



Personalized Cognitive Counseling (PCC)

IMPLEMENTATION MANUAL

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SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

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ORIGINAL RESEARCH PRINCIPAL INVESTIGATORS

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Dilley JW, Woods WJ, Loeb L, Nelson K, Sheon N, Mullan J, Adler B, Chen S, McFarland W. Brief cognitive counseling with HIV testing to reduce sexual risk among men who have sex with men: results from a randomized controlled trial using paraprofessional counselors. *Journal of Acquired Immune Deficiency Syndrome*. 2007; 44(1): 569–77.

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HOW TO USE THIS MANUAL

This manual provides an overview of the Personalized Cognitive Counseling (PCC) Intervention, the important steps needed to implement the program successfully, and the resources needed to conduct the intervention. The following overview explains content arrangement.

This manual complements a CDC-sponsored training of counselors, a prerequisite for individuals implementing PCC. Implementing agencies will benefit from referring to this manual in the planning, implementation, and maintenance stages of the PCC intervention. There are six sections:

- 1) Overview and Background
- 2) Getting Started
- 3) Pre-Implementation
- 4) Implementation
- 5) Maintenance
- 6) Appendices

Overview and Background

This section provides information an agency needs to understand the conceptual basis for the PCC intervention and the research that determined its efficacy. In this section, you will find:

- An overview of PCC
- A description of the intervention's goal
- A description of the science that supports PCC
- An explanation of the Core Elements and Key Characteristics of PCC

Getting Started

This section addresses the primary concerns an agency may have while becoming familiar with PCC. These include:

- Agency capacity issues
- Budget development
- Engaging key stakeholders
- Checklists and tools an agency can use when getting started

Pre-Implementation

This section addresses practical issues involved in preparing an organization to implement PCC. Topics include:

- Implementation planning timeline
- Implementation summary
- Staffing needs
- Other considerations before implementing the intervention
- Helpful reminders to be used during the pre-implementation phase

Implementation

This section addresses items needing attention when conducting PCC. In this section, you will find:

- An overview of the six steps of PCC
- A detailed guide on how to implement each step of the PCC intervention
- The PCC *Checklist of Thoughts*, which is a *Core Element* and necessary for implementation of PCC.

Maintenance

This section provides information and ideas on how to integrate PCC into an organization's ongoing prevention services. Topics include:

- How to keep the PCC intervention going
- Tools for monitoring adherence and client satisfaction

Appendices

Appendix 1. PCC Glossary and Guide to Abbreviations

Appendix 2. PCC Checklist of Thoughts

Appendix 3. Examples of Probing Questions for PCC

Appendix 4. PrEP Basics

OVERVIEW AND BACKGROUND

Introduction to the Personalized Cognitive Counseling Intervention

Personalized Cognitive Counseling (PCC) is a single-session, one-on-one counseling intervention, delivered in the context of HIV testing by experienced HIV test counselors. It was developed for HIV-negative, gay, bisexual, and other men who have sex with men (MSM), who are repeat testers and already know HIV transmission facts. The goal of the session is to assist clients in reexamining their justifications (or rationalizations) for engaging in condomless anal intercourse (CAI), sharing their thoughts, and discussing other positive plans about potential CAI situations in the future. An adaptation of PCC for transwomen also exists.

PCC is for clients who already have a basic understanding of how HIV is transmitted. Although a moderate degree of denial of risk does not mean a client cannot participate in PCC, men who truly do not feel at risk or know how HIV is transmitted are not suitable for PCC. An educational or other behavioral intervention, or prevention case management would be more appropriate in these cases.

The goal of PCC is to help clients avoid future episodes of CAI with partners of unknown- or positive- HIV status. PCC encourages the client to explore the reasons or self-justifications (thoughts, attitudes, and beliefs) for engaging in CAI and to develop strategies to avoid future episodes with partners of unknown or positive HIV status. The process of PCC is to identify the specific thoughts used by the client when he decided to engage in CAI, aid him in reconsidering those thoughts, and

create an opportunity for him to share thoughts and other positive plans for future sexual situations where CAI could occur.

Once the client is determined eligible (Step 1) for PCC, the (Step 2) counselor assists the client in selecting a recent memorable episode of CAI. The memorable episode may or may not include the use of substances before or during the event. With this specific episode in mind, (Step 3) the client is asked to complete the PCC *Checklist of Thoughts*, which generally assists the client in recalling thoughts related to the CAI episode and any substances which may have been used. After the client completes the checklist (Step 4), the counselor helps the client talk about the CAI episode in detail; including thoughts before, during, and after the episode as well as any substances used. Throughout this narrative the counselor asks questions to clarify the story, and begins identifying the thoughts and feelings that may have affected the client's behavior. At the same time (Step 5) the counselor helps the client to identify thoughts and feelings he was having and how they are associated with his decision to engage in the CAI episode. Finally, the counselor asks the client (Step 6) to share thoughts or other positive plans regarding future sexual situations where CAI could occur.

The counselor may offer referrals to substance use services and PrEP, based on the client's interest at the conclusion of the six-step process.

Development, Conceptual FRAMEWORK, and Research Findings of PCC

The content of the PCC intervention was inspired by the research of Australian psychologist Ron Gold, who was studying how people make decisions in situations which they know could put them at risk, but engage

nonetheless. In order to engage in a risk behavior, Gold reasoned that people find ways of justifying their behavior leading up to their decision-making by using what he called self-justifications. By having one or more self-justifications at the time of arousal, the individual uses these justifications to allow the desired behavior, with known risk, to occur.

Using these concepts, the PCC intervention was developed in 1997-2000 by James Dilley, MD, in San Francisco, CA and the staff at UCSF's Alliance Health Project. The intervention, a 30-50-minute counseling session, was tested with MSM who had previously tested negative for HIV and who, in the last 12 months, reported CAI with a non-primary partner whose serostatus was HIV positive or was unknown to him.

MSM who received a single-session of PCC reduced their number of episodes of CAI more than MSM who received standard risk reduction counseling alone. It was also found that those who received PCC were more satisfied with their services.

Ten years later, *Project ECHO*, a randomized controlled trial funded by CDC and conducted by the San Francisco Department of Public Health (SFDPH) with Dr. Dilley as consultant, tested PCC with Episodic Substance Using (ESU) MSM. Binge drinking and episodic substance use are well-documented drivers or factors of HIV in MSM. The original PCC trial did not actively recruit substance-using MSM (less than 20% of MSM in Dilley's trial reported any substance use).

A Core Element in PCC is the Self-Justification Elicitation Instrument (SJEI), now called the *Checklist of Thoughts*. During the qualitative phase of ECHO, an adapted SJEI was created that included new self-justifications used by Episodic Substance Using Men who have Sex with

Men (ESUMSM) and retained many of the original PCC self-justifications still relevant to ESUMSM.

The ECHO study demonstrated that the PCC intervention was effective in reducing CAI events among non-dependent, HIV-negative ESUMSM. Additionally, men randomized to ECHO's PCC reported significantly greater reductions in alcohol consumption, marijuana use and erectile dysfunction drug use.

How PCC is Different from Other HIV Prevention Counseling

Using PCC requires not only the learning of new skills, but the “unlearning” of certain routines and assumptions that go with other types of counseling. In training people to deliver PCC, we have found it useful to highlight not only what PCC is, but also what it is not. This helps clarify how PCC fits into the spectrum of interventions an agency can provide. It also helps counselors adjust their own expectations of what they are to do and how they are to do it.

Not primarily educational. PCC is designed for HIV-negative men who have already received basic HIV information and risk counseling. These men know that CAI may have health risks, namely the transmission of HIV or sexually transmitted infections (STIs). Clients who do not understand the fundamentals of HIV risk behaviors are not appropriate for PCC and should receive an educational intervention instead. While some information may be provided in PCC’s last step if needed, the emphasis of the intervention is helping clients use, rather than ignore, what they already know about HIV risk.

Not an unstructured session led by the client. Sometimes the term “client-centered” is used to mean a counseling approach where the client’s feelings and concerns guide the session. In contrast, PCC structures the session to address risk-related *thinking* or *thoughts*. The client’s feelings and concerns are important in PCC, and are drawn out and addressed by the counselor, but primarily as they relate to the PCC steps.

Not directed at soothing any negative feelings the client may have.

Counselors sometimes feel a sense of responsibility to try to make clients feel better in the short term. While PCC counselors are to be empathic

and concerned about the client, their goal is not to cheer or calm the client. The goal of PCC is to help the client look at the thinking that he used to justify behavior he knew was risky. The intervention may result in the client getting in touch with his reality-based anxiety—that is, his anxiety that if he takes risks he may get HIV, STIs or other infectious diseases. This anxiety is seen as constructive because it helps motivate the client to avoid future risk behavior.

Not completed by the counselor handing the client a solution. The PCC session closes by asking the client to share any thoughts about future CAI situations and encouraging any constructive ideas.

To summarize the difference between PCC and standard HIV prevention counseling, PCC is:

- for negative MSM who are repeat testers
- a structured process of six steps
- rooted in cognitive therapy and motivational interviewing techniques
- not information-oriented
- focused on a particular, memorable episode of CAI
- focused on risk behavior made possible through the use of self-justifications such as, “I didn’t decide to, it just happened”
- not to advise, direct, or suggest
- the counselor asking questions that guide the client to finding their own solutions
- not traditional risk assessment. The counselor and client look at one episode in depth, not at their sexual behavior across all possible episodes or sexual events.

PCC Core Elements

Core Elements: PCC will be provided by counselors who are paraprofessionals or mental health professionals, trained in HIV counseling and testing and in the PCC intervention, who will:

Core Element 1: Provide one-on-one counseling, focusing on a recent memorable episode of condomless anal intercourse (CAI).

Core Element 2: Provide the service within the context of HIV testing and counseling, prevention case management, primary medical care, or mental health services.

Core Element 3: Use the *PCC Checklist of Thoughts* specifically tailored to identify key self-justifications used by clients in the target population.

Core Element 4: Use the *Checklist* and subsequent discussion to identify specific self-justifications (thoughts, attitudes, and beliefs) used by clients in making the decision to engage in the specific CAI episode.

Core Element 5: Explore the circumstances and context of the CAI episode in detail (including any substances consumed) before, during, and after the event.

Core Element 6: Clarify how the circumstances, substances used and self-justifications are linked to the decision to engage in CAI.

Core Element 7: Guide clients to re-examine the thinking that led to their decisions to engage in CAI, their use of substances if applicable, and identify ways they might think differently in the future and therefore reduce their risk for HIV and STIs.

IMPLEMENTING PCC

Getting Started, Pre-Implementation, Implementation, and Maintenance of PCC

The following materials provide the important steps needed to implement the PCC intervention successfully. These materials are designed to support and complement CDC-sponsored programs planning to implement PCC. An implementing agency will benefit from referring to these materials at each point in the planning, pre-implementation, implementation, and maintenance stages of the PCC intervention.

Implementation materials consist of four sections; this overview explains content arrangement.

1) Getting Started Section

This section includes information that speaks to many of the concerns an agency may have when learning about and implementing a new intervention. This includes the PCC Agency Readiness Checklist which assesses agency readiness and ability to implement PCC and helps develop a plan to ensure successful implementation. This section also includes a Stakeholder's Checklist as well as information about developing a budget for implementation of PCC. This information will need to be reviewed in order to ensure that an agency has assigned the necessary resources to implement PCC.

2) Pre-Implementation Section

This section addresses practical issues involved in preparing an organization for the implementation of PCC. This will be of particular interest to program management since supervisors do not attend the

training. It includes an implementation timeline, useful for planning the implementation process, and descriptions of staffing qualifications and training.

3) Implementation Section

The Implementation Section describes how to implement the PCC intervention in an HIV counseling and testing setting. The PCC 6-Step process, which is included in earlier parts of this manual and which were practiced in great detail during this training, will need to be reviewed by supervisors and program managers so they understand what the intervention is and how it will need to be implemented. Additionally, there is an on-line training for PCC Program Managers.

4) Maintenance Section

The Maintenance section provides ideas on how to make PCC part of an organization's prevention services. The PCC *Steps Checklist* is completed by PCC counselors and can be used in supervision and case conferencing to see how well counselors are implementing PCC with fidelity. The PCC *Satisfaction Checklist* is completed by PCC clients and used to gather information about the client's satisfaction with PCC sessions.

GETTING STARTED

Assessing Agency Capacity

Before an agency plans implementation of PCC, two activities are necessary: assessing agency capacity and developing the budget. These activities do not happen strictly in the order they appear in these materials— they may occur at the same time. The activities appear in this particular order in these materials because they build on one another: capacity issues lead to discussions regarding budget development.

