"Mental Health Counseling Needs of HIV+ Alcohol and Other Drug Abusers"

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PeachTree Professional Education, Inc.
Richard K. Nongard, LMFT/CCH
15560 N. Frank L. Wright Blvd, #B4-118
Scottsdale, AZ 85260

Voice: (800) 390-9536
Fax: (888) 877-6020
www.FastCEUs.com

Mental Health Counseling Needs of HIV+ Alcohol and Other Drug Abusers

3 CEU Credit Hours

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Course Description:
This course covers counseling and social work needs assessment and intervention protocol information for those working with HIV infected clients.

Course Objectives:
At the conclusion of this course, the professional will be able to:
1. Identify mental health counseling needs unique to HIV+ clients
2. Understand common mental health conditions and medication induced mental health conditions of HIV clients.
3. Develop treatment improvement protocol.
4. Explore case management protocol, managing children of HIV infected parents, and utilize appropriate social supports.

Purpose of this course:

The purpose of this continuing education course is to provide a current understanding of issues relevant to the professional counselor and social worker concerning the mental health needs of HIV positive clients who may be alcohol or other drug abusers. Current government facts, guidelines and information is provided to assist counselors in clarifying case management and treatment protocol concerns.

Course Outline:
Part 1: Reading of Course Introduction
Part 2: Reading of Course Materials (this document)
Part 3: Administration and Completion of the Evaluation of Learning Quiz
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3 Clock / Credit Hours

If you ever have any questions concerning this course, please do not hesitate to contact **PeachTree at (800) 390-9536**.

Your instructor is **Richard K. Nongard**, a Licensed Marriage and Family Therapist, Certified Clinical Hypnotherapist and a Certified Personal Fitness Trainer.

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INTRODUCTION

The purpose of this 3-Credit Hour Continuing Education course is to provide counselors and healthcare professionals with the tools necessary to effectively work with the HIV infected substance abuser.

The materials for this course come from the National Institute of Health. This text was chosen both because of the substantial research behind the information, and because of its nonbiased analysis of methods for improving client outcomes.

The content overviews concomitant disorders, dual-diagnosis and dealing with creating effective interventions for the HIV positive substance abuser -- essential knowledge for any substance abuse counselor, metal health counselor or person providing services to HIV positive clients.

As a bonus, this particular publication is actually a fairly interesting read for the most part, and not nearly as dry or boring as one might assume.

While other industry related 'disorders-' or 'diseases-of-the-day' may seem to relegate HIV/AIDS as 'old news', the topic remains extremely important, and we hope that you benefit from the material and continue to devise interventions that are effective with this still growing population.

Sincerely,

Richard K. Nongard, MA, LMFT, CPFT
Instructor

Treatment for HIV-Infected Alcohol and Other Drug Abusers

Treatment Improvement Protocol (TIP)

Mental Health and Counseling Needs of HIV-Infected AOD Abusers

Alcohol and **o**ther **d**rug (**AOD**) abusers, whether or not they are HIV-infected, are subject to higher rates of mental disorders than the rest of the population. The Epidemiologic Catchment Area study found that nearly 30 percent of AOD abusers living in the community had comorbid psychiatric disorders (Regier et al., 1990).

Other studies have shown higher rates of psychiatric disorders among AOD abusers in treatment programs. In some studies, the lifetime prevalence of such disorders is as high as 80 percent (Ross et al., 1988).

It is not clearly known what proportion of HIV-infected AOD abusers has psychiatric disorders. One recent study found that 79 percent of HIV-infected **i**njection **d**rug **u**sers (**IDU**s) in treatment required psychiatric consultation and 59 percent had psychiatric disorders other than AOD abuse. Forty-five percent of these patients had organic mental disorders such as cognitive impairment, organic anxiety disorders, and organic mood disorders (Batki et al., 1992).

Counselors working with HIV-infected AOD abusers should be aware of the variety of both HIV-induced and AOD-induced psychiatric symptoms that may be seen in these patients. It is also important to recognize that psychiatric symptoms may be caused by starting, stopping, or mixing medications used to treat HIV disease.

Linkages Between AOD Treatment And Mental Health Services

Ideally, AOD abuse treatment programs that do not possess resources to adequately assess and treat mental illness onsite should have the capacity to rapidly refer patients to closely linked mental health services. It is helpful to have clearly identified lines of communication between AOD abuse treatment programs and mental health services to facilitate clinical interaction concerning patients with complex needs.
Most mental health programs are not adequately equipped to provide AOD treatment. The AOD abuse treatment program should therefore

maintain contact with the patient and continue the patient's AOD treatment during and after the psychiatric referral. AOD treatment staff may need to help patients obtain transportation to the psychiatric referral site. Providing concrete assistance such as transportation may increase the likelihood of patients' success in following through on referrals to psychiatric services.

Because it may be difficult for any one clinician to address the complex mental health and counseling needs of HIV-infected AOD abusers, the care of these patients is likely to involve multiple providers. A coordinated, holistic approach should be taken to the multiple problems of this target population.

Common Mental Disorders in HIV-Infected AOD Abusers

In general, mental disorders that are of particular concern in HIV-infected AOD abusers may be divided into these broad categories:

- Alcohol and drug-induced mental disorders
- HIV-related mental disorders
- Medication-related disorders
- Pre-existing mental disorders.

Any given patient may fall into one or more of these categories. Common mental disorders among HIV-infected AOD abusers include the following. (Terms used are those found in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders [DSM-IV].)

- Adjustment disorders
- Insomnia
- Depressive disorders
- Mania
- Dementia
- Delirium
- Psychosis
- Personality disorders.

Adjustment Disorders.
Often characterized by anxious mood, these disorders tend to be time-limited (for example, 3 to 4 weeks) acute responses to acute stresses such as receiving news of HIV infection or increasing disease severity. Stages of adjustment to the stress of life-threatening HIV infection have been described as analogous to the stages of adjustment to other illnesses. These generally begin with a crisis and progress to acceptance of and adaptation to the

stressor.

Insomnia.
This is a frequently seen problem that is often associated with some forms of AOD abuse such as stimulant intoxication or withdrawal from alcohol or other depressants. The incidence of insomnia also increases with the development of HIV disease (Wiegand et al., 1991).

Depressive disorders.
Depression is a common response to learning of HIV infection or becoming more ill. Depression can also exist with or precede substance abuse. Patients may also become depressed for prolonged periods of time after withdrawal from abuse of alcohol, opiates, stimulants, and other substances (Kanof et al., 1993).

Mania.
Mania is frequently seen in HIV patients. In one study, mania was seen in as many as 8 percent of patients in an HIV medical clinic. Mania can also be a complication of AOD abuse, particularly abuse of cocaine and other stimulants. It can be difficult to determine whether mania is AOD- or HIV-induced (Lyketsos et al., 1993; Mirin et al., 1988).

Dementia.
Dementia may be due to alcoholism, head trauma, and numerous other causes, in addition to HIV disease. Differentiating these dementias can be difficult. All forms of dementia can be present with cognitive, behavioral, and motor abnormalities. Neuropsychological examination is useful in helping to make the diagnosis of dementia.

Delirium.
Mental confusion associated with acute encephalopathy or delirium can stem from many sources, including infection, AOD intoxication or withdrawal, toxicity from medication, or metabolic disturbances.

Psychosis.
Psychotic symptoms may be seen in advanced HIV dementia or in delirium and can be difficult to differentiate from substance-induced hallucinations and delusions as in, for example, paranoid psychosis resulting from the use of "crack" cocaine.

Personality disorders.
The presence of antisocial personality disorder or borderline personality disorder often complicates AOD abuse treatment for the HIV-infected patient. Please see the TIP, *Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse* for information regarding the interaction of personality disorders with AOD abuse treatment. HIV-infected AOD abusers have high rates of personality disorders, particularly antisocial personality disorder. The management of these chronic disorders is

generally similar in both HIV-infected and non-HIV-infected AOD abuse patients.

Medication-related mental disorders.

It is essential to be aware that psychiatric symptoms in HIV-infected AOD abusers may result from the use of prescription medication. For example, high doses of zidovudine (AZT) (greater than 600 mg per day) can produce anxiety, insomnia, or hyperactivity.

In cognitively impaired AOD abusers with late-stage HIV disease, memory and other cognitive functions may be worsened by combinations of medications, particularly central nervous system depressants such as benzodiazepines (for example, diazepam [Valium and other drugs]) and anticholinergic medications such as the tricyclic antidepressants (for example, amitriptyline [Elavil and others]).

Interventions.

Both pharmacologic and psychotherapeutic interventions should be used in the treatment of mental disorders in HIV-infected AOD abuse patients. This chapter describes some of the basic interventions and notes particular concerns, risk factors, and other issues relevant to HIV-infected patients. The important role of support groups in counseling this patient population is also discussed. Psychotherapy and support groups are also important parts of treatment for HIV-infected AOD-abusing patients who are not mentally ill.

