

# *Comprehensive HIV Risk Assessment: Building Skills in Sexual and Substance Use History Taking*

## **A PROVIDER TRAINING MANUAL**

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# Introduction to *Comprehensive HIV Risk Assessment: Building Skills in Sexual and Substance Use History Taking – A Manual for Trainers*

## Purpose of the Manual

In April 2002, JSI Research & Training Institute produced two publications focused on the important work of HIV risk assessment in reproductive health settings: *Asking the Hard Questions: A Reproductive Health Provider's Guide to Client-Centered HIV Risk Assessment* and *Supporting Quality HIV Risk Assessment: A Guide for Reproductive Health Clinic Managers and Supervisors*. Both Guides were developed as self-instructional tools. The Managers' and Supervisors' Guide also includes directions on using the content of the Guides for staff training.

This Manual is designed to prepare local personnel to offer trainings in comprehensive sexual health and HIV risk assessment based on these JSI publications.

## Contents of the Manual

The purpose of this manual is to support a trainer in preparation and delivery of training related to comprehensive HIV risk assessment. There are two sets of Units.

One set is composed of six Units intended for the training of providers – clinicians, counselors and other healthcare professionals – in performing risk assessment. All the Units in this set are indicated by this graphic:



### The Units for Providers include:

#### Unit One: What is Risk Assessment, and Why Do It?

This Unit establishes the rationale for doing risk assessment. Data supportive of the need for risk assessment helps providers to understand the reasons for the questions asked and to appreciate the value of risk assessment to clients. Activities in this Unit also focus on the practical barriers many providers anticipate to doing risk assessment, and on strategizing ways to overcome those barriers. An optional activity, Paper Toss, personalizes the need for risk assessment in a powerful fashion.

## **Unit Two: “Listening In” on Risk Assessment**

This Unit helps providers to recognize effective approaches to risk assessment via the use of two brief vignettes from risk assessment sessions.

## **Unit Three: Overcoming Personal Barriers to Risk Assessment – Our Clients’ and Our Own**

This Unit facilitates identification of personal concerns regarding risk assessment from the perspective of both provider and client, and addresses providers’ judgments about clients’ behaviors and life circumstances. Providers can pinpoint issues most difficult for them to handle and have the opportunity to role-play and process those challenging client interactions.

## **Unit Four: The Language of Risk Assessment**

The focus of this Unit is on all aspects of communication between clients and providers – verbal, non-verbal and paraverbal – looking at the words used and way in which they are expressed. Particular attention is given to the essential skill of open-ended questioning.

## **Unit Five: Responding to Difficult Questions and Statements – The 3C Model**

This Unit introduces providers to a simple model with which to structure response to difficult questions and statements from clients. Providers will practice with the model, trying it out on a list of difficult lines, as well as with questions and statements from clients in their own clinical experience.

## **Unit Six: Case Presentation and Processing**

This Unit can serve as a model for on-going quality assurance of risk assessment work. Providers present their own difficult cases for discussion.

The second set is composed of four Units intended for the training of supervisors and clinic managers to enhance their ability to ensure the on-going quality of risk assessment work. All the Units in this set are indicated by this graphic:



**The Units for Supervisors include:**

**Unit One: Nuts and Bolts of Risk Assessment – Developing Protocols and Forms**

This Unit offers a model protocol to supervisors and gives them opportunity to consider how this model might inform development or improvement of a protocol for their setting. Current and proposed risk assessment and history-taking forms will be reviewed.

**Unit Two: Introducing Observation and Feedback to your Staff**

The heart of active supervision involves observation of providers conducting risk assessment in actual clinical encounters, followed by giving feedback to the provider, and strategizing for skill improvement. This Unit will give supervisors the opportunity to identify barriers to doing clinical observation, and develop approaches for introducing it to staff.

**Unit Three: The Art of Feedback and Strategizing**

This Unit presents guidelines for giving feedback to providers and strategizing with them for improvement. The Unit includes the use of the video, “Client-Centered Counseling,” as well as role-play using feedback and strategizing skills.

**Unit Four: Making Effective Referrals**

This Unit will help supervisors identify any deficits in their current referral protocols and practices, and give them a process for enhancing the effectiveness of referrals.

## How to Use this Manual

All Units are made up of activities focused on one aspect of the delivery or supervision of risk assessment. Most Units can be used for either one-on-one or group trainings. Activities for one-on-one facilitation are presented under this graphic:



Activities for working with groups of 2 or more are presented under this graphic:



All Units include sections on **Group Size**, **Time Duration**, and **Materials and Preparation**. Here you will find information on the recommended number of trainees for each Unit, approximate time needed, and a list of handouts and other materials. Look for this clock symbol for descriptions of ways to vary activities so as to allow adjustments for different time allotments.



Handouts should be distributed at specific points in the training session, as directed in the **Procedure** section. Handouts may be reproduced to create overheads, or copied onto newsprint to facilitate group discussions.

The **Procedure** section of each Unit includes specific language to be directed to trainees. This language is designed to help the trainer develop important verbal content. Where appropriate, examples are included of trainee input likely to be elicited by interactive training activities. While this language is not intended to be a script, the “scripting” may be useful for a trainer in developing his or her own language to express the content being presented. It is not intended that the trainer speak this “scripting” word-for-word. The “scripting” is intended to convey the key ideas to be related at a level of detail that will fit with the time allotted, and the kinds of examples useful for presentation. It is hoped that trainers will personalize this material according to their own style and experience.

In some Units, extended **Discussion Points** expand on the content of the Unit, offering important background narrative, as well as notes to alert the trainer to particular issues that might arise during an activity.

For ease of reading, most pronouns used in these Units are feminine.

# Asking the Hard Questions: Training Activities to Enhance Providers' Risk Assessment Skills



## Unit Title

**Unit One: What is Risk Assessment, and Why Do It?**

## Objectives

- To introduce the content of sexual and substance use risk assessment.
- To increase providers' understanding of the rationale for conducting sexual and substance use risk assessment with reproductive health clients.
- To enhance appreciation of the value of risk assessment from the perspective of the client.
- To identify practical barriers to doing risk assessment, and strategize responses to those barriers.


## Group Size

While this Unit may be done one-on-one, it is best suited to a group of at least 3 trainees.

## Time Duration

30 - 45 minutes for one-on-one session

45 minutes – 1 hour, 30 minutes for group sessions

Look for this symbol  for instructions on how to change the length of a training session by varying the use of different activities.

## Materials & Preparation



*Handout – Identifying Benefits of and Concerns About Doing Risk Assessment*  
*Handout – Paper Toss* (to be used with a minimum of 10 participants)  
*Handout – Questions to Guide Risk Assessment*

*Handout – The Facts Behind Risk Assessment* (Be sure to update information, as new data becomes available. Data regarding trainees' own state or region may have particular relevance and meaning for them.)

*Handout – Clients' Expectations Regarding Risk Assessment*

*Handout – Practical Concerns About Doing Risk Assessment*

*Handout – Responses to Practical Concerns About Doing Risk Assessment*

Prepared newsprint or overheads with content of handouts, if desired

Easel, newsprint and markers for group training

## Procedure



### One-on-one training:

- Review the objectives for this Unit.
- Give the trainee the handout, *Identifying Benefits of and Concerns About Doing Risk Assessment*. Ask trainee what she thinks the benefits of sexual and substance use risk assessment are for a client. She may record her responses on the handout, if desired. Listen for and confirm, adding if necessary, responses such as:
  - ✓ The provider can educate the client regarding risk behavior and risk reduction, focusing specifically on the client's need.
  - ✓ The client can gain a greater and more accurate perception of her own risks.
  - ✓ The provider can better provide medical screening and care based on understanding the client's risk-related behavior.
  - ✓ The client can have the opportunity to discuss difficult, personal concerns, and ask and answer questions that are often not dealt with by her health care providers.
  - ✓ The provider can offer referrals to respond to needs that emerge during risk assessment.
  - ✓ The client may be able to use the support of an understanding provider in taking the step of changing behavior.
  - ✓ A provider's sensitive approach in doing risk assessment can create rapport with the client.

- If necessary, explain that sexual and substance use risk assessment is a required service in Title X-funded reproductive health care settings, and is becoming a standard of care for health care providers in many other settings. Acknowledge that, at the same time, doing risk assessment creates challenges for many providers.
- Provide trainee with the handout, *Questions to Guide Risk Assessment*. Allow trainee time to review the questions, and then begin a discussion of the trainee's reactions to the questions. Discuss any questions she has about the reason[s] behind any of the questions.
- Be certain to let the trainee know that this handout is not intended to be used as a data collection form. Ideally, risk assessment doesn't involve a question-and-answer and form completion format. An informal conversation based on these questions can generate all the answers needed, and forms can be completed after that conversation is over.
- Give trainee the handout, *The Facts Behind Risk Assessment*. Allow time for trainee to review materials, or you can go over the material together. Discuss reactions to the data.
- Give trainee the handout, *Clients' Expectations Regarding Risk Assessment*. After she has reviewed it, ask for her reactions. Ask trainee,

*How would you feel if your own health care provider asked you these risk assessment questions?*

- Ask trainee to list all the concerns she has associated with doing risk assessment. She can record them on the handout, *Benefits of and Concerns About Doing Risk Assessment*. Review the list, and confirm responses, adding as necessary:
  - ✓ Not enough time
  - ✓ Not enough privacy
  - ✓ Language barriers
  - ✓ Client's discomfort in discussing these issues
  - ✓ Client's discomfort discussing these issues in front of a person who has come with her (partner, parent, friend)
  - ✓ Concerns about cultural sensitivity
  - ✓ Fear of offending the client
  - ✓ Provider's lack of knowledge about issues raised
  - ✓ Provider's discomfort with behaviors described by client
  - ✓ Provider's judgments
- Give trainee the handout, *Practical Concerns About Doing Risk Assessment*. Discuss strategies to respond to these concerns. Use the

handout, *Responses to Practical Concerns About Doing Risk Assessment* to guide your discussion.



### Group training:



- Review the objectives for this Unit.
- Facilitate the Paper Toss Activity. (See page 8 of this Unit for instructions.) **If necessary to save time, you can omit the Paper Toss activity.**
- Explain that sexual and substance use risk assessment is a required service in Title X-funded reproductive health care settings, and is becoming a standard of care for health care providers in many other settings. Acknowledge that, at the same time, doing risk assessment creates challenges for many providers.
- Distribute the handout, *Identifying Benefits of and Concerns About Doing Risk Assessment*. Divide trainees into 2 groups. (If you have more than 16 trainees, divide them into 4 groups.) Explain that each group (or each set of two groups) will discuss a question from the perspective of either a provider or a client.
- Ask each group to brainstorm, and record on the handouts, responses to the following question:

*What are all the benefits of sexual and substance use risk assessment? (Ask one group – or one set of two groups – to answer from the perspective of the client; the other from the perspective of the provider.)*
- Elicit responses from each of the groups. Record responses on newsprint, if desired. Listen for and confirm, adding if necessary, responses such as the following:
  - ✓ The provider can educate the client regarding risk behavior and risk reduction, focusing specifically on the client's need.

- ✓ The client can gain a greater and more accurate perception of her own risks.
  - ✓ The provider can better provide medical screening and care based on understanding the client's risk-related behavior.
  - ✓ The client can have the opportunity to discuss difficult, personal concerns, and ask and answer questions that are often not dealt with by her health care providers.
  - ✓ The provider can offer referrals to respond to needs that emerge during risk assessment.
  - ✓ The client may be able to use the support of an understanding provider in taking the step of changing behavior.
  - ✓ A provider's sensitive approach in doing risk assessment can create rapport with the client.
- Distribute the handout, *Questions to Guide Risk Assessment*. Ask trainees, in their small groups, to review the questions. Facilitate a full group discussion of reactions to the questions: Ask:

*What questions do you have about the reason[s] behind any of the questions?*

- Be certain to let trainees know that this handout is not intended to be used as a data collection form. Ideally, risk assessment doesn't involve a question-and-answer and form completion format. An informal conversation based on these questions can generate all the answers needed, and forms can be completed after that conversation is over.
- Distribute the handout, *The Facts Behind Risk Assessment*. Ask trainees to read over the handout. Invite them to discuss it with other trainees, if time allows. Referring to the prepared newsprint or overhead of this handout, if you are using one, facilitate a discussion of reactions to the data.
- Distribute the handout, *Clients' Expectations Regarding Risk Assessment*, and then facilitate a discussion. Ask trainees:

*How would you feel if your own health care provider asked you these risk assessment questions?*

- Ask each group to brainstorm, and record on the bottom half of the handout, *Benefits of and Concerns About Doing Risk Assessment*, responses to this question:

*What are your concerns associated with doing risk assessment?*  
(Again, one group answering as a client, one as a provider.)

- Elicit responses from each of the groups. Record responses on newsprint, if desired. Listen for and confirm, adding if necessary, responses such as the following:
  - ✓ Provider doesn't have enough time
  - ✓ There is not enough privacy
  - ✓ Language barriers exist between provider and client
  - ✓ Client's discomfort in discussing these issues
  - ✓ Client's discomfort discussing these issues in front of a person who has come with her (partner, parent, friend)
  - ✓ Concerns about cultural sensitivity
  - ✓ Fear of offending the client
  - ✓ Provider's lack of knowledge about issues raised
  - ✓ Provider's discomfort with behaviors described by client
  - ✓ Provider's judgments
- Distribute handout, *Practical Concerns About Doing Risk Assessment*. Have trainees form groups of two or three. Assign one or two of the practical concern questions to each small group. Explain that each group is to come up with some ideas for how to respond to their assigned practical concerns. After 5-8 minutes, ask for verbal reports from each group. Use the handout, *Responses to Practical Concerns About Doing Risk Assessment*, to guide your discussion.
- Following group discussion, distribute the handout, *Responses to Practical Concerns About Doing Risk Assessment*.



Alternative activity, if time is short:

- Instead of having trainees work in small groups to strategize responses to the practical concerns, distribute the handout, *Responses to Practical Concerns About Doing Risk Assessment*. Use it to guide a brief, didactic presentation of responses to concerns.

## Discussion Points

- Trainees may express concerns about the number of questions on the handout, *Questions to Guide Risk Assessment*. Explain that it is not expected that all of these questions would be used in every session. By asking just one question in each topic area, it is likely the response to several will emerge.
- Trainees may express concern about the choice of words used in these questions. These are intended as examples for providers, not as a script.

Providers will want to put them into their own words, being aware of the judgment that may be inherent in some word choices.

- The Paper Toss activity is a quick and lively way of surfacing difficult experiences in the lives of trainees. It is crucial to ensure anonymity in the survey of responses. It is worth reiterating to the group that trainees, who are standing to represent any particular response, are not representing their own response, but that of the paper they hold.
- The Paper Toss questions suggested on p.8 touch on very sensitive topics. Any time trainees are asked to reflect on their own life experiences it is important to acknowledge that the questions may be surfacing painful memories. Assure the trainees that they will not be expected to share anything about those experiences. Do not insist on participation by anyone who seems reluctant to be a part of the activity. She may be withdrawing to manage her emotional response to the issues raised.
- The Paper Toss activity is adaptable to many topic areas by simply changing the questions asked.

### Follow-up Activities

- This Unit should be followed by Unit Two: **Listening In on Risk Assessment**. If trainees are extremely troubled about doing this work, you might first go to Unit Three– **Overcoming Personal Barriers to Risk Assessment – Our Clients and Our Own**.

### Paper Toss

- Distribute the *Paper Toss* handout.
- Tell trainees that this activity will be an anonymous way to surface experiences in the group that might be similar to those of clients. Instruct them not to write their names on the papers, or to look at one another's papers.
- Tell them that you will ask three questions about possible life experiences. They are to circle "Yes" or "No" in response to each question.
- After responding to the questions, they will crumple the papers into balls, and throw them around the room for another trainee to pick up. When a paper is picked up, it should be thrown again – each trainee should make three tosses of three different paper balls. This process should ensure confidentiality when the papers are unfolded and the responses shared.
- Choose **three** of the following questions to ask, reminding trainees to circle "Yes" or "No" on the handout: (You may want to come up with different questions than those suggested.)
  - ① *Have you ever risked becoming infected with HIV, or any other infection in your own sexual or substance use behavior, even though you may have known about how those infections are transmitted?*
  - ② *Have you ever had a sexual experience under the influence of alcohol or another drug that you might not have had if you hadn't been "under the influence?"*
  - ③ *Have you ever experienced intimate partner violence (domestic violence) or sexual abuse or assault?*
  - ④ *Have you ever had sex with someone because of fear, coercion or pressure?*
  - ⑤ *Have you ever had a sexual experience enhanced by the use of alcohol or other drugs?*

**Reminder:**

***These Paper Toss questions touch on very sensitive topics. Any time trainees are asked to reflect on their own life experiences it is important to acknowledge that the questions may be surfacing painful memories. Assure the trainees that they will not be expected to share anything about those experiences. Do not insist on participation by anyone who seems reluctant to be a part of the activity. She may be withdrawing to manage her emotional response to the issues raised.***

- After asking the questions, instruct trainees to quickly crumple paper into balls and begin tossing them toward other trainees, for three tosses. After the third toss, trainees may open the papers they are now holding.
- Do a standing survey for each question, having trainees holding “yes” responses stand first, followed by those with “no” responses, to give a visual summary of the group’s experiences.
- After the standing survey, ask these questions:

*What’s your reaction to this survey of our own experiences? How might the presence or absence of these experiences in a provider’s own life impact her work with clients?*

- Based on the group’s responses, facilitate a discussion, focusing on the ways in which personal experience can both help and hinder work with a client. Include discussion of the influence of these factors: the provider’s relationship to her own experience; her judgments about the behavior; her continued need for healing from her experience; any assumption that her way of dealing with the experience “ought” to be right for others.

**Identifying Benefits of and Concerns About Doing Risk Assessment**

What are all the benefits of sexual and substance-use risk assessment?

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What concerns do you have about doing sexual and substance-use risk assessment?

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## QUESTIONS TO GUIDE RISK ASSESSMENT

### ***Sexual Behaviors***

*Tell me about your current sexual relationship or relationships.*

*Tell me about your sexual activity in the past.*

*How old were you the first time you had a sexual experience with another person?*

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### ***HIV/STI Risk***

*What are you doing now to protect yourself from HIV (the virus that causes AIDS) and other sexually transmitted infections? How about in the past?*

*Have you ever had a sexually transmitted infection - such as chlamydia, trichomoniasis or "trich," herpes, HPV or warts, gonorrhea, syphilis?*

*Have you ever been tested for HIV?*

*Have you or any of your sex partners ever been in prison?*

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### ***Pregnancy Intentions***

*What are you doing to avoid unintended pregnancy?*

### ***Substance Use History***

*Have you ever felt that alcohol or drugs were a problem for you?*

*How many times in the past week have you used alcohol or other drugs?*

*Have you ever injected drugs?*

*To your knowledge, have any of your sexual partners injected drugs?*

*How has drinking or using drugs affected your sexual behavior?*

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### ***Sexual Functioning & Relationship Issues***

*How satisfied are you with your sexual relationship(s)?*

*Has your partner ever tried to hurt you?*

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### ***Domestic Violence/ Sexual Assault or Abuse***

*Have you ever been forced to have sex when you didn't want to?*

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### ***Other HIV-Related Risks***

*Since 1977, have you had a blood transfusion? Have you had sex with someone who has had a blood transfusion?*

*Do you have hemophilia? Have you had sex with someone who has hemophilia?*

*Have you shared equipment for tattoo, body piercing?*

## *The National Scene*<sup>12</sup>

- In 1981, adult and adolescent women made up only 8% of total AIDS cases. By the year 2000, they made up almost 23% of cases.
- HIV is the fifth leading cause of death for all women, ages 25 to 44.
- For African-American women HIV is the third leading cause of death, and for Latinas the fourth leading cause. These women of color make up only a quarter of the female population of the U.S. Yet they now represent over 77% of all AIDS cases among women in this country.
- In 2000, almost 60% of AIDS cases among adolescents, ages 13 to 19, were female. Among these young women, the majority reports that they contracted HIV through heterosexual contact.

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<sup>1</sup> Centers for Disease Control and Prevention (CDC) (January 31, 2001) *HIV/AIDS among US Women: Minority and Young Women at Continuing Risk*. Available at <http://www.cdc.gov/hiv/pubs/facts/women.htm>.

<sup>2</sup> Kaiser Daily HIV/AIDS Report. (May 4, 2001) *Women Increasingly Bearing the Burden of HIV/AIDS, Study Finds*. Available at [http://www.kaisernetwork.org/daily\\_reports/print\\_report.cfm?DR\\_ID=4415&dr\\_cat=1](http://www.kaisernetwork.org/daily_reports/print_report.cfm?DR_ID=4415&dr_cat=1).

## *Closer to Home - Women in New England*

*Here are some findings from a 1996 survey of 2000 clients of family planning clinics in Massachusetts<sup>3</sup>*

- Of those who reported having more than one partner in the past 12 months, 65% did not use condoms at last intercourse. Almost 60% did not use condoms consistently.
- Almost half of the women who reported just one sex partner in the past 12 months, believed that their current partner, or a prior one, had other partners.
- Of those who had anal sex, over 85% had done so without using condoms.
- Over 35% reported the use of drugs and/or alcohol along with sexual activity.
- The younger a woman was when she first had intercourse, the more likely she was to have one or more of several risks - having ever had an STI, experienced coerced sex, and/or engaged in anal intercourse. And the younger she was when she first had intercourse, the more likely alcohol or drugs were involved.
- Teens were twice as likely as older women to have used non-injection drugs, and/or to have a partner who was using them, the last time they had intercourse.

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<sup>3</sup> Massachusetts Department of Public Health, Office of Statistics and Evaluation. (1998) *Family Planning Clients and HIV Risk: A Survey of Massachusetts Women*. Available at <http://www.state.ma.us/dph/ose/fpcexec.htm>.

### ***Lack of Communication Between Sex Partners***

Although we encourage clients to ask their partners about their sexual histories, they frequently hesitate to do so, and even if they do a partner's honesty can't be guaranteed. A 1998 Kaiser Family Foundation/Glamour Magazine *Survey of Men and Women on Sexually Transmitted Infections*<sup>4</sup> found the following:

- About 35% of both men and women who had ever had intercourse had not discussed STIs with partners.
- Of those who had ever had an STI, about 25% of both men and women said that their current partners were not aware of that.
- Of those who said that their current partner was aware of their past or current diagnosis of an STI, about half did not tell their partner about the STI prior to the first time they had intercourse.

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<sup>4</sup> Kaiser Family Foundation/Glamour Magazine. (August 1999) *Survey of Men and Women on Sexually Transmitted Infections*. Available at <http://www.cdc.gov/hiv/pubs/facts/women.htm>.

### ***The Sex and Drug Connection***

The connection between risky sexual behavior and substance use is extremely strong. We can not adequately respond to our clients' sexual and reproductive health care needs if we do not ask about substance use.

- **In 1999, 40% of women diagnosed with AIDS were infected through heterosexual contact, often through sex with an injection drug user.<sup>5</sup>**
- **In 1999, almost 30% of women diagnosed with AIDS were infected via their own injection drug use.<sup>6</sup>**
- **Substance use (alcohol and other drugs) is linked with unplanned pregnancies, sexual assault, domestic violence, and HIV.<sup>7</sup>**
- **Men and women of all ages are more likely to engage in unsafe sexual behaviors if they are under the influence of alcohol or other drugs.<sup>8</sup>**
- **Teens who use substances are more likely to have sex, to start having sex at younger ages, and to have multiple partners.<sup>9</sup>**
- **The overwhelming majority of primary care physicians are not adequately addressing their patients' substance using behavior.<sup>10</sup>**

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<sup>5</sup> Centers for Disease Control and Prevention (CDC) (January 31, 2001) *HIV/AIDS among US Women: Minority and Young Women at Continuing Risk*. Available at <http://www.cdc.gov/hiv/pubs/facts/women.htm>.

<sup>6</sup> *ibid*

<sup>7</sup> The National Center on Addiction and Substance Abuse at Columbia University (CASA) (December 1999) *Dangerous Liaisons: Substance Abuse and Sex*. Available at [http://www.casacolumbia.org/usr\\_doc/21598.PDF](http://www.casacolumbia.org/usr_doc/21598.PDF)

<sup>8</sup> *ibid*

<sup>9</sup> *ibid*

<sup>10</sup> The National Center on Addiction and Substance Abuse at Columbia University (CASA) (June 5, 1996) *Substance Abuse and The American Woman*. Available at [http://www.casacolumbia.org/usr\\_doc/5894.PDF](http://www.casacolumbia.org/usr_doc/5894.PDF)

***Incarceration: Its Link to HIV<sup>11</sup>***

We see clients who have been incarcerated, as well as clients who have partners who have been incarcerated. Men and women in prison are especially affected by the HIV epidemic.

- **The rate of AIDS is over five times higher among prisoners than in the general population.**
- **In the Northeast, HIV among incarcerated men is 7% and 13% among incarcerated women, as compared to 0.6% of men and 0.1% of women in the general population.**
- **In 1995, HIV infection rose 88% among incarcerated women and 28% among incarcerated men.**
- **Incarcerated women report extremely high rates of drug use. 74% used drugs regularly.**
- **Incidence of sexual and physical abuse is extremely high for incarcerated women.**

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<sup>11</sup> De Groot, A. (April 2000) HIV Infection Among Incarcerated Women: An Epidemic Behind the Walls. *HEPP News, HIV Education/Prison Project*. Available at [Brown University AIDS Program, http://www.hivcorrections.org/archives/april00/](http://www.hivcorrections.org/archives/april00/)

### ***Domestic Violence and Sexual Abuse History<sup>12</sup>***

Numerous studies have demonstrated the connection between HIV and domestic violence, as well as sexual and physical abuse. For some abused women, our sites may be the primary source of care that they utilize. It is essential that HIV risk assessment include questions about domestic violence.

- **In a study of over 1000 women, higher rates of domestic violence occurred in women with a history of drug use; over 10 sex partners; a history of exchanging sex for money, shelter, or drugs; and with a past or present sex partner at risk for HIV.**
- **Over 30% of the women who reported domestic violence had experienced sexual abuse during childhood.**

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<sup>12</sup> Cohen, M., Deamant, C., Barkan, S, et al. (April 2000) Domestic Violence and Childhood Sexual Abuse in HIV-Infected Women and Women at Risk for HIV. *American Journal of Public Health*. Vol. 90, No. 4, 560. Abstract available at [http://www.lawihs.com/abstracts/abstract\\_PREVALENCEOFDOMESTICVIOLENCEANDCHILDHOODABUSEAMONGWOMENWITHHIVANDHIGHRISKUNINFECTEDWOMEN.htm](http://www.lawihs.com/abstracts/abstract_PREVALENCEOFDOMESTICVIOLENCEANDCHILDHOODABUSEAMONGWOMENWITHHIVANDHIGHRISKUNINFECTEDWOMEN.htm)



### ***Clients DO Want to Talk About These Things***

A Kaiser Family Foundation study, *Talking About STIs with Health Professionals*<sup>1</sup>, reveals surprising data based on a survey of 482 women, ages 18-44.

- **12% of health care professionals raised the subject of STIs during gynecological or obstetrical visits.**
- **83% of the women felt STIs should be a part of routine counseling.**
- **20% of the women felt their health care provider did not have enough information to truly assess their risk.**
- **30% of the women said the provider still did not have enough information for accurate risk assessment, even if the subject of STIs was raised.**

The data show that many women assume that they are tested for STIs as a part of routine gynecological care. In addition, women generally feel that it is the provider's responsibility to raise issues relating to sexual behavior. They express relief when the provider initiates a conversation concerning STIs.

Women also aren't being asked about drug and alcohol use. One researcher states, "In America, drinking and drug abuse are bundled with high-risk sex. Yet despite the high coincidence of substance abuse and sexual activity, remarkably few public or private prevention, treatment and counseling programs deal with this connection."<sup>2</sup> As one respondent in a survey of

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<sup>1</sup> Kaiser Family Foundation. (1997) *Talking About STIs with Health Professionals: Women's Experiences*. Available at <http://www.kff.org/content/archive/1313/stds.html>

<sup>2</sup> Susan Foster, Vice President & Director of Policy Research and Analysis at The National Center on Addiction and Substance Abuse at Columbia University (CASA) (1999) Available at [http://www.theantidrug.com/drug\\_info/studies\\_casa\\_sex.html](http://www.theantidrug.com/drug_info/studies_casa_sex.html)

Massachusetts family planning counselors said, "I can't believe that I've had providers who don't talk to me about these issues!"<sup>3</sup>

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<sup>3</sup> Reproductive Health Counselor/Provider Feedback Survey in MA: HIV Risk Assessment Activities, JSI Research & Training Institute, Inc. (March 2001)

## Practical Concerns about Doing Risk Assessment

1. " We're already asking clients about their sexual history. How is this different?"
2. "There's not enough time!"
3. "There's not enough privacy!"
4. "I can't discuss these things if the client has someone else with her."
5. "My client speaks a language that I do not speak."



