

**Comprehensive Risk Counseling and Services (CRCS)
Implementation Manual Feedback Request
Spring 2006**

Dear Health Department or CBO Grantee –

The CRCS Workgroup at CDC appreciates your patience awaiting the release of this manual. We sincerely hope you've received it in time to assist your agency's HIV prevention program activity.

We are anxious to hear back from you about the manual, primarily to be able to make improvements in future editions and for additions to the upcoming CRCS website, which you will be able to access at http://www.cdc.gov/hiv/topics/prev_prog/crcs.

Please take a moment to respond to the following questions, either via email or direct mail, to Dale Stratford, 1600 Clifton Road NE, MS E-47, Atlanta GA 30333, bbs8@cdc.gov.

1. Implementation manual
 - a. How have you used the CRCS implementation manual?
 - b. In what ways have you found the manual useful?
 - c. How could the manual have been more useful to you?
 - d. Who (e.g., supervisor, prevention counselor, etc.) has been the primary users of the manual in your agency?
 - e. What questions do you have about the use of the manual?
 - f. What additional suggestions do you have regarding the CRCS implementation manual?

2. Data collection templates
 - a. Which data collection templates have you been able to utilize?
 - b. How have you used them (i.e., have you adapted them, used them 'as is')?
 - c. How could the data collection templates be more useful to you?
 - d. What data collection needs do you have that are not addressed by the templates provided?
 - e. Who in your agency has utilized these templates for data collection or input?
 - f. What additional suggestions do you have regarding the data collection templates provided with the CRCS implementation manual?

Comprehensive Risk Counseling and Services (CRCS)

Implementation Manual

Spring 2006

NEWS FLASH!!



Prevention Case Management (PCM) is now called Comprehensive Risk Counseling and Services (CRCS). CDC made this change in order to reduce confusion among providers and clients regarding differences between CRCS and other case management systems. We will be using 'PCM' in this manual to refer only to previous PCM programs.

Document Overview

What are the reasons for this new Implementation Manual?

Because CRCS is a complex intervention, there has been ongoing demand for more detailed resources. Many agencies have indicated that they need hands-on tools and guidance, in addition to the various trainings that are available for CRCS, to help meet day-to-day implementation challenges. We developed this manual, based on the 1997 *Prevention Case Management Guidance*¹, for that purpose.

We also wanted to share ***lessons learned*** from previous PCM projects, including the PHIPP (Prevention with HIV-positive Persons) and AHP (Advancing HIV Prevention) PCM demonstration projects.

Finally, we encourage you to share ***your feedback*** on this manual with us, with an eye toward improving our guidance on CRCS and the work that we all do against HIV and AIDS. In addition, we look forward to your input on the new CRCS website, accessible at: http://www.cdc.gov/hiv/topics/prev_prog/crcs by July 2006.

This manual is intended to provide day-to-day guidance and assistance for implementing your CRCS intervention. It should also be used as a general guide to planning CRCS services and developing your agency's CRCS protocols. You also need to take into account the characteristics of your clients, location, community, resources, and local and state laws as you develop your agency-specific program guidelines and intervention protocols.

The data collection templates and other tools appended to this manual are provided as examples and are not required by CDC, although some of the variables may be required by PEMS for programs funded by CDC. We have indicated those items by the superscript[®], followed by the respective PEMS table and item number. Optional PEMS variables are indicated by *. You can use these templates as they are, adapt them to suit your agency, or you may find other tools more useful for your program. References to the relevant data collection template occur at the end of each section rather than when the topic is first mentioned.

Finally, the CDC/DHAP CRCS workgroup would like to thank the health department and CBO staffs and others whose hard work, critical thinking, and perspectives provided the impetus and information for this manual.

- *The CDC /DHAP CRCS Workgroup*

¹ http://www.cdc.gov/hiv/topics/prev_prog/CRCS/resources/PCMG/index.htm

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Background

Over 1 million people are currently living with HIV/AIDS in the United States (Glynn and Rhodes 2005ⁱ), and approximately 40,000 new HIV infections are estimated to occur every year (Fleming *et al.* 1998ⁱⁱ). As part of an initiative to combat this epidemic, CDC recommends greater access to prevention services for people at high risk for transmitting or acquiring HIV.

The primary goal of CRCS is to help HIV-positive and HIV-negative persons who are at high risk for HIV transmission or acquisition to reduce risk behaviors and address the psychosocial and medical needs that contribute to risk behavior or poor health outcomes.

In order to highlight the focus on reducing risk and eliminate confusion with traditional case management, we've changed the name from Prevention Case Management (PCM) to Comprehensive Risk Counseling and Services (CRCS). Additionally --

This is a clarification of the 1997 PCM Guidance, which indicates that there should be no duplication of case management services.

Psychosocial service utilization can contribute to risk reduction.

➤ ***We're suggesting the following program changes -***

- *CRCS staff do not conduct case management if client has been or can be referred to other case management.*
- *CRCS staff should refer clients to available case management and other services and monitor clients' use of these services.*
- *CRCS staff can provide case management or referrals if the client has no existing case manager or referral system or if a particular service isn't covered by case management.*
- *In any case, CRCS staff work with other service providers and help with referrals and coordination.*

The primary focus is on client needs, therefore building and establishing in your agency a tradition of staff working closely together to support clients is important to the success of interventions such as CRCS.

**LESSONS
FROM THE
FIELD**

- *“I only do risk reduction counseling – our case managers don’t have time to do much of it, and if I provided case management services, I wouldn’t be able to ever get to risk reduction with my clients. But that doesn’t stop me from, say, making a referral to housing or substance abuse treatment when our case manager is busy and it’s a clear need of the client – I’m just sure to let her know and talk about it in case conferences.”*

Originally, PCM was a hybrid of psychosocial case management and risk reduction counseling for all clients. However, we have learned that staff and clients often were confused about who provides what type of service because some clients already had a case manager. There has also been resistance from case managers about sharing clients with CRCS programs and vice versa. And, some clients are hesitant to disclose risk to those who provide access to benefits, such as case managers.

For all these reasons, CDC now recommends that CRCS prevention counselors focus primarily on risk-reduction with all clients. In addition, the CRCS prevention counselor can provide case management services, but only if these services are not available to CRCS clients. In cases where your clients do utilize other case management services, you can still provide referrals for particular services not handled by existing case management. And you should keep in mind how the services that clients use affect their risk reduction efforts.

CRCS service strategies --

- CRCS counselors focus on risk reduction, and case managers provide access to support services, especially for HIV-positive clients.
- CRCS counselors provide both risk reduction and case management services when case management services are not otherwise available to clients.
- In all cases, CRCS counselors work closely with other service providers to help high risk, high need clients reduce their risks.

**LESSONS
FROM
THE
FIELD**

“PCM staff currently do not conduct case management, and we have clear boundaries around who does what within the agency – and the clients always know who to go to for what service. And we have strong team approaches to serving clients. Teamwork is enhanced by physical proximity, sharing tasks when needed (bartering), buy-in from management, and the mobile advocates serving as a bridge between the prevention and care functions of the agency.

This model works very well for us and helps us provide better services to our clients.”

ⁱ Glynn MK, Rhodes P. Estimated HIV prevalence in the United States at the end of 2003 [Abstract T1-B1101]. Presented at the 2005 National HIV Prevention Conference, Atlanta, GA; June 14, 2005.

ⁱⁱ Fleming PL, Ward JW, Karon JM, Hanson DL, DeCock KM. Declines in AIDS incidence and deaths in the USA: a signal change in the epidemic. *AIDS* 1998; 12(suppl A):S55–S61.

An Introduction to CRCS

Comprehensive Risk Counseling and Services (CRCS, formerly PCM) is intensive, individualized client-centered counseling for adopting and maintaining HIV risk-reduction behaviors. CRCS is designed for HIV-positive and HIV-negative individuals who are at **high risk** for acquiring or transmitting HIV and STDs and struggle with issues such as substance use and abuse, physical and mental health, and social and cultural factors that affect HIV risk.

- For people who are HIV-positive, psychosocial challenges such as depression or mental illness, substance use, or homelessness may adversely affect their ability to obtain medical care, adhere to HIV/AIDS treatment, and reduce risk behaviors.
- Some HIV-negative people also experience challenging life circumstances that leave them unable to prioritize risk reduction.
- A client with an urgent need for housing, food, or treatment for substance use may find risk reduction difficult.
- Often, through less intensive, group-based prevention interventions, we find out that certain clients need the more intensive attention to risk reduction challenges such as that offered by CRCS.

Core elements

The 7 core elements of CRCS (referred to as ‘essential components in the 1997 *PCM Guidance*) – These elements should always be present in any CRCS program, although their design may vary to suit the client population, resources, and agency mission. The core elements are described in detail in the 1997 *PCM Guidance*² and are listed below.

- 1) Develop and implement a strategy to recruit and engage high risk clients
- 2) Screen clients to identify those who are at highest risk and appropriate for CRCS, enroll them in CRCS, and assess enrolled clients to determine specific risk and psychosocial needs
- 3) Develop an individualized prevention plan with goals and measurable objectives
- 4) Provide ongoing, multi-session intensive HIV risk and behavior change counseling
- 5) Coordinate client support with other case management programs and provide referrals as needed
- 6) Conduct on-going monitoring and reassessment of client progress and needs
- 7) Discharge clients when they attain and can maintain behavior change goals. In preparing discharge policies, agencies should establish protocols to classify

² http://www.cdc.gov/hiv/topics/prev_prog/CRCS/resources/PCMG/index.htm

clients as “active,” “inactive,” or “discharged.” Your agency should outline the minimum active effort required to retain clients. Finally, your CRCS program should be willing to readmit clients who need new or additional risk reduction support.

