HIV and AIDS CE Course
(7 hours/units)

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Course Objectives: In addition to the course objectives listed below, this course addresses the following content areas related to HIV and AIDS:

- Counseling theory and practice
- Social and Cultural Foundations
- Assessment
- Professional practice issues
- Wellness and prevention

This course is designed to help you:

1. Differentiate between HIV and AIDS.
2. Identify the causes of HIV and AIDS.
3. Increase familiarity with the statistics and epidemiology of HIV/AIDS.
4. Learn the historical framework related to the development of HIV/AIDS.
5. Increase familiarity regarding the impact HIV/AIDS on culture.
6. Identify and recognize common stigmas associated with HIV/AIDS.
7. Increase familiarity with the relationship between HIV/AIDS and mental health.
8. Increase knowledge with the relationship between HIV/AIDS and substance abuse.
9. Develop the ability to identify the characteristics, method of assessment, and treatment of people who live with HIV/AIDS.

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1. Definitions

Human immunodeficiency virus (HIV) is a lentivirus (a member of the retrovirus family) that can lead to acquired immunodeficiency syndrome (AIDS), a condition in humans in which the immune system begins to fail, leading to life-threatening opportunistic infections. This condition progressively reduces the effectiveness of the immune system and leaves individuals susceptible to opportunistic infections and tumors. HIV is transmitted through direct contact of a mucous membrane or the bloodstream with a bodily fluid containing HIV, such as blood, semen, vaginal fluid, preseminal fluid, and breast milk. This transmission can involve anal, vaginal or oral sex, blood transfusion, contaminated hypodermic needles, exchange between mother and baby during pregnancy, childbirth, or breastfeeding, or other exposure to one of the above bodily fluids (Appay V, Sauce D, January 2008. "Immune activation and inflammation in HIV-1 infection: causes and consequences". J. Pathol).

Apart from psychological impact, HIV infection has direct effects on the central nervous system, and causes neuropsychiatric complications including HIV encephalopathy, depression, mania, cognitive disorder, and dementia, often in combination. Infants and children with HIV infection are more likely to experience deficits in motor and cognitive development compared with HIV negative children. Cognitive impairment in HIV/AIDS has been associated with greatly increased mortality, independent of other factors such as baseline clinical stage, CD4+ cell count, and serum hemoglobin concentration, antiretroviral treatment, and social and demographic characteristics (World Health Organization, Executive Board EB124/6, 124th Session 20 November 2008, Provisional agenda item 4.3 November 20th, 2007).

Although treatments for AIDS and HIV can slow the course of the disease, there is currently no vaccine or cure. Antiretroviral treatment reduces both the mortality and the morbidity of HIV infection, but these drugs are expensive and routine access to antiretroviral medication is not available in all countries. Due to the difficulty in treating HIV infection, preventing infection is a key aim in controlling the AIDS epidemic, with health organizations promoting safe sex and needle-exchange programs in attempts to slow the spread of the virus (Appay V, Sauce D, January 2008. "Immune activation and inflammation in HIV-1 infection: causes and consequences". J. Pathol).

Previous names for the virus include human T-lymphotropic virus-III (HTLV-III), lymphadenopathy-associated virus (LAV), and AIDS-associated retrovirus (ARV). Infection with HIV occurs by the transfer of blood, semen, vaginal fluid, pre-ejaculate, or breast milk. Within these bodily fluids, HIV is present as both free virus particles and virus within infected immune cells. The four major routes of transmission are unprotected sexual intercourse, contaminated needles, breast milk, and transmission from an infected mother to her baby at birth (Vertical transmission). Screening of blood products for HIV has largely eliminated transmission through blood transfusions or infected blood products in the developed world (Appay V, Sauce D, January 2008. "Immune activation and inflammation in HIV-1 infection: causes and consequences". J. Pathol).
HIV infection in humans is now pandemic. The annual number of deaths of persons with AIDS (some of which were not caused by AIDS), as reported to the national HIV surveillance system through June 30, 2012, and adjusted for reporting delay, was 11% to 42% (depending on the year) greater than the number of deaths attributed to HIV infection in death certificate data (by ICD-10 rules for selecting the underlying cause of death). The greater number of deaths of persons with AIDS is partly because some persons with AIDS die of causes not attributable to HIV infection, such as motor vehicle accidents, and partly because some deaths due to HIV infection are not reported as such on death certificates (Sources: National HIV Surveillance System, National Center for Health Statistics, NCHS).

According to current estimates, HIV is set to infect 90 million people in Africa, resulting in a minimum estimate of 18 million orphans. Antiretroviral treatment reduces both the mortality and the morbidity of HIV infection, but routine access to antiretroviral medication is not available in all countries. HIV primarily infects vital cells in the human immune system such as helper T cells (specifically CD4+ T cells), macrophages, and dendritic cells. HIV infection leads to low levels of CD4+ T cells through three main mechanisms: firstly, direct viral killing of infected cells; secondly, increased rates of apoptosis in infected cells; and thirdly, killing of infected CD4+ T cells by CD8 cytotoxic lymphocytes that recognize infected cells. When CD4+ T cell numbers decline below a critical level, cell-mediated immunity is lost, and the body becomes progressively more susceptible to opportunistic infections (Appay V, Sauce D, January 2008. "Immune activation and inflammation in HIV-1 infection: causes and consequences". J. Pathol).

Eventually most HIV-infected individuals develop AIDS (Acquired Immunodeficiency Syndrome). These individuals mostly die from opportunistic infections or malignancies associated with the progressive failure of the immune system. Without treatment, about 9 out of every 10 persons with HIV will progress to AIDS after 10-15 years. Many people deteriorate much sooner. Treatment with anti-retrovirals increases the life expectancy of people infected with HIV. Even after HIV has progressed to diagnosable AIDS, the average survival time with antiretroviral therapy is estimated to be more than 5 years. Without antiretroviral therapy, death normally occurs within a year. It is hoped that current and future treatments may allow HIV-infected individuals to achieve a life expectancy approaching that of the general public (Appay V, Sauce D, January 2008. "Immune activation and inflammation in HIV-1 infection: causes and consequences". J. Pathol).
2. Causes

AIDS is the most severe acceleration of infection with HIV. HIV is a retrovirus that primarily infects vital organs of the human immune system such as CD4+ T cells (a subset of T cells), macrophages and dendritic cells. It directly and indirectly destroys CD4+ T cells. Once HIV has killed so many CD4+ T cells that there are fewer than 200 of these cells per microliter (µL) of blood, cellular immunity is lost. Acute HIV infection progresses over time to clinical latent HIV infection and then to early symptomatic HIV infection and later to AIDS, which is identified either on the basis of the amount of CD4+ T cells remaining in the blood, and/or the presence of certain infections (Appay V, Sauce D, January 2008. "Immune activation and inflammation in HIV-1 infection: causes and consequences". J. Pathol).

![Scanning electron micrograph of HIV-1, colored green, budding from a cultured lymphocyte.](image)

In the absence of antiretroviral therapy, the median time of progression from HIV infection to AIDS is nine to ten years, and the median survival time after developing AIDS is only 9.2 months. However, the rate of clinical disease progression varies widely between individuals, from two weeks up to 20 years. Many factors affect the rate of progression. These include factors that influence the body's ability to defend against HIV such as the infected person's general immune function. Older people have weaker immune systems, and therefore have a greater risk of rapid disease progression than younger people. Poor access to health care and the existence of coexisting infections such as tuberculosis also may predispose people to faster disease progression. The infected person's genetic inheritance plays an important role and some people are resistant to certain strains of HIV. An example of this is people with the homozygous CCR5-Δ32 variation are resistant to infection with certain strains of HIV. HIV is genetically variable and exists as different strains, which cause different rates of clinical disease (Appay V, Sauce D, January 2008. "Immune activation and inflammation in HIV-1 infection: causes and consequences". J. Pathol).
Sexual transmission

Sexual transmission occurs with the contact between sexual secretions of one person with the rectal, genital or oral mucous membranes of another. Unprotected receptive sexual acts are riskier than unprotected insertive sexual acts, and the risk for transmitting HIV through unprotected anal intercourse is greater than the risk from vaginal intercourse or oral sex.

However, oral sex is not entirely safe, as HIV can be transmitted through both insertive and receptive oral sex. Sexual assault greatly increases the risk of HIV transmission as protection is rarely employed and physical trauma to the vagina occurs frequently, facilitating the transmission of HIV. Other sexually transmitted infections (STI) increase the risk of HIV transmission and infection, because they cause the disruption of the normal epithelial barrier by genital ulceration and/or microulceration; and by accumulation of pools of HIV-susceptible or HIV-infected cells (lymphocytes and macrophages) in semen and vaginal secretions. Epidemiological studies from sub-Saharan Africa, Europe and North America suggest that genital ulcers, such as those caused by syphilis and/or chancroid, increase the risk of becoming infected with HIV by about fourfold. There is also a significant although lesser increase in risk from STIs such as gonorrhea, Chlamydial infection and trichomoniasis, which all cause local accumulations of lymphocytes and macrophages (Appay V, Sauce D, January 2008. "Immune activation and inflammation in HIV-1 infection: causes and consequences". J. Pathol).

Transmission of HIV depends on the infectiousness of the index case and the susceptibility of the uninfected partner. Infectivity seems to vary during the course of illness and is not constant between individuals. An undetectable plasma viral load does not necessarily indicate a low viral load in the seminal liquid or genital secretions. However, each 10-fold increase in the level of HIV in the blood is associated with an 81% increased rate of HIV transmission. Women are more susceptible to HIV-1 infection due to hormonal changes, vaginal microbial ecology and physiology, and a higher prevalence of sexually transmitted diseases. People who have been infected with one strain of HIV can still be infected later on in their lives by other, more virulent strains. Infection is unlikely in a single encounter. High rates of infection have been linked to a pattern of overlapping long-term romantic relationships. This allows the virus to quickly spread to multiple partners who in turn infect their partners. A pattern of serial monogamy or occasional casual encounters is associated with lower rates of infection. HIV spreads readily through heterosexual sex in Africa, but less so elsewhere. One possibility being researched is that schistosomiasis, which affects up to 50 per cent of women in parts of Africa, damages the lining of the vagina (Appay V, Sauce D, January 2008. "Immune activation and inflammation in HIV-1 infection: causes and consequences". J. Pathol).
Exposure to blood-borne pathogens

This transmission route is particularly relevant to intravenous drug users, hemophiliacs and recipients of blood transfusions and blood products. Sharing and reusing syringes contaminated with HIV-infected blood represents a major risk for infection with HIV. Needle sharing is the cause of one third of all new HIV-infections in North America, China, and Eastern Europe. The risk of being infected with HIV from a single prick with a needle that has been used on an HIV-infected person is thought to be about 1 in 150. Post-exposure prophylaxis with anti-HIV drugs can further reduce this risk. This route can also affect people who give and receive tattoos and piercings. Universal precautions are frequently not followed in both sub-Saharan Africa and much of Asia because of both a shortage of supplies and inadequate training. The World Health Organization (WHO) estimates that approximately 2.5% of all HIV infections in sub-Saharan Africa are transmitted through unsafe healthcare injections. Because of this, the United Nations General Assembly has urged the nations of the world to implement precautions to prevent HIV transmission by health workers. The risk of transmitting HIV to blood transfusion recipients is extremely low in developed countries where improved donor selection and HIV screening is performed. However, according to the WHO, the overwhelming majority of the world's population does not have access to safe blood and between 5% and 10% of the world's HIV infections come from transfusion of infected blood and blood products (Source: The World Health Organization).

Perinatal transmission

The transmission of the virus from the mother to the child can occur in utero during the last weeks of pregnancy and at childbirth. In the absence of treatment, the transmission rate between a mother and her child during pregnancy, labor and delivery is 25%.
However, when the mother takes antiretroviral therapy and gives birth by caesarean section, the rate of transmission is just 1%. The risk of infection is influenced by the viral load of the mother at birth, with the higher the viral load, the higher the risk. Breastfeeding also increases the risk of transmission by about 4% (Source: The World Health Organization).

2008-2011 Summary of Causes

The percentage of adults and adolescents with diagnosed HIV infection attributed to male-to-male sexual contact increased from 55% in 2008 to 62% in 2011. The percentages of diagnosed HIV infections attributed to injection drug use, male-to-male sexual contact and injection drug use, and heterosexual contact remained relatively stable (less than a 5% increase or decrease) from 2008 through 2011. A very small percentage of diagnosed infections each year were attributed to other transmission categories.

Data include persons with a diagnosis of HIV infection regardless of stage of disease at diagnosis. All displayed data are estimates. Estimated numbers resulted from statistical adjustment that accounted for reporting delays and missing transmission category, but not for incomplete reporting. Heterosexual contact is with a person known to have, or to be at high risk for, HIV infection. Other transmission categories include hemophilia, blood transfusion, perinatal exposure, and risk factor not reported or not identified.

This slide below presents the distribution of diagnoses of HIV infection among adults and adolescents diagnosed from 2008 through 2011, by transmission category, for the United States and 6 dependent areas.
Misconceptions

A number of misconceptions have arisen surrounding HIV/AIDS. Three of the most common are that AIDS can spread through casual contact, that sexual intercourse with a virgin will cure AIDS, and that HIV can infect only homosexual men and drug users. Other misconceptions are that any act of anal intercourse between gay men can lead to AIDS infection, and that open discussion of homosexuality and HIV in schools will lead to increased rates of homosexuality and AIDS (Source: The World Health Organization).

Pathophysiology

The pathophysiology of AIDS is complex, as is the case with all syndromes. Ultimately, HIV causes AIDS by depleting CD4+ T helper lymphocytes. This weakens the immune system and allows opportunistic infections. T lymphocytes are essential to the immune response and without them, the body cannot fight infections or kill cancerous cells. The mechanism of CD4+ T cell depletion differs in the acute and chronic phases.

During the acute phase, HIV-induced cell lysis and killing of infected cells by cytotoxic T cells accounts for CD4+ T cell depletion, although apoptosis may also be a factor.
During the chronic phase, the consequences of generalized immune activation coupled with the gradual loss of the ability of the immune system to generate new T cells appear to account for the slow decline in CD4+ T cell numbers.

Although the symptoms of immune deficiency characteristic of AIDS do not appear for years after a person is infected, the bulk of CD4+ T cell loss occurs during the first weeks of infection, especially in the intestinal mucosa, which harbors the majority of the lymphocytes found in the body. The reason for the preferential loss of mucosal CD4+ T cells is that a majority of mucosal CD4+ T cells express the CCR5 coreceptor, whereas a small fraction of CD4+ T cells in the bloodstream do so.

HIV seeks out and destroys CCR5 expressing CD4+ cells during acute infection. A vigorous immune response eventually controls the infection and initiates the clinically latent phase. However, CD4+ T cells in mucosal tissues remain depleted throughout the infection, although enough remain to initially ward off life-threatening infections (Source: The CDC, The World Health Organization).

Continuous HIV replication results in a state of generalized immune activation persisting throughout the chronic phase. Immune activation, which is reflected by the increased activation state of immune cells and release of proinflammatory cytokines, results from the activity of several HIV gene products and the immune response to ongoing HIV replication. Another cause is the breakdown of the immune surveillance system of the mucosal barrier caused by the depletion of mucosal CD4+ T cells during the acute phase of disease.

This results in the systemic exposure of the immune system to microbial components of the gut’s normal flora, which in a healthy person is kept in check by the mucosal immune system. The activation and proliferation of T cells that results from immune activation provides fresh targets for HIV infection. However, direct killing by HIV alone cannot account for the observed depletion of CD4+ T cells since only 0.01-0.10% of CD4+ T cells in the blood are infected. A major cause of CD4+ T cell loss appears to result from their heightened susceptibility to apoptosis when the immune system remains activated. Although new T cells are continuously produced by the thymus to replace the ones lost, the regenerative capacity of the thymus is slowly destroyed by direct infection of its thymocytes by HIV. Eventually, the minimal number of CD4+ T cells necessary to maintain a sufficient immune response is lost, leading to AIDS (Source: The World Health Organization).

3. Statistics and Epidemiology

1.3 million people are living with HIV in the United States of America, with a fifth unaware of their status. Since the epidemic began, an estimated 1,155,792 people in the USA have been diagnosed with AIDS.
In 2011:

- 49,273 people were diagnosed with HIV infection in the 46 states which report diagnoses.
- 32,052 people throughout the USA were diagnosed with AIDS.

All following statistics on this page have been sourced from the 'Diagnoses of HIV Infection and AIDS in the United States and Dependent Areas, 2011’ report, published by Centers for Disease Control and Prevention in February 2013:

From 2008 through 2011, in the United States and 6 dependent areas, the number of diagnoses of HIV infection among adult and adolescent females decreased; the number among males remained stable. In 2011, an estimated 50,007 adults and adolescents were diagnosed with HIV infection; of these, 79% of diagnoses were among males and 21% were among females.

Data include persons with a diagnosis of HIV infection regardless of stage of disease at diagnosis. All displayed data are estimates. Estimated numbers resulted from statistical adjustment that accounted for reporting delays, but not for incomplete reporting.
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(Source: Centers for Disease Control and Prevention, 2013 'Basic Statistics')
In 2011, among adults and adolescents diagnosed with HIV infection in the United States and 6 dependent areas, an estimated 62% of all diagnosed infections were attributed to male-to-male sexual contact. An estimated 18% of all diagnosed infections were attributed to heterosexual contact for females and 10% for males. An estimated 5% of all diagnosed infections were attributed to injection drug use for males and 3% for females. Approximately 3% of diagnosed infections were attributed to male-to-male sexual contact and injection drug use. Less than 1% of diagnosed infections were attributed to other transmission categories.

Other transmission categories include hemophilia, blood transfusion, perinatal exposure, and risk factor not reported or not identified.
In 2011, among adults and adolescents diagnosed with HIV infection in the United States and 6 dependent areas, an estimated 62% of all diagnosed infections were attributed to male-to-male sexual contact. An estimated 18% of all diagnosed infections were attributed to heterosexual contact for females and 10% for males. An estimated 5% of all diagnosed infections were attributed to injection drug use for males and 3% for females. Approximately 3% of diagnosed infections were attributed to male-to-male sexual contact and injection drug use. Less than 1% of diagnosed infections were attributed to other transmission categories. Data include persons with a diagnosis of HIV infection regardless of stage of disease at diagnosis. All displayed data are estimates. Estimated numbers resulted from statistical adjustment that accounted for reporting delays and missing transmission category, but not for incomplete reporting.