Cultural Sensitivity

Therapeutic interventions related to patients' mental health must be sensitive to the culture and ethnicity of the patient population. Whenever possible, therapists and support group leaders should share the culture of their patients and should speak the same language or vernacular. Cultural compatibility between therapists and patients is important in creating an atmosphere of trust in which sensitive issues such as family support and group mores can be addressed.

Some individuals may have strong spiritual beliefs that differ from dominant cultural norms. If their cultural context is not understood, such beliefs may be labeled delusional.

Generally, the clinician's best guide is the patient's immediate family or community context. If the patient's beliefs are consistent with his or her community or culture of origin, it is less likely that they are delusional (Perez-Arce et al., 1993.)

Importance of Case Management

The healthcare needs of HIV-infected AOD abusers with mental disorders are complex, and treatment may involve multiple providers from a variety of disciplines. Communication and coordination among physicians, counselors, and other practitioners involved in a patient's care are therefore essential. Case management may be a useful way of ensuring that such coordination occurs.

For example, patients may not always fully divulge to a treating physician that they have a history of psychiatric disorder or that they are already receiving psychotropic or analgesic medication from another medical provider. By facilitating communication among providers, a case manager can help to ensure that all parties involved in the care of an individual patient are as fully informed as possible about the patient's treatment status.

A comprehensive treatment plan and an individualized risk reduction plan should be prepared and followed for each patient. Case management must be flexible so that patients receive more attention as their needs increase.

Assessment and Diagnosis

Assessment and diagnosis of mental illness in HIV-infected AOD abuse patients can present a daunting challenge because of these patients' complex problems. It is important to evaluate patients' behavior in context. For example, acute depression is relatively common among individuals who learn that they are HIV-positive. This type of time-limited adjustment disorder may lead to worsened AOD use. In turn, depression may be made more severe or prolonged by concurrent AOD abuse.

It can be difficult to determine whether AOD abuse preceded the psychiatric disorder or vice versa. AOD abuse may be an attempt at self-medication in response to an underlying psychiatric disorder. Although mental disorders may predate AOD abuse, generally the reverse is true.

Because an accurate and complete history cannot always be obtained from the patient, corroborative sources of information (such as the patient's family or a previous healthcare provider) are essential to a complete assessment.

History-taking.

Counseling staff should begin the assessment of the HIV-infected AOD abuse patient by taking a psychosocial history that is as judgment free as possible and that includes open-ended questions. It is important that this questioning acknowledge and respect not only

ethnic and cultural differences but also alternative sexual lifestyles.

A complete medical history focusing on HIV and AOD abuse should be taken at intake to AOD treatment.

A recent physical examination and laboratory test results should be readily accessible because they may help in the assessment of the patient's counseling needs. For example, a CD4+ lymphocyte count ("T" cell count) below 200 informs the mental health or counseling professional that the patient is at higher risk for organic mental disorders such as HIV-related dementia.

Mental status examination.
A comprehensive mental status examination is the key to detecting mental disorders. Among other things, this exam may reveal cognitive problems such as deficit memory. The cognitive portion of the mental status examination can be expedited by the use of standardized questionnaires such as the Mini Mental State Exam.

It is helpful to have a psychiatrist or psychologist perform the examination, but most nonpsychiatric physicians are familiar with the basic components of a brief mental status examination. Nursing staff and counselors can also be taught to administer screening examinations such as the Mini Mental State Exam.

A good screening instrument can assist clinicians in asking appropriate questions. In addition to the Mini Mental State Exam, other examinations, such as the Beck Depression Inventory, may be particularly useful in assessing the severity of depressive symptoms (Beck, 1993).

In addition to receiving an initial assessment of needs, HIV-infected patients should be periodically reassessed. Fluctuating health status and functional capacity will mean that clients' needs change over time. Repeated mental status examination is also helpful when a change in cognitive or behavioral status is noted by AOD counselors or medical staff.

Treatment goals.
It is essential to set realistic treatment goals that vary with the patient's functional capacity. For example, immediate abstinence from AODs may be too much to expect from severely psychiatrically disturbed AOD abusers, and AOD programs may need to have a flexible range of treatment goals for such patients.

Dementia in HIV Disease

Neurocognitive impairment is a common complication of HIV disease. In its severe form it is known as AIDS dementia complex (ADC). This complication is one of the most challenging and anxiety-provoking manifestations of HIV disease for the patient and his or her family, as well as for the AOD treatment provider.

The diagnosis of dementia in the HIV-infected AOD abuser is based on the presence of significant and disabling impairment of functioning. Usually, impairment is present in three areas:

- Cognitive functioning (for example, memory disturbance),
- Behavioral functioning (for example, altered behavior such as agitation or psychosis)
- Motor functioning (for example, gait disturbance or incontinence).

Diagnosis requires neuropsychological evaluation employing a battery of neuropsychological tests. A diagnosis cannot reliably be made using a brief cognitive capacity examination such as the Mini Mental State Exam. However, poor performance on a brief cognitive screen is an indication that dementia may be present and calls for further testing.

HIV-related neurocognitive loss usually progresses gradually. Early signs and symptoms of neurocognitive impairment include:

- Short-term memory loss (forgetting appointments, misplacing items, forgetting to take important medications)
- Loss of visual, spatial, and fine coordination (impaired handwriting, difficulty assembling objects or equipment)
- Cognitive slowing (taking longer to speak or to understand, appearing "slow" in interviews)
- Mood changes (mild apathy, depression, hyperactivity).

In later stages of dementia major impairments become obvious, such as:

- Mutism or unresponsiveness to speech
- Agitation, hallucinations, paranoia or other delusions
- Severe neurological problems (incontinence, inability to walk).

The risk of dementia and other cognitive deficits is highest in HIV-infected patients who are severely immunocompromised. The CD4+ lymphocyte count ("T-cell count") is a useful index of an individual's risk for AIDS dementia. Generally, dementia is most likely to occur in patients with CD4+ counts below 200 (Boccellari et al., 1993a, 1993b).

Pharmacologic Treatment

Introduction

Standard pharmacologic approaches may be taken in the treatment of psychiatric disorders in HIV-infected AOD abuse patients, with some specific caveats.

Without exception, a medical/psychiatric diagnostic evaluation should always be carried out before medication is provided.

Some AOD abuse treatment staff may oppose the use of pharmacologic interventions in AOD abuse patients because of a concern that these medications may place patients at risk for relapse into substance abuse. While these concerns must be acknowledged, it is necessary to distinguish medications from drugs of abuse. An approach to care that does not permit the use of psychiatric medications when appropriate may deprive patients of the opportunity to benefit from a legitimate and necessary treatment option.

Abuse of Psychiatric Medications

In animal and human testing, most of the major classes of psychiatric medications have been proven not to have abuse potential. Examples are antipsychotic medications such as chlorpromazine (Thorazine), mood stabilizers such as lithium, and nonpsychostimulant antidepressants such as fluoxetine (Prozac).

On the other hand, two types of medications are known to have abuse potential:

- Central nervous system depressant, antianxiety, and anti-insomnia medications such as diazepam (Valium) and chlordiazepoxide (Librium)
- Psychostimulants such as amphetamine and methylphenidate (Ritalin).

When working with any AOD-abusing patient, it is reasonable to expect that some misuse of legally prescribed controlled substances may take place.

A hierarchical approach to prescribing is recommended to minimize the potential for abuse of psychiatric medications.

In this approach, the least abusable medications are prescribed first and the most potentially abusable are used only when other

agents have not been effective. Dispensing medication in small amounts (for example, 1 day or 1 week's supply) helps to limit the overuse, misuse, or abuse of potentially abusable medications.

HIV-infected persons may be more than usually sensitive to prescription medications as well as to drugs of abuse. When prescribing, clinicians should attempt to use the lowest effective dose to minimize side effects.

With patients who have advanced HIV disease, it may be wise to start out with very low doses of the magnitude generally associated with geriatric psychiatry.

Suicide.
AOD abusers are at increased risk of suicide. HIV-infected individuals may also be at risk of suicide, especially if they are suffering from a mood disorder. Medication should be dispensed in small amounts (one week's supply or less) until a patient's level of responsibility can be fully assessed. Tricyclic antidepressants (TCAs) such as amitriptyline (Elavil) and others are especially likely to be lethal in overdose.

Abuse of intravenous infusion lines.
Patients with advanced HIV disease are frequently prescribed narcotic analgesics and may have an indwelling intravenous line for infusion therapy. Clinical experience has shown that IDUs are at very high risk of using this indwelling intravenous line to administer heroin, cocaine, and other drugs of abuse. It is therefore essential that patients with such lines be cared for in residential settings where adequate monitoring and support can be provided.

