COMPREHENSIVE RISK COUNSELING AND SERVICES (CRCS)

INTERVENTION PROFILE

What’s in a name? CRCS is a useful means of providing clients with focused risk reduction counseling to facilitate their achieving and/or maintaining healthier choices around HIV. This strategy is client-centered by tailoring services individually for participants’ needs. Formerly known as Prevention Case Management (PCM), CRCS now services those not only at high risk for HIV, but also for Persons Living with, HIV/AIDS (PLWHA).

After a client with high levels of risk has expressed some degree of commitment to participating in ongoing risk-reduction counseling, the race is on. The client is assigned to a CRCS Counselor who helps s/he develop a prevention plan after an initial assessment. During this phase of CRCS, these sessions lend themselves to meaningful exchanges between client and counselor, in which the client’s individualized risk-reduction plan is revisited at each scheduled session until both client and counselor agree upon goals. Ongoing needs assessment(s) during the sessions allow the CRCS counselor to monitor progress and supply the client with referrals (both internally and externally) to a variety of services, such as psychological, (CRCS, pg. 3)

The Commission’s Latinos in the Deep South Program (LDSP) is helping catalyze a groundswell of HIV research, prevention and care activities for underserved Latinos in the seven states highlighted in blue. See page 2 for more.

TRIP — Turning Research Into Prevention

PROGRAM PROFILE

Bethsy Morales-Reid is the Director of The Turning Research into Prevention (TRIP), a project under the Commission’s Research and Evaluation Department purview. The project was created to package a new intervention called Insights for the Centers for Disease Control and Prevention (CDC). The Insights intervention is a minimal self-help tailored intervention for sexually active, non-monogamous women, ages 18-24.

This behavioral intervention, conducted at an individual-level, aims to increase the use of condoms for this at risk population. Insights entails two magazines with per - (TRIP, pg. 2)

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UPCOMING EVENTS/SEMINARS

April 6-9, New York, NY: SISTA Training

May 11, New York, NY: The Commission’s Annual Gala, Cielo Latino

June 21-22, Birmingham, AL: LDSP Summit on Community-Based Participatory Research
-sonally relevant information collected through a survey on sexual health practices and attitudes. The use of tailored information provides relevant information and works effectively to influence behavioral change. Self-help interventions are beneficial both for increasing self-efficacy in safer sex practices and for its broader reach.

**STAFF PROFILE**

Although her main role is with TRIP, Mrs. Morales-Reid is also a Lead Trainer for the SISTA intervention and an experienced trainer and facilitator. She has been at the Commission for over 5 years and previously held the position of Deputy Director of the Latino Religious Leadership Project (LRLP), where she coordinated a grant-making process for over 39 communities of faith. She received a Bachelor’s Degree in Political Science at Fordham University, and a Masters Degree in International Affairs at the New School University.

**LATINOS IN THE DEEP SOUTH**

**PROGRAM PROFILE**

Focusing on the emerging Latino populations in seven southern states (Alabama, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, and Tennessee), the Latinos in the Deep South Project’s (LDSP) mission is to provide capacity-building services and an on-going needs assessment to Latino-serving agencies in these states.

The programmatic objectives of LDSP are to:
- Build networks among organizations providing HIV and related services to Latinos;
- Link CBOs and other Latino-serving organizations with regional and national resource networks and civil society networks;
- Provide technical assistance and capacity building to CBOs, faith communities, and local/state health departments; and
- Collect data to assess the needs of the emerging Latino population in the Deep South.

As funding decreases for HIV/AIDS programs and services, partnerships must be strengthened and resources need to be leveraged. Coalitions and community mobilization efforts can help mitigate the spread of HIV/AIDS. To date, LDSP has co-sponsored seven statewide roundtables on HIV/AIDS prevention and care services reaching Latinos. This intensive work with partners across the seven states yielded a report titled, “Shaping the New Response: HIV/AIDS and Latinos in the Deep South.” In November 2009, a follow-up meeting in Charlotte, North Carolina brought together researchers, community-based organizations and health departments to outline a research agenda and forge cooperative links. For the complete report and downloadable materials, visit www.latinoaids.org/programs/deepsouth.

— CHRISTIAN F. CASTRO

**CONSUMERS’ CORNER — Letters to the Editor**

INEQUALITY IN FUNDING FOR HIV/AIDS PREVENTION FOR IDUs

Recently, I submitted a request to the Latino Commission on AIDS, with the hope that our agency could take advantage of services described and offered by their CBA Department.

