

How would staff in your clinic respond to a patient who said,

“I don’t like to use condoms.”

- A. What is it you don’t like?
- B. Extra lubrication might help.
- C. You have unprotected intercourse in this day and age?
- D. Me neither, but they protect you from disease.

“If I got AIDS, I would kill myself.”

- A. That’s why I am telling you about safer sex; so you can protect yourself.
- B. How might you avoid getting infected, then?
- C. This is pretty scary to think about, hmm?
- D. It is unlikely that you will get AIDS if you use condoms every time you have sex.

See the end of the article for the most client-centered responses.

Why Talk if Nobody Listens?

Client-Centered Care & Risk Reduction

Integrating HIV/STD prevention services into family planning has been a goal of many service providers over the past decade. Through that time, much has been learned about how to effectively and efficiently integrate those services. Research has taught us that reduction of risk behaviors for HIV is best supported in a clinical setting by client-centered counseling, and that clients are better served by interactions in which the content is driven by the specific needs of that client.¹

However, little research has been done on how an agency can help their staff make the shift from an information-based approach to a client-centered one. This has been the focus of a CDC-funded project conducted since 1996 by Center for Health Training (CHT). CHT designed an intervention model in which we train direct-client contact staff and supervisors as a team, and in which we additionally work with administrative staff to examine and modify organizational systems to support their staff to help clients reduce risk behaviors. We have tested this intervention and refined it to maximize its effectiveness.

In the first three years of the project CHT worked with four agencies, and tested variations of the intervention. Observations were made before, during, and after the intervention in all four agencies. Pre-observations certified that staff were *not* doing client-centered counseling, conducting little to no HIV or STD risk assessment and prevention and very seldom using *any* client-centered skills.

Post-observations and interviews with staff revealed that not only did client-centered behaviors

¹“Efficacy of Risk-Reduction Counseling to Prevent Human Immunodeficiency Virus and Sexually Transmitted Diseases,” *JAMA*, October 7, 1998 and “The Effects of HIV/AIDS Intervention Groups for High-Risk Women in Urban Clinics,” *American Journal of Public Health*, December 1994.

increase, but HIV prevention messages were more often offered to appropriate clients. Finally, staff indicated that they were more satisfied with their jobs. Comments from staff: “I feel so much more rapport with clients.” “My job is so much more interesting now that I’m focusing on what the clients want, and not trying to give them so much information.”

Patient Flow Analysis

Apart from the improvement in *staff behavior* we have also registered very valuable improvements in *clinic flow*. Contact time with clients increased while client wait time decreased. Some of the results from pre-and post-training PFAs conducted in one agency are shown in these charts.

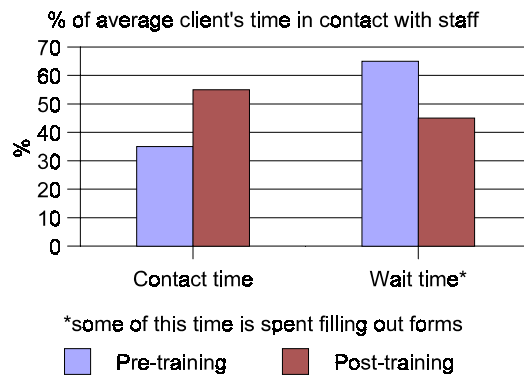
What does it take to shift from information-based education to client-centered care?

It appears that the most effective intervention is to involve administrative level staff to examine and adjust policies and practices, as well as to train and coach supervisors and staff in a team approach. The next most effective intervention is to train staff and supervisors together in client-centered counseling strategies and skills. Simply training supervisors had no impact. We know from previous experience that simply training staff will also not result in the kind of organizational shift needed.

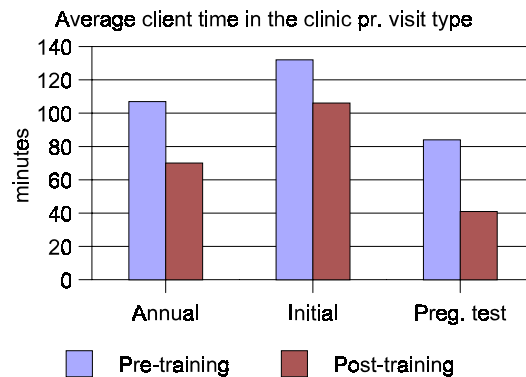
By “effective” we mean that a majority of staff were able to make *some* changes in their behavior, from an information-based approach to a client-centered approach. As behavior change with clients is incremental, so it is with clinic staff. The types of changes observed were behaviors such as increased eye contact, asking more open-ended questions, consistent questions about HIV/STD risk behavior, and providing information that is targeted to the client, rather than providing the same information to each client, regardless of need.

IN our most recent phase of this project, we have created Learning Groups, in

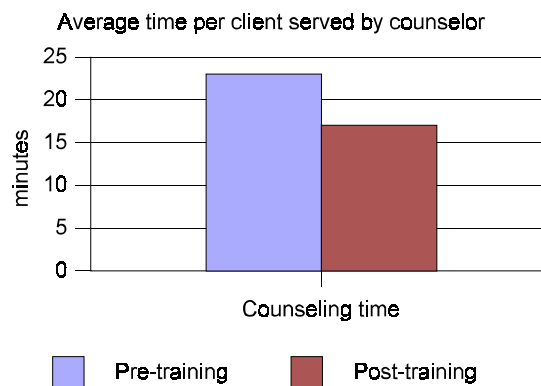
Contact time



Length of visits



Length of counseling



which we bring together teams of staff from a number of agencies to meet several times over the course of a year. Through this process, participants learn from one another as much as from the CHT team. All are experts. The process of becoming client-centered for most clinical staff is not easy. Clinical staff need encouragement, feedback, and reinforcement. The benefits, however, for clients and staff are worth the effort.

How did staff in your clinic do?

“I don’t like to use condoms.”

- A. *What is it you don’t like?* This is the **best** response. It allows the patient to express his/her concerns, and the clinical staff to respond more specifically to the patient.
- B. *Extra lubrication might help.* This is a **good** response, but clinical staff may not know if lubrication is a problem for the client, unless “A” was asked first.
- C. *You have unprotected intercourse in this day and age?* This response is **too judgmental** and will likely result in the patient withholding information.
- D. *Me neither, but they protect you from disease.* This response allies the staff with the client, but **does not address** the reason the client does not like condoms.

“If I got AIDS, I would kill myself.”

- A. *That’s why I am telling you about safer sex; so you can protect yourself.* This response **does not help** clinic staff understand the client’s concerns, and does not help the client express underlying fears.
- B. *How might you avoid getting infected, then?* This response is **premature**. First clinical staff need to determine what the client is thinking and feeling. After responding to these feelings, then staff can develop a prevention plan.
- C. *This is pretty scary to think about, hmm?* This is the **best** response. The staff affirms the client’s feelings, and encourages further communication from the client.
- D. *It is unlikely that you will get AIDS if you use condoms every time you have sex.* This response **ignores** the client’s feelings and possible barriers to using condoms that the client may face.

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