Adverse Effects of Some Medications

Side effects.
As HIV infection progresses, some medications may cause adverse side effects in some patients.

Medications whose anticholinergic effects block saliva flow cause dry mouth. For example, tricyclic antidepressants (TCAs) and antipsychotics can produce dry mouth and cause oral candidiasis and other mouth infections.

Stimulation from antidepressants may trigger hyperactive or manic behavior, especially in the HIV-infected AOD abuser who may already have mild central nervous system impairment because of HIV.

HIV-infected patients are more sensitive than others to movement disorders such as extrapyramidal symptoms (EPS) that can be caused by antipsychotic medications like haloperidol (Haldol).

Central nervous system depressants such as sedative-hypnotics should be used with caution because they may cause confusion, memory impairment, and depression.

It is reasonable to suspect that any sudden behavior change or new physical symptom in a patient on medication may be medication related. With some medications, such as lithium, the TCAs (for example, amitriptyline), and certain antipsychotics (for example, haloperidol), blood levels should be tested periodically to avoid drug toxicity.

Adverse interactions.
Clinicians must be aware of the potential for adverse interactions between HIV treatment medications and psychiatric medications. HIV-infected patients are often prescribed complex medication regimens. Medications, either alone or in various combinations, may cause confusion and other psychiatric symptoms.

For example, a patient may be prescribed fluoxetine (Prozac) for depression plus an antianxiety medication such as lorazepam (Ativan) and may also be receiving zidovudine and the antibiotic trimethoprim-sulfamethaxazole (Septra), as well as other medications.

In any individual patient it can be difficult to predict the outcome of interactions among so many medications.

Because of the potential for adverse interactions among medications, it is essential that medical and psychiatric care providers communicate with each other when treating an HIV-infected AOD-abuse patient.

Communication may also be significantly helped by the pharmacist who fills the patient's prescriptions. Pharmacists can play a role in educating patients and helping to reduce possible adverse effects of drug interactions. In addition, pharmacists are invaluable sources of information about what medications other healthcare providers may have prescribed to the patient.

If a patient appears to be adversely affected by multiple medications, the AOD abuse treatment provider must report the observed physical or behavioral change to the patient's primary medical provider as soon as possible so the problem can be addressed.

Counseling

Introduction

Counseling is an important part of treatment for all AOD abusers, including those with comorbid psychiatric disorders. The goal of counseling is to help HIV-infected AOD abusers maintain health, achieve recovery from AOD abuse, and attain the best possible level of psychological functioning. Counseling may be done individually, in groups, or with patients' families.

Counselors need to be aware that patients are likely to move through different stages in the course of both AOD abuse and HIV disease. Part of the counselor's role is to help the patient to adapt as well as possible to these changes.

Preventing the transmission of HIV must be a major focus of counseling interventions.

Discussion of risk reduction should be incorporated as much as possible into all types of counseling.

Individual Therapy

Individual therapy can be a particularly important component of treatment for a patient who may not be ready to share intimate information with a group. Individual counseling may allow patients to discuss subjects such as sexual behavior, fear of death, and other issues related to HIV infection, AOD abuse, or sexual identity.

For some AOD abusers, a possible disadvantage of individual therapy is that it may not be as potent as group intervention in reducing the sense of isolation, shame, and guilt that many patients feel because of HIV infection. One aim of individual therapy may be to prepare patients to participate in group therapy.

Group Therapy

Most treatment programs working with HIV-infected AOD abuse patients are finding that supportive group therapy can be a highly beneficial modality.

AOD abuse treatment groups can be structured in a variety of ways but generally involve a dozen or so participants with one or two group leaders. HIV-infected AOD abusers who are strongly self-identified as heterosexual may not feel comfortable in a group with openly gay members, and vice versa. AOD abusers may be more reticent about exploring sexuality and sexual behavior in groups.

In general, however, it is not absolutely necessary to segregate group members on the basis of sexual orientation. Good results can be achieved in a group whose membership includes both HIV-infected and non-HIV-infected AOD abusers, as has been shown in the Stimulant Treatment Outpatient Program (STOP) at San Francisco General Hospital (Perez-Arce et al., 1993).

Stage-of-diagnosis model.
A current model for structuring groups, based on the patients' stage of diagnosis, has been used successfully by Boston's Fenway Community Health Center. In this model, patients are grouped as follows:

- Those who have just learned about their HIV infection
- Those in the early stages of HIV disease.

These groups focus on healthy lifestyles and improving quality of life. As the sessions progress, patients often exchange information about treatment.

- Those in the later stages of HIV disease.

This group focuses on adapting to illness, grief, and coming to terms with death and dying.

In addition to their therapeutic role, groups may have important roles to play in educating patients about HIV risk reduction. Discussions about risk reduction should be encouraged. Because it is important to promote behavior change among all AOD abuse patients, those who are not HIV infected should also have the opportunity to attend HIV education groups.

Family Therapy

For some HIV-infected AOD abuse patients, "family" may need to be defined as broadly as possible. Some patients will have traditional nuclear families. For other patients, family may include a nonmarital partner, a same-sex lover, and other significant others. Adult patients have the right to define their families and to decide whether or not to include the people they regard as family in the treatment process. For a socially isolated person, a buddy from an AIDS service organization may fill the role of significant other.

Supporting patients in their recovery from AOD abuse is often a principal goal of family therapy. Questions related to partner or child abuse may also be addressed. In addition, family therapy may be a useful opportunity to address issues of risk reduction for family members who are not (or not yet) HIV infected. This therapeutic setting is uniquely positioned to offer risk-reduction education to people who may not have been identified either as HIV-infected or as AOD abusers.

Effect of Cognitive Impairment

Both AOD abuse and HIV infection may cause cognitive impairment that can reduce adherence to medical care. The effect of cognitive impairment should be taken into account when undertaking patient education. It is important, for example, to allow time for recovery from the acute effects of AOD intoxication or withdrawal. Patients' ability to understand the content of counseling sessions should be assessed before such counseling takes place (Forstein, 1992). In general, it is preferable that counseling be offered in the later stages of a detoxification program.

Communication between medical and counseling staff is important to ensure that cognitively impaired patients are not perceived as deceitful or manipulative. Care providers must keep in mind that cognitively impaired patients' nonadherence to treatment is a result of the impairment and not caused by denial, resistance, or unwillingness to accept care. (See Dementia in HIV Disease, above.)

Risk-Reduction Counseling

Changing risk behavior such as AOD use and unsafe sex requires more than a knowledge of why these are risk behaviors. Patients' attitudes and beliefs must also be addressed.

AOD use can lower inhibitions and increase impulsivity, which may significantly contribute to risk behavior.

In promoting risk reduction, the AOD abuse counselor's roles are to:

- Help the patient understand the need for behavior change
- Provide psychological support for behavior change
- Assist the patient in developing the appropriate skills to sustain the behavior change.

Discussion of risk behaviors should take place in language that is both culturally appropriate and clear and understandable to the target audience. AOD programs should be familiar with how to refer family members for HIV antibody testing and with providing appropriate pre- and posttest counseling to patients. If onsite testing is not possible, referral should be available to an easily accessible site.

Risk-reduction counseling can be particularly difficult when a patient is sent back to a nonsupportive community where high-risk AOD and sexual behaviors are not discouraged. Issues such as poverty and homelessness must be acknowledged and addressed when attempting to change high-risk behavior. Practical assistance, such as providing emergency housing, is usually needed before behavior change can occur.

Sexual practices history.
A comprehensive sexual practices history is important and should be taken early in counseling, although not necessarily at the first session. Patients must be reassured of the confidentiality of the information they provide.

Counselors should address the full range of potential risk behaviors in their questioning, including both needle sharing and unsafe sex. They need to take into account a wide range of sexual practices, including homosexual, bisexual, and heterosexual relations. Condom use must be a special focus of counseling.

A counselor can often proceed from taking the patient's history to HIV education and then to risk reduction. A patient who was diagnosed with HIV infection before the encounter with the counselor may already have discussed sensitive issues and risk reduction with someone. Therefore, it is important for the counselor to discuss with the patient what he or she has been told before.

Standardization of goals.
Although counseling is necessarily an individualized process, some standardization of goals and methods can be helpful. Training, follow up, and support for counselors is an integral part of the treatment program, especially for HIV-infected AOD-abusing patients with mental health problems. Counselors must be prepared to become familiar with all aspects of HIV disease.

Buddy system.
The buddy system is an approach that has been tried in both HIV and AOD abuse treatment to increase patient compliance with treatment by increasing expectations about patients' responsibilities to one another.

