

NWX-OS-OGC-RKVL

Moderator: Jaclyn Ruiz
April 23, 2015
2:00 pm CT

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

For assistance during your conference, please press Star 0. Thank you. You may begin.

Jaclyn Ruiz: Okay. We'll be interviewing Dr. Stephen Magura 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, and 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 an evidence-based program for teen pregnancy prevention.

This Webinar should not be used on its own, but as a complement to various other resources available online. Additional resources are identified later in this PowerPoint presentation.

Please note that inclusion on the HHS Teen Pregnancy Prevention Evidence Review does not indicate HHS or OAH endorsement of a program model.

As I mentioned, today we are talking with Dr. Stephen Magura. Dr. Magura serves as the Director of the Evaluation Center at Western Michigan University. In this capacity, he is responsible for the supervision and administration of all Evaluation Center activities and enhancement of the Center's mission to advance the theory, practice, and utilization of evaluations.

Prior to his work at Western Michigan University, Dr. Magura served as the Director of Science and Research at the National Development and Research Institute Incorporated in New York, New York, a \$23 million national biomedical clinical research training and outreach services organization.

He took the lead in the scientific direction of NDRI in establishing institutional research priorities in collaboration with directors of ten component institutes and centers, including the Center for AIDS Outreach and Prevention, Center for the Integration of Research, and Practice, and the Institute for Research on Youth as Risk.

Dr. Magura has served as the Principal Investigator for 19 awarded health services research grants from the National Institutes of Health.

As an NIH-funded Principal Investigator, he developed and evaluated new model treatment and prevention programs, including the creation and evaluation of in-jail HIV prevention programs for women and male adolescent offenders at Rikers Island -- i.e. the Rikers Health Advocacy Program.

Welcome, Dr. Magura. Can you please briefly describe your program, Rikers Health Advocacy Program?

Stephen Magura: Sure I'd be happy to. So this was developed in the early 1990s at a time when there was relatively little attention being paid to HIV risk populations other than IV drug users and gay men.

This was one of the first programs that focused on high risk adolescents. So the purpose of the program was to increase knowledge among -- about AIDS and HIV and how drug use affects (sexuality) is related to it. To ultimately then reduce HIV risk behaviors by adolescents in the community.

We developed this program for and tested it on incarcerated male adolescents and young adults aged 16 to 19 at the Rikers Island Adolescent Jail Facility in New York City.

The underlying therapeutic principle is problem solving therapy. This was developed by Dr. D'Zurilla can be found in the cognitive behavioral literature. It's a fairly straight-forward approach. Basically you formulate the problem, and in this case you would bring the adolescents in to help formulate what the problem is in respect to HIV and AIDS in the community and how it might

relate to them, generate alternative solutions to the problem, and then the group implements a chosen solution by doing some role play and rehearsal.

The approach is I would say very Socratic and interactive, so the counselor poses questions and the youth are asked to describe situations from their own lives for group analysis. The manual does give very specific guidance to the counselor for this process.

There is information given by the counselor, but the main therapeutic process is basically a group discussion. The groups are small. We designed it for, you know, eight adolescents per group. And there are four one-hour sessions (unintelligible) in the manual.

You don't need a lot of technology for this -- basically some hard copy handouts.

Jaclyn Ruiz: Yes it sounds very easy to implement in terms of, you know, just having space to hold these group discussions.

Stephen Magura: It has to be in private, obviously, and in most settings, you'll be able to get like a private room. Just have to make sure that you can get agreement that a probation officer or a law enforcement officer doesn't have to sit in the room with them, you know?

Jaclyn Ruiz: Yes.

Stephen Magura: But usually these rooms have windows, especially in detention facilities and you can have someone monitoring from outside by being able to look in the window to make sure everything is, you know, going okay.

Jaclyn Ruiz: That was actually really helpful to point out. Can you talk a little bit about your previous evaluation results?

Stephen Magura: Okay. Sure. So we did pre-intervention interviews with about 400 youth at Rikers Island and then we invited some to receive the education. We couldn't provide it to everyone. But what basically happened was that there was some lag time before we could begin the education after we issued the invitations and so on. And in the meantime, some of the youths were released from detention or were transferred to another facility or became unavailable for education for some other reason.

And these became the waiting list comparison group. So we followed them up, too, to compare that the youths that received the education to those who did not. And the ones, as I say, the ones who did not didn't select themselves out. They became unavailable for, you know, other reasons.