Note that CRCS is, by definition, an individual level

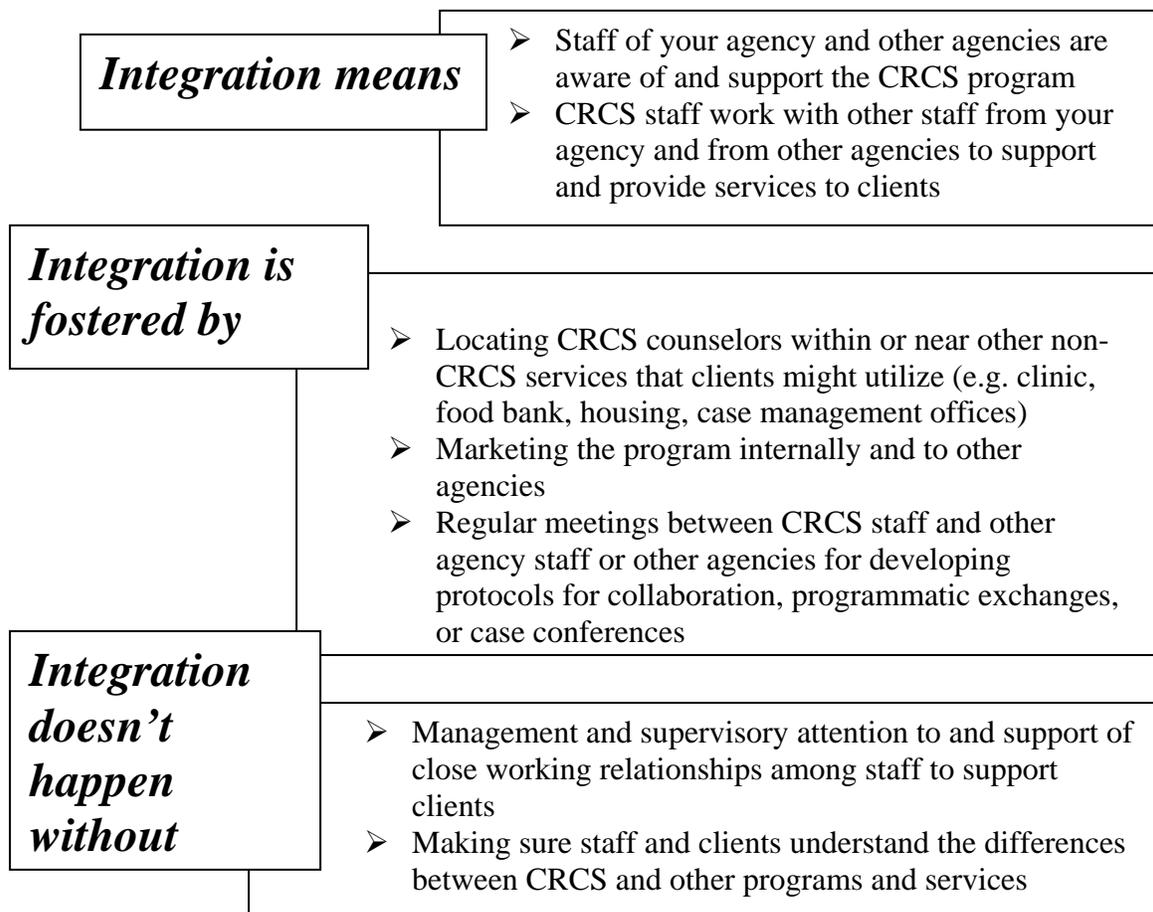
intervention. CRCS clients often are referred to support groups in order to get them ready for CRCS or to help them cope after graduation from CRCS, but CRCS itself is conducted with only one client at a time, unless the client’s partner is involved in the sessions.

Section 1: Organizational Preparation

Preparation for CRCS is similar to launching other new programs. It takes a lot of effort, planning, and preparation. The details of your agency's implementation plan depend on the size of the agency and its policies, the population to be served, and available resources. We have learned that CRCS works better in agencies that consider **integration, staffing, coordination of service providers, environmental issues, and client incentives** when designing their programs.

A. Integration

CRCS programs may be more successful when they are fully integrated into multi-service organizations and the greater HIV prevention community, although single-service agencies with strong collaborative relationships in the service community are also good CRCS service providers.



B. Staffing

Well trained supervisors and counselors are essential to the success of any CRCS program. All CRCS counselors and supervisors should have, at a minimum, training in pre- and post-test counseling, which provides a standard client-centered approach to HIV prevention³. One model for this is Project RESPECT⁴.

Program managers and supervisors

Program managers and supervisors are a crucial part of CRCS. We strongly encourage these CRCS staff to attend CRCS trainings, particularly the management/supervisor trainings⁵. In addition to strong administrative supervision, agencies should provide “clinical” supervision. A clinical supervisor should have experience working with HIV issues, and, depending on the population at risk, mental health or substance abuse training or experience may also be critical.

In a multi-service organization and across agencies, CRCS works well when supervisors support CRCS by

- Finding ways to educate others in the organization about CRCS
- Organizing one-on-one meetings with supervisors of other units
- Presenting on CRCS to staff in other agencies

Supervisors should also keep in mind the potential for resistance to CRCS in organizations where case management is funded by Ryan White, Medicaid, SAMHSA or other systems. This resistance can be overcome when staff in these programs experience the ways in which CRCS, which works with the most challenging clients, can support other case management services and help decrease workloads.

Initially

- Supervisors should help develop an implementation plan that is appropriate for the agency and agency’s clients.

Thereafter

- Supervisors should review active case files and meet with CRCS counselors regularly.
- Supervisors should also watch for opportunities to increase staff skill levels through direct observation, role play, and feedback.

³ <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5019a1.htm>

⁴ <http://www.cdc.gov/hiv/projects/respect>

⁵ <http://depts.washington.edu/nnptc>

We have included a sample framework for supervision in Appendix X.

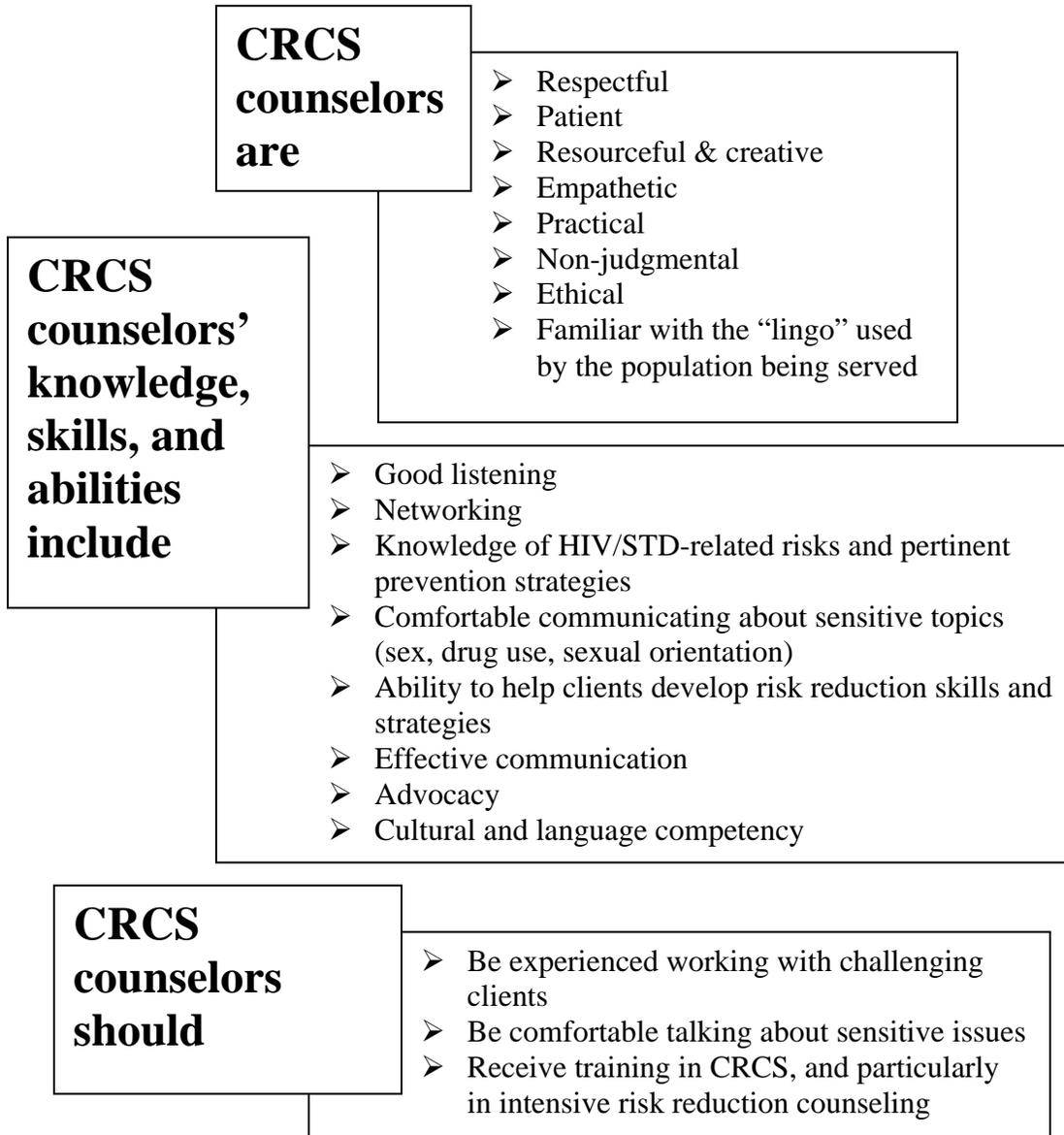
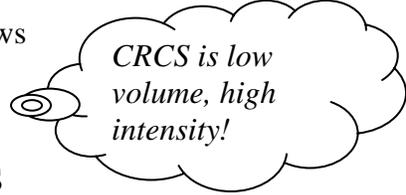
CRCS counselors

CRCS counselors work with the highest risk clients on very difficult issues. Mental health and substance use are the most frequently reported challenges to risk reduction among CRCS clients – thus the need for CRCS counselor expertise and referrals to services in these areas.

LESSONS FROM THE FIELD

- *Successful CRCS counseling appears to depend more on cultural competency (familiarity with the community and ability to communicate effectively with the client) and knowledge of basic counseling techniques (reflective listening, building rapport, motivational interviewing) than on any specific educational level.*
- *However, because of difficult psychosocial issues presented by some clients, particularly mental health issues, some agencies prefer that their counselors have at least a Master's degree or request that clients be referred to mental health specialists within or outside of the agency.*
- *Experience with clients who would benefit from substance use treatment will also be a helpful, if not necessary, background for many CRCS counselors.*
- *Prevention counselors should also consult with clinical supervisors regarding clients who present particularly challenging circumstances.*

Regarding caseload, a full time CRCS counselor should have between 12 and 20 active clients at one time. This caseload is smaller than caseloads for typical case managers. The smaller caseload allows for intensive recruitment and engagement activities and more frequent and intensive risk reduction sessions. Additionally, counselors will likely spend time contacting clients, to assure that they return for services. Caseloads will be larger for CRCS counselors who do not provide case management services.



C. Coordination of Service Providers

What do we mean when we talk about coordination and collaboration?

It takes time and energy to build effective collaborative relationships – and time and energy are often in short supply. This is especially true given the very real and constant demands of working with CRCS clients whose needs are often extraordinary. However, the benefits of collaboration are important to CRCS providers and clients – improved service delivery, reduced stress, and better use of financial and human resources.

Collaboration is a process of participation through which people, groups, and organizations come together in a mutually beneficial and well-defined relationship to work toward results they are more likely to achieve together than alone.

An agency is able to enhance its services through collaborative sharing of resources with other agencies. Collaborating agencies focus on specific efforts or programs, exchanging information and altering activities to derive mutual benefit and achieve a common purpose.

Coordination requires planning, clear roles and a division of labor, and open channels of communication between organizations. An example of coordination would include referral agreements between HIV counseling and testing centers and primary care clinics.

Coordination and collaboration take time and resources and are not always smooth or easy. However, the bottom line is improved services for clients, reduction in people falling through the cracks, and reaching those individuals in need of additional prevention services due to ongoing risk reduction challenges.

Remember to avoid overlap with existing case management services, and make sure that your clients know whom they can go to for which services. And remember to have clients sign release forms, according to your agency's guidelines.