Agency Capacity Issues

Capacity issues are focused on assessing agency readiness and securing stakeholder buy-in. For PCC, capacity issues focus on agency culture and facilities, staff skills and training, and client referrals and screening.

The following *Agency Readiness Checklist* can assist an agency in deciding if they are able and ready to conduct PCC. The results of this assessment will help develop an action plan and identify the best use of resources to ensure successful implementation.

The PCC Agency Readiness Checklist includes six key areas:

1. Mission and Organizational Culture
2. Facilities
3. Training and Supervision
4. Staffing
5. Client Referrals and Eligibility Screening
6. Agency Commitment to Implement PCC

Agencies can use the following *Agency Readiness Checklist* to identify gaps in their readiness to implement PCC and assess whether they can address these gaps through training and technical assistance. If, after

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completing the questionnaire, all responses were in the first two columns, the agency may be suitable for implementation of PCC. If any of the responses were in the last column, it will be important to consider whether the agency is a good candidate to implement PCC and whether training and technical assistance can address these issues.

PCC Agency Readiness Checklist

1) Mission and Organizational Culture

PCC Requirement	Yes	Not now, but this can be addressed	No, and change is not feasible
<i>Nonjudgmental regarding MSM.</i> Can we provide counseling services to men who have sex with men in a nonjudgmental, supportive way?			
<i>Cultural competence.</i> Do we provide services to each of the racial/ethnic or cultural groups within the target population we will reach?			
<i>Sex positive.</i> Are we comfortable assuring clients that they can continue to have very satisfying sexual experiences while promoting safer behavior?			

2) Facilities

PCC Requirement	Yes	Not now, but this can be addressed	No, and change is not feasible
Do we have private office(s) where PCC can be conducted? (Sessions are up to 50 minutes, so at least one office is needed per client per hour during the hours PCC will be provided.)			

3) Training and Supervision

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PCC Requirement	Yes	Not now, but this can be addressed	No, and change is not feasible
Do we have regular, ongoing cultural competence training?			
Are staff available for 3 days of PCC training?			
As staff turnover, will new staff be available to be trained?			
Can we provide regular clinical supervision meetings to PCC counselors by PCC-trained clinical supervisor(s)?			
Do agency policies and procedures enable staff to be mandated to receive training and clinical supervision?			

4) Staffing

PCC Requirement	Yes	Not now, but this can be addressed	No, and change is not feasible
Do we have trained and certified HIV test counselors?			
Do we have staff with at least one year's experience providing HIV test counseling?			

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PCC Requirement	Yes	Not now, but this can be addressed	No, and change is not feasible
Do staff have knowledge and experience with the populations of clients to be served?			
Are staff committed to providing culturally competent services?			
Are staff comfortable with and knowledgeable about men who have sex with men?			
Are staff comfortable discussing sex frankly using everyday language?			

5) Client Availability

PCC Requirement	Yes	Not now, but this can be addressed	No, and change is not feasible
Do we have ongoing access through “in reach,” outreach, and referral of clients who are MSM, who have already had at least one previous HIV test, and who have had high-risk sex since the last test?			

6) Agency Commitment to Implement PCC

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PCC Requirement	Yes	Not now, but this can be addressed	No, and change is not feasible
Do we have an “intervention champion?”			
Do we have commitment from our community advisory board or board of directors?			
Do we have commitment from our senior management staff?			
Do we have commitment from coordinator/line staff supervisors?			
Do we have commitment from line staff?			
Do we have commitment from other key partners if applicable (funders, partner agencies, etc.)?			

Buy-In and the Intervention Champion

Getting “buy-in” is crucial because it ensures the support of agency administration and allows agency resources to be used for intervention implementation. Buy-in is done best with an intervention champion. The champion is often the program manager but could also be a counselor or a team of people. Regardless of the number of champions, the main issue is convincing the agency that implementing PCC would make the quality of its prevention services better and that the agency is capable of implementing PCC.

A champion is someone within the agency who serves as a link between the administration and staff, is good at answering questions, and helps in making changes in the organizational structure. The champion serves as negotiator when trade-offs or compromises are needed and becomes the intervention’s spokesperson in anticipating staff reservations. Answering questions about the interventions’ needs and resources is integral; the champion must have excellent knowledge of the intervention including its costs, Core Elements, the Six Steps, and other relevant information.

The champion can use the marketing materials available in these four sections as well as information presented elsewhere in this manual to address any questions or concerns about PCC. The agency’s intervention champion can use the following stakeholder’s checklist to obtain support in implementing PCC. The stakeholders include the board of directors or executive board members in the community, agency staff, and/or funding sources who have a vested interest in the successful implementation of the PCC intervention.

Stakeholders Checklist

STEP 1: Find out whether or not the community will support PCC.

STEP 2: Identify stakeholders. These will include:

- Agency board of directors/ executive board/ advisory board
- Agency staff who will play a role in the operation of the intervention
- Administrators who will grow support
- Supervisors who will oversee the intervention
- Staff who will interact with clients at any level

Other potential stakeholders include:

- Local agencies where clients, counselors, or both may be recruited
- Agencies with support groups for MSM
- Health care providers and mental health professionals serving MSM
- Social service agencies reaching MSM
- Organizations of MSM and organizations that may have members who are MSM
- Organizations that could provide assistance or other resources
- Agencies, merchants, printers, publishers, broadcasters, and others who can advertise the intervention
- Agencies that can provide transportation to the intervention facility
- Advisory board to help fit an intervention to a population
- Partner agencies that can provide information to be included in resource packets for clients
- Agencies needed for keeping good community and/or professional relations
- Local health department
- Local medical and mental health associations

- Funding source(s)
- Others

STEP 3: Getting stakeholders informed, supportive, and involved

- Decide in advance what specific roles each stakeholder should play.

Who will be asked to:

- Give financial support?
- Refer MSM to the intervention?
- Serve as an intervention counselor?
- Be a resource that PCC clients can be referred to?
- Join the community advisory board?
- Help tailor the intervention for the target population?
- Provide a room where the PCC session can be held?
- Supply refreshments for participants?
- Donate small incentives or prizes for participants?
- Speak supportively about PCC in conversations with their associates?
- Send letters that tell stakeholders about PCC, its importance, that the agency will be making the intervention available, what specific role(s) they might play in the success of the intervention, and offer a chance for them to learn more.
- Call to assess interest. If they are interested, schedule a time to meet (e.g., one-on-one, lunch-and-learn at the agency with a group of other stakeholders, presentation at their agency for several of their staff or association members).
- Hold the meeting and answer questions.

Getting them supportive:

- Describe several specific roles they could play.
- Emphasize benefits of their involvement to themselves, to their agency, to MSM, and to the community—and answer questions.
- Invite them to commit to supporting PCC by accepting one or more roles. Keep track of commitments.

Getting them involved:

- Soon after meeting, send a thank-you letter that specifies the role(s) to which they committed. If they did not commit, send a letter thanking them for their time and interest and ask them to keep the letter on file in case they reconsider later.
- For persons who committed to a role that is important to pre-implementation, put them to work as soon as possible.
- For persons who committed to involvement later in the process, send them brief progress updates and an idea of when they will be called on for their support.
- Hold periodic celebratory meetings for supporters to show appreciation for valuable contributions, update them on the intervention's progress, and keep them engaged.

Developing a Budget for PCC

The second getting-started activity is developing the budget. It is expected that PCC will be embedded within an organization already conducting HIV testing and prevention counseling. For these agencies, PCC will be an enhancement of services that will entail additional costs. The budget can be done either for the additional costs only, or for the entire costs of the PCC portion of the agency's budget. Because the latter is the approach most agencies are expected to take, this is what is illustrated.

The amount of increased cost depends on a number of factors, including:

How many sessions of PCC will be delivered annually?

From this figure, determine how many counselor hours will be needed, how much space will be needed, and how much supervisory time and other expenses, including how much of an agency's operating expenses and overhead should be included in the PCC budget.

Does staff have the qualifications to deliver PCC?

It may be that higher wages will have to be paid to staff to meet educational and training requirements.

Is there a clinical supervisor at the agency?

The clinical supervisor will need to meet weekly with each PCC counselor; this requires a new contract with a qualified clinician or assigning time from a clinician already on staff.

Is there a data entry clerk or other staff who will do the required data entry or will counselors do their own data entry?

If CDC funds the PCC program, a staff person needs to enter program data. Many agencies find it works best to have the counselors enter the

data at the end of each shift. If this option is chosen, add more time to the counselor position. If a data entry clerk or other person will do the entry, they should be represented in the budget.

Is there regular cultural competence training at the agency?

This is necessary for agencies delivering PCC. If staff are not comfortable and experienced in counseling MSM, additional training in this area will also be required.

Is there a private space for conducting PCC sessions? Is there enough time available to use the space?

PCC sessions take longer than most other HIV testing counseling, so increasing the physical space may be needed, or special scheduling required, which could have cost implications.

Will there be any new outreach conducted that could affect the agency's expense?

If there is insufficient outreach or few clients received through referral, the agency may consider starting outreach to MSM as a way to bring in the target population. This includes meeting with organizations, community stakeholders and conducting outreach in bars, religious organizations, and at social organizations that serve MSM. This special outreach may have additional costs, particularly in personnel time.

Will the number of HIV test encounters increase?

If the number of HIV tests the organization conducts will increase when PCC is implemented, estimate the additional expense of HIV testing kits and lab expenses.

Cost of Implementing the PCC Intervention

The list of categories and methods of calculating a budget encompasses all the budgetary requirements of PCC. These are given as a starting point. Use the staffing and payment type appropriate for the agency. If the budget being created is part of an application for funding, thoroughly review the budgeting requirements of potential funders and modify the categories as needed.

Adjust staffing to make it appropriate for the agency and its procedures. For example, if an administrative assistant will conduct the required data entry, include time for this under the administrative assistant. If a counselor or another staff person will do the data entry, include that time in the budget. If there is no role for administrative assistant, or bookkeeper, delete that category.

Some costs shown may not be included depending on the agency. For example, there may not be a Program Coordinator. The individual items in this budget outline should be adapted to each agency.

Personalized Cognitive Counseling

Salaried Service Staff	# Staff	% Time	Salary	PCC Salary
Clinical Supervisor(s)		X		
PCC Counselor(s)		X		

Or, if clinical supervisor and PCC counselors are contractual at the agency:

Contractual Staff	# Staff	% hrs.	Cost/hr.	Contractual Cost
Clinical Supervisor(s)				
PCC Counselor(s)				

Other Supervisors	# Staff	% time	Salary	PCC Salary
Program Director		X		
Project Director		X		
Program Coordinator		X		
Other management		X		

Personalized Cognitive Counseling

Other Salaried/Hourly Staff	# Staff	% time	Salary	PCC Salary
Administrative Assistant		X		
Clerical/Secretary		X		
Outreach Workers		X		

Extra Training Costs	Amount (\$)
Cost of travel to training, lodging, per diem	
Extra hours for contractual employees, such as clinical supervisor	

Other Costs	Amount (\$)
Volunteers	
Other contractual staff	
Facilities (rent)	
Travel	
Supplies (office, HIV testing, etc.)	

Personalized Cognitive Counseling

Other Costs	Amount (\$)
Other expenses and overhead (utilities, telephone, photocopying, insurance, administrative fees)	
Total Cost*	

*Total all the costs for PCC from this and the previous page.

Time for Counselors and Supervisors

For PCC counselor time, estimate one hour per client and estimate the number of clients per week per counselor. Then, estimate supervision time (about one hour per week), training, meeting, and record-keeping time, which could average about one to two hours per week depending on the number of clients and extent of record keeping.

Once the hours per week have been configured, determine the percentage time. For example, if full-time counselors work 40 hours per week, and will be seeing four PCC clients per week and spending 2 hours on related activities such as supervision and record keeping, they are $6/40$ time on PCC, or 15 percent time. Total costs of salaried staff are then determined by multiplying the number of staff at each salary level by the percent time by the salary and then totaling the costs for the entire staffing category.

Contractors and Consultants

If necessary, include costs related to the use of any needed contractors and consultants. For example, the costs of contracting a licensed mental health professional to conduct clinical supervision. Include these costs here.