We interviewed them on an average of five months after their release from Rikers Island. We had a 66 response rate for the ones that we targeted for post Rikers interviews. And we basically found that comparing the youths who had received education to those who were in the comparison group education recipients were more likely to report greater acceptability of condom use. They reported more condom use in various contexts. They reported fewer high risk partners -- for example, drug using partners.

So that was positive. But we did not find any effects on alcohol or drug use after they were released from Rikers Island. So that was our evaluation.

Jaclyn Ruiz: And do you want to talk a little bit -- I know this wasn't your evaluation or necessarily an evaluation of outcomes -- but can you talk a little bit about the field test done by Sociometrics?

Stephen Magura: Sure. So around 1995 Sociometrics, who published the program materials, wanted to do perhaps some update and they did a field test in a residential treatment program for adolescents in Ohio, I believe.

The purpose was basically just to see how the program would be received by this population in a different setting than the one we originally tested it in. And they found that receptivity to the education was quite good. The youths seemed to be interested in it, were engaged in it, you know, found it to be valuable.

There wasn't any follow up of outcomes done, though by that particular field test. But I think that it was good to hear that they had a successful experience in delivering the program to a high-risk male population in a - adolescent population in a different setting.

Jaclyn Ruiz: Thank you for that. And can you talk a little bit more about both the evaluated population and setting in your opinion as the person who developed this program? Any population and setting that it may be applicable for.

Stephen Magura: Yes sure. Although our original population was clearly adolescent offenders, the program itself does not talk about or does not have material in it about criminality. Now, this may come up in discussion, but it is not a focus of any of the sessions.

So my feeling is that this program is applicable to high risk male adolescents in other kinds of settings -- for example, in community programs that may be, you know, focusing on prevention of drug abuse and HIV risk, certainly residential treatment programs of adolescent but also outpatient programs, outpatient counseling programs.

You know, I think it can be used in a wider context than just offenders or a jail context.

Jaclyn Ruiz: Any - and I feel like based on what you said in your previous evaluation results, and maybe what Sociometrics found when they did the field test, do you feel that there's any specific race or ethnicity that it's applicable for? Can it be applied with anybody as long as they're sort of between the ages of 16 and 19 and are considered high risk?

Stephen Magura: Right. Our original work at Rikers was done almost exclusively with minority adolescents. A small percentage were not minority. But it is not I think culture bound in any way. It's, you know, very objective in terms of behavior. So I think this is an intervention that can be used for any population of adolescents that might be considered high risk, irrespective of their ethnicity and also irrespective of their income level.

Jaclyn Ruiz: And in terms of setting, is there a need to implement it in a place -- because, you know, you did implement it in a detention center so you had a very captive audience that wasn't going anywhere -- does it need to be implemented in a setting like that or can it be in more, I know this slide says outpatient counseling. Is it okay for it to be implemented in areas where, you know, youth come in and out, you know, can go home at the end of the day?

Stephen Magura: Absolutely. I don't see why not. There aren't very many sessions. There's you know, only four sessions, one-hour sessions. And I think it would be imminently doable in any kind of an outpatient session and drop in centers, for example, in you know, youth activity programs, you know, perhaps even various kinds of youth clubhouse settings. Sure.

Jaclyn Ruiz: Okay. And so I thought a little bit about adaptations and before I ask you a question, I just want to mention that adaptations do require OAH approval. But it's you know, sometimes helpful for organizations to get a sense of adaptations that may be able to be implemented and certain modifications. Can you talk a little bit about these?

Stephen Magura: Sure. I don't think that modification would necessarily do violence to the curriculum, as long as they are consistent with the problem solving principles that underlie, you know, each session. There is some content, though, that probably should be updated.

For example, there isn't any mention in the current curriculum of Hepatitis C, but I think that that should probably be mentioned in any further implementation of this. And of course, Hepatitis C is transmitted and kind of contracted in almost exactly the same way as HIV. So everything that is said about HIV prevention and transmission in the curriculum is equally applicable to Hepatitis C and I think that should be explicitly mentioned. Because actually, the prevalence of Hepatitis C is higher than HIV today, it actually could be from that standpoint might be even considered more of a threat.