Heterosexual contact is with a person known to have, or to be at high risk for, HIV infection. Other transmission categories include hemophilia, blood transfusion, perinatal exposure, and risk factor not reported or not identified.
In 2011, among the 39,495 diagnoses of HIV infection among adult and adolescent males in the United States and 6 dependent areas, 42% were black/African American, 30% were white, and 23% were Hispanic/Latino. Approximately 2% each was Asian and males of multiple races, and less than 1% each was American Indian/Alaska Native and Native Hawaiian/other Pacific Islander.

Among the 10,512 diagnoses among adult and adolescent females in 2011, 63% were black/African American, 17% were Hispanic/Latino, and 17% were white. Approximately 1% each was among Asians and females of multiple races, and less than 1% each was among American Indians/Alaska Natives and Native Hawaiians/other Pacific Islanders.

Data include persons with a diagnosis of HIV infection regardless of stage of disease at diagnosis. All displayed data are estimates. Estimated numbers resulted from statistical adjustment that accounted for reporting delays, but not for incomplete reporting.

(Source: Centers for Disease Control and Prevention, 2013 'Basic Statistics'.)
In the United States and 6 dependent areas, the estimated rate of diagnoses of HIV infection among adults and adolescents was 19.1 per 100,000 population in 2011. The rate of diagnoses of HIV infection for adults and adolescents ranged from zero per 100,000 in American Samoa, Guam, and the Republic of Palau to 177.9 per 100,000 in the District of Columbia, 39.5 in the U.S. Virgin Islands, 36.6 in Louisiana, and 36.4 in Maryland.

Data include persons with a diagnosis of HIV infection regardless of stage of disease at diagnosis. All displayed data are estimates. Estimated numbers resulted from statistical adjustment that accounted for reporting delays, but not for incomplete reporting.

In recent years the use of antiretroviral therapy has slowed the progression of HIV in many infected persons and hence contributed to a decline in AIDS incidence. This means that AIDS surveillance data are less able to represent trends in the incidence of HIV infection or the impact of the epidemic on the healthcare system. In response, all 50 states have now implemented confidential name-based HIV infection reporting. However, only 40 states have been doing so long enough for the CDC to apply statistical adjustments. The HIV Surveillance Report for 2012 (published in 2014) will be the first time HIV data from all 50 states will be included (Source: Centers for Disease Control and Prevention, 2013 ‘Basic Statistics’).
4. History

AIDS was first reported June 5, 1981, when the U.S. Centers for Disease Control and Prevention recorded a cluster of *Pneumocystis carinii* pneumonia (now still classified as PCP but known to be caused by *Pneumocystis jirovecii*) in five homosexual men in Los Angeles. In the beginning, the Centers for Disease Control and Prevention (CDC) did not have an official name for the disease, often referring to it by way of the diseases that were associated with it, for example, lymphadenopathy, the disease after which the discoverers of HIV originally named the virus. They also used *Kaposi’s Sarcoma and Opportunistic Infections*, the name by which a task force had been set up in 1981. In the general press, the term *GRID*, which stood for Gay-related immune deficiency, had been coined. The CDC, in search of a name, and looking at the infected communities coined “the 4H disease,” as it seemed to single out Haitians, homosexuals, hemophiliacs, and heroin users. However, after determining that AIDS was not isolated to the homosexual community, the term GRID became misleading and *AIDS* was introduced at a meeting in July 1982. By September 1982 the CDC started using the name AIDS, and properly defined the illness. A recent study states that HIV probably moved from Africa to Haiti and then entered the United States around 1969 (*Source: The World Health Organization*).

5. Stigma

*Ryan White became a poster child for HIV after being expelled from school because of his infection.*

AIDS stigma has been further divided into the following three categories:

- *Instrumental AIDS stigma*—a reflection of the fear and apprehension that are likely to be associated with any deadly and transmissible illness.
- *Symbolic AIDS stigma*—the use of HIV/AIDS to express attitudes toward the social groups or lifestyles perceived to be associated with the disease.
- *Courtesy AIDS stigma*—stigmatization of people connected to the issue of HIV/AIDS or HIV-positive people.
Often, AIDS stigma is expressed in conjunction with one or more other stigmas, particularly those associated with homosexuality, bisexuality, promiscuity, prostitution, and intravenous drug use.

In many developed countries, there is an association between AIDS and homosexuality or bisexuality, and this association is correlated with higher levels of sexual prejudice such as anti-homosexual attitudes. There is also a perceived association between AIDS and all male-male sexual behavior, including sex between uninfected men (Source: The World Health Organization).

Originally, the growth of widespread stigma was revealed through patient clinical experiences. Protecting confidentiality, promoting anti-discrimination laws, and emphasizing public education campaigns has been highlighted in The American Psychologist. According to Valdiserri of the World Health Organization, “To underestimate the insidious power of stigma is to risk the very success of effective HIV prevention and care programs. As public health practitioners, it is our responsibility to work toward minimizing the negative health consequences of HIV/AIDS stigma” (Valdiserri, R. O. (2002). HIV/AIDS stigma: an impediment to public health. American Journal of Public Health, 92, 341–342). According to Parker, R., & Aggleton, P. who wrote HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action, “To move beyond the limitations of current thinking in this area, we need to reframe our understandings of stigmatization and discrimination to conceptualize them as social processes that can only be understood in relation to broader notions of power and domination. In our view, stigma plays a key role in producing and reproducing relations of power and control. It causes some groups to be devalued and others to feel that they are superior in some way. Ultimately, therefore, stigma is linked to the workings of social inequality and to properly understand issues of stigmatization and discrimination, whether in relation to HIV and AIDS or any other issue, requires us to think more broadly about how some individuals and groups come to be socially excluded, and about the forces that create and reinforce exclusion in different settings” (Parker, R., & Aggleton, P, 2003. HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action. Social Science & Medicine, 57, 13–24).

6. HIV/AIDS, Mental Health, and Counseling

The prevalence of mental illnesses in HIV-infected individuals is substantially higher than in the general population. Furthermore, HIV tends to be concentrated in highly vulnerable, marginalized and stigmatized populations; in particular, sex workers, men who have sex with men, drug users and prisoners have higher levels of mental health disorders than the general population. Increased psychological distress among people with HIV infection is common. Studies in both low- and high income countries have reported higher rates of depression in HIV-positive people compared with HIV negative control groups. The level of distress often seems to be related to the severity of symptoms of HIV infection. Coping styles and learned resourcefulness may shape the experience of depressive symptoms and the ability to care for oneself. Family relationships and the support of a partner can also influence mental health consequences (World Health
When faced with a diagnosis of HIV or AIDS, there are many emotional issues that a person may experience. Some of the common concerns or issues include anger, loss, stigma and fear of disclosure. There may also be a general fear, as well as anxiety, isolation, and depression. People with HIV must also cope with the psychological effects of fatigue, medication side effects, insomnia, irritability and difficulty with concentration. Substance abuse also frequently either co-occurs or develops after a diagnosis of HIV or AIDS (Blechner MJ, 1997. Hope and mortality: psychodynamic approaches to AIDS and HIV. Hillsdale, NJ: Analytic Press.)

HIV/AIDS imposes a significant psychological burden. People with HIV often suffer from depression and anxiety as they adjust to the impact of the diagnosis of being infected and face the difficulties of living with a chronic life-threatening illness, for instance shortened life expectancy, complicated therapeutic regimens, stigmatization, and loss of social support, family or friends. HIV infection can be associated with high risk of suicide or attempted suicide. The psychological predictors of suicidal ideation in HIV-infected individuals include concurrent substance-use disorders, past history of depression and presence of hopelessness (World Health Organization, Executive Board EB124/6, 124th Session 20 November 2008, Provisional agenda item 4.3 November 20th, 2007).

Studies have demonstrated a high seroprevalence of HIV infection in people with serious chronic mental illnesses. Prevalence rates in mentally ill inpatients and outpatients have been reported to be between 5% and 23%, compared with a range of 0.3% to 0.4% in the general population in the United States of America over comparable time periods. Some studies have reported behavioral risk factors for transmission of HIV in between 30% and 60% of people with severe mental illnesses. These risks include high rates of sexual contact with multiple partners, injecting drug use, sexual contact with injecting drug users, sexual abuse (in which women are particularly vulnerable to HIV infection), unprotected sex between men and low use of condoms. Besides these behavioral risks, mental disorders may also interfere with the ability to acquire and/or use information about HIV/AIDS and thus to practice safer behaviors or increase the likelihood of situations occurring in which risk behaviors are more common (World Health Organization, Executive Board EB124/6, 124th Session 20 November 2008, Provisional agenda item 4.3 November 20th, 2007).

Inadequate provision of integrated services for people with mental-health and substance-use disorders, HIV/AIDS and related physical, psychological and social problems creates an additional serious barrier to treatment and care for HIV/AIDS (World Health Organization, Executive Board EB124/6 124th Session 20 November 2008, Provisional agenda item 4.3 November 20th, 2007).

There is consistently strong evidence from high-income countries that adherence to highly active antiretroviral therapy is lowered by depression, cognitive impairment,
alcohol use and substance-use disorders. Furthermore, such therapy, especially with efavirenz, can be associated with a range of side effects on the central nervous system, including depression, nervousness, euphoria, hallucination and psychosis. Mental disorders, including substance use disorders, are risk factors for contracting HIV, and the presence of HIV/AIDS increases the risk of development of mental disorders. The resulting comorbidity complicates help-seeking, diagnosis, quality of care provided, treatment and its outcomes, and adherence (World Health Organization, Executive Board EB124/6 124th Session 20 November 2008, Provisional agenda item 4.3 November 20th, 2007).

The diagnosis of mental health problems in HIV-infected individuals faces several barriers. Patients often do not reveal their psychological state to health-care professionals for fear of being stigmatized further. Also, health-care professionals are often not skilled in detecting psychological symptoms and, even when they do, they often fail to take the necessary action for further assessment, management and referral (World Health Organization, Executive Board EB124/6 124th Session 20 November 2008, Provisional agenda item 4.3 November 20th, 2007).

Many individuals already have pre-existing psychological issues which make it even more challenging to cope with HIV. Being a victim of sexual abuse is very common among those with HIV. Further, some people may not only be coming out to their families about being HIV+, but also coming out about being homosexual as well. If diagnosed with HIV or AIDS, it is important for the individual to gain emotional and psychological support. Unfortunately, due to the perceived stigma of the disease, many people do not seek the services that they need. However, HIV is treatable and with medical and psychological treatment, people can live happy and productive lives in spite of having the disease (Blechner MJ, 1997. Hope and mortality: psychodynamic approaches to AIDS and HIV. Hillsdale, NJ: Analytic Press).

Therapy can help clients become more proactive, re-engage in life and in relationships, learn to cope with symptoms, and take an active role in their health issues. Therapy can help those with HIV to develop greater self-awareness, especially with self-defeating behaviors, stronger coping skills, and the motivation to engage in meaningful and productive activities. Further, there are many promising studies that indicate a potential link between the HIV positive person’s health, and taking care of their emotional health. If a person is diagnosed with HIV or AIDS, they should reach out to trusted friends and family members. Individuals can also seek a support group for those with HIV, contact their local AIDS Service Organization for information on available psychosocial support, and seek therapy with a competent and licensed therapist who is practiced in working with those who have HIV or AIDS (Blechner MJ, 1997. Hope and mortality: psychodynamic approaches to AIDS and HIV. Hillsdale, NJ: Analytic Press).

**Anxiety**

Anxiety is a common symptom in HIV-infected patients. When anxiety symptoms are severe or persistent, patients may have an anxiety disorder. These disorders include panic
disorder, generalized anxiety disorder, obsessive-compulsive disorder, and post-traumatic stress disorder (PTSD) Among HIV-infected patients receiving medical care, 20.3% have been found to have an anxiety disorder, with 12.3% meeting the criteria for panic disorder, 10.4% for PTSD, and 2.8% having generalized anxiety disorder. Patients with other psychiatric disorders, such as adjustment disorders, major depression, psychosis, or substance use disorders, can also present with significant anxiety. To help patients receive optimal care, clinicians need to be aware of the differences among these specific disorders. Furthermore, patients with histories of anxiety or mood disorders are susceptible to recurrence of anxiety symptoms during the course of HIV illness. Anxiety can manifest in many ways, such as shortness of breath, chest pain, racing/pounding heart, dizziness, diaphoresis, numbness or tingling, nausea, or the sensation of choking. When clients present with these somatic symptoms, for which no underlying medical etiology can be established, clinicians should consider an anxiety disorder as the cause. In addition to somatic complaints, clients with anxiety disorders often present with fear, worry, insomnia, impaired concentration and memory, diminished appetite, ruminations, compulsive rituals, and avoidance of situations that make them anxious (Kranzler HR, Rounsavill BJ, eds. Dual Diagnosis and Treatment: Substance Abuse and Comorbid Medical and Psychiatric Disorders. New York: Marcel Dekker).

Anxiety symptoms such as worry, nervousness, fear, and tension are commonly experienced by people with HIV during periods of their illness and may be a response to stressful situations. An anxiety disorder occurs when symptoms:

- Interfere with a patient’s daily function (e.g., the patient is unable to work, leave home, attend to medical care)
- Interfere with personal relationships
- Cause marked subjective distress

Even brief episodes of anxiety, such as those occurring during a panic attack, may interfere markedly in a patient’s life and may warrant a diagnosis of an anxiety disorder. Anxiety-like symptoms may also be caused by mental health disorders other than anxiety disorders. For example, it may be difficult to distinguish depression with agitation from an adjustment disorder with anxious mood. In general, adjustment reactions follow a stressful event, which is often not true in clinical depression, and are less likely to present with the entire vegetative symptom complex seen in depression, which is characterized by insomnia, diminished appetite, diurnal variation in mood, loss of pleasure/interest, feelings of guilt, fatigue, and attention and concentration problems (Kranzler HR, Rounsavill BJ, eds. Dual Diagnosis and Treatment: Substance Abuse and Comorbid Medical and Psychiatric Disorders. New York: Marcel Dekker).

Certain anxiety symptoms can be effectively managed without the use of medication. There are also patients who prefer to avoid the use of psychotropic medication. Patients with mild anxiety symptoms that do not interfere with function may respond to supportive or behavioral interventions. Clinicians may find the following strategies helpful in such situations:
• Expressing empathy
• Educating patients about anxiety
• Reassuring patients that anxiety is the cause of somatic symptoms experienced during panic attacks
• Identifying the psychological factors that contribute to anxiety
• Preparing patients for stressful situations and assisting in development of coping mechanisms
• Teaching patient’s simple relaxation exercises. Slow, deep breathing with focus on inspiration and expiration of air can be helpful. Such exercises can be useful when patients practice for 1 minute three times a day, increasing to 5 minutes, if possible.

Depression

Clinical depression is the most commonly observed mental health disorder among HIV-infected patients, affecting up to 20% of patients. The prevalence may be even greater among substance users. Depressive symptoms have been associated with risk behavior, non-adherence to medications, and shortened survival. Although sadness and grief are normal responses to many of the consequences of HIV infection, clinical depression is not. Failure to recognize depression may endanger both the patient and others in the community. Patients with depression are at higher risk for co-morbid psychiatric, alcohol, and substance use-related disorders, particularly alcohol, cannabis, and cocaine use (Kranzler HR, Rounsavill BJ, eds. Dual Diagnosis and Treatment: Substance Abuse and Comorbid Medical and Psychiatric Disorders. New York: Marcel Dekker).

Although many of the somatic symptoms of depression may be attributed to HIV infection, opportunistic or other infections, or side effects of medications, the primary care clinician should recognize that the following symptoms can be caused by depression:

• Depressed mood
• Loss of interest or pleasure
• Feelings of guilt
• Suicidal thoughts
• Sleep disturbance
• Appetite/weight changes
• Attention/concentration problems
• Energy level changes/fatigue
• Psychomotor disturbance

Many HIV-infected patients may not recognize or report symptoms. They may present instead with behavioral changes that may indicate the presence of an underlying depressive disorder. Clinicians should recognize the following behavioral changes as possible indications of an underlying depressive disorder:

• A change in treatment adherence
- An inability to make life choices, including those related to medical care and adjustment to HIV disease
- A preoccupation with a particular problem, usually one that presents as minor
- A change in functioning, including an inability to perform activities of daily living, a return to substance use, or a self-imposed isolation
- Unexplained medical complaints, particularly pain or fatigue
- Interpersonal problems
- Presenting with difficult behaviors in the medical setting

HIV-infected patients do not become depressed simply because their disease progresses; however, it is particularly important to screen for depression during the crisis points noted in Table 1. Medically ill patients may experience normal sadness, grief, and discouragement or demoralization. However, the presence of hopelessness, anaerobia (the absence of pleasure from usually pleasurable activities), ruminative guilt, and suicidal ideation may indicate accompanying clinical depression requiring psychiatric intervention (Kranzler HR, Rounsavill BJ, eds. Dual Diagnosis and Treatment: Substance Abuse and Comorbid Medical and Psychiatric Disorders. New York: Marcel Dekker).

Crisis Points for HIV-Infected Persons

- Learning of HIV-positive status
- Disclosure of HIV status to family and friends
- Introduction of medication
- Occurrence of any physical illness
- Recognition of new symptoms/progression of disease (e.g., major decrease in CD4 cells, increase in viral load)
- Necessity of hospitalization (particularly the first hospitalization)
- Death of a significant other
- Diagnosis of AIDS
- A return to a higher level of functioning (e.g., re-entry into job market/school, giving up entitlements)
- Major life changes (e.g., childbirth, pregnancy, loss of job, end of relationship, relocation)
- Necessity of making end-of-life and permanency planning decisions

Data are from Duffy V. The 14 crisis points of AIDS. AIDS Patient Care STDs

Clinicians should use the diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) to diagnose Depressive Disorders

In addition to Major Depressive Disorder, there are other kinds of Depression, such as Minor Depression and Dysthymic Disorder, which share symptoms with Major Depressive Disorder but differ in duration and severity. The clinician should refer to the DSM-IV for more information on these subtypes of depression. The following psychiatric
disorders, which require a different treatment approach, may present with symptoms of depression and should be excluded as possible causes:

- Bipolar Disorder
- Post-Traumatic Stress Disorder
- HIV-associated dementia
- Alcohol and substance use

**Suicidality**

HIV-infected patients may be at higher risk for suicidal behavior, particularly after a diagnosis of HIV disease or during progression to AIDS, as patients’ health and quality of life decline. Other patients, such as those with certain personality disorders, may be at increased risk for violent behavior. Although only a small number of HIV-infected patients attempt or commit suicide or violence, routine mental health assessment and procedures in the clinic setting for responding to mental health emergencies can ensure that the potential for such behavior is identified and appropriately addressed (Côté TR, Biggar RJ, Dannenberg AL. Risk of suicide among persons with AIDS: A national assessment, *JAMA*).