A release form is a separate document that allows you, the CRCS counselor, to talk with your clients' other service providers to help provide more comprehensive and integrated care. This is a form that you should ask clients to sign during enrollment, allowing you to share information about your clients with their other service providers, if need be.



D. Environmental & structural issues

The CRCS counselor should have access to a private space in which to meet clients, where clients will feel comfortable talking about high-risk behaviors.

LESSONS FROM THE FIELD

- *If possible, locate the CRCS counselor near non-CRCS services used by CRCS clients -- this provides an opportunity to follow-up with clients who have difficulties staying engaged with the program and is more convenient for clients.*
- *Locating services near each other also encourages interaction of staff in support of clients.*
- *Consider offering CRCS appointment times that are outside normal business hours (in the evenings or on weekends) in order to accommodate clients' work schedules.*
- *Be willing to provide services to clients where they are more comfortable receiving them, outside of your agency if need be. This will allow CRCS counselors to reach clients who might otherwise have no contact with the agency.*
- *However, your agency's staff and client safety protocols should be in place before you provide off-hour, off-site services. Safety protocols may include -*
 - *Assess the safety and client confidentiality situation in any venue*
 - *Make sure your supervisor knows where you are and how to reach you*
 - *Meet at safe spots, such as safe public parks, restaurants, coffee shops—know your territory!*
 - *Don't go into a home unless you know who else will be there and you know the client well*
- *It's important to have a policy and procedures for handling potentially dangerous situations.*

An example of a safety checklist is provided in Appendix R; a sample program preparation worksheet is provided Appendix S; and tips for setting professional boundaries in Appendix W.

Naming the program

Many agencies that provide CRCS have found it helpful to change the name of the CRCS program to suit the community that they serve. The components of CRCS should not change, but the name can be more appealing and meaningful to your community.

For example –

- *Ask Joe*
- *OPEN Choices*
- *Positive Living*
- *The Next Step*
- *Healthy Living*

E. Incentives

Incentives may encourage client participation – but your goal is that clients come to value reducing risk and living healthier lives. Your agency should decide

- If incentives will be useful for ***recruitment and retention***
- If incentives are a good way to ***maximize existing resources***; that is, if incentives result in better participation and lower no-show rates, and therefore better utilization of staff time (counselors do not wait for clients who don't show up)

Some agencies choose to provide incentives for activities related to monitoring and evaluation (e.g., baseline and follow-up assessments), because these activities often are over-and-above a commitment to the intervention program in general or to behavior change specifically. Other agencies start with incentives and decrease them systematically, as clients become more engaged. You should clearly explain your agency's incentive program to potential clients.

Agencies tend to define incentives differently. For some agencies, transportation tokens are not considered incentives, but are seen as supporting clients to reach their program participation objectives.

Examples of incentives include:

- Transportation support (bus ticket, subway or rail card, taxi voucher)
- Food voucher or access to food pantry
- Phone card
- Gift certificates
- Movie pass
- Hygiene kits
- T-shirts
- Small monetary reimbursement

LESSONS FROM THE FIELD

- *Incentives may be given at completion points, for example, when clients reach even seemingly small or minor objectives.*
- *An incentive program should be sustainable – decide on incentives given client needs and the resources available to your agency for use as incentives.*
- *Note that some agencies decide NOT to provide incentives, expressing the view that reaching behavioral objectives should be its own reward.*

**LESSONS
FROM
THE
FIELD
(CONT.)**

- *Other agencies maintain that clients come at first for the incentives and stay for the program*
- *Caution! Some forms of incentives can be used to purchase alcohol, tobacco, or other drugs*

Section 2: Implementation

Agencies should adapt CRCS to suit the organization and population served, but the seven core elements of CRCS should be present in all CRCS programs. The following includes a description of some of the ways these core elements may differ among agencies. However, two approaches characterize all good programs and are the foundation for all CRCS activities –

- ***A focus on addressing contextual factors that contribute to HIV risk***
- ***The client-centered approach***

There has been some confusion in the past about the use of the term “client-centered” to help define the intervention. In CRCS, being client centered refers to paying attention to the client’s needs and abilities regarding risk reduction. It is NOT intended to mean that the client can focus on any issues that they want to forever. If the client wants to talk about a childhood event week after week and does not want to discuss his or her needs around risk reduction, the client should be referred for mental health counseling. Thus, you should interpret “client-centered” in the context of CRCS – it is a program designed to help clients reduce their HIV risk behaviors, so most of the focus should be on these conversations and on factors related to risk.

The 7 core elements of CRCS discussed below, are not always separate steps in providing CRCS, but we present them as separate topics in this *Manual* in order to describe them.

You’ll find some components are needed most of the time during CRCS. For example, ‘engagement,’ listed in Part 1, is nevertheless an on-going feature of the client-counselor relationship.

Part 1: Recruiting and engaging clients

Part 2: Screening, enrolling, and assessing clients

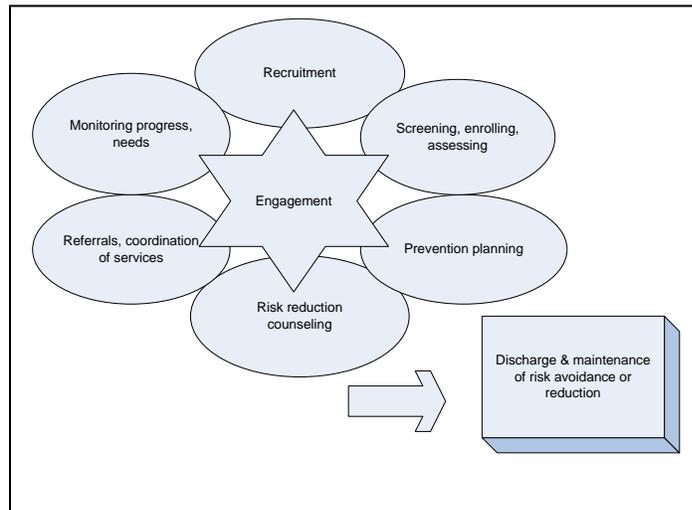
Part 3: Developing a prevention plan

Part 4: HIV risk reduction counseling

Part 5: Referrals and active coordination of services with follow-up

Part 6: Monitoring client progress and ongoing needs

Part 7: Discharge and maintenance



Part 1: Recruiting and Engaging Clients

A. Recruitment

Much of what we know about recruitment comes through having learned from other CRCS providers and their experiences with obtaining referrals to their programs and recruiting clients through their outreach activities.

LESSONS FROM THE FIELD

Do not underestimate the time you need for recruitment!

- *Client recruitment is time and labor intensive.*
- *It may take several months of relationship building with colleagues and prospective clients in order to obtain a full case load.*
- *To reach individuals at high risk for HIV/STD acquisition or transmission, your agency needs to determine eligibility criteria before recruitment begins. Please see Part 2 in this Section (Screening, enrolling, and assessing clients, page 32) for a description of eligibility criteria for CRCS.*
- *Know the particular risk and psychosocial needs of the population you serve and tailor your program to meet those needs.*
- *Describe the program to prospective clients as improving health and quality of life, in addition to reducing risk.*

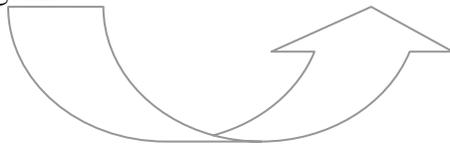
Programs use both active and passive recruitment methods
– ***for example***, a more active method would be recruitment of potential participants by outreach workers. A more passive method might be leaving program flyers at another

agency. In between active and passive might be obtaining clients from internal or external referrals. In such cases, CRCS staff might be very active in developing a referral network (meeting with providers within and outside the agency), but ultimately, the referral usually depends on the action of the referral source.

Quick recruitment overview –

- The CRCS recruiter should clearly explain the CRCS program and help your potential client to understand what to expect from it.
- Clarify roles and expectations for the client and CRCS counselor.
- Distinguish CRCS from other case management and HIV prevention programs.
- Reiterate your agency’s policies on confidentiality.
- Meet where clients will feel comfortable discussing sensitive topics.
- Pay attention to your facial expressions and body language – avoid judgmental reactions when clients disclose risk behaviors or attitudes and values that differ from your own.
- Work on using appropriate language and terms that your clients can relate to.
- Point out that CRCS is an intensive but relatively time-limited program focused on risk reduction. However, clients can re-enroll if they need the support to maintain risk reduction goals.

Remember that risk behavior may be episodic or sporadic



LESSONS FROM THE FIELD

➤ *During an initial session, a CRCS counselor in a multi-service center found out that a CRCS client wanted to go back to school for his degree. In the course of developing their relationship, the counselor and client discussed how the client’s substance abuse was keeping him from achieving his goal of going back to school.*

This discussion was a key part of motivating the client to enter drug treatment and reduce his risk behaviors.

**LESSONS
FROM THE
FIELD
(CONT.)**

*“What’s in
it for me?”*

- *At another CBO, a CRCS counselor asks clients at their first meeting to write notes or key points about what they want from CRCS. The counselor then helps the clients connect their goals with the small steps that lead to risk reduction and other behavioral objectives they may have set.*

Recruitment of clients into CRCS can be challenging –

- The characteristics or situations that make individuals eligible for CRCS – multiple psychosocial needs and high-risk behaviors – also make recruitment and engagement difficult.
- The highest risk people may not have or desire any contact with any systems of care or support, and therefore, they may be difficult to identify and recruit.
- CRCS may be a difficult program to describe and “sell” to clients. Tangible services may not be the primary outputs of the program, particularly for those who already have a case manager. In addition, behavior change or risk education may not be a priority, at least initially, for the potential CRCS client.

Reaching out to clients . . .

**LESSONS
FROM THE
FIELD**

- *Outreach through social networks of otherwise ‘hard to reach’, high-risk clients.*
- *Take recruitment and counseling services to clients, via vans, satellite offices, or other locally appropriate means.*
- *Locate PCM services close to other services used by persons at high risk for HIV transmission or acquisition.*

**LESSONS
FROM THE
FIELD
(CONT.)**

- *Provide PCM services during hours and at locations that are client-friendly.*
- *Adapt PCM linguistically and culturally, to meet the needs of specific ethnic and cultural groups.*
- *Work closely and collaboratively with providers of other services to high risk clients, to assist meeting client needs.*
- *Use the Internet to find out where high-risk sexual behavior occurs and recruit from those places.*

1. Referrals

Referrals are a common source of CRCS clients and can come from inside and outside your agency.

a) Internal referrals

Many multiservice agencies find that most referrals to CRCS come from within the agency. Referrals to single service agencies – that is, agencies that provide only CRCS – depend upon developing good relationships with external partners.

LESSONS FROM THE FIELD

- *Referrals from within agencies work well when the different parts of the organization understand the eligibility requirements for CRCS; that is, the type of client the intervention is intended to serve.*
- *Including CRCS counselors in case conferences or regular meetings at which clients are discussed will build staff relationships and allow CRCS counselors to make recommendations for CRCS when challenging clients are discussed.*
- *Regular meetings between CRCS counselors and other staff increase referrals by keeping CRCS in the minds of those who may need to refer their high-risk clients.*
- *Demonstrating what CRCS has done for clients also helps build relationships with other staff who are concerned about their clients. Case conferences, other staff meetings, are useful venues for sharing CRCS successes.*
- *CRCS clients may refer their friends to the program if they find the service beneficial.*

b) External referrals

While internal referrals are the major source of client recruitment for CRCS in multi-service agencies, particularly for HIV-positive clients, your agency can use other strategies to find clients.

