Including peers as part of a substance use treatment program for individuals living with HIV: The Peer Assisted Treatment of HIV and Substance (PATHS) Model

Having experience on both sides is the greatest asset. The key. Truly understanding can't be taught in school.

PATHS participant

Peers have increasingly been incorporated into HIV programming to provide support, education, and assistance with accessing medical care services and adhering to medications.[1-3] These peers, often referred to as peer support specialists or peer navigators, receive specialized training in providing services for individuals living with HIV. Additionally, their experiences living with HIV provide a unique perspective to their service delivery. Previous research has found evidence of the positive effects of peer support on medication adherence,[2,4] and medical care participation.[5] Other studies found evidence of positive associations between participation in peer-inclusive programs and decreased HIV risk behavior and increased HIV-related knowledge.[3,6-8]

Peers in recovery have also been utilized in substance use treatment settings to provide education, support, and recovery guidance. In a review of peer services offered in substance use treatment, Bassuk and colleagues refer to these services as "peer-based recovery support services" and define them as "the process of giving and receiving nonprofessional, nonclinical assistance to achieve long-term recovery from substance use disorders. This support is provided by peers, also known as recovery coaches, who have lived experience and experiential knowledge to assist others in

initiating and maintaining recovery and in enhancing the quality of personal and family life."[9,10] Bassuk and colleagues differentiated these services from peer support that is provided through "mutual aid modalities" such as 12 step programs. The nine studies that met the inclusion criteria for sufficient rigor generally identified positive effects of the peer-inclusive interventions on outcomes such as alcohol and drug use, psychiatric symptoms, criminal justice interaction, and rehospitalization.[9] No programs for incorporating peers into substance use treatment for individuals living with HIV were identified in this review or through a literature search. There is some evidence of the efficacy of peer interventions in reducing substance use and HIV risk behavior among substance users.[11,12] However, these peer interventions were more generally focused on improving HIV care outcomes such as linkage and retention rather than embedded as part of a substance use treatment program.

Several centers have developed guidelines for training and structuring programs to integrate peers into HIV medical care and other support services. The Peer Education and Evaluation Resource Center (PEER Center) was federally funded to develop training and organizational resources and provide support to assist agencies and communities to launch peer programs, or strengthen ones that were already in place with the goal to engage and retain people living with HIV in medical care.[13] To this end, the PEER Center developed a toolkit to help organizations plan and implement successful peer programs. This toolkit includes information regarding organizational readiness to incorporate peers, designing a peer program, peer training and supervision, and evaluation of peer programs.

As part of a peer initiative, AIDS United developed the guide *Best Practices for Integrating Peer Navigators into HIV Models Care*.[1] This guide was developed based on the experiences and recommendations of evidence-based, collaborative programs that connected individuals living with HIV to supportive services and health care. The AIDS United guide includes an outline on how to design and implement a system to support peer navigation in an HIV care team. The following guide builds on previous peer programs and outlines a program for incorporating peers into a substance use treatment program for individuals living with HIV. The program, Peer Assisted Treatment of HIV and Substances (PATHS) was informed by recommendations from programs involving peers to improve outcomes of individuals living with HIV that were available at the time of development, including the PEER Center, as well as findings from a study to develop an intervention addressing substance use among individuals living with HIV. Once developed, the peer navigator program was implemented as part of a federally funded substance use treatment program for individuals living with HIV, Carolina Alcohol and Drug Resources, (CADRE).

The CADRE program was situated in the Deep South, a region that has been disproportionately affected by HIV. The Deep South had the highest HIV diagnosis rates and death rates where HIV was the underlying cause of death from 2008-2015 of any US region.[14,15] The Deep South states have some of the highest poverty rates, suffer from a lack of availability of health care services and funding sources is some areas, and have cultural climates that often contribute to higher levels of HIV-related stigma and discrimination. These factors have resulted in greater challenges to

providing services for individuals living with HIV. Substance use services that are specifically designed and inclusive of individuals living with HIV have been particularly important in the South due to the high level of HIV-related stigma experienced in the region, which may exacerbate substance use. The substance use services specifically for individuals living with HIV provide an opportunity to discuss HIV-related stigma and the intersection of substance use and HIV. Peer services help to further address these challenges by offering support from someone also living with HIV to assist in combating stigma and providing guidance in navigating challenges in identifying, engaging and maintaining HIV care and other services.

This guide describes the development, implementation, and evaluation of the peer navigation program that was created and implemented within the CADRE program for individuals living with HIV in North Carolina.