Rates of suicidal behavior have been more widely studied in gay men than in other populations, although some studies have shown that HIV-infected women have higher rates of suicide attempts than HIV-infected men. Studies conducted before the introduction of HAART indicated an increased risk of completed suicide in patients with HIV/AIDS that was 7 to 36 times greater than in the non-HIV-infected population. Since the introduction of HAART, more recent evidence suggests that suicide among HIV-infected patients may be mediated more often by factors other than HIV, including depression, alcohol, or other substance-related disorders. Because patients with suicidal behavior often present with comorbid depression, screening for and timely treatment of depression may reduce a patient’s risk for suicide. Suicide risk in HIV-infected patients may be higher than in populations with other chronic medical illnesses, such as cancer. Evidence suggests that risk for suicidal behavior increases during the initial weeks following a diagnosis of HIV disease and then declines as patients adjust to their HIV status. However, as patients’ health and quality of life decline, risk of suicide may again increase, particularly among middle-aged and older patients, who frequently experience poorer health-related quality of life when progressing to AIDS. A comprehensive mental health assessment is essential for any patient who directly expresses suicidal or violent behavior or whose behavior and risk factors suggest potential for suicide or violence (Source: Bellini M, Bruschi C. HIV infection and suicidality, *Affect Disord*).

**Risk Factors for HIV/AIDS related to Suicide and Violence**

<table>
<thead>
<tr>
<th>Category</th>
<th>Suicide</th>
<th>Violence</th>
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<tbody>
<tr>
<td>Demographic</td>
<td>• White</td>
<td>• Young</td>
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<tr>
<td></td>
<td>Male (males more often complete; females more often attempt*)</td>
<td>Male</td>
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<tr>
<td></td>
<td>Older age (&gt;45 years)</td>
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<td>Divorced, never married, or widowed</td>
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<td>Unemployed</td>
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**Historical**

- Previous suicide attempts, especially with serious intent, lethal means, or disappointment about survival
- Family history of suicide
- Victim of physical or sexual abuse
- Previous history of violence to self or others, especially with high degree of lethality
- History of animal torture
- Past antisocial or criminal behavior
- Violence within family of origin
- Victim of physical or sexual abuse

**Psychiatric**

- Diagnosis: Affective disorder, alcoholism, panic disorder, psychotic disorders, severe personality disorder (especially antisocial and borderline)
- Symptoms: Suicidal or homicidal ideation; depression, especially with hopelessness, helplessness, anaerobia, delusions, agitation; mixed mania and depression; psychotic symptoms, including command hallucinations and persecutory delusions
- Current use of alcohol or other drugs
- Recent hospitalization for mental health disorder
- Diagnosis: Substance-related disorders, especially alcoholism; antisocial personality disorder, conduct disorder; intermittent explosive disorder, pathological alcohol intoxication, psychoses (e.g., paranoid)
- Symptoms: Physical agitation; intent to kill or take revenge; identification of specific victim(s); psychotic symptoms, especially persecutory delusions and command hallucinations to commit violence
- Current use of alcohol or other drugs

**Environmental**

- Recent loss such as that of
- Access to guns or other
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<tr>
<th>Medical</th>
<th>Behavioral</th>
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<tr>
<td>- Severe medical illness: Presence of HIV-related physical symptoms; poor adjustment to HIV disease; failed medical treatment or first hospitalization for medical illness; loss of function or intractable or chronic pain from medical illness</td>
<td>- Antisocial acts</td>
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<tr>
<td>- Delirium or confusion caused by central nervous system dysfunction</td>
<td>- Poor impulse control, risk taking, and aggressiveness</td>
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<td>- Preparing for death (e.g., making a will, giving away possessions, stockpiling lethal medication)</td>
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<td>- Well-developed, detailed suicide plan</td>
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<td>- Statements of intent to inflict harm</td>
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<td>- Severe medical illness: Presence of HIV-related physical symptoms; poor adjustment to HIV disease; failed medical treatment or first hospitalization for medical illness; loss of function or intractable or chronic pain from medical illness</td>
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<td>- Delirium or confusion caused by central nervous system dysfunction</td>
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<td>- Disinhibition caused by traumatic brain injuries and other central nervous system dysfunctions</td>
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<td>- Toxic states related to metabolic disorders, such as hyperthyroidism</td>
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<td>- Antisocial acts</td>
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<td>- Agitation, anger</td>
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<td>- Statements of intent to inflict harm</td>
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<td>a spouse or job</td>
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<td>- Access to guns or other lethal weapons</td>
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<td>- Social acceptance of suicide</td>
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<td>- Patient’s perception of a lack of social support,† or actual lack of social support</td>
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<td>- Poisoning or inflicting harm on another person</td>
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<td>- Medication related to metabolic disorders; such as hyperthyroidism</td>
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<td>- Severe medical illness: Presence of HIV-related physical symptoms; poor adjustment to HIV disease; failed medical treatment or first hospitalization for medical illness; loss of function or intractable or chronic pain from medical illness</td>
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infect harm on self or others


PTSD

Exposure to a traumatic event is normally accompanied by distress. For most individuals such distress resolves spontaneously without the onset of any psychiatric illness. Among a subset of people, the type, severity, and duration of symptoms that develop following trauma will meet criteria for either acute stress disorder (ASD) or post-traumatic stress disorder (PTSD).

ASD is not as well studied as PTSD. Some trauma researchers feel ASD is on a continuum with PTSD and that the cut-off times for the two disorders are arbitrary (Cooper J, Carty J, Creamer M. Pharmacotherapy for posttraumatic stress disorder: Empirical review and clinical recommendations. Psychiatry 2005).

Trauma can affect both psychological and physical functioning. Some research has suggested that the physical effects of trauma have been related to significant health problems, such as diminished functioning of the immune system and increased susceptibility to infections. The psychological effects of PTSD may manifest in increased risk-taking behavior, such as substance use, poor eating habits, or unsafe sexual activity. In addition, patients with PTSD may suffer from depression, social isolation, impairments in trust and attachments, and feelings of anger. Patients with HIV/AIDS may be affected by past trauma to the point that it manifests in problems with disease management, such as disrupted or negative interactions with medical personnel and/or medication non-adherence.

A history of previous traumatic experiences increases a person’s vulnerability to developing PTSD upon exposure to subsequent trauma. Previous traumatic experiences may impair his/her ability to handle future stressors. The more severe the trauma is, the greater the likelihood will be that the patient will develop PTSD (Cooper J, Carty J, Creamer M. Pharmacotherapy for posttraumatic stress disorder: Empirical review and clinical recommendations. Psychiatry 2005).

The rate of PTSD following exposure to a particular trauma ranges from 12% to 70%, with the higher rates occurring in populations exposed to traumas that involve interpersonal violence (e.g., rape, sexual abuse, torture). Women have higher rates of PTSD than men. Among women, sexual assault is the most common precipitating
trauma, whereas among men, the most common trauma is combat exposure. Although PTSD has a lifetime prevalence rate of approximately 1.3% to 7.8% in the general population, the rates of PTSD in the HIV-infected population are higher. The prevalence of PTSD in HIV-infected individuals may be as high as 42%. Although onset of a severe, life-threatening illness (such as HIV/AIDS) can sometimes in itself be a traumatic experience leading to PTSD, more often a history of physical or psychological trauma (and diagnosis of PTSD) co-occurs with an individual’s HIV status. Among people with the most severe mental illnesses, specifically schizophrenia, schizoaffective disorder, and bipolar disorder, comorbid PTSD is an important predictor of HIV infection (Cooper J, Carty J, Creamer M. Pharmacotherapy for posttraumatic stress disorder: Empirical review and clinical recommendations. Psychiatry 2005).

Many of the symptoms of ASD overlap with those of PTSD. ASD defines a severe stress response that follows shortly after a traumatic event, whereas PTSD cannot be diagnosed until symptoms have persisted for 30 days or longer. The presence of full or partial ASD is associated with an increased risk of developing PTSD. In various studies, the presence of numbing, depersonalization, a sense of reliving the trauma, motor restlessness, and peri-traumatic dissociation were found to predict progression to PTSD. These associations raise the possibility that effective early treatment of trauma symptoms can be a useful strategy in the prevention of PTSD. However, it should be noted that many trauma survivors who develop PTSD do not have initial ASD symptoms, and many individuals with ASD will not develop PTSD (Cooper J, Carty J, Creamer M. Pharmacotherapy for posttraumatic stress disorder: Empirical review and clinical recommendations. Psychiatry 2005).

Counseling Clients with HIV And Substance Abuse Disorders (Source: SAMSA)

The pandemics of substance abuse and HIV/AIDS are clearly moving along similar paths, and each continues to present unique, yet interrelated, challenges. First, both disorders are considered to be chronic--that is, lifelong diseases. Second, substance abuse is a primary risk behavior for HIV infection. Third, a diagnosis of HIV infection or related conditions can be a stressor for an individual already in recovery from a substance abuse disorder. However, the diagnosis of HIV infection may motivate a client to enter substance abuse treatment. Injection drug users who test positive for HIV are more likely to enter treatment than those who test negative (Bux et al., 1993; McCusker et al., 1994b). Also, studies have noted a reduction in risk-taking behaviors among injection drug users who test positive for HIV (Colon et al., 1996; MacGowan et al., 1997). The diagnoses of a substance abuse disorder and HIV/AIDS require extensive physical and mental health care and counseling in conjunction with extensive social services. To deal with the myriad issues surrounding substance abusers who are HIV positive, substance abuse treatment professionals must continually update their skills and knowledge as well as reexamine their own attitudes and biases.
Staff Training, Attitudes, and Issues

Before conducting any screening, assessment, or treatment planning, counselors should reassess their personal attitudes and experiences in working with HIV-infected substance abusers. This section discusses several ways in which counselors can accomplish this, including formal training within counselors' programs, examining personal attitudes (e.g., counter-transference and homophobia), examining fears of infection, and avoiding burnout. It is important to reassess comfort levels with each client because each client will vary in demographic and cultural background. For instance, a service provider may feel comfortable working with a young Asian American male with a history of alcohol use, yet the same provider may not be at all comfortable with a pregnant Hispanic woman who is an active injection drug user and wishes to have her baby. Figure 7-1 provides an example of a comfort checklist for counselors to use as a routine self-evaluation.

Training

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

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

- **Model skills and competencies.** Less experienced staff can observe supervisors or more tenured staff who demonstrate desired qualities.
- **Peer training and feedback.** Peer teams can provide feedback through direct observation of staff members' interactions with clients, as well as review of staff members' client charts.
- **Case presentations.** Weekly or monthly group case presentations conducted by a different staff member each time can be effective for building skills and monitoring quality. Case simulation, in which each staff member has an opportunity to ask the "client" a question, is a highly useful training tool. At the end of the presentation, everyone attending can provide feedback about the activity.
- **Experiential skills-building exercises.** Many activities can be used to sensitize staff to the client's experiences. Activities can include encouraging staff members to go to a confidential and anonymous HIV/AIDS test site, or anonymously sit in the waiting room of the local food stamp office, HIV/AIDS clinic, or county jail. Staff must use different avenues to maintain a keen sensitivity to and awareness of the client's issues.
- **Assessment instruments.** Use specific assessment tools, such as substance abuse and sexual history questionnaires (e.g., the Addiction Severity Index [ASI]).

- **Formal conferences, training, consultations with clinicians.** Often agency budgets are tight, and the first expense to be cut is staff development. This is a major problem for many programs. Programs must establish that improvement and excellence are serious goals and that attending treatment-oriented conferences is a part of building staff competency and moving toward these goals.

**Attitudes**

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

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

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

**Examining attitudes and skills**

Counter-transference can manifest itself in many different ways. The key to seeing counter-transference issues is awareness and consciousness-raising. The commitment to "do no harm" to clients and their families, along with a desire to provide quality services, should be the driving forces for willingly examining these issues. Following are some common counter-transference issues for providers working with substance abusers who are HIV positive (adapted from National Association of Social Workers):

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

Homophobia

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

Homophobia Questionnaire for Counselors

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

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

- *Overt homophobia* includes violence, verbal abuse, and name-calling.
- *Institutional homophobia* describes the way in which governments, businesses, schools, churches, and other institutions and
organizations treat people differently and less favorably based on their sexual orientation.

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

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

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

Fear of infection

Fear of infection is one of the most challenging issues for counselors. It is essential that providers examine this issue without blaming or judging themselves and others. Most professionals who work with substance abusers and HIV-positive individuals have thought about becoming infected with HIV, hepatitis, or tuberculosis (TB) through their jobs (Sherman and Ouellette). Some fear that scientists are not aware of modes of infection or transmission that might put service providers and their families at greater risk of infection (Montgomery and Lewis). The key to dealing with this fear is to discuss it and vent the feelings with someone who is safe, trusted, and informed, and to practice universal precautions at all times.

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

Special considerations for counselors who treat HIV-infected clients

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

Burnout often is referred to as "bereavement overload." One definition characterizes burnout as lowered energy, enthusiasm, and idealism for doing one's job, that is, as a loss of concern for the people served and for the work (Hayter). Unlike fatigue, burnout does not resolve after a given amount of rest and recreation. Burnout prevention and stress management techniques should be used both in the work setting and in counselors' personal lives. Working with HIV-infected substance abusers requires agencies and individuals to be more creative and flexible in finding new and different ways to support and nurture counselors to prevent burnout. Agencies that have
taken on this challenge with integrity and commitment have seen highly effective staff function at optimal levels for many years.

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

In addition, it is important that agencies allocate time to discuss the deaths and losses faced by staff. This may mean supporting special memorial events at which those who have been lost to HIV/AIDS disease can be remembered. Agencies also can support staff through contracts with employee assistance program therapists and by providing an onsite therapeutic support group for staff members to attend as they wish.

**Screening**

**Client-Specific Needs**
A positive screen for HIV infection typically leads to a referral for formal assessment, usually to an HIV/AIDS case management service. Frequently, substance abuse treatment programs provide referrals to HIV/AIDS care services. Providers will want to identify substance abuse treatment programs and agencies with these networks. At a minimum, services should include the following client needs in priority order:
- Substance abuse treatment
- Medical care
- Housing
- Mental health care
- Nutritional care
- Dental care
- Ancillary services
- Support systems

**Interim substance abuse treatment for clients on waiting lists**

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

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

*Mental health care*

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

*Nutritional care*

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

Good nutrition is a fundamental part of overall medical care. It improves strength, energy, longevity, and quality of life; increases muscle mass and body weight; decreases likelihood of hospitalization and length of stay; and slows progression of HIV to AIDS. Without adequate nutrition, HIV/AIDS clients can easily develop malnutrition. Various causes of malnutrition and weight loss include

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

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

_Lipodystrophy syndrome_

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

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

_Ancillary services_

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

_Disclosure Issues_

Disclosure issues are difficult for all HIV-infected clients. For substance-abusing clients, these issues take on additional challenges. For example, disclosure of positive HIV status may lead to personal threats or harm to both client and family. A client’s family may refuse to associate with him upon learning of his HIV/AIDS status. Particularly for clients whose culture reflects definition of self within a community or self in relation to a clan (as opposed to individual definition), separation from community can serve as a trigger for lapse or relapse into risky substance use and sex-related behaviors. Therefore, providers must use caution when notifying clients of test results and should comply with regulations to ensure that a client’s confidentiality is preserved.

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

**HIV/AIDS-Specific Substance Abuse Counseling Issues**

There are many counseling issues specific to HIV/AIDS that providers should be familiar with when treating HIV-infected, substance-abusing clients.

**Cultural Competency Issues**

Culture is the integrated pattern of human behavior that includes thoughts, speech, actions, and artifacts. Culture depends on the capacity of humans for learning and transmitting knowledge to succeeding generations. It takes into account the customs, beliefs, social norms, and material traits of a racial, religious, or social group. With this type of definition, it is easy to see that there is indeed a culture of addiction, a culture of poverty, a gay culture, and even a recovery culture.

Cross and colleagues present a comprehensive discussion of culturally competent systems of care. Five essential elements contribute to cultural competence (Cross et al., pp. 19-21), which can briefly be described as follows:

1. **Valuing diversity.** Counselors value diversity when they accept that the people they serve come from very different backgrounds and may make different choices based on culture. Although all people share common basic needs, there are vast differences in how people go about meeting those needs. Accepting the fact that each culture finds some behaviors, actions, or values more important or desirable than others helps workers interact more successfully with different people.

2. **Cultural self-assessment.** When counselors understand how systems of care are shaped by dominant cultures, it may be easier for them to assess how these systems interface with other cultures. Care providers can then choose actions that minimize cross-cultural barriers.

3. **Dynamics of difference.** When cultural systems interact, both representatives (e.g., care provider and client) may misjudge the other's actions based on history and learned expectations. Both will bring dynamics of difference—culturally prescribed patterns of communication, etiquette, and problem solving, as well as underlying feelings about serving or being served by someone who is different. Incorporating an understanding of these dynamics and their origins into the system enhances chances for productive cross-cultural interventions.

4. **Institutionalization of cultural knowledge.** Workers must have accurate cultural knowledge and information or access to such information. They also must have available to them community contacts and consultants to answer culturally related questions.

5. **Adaptations to diversity.** The previous four elements build a context for a cross-culturally competent system of care and service. Both workers' and systems' approaches can be adapted to create a better fit between needs of people and services available. For instance, members of certain ethnic groups repeatedly receive negative messages from the media about their culture. Programs can be developed that incorporate alternative culturally enhancing experiences, develop
problem solving skills, and teach about the origins of stereotypes and prejudice. By creating and implementing such programs, workers can begin to institutionalize cultural interventions as a legitimate helping approach.

Finally, becoming culturally competent is a developmental process for individual counselors. It is not something that happens because one reads a book, or attends a workshop, or happens to be a member of a minority group. It is a process born of a commitment to provide quality services to all and willingness to risk. (*Cross et al., p. 21*)

*Making culturally competent decisions*

Treatment providers and counselors must examine two essential factors when working with culturally, racially, or ethnically different populations: the socioeconomic status of the client or group and the client's degree of acculturation. A distinction should be made when discussing a population as a whole and a particular segment of that population. For example, when treating an HIV-infected substance-abusing Hispanic woman, the counselor should focus on the woman as an individual and on the particular circumstances of this individual's life, rather than seeing her as an abstract representative of her culture or race. More often, poverty is the relevant issue to be discussed, rather than specific ethnic or racial factors (*Centers for Disease Control and Prevention (CDC)*).