Training

If funded by CDC, the costs of the actual training will be covered by CDC. However, if the organization is not funded by CDC, be sure to include training costs for the 3-day PCC training. There may be additional costs as well, such as paying contractual counselors and clinical supervisors for the hours spent attending training. Thus, the training expense would be the total costs (when applicable) of transportation, hotel, per diem, meals

if not in per diem, and extra hours for contractual staff.

Facilities

Estimate the proportion of clients that will be PCC clients, and calculate the facilities usage. For example, if 10 percent of clients are anticipated to be PCC clients and annual office rent is \$30,000, then the rental cost charged to the PCC budget would be \$3,000. If additional private meeting spaces need to be rented exclusively for conducting PCC sessions, this amount would go into the budget as well. If the agency conducts HIV testing and counseling at more than one site and is planning to reach PCC clients at those facilities, calculate the cost for each facility.

Travel

Travel to recruit clients and travel to provide PCC at alternate sites should all be included in the budget when applicable. Include travel expenses to professional conferences for staff, where appropriate.

Supplies

HIV test kits and other testing supplies for PCC clients are normally a separate budget item. Other office supplies and equipment directly connected with implementing PCC may go in the supplies or equipment categories, or included in “Other Expenses and Overhead,” as described below.

Other Expenses and Overhead

If ten percent of the organization’s clients are anticipated to be PCC clients, and if permitted by the funding agency, there may be a decision to apportion other expenses, such as photocopying, utilities, telephone, maintenance, insurance, and other overhead to the PCC project.

Personalized Cognitive Counseling

Laboratory fees and transport fees may be included in this category as well.

PCC Sample Budget

Following is an example of a PCC budget. This is for illustration purposes only—every agency will have a different budget. Remember to thoroughly review the budgeting requirements of any possible funding agencies.

This budget assumes a moderate level of salaries and program costs. Obviously, salaries and other costs will vary from program to program depending on geographical area and other variables. Use realistic costs in this budget—higher or lower than the example—based on the true costs of operating an agency in the agency's geographical area.

Salaried Service Staff	# Staff	% Time	Salary	PCC Salary
PCC Counselor(s)	2	15% X	2 @ 45,000 = \$90,000	\$13,500

Notes: In the example above, the budget is determined with the expectation that full-time counselors work 40 hours per week, and will be seeing four PCC clients per week and spending two hours on related activities such as supervision and record keeping, they are 6/40 time on PCC, or 15 percent time.

Contractual Staff	# Staff	% hrs.	Cost/hr.	Contractual Cost
Clinical Supervisor(s)	1	135	\$100	\$13,500

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Other Supervisory Staff	# Staff	% time	Salary	PCC Salary
Program Director	1	5% X	\$85,000	\$4,250
Program Coordinator	1	15% X	\$60,000	\$9,000

Other Salaried/Hourly Staff	# Staff	% time	Salary	PCC Salary
Receptionist	1	15% X	\$40,000	\$6,000

Extra Training Costs	Amount (\$)
Travel for four staff @ \$250 each	\$1,000
Lodging, two nights, for four staff @ \$100 each	\$400
Per diem and misc. expenses for 4 staff @\$200 each	\$800

Note: The CDC charges no fee for the training but transportation and lodging must be figured into the budget.

Facility Costs	Amount (\$)
Rent	\$3,600
Utilities	\$540

Note: This is calculated by apportioning 15 percent of the testing program's rent and utility expenses to PCC. The total rent is \$24,000 and the total utilities are \$3,600.

Total Costs

Program Costs	Amount (\$)
Counselors	\$13,500
Clinical supervisor	\$13,500
Receptionist	\$6,000
Program director	\$4,250
Program coordinator	\$9,000
Lodging and travel costs related to training	\$2,200
Rent	\$3,600
Utilities	\$540
Subtotal	\$52,590
Overhead"	\$7,888.50
Total Cost	\$60,478.50

Note: Overhead cost includes insurance, office supplies, bookkeeping, routine travel, etc., and calculated as 15 percent of total personnel, rent, utilities and supplies.

PRE-IMPLEMENTATION

Introduction to Pre-Implementation

Once an agency has assessed agency capacity and developed the budget, the pre-implementation phase can begin. This phase prepares the implementing agency to conduct the intervention. It's during this period that an agency should develop a timeline for implementation, identify or hire the appropriate staff to implement PCC, compose a community advisory board, develop a monitoring and evaluation plan, and make changes to the intervention to fit the agency's target population, if needed. Each of these topics is discussed in this section.

PCC Implementation Timeline

(Times suggested are approximate and will vary from agency to agency.)

1) Conduct agency readiness assessment (Months 1–2)

The *Agency Readiness Checklist* (included in the *Getting Started* section of these materials) identifies issues that should be addressed before implementing PCC.

2) Select or hire staff to be trained, (Months 3–5)

The *Staff Qualifications Checklist*, included in this section, spells out the skills and education needed to be a PCC counselor or a clinical supervisor.

3) Acquire or schedule additional office space, (Months 3–5)

Because the PCC intervention takes longer than many HIV test counseling protocols, agencies may need to arrange for additional availability of private counseling space.

4) Plan additional efforts to find clients, (Months 3-5)

If the *Agency Readiness Checklist* identifies a need for additional efforts to reach more PCC clients, the agency may need to work with other agencies to get referrals or conduct outreach to recruit clients for PCC. A plan on how to do this, including how “in reach” (reaching in to current client pool and drawing out those eligible for PCC) will be accomplished needs to be developed.

5) Train counselors and clinical supervisor, (Month 6)

Once the arrangements have been made to offer PCC and the staff are available, counselors must attend trainings delivered by people

who have been trained to deliver the PCC Training of Counselor's (TOC) curriculum.

6) Orient other staff and agency partners, (Months 4-6)

Before PCC is instituted, other agency staff (receptionists, nurses, outreach staff, staff conducting monitoring and evaluation, etc.) needs to know what PCC is and is not. They may be providing information to clients, and/or screening and referring clients. Likewise, agency partners and stakeholders—those who refer clients, and those who provide other needed services in tandem—need to be informed about the new service.

7) Begin implementation of PCC, (Month 7, then ongoing)

Following training, implementation should begin as soon as possible, to take advantage of the momentum provided by training, and to reinforce the learning.

8) Implement quality assurance, (Month 7, then ongoing)

Quality assurance consists of:

- a) Weekly supervision sessions, supplemented by Q&A and troubleshooting as needed;
- b) Use of the *PCC Steps Checklist*.
- c) Use of the *PCC Satisfaction Questionnaire*

9) Check-in for “course adjustment” and troubleshooting (Month 8, then ongoing)

For the first three months of implementation, or longer if needed, the agency's entire PCC team should meet semi-monthly to identify any issues that need to be addressed. Consultation with your CDC Project

Officer and/or submitting a request for capacity building assistance (CBA) can be initiated when needed.

10)Implement any needed adjustments (Month 8, then ongoing)

Anticipate that some fine-tuning and problem-solving will need to take place in the first few months of implementation.

11)Finalize implementation of PCC with standard level of clinical supervision (Ongoing)

About six months into implementation, it's anticipated that the initial problems will have been identified and corrected, the staff will be familiar and comfortable with delivering PCC, and the referral processes will be in place. The frequency of supervision sessions can be reduced to monthly, and the use of the PCC Steps Checklist can be reduced to every fourth client, if desired. The PCC team check-in can become a part of regular staff meetings. Regular ongoing training in cultural competence should continue.

12)Train new staff as needed (Ongoing)





Staff turnover will necessitate arranging training for the new staff from a PCC trainer, and more intensive supervision for the new staff will be required for their first three months of work. Contact your CDC Project Officer or health department liaison to schedule training. In the meantime, new staff should become familiar with the PCC implementation manual. Counselors should not conduct PCC until they are formally trained.

Personalized Cognitive Counseling

PCC Sample Timeline

Task:	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Ongoing
1. Conduct agency readiness assessment										
2. Select/hire staff to be trained										
3. Acquire/schedule office space										
4. Plan additional efforts to find clients										
5. Train Counselors and clinical supervisor										
6. Orient other staff and agency partners										
7. Begin implementation of PCC										
8. Implement quality assurance										

Personalized Cognitive Counseling

Task:	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Ongoing
9. Check-in for “course adjustment” troubleshooting										
10. Implement needed adjustments										
11. Finalize implementation of PCC with standard level of clinical supervision										
12. Train new staff										

PCC Implementation Summary

The Implementation Summary provides an overview of the resources, activities and deliverables needed to successfully implement PCC. It can be useful in planning implementation and to verify the intervention has been implemented completely.

Inputs	Activities	Outputs
Inputs are the resources needed to operate a program to conduct the intervention activities	Activities are the actions conducted to implement an intervention	Outputs are the deliverables or products that result when activities are conducted, provide evidence of service delivery
PCC-specific screening protocols and systems to integrate the PCC intervention into flow of HIV testing program services	Screen all male clients who present for HIV testing services for selection criteria: MSM, previous HIV testing, HIV-negative, and CAI since last test	At least 90% of all male clients requesting HIV testing services are screened for counseling with PCC
Private space to conduct the one-on-one PCC intervention	Counsel PCC clients in a private space	100% of all clients counseled with PCC rate their counseling session as having taken place in a private space
30-50 minutes of dedicated time for counseling each PCC client	Counsel each PCC client in a 30-50-minute one-on-one PCC session	90% of all clients counseled with PCC completed the counseling in not less than 30 minutes and not more than 50 minutes

Personalized Cognitive Counseling

Inputs	Activities	Outputs
Inputs are the resources needed to operate a program to conduct the intervention activities	Activities are the actions conducted to implement an intervention	Outputs are the deliverables or products that result when activities are conducted, provide evidence of service delivery
PCC counselor(s) and clinical supervisor of PCC counselor(s)	Ensure competency of HIV test counselors to conduct PCC in the context of HIV testing, including ongoing review of counseling sessions by a PCC clinical supervisor	30% of PCC sessions are reviewed by the PCC clinical supervisor and 80% of the sessions reviewed receive a satisfactory rating by the client and the counseling supervisor
Time for supervision of PCC counselors	PCC clinical supervisors provide 30-minute review of sessions and guidance to PCC counselors for a subset of all clients counseled using PCC	PCC clinical supervisors and PCC counselors conduct a weekly supervision session lasting at least 60 minutes reviewing at least 25% of each counselor's PCC sessions
Sensitivity to issues involved in working with MSM, and cultural competence with populations served	Counselors distribute post-counseling client satisfaction form; provisions made for clients to return this anonymously	60% of clients report a high level of client satisfaction with services received

Implementing PCC in an Existing Service Agency

Embedding

Because the PCC intervention is intended to be offered along with HIV testing, it should be embedded within a service called “counseling and testing.” As recommended by CDC guidelines, these services often include additional components such as consenting processes, referral processes, partner notification services and individual or group education programs. In addition, local laws and organizational policies will be applied to regulate the PCC intervention.

To effectively use this package, providers are encouraged to embed the PCC intervention within their service or program in a way that minimizes disruption and changes to the protocol.

New Programs

If PCC is to be implemented as part of a completely new service program, the complexity of the process is greatly increased. It is beyond the scope of this manual to describe how to set up and operate an HIV testing and counseling program from the ground up. It is recommended to contact the CDC and/or state and local health department for assistance.

Enhancement

Many agencies that will implement PCC will already be serving the target population and will have most of the required systems in place, including ongoing cultural competence training, regular supervision of counselors, and a referral network and/or outreach program that brings in members of the target population for PCC, most commonly MSM.

Implementation of PCC will involve enhancing the agency's services through training the counselors and clinical supervisor(s) in PCC, adding additional quality assurance (supervision, fidelity forms, and client feedback form) and in some cases, increasing outreach efforts.

Screening

If all HIV test counselors who provide services to MSM are trained in PCC, the screening can be conducted in the initial risk assessment with seamless transition into PCC. If only some of the counselors are trained in PCC, those who are not trained need to learn how to screen clients, and then make a referral to a PCC counselor. This may not be practical when a PCC counselor is not immediately available. It may then be necessary for the counselor to provide a conventional HIV counseling and testing session instead of PCC. The client may not want to defer his testing, and it is important not to lose the opportunity to provide the testing service. If the client appears to be genuinely motivated, it may be possible to postpone the testing until a PCC counselor is available; this would be a case-by-case call.

Quality Assurance

PCC comes with a quality assurance (QA) component, including a checklist to be completed by counselors and a feedback form to be completed by clients. Integrating this into the agency's existing QA plan will take some thought. For example, if clients are already completing a satisfaction survey, consider whether to substitute the PCC form or combine the information on one form for these clients.