Support for the Peer Navigation Program

The peer navigator program, Peer Assisted Treatment of HIV and Substances (PATHS), was embedded in a substance use treatment program for individuals living with HIV that was funded through a Substance Abuse and Mental Health Services Administration (SAMHSA) grant. This substance use treatment program used a harm reduction approach and included individual and group treatment and HIV case coordination services. The program addressed substance use, living with HIV (including disease management), mental health, trauma, and psychosocial needs. The program enrollment was for 12 months with the potential for 6 months of aftercare if the client wished to continue with less intensive support services. Clients were interviewed at baseline, 6, and 12 months to assess behavioral health, substance use, social support, housing, and employment.

Quantitative Analysis (Table 1): The evaluation of the PATHS program identified that participation in the program was associated with statistically significant reduction in alcohol and drug use severity as measured by the Addiction Severity Index and decreased psychiatric symptoms including depression, anxiety, obsessive compulsive symptoms, paranoid ideation, and psychotic symptoms. Participation in the substance use treatment intervention was also associated with a statistically significant increase in social support and a decrease in internalized HIV-related stigma

Peer Survey (Table 2): To identify the contribution of the peer navigators to the program outcomes, clients participating in the last year of the CADRE program were asked to complete a survey about their experiences with peer navigation (n=28) and 15 of the individuals participating in the last year of the program who had attended at least 3 sessions of treatment were randomly selected to participate in a qualitative interview that included questions about their experiences with the peer navigators. Three of the participants who had been randomly selected for the qualitative interview were unable to be located or had moved out of the state, and thus three additional individuals were randomly selected.

The individuals completing the peer survey were representative of intervention participants in terms of gender (65% male) and race (85% African-American). Ages of the participants ranged from 34-63. The majority of participants were involved with the CADRE

treatment program for at least 6 months. Findings from the peer survey indicated that nearly all of the clients had received multiple services from peers including support, assistance with transportation, connection to resources, and education regarding HIV and substance use. Close to half (46%) had a peer accompany them to a medical appointment. Most (86%) reported being very satisfied with peer services. The remaining 14% reported being somewhat satisfied with peer services. Three-quarters of those drinking alcohol at baseline said that their use had decreased since they started the program and 74% of those using drugs at baseline reported a decrease in drug use since program entry. Nearly three quarters of respondents (74%) said that they made "very much" progress in the improvement they were seeking when they enrolled in the program.

The findings from the peer survey must be interpreted in the context of the survey limitations. The individuals participating in the survey all received services in the latter half of the 5-year program so do not represent the experiences of individuals participating in the earlier years of the program, though some (n=6) had engaged earlier in the program and then re-enrolled in later years. In addition, although some of the participants experienced lengthy treatment disengagement, they may not be representative of individuals who completely discontinued services and who were therefore unreachable for interview.

Findings from qualitative interviews of 15 individuals who participated in the last year of the program indicated that the vast majority saw CADRE as a safe, welcoming place; one person called the program "a sanctuary from stigma." Nearly all found the peers to be very helpful, particularly in the peers' ability to empathize and understand based on their personal experiences. Specifically, participants described receiving assistance from the peers with education about HIV and substance use, transportation, outreach and obtaining medications and other resources as well as nonjudgmental support.

A theme with individuals who participated in the interviews was that peers shared their own recovery process but did not dwell on it. Participants felt that the peers were more focused on the client's need than their personal story but instilled confidence because they had been through similar experiences and maintained their recovery and health while transitioning into professional roles. Along this theme, participants felt that the peers were helpful with substance use reduction - realizing they were not alone in the recovery process helped with motivation and the ability of peers to freely speak about experiences gave clients hope and empowerment to address their own challenges, stand up for themselves and combat stigma . A number of clients stated the ultimate goal of working in a professional or para-professional role as a peer, thus having successful examples of what they could accomplish if attendant to their recovery and health encouraged participants to move forward. Several participants reported that the treatment program taught them how to make healthy decisions. One participant said that he could hear one of the peer's voice advising in his head when confronted with difficult choices.

Peer Tip! *It's valuable for clients to hear the life experiences of peers, but equally important that the peer's story doesn't overshadow the client's or negate the client's experience.*

Some clients expressed guilt when they relapsed or engaged in unhealthy behaviors, fearing they had let down the peers whom they looked up to. For the most part, peers were able to mitigate this fear through consistent outreach and maintenance of a dialogue with participants during and after relapses. It was essential for the peers to frequently reaffirm their lack of judgment to minimize reluctance to report behaviors and encourage open communication.