The second factor, degree of acculturation, is important and should be part of the assessment process. How acculturated or assimilated are the family and client? What generation is this client? Assessing for this and knowing that several generations with different values and levels of acculturation may all live in one household, can test the communication skills and counseling skills of the best service providers. When discussing acculturation/assimilation and values, counselors should keep in mind that, in general, the more years a family has lived in the United States, the less traditional their values tend to be. Thus a fourth-generation Chinese-American client may not speak Chinese or hold traditional Chinese values. Knowing the values and beliefs of a client is crucial if treatment is to be effective.

Providers must also help develop culturally competent systems of care. A part of this is making services accessible to and often used by the target risk populations. Culturally competent systems also recognize the importance of culture, cross-cultural relationships, cultural differences, and the ability to meet culturally unique needs.

*Guidelines to Minimize Cultural Clashes*

Aside from assessing cultural competence using the five elements discussed previously, it also is helpful to examine some ways in which providers can minimize cultural clashes and blocks that may exist when working with clients. The guidelines given are adapted from a project conducted by the University of Hawaii AIDS Education Project.
One concern in providing culturally competent care is how to discuss values and differences around sex and sexuality. In many cultures, people avoid discussing sex because they find such discussions disrespectful. This is one reason why so many cultures avoid discussing homosexuality. A counselor should consider using a less direct approach when initiating discussion about issues related to sex and sexual orientation. Many providers believe that some of the public health problems faced in communities of color and the gay community are related to their inability to speak often and directly enough about safer sex practices, risky behaviors, and homosexuality. Even in the recovery culture and in many treatment settings, sex and sexuality are blatantly avoided. Service providers must acknowledge that they, too, in addition to their clients, are often uncomfortable talking about sexuality, sexual identity, and sexual orientation. Providers also should be aware of the messages often given to communities of color and particularly women. The message, "stop having sex," often advocated by providers has been mixed with historical issues and fears of racial/ethnic genocide, thus making it difficult for most groups to give any credence to those expounding this method of reducing HIV/AIDS. The value of sex and procreation in many cultures makes it difficult for someone from outside the client's culture, especially someone of a different gender, to tell people to not have sex or to have sex only with a condom.

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

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

Special Populations

Gay, lesbian, bisexual, and transgender populations

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

A sudden increase in the use of methamphetamine, known as "speed," "crystal," "ice," or "crank," by gay and bisexual men has become a matter of grave concern. A primary route of administration for this drug is injection. Combined with its disinhibiting and sexually
stimulating effects, gay male injectors of methamphetamine are at extremely high risk for HIV exposure: The drug causes the abuser to suspend all judgment and leaves him often impotent but extremely sexually aroused and often an anal-receptive partner in sex (Gorman et al.).

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

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

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

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

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

Some substance abuse treatment clients are transgender. The following definitions have been provided to clarify the confusion some providers may feel when working with transgender clients (CSAT, in press [b]).

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

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

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

Substance use plays a significant role in the high HIV prevalence in MTF transgender individuals. One study that investigated 519 transgender individuals in San Francisco found high rates of substance abuse among both MTF and FTM individuals. The study reported that 55 percent of the MTF sample indicated they had been in substance abuse treatment at some time during their lifetime. The study also found that HIV prevalence was significantly higher among MTF individuals (35 percent) than FTM individuals (2 percent), and among the MTF individuals, HIV prevalence for African Americans was 61 percent. Although the HIV prevalence rate was low in the FTM individuals, they commonly reported engaging in many of the same HIV risk behaviors as the MTF individuals (Clements et al., 1998).

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

Additional relapse triggers or clinical issues may include the following: (1) inability to find, engage in, or maintain gainful employment due to employer prejudice against transgender individuals; (2) lack of formal education or training because the client was forced to leave school or home before completing his or her education; (3) the fact that HIV-positive transgender clients may be denied sex reassignment surgery due to their HIV status, even if they are asymptomatic and healthy; and (4) the general lack of substance-free role models and widespread social support for transgender individuals.

Figure 7-5: Guidelines for Working With Transgender Clients (more...)

<table>
<thead>
<tr>
<th>Do</th>
<th>Don’t</th>
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<tbody>
<tr>
<td>• Use the pronouns based on their <em>self-identity</em> when speaking to or about transgender individuals.</td>
<td>• Call someone who identifies as female &quot;he&quot; or &quot;him,&quot; or someone who identifies as male &quot;she&quot; or &quot;her.&quot;</td>
</tr>
<tr>
<td>• Obtain clinical supervision if you have reservations about working with transgender individuals.</td>
<td>• Make transphobic comments to other staff or clients.</td>
</tr>
<tr>
<td>• Allow transgender clients to continue the use of hormones when prescribed; advocate for the transgender client who is using &quot;street&quot; or illegally prescribed hormones to receive immediate medical care and legally prescribed hormones.</td>
<td>• Ask the transgender client to choose between hormone therapy and substance abuse treatment.</td>
</tr>
<tr>
<td>• Ensure that all clinic staff receive training on transgender issues.</td>
<td>• Leave it to the transgender client to educate clinic staff.</td>
</tr>
<tr>
<td>• Ascertain a transgender client’s sexual orientation before treating him or her.</td>
<td>• Assume all transgender individuals are gay.</td>
</tr>
<tr>
<td>• Allow transgender clients to use appropriate bathrooms and showers based on their <em>gender self-identity and gender role</em>.</td>
<td>• Force transgender clients identifying as male to use female facilities; likewise, don't force those identifying as female</td>
</tr>
<tr>
<td>• Require all clients and staff to</td>
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Clinicians, particularly those in rural areas, may have had little experience in treating transgender clients. Figure 7-5 below lists some guidelines that clinicians may find helpful in working with this population. Some resources providers may also find helpful include the Lambda Center in Washington, D.C. (202-965-8434), which provides behavioral healthcare programs for transgender clients and others with HIV/AIDS and substance abuse problems, and the Center Gender Identity Project in New York City (212-620-7310), which provides HIV/AIDS and substance abuse counseling and referral services exclusively for transgender clients.

**Figure 7-5**

**Guidelines for Working With Transgender Clients**

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</tr>
<tr>
<td>Require all clients and staff to create and maintain a hospitable environment for all transgender clients.</td>
<td></td>
</tr>
<tr>
<td>Post a nondiscrimination policy, including sexual orientation and gender identity, in the waiting room.</td>
<td></td>
</tr>
</tbody>
</table>
waiting room.

Women

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

Gender-specific services for women should include the following:

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

A woman's identity as caregiver/caretaker must be recognized as an extremely powerful factor in how she accesses care and treatment and how successful she is in her recovery and health maintenance. There is no question that this identity/role can explain why a woman seeks treatment ("for the kids") or why she leaves treatment ("to get home to my husband/partner/kids"). This is also a factor in a woman's sense of guilt and shame from becoming HIV infected—a societal stigma that only "bad girls" get HIV or are addicts or alcoholics, and the stigma of being an unfit mother if she has lost custody of her children.
Providers must be open and prepared to discuss safer sex and drug and alcohol abuse from a risk-reduction perspective. They must be well informed about and comfortable in discussing sexuality. Risk reduction is an ongoing type of intervention that goes beyond assertiveness training and teaching women how to put condoms on men. It recognizes the need to "start where the client is" and use appropriate interventions, which may help a woman reduce her risk of getting re-infected or of infecting a partner. This includes instructing female injection drug users about how to use bleach to "clean their works," how to use a female condom, or how to use a vaginal spermicide foam (not the safest risk-reduction method, however) to lower their risk of HIV infection when having intercourse. It also involves making referrals to substance abuse treatment and instruction for male partners on how to use a condom correctly.

*Hispanics*

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

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

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

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

Case Study: Heterosexual Minority Men Living

Often, families are aware of homosexual family members, but usually this is not discussed openly. The reality is that many Hispanic men who prefer sex with other men do marry and have children. This partly explains why Hispanics are at such high risk for HIV/AIDS. If the man has married and fathered a child, he has been congruent with the values relating to family; if he then goes out with men, or even with other women, this behavior may be tolerated as long as he continues to provide for his family. Figure 7-7 offers additional considerations for working with Hispanics.

African Americans

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

African American women in particular have special needs. Minority women represent the fastest-growing segment of the U.S. HIV/AIDS pandemic. One study examined the psychological and social factors related to HIV risk among 153 African American inner-city women. The women completed measures of HIV risk history, sexual and substance use behaviors, perceived risk for HIV infection, self-efficacy to reduce risk (i.e., the belief that one can effectively perform specific behaviors), and perceived social norms supporting risk reduction. Fifty-five percent of the women reported at least one factor that had placed them at known risk for HIV infection.

Many African Americans have a deep-seated mistrust of the health system. This dates back to the pre-Civil War period when, because they were considered property and had no legal right to refuse, slaves were sometimes used in medical. A collective memory thus exists among the African American community of their exploitation by the medical establishment. More recently, the syphilis study performed at Tuskegee University from 1932 to 1972, during which 400 African American men infected with syphilis were deliberately denied life-saving treatment, has fostered in some African Americans the
belief that contact with health care institutions will automatically expose them to racist administrators and policies. Several articles point to the Tuskegee study as a significant factor in the low participation of African Americans in clinical trials and organ donation efforts and in the reluctance of many African Americans to seek routine preventive care.

A study that compared the use and perceptions of substance abuse treatment services among African American, Hispanic, and white substance-abusing arrestees confirmed that African American substance abusers were more likely than white substance abusers to hold unfavorable views of treatment. Another study examined the attitudes of African Americans in a northeastern city toward mental health treatment and found that only 34 percent of the sample felt positively toward community mental health centers. The study also revealed that women and married persons demonstrated more positive attitudes than did men and unmarried persons and that participants with a high tolerance of substance abuse possessed more negative attitudes than did others.

Counselors should be aware that the issues of slavery and institutional racism are constant and prevalent facts in the lives of many African Americans and should be addressed early in treatment so they are acknowledged, validated, and brought into the treatment process.

Many African Americans have strong social networks. They may have friends or a pastor with whom they might share information they would not share with a substance abuse counselor. These confidants might act as "co-therapists" for the client. It can be helpful for clients if counselors can identify and integrate clients’ co-therapists into their substance abuse treatment plans. Along these lines, for African Americans with substance use disorders and HIV/AIDS, support groups of friends may be more likely to be helpful and less undermining than support groups of families. This is perhaps due to the lingering stigma of the ways in which HIV/AIDS is acquired—both intravenous drug use and homosexual activity are still highly stigmatized acts within many African American communities. Thus, activating family supports may be difficult, and providers should encourage clients to participate in support groups composed of their peers.

Asian Americans

Asians and Pacific Islanders are a culturally and linguistically diverse people from the Asian continent and the Pacific Islands. In the United States, they include nearly 40 different nationalities, 50 different ethnic groups, and more than 100 languages and dialects.

The following bullets are based on data from the 33 states with long-term, confidential name-based HIV reporting in 2005:

- An estimated 417 Asians and Pacific Islanders were given a diagnosis of HIV/AIDS, representing 1.1% of the 37,331 cases diagnosed that year [2].
• Of the 475,220 persons living with HIV/AIDS, • 2,996 (0.6%) were Asians and Pacific Islanders [2].

• Of those given a diagnosis, 78% were men, 21% • were women, and 1% were children (under 13 years of age) [2].

• The numbers of HIV/AIDS cases may be larger than reported because of underreporting or misclassification of Asians and Pacific Islanders.

(Source: CDC)

The following chart identifies 2011 diagnosis according to ethnicity:

<table>
<thead>
<tr>
<th>Race or Ethnicity</th>
<th>Estimated Number of Diagnoses of HIV Infection, 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian/Alaska Native</td>
<td>212</td>
</tr>
<tr>
<td>Asian</td>
<td>982</td>
</tr>
<tr>
<td>Black/African American</td>
<td>23,168</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>10,159</td>
</tr>
<tr>
<td>Native Hawaiian/Other Pacific Islander</td>
<td>78</td>
</tr>
<tr>
<td>White</td>
<td>13,846</td>
</tr>
<tr>
<td>Multiple Races</td>
<td>827</td>
</tr>
</tbody>
</table>

(Source: CDC)

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

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

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

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

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

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

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

Native Americans

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

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

Limited treatment services for HIV-infected substance abusers exist on and outside tribal lands. In 1991, the American Indian Community House, which ministers to the health, social service, and cultural needs of Native Americans in the New York City area, created the HIV/AIDS Project, the first Native American program east of the Mississippi River to provide culturally sensitive legal services, HIV/AIDS treatment information, emergency assistance, and prevention education. The Friendship House Association of American Indians in San Francisco provides another example of treatment (drop-in centers). This program provides comprehensive treatment to Native Americans living with HIV/AIDS as well as treatment for substance dependency. Services target the gay, lesbian, and bisexual communities. HIV/AIDS is presently underreported for Native Americans and is based on the high incidence of sexually transmitted diseases (STDs) in general, and thus substance abuse treatment centers will be faced with more and more HIV-infected Native Americans.

Clients involved with the criminal justice system

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

Risky behaviors that lead to HIV infection are not eliminated when a person is imprisoned but may actually increase in frequency and availability. This occurs for several reasons. First, drug offenses count for the single largest number of Federal and State crimes for which people are arrested and incarcerated. Injection drug users face particular risk in prison settings as clean syringes are all but impossible to secure. Although syringes are not officially available, they can be acquired through illicit prison markets at exorbitant prices ($34 in one Canadian facility) or through risky exchange of syringes for unprotected sex. Syringes are typically not new or sterile. As a result, injection drug users have as their only recourse used or shared syringes, which increases their chances of HIV infection. Tattooing is also common practice among prisoners and is another source of HIV infection. To date, there have been at least two documented cases of HIV/AIDS related to tattooing with unsterile needles in a correctional facility.

Only six prison systems in the United States distribute condoms: Mississippi, New York City, Philadelphia, San Francisco, Vermont, and the District of Columbia. Distribution strategies range from receipt of a single condom per medical visit to receipt of multiple condoms during HIV/AIDS education workshops. Furthermore, condom distribution programs send mixed messages because sexual activity in some facilities is illegal and a punishable offense. In other facilities, correctional medical and social service staff may advocate condom availability while administration and security officers oppose it. Sixteen prison systems mandate HIV testing, and although 77 percent make testing available to inmates on request, few inmates request it for several reasons. First, confidentiality of results is not guaranteed. Second, mandatory testing may result in the segregation of those who test positive from those who test negative or who do not test. Third, prisoners do not wish to acknowledge activities that could subject them to further sanctions. Fourth, confidentiality on discharge is eliminated because the Federal Bureau of Prisons requires HIV testing for all inmates on their release. HIV-positive inmates are asked to directly notify sex partners and significant others of the results. However, the Bureau of Prisons handles only a small percentage of inmates, and its policy is not the norm.

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

Although there are large numbers of substance abusers within correctional facilities, less than 15 percent participate in treatment programs. This is partly because of lack of program availability and the common type of program offered (i.e., 12-Step, abstinence-based). When persons with substance abuse disorders in treatment relapse, as is often the
case, they may also engage in risky sexual behaviors. They are most likely to engage in risky sexual behaviors with sexual partners from similar treatment networks. These partners may include people who have used syringes, traded sex for money or drugs, or been victims of trauma. All of these populations are likely to have higher rates of HIV infection, making transmission likely.

Inmates who do complete or participate in treatment programs often rapidly relapse on discharge. For inmates who do complete treatment, there are often no aftercare programs to help them remain substance free.

**Adolescents**

Adolescents are another group that is experiencing an increase in incidence and prevalence of HIV. Since 1994, findings from the Monitoring the Future surveys have revealed a dramatic and sustained increase in consumption of licit and illicit drugs among adolescents—this after nearly two decades of sustained decrease in drug consumption. Studies also note that teens are having sex earlier than ever before, often with multiple partners and inconsistent use of condoms, putting them at greater risk for HIV/AIDS. Beyond this, young people find themselves marginalized in U.S. society; this is especially true for young gay and bisexual youth, sexually active young women, and young people of color.

According to the CDC, AIDS is the fifth leading cause of death for Americans between the ages of 25 and 44. At greatest risk are young, disadvantaged females, particularly African American females, who are being infected with HIV at younger ages and higher rates than their male counterparts. Because of the long and variable time between HIV infection and AIDS, surveillance of HIV infection provides a clearer picture of the pandemic in young people than surveillance of AIDS cases. From the States for which HIV is a reportable condition, young people ages 13 to 24 accounted for a much greater proportion of HIV than AIDS cases (Source: CDC).

Adolescents may benefit from treatment that is developmentally appropriate and peer oriented. Addressing educational needs may be particularly important as well as involving family members in the planning of treatment and therapy. Substance abuse among adolescents is frequently associated with depression, eating disorders, and sexual abuse history. Histories of familial sexual and substance abuse are predictive of serious adolescent substance involvement and subsequent treatment needs.

**Older adults**

The last few years have witnessed greater increases in the number of HIV/AIDS cases among middle-aged and older individuals than in those under 40 years of age. Women comprise a greater percentage of all AIDS cases as age increases, ranging from 13 percent of AIDS cases among people aged 50-59, 15 percent of AIDS cases among those aged 60-69, and 21 percent of those 65 and over. For women with HIV, 22 percent of this group is in the 50-59 age bracket; 24 percent is aged 60-64; and 31 percent aged 65 and
older. The rate of HIV infection in older women reflects the greater incidence of surgeries (such as hysterectomy) that require blood transfusions.

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

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

**Sex industry workers**

Among sex workers, street prostitutes are the most vulnerable to HIV infection, given the coexisting features of poverty, homelessness, history of childhood sexual abuse, and alcohol and drug dependence. Comparatively, male and female sex workers who work in massage parlors, escort services, their own apartments, or brothels rather than on the street are far less likely to be at risk for infection, less likely to depend on substances, and more likely to control sexual transactions and insist on condom use. Seroprevalence rates among sex workers vary dramatically. A 1990 study of nearly 1,400 sex workers in six U.S. cities yielded a seroprevalence rate of 12 percent, ranging from 0 to 47 percent as a function of the city and the level of injection substance abuse. Most alarming was the high association of injection substance abuse and HIV infection rate.

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

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

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

Homeless people

Homeless people suffer higher rates of many diseases, including HIV/AIDS and substance abuse disorders, than the general population. No national statistics exist, but studies within major U.S. cities are illustrative.