The other thing that has of course happened is there is much better treatment now for HIV than there was 20 or 25 years ago. And this has resulted in some changes of attitudes and beliefs that perhaps, you know, HIV is now just another treatable disease and you don't have to give it any special status and if you do happen to contract HIV, you can, you know, now be cured. And you know, we do have these particular, you know, some celebrities like Magic Johnson for example who apparently can be considered cured insofar as that word can be used with respect to HIV.

So there may be somewhat less fear of HIV now and I think that should probably be addressed in the curriculum in a realistic way.

Jaclyn Ruiz: Thank you for that. And can you describe any staffing recommendations you may have or successful implementation?

Stephen Magura: Sure. Well one challenge that we had, you know, in implementing -- which may still be the case -- is that in this age group, the youth are, you know, just beginning to use drugs in a serious way. And they don't consider themselves, you know, to have a drug problem.

So that one has to not sort of assume that they're, you know, searching for drug treatment or intervention on these problems that drugs are causing them because they don't perceive an (unintelligible). So one has to take that into account in the delivery of the education.

The other thing I would say is that it is important to you as non-directive in a counseling approach and education approach as possible -- that is, try to let the youth find the problems, then come up with the solutions rather than telling them what the problem is.

You know, that usually has more of a persuasive effect than a more directive approach, which as I say they may not define themselves as being at high risk at this point. Yes.

Jaclyn Ruiz: And in terms of, because I know you mentioned that a counselor was used in the original evaluation study to do the lecture, do you have to be like a licensed social worker or is there any sort of specific type of staff that has - like any sort of credentials or licensing or education that a staff has to have in order to implement the program?

Stephen Magura: Well we used what used to be called paraprofessional counselors. These were people with counseling experience but actually didn't have any certification and didn't have a counseling degree or a social work degree and it worked well. I would say certainly training in counseling is always a plus, but experiential credentials are I think probably not only adequate, but some street cred might actually be very beneficial. So I would not say that a high level of counseling education and certification is necessary as long as the counselor knows their stuff in this area.

Jaclyn Ruiz: And then I just sort of wanted to point out that I know you specifically don't offer any training in the program nor is any training required by Sociometrics. Is that correct?

Stephen Magura: That's correct. I'm not able to do that at this point. The materials are really very self-explanatory. The guide to the education gives the counselor or the educator all kinds of specific direction as to how to present the sessions. So that I don't think that explicit, you know, sort of in person training in this is necessary in order to be able to do it successfully.

However, as with any (unintelligible), some training could be helpful and I believe perhaps that if those interested in implementing this were to contact your office, for example, you might be able to direct them to some training resources, possibly.

Jaclyn Ruiz: We can definitely try, yes. And I would suggest that anybody who is thinking of implementing this program, if they are looking for those opportunities and they can't find it, to please, you know, contact if they have a project officer their project officer. I'm sure they could try to get them into contact with some training organizations out there that can offer them that support.

For anybody who may be listening to this and trying follow along with the slides, we sort of bounced around but Dr. Magura, you've done a really good job of just sort of addressing some of the questions we had. And so you know, bear with us in audio. If you're listening to audio and watching the slides, the slides explains everything but Dr. Magura did a really good job of also addressing that information in the audio.

So I just want to point out that slide 13 does have some more additional resources on Rikers Health Advocacy Program if you're interested in knowing more about the program. As we mentioned, this Webinar should not be used on its own but in conjunction with some of these other resources. So we hope these resources in conjunction with today's Webinar provides a more comprehensive understanding of this evidence-based teen pregnancy prevention program, and will assist you in making not only an informed decision on which evidence-based program to select for your community, but how to best prepare for and implement the program.

Is there anything else you'd like to make sure to address that we may not have gotten to today, Dr. Magura?

Stephen Magura: No I think that's pretty complete and as you said, the slides are I think quite informative. You know we worked hard on them. And that's not to say that anyone seriously interested in implementing this could not contact me and ask me some questions directly. I would certainly be available for that so I'm not incommunicado.

And as I say, certainly feel free to contact me if you think that there is anything that would be helpful for me to be able to answer.

Jaclyn Ruiz: Thank you so much for offering that, and we do have your contact information on the last slide. So we greatly appreciate that. But I just want to thank you again Dr. Magura for joining us today and like you mentioned, we did put a lot of hard work into these slides so hopefully the grantees find it helpful. I know I found this information incredibly helpful and I'm sure they will, too. So thank you again.

Stephen Magura: Well, thank you for this opportunity.

END