## Responses to Practical Concerns About Doing Risk Assessment

Even if you know the importance of sexual and substance use risk assessment, it can be a challenge to figure out how to fit it into what you are already doing. Here are some practical statements and questions providers have raised regarding risk assessment activities.

### 1. “ We’re already asking clients about their sexual history. How is this different?”

The information gathered on a standard medical history is part of a clinical evaluation. This data helps a clinician to determine a client's medical needs. Client-centered risk assessment, however, is a conversation between a provider and a client aimed at supporting a client in reducing risk.

### 2. “There’s not enough time!”

Risk assessment itself is a brief interaction. On average it should take less than ten minutes. Focusing on risk can actually give you a chance to streamline your work. When you talk about sexual and substance use risk reduction, you’re covering almost all the bases of reproductive health care, such as contraceptive use and STIs. Think about the reproductive health issues that are raised when you ask the two questions below:

*“What are you doing to protect yourself from, sexually transmitted infections, including HIV (the virus that causes AIDS)?”*

*“What are you doing to prevent an unplanned pregnancy?”*

The HIV epidemic has increased our awareness that effective reproductive healthcare necessitates talking not only about pregnancy and STIs, but also about drug and alcohol use, domestic violence, and forced sexual experience.

### 3. “There’s not enough privacy!”

If there isn’t enough privacy, work with your clinic supervisor or manager to arrange for it. The work is too important to let this barrier stand in the way.

**4. “I can't discuss these things if the client has someone else with her.”**

The presence of a third person may prevent the client from being honest and from asking questions. A possible solution is to enact a policy by which a client is always initially seen alone. You can simply say, *“We always see a client alone first.”*

If the client says she wants the other person with her, you can use the one-to-one moment to describe what you will be discussing, so she can make a fully informed decision about having the other person present.

**5. “My client speaks a language that I do not speak.”**

When a client speaks a language other than English, it's important to have an interpreter who is familiar with sexual and substance use risk assessment. Ideally, a bilingual provider trained in risk assessment is available.

When there is no staff person who knows the client's language, additional accommodations should be arranged. Spouses, partners, and children are often not appropriate translators, especially for these topics. If you don't know the language, you won't know if that person is accurately translating your words. You also don't know the meaning of the interaction for her and the client. At the same time, cultural norms may make it important for the other person - most likely the spouse - to be present. A good compromise would be to ask the family member or friend who is acting as translator and the client to come in for another visit. At that time, an independent translator can join the three of you. This might also give you a chance to find print materials in the client's language.

When working with a translator (for spoken or signed language), remember to direct all of your conversation towards your client. Look at the client, not at the translator, even when the translator is speaking to you.

**6. “The client is already stressed. How can I bring these issues up?”**

Sometimes you can't. At the same time, the issues that stress our clients most - unintended pregnancies and STIs - are often connected to risky behavior. Responding to those issues may naturally involve risk assessment.

**7. “We see guys in the clinic, too. How can I talk to them about sex?”**

Males have a special burden when it comes to sex - they think that they're supposed to know all the answers. Of course, young men grow up in the same world as women, and honest, open discussion of sexual issues is a rare event for them as well. The only thing that will get in your way of talking with a guy about sex is your own anxiety. If you are brave enough to ask, you may encourage him to be brave enough to answer...and to ask, too!

**8. “How can I ask about sexual behavior and be culturally sensitive?”**

It is certainly true that for many of our clients, discussions concerning sexual matters are not acceptable within their communities. This makes our willingness to discuss such issues even more essential. You may be the only person who gives the client the opportunity to deal with their personal risk.

Obviously you will want to approach the client in a sensitive manner. You will want to acknowledge that discussing personal sexual issues may feel strange and uncomfortable. You will want to be patient in waiting for answers, and accepting of different ways of communicating. You can't be an expert in everyone's cultural background and the behavioral norms associated with them. Be willing to admit confusion and ask questions when you don't understand.

**9. “What if I don't have all the information a client needs or wants?”**

You don't have to know the answer to every question to be of value to your clients. It is fine to say, “*That's a good question. I'm not sure of the answer. I'd like to check it out and get back to you, so I'm sure I'm giving you the right information. Would that be okay with you?*” To find the answer to a question, you might ask a colleague or find an Internet resource.

**Section VE. Internet Resources, of *Asking the Hard Questions: A Reproductive Health Providers' Guide to Client-Centered HIV Risk Assessment*** has an excellent list of websites that can be good resources to questions that surface during risk assessment.

Practice saying, “*I don't know.*” When you're with a client, if you follow that honest response with a promise to research and let her know the answer, or

connect her with someone who does, then you have all the knowledge you need!

**10. "How do I avoid insulting the client who is in a mutually monogamous relationship?"**

If you're concerned that you might insult your client, you might say something like:

*"Some married women are offended when I ask these questions. At the same time, most of us, married or not, know someone who's had a partner step out on her or him. I might miss giving some important information to a client who needs it if I assume she doesn't need it."*

If she says she's not at risk, and her medical history gives you no reason to doubt her, let go of any need to do extensive risk assessment and reduction work with her, beyond gathering the data requested for your medical history form. Offer any educational materials you have. You can suggest she share them with someone else, if they're not of interest to her.

On the other hand, if a client denies any risk, yet her medical history shows you otherwise - treatment for STIs, unintended pregnancy, especially if those events are recent - you might want to respectfully challenge.

*"You're telling me that you don't think that you're at any risk. At the same time, I see that you were recently treated for chlamydia. What are you doing differently now to protect yourself?"* You might also add this question, *"How comfortable are you with trusting your partner with your health, your life?"*

**Remember: Your client has the right to take the risk of trusting his or her partner. Any of us who are in a relationship that we assume is mutually monogamous, may be taking that risk every time we have unprotected sex with our partner. We are saying, "I trust you with my health; I trust you with my life."**



## Asking the Hard Questions: Training Activities to Enhance Providers' Risk Assessment Skills



### Unit Title

**Unit Two: “Listening In” on Risk Assessment**

### Objectives

- To help providers identify effective approaches to doing risk assessment.
- To introduce risk assessment and to introduce more extensive training on counseling and communication skills.

### Group Size

Variable. May be used in a one-on-one session with an individual provider, or group of any size.

### Time Duration

30 - 45 minutes – depending on which activities are used – Look for this symbol for instructions on how to change the length of the training session by varying the use of different activities.



### Materials & Preparation



*Handout– Listening In on Risk Assessment*  
*Handout– Annotated Dialogue One*  
*Handout– Risk Assessment Journal Page*

For a group of more than 8 trainees, you will need newsprint, an easel stand and markers for recording responses. Prepare two newsprint pages, one for recording responses to each of the two dialogue reading. Draw a vertical line down the center of a page to form two columns, preparing one page for each dialogue. Title the two columns on each page— one column, “**Most Effective**”; the other column, “**Least Effective**”.

## Procedure



### One-on-one training

- Review the objectives for this Unit.
- Using the handout, *Listening In on Risk Assessment*, have trainee read the role of the client in the first dialogue, Melissa, while you read the provider's role, Angie. Read Angie's lines with caring and sensitive paraverbals.\*
- After completing the first dialogue, discuss the questions which follow the first dialogue.

*How did you feel about Angie's approach? What seemed most effective in Angie's approach? What seemed least effective in Angie's approach?*

- Repeat the process above with the second dialogue. Read Carolyn's lines in the same caring and sensitive manner you used when reading Angie's lines.
- Discuss the process questions which follow the second dialogue:

*How did you feel about Carolyn's approach? What seemed most effective in Carolyn's approach? What seemed least effective in Carolyn's approach?*

- After completing both dialogues and associated process questions, ask the trainee to respond to the questions on page 5 of the handout, *Listening In on Risk Assessment*.

*Which of these two providers – Angie or Carolyn – would you want to do a risk assessment with you? What are the reasons you chose that provider? What did you like about her approach?*

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\* "Paraverbal" refers to the way in which words are communicated, in terms of vocal tone, pitch, rate of speech, inflection, and volume.

Anticipate that the trainee will prefer Carolyn’s approach. Use the **Discussion Points** below to guide and support the discussion.

If time permits:



Read the handout, *Annotated Dialogue One*, aloud with the trainee reading the provider, Carolyn’s, role.

- Use the annotations to support an analysis of Carolyn’s approach to risk assessment.



### Group training:

- Review the objectives for this Unit.
- Distribute the handout, *Listening In on Risk Assessment*. Have trainees get into groups of three or four. If there are only two trainees, they can do this activity together. Ask one trainee in each group to play the client, Melissa, during the reading of both dialogues; ask another trainee in each group to play the provider in both dialogues. Any other trainees in each group will act as observers.
- Instruct the groups to begin by reading the first dialogue out loud. Suggest to the trainee playing “Angie” that she should read her lines with caring and sensitivity. After a few minutes, when you sense that the dialogue reading is complete, ask the groups to discuss the process questions found at the end of the first dialogue.
- After several minutes, elicit responses to the process questions from the entire group. Record responses from the second two questions on the prepared newsprint.

*How did you feel about Angie’s approach?*

*What seemed most effective in Angie’s approach?*

*What seemed least effective in Angie’s approach?*

- Repeat this process for the second dialogue. The trainee in each group who played the client for the first reading, should play her for this dialogue as well; the provider, Carolyn, should be read by the same trainee who played Angie for the first reading. Remind trainees playing the provider to

read Carolyn’s words with the same degree of caring and sensitivity as she used for Angie.

- Give the groups time to finish the reading and to discuss the process questions. After several minutes, elicit responses to the process questions from the entire group. Record responses from the second two questions on the prepared newsprint.

*How did you feel about Carolyn’s approach?*

*What seemed most effective in Carolyn’s approach?*

*What seemed least effective in Carolyn’s approach?*

- Ask and discuss response to the final process question.

*Which of these two providers – Angie or Carolyn – would you want to do a risk assessment with you? What are the reasons you chose that provider? What did you like about her approach?*

- State that Carolyn’s approach is an example of a “client-centered” risk assessment. Offer this definition: “Client-centered” refers to an approach to a client based on what that individual client reveals about her unique needs and circumstances, rather than a standardized way of collecting and giving information.

If time permits:



- Distribute the handout, *Annotated Dialogue One*. Have trainees work in triads and read aloud the entire dialogue – one member of each triad can be an observer. Observers are asked to take notes, focusing on details about the “good” work they see.
- Facilitate a discussion of trainees’ thoughts about the session. Use the annotations to support an analysis of Carolyn’s approach to risk assessment.

If time permits:



- Have trainees continue the interaction beyond the end of the written dialogue, creating their own dialogue.
- After 5 minutes, ask trainees to discuss the role play within their triads. Instruct them to use the following guidelines for the discussion:
    - ✓ The trainees who played “Carolyn” speak first about the experience of playing that role.
    - ✓ The trainees playing “Melissa” talk about how it felt to be the client.

- ✓ The observers describe all the “good” work they saw being done. They are not to offer any critical feedback.

- Facilitate a large group discussion. Ask observers to each describe one piece of good work they noted. Do not allow any criticism.
- Next, ask those who played Carolyn to describe one point at which they felt most challenged. Invite ideas from the entire group about possible strategies to respond to each challenge identified.

To use this Unit to introduce observation and feedback to providers, have a pair of trainees read the first dialogue in front of the group, followed by your delivery of feedback to the trainee playing the provider. Repeat this with the second dialogue. Be certain to follow the guidelines for supportive feedback so that trainees have a positive experience of the process. (See the handout – *Guidelines for Feedback and Strategizing.*)

Follow this with a large group discussion about being observed and receiving feedback – the up- and downsides of the experience.

### Discussion Points

In discussion of the approaches used by the providers in each dialogue, work towards identification and understanding of the value of the following:

- **Use of a warm, conversational style**

Providers sometimes assume that professionalism is conveyed by a formal, detached and business-like approach in their communication. Facilitate understanding that a more informal, conversational style will better express genuine caring, and may help clients feel more comfortable responding to risk assessment questions, and discussing personal concerns.

Emphasize the importance of a provider’s non-verbal and paraverbal communication. Demonstrate the importance of paraverbals by reading one of Carolyn’s lines from the second dialogue. For example:

*So what have you been doing to keep from getting pregnant?*

Placing a vocal emphasis on the word “you,” and adding a slightly sarcastic tone to the whole statement dramatically changes the way in which the line is heard.

- **Use of open-ended questions**

Open-ended questions invite extended response, rather than the “yes,” “no,” or “maybe” responses that answers a closed-ended question. “How” and “what” are especially good to begin open-ended questions. “Why” questions are best avoided because they often create defensiveness.

*What are you doing to prevent becoming infected with a sexually transmitted infection? (rather than “Are you two using condoms?”)*

*How would you feel about getting pregnant? (rather than “Do you want to get pregnant?”)*

- **Support of client’s knowledge, rather than focus on knowledge deficits**

In response to the question, “What have you heard about HIV and AIDS?” the client says, “I know that homosexuals get HIV, and people who use drugs.”

A supportive response would be:

*You know a lot. There has been a lot of HIV infection in this country among men having sex with men, and among people who use drugs – especially if they share needles and works to use them. We also now know that HIV can infect anyone, and that heterosexuals get infected too. (rather than, “You don’t know the whole story – heterosexuals can get HIV infection too!”)*

- **Praise for client’s healthy behaviors and healthy behavioral intentions. For example:**

*It sounds like not getting pregnant is very important to you. You and your boyfriend have been using one of the most difficult methods around – withdrawal. Lots of people use it, and they’re surprised to learn that it’s not very effective. (rather than, “Withdrawal is not a method of birth control. You could still get pregnant that way because of pre-ejaculatory fluid.”)*

- **Normalization of the risk assessment process**

*I ask these questions of every client, because these things have a big impact on people’s health.*

Trainee(s) may question whether Carolyn’s style would be effective with the clients in their setting. Explain that Carolyn’s style is appropriate for the client

she is working with, and not intended to be a model for interaction with every client. No one example can serve as that model.

Trainee(s) may raise concerns regarding cultural sensitivity. To be culturally sensitive is to be responsive to the individual. One cannot assume that by knowing who a client is in terms of culture and ethnicity, one knows what approach will be best with that client. The culturally-sensitive provider is client-centered, attending to the individual client and using awareness of that client's culture – its general styles of interaction and norms of behavior and beliefs – to enhance her understanding and approach.

### Follow-up Activities



- If time did not permit work with the handout, *Annotated Dialogue One*, distribute it and ask trainee(s) to review it for discussion at a later session.
- Distribute Handout – *Risk Assessment Journal Page*. Ask trainee(s) to complete a journal page for at least one encounter prior to the next time you will work together.
- Follow with Unit Three: **Overcoming Personal Barriers to Risk Assessment – Our Clients and Our Own.**

## Listening In on risk assessment

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Here are two different providers' approaches to HIV risk assessment. "Listen" in on the first minute of each exchange.

*The client, Melissa, is 25 years old. This is her initial visit to the clinic. The first provider, Angie, has come to the part of history taking that focuses on sexual and drug-use history:*

*Angie:* I'm going to ask you some questions about your sex life. Are you currently sexually active?

*Melissa:* Yes.

*Angie:* When did you first become sexually active?

*Melissa:* [pauses] Uh, well, I guess you might say...at 15.

*Angie:* Fifteen.... okay. How many sex partners have you had since then?

*Melissa:* [appears to be mentally counting] Well, I dunno...I guess maybe three, or four?

*Angie:* How about in the past year - how many in the past year?

*Melissa:* Just one. My boyfriend.

*Angie:* That's great. Do you two always use condoms?

*Melissa:* [looks away from Angie] Not always...

*Angie:* Why? I'm sure you know about sexually transmitted infections, like HIV. You really should use them, you know. So what kind of intercourse have you had - vaginal, anal, oral?

*Melissa:* [shaking her head] Boy, this does get nosy! I've...I've had 'em all. I mean, don't most people?

*Angie:* Yes, lots do. But you know that you can get infections from oral sex too, and anal sex is really dangerous.

*Melissa:* [very emphatically] But at least you can't get pregnant that way!

*Angie:* Well, sometimes semen can get on the outside of your vagina, even during anal sex, and then you could get pregnant.

*Melissa:* But is that really going to happen?

*Angie:* It could. See, Melissa, we don't want you to get pregnant, until you want to of course, and we don't want you to get any diseases either. I really think you should talk to your boyfriend about using condoms. I want to show you how they work.

**How did you feel about Angie's approach?**

**What seemed most effective in Angie's approach?**

**What seemed least effective in Angie's approach?**

Now, “listen” to how another provider, Carolyn, does risk assessment with the same client.

*Carolyn:* Melissa, the part of your medical history that I’m going to go over now is about sexual behavior and drug use. I ask these questions of every client, because these things have a big impact on people’s health.

*Melissa:* Okay.

*Carolyn:* I know you came in today to get a method of birth control. What’s going on in your life right now, sexually speaking?

*Melissa:* [responds rapidly] I have a boyfriend - he’s a great guy. We’ve been together a year and-a-half. And we do have sex. Not a lot, I mean not as much as he wants [laughs] but we do. But, you know, that’s why I’m here - for birth control.

*Carolyn:* So what have you been doing to keep from getting pregnant?

*Melissa:* Well, he pulls out before he comes, and, I guess I’ve been lucky...[her voice trails off]

*Carolyn:* It sounds like not getting pregnant is very important to you. You and your boyfriend have been using one of the most difficult methods around - withdrawal. Lots of people use it, and they’re surprised to learn that it’s not very effective.

*Melissa:* Yeah, I know.

*Carolyn:* The good news is that there are much, much more effective methods that are so much easier than withdrawal.

*Melissa:* Yeah. My boyfriend really wants me to get the pill

*Carolyn:* How do you feel about taking the pill?

*Melissa:* Well, I’m sure not ready for a baby!

*Carolyn:* When pills are taken correctly, they are very effective at preventing pregnancy. But - and you probably know this - the pill doesn’t protect against sexually transmitted infections. What are you doing to prevent getting STIs, like HIV, the virus that causes AIDS?

*Melissa:* [shaking her head “no”] I don’t really think that’s an issue for me.

*Carolyn:* You know, I think it's hard for any of us to imagine that these diseases could have anything to do with us. At the same time, I've seen so many young women learn the hard way about these diseases.

*Melissa:* [nodding] You're right about that. Actually I got something once. "Calmidia", I think it was called, but I got treated for that. That was a couple of years ago.

*Carolyn:* Yes, chlamydia is one of the most common STIs. And luckily, it can be treated. I bet that was unnerving for you.

*Melissa:* [nods vigorously] You're right about that. I couldn't believe it. I was so embarrassed! I ended up breaking it off with that guy.

**How did you feel about Carolyn's approach?**

**What seemed most effective in Carolyn's approach?**

**What seemed least effective in Carolyn's approach?**

*Now that you've "listened" to these two excerpts, consider the following questions:*

Which of these two providers - Angie or Carolyn - would you want to do a risk assessment with *you*?

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What are the reasons you chose that provider? What did you like about her approach?

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## GUIDELINES FOR FEEDBACK AND STRATEGIZING

### ***Feedback***

Invite provider's self-appraisal. Sample questions:

*How do you feel that session went?*

*What did you do well?*

*What do you wish you could have done differently?*

*What was the most challenging part of the session?*

*What, if anything, specifically do you want feedback on from me?*

Describe and praise good use of skills. Be as detailed as possible in describing "good" work you observed.

Poor Feedback:     *"You did a great job."*

Good Feedback:     *"You did an excellent job of helping the client think about getting tested. I particularly noted that when you saw that look of confusion cross her face when you said the phrase 'HIV antibody test,' you immediately offered a simpler phrase- 'the test that tells whether a person has been infected with HIV, the virus that causes AIDS'-and then checked out that you were being understood by asking, 'This can be confusing stuff to talk about. What questions do you have about HIV tests?'"*

For areas needing improvement describe what you observed, holding back on suggestions for improvement. Select the one or two areas that are most important to address. Do not link positive feedback to criticism with "but" or "however." Describe the behavior specifically, without judgment.

Poor Feedback:     *"You did a good job, but dismissing the client's confidentiality concerns was unprofessional."*

Good Feedback:     *"When the client said she was concerned about word of her being here getting out, you waved your hand and said, 'Not to worry.' I think that dismissing her concern does not take away her fears about confidentiality."*

Describe your own reactions or those of the client; do not blame or excuse the provider.

Poor Feedback: *"You insulted the client when you..."*

Good Feedback: *"I saw the client pull back from you when you..."*

Here's an example of a statement in response to a provider's defensiveness:  
*"Isn't it important to know that while you intended your statement to sound like concern, it could come across as judgment?"*

Talk about things that are in the provider's control.

Poor Feedback: *"You didn't get that client to commit to using condoms."*

Good Feedback: *"I didn't hear you address the client's concern that her boyfriend would never agree to using condoms."*

### ***Strategizing***

Allow provider time to suggest on her own how she might do better.

Sample questions for strategizing:

*"How could you do that differently in the future?"*

*"What will be most challenging about doing this differently?"*

*"How do you imagine changing your approach might work for your clients?"*

*"What resources/training/support will you need to help you make this change?"*

*"What could you do to remind yourself that you want to try this approach?"*

*Reinforce provider's strategizing by verbally summarizing the components of her plan. Check to ensure your mutual understanding.*

Invite feedback from the provider about her experience of being observed and receiving feedback from you

*Some guidelines for receiving feedback:*

*React objectively, not personally.*

Poor receiving: *"What do you mean my presence is distracting?"*

Good receiving: *"Thank you - How do you think I could minimize the distractions that my presence causes?"*

Be inquisitive, not defensive

Poor receiving: *"Why do you have trouble with my sitting in on your sessions?"*

Good receiving: *"What is the most difficult part for you of having me observe?"*

## Annotated Dialogue One

***The client is 25 year-old Melissa. This is her initial visit to the clinic. The provider has been going over Melissa’s medical history, and is at the part that focuses on sexual and substance use behavior.***

Begins by explaining and normalizing the process.

*Carolyn:* Melissa, the part of your medical history that I’m going to go over now is about sexual behavior and drug use. I ask these questions of every client, because these things have a big impact on people’s health.

*Melissa:* Okay.

Open-ended question, “What’s going on...?” gathers a lot of information from client.

*Carolyn:* I know you came in today to get a method of birth control. What’s going on in your life right now, sexually speaking?

*Melissa:* [responds rapidly] I have a boyfriend – he’s a great guy. We’ve been together a year and-a-half. And we do have sex. Not a lot, I mean not as much as he wants [laughs] but we do. But, you know, that’s why I’m here – for birth control.

Open-ended question.

*Carolyn:* So what have you been doing to keep from getting pregnant?

*Melissa:* Well, he pulls out before he comes, and, I guess I’ve been lucky...[her voice trails off]

Doesn’t criticize Melissa’s admission; offers praise; adds information in a supportive and normalizing way.

*Carolyn:* It sounds like not getting pregnant is very important to you. You and your boyfriend have been using one of the most difficult methods around – withdrawal. Lots of people use it, and they’re surprised to learn that it’s not very effective.

*Melissa:* Yeah, I know.

Open-ended question.

*Carolyn:* The good news is that there are much, much more effective methods that are so much easier than withdrawal.

*Melissa:* Yeah. My boyfriend really wants me to get the pill

Information presented without challenging Melissa’s knowledge; open-ended question.

*Carolyn:* How do you feel about taking the pill?

*Melissa:* Well, I’m sure not ready for a baby!

*Carolyn:* When pills are taken correctly, they are very effective at preventing pregnancy. But – and you probably know this – the pill doesn’t protect against sexually

transmitted infections. What are you doing to prevent getting STIs, like HIV, the virus that causes AIDS?

*Melissa:* [shaking her head “no”] I don’t really think that’s an issue for me.

3<sup>rd</sup> person normalization, with a gentle confrontation.

*Carolyn:* You know, I think it’s hard for any of us to imagine that these diseases could have anything to do with us. At the same time, I’ve seen so many young women learn the hard way about these diseases.

*Melissa:* [nodding] You’re right about that. Actually I got something once. “Calmidia”, I think it was called, but I got treated for that. That was a couple of years ago.

Not important to correct her mistake explicitly. Attends to Melissa’s feelings – “I bet that was unnerving...”

*Carolyn:* Chlamydia is one of the most common STIs. And luckily, it can be treated. I bet that was unnerving for you.

*Melissa:* [nods vigorously] You’re right about that. I couldn’t believe it. I was so embarrassed! I ended up breaking it off with that guy.

More support for Melissa’s behavior. Carolyn precedes an open-ended question used to confront, with acknowledgement that it’s a “tough” one.

*Carolyn:* And even though it was embarrassing, you took care of it. And you know from that experience that a person can get an infection when they don’t expect it at all. Here’s a tough question to think about. How does it feel to trust your boyfriend with your health, and maybe even your life?

*Melissa:* I never really thought of it that way. I know we’re supposed to use condoms, but guys just don’t want to use those thing. Besides, we’re only having sex with each other!

Starts by praising Melissa’s behavior. Melissa may not have even thought about her monogamy in terms of risk reduction. This can help give her the sense that she’s able to take such steps. Confronts with a normalizing statement – “What’s sometimes hard to think about is...”

*Carolyn:* Only having sex with someone who’s only having sex with you is a big part of protection. What’s sometimes hard to think about is that people we’re with, or have been with in the past, probably had sex with other people at some time. And with many STIs, like HIV, not only would you not know that person had it, he might well not know either.

*Melissa:* Yeah, I guess that’s true... [her voice trails off]

Open-ended question.

*Carolyn:* What has your boyfriend told you about his sexual history?

*Melissa:* Not much, really. I guess I haven’t really asked.

Confirming; open-ended question.

*Carolyn:* It’s not an easy thing to do. What would it be like to talk with him about using condoms?

*Melissa:* [very hesitantly] Not easy...he might think I’ve got something. I dunno...I guess I should... [stops talking]

Offers strategizing support,

asks permission to pursue her agenda a bit longer; this also takes some pressure off Melissa. Melissa's discomfort is indication that her risk perception has been raised.

Avoids “sexually active.”

Introduces sensitive questions.

Provides a bit of information without sounding like she's teaching.

Normalizes.

Responds to Melissa's embarrassment with normalization. Asks open-ended question to begin focusing in on HIV once more.

Praise; open-ended question.

*Carolyn:* If you like, we could talk some more in a moment about how you might bring this issue up with him. Would it be okay if I finish up these history questions first?

*Melissa:* [looks relieved] Sure.

*Carolyn:* How old were you when you first had intercourse?

*Melissa:* Fifteen, I think...yeah, fifteen.

*Carolyn:* And how many sexual partners have you had since then?

*Melissa:* [appears to be mentally counting, then looks up] Four...no, actually five.

*Carolyn:* And you've told me you've been with your current boyfriend over a year – am I remembering that right?

*Melissa:* Yes.

*Carolyn:* Here are two questions that sometimes surprise people. First, I know you've had sex with men, how about with a woman?

*Melissa:* No, never. Do lesbians come here, too?

*Carolyn:* Yes, and also people who've had sex with both men and women. Here's another question that can feel awkward; what kind of intercourse do you have with men? Vaginal intercourse?

*Melissa:* Yes.

*Carolyn:* Oral sex?

*Melissa:* Yeah...what guy doesn't like that!

*Carolyn:* And lots of women do too. How about anal intercourse?

*Melissa:* Just once or twice. I guess I've done it all! [looks a little embarrassed]

*Carolyn:* And that makes you like so many people. Melissa, what have you heard about HIV and AIDS, about how people get it?

*Melissa:* [speaks confidently] I've heard lots of stuff about AIDS. I know people get it from shooting drugs, and having unprotected sex, and babies from their mothers.

*Carolyn:* You've got all that right. What experiences have you had with drugs?

*Melissa:* [forcefully] Well, I've never injected drugs, if that's what you mean! [pauses, then says] I smoke a little dope every once in a while.

*Carolyn:* How about any of your sexual partners – have any of them injected drugs?

*Melissa:* No, no, I mean I sure don't think so. I don't hang out with that kind of crowd.

3<sup>rd</sup> person normalization of social use of substances, combined with information on the connection between that behavior and HIV risks.

*Carolyn:* For lots of people, getting high, with alcohol or any other drug, can affect their sexual behavior. What's that been like for you?

*Melissa:* I guess a few times, not too many, I've had sex with a guy when I was high a lot faster than I would have if I hadn't been. [looks annoyed]

Attends to Melissa's non-verbal expression of feeling with an open-ended question to surface feeling identification.

*Carolyn:* How do you feel about that?

*Melissa:* [shaking her head and looking down] I felt awful about it the next day.

Offers a strategy using the 3<sup>rd</sup> person, which allows Melissa to more honestly say what she thinks about the strategy than she might if it came directly from the provider.

*Carolyn:* Some women decide to be sure they at least have condoms with them if they think they might be in that situation. Still, it can be hard to remember to use them when you're high.

*Melissa:* Yeah, you're right about that. I don't think I'll be in that situation again, though.

Continues strategizing with use of open-ended question.

*Carolyn:* What could you do if you realized a situation like that was developing?

*Melissa:* Like I said, I don't think it will happen again, but if it did, I'd just leave before things got messy.

Supports Melissa's intention. 3<sup>rd</sup> person approach to transition into another possibly sensitive subject.

