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Moderator: Jaclyn Ruiz
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6:55am CT

Coordinator: Welcome and thank you for standing by. I would like to inform parties that today's conference is being recorded. If you have any objections, you may disconnect at this time, please.

I would now like to turn the call over to Jaclyn Ruiz. Thank you and you may begin your conference.

Jaclyn Ruiz: Thank you. Today we'll be interviewing Dr. Ralph DiClemente as part of our developer interview series. The Office of Adolescent Health will be hosting a series of interviews with developers of those programs identified by the Department of Health and Human Services Teen Pregnancy Prevention Evidence Review as having shown effectiveness in reducing teen pregnancy, sexually transmitted infections, or sexual risk behaviors.

The goal of these interviews is to ask developers some of the most frequently asked questions by OAH grantees. The webinar series was developed as a technical assistance product for use with OAH grant programs to provide additional guidance on selecting, planning, and implementing evidence-based programs for teen pregnancy prevention. This webinar should not be used on

its own but as a compliment to various other resources available online.
Additional resources are identified later in the PowerPoint presentation.

Please note that inclusion on the HHS TTP evidence review does not imply endorsement from OAH and that program selection is up to grantees.

As I mentioned, we're interviewing Dr. DiClemente who is a Charles Howard Candler Professor of Public Health, Associate Director for the Prevention Sciences and Co-Director of the Emory University Center for AIDS Research Developmental Core.

He holds concurrent appointments as professor in the School of Medicine, Department of Medicine in the Division of Infectious Diseases, and in the Department of Pediatrics Division of Infectious Diseases, Epidemiology, and Immunology.

Dr. DiClemente's area of expertise is in the development and evaluation of prevention programs tailored to African-American adolescents and young adults. He's published extensively in the area of HIV STI prevention, particularly among African-American adolescents and young adults, as well as in the area of partner violence. He is the author of more than 500 publications including eighteen books including the recent Handbook of Adolescent Health Risk Behaviors and the Handbook of HIV Prevention just to name a few.

Good morning, Dr. DiClemente.

Dr. DiClemente: Good morning. How are you?

Jaclyn Ruiz: I'm doing well. I'm just going to jump right in after that pretty extensive bio and get you to please briefly describe your program, Horizons.

Dr. DiClemente: Well Horizons - it's clearly a gender and culturally congruent intervention designed to promote more responsible or healthy sexuality.

Jaclyn Ruiz: Do you want to talk a little bit about the goals and the components of it?

Dr. DiClemente: Sure. The goals of the program are manifold. First and foremost, the primary outcome is to reduce incident STI's -- sexually transmitted infections. Behavioral goals include increasing condom use and increasing the psychosocial mediators associated with healthy sexual behavior.

These include increasing communication, negotiation skills. And third, Horizons has a slightly different focus than many interventions. The goal was to increase male partners' access to STI screening and treatment services as a way of reducing risk for reinfection.

I can give you a little background on the target population for the study. It was African-American young women fifteen to twenty-one years of age. They were all recruited receiving care at sexual health clinics and they all reported vaginal sex in the previous sixty days.

Now the program has a number of key components. First and foremost, it's delivered as two four-hour group sessions with roughly eight to ten young women in a group. Following the group sessions there are four individualized intervention follow-up telephone calls and those calls are scheduled within the first three months after the group is expired.

Now there are a lot of delivery methods as well. As you know, people learn thought different modalities. So no single modality will be equally effective for everyone. So we have interactive group activities. We do a lot of role

playing and we expose the young people to media. We want them to see the negative representation of young women in the media and we want them to be able to address that in those groups. And then of course we have didactic modeling, particularly when it comes to condom skills like application.

Jaclyn Ruiz: And those media - is it done through the form of videos that are shown to them?

Dr. DiClemente: It's both videos and - is - the predominant mode is our videos, but we also take scripts from different music and we actually present the scripts on the screen. So young people can see what they're actually singing and dancing to. And they're sometimes rather appalled to know what the words really are.

Jaclyn Ruiz: I'm sure. Okay, so it sounds as if - for grantees who may be looking to implement this intervention that they would want to have access to a TV and DVD player, things of that nature.

Dr. DiClemente: Exactly. So the pretty common audiovisual technology.

Jaclyn Ruiz: Okay. I know you were talking about your - the - when the intervention was studied and the population that was studied with. Can you talk a little bit about the findings from that study?

