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# *SUBSTANCE ABUSE COUNSELING FOR CLIENTS WITH HIV / AIDS*

## Internet Based Coursework

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# Substance Abuse Counseling for Clients with HIV / AIDS

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This distance learning coursework was developed for CEUMatrix by Robert A. Shearer, Ph.D.

This course is reviewed and updated on an annual basis to insure that the information is current, informative, and state-of-the-art. This package contains the complete set of course materials, along with the post test and evaluation that are required to obtain the certificate of completion for the course. You may submit your answers online to receive the fastest response and access to your online certificate of completion. To take advantage of this option, simply access the Student Center at http://www.ceumatrix.com/studentcenter; login as a Returning Customer by entering your email address, password, and click on 'Take Exam'. For your convenience, we have also enclosed an answer sheet that will allow you to submit your answers by mail or by fax.

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# About the Instructor:

**Dr. Robert A. Shearer** is a retired professor of Criminal Justice, Sam Houston State University. He received his Ph.D. in Counseling and Psychology from Texas A & M University, Commerce. Prior to teaching Criminal Justice, he taught Educational Psychology at Mississippi State University on campus and in the extension program across rural Mississippi during the civil rights era.

He has been teaching, training, consulting and conducting research in the fields of Criminal Justice, human behavior, and addictions for over thirty-six years. He is the author of over sixty professional and refereed articles in Criminal Justice and behavior. He is also the author of *Interviewing: Theories, techniques, and practices, 5th edition* published by Prentice Hall. Dr. Shearer has also created over a dozen measurement, research, and assessment instruments in Criminal Justice and addictions.

He has been a psychotherapist in private practice and served as a consultant to dozens of local, state, and national agencies. His interests continue to be substance abuse program assessment and evaluation. He has taught courses in interviewing, human behavior, substance abuse counseling, drugs-crime-social policy, assessment and treatment planning, and educational psychology. He has also taught several university level psychology courses in the Texas Department of Criminal Justice Institutional Division, led group therapy in prison, trained group therapists, and served as an expert witness in various courts of law.

He has been the president of the International Association of Addictions and Offender Counseling and the editor of the *Journal of Addictions and Offender Counseling* as well as a member of many Criminal Justice, criminology, and counseling professional organizations prior to retirement.

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# Substance Abuse Counseling For Clients With HIV / AIDS

## Goals and Objectives

Goals: The goals of this course are for the student to understand the primary elements of counseling individuals with substance abuse and HIV/AIDS.

Objectives: The primary objectives of this course are for the student to:

a. Understand the treatment model
b. Identify the training, attitudes, issues, and skills for counseling individuals with substance abuse and HIV/AIDS
c. Identify counselor and client barriers to effective treatment
d. Understand the issues of treating HIV/AIDS in the Criminal Justice System
e. Identify new treatment goals
f. Understand a continuum of care
g. Understand the process of counseling terminally ill clients

Pedagogy: The Primary learning methods for this course are:

a. Reading comprehension
b. Visual Aids—Color figures
c. Instrumented feedback—self-evaluation

# Introduction

The intertwined pandemics of substance abuse and HIV/AIDS are clearly moving along similar paths; and each continues to present unique, yet interrelated, challenges. First, both disorders are considered to be chronic—that is, lifelong diseases. Second, substance abuse is a primary risk behavior for HIV infection. Third, a diagnosis of HIV infection or related conditions can be a stressor for an individual already in recovery from a substance abuse disorder. However, the diagnosis of HIV infection may motivate a client to enter substance abuse treatment. Injection drug users who test positive for HIV are more likely to enter treatment than those who test negative. Also, studies have noted a reduction in risk-taking behaviors among injection drug users who test positive for HIV. The diagnoses of a substance abuse disorder and HIV/AIDS require extensive physical and mental health care and counseling in conjunction with extensive social services. To deal with the myriad of issues surrounding substance abusers who are HIV positive, substance abuse treatment professionals must continually update their skills and knowledge as well as reexamine their own attitudes and biases.

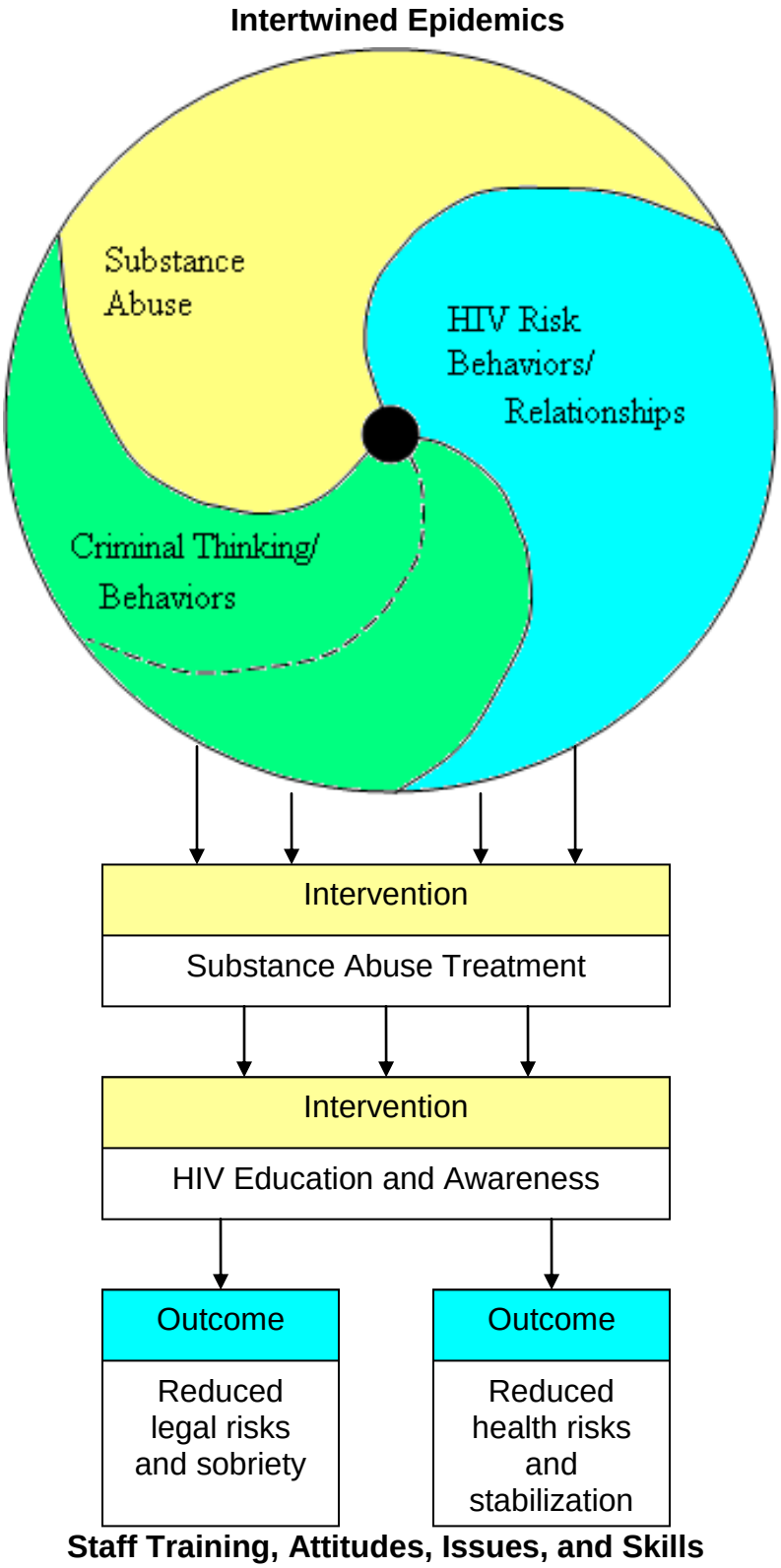
# The Course

This course is an update of skills and knowledge for treatment and supervision professionals who are intertwined in the intertwined pandemics, either, directly or indirectly, with substance abusers who are HIV positive. This is a basic introductory course; consequently it does not cover related HIV/AIDS subjects such as basic HIV/AIDS information, mental health issues, medical issues, prevention, and funding issues. The course includes both non-criminal justice and criminal justice settings, including probation and parole.

## The Treatment Model

Figure 1 presents a visual representation of the HIV and substance abuse treatment intervention model. The intertwined epidemics of substance abuse and HIV are moderated by criminal thinking and behaviors. The dotted line represents the variant effect that criminal thinking and tendencies may have on the intertwined epidemics. Thus, criminal thinking and tendencies may play a minor or major role in substance abuse or HIV. This is consistent with the recognition that the treatment of substance abusing offenders is approached as a dual disorder. On the other hand, criminal thinking and tendencies may play a mirror role for clients who have little, if any, legal difficulties associated with substance abuse and HIV.

Figure 1: HIV and Substance Abuse Treatment Intervention Model



Before conducting any screening, assessment, or treatment planning, counselors should reassess their personal attitudes and experiences in working with HIV-infected substance abusers. This section discusses several ways in which counselors can accomplish this, including formal training within counselors' programs, examining personal attitudes (e.g., counter transference and homophobia), examining fears of infection, and avoiding burnout. It is important to reassess comfort levels with each client because each client will vary in demographic and cultural background. For instance, a service provider may feel comfortable working with a young Asian American male with a history of alcohol use, yet the same provider may not be at all comfortable with a pregnant Hispanic woman who is an active injection drug user and wishes to have her baby. Figures 2 and 3 provide an example of a comfort checklist for counselors to use as a routine self-evaluation.

## Training

Staff members must have the proper training to screen, assess, and counsel clients. Achieving staff competency is an ongoing process. The complexities related to people with HIV/AIDS and substance abuse disorders are constantly changing and do not allow staff members to defer learning or training or even to maintain a "status quo" attitude about their competency.

Examples of methods to help the staff grow in the areas of assessment, screening, and treatment planning include the following:

- *Model skills and competencies.* Less experienced staff can observe supervisors or more tenured staff who demonstrate desired qualities.
- *Peer training and feedback.* Peer teams can provide feedback through direct observation of staff member' interactions with clients, as well as review of staff members' client charts.
- *Case presentations.* Weekly or monthly group case presentations conducted by a different staff member each time can be effective for building skills and monitoring quality. Case simulation, in which each staff member has an opportunity to ask the "client" a question, is a highly useful training tool. At the end of the presentation, everyone attending can provide feedback about the activity.

Figure 2: Self-Inventory Comfort Scale

**Self-Inventory Comfort Scale**

Listed below are several situations in which a caregiver may find herself while working with a substance-abusing client. Rate your comfort level in response to each situation, with "1" being *least* comfortable and "5" being *most* comfortable.

- _____Conducting an assessment of a client's substance abuse history.
- _____Confronting a client who differs from your own race or ethnicity about his substance abuse.
- _____Working with a substance-abusing client who is gay or lesbian.
- _____Differentiating between depression, anxiety, delirium, psychosis, and substance abuse disorders.
- _____Demonstrating the proper way to disinfect drug injection equipment
- _____Counseling an HIV-infected female client who is pregnant and actively using substances.
- _____Referring a substance-abusing client to a local syringe exchange program.
- _____Accompanying a client to an open meeting of Narcotics Anonymous (NA).
- _____Confronting a colleague on his suspected substance abuse.
- _____Advocating that an HIV-infected client with a history of substance abuse be placed on HIV combination therapy.
- _____Supporting a non-substance-abusing client with HIV/AIDS who is considering using marijuana to help curb nausea and increase appetite
- _____Confronting a client who is actively putting others at risk
- _____Confronting a client whom you believe is not adhering to a medication regimen but who claims to be.

Figure 3: Attitudes Toward Working with HIV/AIDS Clients/Offenders

1. I would feel resentful if HIV/AIDS clients/offenders were a major part of my caseload

   Agree_____ Disagree_____

2. Given a choice, I would prefer not to work with HIV/AIDS clients/offenders

   Agree_____ Disagree_____

3. I would rather work with a better class of clients/offenders than those with HIV/AIDS

   Agree_____ Disagree_____

4. I don't want those at higher risk for AIDS such as IV drug users and homosexuals as clients/offenders.

   Agree_____ Disagree_____

5. If given a choice, I am willing to have a counseling practice that has clients/offenders with HIV/AIDS.

   Agree_____ Disagree_____

6. I feel angry about the risk of AIDS which homosexuals have imposed on the straight community.

   Agree_____ Disagree_____

- *Experiential skills-building exercises.* Many activities can be used to sensitize staff to the client's experiences. Activities can include encouraging staff members to go to a confidential and anonymous HIV/AIDS test site, or anonymously sit in the waiting room of the local food stamp office, HIV/AIDS clinic, or county jail. Staff must use different avenues to maintain a keen sensitivity to and awareness of the client's issues.
- *Assessment instruments.* Use specific assessment tools, such as substance abuse and sexual history questionnaires (e.g., the Addiction Severity Index [ASI]).
- *Formal conferences, training, consultations with clinicians.* Often agency budgets are tight, and the first expense to be cut is staff development. This is a major problem for many programs. Programs must establish that improvement and excellence are serious goals and that attending treatment-oriented conferences is a part of building staff competency and moving toward these goals.

Attitudes

It is important that counselors be aware of any of their own attitudes that might interfere with helping a client. By learning to put aside personal judgments and focus on client needs, staff members can build trust and rapport with the client. When a counselor can deal with a client in a sensitive, empathic manner, there is a much greater chance that both will have a positive and successful encounter.

*Counter transference* is a set of thoughts, feelings, and beliefs experienced by a service provider that occurs in response to the client. Although sometimes these beliefs and feelings are conscious, generally they are not. It is thus unrealistic to expect counselors, usually untrained in addressing unconscious mental processing, to be aware of counter transference. Regular clinical supervision, which should be integrated into the staffing of the program, can help raise their awareness. If such resources exist, counselors may, with caution, address this issue.

In order to deal with counter transference issues, counselors must be willing to examine their skills and attitudes. Working with clients who have HIV/AIDS and substance abuse disorders brings up issues for treatment staff that can be both physically and emotionally demanding. Counselors see a broad range of diverse clients from all walks of life. To work in both these fields, providers must learn to be comfortable in discussing topics they may never have talked about openly—sex, drug use, death, grief, and so on. To effect positive change, counselors also must be willing to seek additional specialized training and support.

Attitudes: Examining attitudes and change

Counter transference can manifest itself in many different ways. The keys to seeing counter transference issues are awareness and consciousness-raising. The commitment to "do no harm" to clients and their families, along with a desire to

provide quality services, should be the driving forces for willingly examining these issues.

Following are some common counter transference issues for providers working with substance abusers who are HIV positive.

- Fear of contagion
- Fear of the unknown
- Fear of death, dying, grief, and loss
- Stigmatization (e.g., of people with mental health problems, "addicts," people who are HIV positive, homosexuals)
- Powerlessness, helplessness, and loss of control
- Shame and guilt
- Homophobia
- Anger, rage, and hostility
- Frustration
- Overidentification
- Denial
- Differences in culture, race, class, and lifestyle
- Fantasies of professional omnipotence
- Burnout
- Measures of success and personal reward

Issues: Homophobia

To be aware of homophobic responses among treatment professionals and of their own counter transference issues, it is important that counselors understand how the client is handling his homosexuality. The counselor should understand the possible link between substance abuse and gay or lesbian identity formation. Substance abuse can be an easy relief, can provide acceptance; and, more important, can mirror the "comforting" dissociation developed in childhood. The "symptom-relieving" aspects of substance abuse help fight the effects of homophobia; substance abuse can allow "forbidden" behavior, allow social comfort in bars or other unfamiliar social settings and provide comfort just from the dissociative state itself. For example, some men have their first homosexual sexual experience while drinking or being drunk. This connection is a very powerful behavioral link—the pleasure and release of substance abuse with the pleasure and release of sex—and is very difficult to change or "unlink" later in life.