Individual Therapy Strategies

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

- Feeling the problem (of HIV infection or living with AIDS) has not "hit them" yet. The counselor can provide the client with education about risky behaviors, living with AIDS, and so on. Presenting the client with future scenarios and life trajectories if behaviors remain unchanged may be helpful. Sharing success stories about positive changes in peers may also be a helpful strategy.

- Expressing the need to make their own decisions and choices regarding care, treatment, and their lives. Counselors should underscore the fact that clients must decide what is in their best
interests, taking care to define "their best interests" within the client's definition of self as either an individual, a provider, a parent or caregiver, a member of a family or community, or a combination thereof. Counselors should balance this by letting clients know that no one has all the answers to their problems, and reassure clients that their feelings are valid, not unusual, and realistic. Changing one's life is hard work.

- Knowing how to change behavior, yet not making these changes. The counselor should support client efforts to reduce risk behaviors but educate the client as to why risk remains. Exploring what the client is willing to consider changing provides an outline of possible actions. Working together with the client on strategies to resolve barriers to change in small steps may be a useful tactic as well.

- Giving up hope for change or feeling overwhelmed by problems. Workers should reassure clients that their feelings are typical and that change is hard. Telling clients about positive role models who have successfully changed after facing many difficulties along the way is another useful approach.

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

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

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

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

**Group Therapy Strategies**

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

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

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

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

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

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

- How would you feel about bleaching all the time?
- Are there times you are willing to take risks by not using a condom? Why or why not?
- How often do you think about HIV/AIDS?
- Do you ever worry about getting something from your partner? What do you worry about? Why do you worry?
• Do you ever worry about giving something to your partner? What do you worry about? Why do you worry?

Environmental reevaluation can be facilitated with questions such as the following:
• How does your partner (partners) feel about using condoms?
• How would your partner (partners) feel if condoms were used?
• Do people close to you ever talk about your addiction? What do they say?
• Do people close to you ever talk about HIV/AIDS? What do they say?
• How does your addiction affect people who are close to you?

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

**Stage of HIV Infection**

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

Because treatment programs have limited resources, separating groups by stage of HIV infection may be impractical. Programs able to support separate groups may wish to use the three-group model, with groups consisting of
• Clients newly aware of their positive HIV status
• Those who are asymptomatic or mildly symptomatic
• Those with more advanced disease

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

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

**Outpatient Treatment**

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

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

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

Stimulus control helps clients restructure their environment so they can avoid circumstances that elicit problem behaviors. There are three methods for managing tempting stimuli:

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

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

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

Counter conditioning involves exchanging risky behaviors with less risky alternatives in situations that are not amenable to stimulus control. To develop counter conditioning strategies, questions such as the following can be used:
If you found yourself in a situation where you were tempted to have sex without a condom, how could you deal with it so that you could have safer sex?

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

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

**Drop-in Centers**

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

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

Service providers may work with clients so that they can realize that their past successes indicate better chances of success in the future. They should underscore the fact that clients have learned new ways of coping with old behaviors and have developed supportive relationships. Service providers may find the use of reinforcement management a helpful strategy that can be facilitated in either individual or group level modes. Reinforcement management helps clients develop internal and external reinforcers and rewards that increase the chance of new behaviors continuing. Workers can also reassure clients that relapse encounters are part of an ongoing process. Helping clients determine what caused the slip can be useful in helping them develop strategies to avoid lapses in the future. Workers can also work with clients to help them learn more about themselves, their environment, and their addiction and risky behaviors. Questions similar to the following can help determine if clients need better or more reinforcement management:
• Do you feel good about your new behavior?
• What kind of things do you tell yourself, knowing you are practicing safer sex?
• What kind of things do you tell yourself, knowing you are controlling your substance abuse?

Counseling Terminally Ill Clients

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

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

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

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

Counselors who will be working with clients at the end stages of AIDS should examine their own beliefs about death and dying. In addition to this, counselors may need to learn about the physical and biological process of dying so that it can be explained to clients. It is also important to keep in mind that clients' perspectives on death and dying are deeply
rooted in their personal histories, religious practices, ethnic customs, family traditions, and community standards.

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

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

**Pain management**

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

**Unfinished business**

One important area that counselors should explore with their clients is "unfinished business." For example, a counselor might suggest that a client make a will. But there may remain other issues to be addressed. Should a client consider making an advance directive or a living will? Will the client want to appoint a health care proxy? Should he consider granting power of attorney to a significant other? Should he appoint a guardian for his children? Are there family issues that he wants to address? Some counselors express a desire to be there at the time of a client's death, or a client may request that someone be there until death. Counselors and health care providers may also spend more time counseling the client's significant others or support people during this time than they spend counseling the client. Here again, a little information can go a long way to reduce fear and anxiety in clients and their significant others.

**Bereavement**

Bereavement is a particular problem for programs with large numbers of HIV-infected clients. Bereavement can affect clients (who may grieve at the deaths of other clients, friends, or loved ones from HIV/AIDS); clients’ significant others; and counselors who work with dying clients. The following strategies may be helpful in supporting those clients who are dealing with bereavement.
• Acknowledge the reality of the bereavement in supportive individual counseling.
• Encourage the expression of grief both verbally and nonverbally (e.g., art therapy, expressive movement, psychodrama).
• Provide group support for clients and their significant others who are experiencing grief and bereavement.
• Acknowledge deaths with memorial services, flowers, photographs, and participation in commemorative projects such as The NAMES Project Foundation's AIDS Memorial Quilt, which attempts to include the names of everyone who has died of AIDS.

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

Individual interpretations of and responses to death and dying vary greatly, not only between people, but between cultures and religions. Yet, as this model eloquently describes, adjusting to death is a process, not an event that occurs seamlessly and in a logical sequential order. The coping strategies and stages described below are not a recipe for health. Acceptance may not be the goal for everyone. Emotional processing is made more challenging when survival needs such as shelter, food, and medical care are not being met. Many clients are used to surviving with "street smarts" and not by psychoanalytical parameters and discussions about childhood. This model is included merely to help providers understand and relate to their experiences and their clients' experiences.

• Denial
  This is a time of terror management, an effort to psychologically buy some time while adjusting to the information or situation. It is here that people can feel the most isolated and the most suspicious and doubtful of the information that they are receiving. Denial is a natural and healthy response. It is not necessarily something that counselors must feel compelled to confront and rid clients of at the earliest possible moment. Allowing clients to have denial can be challenging, and for the caregivers and support staff it can be anxiety producing, but it is important to remember that above all else, this is the client's experience. Denial is not always negative. The times that denial must be confronted are when it causes a danger to self or others.
• **Anger**
  This stage emerges as the person accepts the diagnosis and begins to strike out. The most common targets for this anger are the people closest and safest to him, especially caregivers and service providers. Anger can also be a test. The person facing death may want to know who can be counted on as the end nears. This can sometimes be indirectly demonstrated by the client who may test the counselor's tolerance of anger; if the anger can be tolerated, perhaps the counselor can be trusted to tolerate the client's death and feelings of fear.

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

• **Depression**
  Depression represents a loss of denial, and an acknowledgment that the information is accurate and the situation and its consequences are unavoidable. As with clinical depression, the depth and severity depends on the specifics of the situation, mitigating factors, available resources, and the individual. This stage is marked by surrender to sadness; it is appropriate and adaptive. It is a time to collect resources and energies so that more processing can occur at a later time.

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

*No code or do-not-resuscitate orders*

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

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

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

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

Health care providers and counselors must maintain a sense of how their communication efforts are affecting the people they are trying to help. A specific and practical example of this is in discussions around no code or DNR orders. As health care providers discuss treatment options with clients and their significant others and the possibility of changing the goal of treatment to comfort care, one distinction that can be helpful for some people is the difference between "life support" and "death prolonging."

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

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

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

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

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

- **Legal guardianship.** Workers should help clients identify significant others or friends within the client system who could serve as legal guardians for their children. By stressing that children without legal guardianship become wards of the State, clients sometimes find the motivation to search for and secure guardians for their children. Workers should understand that the search for guardians for children of clients with substance abuse and HIV/AIDS-related issues can be difficult because clients often have exhausted their support system of family and friends well before involvement in formal treatment systems or programs.

- **Standby guardianship.** A standby guardian is someone who agrees to stand ready to assume guardianship (legal responsibility) for a minor when the parent of that child dies or becomes incapacitated. A parent will use the procedure when there is significant risk that he will die or become incapacitated within a certain period of time (e.g., in New York, this period is 2 years). The parent must usually petition a court for the appointment of a specific individual to be the standby guardian. The standby guardian can assume responsibility when the parent becomes incapacitated and then relinquish it when and if the parent recovers. The standby guardian's authority is effective when she receives notification of the parent's incapacity or death.

- **Leaving a legacy of living memories.** An approach often used in agencies is working with parents to create living legacies for their children. For instance, families may be encouraged to make videotapes or audiotapes of themselves for their children. The National Hospice Organization has an excellent library of grief and bereavement materials, including some very good age-appropriate materials for children.

- **Dealing with survivor guilt.** The issue of survivor guilt is relevant for all family members but particularly so for the infected parent whose infant dies first. The problem of guilt must be brought forth,
discussed, and processed so that clients can take a more proactive approach to their other problems.

**HIV and Risk of Relapse**

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

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

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

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

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

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

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

Case Studies

Case Study 1
Frankie is a 21-year-old, self-admitted gay man. He has been injecting "crystal meth" off and on for 3 years. He has also been a chronic marijuana and alcohol abuser since he was 12 years old. He uses these substances particularly when he can't afford the "rig" and other drugs. He has sold his body for drugs but claims that he only has sex with "nice businessmen types." Frankie is new to the area and has been in town for about 9 months. He says his family does not approve of his lifestyle, so they made him leave home. He is in phone contact with his sister occasionally but only to let her know that he is "alive." Frankie lives in shelters and on the streets with other homeless adults and youth.

Frankie decides to enroll in an outpatient program because he has been hassled by the police lately and he went on a bad run using something called "fry" (marijuana soaked in formaldehyde, then smoked). He ended up in the emergency psychiatric unit at the county hospital and the staff there suggested that he seek some help. In addition, Frankie does know about HIV/AIDS and STDs and is concerned about his sexual behavior.

Issues for the alcohol and drug abuse counselor

Referral and linkages
Frankie will need referrals for counseling and possibly testing for HIV and STDs if the facility does not provide these services. Referrals and linkages can be obtained by getting Frankie's written consent if the facility is communicating with another organization about services for its clients. However, if an outside agency is providing services to the facility, then a Qualified Service Organizational Agreement (QSOA) or Release of Information form will be required in order for the substance abuse treatment facility to be compliant with confidentiality laws. Frankie will also need a risk assessment to help him determine just what his risks are and risk-reduction counseling regardless of his decision about any medical testing.
**Special population/cultural competency**
The fact that Frankie is gay could be a concern if the treatment facility has not dealt with members of the gay population or has difficulty in dealing with this population. It will be important that Frankie is assigned to a counselor who is nonjudgmental and has had some experience with young gay men.

**Relapse**
With Frankie, it may not be an issue of relapse as much as getting Frankie to discontinue or cut down his use. He is currently motivated for treatment but this "scare" may not last. A risk reduction model may work best with Frankie as this appears to be his first attempt at treatment and total abstinence may be unrealistic. This should be explored further with Frankie.

**Denial/anger**
Although Frankie may not have shown any of these emotions yet, they probably should be explored with him (as well as others, such as depression, grief, loss) specifically as it relates to his family and their treatment of him, as well as his having to survive on the streets.

**Medical complications**
The medical complications to the heart, kidneys, lungs, and brain would be worse if he has HIV/AIDS or any other STDs. Because he has been on the streets, he probably has not seen a doctor for anything until he ended up in the emergency room.

**Case Study 2**
Tina is a 29-year-old African American female. She has been using marijuana and alcohol since she was a teenager and progressed to using cocaine by her early 20s. Tina reports snorting cocaine for a couple of years when working as a dancer. She then discovered crack, which has been her drug of choice for the last 6 years.

Tina has been in and out of jail several times over the past few years, usually on prostitution charges. While in jail, she always tests for STDs and HIV/AIDS. She has repeatedly tested positive for Chlamydia and has received treatment numerous times. Despite the treatments for the STD, she continues to test positive. During her most recent incarceration she was diagnosed with pelvic inflammatory disease, had an abnormal Pap smear, and tested positive for HIV. Other than being a little underweight she looks good and states that she feels fine with the exception of some abdominal pain.

Tina is very excited about her "new life" with her boyfriend, by whom she has been trying to become pregnant. Having HIV/AIDS does not seem to be a major concern for Tina because she knows that there is medication out there for the disease. She reports that she was already getting off drugs before the bust because she wants to get married and have a baby now that she's found the right man. She reports her main support to be her boyfriend of 2 months. She does have a couple of female friends but does not consider them close.
She has been court ordered to go to substance abuse treatment. She has made several treatment attempts before and states she doesn't understand why she has to go to treatment now when she was already planning to stop her drug use voluntarily. She is now being admitted to a 30-day inpatient treatment program; otherwise, she faces going to jail for a minimum of 1 year.

**Issues for the Alcohol and Drug Abuse Counselor**

**Relapse**
This is the main area of concern. Tina has a long history of substance abuse. She reports little to no social support for her recovery. The nature of crack addiction suggests that a 30-day inpatient setting will "only be the beginning" of the treatment episode. The connection and consequences of high-risk activities need to be discussed and risk-reduction practices demonstrated and rehearsed. It appears that Tina is clearly in denial about her addiction and does not understand treatment and recovery. This may be exhibited through her either becoming a "compliant client" just to get along or a defiant, angry client because she doesn't think she needs treatment.

**Medical**
Tina has a number of medical issues that must be addressed and further explored. Tests and treatment for recurrent STDs, pelvic inflammatory disease, abnormal Pap smear, and HIV/AIDS are needed. With further exploration cervical cancer may be revealed, which could, in turn, give her an AIDS diagnosis. A pregnancy test may also be needed. The counselor needs to remember that it is Tina's decision about the issue of pregnancy. A counselor should watch for the issues relating to HIV/AIDS and pregnancy that can arise.

**Referrals and linkages**
Tina will need medical referrals. She has so many issues in this area she would benefit by having an HIV/AIDS case manager to assist her in linking with and coordinating appointments, medication, and so on. She may also need all the "standard" services such as housing, transportation, and clothing.

**Compliance**
There could be some compliance issues with this client. This is indicated by the good possibility that she was not taking her STD medication as directed and her statement that she doesn't understand why she has to go to treatment. This belief should be explored further because it could be a lack of information/education and not a compliance issue at all.

**Integrating Treatment Services**
Substance abuse treatment is moving away from more intensive treatment programming toward less intensive, shorter term treatment; HIV/AIDS treatment also has shifted from intensive inpatient care to focus more on primary, clinic-based care. Providers are under pressure to perform with less money, less time, and more challenges. As a result, substance abuse treatment and HIV/AIDS treatment should reflect their interconnected
relationship by coordinating as much as possible to maximize care for persons having both HIV/AIDS and substance abuse disorders. Substance abuse treatment programs and their personnel must stretch their dwindling resources by integrating the care they provide with that of other service providers.

HIV/AIDS Services in Substance Abuse Treatment

HIV prevention is an essential part of substance abuse treatment and relevant to any treatment setting. Addressing HIV/AIDS issues beyond prevention, however, is much more complicated. For the person who abuses substances and has HIV/AIDS, the complicated physical and mental health problems--such as tuberculosis (TB); hepatitis A, B, and C; sexually transmitted diseases (STDs) other than HIV/AIDS; dental problems; diabetes; poor nutrition; dementia; and depression--require that each substance abuse treatment setting incorporate a holistic, integrated model of treatment. Treatment for the client with HIV/AIDS must be carefully reviewed. Important areas to examine are issues of confidentiality, quality of services to clients, complex treatments, staff training, client readiness, and use and allocation of limited resources.

Persons with HIV/AIDS and substance abuse disorders require more than the typical physical examination and TB test. The addition of nontraditional treatment components--such as nutritional counseling, exercise regimens, education about testicular self-examination (for men), breast exams (for women), and ways to lower cholesterol--will greatly enhance the mental and physical health of persons with HIV/AIDS. For persons with a long history of substance abuse, the possibility of mental health issues and psychiatric disorders should be explored. Many inpatient treatment and detoxification settings use a nurse to assist with physical withdrawal symptoms, medications, and occasional medical concerns. This type of care can be augmented by (1) incorporating some of the treatment components listed above, (2) using health educators and nutritionists, and (3) cross-training the treatment staff.

People with HIV/AIDS are in need of all levels of treatment for substance abuse disorders. In the early days of the HIV pandemic, individuals with HIV/AIDS did not have access to a full range of substance abuse treatment services; even today, some providers still do not offer all levels of care. Often, clients with HIV/AIDS present only their substance abuse for treatment. Their fear of disclosing HIV/AIDS status, their denial of having a substance abuse disorder, the lack of training of staff and clients, and homophobia make treatment of the "whole" person very difficult. Furthermore, the fact that HIV/AIDS case managers and health care providers are not adequately trained to screen and assess for either substance abuse disorders or psychiatric disorders and refer to appropriate treatment has limited the range of services for clients with HIV/AIDS who have substance abuse disorders.

Treatment of HIV/AIDS continues to become more complex and specialized. The resources and time needed to provide ongoing HIV/AIDS medical care are great. For the most part, it is unrealistic to expect these services to be provided within substance abuse treatment settings, but it is imperative that every substance abuse treatment program maintain a close relationship with HIV/AIDS medical care providers within its
community and surrounding area. Drug and alcohol counselors and HIV/AIDS service providers must continue to develop their skills in assessing and establishing appropriate treatment plans that support the "whole" person. Medical providers and counselors can work together closely to support medical and substance abuse treatment and adherence to treatment goals. This includes establishing agency agreements and creating formal referral mechanisms.

**Issues of Integrated Care**

*Early Intervention Settings*

Early intervention often can be the first step in addressing HIV/AIDS issues in substance abuse treatment, or vice versa. The practice in early intervention for persons with substance abuse disorders has been to provide HIV pre- and posttest counseling to stop the spread of AIDS. Today the emphasis is on testing, treatment, and follow-up. The latest medical research indicates that beginning combination therapy early in the pathogenesis of HIV/AIDS may enhance the health of the client over a long period (*Hodgson*). This will result in fewer opportunistic infections and, as revealed by the latest statistics from the Centers for Disease Control and Prevention (CDC), fewer people dying of HIV/AIDS-related illnesses (*Vittinghoff et al*). Now that there are known benefits to early treatment, counselors can feel justified in encouraging clients to be tested and then begin treatment.