Peer Tip! *The support and encouragement of a peer is as important during a client's relapse as during their recovery.*

A small minority of the clients did not feel that the program had been helpful in addressing substance use and felt peers were aggravated with them when they did not make progress toward their goals. Peer work can be very personal so it is not unreasonable to expect that a peer may view a client's relapse or decline in health as a reflection on their work. On-going supervision, counseling, and encouraging of self-care will help peers maintain boundaries and reasonable expectations while avoiding transference.

For participants who had periods of treatment disengagement, which was nearly all of the participants, they had mixed reports about the peer outreach that occurred after they stopped coming to treatment. Some individuals reported that they thought the staff should have contacted them more to assist with reengagement while others thought that the amount of outreach when not at treatment was overwhelming; they didn't want to engage the staff while they were actively using. For others, outreach and consistent contact were helpful, as the peers helped them feel supported and get to medical visits or other care even when they were not engaging in substance use treatment. The variety of responses regarding outreach to clients that have disengaged from treatment illustrates the complexity and challenge of delivery of services and the need to gain as much information from the client as possible regarding their wishes should they drop out of treatment.

Peer Tip! *Peers may feel the urgency to reach out to clients who have disengaged from care, even when the client rebuffs the peer's attempts at communication. A team-based approach to such cases will temper personal pressure on the peer and may result in more creative ideas to reengage clients.*

Creation of the Peer Navigation Model

We utilized components from existing peer navigation models and guidelines, including the PEER Center's Toolkit, to inform the development of the PATHS substance use treatment peer model.[13] The PEER Center toolkit includes steps for development of peer programs such as job descriptions, roles, training, and supervision. In addition, to develop the PATHS model we utilized recommendations from Project Consumer LINC, a federally funded project to support implementation of peer models aiming to link individuals living with HIV to medical care and other services.[16] The recommendations incorporated into PATHS from Project Consumer LINC included roles for peers,

essential core competencies of peers, and necessary trainings for peers including medications, comorbidities, communication skills, and crisis management.

Finally, the development of the peer model was informed by a qualitative study performed by the model authors that sought to inform the creation of a substance use treatment program for individuals living with HIV and substance use. This study included focus groups and interviews with individuals living with HIV in the Deep South who had a history of substance use and with individuals working in HIV prevention, HIV care and behavioral health care. These qualitative data revealed that study participants experienced high levels of HIV-related stigma in the community and most did not feel comfortable revealing their HIV status in general substance treatment programs or AA/NA. Study participants strongly and consistently recommended the use of HIV-positive peers to address substance use issues among individuals living with HIV. Study participants asserted that through a relationship with a peer mentor who had experienced similar challenges, HIV-positive substance users would experience less stigma and social isolation and increased motivation for change.With the assistance of the study task force and community advisory board, a framework for a peer navigation intervention was created that involved community outreach to identify individuals living with HIV and substance use and provision of standardized peer navigation services to these individuals. The peer navigation services included providing manualized substance use and HIV education, building skills for navigating complex substance use and medical care systems, and providing motivational enhancement. Educational modules to be used as tools by peers were developed regarding HIV, substance use, risk reduction, navigating the health care system, substance use recovery, and mental health to assist with providing education to individual living with HIV.

The PATHS model differs from peer models that were designed to improve medical outcomes, such as connection to care and medication adherence, for individuals living with HIV because it was designed to address substance use outcomes in addition to medical outcomes by embedding peers as part of a substance use treatment program specifically for individuals living with HIV. The peers focused on substance use education and change as well as addressing HIV education and care needs. The inclusion of peers who have experience living with HIV in addition to substance use histories expands and enhances traditional peer models for substance use alone, thereby allowing clients to engage with the peers on multiple levels. By targeting substance use, the program addresses a core area that has been consistently shown to result in poorer medical outcomes.[18,19]

Model Structure

Peer requirements, education, and supervision:

To maximize the effectiveness of the peer navigation services, it is critical that individuals functioning in these positions have adequate preparation and ongoing support. The requirements for peers in the program included an HIV diagnosis, a history of substance use with substantial recovery time, peer support specialist certification, and experience providing peer support in a

paid or supervised volunteer capacity. Additional training was provided for peers beyond the required peer certification including:

- Motivational interviewing
- Harm reduction model of care
- Trauma informed care
- LGBT cultural competency with additional training on the transgender experience
- HIV medical treatment and medications
- Mental health diagnoses and treatment
- Opioid epidemic and treatment
- Substance use recovery
- Developing service plans with clients

Routine and consistent supervision for peers is essential for offering support, education, and guidance in this model as well as other peer models.[1] Peers receive both administrative supervision to provide guidance around completion of required paperwork, work policies etc. along with clinical supervision to discuss specific client issues and peer self-care and boundaries. Weekly supervision with peers is preferred. The PEER Center toolkit provides a detailed guide for provision of supervision for peers. http://cahpp.org/wp-content/uploads/2016/04/6._SupervisingPeersComplete.pdf.