*Carolyn:* Sounds like a good plan. Another situation that lots of people have been in is being forced to have sex when they didn't want to. What's your experience been with that?

*Melissa:* It hasn't really happened to me. Like I said, I've given in a couple of times when I was high, but no one ever forced me.

Paraphrases as a summary, contracts to return to the risk reduction concerns.

*Carolyn:* So what you're saying is that, for now, the one situation you want to think about is the one with your boyfriend. Would it be okay if we talked some more about how to talk with him about sexually transmitted infections, how to bring up using condoms?

*Melissa:* Yes, sure.

This portion of a longer session took a little less than 6 minutes. The provider has taken every opportunity to offer genuine praise and support. She has anticipated and normalized any uncomfortable reactions, and attended to feelings she sensed in Melissa. In the course of a genuine, client-centered interaction, she managed to accomplish a lot in a very short amount of time. In addition, by creating a comfortable relationship with the client, she's helped to build an even more important relationship – Melissa's connection to the clinic.

## RISK ASSESSMENT JOURNAL PAGE FOR PROVIDERS

**Record sessions that you found to be:**

- ▶ particularly challenging
- ▶ ones in which you felt especially effective
- ▶ ones in which you felt stuck

Try to record the session on the journal page as soon after the session as possible.

1. Give a brief description of the interaction; including information about the client. Write only enough so that you will be able to recall the interaction based on your notes.

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2. What do you feel you did best in working with this client? What was most effective?

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3. What happened that felt challenging- that made you feel stuck or ineffective? What do you wish you could have done differently?

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4. What is your strongest feeling in response to this interaction? (Feeling, not thought.)

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5. What is one key thing you learned from working with this client?

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# Asking the Hard Questions: Training Activities to Enhance Providers' Risk Assessment Skills



## Unit Title

**Unit Three: Overcoming Personal Barriers to Risk Assessment – Our Clients' and Our Own**

## Objectives

- To help providers identify and express their personal concerns about doing sexual and substance use risk assessment with clients.
- To equip providers with strategies to deal with the judgment they may feel in response to clients' situations.
- To increase providers' appreciation of clients' expectations and concerns regarding the risk assessment process.
- To help providers identify communication styles which minimize clients' discomfort with risk assessment.


## Group Size

While this Unit may be done one-on-one, it is best suited to a group of at least 4 trainees.

## Time Duration

30 - 45 minutes for one-on-one session

45 minutes – 1 hour, 30 minutes for group sessions

Look for this symbol  for instructions on how to change the length of a training session by varying the use of different activities.

## Materials & Preparation



*Handout– The Challenge of Asking the Questions*  
*Handout – Our Own Values and Judgments*

*Handout – Tips for Dealing with Judgments*

*Handout – Clients’ Concerns About Risk Assessment*

*Handout – Risk Assessment Role Play.*

*Handout – Guidelines to Giving and Receiving Feedback*

*Handout – Role Play Scenarios (You will need to cut these apart ahead of time.)*

*Handout – Ways to Encourage Dialogue*

Trainee(s) will need to bring copies of the medical history/risk assessment form used in their own clinical settings.

Easel, newsprint and markers for group training

Prepared newsprint or overheads with content of handouts, *Tips for Dealing with Judgments*, *Guidelines to Giving and Receiving Feedback*, and *Ways to Encourage Dialogue*, if desired.

## Procedure



### One-on-one training:

- Review the objectives for this Unit.
- If trainee completed a *Risk Assessment Journal Page* (see Unit Two for Providers,) talk with her about her experience. Acknowledge that asking risk assessment questions, and dealing with the responses to them, can be challenging.
- Provide trainee with the handouts, *The Challenge of Asking the Questions* and *Our Own Values and Judgments*. Give the trainee time to complete the handouts, and then discuss her responses.
- Go over the handout, *Tips for Dealing with Judgment*. Ask the trainee what other strategies might be useful to help one deal with judgmental reactions.
- Provide the trainee with the handout, *Clients’ Concerns about Risk Assessment*. The trainee may either complete the handout and discuss it with you, or you can review it verbally with her, discussing her responses as you go over it together.

- Conduct a role-play, following these steps:
  1. Use a copy of the medical history form from the trainee's setting to role-play a risk assessment with her.
  2. Have the trainee play the client. Her role can be determined in a number of ways: You can use the handouts, *Role Play Scenarios*, and assign a client role to the trainee; you may read the provider information from all three scenarios aloud, and let the trainee select a role; or you may invite the trainee playing the client to create her own character.
  3. After about 5-8 minutes, ask the trainee to identify all the techniques you used that helped her to feel as comfortable as possible during the risk assessment. She can record these on the handout, *Risk Assessment Role Play*.

If time permits:



Do another role-play. This time, you will play the client, with the trainee playing the provider. After about 5-8 minutes, stop the role-play. Process the experience with the trainee, being sure to follow guidelines for giving feedback. (See Unit Two for Supervisors, **The Art of Feedback & Strategizing.**)

- Provide the trainee with the handout, *Ways to Encourage Dialogue*. Review and discuss the handout.



### Group training:

- Review the objectives for this Unit.
- If trainees completed a *Risk Assessment Journal Page* (see Unit Two for Providers, **Listening in on Risk Assessment**) give them time to discuss their experiences in small groups. After a few minutes, stop the discussions. Acknowledge that asking risk assessment questions, and dealing with the responses to them, can be challenging.
- Distribute the handout, *The Challenge of Asking the Questions*. Ask trainees to complete the handout.

- Have trainees form small groups. If possible, group people with others with whom they do not work on a regular basis. Invite group members to share their responses to the handout – which questions did they find most difficult to deal with?
- Distribute the handout, *Our Own Values and Judgments*. Give the trainees time to complete the handout. After a few minutes, ask trainees to discuss their responses in their small groups. Ask them to focus their discussions on the words at the bottom of the handout:

*Take some time now to think about what it is that makes the checked items difficult for you. Some of the descriptions don't say if the client is male or female. How would the client's gender affect how the situation would feel to you?*

If time permits:



While trainees are engaged in the small group discussion described above, you could collect the first handout, *The Challenge of Asking the Questions*, and do a quick tally of responses. Count the number of 1s, 2s, 3s, (and so on) that rate difficulty for each question. As part of the next large group discussion time, report results back to the group. Invite reaction.

- Distribute the handout, *Tips for Dealing with Judgment*. Refer to the prepared newsprint/overhead, if you are using one. Ask the trainees to suggest other strategies that might be useful to help one deal with judgmental reactions. Record responses.
- Distribute the handout, *Clients' Concerns about Risk Assessment*. Ask trainees to discuss the questions on this handout in their small groups, recording responses on the handout. Facilitate a brief, large group discussion by eliciting a few responses from each group, and inviting reaction and comment.

If time permits:



Prior to doing the role-plays, distribute the handout, *Guidelines for Giving & Receiving Feedback*, and do a quick overview of the art of giving feedback. (See Discussion Points) If you are unable to do this, follow the recommendation in the role-play instructions below that only positive feedback can be given.

## Role Play & Processing

- Facilitate the first risk assessment role-play. The role play will include the following steps:
  1. Have trainees form dyads, ideally pairing with someone with whom they do not regularly work.
  2. Distribute the handout, *Risk Assessment Role Play*.
  3. Have trainees role play a risk assessment session. Ask the trainee who is playing the provider to use a copy of the medical history form she brought from her own setting.
  4. Client role can be determined in a number of ways: You can use the handouts, *Role Play Scenarios*, to assign a client role to one of the trainees in each dyad; you may read the provider information from all three scenarios aloud, and ask dyads to select a scenario; you may assign one client role, based on the needs of the group in terms of their client population; or you may invite the trainee playing the client to create her own character.
  5. Stop the role-play after about 5-8 minutes. Direct dyad members to discuss the experience, beginning by allowing the person who played the provider to speak about her self-assessment of her work in the process. The trainee who played the client should then identify all the techniques used that helped her to feel as comfortable as possible during the risk assessment. These can be recorded on the handout, *Risk Assessment Role Play*. Instruct trainees to give only positive feedback to their “providers.”
  6. Facilitate a full group discussion of the role-play experience. Ask for specific examples of techniques used that were effective in increasing the comfort of the risk assessment process. Record responses. **Do not allow any critical comments.** Listen for opportunities to confirm and reinforce the tremendous importance of the provider’s non-verbal and paraverbal communication in creating that comfortable exchange.

If time permits:



- Facilitate a second role-play, following the same steps as above.

- Distribute the handout, *Ways to Encourage Dialogue*. Review and discuss content of handout, referring to the overhead or prepared newsprint of its content, if you are using one.

## Discussion Points

- You will want to be certain to model a non-judgmental style when trainees discuss their own value-shaped responses to the questions and situations on the handouts, *The Challenge of Asking the Questions and Our Own Values and Judgments*. If you are taken aback by something said by a trainee, a good approach is to follow the **3Cs** model. Start with a statement of confirmation. For example:

*A lot of people feel that way.  
That's a hard question/situation for many of us.  
It's not easy to acknowledge how uncomfortable that can make one feel.*

Follow this with an open-ended question to invite clarification. This can be directed to the trainee who spoke, or to the entire group:

*Tell me some more about how it is for you to deal with that kind of question/situation.  
What's the hardest part of dealing with that kind of question/situation?*

Next you could help the trainee, or entire group, begin to strategize about how to handle one's response to the question/situation. If no ideas emerge, offer some suggestions in the third person, so trainee(s) can be free to critique/accept/reject them without concern about your response. For example, you might say:

*Some providers, when confronted with something that they react to with shock, realize that their shock is likely immediately sensed by the client. So they acknowledge it, and try to go on, saying something like this to the client – "That was a new one for me; tell me some more about how you feel about it." How would that work for you?*

- During the role plays, you will note that, unless you have instructed the group in how to give and receive feedback, trainees are asked to give only positive feedback to their partners. There are several reasons for this request: Unless trainees are extremely well-versed in the skill of giving feedback, what they most often do is combine criticism with directive suggestions about how something should have been done differently. The recipient of such "feedback" will often react in a defensive manner, and will not be able to truly hear or learn from this approach. On the other hand, the person playing the client will have learned a lot by being in that role

and experiencing the “provider’s” approach. You will need to trust the value and effectiveness of learning in the absence of the explicit use of critical feedback.

You will also note that in the large group discussion following the role-plays, critical observations about the work are not permitted. This is because of the “high-risk” nature of role-play. Trainees will be very reluctant to do role-play if they anticipate or experience public criticism.

If you have time to instruct trainees in how to give and receive feedback, distribute the handout, *Guidelines for Giving & Receiving Feedback*, and use the content in Unit Two for Supervisors, **The Art of Feedback & Strategizing**, to guide your presentation. Emphasize the following:

*The purpose of giving critical feedback is not to tell someone how he or she might have done it differently; rather, it is to describe an observation, a perception or reception of the impact of the provider's approach on the observer or client. For example: "I noticed that your client appeared uncomfortable when you used the word 'promiscuous'", rather than, "You shouldn't say promiscuous." The provider is certainly welcome to invite suggestion, if time permits; the invitation is in her/his control.*

*In receiving feedback, it's helpful to remember that feedback is about observation/reception/perception; it is not a questioning of the provider's intention. That understanding of receiving feedback can help the provider avoid defensiveness. Rather than needing to say (in response to the above example), "But I didn't mean to make her uncomfortable!" the provider can benefit from the opportunity to learn that what she intended did not work the way she hoped.*

## Follow-up Activities

- This Unit can be followed by either Unit 4 for Providers, **The Language of Risk Assessment**, or Unit 5 for Providers, **Responding to Difficult Questions & Statements: The 3 C Model**.

### The Challenge of Asking the Questions

Please read each column. In columns A and B, write the number that best describes how difficult you feel it is to ask (column A) or respond to (column B) each question:

1	2	3	4	5
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This is not difficult for me.

This is very difficult for me.

<i>Questions about:</i> ↓	A) How difficult do you find this to ask your clients?	B) How difficult do you find it to handle your clients' responses to this question?
Age at first intercourse		
Number of sex partners		
Alcohol and other drug use		
Sexual coercion, abuse, incest, assault		
Sexual behaviors with males and females		
Sex partners' sexual behaviors		
Sex partners' substance use behaviors		
Intimate partner violence		
History of incarceration - client &/or client's partner[s]		
Vaginal sex		
Anal sex		
Oral sex		
Sexual pleasure		

### Our Own Values and Judgments

*These situations might surface in response to the risk assessment questions we ask. Place a check mark ► in the column on the right if the situation would be hard for you to deal with. Use the blank lines to add other situations that "push your buttons."*

►  
Difficult  
for you

1. Client doesn't want pregnancy or infection with STIs/HIV; yet refuses to consider condom use.	
2. Client has had 5 abortions.	
3. 18 year-old client says she's dating a 35 year-old man.	
4. Client challenges you, "What gives you the right to ask me these questions?"	
5. Client has gonorrhea, insists the clinician is wrong because "my boyfriend wouldn't run around on me!"	
6. Client refuses to answer any of your questions; just sits with arms crossed and looks at you angrily.	
7. Client complains about everything that happens in the clinic.	
8. Client says that her boyfriend is a "jerk."	
9. Client says she/he doesn't care what happens - "we've all gotta die of something!"	
10. Client tells you she or he has been trading sex for money or drugs.	
11. Client is high.	
12. Client is lesbian or gay.	
13. Client says drug use is "no big deal - everybody gets high sometimes!"	
14. Client has 6 children, all under the age of 8.	
15. Client brings 2 very poorly behaved children to the clinic, and appears to be doing nothing about it.	
16. A client tells you that condoms don't fit him.	
17.	
18.	

**Take some time now to think about what it is that makes the checked items difficult for you.**  
Some of the descriptions don't say if the client is male or female. How would the client's gender affect how the situation would feel to you?

## Tips for Dealing with Judgments

### ✓ *Check your assumptions.*

Do you make judgments about a client based on age, appearance, speech, or medical history? Do you sometimes think you know what he or she 'ought to do' before you hear from the client? Be aware of your thoughts and be careful that such assumptions aren't biasing your interaction.

Here's an example: A client says she's having difficulty remembering to take birth control pills. Without asking any questions, the provider immediately tells her she should "get Depo." Unfortunately, the provider is missing two important pieces of information: 1) the client has a job with constantly changing hours, which creates problems for her in remembering her pills. 2) The client faints whenever she sees a needle - she'll never be happy with Depo.

A more helpful approach would be to start by asking the client what is making it difficult for her to remember her pills. This could lead to some practical problem solving.

### ✓ *Don't take things personally.*

If a client is 'being difficult', it's probably because she's having a hard time. Try not to take her anger personally. It's not about you - you just happen to be the person who's there. Being aware of this can help you to avoid reacting judgmentally to negative behavior. If you respond with kindness and interest, the client may be able to make a connection with you.

### ✓ *Take a look at your own issues.*

Sometimes clients raise concerns or describe events that mirror issues in our own lives. In such cases, it is even more difficult to respond non-judgmentally. Just as talking about difficult matters may help clients, providers too can benefit from counseling interactions. If your agency participates in an employee assistance program (EAP), you may be able to get a referral to someone you can talk to.





## **Guidelines for Giving and Receiving Feedback**

### ***Guidelines for Giving Feedback***

1. *Open by asking for the provider's self-assessment.*
2. *Focus on the positive, and "microscope" it!*
3. *When giving critical feedback . . .*

*Do not link to positive feedback with "but" or "however."  
Describe the behavior specifically, without judgment.*

4. *Describe your own reactions or those of the client; do not blame or excuse the provider.*
5. *Talk about things the provider can do something about* (versus things she has no control over).
6. *Only offer suggestions if the provider asks for them!*

### **Guidelines for Receiving Feedback -**

***It's about perception/reception, not intention!***

Remember to hear the feedback as a description of perception, not a questioning of your intention.

1. *React objectively, not personally.*
2. *Be inquisitive, not defensive.*
3. *Ask for suggestions!*

## **Scenario #1 - Sandy**

### Provider

Your client is Sandy, a 22 year-old in for her annual exam. She says she needs more birth control pills, and also wants condoms. She checked off "yes" to drug use, but then seemed to have scratched it off, or tried to erase it.



## **Scenario #1 - Sandy**

### Client

You are Sandy, a 22 year-old. You've come to the clinic for an annual exam, and to get more birth control pills and condoms. You've been getting high a lot lately, smoking a lot of pot and drinking pretty heavily. People sometimes nag you about this but you feel your using is under control, and no big deal. Also, sometimes you have sex with someone when you need extra money. You always try to use condoms with these guys, but not with your regular boyfriend.

## **Scenario #2 - Ashley**

### Provider

Your client is Ashley, a 17 year-old. She acknowledges using condoms to prevent disease, but she also indicates that she has been treated for chlamydia. She wants to get Depo at her next period. You want to talk more about condoms with this client; she seems to tune you out when you start talking about them



## **Scenario #2 - Ashley**

### Client

You are Ashley, a 17 year-old. You acknowledged using condoms to prevent disease, but the truth is you haven't been using condoms regularly because you are not sure how to ask a guy to use them, and you are not sure what you would do or say if he said "No!" You tell the provider you want to get that shot - Depo - at your next period. When the provider starts talking about condoms, you get quiet and look at the floor. You have had sex with a number of guys. Now you have a steady boyfriend, and you don't want to get pregnant, at least not yet.

### **Scenario #3 - Jason**

#### Provider

Your client is Jason, a 23 year-old. He has come in for a STI check and treatment. He says he uses condoms sometimes. You want to find out more about his condom use. He appears extremely uncomfortable when you try to talk to him about this.



### **Scenario #3 - Jason**

#### Client

You are Jason, a 23 year-old. You've come to the STD clinic because you have been having burning when you urinate. When the provider asks if you use condoms, you say "sometimes." When the provider asks you more about your condom use, you say they don't fit, so you don't like to use them. The truth is that when you are putting on a condom, you get too excited and come too quickly; if the woman puts it on you, you come immediately. It's incredibly embarrassing.

## Scenario #4 - Yvonne

### Provider

Your client is Yvonne, a 17-year-old. She has been diagnosed with Chlamydia. She becomes sullen and withdrawn when the issue of HIV risk is raised. She also seems disinterested in talking about birth control and is vague about the date of her last menstrual period. She says she just came here today to get rid of this infection.



## Scenario #4 - Yvonne

### Client

You are Yvonne, a 17-year-old, in the 10th grade and struggling to remain in school. Actually, you've been seriously considering dropping out. You have 2 friends who have and they both have jobs and seem to be doing OK. They certainly have more money than you do! You came to the clinic because you heard that an old girlfriend of your boyfriend Tony had some sort of infection. You've just been told you have chlamydia. You're really scared about this. Tony must be stepping out on you, you think, and you are both angry at him and afraid of losing him. You have also been daydreaming occasionally about having Tony's baby. While the provider is talking you keep thinking - *Does this mean I can't get pregnant? What am I going to tell Tony? Should I just leave him? Then what would I do??* The counselor wants to talk about AIDS – can't she see you've got enough to deal with?

## **Scenario #5 - Cassandra**

### Provider

Your client is Cassandra, a 26-year-old woman. She has a history of drug use, including injection drug use, since age 16. She was referred to the clinic to talk about getting on a method of birth control. She appears very depressed and anxious. She suddenly says to you, "I just found out I've got that HIV virus. All my dreams are dead. I always wanted to have kids, and now I never will!".



## **Scenario #5 - Cassandra**

### Client

You are Cassandra, a 26-year-old woman. You have been in recovery from heroin use for 2 months. You had finally decided to get your life together and go into recovery. When you entered the recovery program, they urged you to get tested for HIV, and the test was positive. You are feeling completely hopeless - why did you ever stop using? You have had two abortions, because at least you knew better than to have a baby when you were getting high. And now you'll never be able to have a baby!

## **Scenario #6 - Maria**

### Provider

Your client is Maria, a 30 year old married woman. Maria has a 3 year old son who is HIV+. Her husband, James is also infected. He is recovering from dual addiction to alcohol and heroin. James has expressed to Maria tremendous, paralyzing guilt over the family's infectious status as he assumes he was the source of their infection. Maria desperately wants to try again to have a healthy baby. She is very willing to take whatever prophylaxis is recommended to protect a baby, if she becomes pregnant. James has been struggling of late to maintain his sobriety, and Maria thinks that a new baby would help him.



## **Scenario #6 - Maria**

### Client

You are Maria, a 30 year old married woman. Your 3 year old son Michael is HIV infected, as is your husband James and yourself. Your first child died when he was 9 in a traffic accident. You have always felt responsible for this because he was playing outside in the evening, and you were not watching him. When Michael was born it seemed like a miracle to you and James. James had just recently begun recovery from dual addiction to alcohol and heroin; despite what others say, he has always been a good husband to you. Shortly into his recovery, James was tested for HIV infection. When his test was positive you, and then the baby, were tested, and both were positive. James came close to killing himself at that news; only his sense of responsibility to you and Michael kept him going. But he's never been the same. He's so depressed. You think that if you could become pregnant again, and have a healthy baby, it would turn things around for James. You know there are drugs now that can help keep a baby from getting infected. You feel determined to do this.

## Ways To Encourage Dialogue

- Use open-ended questions to encourage a more in depth response.  
*"What's going on in your life right now, sexually speaking?"*
- Introduce sensitive questions.  
*"Here's a question that sometimes surprises people." "Some of these things can be difficult to talk about."*
- Normalize clients' responses when possible, to minimize embarrassment or discomfort.  
*"That makes you like so many people." "Many people are surprised to learn that..."*
- Express caring and compassion for the client. Acknowledge client's feelings and be supportive.  
*"I'm sorry to hear about your cousin's death. That means you know for real that AIDS is in your community."*
- Use "reflective listening" to ensure that you understand the client's meaning and invite further discussion.  
*"I get the feeling condoms aren't your favorite things." "It sounds like it's hard to bring that up with your boyfriend."*
- Look for opportunities to support, rather than to chastise or correct. Support intentions to reduce risk. Acknowledge what is correct in the client's information.  
*"It sounds like not getting pregnant is very important to you."  
"You know from that experience that a person can get an infection when they don't expect it at all."*
- When providing information, present it clearly and in a conversational manner. Don't lecture.
- Allow clients time to respond. If the client is shy, or hesitates for a moment, don't rush to fill the void. Be silent for a few moments to give her time to speak.
- Give clients permission not to respond to something you've asked.  
*"You don't have to tell me anything you don't want to. The more you're able to tell me, the more useful I can be to you."*

# Asking the Hard Questions: Training Activities to Enhance Providers' Risk Assessment Skills



## Unit Title

### Unit Four: The Language of Risk Assessment

## Objectives

- To increase providers' awareness of their reactions to the words clients use.
- To raise providers' awareness of the importance of asking open-ended questions and enhance their ability to use that skill.
- To enhance providers' self-awareness of their non-verbal and paraverbal communication styles.
- To provide language alternatives to words which may unintentionally convey judgment.


## Group Size

While this Unit may be done one-on-one, it is best suited to a group of at least 4 trainees.

## Time Duration

45 minutes for one-on-one session

60 minutes – 1 hour, 30 minutes for group sessions

Look for this symbol  for instructions on how to change the length of a training session by varying the use of different activities.

## Materials & Preparation



*Handout– The Words Clients Use*

*Handout – Non-Verbal and Paraverbal Communication*

*Handout – The Questions Providers Ask: Open-Ended Question Practice Sheet & Suggested Alternatives*

*Handout – The Questions Providers Ask: Alternatives to “Why?” Questions*

*Handout – The Words Providers Use*

Easel, newsprint and markers for group training

## Procedure



### One-on-one training:

- Review the objectives for this Unit.
- Provider trainee with the handout, *The Words Clients Use*. Go over the handout aloud, encouraging the trainee to say out loud the uncomfortable words, if necessary. Discuss the following questions from the handout:

*How does it feel to say these words to someone else? How does it feel to write down those words? Are some words more difficult to speak or write than others? Which ones are the most difficult?*

*Has a client ever used any of those words when talking with you? How did you respond? How do you feel about your response?*

- Offer an example of a phrase or sentence a client might say that could potentially be uncomfortable for a provider. Try to incorporate some of the words the trainee has identified as difficult for her. An example: A client says, “I don’t know why you’re asking me about this. I’m no whore, I’m no junkie – why should I worry about getting AIDS?”
- Ask trainee:  
*What are all the reasons a client might use these words?*

Listen for and confirm, adding if necessary, responses such as:

- ✓ The client is insulted, feels the provider is judgmental, and is expressing anger through her choice of words.
- ✓ The client is attempting to distance herself from “those people” by using judgmental terminology.

- ✓ The client in fact does engage in risky sexual and/or drug using behavior, and does not want the provider to suspect it.
- ✓ The client has strong feelings about such behaviors due to issues in her personal life; e.g. family members or partners who have been risky in their sexual and/or drug using behaviors.
- ✓ The client is testing the provider, to see how the provider will react. That reaction might determine how much the client is willing to share.
- ✓ Those words are the words the client knows, and the words don't have the same judgmental associations for the client that they do for the provider.

- Ask the trainee:

*How might a client know that you were uncomfortable in response to something she said, even if you didn't say anything about it?*

Listen for and confirm, prompting if necessary, responses about non-verbal and paraverbal communication.

- Demonstrate a conflicting message by using nonverbal behavior that directly conflicts with a verbal message. Tell the trainee how happy you are to be with her today while looking at your watch, speaking slowly, and giving nonverbal clues that suggest you "really don't want to be there." Ask the trainee:

*What did you just hear from me? What did you see? How did my nonverbal communication make you feel?  
If you didn't know me at all, what would you believe – the verbal or nonverbal message?*

- Give the trainee a copy of the handout, *Non-Verbal and Paraverbal Communication*. Review as needed.

If time permits:



- Give the trainee the handout, *Non-Verbal and Paraverbal Communication Exercise*. Take turns doing the two parts to this exercise, each time letting one another know how accurately the receiver understood the message being conveyed non-verbally and paraverbally. Emphasize that clients, like all of us, will most often interpret the non-verbal and paraverbal to be the correct message, even if it contradicts the words being spoken.

- Explain that open questioning is a vital skill in communication with clients. Ask the trainee for a quick definition of an open-ended question.

- Acknowledge that this skill seems to be a simple one, and yet we often ask closed-ended questions when an open-ended one could invite much more response. Closed-ended questions are useful for collecting data. For example, “*Have you ever been treated for an STI?*” They are less effective for assessing knowledge and exploring behavioral issues.
- State that “how” and “what” are particularly useful words with which to begin open questions.

If time permits:



- Give the trainee the handout, *The Questions Providers Ask: Open-Ended Question Practice Sheet*. Have the trainee work on it alone. Remind her to attempt to begin questions with “how” or “what.” After about 5 minutes, facilitate a brief review of their responses.
- Give the trainee the handout, *The Questions Providers Ask: Open-Ended Question Practice Sheet with Suggested Revisions*, to offer some examples.
- If you don’t have time for the trainee to complete the handout during the training, have the trainee take the handouts with her to review and complete.

- Explain that it is a good idea to avoid using “why” questions. Ask the trainee (with humor):

*“Why might one want to avoid asking “why” questions?”*

- Listen for and confirm responses that suggest that “why” questions tend to make people feel defensive, feel the need to explain and defend their behavior. State that “why” questions make people defensive because we invariably ask them about behavior we judge negatively! Offer these examples to make the point:

*Why were you exactly on time for your appointment today?*

*Why have you taken your medications properly?*

*Why haven’t you had another STI since the last time I saw you?*

- Ask trainee:  
*Don’t those questions sound odd?*
- Explain that in fact those are the kinds of “why” questions we should be asking – ones that ask clients to describe how they have succeeded,

rather than the usual ones that seem to ask them to explain how they have “failed.”

- Acknowledge that of course there are times that one wants to understand the underlying “why” of a situation, but, because “why” questions tend to create defensive reactions, it’s good to use other words to form those questions. Once again, “how” and “what” make good openers.

- Offer this example:

Imagine you’ve asked a client: “What are you doing to reduce the risk that you might get a sexually transmitted infection?”

The client responds, “I try to use condoms when I have sex, but it doesn’t always happen.”

The traditional response focuses on what’s not being done: “Why not? If you’re really going to protect yourself, you need to use them all the time.” We chastise because we care. Unfortunately it can feel like judgment and criticism.

Instead try, “It’s great that you’re trying to use condoms! You obviously know that condom use can be a very important part of prevention. What are the situations when it doesn’t happen...what would need to be different for condoms to be used more often?”

One might also say:

“Tell me about the times you are able to use them. What’s happening then?”

- Summarize by saying that these responses support the client’s knowledge and behavioral intention, and then move on to start problem solving, rather than chastising the client. Problem solving works much more effectively when it’s based on a foundation of support, rather than one of negative judgment.

If time permits:



- Give the trainee the handout, *The Questions Providers Ask: Alternatives to “Why?” Questions*. Allow time for the trainee to complete the handout. Remind her to attempt to begin her questions with “how” or “what.” After a few minutes, facilitate a brief review of her responses.
- Give the trainee the handout, *The Questions Providers Ask: Alternatives to “Why?” Questions – Suggested Revisions*.
- If you don’t have time to for the trainee to complete the handout during the training, have the trainee take the handouts with her to review.