Funding

It may be necessary to think through the funding implications of PCC. If the agency is being funded on a per-session basis, additional funds for PCC will probably be necessary since the session is usually longer and hence costs more to deliver than conventional HIV counseling and testing.

Staff Qualifications, Training, Roles, and Responsibilities

Counselor Qualifications and Training

Based on the research projects in which PCC was tested, the necessary qualifications for a PCC counselor are:

- Training as an HIV-antibody test counselor.
- At least one year of experience providing HIV test counseling.
- Experience with and dedication to pursuing cultural competence with the populations of clients to be served.
- Comfort and knowledgeable about men who have sex with men.
- Comfort with discussing sex frankly using everyday language.
- Completion of training to learn the PCC intervention.

Counselor Roles and Responsibilities

- Screen clients for the PCC intervention. (Other staff may also screen clients.)
- Conduct the PCC intervention.
- Complete *PCC Steps Checklist*.
- Provide clients with *PCC Satisfaction Questionnaire* and inform clients about the importance of returning completed questionnaires.
- Review returned *PCC Satisfaction Questionnaires* from clients.
- Record and enter any required program data. (Other staff may also enter data.)

Clinical Supervisor Qualifications and Training

- Master's level training as a counselor, social worker, or therapist with a degree in psychology, social work, counseling, or similar field.

- At least one year of experience as a clinical supervisor.

Clinical Supervisor Roles and Responsibilities

Provide one hour a week or more of clinical supervision to counselors, which includes:

- Review of session recordings,
- Discussion of issues raised in PCC sessions,
- Review of the PCC *Steps Checklist*,
- Review of completed *Satisfaction Questionnaires*,
- Aiding counselors in understanding and dealing with feelings raised by PCC sessions, and
- Providing feedback and advice to optimize service fidelity and quality.

Program Director/ Executive Director/ Clinic Manager/ Program Coordinator/ Program Manager, Qualifications, and Training

Management staff may have different titles, as well as different types of education and training. There is no specific educational background required. The key qualifications are:

- Ability to manage an HIV-related counseling program.
- Knowledge and experience with the target population.
- Overall understanding of PCC including knowing the target populations, qualifications of staff needed, need for clinical supervision and relationship to HIV testing.

Program Director/ Executive Director/ Clinic Manager, Roles, and Responsibilities

- Provide leadership and oversight of the implementation of PCC.

- Conduct the implementation steps described in these materials, and/or delegate them to others; monitor progress of activities delegated to others and take corrective action as necessary.
- Oversee the other staff and make sure they are performing their duties, i.e., that the PCC counselors are counseling clients, the clinical supervisor is meeting with counselors weekly, the bookkeeper is recording expenses, and so on.
- Ensure that PCC counselors and other staff have the resources necessary to perform their duties. These resources include training, space, time, and day-to-day guidance.
- Oversee budgeting and tracking expenditure of funds.
- Review process and outcome data and make course corrections as necessary.
- Assist with quality assurance through review of data, direct observation, and consultation with staff.

Administrative Staff (Receptionist, Data Entry Clerk, Bookkeeper, etc.), Qualifications and Training

- Past experience in the job or a job with similar duties.
- Data entry clerks, if any, should have training on entering the CDC required reporting data in the data system required by CDC.
- The bookkeeper should be oriented as to which expenses are to be assigned to the PCC budget.
- The receptionist should have training in cultural competency and be knowledgeable of and comfortable with the target population. If the receptionist is to aid with screening, he or she should have training in the PCC screening criteria.

Administrative Staff Roles and Responsibilities

- The data entry clerk attends required program data processing training and enters the data as required (unless this responsibility is assigned to the counselors).
- The receptionist welcomes clients and orients them to the testing procedures, telling them where to wait, how long they will wait and answers related questions. In some agencies, the receptionist may perform part of the PCC screening and direct the clients to PCC counselors or schedule PCC appointments.
- The bookkeeper tracks and accurately records the PCC-related expenses.

Finding Clients: In reach, Outreach, and Referrals

This section addresses how to review and improve current client-finding efforts in reference to members of the target population. PCC was originally developed as an enhancement to existing HIV testing and counseling services, serving the target population. It is presumed the agency already has MSM in the target population coming for HIV testing, and that it will be able to reach into this pool of clients and identify participants for PCC. This is **in reach**. Agencies may also choose to build organizational linkages to receive increased **referrals** of PCC-eligible men from other agencies. Finally, consider conducting **outreach** directly to identify appropriate participants.

Publicity and Organizational Linkages

Implementing PCC is also a good time to review existing marketing and publicity materials, as well as organizational linkages. These are some of the ways that agencies communicate their mission and programs to the larger community, and recruit members of the PCC target population. Some important aspects of this are discussed below.

Websites

- Websites are increasingly important in disseminating information to the public. Agencies should revisit their own website, along with any other websites that describe their services. In addition to the hours and location that HIV testing and counseling is offered, the website content should emphasize confidentiality, sensitivity to the needs of MSM, and that all races and ethnicities are welcome with a nonjudgmental attitude.

- Consider stating explicitly, “If you are a man who has sex with men, and you have had condomless anal intercourse since your last HIV test, we would be more than happy to provide another HIV test. Our test counselors do not judge or criticize.”
- CDC does not recommend trying to explain PCC directly to the public or target populations because it is a counseling intervention that requires training to fully understand. However, the nonjudgmental stance and sensitivity to needs of MSM is worth emphasizing wherever possible.

Brochures and Directory Listings

- The same kind of language described above should be included in brochures and in-print directories. Directories put out by other organizations may be out of date, so it is worth making a special effort to seek them out and update them if necessary.

Where to Conduct Outreach

- Bars, bathhouses, sex clubs and areas in gay neighborhoods are all places outreach can be conducted. Sending outreach staff to events that are frequented by MSM is also a productive strategy. Consider placing advertisements in both gay and general-readership publications. Some agencies find that posters and flyers are helpful.
- For more information on outreach to MSM, including guides, materials and other resources, visit: [U.S. Preventative Service Task Force website](#) and [Innovative Approaches to Engaging Hard-to-Reach Populations Living with HIV/AIDS into Care curriculum](#).

Linkages

- Linkages to other organizations are key to getting a stream of referrals. In addition to outreach programs and medical services, organizations that serve or represent MSM can be important partners. Traditionally, bars, clubs, and bathhouses have been important partners in spreading the word about HIV prevention services, including testing. Other organizations that align well include gay sports clubs, political groups, and religious organizations. If an agency is not in touch with these, consider recruiting a Community Advisory Board that is. Their input will aid in terms of sensitivity, as well as help build linkages in the community.

Planning How to Integrate PCC into the Testing/ Counseling Session

Before an agency begins to offer PCC, decisions on integrating it into the process of intake, testing and counseling used will need to be made. These decisions should come after staff have been trained and are fully conversant with the PCC intake requirements and the PCC steps.

Write it Down

Before implementing PCC, it is recommended that each agency write down its plan for integrating PCC into its service sequence, and that all staff involved be brought together in person to become familiar with the plan. Several role-play walk-throughs should be conducted to make sure everyone knows what will happen when, and what they will say to the client at each step.

Adjustments

As PCC is implemented, it is likely that some questions and exceptions will come up, so the service sequence should be revisited weekly until everything works smoothly. Adjustments to the procedure should be documented for clear communication and for new staff orientation.

Community Advisory Board

The advisory board is made up of individuals from the community which the agency serves. They understand the various needs of the community and know the best way to effectively communicate with the target population.

The advisory board is not absolutely necessary to successfully implement PCC. However, because of the members' unique insights into the target population, the advisory board can be helpful in modifying PCC and facilitating organizational linkages.

Assembling an advisory board is not a long or extensive process, and the size of the board will vary. An agency can pilot the intervention with the board, and the members' feedback can help improve the quality of delivery. Some other ways that the advisory board can assist are by providing ideas about marketing and recruiting.

The advisory board may be a valuable resource in making PCC a culturally appropriate intervention in the community.

Adaptation of PCC

PCC has been proven to be a successful intervention for MSM. The intervention has been tested with hundreds of MSM. However, no two communities are exactly alike, so PCC may need to be modified to fit the needs of specific agencies and their corresponding communities. Before making any adaptations to the program, it is strongly recommended to try delivering the intervention as written with no changes. This is the best way to assess how the session flows, how MSM respond to the program, and how the intervention works for the agency. It may be that the intervention works perfectly as is, or that it will need to be adapted fit the specific needs of the population.

Considerations to keep in mind when adapting the intervention include the needs of the population, the capabilities and resources of the agency and the intervention's Core Elements. Adaptation should improve the delivery of the intervention and make the information more accessible for the clients. Adapting does not and should not alter, delete, or add to the Core Elements of PCC. Working closely with the CDC Project Officer will help the agency to make the most appropriate changes. Some areas where adaptation may be necessary include:

Populations

When agencies are considering adapting PCC for other populations, they should take into account the populations' sexual risk behaviors. PCC was designed and shown to be effective with MSM engaging in CAI with non-primary partners. Thus, the PCC *Checklist of Thoughts* reflects the self-justifications MSM may have in this type of sexual encounter. If PCC were to be adapted to other populations, extensive background research would

be required to identify the self-justifications used by the target population when engaging in CAI. If the findings indicate different self-justifications, the *Checklist of Thoughts* would need to be modified and tested through focus groups and other means.

Settings

PCC has been delivered by a community-based organization in their STI testing clinics and by a public health department in a space made available in a gay bathhouse.

Another appropriate setting could be a mobile van testing facility equipped with an area that is private and soundproof, with trained HIV counselors who are culturally appropriate to the target population.

A third scenario could be a mental health center or prevention case management program, with HIV counselors who have been trained in PCC and who are culturally appropriate for the target population and MSM clients requesting HIV testing.

Monitoring and Evaluation

To achieve the best performance and outcome, agencies should plan to conduct evaluations of the intervention. There are four types of evaluation: formative, process monitoring, process evaluation, and—when possible—outcome monitoring.

Formative evaluations are performed during the pre-implementation phase to assess the needs of the target population for PCC.

The other three evaluations—process monitoring, process evaluation and outcome monitoring—are performed in the maintenance phase, after the program has been delivered.

IMPLEMENTATION

Introduction to Implementation

The purpose of this section is to provide an overview of how counselors conduct PCC.

It begins with an overview of the PCC intervention. The summary is followed by a detailed step-by-step description of how to conduct the intervention.

The step-by-step material does not give a script, because PCC needs to be personalized for each client, but it gives sample language. Transcripts from two sample PCC sessions are included in the Appendix.

OVERVIEW OF THE SIX-STEP PCC INTERVENTION

This brief overview is provided as an introduction to the six steps of PCC. New PCC counselors can also use this overview as a reference during PCC sessions. A more detailed discussion of each step with sample dialogue follows this section.

THE SIX STEPS OF PERSONALIZED COGNITIVE COUNSELING

The Six Steps of PCC, Condensed

Step 1

Screen the client's eligibility to receive PCC.

Step 2

Help the client choose a memorable recent episode of CAI to discuss in detail during the PCC session; it may (or may not) involve episodic use of substances.

Step 3

The client completes the *Checklist of Thoughts*.

Step 4

With focus on the same CAI episode, details are drawn out of story by the counselor. The client is asked what his thoughts and feelings were before, during and after the episode as well as any substances used.

Step 5

Assist the client to identify his specific self-justifications for engaging in CAI and discuss. When necessary, provide correct HIV risk information.

Step 6

Ask the client to share his thoughts about future situations that may lead to CAI. Support his reframing of previous thoughts or other positive plans, and provide referrals when appropriate.

The Six Steps of PCC Expanded (sample questions)

Step 1

Screen the client's eligibility to receive PCC.

Sample Question:

"What brings you in for testing today?"

Basic Screening Questions

- "Have you been tested before? What were your test results?"

If the answer is negative, the next question continues the screening process:

- "Are you currently taking PrEP?"

If the answer is no, the next question continues the screening process.

- "Have you had condomless anal intercourse (CAI) with a man, other than your boyfriend or primary partner, whose HIV status you didn't know or who was HIV positive?"

Serostatus Question, Divided into Two

- "Have you had condomless anal intercourse with a man other than a boyfriend or primary partner?"

If the answer is yes, then ask:

- "Did you know if he was HIV positive?"

If he did not know, or the partner was HIV positive, the client is eligible for PCC, unless they have been using substances chronically. If the client is dependent on substances, they are not a candidate for PCC.