In regard to the issue of homophobia, it is also critical to understand how stereotypes affect the treatment options offered. The professional should take an inventory of these stereotypes to assess her homophobia potential and should be aware of the roles counter transference can play. The short assessment tool provided in Figure 4 can be used to examine where providers and clients alike might rank on a continuum of homophobic reactions. This tool is also useful in group supervision sessions or discussions with both gay/lesbian and heterosexual colleagues.

It is important that counselors have a working knowledge of some of the terminology and definitions pertaining to homophobia. Following is a brief list of terms and definitions.

- Overt *homophobia* includes violence, verbal abuse, and name-calling.
- *Institutional homophobia* describes the way in which governments, businesses, schools, churches, and other institutions and organizations treat people differently and less favorably based on their sexual orientation.
- *Cultural homophobia* includes social standards and norms requiring heterosexuality.
- *Internalized homophobia* is acceptance and integration by lesbians and gays of the negative attitudes expressed by society toward them.
- *Heterosexism* is the system of advantages bestowed on heterosexuals. It is the institutional form of homophobia that assumes all people are or should be heterosexual and therefore excludes the needs, concerns, and life experiences of lesbians, gays, and bisexuals.
- *Coming out* may be the most important part of gay and lesbian development. This is the process, often lifelong, in which a person acknowledges, accepts; and. in many cases, appreciates his or her own lesbian, gay, bisexual, or transgender identity. This often involves sharing this information with others. Family members of gay and lesbian individuals go through a similar process.
- *Oppression* is the systemic subjugation of a particular social group by another group with access to social and political power, by withholding access to that power.
- *Lesbian/gay baiting* involves actions or words that imply or state that the presence of a gay man or lesbian hurts or discredits a social system. The purpose is to hurt, demean, intimidate, or control, and to stop social change or acceptance of lesbians and gays within the social system.

These definitions can help the counselor become aware of the added layer of discrimination felt by gay men and lesbians in treatment for HIV/AIDS and a substance abuse disorder. Following is a list of some "Do's" to keep in mind when working with homosexual clients.

- Identify the lesbian/gay client's strengths and accept them as you find them.
- Listen empathetically and refrain from making judgments about the client's lifestyle.
- Remain aware of the client's sexual orientation and the possible effects of this orientation on the client's experience and world-view.
- Explore the client's sexual practices with an eye toward internalized homophobia
- Be aware of your own preference and mindful of possible homophobia or confusion in your own sexual identity.
- Be knowledgeable about compulsive sexual behavior and sexual practices in the lesbian/gay community.
- Ask your lesbian/gay clients what terms they prefer when discussing their sexual orientation and those of others.
- Encourage self-empowerment, consciousness-raising, and participation in the lesbian and gay community.
- Encourage your program to hire openly lesbian and gay counselors/therapists.
- Educate others about internalized homophobia and heterosexism. Be gay- and lesbian-affirming rather than just gay- and lesbian-tolerant.
- Stray abreast of current information on resources and display this information in your office. Attend seminars and professional workshops about working with lesbian and gay clients.

Figure 4: Homophobia Questionnaire/Discussion Topics for Counselors/Supervisors

| Homophobia Questionnaire for Counselors and Clients |
| --- |
| • Do you ever stop yourself from doing or saying certain things because someone might think you are gay or lesbian? What kind of things?<br>• Do you ever intentionally do or say things so that people will think you're not gay/lesbian? What kinds of things?<br>• Do you think that lesbians or gays can influence others to become homosexual?<br>• Do you think someone could influence you to change your sexual orientation?<br>• If you are a parent, how would you (or do you) feel about having a lesbian daughter or a gay son?<br>• How do you think you would feel if you discovered that one of your parents, a parent figure, a brother, or sister were gay or lesbian?<br>• Are there any jobs, positions, or professions that you think gays and lesbians should be barred from holding or entering? Which ones and why?<br>• Would you go to a physician whom you knew or believed to be gay or lesbian if he or she were a different gender from you? If he or she were the same gender as you? If not, why not?<br>• If someone you cared about said to you, "I think I'm lesbian or gay," would you suggest that the person see a therapist?<br>• Have you ever been to a gay or lesbian social club, party, bar, or sporting event? If not, why not?<br>• Would you wear a button that says, "How dare you assume that I'm heterosexual?" If not, why not?<br>• Can you think of three positive aspects of a lesbian or gay lifestyle? Can you think of three negative aspects of a heterosexual lifestyle?<br>• Have you ever laughed at or told a "queer" joke? |

Issues: Fear of Infections

Fear of infection is one of the most challenging issues for counselors. It is essential that providers examine this issue without blaming or judging themselves and others. Most professionals who work with substance abusers and HIV-positive individuals have thought about becoming infected with HIV hepatitis, or tuberculosis (TB) through their jobs.

Some fear that scientists are not aware of modes of infection or transmission that might put service providers and their families at greater risk of infection. The key to dealing with this fear is to discuss it and vent the feelings with someone who is safe, trusted, and informed, *and* to practice universal precautions at all times.

Beyond this, it is essential for providers to have regular and frequent in-service training with updates on the latest research and data about transmission and treatment of HIV/AIDS, hepatitis, and TB.

Issues: Special considerations for counselors who treat HIV-infected clients

The challenges and stresses related to working with people with HIV/AIDS are in some ways unique. The fact that providers often deal with multiple and serial losses and see clients suffering on daily basis clearly affects the providers' psychological health. In recent years, therapists have begun to examine and assess these service providers for symptoms of posttraumatic stress disorder (PTSD).

Burnout often is referred to as "bereavement overload." One definition characterizes burnout as lowered energy, enthusiasm, and idealism for doing one's job, that is, as a loss of concern for the people served and for the work. Unlike fatigue, burnout does not resolve after a given amount of rest and recreation.

Burnout prevention and stress management techniques should be used both in the work setting and in counselors' personal lives. Working with HIV-infected substance abusers requires agencies and individuals to be more creative and flexible in finding new and different ways to support and nurture counselors to prevent burnout. Agencies that have taken on this challenge with integrity and commitment have seen highly effective staff function at optimal levels for many years.

Suggestions for ways in which agencies can take care of counselors at work include:

- Assigning clearly specific duties
- Having clear boundaries on professional obligations
- Enlisting volunteer help from community organizations
- Allowing for “time out” activities
- Varying tasks and responsibilities
- Building in “mental health days”
- Providing for continuing education
- Holding staff retreats (with enjoyable activities planned)
- Holding discussion, process, and support groups
- Convening regular staff/team supervision meetings

In addition, it is important that agencies allocate time to discuss the deaths and losses faced by staff. This may mean supporting special memorial events at which those who have been lost to HIV/AIDS disease can be remembered.

Agencies also can support staff through contracts with employee assistance program therapists and by providing an onsite therapeutic support group for staff members to attend as they wish. Figures 5 and 6 present visual representation of client and counselor barriers to effective treatment.

Figure 5: Client Barriers
To Effective Treatment

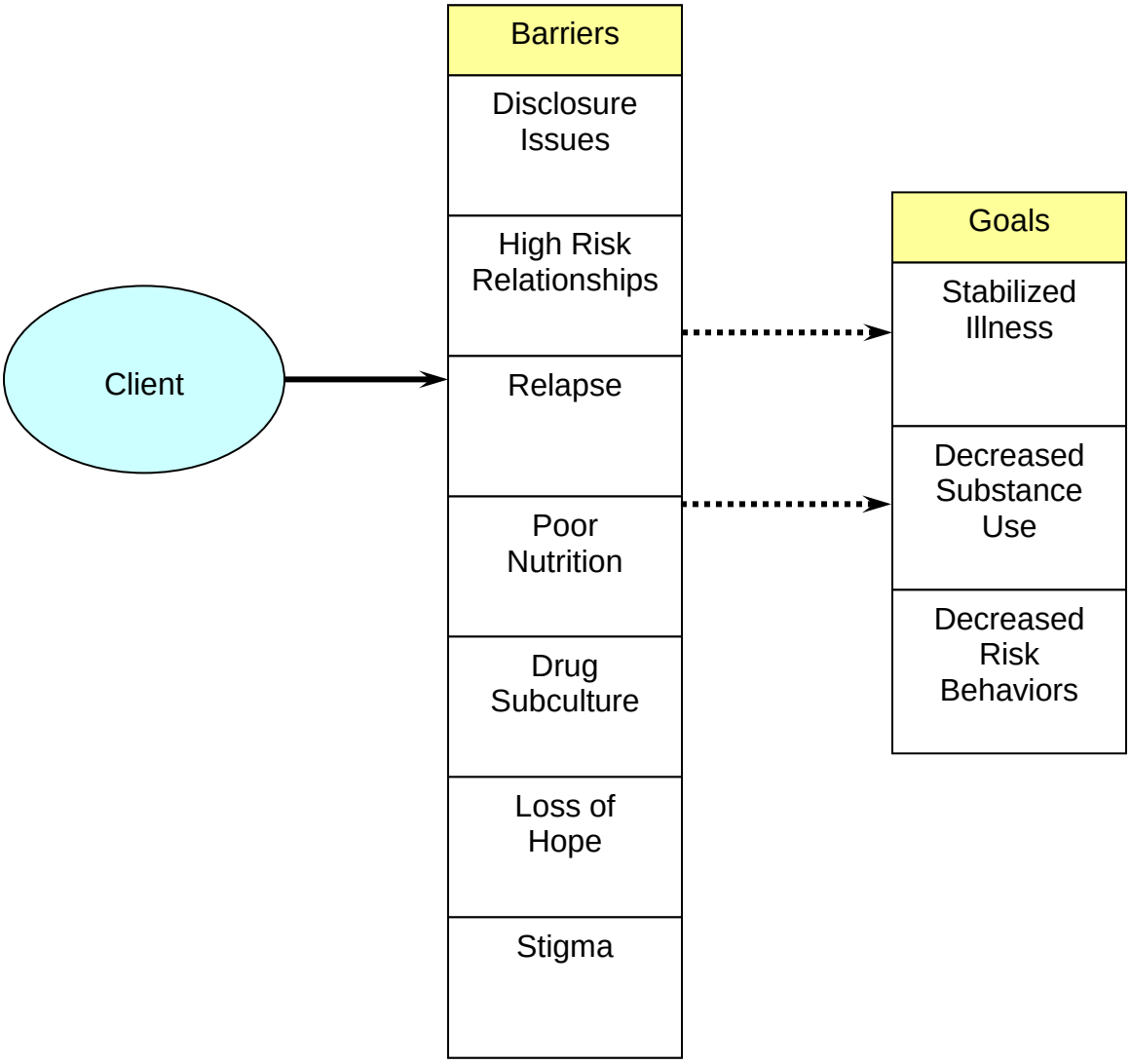
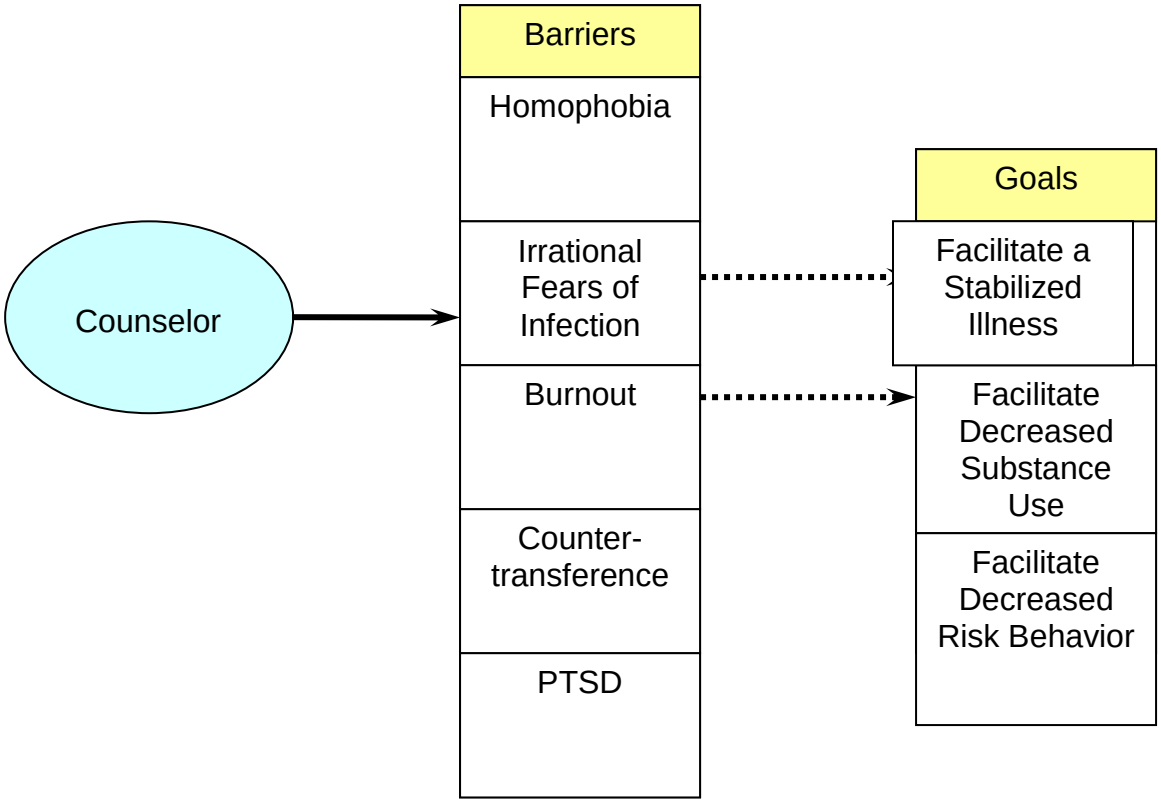


Figure 6: Counselor Barriers
To Effective Treatment



Issues - Screening: Client-Specific needs

A positive screen for HIV infection typically leads to a referral for formal assessment, usually to an HIV/AIDS case management service. Frequently, substance abuse treatment programs provide referrals to HIV/AIDS care services. Providers will want to identify substance abuse treatment programs and agencies with these networks. At a minimum, services should include the following client needs in priority order:

- Substance abuse treatment
- Medical care
- Housing
- Mental health care
- Nutritional care
- Dental care
- Ancillary services
- Support systems

Discussion of some of these needs appears below.

Issues - Client-Specific needs: Interim substance abuse treatment for clients on waiting lists

Because of an insufficient umber of substance abuse treatment slots, clients often must wait for treatment. Risk-reduction efforts can be made, however, while the client is waiting for substance abuse treatment.

If substance abuse treatment slots remain unavailable, alcohol and drug counselors should refer clients who need medical care to primary medical care services. Clients who display more acute symptoms or conditions should probably be referred to an emergency department. However, emergency department care typically is limited to wound care and provision or nutritional supplement. Clients who do not have acute symptoms or conditions but need medical care should be referred for primary medical care, either to their own physicians or to primary medical care clinics or services.

Issues - Client-Specific needs: Primary medical care

Primary medical care should consist of a comprehensive physical exam, treatment for HIV/AIDS (e.g., combination therapy), and treatment for opportunistic infections. In particular, chronic substance use can result in significant weight loss, lack of appetite, poor digestion, substandard elimination, kidney and liver dysfunction, and weakened immune system functioning.