Dr. DiClemente: Yes, sure. The findings were evaluated twelve months post-intervention. The key finding was a lower incidence of chlamydial infections. And another key finding was the lower incidence of recurrent infections vis-à-vis the comparison condition. In addition, there was a higher proportion of condom use in the sixty days prior to ER assessments, higher rates of condom use at last sex, and less frequent douching.

Jaclyn Ruiz: And funny enough, I sort of want to take these slides a little bit out of order. So when our listeners are listening to this, I'm doing slide seven before six because I think it might be helpful to know the setting first because you mention that the population that it was done on was a sexually active population.

Dr. DiClemente: Correct.

Jaclyn Ruiz: So knowing the setting that you evaluated in might be really helpful for people to understand how you could determine the sexual activity of the population.

Dr. DiClemente: Yes. Well, let's take a look at those settings. As I mentioned, they were in clinics and young people were coming to those clinics for reproductive or sexual health services. So we approached young people in the waiting room of the clinics and they completed a brief screener. The screener also had questions pertaining to - have they had sex in the previous sixty days? Which is another eligible criterion. So we were able to screen in only young women who reported being sexually experienced.

Jaclyn Ruiz: And so do you have any other recommendations as to where this intervention can be implemented?

Dr. DiClemente: Well, certainly it can be implemented anywhere that you're working with young sexually active women. Essentially what you need is space to conduct groups and some pretty basic audiovisual equipment.

Jaclyn Ruiz: And so I'll go back to the population slide, which is slide six for our listeners. Do you want to expand, as well, on any other population that you think the intervention may work best with?

Dr. DiClemente: Well, we've actually used a briefer version of Horizons, a one-session version with alcohol-using young African-American women, as well as with slightly older African-American women coming through STD clinics rather than reproductive or sexual health clinics. And both of those studies yielded very nice results in the sense that the groups participating in the briefer version of Horizons showed lower STIs and higher protective behaviors at the end of their respective follow-ups.

Now we did not administer Horizons alone in those conditions. Horizons was part of a package of interventions. We have, however, as part of one of those studies administered the brief version of Horizons -- the single session version -- and we followed up the cohort.

And we found that there was significant changes almost all the way out to a year before decay of effects started showing up and when you start to lose your intervention effects after one year if you just delivered a one-session group and don't do anything else to booster or enhance those effects.

Jaclyn Ruiz: And I think this was a good segue, actually, into adaptation. I just want to note that adaptations do require OAH prior approval and, at times, approval by a developer, but it can be helpful for organizations to get a sense of previous adaptations that organizations have successfully implemented. Can you talk a little bit about these adaptations?

Dr. DiClemente: Yes. I think one of the issues with adaptations is that developers are often unaware that their program is being adapted. And sometimes when we are aware they're being adapted, we're not really informed as to the results. So we need to really close that loop between the developers and the investigators and

agencies who are doing the adaptations so we can - we have that data and now we can report it out.

I think certainly, as I mentioned, we've adapted it as to - Horizons to a one-session, five-hour intervention. We've kept a lot of the core elements of course, but were able to intensify it a bit. We've applied it to alcohol-using young women as well as young - slightly older African-American women, actually, recruited from STD clinics. And so the results were very encouraging.

I think the key issue here is the cultural relevance. If you are working with young African-American women, typically women who are sexually experienced, the program is certainly applicable. In my mind, whether you're recruiting from clinics, from communities, or from street recruitment -- which in fact our alcohol study was basically a street-recruited sample -- it doesn't really make a difference where you're recruiting as long as some of the eligibility criteria are comparable.

Jaclyn Ruiz: And so for the cultural relevance, would you recommend keeping this intervention with African-American females or any other culture that you may find applicable?

Dr. DiClemente: I think most of these interventions or the evidence-based interventions will be adapted and they'll be applied for a range of populations for which they were not developed. Horizons can certainly be modified for other cultural groups -- Hispanics, Asian, transgender, et cetera - white adolescent girls. I think also it may even be applicable to males, but that would require some extensive modification to make it gender appropriate.

The key is always - if you modify these programs, can you maintain the gender and cultural relevancy and target the program for - to be developmentally and behaviorally appropriate for the population?

Jaclyn Ruiz: That's very important to know and that's why we also talk about grantees requiring OAH approval because that is also a concern of the office as well. So thank you for that clarification.

Can you describe any staffing recommendations or training opportunities that are available through the program?

Dr. DiClemente: Yes. In terms of staffing, the research study was certainly different than if this program was delivered as a service. As a service, you'll need at least two facilitators. Background facilitators or backup facilitators are also good ideas as facilitators get ill. Sometimes facilitators can't get to the groups, and other times there's staff turnover. So we certainly recommend an experienced backup.