If the answer is no, my partner(s) are negative, then ask:

- “How do you ask your partner(s) about their status?”

and/or

- “How comfortable are you when they tell you they are negative?”

If he did not firmly know the partner was HIV negative, the client is eligible for PCC (unless they are diagnosed with a substance use disorder episode, in which case they are to be excluded).

Definition of Primary Partner

The definition of “boyfriend” or “primary partner” is:

A person the client has been involved with for three months or more and thinks of as a ‘boyfriend or primary partner.’

Chronic Substance Use Screening Question

“Have you been diagnosed with a substance abuse disorder and been using substances during your episodes of exposure to HIV?”

If so, this client should not be offered PCC.

Step 2

Help the client choose a memorable recent episode of CAI to discuss in detail during the PCC session.

- a) This episode may (or may not) involve the use of substances. Episodic Substance Use (ESU) may be used as criteria in the selection of a CAI episode for the focus of the PCC session with the client.
- b) The other required criteria are: CAI since last (negative) test with a non-primary partner of unknown HIV status.
- c) Chronic substance users should have already been excluded.

Step 3

The client completes the *Checklist of Thoughts* about the memorable CAI selected for discussion. The counselor:

- a) Stays in the room while the client answers questions.
- b) May do paperwork while client completes the checklist.
- c) May read the checklist aloud to those with vision or literacy difficulties.

Step 4

Draw out the story of the memorable CAI episode. Ask the client what his thoughts and feelings were before, during and after the episode. Ask the client to recount in as much detail as possible the who, what, when, where and how leading up to, during the actual sex and immediately afterward. Substance use is, of course, part of “what he did.”

Again, it’s important for the client to relate their thoughts and feelings at the time of the selected episode throughout their telling of the “story,” which needs to be detailed. It’s okay if the client experiences some anxiety

Step 5

Help the client identify his specific self-justifications for engaging in CAI and talk about them. When necessary, provide correct HIV risk information.

- a) Step 4 should lead into this activity. Step 5 likely overlaps with Step 4 as the client moves through telling the story.
- b) Responding to the *Checklist of Thoughts* will remind him of some self-justifications.

Step 6

Ask the client to share his thoughts about future situations that may lead to CAI. If the client expresses regret about combining substance use and sex, support his reframing of previous thoughts or other positive plans, and provide referrals when appropriate.

Sample Questions about the Future

- “Thinking about our conversation, what are your thoughts about combining substances and sex?”
- “If you were to go to that club again, is there anything you’d think about differently?”
- “Can you tell me, if you were in a similar situation again, what thoughts you might now have?”

Brief Guide to PCC, Step-by-Step Activities, and Skills

The description that follows describes in detail how to conduct PCC and gives sample dialogues illustrating how each step can be conducted. Please note that the sample dialogues are not scripts to be used with clients.

Throughout the steps, the following counseling skills are used:

Open-Ended Probing Questions

These types of questions are used to help the client tell his story, including substances used and start time/duration of use. They can also help identify the thoughts and feelings he was having before, during and after the CAI encounter. Probes are to be used as needed. When clients tell the story of their selected risk episode easily, the counselor's main focus will be to stay out of the way. Others will need more guidance and encouragement.

Do's and Don'ts

How probes are used is more important than which probes are used. The following "Do's and Don'ts" can help with probing questions.

Do's:

- Use open-ended probing questions
- Tie the next question to what the client just said
- Let the client be in charge of his own narrative
- Using the client's words, briefly summarize the content and feeling the client is expressing, to show understanding
- Use silence to cue the client to think about and expand on what he just said

Don'ts

- Ask a series of closed questions
- Read off the probes like a checklist
- Let probes structure the narrative
- Spoon-feed words describing the client's experience, making the counselor rather than the client responsible for telling his story
- Interrupt while the client is thinking

Active listening is a way of engaging the client in a conversation where a variety of techniques is used to let the person know that they are being heard, encouraging the person to talk more. Active listening draws out the story, especially if the client is not stating a clear self-justification, such as, "You said when you went to his place you thought about condoms, but you didn't say what those thoughts were. What were your thoughts?" Active listening includes mirroring, reflecting, summarizing, and pausing.

Mirroring simply means repeating what the client said and then not saying any more. An example of this would be mirroring back to the client a statement he had just made like, "You said you didn't want to bring up the subject of condoms because you were afraid he wouldn't want to have sex." When mirroring, some clients may comment on their self-justifications without needing to be asked; saying things like, "I know it's stupid."

Reflecting refers to restating the client's comments and feelings, perhaps with some of his own words and some other words as well. Reflecting statements are validating statements and, by allowing the client to hear his words in another person's voice, may help to further clarify his feelings. An example of this would be reflecting back to the client a statement he had just made. For example, if the client said, "I wanted to

talk about condoms but there wasn't any time," the counselor might reflect back, "You wanted to bring up using condoms but it sounds like that the conversation didn't happen."

Summarizing refers to the technique of highlighting for the client the most important aspects of the session that have been discussed.

Pausing provides an opportunity for clients and counselors to digest material and to make room for feelings or thoughts to emerge. Giving the client some time to experience the moment by allowing silence to happen is a sign of respect for the power of the client's thoughts and feelings. Sometimes a counselor's discomfort with silence can interrupt the client's process. Remember: silence is also a form of communication.

PCC Adaptation for Episodic Substance Users

Why is PCC an appropriate counseling approach for episodic substance use (ESU)?

ESU is cited as being part of the self-justifications that clients use to engage in CAI. Because PCC is an intervention that reflects a client's self-justifications back to them, the counselor does not need to be a substance use counselor in order for PCC to be effective. The ECHO study, which used PCC on Substance-Using Men who have Sex with Men (SUMSM) showed that some clients reduced the amount of substances consumed before CAI.

Data show that MSM have a higher lifetime prevalence of substance use and a higher prevalence of symptoms, relative to other men in the United States. Data also suggest that heavy episodic drinking among MSM exceeds that of the general population.

Often, Substance-Using MSM do not view the use of substances as problematic and thus do not seek out traditional substance use treatment services. It's important that counselors understand their role is NOT to diagnose clients as having a substance use disorder, but to track a client's substance use (if there is any) during the retelling of the memorable CAI episode in order to offer a tailored substance use referral at the end of the session (if the client is interested in one).

As mentioned previously, binge drinking and Episodic Substance Use (ESU) has been shown to increase sexual risk for MSM. Although the ECHO study found that PCC was efficacious for MSM who were episodic substance users, chronic users (i.e., dependent on substances) did not

benefit from PCC. Reductions in condomless anal intercourse events by substance dependent clients were not significant among this population.

If, over the course of the PCC session, dependence on substances is disclosed the counselor should continue the session and follow the remaining steps; including the offer of a substance use referral after the negative test disclosure. Remember, client screening for PCC should have excluded anyone with substance dependency issues.

It's also important to note that many studies and reports indicate that MSM throughout the US are using substances including alcohol, meth, cocaine, crack, etc. and some MSM may be injecting substances. Some clinics will have an intake process that includes filling out general demographic and frequency of substance use questions. This process will make it easy to screen out non-episodic injection drug use. If over the course of the PCC session injection drug use is disclosed, the counselor can continue the session and follow the remaining steps, including the offer of a substance use referral after the HIV test disclosure.

Substances That Most Affect Sexual Risk-Taking among MSM

- Alcohol
- Poppers
- Cocaine/crack
- Methamphetamine
- Prescription drugs/opioids

Key Terms and Definitions, Substance Use

Episodic Substance User (ESU)

As a general term, refers to substance use that occurs on an occasional basis. Episodic binge drinking typically happens on weekends and/or on specific events during the week (work party, birthday party). Episodic drug use is typically defined as less than weekly. In general, episodic is considered once in a while.

Substance Use Disorder (SUD)

In DSM-V (the Diagnostic and Statistical Manual of Mental Disorders-5th Edition) a Substance Use Disorder (formerly called “dependence” in DSM IVR) is defined as “a cluster of cognitive, behavioral and physiologic symptoms that indicate a person has impaired control of psychoactive substance use and continues use of the substance despite adverse consequences.” As applied to alcohol and other drugs, the term implies a need for repeated doses of the substance to feel good or to avoid feeling bad.

Definitions of Binge Drinking, Episodic Binge Drinking and Episodic Drug Use

- **Binge drinking** for men is defined as having five or more drinks on a single occasion. A drink is typically defined as 1.5 ounces of liquor (like a shot or in a mixed cocktail), a 4-ounce glass of wine, or a 12-ounce bottle of beer.
- **Episodic binge drinking** typically happens on weekends and/or on specific events during the week (work party, birthday party).
- **Episodic drug use** is typically defined as less than weekly. In general, episodic is considered once in a while.

Symptoms and Characteristics of an Alcohol/Substance Disorder (DSM-V)

- Substance (including alcohol) is taken in **larger amounts** or over a longer period than was intended.
- **Persistent desire or unsuccessful efforts to cut down or control use.**
- **A craving or a strong desire to use the substance.**
- A great deal of time spent to obtain, use, or recover from the substance.
- Continued use despite knowledge of physical or psychological problems likely caused or exacerbated by use.
- **Failure to fulfill** major role obligations at work, school, or home.
- Recurrent use in situations in which it is physically **hazardous**.
- **Tolerance** marked by need to use increased amounts to achieve the same desired effects, or diminished effect with same amount of use.
- **Withdrawal** symptoms, or the need to use the substance in order to avoid withdrawal.
- Severity of disorder:
 - Mild: Presence of 2-3 symptoms
 - Moderate: Presence of 4-5 symptoms
 - Severe: Presence of 6 or more symptoms

Guidelines for Providing a Substance Use Referral

- **Recap** the memorable CAI and related substance use
- **Explore** concerns about the CAI/substance use
- **Assess** interest/readiness in substance use referral
- **Provide** referral
- **Follow** the client's lead

PCC Do's and Don'ts When Addressing Substance Use

Do's:

- Ask about the amount and type of substance(s) being used before, during and after the CAI episode.
- Ask the client how they think the substance use impacted decision to engage in CAI.
- (After the negative test disclosure) reflect back on the amount of substance use the client reported that impacted the CAI and simply ask:
 - *“Having shared with me your substance use during this incident, I’m wondering how concerned are you about your substance use in general?”*
 - Or
 - *“How interested are you in talking to someone further about any substance use concerns you may have?”*
- Leave the door open. If a client rejects a potential referral, accept the client’s decision. Consider saying:
 - *“Certainly, that is your choice. If you ever change your mind you can always contact (me, the clinic, agency) and we will be happy to share the referral with you.”*

Don'ts

- Share personal concern with the client’s level of substance use. Better to simply reflect back what the client has shared about their use and the unwanted consequences it brought them.
- Overwhelm the client with multiple referrals. Provide one or two and then follow their lead.
- Assume that a client who reports substance use which contributed to CAI (and other unwanted consequences) will automatically be ready and willing to receive the referral. Be open to possible resistance.

PCC AND PREP

PrEP has been shown to protect MSM from HIV infection; therefore, PCC counselors should provide interested clients PrEP information, including a handout about PrEP and referral to PrEP availability in their local area.

Benefits and Concerns of PrEP

Benefits:

- Extremely effective when taken daily
- Engages people in new dialogue about HIV
- An additional option for HIV prevention
- Increases psychological value: *“Now there’s something I can do to protect myself even further”*
- Reduces stress associated with worrying about HIV
- Quality of life improvement: *“The kind of sex I’m having, etc.”*
- Empowerment: *“Allows me to take control of my own sexual health”*
- Empowering for women: PrEP is an intervention where the receptive partner controls it themselves, whether or not it’s discussed (or safe to discuss) with partners.
- May reduce stigma because of increased communication about prevention
- May increase sexual health/life dialogue with providers because of prescription, HIV testing and other clinical monitoring needs
- Provides a gateway to primary care for many who are not in care
- Few serious side effects in most people, with many effects being short-lived

Concerns:

- Lowered condom use, can lead to increased risk for STIs
- Access/availability issues, especially outside larger urban centers
- Potential for more HIV disparity (i.e., increased access for wealthier communities vs. poorer ones)
- Being on PrEP can be stigmatizing
- Can lead to misinformation, for example: confusing PrEP and PEP (Post Exposure Prophylaxis), and the use of HIV antiretrovirals for HIV treatment
- Lack of adherence could lead to increased resistance of HIV
- Future treatment concerns, i.e., if seroconverting while on PrEP it could make Truvada® ineffective for future treatment
- Can add to the concerns of the “worried well”
- Perceived conflict with some public health messages (i.e., use a condom even when on PrEP)
- Some agencies have been less than supportive of PrEP, though that may be changing
- Some providers are resistant to move away from “Use a condom every time” messaging
- Potential side effects such as reduction in bone density and changes in kidney function
- Initial few weeks can be challenging with side effects such as nausea and stomach distress
- Cultural concerns and obstacles, mistrust of the health system and hesitancy to access care
- Informal dosing, such as receiving PrEP from friends
- Beliefs “*We don’t really know the long-term effects of PrEP*”

- Required regular monitoring
- Lack of clinical provider knowledge
- Level of comfort discussing sex and providing PrEP
- Clients that are more knowledgeable than their providers

Four Questions About PrEP

1. What is PrEP?

PrEP is a pill which, when taken daily, is highly effective at stopping an individual getting infected with HIV.