Issues - Client-Specific needs: Mental health care

A diagnosis of mental illness may reflect the client's affective and mood responses to this medical judgment, may be a consequence of self-medication, or may reflect neurological complications of HIV/AIDS, as well as an underlying mental health disorder. Mental health care should consist of both a neuronpsychiatric workup and full mental health status examinations. Service providers should be alert to and notify clients and psychiatrists that complications may arise from the use of prescription medication for mental health problems and interactions between drug residue in the body and medications for HIV/AIDS and opportunistic infections.

Issues - Client-Specific needs: Nutritional care

Substance-abusing clients living with HIV/AIDS are typically mal- or undernourished because of street lifestyles, the effects of HIV disease, and the physical effects of substance abuse. This combination typically results in diminished appetite, weight loss (especially of lean muscle mass), poor hygiene, immune suppression, protein deficiencies, vitamin and mineral exhaustion, and anemia. In addition, providers should be aware that apparent lack of nutrition is not associated with digestive disease or parasites.

Good nutrition is a fundamental part of overall medical care. It improves strength, energy, longevity, and quality of life; increases muscle mass and body weight; decreases likelihood of hospitalization and length of stay; and slows progression of HIV to AIDS.

Without adequate nutrition, HIV/AIDS clients can easily develop malnutrition. Various causes of malnutrition and weight loss include:

- Inadequate intake of food
- Anorexia
- Malabsorption of food
- Altered metabolism
- Food and drug interactions
- Androgen deficiency
- No cooking facilities
- Limited income
- Reliance on community food programs

With the onset of malnutrition, the client loses weight and experiences several body composition changes. *Starvation* results in loss of body fat and muscle. *Wasting syndrome* produces a loss of a serious percentage of body weight, with accompanying diarrhea and fever, and has been considered a defining symptom of AIDS since 1987. The degree of loss of lean body mass can indicate the length of time that the client has left to live.

Issues - Client-Specific needs: Lipodystrophy syndrome

Lipodystrophy syndrome occurs in early end-stage AIDS and produces altered body composition and various hormonal and physiological changes. The cause of the syndrome and its relationship with HIV and protease inhibitors are unknown. Because of the disfiguring nature of some symptoms, lipodystrophy can be particularly distressing for women. Symptoms include:

- Redistribution of body fat
- Increase in waist size
- Thinning of the arms and legs
- Increased facial wrinkling
- Weakness and muscle wasting
- Gastrointestinal symptoms
- Increased triglycerides and cholesterol
- Decreased testosterone levels
- Hypertension
- Diabetes

To determine body composition changes, provider staff should recommend that clients be measured on a bioelectrical impedance analysis machine. This noninvasive machine sends a weak electrical current through electrodes placed on the client's hands and feet to measure fluid volume, blood cell mass, extracellular mass, and level of body fat. Repeated every 3 to 6 months, this procedure can provide an accurate gauge of the client's biophysiological status.

Providers can treat weight loss and malnutrition by prescribing a nutritious, balanced diet with plenty of fluids and daily multivitamin, if needed. Protein and calorie supplements are recommended if the client is losing weight. The client should avoid toxic substances such as alcohol, tobacco, and recreational drugs; and should practice a daily routine of moderate exercise. Pharmaceutical interventions that may be required include appetite stimulants, thalidomide, and growth hormones.

Treatment staff should also discuss integrative therapies with the client. These can include herbs, acupuncture, meditation, massage, yoga, chiropractic, homeopathic medicine, megadosing, tai chi, qigong, and various religious practices.

Issues - Client-Specific needs: Dental Care

Substance-abusing clients typically have poor histories of routine dental care, which can lead to extreme physical pain and incapacitation. Persons living with HIV/AIDS usually require extensive dental care, up to and including tooth extraction, jaw line reconstruction, and dental plate replacement.

Issues - Client-Specific needs: Ancillary Services

The steady increase in the number of women living with HIV/AIDS is creating a great demand for ancillary services such as child care, housing, and transportation. Families needing housing may face long waiting lists for Section 8 housing or may receive Section 8 certificates only to find few landlords willing to accept Section 8 housing payments. Another concern for substance abusers, whether currently using or in recovery, is the fact that most low-cost housing tends to be in areas known for high drug traffic and crime.

Disclosure Issues

Disclosure issues are difficult for all HIV-infected clients. For substance-abusing clients, these issues take on additional challenges. For example, disclosure of positive HIV status may lead to personal threats or harm to both client and family. A client's family may refuse to associate with him upon learning of his HIV/AIDS status. Particularly for clients whose culture reflects definition of self within a community or self in relation to a clan (as opposed to individual definition), separation from community can serve as a trigger for lapse or relapse into risky substance use and sex-related behaviors. Therefore, providers must use caution when notifying clients of test results and should comply with regulations to ensure that a client's confidentiality is preserved. Figure 7 presents a visual representation of the relationship between stigma, disclosure issues and relapse. This figure illustrates the ambivalence that exists between social relationships and health/relapse in substance abusers with HIV/AIDS. The social worlds of substance abusers living with AIDS are impoverished by the deaths of close associates and the stigmatization of being HIV positive. These individuals become lonely and develop a desire for inclusion with friends, family, or a community that everyone experiences. Attempts to act on this social desire come into conflict with health and sobriety concerns when being seen taking medications is a real fear. This creates the risk of disclosure of a stigmatized status—being HIV positive. This creates an ambivalence of whether to choose social interests or health/relapse interests.

Also, during group therapy, clients often feel an obligation to reveal their HIV status to the rest of the group. Counselors should caution clients about the impact of such disclosure and consider discouraging them from making it. Clients who wish to disclose their HIV status generally do so in response to treatment themes of honesty and openness and are not completely aware of the consequences. Of course, in treatment settings where all patients are HIV positive, there is no need for this concern.

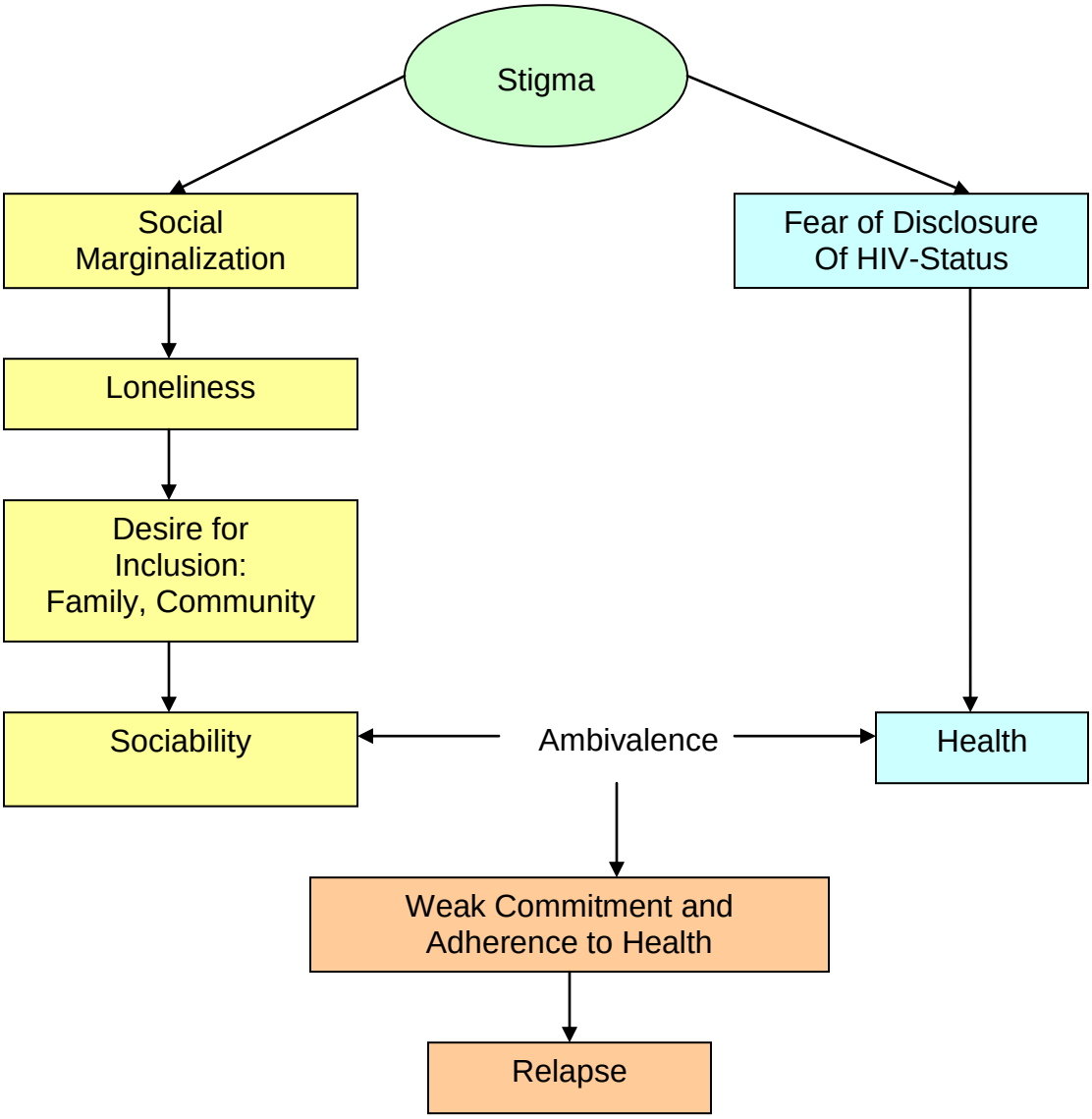
Skills

In addition to the traditional counseling skills of screening, assessment, and treatment planning, substance abuse counselors working with HIV/AIDS clients may be called on to perform any or all of the following:

- Providing HIV/AIDS basic information
- Implementation of an HIV/AIDS prevention program
- Linking substance abuse counseling with mental health services
- Coordinating medical services for HIV/AIDS
- Providing culturally competent leadership, supervision, and counseling skills for a diverse population of HIV/AIDS clients/offenders including:
    1. Homeless people
    2. Women
    3. Sex industry workers
    4. Older persons
    5. Gay, lesbian, bisexual, and transgender populations
    6. HIV positive parents
    7. Hispanics
    8. African Americans
    9. Asian Americans
    10. Native Americans

Limited budgets and smaller programs will increase the role and skill demands on the Substance Abuse Counselors to provide a broader range of skills.

Figure 7: Stigma, Ambivalence, And Disclosure Issues for HIV Substance Abusers



## Criminal Justice System

In the United States in 2004, 1.8% of prison inmates were HIV-positive, more than four times the estimated rate in the general population; the rate of confirmed AIDS cases is also substantially higher. Some behaviors that increase the risk of contracting HIV can also lead to incarceration. It has been estimated that each year, about 25% of all HIV infected persons in the United States spend time in a correctional facility.

Many persons with substance abuse disorders receive treatment only after arrest and are offered treatment as a diversionary service or receive treatment as a diversionary service or receive treatment while they are in jail or prison. The racial and class patterns characterizing arrest, adjudication, and sentencing in the United States skew more white Americans (regardless of social class or income) to treatment trajectories and more persons of color to jail or prison trajectories. Access to treatment within the criminal justice system is thus highly associated with ethnicity and social class. Only a handful of correctional facilities in the United States have instituted some type of therapeutic community treatment program in prison with a parallel transitional program for new parolees. Unfortunately, many HIV-infected individuals who are in treatment for HIV find it impossible to remain on their medication schedules after being arrested because their medications are often confiscated for days at a time.

The population in prisons and jails tripled between 1987 and 1997. Overcrowding and understaffing are common in prison facilities and can increase inmates' risk of contracting HIV. In 1992, HIV/AIDS cases for people in State and Federal prisons reached 195 per 100,000 compared with 18 per 100,000 for the general U.S. population.

Risky behaviors that lead to HIV infection are not eliminated when a person is imprisoned but may actually increase in frequency and availability. This occurs for several reasons. First, drug offenses count for the single largest number of Federal and State crimes for which people are arrested and incarcerated. In 1996, 79 percent of State inmates reported at least one use of illicit drugs during their lifetime. Therefore, high rates of HIV infection are not surprising in a population so closely characterized by heavy substance abuse involvement. In addition, many people enter jail or prison already infected with HIV. A 1993 study of 46 correctional facilities found people entering these facilities had an average infection rate of 1.7 percent. In some facilities, however rates for women were as high as 21 percent and 15 percent for men. Among injection drug users, rates ranged from less than 1 percent to 43 percent.

Injection drug users face particular risk in prison settings as clean syringes are all but impossible to secure. Although syringes are not officially available, they can be acquired through illicit prison markets at exorbitant prices ($34 in one Canadian facility) or through risky exchange of syringes for unprotected sex. Syringes are typically not new or sterile. As a result, injection drug users have as their only recourse used or shared syringes, which increases their chances of HIV

infection. Tattooing is also common practice among prisoners and is another source of HIV infection. To date, there have been at least two documented cases of HIV/AIDS related to tattooing with unsterile needles in a correctional facility.

Only six prison systems in the United States distribute condoms: Mississippi, New York City, Philadelphia, San Francisco, Vermont, and the District of Columbia. Distribution strategies range from receipt of a single condom per medical visit to receipt of multiple condoms during HIV/AIDS education workshops. Furthermore, condom distribution programs send mixed messages because sexual activity in some facilities is illegal and a punishable offense. In other facilities, correctional medical and social service staff may advocate condom availability while administration and security officers oppose it.

Sixteen prison systems mandate HIV testing, and although 77 percent make testing available to inmates on request, few inmates request it for several reasons. First, confidentiality of results is not guaranteed. Second, mandatory testing may result in the segregation of those who test positive from those who test negative or who do not test. Third, prisoners do not wish to acknowledge activities that could subject them to further sanctions. Fourth, confidentiality on discharge is eliminated because the Federal Bureau of Prisons requires HIV testing for all inmates on their release. HIV-positive inmates are asked to directly notify sex partners and significant others of the results. However, the Bureau of Prisons handles only a small percentage of inmates, and its policy is not the norm.

Treatment for HIV-positive inmates is often inadequate when available. Primary medical care may be limited to *Pneumocystis carinii* pneumonia prophylaxis and HIV monotherapy. Combination therapy may not be available or accessible to inmates, given the cost of medications, limited storage, refrigeration requirements for some medicines, and the strict adherence regimen required by combination therapy, which would require round-the-clock monitoring and assistance by typically unwilling and suspicious security staff.

Although, there are large numbers of substance abusers within correctional facilities, less than 15 percent participate in treatment programs. This is partly because of lack of program availability and the common type of program offered (i.e., 12-Step, abstinence-based.) A 1991 study reported that only 1 percent of inmates with moderate to severe substance abuse disorders received appropriate treatment. Many of these treatment programs advocate sexual abstinence during recovery. Often, these programs offer no or little information about safer sex practices or advocacy around changing sexual behaviors. When persons with substance abuse disorders in treatment relapse, as is often the case, they may also engage in risky sexual behaviors. They are most likely to engage in risky sexual behaviors with sexual partners from similar treatment networks. These partners may include people who have used syringes, traded sex for money or drugs, or been victims of trauma. All of these populations are likely to have higher rates of HIV infection, making transmission likely.

Inmates who do complete or participate in treatment programs often relapse on discharge. They are more likely to relapse if:

- They were not assessed for risk level
- They were not treated for criminal thinking, attitudes, and sentiments

- They were not assessed for responsivity level.

For inmates who do complete treatment, there are often no aftercare programs to help them remain substance free. A 1995 study of Hispanic inmates in California State prisons found that 51 percent reported having sex within the first 12 hours after release, and 11 percent reported injection of drugs during the first day after release.