The buddy system can place AOD abusers at risk if both buddies are in early recovery, in which case they may reinforce the possibility of relapse in each other. One strategy may be to pair a patient in early recovery with a buddy who has been in treatment longer. The appropriateness of the buddy system needs to be assessed individually in each patient.

Dealing With Ongoing AOD Abuse
Many HIV-infected AOD abusers are unable to maintain abrupt and total discontinuation of substance use. In dealing with patients' ongoing AOD use, treatment programs must find a balance between the abstinence-oriented and the public-health-oriented approaches to substance abuse treatment.

Abstinence model.
This approach traditionally uses confrontation, consistency of expectations, behavioral contracting, and limit setting as treatment modalities, with the goal of achieving abstinence from all substance

use. This approach may involve termination from treatment if abstinence is not achieved.

Public health model.
This approach, sometimes called the harm reduction model, emphasizes incremental decreases in AOD use or HIV risk behaviors as treatment goals. This approach tends to try to keep patients in treatment even if complete abstinence is not achieved.

The public health model may sacrifice some of the consistency of expectations that is such an important part of abstinence-oriented treatment. Rather, it seeks to keep abusers in treatment and to reduce, if not eliminate, AOD- and HIV-related risk behaviors. Each incremental change may be viewed as a success, helping individuals to see that they can positively affect their lives.

By contrast, a model that regards anything less than complete abstinence as failure may reinforce individuals' sense of helplessness and hopelessness at their inability to sustain behavior change.

Flexibility is needed with HIV-infected patients because of the public health importance of keeping these patients in AOD treatment (they are likely to continue to put others at risk if they leave treatment and resume injection or other drug use). If reduction in the spread of HIV is an important goal, it may be necessary to keep working with these patients despite continuing abuse.

Each AOD treatment program must establish its own balance between the abstinence and public health approaches, based on the needs of the community it serves. For example, harm reduction models may be employed to educate active IDUs about safer sex and drug use practices, such as using condoms and sterilizing needles with bleach.

Differential standards of care.
One current model for applying a flexible approach to the AOD abuse treatment of HIV-infected patients is the differential standards of care approach used by the Opiate Treatment Outpatient Program at San Francisco General Hospital's Substance Abuse Services.

This approach applies different standards of care to patients, based on an assessment of the individual's level of functioning in the areas of physical health, mental health, social support, housing, and employment. Very ill patients generally are treated according to lower expectations of AOD abuse treatment outcome, while higher functioning patients are treated with higher expectations (for example, to maintain drug-negative urine tests, attend self-help group activities, etc.).

HIV Disease and Risk of Relapse

Declining health as a result of HIV disease is a recognized risk factor for relapse into AOD abuse. Physical and psychological stresses associated with HIV disease include pain, decreased functional ability, fatigue and weakness, as well as fear, anxiety, and grief, all of which increase individuals' risk of resuming substance use.

In particular, certain "milestones" in the progression of HIV present an elevated risk of patient relapse. Many patients may need additional support at these times. It is important that counselors review a patient's treatment plan when one of these milestones is reached and consider whether the patient would benefit from changes in treatment.

For most patients, four major milestones are:

- Deciding to be tested for HIV infection and waiting for the test results. (Although making this decision can be a risk factor for relapse in some patients, for other individuals it may be a stimulus to begin AOD abuse treatment.)
- Obtaining the results of an HIV antibody test
- Developing the first symptoms of HIV disease
- Being diagnosed with AIDS.

AOD treatment counselors may wish to suggest the following strategies to patients 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 Patient Relapse

The most successful relapse counseling is nonjudgmental. However, patients should understand that preventing relapse is their responsibility. If a patient relapses into a risk behavior for AOD or HIV, the counselor's role is to help the patient 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. Patients should not be dismissed from AOD abuse treatment or HIV support groups because of a relapse. Rather, peer pressure may be constructively used to help patients acknowledge the reasons for and the consequences of their actions.

Support Groups

Support groups fulfill a wide range of needs. In the AOD recovery process and in HIV treatment, they may be an important source of psychosocial support. They may also have an educational function, helping patients to gain knowledge and skills about the systems they must negotiate. Some support groups may have a patient advocacy role, helping to link programs and lobbying for funding to fill gaps in services.

No single organization can provide all the services needed by HIV-infected AOD abusers with mental health problems.

AOD treatment programs should actively refer patients to appropriate outside support groups where their specialized needs can be met.

Structuring Support Groups

Among the factors that must be considered in structuring support groups are the need to protect patient confidentiality and the possible stigmatizing effect of identifying a group as being for HIV-infected patients.

Among the issues that should be considered in establishing and maintaining support groups are language and ethnicity, gender, sexual orientation, type of AOD use, stage of recovery from AOD use, and stage of HIV infection. Trust tends to develop more quickly in homogenous groups than in groups with a heterogenous membership, although the latter can also work very well.

Language.

The language or language style of the therapist or support group leader sets a tone for the group and influences how successfully group members interact. Group leaders must be fluent in the language or vernacular spoken by patients.

Gender.

Single-sex groups may be beneficial for both women and men in certain circumstances. Women who have suffered abuse may feel more able to divulge this information in a women-only group.

Many HIV-positive women may not have told their partners about their status and some may be afraid of losing custody of their children if their status becomes known. Women who have been involved in the sex industry or in sex-for-drugs transactions may have difficulty speaking about these experiences in mixed settings and may benefit from participation in specialized single-sex groups.

Single-sex groups may also be beneficial for men who have difficulty discussing issues of sexuality, such as sexual abuse and incest, in a mixed-gender group.

Sexual orientation.
Some patients may have difficulty achieving full recovery from AOD abuse without addressing issues related to sexual orientation. Homosexual and heterosexual IDUs may not always be comfortable with one another in groups. Ideally, if resources allow, specialized groups should be offered that are defined by both sexual orientation and gender.

Type of AOD use.
Patients' perceptions and prejudices about the use of different substances are likely to surface in groups and affect the treatment process. For example, alcohol abusers may consider themselves less addicted than IDUs and may be unwilling to admit that they also use illicit drugs. In general, it is preferable to have separate groups for alcohol abusers, heroin abusers, cocaine abusers, and so on.

Stage of recovery from AOD use.
An individual's stage of recovery may be as important as the type of substance abused. Although most AOD abuse treatment programs stress abstinence, patients in early recovery who are also dealing with HIV infection may find total abstinence difficult to achieve.

Stage of HIV infection.
Segregating groups by stage of HIV infection presents difficulties, but not doing so can also be problematic. Patients who are HIV-positive but asymptomatic and attending a support group for the first time may be uncomfortable at encountering patients 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 (See Group Therapy, above) may wish to use the three-group model with groups of:

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

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

In a group consisting solely of patients with advanced HIV disease, 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.

Alternative Therapies

Peer programs.
Peer programs can provide support for AOD recovery and other psychosocial services. There are many resources in the community for these interventions; all that a program has to 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 AOD program volunteers receive.

Potential problems with peer programs are confidentiality and liability. 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 patients.

Role playing is an effective health education technique that can be used to build patients' skills at negotiating for the use of a condom during sex, telling a partner or family members that one is HIV-infected, turning down an offer of drugs, or dealing with a public official.

Acupuncture.
There is some evidence that acupuncture may be a beneficial adjunct to treatment for many forms of AOD abuse. It may, for example, help some patients to continue in treatment longer than they otherwise might.

Meditation is another supplement to traditional treatment that some patients may find helpful.

Grief and Bereavement

In addition to facing the prospect of disability and death from AIDS, many HIV-infected AOD abusers experience grief and bereavement as a result of the deaths of friends, lovers, spouses, and other family members. For AOD programs, dealing with patients' grief and bereavement presents three sets of issues:

- Providing support and counseling for patients who are dying as well as for patients who are experiencing the deaths of significant others
- Supporting staff who are experiencing grief and stress as a result of working with dying patients
- Establishing flexible program policies that accommodate the limitations of symptomatic HIV-infected patients.

Supportive Services for Ill, Dying, and Bereaved Patients
Patients facing progressive illness and disability need a variety of supportive services:

- Support groups and supportive individual counseling
- Education about healthcare and the expected course of illness (to reduce uncertainty, anxiety, and fear)
- Support in dealing with denial, especially if it interferes with receiving medical care.

Counseling of ill and dying patients should be supportive and nonconfrontational, addressing issues relevant to the patient's illness at a pace determined by the patient.

Patients who are in denial about their illness will delay making arrangements for medical and nursing care and procuring assistance with activities of daily living. Counseling can play an important role in helping patients to accept the eventual need for home health or hospice care.