Another trend in early intervention is increased use of medical case management for persons with HIV/AIDS and of case management for those at high risk for becoming infected with HIV, specifically persons with substance abuse disorders. The complex regimens associated with HIV/AIDS care, along with the challenges of substance abuse treatment and aftercare, make it essential to include case managers as part of a substance abuse treatment program's responses. Many treatment centers and HIV/AIDS service organizations are receiving funding for case managers, who are sometimes called early interventionists. This service component targets those at high risk for HIV infection and provides long-term case management services focusing on risk reduction and supportive services. Risk reduction is defined with the client and based on the client's specific needs. This might mean, for example, that the case manager and client are focusing on other care needs such as dental care, mental health care, or finding stable housing. See Chapter 4 for discussion of risk reduction.

Once the client with HIV/AIDS is ready to obtain HIV-specific medical care, the case manager or early interventionist will focus on supporting medical adherence and maintenance of sobriety along with assisting with the psychosocial adjustments and the need for continued support and resources. Early intervention also can be supported through the efforts of outreach workers or other community-based workers. Outreach workers have been an important part of HIV prevention work for many years. They have been involved in many high-risk communities and have learned much about the specific needs of high-risk clients. Outreach workers can have a great impact in helping people obtain substance abuse and HIV/AIDS treatment. Outreach workers also recognize that many people at high risk have ongoing medical, housing, and social problems and that
neither HIV/AIDS nor substance abuse treatment may be the client's most pressing and immediate need.

Many clients from poorer, disenfranchised communities are dealing with basic survival needs (see Maslow's Hierarchy of Needs, in Maslow, 1970), such as food, escaping violence from an abusive partner, or keeping the electricity from being cut off. Early intervention within the context of the "culture of poverty" begins with tangible concrete service provision and establishment of trust and rapport. From this perspective--"starting where the client is"--the worker may spend time talking and getting to know the client while helping to find emergency assistance for the electricity bill and food. The worker will gradually shift from helping with the "here-and-now" challenges to developing a trusting relationship based on mutuality, which will allow the client and worker to eventually discuss long-term goals that may lead to sobriety, safer sex practices, and establishment of a more stable environment.

Obstacles to Integrated Care

Because of the many overlapping issues related to substance abuse and HIV/AIDS treatment and prevention, agencies providing both services must coordinate their efforts to offer clients a full array of services. There are, however, significant barriers to complete integration of services. Some of these are:

- **Differences in priority.** A client entering either substance abuse treatment or HIV/AIDS treatment faces a myriad of required activities and treatments. Some of these activities may appear mutually exclusive, creating significant challenges in developing a treatment plan for clients seeking treatment in both areas.

- **Differences in philosophy.** Substance abuse treatment agencies often operate from an abstinence model. HIV/AIDS service and medical treatment organizations and public health professionals frequently use a risk-reduction model. This philosophical difference can create dramatic conflict in programs and approaches.

- **Differences in funding.** Public funding of prevention and treatment of substance abuse has generally focused on drug interdiction and prevention. Conversely, HIV/AIDS funding has focused on treatment and research. Although still inadequate, higher levels of social service funding are available for persons diagnosed with HIV/AIDS. Funding sources rarely recognize the challenges of coexisting disorders; however, some resources exist. Although funding amounts are difficult to obtain, both Title I and Title II of Ryan White allow for the funding of substance abuse treatment for HIV-positive individuals (see Chapter 10).

- **Differences in training.** Many substance abuse treatment providers are experts at detecting substance abuse disorders and developing treatment goals for substance-dependent clients but at the same time do not thoroughly address their clients' medical needs. Similarly, many public health providers do not address a client's possible substance abuse while
dealing with the client's latest STD. Clearly there is a need for ongoing staff in-services and cross-training. The recently published CDC/CSAT cross-training curriculum, *HIV/AIDS, TB, and Infectious Diseases: The Alcohol and Other Drug Abuse Connection, A Practical Approach to Linking Clients to Treatment*, is an excellent resource for both mental health treatment providers and alcohol and drug counselors.

Any effort to develop integrated treatment for substance abuse disorders and HIV/AIDS, either within a single agency or through individual care plans, should include the following components:

- **Shared philosophy and priorities between the care providers in regard to the client.** The client must receive clear and consistent messages if he is to act as a full partner in his care.
- **A strong case management model.** One professional within the care system should be designated to work with the client as the lead case manager across all agencies. The case manager must be empowered to negotiate schedules and control resources to develop a care plan with the client. Within each client care team, only one provider should have the title of case manager. (For more information on case management, please refer to TIP 27, *Comprehensive Case Management for Substance Abuse Treatment*.)
- **Social services at the core of the treatment plan.** For many clients, the first priority is day-to-day survival. The individual's definition of survival may vary and may include housing, food, financial services, family maintenance, or work. Without addressing these basic client priorities, treatment cannot be successful.
- **All providers within HIV/AIDS and substance abuse treatment trained about the services available and requirements of the other setting.** For example, several federally funded programs subsidize housing costs for persons with HIV/AIDS. These same services may not be available to an individual who is in recovery for substance abuse only. Availability of housing for an individual with coexisting disorders could be the determining factor in maintaining treatment adherence.
- **Cooperative eligibility determinations, which often are a key barrier to achieving integrated care.** Every agency establishes requirements for its own purposes, including varied documentation. It is essential that the client newly in recovery or recently diagnosed with HIV/AIDS be assisted in dealing with bureaucratic requirements that are often redundant. Workers from each agency must be willing to cross agency lines to cooperate with colleagues and advocate on behalf of the client.

Developing integrated services is rarely accomplished at the administrative level. Although solid, formal understandings and agreements are helpful, most success actually is achieved at the direct-care staff level. When working with two closely linked diagnoses that are also tied to other diseases such as TB, hepatitis, and mental disorders, the care provider cannot afford to think or work solely within the confines of his own agency or personal experience. Instead, the provider must build bridges to other providers that enable clients to address all of their needs.
Dealing With Ongoing Substance Abuse

Many HIV-infected substance abusers are unable to maintain total abstinence from substance abuse after the abrupt discontinuation at the start of treatment. In dealing with clients' ongoing substance abuse, treatment programs must find a balance between abstinence and public health 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 abuse. This approach might require termination from treatment if abstinence is not achieved.

**Public Health Model**

This approach, sometimes called the risk-reduction model, emphasizes incremental decreases in substance abuse or HIV risk behaviors as treatment goals and tries to keep clients in treatment even if complete abstinence is not achieved. The public health model sacrifices some of the consistency of expectations that is such an important part of abstinence-oriented treatment. Instead, it seeks to keep substance abusers in treatment and to reduce, if not eliminate, substance abuse- and HIV-related risk behaviors. Each increment of change is viewed as a success, which helps clients see that they can positively affect their lives. By contrast, a model that regards less than complete abstinence as failure may reinforce clients' feelings of helplessness and hopelessness at their inability to sustain behavior change.

Flexibility is needed with HIV-infected clients because of the importance to public health of keeping them in substance abuse treatment; they are likely to continue to put others at risk if they leave treatment and resume injection or other drug use. In order to reduce the spread of HIV, clinicians may need to work with these clients even if they continue to abuse substances. Every substance abuse treatment program must establish a balance between the abstinence and public health approaches, based on the needs of the community it serves. For example, even a program that stresses abstinence may use a risk-reduction model to educate active injection drug users about safer sex and drug use practices, such as using condoms and sterilizing syringes with bleach.

**Differential standards of care**

One current example of a flexible approach to substance abuse treatment of HIV-infected clients 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 varying clinical expectations and levels of care to clients based on assessment of the clients' level of functioning in the areas of physical health, mental health, social support, and housing.
The treatment staff use a "standards of care" assessment tool to determine the level of severity of impairment among methadone treatment patients with HIV. Impairment is assessed along three domains of functioning--physical health, mental health, and social resources. The latter domain represents both social support and housing. Assessment of severity of impairment takes place during a team meeting in which substance abuse counselors, the program physician, nurses, and the program social worker offer input regarding each domain. Treatment decisions are subsequently made by consensus in accordance with this assessment. Clients with evidence of severe impairment are generally approached with lower expectations for treatment outcome (i.e., applying risk-reduction principles), and higher functioning clients are approached with higher expectations (e.g., maintaining substance-negative urine tests, attending self-help group activities).

Referral to and Coordination of Linkages

Development of care networks
Counselors who work with HIV-positive individuals with substance abuse disorders should familiarize themselves with the local AIDS Service Organizations (ASOs) and substance abuse treatment services. Listed below are questions that all counselors who treat substance-abusing individuals with HIV/AIDS should be able to answer:

- What area physicians or clinics with experience in HIV/AIDS issues accept HIV-positive patients? Which ones accept Medicaid, Medicare, or specific insurance plans?
- What ASOs exist in the area?
- Are Ryan White Funds available in the area? If so, who administers them?
- Are Housing Opportunities for People with AIDS (HOPWA) funds available in the area and if so, who administers them?
- Does the State provide medical coverage for single adults who have no dependents, for indigent patients, or for undocumented workers?
- Where can an individual with HIV/AIDS obtain inpatient, residential, intensive outpatient, extended outpatient, or detoxification treatment for substance abuse disorders?
- Are area substance abuse treatment programs prepared to deal with a client's complicated HIV/AIDS treatment regimen?
- What forms of support are offered in the area to help with loss, death, and dying? Are there community mental health centers that can provide psychiatric evaluation, medication management, neuropsychological testing, or case managers with skill and sensitivity toward those with mental disorders?
- Are culturally appropriate local support groups available for persons living with HIV/AIDS and substance abuse disorders?
- What financial assistance is available to clients to pay for expensive HIV/AIDS treatment?
- What are the eligibility guidelines for the State's AIDS Drug Assistance Program (ADAP), and what drugs are covered by the program?
Creating medical referral networks or institutional linkages is essential and must be a top priority for anyone working with a person with HIV/AIDS. Counselors and case managers can often make the job of working with persons with substance abuse disorders easier for medical care providers by providing consultations, follow-up, and help acquire resources that affect the client's ability to obtain prescriptions, come to appointments, and so on. Service providers and agencies must coordinate with medical providers, including private doctors, public health clinics, and specialized HIV/AIDS facilities and treatment centers. Providers should also explore the possibility of becoming members of their community's Ryan White Title II consortium of providers. There are usually two key areas in which providers can begin making contacts:

1. Local city, county, and State health departments. Every State has an HIV/AIDS or substance abuse treatment coordinator, or both (perhaps through the State department of mental health services or substance abuse treatment services). These coordinators should be able to provide information about medical resources and special funding.

2. Regional and area teaching hospitals and medical schools. These programs often have special indigent care funding and specialized HIV/AIDS treatment programming and funding. They might also be research sites for HIV/AIDS clinical trials that could not only help clients access newer treatments but also provide high-quality, specialized HIV/AIDS care within their specific substance abuse treatment protocols.

When attempting to coordinate a service plan between several agencies or resources, counselors may encounter barriers, both expected and unexpected. Here are several issues that could arise:

- The clinic or service provider from whom the counselor is attempting to obtain services may be too busy to talk. The counselor may have difficulty communicating the request directly to a person (rather than voice mail).
- The service provider may consider HIV/AIDS a specialty condition and thus may be unable to provide the level of care the client needs.
- Long waiting lists and applicant pools for services and resources may exist.
- Other service providers may be judgmental or discourteous because the client is HIV positive or substance dependent.
- Few or no services are available for the HIV-positive client living in rural or isolated areas.
- "Turf" issues may cause providers to make inappropriate referrals or be resistant to serving a referred client.

Networking with other agencies is a valuable tool for the counselor who is attempting to coordinate a service plan for a client with HIV/AIDS and a substance abuse disorder. It is essential to find out what services are offered in the local and surrounding areas.

In addition to standard treatment services, less traditional therapeutic interventions or culturally based interventions may be available to clients. For instance, acupuncture is being used for detoxification and outpatient treatment for addictive behavior. Massage is
a nurturing, hands-on therapy that can promote a positive attitude in the client. Yoga and breath training may be available to help a client stay focused on sobriety and a path toward health.

Holistic knowledge of living systems, both physical and mental (the mind/body connection), can be integrated into the treatment plan. Helping the client "tune into" the connections between thoughts, emotions, and physical health can facilitate treatment regimens.

The Internet can provide helpful treatment information and resources to the client. Many public libraries offer free Internet access. Local colleges usually have Internet access available to the public for free or for a small fee. If a remote area lacks resources but a client must live there, the counselor faces challenges in networking and resource coordination that are clearly different from those in urban settings.

When establishing a network of care coordination, the provider must consider the issue of confidentiality. Providers must be aware of State and Federal laws and professional codes of ethics, along with agency and community policies and agreements. Confidentiality raises issues of consent, disclosure, and release of information. Because linkages and referrals for needed resources are part of the client's overall treatment plan, the client should not be surprised that other treatment providers will be contacted and that releases of information will be needed. The client might have fears about disclosure--talking about this fear with the client is important. The counselor and client must develop a partnership that places the client in an active, empowered position so that she understands the value of connecting with other agencies. Eligibility for services at another agency may be based on need, and the agency may inquire about the client's condition to ascertain whether it pertains to the agency's services.

The counselor should also understand the difference between the terms "informed consent" and "consent." "Informed consent" refers to a client's consent to begin treatment after she understands her treatment options and the advantages and disadvantages of each option. "Consent" refers to the client's consent to allow confidential information to be disclosed as needed.

**Home health**

The home health care team provides skilled nursing care for patients who are homebound. These services may also include social work, physical therapy, occupational therapy, respiratory therapy, and home health aides. Clients receiving Medicare benefits can receive home care services if they are homebound, have services provided under a plan of care, have only reasonable and necessary services reimbursed, require a skilled service, and require service only on a part-time or intermittent basis. Some coverage also is provided by Medicaid and private insurance policies (which may differ from State to State).
**Hospice**

The hospice care team provides all the same services as home health but with a focus on palliative or comfort care for the client. The physician’s order must certify a life prognosis of fewer than 6 months. The hospice team members focus on spiritual, psychosocial, and emotional issues as well as the physical needs of the client. Coverage is provided by Medicare, Medicaid, and some insurance policies (this may differ somewhat from State to State).

**Figure 5-1: Medicare and Medicaid Coverage of Home Health and Hospice Services**

<table>
<thead>
<tr>
<th>Services</th>
<th>Hospice</th>
<th>Home Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services even if client is not homebound</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Prescription medicines related to hospice diagnosis</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Medical equipment/supplies</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Home health aide</td>
<td>Yes</td>
<td>Limited</td>
</tr>
<tr>
<td>Social work services/grief counseling</td>
<td>Yes</td>
<td>Limited</td>
</tr>
<tr>
<td>Pastoral/spiritual counseling</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Respiratory therapy</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Short-term hospitalization for pain control and symptom management</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Limited, intermittent, palliative radiation therapy</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Many in the health care field find it difficult to educate clients about home health and hospice services; Figure 5-1 should help distinguish between these two options.

**Family caregivers**

Whether home health or hospice services are used by the family at home, competent family members will likely be the primary caregivers for the client with end-stage HIV/AIDS and should not be supplanted by professional health care providers. It is helpful to define "family" broadly to include nontraditional families. Family may include significant others—individuals who may be unrelated but have a close relationship with the client and provide for the client's physical, emotional, and spiritual well-being. Family caregivers can include same-sex partners, friends, and fellow support group members.

It is important for counselors to remember that family members who provide close support to the seriously ill client often need support themselves. Social service support for the family is a cornerstone in the provision of coordinated, comprehensive care to HIV-infected substance abuse disorder clients. Home-based services may be critical in enabling a family to remain together and may be more cost-effective than institutionalizing the ill family member.

**Examples of Integrated Treatment**

Provided below are examples of successful programs that have linked HIV/AIDS and mental health treatment. Also discussed are common elements of effective programs and future challenges to building effective treatment programs.

*Active Referral Linkages for HIV/AIDS and Mental Health Treatment*

**Bailey Boushey**

A successful program in Seattle, Bailey Boushey is a skilled nursing facility originally created for persons with AIDS (given the more recent changes in AIDS treatment, the...
facility's beds are sometimes used for other kinds of patients such as transplant or oncology patients). The facility's most relevant feature is its day health program, which provides services mostly to HIV/AIDS, mentally ill, and substance-abusing persons. Treatment includes the services of mental health professionals as well as substance abuse treatment specialists.

**Montrose Center**
Montrose Center, in Houston, Texas, has years of experience working with and strong linkages to the Thomas Stre...t HIV/AIDS Clinic, private doctors, and area substance abuse treatment programs. It includes intensive treatment services, outpatient support/therapy groups at various locations, and outreach programs. Its providers have a good reputation for working with dually and triply diagnosed clients (i.e., HIV/AIDS, mental health disorders, and substance abuse). The staff consists primarily of therapists with licensed professional counselors (LPCs) and masters-level social workers.

**Hilltop Center**
Hilltop Center, in Longview, Texas, is a new program offering inpatient treatment services for multiply diagnosed clients throughout Texas. The program has developed a strong linkage to traditional treatment programs, but also focuses on a variety of alternative models. Its providers have a positive relationship with funders and a strong commitment from the State drug and alcohol services department. This program also includes an evaluation component. The staff are well trained, motivated, and focused on the importance of preventing clients from "falling through the cracks."

**The AIDS Health Project**
The AIDS Health Project in San Francisco offers mental health services to HIV-infected clients with and without substance abuse disorders. It works in collaboration with Shanti and the San Francisco AIDS Foundation through the HIV Services Partnership. Shanti provides volunteers for practical and emotional support, and the AIDS Foundation provides case management housing in a treatment-centric model that includes treatment advocates to work one-on-one or in groups with clients struggling with HIV and substance abuse issues and/or mental health issues. The Project is committed to working toward a fully funded "treatment on demand" service for residents with substance abuse treatment challenges.

**Opiate Treatment Outpatient Program**
The Opiate Treatment Outpatient Program (OTOP) at San Francisco General Hospital treats nearly 160 HIV-positive patients as part of its 250-patient methadone treatment program. OTOP offers substance abuse treatment combined with onsite psychiatric care and HIV/AIDS primary care.