Table 1 illustrates the decline in support services for HIV-positive inmates. Smaller percentages of correctional systems were providing support services for HIV-positive inmates in 2005 than was true in 1996-1997. In state/federal systems, the share providing peer support groups declined from 33 percent to 30 percent, support groups provided by correctional staff dropped from 63 percent to 36 percent, and support groups provided by outside organizations dropped from 67 percent to 28 percent. In city/county jail systems the percentage providing peer support groups remained very small and there were declines in the other two categories.

Table 1

Support Services Provided Within Correctional Facility

| | State & Federal | | City & County | |
|---|---|---|---|---|
| | 2005 (n=47) | 1997 (n=51) | 2005 (n=33) | 1997 (n=41) |
| Peer counseling groups/support groups | 30% | 33% | 9% | 5% |
| Counseling/support groups provided by correctional staff | 36% | 63% | 15% | 32% |
| Counseling/support groups provided by outside organizations | 28% | 67% | 45% | 61% |
| Mental health services (individual or group) by credentialed professionals | 94% | | 79% | |
| Case Management | 26% | | 33% | |

## Women

The needs of women have always represented a unique challenge to health care and substance abuse treatment systems. Traditionally, these challenges have not been well met and are being exacerbated by the growing number of substance-abusing women infected with HIV. The diseases of substance abuse and HIV/AIDS present differently in women than in men and progress at different rates for a variety of reasons, including the fact that women usually present later in the HIV/AIDS disease process than men.

Gender-specific services for women should include the following:

- Medical and substance abuse treatment that is accessible, available, and incorporates:
    - General health (including reproductive health) and wellness across the life span
    - Mental health counseling (particularly for PTSD)
    - Parenting skills and support
    - Family-focused support
    - Relationship issues
    - Trauma/abuse support
    - Educational/vocational services
    - Legal services
    - Sexuality and sexual orientation issues
    - Eating disorder support
    - Women-only support groups
- Empowerment--that is, holistic programming that emphasizes the development of a partnership with a female service provider, one in which there is mutual respect and many opportunities for positive role modeling
- Transportation services
- Child care, both onsite and supervised
- Woman-sensitive women working with women
- Long-term case management services that extend to the client and her family

A woman's identity as caregiver/caretaker must be recognized as an extremely powerful factor in how she accesses care and treatment and how successful she is in her recovery and health maintenance. There is no question that this identity/role can explain why a woman seeks treatment ("for the kids") or why she leaves treatment ("to get home to my husband/partner/kids"). This is also a factor in a woman's sense of guilt and shame from becoming HIV infected--a societal stigma that only "bad girls" get HIV or are addicts or alcoholics, and the stigma of being an unfit mother if she has lost custody of her children.

Providers must be open and prepared to discuss safer sex and drug and alcohol abuse from a risk-reduction perspective. They must be well informed about and comfortable in discussing sexuality. Risk reduction is an ongoing type of intervention that goes beyond assertiveness training and teaching women how to put

condoms on men. It recognizes the need to "start where the client is" and use appropriate interventions, which may help a woman reduce her risk of becoming reinfected or of infecting a partner. This includes instructing female injection drug users about how to use bleach to "clean their works," how to use a female condom, or how to use a vaginal spermicidal foam (not the safest risk-reduction method, however) to lower their risk of HIV infection when having intercourse. It also involves making referrals to substance abuse treatment and giving instruction for male partners on how to use a condom correctly. Figure 8 presents a visual representation of a model of cognitive intervention for women's relationships in HIV risk.

## Reproductive Decision Making

Reproductive decision making is an important area for providers to examine with both female and male clients. Providers must be prepared to discuss pregnancy and family planning with respect and without judgment. This is a difficult task for providers and clients; counselors may have many judgments about "right" and "wrong" and many opportunities for counter transference. One way providers can interact with clients is to help them openly and honestly consider various factors when making reproductive decisions. Figures 6 and 7 are adapted from an article written by Rebecca Dennison, director of a women's health advocacy organization based in San Francisco, who is HIV positive and considered these issues with her husband in her own reproductive decision making.

The questions listed in Figures 2 and 3 are extremely helpful, but it is also important to remember that many clients have never made reproductive decisions. Their substance abuse problems have been at the forefront of their lives for so long that they may find it difficult, even in recovery, to "own" their decision making responsibilities. One way to provide support in this area, and help build coping skills, is to encourage women to talk with other women--to become part of a support group that is based on empowerment and women helping women. Counselors should see reproductive decision making as a very high priority and move toward this goal in small, incremental steps.

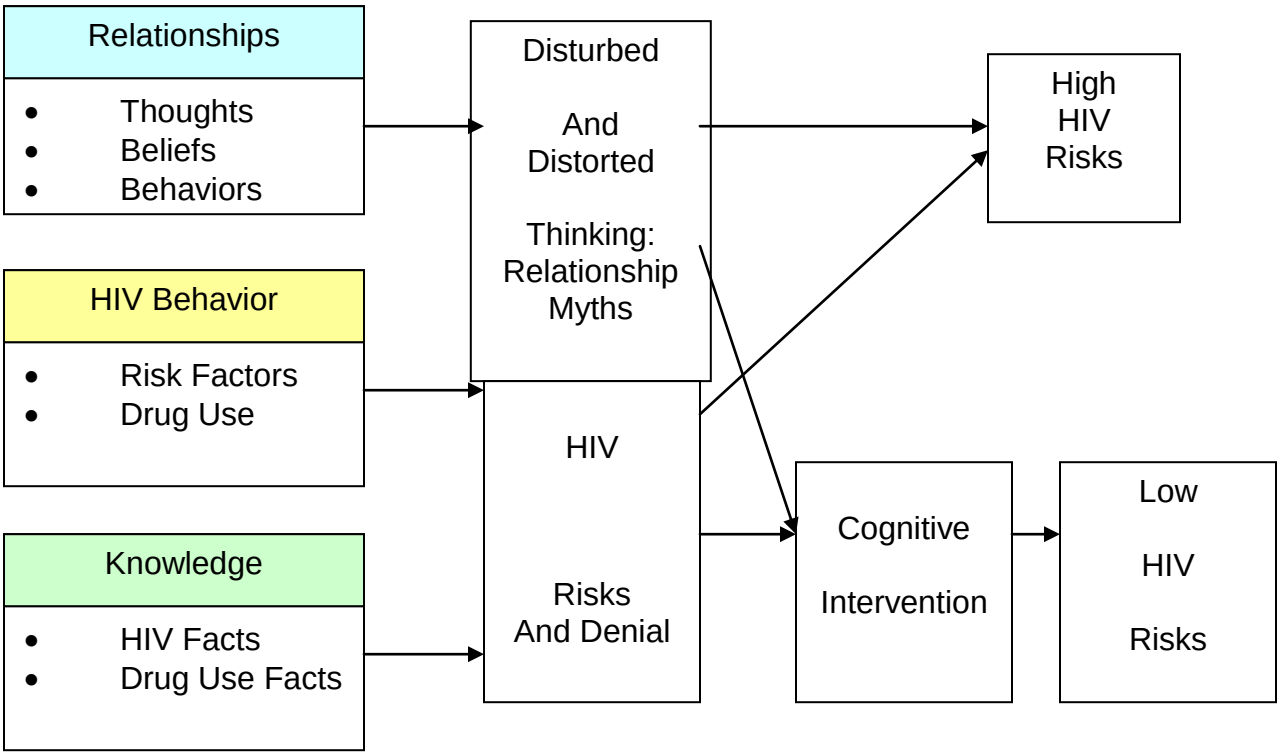
At present, no one knows exactly how to predict which mothers will transmit HIV to their infants. Although there is some speculation that a mother's viral load, measured through viral load assays, may indicate whether her infant becomes HIV infected. Much is still unknown, and controversies abound, but providers must understand and respect the importance of self-determination and the right of women to make their own decisions. Ultimately, it is the woman's choice.

Today, HIV-positive women are looking at the prospect of pregnancy differently than they did in 1989. HIV-positive women who think about becoming pregnant have access to information about viral load testing and the possibility of artificial insemination. Also, HIV-positive women can consider a natural rhythm method, identifying fertile days and limiting unprotected intercourse to those times to decrease their partner's risk of HIV infection. There is no question that even today, facing pregnancy while HIV positive, examining the options related to terminating or continuing a pregnancy, deciding about medications, examining the woman's health

and the infant's health, and addressing the long-term implications are all complex issues.

It is essential that providers examine these issues with clients within the context of a biopsychosocial framework. Counselors and health care providers must work together, along with the female client, to stay aware of the latest research and information regarding HIV/AIDS treatment. It is also important to remember that data and information on HIV/AIDS are constantly changing and that the "facts" provided to clients today may be very different tomorrow.

Figure 8: HIV Risk Reduction
Cognitive Intervention Model for
Women's Relationships



## Parents Who Are HIV Positive

More and more resources have been developed for single- and two-parent households in which one or both parents are HIV positive and/or the children are HIV positive. There must be a continued awareness of the needs of these families.

These families experience the need for a variety of services, both child-centered and adult-centered. Concerns about guardianship for children after the parent is unable or unavailable to care for them must be a major focus for the parent and the service provider. Unfortunately, many clients who have long histories of substance abuse may have "burned many bridges," and the family support they need for permanency planning and establishing an appropriate guardian for their children is no longer available. All too often, there is only a tired, abused, and used grandparent who is dealing with chronic ailments, limited resources, and little emotional energy to raise more children.

If a child also is HIV positive, there will be special needs that the parent may not be able to address while facing her own issues. The already demanding dynamics of childhood, school, and growing up become more challenging for an HIV-infected child and parent. Even if the child is not HIV positive, the demands of parenting can prove rigorous for single parents with HIV/AIDS. Although the parent experiences the relief of knowing the child is all right, the poignant realization that he may not live to see that child grow up can still be painful.

The HIV-infected single parent with a substance abuse disorder is at risk of losing custody of her minor children if convicted of drug possession or substance abuse. If family members disapprove of the single parent's lifestyle, they may seek custody of the active substance abuser's minor children. The counselor may facilitate a plan encouraging the single parent toward goals that support the parenting relationship. This enables the recovery process to take place while the parent and child are working out their own version of permanency planning.

It is difficult for a child to witness the effects of a substance abuse disorder on a parent; surely the difficulty increases enormously when the child is told that the parent has HIV/AIDS. Children whose parents are in recovery from substance abuse disorders or who are maintaining some stability despite periodic substance abuse may experience some changes in their relationships with their parents.

There are support groups and programs for children whose parents are affected by HIV. Although not available in all communities, these groups offer children a chance to talk about their fears regarding their parents' health, learn more about the disease, and socialize with others who are facing these problems. At the same time, the programs can provide the parent with some respite time. In addition, groups like Al-Anon and Alateen can provide children with support and education about the recovery process.

If service providers work in a large urban area, chances are there will be an AIDS Service Organization (ASO) listed in the phone book. This agency is likely to have lists of support groups of all kinds. Single parents with substance abuse disorders who are HIV positive should also have a support group.

## Hispanics

The Hispanic population in the United States is diverse, composed of a wide range of racial, indigenous, and ethnic groups. The following are important statistics related to the U.S. Hispanic population that affect how outreach, prevention, and treatment planning should be conducted:

- Hispanics have the highest labor force participation rate of all groups.
- Hispanic men have the highest fertility rate of all groups across all ages.
- Hispanic men have the lowest divorce rate of all groups.
- Hispanic men are on average younger than other men in the United States (with median age of 26.2 years).
- Hispanic women seek detoxification and treatment for substance abuse disorders in lower numbers than women from any other ethnic/cultural group.
- 90 percent of Hispanics are Catholic.
- 36 percent of Hispanic children live below the poverty level.
- There is a clear increase in substance abuse as Hispanics become more acculturated (i.e., in second and third generations, and so on).
- Hispanics are overrepresented among HIV/AIDS cases for men, women, and children.
- Hispanics as a group may include aliens who are undocumented or carry immigrant visas (green cards) and who avoid contact with the health care system because they fear possible deportation.

Within the context of acculturation and socioeconomic status, providers should be aware of specific cultural issues that can support interventions and improve a provider's ability to engage Hispanic clients, such as the role of the family, the values of interdependence, respect, and "personalismo" (i.e., importance of personal contact). Understanding these concepts will help establish rapport and trust.

The Hispanic family is generally extended and has many members. A Hispanic client's support system may be composed of siblings, godparents, aunts, and uncles who are all very involved with the client. The family as a whole is of great importance, and often what is best for the family will override what is best for one of its members. Because the family is so important to most Hispanics, children are highly valued. This makes it easier to see how some Hispanic women who are HIV positive grieve deeply about the decision not to have children and may feel unfulfilled and inadequate as a result. This also sheds some light on the challenges of involving Hispanics in substance abuse treatment. Leaving their children behind while in treatment or turning guardianship over to a State agency may be unacceptable and create more conflict.

Often, families are aware of homosexual family members, but usually this is not discussed openly. The reality is that many Hispanic men who prefer sex with other men do marry and have children. This partly explains why Hispanics are at such high risk for HIV/AIDS. If the man has married and fathered a child, he has been congruent with the values relating to family; if he then goes out with men, or

even with other women, this behavior may be tolerated as long as he continues to provide for his family.

## African Americans

As is the case with members of other minority groups, the health and social repercussions of substance abuse problems are magnified in the lives of African Americans. In terms of past-year prevalence rates of illicit drug use, the 1998 NHSDA found that the rate for African Americans (8.2 percent) was somewhat higher than for whites (6.1 percent) and Hispanics (6.1 percent). In addition, HIV/AIDS disproportionately affects African Americans, and from July 1998 through June 1999, injection drug use accounted for 26 percent of AIDS cases among African American males and 26 percent of cases among African American females.

African American women in particular have special needs. Minority women represent the fastest-growing segment of the U.S. HIV/AIDS pandemic. One study examined the psychological and social factors related to HIV risk among 153 African American inner-city women. The women completed measures of HIV risk history, sexual and substance use behaviors, perceived risk for HIV infection, self-efficacy to reduce risk (i.e., the belief that one can effectively perform specific behaviors), and perceived social norms supporting risk reduction. Fifty-five percent of the women reported at least one factor that had placed them at known risk for HIV infection. Results showed that HIV risk history was associated with a self-perceived risk for HIV infection and low self-efficacy to perform risk-reducing actions, suggesting that HIV risk-reduction interventions targeting inner-city women should focus on skills training approaches to build self-efficacy and empower women to adopt risk-reducing practices.

Many African Americans have a deep-seated mistrust of the health system. This dates back to the pre-Civil War period when, because they were considered property and had no legal right to refuse, slaves were sometimes used in medical experiments. A collective memory thus exists among the African American community of their exploitation by the medical establishment. More recently, the syphilis study performed at Tuskegee University from 1932 to 1972, during which 400 African American men infected with syphilis were deliberately denied life-saving treatment, has fostered in some African Americans the belief that contact with health care institutions will automatically expose them to racist administrators and policies. Several articles point to the Tuskegee study as a significant factor in the low participation of African Americans in clinical trials and organ donation efforts and in the reluctance of many African Americans to seek routine preventive care. As one AIDS educator said, "so many African American people that I work with do not trust hospitals or any of the other community health care service providers because of that Tuskegee experiment. It is like, “If they did it once, then they will do it again."

A study that compared the use and perceptions of substance abuse treatment services among African American, Hispanic, and white substance-abusing arrestees confirmed that African American substance abusers were more likely than white substance abusers to hold unfavorable views of treatment. Another study examined

the attitudes of African Americans in a northeastern city toward mental health treatment and found that only 34 percent of the sample felt positively toward community mental health centers. The study also revealed that women and married persons demonstrated more positive attitudes than did men and unmarried persons.