Bereavement is a particular problem for programs with large numbers of HIV-infected patients. The following are some strategies that may be helpful in supporting patients who are dealing with bereavement:

- Acknowledging the reality of bereavement in supportive individual counseling
- Encouraging the expression of grief both verbally and nonverbally (for example, through art therapy and other similar interventions)
- Providing group support for clients who are experiencing grief and bereavement
- Acknowledging patients' deaths with memorial services, flowers, photographs, and participation in commemorative projects such as the NAMES quilt.

Avoiding Staff Burnout

Staff working with HIV-infected AOD abuse patients may experience high levels of stress. Not only are counselors and other staff members continually confronting the illness and death of their patients, but AOD treatment personnel themselves -- many of whom are themselves recovering AOD abusers -- may also be infected with HIV and facing the same health problems as their patients.

To address these problems, staff should be rotated periodically, although not so frequently that there is no consistency for patients. Attendance at a staff support group should be mandatory; whatever the scheduling difficulties, this group should meet at least monthly. Staff members who are themselves recovering AOD abusers need to acknowledge their own potential for relapse because of the stress of their work.

Inservice training programs on stress management and issues related to death and dying can also be helpful to staff working with HIV-infected AOD abuse patients.

Program Flexibility

Programs may need to adjust their expectations of treatment outcome to accommodate patients who are facing progressive disability from HIV disease. Standards established for the treatment of relatively healthy AOD abusers may not be appropriate for symptomatic HIV-infected individuals.

Opioid substitution therapy programs.

Patients maintained on methadone are normally expected to attend the methadone clinic every day to receive their medication. But as HIV-infected patients develop symptoms such as fatigue, shortness of breath, and nerve and muscle damage, daily clinic attendance will become more difficult and may eventually become impossible. Flexible policies regarding "take home" methadone doses are required to meet the needs of these patients.

Residential treatment programs.

Patients with symptomatic HIV disease may be physically unable to perform all the tasks normally expected of members of a residential treatment program. Programs should have the flexibility to accommodate these patients' limitations by offering them lighter duties.

In addition, the length of residential treatment programs may be unrealistic for symptomatic HIV-infected patients. Walden House, a residential AOD treatment program in San Francisco, offers a 6- to 12-month program for patients with HIV disease. Shorter treatment programs may be necessary to meet the needs of individuals with HIV disease whose life expectancy may be limited but who nevertheless can benefit from AOD treatment.

Counselor Training

HIV education.

At this stage in the HIV epidemic, given the close links that exist between HIV and AOD, all those working in the AOD treatment field should be knowledgeable about HIV disease. In particular, AOD abuse counselors should understand HIV transmission routes, risk assessment and reduction techniques, and basic medical information about HIV/AIDS.

Sexuality.

Good clinical supervision can help counselors overcome their difficulty in discussing sensitive issues such as sexuality. With training, AOD counselors can learn techniques for helping clients to talk about the intimate details of their sexual behavior. They can also learn how to use a candle, banana, or some other prop to demonstrate the proper use of a condom.

Education about mental illness.
Counselors should receive training that addresses fundamental mental illness issues. Cross-training that addresses mental illness in relation to HIV disease is also important.

Risk reduction.
Programs may find that discussions of risk reduction can best be handled by a staff member who specializes in HIV education. Educational material for patients about HIV is available from most State health department libraries. For information about training programs in HIV education for AOD abuse treatment providers, contact the appropriate State health department.

In this rapidly changing field, counselors must be ready to be honest about not knowing the answer to every question. Because of the large volume of new information that is continually being generated about both HIV infection and AOD abuse, regular educational updates for staff are essential. Educational sessions should be held at least once a month.

Social Services for HIV-Infected AOD Abusers

Meeting the social service needs of alcohol and other drug (AOD) abusers who become infected with HIV is an enormous challenge. A population that already has complex social service needs because of AOD abuse now has additional needs as a result of HIV infection. Further, this population may not be accustomed to going outside of the AOD abuse provider community to obtain services.

The nature of HIV disease requires an individual to actively utilize many social services, including housing; home healthcare; entitlement programs for medical care, food, transportation, and childcare services; respite care and support for caregivers and families; and legal and advocacy services.

Meeting these needs in an appropriate, comprehensive, and coordinated manner is a challenge because HIV-related disease is a complex condition and the social service system is decentralized. Typically, agencies at different levels of government are charged with providing different services such as housing, child welfare services, or entitlements. As a result, providers often must work with many agencies, secure different types of documentation from clients, and make sure clients follow through with procedures to become eligible for or receive services. The process can be confusing, labor intensive, and frustrating. Regulations, procedures, and eligibility requirements sometimes differ within and

among agencies, further complicating efforts to secure needed social services for clients.

Providing social services to HIV-infected AOD abusers requires a high degree of cooperation and coordination among agencies. By working together, agencies can utilize existing services more effectively and break down barriers preventing service delivery.

Different provider agencies serving HIV-infected AOD abusers must become familiar with various services, procedures, and eligibility requirements; develop good working relationships; devise ways to use existing community resources; and develop new mechanisms and resources to better meet the social service needs of this population.

In addition, staff from each provider agency should receive training in cultural sensitivity and competence so that they can provide effective services to this diverse population. Different cultures respond in a variety of ways to drug use, homosexuality, and illnesses such as HIV disease, and staff should understand these issues and their effects on clients' beliefs and behaviors. Moreover, staff members should understand that they themselves have likely internalized many beliefs and values of their own culture that must be examined.

AOD programs providing services to HIV-infected AOD abusers should have a thorough knowledge of the broad range of needs of this population. They should keep in mind, for example, that after years of chronic substance use and distressing behavior many substance abusers have alienated their family members and severed ties with friends who might provide support. This isolation can affect the individual's emotional and physical health and create an obstacle to even the most integrated delivery of social services.

Persons with HIV disease have a variety of special needs. Many persons with AIDS need daily intravenous infusions of medications, either self-administered or provided by a caregiver or home health aid. Many need appetizing meals or transportation to grocery stores and physicians' offices. Some need periodic care for their children or help with housework. Some individuals lose their sight and need assistance in daily activities. Some may need help caring for pets -- for example, walking dogs. Others may need assistance with legal problems with employers or landlords or with making a will or arranging for guardianship of their children. It is only when providers understand the many needs of this population that they can take constructive and creative steps toward meeting them.

Cultural Sensitivity and Competence

The following are steps that treatment programs can take to enhance their cultural sensitivity and competence:

- Establishing liaisons with culturally specific community groups and services.
- Making active efforts to hire staff who are diverse in ethnicity, sexual orientation, and cultural identification. A commitment to the recruitment of a diverse staff involves advertising vacancies in specialist publications and accepting that additional time may be needed to fill vacancies.
- Training treatment staff about the lifestyles, value systems, and communication styles of ethnic, homosexual, and bisexual populations through inservice training, literature, and offsite workshops (Cabaj, 1989; Marin, 1989). Treatment staff may rotate through community clinics that serve specific populations to become more knowledgeable about education, prevention, and treatment in a culturally aware context.
- Displaying nonjudgmental, culture-affirming attitudes. Asking questions that relate to the client's sexual orientation and link to his or her community affiliations (for example, through the church, through various cultural ceremonies, or through the acceptance of non-Western healing practices such as acupuncture, curanderismo, sweat lodges, and santerRa) provides a sense that members of ethnic and cultural communities and their practices are accepted.

The social service needs of HIV-infected AOD abusers in four areas are described:

- Housing (including supported housing programs, home healthcare, homeless shelters, and hospice care)
- Family support
- Case management
- Outreach.

Housing

An individual's untreated AOD abuse may in itself lead to homelessness, a condition that becomes doubly critical when the individual is also HIV infected.

Appropriate and affordable housing is often not available for those living with HIV. It is not uncommon for them to encounter substantial barriers that make it difficult to obtain adequate housing.

These barriers may include discrimination, lack of financial resources or health insurance, and the need for support and assistance with activities of daily living.

Need for a Continuum of Care
Ideally, housing services should address both HIV disease and AOD addiction through the provision of comprehensive in-home services or through collaboration with other providers. Housing should be available for all HIV-infected AOD abusers, from asymptomatic to terminally ill persons, and from active AOD abusers to those in long-term recovery. Residential programs should provide a continuum of care because clients' needs vary at different stages in AOD or HIV treatment. It is unrealistic to expect programs to provide all the services that clients may need at different times. However, programs should establish referral mechanisms and internal policies and procedures that enable them to provide a continuum of care to AOD abuse clients who are living with HIV/AIDS.

In addition to referral mechanisms, collaborative relationships need to be established with outside agencies for additional resources and technical assistance. Residential programs and facilities also should provide training for staff in the complex needs of this population, both in terms of their AOD abuse and their HIV disease.