A critical area for supervision of peers working in substance use treatment settings is examining how the position is affecting their own recovery and how they can set boundaries and ask for help from their supports as needed. For example, a peer may discuss concerns about doing outreach in certain areas where there is active drug use, as this may threaten his/her recovery or feel uncomfortable based on his/her history. Issues of peer safety are also important to address at program initiation and routinely in supervision to assure that safety while providing community outreach, transportation, and in-home visits is optimized. This may include policies such as assuring that the peer is accompanied by other staff as needed in situations assessed as concerning and/or providing training in self-defense and crisis management for peers.

Training example*:* In the last year of the CADRE grant, a program was developed specifically for transgender individuals and a transgender peer was brought on to the staff. It was essential to provide in-depth training to all staff including the existing peers to enhance knowledge on the salient issues in working with transgender individuals and proficiency in providing these services. Ongoing supervision was needed to address concerns and continue to improve proficiency.

Peer roles and protocols:

In the PATHS model, the peers filled traditional peer roles, including HIV education, linkage and engagement in HIV care services, support for HIV disease management including medication adherence, emotional support, transportation, and community education along with roles relevant to substance use recovery. To maximize educational opportunities, peers facilitated educational programming within the treatment group to provide basic education about HIV, disease management and wellness, and risk reduction. They also worked with clients on a one-on-one basis or in smaller groupings to provide targeted education, support, recovery coaching and crisis management.

The HIV educational modules developed in the authors' prior studies were adapted by the staff, including peers, and used to assist with these trainings.

Motivation:

To assist clients in addressing substance use, the peers utilized a harm reduction approach that worked with clients in the context of their readiness to change. For example, a client who was in an early stage of change such as precontemplation was encouraged to attend group and individual sessions to begin to explore their goals and their interest in decreasing substance use. Although the peers were in recovery themselves, they were careful to approach clients in a nonjudgmental way and let their stories offer information and encouragement for clients. The peer navigators used motivational interviewing skills to assist clients to examine their current situations in the context of their goals for the present and future and to identify potential for growth and change as they were ready for this step. The harm reduction approach was particularly helpful for the peers in the context of relapse among the clients. The peers were able to continue services with the clients during and after relapse and throughout ongoing use, providing support and continued engagement in treatment that would have potentially been withdrawn in more traditional program modalities. Rather, the peers could aid the clients to routinely reflect on and adjust their goals as needed and provide support for both substance use and continuation in medical care and medication adherence regardless of stage of change.

> Peer Navigator Quote from the Field: "I have been able to do education groups and the experience has been great. I have been able to share some very personal experiences with the group to put them at ease. The rapport that was gained has given me the confidence I needed to continue on this journey. After doing groups, my peers seemed to open to me about things they thought they would be judged on by the team, myself included. They expressed to me that it made them feel a part of being able to learn from someone with similar experiences."

Several clients referenced the peers as contributing to motivation through seeing their current state of recovery and health while also knowing some about the journey and setbacks they incurred to get to their current recovery status. These clients regarded the peers' status as aspirational, which provided motivation to change while in treatment as well as when they were not necessarily physically at the program. Additionally, the inclusion of peers in the treatment program provided motivation for several clients to aspire to be professional peers themselves during and after treatment. The peers were able to assist several clients to participate in peer training after completion of the treatment program.

Outreach:

The peer navigators also provided outreach to locate clients who had missed treatment services or dropped out of care to check on their wellbeing and encourage them to return to the treatment program and other services, such as medical care, if possible.

Education:

The peers offered outreach services in the community, including at a local job training

and linkage program, at education and wellness fairs and in support groups, to provide substance use and HIV education for community service providers and individuals living in the community. Peer outreach and education endeavors assisted in addressing myths, misinformation and stigma regarding HIV that persist in the South both in the general communities and among some medical and social service organizations.