2. Why would I want to take it?

People who are penetrated anally and vaginally without use of condoms or who have recent sexually transmitted diseases would want to take PrEP to avoid an HIV infection.

3. Where would I go to find out more information and gain access to PrEP?

Call your local health department or visit the [PrEP webpage](#) on AIDS.gov.

4. How can I afford PrEP?

Visit [CDC's "Paying for PrEP" webpage](#) for information about paying for PrEP. Your insurance may cover the cost and there are other assistance programs which can help as well.

Definitions of PrEP and PEP

PrEP

Pre-Exposure Prophylaxis, or PrEP, is for people who do not have HIV but are at substantial risk; it works to prevent HIV infection. The

pill (brand name Truvada®) contains two medicines (Tenofovir Disoproxil Fumarate (TDF) and Emtricitabine) used in combination with other drugs to treat HIV. When someone is exposed to HIV through sex or sharing injection equipment, these medicines work to keep the virus from establishing a permanent infection within the body. When taken consistently, PrEP has been shown to significantly reduce the risk of HIV infection. In several large studies, there was no HIV infection when PrEP was taken as prescribed.

PEP

PEP stands for Post-Exposure Prophylaxis. It involves taking antiretroviral medicines as soon as possible after a possible exposure to HIV, beginning no more than 72 hours (3 days) after the potential exposure. Two to three drugs are usually prescribed and must be taken for 28 days. Taking PEP does not guarantee that someone exposed to HIV will not become infected with HIV. Some individuals who have taken PEP—particularly those who have accessed it repeatedly—may be good candidates for PrEP.

Probing Questions to Assess Interest in PrEP

- “It sounds like your HIV negative status is important to you. What do you think you could do to protect yourself even further?”
- “Have you heard of PrEP?”
- “Can I take a few more minutes to talk to you about an HIV prevention medication called PrEP?”
- “Tell me what you’ve heard about PrEP.”

Guidelines for Providing PrEP Referrals

- **Recap** the memorable CAI
- **Explore** concerns about the CAI
- **Assess** interest/readiness in PrEP information
- **Provide** handout
- **Follow** the client's lead

PrEP Referral Handout

What is PrEP?

- PrEP = Pre-Exposure Prophylaxis
- Truvada® is the brand name of a medication used for PrEP
- Truvada contains two HIV medications in one pill and, to date, is the only FDA-approved medication used for PrEP
- PrEP inhibits the replication of HIV in the body
- Truvada for HIV PrEP was first approved for treatment of HIV in 2012.
- Many HIV positive individuals are prescribed it as part of their HIV treatment regimen
- Truvada was approved for PrEP by the FDA in 2012
- The current recommendation is to take one pill daily and to get clinical follow up every 3 months
- Since PrEP doesn't protect against other STIs, condoms should be combined with PrEP.

Why would someone who is HIV negative want to take PrEP?

- Helps protect negative individuals from acquiring HIV and is highly effective when taken as prescribed
- Use of PrEP may greatly reduce the worry and stress many MSM feel in maintaining their HIV negative status
- Use of PrEP may be appropriate in certain periods of a person's life. PrEP use does not need to be a life-long necessity.

PrEP does NOT:

- Provide 100% protection against HIV
- Cure HIV/AIDS
- Function like a vaccine
- Provide protection against STIs or other infectious diseases
- And, most importantly, PrEP does not work when it isn't taken on a regular basis!

How to gain access to PrEP?

- Primary care provider
- Local STI clinic
- Other community clinics and health centers

How can someone afford PrEP?

- Health/medical insurance—public and private plans often cover PrEP
- Assistance programs such as Gilead's Patient Assistance Network can cover the cost of medication and copayments and deductibles for those who are insured.

[Project Inform](#) is a great resource for current PrEP information.

MAINTENANCE

After PCC has been implemented, maintaining it requires ongoing efforts including training, supervision, and quality assurance. These are described in the following pages. Tools for monitoring fidelity and client satisfaction—both important parts of quality assurance—are also provided.

Once PCC has been successfully implemented, there will need to be ongoing efforts to support and maintain PCC so that it will keep going and become part of standard practice in the program. Some elements that will need attention in order to maintain PCC are:

Staff Recruitment

Trained staff may leave or change positions. There should be a plan in place to recruit appropriate staff, as staff turnover. This will help maintain PCC implementation.

Training Plan

A plan for ongoing training of existing PCC staff and training of new replacement staff will be necessary to assure continuation of PCC in the agency.

Clinical Supervision

It will also be necessary to maintain PCC clinical supervision of PCC counseling staff in order to keep the intervention as part of the program. As detailed earlier in *Staff Qualifications, Roles, and Responsibilities*, this means allocating time for supervision, supervisor training and recruiting, and training a new supervisor as clinical supervisory staff leave.

Quality Assurance

Utilizing the QA tools and procedures will also help to maintain PCC.

Funding

Ongoing funding development efforts may need to be incorporated into organizational plans in order to support and maintain PCC counseling staff, clinical supervision and other time and space requirements.

Adopt PCC

Adopting PCC as part of the culture of the organization and establishing it as one of the program services that the agency provides will ensure that PCC is maintained. If PCC is required as part of the counseling protocol for appropriate clients, then the organization will allocate the time, space, staff, training, and budget to carry out this program component.

Quality Assurance Procedures

Clinical Supervision

Clinical supervision can include discussion of issues raised in PCC sessions, review of session recordings, review of the *PCC Steps Checklist*, review of returned *Satisfaction Questionnaires*, aiding counselors in understanding and dealing with feelings raised by PCC sessions and providing feedback and advice to optimize service fidelity and quality.

Clinical supervisors can monitor counselors' PCC sessions in regular individual or in group supervision meetings. The sessions can also be reviewed in case conferences. One option for monitoring sessions is audio recording. Clients must give consent for sessions to be recorded and be informed that the recordings will only be used for supervision and then erased. Clinical supervision can also use the *PCC Steps Checklist* and the *PCC Satisfaction Questionnaire* as tools for monitoring sessions.

Tools for Monitoring Adherence and Client Satisfaction

The *PCC Steps Checklist* and the *PCC Satisfaction Questionnaire* are provided as tools that can be used in clinical supervision and case conferencing to monitor adherence to the *Core Elements* and client satisfaction with the PCC intervention.

PCC Steps Checklist

The *PCC Steps Checklist* is to be completed by the counselor after a PCC session. It specifies each step of the PCC process and provides check boxes to indicate completed steps. There is space provided for counselor comments under each step. Noting comments provides helpful

information during the counseling process, such as specific issues or any difficulties in completing the step relevant to understanding what happened with the client. There is also an area at the bottom of the checklist for any additional counselor notes (i.e., referrals made, testing issues, problems handling the client, counselor's management issues, etc.). It is not necessary to write the client's name anywhere on the checklist.

It is recommended that the *Checklist* be used as a training tool for the counselor's first ten PCC sessions. As a QA tool, the *Checklist* should be used after every fourth session, or more often at the discretion of the implementing agency.

PCC Satisfaction Questionnaire

The PCC *Satisfaction Questionnaire* is a tool to determine client satisfaction with the counseling session. Clients are asked to rate their experience in the session on:

- Quality of service provided by the counselor
- Counselor's competency during the session
- Satisfaction with the help received
- Dealing with identified problems
- Learning something new
- Causing any mental stress
- Effect on future engagement in CAI

Each client that completes a PCC session should complete the PCC *Satisfaction Questionnaire*. The questionnaire is completed anonymously. The client can complete the questionnaire and place it through a slot into a box in the lobby, or the questionnaire can be handed out with a stamped

Personalized Cognitive Counseling

return envelope so the client can complete the questionnaire away from the program site and mail it back to the agency.

PCC Steps Checklist

Counselor Name: _____ Date of Session: _____

Client eligibility for PCC:

- ☐ MSM
- ☐ repeat tester for HIV
- ☐ knows condomless anal intercourse has risk for HIV/STIs
- ☐ is not already taking PrEP
- ☐ has engaged in condomless anal intercourse (since last test)
- ☐ with non-primary partner
- ☐ whose HIV status was unknown or positive

PCC Step	Completed	NOT Completed
1. Screen the client's eligibility to receive PCC Comments:		
2. Choose memorable recent episode of CAI Comments:		
3. Complete PCC Checklist of Thoughts Comments:		
4. Draw out the story of the CAI; ask about thoughts and feelings before, during, and after Comments:		

Personalized Cognitive Counseling

PCC Step	Completed	NOT Completed
5. Identify self-justifications and discuss them Comments:		
6. Talk about thoughts regarding future CAI Comments:		
Additional Comments:		

PCC Satisfaction Questionnaire

We would like to know about your recent counseling session with us. We want to know if it was helpful for you, and how we might improve our service. Please circle your answers—only one number for each question.

Do NOT write your name on the form.

1. How would you rate the quality of the service you have received from your counselor?

- 1) Excellent
- 2) Good
- 3) Fair
- 4) Poor

2. How competent was your counselor?

- 1) Highly competent
- 2) Competent
- 3) Somewhat competent
- 4) Not at all competent

3. How interested was your counselor in helping you?

- 1) Very interested
- 2) Interested
- 3) Uninterested
- 4) Not at all interested

4. How satisfied are you with the help you have received from your counselor?

- 1) Very satisfied
- 2) Satisfied
- 3) Somewhat dissatisfied

- 4) Very dissatisfied
- 5. **Would you recommend you program to a friend with similar concerns?**
 - 1) Yes, definitely
 - 2) Yes, probably
 - 3) Probably not
 - 4) Definitely not
- 6. **How much did your participation in the counseling session result in your changing some risk-related thoughts, beliefs, or attitudes?**
 - 1) A great deal of change
 - 2) A lot of change
 - 3) Some change
 - 4) No change
- 7. **Did your participation in the counseling session result in your having a plan for thinking and behaving more safely in future situations?**
 - 1) Yes
 - 2) Sort of
 - 3) No
- 8. **Did your participation in your counseling session cause you any particular mental stress?**
 - 1) No stress
 - 2) Some stress
 - 3) Moderate stress
 - 4) Considerable stress
- 9. **Will your participation in the counseling affect your likelihood of engaging in condomless anal intercourse in the future?**

- 1) Made it almost impossible that I will engage in condomless anal intercourse in the future
- 2) Made it a lot less likely
- 3) Made it a bit less likely
- 4) Made no difference

10. How old are you? Please check one.

- ☐ 18 or less
- ☐ 19-30
- ☐ 31-40
- ☐ 41-50
- ☐ 51-60
- ☐ Over 60

11. What is your ethnicity? Select one.

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino

12. What is your racial background? Select one or more.

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African-American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White

13. Comments or suggestions:

Thank you very much for your ratings and comments! Please place your survey in the box in the lobby or return it in the supplied stamped envelope.

APPENDICES

Appendix 1. PCC Glossary and Guide to Abbreviations

Active Listening

A way of engaging the client in conversation using a variety of techniques to let the person know that they are being heard, and to encourage the person to talk more. Active listening draws out the story, especially if a client is not stating clear self-justification, such as, “You said when you went to his place you thought about condoms, but you didn’t say what those thoughts were. What were your thoughts?” Active listening includes mirroring, reflecting, summarizing, and pausing.

Alcohol

In general, alcohol is a depressant, so it relaxes the central nervous system and reduces anxiety. Alcohol can lower inhibitions and make condomless anal intercourse more difficult. Impotence while drunk may lead to stimulant use to raise sexual desire or function. Research has consistently found binge drinking can increase HIV risk behavior among MSM.

Binge Drinking

For men, binge drinking is defined as having five or more drinks on a single occasion. A drink is typically defined as 1.5 ounce of liquor (like a shot or in a mixed cocktail), a 4-ounce glass of wine or a 12-ounce bottle of beer.