Referrals from outside your agency – by case managers, medical staff, or others – may also be productive. This type of referral requires the cultivation of collaborative relationships between agencies and their respective staff to support clients who are particularly challenged by life circumstances. The CRCS counselor or program manager can make presentations about CRCS to staff at other agencies (hospitals, jails, clinics, private medical providers, etc...) in order to increase awareness about CRCS and develop relationships with potential referral sources. You also may want to leave a CRCS brochure with the staff of other agencies for future reference.

Interagency relationships have to be frequently nurtured in order to foster collaboration. Previous demonstration projects have shown that steady referrals depend on ongoing or regular communication with staff of other agencies. One strategy that your agency might consider is co-locating your CRCS program in medical clinics and in other agencies with potential CRCS clients. This would provide an added service in the host agency and strengthen your agency's ties within the HIV/AIDS service community and your ability to recruit and serve clients.

Don't forget – your agency needs to have current Memoranda of Understanding (MOU) with other service providers, which are important for establishing and supporting protocols for interagency communication and collaboration.

LESSONS FROM THE FIELD

- *A 2005 UCLA report on PCM programs found that agencies that had early development of implementation protocols and “clear program designs” had fewer problems interfacing with other agencies or case management services, recruiting clients, and referring clients to other agencies.*

2) Outreach

One specific and active recruitment source can be through outreach workers at your agency or from other agencies.

CRCS counselors or outreach workers can recruit clients through such venues as

- Support groups
- HIV counseling and testing sites
- Social marketing campaigns or handing out brochures to potential clients or displaying posters describing CRCS and the kinds of services that CRCS provides
- Medical providers
- Prevention activities at venues where high risk individuals are likely to be encountered
 - Crack houses and shooting galleries
 - Bath houses and sex clubs
 - STD clinics
 - Commercial sex worker venues
 - 12-step programs

Outreach workers may have a relationship with and therefore access to a particular community.

- They are often from or are a part of the community
- They know the population
- They are familiar with the venues frequented by high risk clients
- They have an ability to quickly form bonds with community members

With training and practice, outreach workers will be able to describe CRCS to people who otherwise may not be involved with HIV programs or other health-related services.

LESSONS FROM THE FIELD

- *In multi-service agencies, outreach workers also can serve as a bridge between the prevention and care services of the agency and thereby assist with retaining clients.*
- *In one PCM project, outreach workers conducted recruitment & eligibility screening while discussing risk issues and risk reduction needs with potential clients. They have great rapport with their target population and use terms and references the clients are sure to understand.*

3) What Recruitment Strategy Works Best?

Use multiple approaches for recruitment & engagement.

LESSONS FROM THE FIELD

A program example –

- *A program located in the northeast collaborates internally with its agency's short-term transitional housing program for HIV-positive persons to provide CRCS to those clients who are about to lose their housing due to substance abuse and other issues. CRCS helps the client identify underlying issues that may be contributing to substance use or non-adherence and helps them gain skills to live independently.*
- *In addition, the program works externally with the Department of Corrections in order to provide CRCS to inmates with a history of high-risk behaviors who will be released within the next two to six months.*
- *Finally, the program also has a CRCS counselor who sees clients in a local drug treatment facility, and this relationship continues once the person leaves treatment.*

**LESSONS
FROM THE
FIELD
(CONT.)**

- *Develop your recruitment plan with staff who are familiar with the client base and with the risks that clients face.*
- *You might also check with potential clients about the best ways to recruit.*
- *Be careful to document your recruitment successes and failures in order to systematically learn from them and share them with other providers.*

PEMS NOTE: To keep track of how long you work with clients in outreach, recruitment, or engagement before you enroll clients in CRCS and to get credit for this activity in PEMS:

Select 'CRCS' as your **Program Model** in Table E. Then in Table F, select 'CRCS' and 'Outreach' as the interventions that are a part of the CRCS program model.

B. Engagement

Engagement is an on-going process of working with clients and the community. Engagement is how we encourage people to be interested in CRCS, since they will not, in all likelihood, be walking into our offices looking for it. Engagement takes time, energy, and commitment. To make sure that the time spent on engaging potential clients is counted, some agencies define this time as another intervention within CRCS, such as ‘outreach’.

During recruitment, engagement involves helping clients to understand the value that CRCS may hold for them. The initial engagement process may be lengthy, sometimes taking weeks or months, so patience is necessary.

Potential clients may have many reasons for not wanting to participate in CRCS. To help engage clients, you or the outreach worker must be able to link things that clients value in their lives with the notion of risk-reduction, for example –

- Physical and emotional well-being
- Stronger, more honest and satisfying relationships
- Obtaining substance use treatment in order to regain health, employment, and relationships
- Developing healthy personal relationships versus high risk activities
- Disclosure about issues such as HIV status, sexual orientation, or drug use to partner/friends/family
- Dealing with stigma
- Protecting oneself and one’s partner from harm

As a CRCS counselor, you have an important task of nurturing the relationship between yourself and your clients.

- First, you want to help the client feel comfortable during their first encounter with you – it will help them want to return for another. You never get a second chance to make a first impression – if it is uncomfortable for the client, he or she will probably not return for additional sessions no matter what you are offering.
- Part of your initial encounter may involve providing referrals to other needed services, so be prepared to do so.
- For some clients, disclosing risk is difficult. It will probably take some time for their trust in you, the CRCS counselor, to build.

**LESSONS
FROM THE
FIELD**

- *It may help generate interest in CRCS to refer a potential client to other prevention-related activities until they are ready for CRCS. For example, a CRCS agency often refers clients to one of the agency's support groups when they are initially reluctant to discuss risk behavior. Support groups or other more structured group intervention activity may enable potential CRCS clients to open up about risk and therefore become eligible for CRCS.*
- *This strategy is particularly helpful in some cultural groups within which it is difficult to discuss sensitive topics of a personal nature with a stranger.*

Part 2: Screening, Enrolling, and Assessing Clients

Potential CRCS clients should be screened to determine their eligibility. If they are eligible and want to participate in CRCS, clients are then enrolled. As soon as possible after a client enrolls, your agency should conduct a more thorough assessment of psychosocial needs and risk behaviors. Your agency may have different personnel (for example, outreach workers) to conduct screenings, though this is not a CRCS requirement. Some agencies have found it useful to have CRCS prevention counselors also involved in client screening, enrollment, and assessment.

We recommend that you conduct screenings and assessments in a conversational manner, rather than in a survey-type manner. Many potential CRCS clients are put off by long questionnaires, or they quickly get tired of them, and you may not see them again.

A. Prescreening

Some programs also find a prescreener is useful for helping to determine which programs in their agencies would be most useful for clients. ***Case managers, health care providers, and outreach workers*** as well as CRCS prevention counselors can prescreen potential clients and refer eligible clients to CRCS services. Prescreening is a type of triage, meaning you talk with potential clients enough to get a good idea of the kinds of services they might need. If you think a client might need an intensive HIV prevention intervention, then refer that client for a full CRCS screening.

Not all clients should be in CRCS, so prescreening can provide a first general assessment of a client's eligibility rather than having all potential clients go through a more extensive screening.

LESSONS FROM THE FIELD

Caution -

- *Individuals who are doing the prescreening can sometimes “drift” in their understanding of screening requirements.*
- *This is a point at which eligible clients could be lost.*
- *To avoid this, your agency should communicate regularly with its prescreeners about CRCS eligibility criteria and prescreening requirements.*

Also -

- *Persons who have just received a positive HIV diagnosis often reduce their transmission risk, at least for a time.*
- *And it may take time for some newly-diagnosed individuals to be ready to be involved in any prevention intervention, especially one involving the level of commitment that CRCS requires.*
- *Many individuals at high risk of HIV infection or transmission will be reluctant to disclose risk at first for many different reasons.*
- *Therefore, prescreening – like much of the work in CRCS – is best done by individuals who know the population or client base, who are often from the same community and speak the same languages, and who are familiar with HIV-related risk issues in their community.*

CRCS prescreening can be included as part of your agency's standard client intake procedures.

A sample prescreener template is included in Appendix A.

B) Screening

Your agency will screen potential clients for eligibility for CRCS.

In general, eligibility criteria should be based on an informed understanding of the epidemic in your area and the resources available to your agency.

If high risk behaviors are very common in the community your agency serves, but you only have one CRCS counselor on staff, you might want to require that clients have several risk factors in order to be eligible for CRCS.

- How many clients can you take on, given the number and skill sets of CRCS counselors?
- What are the primary routes of HIV transmission within the high risk population with whom you'll be working?
- What are the psychosocial issues that contribute to risk in this population?
- How much risk is high risk within that group?

Agencies differ in their eligibility requirements and use a specific number of risks or combination of risk behaviors as criteria. The number of risk issues that a client reports for eligibility for CRCS may also depend on your agency's capacity to recruit and retain high-risk clients.

Keep in mind that you will want to know enough information about a **prospective** client to be able to answer program evaluation questions such as --

- Are we reaching and enrolling high risk persons?
- Are we reaching and enrolling our target population?
- Who on our staff is good at reaching and enrolling these persons?

A sample screening tool template is included in Appendix B. You may revise this tool to suit your agency's information needs and the risk characteristics of your potential clients.

The eligibility criteria should be distributed to anyone who may help with recruiting or pre-screening potential clients; for example, Ryan White case managers, medical or mental health staff, substance abuse counselors, intake staff, or outreach workers.

It is also a good idea for CRCS counselors themselves to help with screening – the screening process can be seen as the beginning of CRCS risk counseling.

**LESSONS
FROM
THE
FIELD**

- *In some cases, agencies recruit from programs in which clients have not recently had the opportunity for high-risk behavior, such as drug treatment programs.*
- *The agency will determine eligibility based on their familiarity with the client base and a determination that these clients need CRCS-type support in order to avoid high risk in the future.*
- *For example, an agency may hold office hours at the facility where clients are about to be released and have not engaged in any drug or sexual activities either inside or outside of the facility.*

Finally, prospective clients, even though they are ‘high risk’, should be open to the idea of changing some of their risk behaviors. Experience has shown that clients who perform best in CRCS are those who either have a desire to change, have already begun to make positive changes in their lives and just need intensive counseling to hasten the process, or have at least indicated that they are willing to discuss risk reduction.

Although the highest risk persons may not currently be ready for CRCS, you should keep open the lines of communication, so that when ready, they can be enrolled in CRCS.