Story from the field: Outreach to reengage clients was particularly successful in the following situation. The client was initially very reluctant to participate in treatment and had several hiccups in treatment including an instance where she went to jail during a relapse. She also experienced some injuries during this time due to physical altercations. The peer and other staff continued to contact and visit her through her relapses and finally she decided she wanted to stop drug use and reenter medical care. Since her reengagement, she has gained two years of clean time and despite receiving another life threatening diagnosis, she continues to remain clean and in medical care. She gives back by sharing with others what has happened in her life.

Multidisciplinary teams:

The peer navigators were integrated into the substance use treatment team, which included clinical supervisors, counselors and a case coordinator. Inclusion of the peer navigators in the substance use treatment team required education of peers regarding the role of the other team members as well as education of the other team members regarding the role and contribution of the peer to the treatment process and outcomes. This education was particularly critical in situations where team members had not had the opportunity to work with peers previously. It was also critical for the team to discuss areas where their roles may overlap and plan for how to share and divide responsibilities optimally in these situations. Devising systems for regular, effective communication between team members was critical for addressing situations of overlap, overall team success and maximized client experience. In the PATHS program, weekly staff meetings were essential for sharing information and delineating responsibilities for individual clients. Additional modes of sharing client updates, such as shared computer drives or regular structured check ins between team members who had overlapping clients also increased effective collaboration on client care. Opportunities for team building such as team retreats and outings were important to foster healthy collaboration. More frequent informal check-ins, both in person and via email were also needed to maintain adequate communication. In programming with multiple peers, it was found to be helpful to assign treatment participants a primary peer contact to ensure accountability for outreach and optimized support. Challenges to multidisciplinary collaboration were discussed in supervision time for peers and other staff to devise appropriate solutions. Even when challenges occur between team members, clients who participated in the evaluation interviews did not report strain among the team and felt that they could share in different ways with peers and other staff members and that services were not duplicated among staff.

Enhancing engagement:

In response to the problem of treatment

dropout that was occurring soon after intake, the PATHS program initiated an engagement program in which intensive linkage to treatment and outreach were implemented for a period of time following intake to address this concern. One aspect of the engagement program was that the peers provided transportation to the program twice a week for the first month of treatment, which usually allowed sufficient time to have an adequate plan for transportation in place once the month had passed. The engagement program also included immediately assessing and addressing other barriers to program participation and client concerns such as housing, financial issues, legal concerns, and medical issues. In addition to improving client situations, initiating the process of addressing these concerns as soon as possible had the added benefit of helping to build relationships with clients and strengthening collaborations with care providers in the community.

Specific comments regarding the contribution of peers to the treatment program included:

- *"Sharing their* (peers') *experiences, strength and hope";*
- *"*(Providing) *transportation, medication, special needs, being there listening in general to my problems";*
- *"Talking with me, and understanding me was helpful, and I was not judged; that made me feel welcome"; and*
- *"Having experience on both sides is the greatest asset. The key. Truly understanding can't be taught in school."*

Peer evaluation:

In addition to the evaluation of the peer program for the grant funded program, which involved the client peer survey, qualitative interviews, and quantitative findings described above, the peer program was evaluated through other required documentation. For example, the peers completed brief online service tracking forms, which gathered information about the amount of time spent with a client as well as the types of services provided for each client interaction. The peers also completed engagement forms documenting immediate needs for services at intake as well as crisis plans, including contact information, historic signs of client crisis, and clients' wishes as to extent of outreach in the event of disengagement from care and updated these forms as progress was made on addressing client needs and goals. These documents were reviewed quarterly. This program included only one survey regarding client experiences with the peers, though based on our experience, more frequent peer satisfaction surveys would be beneficial to gather information regarding client experiences. This information would be useful in making ongoing adjustments to the peer program as needed.

Conclusions

The program described in this guide offers a method for enhancing substance use services for individuals living with HIV by integrating peer support expertise, which has shown evidence of effectiveness in improving medical and behavioral health outcomes.

Enhancing substance use treatment services for individuals living with HIV by including peer navigators is important to provide the unique support and modeling that can only be offered by individuals with lived experience with HIV and substance use. Findings from qualitative analysis of participant surveys and interviews illustrate the benefit of this service. Peers can supplement the work of treatment counselors by providing recovery education and support and by offering tangible support including transportation and linkage to critical services including HIV medical care.

Although the peer program was implemented as part of a free standing substance use treatment program, the program could also be implemented to supplement substance use services that are part of a medical provider organization or other organization working with individuals living with or at higher risk for HIV. Integrating the program into a setting such as an infectious diseases clinic that does not provide substance use treatment may also be feasible if the peer has access to adequate supervision for working with substance use issues.