As a relatively new Executive Director, I’ve quickly assessed that some of my biggest challenges and concerns are centered around agency infrastructure, sustainability, the need to develop tighter fundraising strategies and the need to work more closely with our Development Director in creating a donor base for us to reach out to.

As I’m sure many of you are aware, donating to drug use/drug user causes is not necessarily on top of the list for many donors. Unfortunately, this is particularly true with syringe exchange programs. Although numerous studies have shown that the rates of HIV, HCV and overdose among active injectors/users has decline steadily for a number of years, the amount of other-than-government funding has either stagnated or declined. Harm reduction as a philosophy defines our work as ‘meeting people where they’re at’. But for some funders referrals and keeping people in treatment is the only way to go (remember the word ‘outcomes’?). Now this does not mean that we don’t support the idea of participants getting into treatment, but how realistic is it to place a dollar amount on how long and whether or not that individual actually stays in treatment for the long haul? Even in non-harm reduction programs, this is not always the case.

I would like to hear from others who struggle with this dilemma, and in the meantime am anxious to begin to work with the Commission’s CBA Team!

— Rev. Raquel Algarin, Executive Director Lower East Side Harm Reduction Center
Utilizing the Stages of Change Model with Comprehensive Risk Counseling and Services (CRCS)

BEHAVIORAL THEORIES

As HIV prevention interventions and public health strategies advance, the importance of understanding and utilizing behavioral theories has become more apparent. Best practices in the field show that effective prevention work is guided by specific models and theoretical frameworks.

Behavioral theories are not only useful for designing a prevention intervention, but also for implementing PHS (i.e., HIV testing, CRCS, Partner Notification, etc). One useful behavioral theory that can be utilized across public health strategies is the Transtheoretical Model, also known as the Stages of Change Model. Developed by Prochaska and DiClemente in 1977, the model emerged from an examination of 18 psychological and behavioral theories about how change occurs. The premise of this theory is that behavior change is not an immediate or linear process, but one that occurs in five different stages:

- **Pre-Contemplation:** the person is not thinking about changing behavior
- **Contemplation:** the person is thinking about changing behavior
- **Preparation:** the person is getting ready to change behavior; has a plan.
- **Action:** The person made the change and has maintained it for 30 days or more
- **Maintenance:** the person has maintained the change for six months or more

The transition from one stage to the other is different for each person and is affected by different elements such as social and psychological factors. Also, this model understands that the transition through the stages can be bi-directional, because people can relapse to a prior stage after making the behavior change.

In counseling, there is no one-size fits all approach for eliciting behavior change, because each person experiences change at different levels. Consequently, a great part of the effectiveness of public health strategies like CRCS lies on the counselor’s ability to meet clients where they are. The core elements of CRCS includes creating an individualized prevention plan with goals and measurable objectives as well as providing ongoing behavior-change counseling to clients. If used with CRCS, the Stages of Change Model can help the counselor in tailoring each session to the particular stage the client is in. For example, someone who is in the pre-contemplation stage might need information to start thinking about their behavior as problematic, whereas someone who is in the Preparation stage might need some guidance in creating an action plan for behavior change.

The Stages of Change Model is a great framework to broaden the toolbox of CRCS counselors. It facilitates a deeper insight into the client’s progress towards their behavioral goal, and ensures an individualized provision of risk reduction counseling services. — ERIKA MORILLO

CRCS, cont. from page 1

Social, and medical service which may be contributors to affecting risk behavior (e.g., mental health, substance abuse, as well as diagnosis and treatment of sexually transmitted infections). The collaboration between the client and counselor continues, and when both parties agree that the client has attained and maintained his/her risk reduction goals, the client is discharged.

CRCS is a popular tool for use among high risk populations. Clients generally feel encour-aged and empowered to participate in the process of selecting, monitoring and obtaining goals which are beneficial to maintaining their holistic health (physical, mental and emotional), often referred to by clients as “buy-in.” This buy-in, once established, helps reinforce the individual’s commitment to working towards less risky behavior while being supported through counseling and appropriate referrals. CRCS ultimately empowers clients to introduce their social networks and partners to the idea and benefits of the program — a boon for CBOs that traditionally had little to no success in recruiting and outreaching for this type of intervention. The key to harmonious integration of this strategy is first assessing whether or not the organization has the capacity to implement the program — a service that the Commission’s CBA team is ready and eager to provide. — KEVIN WILLIAMS

For more information on our capacity building activities, trainings and leadership institutes, please contact Natasha Quirch at nquirch@latinoaids.org or 212.675.3288 ext. 316.

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