- Give trainee the handout, *The Words Providers Use*. Go over it together, discussing how these words might be heard by a client, and what language could be used instead.



### Group training:

- Review the objectives for this Unit.
- Distribute the handout, *The Words Clients Use*. Ask trainees to talk with one or two other trainees nearby, sharing their responses to the questions on the handout.

*How does it feel to say these words to someone else? How does it feel to write down those words? Are some words more difficult to speak or write than others? Which ones are the most difficult?*

*Has a client ever used any of those words when talking with you? How did you respond? How do you feel about your response?*

- After a few minutes, ask trainees for examples of words or phrases that are difficult for them.

- Offer an example of a phrase or sentence a client might say that could potentially be uncomfortable for a provider. Try to incorporate some of the words the trainees have identified as difficult. An example: A client says, “I don’t know why you’re asking me about this. I’m no whore, I’m no junkie – why should I worry about getting AIDS?”
- Ask trainees:  
*What are all the reasons a client might use these words?*

Listen for and confirm, adding if necessary, responses such as:

- ✓ The client is insulted, feels the provider is judgmental, and is expressing anger through her choice of words.
  - ✓ The client is attempting to distance herself from “those people” by using judgmental terminology.
  - ✓ The client in fact does engage in risky sexual and/or drug using behavior, and does not want the provider to suspect it.
  - ✓ The client has strong feelings about such behaviors due to issues in her personal life; e.g. family members or partners who have been risky in their sexual and/or drug using behaviors.
  - ✓ The client is testing the provider, to see how the provider will react. That reaction might determine how much the client is willing to share.
  - ✓ Those words are the words the client knows, and the words don’t have the same judgmental associations for the client that they do for the provider.
- Ask trainees:  
*How might a client know that you were uncomfortable in response to something she said, even if you didn’t say anything about it?*

Listen for and confirm, prompting if necessary, responses about non-verbal and paraverbal communication.

- Demonstrate a conflicting message by using nonverbal behavior that directly conflicts with a verbal message: Tell the trainees how happy you are to be with them today while looking at your watch, speaking slowly, and giving nonverbal clues that suggest you “really don’t want to be there.” Ask the trainees:  
*What did you just hear from me? What did you see? How did my nonverbal communication make you feel?  
If you didn’t know me at all, what would you believe – the verbal or nonverbal message?*

- Give the trainees a copy of the handout, *Non-Verbal and Paraverbal Communication*. Invite comments regarding the content of the handout.

If time permits:



- Distribute the handout, *Non-Verbal and Paraverbal Communication Exercise*. Ask trainees to form groups of 3-5. Instruct them to take turns doing the two parts to this exercise, each time asking other group members their interpretation of the message being conveyed by the non-verbal and paraverbal communication. They should then let one another know how accurately the receiver understood that message.
  - Emphasize that clients, like all of us, will most often interpret the non-verbal and paraverbal to be the correct message, even if it contradicts the words being spoken.
- Explain that open-ended questioning is a vital skill in communicating with clients. Ask the trainees for a quick definition of an open-ended question.
  - Acknowledge that although this skill seems to be a simple one, we often ask closed-ended questions when an open-ended one could invite much more substantive response. Closed-ended questions are useful for collecting data. For example, “*Have you ever been treated for an STI?*” They are less effective for assessing knowledge and exploring behavioral issues.
  - State that “how” and “what” are particularly useful words with which to begin open questions.

If time permits:



- Distribute the handout, *The Questions Providers Ask: Open-Ended Question Practice Sheet*. Have the trainees work on it alone, first. Remind them to attempt to begin questions with “how” or “what.” After about 5 minutes, facilitate a large group discussion, eliciting examples of revised questions.
- Distribute the handout, *The Questions Providers Ask: Open-Ended Question Practice Sheet with Suggested Revisions*, to offer some examples.
- If you don’t have time for the trainees to complete the handout during the training, have them take the handouts with them to review.

- Explain that it is a good idea to avoid using “why” questions. Ask the trainees (with humor):

*“Why might one want to avoid asking “why” questions?”*

- Listen for and confirm responses that suggest that “why” questions tend to make people feel defensive. State that “why” questions make people defensive because we invariably ask these questions about behavior we judge negatively! Offer these examples to make the point:

*Why were you exactly on time for your appointment today?*

*Why have you taken your medications properly?*

*Why haven’t you had another STI since the last time I saw you?*

- Ask trainees:

*Don’t those questions sound odd?*

- Explain that in fact those are the kinds of “why” questions we should be asking – ones that ask clients to describe how they have succeeded, rather than the usual ones that seem to ask them to explain how they have “failed.”
- Acknowledge that of course there are times that one wants to understand the underlying “why” of a situation, but, because “why” questions tend to create defensive reactions, it’s good to use other words to form those questions. Once again, “how” and “what” make good openers.
- Offer this example:

Imagine you’ve asked a client: “What are you doing to reduce the risk that you might get a sexually transmitted infection?”

The client responds, “I try to use condoms when I have sex, but it doesn’t always happen.”

The traditional response focuses on what’s not being done: “Why not? If you’re really going to protect yourself, you need to use them all the time.” We chastise because we care. Unfortunately it can feel like judgment and criticism.

Instead try, “It’s great that you’re trying to use condoms! You obviously know that condom use can be a very important part of prevention. What are the situations when it doesn’t happen...what would need to be different for condoms to be used more often?”

One might also say:

“Tell me about the times you are able to use them. What’s happening then?”

- Summarize by saying that these responses support the client’s knowledge and behavioral intention, and then move on to start problem solving, rather than chastising the client. Problem solving works much more effectively when it’s based on a foundation of support, rather than one of negative judgment.

If time permits:



- Distribute the handout, *The Questions Providers Ask: Alternatives to “Why?” Questions*. Allow time for the trainees to complete the handout. Remind them to attempt to begin their questions with “how” or “what.” After about 5 minutes, facilitate a brief review of their responses.
  - Give trainees the handout, *The Questions Providers Ask: Alternatives to “Why?” Questions – Suggested Revisions*.
  - If you don’t have time to for trainees to complete the handout during the training, have them take the handouts with them to review.
- Give trainee the handout, *The Words Providers Use*. Go over it together, discussing how these words might be heard by a client, and what language could be used instead.

## Discussion Points

- Trainees may express concern that this training is encouraging them to “accept” any kind of communication from the client – that any language is acceptable. It is certainly not intended that providers accept verbal abuse from clients.

You want trainees to understand is that providers often take clients’ language personally, and then react personally, when, in fact, the language is not about the provider at all. When a provider’s immediate reaction is to reprimand the client about his or her language, the interaction may spiral into a personal attack. If a provider can avoid that initial reaction to reprimand, then she may be able to prevent that escalation. A provider’s understanding that the client’s language is most

likely an expression of the client’s emotional state – the client’s fear, anger, anxiety – can help the provider to tone down her own response.

- Most trainees will know what an open-ended question is, and will also know that they “should” be using that approach to questioning. At the same time, trainees will likely ask many closed-ended questions that they assume to be “open.” To help raise awareness of this, listen for trainees’ use of closed-ended questions during discussions, and, if appropriate, encourage them to “open the question up.” Doing this with gentle persistence throughout the training can be very instructional. Also, be conscious of your own style of questioning in your work with trainees, and wherever possible choose to make the majority of your questions open ones.

### Follow-up Activities

- This Unit can be followed by Unite Five for Providers: **Responding to Difficult Questions & Statements: The 3 C Model.**

### The Words Clients Use

Think about the words or phrases a client might use when talking about sexual or substance use behavior that could make you feel some discomfort - perhaps a lot of discomfort!

Words for  
Sexual Behaviors

Words for  
Substance Use Behaviors


How does it feel to say these words to someone else? How does it feel to write down those words? Were some words more difficult to speak or write than others? Which ones were hardest?

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Has a client ever used any of those words when talking with you? How did you respond? How do you feel about your response?

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## Non-Verbal and Paraverbal Communication

This list gives both effective  and less effective  examples of many forms of non-verbal and paraverbal expression. Take a moment to review the list.

### *Eye Contact*

- √ Spontaneous eye contact and eye movement
- √ Looking directly at speaker when speaking
- √ Looking directly at speaker when listening
- × Breaking eye contact
- × Staring too intensely
- × Looking down
- × Looking away
- × Staring blankly

### *Body Posture*

- √ Slight forward lean
- √ Body facing speaker
- √ Relaxed posture
- √ Relaxed hand position
- √ Spontaneous hand and arm movements
- √ Gestures for emphasis
- √ Relaxed leg position
- × Slouching
- × Fixed, rigid position
- × Physically too close to speaker
- × Physically distant from speaker
- × Arms across chest
- × Body turned sideways
- × Leaning away

### *Vocal Quality*

- √ Pleasant intonation
- √ Appropriate loudness
- √ Moderate rate of speech
- √ Simple, precise language
- √ Fluid speech
- × Monotone
- × Too much effort
- × Too loud

### *Distracting Personal Habits*

- × Playing with hair
- × Fiddling with pen or pencil
- × Chewing gum
- × Eating or drinking
- × Tapping fingers or feet

In the space below, describe how you would want a provider to look and sound while asking you about your sexual and substance use behaviors.

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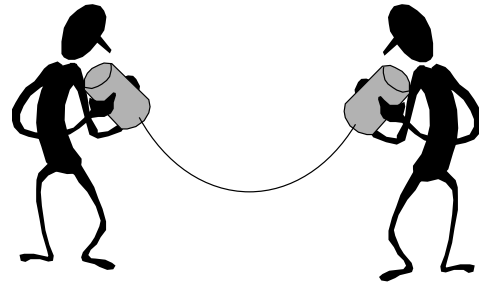
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## Non-verbal & Paraverbal Communication Exercise

- Pick one of the messages below, and attempt to communicate it by non-verbal means only.

1. I'm startled
2. I'm confused
3. I'm angry
4. I'm anxious
5. I'm sleepy
6. I'm bored
7. I want you to go away
8. I'm happy
9. I'm sad
10. I'm pouting
11. I'm amused
12. I'm in love



- Next, try saying the following phrase three different times, each time using non-verbal and paraverbal communication to convey a different one of the messages from the list above:

*"I want to help you get what you came here for."*

**The Questions Providers Ask:  
Open-Ended Question Practice Sheet**

Here are some closed-ended questions. For each one, try composing an open-ended question, starting with "what" or "how." An example is given to get you started.

The "Closed-ended" Approach	Open-Ended Approach
Do you know there are a number of different sexually transmitted infections?	<i>What have you heard about sexually transmitted infections?</i>
Do you know how to keep from getting a sexually transmitted infection?	
Have you thought about getting tested for HIV?	
Are you going to stop using drugs?	
Can you talk with your partner about this?	

**The Questions Providers Ask:  
Open-Ended Question Practice Sheet with Suggested Revisions**

The "Closed-ended" Approach	Open-Ended Approach
Do you know there are a number of different sexually transmitted infections?	<i>What have you heard about sexually transmitted infections?</i>
Do you know how to keep from getting a sexually transmitted infection?	<i>How do you think you could keep yourself safe from sexually transmitted infections, like HIV?</i>
Have you thought about getting tested for HIV?	<i>How would you feel about getting tested for HIV?</i>
Are you going to stop using drugs?	<i>What would be the hardest part about not using drugs? What could you do to help yourself to stop using?</i>
Can you talk with your partner about this?	<i>How do you feel about talking with your partner? What concerns you the most about talking with your partner?</i>

**The Questions Providers Ask:  
Alternatives to “Why?” Questions**

Here are some “why” questions. For each one, try composing an open-ended question, starting with “what” or “how.” An example is given to get you started.

The “Why” Approach	Open-Ended Approach
<i>Why aren't you using condoms?</i>	<i>How do you feel about using condoms? What keeps you from using condoms?</i>
<i>Why do you think you can't get infected?</i>	
<i>Why don't you want to get tested for HIV?</i>	
<i>Why are you late for your appointment?</i>	
<i>Why can't you talk to your partner about STIs and HIV?</i>	
<i>Why don't you stop using drugs?</i>	

**The Questions Providers Ask:  
Alternatives to “Why?” Questions – Suggested Revisions**

The “Why” Approach	Open-Ended Approach
<i>Why aren't you using condoms?</i>	<i>How do you feel about using condoms? What keeps you from using condoms?</i>
<i>Why do you think you can't get infected?</i>	<i>What do you think is protecting you from infection? How would you feel if you became infected, when you might have been able to prevent it?</i>
<i>Why don't you want to get tested for HIV?</i>	<i>How do you feel about getting tested for HIV? What concerns you most about getting tested?</i>
<i>Why do you keep missing appointments?</i>	<i>What's keeping you from your appointments? How do you feel about coming here? What could help you to keep these appointments?</i>
<i>Why can't you talk to your partner about your infection?</i>	<i>What concerns you most about talking with your partner about your infection? What's the worst thing your partner might say or do? How do you feel about talking with your partner?</i>
<i>Why don't you stop using drugs?</i>	<i>What will be the hardest part about not using drugs? What will you miss the most? What would be the best part about not using drugs?</i>

## The Words Providers Use

Take a look at the words listed. Imagine how these words might sound to a client. Next to each word, write another non-judgmental way to express the idea. If you can think of others, add them to the list.

Promiscuous

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Non-compliant

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Resistant

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Immature

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Hooker

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Victim (of abuse/incest)

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Illegitimate

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Illegal (as in illegal alien)

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Manipulative

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Difficult

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Abnormal

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Junkie

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# Asking the Hard Questions: Training Activities to Enhance Providers' Risk Assessment Skills



## Unit Title

**Unit Five: Responding to Difficult Questions & Statements:  
The 3 C Model**<sup>□</sup>

## Objectives

- To give providers a simple communication tool with which to structure response to difficult questions and statements.


## Group Size

While this Unit may be done one-on-one, it is best suited to a group of at least 3 trainees.

## Time Duration

45 - 60 minutes for one-on-one session

60 minutes – 1 hour, 30 minutes for group session

Look for this symbol  for instructions on how to change the length of a training session by varying the use of different activities.

## Materials & Preparation

*Handout– Answering Difficult Questions: The 3Cs Approach*

*Handout – Answering Difficult Questions: What’s Difficult for You?*

*Handout – Response Practice: Challenging Questions & Concerns*

*Handout – 3Cs Worksheet*

*Handout – Using the 3Cs Model: An Exercise*

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<sup>□</sup> 3Cs Model, developed by Joan Mogul Garrity

Easel, newsprint and markers for group training  
Overhead or prepared newsprint of the content of the handout, *Answering Difficult Questions: The 3Cs Approach*, if desired

## Procedure



### One-on-one training:

- Review the objective for this Unit.
- Provide trainee with the handout, *Answering Difficult Questions: The 3Cs Approach*.
- Present this overview of the model:

The **3Cs** Model is a simple guide for responding to difficult questions and statements. The model begins with a respectful, empathetic, and very brief acknowledgment of what the client has said. This is followed by a request for more information. These steps give the provider a chance to assess her own ability to respond to the client, and determine how she will proceed.

- Referring to the left hand column of the handout (or overhead/prepared newsprint, if you are using one), walk the trainee through each step. Use the example at the bottom of the handout for illustration.

### Step 1. Confirm

Begin by offering a confirmation of 1) the act of expressing the question or statement; 2) the general subject of the question or statement; and/or 3) recognition of the client's emotions regarding the question or statement.

### Step 2. Clarify

Ask an open-ended question to encourage the client to talk more about the concern. This facilitates a better understanding of the issue for both you and

the client, and gives you a chance to assess your ability to respond to the issue.

### Step 3. Content or Contract

If you feel that the issue can be addressed by providing information and you have the knowledge and time, a content response could be given. Follow the content response with another clarification question to check if the answer is sufficient. If you don't feel skilled enough to handle the client's issue, or don't have sufficient time, then a contract for referral or another appointment could be given.

- Use an interactive approach with the trainee to further explain the **3Cs**.

- ✓ Ask the trainee to imagine that she has been talking to a client – a 28-year-old married woman who has been taking oral contraceptives for about 2 years. The client is here for her annual check up. The trainee has asked the client about her current sexual behavior. The client looks very uncomfortable. She says she's having sex with her husband, and then quietly adds,

*"I just don't seem to be enjoying sex these days."*

- ✓ Ask the trainee,

*What do you think your first reaction might be to this statement?*

Anticipate that the trainee's first thought might be that this is a subject that requires an in-depth intervention with a specially trained person. Suggest to the trainee that before one rushes to make that referral, the **3Cs** approach might be worth a try.

- ✓ Ask the trainee,

*What could you say to her that would offer confirmation?*

Listen for and confirm, prompting if necessary, a response like,

*"It looks like this isn't an easy thing for you to talk about."*

This is a **Confirmation** of her feelings, based on her non-verbal and paraverbal communication.

- ✓ Ask the trainee,

*What could you say to invite some clarification from this client?*

Listen for and confirm, prompting if necessary, a response like,

*“Tell me a little more about what’s going on.”* .

- ✓ Tell the trainee that the client responds, saying,

*“Well, I really love him, and sex used to be so good. But it seems that lately I just don’t get...you know...wet anymore, and it hurts.”*

- ✓ Ask the trainee,

*What does that response suggest to you, in terms of what might be helpful to this client?*

Listen for and confirm, prompting if necessary, responses like the following: It could be that the oral contraceptives she’s taking are decreasing lubrication. One might say to her:

*“I know you’re taking the pill now. A lot of women find that they don’t get as wet when they’re on the pill. Using a lubricating jelly, like KY, seems to help a lot. What do you think about that?”*

- ✓ Explain that this **confirmation**, followed by a **content** response, then a further **clarification** question, should invite more questions or thoughts from her. The client’s next answer should let you know if you’ve offered a good suggestion, or if this is really a more complex problem, perhaps a relationship problem that needs more intervention than you can provide. At that point, **contracting** for a referral would be best.
- Refer to the right hand column of the handout (or overhead/prepared newsprint, if you are using one), and offer the following explanation for the alternatives listed there:

- ✓ Explain that sometimes a client’s question seems to be a very straightforward request for information. For example, a client asks,

*“How effective are condoms at preventing HIV infection?”*

- ✓ Ask the trainee:

*What might a simple content response be to this question?*

Listen for and confirm, prompting if necessary, responses like the following:

*“When condoms are used correctly, and used every time that someone has intercourse, they are very effective at preventing HIV infection.”*

- ✓ Explain that one could follow that with a clarification to be sure that the client’s question had been fully addressed; for example:

*“What have you heard about condoms and HIV prevention?” Or “What else can I tell you about condoms and HIV?” Or “How do you feel about using condoms?”*

If time permits:



Give the trainee the handout, *Answering Difficult Questions: What’s Difficult for You?* Have her complete this handout, or go through it aloud, together. This is a good opportunity to discuss what the trainee thinks underlies what the client says, and to discuss what are the trainee’s expectations of herself, in response to the client.

- Give the trainee the handout, *Response Practice: Challenging Questions & Concerns* and *3 Cs Worksheet*. Take turns asking one another any question or statement selected from the handout. Practice responding, following the **3Cs Model** approach. Responses can be recorded on the worksheet. Remind the trainee to include the initial **confirmation** step – it’s the one most often omitted.

If time permits:



Describe another situation appropriate for this approach:

The **3Cs** model can be useful for handling one of the toughest kinds of questions we get – when a client asks us about our own experiences. For example, when she says,

*“Do you always use condoms?” “Have you ever had a guy cheat on you, and give you an infection?” “Have you ever had an abortion?”*

A client doesn’t ask these questions because she’s really interested in your life. She asks for reasons that have to do with her needs, such as not wanting to feel alone, wondering if you can understand, hoping a shared experience means that you won’t be critical of her.

A **confirmation** statement can respond to the feelings that underlie such questions. For example:

*“It can feel comforting to know that someone else has had an*

*experience that you've had."*

Or,

*"Sometimes people ask that because they think that if I've had the same experience, I can do a better job helping them with it."*

A **clarification** question could be:

*"How will it be helpful to you to know if I've had that experience or not?"*

Based on the client's response, you might offer something like:

*"You know, even if I have had the same experience, I don't want to assume that means I understand what this is like for you. Tell me some more..."*

If you decide to simply answer her question, what's most important is to get the attention back to the client. Talking about your own experiences can change the focus of your session with her. Try saying something like:

*"I have had that experience. But I don't think that means I know what this is like for you. Tell me some more..."*



### **Group training:**

- Review the objective for this Unit.
- Distribute the handout, *Answering Difficult Questions: The 3Cs Approach*.
- Using an overhead or prepared newsprint of the content of the model, present an overview:

The **3Cs** Model is a simple guide for responding to difficult questions and statements. The model begins with a respectful, empathetic, and very brief acknowledgment of what the client has said. This is followed by a request for more information. These steps give the provider a chance to assess her own ability to respond to the client, and determine how she will proceed.

- Referring to the left hand column of the handout (or overhead/prepared newsprint, if you are using one), walk the trainees through each step. Use the example at the bottom of the handout for illustration.

### **Step 1. Confirm**

Begin by offering a confirmation of 1) the act of expressing the question or statement; 2) the general subject of the question or statement; and/or 3) recognition of the client's emotions regarding the question or statement.

### **Step 2. Clarify**

Ask an open-ended question to encourage the client to talk more about the concern. This facilitates a better understanding of the issue for both you and the client, and gives you a chance to assess your ability to respond to the issue.

### **Step 3. Content or Contract**

If you feel that the issue can be addressed by providing information and you have the knowledge and time, a content response could be given. Follow the content response with another clarification question to check if the answer is sufficient. If you don't feel skilled enough to handle the client's issue, or don't have sufficient time, then a contract for referral or another appointment could be given.

- Use an interactive approach to further explain the **3Cs**.

- ✓ Say to the group:

*Imagine that you have been talking to a client – a 28-year-old married woman who has been taking oral contraceptives for about 2 years. The client is in the clinic for her annual check up. You have asked the client about her current sexual behavior. The client looks very uncomfortable. She says she's having sex with her husband, and then quietly adds,*

*"I just don't seem to be enjoying sex these days."*

- ✓ Ask:

*What do you think your first reaction might be to this statement?*

Anticipate that first thoughts might be that this is a subject that requires an in-depth intervention with a specially trained person.

Suggest that before one rushes to make that referral, the **3Cs** approach might be worth a try.

- ✓ Ask the group:

*What could you say to her that would offer confirmation?*

Listen for and confirm, prompting if necessary, responses like,

*“It looks like this isn’t an easy thing for you to talk about.”*

- ✓ Explain that this is a **Confirmation** of her feelings, based on her non-verbal and paraverbal communication.

- ✓ Ask the group:

*What could you say to invite some clarification from this client?*

Listen for and confirm, prompting if necessary, a response like,

*“Tell me a little more about what’s going on.”* .

- ✓ Tell the trainee that the client responds, saying,

*“Well, I really love him, and sex used to be so good. But it seems that lately I just don’t get...you know...wet anymore, and it hurts.”*

- ✓ Ask the group:

*What does that response suggest to you, in terms of what might be helpful to this client?*

Listen for and confirm, prompting if necessary, responses like the following: It could be that the oral contraceptives she’s taking are decreasing lubrication. One might say to her:

*“I know you’re taking the pill now. A lot of women find that they don’t get as wet when they’re on the pill. Using a lubricating jelly, like KY, seems to help a lot. What do you think about that?”*

- ✓ Explain that this **confirmation**, followed by a **content** response, then a further **clarification** question, should invite more questions or thoughts from her. The client’s next answer should let you know if you’ve offered a good suggestion, or if this is really a more complex problem, perhaps a relationship problem that needs more

intervention than you can provide. At that point, **contracting** for a referral would be best.

- Refer to the right hand column of the handout (or overhead/prepared newsprint, if you are using one), and offer this explanation for the alternatives listed there.

Sometimes a client's question seems to be a very straightforward request for information. For example, a client asks,

*“How effective are condoms at preventing HIV infection?”*

- ✓ Ask the group:

*What might a simple content response be to this question?*

Listen for and confirm, prompting if necessary, responses like the following:

*“When they're used correctly, and used every time that someone has intercourse, they are very effective at preventing HIV infection.”*

- ✓ Explain that one could follow that with a clarification to be sure that the client's question had been fully addressed; for example:

*“What have you heard about condoms and HIV prevention?” Or “What else can I tell you about condoms and HIV?” Or “How do you feel about using condoms?”*

If time permits:



Distribute the handout, *Answering Difficult Questions: What's Difficult for You?* Ask trainees to work in small groups of 3-4 trainees sitting nearby. Instruct group members to share their responses to the handout.

- After about 8 minutes, facilitate a full group discussion, eliciting examples of difficult statements and questions, and sharing reactions to the question, *What makes this [question or statement] difficult for you?*
- Distribute the handout, *Response Practice: Challenging Questions & Concerns* and *3 Cs Worksheet*, and set up the practice:
    1. Have trainees form triads, with any extra trainees joining groups to make foursomes.

2. Instruct group member to take turns selecting a question or statement from the handout, and directing it to one of the other members of her small group. The person to whom the statement is directed is to respond to it, using the **3Cs Model** approach.
  3. Other group members can serve as coaches. They can record responses on the worksheet, if desired.
  4. Tell trainees that they do not need to do an extensive role-play – a few dialogue exchanges for each statement they try is sufficient.
  5. Remind the trainees to include the initial **confirmation** step – it's the one most often omitted.
- Allow about 15 minutes for the small group activity. At the end of that time, acknowledge how challenging the task was, and ask trainees to identify questions or statements they found most difficult. Work through those with the whole group, eliciting ideas for each step of the model.

If time permits:



Describe another situation appropriate for this approach:

The **3Cs** model can be useful for handling one of the toughest kinds of questions we get – when a client asks us about our own experiences. For example, when she says, *“Do you always use condoms?” “Have you ever had a guy cheat on you, and give you an infection?” “Have you ever had an abortion?”* A client doesn't ask these questions because she's really interested in your life. She asks for reasons that have to do with her needs, such as not wanting to feel alone, wondering if you can understand, hoping a shared experience means that you won't be critical of her.

A **confirmation** statement can respond to the feelings that underlie such questions. For example:

*“It can feel comforting to know that someone else has had an experience that you've had.”*

Or,

*“Sometimes people ask that because they think that if I've had the same experience, I can do a better job helping them with it.”*

A **clarification** question could be:

*“How will it be helpful to you to know if I've had that experience or not?”*

Based on the client's response, you might offer something like:

*“You know, even if I have had the same experience, I don't want to assume that means I understand what this is like for you. Tell me some more...”*

If you decide to simply answer her question, what's most important is to get the attention back to the client. Talking about your own experiences can change the focus of your session with her. Try saying something like:

*"I have had that experience. But I don't think that means I know what this is like for you. Tell me some more..."*

### Discussion Points

- You will want to be very proficient with the use of this model in order to comfortably present it. Be sure to spend time practicing with the handout, *Response Practice: Challenging Questions & Concerns*.

### Follow-up Activities

- This Unit can be followed by regular opportunities to meet for case presentation, journal review, role-play and processing. Use Unit 6 for Providers – **Case Presentation & Processing**.

## Answering Difficult Questions: The 3 C's Approach <sup>□</sup>

☺ **Statement of Confirmation/**  
acceptance  
or feeling reflection

🚪 **Question to Clarify**  
understanding

ℹ **Content/**  
informational  
response, or **Contract**  
for continued  
interaction or referral

☺ **Simple Content/**  
informational response

Or

🚪 **Question to Check**  
out if response met  
need

ℹ **Further**  
**Confirming** and  
**Clarifying** responses  
to concern

Example: Client says, "I really don't like using condoms"

### Confirmation

A confirmation of the statement could be, "A lot of folks feel that way." Or "People have a lot of different feelings about condoms." Or "Thank you for being willing to tell me that." Or, if a client appeared upset when making the statement, you might say, "Even talking about them can be uncomfortable."

### Clarification

The simplest clarification is to say, "Tell me more..." You could also say to this client, "What do you dislike the most about using them?" The more general and open-ended the clarification statement is, the more useful it will be in finding out what's really going on for the client.

### Content or Contract

The substance of this step is dependent on what has emerged from the clarification. For this example, it might be as simple as explaining how to eroticize the use of condoms. If the clarification revealed concerns between the client and a partner, you might want to help her rehearse how to talk about condom use. You might want to explore the issue further, but not have time, so you could contract for another visit. Or you might contract for a referral to someone else who could talk with her right now.

## Answering Difficult Questions: What’s Difficult for You?

In the first column, write the most difficult questions or statements clients have ever presented to you, or ones you hope you never hear. In the second column, write your thoughts about what makes this question or statement hard for you.

Difficult Question or Statement	What Makes This Difficult for You?

Now, try using the 3 Cs Model to respond to a few of the questions or statements you have written.