Although the overall treatment program was associated with positive outcomes for participants and the clients almost universally reported satisfaction with the peer program, there were modifications that we would recommend based on the experience and feedback of the treatment team and clients. These modifications include adding opportunities for peer satisfaction surveys throughout the program, incorporating more trainings for staff regarding mental health diagnosis and treatment, opioids, and motivational enhancement; and including routine team building opportunities.

A Day in the Life of a Peer Navigator:

A typical day may consist of me meeting with my peers and discussing what they may want to accomplish during the day that would be beneficial in helping them reach their goals.

Sometimes we have to set very small goals in order to keep them from becoming overwhelmed, there are other times that we may set long-term goals and when we accomplish items, we remove them from the treatment plan and add new goals. An example may be that a person that I am working with might want to stop using a particular drug or behavior so this would be an opportunity to talk about how he or she might want to accomplish this.

I am careful not to have them trying to do too much and if things do not work out the first time, we keep trying. This is the time I would share some of my own experiences and encourage them to continue trying.

I have on many occasions transported someone to a doctor's appointment. I have often had to stay with them and try to help them understand the process, especially if this is the first visit. We may also make the next visit together to make sure that he or she is able to stand alone in the doctor's office.

I have also helped some of my peers disclose to a family member. This has been tricky in some instances and the family member is not accepting. Other times it has worked very well and the family member has been very supportive. There are times that I have had to share some of my experiences in that situation and try to assure them that things would work out.

I think that the most important thing that I give any of my peers is the empathetic ear that they are so desperately seeking. I share how scared and confused I was in the beginning of my journey and how that listening ear played a role in my recovery, whether it was from drugs or my diagnosis or any other traumatic experience in my life.

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Table 1: CADRE outcomes for changes from baseline to 12 month interview

Variable	Coefficient	P-value
Not on HIV medications	.43	.009
Social Support	7.78	.001
Alcohol Severity Score	-3.51	.000
Drug Severity Score	-2.18	.013
Anxiety	-3.47	.001
Depression	-4.05	.000
Obsessive Compulsive Symptoms	-2.52	.005

Table 2: Peer Survey Findings

Variable	Percentage
Male	.64
African American	.86
Hispanic/Latinx	.035
Average Age	50.6
Duration of Participation	
Less than a month	.074
1-6 months	.22
6 months or more	.68
Services Received	
Transportation	.96
HIV education	.93
Substance use education	.96
Support	1.00
Connection with medical care	.89
Connection to resources	.93
Overall satisfaction with peer program	
Very satisfied	.86
Somewhat satisfied	.14
Satisfaction with specific services (very satisfied)	
Transportation	.81
Support	.86
Connection to resources	.85
HIV education	.92
Decrease in alcohol use since entering the program	.75
Decrease in alcohol use since entering the program	.74

Table 3: Peer Roles and Activities

PATHS Component	Specific Activities
Peer training and supervision	· Weekly administrative and clinical supervision · Routine training opportunities related to MH, SU, HIV
Peer-provided education	· Group education regarding HIV 101, risk reduction, enhancing medication adherence, talking with medical providers, community resources · Individual education regarding these topics and other areas relevant to the client including recovery support, substance use and HIV resources in the community, etc.
Assessment	· Assessment of resource needs · Assessment of psychosocial needs · Goals assessment and routine reassessment
Motivational Interviewing (MI)	· Identifying stage of change for MH, SU, and HIV · Providing MI as part of the goal setting process · Using MI as tool for addressing MH, SU, and HIV issues (such as engagement in HIV medical care)
Provision of need-based linkage to social services and transportation	· Assisting clients to identify needs · Assisting clients to identify resources to address needs and goals · Providing transportation as needed to treatment services
Provision of linkage to medical care and adherence monitoring	· Assisting client to identify and engage (or reengage) with HIV medical care and other medical care as needed · Assisting client to prepare for medical appointments including question preparation · Accompanying client to medical appointments as needed · Assisting clients to identify barriers to assistance and to address these barriers (i.e. setting phone reminders to remember medications)
Outreach	· Routinely visiting organizations utilized by people living with HIV including medical care and case management organizations to provide program materials and talk with potential clients · Outreach to other community organizations including homeless services and barber shops, and community events to provide materials and meet with potential clients · Outreach to clients' home and other community areas where clients have indicated that they frequent (with initial permission from client) to follow-up with clients who have disengaged from care

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If you're walking down the right path and you're willing to keep walking, eventually you'll make progress.

Barack Obama