**Common Elements of Effective Programs**
The challenges to developing effective treatment programs that meet the needs of those who are dually and triply diagnosed continue to be substantial. Few programs across the United States have been able to maintain a high level of success along with the needed
funding levels. The cost of these types of programs is a continuing challenge. Some programs are just now exploring new methods of treatment, although some began providing new services simply out of desperation and frustration. Effective treatment programs, although they vary greatly, have common elements that contribute to their success. These traits, discussed below, include the program's treatment philosophy, outreach efforts, staff training, support groups, community linkages, and funding.

**Treatment philosophy**
The clear and repeated message from effective programs is that counselors must "start where the client is." Offering what the client wants is the key. It is essential that counselors shift from the rigid thinking that there is only one way for clients to become healthier and to recover. Effective programs have discovered that different treatment modalities are not mutually exclusive and can indeed coexist, particularly when it comes to risk reduction. Nontraditional treatment, neurotherapy, biofeedback, acu-detox, and other alternative therapies can be encouraged and integrated into clients' treatment programs.

Also, counselors and therapists in effective programs believe that labeling clients, confronting them too strongly or too often, and talking "at them" rather than "to them" are counterproductive approaches, create too much distance, and may be a major factor why many clients never return to programs.

**Outreach efforts**
Some effective programs send a newsletter to their dually diagnosed clients. The newsletter discusses topics that are supportive; for example, stress might be discussed, including how stress affects the immune system and can trigger relapse, and ways to reduce stress. The newsletter also can be distributed to every treatment program in the community, thus serving as an outreach tool. Although using a newsletter may sound simple, it is not a common practice.

Some treatment programs have brought in HIV/AIDS pre- and posttest counselors and educators to their treatment programs. These counselors are encouraged to run support or therapy groups for dually diagnosed clients. Because of stigmas and confidentiality, the roles of the HIV/AIDS counselors can vary; for example, one person may conduct the testing, another may serve as the educator, and a third may lead a support group, so that clients have less fear of disclosure of their HIV/AIDS status.

**Staff cross-training**
Effective treatment programs also are strong proponents of staff cross-training. One view is that substance abuse treatment providers should become experts in mental health and HIV/AIDS, and the HIV/AIDS providers should learn about substance abuse and mental health, and so on. Staff working with HIV-positive clients must pay vigilant attention to the constantly changing world of medications, side effects, and new discoveries. The main point is that the issues of HIV/AIDS, mental health, and substance abuse disorders coexist, and the only way to really effect long-term change is to combine treatments. The best integrated programs encourage continuing education for staff. Continuing education
may include buying journal subscriptions, allowing staff time off for coursework, and providing frequent in-service training sessions. It is also important that programs hire highly trained, flexible, open-minded staff. To be successful, these staff must see beyond traditional substance abuse treatment modalities and be able to accept and affirm all cultures and lifestyles.

**Support groups**
An effective treatment program will integrate support groups. For instance, a special group for HIV-positive substance abusers might integrate relapse prevention with adherence to combination therapy. The aim is to connect the milestones of HIV/AIDS disease with triggers for relapse, so that the group becomes relevant and provides the support needed.

**Community linkages**
One of the most important community linkages in successful programs is the relationship with the medical community and practicing physicians. This includes nurse practitioners, psychiatrists, internists, nutritionists, and others. Choosing medications, assessing medical status, and ruling out a diagnosis can be very challenging with dually or triply diagnosed clients. When service providers work closely with the medical care team to solve problems and formulate treatment plans, this allows clients and providers to be more proactive. Service providers may have to educate medical care providers about addictions and recovery. Working together is essential so that clients are not overmedicated or medicated in a way that jeopardizes their recovery.

**Funding**
The most successful programs that effectively treat HIV/AIDS, substance abuse, and mental health problems have learned how to obtain funds from a variety of funding streams. Successful programs apply for funding from sources such as the CDC, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, and many local and State programs. Chapter 10 provides a more in-depth discussion about funding resources.

**Current Challenges**
Substantial challenges continue to face providers who wish to develop effective treatment programs that meet the needs of clients who are dually and triply diagnosed (HIV/AIDS, mental health, and substance abuse). Few programs across the United States have been able to develop highly successful programs and maintain the needed funding levels. For the most part, it is believed that these types of programs are quite costly. When providers examine multiply diagnosed clients, they can see that these clients are a highly vulnerable group of people at great risk: risk for death, as well as risk for numerous medical problems and chronic illnesses, other infectious diseases, physical abuse, rape, poverty, starvation, and so on. They are also often the same clients who most easily "fall through the cracks" and challenge treatment providers' knowledge, skills, and patience. Efforts to create more effective programs that decrease the number of people
"falling through the cracks" must be encouraged and these programs thoroughly evaluated in order to ensure that every client receives the best treatment possible.

7. HIV/AIDS and Substance Abuse

(Source: U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, Rockwall II, 5600 Fishers Lane, Rockville, MD 20857)

Substance use is common among people with HIV infection. Unfortunately, substance use can trigger and often complicate mental health problems. For many, mental health problems predate substance use activity. Substance use can increase levels of distress, interfere with treatment adherence, and lead to impairment in thinking and memory. Diagnosis and treatment by a psychiatrist or other qualified physician is critical as symptoms can mimic psychiatric disorders and other mental health problems (Kranzler HR, Rounsavill BJ, eds. Dual Diagnosis and Treatment: Substance Abuse and Comorbid Medical and Psychiatric Disorders. New York: Marcel Dekker).

The Reference Group to the United Nations on HIV and Injecting Drug Use recently estimated that worldwide about three million injecting drug users might be infected with HIV. About 10% of HIV cases worldwide are attributable to injecting drug use (mostly with opioids, although the use of other substances, including stimulants, has been associated with unsafe injecting practices and sexual risk behaviors). Injecting drug users principally acquire HIV through sharing injection equipment, whereas non-injecting use of drugs, such as cocaine or amphetamine-type stimulants, is associated with transmission of HIV through high-risk sexual behaviors. Some drug users practice unsafe sex with multiple partners in exchange for drugs or money, providing a bridge for HIV to spread from populations with high HIV prevalence to the general population.

Interventions that reduce the spread of HIV in injecting drug users include, among others, HIV testing and counseling, needle and syringe programs, opioid substitution therapy and other drug dependence treatment. Drug dependence is associated with particularly high-risk patterns of drug use and related risks of HIV transmission for the following reasons: drug users experience difficulties in controlling drug-taking behaviors and frequent episodes of intoxication and withdrawal (often accompanied by a strong desire to take drugs); furthermore, they persist with drug use despite clear evidence of harmful consequences or high risk of such consequences. Effective and ethical prevention and treatment at the early stages of drug use and dependence can reduce the drug-related risks of HIV transmission. A recent WHO collaborative study on drug dependence treatment and HIV/AIDS found that substitution therapy of opioid dependence significantly reduced risks of HIV transmission in opioid-dependent individuals in low- and middle-income countries, consistent with the findings in high-income countries (World Health Organization, Executive Board EB124/6, 124th Session 20 November 2008, Provisional agenda item 4.3 November 20th, 2007).

The incidence of AIDS-defining illness in patients receiving highly active antiretroviral therapy has been reported to be especially high in injecting drug users. In a study conducted in HIV-positive women in the United States of America, chronic depressive
symptoms were associated with increased AIDS-related mortality and rapid disease progression independent of treatment and comorbid substance use (World Health Organization, Executive Board EB124/6, 124th Session 20 November 2008, Provisional agenda item 4.3 November 20th, 2007).

Mental and substance-use disorders affect help-seeking behavior or uptake of diagnostic and treatment services for HIV/AIDS. Mental illnesses have been associated with lower likelihood of receiving antiretroviral medication. In a study of women who were medically eligible to receive highly active antiretroviral therapy, its non-receipt was associated with substance use and with a history of childhood sexual abuse. Among people with HIV/AIDS, those with drug-use disorders typically experience the greatest barriers in accessing treatment because of negative societal attitudes and reluctance to seek any kind of treatment. Injection drug use has consistently been shown to be associated with low uptake of highly active antiretroviral therapy (World Health Organization, Executive Board EB124/6, 124th Session 20 November 2008, Provisional agenda item 4.3 November 20th, 2007).

Substance-use disorders affect both the progression of HIV disease and the response to treatment. In untreated comorbid drug dependence, rates of adherence to highly active antiretroviral therapy are low, and rates of coinfection with hepatitis B and C viruses are high. Several randomized controlled trials have indicated that, with integrated treatment of both drug dependence and HIV/AIDS, rates of adherence approach the rate for the non-drug-dependent population. Recent research suggests that harmful patterns of alcohol use are associated with higher mortality in patients with HIV/AIDS. Several mechanisms appear to be responsible, including a direct effect of alcohol on HIV disease progression, probably mediated through the immune system, and the undermining of adherence to treatment. Even relatively low levels of alcohol consumption, such as one standard drink per day, have been associated with a reduction in adherence to treatment regimens (World Health Organization, Executive Board EB124/6, 124th Session 20 November 2008, Provisional agenda item 4.3 November 20th, 2007).

The use of alcohol is known to be associated with an increased risk of unsafe sexual behavior. Given the widespread harmful use of alcohol in many countries with a high incidence and prevalence of HIV, levels and patterns of alcohol consumption may substantially influence HIV spread in populations. Several studies, including those conducted in African countries with high prevalence of HIV, have shown a positive association between HIV and alcohol consumption, with a prevalence of HIV infection among people with alcohol-use disorders higher than in the general population (World Health Organization, Executive Board EB124/6, 124th Session 20 November 2008, Provisional agenda item 4.3 November 20th, 2007).

The National Institute on Alcohol Abuse and Alcoholism reports that the changing patterns of HIV transmission in the United States; the role of alcohol in the transmission of HIV within, and potentially beyond, high-risk populations; the potential influence of alcohol abuse on the progression and treatment of HIV-related illness; and the benefits of making alcoholism treatment an integral part of HIV prevention programs (Sources:
With 31 percent of all HIV cases among men, and 57 percent among women, attributed to injection drug use, it is obvious the shooting illegal drugs increases the risk of contracting the AIDS virus, but drinking alcohol can also contribute to the spread and progression of the disease. According to the Health Resources and Services Administration, non-injection drug use can also lead to contracting the HIV virus, because drug users may trade sex for drugs or money or engage in behaviors under the influence that put them at risk. Binge drinking is also risky. The same is true for people who drink to excess. People who are intoxicated loose their inhibitions and have their judgment impaired and can easily find themselves involved in behavior that would put them at risk for contracting HIV.

National Institute on Drug Abuse research reports that most young people are not concerned about becoming infected with HIV, but they face a very real danger when they engage in risky behaviors, such as unprotected sex with multiple partners.

Alcohol Increases HIV Susceptibility:

Risky behavior is not the only way drinking alcohol can increase the risk for becoming infected with HIV. A study by Gregory J. Bagby at the Louisiana State University Health Sciences Center found that alcohol consumption may increase host susceptibility to HIV infection. Bagby's student, conducted with rhesus monkeys infected with simian immunodeficiency virus (SIV), found that in the early stages of infection, monkeys who were given alcohol to drink had 64 times the amount of virus in their blood than the control monkeys. Bagby concluded that the alcohol increased infectivity of cells or increased the number of susceptible cells (Sources: Health Resources and Services Administration; National Institute on Drug Abuse; Alcoholism: Clinical and Experimental Research).

Virus Progresses Faster

For people who have already been infected with HIV, drinking alcohol can also may accelerate their HIV disease progression, according to a study by Jeffrey H. Samet at Boston University. The reason for this is both HIV and alcohol suppress the body's immune system. Samet's research found that HIV patients who were receiving highly active antiretroviral therapy (HAART), and were currently drinking, have greater HIV progression than those who do not drink. They found that HIV patients who drank moderately or at at-risk levels had higher HIV RNA levels and lower CD4 cell counts, compared with those who did not drink (Sources: Health Resources and Services Administration; National Institute on Drug Abuse; Alcoholism: Clinical and Experimental Research).
**Drinking Impacts Medication Compliance:**

Patients with HIV who drink, especially those who drinking heavily, or less likely to adhere to their prescribed medication schedule. Both the Samet study and research at the Center for Research on Health Care at the University of Pittsburgh School of Medicine found that nearly half of their patients who drank heavily reported taking medication off schedule. The researchers reported that many of the heavy drinkers simply would forget to take their medications. This is potentially a big problem for healthcare providers due to the fact that alcohol dependence in those with HIV runs at rates twice as high as the general population (Sources: Health Resources and Services Administration; National Institute on Drug Abuse; Alcoholism: Clinical and Experimental Research).

**Parents who are HIV positive**

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

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

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

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

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

There are support groups and programs for children whose parents are affected by HIV. Although not available in all communities, these groups offer children a chance to talk about their fears regarding their parents’ health, learn more about the disease, and socialize with others who are facing these problems. At the same time, the programs can provide the parent with some respite time. In addition, groups like Al-Anon and Alateen can provide children with support and education about the recovery process. If service providers work in a large urban area, chances are there will be an AIDS Service Organization (ASO) listed in the phone book. This agency is likely to have lists of support groups of all kinds. Single parents with substance abuse disorders who are HIV positive should also have a support group.

Stigma of HIV/substance abuse

Many professional caregivers lack education and experience in working with homebound clients with HIV/AIDS and substance abuse disorders. Even though some home-based service providers employ staff with mental health/substance abuse experience, many do not, and it is important that the counselor intervene in providing coordinated home-based services.

Substance abuse in the home

The client may have a relapse, especially when faced with approaching end-of-life decisions. Both professional and family providers may be unable to continue to provide needed care when faced with a client/family member who has relapsed and who is not capable of following the plan of care. It is critical in these situations that the client and caregivers continue receiving substance abuse counseling and intervention in the home setting. However, providers should be aware that the home setting can present certain problems, including the possibility that other substance-abusing persons in the client’s home are stealing or utilizing opioids intended for the client.

Economic needs

Even though home-based services are covered by some Federal, State, and private resources, additional stressors can affect the delivery of services. The loss of income from either the client or the family caregiver can create potential problems with housing, health insurance, nutrition, and medications. The counselor must be aware of how these conditions can disrupt the plan of care.

Emotional needs

As the client continues to need more interventions, the roles of family caregivers change, and health care professionals must be aware of the need to adapt to these changes. Family
caregivers will need support in processing the anticipatory grief of losing their family members. After the client’s death, help with funeral arrangements and further support of family members, who may also be dealing with their own addiction issues, may be needed.

8. HIV and the Elderly

While much of the public’s attention is focused on young people contracting almost half of all new HIV and AIDS cases, there’s a growing HIV/AIDS problem developing among the elderly, a problem that will only grow worse as baby boomers reach retirement.

In 2005, persons aged 50 and over accounted for
- 15% of new HIV/AIDS diagnoses
- 24% of persons living with HIV/AIDS (increased from 17% in 2001)
- 19% of all AIDS diagnoses
- 29% of persons living with AIDS
- 35% of all deaths of persons with AIDS

The rates of HIV/AIDS among persons 50 and older were 12 times as high among blacks (51.7/100,000) and 5 times as high among Hispanics (21.4/100,000) compared with whites (4.2/100,000). Persons over the age of 50 may have many of the same risk factors for HIV infection that younger persons have. Prevention challenges among persons 50 and older include:

- Many older persons are sexually active but may not be practicing safer sex to reduce their risk for HIV infection.
- Older women may be especially at risk because age-related vaginal thinning and dryness can cause tears in the vaginal area.
- Some older persons inject drugs or smoke crack cocaine, which can put them at risk for HIV infection. HIV transmission through injection drug use accounts for more than 16% of AIDS cases among persons aged 50 and older.
- Some older persons, compared with those who are younger, may be less knowledgeable about HIV/AIDS and therefore less likely to protect themselves. Many do not perceive themselves as at risk for HIV, do not use condoms, and do not get tested for HIV.
- Older persons of minority races/ethnicities may face discrimination and stigma that can lead to later testing, diagnosis, and reluctance to seek services.

(Source: CDC)
People of color are still disproportionately affected. Fifty-two percent of older Americans living with HIV/AIDS are either Black or Hispanic, reports the CDC. Among men over 50 living with HIV and AIDS, 49 percent are of color. Among women, 70 percent are of color.

The continued increase in HIV among those over 50 can also be attributed to their living longer, thanks to advanced HIV therapy. According to Bill Rydwels, a 73-year-old man who has been living with HIV for 20 years, who works with the Chicago Forum on HIV and Aging, the perception that people over 50 aren’t sexually active is one of the leading causes of high rates of HIV and AIDS among this group, “People over 50 come from a generation where the discussion of sex was an under-the-table thing,” he said. “Nobody wants to discuss the sexual habits of older people. It’s the concept that older people stop having sex, and it’s just not a reality.”

According to a study by the University of Chicago, 60 percent of men and 37 percent of women 50 years old and above report engaging in sexual intercourse a few times per month. Rita Strombeck, a physician with Healthcare Education Associates, a group that has recently developed a continuing medical education program for doctors and nurses to recognize HIV/AIDS as a problem among older people, agrees, “It has to do with the fact that they [older people] don’t consider themselves at risk and they are. One of the problems with doctors and primary care providers is they don’t recognize it’s a problem with older adults, either”.

According to Patricia Hawkins, associate executive director of the D.C.-based Whitman-Walker Clinic, the popularity of medications such as Viagra has also contributed to the surge of HIV and AIDS among this group, “Viagra has contributed a lot to this because there is so much more sexual activity among seniors and yet they are not often using contraception because they aren’t worried about pregnancy,” she said. “I don’t think that our medical community has caught up to the impact of Viagra.”

Because of a general lack of awareness in older adults, they have been omitted from research, trials, prevention and intervention efforts. Nonetheless, because of their age, they may be more at risk than young people. For older women, the use of condoms becomes unimportant after menopause.

Not only are older people at risk, the symptoms of HIV are hard to detect because of aging. Sometimes it’s difficult for physicians to determine if a person has the flu or is infected with the virus. Many of the early symptoms such as night sweats, chronic fatigue, weight loss, dementia and swollen lymph nodes mimic the natural aging process.

The National Association on HIV Over Fifty (NAHOF) says that there are specific ways to target older people, “Specific programs must be implemented for older adults who need to be informed about the transmission and prevention of HIV, more research is needed to study seniors’ sexual and drug-using behaviors to determine HIV disease
progression and treatments and programs aimed at reaching health care and service providers should cover misdiagnoses, treatments, support groups and more.”