## **Response Practice: Challenging Questions & Concerns**

1. I don't know how to ask a guy to use a condom.
2. What's the average size of a penis?
3. If somebody a girl knows has sex with her when she didn't really want to, is that rape?
4. Doesn't everybody have oral sex?
5. Can masturbation hurt a person?
6. I don't understand why you have to ask me these questions - after all, I am married.
7. So I get high sometimes, I'm just smoking marijuana. It's really no big deal.
8. Can I get AIDS if we only do it in the mouth?
9. I've never told anybody this before...I was raped when I was twelve.
10. My friends say they only have anal sex so that they won't get pregnant. What do you think of that?
11. My mom's boyfriend has AIDS...She's going to die, isn't she?



## Using the 3Cs Model: An Exercise

Here is another example that illustrates the **3Cs Model**.

Imagine that you're talking to a client about condom use. She is listening to you, but looks very uncomfortable. You say to her that it looks like she's thinking about something important, and she says,

*"I really feel yucky when I look at my boyfriend's...penis."*

What do you imagine you would say to her in response? Write it down here.

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It's likely you responded in one of several ways:

- You asked a question to find out why she's reacting this way.
- You encouraged her not to feel that way.
- You empathized with her feelings.

Now consider what might be underlying her statement. What are some possibilities? Write them down here.

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Here are some possibilities:

- Her boyfriend has something wrong with his penis, making it look “yucky.”
- She’s a survivor of incest or sexual abuse, and is repulsed by anything sexual, or repulsed specifically by a penis.
- Her boyfriend wants her to have oral sex with him, and she’s not interested.
- Her boyfriend wants her to have oral sex with him, and she is interested, but she’s uncomfortable about feeling that way, and trying to present herself as someone who “wouldn’t do that.”
- She is uncertain about whether it’s okay to be looking.
- She has never seen a penis before, so it looks strange to her.
- She has only seen either circumcised or uncircumcised penises, and her boyfriend’s is different from what she’s used to seeing.
- Prior partners have always kept the lights off during sex; this boyfriend wants to see.
- She’s uncomfortable about discussing sex or condom use with you, and is trying to find a way to cut short the discussion.

Based on her statement, you don’t yet really know what’s going on. Any response you make now is going to be based on your assumptions. Instead of responding, start with a **confirmation**. While you can’t honestly tell her that this is a statement you frequently hear, you can confirm a very generalized notion of what the statement is about.

*“People react in lots of different ways when they look at someone else’s body.”*

Follow with a **clarification**:

*“Tell me some more about what’s going on for you.”*

Her response will likely give you a good idea of your ability to address her concerns. If it turns out that she just needs some simple information, give it to her. For example, *“Sounds like your partner’s penis is not circumcised. That could make it look different from what you’re used to.”* If there’s not a simple, informational response to give, but you do feel able to talk with her, you might **contract** with her for another visit. If you’re not prepared to deal with the issue, you would **contract** for referral.

## Asking the Hard Questions: Training Activities to Enhance Providers' Risk Assessment Skills



### Unit Title

### Unit Six: Case Presentation & Processing

### Objectives


- To give an opportunity for providers to present and process challenging interactions involving risk assessment.
- To assist providers in strategizing approaches to respond to challenges.

### Group Size

This activity is designed for a group of at least three trainees.

### Time Duration

45 min – 2 hours

The length of this Unit is dependent on the number of small groups, and whether or not you choose to have small groups do presentations for the entire group. Each round of small group role-play followed by full group discussion should take about 30 minutes. Presentations will add about 15-20 minutes per presentation. (See this symbol for instructions on facilitating presentations:  )



### Materials & Preparation



*Handout– Challenging Client Scenarios*  
*Handout– Guidelines for Giving and Receiving Feedback*  
*Handout – “Stuck” Places and Strategies*  
*Handout– Risk Assessment Journal Page for Providers*

For a group of more than 9 trainees, you will need newsprint, easel stand and markers for recording responses. Prepare a newsprint page: Draw a vertical line

down the center of a page to form two columns. Title the columns — one column, “**Stuck Places**”; the other column, “**Strategies**”.

## Procedure



### Group training:

- Review the objectives for this unit.
- Have trainees form triads, with any extra trainees joining groups to make foursomes. Distribute the handouts, *Challenging Client Scenarios*, *Guidelines for Giving and Receiving Feedback*, and “*Stuck*” *Places and Strategies*.
- Provide the following instructions for the small group work of this activity:
  1. Small group members should take turns sharing a challenging interaction experienced with a client.
  2. After the sharing, small group members will discuss what it is that makes challenging cases “challenging,” looking for any common themes among the cases they have described.
  3. Each group will select one challenging case on which to focus. It can be an exact case described by one of the group members, or a case created by the group that represents themes that are difficult for them.
  4. Each group will conduct a role-play. The trainee who “had” this challenging case should be the one to play the client. One of the other group members should play the “provider,” with the remaining member(s) playing observer.
  5. Explain that observers should observe silently, unless the person playing the “provider” asks for coaching. The observer should take notes in the space provided on page 2 of the *Challenging Client Scenarios* handout.
- Before starting the small group work, spend a few moments addressing the anxiety associated with role-play, and offer guidelines on giving and receiving feedback.
  - ✓ Emphasize the following:

*The purpose of doing these skill practices is not to demonstrate perfect, or even near perfect, counseling skills. The purpose is to surface those moments when almost any of us might wish we could run from the situation, or find someone else to deal with it. If you are playing the provider and find yourself stuck or not feeling good about how it's going—terrific! That means you are providing the heart of this experience—the material that we can work on together to strategize possible options when confronted with these challenges.*

- ✓ Refer to the handout, *Guidelines for Giving and Receiving Feedback*, and the prepared OH/slide if you are using one, and explain those guidelines.

Request that, during feedback, observers focus on all the *positives*, being as specific as possible. Emphasize that they should limit themselves to only **one** piece of critical feedback.

Provide the following description of giving and receiving feedback.

*The purpose of giving critical feedback is not to tell someone how he or she might have done something differently. Rather, its purpose is to describe an observation, a perception or reception of the impact of the provider's approach on the observer or client. For example, "I noticed that your client appeared uncomfortable when you used the word 'promiscuous'", rather than, "You shouldn't say promiscuous." The provider is certainly welcome to invite suggestions, if time permits; this invitation is in her/his control.*

*In receiving feedback, it's helpful to remember that feedback is not a questioning of the provider's intention. That understanding of receiving feedback can help the provider avoid defensiveness. Rather than needing to say (in response to the above example), "But I didn't mean to make her uncomfortable!" the provider can benefit from learning that what she intended to communicate did not work the way she hoped.*

- Ask small groups to begin their sharing of challenging cases. After about 10 minutes, encourage them to begin to discuss common themes, and to then select or create one challenging case on which to focus.
- After 10 minutes, ask groups to begin their role-plays, if they have not already done so.
- Allow about 8-10 minutes for the role-plays. Stop the groups after that time and instruct them to begin a feedback exchange in their small groups. Remind them to follow the guidelines for giving and receiving feedback, reinforcing the instruction to give only one piece of critical feedback. Suggest that they begin by letting the person who played the “provider” talk about his/her experience.
- After 5-8 minutes for the small group feedback sessions, facilitate a large group discussion of the role-play experience. Ask observers for specific examples of effective techniques that were used by the “provider.” Do not allow any critical comments. Listen for opportunities to confirm and reinforce the tremendous importance of the provider’s non-verbal and paraverbal communication in creating a comfortable exchange.
- Ask each trainee who played a “client” to briefly describe the client and the client’s situation. After that trainee speaks, ask the trainee who played the “provider” to describe one point at which she felt most “stuck” – what was going on, what was being said that created that most challenging moment. Record these “Stuck Places” in the left-hand column of the prepared newsprint.
- After recording all of the “Stuck Places”, facilitate a discussion with the entire group about strategies to respond to the recorded challenges. If no ideas emerge, offer some suggestions in the third person, so trainees can be free to critique/accept/reject them without concern about your response. Record strategies in the right-hand column of the prepared newsprint, across from their corresponding “Stuck Place.”

If time permits:



The small group role-play process may be repeated to give each triad member a chance to play “provider,” “client,” and observer. Follow the same procedure as above.

If time permits, and/or as an alternative to repeating the small group role-play



- Have each group do a presentation in front of the entire group. Assure trainees that the intention is to demonstrate the challenges – those moments when one might like to escape the interaction – not to demonstrate “perfect” skills.
- Offer these instructions to the small groups:
  - ✓ Select a 5-minute portion of the role-play that best illustrates the challenges of your case.
  - ✓ The observer should prepare brief contextual background to give the full group: demographic data about the client, type of clinic, intended purpose of the session, and any history of the client known by the provider prior to the session. This is followed by the brief role-play demonstration and group discussion.
- Invite the first group to present to the rest of the trainees – the observer first giving brief background information, followed by the role-play. If the trainee playing “provider” is having an extremely difficult time, or is doing a very poor job, stop the role-play. You are not trying to create discomfort or embarrassment!
- Follow the demonstration with a full group discussion of what was observed. Encourage positive feedback to the “provider” – do not allow any negative feedback. These demonstrations can feel very risky. You can minimize the risk by ensuring that trainees are not subject to criticism. Remember, the purpose is not to present perfect skills, but to stimulate strategic thinking about the work.
- Facilitate a large group discussion of various approaches to the demonstrated challenge.
- If the “client” was played by a trainee who actually dealt with the challenge in real life, ask that trainee what she can take from the experience of being the “client” that would be beneficial if she were ever confronted with that kind of challenge again.
- Repeat this process for each small group.

If time permits, facilitate this closing activity:



- Ask trainees to speak with the members of their small group. First, invite them to share what they identify as the greatest strength that they bring to their work — skills, knowledge, life experience, sensitivities. (If all trainees have had the chance to play “provider” in a small group role-play, you can have them tell one another what they perceive to be the other’s greatest strengths.)
- Next, each small group member should identify one skill or area of knowledge they want to strengthen or improve, being as specific as possible (e.g. "I want to become more comfortable with silence" as opposed to "I want to have better counseling skills,"). Group members should then discuss how they might each work toward this goal.
  - You may also suggest that group members could support one another in achieving his or her goal— exchanging phone numbers, email addresses, specifying times for follow-up conversations and check-ins.
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- Ask the small groups to discuss their most important “take-home” learnings from this activity. Elicit a few examples from the whole group.

### Discussion Points

- Depending on responses during the large group discussions, you may want to stimulate consideration of what is meant when one says that some approach did or did not “work,” i.e., what client outcome, in response to a provider’s action/statement, would indicate that the action/statement “worked”? Participants may express expectations and assumptions that a strategy that “works” is one that results in the client proceeding to do what the provider wants—for example, feeling “better” before leaving the session, or coming to a decision about reducing risky behavior. The problem with this mindset is that if a strategy is seen as useful to employ only if it will result in a specific outcome, then a provider might hesitate to try anything without the guarantee that it will “work!” Of course, whether or not something “works” is largely in the client’s control. Something “works” as long as it does not impede, and ideally facilitates, a client’s willingness and ability to utilize the provider and the interaction.
- There are a number of benefits to using the demonstration approach to this activity: The experience of demonstrating in an atmosphere of support is a great confidence booster. It is very confirming for trainees to hear that what they find challenging also challenges others. It can also lay

- a foundation for future role-play and observation/feedback, both in the context of training and in clinical observation by a trainee's supervisor.
- In preparing to facilitate this activity, you might want to review your personal reactions to your own challenges in doing risk assessment and counseling. Try to anticipate what situations are liable to be difficult for you to process. Consider consulting with a peer to enhance your sense of confidence in processing particular types of situations.
  - Here are some other ideas to keep in mind:
    - ✓ Avoid being overly directive in processing. You might wish to turn to the group first to begin the strategizing process. You don't need to be the only source of strategies in processing a situation. Group members are a resource of rich and varied experience. Use them!
    - ✓ Be aware of your reaction to approaches that may differ stylistically from yours. You will want to differentiate between what may be truly ineffective or even harmful, and what may simply be different from how you would handle the situation. Tolerance for differences in style is essential.
    - ✓ Processing the demonstrations obviously demands sensitivity. These role-plays are not designed to develop the individual skills of the presenters; they are intended to illuminate those most difficult moments that might confound providers and suggest appropriate strategies. Work to steer yourself and the group away from critical feedback to "providers."
    - ✓ While withholding critical feedback and repressing the desire to correct and improve can feel uncomfortable, trainees most likely are able to observe what didn't work well without attention being drawn to it. Trust them!
    - ✓ It's OK to acknowledge that a situation would be tough for you too!

### Follow-up Activities

- This Unit may be repeated on a regular basis. Distribute the handout, *Risk Assessment Journal Page for Providers*, to facilitate subsequent sessions.

## **Challenging Client Scenarios**

### **Sharing of Challenging Situations**

As you and other group members share your challenges, try to identify themes - issues, emotions, behaviors - that constitute challenges for providers.

### **Selection of Challenge for Focus**

Select a challenge that the group would most like to work on; or create one from elements of those described by members. Use the space below to record a brief description.

## **Roleplay**

Select a segment of the situation that best captures its challenging elements, and conduct a roleplay of *no more than 10 minutes*. The roles include:

"Client" - ideally played by the provider whose challenge you are working on

"Provider" - ideally, a group member not involved in the challenge

Observers, who use the spaces below to take notes.

## **Observation Notes**

## **Discussion of Roleplay**

The "client" should begin by discussing the experience and how it compared to "real life."

The "provider" should describe her/his sense of how the role-play went, what the chief challenges were.

Observers should provide feedback to the "provider," focusing on the positive.

## **Preparation of Presentation**

Select a 5-minute portion of the role-play that will best illustrate the challenges to the full group.

An observer prepares brief contextual background to give the full group: demographic data about the client, type of clinic, intended purpose of the session, and any history of the client known by the provider prior to the session.

## **Guidelines for Giving and Receiving Feedback**

### **Guidelines for Giving Feedback**

1. *Open by asking for the provider's self-assessment.*

2. *Focus on the positive, and "microscope" it!*

3. *When giving critical feedback . . .*

*Do not link to positive feedback with "but" or "however."  
Describe the behavior specifically, without judgment.*

4. *Describe your own reactions or those of the client; do not blame or excuse the provider.*

5. *Talk about things the provider can do something about* (versus things she has no control over).

6. *Only offer suggestions if the provider asks for them!*

### **Guidelines for Receiving Feedback -**

*It's about perception and reception, not intention!*

Remember to hear the feedback as a description of perception, not a questioning of your intention.

1. *React objectively, not personally.*

2. *Be inquisitive, not defensive.*

3. *Ask for suggestions!*

<b>“Stuck Places”</b>	<b>Strategies</b>

## RISK ASSESSMENT JOURNAL PAGE FOR PROVIDERS

**Record sessions that you found to be:**

- ▶ particularly challenging
- ▶ ones in which you felt especially effective
- ▶ ones in which you felt stuck

Try to record the session on the journal page as soon after the session as possible.

1. Give a brief description of the interaction; including information about the client. Write only enough so that you will be able to recall the interaction based on your notes.

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2. What do you feel you did best in working with this client? What was most effective?

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3. What happened that felt challenging- that made you feel stuck or ineffective? What do you wish you could have done differently?

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4. What is your strongest feeling in response to this interaction?  
(Feeling, not thought.)

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5. What is one key thing you learned from working with this client?

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## Supporting Quality Risk Assessment: Training Activities to Enhance Supervision of Risk Assessment Skill



### Unit Title

**Unit One: Nuts and Bolts of Risk Assessment – Developing Protocols and Forms**

### Objectives

- To provide opportunity for appraisal and strengthening of existing protocol for HIV risk assessment.
- To support supervisors' evaluation and development of risk assessment forms.

### Group Size

Variable. May be used in a one-on-one session with an individual supervisor, or with a group of any size.

### Time Duration

30 minutes – 1 hour, depending on the number of trainees involved.

### Materials & Preparation



*Handout – Key Components of A Model Comprehensive HIV Risk Assessment Protocol*

*Handout – Privacy and Confidentiality*

*Handout – Documentation*

*Handout – Referrals*

*Handout – Questions to Guide HIV Risk Assessment*

*Handout – Reasons for Risk Assessment Questions*

*Handout – Selecting a Risk Assessment Form*

*Handout – Methods to Support Skill Building*

Invite trainee(s) to bring any existing risk assessment-specific protocol and forms, as well as medical history forms used in risk assessment.

If desired, for larger groups have newsprint, easel stand and markers available, as well as overheads/slides of the content of the handouts.

## Procedure:



### One-on-one training

- Review the objectives for this Unit.
- Discuss with the trainee the current status of risk assessment protocol in his/her setting. Ask him/her to consider the following questions from his/her own perspective.

*What are the challenges of doing HIV risk assessment?  
How would you improve or change the forms used for risk assessment?  
What do you need in order to do this work well?*

- Ask the trainee to consider and discuss how his/her staff would respond to those same questions.
- Ask trainee:

*What steps might help to assure staff investment and cooperation in introducing HIV risk assessment as a new activity, or in taking steps to assure the quality of current risk assessment activities?*

Listen for and confirm responses that suggest that early, regular, and frequent involvement from staff throughout the process is essential.

- Explain that if the trainee's clinic has been doing comprehensive HIV risk assessment for some time, there is tremendous value in regularly reviewing risk assessment policies and procedures. If risk assessment is being initiated for the first time, it's important to remember that from the

providers' perspective, risk assessment can look like a difficult and time-consuming addition to an already packed agenda.

- Give the trainee the handout, *Key Components of A Model Comprehensive HIV Risk Assessment Protocol*. Allow time for the trainee to read the handout, or go over it together. Review with the trainee any existing protocol he/she brought with him/her. Ask:

*How well does your current HIV risk assessment protocol address these components? If you are developing a risk assessment protocol for the first time, how able are you to address each of these components? What do you need in order to fully address any of these components?*

Discuss responses to those questions.

- Give the trainee the handouts, *Privacy and Confidentiality, Documentation, and Referrals*. Discuss the content of these handouts. For each one, go over the "Questions to Consider."

*What concerns do you have about this issue?  
What are the biggest challenges you face regarding this issue?  
How can you respond to those challenges?  
What concerns do providers have about this issue?  
What can you do to address their concerns?*

- Give the trainee the handout, *Questions to Guide HIV Risk Assessment*. Ask the trainee which questions she/he anticipates might be the most difficult for providers. Suggest that training to address providers' discomfort and enhance skills can help reduce that difficulty. Ask the trainee:

*How would you explain the reason for any of these questions to a provider, or to a client?*

Discuss the trainee's response to the question. Use the handout, *Reasons for Risk Assessment Questions*, to help guide the explanations.

- Give the trainee the handout, *Selecting a Risk Assessment Form* and go over it together. Discuss how forms currently used in the trainee's setting are administered. If the trainee has brought risk assessment or medical history forms, review them together. Be certain that the trainee understands that the questions on the handout, *Questions to Guide HIV Risk Assessment*, are not intended to be used as a form or checklist, but rather as an adjunct to existing forms, and to suggest possible language and approaches to the various components of risk assessment.

- Give the trainee the handout, *Methods to Support Skill Building*. Discuss with trainee what he/she is currently doing to support skill building. Go over the various suggestions on the handout, eliciting the trainee's thoughts about each.
- If possible, ensure that the trainee has copies of the two publications, ***Asking the Hard Questions: A Reproductive Health Provider's Guide to Client-Centered HIV Risk Assessment*** and ***Supporting Quality HIV Risk Assessment: A Guide for Reproductive Health Clinic Managers and Supervisors*** (Companion Guide to "Asking the Hard Questions.") Invite the trainee to skim through these publications and to then discuss with you how they might be used in the clinic setting. \*



### Group training:

- Review the objectives for this Unit.
- Ask trainees to discuss with you – and/or in small groups, depending on the number of trainees – the current status of risk assessment protocol in their own settings. Ask them to consider the following questions from their own perspective.

*What are the challenges of doing HIV risk assessment?  
How would you improve or change the forms used for risk assessment?  
What do you need in order to do this work well?*

- Ask the trainees to consider and discuss how their staff would respond to those same questions.
- Ask trainees:

*What steps might help to assure staff investment and cooperation in introducing HIV risk assessment as a new activity, or in taking steps to assure the quality of current risk assessment activities?*

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\* These publications can be obtained on line at <http://www.famplan.org/docs/providersguide.pdf> and <http://www.famplan.org/docs/supervisorsguide.pdf>

Listen for and confirm responses that suggest that early, regular, and frequent involvement from staff throughout the process is essential.

- Explain that if a clinic has been doing comprehensive HIV risk assessment for some time, there is tremendous value in regularly reviewing risk assessment policies and procedures. If risk assessment is being initiated for the first time, it's important to remember that from the providers' perspective, risk assessment can look like a difficult and time-consuming addition to an already packed agenda.
- Distribute the handout, *Key Components of A Model Comprehensive HIV Risk Assessment Protocol*. Allow time for the trainees to read the handout, or go over it together in dyads or small groups. Invite them to share and discuss any existing protocols they have brought with them. Ask them to discuss the following questions:

*How well does your current HIV risk assessment protocol address these components?*

*If you are developing a risk assessment protocol for the first time, how able are you to address each of these components?*

*What do you need in order to fully address any of these components?*

Elicit responses to the questions from several trainees.

- Have trainees form three dyads or three small groups, ideally combining trainees from different settings. For each small group, assign one of the following three handouts; *Privacy and Confidentiality, Documentation, and Referrals*. (Each small group will focus on just one of the handouts.) Each trainee should have a copy of the handout they were assigned. Ask each group to discuss the "Questions to Consider" on the bottom of their handout.

*What concerns do you have about this issue?*

*What are the biggest challenges you face regarding this issue?*

*How can you respond to those challenges?*

*What concerns do providers have about this issue?*

*What can you do to address their concerns?*

After a few minutes, have a member of each dyad or small group summarize his/her group's thoughts to the rest of the trainees. Facilitate a discussion of reactions or additional ideas in response to what is said. At the end of this discussion, make sure that all trainees have copies of all three handouts discussed.

- Distribute the handout, *Questions to Guide HIV Risk Assessment*. Ask trainees to discuss which questions they anticipate might be the most

difficult for providers. Suggest that training to address providers' discomfort and enhance skills can help reduce that difficulty. Ask:

*How would you explain the reason for any of these questions to a provider, or to a client?*

Discuss trainees' responses to the question, using the handout, *Reasons for Risk Assessment Questions*, to help guide the explanations.

- Distribute the handout, *Selecting a Risk Assessment Form*. Ask trainees to review the handout, and discuss it with other trainees sitting close by. If trainees have brought risk assessment or medical history forms with them, have them share the forms during the discussion. Be certain that trainees understand that the questions on the handout, *Questions to Guide HIV Risk Assessment*, are not intended to be used as a form or checklist, but rather as an adjunct to existing forms and to suggest possible language and approaches to the various components of risk assessment.

Facilitate a large group discussion regarding this topic of form selection. Ask questions such as:

*What do you see as the relative advantages and disadvantages of self-administered vs. provider-administered assessments?*

Acknowledge that providers will certainly benefit from skill building in using these tools, regardless of which approach is used.

- Distribute the handout, *Methods to Support Skill Building*. Ask trainees to describe what they are currently doing to support skill building. Go over the various suggestions on the handout, eliciting the trainees' thoughts about each.
- If possible, ensure that all trainees have copies of the two publications, ***Asking the Hard Questions: A Reproductive Health Provider's Guide to Client-Centered HIV Risk Assessment*** and ***Supporting Quality HIV Risk Assessment: A Guide for Reproductive Health Clinic Managers and Supervisors***.<sup>\*</sup> Invite trainees to skim through these publications and talk together about how they might use them in their clinic setting.

### Discussion Points:

Discussion points are included above.

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<sup>\*</sup> These publications can be obtained on line at <http://www.famplan.org/docs/providersguide.pdf> and <http://www.famplan.org/docs/supervisorsguide.pdf>

## Follow-up Activities

- Ask the trainee(s) to outline a plan to develop a protocol, including ways to solicit input from staff.
- Follow this unit with the Unit Two for Supervisors – **Introducing Observation and Feedback to your Staff.**

## **Key Components of a Model Comprehensive HIV Risk Assessment Protocol**

### **1) Description and Purpose of HIV Risk Assessment**

Client-centered risk assessment is an interactive exchange between a provider and a client in which the provider asks open-ended questions designed to elicit response and reflection that can raise a client's self-perception of risk. The provider also presents education about HIV risks and risk reduction to support a client's willingness to change risky behavior. This process helps the provider to target more intensive interventions to clients who need it most. Risk assessment itself is a brief interaction. It should require, on average, no more than ten minutes.

### **2) HIV Risk Assessment as Part of Standard Care**

Evaluation of a client's risk for HIV infection must be a routine part of reproductive health care. All providers must be trained in conducting client-centered risk assessment in a non-judgmental, professional, and culturally sensitive manner. Staff to conduct HIV risk assessment should be identified.

### **3) Topics to be Covered in HIV Risk Assessment**

HIV risk assessment involves questions on the following risk-related areas:

1. Sexual Behaviors (current and in the recent past)
2. HIV/STI Risk Factor (including prior STI diagnoses and incarceration)
3. Substance Use History
4. Pregnancy Intentions
5. Sexual Functioning and Relationship Issues
6. Domestic Violence/ Sexual Assault or Abuse
7. Other HIV-Related Risks

At a minimum, the client should be asked at every visit:

*What are you doing to protect yourself from HIV (the virus that causes AIDS)?*

**4) Frequency of Administration**

Initial and annual visits must include administration of a complete risk assessment. Clinics should clearly specify the frequency and depth of HIV risk assessment at interim visits.

**5) Client Right of Refusal**

Clients may refuse to participate in risk assessment. Nevertheless, it must be routinely offered to all clients.

**6) Risk Assessment Data Collection Guidelines**

Risk assessment-related data may be collected using self-administered or provider-administered forms. If a self-administered form is used, a provider must review responses with the client. The client completing a self-administered form must be given sufficient privacy to complete the form. The interaction between the provider and the client must be conducted in a private space.

**7) Integration with Other Aspects of Reproductive Health Care**

HIV-related risk assessment may be integrated into care regarding other reproductive health care concerns, such as pregnancy prevention or STI diagnosis or treatment; it does not have to occur as a separately identified event. As long as the provider has addressed all the component parts of HIV risk assessment in the course of delivering other care, she has complied with the mandate to do it.

**8) Required Explanation of Confidentiality**

Providers should advise clients of the meaning and limitations of confidentiality. Absolute guarantees of confidentiality regarding all subjects discussed cannot be given because a client may reveal a dangerous or abusive situation that the provider is compelled to report.

**9) Documentation Guidelines**

Providers must document that risk assessment was conducted and identify any next steps taken or recommended, such as HIV antibody test-decision counseling, case management, or referral to needed services.

**10) Guidelines for Making Referrals**

Providers in reproductive health settings will not have the expertise or the time to fully respond to all risks revealed by the risk assessment. However, they should be able to recognize when a referral is needed and be able to provide appropriate referrals to selected agencies and programs included in the clinic's referral network.

***Questions to consider:***

*How well does your current HIV risk assessment protocol address these components? If you are developing a risk assessment protocol for the first time, how able are you to address each of these components? What do you need in order to fully address any of these components?*

## PRIVACY AND CONFIDENTIALITY

Providers must have a private space in which to do HIV risk assessment. Interruptions should happen only for urgent reasons. All staff should be reminded to be cautious about conversation within earshot of other clients. Even if names are not mentioned, overhearing staff discuss clients' sexual and substance use behavior can undermine a client's trust.

Providers should know how to explain the meaning and limitations of confidentiality. Absolute guarantees of confidentiality regarding all subjects discussed cannot be given, because a client may reveal a dangerous or abusive situation that the provider is compelled to report.

Refer to your state's laws regarding confidentiality issues (i.e., parental access to medical records, or requirements about informing parents of services provided to minors).

### Question to Consider:

*What concerns do you have about this issue?*

*What are the biggest challenges you face regarding this issue?*

*How can you respond to those challenges?*

*What concerns do providers have about this issue?*

*What can you do to address their concerns?*

## DOCUMENTATION

Documentation is critical to the delivery of high quality care. You will want to help counselors, clinicians, and other providers determine what kind of documentation will best facilitate the next provider's interaction with a client.

Documentation should include only what is directly observed by the provider or stated by the client. Avoid including providers' assumptions or her interpretations of the clients' behavior. Developing a standard set of phrases for providers can be useful in that it simplifies documentation and minimizes inappropriate entries. For example, "*Sexual and substance use risk assessment completed. HIV prevention education provided.*" Referrals should always be documented.

Documentation can be a great challenge. Different oversight agencies, funders, and evaluators want different kinds of data and reports, and their requests seem to change on a regular basis. Be aware of the burden this places on staff, and look for ways to streamline information gathering.

In some clinical sites, as a matter of protocol, no record is made of the information shared by a client during an HIV risk assessment. In such cases, documentation should be done stating that HIV risk assessment and prevention education were completed.

### Question to Consider:

*What concerns do you have about this issue?*

*What are the biggest challenges you face regarding this issue?*

*How can you respond to those challenges?*

*What concerns do providers have about this issue?*

*What can you do to address their concerns?*

## REFERRALS

It is not expected that providers in reproductive health settings will have the experience or the time to fully respond to all risks revealed by the HIV risk assessment process. However, providers should be able to make appropriate referrals for clients who need them, for example to HIV counseling and testing services, to substance abuse treatment services, or to domestic violence services.