Counselors should be aware that the issues of slavery and institutional racism are constant and prevalent facts in the lives of many African Americans. They should be addressed early in treatment so they are acknowledged, validated, and brought into the treatment process. To provide effective substance abuse treatment for African American clients, providers need to take into account the social, economic, political, and cultural contexts of their lives.

Spirituality is very important for many African Americans. The relationship between an individual and the faith community is a critical source of strength that can help prepare clients to succeed in substance abuse treatment. In addition, many African Americans have strong social networks. They may have friends or a pastor with whom they might share information that they would not share with a substance abuse counselor. These confidants might act as "co-therapists" for the client. It can be helpful to clients when counselors can identify and integrate the clients' co-therapists into their substance abuse treatment plans (keeping in mind the clients' rights to confidentiality and the need for signed consent forms). Along these lines, for African Americans with substance use disorders and HIV/AIDS, support groups of friends may be more likely to be helpful and less undermining than support groups of families. This is perhaps due to the lingering stigma of the ways in which HIV/AIDS is acquired--both intravenous drug use and homosexual activity are still highly stigmatized acts within many African American communities. Thus, activating family supports may be difficult, and providers should encourage clients to participate in support groups composed of their peers.

## Asian Americans

Asians and Pacific Islanders are a culturally and linguistically diverse people from the Asian continent and the Pacific Islands. In the United States, they include nearly 40 different nationalities, 50 different ethnic groups, and more than 100 languages and dialects. Asians and Pacific Islanders comprised 4 percent of the total U.S. population in 1999. From July 1998 through June 1999, they accounted for 0.7 percent of all adult and adolescent HIV cases (these include only persons reported with HIV infection who have not developed AIDS), and 0.4 percent of adult and adolescent AIDS cases. Of the total AIDS cases reported for this population through December 1998, 89 percent were men; 79 percent of those were reported as men who have sex with men. Among women, nearly half the cases (48 percent) are associated with sex with an infected or high-risk partner, and 17 percent are reported from IDU.

The increasing size and diversity of the Asian and Pacific Islander population make it difficult to discuss group norms regarding substance abuse. Norms for alcohol and tobacco use vary by culture and there appear to be no norms governing the consumption of narcotics or other substances.

Service providers also should shed the notion of the "model minority," which often typecasts Asians and Pacific Islanders and limits treatment access. Often, Asians and Pacific Islanders believe the model minority myth and feel isolated when they test positive or report substance abuse disorders. They may also feel they have let down their families and communities.

Despite differences in cultural norms and mores among Asians and Pacific Islanders, cross-cultural beliefs in the importance of group and collective identity, service, and responsibility suggest the use of treatment strategies that incorporate biological or constructed families and communities rather than a focus on individual behavior change. Moreover, treatments that emphasize nonverbal or indirect communication skills, not confrontation, may be more culturally appropriate and more effective. Most American treatment modalities rely heavily on verbal therapies that require direct verbal emotional expression and a high level of personal disclosure. Many substance abuse treatment programs favor a confrontational approach, and many HIV/AIDS programs favor support groups and psychotherapy. These treatment approaches, unless modified for Asian and Pacific Islander clients, are often unsuccessful because they violate Asian and Pacific Islander cultural norms. By American standards, Asians and Pacific Islanders tend to communicate more indirectly, often by telling stories and discussing what happened to themselves and others. Their feelings and opinions are implied rather than directly stated. Asians and Pacific Islanders are also less likely to provide direct verbal expression of their feelings by using "I" statements than are members of other groups. Providers should expect to reveal personal information about themselves if they want clients to disclose their own problems. Asians and Pacific Islanders may prefer keeping strong feelings under control so that they will not become disruptive. Caring is often demonstrated by physical support such as by giving money, cooking favorite foods, or giving advice rather than by verbal expression or physical affection.

A problem solving approach rather than an intrapsychic one is more effective with Asian and Pacific Islander clients. Problem solving enables a counselor to provide information, educational materials, and referrals without probing for more personal information and pushing a client to express feelings. For Asian and Pacific Islander clients with somatic complaints, suggest relaxation and breathing techniques, meditation, qigong, yoga, massage, acupuncture, tai chi, or biofeedback. It is generally not helpful to discuss underlying feelings because it is not only culturally unacceptable, but many Asian and Pacific Islander clients do not see the emotional-physical connection. In problem solving, providers should actively give suggestions and if necessary, be directive rather than let Asian and Pacific Islander clients struggle to figure out what options are available to them.

Asking personal questions about substance abuse and sexual risk factors, especially early in the helping relationship, could be viewed as intrusive and disrespectful. Asian and Pacific Islander clients may not answer truthfully, if at all, and may not return. It is best to start with the least intrusive or nonthreatening questions during the intake and explain why the information is needed. If clients seem uncomfortable with certain questions, ask them at a later date.

Making an effort to connect with clients outside actual treatment appointments; such as, when they come to the agency for other activities or via

follow-up calls is also helpful. Asian and Pacific Islander clients may not initiate contact when they have a problem because of cultural tendencies to minimize problems to reduce stigma and because they do not want to be intrusive and bothersome. In all interactions, it is helpful to minimize the stigma Asian and Pacific Islander clients attach to their HIV/AIDS status and substance abuse disorders. Counselors should not refer to themselves as HIV/AIDS, mental health, or alcohol and drug counselors unless they know the client is comfortable with this. These titles imply the client has an unacceptable condition and can increase stigma. Clients may be more receptive to treatment for HIV/AIDS and substance abuse issues if they are combined with other, less stigmatized health issues.

Group interventions can be effective if everyone speaks the same language well enough and if the group is centered around an unstigmatized activity, social gathering, or education session. Providing refreshments also facilitates bonding. Asian and Pacific Islander participants will look to a facilitator to provide direction and guidance. Rather than be assertive in talking, Asian and Pacific Islander clients will more likely wait for a space to open up for them to speak and consequently will rarely have the opportunity to do so when in a group with predominately non-Asians and non-Pacific Islanders. Should this happen, the group leader needs to facilitate opportunities for Asian and Pacific Islander clients to participate.

## Native Americans

Native Americans and Alaskan Natives comprised 0.9 percent of the total U.S. population in 1999. From July 1998 through June 1999, they accounted for 0.4 percent of all adult and adolescent HIV cases reported (these include only persons reported with HIV infection who have not developed AIDS) and 0.6 percent of adult and adolescent AIDS cases. The largest percentage of HIV and AIDS cases in women was from heterosexual contact (39 percent and 23 percent, respectively). The largest percentage of HIV and AIDS cases in men was reported in men who have sex with men (43 percent and 47 percent, respectively).

The CDC found that Native Americans have high rates of STDs and substance abuse, which in turn raise their risk of HIV/AIDS. They also lack access to diagnosis and treatment. Gay men and substance abusers run the highest risk of HIV/AIDS among Native Americans and Alaskan Natives, just as they do among white Americans.

The combination of high rates of cofactors for HIV/AIDS, limited access to health care, lack of information and education about HIV/AIDS issues, substantial numbers of Native Americans who are already infected with HIV, and the flow of Native Americans between urban centers and reservations all lead to an HIV/AIDS crisis for Native American communities.

Limited treatment services for HIV-infected substance abusers exist on and outside tribal lands. In 1991, the American Indian Community House, which ministers to the health, social service, and cultural needs of Native Americans in the New York City area, created the HIV/AIDS Project, the first Native American program east of the Mississippi River to provide culturally sensitive legal services, HIV/AIDS treatment information, emergency assistance, and prevention education.

The Friendship House Association of American Indians in San Francisco provides another example of treatment (drop-in centers). This program provides comprehensive treatment to Native Americans living with HIV/AIDS as well as treatment for substance dependency. Services target the gay, lesbian, and bisexual communities. HIV/AIDS is presently underreported for Native Americans and is based on the high incidence of sexually transmitted diseases (STDs) in general, 15 percent of AIDS cases among those aged 60-69, and 21 percent of those 65 and over. For women with HIV, 22 percent of this group is in the 50-59 age bracket; 24 percent is aged 60-64; and 31 percent aged 65 and older. The rate of HIV infection in older women reflects the greater incidence of surgeries (such as hysterectomy) that require blood transfusions.

Although many of these AIDS cases are the result of HIV infection at a younger age, many people become infected after age 50. Rates of HIV infection among older adults are difficult to ascertain because very few people over 50 years of age routinely test for HIV. Because older adults are diagnosed with HIV/AIDS at advanced stages, older adults are less amenable to treatment, become sicker, and die faster than their under-50 counterparts. In addition, retroviral treatments and opportunistic infection prophylaxis may interact with medications the older person is taking to treat other preexisting chronic illnesses and conditions. Also, the vast majority of medication studies are done on much younger subjects. There is little research on the metabolism of anti-HIV drugs in older adults.

There is, as well, little research on the substance-abusing behavior of older adults, and very few substance abuse treatment programs address the needs of older adult substance abusers. Unfortunately, many medical professionals do not consider older patients to be at risk for either substance abuse (with the exception of alcohol use) or HIV infection. A study in Texas found that most doctors never asked patients older than 50 years questions about substance abuse or HIV/AIDS or discussed risk factor reduction. Doctors were much more likely to rarely or never ask patients over 50 about HIV/AIDS risk factors (40 percent) than to rarely or never ask patients under 30 (7 percent). Older persons may not be comfortable disclosing their sexual behaviors or substance abuse to others, since their generation or culture may not encourage such disclosures. This can make finding treatment programs and support programs especially difficult.

Certainly, there is a need to educate service providers about the sex- and substance-related behaviors of older persons. At the very least, service providers should conduct thorough sex and substance abuse risk assessments with their patients over 50, and challenge all assumptions that older people do not engage in these activities or will not discuss them.

## Sex Industry Workers

Among sex workers, street prostitutes are the most vulnerable to HIV infection, given the coexisting features of poverty, homelessness, history of childhood sexual abuse, and alcohol and drug dependence. Comparatively, male and female sex workers who work in massage parlors, escort services, their own apartments, or brothels rather than on the street are far less likely to be at risk for

infection, less likely to depend on substances, and more likely to control sexual transactions and insist on condom use.

Seroprevalence rates among sex workers vary dramatically. A 1990 study of nearly 1,400 sex workers in six U.S. cities yielded a seroprevalence rate of 12 percent, ranging from 0 to 47 percent as a function of the city and the level of injection substance abuse. Most alarming was the high association of injection substance abuse and HIV infection rate.

Among female sex workers, IDU continues to be the major cause of HIV infection. Female injection drug users who trade sex for money or drugs are more likely to share syringes than injection drug users who do not exchange sex for money or drugs. Drug use also increases the likelihood of sex work and risky sex. Studies of crack cocaine abusers in three urban neighborhoods found that 68 percent of the women who were regular crack smokers exchanged sex for drugs or money. Of those, 30 percent had not used a condom in 30 days. Recent research has also demonstrated an association between HIV infection, heavy crack use, and unprotected fellatio. This is likely due to the combination of poor dental hygiene, damage to the mouth from hot crack stems or pipes, high frequency of fellatio, and inconsistent or marginal condom use. Street-based sex workers may agree to unprotected sex if clients offer more money, if workers themselves are desperate for money to buy drugs, or if activity has been slow.

HIV treatment challenges may occur given the sex workers' more immediate needs for drugs, food, and housing. These needs overshadow future concerns about living with HIV/AIDS. Beyond this, sex workers with HIV/AIDS may continue to work routinely for the purpose of exchanging sex for drugs or money. Sex workers thus run risks of spreading HIV/AIDS as well as reinfection of HIV and the acquisition and transmission of other diseases such as hepatitis and STDs.

There are many examples of effective treatment programs for sex workers with substance abuse disorders, including the California Prostitutes Education Project (CAL-PEP); Sisters Helping Each Other in Chicago, Illinois; Second Chance in Toledo, Ohio; the Threshold Project in Seattle, Washington; Alternatives for Girls in Detroit, Michigan; and the On the Streets Mobile Unit-Options Program in New York City. Most of these programs use former sex workers as outreach staff, use a risk-reduction model of care, and establish linkages with organizations in the treatment continuum.

## Homeless people

Homeless people suffer higher rates of many diseases, including HIV/AIDS and substance abuse disorders, than the general population. No national statistics exist, but studies within major U.S. cities are illustrative. In a 1990 survey of homeless adults in St. Louis, Missouri, 40 percent of men and 23 percent of women reported substance abuse, and 62 percent of men and 17 percent of women reported alcohol abuse. The value of sex and procreation in many cultures makes it difficult for someone from outside the client's culture, especially someone of a different gender, to tell people to not have sex or to have sex only with a condom.

Finally, it is important that the counselor recognize that much of what is asked of clients and their families is personal and private. Questions related to sex, dying, and substance abuse are not usual topics of conversation, and when asking these questions, the counselor crosses many boundaries. It often is considered disrespectful (and offensive to certain cultural values) to ask questions about these specific areas. One wise way to broach these subjects with clients, especially clients who are significantly older than the provider or from a more traditional culture, is to simply apologize

The most practical advice is for providers to (1) maintain an open mind, (2) use cultural consultants for training and support, and (3) when in doubt, defer to the concepts of health and stability over pathology and dysfunction.

## Gay, lesbian, bisexual, and transgender populations

Providers wishing to serve the needs of particular ethnic or cultural groups have learned that communities must be understood, respected, and consulted in order to make effective interventions; this also holds true when working with gay men, lesbians, and bisexual men and women. This population is defined not by traditionally understood cultural and ethnic minority criteria, but by having a sexual orientation that differs from that of the majority. Transgender people also form a unique population, often linked to gay men, lesbians, and bisexuals, although they differ from the majority by gender identification rather than sexual orientation.

Until recently, there has been no solid agreement about the amount of substances used or the incidence of substance abuse in the gay, lesbian, bisexual, or transgender populations. Most studies, reviews of surveys, and the experiences of most clinicians working with gay men and lesbians have estimated an incidence of substance abuse of all types at approximately 30 percent, with ranges of 28 to 35 percent (contrasting with an incidence of 10 to 12 percent for the general population). The CDC's biannual report on HIV/AIDS clearly indicates a subgroup of gay and male bisexual injection drug users, and one of the routes of HIV infection for lesbians is via IDU.

A careful review of these reports, however, has demonstrated significant and persistent methodological problems, ranging from poor or absent control groups and nonrepresentative population samples (some studies gathered subjects only from gay and lesbian bars) to a failure to use uniform definitions of substance abuse or of homosexuality itself. Nevertheless, a recent study was conducted using data from the 1996 National Household Survey of Drug Abuse (NHSDA), a yearly population-based survey that applies standard epidemiological methods to determine the prevalence of substance use in the U.S. population. This study has concluded that homosexually active women are indeed more likely than heterosexually active women to evidence drug or alcohol dependency.

A sudden increase in the use of methamphetamine, known as "speed," "crystal," "ice," or "crank," by gay and bisexual men has become a matter of grave concern. A primary route of administration for this drug is injection. Combined with its disinhibiting and sexually stimulating effects, gay male injectors of methamphetamine are at extremely high risk for HIV exposure: The drug causes the

abuser to suspend all judgment and often leaves him impotent but extremely sexually aroused and often an anal-receptive partner in sex.

Men who have sex with men (or MSMs--the CDC category used to report its data) may self-identify as gay (men with homosexual sexual orientations), bisexual (men who feel sexually drawn to both men and women), or heterosexual (men having sex with men as a purely physical act and not a reflection of innate sexual orientation). No matter what their sexual orientation, unprotected sexual contact puts MSMs at risk for HIV. In most reviews of gay men and safer sex practices, most men who were knowledgeable about safer sex failed to practice it while under the influence of some substance. Many men from minority backgrounds who have sex with other men do not self-identify as gay or bisexual, so interventions should be based not on sexual orientation, but on sexual behavior.