The experience of the facilitator should be that of having managed groups or worked with groups before. And there are group management skills that are really critical to make a group very efficient. We strongly recommend that the group intervener or facilitator have those facilitation skills.

Now there are some training considerations. One is the train the trainer model has been shown to be effective and we have master trainers on staff who can, in fact, assist in training other facilitators around the country. And as we'll talk about later, we've actually done some of these trainings in Europe and Asia and Africa.

And there are certainly some costs associated with training but that's relatively minimal. It can be arranged directly with me, subsequently.

Jaclyn Ruiz: Can you describe some implementation challenges that you're aware of, and if possible, any strategies that you've known to overcome these challenges?

Dr. DiClemente: Yes. Some of the - I think there were three challenges and they're not uncommon to groups. One is the session length. As I mentioned, the original Horizons was two four-hour group sessions. That necessitated young people of returning to our treatment facility or our intervention facility and a lot of young people don't have access to transportation. So that made it a little bit more challenging.

So as a consequence, we've developed a one-session version of Horizons which I think will alleviate that issue of session length and the return to complete sessions.

The second challenge is always space. You need space to implement the group session and it has to be confidential, private space where people can be very candid in expressing their attitudes, their beliefs, and talking about their behaviors.

And third is always the issue of staff turnover. We briefly touched on this earlier. People are going to be coming and people are going to be going. They're going to transit in, they're going to transit out. What's important is to always have a trained backup ready to step in so there's no break in the continuity of the program or its administration.

Jaclyn Ruiz: And then do you want to talk any about the strategies for success that you have as far as partnering with community sites - but using interns for facilitators, actually?

Dr. DiClemente: Yes. We've actually moved toward a strategy of training interns to help deliver Horizons. Interns are work study students, essentially. We go through an extensive training program and that training program is very detailed, very comprehensive, and allows the interns to practice their skills to a level of proficiency which we think is needed to implement the program with fidelity.

Jaclyn Ruiz: Now, Dr. DiClemente, you mentioned the training and I know we have your contact information at the end. For the training, they should arrange it with you, I assume; and then if you have any other questions about these strategies for success, are grantees also able to contact you if they have any questions about that?

Dr. DiClemente: Without a doubt. Just feel free to contact me on cell phone or on my email address, and I'll certainly get back to you promptly.

Jaclyn Ruiz: Okay, great. Sorry I put you out there. And then can you talk any about the recent or planned revisions that you have for the program?

Dr. DiClemente: Yes. Well the recent revision, as I mentioned, was the shortening of the intervention from two four-hour sessions to a single five-hour session. We think that's a major change in that - maintaining the core curriculum and testing it in a randomized design as well, and observing some sharp increases in protective behavior as a function of the one-session intervention. So that, I think, is going to reduce the cost of delivering the intervention and it'll reduce the attrition as some young folks may not be able to attend both sessions but they can certainly attend one.

Jaclyn Ruiz: Great. And so just to note that on slide twelve there are additional resources for Horizons and so we hope that any grantee will use these resources in conjunction with today's webinar and get a more comprehensive understanding of this evidence-based teen pregnancy prevention program.

We also hope it will assist you in making not only an informed decision on which evidence-based program to select for your community, but - how would you thus prepare for and implement the program? Dr. DiClemente, do you have any final words?

Dr. DiClemente: I think the only final word I would have is that I know that there are lots of programs being developed and the Office of Adolescent Health has reviewed many of these, if not all. I think one distinction between Horizon and perhaps some other programs is the non-reliance on self-reported behavior that the program not only has the traditional measures of sexual behavior and the hypothesized mediators that we think are important, but to drive that behavior.

But we also rely heavily on objective and quantifiable biological markers -- new sexually transmitted infections as a way of measuring the efficacy or impact of the program. I think that's important because clearly that's our goal - is to prevent disease.

We can certainly change behavior and not prevent disease but we want to make sure we do - we have a nice mediation model where we would change some of the mediators. That affects behavior change and hopefully that behavior change affects the likelihood of developing or acquiring a new sexually transmitted infection.

Jaclyn Ruiz: Well thank you so much for that information. I also want to thank you so much for taking time today to put together all this information and present it to our grantees. I know they'll find this information incredibly helpful. So thank you again.

Dr. DiClemente: My pleasure. Take care.

END OF HORIZONS