Establishing and maintaining an up-to-date referral listing of local agencies and programs is an essential cornerstone of HIV risk assessment work.

Making referrals is a critical component of your clinic's work. Training opportunities may be available to you from your regional trainers regarding this: **Making Effective Referrals**.

### Question to Consider:

*What concerns do you have about this issue?*

*What are the biggest challenges you face regarding this issue?*

*How can you respond to those challenges?*

*What concerns do providers have about this issue?*

*What can you do to address their concerns?*

## QUESTIONS TO GUIDE HIV RISK ASSESSMENT

### **Sexual Behaviors**

*Tell me about your current sexual relationship or relationships.*

*Tell me about your sexual activity in the past.*

*How old were you the first time you had a sexual experience with another person?*

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### **HIV/STI Risk**

*What are you doing now to protect yourself from HIV (the virus that causes AIDS) and other sexually transmitted infections? How about in the past?*

*Have you ever had a sexually transmitted infection - such as chlamydia, trichomoniasis or "trich," herpes, HPV or warts, gonorrhea, syphilis?*

*Have you ever been tested for HIV?*

*Have you or any of your sex partners ever been in prison?*

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### **Pregnancy Intentions**

*What are you doing to avoid unintended pregnancy?*

### **Substance Use History**

*How has drinking or using drugs affected your sexual behavior?*

*Have you ever felt that alcohol or drugs were a problem for you?*

*How many times in the past week have you used alcohol or other drugs?*

*Have you ever injected drugs?*

*To your knowledge, have any of your sexual partners injected drugs?*

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### **Sexual Functioning & Relationship Issues**

*How satisfied are you with your sexual relationship(s)?*

*Has your partner ever tried to hurt you?*

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### **Domestic Violence/ Sexual Assault or Abuse**

*Have you ever been forced to have sex when you didn't want to?*

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### **Other HIV-Related Risks**

*Since 1977, have you had a blood transfusion? Have you had sex with someone who has had a blood transfusion?*

*Do you have hemophilia? Have you had sex with someone who has hemophilia?*

*Have you shared equipment for tattoo, body piercing?*

## MINIMUM RISK ASSESSMENT

If you only have a minute, ask:

- ✓ **What are you doing to protect yourself from HIV (the virus that causes AIDS)?**
- ✓ **What are you doing to prevent an unplanned pregnancy?**

If you have a little more time, ask these additional questions:

- *Tell me about your current sexual relationship(s).*
- *Have you ever felt that alcohol or drugs were a problem for you?*
- *How many times in the past week have you used alcohol or drugs?*
- *Have you or any of your sex partners ever been in prison?*
- *How satisfied are you with your current sexual relationship(s)?*
- *Have you ever had sex against your will?*
- *Has your partner ever tried to hurt you?*

## Reasons for Risk Assessment Questions

- ✓ **Tell me about your current sexual relationship or relationships.**

*Reason:* This question is asked to avoid making any assumptions about a client's relationships or sexual activity.

- ✓ **Tell me about your sexual activity in the past.**

*Reason:* Clients often have sexual experiences in the past that can have an impact on their health.

- ✓ **How old were you the first time you had a sexual experience with another person?**

*Reason:* There is some evidence that the earlier someone starts to have sexual intercourse, the greater the chance of problems like cervical dysplasia- abnormal cells on the cervix. Also, answers to this question sometimes reveal a history of sexual abuse, which a client might want to talk about.

- ✓ **What are you doing now to protect yourself from HIV (the virus that causes AIDS) and other sexually transmitted infections? How about in the past?**

*Reason:* This question can show what information a client might need, while not assuming that the client isn't already doing things to reduce the chance of infection.

- ✓ **Have you ever had a sexually transmitted infection - chlamydia, trichomoniasis or "trich," herpes, HPV or warts, gonorrhea, syphilis?**

*Reason:* A history of any of these sexually transmitted infections can make someone more susceptible to infection with HIV, the virus that causes AIDS.

- ✓ **Have you or any of your sex partners ever been in prison?**

*Reason:* There is a very high rate of HIV infection among people who have been in prison.

- ✓ **Have you ever felt that alcohol or drugs were a problem for you?**

*Reason:* The use of alcohol and other drugs can make someone more vulnerable to sexually transmitted infections, including HIV.

✓ **Have you ever injected drugs?**

✓ **To your knowledge, have any of your sexual partners injected drugs?**

*Reason:* Injection drug users and their sexual and/or needle-sharing partners have a very high rate of HIV infection.

✓ **How has drinking or using drugs affected your sexual behavior?**

*Reason:* When a person is using alcohol and other drugs, the decisions he or she makes about sexual behavior are not always the healthiest ones.

✓ **What are you doing to avoid an unintended pregnancy?**

*Reason:* Sometimes clients use methods of birth control that might not be the most effective or appropriate one for them, and sometimes they assume that a birth control method is also protection against STIs when, in fact, it is not.

✓ **Have you ever been forced to have sex when you didn't want to?**

✓ **Has your partner ever tried to hurt you?**

*Reason:* Our responsibility to our clients includes doing whatever we can to be sure that they are safe and healthy. This includes giving every client the chance to tell us what might be happening to him or her that might deserve our intervention.

## SELECTING A RISK ASSESSMENT FORM

A form that includes the HIV risk assessment questions along with spaces to record responses can support and guide the risk assessment dialogue. A self-administered or provider-administered form may be selected to help structure the dialogue, but should never replace the dialogue between client and provider. Client-centered HIV risk assessment requires a conversation about HIV risk.

### **Self-Administered Form**

A self-administered form can help to pave the way for a client-provider conversation about HIV risk. For some clients, filling out a form may be easier than answering questions out loud. At the same time, it may be too easy for providers to quickly skim a self-administered form, and neglect exploring items that might reveal the need for more in-depth prevention work. If a self-administered form is used, providers should *always* review it with the client, and talk in more depth about any responses that raise questions or concerns.

Clients who speak English as a second language may have difficulty completing forms in English. If your clinic regularly serves non-English speaking clients, be sure you have forms available in the appropriate language(s).

Be sure that staff does not assume that all clients are able to read. Rather than guessing or directly asking about a client's reading ability, staff who distribute the forms can say, *"You can fill this out while you're waiting if you like. It should take just a few minutes. If you prefer, you can wait to go over it with the counselor or clinician."*

Prepare front desk staff to answer questions about the form. They should be familiar with its content, and able to explain the reason for any question if a client asks.

If the client is will be filling out the questionnaire in a public area, consider using a handout for the sexual and substance use history that does not

require any written response. If a client is sitting with family or friends, privacy can be an issue.

### **Provider-Administered Form**

The provider-administered form helps to structure the risk assessment conversation and offers the possibility of making a connection with a client regarding some very personal details of her life. When this is done well, it becomes the basis for meaningful prevention work. HIV risk assessment questions need not require a separate form; they can be easily integrated with questions about other reproductive health care concerns, such as pregnancy prevention or STI diagnosis or treatment.

### **Other Methods**

Some clinics use a combined approach. The client completes a basic medical history form on her own and the provider asks the more sensitive questions when she meets with the client. Another approach is for counselors to conduct the 'social' risk assessment, and medical providers to conduct the medical history.

Discuss with your clinic staff the current risk assessment process. What works? What is not working? Brainstorm possible changes that fit with your clinic system, staffing, and clients. Your clinic can pilot new methods or forms for a few months and see how they are working.

### **GUIDELINES FOR DESIGNING AN EFFECTIVE SELF-ADMINISTERED FORM**

- Write questions in clear, easy-to-understand language
- Keep questions brief, with one idea per question
- Avoid abbreviation and medical jargon. For example:
  - Use "Last menstrual period" instead of "LMP"
  - Use "age of first menstrual period" instead of "age of menarche"
- Give examples to clarify medical terms. Examples:
  - "Have you ever had a sexually transmitted infection (STI), such as herpes, chlamydia, genital warts, or gonorrhea?"*
- Use a large font of 12 point or larger
- Leave lots of white space to increase readability; don't crowd questions on the page

## METHODS TO SUPPORT SKILL BUILDING

### **Observation, Feedback and Strategizing**

Observing a provider work with a client, followed by offering feedback and strategizing with the provider for on-going improvement or strengthening of skills is the heart of active supervision. It is also complex and time-consuming. *Supporting Quality HIV Risk Assessment: A Guide for Reproductive Health Clinic Managers and Supervisors* contains detailed guidelines and recommendations for performing this valuable activity with staff. In addition, two training opportunities may be available to you from your regional trainers to support you in this work: **Introducing Observation and Feedback to Your Staff** and **The Art of Feedback and Strategizing**.

### **Peer Coaching**

Pair a less experienced provider with one who is more experienced. Together, they can discuss cases, strategize different approaches, do role-plays, and brainstorm how to handle difficult situations.

### **Peer Observation**

Experienced staff can observe and provide feedback to one another. Providers who have become accustomed to one particular approach can have the chance to see other styles.

### **Journaling**

Recording one's experiences can be a powerful learning tool. Ask staff to bring journal pages to meetings or in-service trainings, during which they can share their experiences and strategize together in response.

### **Readings**

Ask staff to recommend books, fiction as well as non-fiction, that may help the reader gain a greater understanding of the dynamics of clients' behaviors. These might be books that have no direct connection to HIV, but rather contain general information or insight about sexual behavior and/or substance use. TV and movie recommendations can be useful, too. Staff can discuss these informally, or at in-service trainings.

### **Video/Audio Taping of Providers**

You can ease staff into 'live' observation by arranging for video or audio taping of role-plays or skill practices. Always let the person being taped view or listen alone first, without any feedback. Afterwards, facilitate discussion by asking for self-appraisal. During a second viewing or listening, the observed provider could use a written observation tool to assess her own performance.

Viewing and discussing a training video that demonstrates risk assessment techniques might address anxiety over the need to demonstrate 'perfect' skills.

### **Thought-Provoking Questions**

In a staff common area post case description questions related to HIV issues and invite staff to discuss them. A good source of ideas for this activity is *HIV Counseling Perspectives*, a bimonthly newsletter that reviews research, as well as counseling and communication strategies on HIV-related topics. Self-test questions and counseling scenarios are included.

Newsletters are available through <http://www.ucsf-ahp.org>.

### **Chart Reviews**

Chart reviews are most useful for assessing consistency and appropriateness of documentation. If chart review is used as your exclusive or primary assessment tool, you risk conveying the notion that form completion is the most important part of a provider's work. Chart reviews are most effective as a supervisory tool if they are used along with observation.

## Using the Providers' Guide Activities for Skill Building

All of the self-instructional exercises found in the *Providers' Guide* can also be used as training activities. Here are some suggested ways to use the sheets during a training, in-service, or staff meeting.

- Have each participant complete an activity sheet. Follow this with a group discussion.
- Have each participant complete an activity sheet, then form dyads or small groups for discussion. This could be followed by a full group discussion, including sharing of thoughts from the dyad or small group exchanges.
- Write the title of an activity on flipchart paper and facilitate a group brainstorm. Read or paraphrase the instructions on the activity sheet, and record responses on the flipchart. Follow this with a group discussion. Each participant should have a blank copy of the activity sheet so that she can record responses as well, if she desires.
- Have staff members bring completed activity sheets with them to the meeting. Discuss the sheets either as a large group, in smaller groups, or in dyads.

## Formal Trainings

Invite a regional trainer to facilitate a training for your staff. A series of trainings have been developed, based on the content of *Answering the Hard Questions: A Reproductive Health Provider's Guide to Client-Centered HIV Risk Assessment*. These trainings include:

What is Risk Assessment, and Why Do It?

"Listening In" on Risk Assessment

Overcoming Personal Barriers to Risk Assessment - Our Clients' and Our Own

The Language of Risk Assessment

Responding to Difficult Questions and Statements: The 3Cs Model

## Case Presentation & Processing

# Supporting Quality Risk Assessment: Training Activities to Enhance Supervision of Risk Assessment Skill



## Unit Title

**Unit Two: Introducing Observation and Feedback to your Staff**

## Objective

- To increase clinic supervisors' understanding of the barriers and benefits of observation and feedback.
- To develop strategies for introducing and implementing observation and feedback with staff.

## Group Size

Variable. May be used in a one-on-one session with an individual supervisor, or with a group of any size.

## Time Duration

30 - 45 minutes

## Materials & Preparation

*Handout– Conducting an Observation of a Clinical Encounter*

*Handout– Observation Tool*

*Handout–Guidelines for Use of Observation Tool*

*Handout– Guidelines for Feedback and Strategizing*

*Handout– Annotated Dialogue One*

For group of 4 or more, newsprint, easel stand and markers



Prior to conducting this activity, review pp. 14 –17 in ***Supporting HIV Risk Assessment: A Guide for Reproductive Health Clinic Managers and Supervisors.***

## Procedure



One-on-one training

***(Note: variations for working with a larger group are provided in bold italics):***

- Review the objectives for this Unit.
- Have trainee identify all the barriers associated with conducting clinical observation of a provider in a counseling/education session with a client. ***(Facilitate full group brainstorm, and record responses on newsprint.)*** Listen for, confirm and add as necessary:
  - ✓ Providers' anxiety about being observed and the impact of observation on her performance
  - ✓ Concern regarding clients' receptivity of supervisors' presence and the impact of that on the interaction
  - ✓ Provider associating observation with performance evaluation.
- Follow this with a discussion of the benefits of observation and feedback to both the supervisor and the provider. ***(Facilitate full group brainstorm, and record responses on newsprint.)*** Listen for, confirm, and add as necessary:

(Benefits for the supervisor)

- ✓ Provides information to inform and support various programmatic decisions
- ✓ Accountability to management for quality/performance
- ✓ Shapes planning for training and development supports

- ✓ Promotes and nurtures skill development and refinement  
(Benefits for the provider)
  - ✓ Provides needed on-the-job skills training
  - ✓ Creates an opportunity for support and affirmation
  - ✓ Facilitates provider's access to targeted resources for continued skill development
  - ✓ Helps keep a veteran's approach from getting "stale" or rote
  - ✓ Gives provider a chance to be identified as someone who can offer peer support or training
- Use the handout, *Conducting an Observation of a Clinical Encounter*, as the basis for a discussion of strategies for setting up and conducting observation.
  - Give trainee(s) the handouts, *Observation Tool* and *Guidelines for the Use of Observation Tool*, to review. Elicit and respond to any questions about the tool and/or guidelines. Explain the value of sharing this material with a provider prior to doing an observation.
  - Do a brief role-play with trainee to provide practice in introducing observation and feedback to a provider. Play a "provider" who is anxious about being observed. Have the trainee play your "supervisor," using the observation tool and observation guidelines (*Handouts Two and Three*) to discuss observation with you, the "provider." ***(Have trainees work in pairs, practicing the process of introducing observation and feedback with a provider, as above. Follow with full group discussion of experience.)***
  - If time allows, proceed to the follow-on activity – **The Art of Feedback & Strategizing: Clinical Observations and Case Reviews**. If that activity will happen at a later time, distribute the handouts, *Guidelines for Feedback and Strategizing* and *Annotated Dialogue One* for review prior to next session. Explain that the annotations found alongside the dialogue in *Annotated Dialogue One* can support practice in giving feedback.

## Discussion Points

Discussion points are included above.

## Follow-up Activities

- Plan to follow this activity with Unit Three for Supervisors: **The Art of Feedback & Strategizing: Conducting Clinical Observations.**

## CONDUCTING AN OBERVATION OF A CLINICAL ENCOUNTER

Observation of actual clinical encounters requires careful preparation to ensure a positive reception from staff and clients. Emphasize to the provider that your objective is skill building and skill recognition not performance evaluation.

### ***Set Expectations:***

- ✓ *Contract with provider about scheduling of observation.*
- ✓ *Give as much control as possible over experience.*
- ✓ *Clarify purpose of observation (development vs. evaluation; focus on skills and perception rather than counselor's intentions).*
- ✓ *Ensure that the provider knows standards and tools to be used*
- ✓ *Specify arrangements for feedback/strategizing, minimizing elapsed time from actual observation.*
- ✓ *Provide opportunity for the provider to express anxieties, expectations, and needs; encourage her to anticipate aloud supervisor's reactions.*

### ***Observation Logistics:***

- ✓ *Strategize with provider about how client's permission and cooperation can be obtained.*
- ✓ *Strategize with provider about how client's anxieties can be addressed.*
- ✓ *Specify in detailed manner how supervisor will behave during observation.*
- ✓ *Plan with provider the physical arrangement for seating, introductions, etc.*

### ***Observer's Behavior During Observations:***

- ✓ *Preplan roles/communication vis-a-vis client.*
- ✓ *Plan ways to minimize impact of supervisor's presence, and means for observer to withdraw if necessary.*
- ✓ *Consider mechanisms for "damage control" (when is it imperative for a supervisor to intervene).*
- ✓ *Minimize note taking.*

## OBSERVATION TOOL

Provider: \_\_\_\_\_ Date: \_\_\_\_\_

Observer: \_\_\_\_\_ Site: \_\_\_\_\_

### I: Basic Communication and Counseling Skills

Skills	Notes:
1. Demonstrates professionalism	
2. Establishes rapport	
3. Affirms/ supports client	
4. Addresses significant problems	
5. Uses open-ended questions	
6. Gives information as-needed and simply	
7. Paraphrases and reflects feelings	
8. Attends non-verbally	
9. Uses silence appropriately	
10. Explains confidentiality	
11. Demonstrates comfort with sexual issues	

**Summary:**

**II: Risk Assessment Skills**

Component	Notes:
1. Normalizes risk assessment process	
2. If necessary, gives client right to not answer	
3. Helps client assess level of risk	
4. Confronts, if necessary	
5. Addresses all topics of risk assessment	
6. At least asks: What are you doing to avoid HIV?	
7. Provides appropriate referrals	
8. Offers referral assistance	

**Summary:**

## GUIDELINES For USE of OBSERVATION TOOL

During observation, jot down notes and comments using the **Observation Tool**. Specific examples of the skills and behaviors, particularly those that describe *good* work that you have observed, will be helpful feedback for the provider. It is useful to share these guidelines and the observation tool with providers. They can clarify expectations and help identify knowledge and/or skill deficits needing attention.

### What to Look For: **Basic Communication and Counseling Skills**

1. *Demonstrates professionalism*: Displays self-confidence, competence, dependability, preparation, integrity, and appropriate seriousness. Convincingly conveys commitment to confidentiality. Appears non-judgmental and objective about behavior and lifestyle.

As appropriate, may also include: Wears name tag, selects confidential area, ensures no interruptions, ensures no physical barriers, reviews record, calls patient by full name, greets client and introduces self, gets permission from client for the presence of the observer, and introduces observer.

2. *Establishes rapport*: Displays respect, empathy, sincerity, and politeness. Seeks out and deals with clients' concerns.
3. *Affirms/supports client*: Takes advantage of opportunities to affirm, such as, "I'm glad you asked that. You know a lot about HIV."
4. *Addresses significant problems*: Helps client to express concerns without making assumptions about needs; explores clients' issues further, provides information, makes referrals, and notes on chart when issues/problems arise.
5. *Uses open-ended questions*: Avoid the use of "why" questions.
6. *Gives information simply and as needed*: Communicates at client's level; avoids technical terms, jargon, etc. Demonstrates accurate and up-to-date information. Offers to investigate unanswered questions. Avoids overwhelming client with information, focuses on main points, and offers information that is specific to individual client's needs and situation.
7. *Paraphrases and reflects feelings*: When appropriate, restates client's words to demonstrate and clarify understanding. Uses active listening to validate and check out feelings.
8. *Attends non-verbally*: Uses appropriate body language; respectful, open gestures and facial expressions. Non-verbal and verbal communication congruent.
9. *Uses silence appropriately*: Pauses, relaxes, and doesn't rush the client.

10. *Demonstrates comfort in openly discussing sexuality issues:* Body language and other communication skills do not alter when sexuality is discussed; is open and non-judgmental in communicating across diverse sexual behaviors and values.

**What to Look For: *Risk Assessment Components***

1. *Normalizes risk assessment process with client:* States rationale for risk assessment.
2. *Gives client permission to not answer questions:* Lets the client know that the more she is able to share, the better the provider will be able to meet her needs.
3. *Helps client assess her level of risk:* Asks open-ended questions to elicit client's self-awareness of risk-taking behavior.
4. *Confronts, if necessary:* Respectfully challenges client's self-perception of risk, if evidence of risky behavior is apparent. Uses a supportive tone when confronting client who expresses contradictory desires ("I don't want to get infected, but I'm not going to use condoms!") or whose medical history conflicts with self-perception (client insists she is not at risk; has been treated for STI.)
5. *Addresses all topic areas of risk assessment:* Asks about current and recent past sexual behaviors, HIV/STI risk, substance use history, pregnancy intentions, and domestic violence/sexual abuse.
6. *At a minimum, asks:* "What are you doing to protect yourself from HIV, the virus that causes AIDS?"
7. *Provides appropriate referrals:* Offers accurate, up-to-date information on who, where, what, and how, considering specific client needs.
8. *Offers referral assistance:* Facilitates connection with referral agency, encourages feedback, and sets follow-up appointments as needed.

## **GUIDELINES FOR FEEDBACK AND STRATEGIZING**

### ***Feedback***

Invite provider's self-appraisal. Sample questions:

*How do you feel that session went?*

*What did you do well?*

*What do you wish you could have done differently?*

*What was the most challenging part of the session?*

*What, if anything, specifically do you want feedback on from me?*

Describe and praise good use of skills. Be as detailed as possible in describing "good" work you observed.

Poor Feedback:     *"You did a great job."*

Good Feedback:     *"You did an excellent job of helping the client think about getting tested. I particularly noted that when you saw that look of confusion cross her face when you said the phrase 'HIV antibody test,' you immediately offered a simpler phrase- 'the test that tells whether a person has been infected with HIV, the virus that causes AIDS'-and then checked out that you were being understood by asking, 'This can be confusing stuff to talk about. What questions do you have about HIV tests?'"*

For areas needing improvement describe what you observed, holding back on suggestions for improvement. Select the one or two areas that are most important to address. Do not link positive feedback to criticism with "but" or "however." Describe the behavior specifically, without judgment.

Poor Feedback:     *"You did a good job, but dismissing the client's confidentiality concerns was unprofessional."*

Good Feedback:     *"When the client said she was concerned about word of her being here getting out, you waved your hand and said, 'Not to worry.' I think that dismissing her concern does not take away her fears about confidentiality."*

Describe your own reactions or those of the client; do not blame or excuse the provider.

Poor Feedback: *"You insulted the client when you..."*

Good Feedback: *"I saw the client pull back from you when you..."*

Here's an example of a statement in response to a provider's defensiveness:  
*"Isn't it important to know that while you intended your statement to sound like concern, it could come across as judgment?"*

Talk about things that are in the provider's control.

Poor Feedback: *"You didn't get that client to commit to using condoms."*

Good Feedback: *"I didn't hear you address the client's concern that her boyfriend would never agree to using condoms."*

### ***Strategizing***

Allow provider time to suggest on her own how she might do better.

Sample questions for strategizing:

*"How could you do that differently in the future?"*

*"What will be most challenging about doing this differently?"*

*"How do you imagine changing your approach might work for your clients?"*

*"What resources/training/support will you need to help you make this change?"*

*"What could you do to remind yourself that you want to try this approach?"*

*Reinforce provider's strategizing by verbally summarizing the components of her plan. Check to ensure your mutual understanding.*

Invite feedback from the provider about her experience of being observed and receiving feedback from you

*Some guidelines for receiving feedback:*

*React objectively, not personally.*

Poor receiving: *"What do you mean my presence is distracting?"*

Good receiving: *"Thank you - How do you think I could minimize the distractions that my presence causes?"*

Be inquisitive, not defensive

Poor receiving: *"Why do you have trouble with my sitting in on your sessions?"*

Good receiving: *"What is the most difficult part for you of having me observe?"*

## Annotated Dialogue One

*The client is 25 year-old Melissa. This is her initial visit to the clinic. The provider, Carolyn, has been going over Melissa's medical history, and is at the part that focuses on sexual and substance use behavior.*

Begins by explaining and normalizing the process.

*Carolyn:* Melissa, the part of your medical history that I'm going to go over now is about sexual behavior and drug use. I ask these questions of every client, because these things have a big impact on people's health.

*Melissa:* Okay.

Open-ended question, "What's going on...?" gathers a lot of information from client.

*Carolyn:* I know you came in today to get a method of birth control. What's going on in your life right now, sexually speaking?

*Melissa:* [responds rapidly] I have a boyfriend – he's a great guy. We've been together a year and-a-half. And we do have sex. Not a lot, I mean not as much as he wants [laughs] but we do. But, you know, that's why I'm here – for birth control.

Open-ended question.

*Carolyn:* So what have you been doing to keep from getting pregnant?

*Melissa:* Well, he pulls out before he comes, and, I guess I've been lucky...[her voice trails off]

Doesn't criticize Melissa's admission; offers praise; adds information in a supportive and normalizing way.

*Carolyn:* It sounds like not getting pregnant is very important to you. You and your boyfriend have been using one of the most difficult methods around – withdrawal. Lots of people use it, and they're surprised to learn that it's not very effective.

*Melissa:* Yeah, I know.

Open-ended question.

*Carolyn:* The good news is that there are much, much more effective methods that are so much easier than withdrawal.

*Melissa:* Yeah. My boyfriend really wants me to get the pill

Information presented without challenging Melissa's knowledge; open-ended question.

*Carolyn:* How do you feel about taking the pill?

*Melissa:* Well, I'm sure not ready for a baby!

*Carolyn:* When pills are taken correctly, they are very effective at preventing pregnancy. But – and you probably know this – the pill doesn't protect against sexually transmitted infections. What are you doing to prevent getting

STIs, like HIV, the virus that causes AIDS?

*Melissa:* [shaking her head “no”] I don’t really think that’s an issue for me.

3<sup>rd</sup> person normalization, with a gentle confrontation.

*Carolyn:* You know, I think it’s hard for any of us to imagine that these diseases could have anything to do with us. At the same time, I’ve seen so many young women learn the hard way about these diseases.

*Melissa:* [nodding] You’re right about that. Actually I got something once. “Calmidia”, I think it was called, but I got treated for that. That was a couple of years ago.

Not important to correct her mistake explicitly. Attends to Melissa’s feelings – “I bet that was unnerving...”

*Carolyn:* Chlamydia is one of the most common STIs. And luckily, it can be treated. I bet that was unnerving for you.

*Melissa:* [nods vigorously] You’re right about that. I couldn’t believe it. I was so embarrassed! I ended up breaking it off with that guy.

More support for Melissa’s behavior. Carolyn precedes an open-ended question used to confront, with acknowledgement that it’s a “tough” one.

*Carolyn:* And even though it was embarrassing, you took care of it. And you know from that experience that a person can get an infection when they don’t expect it at all. Here’s a tough question to think about. How does it feel to trust your boyfriend with your health, and maybe even your life?

*Melissa:* I never really thought of it that way. I know we’re supposed to use condoms, but guys just don’t want to use those thing. Besides, we’re only having sex with each other!

Starts by praising Melissa’s behavior. Melissa may not have even thought about her monogamy in terms of risk reduction. This can help give her the sense that she’s able to take such steps. Confronts with a normalizing statement – “What’s sometimes hard to think about is...”

*Carolyn:* Only having sex with someone who’s only having sex with you is a big part of protection. What’s sometimes hard to think about is that people we’re with, or have been with in the past, probably had sex with other people at some time. And with many STIs, like HIV, not only would you not know that person had it, he might well not know either.

*Melissa:* Yeah, I guess that’s true... [her voice trails off]

Open-ended question.

*Carolyn:* What has your boyfriend told you about his sexual history?

*Melissa:* Not much, really. I guess I haven’t really asked.

Confirming; open-ended question.

*Carolyn:* It’s not an easy thing to do. What would it be like to talk with him about using condoms?

*Melissa:* [very hesitantly] Not easy...he might think I’ve got something. I dunno...I guess I should... [stops talking]

Offers strategizing support, asks permission to pursue her

*Carolyn:* If you like, we could talk some more in a moment

agenda a bit longer; this also takes some pressure off Melissa. Melissa's discomfort is indication that her risk perception has been raised.

Avoids "sexually active."

Introduces sensitive questions.

Provides a bit of information without sounding like she's teaching.

Normalizes.

Responds to Melissa's embarrassment with normalization. Asks open-ended question to begin focusing in on HIV once more.

Praise; open-ended question.

about how you might bring this issue up with him. Would it be okay if I finish up these history questions first?

*Melissa:* [looks relieved] Sure.

*Carolyn:* How old were you when you first had intercourse?

*Melissa:* Fifteen, I think...yeah, fifteen.

*Carolyn:* And how many sexual partners have you had since then?

*Melissa:* [appears to be mentally counting, then looks up] Four...no, actually five.

*Carolyn:* And you've told me you've been with your current boyfriend over a year – am I remembering that right?

*Melissa:* Yes.

*Carolyn:* Here are two questions that sometimes surprise people. First, I know you've had sex with men, how about with a woman?

*Melissa:* No, never. Do lesbians come here, too?