Residential programs should be aware that one of the priorities of the Ryan White CARE Act is to provide a comprehensive continuum of care to individuals with HIV disease and their families. Programs may wish to explore obtaining CARE Act funds to create home health services and hospice services for HIV-infected AOD abuse clients.

Several residential programs have been developed by therapeutic communities (TCs) to respond to treatment needs of persons with HIV/AIDS, and others may wish to model their services on these programs. Prototypes, a TC for women and children in the Los Angeles area, has revised some of its rules and procedures to provide a continuum of care and meet the special medical and other needs of HIV-infected women. RAP, Inc., an Afrocentric TC in Washington, D.C., has established a special HIV/AIDS residence that includes people at different stages of AOD recovery and has adjusted rules and procedures to provide a continuum of care that meets the needs of HIV-infected residents.

Housing Access and Availability
Access to and availability of housing are two key issues for HIV-infected AOD abusers.

In many communities, the demand for housing and residential treatment programs for HIV-infected AOD abusers far exceeds the availability of programs or slots.

In addition, existing HIV/AIDS residential programs often have regulations or requirements that make HIV-infected AOD abusers ineligible for their services. For example, programs may require

that residents be free of AOD use for 6 to 12 months, have no convictions for sales of drugs or sex, have no mental health disorders, and do not receive methadone maintenance treatment. The latter requirement is usually related to the HIV/AIDS residential program staff's lack of familiarity with methadone maintenance.

Two models of independent-living residential programs for HIV-infected AOD abusers are "sober hotels" and Oxford Houses. Sober hotels were developed in San Francisco to provide single rooms in a downtown location for homeless men, many of whom are HIV infected and who are not currently abusing AODs. Oxford Houses are group residences for people in recovery from AOD abuse, managed by the residents with the assistance of professional staff. The first Oxford House was established in the Washington, D.C., metropolitan area in 1975, and there are now hundreds of similar recovery houses throughout the United States. Under Public Law 100-690 (the Anti-Drug Abuse Act of 1988), each State is required to establish a revolving fund to make loans to cover the first month's rent and security deposit for housing for groups of recovering individuals. Each new Oxford House group is given an Oxford House charter and receives assistance from a national office in operating a successful recovery house.

Active AOD abusers are the most difficult clients to house. A balance must be struck between empathy and harm reduction on one side and collusion and enabling on the other. Housing a known AOD user can be problematic for a residential program. It can create discipline and safety problems, as well as discomfort for the other residents. Some HIV/AIDS residences admit AOD users, with no particular requirements affecting them. Others may impose requirements. If a program does not impose sanctions for active AOD use, it may be aiding in the client's addiction and may jeopardize others' progress in recovery. On the other hand, requiring abstinence and/or participation in treatment (such as methadone maintenance or counseling) can present problems if an individual is too ill to comply; such requirements may jeopardize the individual's participation in a residential program.

Providers of residential services need education about opioid substitution therapy. Such education would help end the discrimination against methadone-maintained clients that still exists in some areas and would increase their access to residential and housing programs. Residential service providers should familiarize themselves with methadone maintenance treatment programs (MMTPs) and establish collaborative relationships with them to enable residents to remain in methadone maintenance treatment while they are in residence. Likewise, MMTPs should network with residential programs, educate them about their clients' needs, and establish collaborative relationships with staff of residential programs to increase their clients' access to these services. Three other Treatment Improvement Protocols (TIPs) in this series contain

detailed information about providing opioid substitution therapy services -- methadone and LAAM -- and an array of adjunct services. These TIPs include State Methadone Treatment Guidelines, Matching Treatment to Patient Needs in Opioid Substitution Therapy, and LAAM in the Treatment of Opiate Addiction.

Custody of Children of HIV-Infected Parents

Guardianship or custody of children in the event of serious illness or death of a parent who has AIDS may be determined in a number of ways, including:

- Adoption while the parent is alive. This provides certainty in determining who the children's legal guardian will be.
- Legal custody that allows another adult to make decisions concerning the child. Custody arrangements vary from State to State.
- Appointment of a permanent guardian in a parent's will.
- Some States permit "springing guardianship" or "standby guardianship," a flexible arrangement that enables a seriously ill parent to remain involved in children's upbringing while competent but provides for temporary guardianship during periods when the parent becomes incompetent. Legal advice should be sought, preferably from an attorney who is experienced in both HIV and child welfare issues, before a client makes important decisions about the future of a child or children.

HIV-Infected Children

AOD program staff should be educated about the foster care and adoption systems in their States and in particular about specific regulations that may exist concerning HIV-infected children. Special training should be provided to staff of AOD abuse programs on issues regarding AOD/HIV and children. The names of national and State organizations with expertise in this area can be obtained by contacting State HIV/AIDS agencies.

Support for Prospective Foster and Adoptive Parents of HIV-Infected Children

Prospective caretakers must clearly understand the legal and financial ramifications of being a foster or adoptive parent of an HIV-infected child. Providing emotional support and social services to foster or adoptive parents will help them in caring for the children of dying or deceased clients. Programs should ensure that prospective foster or adoptive parents receive competent advice and accurate information. If program staff do not have the necessary expertise, the prospective parents should be referred to child

welfare agencies or to attorneys knowledgeable about legal issues relating to both HIV and child welfare.

Programs should contact the social service/child welfare agencies in their States for information about the support services and benefits available to natural, foster, or adoptive parents of an HIV-infected child. Typically, the State social service/child welfare agency pays a monthly stipend to foster and adoptive parents for the care of the child. State child welfare agencies provide supplemental stipends to children designated to have special needs, and HIV-infected children sometimes receive this designation. Foster children are automatically eligible for Medicaid. Also, children are eligible for Medicaid once they are legally adopted.

Community education is also needed to facilitate placing residential programs in neighborhoods conducive to the maintenance of a healthy lifestyle. At present, supported housing services are often located in areas with high rates of AOD use, challenging residents' continued abstinence. The Federal Fair Housing Assistance Act, the Federal Americans With Disabilities Act, and the Public Health Service Act authorizing the provision of substance abuse prevention and treatment block grants have removed substantial barriers to the establishment of special housing programs. However, community education by AOD treatment programs, residential programs, and advocacy groups is still essential to overcome the "not in my backyard" (NIMBY) syndrome.

Active AOD abusers are the most difficult clients to house. A balance must be struck between empathy and harm reduction on one side and collusion and enabling on the other.

Residential AOD treatment programs that are publicly funded or licensed should be aware that they are required to comply with the provisions of the 1990 Americans With Disabilities Act regarding housing accessibility for individuals with physical disabilities (National Council on Disability, 1993.) Appropriate modifications might include, for example, adding ramps and wheelchair-accessible toilet and bathing facilities.

Symptomatic HIV-infected persons often require services in addition to those offered in traditional residential housing programs. Helpful efforts might include referrals to appropriate resources or incorporation of new services into existing residential programs. For example, residential programs can help residents arrange for take-home methadone or provide transportation to AOD treatment programs, medical appointments, and support group meetings.

Home Healthcare

Comprehensive and coordinated home healthcare services for HIV-infected AOD patients should include the following elements:

- Coordination with public health nurses, home health aides, AOD counselors, and other individuals working with patients
- Case conferences with the patient, family, and other health workers involved in the patient's care
- Family counseling and education
- A team approach: representatives from all institutions and disciplines should be involved in planning and monitoring home-based care.

Although home healthcare is an important part of the continuum of housing support services, it is often fragmented, with a confusing array of services, funding sources, and restrictions. Resources are often insufficient to meet needs. Coordination and collaboration among housing programs, social service agencies, and home healthcare agencies are essential to ensure the effective delivery of these services to HIV-infected AOD abusers.

For patients on opioid substitution therapy, home healthcare presents special problems. Home healthcare workers are typically not authorized to dispense medications. As a result, many individuals receiving methadone maintenance treatment must be hospitalized in order to be kept on their treatment regimen. However, the Food and Drug Administration grants waivers on an individual basis so that clients who are too sick to pick up their methadone can arrange for it to be picked up for them -- by home health workers or residential staff, for example.

Home healthcare workers could benefit from training in AOD abuse and HIV issues. Certified and/or approved training courses offered by agencies such as the American Red Cross may be utilized, or home health agencies may wish to develop inhouse staff training programs. In addition, home health staff should receive cultural sensitivity training to increase their level of comfort in dealing with people of different ethnicities, economic backgrounds, and sexual orientations.

Hospice Care

A hospice program provides palliative care (care that enhances comfort and strives to improve quality of life) to individuals who are terminally ill. Hospices also provide around-the-clock supportive services to patients and their families or significant others.

Hospices originated in England as residential facilities; however, in the United States, 90 percent of hospice care is provided in the home. Hospice care typically involves a primary caregiver -- usually a partner or family member living at the same residence -- who is willing and able to provide ongoing care to the patient. Most hospices provide volunteers to help the primary caregiver.