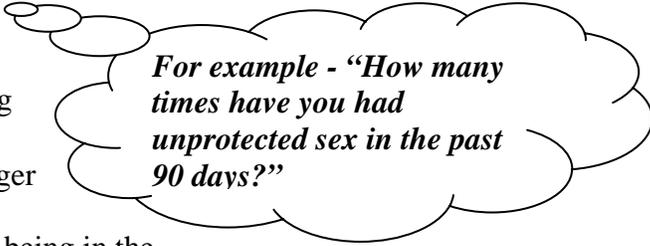
**LESSONS
FROM THE
FIELD**

- *Some prospective clients may need referral to mental health or substance use treatment or other appropriate referral prior to enrolling in CRCS, in order to really benefit from CRCS risk prevention services.*

Remember to ask about a time frame when trying to establish the risk level of a given behavior. Someone may indicate they have had several sex partners, but this may not indicate high risk if the time frame covers many years. In other words, the risk may have occurred in the distant past and may not indicate current levels of risk.

We generally recommend asking about a time period of 3 months or 90 days.

That is, since risk is episodic, asking about a short time period (such as 1 month) may not capture the high-risk behavior, but asking about a longer time period (more than 3 months) may not provide an accurate picture of risk due to poor recall and the risk being in the distant past.



For example - “How many times have you had unprotected sex in the past 90 days?”

PEMS NOTE: To report risk assessment data in PEMS, you need to specify the recall period as 15 or 30 days and 90 days in the initial assessment.

C) Enrollment

Once you determine a client's eligibility for the program, you should once again make sure the client understands what the CRCS counselor will expect of them, as well as what they can expect from the counselor and the program.

Enrollment is

- Agreement to work together to make healthy choices and improve well-being
- Formal client consent

A consent form is a written document that describes the services provided by the agency and the rights and responsibilities of both the client and the agency. A consent form also usually addresses confidentiality and the limits of confidentiality (e.g., in most states, if a client reports child abuse, this must be reported to appropriate child protective services agency). Each agency should develop its own consent form that meets the requirements of state laws, as well as agency policies and procedures. If your agency does not have a form, asking another agency in your state that provides similar services may be a good place to start.

The consent process for CRCS typically includes your clients understanding and signing consent form(s). Although many interventions do not require formal consent from clients, the nature of CRCS – involving collaboration across services in support of clients – requires that clients understand and agree to this type of service.

Your agency should ensure that your consent forms and other forms required by your agency or local or state government are in full compliance with local, state, and federal confidentiality and consent guidelines, including Health Insurance Portability and Accountability Act (HIPAA) standards.

Make sure you have your clients' contact information in their files. Contact information will allow CRCS counselors or outreach workers to follow up with a potential client. Remember to ask if it is okay to leave the name of the agency when leaving a message.

D) Assessment

In order to help the client reduce risk behaviors, you will need to assess your clients' knowledge, attitudes, and beliefs about HIV and STD transmission. You will also need to determine which behaviors put your client at risk of acquiring or transmitting HIV and other STDs. In addition, it's important to gather information about psychosocial factors that may affect risk. ***This assessment should take place as early as possible in the CRCS process and may take more than one CRCS session.***

LESSONS FROM THE FIELD

- *The assessment should **not** be a structured set of questions; rather, it should be a conversation that reduces anxiety and motivates confidence and disclosure, especially in the initial stages of the assessment.*
- *You might think of the assessment as a two-stage process:*
 - *Stage 1 – In the context of your getting to know your client, you will begin to develop a good picture of their risk issues. This will occur during your first session with the client, and may extend beyond the first session to other sessions.*
 - *Stage 2 – This is the point at which you need to obtain more specific information about risk or ask about topics that may not have been addressed. At this point, you may need to refer to a set of questions, explaining to the client the importance of your understanding the nature of the issues they face in order to better help them address those issues.*

LESSONS FROM THE FIELD (CONT.)

The recruitment phase and engagement process prior to enrolling clients will contribute to developing your relationships with your clients

- *While the initial assessment provides a baseline for client monitoring and program evaluation, keep in mind that some clients tend to disclose more risk after having participated in CRCS for some time.*
- *That is, as clients become more comfortable with their CRCS counselors, they open up more about sensitive issues. Although it may appear that participation in the program increases risk, it is actually disclosure of risk that increases during a successful client-counselor relationship.*
- *Some agencies have clients write a short paragraph about what they want out of CRCS, or fill out a brief survey about their risk behavior, to jump-start the initial assessment.*
- *A stronger relationship between CRCS staff and client makes the assessment easier and more accurate.*

Assessment topics

The following topic areas can be discussed during assessment.

You may want to discuss some of these issues with your clients, even though you may not provide referral services related to these issues, because they pose barriers to risk reduction or increase risk behavior.

For clients who are either HIV-negative or HIV-positive -

- Demographic information
- Health status
- Personal relationships
- Alcohol and substance use
- STD history
- Mental health
- Sexual history
- Social and environmental support
- Skills and confidence to reduce HIV risk
- Intentions and motivation for behavior change
- Barriers to safer behavior

- Protective factors, for example, culturally defined values and behaviors that reduce risk
- A list of services in which the client is currently enrolled
- A list of services for which the client may be eligible but not currently enrolled

For clients who are HIV-positive, you may also add –

- Access to medical care and HIV treatment
- Adherence to HIV treatment, if applicable
- HIV status and personal relationships; partner notification
- Other health-related issues

Many potential CRCS clients will have mental health, substance use, and other psychosocial needs. There are a number of tools you may choose from to aid in screening for one or more of these circumstances. We have included the CAGE questionnaire in Appendix O, the SAMISS screener in Appendix P, and the Client Diagnostic Questionnaire in Appendix Q as examples of good screening tools.

You may not cover all of these assessment topics with each client, nor will you discuss all relevant items at one session. Some of these topics may come up later as your clients become more comfortable with you as their CRCS counselor. At a minimum, however, the counselor should at least touch on each topic to ascertain whether it is relevant for the client.

You should try to address the topics listed above during the initial assessment, however you should obtain this information in an informal, conversational manner. You might consider beginning your assessment session with the following types of questions.

“You have heard about CRCS from our outreach counselor. How do you think CRCS can help you?”

Then discuss the risk and other issues that your client raises. Information from the assessment should be recorded on the initial assessment form that your agency is using, either unobtrusively during the session or after the session. Later in the session, or during a later session, you can ‘fill in the blanks’ of the assessment form by asking questions in a more structured way. For example –

“You’ve told me a lot about the needs that you have and how CRCS can help you. Now I have more questions that I need to ask you to make sure that we’ll be helping you as much as we can.”

Thus, the point of the initial assessment is to get to

- 1) Know the client
- 2) Identify the most pressing risk-related issues
- 3) Understand some of the details surrounding these issues

With these goals, you should have a conversation with your client during which you raise the assessment issues in a natural way. This is a skill that may take some practice, and counselors should be trained and practice initial assessment before they see clients. Getting to know a client well enough to gain their trust and complete the initial assessment may take more than one session.

In sum, the initial assessment is so important in CRCS because it allows the counselor to identify the most pressing risk reduction issues and psychosocial issues affecting risk reduction. It also helps to begin deepening the relationship with your client.

Remember to prioritize risk reduction needs with your client – typically there are only one or two primary needs that should be dealt with at a time. Dealing with those successfully will pave the way for helping your client to address other issues. With this information, you can begin working on the prevention plan with the client.

We have included sample initial assessment templates in Appendix D useful for different recall periods. Appendix N contains examples of conversational-style interviewing, which are useful to obtain information the assessment items listed in Appendix D. We have included conversational-style questions for only some of those assessment items.

E. FAQs on screening, enrolling, and assessing clients

Q: Can I make referrals, even if the individual is not eligible or ready for CRCS?

A: Yes, you are encouraged to make referrals for all clients, regardless of whether or not they are eligible or enroll in CRCS.

Q: If the person doesn't know their HIV status, are they eligible?

A: If the person meets your agency's eligibility criteria, they are eligible to enroll in CRCS. However, you should also encourage clients to be tested and discuss with them the importance of knowing their status. In some agencies, knowledge and evidence of serostatus is a prerequisite for enrolling in CRCS. You should help a client locate an appropriate HIV counseling and testing site if they want to be tested.

Q: The person is in crisis – they have severe mental health or drug treatment needs – should I enroll them?

A: Probably not at this time. You should definitely refer them for appropriate treatment and follow up to see how the treatment is going. When this is the case, build the relationships so that these clients *can* begin to work on risk-reduction after they have taken care of their more immediate or pressing needs.

Q: Do I need to collect demographic information (or any information) on those people who are not eligible for the program but do not enroll?

A: Yes! There are several ways this information can be used in program evaluation.

- Compare eligible to non-eligible people to see if you can more efficiently target your outreach or screening efforts.
- Among the eligible people, compare those who enroll in CRCS with those who do not. Using this information can help you describe the people who are not enrolling in CRCS and adapt your recruitment or other service delivery techniques for them.
- Follow-up with those screened if they do not enroll in the program. During the follow-up, you can determine why they did not enroll (if eligible) and use this information to improve your program.
- Finally, some of this information will be required by PEMS, and we have indicated PEMS-related information or data points on the sample data collection formats included in this manual.

Q: What date do we enter for initial assessment data that has taken more than one session with the client to obtain?

A: Your agency should determine its policy for this, based on how the information will be most useful to you. But in any case, the policy should be consistently applied in order to be able to evaluate progress that your clients make.

Q: Are newly diagnosed persons eligible for CRCS?

A: Depending on your agency's policy, CRCS may not be the best intervention for some newly diagnosed individuals. We know that many individuals reduce their risk after a positive diagnosis, at least for some period of time. Also, newly diagnosed individuals may not be ready for intensive intervention activities. However, for those newly diagnosed individuals who do not have access to case management services, CRCS may be an important resource for them, as well as a tool for them to deal with risk issues when they are prepared to do so.

Q: How can we get the assessment done early if the client is reluctant to discuss their risk right away? We're worried that we'll lose clients if we press them about risk early in their relationship with us.

A: It's true that counselors have to be good at balancing building a trusting relationship with clients while assessing the factors that make them at risk for HIV/STD transmission or acquisition. CRCS counselors are assessing clients from the minute they start talking with them. If the assessment is seen as naturally flowing out of the counselor's concern for the client, the client will be more open to discussing the assessment topics. Again, this is a skill that takes some training and practice.

Part 3: Developing a Prevention Plan

Based on the information gathered during the assessment, CRCS counselors should work with clients to develop a written prevention plan. This plan will define HIV risk-reduction priorities, strategies, and concrete steps for making behavioral changes. The plan may also track psychosocial and medical services needed. That is, the plan should keep track of, but is not necessarily responsible for, the psychosocial issues that affect risk. Otherwise, if the prevention counselor is also the case manager, the written prevention plan may include helping clients to access needed services.

The clients' active contribution and commitment to the plan are essential for their continued participation.

LESSONS FROM THE FIELD

- *Make sure clients are committed at some level to discussing risk and the potential for behavior change.*
- *Start small – that is, don't try to cover everything at once. **You will discourage clients if they see you wanting them to do it all right away.***
- *The clients most easily discouraged by big challenges are those who are most challenged in their lives by issues such as homelessness, substance use, or mental health problems.*
- *Prevention planning with CRCS clients is on-going and usually frequently revised.*
- *For example, you may want to base your **initial** prevention plan on small steps toward accomplishing the first goal – usually the goal most important to your client.*
- *For some clients, getting to the next CRCS session may be an appropriate first step or objective.*

LESSONS FROM THE FIELD (CONT.)