CAI

Acronym for Condomless Anal Intercourse

CBA

Acronym for Capacity Building Assistance in this document.

CBO

Acronym for Community-Based Organization

Cocaine

Also called coke, blow, cola, powder, nose candy, white lady, lines, snow, toot, vitamin C. People mostly snort, smoke, or inject cocaine. Cocaine is a stimulant that initially increases sex drive, energy, and motor control, as well as feelings of euphoria, alertness, and stamina. The high lasts 15-30 minutes when snorted or injected. Heavy use can result in anxiety, depression, nausea, agitation, insomnia, weight loss, loss of sex drive and compulsive behavior. Taking too much can lead to overdose and heart problems. Cocaine may stimulate desire and prolonged sexual activity, increasing mucous membrane tears or the chance of a torn condom thus increasing the risk for HIV and other STIs. Coke acts as an anesthetic and may numb feelings of tearing if applied to the anus or vagina.

Cognitive Therapy

A relatively short-term form of psychotherapy based on the concept that the way we think about things affects how we feel emotionally. It is also a type of psychotherapy in which negative patterns of thought about the self and the world are challenged in order to alter unwanted behavior patterns or treat mood disorders such as depression.

Core Elements

Core Elements are the required components representing the theory and internal logic of the PCC intervention, and are most likely to produce the intervention's main effects.

CRIS

Acronym for Capacity Building Assistance Request Information System (CRIS)

Dependent Substance User

As a general term, applies to a person needing or depending on something for support or to function or survive. As applied to alcohol and other drugs, the term implies a need for repeated doses of the substance to feel good or to avoid feeling bad. In DSM-V, Alcohol disorder (formerly called dependence in DSM IVR) is defined as "a cluster of cognitive, behavioral and physiologic symptoms that indicate a person has impaired control of psychoactive substance use and continues use of the substance despite adverse consequences."

Episodic Binge Drinking

Alcohol consumption which typically happens on weekends and/or on specific events during the week (work party, birthday party).

Episodic Substance User (ESU)

As a general term, refers to substance use that occurs on an occasional basis. Episodic binge drinking typically happens on weekends and/or on specific events during the week (work party, birthday party). Episodic drug use is typically defined as less than weekly. In general, episodic is considered once in a while.

Female to Male (FTM)

FTM refers to people who were female at birth but identify and live as male and alter or wish to alter their bodies through medical intervention to more closely resemble their gender identity are known as transsexual men or transmen (also known as female-to-male or FTM).

Genderqueer

Genderqueer is a term that some people use who identify their gender as falling outside the binary constructs of “male” and “female.” They may define their gender as falling somewhere on a continuum between male and female, or they may define it as wholly different from these terms. They may also request that pronouns be used to refer to them that are neither masculine nor feminine, such as “zie” instead of “he” or “she,” or “hir” instead of “his” or “her.” Some genderqueer people do not identify as transgender.

GHB (gamma-hydroxybutyrate)

Also known as G, Liquid X, Liquid E, GBH, Gamma-oh, Blue Verve, Grievous Bodily Harm, Georgia home boy, Goop, EZLay, Gina.

People drink and inject GHB which is an odorless, salty-to-the-taste liquid. GHB is also found in powder and capsule form and is usually taken with juice or alcohol. At lower doses people feel a euphoric effect similar to alcohol: relaxed, sociable, happy with increased libido. At higher doses, people report feeling dizzy and sleepy, with difficulty focusing the eyes. The effect takes 10 minutes and lasts 1-3 hours. Known in popular media as a “date

rape” drug, GHB is odorless and can be added to drinks very easily.

HCAT

Acronym for HIV Counseling and Testing

Ketamine

Also called K, Kelly, Special K, Ketaset, Lady K, Vitamin K, tripping, K-ing. People often cook liquid K into a white powder to be snorted or simply inject the liquid. K belongs to a class of drugs called “dissociative anesthetics” which separate perception from sensation. At lower doses people feel mild and dreamy, similar to nitrous oxide (laughing gas). Users report feeling floaty and slightly outside their bodies. Higher doses produce a hallucinogenic effect, and users may feel very far away from their bodies. This experience is often referred to as a “K-hole” and has been compared to a near death experience with sensations of rising above oneself. Some users find the experience spiritually significant, while others find it frightening. Can lower inhibitions and make safer sex more difficult. Sharing of injection equipment (needle, syringe, plunger, cooker, cotton, and water) may lead to HIV transmission. Drugs and their adulterants can inhibit the immune system, making HIV infection easier.

Key Characteristics

Key Characteristics are crucial activities and delivery method components of the intervention that can be changed without undermining fidelity to the original intervention.

Marijuana

Also called weed, cannabis, pot, mota, bud, bomb, dank, herb, dope, ganja, grass, indica, Thai stick, hash, 420, Mary Jane, chronic, reefer, KGB, bomba, hydro, yesca, mota, yerba buena, toké, stash, toké. People smoke and eat marijuana (brownies, cookies, etc.). Impaired attention may make safer sex or negotiated sex more difficult. Note: Pot has not been associated with risk on community level, but on individual level it could be. In some cases, individuals use pot as a harm reduction tool, for instance as way to decrease alcohol consumption.

Methamphetamine

Also called meth, speed, crank, ice, Chrissy, crystal, water, go fast, glass, uppers, yabu, shabu shabu, clavo, Jenny Crank, 8-ball. People smoke, snort, inject and swallow speed. People also use speed by booty bumping (inserting into the rectum with a syringe without the needle). People feel alert, confident, energetic, with increased sexual stamina and sensitivity, able to drink more, talkative, and focused. “Tweaking” refers to manic cleaning and fixing, an inability to stay still. Some users take speed to prolong sex and to increase sensitivity (speed increases blood flow, which can make anal sex more pleasurable). Prolonged sex may lead to tears in both mucous membranes and barriers thus increasing the risk for HIV and other STIs.

Mirroring

A counseling technique which simply means repeating what the client said and then not saying any more. An example of this would be mirroring back to the client a statement he had just made like,

“You said you didn’t want to bring up the subject of condoms because you were afraid he wouldn’t want to have sex.” When you use mirroring, some clients may comment on their self-justifications without needing to be asked, saying things like, “I know it’s stupid.”

Men who have sex with men (MSM)

This includes people who identify themselves as “gay,” men who identify themselves as “bisexual,” and men who have some male sex partners but do not identify themselves as gay or bisexual in terms of sexual orientation.

Motivational Interviewing (MI)

A counseling approach that works on facilitating and engaging intrinsic motivation within the client in order to change behavior. MI is a goal-oriented, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve their ambivalence.

Male to Female (MTF)

MTF refers to people who were male at birth but identify and live as female and alter or wish to alter their bodies through medical intervention to more closely resemble their gender identity are known as transsexual women or transwomen (also known as male-to-female or MTF).

Off-Line Thinking

“Off-line” thinking happens away from the immediate temptation and pressure of a potentially sexual situation. It is “cold light of day” thinking.

On-Line Thinking

“On-line” thinking is thinking in the “heat of the moment” in a potentially sexual situation, where there are immediate rewards for risky behavior.

Open-ended Questions

Open-ended questions are those which are not easily answered with a one-word response (“yes” or “no”) and do not assert the counselor’s values or objectives. Counselors should use them when they are seeking information about the context in which the CAI incident occurred. Open-ended questions invite further disclosure and help to build rapport and trust. What the counselor asks and how it is asked can also demonstrate positive regard for the client and a genuine interest in knowing how the client feels and thinks about the incident that occurred and the possible substance use that were used before, during and after.

Pausing

A counseling technique which provides an opportunity for clients and counselors to digest material and to make room for feelings or thoughts to emerge. Giving the client some time to experience the moment by allowing silence to happen is a sign of respect for the power of the client’s thoughts and feelings. Sometimes a counselor’s discomfort with silence can interrupt the client’s process. Remember: Silence is also a form of communication.

Personalized Cognitive Counseling (PCC)

PCC is a single-session, one-on-one counseling intervention, delivered in the context of HIV testing by HIV test counselors. It is

developed for HIV negative men who have sex with men (MSM), who are repeat testers and already know HIV transmission facts. The goal of the session is to assist clients in reexamining their justifications (or rationalizations) for engaging in Condomless Anal Intercourse (CAI) and then think about how they might approach CAI in the future. An adaptation of PCC for transgender women also exists.

PEP

PEP stands for Post-Exposure Prophylaxis. It involves taking antiretroviral medicines as soon as possible, but no more than 72 hours (3 days) after potential exposure to HIV, to try to reduce the chance of becoming HIV positive. These medicines keep HIV from making copies of itself and spreading through your body. Two to three drugs are usually prescribed, and they must be taken for 28 days. PEP is not always effective; it does not guarantee that someone exposed to HIV will not become infected with HIV.

Poppers

Also called amyl nitrate, isobutyl nitrite, butyl nitrite, rush.

Poppers are volatile substances that evaporate quickly into a gaseous state and can then be inhaled. Poppers are some of the most available and widely used legal substances. Because they facilitate anal intercourse by relaxing the internal and external anal sphincter muscles, poppers are often used in preparation for anal sex. Poppers cause blood vessels to dilate and thus can increase risk for HIV and other STIs.

Pre-Exposure Prophylaxis (PrEP)

PrEP is a way for people who do not have HIV but who are at substantial risk of getting it to prevent HIV infection by taking a pill every day. Truvada®, a medication currently used for PrEP, contains two medicines (tenofovir and emtricitabine). When someone is exposed to HIV through sex or injection drug use, these medicines can work to keep the virus from establishing a permanent infection. When taken consistently, PrEP has been shown to reduce the risk of HIV infection in people who are at high risk by up to 92%. PrEP is much less effective if it is not taken consistently.

Primary Partner

In the PCC research, a “primary partner” was defined as a boyfriend of greater than three months, a husband, or a domestic partner.

Probing Questions

These types of questions are used to help the client tell his story, including substances used and start time/duration of use as well identifying the thoughts and feelings he was having before, during, and after the CAI encounter. The probes are to be used as needed. Some clients will tell their story easily and the counselor’s main focus will be to stay out of the way. Others will need more guidance and encouragement.

Reflecting

A counseling skill which refers to restating the client’s comments and feelings, perhaps with some of his own words and some other words as well. Reflecting statements are validating statements and, by allowing the client to hear his words in another person’s

voice, may help to further clarify his own feelings. “It sounds like you’re disappointed that you waited too long to mention condoms, and so the conversation didn’t happen at all.”

Self-Justifications

Self-justifications are thoughts that allow an individual to make a decision to engage in a risky behavior, even though they contradict other knowledge and beliefs the individual has which supports avoiding the risk. The individual uses self-justifications to allow desired, but known, risky behavior to occur.

Serodiscordant

Refers to partners with differing serostatus. An HIV-positive person is a serodiscordant partner with an HIV-negative person.

Seropositioning

Seropositioning has been used to describe the choosing of certain sexual behaviors and sexual positions based on someone's HIV status and the status of their partner. This means that partners, once they disclose their HIV status to one other, may consider the perceived risk from some type of sex, for example engaging in anal sex, and whether to use a condom or not.

Serosorting

The choice of sex partner based on disclosed HIV status has been referred to as "serosorting." This may reduce anxiety about possible condom failure and offer a greater sense of support when dating others who can understand firsthand the experience of living with HIV. While serosorting among HIV infected individuals may reduce the likelihood of HIV transmission to those who aren't

infected, there are other important issues to consider if condoms are not used. These include the risk of STIs and reinfection.

Serostatus

Status of being HIV-negative or positive in terms of blood antibodies. People without HIV do not have HIV antibodies in their blood, so their serostatus is HIV- negative. People with HIV antibodies in their blood have an HIV positive serostatus.

Substance Use Disorder

In DSM-V, a substance use disorder (formerly called “dependence” in DSM IVR) is defined as “a cluster of cognitive, behavioral and physiologic symptoms that indicate a person has impaired control of psychoactive substance use and continues use of the substance despite adverse consequences.” As applied to alcohol and other drugs, the term implies a need for repeated doses of the substance to feel good or to avoid feeling bad.

Summarizing

A counseling skill which refers to the technique of highlighting for the client the most important aspects of the session that have been discussed.

Transgender

Transgender is an umbrella term for persons whose gender identity, gender expression or behavior does not conform to that typically associated with the sex to which they were assigned at birth. Gender identity refers to a person’s internal sense of being male, female or something else; gender expression refers to the way a person communicates gender identity to others through

behavior, clothing, hairstyles, voice, or body characteristics.