*Carolyn:* Yes, and also people who've had sex with both men and women. Here's another question that can feel awkward; what kind of intercourse do you have with men? Vaginal intercourse?

*Melissa:* Yes.

*Carolyn:* Oral sex?

*Melissa:* Yeah...what guy doesn't like that!

*Carolyn:* And lots of women do too. How about anal intercourse?

*Melissa:* Just once or twice. I guess I've done it all! [looks a little embarrassed]

*Carolyn:* And that makes you like so many people. Melissa, what have you heard about HIV and AIDS, about how people get it?

*Melissa:* [speaks confidently] I've heard lots of stuff about AIDS. I know people get it from shooting drugs, and having unprotected sex, and babies from their mothers.

*Carolyn:* You've got all that right. What experiences have you had with drugs?

*Melissa:* [forcefully] Well, I've never injected drugs, if that's what you mean! [pauses, then says] I smoke a little dope every once in a while.

*Carolyn:* How about any of your sexual partners – have any of them injected drugs?

*Melissa:* No, no, I mean I sure don't think so. I don't hang out with that kind of crowd.

3<sup>rd</sup> person normalization of social use of substances, combined with information on the connection between that behavior and HIV risks.

*Carolyn:* For lots of people, getting high, with alcohol or any other drug, can affect their sexual behavior. What's that been like for you?

*Melissa:* I guess a few times, not too many, I've had sex with a guy when I was high a lot faster than I would have if I hadn't been. [looks annoyed]

Attends to Melissa's non-verbal expression of feeling with an open-ended question to surface feeling identification.

*Carolyn:* How do you feel about that?

*Melissa:* [shaking her head and looking down] I felt awful about it the next day.

Offers a strategy using the 3<sup>rd</sup> person, which allows Melissa to more honestly say what she thinks about the strategy than she might if it came directly from the provider.

*Carolyn:* Some women decide to be sure they at least have condoms with them if they think they might be in that situation. Still, it can be hard to remember to use them when you're high.

*Melissa:* Yeah, you're right about that. I don't think I'll be in that situation again, though.

Continues strategizing with use of open-ended question.

*Carolyn:* What could you do if you realized a situation like that was developing?

*Melissa:* Like I said, I don't think it will happen again, but if it did, I'd just leave before things got messy.

Supports Melissa's intention. 3<sup>rd</sup> person approach to transition into another possibly sensitive subject.

*Carolyn:* Sounds like a good plan. Another situation that lots of people have been in is being forced to have sex when they didn't want to. What's your experience been with that?

*Melissa:* It hasn't really happened to me. Like I said, I've given in a couple of times when I was high, but no one ever forced me.

Paraphrases as a summary, contracts to return to the risk reduction concerns.

*Carolyn:* So what you're saying is that, for now, the one situation you want to think about is the one with your boyfriend. Would it be okay if we talked some more about how to talk with him about sexually transmitted infections, how to bring up using condoms?

*Melissa:* Yes, sure.

This portion of a longer session took a little less than 6 minutes. The provider has taken every opportunity to offer genuine praise and support. She has anticipated and normalized any uncomfortable reactions, and attended to feelings she sensed in Melissa. In the course of a genuine, client-centered interaction, she managed to accomplish a lot in a very short amount of time. In addition, by creating a comfortable relationship with the client, she's helped to build an even more important relationship – Melissa's connection to the clinic.

# Supporting Quality Risk Assessment: Training Activities to Enhance Supervision of Risk Assessment Skill



## Unit Title

### Unit Three: The Art of Feedback & Strategizing

## Objectives

- To develop strategies for giving feedback to providers after observation.
- To increase supervisors' ability to strategize with providers for the improvement of skills.

## Group Size

Variable. May be used in a one-on-one session with an individual supervisor, or with a group of any size.

## Time Duration

45 – 60 minutes for one-on-one session  
60 minutes – 1 hour, 45 minutes for group, depending on which activities are used – See symbol for instructions:



## Materials & Preparation

Video – “Client-Centered Counseling.”\*

VCR and monitor

*Handout – Listening in on Risk Assessment*



\* “Client-Centered Counseling” [Videotape] Austin, TX: Center for Health Training (Region VI), 1999.

*Handout – Conducting an Observation of a Clinical Encounter*

*Handout – Guidelines for Feedback and Strategizing*

*Handout – Observation Tool*

*Handout – Guidelines for Use of the Observation Tool*

*Handout – Role-Play Scenarios* – you will need to cut the pages in half for distribution

*Handout – Annotated Dialogue One*

Overhead or prepared newsprint of *Guidelines for Feedback and Strategizing* – optional for one-on-one training

## Procedure:



### One-on-one training:

Ideally, this activity involves both the use of the video, “Client-Centered Counseling,” and actual role-play. Role-play in feedback and strategizing requires a minimum of three people. In one-on-one training session, this can be accomplished by having the trainer participate in the role-play, and enlisting a volunteer.

The volunteer should be a staff person, not an actual client. Briefly explain the process to the volunteer and let her know that she can leave as soon as the second role-play concludes. If a volunteer is not available, use only the video approach described below.

- Review the objectives for this Unit.
- If there has been a break between this activity and Activity One for Supervisors, **Introducing Observation and Feedback to your Staff**, check in with the trainee regarding any questions related to that prior activity.

- Review the handout, *Guidelines for Feedback and Strategizing*, using prepared newsprint or overhead of guidelines if desired. Ask the trainee what concerns she has about any of the guidelines; what part of giving feedback and strategizing with a provider does she think will be most challenging to her?

### **Video Viewing & Processing – First Vignette**

- View the first vignette of the videotape. This vignette, showing a session between a provider and client, lasts approximately 4 minutes. The trainee may wish to use the observation form while watching. Stop the video at the end of the session.
- Ask the trainee to list all her concerns about the approach of the provider in the video. Listen for and confirm:
  - ✓ Provider does not introduce herself or the risk assessment/history taking process to the client.
  - ✓ Provider asks only closed-ended questions.
  - ✓ Provider's body language – frequent lack of eye contact, body positioned away from client and toward her desk, tone of voice – conveys disinterest.
  - ✓ Provider misses opportunity to support client's acknowledgement of "some" condom use.
  - ✓ Provider asks leading questions that imply the desired answer – for example "And so, you know how to put a condom on?" asked while nodding her head repeatedly.
  - ✓ Provider appears focused only on gathering data and completing the form.
  - ✓ Provider is inattentive to the client's anxiety, as conveyed by her non-verbal and paraverbal language.
- Ask the trainee to identify all the positive qualities she noted in the provider's approach. Listen for and confirm:
  - ✓ Provider seems knowledgeable about the form.
  - ✓ Provider appears respectful.

- ✓ Provider’s non-verbal and paraverbal language does not convey judgment .
- Explain to the trainee that it’s best not to overload with critical feedback. An individual will often tune out more than one or two negative pieces of feedback. Ask the trainee to identify what she feels are the two most crucial pieces of critical feedback.
- Ask the trainee to develop statements to convey both the positive and critical feedback she would give to the provider in the video. She can practice making those statements to you in a brief feedback role-play.

### **Video Viewing & Processing – Second Vignette**

- Watch the next segment of the video. This shows a supervisor giving feedback to the provider following her session with the client. Discuss the supervisor’s approach. Reinforce the following points:
  - ✓ Supervisor acknowledges the discomfort of observation process.
  - ✓ Supervisor offers statements of genuine support.
  - ✓ Supervisor asks for the provider’s self-assessment.
  - ✓ Supervisor enlists the provider’s problem-solving skills to strategize for improvement, rather than telling the provider how she should do something differently.
  - ✓ Supervisor summarizes the provider’s plan for improvement.
  - ✓ Supervisor plans with provider for follow-up.

### **First Role-Play**

- Facilitate a role-play using the first dialogue from the handout, *Listening in on Risk Assessment*. The role-play will include these steps:
  1. The trainee will play the part of the provider, “Angie” and the volunteer will play the client, “Melissa.”
  2. Prior to beginning the reading of the dialogue, negotiate with “Angie” regarding the conduct of the observation, following the recommendations on the handout, *Conducting an Observation of a Clinical Encounter*.
  3. If necessary, remind “Angie” to obtain permission from “Melissa” for the observation to take place.

4. Use the observation tool – the handout, *Observation Tool* – in an unobtrusive manner during the brief exchange.
5. At the end of the reading, give “Angie” feedback on her work with the client and strategize with her for possible improvement. Remember to conclude by asking “Angie” for feedback to you regarding the process.

## **Second Role-Play**

- Facilitate a second role-play. The role-play will include these steps:
  1. You will play the provider.
  2. Explain to the trainee and volunteer that this will be an 8-10 minute role-play, intended to demonstrate just a portion of a risk assessment session. Inform them that you will intentionally commit a few mistakes in your approach as the provider.
  3. Have the volunteer play a client from one of the three scenarios from the handout, *Role-play Scenarios*. Give the trainee the Provider Information portion of the selected scenario. You may want to let the trainee choose which one the volunteer should play, based on the Provider Information portion of all of the scenarios, or you may assign a client role to the volunteer. Do not let the trainee read the Client Information portion of the Scenario handouts. The volunteer may see both the Provider and the Client Information portions.
  4. Remind the trainee that prior to the role-play, she should negotiate with you, the “provider,” regarding the logistics of the observation. The trainee should use the observation tool.
  5. While playing the “provider,” intentionally commit a few “errors” in your approach: Do not play a totally incompetent provider, rather be conscious of doing such things as asking too many closed-ended questions; subtly revealing judgment in tone of voice or choice of words; missing non-verbal cues from the “client”; focusing on data collecting rather than engaging in a risk assessment dialogue.
  6. End the role-play after 6-8 minutes. The volunteer may leave at this time.
  7. The trainee, as “supervisor,” will now give you feedback. If necessary, remind her to ask you for your self-assessment first. (This step is often overlooked.)
  8. Conclude this role-play by giving the trainee feedback on her feedback process with you.

### Video Viewing & Processing – Third & Fourth Vignettes

- Watch the third segment of the video: The provider conducts another session, in a much more skillful way. Stop the video and discuss with the trainee her observations, and what feedback she would want to give to the provider in the video.
- Listen for and confirm responses such as:
  - ✓ Provider's open body posture – away from her desk, not focused on the chart, facing toward the client – is welcoming.
  - ✓ Provider begins by asking for the client's agenda.
  - ✓ Provider uses many open-ended questions; for example, *What made you choose the pill? How do you feel it will work for you?*
  - ✓ Provider confirms client's feelings – her embarrassment about purchasing condoms.
  - ✓ Provider genuinely supports the client's decision to purchase condoms despite the embarrassment.
- If the trainee has not noted any negatives in the provider's performance, ask what, if any, skill improvement needs might be addressed. Listen for and confirm responses such as:
  - ✓ Provider appeared anxious and perhaps overly directive regarding the issue of using condoms along with pills, and HIV testing.
  - ✓ Provider does not respond to client's discomfort regarding this issue, as is apparent in the client's non-verbal communication.
- Watch the final segment of the video, in which the supervisor gives feedback on the provider's improved skills. Discuss reactions to their exchange. Focus on the following:
  - ✓ Supervisor uses open-ended questions to elicit provider's input and involvement:
    - How did you feel about being observed?*
    - How did you think it [the session] went?*
    - What do you think you did to make her open up?*
  - ✓ Supervisor offers support re: provider's use of open-ended questions; her maintenance of eye contact and avoidance of focus on the chart.
  - ✓ Supervisor asks a closed-ended question to begin discussions of any deficits: *Did you perceive any problems...anything uncomfortable?* Ask trainee how that question might be made open-ended. Listen for and confirm responses such as:

*What, if any, problems or concerns do you have about how the session worked? What, if anything, made you uncomfortable?*

- ✓ In response to the supervisor’s question about problems, the provider expressed recognition of her own judgmental reaction and directive approach regarding the need for condom use along with pills. Ask the trainee how the supervisor might have helped the provider recognize that she might do more effective work toward that condom use by recognizing the client’s discomfort more explicitly.

Listen for and confirm responses that suggest that, since the client’s discomfort and the source of that discomfort could be major barriers to that condom use, acknowledging and probing that discomfort could lay the ground work for practical strategizing with the client. For example, if the client’s discomfort lies in her concern about how to address the issue of condom use with her partner, the provider might have the opportunity to help the client to prepare for that conversation.



- If time permits, give trainee the handout, *Annotated Dialogue One*. Read the dialogue aloud, having the trainee read Carolyn’s lines, followed by discussion of the content and annotation. If time is not available to do this during the training session, recommend reading and review of the handout to help trainee enhance attentiveness to counseling and communication techniques.



**Group training:**

**(Note: Look for this symbol –  – for instructions on modifying the group training for different time frames.)**

- Review the objectives for this Unit.
- If there has been a break between this Unit and the Unit, **Introducing Observation and Feedback to your Staff**, check in with trainees regarding any questions related to that prior activity.
- Refer to the prepared newsprint, *Guidelines for Feedback and Strategizing*, and the handout, *Guidelines for Feedback and Strategizing*. Ask trainees what concerns they have about any of the guidelines; what

part of giving feedback and strategizing with a provider do they think will be most challenging?

### **Video Viewing & Processing – First Vignette**

- Show the first vignette of the videotape. This vignette, showing a session between a provider and client, lasts approximately 4 minutes. Invite trainees to use the observation form while watching. Stop the video at the end of the first session.
- Facilitate a brainstorm of concerns about the approach of the provider in the video. Listen for and confirm, and record on newsprint if desired:
  - ✓ Provider does not introduce herself or the risk assessment/history taking process to the client
  - ✓ Provider asks only closed-ended questions
  - ✓ Provider's body language – frequent lack of eye contact, body positioned away from client and toward her desk, tone of voice – conveys disinterest
  - ✓ Provider misses opportunity to support client's acknowledgement of "some" condom use
  - ✓ Provider asks leading questions that imply the desired answer – for example "And so, you know how to put a condom on?" asked while nodding her head repeatedly.
  - ✓ Provider appears focused only on gathering data and completing the form
  - ✓ Provider is inattentive to the client's anxiety, as conveyed by her non-verbal and paraverbal language
- Ask trainees to identify all the positive qualities noted in the provider's approach. Listen for and confirm, and record if desired:
  - ✓ Provider seems knowledgeable about the form
  - ✓ Provider appears respectful
  - ✓ Provider's non-verbal and paraverbal language does not convey judgment in response to anything the client says.

- Explain that, unless one is intending to terminate an employee, it's best not to overload with critical feedback. An individual will often tune out more than one or two negative pieces of feedback. Ask trainees to identify what they feel are the two most crucial pieces of critical feedback.
- Ask trainees to develop statements to convey both the positive and critical feedback they would give to the provider in the video.

### **Video Viewing & Processing – Second Vignette**

- Show the next segment of the video. This shows a supervisor giving feedback to the provider following her session with the client. Stop the video at the end of that portion.
- Discuss the supervisor's approach. Reinforce the following points:
  - ✓ Supervisor acknowledges the discomfort of observation process.
  - ✓ Supervisor offers statements of genuine support.
  - ✓ Supervisor asks for the provider's self-assessment.
  - ✓ Supervisor enlists the provider's problem-solving skills to strategize for improvement, rather than telling the provider how she should do something differently.
  - ✓ Supervisor summarizes the provider's plan for improvement.
  - ✓ Supervisor plans with provider for follow-up.

If time is limited, skip this first role-play, and move to the viewing of the third video segment, followed by the "second" role-play. Begin at this symbol:



### **First Role-Play**

- Set up the first role-play, using the first dialogue from the handout, *Listening in on Risk Assessment*. Have trainees form triads. (If the total number of trainees does not divide evenly into triads, let extra trainees act as observers.) The role-play will include these steps:
  1. Ask trainees to determine who will play the client, Melissa, who will play the provider, Angie, and who will be the supervisor.
  2. "Supervisors" begin the role-play by discussing the conduct of the observation with "Angie," following the guidelines in the handout, *Conducting an Observation of a Clinical Encounter*. The "Angie" in

- each triad gets permission from the client, “Melissa,” to have the “supervisor” observe the session.
3. Using the written dialogue, “Angie” begins the risk assessment session with “Melissa.” “Supervisors” should use the handout, *Observation Tool*, in an unobtrusive manner during the brief exchange.
  4. At the end of the reading, “supervisors” give “Angie” feedback on her work with the client, and strategize with her about possible improvement. Remind “supervisors” to conclude by asking “Angie” for feedback to you regarding the process.
  5. Facilitate a large group discussion of the role-play experience. Some possible discussion questions:

To the “providers” (Angie): *How did it feel to be observed and given feedback?*

To the “supervisors”: *What was the most difficult part of this experience?*



### Video Viewing & Processing – Third & Fourth Vignettes

- Show the third segment of the video: The provider conducts another session, in a much more skillful way. Stop the video and facilitate a discussion about the group’s observations, and what feedback trainees would want to give to the provider in the video.
- Listen for and confirm responses such as:
  - ✓ Provider’s open body posture – away from her desk, not focused on the chart, facing toward the client – is welcoming.
  - ✓ Provider begins by asking for the client’s agenda.
  - ✓ Provider uses many open-ended questions; for example, *What made you choose the pill? How do you feel it will work for you?*
  - ✓ Provider confirms client’s feelings – her embarrassment about purchasing condoms.
  - ✓ Provider genuinely supports the client’s decision to purchase condoms despite the embarrassment.
- If trainees have not noted any negatives in the provider’s performance, ask what, if any, skill improvement needs might be addressed. Listen for and confirm responses such as:
  - ✓ Provider appeared anxious and perhaps overly directive regarding the issue of using condoms along with pills, and HIV testing.
  - ✓ Provider does not respond to client’s discomfort regarding this issue, as is apparent in the client’s non-verbal communication.

- Show the final segment of the video, in which the supervisor gives feedback on the provider's improved skills. Discuss reactions to their exchange. Focus on the following:
  - ✓ Supervisor uses open-ended questions to elicit provider's input and involvement:
    - How did you feel about being observed?*
    - How did you think it [the session] went?*
    - What do you think you did to make her open up?*
  - ✓ Supervisor offers support re: provider's use of open-ended questions; her maintenance of eye contact and avoidance of focus on the chart.
  - ✓ Supervisor asks a closed-ended question to begin discussions of any deficits: *Did you perceive any problems...anything uncomfortable?* Ask trainees how that question might be made open-ended. Listen for and confirm responses such as:
    - What, if any, problems or concerns do you have about how the session worked. What, if anything, made you uncomfortable?*
  - ✓ In response to the supervisor's question about problems, the provider expressed recognition of her own judgmental reaction and directive approach regarding the need for condom use along with pills. Ask trainees how the supervisor might have helped the provider recognize that she might do more effective work toward that condom use by recognizing the client's discomfort more explicitly.

Listen for and confirm responses that suggest that, since the client's discomfort and the source of that discomfort could be major barriers to that condom use, acknowledging and probing that discomfort could lay the ground work for practical strategizing with the client. For example, if the client's discomfort lies in her concern about how to address the issue of condom use with her partner, the provider might have the opportunity to help the client to prepare for that conversation.

## Second Role-Play

- Facilitate a second role-play. The role-play will include these steps:
  1. Have triad members determine who will play the roles of provider, supervisor and client for this role-play. Select a scenario from the handout, *Role-play Scenarios*, by one of these methods: choosing one scenario for all the triads to use; reading aloud the provider information on the top half of each scenario page, and letting triads select the client with whom they wish to work; or assigning a different client to each triad, having more than one triad dealing with the same client, if there are more than three triads. Give the

selected client information to the person in each triad who will be playing the client role.

2. Explain that that this will be an 8-10 minute role-play, intended to demonstrate just a portion of a risk assessment session.
3. Remind trainees who are playing the “supervisor” that prior to the role-play, to negotiate with the “provider” the logistics of the observation. The “supervisors” may choose whether or not to use the observation form.
4. End the role-play after 6-8 minutes.
5. Direct those playing “supervisor” to begin a feedback and strategizing session with the “provider.” Remind “supervisors” to ask “providers” for their self-assessment first. (This step is often overlooked.) The trainees who played the “client” will now be observers to that feedback session.
6. After 5 minutes, invite “observers” to offer feedback to “supervisors.”
7. Facilitate a large group discussion of the role-play experience. Some possible discussion questions:

To the “providers”: *How did it feel to be observed and given feedback?*

To the “supervisors”: *What was the most difficult part of this experience?*



- If time permits, distribute the handout, *Annotated Dialogue One*. Have trainees read the dialogue aloud in pairs, followed by discussion of the content and annotation. If time is not available to do this during the training session, recommend reading and review of the handout to help trainees enhance attentiveness to counseling and communication techniques.

- Conclude the session with this question:

*What will you take from this experience that will be useful to you in actual observation, feedback and strategizing work with providers?*

### Discussion Points:

Discussion points are included above.

## Follow-up Activities

- Follow this Unit with Unit Four for Supervisors – **Making Effective Referrals.**

## Listening in on Risk Assessment

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Here are two different providers' approaches to HIV risk assessment. "Listen" in on the first minute of each exchange.

*The client, Melissa, is 25 years old. This is her initial visit to the clinic. The first provider, Angie, has come to the part of history taking that focuses on sexual and drug-use history:*

*Angie:* I'm going to ask you some questions about your sex life. Are you currently sexually active?

*Melissa:* Yes.

*Angie:* When did you first become sexually active?

*Melissa:* [pauses] Uh, well, I guess you might say...at 15.

*Angie:* Fifteen.... okay. How many sex partners have you had since then?

*Melissa:* [appears to be mentally counting] Well, I dunno...I guess maybe three, or four?

*Angie:* How about in the past year - how many in the past year?

*Melissa:* Just one. My boyfriend.

*Angie:* That's great. Do you two always use condoms?

*Melissa:* [looks away from the Angie] Not always...

*Angie:* Why? I'm sure you know about sexually transmitted infections, like HIV. You really should use them, you know. So what kind of intercourse have you had - vaginal, anal, oral?

*Melissa:* [shaking her head] Boy, this does get nosy! I've...I've had 'em all. I mean, don't most people?

*Angie:* Yes, lots do. But you know that you can get infections from oral sex too, and anal sex is really dangerous.

*Melissa:* [very emphatically] But at least you can't get pregnant that way!

*Angie:* Well, sometimes semen can get on the outside of your vagina, even during anal sex, and then you could get pregnant.

*Melissa:* But is that really going to happen?

*Angie:* It could. See, Melissa, we don't want you to get pregnant, until you want to of course, and we don't want you to get any diseases either. I really think you should talk to your boyfriend about using condoms. I want to show you how they work.

**How did you feel about Angie's approach?**

**What seemed most effective in Angie's approach?**

**What seemed least effective in Angie's approach?**

Now, “listen” to how another provider, Carolyn, does risk assessment with the same client.

*Carolyn:* Melissa, the part of your medical history that I’m going to go over now is about sexual behavior and drug use. I ask these questions of every client, because these things have a big impact on people’s health.

*Melissa:* Okay.

*Carolyn:* I know you came in today to get a method of birth control. What’s going on in your life right now, sexually speaking?

*Melissa:* [responds rapidly] I have a boyfriend - he’s a great guy. We’ve been together a year and-a-half. And we do have sex. Not a lot, I mean not as much as he wants [laughs] but we do. But, you know, that’s why I’m here - for birth control.

*Carolyn:* So what have you been doing to keep from getting pregnant?

*Melissa:* Well, he pulls out before he comes, and, I guess I’ve been lucky...[her voice trails off]

*Carolyn:* It sounds like not getting pregnant is very important to you. You and your boyfriend have been using one of the most difficult methods around - withdrawal. Lots of people use it, and they’re surprised to learn that it’s not very effective.

*Melissa:* Yeah, I know.

*Carolyn:* The good news is that there are much, much more effective methods that are so much easier than withdrawal.

*Melissa:* Yeah. My boyfriend really wants me to get the pill

*Carolyn:* How do you feel about taking the pill?

*Melissa:* Well, I’m sure not ready for a baby!

*Carolyn:* When pills are taken correctly, they are very effective at preventing pregnancy. But - and you probably know this - the pill doesn’t protect against sexually transmitted infections. What are you doing to prevent getting STIs, like HIV, the virus that causes AIDS?

*Melissa:* [shaking her head “no”] I don’t really think that’s an issue for me.

*Carolyn:* You know, I think it's hard for any of us to imagine that these diseases could have anything to do with us. At the same time, I've seen so many young women learn the hard way about these diseases.

*Melissa:* [nodding] You're right about that. Actually I got something once. "Calmidia", I think it was called, but I got treated for that. That was a couple of years ago.

*Carolyn:* Yes, chlamydia is one of the most common STIs. And luckily, it can be treated. I bet that was unnerving for you.

*Melissa:* [nods vigorously] You're right about that. I couldn't believe it. I was so embarrassed! I ended up breaking it off with that guy.

**How did you feel about Carolyn's approach?**

**What seemed most effective in Carolyn's approach?**

**What seemed least effective in Carolyn's approach?**

***Now that you've "listened" to these two excerpts, consider the following questions:***

Which of these two providers - Angie or Carolyn - would you want to do a risk assessment with *you*?

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What are the reasons you chose that provider? What did you like about her approach?

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## OBSERVATION TOOL

Provider: \_\_\_\_\_ Date: \_\_\_\_\_

Observer: \_\_\_\_\_ Site: \_\_\_\_\_

### I: Basic Communication and Counseling Skills

Skills	Notes:
1. Demonstrates professionalism	
2. Establishes rapport	
3. Affirms/ supports client	
4. Addresses significant problems	
5. Uses open-ended questions	
6. Gives information as-needed and simply	
7. Paraphrases and reflects feelings	
8. Attends non-verbally	
9. Uses silence appropriately	
10. Explains confidentiality	
11. Demonstrates comfort with sexual issues	

**Summary:**

**II: Risk Assessment Skills**

<b>Component</b>	<b>Notes:</b>
1. Normalizes risk assessment process	
2. If necessary, gives client right to not answer	
3. Helps client assess level of risk	
4. Confronts, if necessary	
5. Addresses all topics of risk assessment	
6. At least asks: What are you doing to avoid HIV?	
7 .Provides appropriate referrals	
8. Offers referral assistance	

**Summary:**

## GUIDELINES For USE of OBSERVATION TOOL

During observation, jot down notes and comments using the **Observation Tool**. Specific examples of the skills and behaviors, particularly those that describe *good* work that you have observed, will be helpful feedback for the provider. It is useful to share these guidelines and the observation tool with providers. They can clarify expectations and help identify knowledge and/or skill deficits needing attention.

### What to Look For: **Basic Communication and Counseling Skills**

1. *Demonstrates professionalism*: Displays self-confidence, competence, dependability, preparation, integrity, and appropriate seriousness. Convincingly conveys commitment to confidentiality. Appears non-judgmental and objective about behavior and lifestyle.  
  
As appropriate, may also include: Wears name tag, selects confidential area, ensures no interruptions, ensures no physical barriers, reviews record, calls patient by full name, greets client and introduces self, gets approval, and introduces observer.
2. *Establishes rapport*: Displays respect, empathy, sincerity, and politeness. Seeks out and deals with clients' concerns.
3. *Affirms/supports client*: Takes advantage of opportunities to affirm, such as, "I'm glad you asked that. You know a lot about HIV."
4. *Addresses significant problems*: Helps client to express concerns without making assumptions about needs; explores clients' issues further, provides information, makes referrals, and notes on chart when issues/problems arise.
5. *Uses open-ended questions*: Avoid the use of "why" questions.
6. *Gives information simply and as needed*: Communicates at client's level; avoids technical terms, jargon, etc. Demonstrates accurate and up-to-date information. Offers to investigate unanswered questions. Avoids overwhelming client with information, focuses on main points, and offers information that is specific to individual client's needs and situation.
7. *Paraphrases and reflects feelings*: When appropriate, restates client's words to demonstrate and clarify understanding. Uses active listening to validate and check out feelings.
8. *Attends non-verbally*: Uses appropriate body language; respectful, open gestures and facial expressions. Non-verbal and verbal communication congruent.
9. *Uses silence appropriately*: Pauses, relaxes, and doesn't rush the client.
10. *Demonstrates comfort in openly discussing sexuality issues*: Body language and other communication skills do not alter when sexuality is discussed; is open and non-judgmental in communicating across diverse sexual behaviors and values.

### **What to Look For: *Risk Assessment Components***

1. *Normalizes risk assessment process with client:* States rationale for risk assessment.
2. *Gives client permission to not answer questions:* Lets the client know that the more she is able to share, the better the provider will be able to meet her needs.
3. *Helps client assess her level of risk:* Asks open-ended questions to elicit client’s self-awareness of risk-taking behavior.
4. *Confronts, if necessary:* Respectfully challenges client’s self-perception of risk, if evidence of risky behavior is apparent. Uses a supportive tone when confronting client who expresses contradictory desires (“I don’t want to get infected, but I’m not going to use condoms!”) or whose medical history conflicts with self-perception (client insists she is not at risk; has been treated for STI.)
5. *Addresses all topic areas of risk assessment:* Asks about current and recent past sexual behaviors, HIV/STI risk, substance use history, pregnancy intentions, and domestic violence/sexual abuse.
6. *At a minimum, asks:* “What are you doing to protect yourself from HIV, the virus that causes AIDS?”
7. *Provides appropriate referrals:* Offers accurate, up-to-date information on who, where, what, and how, considering specific client needs.
8. *Offers referral assistance:* Facilitates connection with referral agency, encourages feedback, and sets follow-up appointments as need.