- *Prevention plans should be based on a combination of clients' risk reduction needs, priorities among those needs, and clients' readiness to address them.*

See sample prevention plan worksheet template and instructions for prevention plan worksheet in Appendix E.

Prevention plans include --

- ***Setting goals*** – Goals are risk reduction targets on the road to risk elimination and are usually longer term; for example, *I want to reduce my sexual exposure to HIV*. A client should work on only one or two goals at a time, and the goals should focus on behaviors that the client is motivated to change or address. ***Goals should be set by your client with your help and support – they are your client's goals, not yours.***
- ***Setting objectives*** – These are tangible achievements that the client strives to accomplish on the way to meeting longer term goals; for example (using an objective that might be related to the sample goal, above), *I will not use party drugs next Friday night, or I will cut my use of party drugs by 50% in the next two weeks*. ***Objectives are more short term than goals and are increments on the way to achieving goals.***

Objectives allow clients to obtain their goals over time, incrementally, and in realistic steps.



SMART Objectives -

Specific – Precisely what client wants to achieve

Measurable – Quantify so that you and your client can measure improvement

Appropriate – Objective is related to the goal and to the client's skills and motivations

Realistic – Can conceivably be accomplished given the skills and the time frame that your client has

Time-phased – The amount of time to achieve the objective or the specific target date

LESSONS FROM THE FIELD

- *Setting concrete objectives can also help you and your client determine what kinds of skills your client needs to accomplish the objectives.*
- *As the client becomes more confident, the **prevention plans change** -- objectives should become more challenging and new goals, objectives, and strategies for risk reduction may be included.*
- *One person's objective may be another person's action step, depending on where the person is in the risk-reduction process and other issues they have to tackle.*

See Appendix V for a sample worksheet on developing SMART objectives.

- **Assessing barriers and other influencing factors** – You will want to help your clients recognize and talk about the primary barriers that might be in their way; for example, being intoxicated or high on drugs during sex; not having access to condoms; having a circle of friends who engage in risk behavior. Psychosocial factors such as unemployment, unstable housing, etc. should also be considered. Assessing barriers can also lead to determining the skills or information a client may need to overcome risk-reduction barriers.

Sometimes you and your client may not realize that a barrier is present until the client faces it in an attempt to reduce risk.

- You should also pay attention to other factors** that may have an influence on risk behavior or risk reduction, such as perceptions of risk, peer or group pressures, and attitudes and misconceptions regarding HIV/STD acquisition or transmission, to mention just a few of the possibilities.
- **Determining appropriate action steps** – This is how your client will know what to do and when. For example, a simple action step for a client would be putting a condom in her purse during your session, or buying condoms this week. Another type of action step would be enrolling in a

substance use treatment program or identifying and frequenting a needle exchange location.

But don't lecture!

LESSONS FROM THE FIELD

You can receive additional information about risk reduction readiness and other related topics at CRCS trainings.

- *If your clients don't want to give up risk behavior, you may be able to help them by talking about their priorities and perceptions of risk and the benefits of living healthier.*
- *If clients find risk-reduction important but are not confident in their ability to make changes, you can work with them on appropriate support services, skills, and behaviors needed for behavior change. For example, if a client would like to increase condom use within a relationship in which they feel unsure about raising the topic, you might role play the negotiation process in order to help increase confidence.*
- *Keep in mind that you can refer clients to other prevention activities, such as Healthy Relationships or Voices/Voces, if you think they might benefit from these activities – but you should then work with your client to build on the effectiveness of these interventions.*

- ***Follow-up*** – Each session with your clients should provide some opportunity for you jointly to review progress and barriers in your clients' implementation of their prevention plans. It's important to empathize with clients who are having difficulty changing behaviors – don't come across as being judgmental or admonish clients for failing. Always praise success.

When new risk factors or barriers are identified, you and the client should agree on the appropriate revisions to the plan in

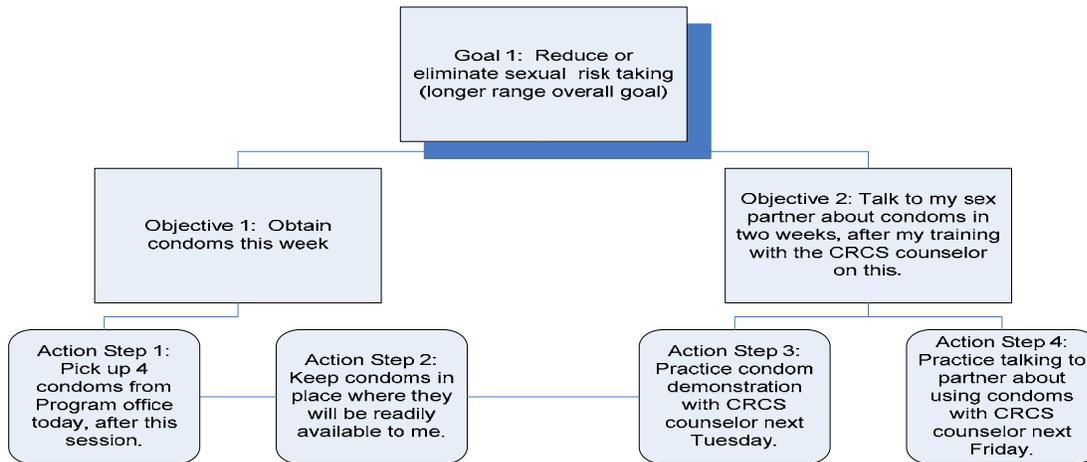
goals, objectives, or action steps. You should celebrate accomplishments such as meeting goals and objectives with a sense of pride and empowerment.

- **Agreement** – Having your client sign and date the prevention plan and its revisions is a signal to both of you that your client agrees that the plan is reasonable and otherwise acceptable. It is a sign of commitment.

LESSONS FROM THE FIELD

- *The importance of the client-centered approach cannot be stressed enough! There are no cookie cutter prevention plans for risk-reduction – meet your clients ‘where they are at’, find out what their needs and priorities are, what motivates them, and what stands in the way of risk reduction.*
- *Then you can together be creative and design a prevention plan in a way that your client will stay engaged and ultimately succeed.*
- *Make sure your clients have the most up-to-date copy of their prevention plans. It will help them keep up with their commitments.*

Example of Goal-Oriented Prevention Planning



In this example, the CRCS client and her counselor determined that her primary and overall goal should be eliminating sexual risk taking, although she was not sure she would be able to do so completely. This type of goal is longer range in time, because it takes several steps to get to that point.

The objectives are shorter range aims to be accomplished on the way to meeting the longer range goals. In this example, the client needs very small steps at first (e.g., ‘Pick up 4 condoms from program office today, after this session’). The objectives must be realistic for the client, and action steps should be those that the client is likely to accomplish early on in their CRCS experience.

Please note that this is only an example. CRCS counselors should work with their clients to create client-driven prevention goals, objectives, and action steps.

We have included examples of case scenarios in Appendices T and U.

Part 4: HIV Risk Reduction Counseling

Individual HIV risk reduction counseling is the most important service provided by CRCS – it is the heart of CRCS and is based on development and ongoing revision of the prevention plan. CRCS risk reduction counseling is interactive and client-centered, using education, skills-building, role plays, support, crisis management, and other strategies to help clients to reduce and eliminate risk behaviors and then maintain these changes over the long-term.

CRCS risk counseling centers around the prevention plan discussed in Part 3. As early as possible, the prevention counselor should discuss goals and objectives to reduce and eliminate risk. This goal setting process is a dynamic process moved along with ongoing input and feedback from both the client and the counselor. Initially, the prevention counselor helps the client to focus on a limited number of reasonable and achievable objectives, and as these are accomplished, helps to choose new ones.

There are often questions about the meaning of ‘client-centered.’ For CRCS, ‘client-centered’ means tailoring the intervention to focus on the individual client’s HIV prevention needs, but it does not mean that the client gets to do whatever they want. The CRCS counselor will guide the sessions so that risk reduction is the primary focus, keeping the client’s particular challenges and needs in mind.

A. Risk counseling sessions

The basic model for risk counseling sessions should be client centered prevention counseling, which was found to be effective in reducing HIV/STD-related risk behaviors in Project RESPECT⁶. At a minimum, prevention counselors should be trained in basic client centered pre- and post- test prevention counseling before conducting CRCS.

Additionally, the overall model for risk counseling may be described as client centered. That is, within the component ‘risk counseling’ in CRCS, a menu of options exist, the basic one being client-centered prevention counseling described above. However, at all times, you will be choosing the kinds of counseling approaches and scenarios that best fit the needs of each client, and at times you may include other intervention approaches to address particular needs.

Some components of risk counseling in CRCS may be structured, unstructured, or a combination of the two.

⁶ <http://www.cdc.gov/hiv/projects/respect> and Rotheram-Borus MJ, et al. (2004). Prevention for substance - using HIV-positive young people: telephone and in-person delivery *JAIDS* 37(suppl 2):S68-S77.

- Structured sessions follow previously developed, standard protocols for each client. For example, prevention counselors may use structured sessions from interventions such as CLEAR⁷ or some of the other individual-level DEBI interventions⁸.
- Unstructured sessions are more flexible, allowing you to address the specific risk issues raised by your clients in a manner that seems most appropriate. For example, you can arrange sessions to help clients build skills or learn prevention strategies when those needs become apparent in the course of your counseling relationship.
- In unstructured sessions, risk reduction counseling should be theory-based and tailored to the clients' circumstances. The Prevention Training Centers (PTCs) provide theory-based intervention trainings⁹.
- CRCS is an individual level intervention, but a client may bring in a partner for risk counseling where appropriate. You should offer or refer all clients to Partner Counseling and Referral Services (PCRS), which is usually provided through local health departments.
- While individual sessions are the essence of CRCS, group sessions or group-level interventions can be used as an additional resource, not only for recruiting to CRCS, but also to support behavior change.

For example, you may think that it would be helpful for a client to participate in a group or individual level intervention that directly addresses a particular risk issue (for example, couples counseling on disclosure issues). In this case, you would be 'monitoring' your client's participation to make sure that you can help him or her to benefit from the experience.

Overall approach: Client centered risk reduction counseling

Client needs	Menu or toolbox of risk reduction interventions
determine selection of approaches or combination of interventions	<ul style="list-style-type: none"> ➤ HIV client centered prevention counseling (standard CTR) ➤ Other, less structured sessions that rely primarily on assessment of client prevention needs to drive content of session ➤ More structured sessions or interventions that address specific risk reduction needs and that are standardized (for all clients), such as some of the DEBIs ➤ Combination of structured and unstructured interventions, such as CLEAR

⁷ <http://chipts.ucla.edu/interventions/manuals/intervclear.html>

⁸ <http://www.effectiveinterventions.org>

⁹ <http://depts.washington.edu/nnptc>

LESSONS FROM THE FIELD

- A PCM demonstration project for HIV-positive persons found that the following topics were the focus of prevention counseling for more than 50% of the participants:
 - Relationship building
 - Coping with being HIV-positive
 - Psychosocial issues and risk
 - Condom use
 - Medical care and adherence
 - Substance use and sexual behavior

When your client first enters CRCS, you should try to hold weekly risk reduction counseling sessions with the client – more or less often, as appropriate. As the client makes progress, you can have sessions less frequently.