“Trans” is sometimes used as shorthand for “transgender.” While transgender is generally a good term to use, not everyone whose appearance or behavior is gender-nonconforming will identify as transgender person. Some individuals who transition from one gender to another prefer to be referred to as a man or a woman, rather than as transgender.

Appendix 2. PCC Checklist of Thoughts

Here's a list of thoughts some guys have had when making decisions to have condomless anal sex. Thinking about the most recent OR most memorable time you had condomless anal sex with a partner that is not close to you (like a husband or ongoing boyfriend) try to recall what you were thinking that allowed you to have sex without a condom. Were you drinking alcohol and/or using drugs? Use the list below to check off any thoughts similar to yours.

At the time I decided to have condomless anal intercourse I thought something like:

- ☐ He said he was negative, and I have been tested. So, it must be safe.
- ☐ He said he is on PrEP so we are both protected.
- ☐ Fucking without a condom makes me feel closer to him.
- ☐ Alcohol and/or drugs let me forget about HIV risk.
Sometimes I just want
to stop thinking about all that.
- ☐ It'll be all right to fuck without a condom as long as we don't cum in the
ass.
- ☐ The condom broke so we should just go for it.
- ☐ We've already fucked earlier (today/tonight) without a condom, so there's
no point in using one now.
- ☐ I'm feeling kind of lonely/depressed and I don't care so much.
- ☐ I drank/used more than I'd planned and it just happened.
- ☐ He's so young he must be negative.

- ☐ I've done this before and I'm still negative so it can't be that risky.
- ☐ This guy looks healthy, he is probably negative.
- ☐ Condoms make it more difficult to keep an erection.
- ☐ Part of me is saying this is risky, but another part is telling me to go for it.
- ☐ Alcohol and/or drugs gave me permission to do all the things I know I'm not supposed to.
- ☐ He let me fuck him without a condom, so I have to let him fuck me the same way.
- ☐ Topping isn't that risky.
- ☐ I usually use condoms. This one time without a condom won't matter.
- ☐ I know enough about this guy, I think I can trust him.
- ☐ I am not going to bring up HIV status now. It would ruin the moment.
- ☐ I don't want to interrupt the flow just to put on a condom.
- ☐ This feels more natural. Sex is just better without condoms.
- ☐ He seems really concerned about HIV so he must be negative.
- ☐ He would have told me if he was HIV positive.
- ☐ His profile said he's on HIV meds and has an undetectable viral load so this is low risk.
- ☐ I know this is risky, but that's partly what makes it so hot.
- ☐ Usually I'm more careful but I'm too high to think about using a condom.
- ☐ I didn't want to fuck without a condom but the alcohol/drugs made me so horny I just did it.
- ☐ I don't want to think about risk. I just want to be drunk/high and have hot sex.

Personalized Cognitive Counseling

- ☐ Escape, escape, escape! I just want to forget about everything and have sex.
- ☐ Alcohol and/or drugs made it easier for me to have sex without a condom.
- ☐ I don't want to feel any inhibitions. I just want to get wild.
- ☐ Sex is always better when I have been drinking (or using drugs) and I didn't want to ruin that.
- ☐ This guy is really hot and he doesn't want to use a condom. I don't want to lose this opportunity.
- ☐ Please write in any other thoughts that allowed you to have anal sex without a condom:

Appendix 3. Examples of Probing Questions for PCC

Substance Use Probes

- “Please include in your story any substances used by you and, if known, used by your partner at the time you (and partner) began using and duration of use.”
- “Were either you or your partner drinking or using substances? “
If the answer is yes:
- “Tell me what was being consumed while the evening continued.”
- “How did being high impact your decision to engage in CAI?”
- “How much had you been drinking/using?”
- “How was the alcohol/drug making you feel?”
- “How was the (alcohol, cocaine/crack, meth etc.) affecting how you were thinking?”
- “What, if any, connection was there between how high you were and your thoughts about CAI?”

Partner Probes

- In this context, “partner” refers to the sexual partner in the episode of CAI.
- “Tell me about your partner.”
- “How did you meet?”
- “What made him attractive?”
- “At what point did you realize that your interaction with this man might become sexual? How did you know? How were you feeling about it?”
- “How did the (alcohol, cocaine/crack, meth etc.) impact, if at all, your interaction or attraction to this partner?”

[Only if interaction was with a boyfriend]: “How did being in a relationship influence the types of sex you had and how you felt about it?”

Mood Probes

- “How were you feeling emotionally the day before you had sex with [name]?” “What kind of mood were you in that day or week?”
- “How were you feeling about yourself in general?”
- “In what way did the (alcohol, cocaine/crack, meth etc.) impact/alter your mood?”

Time Probes

- “What time of day was it when you guys had sex?”
- “What had you just been doing at the time you met?”
- “Were you expecting to hook up with someone that night/day? Why?”
- “What were your thoughts about whether or not you would have sex that night/day?”

Place Probes

- Type of venue, chat room, time of day, environment, social situation, work setting, etc.
- “Where did you meet your partner?”
- “Where did you have sex?”
- “What was the place like?”
- “How were you feeling about the place?”
- “What substances were used at the place and by whom?”

Sex Probes

- “How did the sexual activity get started?”
- “What did you guys do sexually?”
- “How often do you have sex?”
- “At that time, what was going through your mind?”
- “At what point did you decide to have anal sex?”
- “How, if at all, did the (alcohol, cocaine/crack, meth etc.) impact your decision to have anal sex without a condom?”
- “What was going through your mind while you were having anal sex?”
- “How were you feeling while you were having anal sex?”
- “What were you feeling afterward?”
- “How satisfying was the sex?” How so/why not?”

Communication Probes

- “What kinds of body language did the two of you exchange about whether you would use a condom?”
- “What did you say about whether you would use a condom?”
- “How, if at all, did the (alcohol, cocaine/crack, meth, etc.) impact your communication with your partner?”
- “What assumptions, if any, did you make about your partner’s HIV status?”
- “Did these assumptions affect what you did?”

Perceived HIV Risk

- “Would you consider what you guys did to be safe or unsafe with respect to HIV?”
- “What part made it safe or unsafe?”

Probes for Thoughts Before Sex

Goal is to make sure there is a clear understanding of any distorted thoughts the person had prior to sex that could be influencing his behavior. This is important because it lays the groundwork for the next step.

- “What kinds of thoughts were you having earlier that day?”
- “Do you have a sense of what was triggering those thoughts?”
- “How was any substance use impacting your thoughts before sex?”
- “How does that kind of thinking make you feel? What does that mean to you?”
- “What were you thinking when you first got there? What were you saying to yourself?” “At what point did that thought change? What made it change?”
- “What were you thinking when you first started talking?”
- “How long were you thinking that? Do you usually think those kinds of things when you are in situations like that?”

Probes for Feelings Before Sex

Goal is to make sure there is a clear understanding of the client’s feelings prior to sex that could be influencing his behavior. His strategies to manage his feelings may be important in leading to the risk incident.

- “How were you feeling earlier that day?”
- “Do you have a sense of what was triggering those feelings?”
“What does that mean to you that you were feeling that way?”
- “How was any substance use impacting your thoughts before sex?”

- “What were you feeling when you first got there? What was that like for you?” “At what point did your mood shift? What made it change?”
- “How were you feeling when you first started talking?”
- “How long did that feeling last? Do you always feel that way when you are in situations like that?”
- “What do you usually do when you feel that way?”

Probes for Thoughts During Sex

Goal is to get a sense of his specific thoughts at various moments during the sexual encounter. Give the client plenty of time to recreate it in his mind so he can give you specifics.

- “While you were having sex, do you remember what you were thinking?” “How did that thinking make you feel?”
- “How, if at all, was your use of substances impacting your thoughts during sex?”
- “At what point (of sexual encounter) did your thought change?”
- “Do you think those thoughts had anything do with what you did sexually? How or why?”
- “If not, can you imagine how your thoughts might interfere with you being able to have safer sex?”

Probes for Feelings During Sex

Goal is to get a sense of his specific emotions at various moments during the sexual encounter. As with probes for thoughts, give the client plenty of time to recreate it in his mind so he can give you specifics.

- “While you were having sex, do you remember what you were feeling emotionally?” “At what point (of sexual encounter) did your feelings change?”
- “Do you think your feelings had anything to do with what you did sexually? How or why?”
- “How, if at all, was your use of substances impacting your feelings during sex?”
- “If not, can you imagine how your feelings might interfere with you being able to have safer sex?”

Suggested Probes for Thoughts After Sex

Goal is to obtain helpful information for when identifying a problem/distorted thought. These questions will reflect the negative consequences of their behavior, which they will want to avoid re-experiencing.

- “What about afterward? What were you thinking then? What were you saying to yourself about that encounter?”
- “What thoughts, if any, were you having about your substance use before and/or during condomless anal sex?”
- “How did you feel about yourself at that point?”
- “So, when you have thoughts about before or during sex and have condomless anal sex you end up feeling? Is that right? Do you see that as a problem?”

Suggested Probes for Feelings After Sex

Goal is to obtain information helpful to identifying a problem. These questions will reflect the negative consequences of their behavior, which they will want to avoid re-experiencing.

- “What feelings, if any, were you having about your substance use before and/or during condomless anal sex?”
- “What about afterward? What were you feeling then? How did you feel about yourself?” “How long did you feel that way? What did you do?”
- “So, when you feel before or during sex and have condomless anal sex you end up feeling? Is that right? Do you see that as a problem?”

Appendix 4. PrEP Basics

PrEP: The Basics

1. Medication Instructions

- There are 30-pills of Truvada in each bottle (30-days' worth of PrEP).
- Store the bottle at room temperature (not in fridge/hot car).
- Can be taken with or without food.
- Can be taken when drinking alcohol or using drugs.

2. One Pill Per Day

- Take 1 pill every day.
- People who use PrEP more consistently have higher levels of protection against HIV.
- You should take Truvada at least 7 days to achieve high enough levels in the body to protect against HIV from a possible exposure through anal sex.
- We have no evidence that taking more than one pill a day gives any additional protection. In fact, taking too many can be bad for your health or make you feel sick.
- There are studies going on right now to try to see if less than once a day PrEP would still help protect people from HIV. Based on what we know right now, we recommend people take PrEP as close to daily as possible.

3. Potential Side-effects

- Some people experience early side effects when taking Truvada for PrEP. This may involve gas, bloating, soft/more frequent stools, or nausea.
- These symptoms are usually mild and go away after the 1st month on PrEP.
- Strategies to deal with stomach related symptoms:
 - Take pill with food/snack
 - Take pill at night before bedtime
- Contact your medical provider if you have side effects.

4. Sometimes Doses are Missed

- People sometimes forget or skip doses. It is not uncommon.
- If you forget a dose just take it when you remember. For example:
 - *If usually take in AM, but realize at 10 pm that you forgot, it's okay to take 1 pill then and continue with your usual schedule the next day.*

5. Getting into a Routine

- Many people find it helpful to take their pills at the same time as something else they regularly do each day (e.g. eating breakfast, brushing teeth).
- Reminders (alarm or seeing the bottle somewhere you look each day) can also help.
- Pill boxes can be used to help with regular pill taking.
- When routines are disrupted (e.g. staying out overnight, going on vacation, skipping meals), consider carrying extra pills on you.

6. Discussing PrEP with Others

- People sometimes find it helpful to tell friends or family that they are taking PrEP (can help support pill taking). Think carefully about who you might want to tell you're taking PrEP (you want it to be someone who will be supportive).
- It's your personal decision, and you should not feel pressured to tell anyone.

7. Stopping PrEP

- Whether or not you want to take PrEP is your decision.
- If you choose to stop PrEP, please notify your medical provider.

8. Restarting PrEP

- If you have stopped PrEP for more than 7 days and would like to re-start, please call your medical provider and let them know so they can help you do this safely.
- Getting an HIV test before you re-start PrEP is very important. If you are already infected with HIV and take Truvada, the virus could become resistant to this medication, which means that the medication will no longer work for HIV treatment.
- Report any flu-like symptoms or rashes to your provider as they could be symptoms of early HIV infection.

9. Combining PrEP with other prevention strategies

- PrEP isn't 100% effective and also doesn't protect against other STDs. PrEP should be combined with other prevention strategies.

Questions/Concerns

- Contact your medical provider if you have any questions or concerns, or if you're going to run out of pills before your next visit. If you have an emergency, call 911 or go to the hospital emergency room.