## **Scenario #1 - Sandy**

### Provider Information

Your client is Sandy, a 22 year-old in for her annual exam. She says she needs more birth control pills, and also wants condoms. She checked off "yes" to drug use, but then seemed to have scratched it off, or tried to erase it.



## **Scenario #1 - Sandy**

### Client Information

You are Sandy, a 22 year-old. You've come to the clinic for an annual exam, and to get more birth control pills and condoms. You've been getting high a lot lately, smoking a lot of pot and drinking pretty heavily. People sometimes nag you about this but you feel your using is under control, and no big deal. Also, sometimes you have sex with someone when you need extra money. You always try to use condoms with these guys, but not with your regular boyfriend.

## **Scenario #2 - Ashley**

### Provider Information

Your client is Ashley, a 17 year-old. She acknowledges using condoms to prevent disease, but she also indicates that she has been treated for chlamydia. She wants to get Depo at her next period. You want to talk more about condoms with this client; she seems to tune you out when you start talking about them



## **Scenario #2 - Ashley**

### Client Information

You are Ashley, a 17 year-old. You acknowledged using condoms to prevent disease, but the truth is you haven't been using condoms regularly because you are not sure how to ask a guy to use them, and you are not sure what you would do or say if he said "No!" You tell the provider you want to get that shot - Depo - at your next period. When the provider starts talking about condoms, you get quiet and look at the floor. You have had sex with a number of guys. Now you have a steady boyfriend, and you don't want to get pregnant, at least not yet.

### **Scenario #3 - Jason**

#### Provider Information

Your client is Jason, a 23 year-old. He has come in for a STI check and treatment. He says he uses condoms sometimes. You want to find out more about his condom use. He appears extremely uncomfortable when you try to talk to him about this.



### **Scenario #3 - Jason**

#### Client Information

You are Jason, a 23 year-old. You've come to the STD clinic because you have been having burning when you urinate. When the provider asks if you use condoms, you say "sometimes." When the provider asks you more about your condom use, you say they don't fit, so you don't like to use them. The truth is that when you are putting on a condom, you get too excited and come too quickly; if the woman puts it on you, you come immediately. It's incredibly embarrassing.

## Scenario #4 - Yvonne

### Provider

Your client is Yvonne, a 17-year-old. She has been diagnosed with Chlamydia. She becomes sullen and withdrawn when the issue of HIV risk is raised. She also seems disinterested in talking about birth control and is vague about the date of her last menstrual period. She says she just came here today to get rid of this infection.



## Scenario #4 - Yvonne

### Client

You are Yvonne, a 17-year-old, in the 10th grade and struggling to remain in school. Actually, you've been seriously considering dropping out. You have 2 friends who have and they both have jobs and seem to be doing OK. They certainly have more money than you do! You came to the clinic because you heard that an old girlfriend of your boyfriend Tony had some sort of infection. You've just been told you have chlamydia. You're really scared about this. Tony must be stepping out on you, you think, and you are both angry at him and afraid of losing him. You have also been daydreaming occasionally about having Tony's baby. While the provider is talking you keep thinking - *Does this mean I can't get pregnant? What am I going to tell Tony? Should I just leave him? Then what would I do??*

The counselor wants to talk about AIDS – can't she see you've got enough to deal with?

## **Scenario #5 - Cassandra**

### Provider

Your client is Cassandra, a 26-year-old woman. She has a history of drug use, including injection drug use, since age 16. She was referred to the clinic to talk about getting on a method of birth control. She appears very depressed and anxious. She suddenly says to you, "I just found out I've got that HIV virus. All my dreams are dead. I always wanted to have kids, and now I never will!".



## **Scenario #5 - Cassandra**

### Client

You are Cassandra, a 26-year-old woman. You have been in recovery from heroin use for 2 months. You had finally decided to get your life together and go into recovery. When you entered the recovery program, they urged you to get tested for HIV, and the test was positive. You are feeling completely hopeless - why did you ever stop using? You have had two abortions, because at least you knew better than to have a baby when you were getting high. And now you'll never be able to have a baby!

## **Scenario #6 - Maria**

### Provider

Your client is Maria, a 30 year old married woman. Maria has a 3 year old son who is HIV+. Her husband, James is also infected. He is recovering from dual addiction to alcohol and heroin. James has expressed to Maria tremendous, paralyzing guilt over the family's infectious status as he assumes he was the source of their infection. Maria desperately wants to try again to have a healthy baby. She is very willing to take whatever prophylaxis is recommended to protect a baby, if she becomes pregnant. James has been struggling of late to maintain his sobriety, and Maria thinks that a new baby would help him.



## **Scenario #6 - Maria**

### Client

You are Maria, a 30 year old married woman. Your 3 year old son Michael is HIV infected, as is your husband James and yourself. Your first child died when he was 9 in a traffic accident. You have always felt responsible for this because he was playing outside in the evening, and you were not watching him. When Michael was born it seemed like a miracle to you and James. James had just recently begun recovery from dual addiction to alcohol and heroin; despite what others say, he has always been a good husband to you. Shortly into his recovery, James was tested for HIV infection. When his test was positive you, and then the baby, were tested, and both were positive. James came close to killing himself at that news; only his sense of responsibility to you and Michael kept him going. But he's never been the same. He's so depressed. You think that if you could become pregnant again, and have a healthy baby, it would turn things around for James. You know there are drugs now that can help keep a baby from getting infected. You feel determined to do this.

## Annotated Dialogue One

*The client is 25 year-old Melissa. This is her initial visit to the clinic. The provider, Carolyn, has been going over Melissa's medical history, and is at the part that focuses on sexual and substance use behavior.*

Begins by explaining and normalizing the process.

*Carolyn:* Melissa, the part of your medical history that I'm going to go over now is about sexual behavior and drug use. I ask these questions of every client, because these things have a big impact on people's health.

*Melissa:* Okay.

Open-ended question, "What's going on...?" gathers a lot of information from client.

*Carolyn:* I know you came in today to get a method of birth control. What's going on in your life right now, sexually speaking?

*Melissa:* [responds rapidly] I have a boyfriend – he's a great guy. We've been together a year and-a-half. And we do have sex. Not a lot, I mean not as much as he wants [laughs] but we do. But, you know, that's why I'm here – for birth control.

Open-ended question.

*Carolyn:* So what have you been doing to keep from getting pregnant?

*Melissa:* Well, he pulls out before he comes, and, I guess I've been lucky...[her voice trails off]

Doesn't criticize Melissa's admission; offers praise; adds information in a supportive and normalizing way.

*Carolyn:* It sounds like not getting pregnant is very important to you. You and your boyfriend have been using one of the most difficult methods around – withdrawal. Lots of people use it, and they're surprised to learn that it's not very effective.

*Melissa:* Yeah, I know.

Open-ended question.

*Carolyn:* The good news is that there are much, much more effective methods that are so much easier than withdrawal.

*Melissa:* Yeah. My boyfriend really wants me to get the pill

*Carolyn:* How do you feel about taking the pill?

*Melissa:* Well, I'm sure not ready for a baby!

*Carolyn:* When pills are taken correctly, they are very

Information presented without challenging Melissa's knowledge; open-ended question.

effective at preventing pregnancy. But – and you probably know this – the pill doesn't protect against sexually transmitted infections. What are you doing to prevent getting STIs, like HIV, the virus that causes AIDS?

*Melissa:* [shaking her head “no”] I don't really think that's an issue for me.

3<sup>rd</sup> person normalization, with a gentle confrontation.

*Carolyn:* You know, I think it's hard for any of us to imagine that these diseases could have anything to do with us. At the same time, I've seen so many young women learn the hard way about these diseases.

*Melissa:* [nodding] You're right about that. Actually I got something once. “Calmidia”, I think it was called, but I got treated for that. That was a couple of years ago.

Not important to correct her mistake explicitly. Attends to Melissa's feelings – “I bet that was unnerving...”

*Carolyn:* Chlamydia is one of the most common STIs. And luckily, it can be treated. I bet that was unnerving for you.

*Melissa:* [nods vigorously] You're right about that. I couldn't believe it. I was so embarrassed! I ended up breaking it off with that guy.

More support for Melissa's behavior. Carolyn precedes an open-ended question used to confront, with acknowledgement that it's a “tough” one.

*Carolyn:* And even though it was embarrassing, you took care of it. And you know from that experience that a person can get an infection when they don't expect it at all. Here's a tough question to think about. How does it feel to trust your boyfriend with your health, and maybe even your life?

*Melissa:* I never really thought of it that way. I know we're supposed to use condoms, but guys just don't want to use those thing. Besides, we're only having sex with each other!

Starts by praising Melissa's behavior. Melissa may not have even thought about her monogamy in terms of risk reduction. This can help give her the sense that she's able to take such steps. Confronts with a normalizing statement – “What's sometimes hard to think about is...”

*Carolyn:* Only having sex with someone who's only having sex with you is a big part of protection. What's sometimes hard to think about is that people we're with, or have been with in the past, probably had sex with other people at some time. And with many STIs, like HIV, not only would you not know that person had it, he might well not know either.

*Melissa:* Yeah, I guess that's true... [her voice trails off]

Open-ended question.

*Carolyn:* What has your boyfriend told you about his sexual history?

*Melissa:* Not much, really. I guess I haven't really asked.

Confirming; open-ended question.

*Carolyn:* It's not an easy thing to do. What would it be like to talk with him about using condoms?

*Melissa:* [very hesitantly] Not easy...he might think I've got

something. I dunno...I guess I should... [stops talking]

Offers strategizing support, asks permission to pursue her agenda a bit longer; this also takes some pressure off Melissa. Melissa's discomfort is indication that her risk perception has been raised.

*Carolyn:* If you like, we could talk some more in a moment about how you might bring this issue up with him. Would it be okay if I finish up these history questions first?

*Melissa:* [looks relieved] Sure.

*Carolyn:* How old were you when you first had intercourse?

*Melissa:* Fifteen, I think...yeah, fifteen.

Avoids “sexually active.”

*Carolyn:* And how many sexual partners have you had since then?

*Melissa:* [appears to be mentally counting, then looks up] Four...no, actually five.

*Carolyn:* And you've told me you've been with your current boyfriend over a year – am I remembering that right?

*Melissa:* Yes.

Introduces sensitive questions.

*Carolyn:* Here are two questions that sometimes surprise people. First, I know you've had sex with men, how about with a woman?

*Melissa:* No, never. Do lesbians come here, too?

Provides a bit of information without sounding like she's teaching.

*Carolyn:* Yes, and also people who've had sex with both men and women. Here's another question that can feel awkward; what kind of intercourse do you have with men? Vaginal intercourse?

*Melissa:* Yes.

*Carolyn:* Oral sex?

*Melissa:* Yeah...what guy doesn't like that!

Normalizes.

*Carolyn:* And lots of women do too. How about anal intercourse?

*Melissa:* Just once or twice. I guess I've done it all! [looks a little embarrassed]

Responds to Melissa's embarrassment with normalization. Asks open-ended question to begin focusing in on HIV once more.

*Carolyn:* And that makes you like so many people. Melissa, what have you heard about HIV and AIDS, about how people get it?

*Melissa:* [speaks confidently] I've heard lots of stuff about AIDS. I know people get it from shooting drugs, and having unprotected sex, and babies from their mothers.

Praise; open-ended question.

*Carolyn:* You've got all that right. What experiences have you had with drugs?

*Melissa:* [forcefully] Well, I've never injected drugs, if that's what you mean! [pauses, then says] I smoke a little dope every once in a while.

*Carolyn:* How about any of your sexual partners – have any of them injected drugs?

*Melissa:* No, no, I mean I sure don't think so. I don't hang out with that kind of crowd.

3<sup>rd</sup> person normalization of social use of substances, combined with information on the connection between that behavior and HIV risks.

*Carolyn:* For lots of people, getting high, with alcohol or any other drug, can affect their sexual behavior. What's that been like for you?

*Melissa:* I guess a few times, not too many, I've had sex with a guy when I was high a lot faster than I would have if I hadn't been. [looks annoyed]

Attends to Melissa's non-verbal expression of feeling with an open-ended question to surface feeling identification.

*Carolyn:* How do you feel about that?

*Melissa:* [shaking her head and looking down] I felt awful about it the next day.

Offers a strategy using the 3<sup>rd</sup> person, which allows Melissa to more honestly say what she thinks about the strategy than she might if it came directly from the provider.

*Carolyn:* Some women decide to be sure they at least have condoms with them if they think they might be in that situation. Still, it can be hard to remember to use them when you're high.

*Melissa:* Yeah, you're right about that. I don't think I'll be in that situation again, though.

Continues strategizing with use of open-ended question.

*Carolyn:* What could you do if you realized a situation like that was developing?

*Melissa:* Like I said, I don't think it will happen again, but if it did, I'd just leave before things got messy.

Supports Melissa's intention. 3<sup>rd</sup> person approach to transition into another possibly sensitive subject.

*Carolyn:* Sounds like a good plan. Another situation that lots of people have been in is being forced to have sex when they didn't want to. What's your experience been with that?

*Melissa:* It hasn't really happened to me. Like I said, I've given in a couple of times when I was high, but no one ever forced me.

Paraphrases as a summary, contracts to return to the risk reduction concerns.

*Provider:* So what you're saying is that, for now, the one situation you want to think about is the one with your boyfriend. Would it be okay if we talked some more about how to talk with him about sexually transmitted infections, how to bring up using condoms?

*Melissa:* Yes, sure.

This portion of a longer session took a little less than 6 minutes. The provider has taken every opportunity to offer genuine praise and support. She has anticipated and normalized any uncomfortable reactions, and attended to feelings she sensed in Melissa. In the course of a genuine, client-centered interaction, she managed to accomplish a lot in a very short amount of time. In addition, by creating a comfortable relationship with the client, she's helped to build an even more important relationship – Melissa's connection to the clinic.

## Supporting Quality Risk Assessment: Training Activities to Enhance Supervision of Risk Assessment Skill



### Unit Title

#### Unit Four: Making Effective Referrals

### Objectives

- To enhance the effectiveness of the referral process used by clinic staff.
- To strengthen assurance of client confidentiality in making referrals.

### Group Size

Variable. May be used in a one-on-one session with an individual supervisor, or with a group of any size.

### Time Duration

45 minutes for one-on-one session  
60 minutes – 1 hour, 30 minutes for group, depending on which activities are used – See symbol for instructions:



### Materials & Preparation



*Handout – Making Effective Referrals*  
*Handout – Template for Gathering Resources*

Invite participants to bring any referral-related materials used by clinic staff with them to this training; for example, referral forms, referral or resource guide, protocol for referral identifying and/or updating

Newsprint, easel stand and markers

For groups of four or more: Overhead or prepared newsprint of *Making Effective Referrals* – optional for one-on-one training;

**Procedure:**



**One-on-one training**

- Review the objectives for this Unit.
- Discuss with the trainee her sense of the importance of an effective referral process to the quality of the services delivered by the clinic.
- Ask trainee to identify all the potential referral needs that might surface during a risk assessment. Listen for and confirm, adding as necessary:
  - ✓ Substance abuse treatment
  - ✓ Services for clients experiencing intimate partner violence
  - ✓ Medical care
  - ✓ Mental health diagnosis and treatment
  - ✓ Housing, employment, related social services
  - ✓ Harm-reduction supports for active drug users
- Ask the trainee:
  - From the perspective of clients who have these needs, how easy do you think it is for them to gain these services? What barriers might they perceive?* Facilitate a discussion addressing these points:
    - ✓ Many of these services are scarce and can be difficult to access, particularly by the most needy clients.
    - ✓ Many chronic substance users, especially those with negative or less than successful past experiences with health and human services, are likely to feel that it's not worth the effort.

- ✓ Clients experiencing intimate partner violence may feel that have much at stake if they try to escape the violent relationship, including shelter, economic security, their own safety and the safety and well-being of their children
- Give the trainee the handout, *Making Effective Referrals*. Suggest that content of the discussion could be recorded on the handout. Refer to the newsprint or overhead of the content of this handout, if you are using one. Review the three steps to effective referrals, asking questions and facilitating discussion as outlined below:

### **Step 1 – Assessing Needs**

#### **① Identify client perceptions of present needs and priorities.**

*What might a provider ask to assess a client's perceptions?* Listen for and confirm responses like these, adding as necessary:

- ✓ What kind of support do you think would be most helpful to you?
- ✓ What help do you most need to support your plans to protect yourself?
- ✓ Sometimes clients who have issues like yours want further support with how to talk with partners. Some want help with learning how to use drugs more safely. Some want to get into treatment. What would help you the most?
- ✓ What have been your experiences with service providers in the past?
- ✓ Which ones have worked for you and what made them work... which ones have not worked for you, and what make those not work?

#### **② Identify costs and benefits of seeking different services.**

*What might a provider ask to help a client to identify the costs and benefits of acting on the referral?* Listen for and confirm responses like these, adding as necessary:

- ✓ What do you most want in a service provider?
  - ✓ What do you really dislike in a service provider?
  - ✓ What would be the biggest barrier to using to using a referral?
- Explain to the trainee that just asking questions like these can make a referral seem more individualized to the client, and may increase the chance of follow-through.

## Step 2 – Making the Referral

### ① Identify a service that is likely to meet assessed needs.

- Discuss with the trainee what factors get in the way of identifying appropriate referrals. Focus on factors such as:
  - ✓ Lack of health insurance or inadequate health insurance coverage
  - ✓ Need for child care
  - ✓ Access issues like transportation and hours of service
  - ✓ Change in personnel in referral agencies
- Ask the trainee what kind of information about a referral is important for a provider to have in order to best match need to resource? Listen for and confirm, adding as necessary:
  - ✓ Exact nature of service offered by resource
  - ✓ Current capacity to take on new clients
  - ✓ Sensitivities to issues of substance use, gender, age, culture, sexual orientation
  - ✓ Basic logistics about hours and location, including availability of child care
  - ✓ Service access or intake procedures
  - ✓ Financial requirements
- Invite trainee to look at any referral materials she has with her, and discuss how well these materials do in covering the information described above. Discuss what it would take to make any needed improvements.
- Give trainee the handout, *Template for Gathering Resources*. Discuss the her sense of the usefulness of this template, as well as other types of service providers she might wish to include in the first column.

### ② Support client follow-through

- Engage in discussion about ways providers can support client follow-through. Focus on strategies such as:
  - ✓ Clearly stating the limits and requirements, as well as the benefits of the services available, and exploring client's feelings about the limitations

- ✓ Exploring clients' personal resources for factors such as transportation and child care
- ✓ "Walking" the client through preparation for service access, e.g., what documents to pull together for insurance or Medicaid certification; what arrangements to make to get to the location on time; what requirements to anticipate when accessing service
- ✓ Providing direct referral assistance – for example, setting up appointments, helping clients complete forms, arranging for required TB test at your clinic.

### **Step 3 – Follow-Up on Referral**

- Engage in discussion about ways providers can help make more effective referrals to future clients. What follow-up activities might be conducted for this purpose? Focus on strategies such as:
  - ✓ Invite feedback from and/or checking in with client about the referral.
  - ✓ Contacting the referred provider.
  - ✓ "Updating referral lists with feedback about provider responsiveness.

### **Step 4 – Addressing Confidentiality Issues**


- Discuss with the trainee what concerns providers have about confidentiality related to making referrals. Refer to the second page of the handout, entitled, "Guidelines for Confidentiality of Referrals."
- Ask the trainee to describe what procedures or strategies might be used to address those concerns. Listen for and confirm, adding as necessary:
  - ✓ Supervisors/clinic managers can confer with providers to learn for which resources personalized referrals – referrals made directly with the referral agency and providing confidential information regarding the client – are important or needed. Negotiate "Qualified Service Organization Agreements" (QSOAs) with these agencies. The CDC defines QSOAs as interagency agreements that allow substance abuse treatment and public health provider agencies to share some information about patients within the legal constraints of federal confidentiality protections.

- ✓ Providers can explain to clients the confidentiality protections of clinic information and how those protections extend to referred providers with which the clinic has legal, written agreements
  - ✓ Providers can explain how referrals can be made anonymously and, if any, the limitations of such referrals
  - ✓ A provider should obtain client's consent to release information about substance use, HIV status or any other similar data for any personalized referral.
  - ✓ Any provider who becomes aware of a potential violation of confidentiality or related service laws (e.g. the Americans with Disabilities Act) should report the possibility immediately to her supervisor.
- Summarize by explaining that the QSOA is the main support for confidentiality protections within referral networks. These inter-agency agreements are the legal backbone of the substance abuse treatment system. They require the personal attention of senior clinic staff, and a commitment to report suspected violations. This process will nurture stronger relationships among service providers, and more effective referrals.



**Group training:**



**(Note: This symbol –  – indicates places where training time may be reduced. Instead of facilitating small group and/or large group discussions, at points where you see the symbol, you may want to substitute a more didactic presentation of material to hasten the training process.)**

- Review the objectives for this Unit.
- Facilitate a discussion of the importance of effective referral process to the quality of the services delivered by a clinic.

- Ask trainees to identify all the potential referral needs that might surface during a risk assessment. Record responses on newsprint. Listen for and confirm, adding as necessary:
  - ✓ Substance abuse treatment
  - ✓ Services for clients experiencing intimate partner violence
  - ✓ Medical care
  - ✓ Mental health diagnosis and treatment
  - ✓ Housing, employment, related social services
  - ✓ Harm-reduction supports for active drug users
- Ask trainees:
- *From the perspective of clients who have these needs, how easy do you think it is for them to gain these services? What barriers might they perceive?* Record responses. Listen for and confirm, adding as necessary:
  - ✓ Many of these services are scarce and can be difficult to access, particularly by the most needy clients.
  - ✓ Many chronic substance users, especially those with negative or less than successful past experiences with health and human services, are likely to feel that it's not worth the effort.
  - ✓ Clients experiencing intimate partner violence may feel that have much at stake if they try to escape the violent relationship, including shelter, economic security, their own safety and the safety and well-being of their children
- Distribute the handout, *Making Effective Referrals*. Suggest that content of the discussion could be recorded on the handout. Refer to the newsprint or overhead of the content of this handout. Review the three steps to effective referrals, asking questions and facilitating discussion as outlined below:

### **Step 1 – Assessing Needs**

- ① **Identify client perceptions of present needs and priorities.**

- Ask trainees:

*What might a provider ask to assess a client's perceptions?* Listen for and confirm responses like these, adding as necessary (record responses on newsprint, if desired):

- ✓ What kind of support do you think would be most helpful to you?
- ✓ What help do you most need to support your plans to protect yourself?
- ✓ Sometimes clients who have issues like yours want further support with how to talk with partners. Some want help with learning how to use drugs more safely. Some want to get into treatment. What would help you the most?
- ✓ What have been your experiences with service providers in the past?
- ✓ Which ones have worked for you and what made them work... which ones have not worked for you, and what make those not work?

**2 Identify costs and benefits of seeking different services.**

- Ask trainees:

*What might a provider ask to help a client to identify the costs and benefits of acting on the referral?* Listen for and confirm responses like these, adding as necessary (record responses on newsprint, if desired):

- ✓ What do you most want in a service provider?
  - ✓ What do you really dislike in a service provider?
  - ✓ What would be the biggest barrier to using to using a referral?
- Explain that just asking questions like these can make a referral seem more individualized to the client, and may increase the chance of follow-through.

## Step 2 – Making the Referral

### 1 Identify a service that is likely to meet assessed needs.

- Ask trainees:

*What factors can get in the way of identifying appropriate referrals?* Listen for and confirm responses like these, adding as necessary (record responses on newsprint, if desired):

- ✓ Lack of health insurance or inadequate health insurance coverage
- ✓ Need for child care
- ✓ Access issues like transportation and hours of service
- ✓ Change in personnel in referral agencies

- Ask trainees:

*What kind of information about a referral is important for a provider to have in order to best match need to resource?* Listen for and confirm, adding as necessary (record responses on newsprint, if desired):

- ✓ Exact nature of service offered by resource
- ✓ Current capacity to take on new clients
- ✓ Sensitivities to issues of substance use, gender, age, culture, sexual orientation
- ✓ Basic logistics about hours and location, including availability of child care
- ✓ Service access or intake procedures
- ✓ Financial requirements

- Have trainees form small groups. Ask groups to look at any referral materials trainees have brought with them, and discuss how well these materials do in covering the information described above. Facilitate a large group discussion about what steps could be taken to make any needed improvements. Record as desired.
- Distribute the handout, *Template for Gathering Resources*. Ask trainees to discuss the usefulness of this template, and to identify other types of service providers that might be included in the first column.



## 2 Support client follow-through

- Have trainees continue to work in their small groups. Ask groups to discuss ways providers can support client follow-through. After about 8 minutes, elicit ideas from groups. Listen for and confirm responses like these, adding as necessary (record responses on newsprint, if desired):
  - ✓ Clearly stating the limits and requirements, as well as the benefits of the services available, and exploring client's feelings about the limitations
  - ✓ Exploring clients' personal resources for factors such as transportation and child care
  - ✓ "Walking" the client through preparation for service access, e.g., what documents to pull together for insurance or Medicaid certification; what arrangements to make to get to the location on time; what requirements to anticipate when accessing service
  - ✓ Providing direct referral assistance – for example, setting up appointments, helping clients complete forms, arranging for required TB test at your clinic.

### Step 3 – Follow-Up on Referral

- Facilitate a discussion about ways providers can help make more effective referrals to future clients. Ask,

*What follow-up activities might be conducted for this purpose?*
- Listen for and confirm responses like these, adding as necessary (record responses on newsprint, if desired):
  - ✓ Invite feedback from and/or checking in with client about the referral.
  - ✓ Contacting the referred provider.
  - ✓ "Updating referral lists with feedback about provider responsiveness.

### Step 4 – Addressing Confidentiality Issues

- Ask trainees:

*What concerns might providers have about confidentiality in following these steps for making effective referrals?*



- Ask trainees to discuss with others what procedures or strategies might be used to address those concerns. Listen for and confirm responses like these, adding as necessary (record responses on newsprint, if desired):
  - ✓ Supervisors/clinic managers can confer with providers to learn for which resources personalized referrals – referrals made directly with the referral agency and providing confidential information regarding the client – are important or needed. Negotiate “Qualified Service Organization Agreements” (QSOAs) with these agencies. The CDC defines QSOAs as interagency agreements that allow substance abuse treatment and public health provider agencies to share some information about patients within the legal constraints of federal confidentiality protections.
  - ✓ Providers can explain to clients the confidentiality protections of clinic information and how those protections extend to referred providers with which the clinic has legal, written agreements
  - ✓ Providers can explain how referrals can be made anonymously and, if any, the limitations of such referrals
  - ✓ A provider should obtain client’s consent to release information about substance use, HIV status or any other similar data for any personalized referral.
  - ✓ Any provider who becomes aware of a potential violation of confidentiality or related service laws (e.g. the Americans with Disabilities Act) should report the possibility immediately to her supervisor.
- Summarize by explaining that the QSOA is the main support for confidentiality protections within referral networks. These inter-agency agreements are the legal backbone of the substance abuse treatment system. They require the personal attention of senior clinic staff, and a commitment to report suspected violations. This process will nurture stronger relationships among service providers, and more effective referrals.

**Discussion Points:**

Discussion points are included above.

## Follow-up Activities

- Ask the trainee(s) to outline a plan to strengthen relationships with referral agencies, and to ensure on-going quality improvement of the referral process.
- Invite representative of referral agencies to present. Since referrals to substance abuse treatment is greatly facilitated by a central intake system, it can be particularly helpful to ask a guest speaker to talk about the any such a system in your locality.





### **3. Follow-Up on Referral**

### **4. Addressing Confidentiality Issues**

What are possible concerns about client confidentiality in following these steps for making effective referrals?

Confidentiality guidelines protecting HIV information were taken from federal regulations for substance abuse treatment. How do the provisions below protect confidentiality of your referrals for substance abuse treatment or harm reduction?

*The Qualified Service Organization Agreement (QSOA)*

*Personalized versus Anonymous Referrals*

*Obtaining Client Consent*

*Reporting Violations*

Here is a template for gathering resources in your community so that you can refer clients as needed. Keeping updated resources is critical to offering comprehensive services to clients.

<b>Service Provided</b>	<b>Agency Name</b>	<b>Contact Name/ Address/ Phone/ Email</b>	<b>Hours of Operation</b>	<b>Additional Comments</b>	<b>Date of Last Update</b>
<b>HIV Counseling/ Testing</b>					
<b>HIV Medical Clinic</b>					
<b>Substance Abuse Counseling/ Treatment Program</b>					
<b>Methadone Treatment Program</b>					
<b>Domestic Violence Services</b>					
<b>Gay, Lesbian, Bisexual, Transgender Services</b>					
<b>Needle Exchange Program</b>					
<b>Other</b>					
<b>Other</b>					