options that the group believes would be ineffective or unworkable.



7. From the remaining circles, determine which option for change is the most viable. For the purpose of this activity, we will assume that the client decides to adopt this option. The following issues and strategies are pertinent to each of the case studies:
   Melissa: Heroin may/may not be the priority harm – use of open-ended questions; Significance of her desire to stop taking meds – use of decisional balance questions.
   Raymond: Ability to stick with regimen – use of open-ended questions and reflective listening.
   Krista: Multiple issues: medical, housing, drug use and transmission risks – use of risk assessment scales.
   Marlon: Inconsistent use of condoms with boyfriend and anonymous sex – use of decisional balance questions.

8. Display Slide III-38, "Options/Choices: **E**valuate." Assess what other supports the person may need and consider how effective they are likely to be.



9. Ask participants whether the ABCDE model could be applied effectively in their work with clients. Could they use this approach to help clients reduce harm in their lives? Could this model also be used for other purposes, such as helping clients take their medications properly or improving provider-client communication skills?

10. You can end this activity by noting that the ABCDE model supports the following harm-reduction principles:
    - The client prioritizes the behaviors that will be changed.
    - The client sets the timetable for behavior change.
    - The provider's role is to be the client's advisor and cheerleader.
    - The provider gives the client the opportunity to explore ambivalence.

TEACHBACK OPPORTUNITY

When the curriculum is used, as a Training of Trainers, here is an opportunity to allow for teach back exercises and activities.

Session 9: Harm-Reduction Approaches and Barriers

Activity: Approaches and Barriers to Using Harm Reduction in Our Work

Purpose:

- To reinforce key concepts and skills learned in the earlier sessions of this training module
- To help participants identify the relevant approaches and barriers to using harm reduction techniques with their patients/clients

Time: 20 minutes

Materials:

- Newsprint sheet entitled "Ways We Already Incorporate Harm Reduction" from Session 3
- Newsprint and colored markers
- Slide III-39, "Ways We Can Integrate Harm Reduction and Barriers to Doing So"

Instructor Notes:

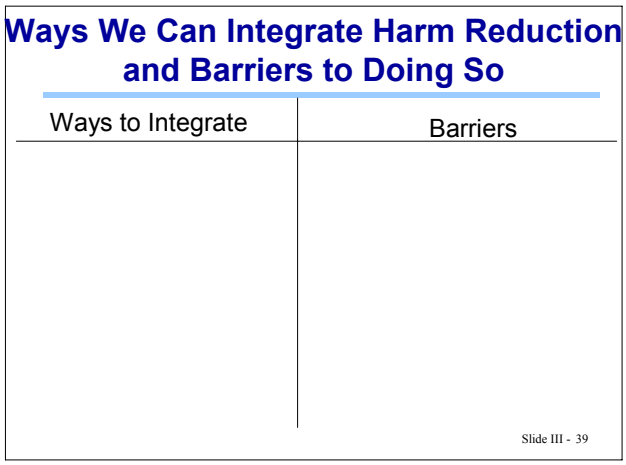
1. Refer to the newsprint sheet "Ways We Already Incorporate Harm Reduction" from Session 3. Ask participants to review the list they made earlier in the training on how they incorporate harm reduction.

2. Check in with participants about the applicability and appropriateness of harm reduction approaches in their work. Discuss which techniques could be easily adapted to their work setting.

3. Divide participants into small groups of three to five persons.

4. Give a sheet of newsprint paper and colored markers to each small group.

5. Display Slide III-39, "Ways We Can Integrate Harm Reduction and Barriers to Doing So". Ask the participants to write the contents of the slide on their newsprint sheets.



6. Ask each group to brainstorm about the ways to integrate harm reduction into their work and the barriers they either have encountered or might encounter. Ask them to write down their ideas on their newsprint sheets.

7. Ask the small groups to share their lists with the entire group. Ask the entire group to suggest strategies for addressing and overcoming these barriers.

8. Use this discussion as an opportunity to reinforce some of the important concepts covered in this training module. As you lead the discussion, you can model some of the techniques that have been described. For example, you can acknowledge and support the efforts that the participants have already made to incorporate harm reduction into their work. You can express empathy and validate the participants' concerns about the challenges they have identified. You can remind the participants that this training module has given them some new tools that they can bring back to their workplace. You can also point out that professional change, such as the integration of harm reduction into their work, is likely to occur slowly and gradually. Encourage the participants to focus on one thing they can do to integrate harm reduction into their work. Remind them to think small and to celebrate their small changes.

Presentation: Key Takeaways

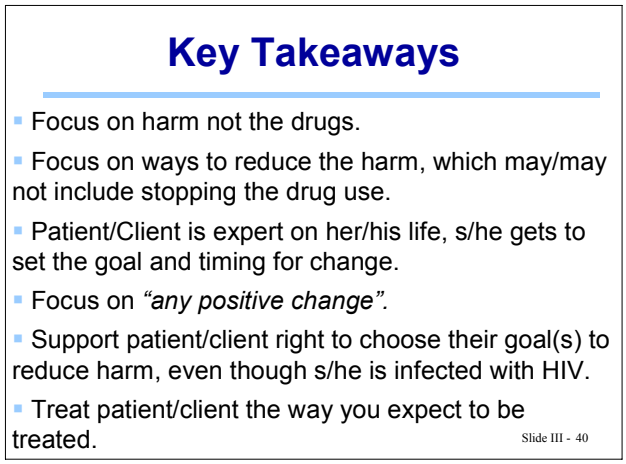
Purpose: To summarize the most important elements of harm reduction as simply as possible

Time: 2 minutes

Materials: Slide III-40, "Key Takeaways"

Instructor Notes:

1. Display and review Slide III-40, "Key Takeaways"



2. Remind participants of the skills they already incorporate into their work, as discussed in Session 3 and in the previous activity.

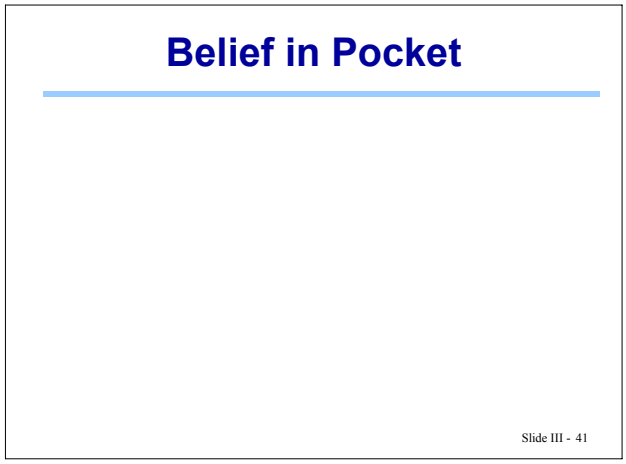
Activity: Is That a Belief in Your Pocket?

Purpose: To give participants the opportunity to examine whether their experience of this training module has affected their personal beliefs.

Time: 1 minute
Materials: Slide III-41, "Belief in Pocket"

Instructor Notes:

1. Display Slide III-41, "Belief in Pocket". Ask participants to remove from their pockets the sheet of folded papers on which they described their beliefs about drug use and drug users at the beginning of this training.



2. Ask participants to review what they wrote.

3. Tell the participants that if they still think their beliefs about drug use and drug users are true, then they are welcome to take their pocketed belief home with them. However, if the participants have changed their beliefs, ask them to leave their pocketed belief on your desk.