Some women who have sex with women continue to have sex with men. A number of these women may be injection drug users and share syringes; consequently, they are prone to HIV infection. Although it is unlikely that female-to-female transmission of the virus will occur, lesbians have been urged to use safer sex precautions, such as using dental dams during oral sex.

Lesbians present some specific issues that must be highlighted. Compared with gay men, they are more likely to have lower incomes (as do women in general when compared with men); are more likely to be parents (about one-third of lesbians are biological parents); face prejudice as women as well as for being gay, including the stronger reaction against and willingness to ignore females with substance abuse disorders; are more likely to come out later in life (about 28 years of age versus 18 years of age in men); and are more likely to have bisexual feelings or experiences, so that they are still at sexual risk for HIV infection as well as possible IDU risk.

Gay youth also present treatment challenges. Special sensitivity and understanding are needed to work with youth of any background, especially youth who are gay or lesbian or from an ethnic minority background. Young gay males in particular may be subjected to harassment at home or school; and they are prone to alcohol use, dropping out of school, running away, and getting involved in sex for drugs or money. Many young gay male streetworkers abuse amphetamines, "tweaking" to have a sexual experience, and may exchange sex for drugs.

In general, gay men, lesbians, bisexuals, and transgender people are wary of the medical establishment and may resist seeking health care, distrust the advice given, or question the treatment plan suggested if the provider displays evidence of homophobia or heterosexism.

Transgender individuals

Some substance abuse treatment clients are transgender. The following definitions have been provided to clarify the confusion some providers may feel when working with transgender clients.

Transgender people are a diverse group of individuals who cross or transcend culturally defined categories of gender. They can include the following:

- Male-to-female (MTF) and female-to-male (FTM) *transsexuals*--those who desire or have had hormone therapy or sex reassignment surgery
- *Cross-dressers* or *transvestites*--those who desire to wear clothing associated with another sex
- *Transgenderists*--those who live in the gender role associated with another sex without desiring sex reassignment surgery
- *Bigender persons*--those who identify as both man and woman
- *Drag queens* and *kings*--usually gay men and lesbian women who "do drag" and dress up in, respectively, women's and men's clothing
- *Female* and *male impersonators*--males who impersonate women and females who impersonate men, usually for entertainment

Gender identification is different from sexual orientation. Gender identity refers to a person's basic conviction of being male, female, or transgender. Sexual orientation refers to sexual attraction to others (men, women, or transgender persons). For example, many cross-dressers are heterosexual men who have active sexual relationships with women. Many homosexual men, although historically considered effeminate, identify strongly as men and appear very masculine.

Substance abuse plays a significant role in the high HIV prevalence in MTF transgender individuals. One study that investigated 519 transgender individuals in San Francisco found high rates of substance abuse among both MTF and FTM individuals. The study reported that 55 percent of the MTF sample indicated they had been in substance abuse treatment at some time during their lifetime. The study also found that HIV prevalence was significantly higher among MTF individuals (35 percent) than FTM individuals (2 percent); and among the MTF individuals, HIV prevalence for African Americans was 61 percent. Although the HIV prevalence rate was low in the FTM individuals, they commonly reported engaging in many of the same HIV risk behaviors as the MTF individuals.

Counseling transgender individuals who are HIV positive and in substance abuse treatment can involve many different issues. Some of these issues are obvious: lack of family and social supports, isolation, low self-esteem, and internalized transphobia, to name a few. Some issues are not so obvious; for example, transgender clients currently undergoing hormone therapy often experience emotional and physical changes that can make treatment for substance abuse more difficult and relapse more likely. Although medically managed hormone treatment should not be interrupted, both the clinician and client must be aware that estrogen and testosterone therapies are mind- and mood-altering substances, particularly when incorrectly taken. Improper administration of estrogen mimics the premenstrual symptoms of nontranssexual women, which can have a deleterious effect on recovery. These premenstrual symptoms can trigger or exacerbate Post Acute Withdrawal Syndrome, which is believed to be the leading cause of relapse.

Additional relapse triggers or clinical issues may include the following: (1) inability to find, engage in, or maintain gainful employment due to employer prejudice against transgender individuals; (2) lack of formal education or training because the client was forced to leave school or home before completing his or her education; (3) the fact that HIV-positive transgender clients may be denied sex

reassignment surgery due to their HIV status, even if they are asymptomatic and healthy; and (4) the general lack of substance-free role models and widespread social support for transgender individuals.

## Developing New Substance Abuse Treatment Goals

Altering admission requirements

A "one-size-fits-all" abstinence-based approach to admission effectively serves only a small number of clients. Insisting that clients detoxify and remain substance free prior to admission to substance abuse treatment programs assumes a homogeneity of substance abuse and substance abuse behavior that does not exist.

Providers should realize that some clients use substances as a way to control mood, monitor affect, and adhere to a schedule of activity. Drug use as a life management strategy may seem dysfunctional but is not necessarily a personal deficit. Eliminating substance abuse without understanding the context and role it plays in the lives of clients may, in counter-intuitive fashion, increase the chances of lapse and relapse among clients. Stopping substance abuse without substitutes or proxies for its socially constructed meaning is fraught with risk.

Removing substances of abuse without acknowledgment of the psychological benefits perceived by abusers is also laden with risk. Providers should appreciate (without necessarily agreeing) that many people use substances because they like the way substances make them feel. Many substance abusers find replacement of this feeling extremely difficult, if not impossible, to obtain. Breaking, changing, or altering a chronic cycle of substance abuse is difficult under optimal circumstances where clients have social, psychological, and material supports and services. Changing chronic cycles of substance abuse without these supports and services is not impossible but very nearly so.

Programs should include a harm-reduction treatment track that can accommodate the retention in treatment of clients who are active substance abusers but willing to control their substance use (i.e., agreeing not to consume substances on the premises and agreeing not to participate in programs when under the influence). Admission requirements might be altered depending on level of care, motivation and coping resources of client, and treatment agency and philosophy.

This program flexibility is crucial to improving treatment outcomes. Because HIV is a pandemic that has spread across the globe over the past two decades and remains a public health crisis of epic proportions, an "abstinence-only approach" will not be effective. The goal for treatment programs that serve HIV-infected substance abusers must be to initiate treatment, for these individuals as soon as possible. Awareness of and education in HIV-related issues can help treatment providers recognize potential barriers to effective treatment, such as homophobia and irrational fears of infection, that can occur in both counselors and clients.

What programs should try to achieve in treating the HIV-infected substance abuser is a base of clients who are as healthy as available treatment can make

them. A client who has stabilized his illness has a better chance of decreasing his substance use than one who has not.

## Continuum of Care: Different Treatment Strategies for Different Levels of Care

### Detoxification

Most of the client work during this stage of care is directed at surviving the physical and psychological traumas of separation from addictive substances. The degree and range of trauma will vary greatly depending on the substance used. Often clients will benefit from an initial placement in a 12-Step program to begin the long process of breaking through denial, consciousness raising, and discussing feelings.

Medical supervision during this process is critical. Detoxification of HIV-infected clients presents considerations not usually encountered in other clients. Many HIV-infected clients either are on, or will soon be on, a complicated schedule of medications to which strict adherence is necessary. These clients may also suffer from medical conditions that have occurred as a result of the disease, which can interfere with the detoxification process. Thus, while the counselor focuses on the client's psychosocial issues, it is imperative that an experienced physician monitor her closely and supervise treatment during this process.

### Inpatient and Residential Treatment

Care strategies during inpatient treatment consist of consciousness raising, contemplation of behavior and personal changes around risky behaviors, and developing plans for action. It is recommended further that clients begin to discuss the problems of relapse and the interaction of competing problems from sex and drug domains.

Individual therapy is often used to clarify comments and observations raised by clients who participate in group therapy, which in turn usually reinforces personal gains achieved in individual sessions. Group therapy is optimal for consciousness raising and convincing clients to move toward a more consistent level of safe behaviors. During this initial period, efforts should be made simply to get the client to begin thinking about safer behaviors and activities.

### Individual Therapy Strategies

Clients may raise several issues in therapy that then become clinical issues. Following are common issues that clients raise during the inpatient treatment process along with suggested responses from the counselor during individual therapy:

- *Feeling the problem (of HIV infection or living with AIDS) has not "hit them" yet*. The counselor can provide the client with education about risky

behaviors, living with AIDS, and so on. Presenting the client with future scenarios and life trajectories if behaviors remain unchanged may be helpful. Sharing success stories about positive changes in peers may also be a helpful strategy.

- *Expressing the need to make their own decisions and choices regarding care, treatment, and their lives*. Counselors should underscore the fact that clients must decide what is in their best interests, taking care to define "their best interests" within the client's definition of self as an individual, a provider, a parent or caregiver, a member of a family or community, or a combination thereof. Counselors should balance this by letting clients know that no one has all the answers to their problems, and reassure clients that their feelings are valid, not unusual, and realistic. Changing one's life is hard work.
- *Knowing how to change behavior, yet not making these changes*. The counselor should support client efforts to reduce risk behaviors but educate the client as to why risk remains. Exploring what the client is willing to consider changing provides an outline of possible actions. Working together with the client on strategies to resolve barriers to change in small steps may be a useful tactic as well.
- *Giving up hope for change or feeling overwhelmed by problems*. Workers should reassure clients that their feelings are typical and that change is hard. Telling clients about positive role models who have successfully changed after facing many difficulties along the way is another useful approach.

Service providers should know that this initial phase of client change is the longest and most difficult for many clients. It is not uncommon for clients to spend a lot of time in inpatient treatment weighing the pros and cons of their behavior. Clients may have invested much energy in intentionally not thinking about the problem. Thinking about the problem may surface painful issues (real or perceived) for clients that they have not allowed themselves to reflect on. Service providers should be acutely aware of the power of denial for many substance-abusing clients living with HIV/AIDS.

It is often difficult for the client to anticipate potential problems, interactions, and pitfalls, particularly those that will be faced in the external community. The counselor must help the client examine the barriers that may arise and develop strong responsive coping skills and activities. A weak plan of action can lead to quick lapses and relapses. This level of client activity (preparing for action) is characterized by switches in both personal external cues for behaviors and the ways in which clients perceive and cope with internal situations. This is a time for counselors to develop specific plans and identify individuals in a person's social environment who may provide support or information to the client upon discharge.

The idea of self-liberation can be used to influence a client to choose to act in a specific manner or believe in his ability to change. Clients can benefit from thinking about what may change once the new behavior(s) have begun so they can be prepared for those changes. Questions similar to the following can be used to facilitate self-liberation:

- Is this what you want to do? Are you prepared for the risks involved?

- What are your reasons for changing your behavior?
- When do you want to make your change?
- What problems do you think you may face in the future?
- Whom have you discussed this with?
- How do you feel the environment is going to affect your change?
- Are there any support groups you could join in the area? Would you like to join any?

Group Therapy Strategies

The gains made in individual treatment can be consolidated in well-designed and well-facilitated group therapy. Consciousness-raising techniques may help when talking with a client who seems to lack basic information about behaviors or topics, such as HIV transmission. Questions such as the following can determine how much consciousness raising is needed:

- What are your concerns about HIV/AIDS?
- What do you think about "cleaning your works" in order to protect yourself?

Dramatic relief strategies can be used when talking with a client who knows something about topics like HIV/AIDS but still engages in unsafe behavior. Questions such as the following are helpful in determining the level of dramatic relief strategies:

- Do you feel you are at risk for HIV/AIDS?
- Do you worry about getting an STD?

Group therapy also can be used to present role models (peers) who have successfully addressed many of the issues clients in inpatient treatment may face. Peer programs can provide support for substance recovery and other psychosocial services. There are many resources in the community for these interventions; all a program must provide is a meeting place. It is helpful if the peer group facilitator has some training, even if this consists solely of the orientation that all substance abuse treatment program volunteers receive. Because they are not led by professionals, peer groups may be limited in what they can achieve. However, the absence of professional involvement may give peer groups greater credibility with hard-to-reach clients.

Self-reevaluation (or self-reflection) and environmental reevaluation are good activities to use in group settings during inpatient treatment when clients might be motivated to change behavior. Self-reevaluation occurs when clients think about their behavior, and environmental reevaluation occurs when they think about the impact of their behavior on others. A counselor can initiate self-reevaluation by asking questions such as the following:

- How would you feel about bleaching all the time?
- Are there times you are willing to take risks by not using a condom? Why or why not?
- How often do you think about HIV/AIDS?

- Do you ever worry about getting something from your partner? What do you worry about? Why do you worry?
- Do you ever worry about giving something to your partner? What do you worry about? Why do you worry?

Environmental reevaluation can be facilitated with questions such as the following:

- How does your partner (partners) feel about using condoms?
- How would your partner (partners) feel if condoms were used?
- Do people close to you ever talk about your addiction? What do they say?
- Do people close to you ever talk about HIV/AIDS? What do they say?
- How does your addiction affect people who are close to you?

Group therapy in inpatient settings can be very helpful in setting the stage for actual behavior change. It is challenging for clients who have started to change behavior within a structured setting to continue the change when they return to the less structured environment from which they came. This environment may not necessarily support newly acquired lifestyle changes.

Stage of HIV Infection

Segregating groups by stage of HIV infection presents difficulties, but not doing so can also be problematic. Clients who are HIV positive but asymptomatic and attending a support group for the first time may be uncomfortable when encountering clients in the late stages of AIDS. Such a meeting may force them to confront fears about their own mortality before they are ready to do so.

Because treatment programs have limited resources, separating groups by stage of HIV infection may be impractical. Programs able to support separate groups may wish to use the three-group model, with groups consisting of

- Clients newly aware of their positive HIV status
- Those who are asymptomatic or mildly symptomatic
- Those with more advanced disease

The interplay between substance abuse disorders and HIV infection in groups can be complicated. As clients move further into substance abuse recovery, they may be getting progressively more ill from HIV disease. In a mixed group, healthier clients may provide support to sicker ones.

In a group consisting solely of clients symptomatic with AIDS, members are vulnerable to becoming involved in a process of continual grieving. Sometimes groups have to discontinue for a period of time when too many members become sick or die. For this reason, it may be helpful to establish support groups for time-limited periods.

Outpatient Treatment

Outpatient treatment consolidates the gains made in the detoxification and inpatient and residential treatment levels of care. Typically, clients may still need to think about change or begin to plan for change on their discharge from inpatient or residential treatment. On entering outpatient treatment, clients may have actually begun some behavior change, but the novelty of the change can lead to relapse as the client moves away from the controlled and structured environment.

Clients in outpatient treatment usually need support from at least one other person who cares about them. This can be a time when clients are vulnerable because as they change, others around them may change in response. Friends and significant others may feel threatened, abandoned, jealous, or angry and may try to sabotage the client's efforts. This puts tremendous pressure on clients because they are experiencing new feelings and new, difficult ways of life. Although many of these life changes may be positive, they are also unfamiliar for many clients.

During outpatient treatment, group therapy could focus on the use of successful peers in modeling helpful but difficult strategies such as stimulus control and counter conditioning. Individual therapy will involve helping the client balance and coordinate recovery with other issues, such as assessing client responses and concerns with case management, care coordination, and child and family issues when relevant.

Stimulus control and counter conditioning are two strategies clients may find helpful. Stimulus control helps clients restructure their environment so they can avoid circumstances that elicit problem behaviors. There are three methods for managing tempting stimuli:

- Develop a plan for managing the situation.
- Manage the situation so the temptation does not occur. For instance, a person who knows alcohol puts her at risk for unsafe sex will not drink when sex may occur.
- Restructure the environment so that stimuli for more positive events occur and so clients remain aware of people, places, and things that cause relapse.