Getting CRCS clients to return to risk reduction sessions may be difficult at first. There are a number of strategies you can use to help with this. Agencies in previous PCM programs have found that early engagement of clients in risk reduction discussions, from the clients’ perspectives and in terms of the clients’ own interests, may encourage clients to return.

While weekly sessions are recommended, this is not a requirement – you should try to match frequency of sessions to the seriousness and immediacy of your clients’ needs.

LESSONS FROM THE FIELD

➤ *“In our program, risk reduction actually begins the very moment clients enroll, and each contact with the client is used as an opportunity to provide risk reduction counseling. Clients right away write something up about what they want out of the program, and this is used to construct the first risk-reduction plan. Mobile advocates – who provide the first contact with the program – also know the community well enough that they can introduce the topic of risk reduction, in their own terms, during their first contact with the potential client.”*

You can help clients write if they have trouble with this, or they can do it at home.

**LESSONS
FROM THE
FIELD
(CONT.)**

- *Our approach to risk reduction is that it begins right away and gradually uncovers clients' risk issues and provides opportunity for small steps and successes. This helps build the clients' confidence in their ability to make the changes they want to make to live healthier."*
- *Your first session may be as much about relationship-building as anything else, but you should always be prepared to follow-up your clients' comments and questions with your queries that will help you get to your clients' risk reduction needs quickly.*

B. When clients raise issues that may not be related to risk –

Sometimes clients want to talk about issues in their lives that are not directly relevant to risk reduction. At this point, you should consider whether you'll need to work with other case managers to help the client or make referrals to needed services that would support your risk reduction counseling.

Discussions about issues that are not risk issues but related to risk in some way will help you understand more about your clients, their priority concerns, and the factors that influence risk behavior. These discussions, and your work with case managers or making referrals to support the client, will also help build your relationship with your clients.

**LESSONS
FROM
THE
FIELD**

- *There is often a fine line between issues that are not related to risk on the surface but in fact contribute to risk in some way, and issues that are of concern to your client but do not contribute to risk.*
- *It's the CRCS prevention counselor's job to help clients understand which issues are related to risk and which are not.*
- *If discussion about apparently non-risk related issues tends to dominate a session with your client, it's important to figure out, with your client, how these issues are related to risk. Non-risk related topics can also be explored if referrals may be needed.*

Additionally, as your relationships with your clients grow, they often disclose risk behaviors that weren't initially acknowledged or that have been recently added to their lives.

C. Engagement should be an on-going process

Remember 'engagement'! It is through continuing to engage clients that they will continue to attend sessions and work on difficult issues. If you are non-judgmental, your clients will grow to trust the CRCS intervention because of their own skills development and empowerment.

Remember to acknowledge and reward small accomplishments

To retain CRCS clients, who face numerous challenges to overcoming risk for HIV infection or transmission, you will need to help them develop strategies to manage their complex lives. For example, for HIV-positive clients who are not sure how to go about managing their relationships with HIV-negative partners, you might consider including partners in counseling sessions.

In addition to working with other service providers to support clients and keep them engaged, you may need to be creative in your attempt to help

clients achieve risk reduction and related objectives. The following *Lessons from the Field* insert is a good case example of this kind of creativity.

**LESSONS
FROM
THE
FIELD**

- *A CRCS counselor indicates that a client has kept many of his CRCS appointments, in part due to the assistance she is providing the client to get a job. The counselor has helped the client develop his resume and, working through another agency, directed the client to employment placement programs in the city. She allows a little time during CRCS sessions for the client to talk about his experiences finding work, because not having work is related to the client's risk for HIV transmission. The client is getting discouraged continually being rejected by potential employers, and this tends to increase his use of alcohol, sometimes drugs, and these are associated with his risky sexual behavior. For this client, sex and self-esteem are closely related.*
- *The counselor has begun to provide feedback to the client on how to better prepare for job interviews, encouraging him not to give up. During these discussions, the client and counselor also talk about the specific risk issues the client is facing, and safer ways to deal with increasing his self-esteem.*

D. Documenting client sessions

Documenting your sessions as soon as possible after the session is over is extremely important –

- Keeps track of the content of your sessions, including new info and outcomes
- Helps you and your clients identify successes and barriers

- Tracks the development of and changes in your clients' prevention planning
- Tracks the referrals you make for your clients and the outcomes of those referrals

There are several uses for the data you collect in documenting your sessions. Most of the data you collect should be for managing the work with your clients. Some of these data will also be used for reporting; at least, there should be some overlap with these two types of data uses. Much of the data you collect will be useful for monitoring your program as well as your clients' progress and for program evaluation.

You should document –

- Reduction or elimination of your clients' risk behaviors
- Your clients' utilization of referrals
- Disclosure of risk behaviors over time
- Revisions to the prevention plan as new information is gathered and new priorities are set
- New goals or objectives toward risk reduction
- Small action steps to reach objectives
- Problems encountered as prevention plan unfolds; that is, progress and successes with goals, objectives, or action steps and barriers to risk reduction faced by your clients

A sample case notes template is in Appendix F1, and instructions for the case notes template is in Appendix F2. A sample session activities and content template is in Appendix G.

Part 5: Referrals and Active Coordination of Services with Follow-Up

CRCS clients have multiple, complex issues and are likely to need referrals to a number of services, such as mental health, substance use treatment, or housing, to name a few. If your clients are already enrolled in case management services, or if you can refer them to case management services, then you, as the CRCS counselor, will typically not serve as your clients' case manager. You will be able to concentrate on risk reduction. You may refer clients to services that they need that aren't covered by existing case management services.

Remember that substance use and mental health services are the most frequent challenges to risk reduction faced by CRCS clients. Your clients may need to access these highly specialized services before CRCS can be an effective risk reduction program for them.

The SAMISS Screener in Appendix P is a good first-line screening tool for substance use and mental health needs screening. It misses few cases and is easily incorporated into a busy setting. Keep in mind that persons screening positive require a more rigorous confirmatory mental health evaluation. Also, see Pence et al. (2005). Validation of a brief screening instrument for substance abuse and mental illness in HIV-positive patients. *JAIDS* 40(4):434-444.

A. Coordination of services

Because many of the issues for which clients need referrals actually influence risk behavior, you should

- Work with your clients' other service providers to address needs – especially those that influence risk – and assure services are being provided
- Discuss with your client the ways in which need for services and service provision (e.g., housing or substance use treatment) influences their risk behavior; for example, substance use can interfere with the ability to use protective measures such as condoms.

Coordination of services is important in order to provide the most effective and comprehensive support to your clients. It also helps prevent service duplication. It's a good idea to have service providers – including the CRCS counselor and others such as Ryan White case managers (for HIV-positive clients), substance abuse and mental health counselors, and medical providers – meet regularly to discuss your clients' progress and share information regarding services and referrals.

Remember that different service coordination activities may require different levels of confidentiality assurance; for example, case conferencing with medical service providers in another agency requires two-way release of information. The agencies would establish procedures for this in Memoranda of Agreement/ Understanding (MOA/MOU) between agencies.

When you work closely with your clients' case managers and other service providers, you may find that you can pitch in where needed and make referrals, but you should keep your clients' case managers in the loop.

You should have access to up-to-date lists of service providers, whether they are internal or external to your agency, for referrals. You also need to be familiar with the types of services provided, eligibility criteria (if any), location, public transportation options, cost of services (if any), and insurance coverage.

**LESSONS
FROM THE
FIELD**

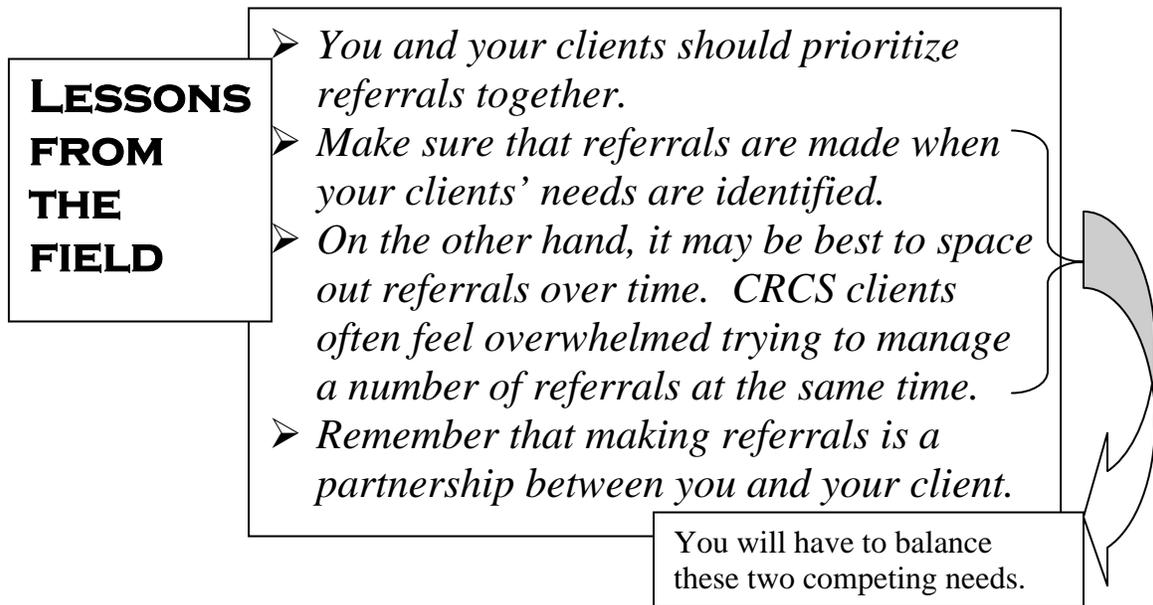
- *In a recent PCM demonstration project, a multidisciplinary team approach proved to be very effective for providing a full range of services that are mutually supportive for each client.*
- *This particular multidisciplinary team consisted of the CRCS prevention counselor, the case manager, a substance use counselor, a physician, a nurse practitioner, and a client advocate.*
- *The team approach is a model that requires a lot of managerial and supervisory support and time and energy to put together and operate, but agencies that use this model are sold on its usefulness in supporting their clients.*

B. Follow-up on referrals

Always follow-up on a referral you've made for a client. If the referral is unsuccessful in some way, find out why. In some cases, clients need help, for example, obtaining childcare, translation services, transportation to the service provider, or someone to accompany them to the referral. *Throughout this process, the CRCS counselor can help clients build skills needed to advocate for themselves with other providers.*

Typical referrals made for CRCS clients

- Partner Counseling and Referral Services (PCRS)
- Mental health counseling
- STD testing and treatment
- Hepatitis testing
- HIV testing
- Housing, other social services
- Substance use treatment
- Domestic violence support
- Childcare agencies



C. Documenting referrals

Referrals and their outcomes should be documented. One model is the use of a referral form that can be duplicated – one for your client, one for your client's file in the agency. You can fax this to a service provider to sign and send back to the CRCS counselor.