Some hospices are inpatient facilities, either freestanding independent facilities or based in hospitals or nursing homes. Depending on their needs, patients may receive hospice care both in a hospital and at home during the end stage of their illness. Although most hospice care requires that the patient have a place to live, some hospices will provide care in residential facilities other than in a private home. Some hospices also provide a residence for homeless people.

Traditionally, hospice care was designed to deliver care in the end stage of a terminal illness. However, in response to the AIDS crisis, many hospices now accept AIDS patients at earlier stages of disease and are more flexible about accepting AIDS patients who are receiving medical treatment for opportunistic infections. Hospices do not accept patients who are receiving medical treatment to prolong life; however, they will accept patients who are receiving treatment to make them more comfortable. Hospice care would not be appropriate for asymptomatic or mildly symptomatic HIV patients.

Most hospices are Medicare certified and in some States they can accept Medicaid. In addition, many private insurers provide coverage for hospice care.

Homeless Shelters

According to the report of the National Commission on AIDS Working Group on Social/Human Issues, "Affordable and appropriate housing is of critical importance to persons with HIV disease, yet an estimated 20,000 to 32,000 HIV-infected individuals are homeless. Many others are in immediate danger of becoming homeless" (National Commission on AIDS, 1991). Tuberculosis (TB) is a serious problem in many homeless shelters, and a significant percentage of people living in shelters are HIV-infected AOD abusers.

Despite the high incidence of AOD abuse among homeless people, homeless shelters are often not considered part of the AOD treatment system and are excluded from the service planning and delivery process. Medical care and AOD services provided in shelters are often inadequate. Many shelters require residents to leave the facility early in the morning and return in the evening; such policies are particularly problematic for residents who are ill, including those with HIV disease or TB. Shelter residents and staff may lack knowledge about the relationships between AOD use and infectious diseases, including HIV and TB. AOD treatment providers should make efforts to develop linkages with homeless shelters in order to overcome these barriers and provide services to this hard-to-reach population.

Tuberculosis is a serious problem in many homeless shelters, and a significant percentage of people living in shelters are HIV-infected AOD abusers.

Family Support

It is helpful to define "family" broadly to encompass both traditional and nontraditional families. Family may include significant others -- individuals who may be unrelated but who have a close relationship with the client and provide for the client's physical, emotional, and spiritual well-being. Family members and significant others should be encouraged to participate actively in treatment planning and medical care decisions regarding the client's AOD problems and HIV disease.

All family members who provide close support to the seriously ill member often need support themselves. Providing social service support for the family is a cornerstone in the provision of coordinated, comprehensive care to HIV-infected AOD abusers.

For example, the provision of home-based services may be critical in enabling a family to remain together, and it may also be more cost-effective than institutionalization of the HIV-infected family member.

Case Management

Case management is the process of linking patients with needed services, particularly when these services are located at different sites and provided by different agencies. Case management originated in the social work profession and has become a standard practice in the social services and mental health fields.

While there is no single, universally accepted definition of case management, the term can be broadly defined as a process in which the full range of services is identified to meet a person's psychosocial, economic, and health-related needs either directly or through linkage and referral. The case manager is the professional responsible for coordinating the patient's care and arranging access to needed services, often also serving as an advocate and broker. In the AOD treatment field, case management can involve arranging access to needed services that are not part of a client's formal treatment program such as aftercare, follow up, family support, and referrals to other agencies.

An important function of the case manager is to ensure that HIV-infected AOD abusers gain access to entitlement benefits, such as food stamps, Medicare and Medicaid, and supplementary income. Applying for eligibility for various programs and maintaining eligibility status often require special knowledge of program regulations and may involve completing forms and contacting a variety of agency personnel -- procedures that may be daunting or confusing, especially to a person who is ill. Case managers should

develop a working knowledge of entitlement programs that may benefit HIV-infected AOD abusers.

It is important to note that case management with any population involves a high level of skill and knowledge. Traditionally, AOD treatment providers have not hired enough professional social workers to carry out these responsibilities for substance abuse clients. In addition, they often do not provide adequate training to personnel, such as AOD counselors, who are assigned these duties. Case management with HIV-infected AOD abusers is labor intensive and requires specialized knowledge and skills. AOD providers will have to revise their expectations regarding caseload size and frequency and length of client contact when case managers are assigned to work with these clients.

Services for HIV-infected AOD abusers are typically provided by a variety of treatment agencies, each of which has different funding sources, regulations, and responsibilities for specific aspects of care. Case management plays a critical role in promoting a continuum of care by ensuring that clients are linked to needed services and are receiving appropriate therapy that does not conflict with their AOD treatment.

A variety of models of case management for HIV-infected individuals have evolved as a result of different funding sources and methods of healthcare financing. The report of the National Commission on AIDS Working Group on Social/Human Issues (1991) described the various models of case management as follows.

In some instances, case management is funded by the government, is hospital-based, and is primarily linked to discharge planning. Other case management programs, particularly those funded by the Health Resources and Services Administration (HRSA) and the Robert Wood Johnson Foundation (RWJ), are more community based and follow individuals both in the hospital and beyond. In some States, case management is provided by Medicaid programs, especially in States with home- and community-based waiver programs. Yet other programs have emanated from prepaid, managed care programs in health maintenance organizations (HMOs).

Effective case management for HIV-infected AOD abusers encompasses linkages with a full spectrum of services and agencies, including:

- AOD treatment programs
- Mental health services
- Child welfare agencies, including foster care and protective services
- Community resources, including AIDS service organizations, and churches
- Legal services

- Public entitlement programs
- Perinatal addiction programs
- Educational programs, including ones for children who are exposed to drugs in the community
- HIV-specific health and counseling services
- Programs that provide basic services, such as food, housing, transportation, respite care, and childcare.

Case management requires linkages among agencies responsible for different aspects of a client's care. It is recommended that formal interagency agreements be established that clarify the responsibilities of all the organizations providing services to clients. Agencies should also have agreed-upon procedures for interagency communication and evaluation mechanisms to track the effectiveness and outcomes of case management on an individual's or family's health status. It may also be helpful to calculate the levels and types of staff, resources, and facilities needed to carry out effective case management, bearing in mind that clients' needs for intensive case management services will vary depending on their stage of AOD and HIV treatment.

Role of the Case Manager: Four Models

Three models of case management have been described, differentiated by the case manager's level of involvement in managing the care of an individual patient. In each model, the case manager may be affiliated with one of several disciplines, such as social work, nursing, or substance abuse treatment. Because AOD abusers may not be accustomed to going outside of the AOD treatment provider community to obtain services, effective case management can often best be accomplished by an AOD counselor or other personnel in the treatment field. A fourth model, in which the case manager is the primary therapist, was added by the CSAT consensus panel social services workgroup.

Comprehensive Case Manager Model.
In this model, the case manager's responsibilities include service coordination; advocacy; and assistance in dealing with health, social services, and substance abuse treatment agencies. The case manager can be based within an AOD treatment program, a primary healthcare clinic, or a community-based social service organization.

Case Coordinator Model.
The case coordinator is responsible for conducting follow up with the designated contact person at each agency providing services to the client to ensure that appointments are being kept and needs identified. The case coordinator may receive copies of a checklist from each provider. The case coordinator can be based within an AOD

treatment program, a primary healthcare clinic, or a community-based social service organization.

Hospital-Based Caseworker Model.
This model differs from the others in that the caseworker is hospital based. The caseworker is responsible for coordinating referrals for hospitalized patients who are identified as being HIV-infected AOD abusers. Referrals are made to AOD treatment providers, outpatient medical services (for HIV treatment), and social service agencies, as well as to hospital- and community-based recovery support groups, such as 12-step programs. The caseworker is usually employed by the hospital, although funding for the position might come from a foundation or from a local Ryan White CARE consortium.

Case Manager as Primary Therapist.
This model is common in AOD abuse treatment programs, in which the client's primary therapist functions as case manager. In some cases, the AOD abuse counselor can be a very effective case manager for the HIV-infected client.

Outreach Services

Staff members of many social service agencies and community-based organizations perform outreach functions to deliver specific services to populations that may not otherwise seek or have access to services. AOD outreach workers play a key role in encouraging AOD abusers to seek and remain in treatment, comply with medication regimens, and reduce HIV risk behaviors such as unsafe drug-taking practices, unsafe sexual practices, and AOD abuse. Street outreach workers perform an essential public health role; they gather information critical to the development of effective public health policy and are on the front lines in terms of implementing health policy. Screening for infectious diseases such as HIV-disease, TB, and sexually transmitted diseases is an important function of outreach workers. Another TIP in this series, Simple Screening for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases, provides an overview of this important aspect of the role of outreach workers.