In developing stimulus control strategies, consider developing questions such as the following:

- What are the situations where you may be at risk of not using a condom?
- How can you avoid them?
- How do you stay safe when you have sex?
- Where do you keep your condoms?
- What are the situations in which you find yourself using substances?
- Do you keep your own "works" with you?
- When are you tempted not to bleach?

Counter conditioning involves exchanging risky behaviors with less risky alternatives in situations that are not amenable to stimulus control. To develop counter conditioning strategies, questions such as the following can be used:

- If you found yourself in a situation where you were tempted to have sex without a condom, how could you deal with it so that you could have safer sex?

- How would you deal with a situation where you insisted on having safer sex and your partner got angry?

A major risk during outpatient treatment is the involvement of the client in sexual networks and sexual mixing. Many clients in treatment may select sexual partners from similar networks (recovery programs, 12-Step meetings, and so on). These partners might include persons who have used syringes, traded sex for drugs or money, been victims of trauma, or been incarcerated. All of these populations may have higher rates of HIV infection, making transmission more likely, and clients should be counseled about these risks.

Drop-in Centers

Drop-in centers are an excellent way to engage homeless people in treatment. These centers offer a needed service for substance-abusing individuals who are homeless. As individuals start dropping in, they begin to interact with staff and form trusting relationships, which builds a necessary foundation for beginning treatment. The use of maintenance strategies characterizes treatment in drop-in centers. At this phase, service providers must work to prevent relapse and bring together the gains achieved during inpatient and outpatient treatment. During this time, clients may have learned to adjust their new behavior to the environment in which they live, and the behavior has perhaps become habitual.

Also during this time, many clients relapse and may return to earlier treatment levels and milestones. As discussed elsewhere, there are many factors leading to client relapse. Situations such as breaking off relationships, starting new ones, severe temptation, or lack of environmental support may contribute to relapse. In addition, the client can easily choose not to try again due to the negative feelings associated with relapse such as shame, embarrassment, guilt, failure, regret, anger, or denial.

Service providers may work with clients so that they can realize that their past successes indicate better chances of success in the future. They should underscore the fact that clients have learned new ways of coping with old behaviors and have developed supportive relationships. Service providers may find the use of reinforcement management a helpful strategy that can be facilitated in either individual or group level modes. Reinforcement management helps clients develop internal and external reinforcers and rewards that increase the chance of new behaviors continuing.

Workers can also reassure clients that relapse encounters are part of an ongoing process. Helping clients determine what caused the slip can be useful in helping them develop strategies to avoid lapses in the future. Workers can also work with clients to help them learn more about themselves, their environment, and their addiction and risky behaviors.

Questions similar to the following can help determine if clients need better or more reinforcement management:

- Do you feel good about your new behavior?
- What kind of things do you tell yourself, knowing you are practicing safer sex?

- What kind of things do you tell yourself, knowing you are controlling your substance abuse?

## Counseling Terminally Ill Clients

The counseling of ill and dying clients should be supportive and nonconfrontational, addressing issues relevant to the client's illness at a pace determined by the client. However, clients are not the only ones to be affected by the approach of death; counselors too may need assistance in dealing with clients' deaths. This section addresses the issues of denial, planning for death, pain management, unfinished business, and bereavement. A five-stage bereavement and loss model, based on Elisabeth Kubler-Ross' book On Death and Dying, also is presented.

### Denial

Denial about a client's HIV/AIDS diagnosis can be experienced by both clients and counselors. Denial is a natural response and should be confronted only if it causes harm; for example, when a client who is in denial about his illness delays in making arrangements for medical and nursing care or procuring assistance with daily living activities. Counseling can play an important role in helping clients accept their illness and the eventual need for home health or hospice care.

Denial can also affect counselors. For example, because of the advances being made in the medical treatment of HIV/AIDS, a counselor may be in denial that a client will die of AIDS. Counselors must recognize and confront their own denial issues so that they are able to discuss death and dying and realistically explore these issues with their clients. Programs need to have in-service education and proper supervision for counselors who work with terminally ill clients. Proper supervision will help the counselor confront her denial and help lessen her stress.

### Planning for Death

It is often difficult for a counselor to know how or when to talk to a client about planning for death. It is optimal, if possible, to begin a discussion of the client's future, including death, before the client is extremely ill. Questions that often lead the counselor into a discussion of death and dying, and also are centered on contingency planning, include, "If you were to become too ill to care for yourself any longer, what would you do? Who would help? Where would you go?" The counselor and client should also consider where the client would like to die because different arrangements may be required.

Counselors who will be working with clients at the end stages of AIDS should examine their own beliefs about death and dying. In addition to this, counselors may need to learn about the physical and biological process of dying so that it can be explained to clients. It is also important to keep in mind that clients' perspectives on

death and dying are deeply rooted in their personal histories, religious practices, ethnic customs, family traditions, and community standards.

Many clients fear dying alone or in pain, or of losing control of their bodily functions, and thus having to rely on others for care. If clients want to talk about this personal and often frightening experience, the counselor should listen and help the client locate answers to any questions concerning the process of dying. Counselors should ask their clients how much they want to know and make sure that clients know what to expect physically. Understanding the process and planning the details within their power can give clients a sense of control.

In addition, clients may ask counselors to share their own beliefs about death and dying. Minimal sharing can be reassuring, but counselors should focus on the clients' perspectives, beliefs, and needs. As counselors listen, valuable information and insight into possible resources and support needed by clients will come to light.

Pain Management

Pain management is often a difficult struggle for those who are in the end stages of AIDS. The issue of pain is complex because many medical conditions related to a client's HIV/AIDS can cause pain. Clinicians may be concerned that pain medications may reinforce an addiction. Also, clients who have achieved abstinence from drugs may not wish to use medications for pain relief. Another concern of clients is the appropriateness of pain management when it might hasten death. If a client raises this issue, the counselor should be prepared to discuss it; however, the counselor does not initiate discussion on this topic. If the topic arises, clients should be encouraged to discuss pain management issues with their physicians and, if appropriate, their significant others.

## Unfinished Business

One important area that counselors should explore with their clients is "unfinished business." For example, a counselor might suggest that a client make a will. But there may remain other issues to be addressed. Should a client consider making an advance directive or a living will? Will the client want to appoint a health care proxy? Should he consider granting power of attorney to a significant other? Should he appoint a guardian for his children? Are there family issues that he wants to address?

Some counselors express a desire to be there at the time of a client's death, or a client may request that someone be there until death. During this time, counselors and health care providers may also spend more time counseling the client's significant others or support people than they spend counseling the client. Here again, a little information can go a long way to reduce fear and anxiety in clients and their significant others.

## Bereavement

Bereavement is a particular problem for programs with large numbers of HIV-infected clients. Bereavement can affect clients (who may grieve at the deaths of other clients, friends, or loved ones from HIV/AIDS); clients' significant others; and counselors who work with dying clients. The following strategies may be helpful in supporting those clients who are dealing with bereavement.

- Acknowledge the reality of the bereavement in supportive individual counseling.
- Encourage the expression of grief both verbally and nonverbally (e.g., art therapy, expressive movement, and psychodrama).
- Provide group support for clients and their significant others who are experiencing grief and bereavement.
- Acknowledge deaths with memorial services, flowers, photographs, and participation in commemorative projects such as The NAMES Project Foundation's AIDS Memorial Quilt, which attempts to include the names of everyone who has died of AIDS.

### *Kubler-Ross Bereavement and Loss Model*

One of the best and most often referred to models of bereavement and loss comes from physician and psychiatrist Elisabeth Kubler-Ross. In her book, On Death and Dying, she provides a five-stage theory that has become common language when dealing with death and dying. Her model of bereavement is essentially a series of defense mechanisms, or coping strategies, that are used by an individual confronted by death. These stages can also be observed as individuals are confronted with other traumatic circumstances or information, such as a positive HIV test, an HIV/AIDS diagnosis, or the death of a friend or peer. The five stages are denial, anger, bargaining, depression, and acceptance.

Individual interpretations of and responses to death and dying vary greatly, not only between people, but between cultures and religions. Yet, as this model eloquently describes, adjusting to death is a process, not an event that occurs seamlessly and in a logical sequential order.

The coping strategies and stages described below are not a recipe for health. Acceptance may not be the goal for everyone. Emotional processing is made more challenging when survival needs such as shelter, food, and medical care are not being met. Many clients are used to surviving with "street smarts" and not by psychoanalytical parameters and discussions about childhood. This model is included merely to help providers understand and relate to their experiences and their clients' experiences.

- Denial

This is a time of terror management, an effort to psychologically buy some time while adjusting to the information or situation. It is here that people can feel the most isolated and the most suspicious and doubtful of the information that they are receiving. Denial is a natural and healthy response. It is not necessarily something that counselors must feel compelled to confront and rid clients of at the earliest possible moment. Allowing clients to have denial can be challenging, and for the caregivers and support staff it can be anxiety producing, but it is important to remember that above all else, this is the client's experience. Denial is not always negative. The times that denial must be confronted are when it causes a danger to self or others.

- Anger

This stage emerges as the person accepts the diagnosis and begins to strike out. The most common targets for this anger are the people closest and safest to him, especially caregivers and service providers. Anger can also be a test. The person facing death may want to know who can be counted on as the end nears. This can sometimes be indirectly demonstrated by the client who may test the counselor's tolerance of anger; if the anger can be tolerated, perhaps the counselor can be trusted to tolerate the client's death and feelings of fear.

- Bargaining

Bargaining is the stage at which the individual commits to an uncommonly generous or humanitarian act with the belief that she will be spared or miraculously cured if deemed "good enough." The goal is a miraculous correction of the wrongs she has done, or possibly to buy some valuable time for treatment or dealing with end-of-life issues. The obvious danger is that most are not "cured" in that sense of the word, so what can happen is a loss of belief or faith.

- Depression

Depression represents a loss of denial, and an acknowledgment that the information is accurate and the situation and its consequences are unavoidable. As with clinical depression, the depth and severity depends on the specifics of the situation, mitigating factors, available resources, and the individual. This stage is

marked by surrender to sadness; it is appropriate and adaptive. It is a time to collect resources and energies so that more processing can occur at a later time.

- Acceptance

This is the stage in which some come to terms with their situation and feel a welcomed release from struggle and strife. Option formation and reality-based planning, given the circumstances, become the focus. Acceptance occurs when there is agreement between the physical body, the emotional heart, and the cognitive mind, that death will eventually be the outcome.

No Code or Do-Not-Resuscitate Orders

The responsibilities for determining when, how, and under what circumstances to evoke or effect no code or do-not-resuscitate (DNR) orders are properly the role of the family, or those with power of attorney, and the physician. The order itself comes from the physician or from the client through the physician. Although alcohol and drug counselors do not initiate discussion of this topic, they should be aware of these terms and what they mean so that they can help prepare and inform the client and his family of these options.

No code and DNR are terms used while a client is receiving care at an inpatient facility to identify a client who does not wish to receive medical intervention to save his life. For example, if a client has a DNR order and his heart stopped, he would not receive electric shock or cardiopulmonary resuscitation. It is the framing of these decisions and the terms used to help clients understand them that make all the difference. A counselor can help clients and their families talk about these concerns by first normalizing the process. That is, to present issues as no codes or DNRs, wills, and guardianship of minor children as decisions each person or family must come to grips with--whether they are ill or not, HIV positive or not. Counselors can approach and begin to discuss these issues within a context of "hoping for the best and planning for the worst." The discussion, then, is not related to being terminally ill, but rather to choosing, taking control, and making difficult, responsible decisions.

It also is helpful for the client or the family to discuss with the physician changing the goal of medical treatment. For example, at some point in the treatment process, when death is imminent and further aggressive medical intervention will be futile, the goal of treatment could be changed to "comfort care" from "no code."

Some States also permit a person who has been discharged from a hospital to home to have a DNR, which can be tacked to the door. The drawback of home DNRs is when a client dies and emergency medical personnel arrive, in most places they are required to try to revive the client. A counselor should be familiar with State laws about home DNRs so that a client who wants to die at home can be given the best information about this option.

Health care providers and counselors must maintain a sense of how their communication efforts are affecting the people they are trying to help. A specific and practical example of this is in discussions around no code or DNR orders. As health care providers discuss treatment options with clients and their significant others and

the possibility of changing the goal of treatment to comfort care, one distinction that can be helpful for some people is the difference between "life support" and "death prolonging."

The current standard of care as defined by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) states that providers should develop a framework for decision making in situations that may require the withholding of resuscitative services or the foregoing or withdrawing of life-sustaining treatment. Decision making in such cases should reflect the following priorities:

- Enhancing the client's comfort and dignity by addressing treatment of primary and secondary symptoms
- Effectively managing pain
- Responding to the client's and his family's psychosocial, spiritual, and cultural needs

Many believe that decisions about medical treatment should not be based on "heroic" or "extraordinary" measures, or on medical complexity. They should be based on the potential outcomes and the benefits and burdens to clients and their support systems. An open and honest dialogue with the client, followed by a similar meeting with the entire care team, can facilitate decisions and move people to a place of comfort and resolution. Many States allow an individual to designate someone to serve as their "Durable Power of Attorney" for health care. Staff and clients should know what the State's regulations are.

Assisting Clients in Preparing Their Children for the Loss of a Parent

It is estimated that the number of children orphaned by HIV/AIDS will increase by 200 percent in the next 20 years. Parents living with HIV/AIDS face a multitude of issues in preparing both seropositive and seronegative children for the loss of their parents. Fortunately, the child care system is developing credible guidelines on working with children of parents living with HIV/AIDS. In addition, placing a focus on providing for the future care and maintenance of the children can serve as a cause for personal motivation and empowerment. Pragmatically, clients should be assisted in preparing their children for the loss of parents in the following areas:

- **Legal guardianship**. Workers should help clients identify significant others or friends within the client system who could serve as legal guardians for their children. By stressing that children without legal guardianship become wards of the State, clients sometimes find the motivation to search for and secure guardians for their children. Workers should understand that the search for guardians for children of clients with substance abuse and HIV/AIDS-related issues can be difficult because clients often have exhausted their support system of family and friends well before involvement in formal treatment systems or programs.
- **Standby guardianship**. A standby guardian is someone who agrees to stand ready to assume guardianship (legal responsibility) for a minor when the parent of that child dies or becomes incapacitated. A parent will use the procedure when there is significant risk that he will die or become

incapacitated within a certain period of time (e.g., in New York, this period is 2 years). The parent must usually petition a court for the appointment of a specific individual to be the standby guardian. The standby guardian can assume responsibility when the parent becomes incapacitated and then relinquish it when and if the parent recovers. The standby guardian's authority is effective when she receives notification of the parent's incapacity or death.

- **Leaving a legacy of living memories**. An agency approach that is often used in working with parents is to create living legacies for their children. For instance, families may be encouraged to make videotapes or audiotapes of themselves for their children. The National Hospice Organization has an excellent library of grief and bereavement materials, including some very good age-appropriate materials for children.
- **Dealing with survivor guilt**. The issue of survivor guilt is relevant for all family members but particularly so for the infected parent whose infant dies first. The problem of guilt must be brought forth, discussed, and processed so that clients can take a more proactive approach to their other problems.

## HIV and Risk of Relapse

Declining health as a result of HIV disease is a recognized risk factor for relapse into substance abuse. Physical and psychological stresses associated with HIV disease include pain, decreased functional ability, fatigue, and weakness; as well as fear, anxiety, grief, and possibly increased isolation and separation from loved ones. All of which increase individuals' risk of resuming substance abuse.