Memoranda of Agreement/Understanding (MOA/MOU) facilitate the referral and referral documentation process

Some agencies use computerized systems for entering and following-up with referrals, but you can also do it the old-fashioned way. In many cases, for referrals to generate useful information that you can keep track of for your client, the client will need to have signed a release of information form.

Although referral documentation is complicated, it is particularly useful for helping you to keep track of how your client may be doing with regard to some of the day-to-day challenges in life, which influence being able to meet CRCS client goals. Documenting referrals is also important in reporting to CDC.

A sample referral tracking template is included in Appendix H.

Part 6: Monitoring Clients' Progress and Ongoing Needs

Regular meetings between the CRCS counselor and the client allow for assessing clients' changing needs, monitoring progress on goals and action steps, and revising the prevention plan as needed. In essence, once the initial assessment is completed, every session with your clients includes some monitoring of progress and reassessing of the prevention plan.

A. Ongoing engagement and contact

You should continually encourage your clients' active participation and engagement in CRCS and attempt to address the most pressing risk reduction needs at that time. By addressing these critical risk reduction needs, clients will be more engaged in the process. In addition, retention in CRCS is linked to having a strong connection between client and counselor, so counselors should work on engagement and connection with clients during every session.

In addition to regular sessions with clients, you will want to maintain contact with your clients for various reasons –

- To remind clients of appointments
- To check on why a client missed an appointment
- To let clients know that you want to keep up with what is going in their lives.

B. Documenting contact

Remember to document contact: The date, time, how the contact was made – phone, email, personal visit – and the result or outcomes of the contact. This documentation will demonstrate your efforts to keep in touch with and provide services to your clients.

A sample template for client contact tracking is included in Appendix C.

C. Additional topics to document for monitoring progress -

Remember that you will want to keep active case notes for each client, in which you should record the following types of information.

- Review prevention plan – goals, objectives, and action steps – from previous session. Do the objectives still make sense?
- What did and did not work? And why? For example, if a client’s objective was to have used a condom with their sex partner at least once by February 11, 2006, and they did not, you need to determine why, what were the barriers or problems, and develop strategies to solve the problem or develop objectives that are more realistic.
- Is the client ready to continue with the plan?
- Would it help the client to keep a ‘diary’ of their risk reduction efforts?
- What are the costs and benefits of changing the behavior?
- Do you and your client need to brainstorm some new action steps?
- Are there some areas where skills development would assist your client to accomplish objectives?
- Does your client need referrals to take care of other issues?
- Make the next appointment.
- Document the session!

D. Periodic follow-up assessments of risk behaviors and factors affecting risk

In addition to documenting the content of each session, you and your client will need periodically to take a ‘snapshot’ or review of risk issues and progress in addressing them.

Remember that, for some individuals, some types of risk behavior occur only sporadically, depending on the triggers for their risk and how well the clients can cope with the situations that lead to risk. If you are using a 90-day recall period, it makes sense to do a follow-up assessment every 3 months or so. For PEMS reporting, you are only required to report the results of the final follow-up or one that occurs closest to discharge.

A sample follow-up assessment template is included in Appendix I.

Part 7: Discharge and Maintenance

There are several ways a client can leave a CRCS program.

A. Successful completion or graduation

Once your clients accomplish their goals, you and your clients, in consultation with your supervisor, should decide if the next step is graduation from the program or if some additional CRCS support is needed to maintain safer behaviors.

There is no fixed number of sessions that CRCS clients must attend before graduation, unless your State or local regulations require them to do so. In two PCM demonstration projects, the mean number of risk counseling sessions per client was between four and six sessions, but the range was quite wide. In practical terms, many clients had a few sessions while a small number had a larger number of sessions. Keep in mind that clients' needs and strengths vary, so you should expect a range in the numbers of risk counseling sessions per client.

Maintenance of behavior change should be the focus of a discharge plan. You should determine how confident your client is about behavior change – for the present and over time. Are they shaky and unsure about it? Do they foresee any barriers? What will help them have more self-assurance about their recent successes in behavior change?

One thing to keep in mind about discharge: If your client does not appear to be making progress after several risk reduction counseling sessions, you may want to reevaluate not only the prevention plan but also whether or not CRCS is the right intervention for your client at this time. It could be that some other strategy would be more appropriate, such as substance use or mental health treatment. Keeping to the recommended re-assessment every 90 days, in addition to your daily case notes, should help you keep track of your clients' progress.

Successful completion of CRCS results from accomplishing risk-reduction goals, and this could require any number of sessions. Remember that, early on in CRCS sessions with clients, it's often a good idea to introduce the notion of discharge and why discharge is a goal of the program. At the time of graduation, the CRCS counselor should make sure that clients have access to resources that can help them maintain their risk reduction changes (e.g., support groups; other, less intensive interventions). Some clients may relapse and need to re-enroll in CRCS services.

B. Other types of discharge

Some CRCS clients leave the program without graduating -

- Some clients may be incarcerated or enter drug treatment while enrolled in CRCS. Each agency should have its own policy regarding whether these clients are discharged or placed into inactive status.
- The client may quit the program. Participation in CRCS is strictly voluntary – the client can choose not to participate at any time.
- The client may stop attending sessions without offering an explanation. In this case, the agency should develop policies and procedures regarding the number of attempts made to contact clients who have ‘disappeared’. Contact attempts can include phone calls, home visits, visits to places frequented by your client, and speaking with your client’s other healthcare providers. Typically, after a predetermined number of contact attempts or a predetermined passage of time, your agency will place the client’s file into inactive status. The agency should determine the amount of time a client’s file can be ‘inactive’ before the client is discharged.
- The agency may also choose to discharge a client if the client poses a threat to staff members.
- The CRCS program is unable to help the client who does not want to focus on risk reduction.
- The client may have moved away or be deceased.

Remember to document each contact effort and client response!

**LESSONS
FROM
THE
FIELD**

- *“Our prevention counselors introduce the idea of eventual discharge very early in the process of developing a relationship with the client, to emphasize that prevention counseling is not life-long counseling. Clients are also told that the door is always open to them should they need to return to the program at any time. It is important to note, however, that a client’s particular situation should be taken into consideration before the client is discharged due to lack of contact.”*
- *Sending a letter to the client to tell them that they will soon be discharged from the program has proved to be successful in re-engaging clients who were non-responsive to other modes of communication.*

**LESSONS
FROM THE
FIELD
(CONT.)**

- *When to let clients go – Sometimes clients feel they will need your services forever. But your job is primarily to see that their risk for HIV infection or transmission is reduced, that they have met their risk reduction goals. If clients need you for other services that are not related to risk reduction, and they have met and can sustain their risk reduction goals, you should try to refer them to another program that can deliver the services they need.*
- *CRCS is not intended to be psychotherapy. Clients may need services that will help them deal more effectively with risk, such as mental health or substance use counseling, but which are outside the scope of counseling services provided by CRCS. Clients can be referred to these programs and either remain in or come back to CRCS after receiving other services, depending on the seriousness of their needs.*

A sample discharge template is included in Appendix J.

Section 3: Monitoring and Evaluation

Monitoring your CRCS activities and your clients' challenges and progress will provide the information you need to improve your work against the epidemic. Evaluating your activities against some standard – for example, the goals your agency has for recruitment, the risk characteristics of the population you intend to recruit, you and your clients set for their risk reduction – will help you determine if and where you need to change course in your program.

Often program monitoring is done informally, as you and your supervisors keep up with activities and aspects of your programs that need to be developed or changed in order to meet your clients' needs. But a systematic approach to monitoring will assure that your agency captures important information on a regular basis. For example, you should regularly determine whether measurable objectives are being accomplished, and why or why not. Regular monitoring also assures that the information is accessible to persons who need to see it, whenever they need to do so.

Monitoring your clients' progress systematically will also provide you with the information you need for evaluation. That is, you will be able to see the trends in your clients' progress to determine if your work is succeeding and where you may need to make adjustments.

This manual provides templates (Appendices A-J) that your agency can modify to assist your monitoring and evaluation data collection. Additionally, we have included PEMS-related information on the templates, identified with the symbol [®] for required data or * for optional reporting in PEMS. CDC does not require that you use these templates for CRCS monitoring and evaluation or for reporting to PEMS, although the data on the templates indicated by [®] are required for PEMS reporting.

We have included a CRCS- PEMS crosswalk list in Appendix Y.

Also, case notes – the regularly updated files you keep on your clients – can be an important source of monitoring and evaluation data. Often you will be able to use case notes to add information to data collection forms, such as risk-related information. Ultimately, this information can also be used for PEMS reporting. Also, systematic reviews of case notes can reveal strengths and weaknesses in the CRCS process.

Keep in mind that you need more data to monitor your program and for quality assurance than CDC will require for PEMS reporting. The best way to think about reporting to CDC is that you will likely only report to CDC a subset of the data you collect daily if you have a well-developed monitoring and

evaluation system. You just have to know what data CDC requires – the ® will help you with that question.

Section 4: Quality Assurance

Quality assurance is essential to make certain that CRCS is delivered in a consistent manner and in accordance with established standards – for example, are the core elements present in the CRCS intervention.

Each agency should develop a tailored manual describing their plan for implementation of CRCS. The templates contained in the appendices of this document can aid in this task. Your CRCS program should have written quality assurance protocols that are included in protocol manuals. In addition, your CRCS program should routinely use client feedback as a factor in assessing the quality of CRCS services.

Quality assurance activities or goals should include at least the following:

- a) Compliance with local and state standards for certification of CRCS counselors.
- b) Small client case loads – 12-20 clients per counselor; larger case loads may be appropriate for CRCS counselors who are not providing case management services.
- c) Tailored implementation manual to ensure effective delivery of CRCS services and minimum standards of service delivery. For tailoring, each agency will want to add details regarding their CRCS program to this manual.
- d) Examples of quality assurance mechanisms include the following:
 - i) **Written protocols**
Descriptions of specific prevention counseling-related activities, including client engagement, follow-up, screening, risk-reduction counseling, partner notification, and so forth.
 - ii) **Training**
List of needed trainings for CRCS counselors, supervisors, and managers, along with the particular skills the staff will need to fulfill their job descriptions.
 - iii) **Supervision**
Regular review of each staff member's performance, effectiveness in implementing CRCS, and quality of services. This should include direct observation when feasible.
 - iv) **Chart reviews (see Appendices K & L for sample templates)**
At least quarterly reviews by a supervisor of each client's case files (risk behavior and needs assessment, prevention plan, and progress notes) to monitor effectiveness of counseling and appropriate documentation.
 - v) **Case conferencing and presentations**
Regular presentations of cases (case conferences), especially those that are complex or difficult, by CRCS counselors to peers, others who provide

services to CRCS clients, and supervisors in order to invite suggestions and share experiences.

vi) Client satisfaction surveys or interviews (see Appendix M for sample template)

Routine feedback from clients about their satisfaction with the service and ideas for improvement.