Street outreach workers perform an essential public health role; they gather information critical to the development of effective public health policy and are on the front lines in terms of implementing health policy.

Case finding, counseling, and creating linkages with other health and social services agencies are other important responsibilities of outreach workers. Like case managers, outreach workers may have a coordinating role among social service agencies, healthcare providers, community organizations, and AOD treatment facilities to

ensure that clients obtain needed services. AOD programs providing services to HIV-infected AOD abusers should recognize the vital role played by outreach workers in serving many individuals in this population and should include outreach workers in staff planning meetings and case conferences and as active members of the program's interdisciplinary team.

For example, outreach worker participation in discharge planning can facilitate continuity of care for patients. An outreach worker who is in close contact with a client may be in the best position to determine whether a discharge plan realistically meets the individual's needs. In addition, when the outreach worker is involved in the discharge planning process, he or she can more easily track the patient after discharge.

Outreach workers may also provide:

- Crisis counseling and referrals for emergency care to AOD abusers not enrolled in treatment
- Assistance in securing transportation, childcare, and other services that may encourage AOD abusers to enter or reenter treatment
- Monitoring AOD abusers' consumption of medications through home or street visits
- Consultation and education to other social service agencies, healthcare providers, and community- based organizations on AOD abuse and HIV issues.

AOD outreach workers should be familiar with the community in which they work. For example, outreach workers performing HIV risk reduction education among heroin addicts must know where these individuals congregate (for example, in shooting galleries or abandoned buildings) and be comfortable working in these settings. Similarly, they can benefit from knowing about national organizations and hotlines. Both can be the source of helpful information and materials for use in community work.

Many AOD outreach workers are themselves in recovery from AOD abuse. Although support groups for all outreach workers are very important, workers who are in recovery have special needs that should be addressed in support groups. These individuals must be secure enough in their recovery process to resist relapse when their work brings them into close contact with persons who are currently abusing AODs.

Prototypes, a therapeutic community in the Los Angeles area and described in the box on the next page, is a program that successfully employs individuals in recovery to conduct outreach. This program hired and trained 25 local women, many of whom had been sex workers or partners of sex workers. Following their training, the women returned to their communities to educate other female AOD

abusers about high-risk behaviors and encourage them to enter treatment.

Entitlements and the Representative Payee Program

An understanding by case managers of the often confusing process of applying for public assistance -- including Medicaid, Supplemental Security Income (SSI), and food stamps -- will help ensure that clients receive benefits for which they are eligible. AIDS service organizations that have developed expertise in this area can be consulted for technical assistance. Case managers also need to be familiar with the problem of long waiting periods to receive SSI benefits and with the SSI representative payee program.

HIV-infected individuals can qualify for SSI benefits if they are considered to be permanently disabled by HIV disease. Because there is usually a long wait from the time of application for benefits to receipt of the first payment, clients often receive large back payments. To safeguard against the risk that AOD-abusing clients will spend the lump sum or monthly SSI benefit to support their addiction, a "representative payee" arrangement may be established in which the benefit is paid to an individual who acts as the client's representative. The case manager can work with the client to identify a family member or significant other who is willing to be the representative payee. Strict laws and regulations are in effect to prevent misuse of SSI funds by representative payees.

Prototypes: A Program That Keeps Families Together

Prototypes is a therapeutic community (TC) in Los Angeles that provides services to families. It offers comprehensive residential, day treatment, and outpatient AOD services for women and their children. A culturally competent staff provides case management and conducts extensive outreach to women who are not in AOD abuse treatment and are living in homeless shelters, battered women's shelters, or on the street. Program compliance requirements are flexible and are adapted to the needs of HIV-infected women, with the goal of keeping them in the program as long as possible.

Support services are offered for pregnant women who are AOD abusers and/or HIV infected. When an HIV-infected woman has to be hospitalized, her treatment slot is kept open for her and the program continues to provide support for her children. Women on methadone are accepted into the program. Lesbian women are welcomed, and psychological support is provided for their partners.

Vocational rehabilitation and job training are provided for clients, and special programs are offered for women who are HIV infected and

need to work part time. For example, word processing skills are encouraged because there are many part-time employment opportunities in this area. Self-sufficiency is emphasized, with at least three choices of different kinds of work training opportunities offered within the job training and education program.

The health department actively supports screening of Prototypes clients for TB and other infectious diseases. The program has established linkages with child welfare, social services, and criminal justice agencies; entitlement programs; and the school system. In addition, the program has developed diversion programs with the criminal justice system to keep women out of prison and decrease the need for women to be separated from their children.

Prototypes offers more than 25 different core group counseling sessions dealing with a broad range of AOD and self-sufficiency issues. Pastoral care and spiritual support are also available. The program helps HIV-infected women plan for the care of their children after their death by assisting with writing wills and designating guardians, foster parents, or personal representatives for the children.

NCLUSION

The information in this course is part of a broader curriculum focusing on providing services to HIV positive clients.

The complete program can be found at http://www.health.org/govpubs/bkd163/ and should be reviewed by any professional providing such services.

We hope this overview will be of value to you - and to your clients, as well.

THANK YOU FOR PARTICIPATING IN THIS COURSE

You must also complete and return the Evaluation of Learning Quiz and the appropriate fee, either online or by fax or mail. (Instructions are on the next page.)

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Richard K. Nongard, LMFT, CCH, CPFT
Executive Director

"Mental Health Counseling Needs of HIV+ Alcohol and Other Drug Abusers"

3 Continuing Education Clock Hours

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EVALUATION OF LEARNING QUIZ - PAGE 1 of 3

PRINT & FAX or MAIL THIS PAGE AND THE ANSWERS PAGES TO OUR OFFICE

*** * * * OR * * * ***

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EVALUATION OF LEARNING QUIZ - PAGE 2 of 3

"Mental Health and Counseling Needs of HIV-Infected Alcohol and Other Drug Abusers"

3 Hours of Approved Continuing Education Credit

The purpose of the following Evaluation of Learning questions is to:

A.) Verify that you have read the required course materials
B.) Demonstrate an understanding of the practical application of the course materials
C.) Officially document your participation and completion of this course

➲ **ANSWER THE FOLLOWING 20 COURSE EVALUATION OF LEARNING QUESTIONS – TRUE OR FALSE.**

T F 1. I have read the required .pdf text file for this course.

T F 2. Mania is frequently seen in HIV patients.

T F 3. The presence of antisocial personality disorder or borderline personality disorder often complicates AOD abuse treatment for the HIV-infected patient.

T F 4. Pharmacologic and psychotherapeutic interventions should never be used together in the treatment of mental disorders in HIV-infected AOD abuse patients.

T F 5. If their cultural context of patients' spiritual beliefs is not understood, such beliefs may be labeled delusional accidentally.

T F 6. The healthcare needs of HIV-infected AOD abusers with mental disorders are simple.

T F 7. A comprehensive mental status examination is the key to detecting mental disorders.

T F 8. It is essential to set treatment goals that exceed the patient's functional capacity.

T F 9. HIV-related neurocognitive loss usually progresses gradually.

T F 10. HIV-infected persons are usually less sensitive to prescription medications as well as to drugs of abuse.

CONTINUED →

EVALUATION OF LEARNING QUIZ - PAGE 3 of 3

Course Title: "Mental Health and Counseling Needs of HIV-Infected Alcohol and Other Drug Abusers"

T **F** 11. HIV-infected patients are often prescribed complex medication regimens. Medications, either alone or in various combinations, may cause confusion and other psychiatric symptoms.

T **F** 12. Counseling is an important part of treatment for all AOD abusers, including those with comorbid psychiatric disorders.

T **F** 13. One aim of individual therapy may be to prepare patients to participate in group therapy.

T **F** 14. AOD abuse and HIV infection rarely cause cognitive impairment that can reduce adherence to medical care.

T **F** 15. For some HIV-infected AOD abuse patients, "family" may need to be defined as broadly as possible.

T **F** 16. Declining health as a result of HIV disease is a recognized risk factor for relapse into AOD abuse.

T **F** 17. Patients with symptomatic HIV disease may be physically unable to perform all the tasks normally expected of members of a residential treatment program.

T **F** 18. Providing social services to HIV-infected AOD abusers requires very little cooperation and coordination among agencies.

T **F** 19. Access to and availability of housing are two key issues for HIV-infected AOD abusers.

T **F** 20. While there is no single, universally accepted definition of case management, the term can be broadly defined as a process in which the full range of services is identified to meet a person's psychosocial, economic, and health-related needs either directly or through linkage and referral.

GRADE THIS ONLINE COURSE! – Page 4

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Participant Assessment of Home Study CEU Course

"Mental Health Counseling Needs of HIV+ AOD Abusers"

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