HIV/AIDS milestones are significant for the client, her significant others, and her support network. Counselors often can anticipate crisis, upset, or a readiness for change when a client reaches an HIV/AIDS milestone. Counselors who know and understand these milestones have an opportunity to prepare clients through the development of coping skills and strategies. It is a time of great opportunity for change (becoming clean and sober) or for relapsing. Milestones can create the impetus for a new way and learning new behaviors, or they can serve as an impetus for clients to act in self-destructive or harmful ways.

Following are some of the milestones of HIV infection that counselors should learn to recognize.

- Taking an HIV test
- Receiving positive or negative HIV test results
- Experiencing the first symptoms
- Experiencing the first opportunistic infection
- Experiencing the first AIDS-related hospitalization
- Being diagnosed with AIDS
- Losing a friend, or significant other who dies from AIDS
- Beginning the medication regimen
- Experiencing little or no response to various medication regimens
- Decreasing CD4+ T cell count or increasing viral load

Alcohol and drug counselors may wish to suggest the following strategies to clients who are at risk of relapse because of HIV-related stress:

- Individual counseling
- Participation in a peer support group
- Medical attention to relieve physical discomfort and alleviate anxiety
- Relaxation and stress management techniques
- Recreational activities

Dealing with Client Relapse

The most successful relapse counseling is nonjudgmental. However, clients should understand that preventing relapse is their responsibility. If a client relapses into a risk behavior for substance abuse or HIV, the counselor's role is to help the client to understand the conditions that caused the behavior to occur and to identify alternative behaviors that could have been substituted to prevent the relapse. Relapse should be viewed as a learning experience and part of the recovery process. Clients should not be dismissed from substance abuse treatment or HIV/AIDS support groups because of a relapse. Rather, peer pressure may be constructively used to help clients acknowledge the reasons for and the consequences of their actions.

However, if the client's relapse includes the risk of nonadherence to HIV medications, these medications should be stopped entirely to prevent the emergence of resistance. Once the client is recommitted to therapy, the regimen should be reevaluated.

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# Appendix A: Post Test and Evaluation Substance Abuse Counseling for Clients with HIV / AIDS

**Directions**: To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEU Matrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions. Then, submit your test to us for processing. This can be done in any **one** of the following manners:

1. *Submit your test via the Internet.* All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions using the answer sheet found at the end of this appendix. Then, return to your browser and go to the Student Center located at:

   http://www.ceumatrix.com/studentcenter

   Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'Take Exam' and you will be presented with the electronic exam.

   To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater, you will receive a link to the course evaluation. , which is the final step in the process. Once you submit the evaluation, you will receive a link to the Certificate of Completion. This is the final step in the process, and you may save and / or print your Certificate of Completion.

   If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

   **OR**

2. *Submit your test by mail using the answer sheet found at the end of this package.* First, complete the cover page that will identify the course and provide us with the information that will be included in your Certificate of Completion. Then, answer each of the questions by selecting the best response available and marking your answers on the sheet. The final step is to complete the course evaluation (most certifying bodies require a course evaluation before certificates of completion can be issued). Once completed, mail the information, answer and evaluation sheets to this address:

   **CEU Matrix - The Institute for Addiction and Criminal Justice Studies**
   **P.O. Box 2000**
   **Georgetown, TX 78627**

   Once we receive your exam and evaluation sheets, we will grade your test and notify you of the results.

   If successful, you will be able to access your Certificate of Completion and print it. Access your browser and go to the Student Center located at:

   http://www.ceumatrix.com/studentcenter

   Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'Certificate' and you will be presented with a download of your Certificate of Completion that you may save / and or print. If you would rather have your Certificate of Completion mailed to you, please let us know when you mail your exam and evaluation sheets; or contact us at ceumatrix@ceumatrix.com or 800.421.4609.

   If you do not obtain the required 80% score, we will provide you with feedback and instructions for retesting.

   **OR**

3. *Submit your test by fax.* Simply follow the instructions above, but rather than mailing your sheets, fax them to us at **((512) 863-2231**.

If you have any difficulty with this process, or need assistance, please e-mail us at **ceumatrix@ceumatrix.com** and ask for help.

**Answer the following questions by selecting the most appropriate response.**

1. The pandemics of substance abuse and HIV/AIDS are:
   a. Intergenetic
   b. Dually morbid
   c. Interconnected
   d. Intertwined
   e. Episodic

2. Injection drug users who test _____ for HIV are _____ likely to enter treatment than those who test _____.
   a. Negative, more, negative
   b. Positive, more, negative
   c. Positive, less, negative
   d. Negative, more, positive
   e. Positive, more, positive

3. A treatment outcome for HIV and substance abuse treatment is:
   a. Deisolation
   b. Constitutional fortification
   c. Decriminalization
   d. Socialization
   e. Stabilization

4. A set of thoughts, feelings, and beliefs experienced by a service provider that occurs in response to the client is _____.
   a. Counter reaction
   b. Reactive inhibition
   c. Counter transference
   d. Transference
   e. Transendal reaction

5. The desire to provide quality services and a commitment to _____ should be the driving forces for treatment.
   a. “do unto others”
   b. “do your thing”
   c. “just do it”
   d. “do no harm”
   e. “for better, for worse”

6. The symptom-relieving aspects of Substance abuse can
   a. Help fight the effects of homophobia
   b. Allow forbidden behavior
   c. Allow social comfort in bars
   d. Provide comfort from the dissociative state
   e. All of the above

7. The institutional form of homophobia is:
   a. Heterosexism
   b. Cultural homophobia
   c. Coming out
   d. Internalized homophobia
   e. Oppression

8. In recent years, service providers have been assessed for:
   a. STDs
   b. TBI
   c. ADHD
   d. PTSD
   e. Names

9. Burnout is also referred to as:
   a. Stress overload
   b. Fatigue
   c. Bereavement overload
   d. Time incompetency
   e. Mental health overload

10. Substance-abusing clients living with HIV/AIDS are:
    a. Malnourished
    b. Undernourished
    c. Protein deficient
    d. Anemic
    e. All of the above

11. The defining symptom of AIDs since 1987 is:
    a. Anorexia
    b. Altered metabolism syndrome
    c. Wasting syndrome
    d. Androgen syndrome
    e. Malabsorption syndrome

12. Lipodystrophy syndrome occurs in what stage of AIDS?
    a. Early
    b. Middle
    c. Late
    d. Primary
    e. Secondary

13. Integrative therapies include:
    a. Acupuncture
    b. Tai chi
    c. Q-igong
    d. Massage
    e. All of the above

14. The number of women living with HIV/AIDS:
    a. Has leveled off
    b. Decreased
    c. Slowly increased
    d. Has been cyclical
    e. Steadily increased

15. The relationship between social relationships and health in substance abusers with HIV/AIDS is:
    a. Euphoric
    b. Ambivalent
    c. Hostile
    d. Peaceful
    e. Morbid

16. Fear of disclosure of HIV-Status is created by:
    a. Dysthymia
    b. Dysphoria
    c. Anorexia
    d. PTSD
    e. Stigma

17. Disclosing HIV status in a group therapy session where there are members who are not HIV should be done with:
    a. Openness
    b. Honesty
    c. Little concern
    d. Assertiveness
    e. Caution

18. What percent of prison inmates were HIV-positive in 2004?
    a. 5
    b. 3.8
    c. 1.8
    d. 6
    e. 4.8

19. What percent of HIV infected persons spend time in a correctional facility each year:
    a. 5
    b. 25
    c. 10
    d. 6
    e. 30

20. Many HIV-infected individuals find it impossible to remain on medication after being arrested because their medications are:
    a. Contaminated
    b. Stolen
    c. Diluted
    d. Confiscated
    e. Deteriorated

21. What percent of substance abusers participate in treatment programs?
    a. <15
    b. 25
    c. >35
    d. 17
    e. 20

22. Correctional medical and security staff usually disagree over:
    a. Cigarette distribution
    b. Contraband
    c. Syringe distribution
    d. Condom availability
    e. Tattooing availability

23. Few inmates request HIV testing because of what concern?
    a. Confidentiality
    b. Infection
    c. Pneumonia
    d. Punishment
    e. Money

24. Mandatory testing for HIV for inmates may result in:
    a. Pneumonia
    b. PTSD
    c. Segmentation
    d. Integration
    e. Segregation

25. Combination therapy may not be available to inmates because of _____ problems.
    a. Refraction requirements
    b. Refrigeration requirements
    c. Retrograde issues
    d. Retroactive issues
    e. Detox requirements

26. Inmates are more likely to relapse if they were not assessed for:
    a. Risk level
    b. Needs
    c. Criminal sentiments
    d. Responsivity level
    e. All of the above

27. What percent of inmates in a 1995 study reported injection of drugs during the first day after release?
    a. 51
    b. 21
    c. 11
    d. 2
    e. 5

28. Support services provided by outside organizations for HIV-positive inmates dropped between 1997 and 2005 from 67% to _____ in state and federal systems.
    a. 5%
    b. 28%
    c. 36%
    d. 40%
    e. 15%

29. Exchanging risky behaviors with less risky alternatives is termed _____.
    a. Counter transference
    b. Premack principle
    c. Fading
    d. Extinction
    e. Counter conditioning

30. The bereavement and loss model based on Kubler Ross' work involves _____ stages.
    a. 4
    b. 10
    c. 5
    d. 6
    e. 8

31. Women usually present _____ in the HIV/AIDS disease process than men.
    a. Earlier
    b. About the same time
    c. Later
    d. More unpredictably
    e. More falsely

32. Prediction of which mothers will transmit HIV to their infants is:
    a. 50%
    b. 98%
    c. Precise
    d. Known
    e. Unknown

33. Hispanics are overrepresented among HIV/AIDS cases for:
    a. Men
    b. Women
    c. Children
    d. All of the above
    e. None of the above

34. Service providers should shed the notion of the _____ minority.
    a. Model
    b. Median
    c. Mean
    d. Mode
    e. Norm

35. MSM is the category to report
    a. Male street worker using meth
    b. Metro sexual men
    c. Meth sexual men
    d. Model situational morals
    e. Men who have sex with men

Fax/Mail Answer Sheet

*CEU Matrix - The Institute for Addiction and Criminal Justice Studies*

Test results for the course "Substance Abuse Counseling for Clients with HIV / AIDS

**If you submit your test results online, you do not need to return this form.**

Name*:_____

**(* Please print your name as you want it to appear on your certificate)**

Address: _____

City: _____

State: _____

Zip Code: _____

Social Security #*: _____

**(*Most certifying bodies require a personal identification number of some sort – last 4 digits or License is perfect.)**

Phone Number: _____

Fax Number: _____

E-mail Address: _____

On the following sheet, mark your answers clearly. Once you have completed the test, please return this sheet and the answer sheet in ***one*** of the following ways:

1. Fax your answer sheets to the following phone number: **(512) 863-2231**. This fax machine is available 24 hours per day. **OR**

2. Send the answer sheet to:
   **CEU Matrix - The Institute for Addiction and Criminal Justice Studies**
   **P.O. Box 2000**
   **Georgetown, TX 78627**

You will receive notification of your score within 48 business hours of our receipt of the answer sheet. If you do not pass the exam, you will receive instructions at that time.

**Name:** _____

**Course: <u>Substance Abuse Counseling for Clients with HIV / AIDS</u>**

1. [A] [B] [C] [D] [E]
2. [A] [B] [C] [D] [E]
3. [A] [B] [C] [D] [E]
4. [A] [B] [C] [D] [E]
5. [A] [B] [C] [D] [E]
6. [A] [B] [C] [D] [E]
7. [A] [B] [C] [D] [E]
8. [A] [B] [C] [D] [E]
9. [A] [B] [C] [D] [E]
10. [A] [B] [C] [D] [E]
11. [A] [B] [C] [D] [E]
12. [A] [B] [C] [D] [E]
13. [A] [B] [C] [D] [E]
14. [A] [B] [C] [D] [E]
15. [A] [B] [C] [D] [E]
16. [A] [B] [C] [D] [E]
17. [A] [B] [C] [D] [E]
18. [A] [B] [C] [D] [E]
19. [A] [B] [C] [D] [E]
20. [A] [B] [C] [D] [E]
21. [A] [B] [C] [D] [E]
22. [A] [B] [C] [D] [E]
23. [A] [B] [C] [D] [E]
24. [A] [B] [C] [D] [E]
25. [A] [B] [C] [D] [E]
26. [A] [B] [C] [D] [E]
27. [A] [B] [C] [D] [E]
28. [A] [B] [C] [D] [E]
29. [A] [B] [C] [D] [E]
30. [A] [B] [C] [D] [E]
31. [A] [B] [C] [D] [E]
32. [A] [B] [C] [D] [E]
33. [A] [B] [C] [D] [E]
34. [A] [B] [C] [D] [E]
35. [A] [B] [C] [D] [E]

The final step in the process required to obtain your course certificate is to complete this course evaluation. These evaluations are used to assist us in making sure that the course content meets the needs and expectations of our students. Please fill in the information completely and include any comments in the spaces provided. Then, if mailing or faxing your test results, return this form along with your answer sheet for processing. **If you submit your evaluation online, you do not need to return this form.**

NAME:_____

COURSE TITLE: Substance Abuse Counseling for Clients with HIV / AIDS

DATE:_____

| **COURSE CONTENT** | | |
|---|---|---|
| **Information presented met the goals and objectives stated for this course** | ☐ Start Over<br>☐ Good<br>☐ Excellent | ☐ Needs work<br>☐ Very Good |
| **Information was relevant** | ☐ Start Over<br>☐ Good<br>☐ Excellent | ☐ Needs work<br>☐ Very Good |
| **Information was interesting** | ☐ Start Over<br>☐ Good<br>☐ Excellent | ☐ Needs work<br>☐ Very Good |
| **Information will be useful in my work** | ☐ Start Over<br>☐ Good<br>☐ Excellent | ☐ Needs work<br>☐ Very Good |
| **Format of course was clear** | ☐ Start Over<br>☐ Good<br>☐ Excellent | ☐ Needs work<br>☐ Very Good |
| **POST TEST** | | |
| **Questions covered course materials** | ☐ Start Over<br>☐ Good<br>☐ Excellent | ☐ Needs work<br>☐ Very Good |
| **Questions were clear** | ☐ Start Over<br>☐ Good<br>☐ Excellent | ☐ Needs work<br>☐ Very Good |
| **Answer sheet was easy to use** | ☐ Start Over<br>☐ Good<br>☐ Excellent | ☐ Needs work<br>☐ Very Good |

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|---|---|---|
| **COURSE MECHANICS** | | |
| **Course materials were well organized** | ☐ Start Over<br>☐ Good<br>☐ Excellent | ☐ Needs work<br>☐ Very Good |
| **Materials were received in a timely manner** | ☐ Start Over<br>☐ Good<br>☐ Excellent | ☐ Needs work<br>☐ Very Good |
| **Cost of course was reasonable** | ☐ Start Over<br>☐ Good<br>☐ Excellent | ☐ Needs work<br>☐ Very Good |
| **OVERALL RATING** | | |
| **I give this distance learning course an overall rating of:** | ☐ Start Over<br>☐ Good<br>☐ Excellent | ☐ Needs work<br>☐ Very Good |
| **FEEDBACK** | | |
| **How did you hear about CEU Matrix?** | ☐ Web Search Engine<br>☐ Mailing<br>☐ Telephone Contact<br>☐ E-mail posting<br>☐ Other Linkage<br>☐ FMS Advertisement<br>☐ Other: _____ | |
| **What I liked BEST about this course:** | | |
| **I would suggest the following IMPROVEMENTS:** | | |
| **Please tell us how long it took you to complete the course, post-test and evaluation:** | _____ minutes were spent on this course. | |
| **Other COMMENTS:** | | |