9. Human Trafficking and HIV/AIDS

Human trafficking and forced labor are global human rights abuses. Over the past ten years, the United States has supported some excellent programs but it has also adopted an ideologically driven approach to the sex sector that harms women and their families, increases the vulnerability of sex workers to violence, trafficking and HIV infection, prevents health care workers from accessing sex workers, and does little or nothing to prevent trafficking. Sex workers who do not want to be “saved” are being subjected to violent raids and rescues and some of them are being arrested, abused, and deprived of their livelihood. Recipients of U.S. funding must sign a pledge that undermines their ability to work non-judgmentally and collaboratively with sex workers to stop trafficking, child prostitution and violence, and fight HIV/AIDS. In March 2009, the American University Washington College of Law and the Center for Health and Gender Equity co-hosted a symposium, “Human Trafficking, HIV/AIDS, and the Sex Sector,” to explore these challenges and present examples of organizations that provide human-rights based approaches and partnerships with sex workers. Distinguished authorities from the field presented at the symposium, and their articles are included in this publication—Gabriela Leite, director of Davida, a Brazilian NGO devoted to human rights of prostitutes and the regulation of the industry; Sara Bradford, the former technical advisor in Cambodia for the Asian Pacific Network of Sex Workers; Dr. Shilpa Merchant, the pioneer of a groundbreaking AIDS prevention program and sex worker collective in Mumbai; and Sylvia Mollet Sangaré, the co-founder of DANAYA SO, a Malian sex worker collective that provides health services, literacy education, legal protection, and job training. In order to change the negative attitudes and judgments that lead to harmful laws and policies, it is essential to increase public understanding about the lives, hopes, and accomplishments of sex workers and to support human-rights-based programming and partnerships with sex workers. This report brings the voices of women in the sex sector to the center of discussions around prostitution, human trafficking and HIV/AIDS, and offers analysis and recommendations based on what is happening on the ground. We hope it will contribute to meaningful, nonjudgmental discussions that can lead to new policies and programs to improve health and lives of women in the sex sector.

Over the last ten years, the United States has helped make important inroads both in combating human trafficking and treating HIV and AIDS. The anti-prostitution policies that are imbedded in the U.S. response to these issues, however, undermine U.S. success in myriad ways. Such policies ignore the very promising models of sex worker empowerment that have transformed lives around the world and successfully confronted both HIV and trafficking. Human rights must be an essential component to defeating the world’s most difficult problems. However, the United States government’s opposition to prostitution eclipses human rights and evidence of effectiveness in developing human trafficking and HIV/AIDS approaches. This ideological foundation for U.S. policy has created critical failures and blind spots that severely limit U.S. success in ending these scourges. From 2000 to 2008, as part of its response to both human trafficking and the
global HIV epidemic, the U.S. government developed anti-prostitution policies and Congress passed antiprostitution provisions that directly undermine U.S. efforts to prevent trafficking and HIV/AIDS. The focus of these policies is directed at stopping women from selling sex to earn a living. However, sex work is not the same as human trafficking into the sex sector and should not be conflated as such. Conflating human trafficking with prostitution results in ineffective antitrafficking efforts and human rights violations because domestic policing efforts focus on shutting down brothels and arresting sex workers, rather than targeting the more elusive traffickers. Moreover, a growing body of research finds that sex workers’ high risk of HIV infection is due in part to their marginalized and illegal status. Criminalizing sex work thwarts workers’ access to health care services and government benefits and makes them vulnerable to police abuse and exploitation.

The U.S. anti-prostitution loyalty oath (APLO) that is embedded in the President’s Emergency Plan for AIDS Relief (PEPFAR) has exacerbated marginalization of sex workers and curtailed freedom of speech for groups and individuals who are fighting for the rights of adults in the sex sector. A human rights-based approach to HIV prevention among sex workers, which has been endorsed by UNAIDS, World Health Organization, and other leading HIV/AIDS activists, includes advocating for legal reform and addressing police violence and other instances of marginalization and discrimination. The APLO puts this approach at risk because of fear of losing U.S. financial support. The impact of U.S. anti-prostitution policies has been felt around the world. In February 2008, under pressure from the U.S. to crack down on trafficking, the Kingdom of Cambodia passed the Law on the Suppression of Human Trafficking and Sexual Exploitation. Eight of its 52 articles refer to the direct criminalization of adult prostitution, or aspects of adult prostitution. Although the law does not explicitly state that all sex workers are trafficked persons, it has led to a mass campaign to crack down on all prostitution. Raids and arrests have increased steadily and consistently in Cambodia since the new antitrafficking/anti-prostitution law was passed. Arrests have led to numerous human rights violations, including police violence and inhumane detention conditions. It has also become increasingly difficult for NGOs to do street outreach and condom distribution to sex workers because of police harassment. In stark contrast to the punishment paradigm, sex workers themselves are generating innovative approaches to attack HIV/AIDS and human trafficking. Since its creation in November 2006, India’s Sanghamitra has become a vibrant independent community-based organization with more than 3,000 members. Sanghamitra unites sex workers with the fundamental objectives of decreasing their vulnerability, unifying their efforts to espouse safe sexual behavior, and abating the proliferation of HIV/AIDS as well as sexually transmitted infections. It helps them vocalize their issues, aiding their fight for their rights. Through this democratically-run collective, Sanghamitra members have opened their own bank, championed condom unity (a collective agreement that all sex workers benefit when all enforce condom use), ensured health care for sex workers and their children, and helped minors and trafficked women leave forced prostitution. Sanghamitra also advocates for sex workers by meeting with police and other municipal officials to ensure their rights are protected and enforced.
Mali’s DANAYA SO is another example of a democratically-run sex worker organization. It has grown into a national organization operating in five towns. Malian society and government do not provide services for sex workers and their children, so the women organized themselves into a collective. The collective seeks to stop the marginalization of sex workers by removing the difficulties women have in accessing health care (such as HIV/AIDS prevention and treatment programs) and social services; reducing dangers from police raids; fighting housing discrimination; and facilitating participation in social events and religious practice. DANAYA SO meets the immediate and long-term needs of sex workers and their families by providing medical, financial planning, banking, credit, education, and children’s services to its members. Sister organization LAKANA SO works to protect children of sex workers from the impact of stigma and discrimination. Before LAKANA SO, most children of sex workers did not attend school. LAKANA SO helps mothers enroll their children in school and professional training programs, pays half or all of each child’s school fees, and monitors the progress of the children. As a result of the work of LAKANA SO, all members’ children are now in school or professional training and highly unlikely to enter prostitution. Most children accompanied by LAKANA SO turn to professions and succeed in finding their place in the society. Brazil offers a promising example of the contributions sex workers make to society when fully empowered. The mission of Davida—Prostitution, Civil Rights, Health—is to create opportunities for strengthening the citizenship of prostitutes, through the organization of sex workers, the defense and promotion of rights, and the mobilization and monitoring of public policy. Davida coordinates the Brazilian Network of Prostitutes; assists in the formation of new organizations; advocates for public policies in the area of prostitution and health; consults public and private entities nationally and internationally; and produces, distributes, and promotes videos, publications, and manuals on STD and HIV prevention. On a regional and local level, Davida trains organizations that want to work with sex workers and promotes educational actions and citizenship formation with sex workers. One of Davida’s most important early achievements was the formation the Sex Worker Steering Committee that is a part of the Brazilian Ministry of Health’s National STD and AIDS Program in 1995. As a result, any official initiative or research project for the sex worker population in Brazil is evaluated in this committee prior to implementation. As illustrated in the examples from India, Mali, and Brazil, innovative and human-rights-based interventions can make a difference when it comes to preventing HIV, human trafficking, and child prostitution. However, as shown in the case of Cambodia, when governments enact policies and laws that conflate human trafficking and prostitution, they are likely to violate human rights of sex workers, compromise efforts to prevent sexual transmission of HIV, and waste resources that could otherwise be used to locate and assist trafficked persons and minors. Implementation of the following recommendations is essential to promoting and protecting sex workers’ human rights and to effectively combating HIV/AIDS and human trafficking:
To the U.S. Congress

- Pass legislation to remove the anti-prostitution pledge requirement. If it is not possible to pass legislation to remove the anti-prostitution pledge language, pass legislation to limit its impact.
- Assert Congress’ oversight role by monitoring implementation of the pledge and investigating the impact of the pledge on public health, human trafficking, and human rights.

To the U.S. Administration

- Instruct the Department of Justice to cease its appeal of the litigation brought by OSI and others challenging the anti-prostitution pledge under PEPFAR.
- Issue clear guidance that public health and anti-trafficking best practices are not excluded from U.S. funding, and instead are encouraged.
- Notify recipients of U.S. foreign assistance and their affiliates that sex workers are able to claim the benefits to which all citizens are entitled, such as identification or voter cards, national health insurance, and housing and banking rights.
- Promote the inclusion of sex worker groups in the design, implementation, and evaluation of national HIV prevention programs.
- Ensure that all scientific and program evidence is regularly reviewed by experienced researchers and program managers, and is shared with U.S. missions and embassies overseas.

To Governments

- Abolish or revise laws that seek to eliminate human trafficking by criminalizing the sex industry as a whole.
- Focus law enforcement efforts less on emptying the streets of sex workers and more on prosecuting actual traffickers.
- Focus efforts on identifying actual trafficked persons instead of trying to rescue all sex workers from prostitution.
- Train law enforcement to identify trafficking victims.
- Monitor for and strictly condemn corruption.
- Create and implement non-discrimination laws for sex workers and their children.

To Donors

- Focus funding on filling gaps left by the U.S. anti-prostitution pledge requirement. Increase funding to support sex worker collectives and NGOs that advocate rights-based approaches to protecting trafficking victims and HIV/AIDS.
- Treat sex workers as partners to combat trafficking, child prostitution and HIV/AIDS.
Support and allow street outreach to sex workers.
Make regular contact with organizations and health clinics that serve potential trafficking victims.

To Non-governmental Organizations

- Learn about and draw lessons from sex worker-run programs that are highly effective and promote rights.
- Develop methods to collaborate with sex worker collectives, which are part of the solution to addressing HIV/AIDS, trafficking, and child prostitution.
- Cease categorizing all sex workers as victims and refuse to assist governments that pick up adult sex workers who are not trafficked.
- Conduct systematic research, with replicable methodology, to collect accurate data on trafficking victims in the sex industry.
- Tailor vocational training to meet the articulated needs of specific communities and cultures so that skills learned will actually provide a living.

Media

- Report accurately on trafficking issues and educate the public on the realities of trafficking in the sex industry so that the public understands that not all sex workers are trafficking victims and not all trafficking victims are in the sex sector.
- Frame coverage of human trafficking objectively without using inflammatory language that distorts the issue.

Human Rights, HIV and AIDS, and the Sex Sector: A Brief Overview Serra Sippel President, Center for Health and Gender Equity (CHANGE) “…In most countries, discrimination remains legal against women, men who have sex with men, sex workers, drug users, and ethnic minorities. This must change. I call on all countries to live up to their commitments to enact or enforce legislation outlawing discrimination against people living with HIV and members of vulnerable groups…In countries without laws to protect sex workers, drug users, and men who have sex with men, only a fraction of the population has access to prevention. Conversely, in countries with legal protection and the protection of human rights for these people, many more have access to services. As a result, there are fewer infections, less demand for antiretroviral treatment, and fewer deaths. Not only is it unethical not to protect these groups: it makes no sense from a public health perspective. It hurts us all.” —Ban Ki-moon, Secretary-General of the United Nations, Plenary Address to the International AIDS Conference, Mexico City, 2008

Fighting HIV/AIDS with Human Rights Human rights are universal and apply to all individuals in every sector of society. Denying human rights to any one person perpetrates an injustice that has ramifications far beyond the local level. Indeed, it
cripples globally-supported attempts to stem the spread of a plague that has no regard for
gender, age, race, marital status, sexual orientation, immigration status, or religion. HIV/AIDS policies and programs at the global, national, and local levels must support
universal access to prevention, treatment, and care in order to effectively address the
pandemic. This requires a staunch adherence to basic human rights, without judgment or
hesitation. Policies cannot, for any reason, bar any individual or group from accessing
necessary health services—it is both immoral and automatically handicaps the HIV/AIDS
prevention effort. This principle has also been articulated at the global level: At the
United Nations High Level meeting on HIV/AIDS in 2006, world leaders reaffirmed that
“the full realization of all human rights and fundamental freedoms for all is an essential
element in the global response to the HIV/AIDS pandemic.” As stated in the Universal
Declaration of Human Rights, “all human beings are born free and equal in dignity and
rights,” and that encompasses: Right to life, liberty, and security of person—the basis for
individual bodily autonomy Right to make informed choices about their lives free from
coercion, violence Right to not be held in slavery or to be trafficked Right to highest
standard of health, privacy Freedom from violence and arbitrary arrest In addition to the
United Nations affirmation and reaffirmation of the universality of human rights, the
world’s major religions and traditions also teach that all persons are deserving of dignity
and freedom from coercion. Yet despite these pronouncements of justice, both secular
and religious, denying what has been promised at the global level is a regular and
accepted practice.

The Sex Sector and HIV/AIDS Sexual transmission is by far the most common way to
contract HIV. Globally, the vast majority of HIV infections—some 80 percent—are
sexually transmitted, making sex workers among the groups most vulnerable to infection.
As a result, ensuring access to HIV and AIDS prevention, treatment, and care among
communities of female, male, and transgender sex workers is critical to the overall
strategy for ending HIV transmissions.

The Sex Sector The sex sector is a diverse community. It is not restricted to a certain sex,
gender, or age group. Each sex worker enters the sector for different reasons and self-
identifies differently: some call themselves prostitutes, sex workers, or even whores.
Designing effective HIV/AIDS policies and programs based on human rights depends on
understanding the depth and breadth of the entire community. For example:

- The sex sector includes women, men, and transgender adults, as well as young
  adults (“young adults” is defined as 18 to 24 years of age and does NOT include
  children).
- Women in the sex sector are often wives and mothers. Sex work itself may be
  formal and organized.
- Sex work may be also informal, such as independent or self-employed sex
  workers. Sex work may be legal, criminalized, or tolerated.

People enter the sex sector for a range of reasons. For some, sex work is a profession of
choice. For others, it may be a decision made based on certain life circumstances, such as:

- Poverty and indebtedness
Each of these reasons represents a breach of different human rights, and while every effort should be made to assist all individuals who do not want to work in the sex sector, respect and assistance should also be given to those who choose—without force or coercion—to work in the sex sector.

Consequences of Laws that Stigmatize Sex Work

Laws, policies, and attitudes that criminalize sex workers perpetrate human rights violations and actually work against creating safe and healthy communities. As illustrated in this publication, when sex work is illegal, sex workers face societal and legal barriers in accessing safe housing, other forms of employment, birth certificates for their children, and health care services, including HIV/AIDS prevention, treatment, and care. Criminalizing sex work also puts sex workers at an increased risk of violence, be it perpetrated by clients, brothel madams, or even law enforcement officers, and makes it challenging to pursue protection. For example, in Cambodia, police frequently target parks and other soliciting areas in an effort to empty the streets of all sex workers. As described in Sara Bradford’s article, Cambodia's recently passed law criminalizing prostitution along with human trafficking provides no guidance on how the police are to enforce it, resulting in a violent anti-prostitution campaign rather than a concerted effort to arrest and prosecute traffickers. Children often bear the collateral damage of anti-sex worker laws. The repercussions of such laws go beyond the sex worker—their children experience the same stigma, discrimination, and institutional exclusion directed at their parents, and it is not uncommon for them to drop out of school as a result. Sex Work vs. Trafficking: Sex work is not the same as trafficking in persons for the purpose of sex and should not be conflated as such. Conflating human trafficking and into the sex sector with prostitution results in ineffective anti-trafficking efforts and human rights violations. Anti-trafficking efforts based on an anti-prostitution ideology often target the victims and not the perpetrators—the traffickers themselves. They lead to violence, as evidenced by the raids in Cambodia, and misguided trafficking interventions. According to the UNAIDS Reference Group on HIV and Human Rights, an advisory body to UNAIDS: “The blurring of trafficking and sex work and/or treating all sex workers as ‘victims’ can lead to support for coercive efforts to control or reduce sex work, which rarely produce beneficial and lasting outcomes and have even been associated with abuse of sex workers and their families. Mandatory medical treatment or procedures, forced rehabilitation, or programs implemented by police or based upon detention of sex workers are all examples of coercive programming. All such strategies either represent, or are prone to, human rights abuses and corruption. In particular, sex workers should not be subjected to the violence and related human rights violations that all-too-frequently accompany ‘raid and
rescue operations,’ whether these are directed by state agents or non-state actors.”8 To end trafficking and effectively address HIV/AIDS, trafficking and sex work have to be treated differently. And in both cases, human rights must be paramount.

Human rights are critical to any global, national, or local effort addressing HIV/AIDS and human trafficking. The U.S. invests significant financial assistance in national and global efforts to stem the HIV/AIDS epidemic and end human trafficking. In order for this funding to be most effective, U.S. foreign policies and programs must use human rights as a foundation. Stemming global health epidemics and creating a healthy worldwide population depends on it.

Human Trafficking and the Sex Sector: New Partnerships for Change Ann Jordan Director, Program on Human Trafficking and Forced Labor, Center for Human Rights and Humanitarian Law, American University Washington College of Law Scope of the Problem The U.S. has undertaken a commitment to combat both HIV/AIDS and human trafficking. Millions have been spent around the world to provide care, support, and services, as well as to prosecute traffickers. This is primarily a humanitarian response to the millions of people who are living with and dying from HIV/AIDS, and the hundreds of thousands of people who are being held by traffickers in forced labor in homes, brothels, factories, farms, and streets worldwide. According to UNAIDS, in 2007 approximately 33 million people were living with HIV/AIDS, half of whom were women, and the numbers are increasing.9 In many countries, the rate of infection is higher among sex workers than the general population.10 Consequently, health care resources should include a strong focus on this population in order to achieve success. Unfortunately, this is not the case. In fact, less effort and funding reaches sex workers than the general population.11 Many women in the sex sector are victims of trafficking. According to the International Labor Organization, in 2005 approximately 12.3 million people were held in forced labor, of which 2.45 million had been trafficked into forced labor.12 Of those, approximately 1.4 million people were trafficked into the sex sector, the majority of them women and girls. 13 Logically, non-trafficked adults in the sex sector could be extremely helpful in locating trafficked women and minors. However, anti-trafficking NGOs do not work with adult sex workers to combat trafficking and child prostitution; even worse, many anti-trafficking efforts actually stigmatize, marginalize, and even target these women. The actual number of adults in sex work is unknown, but a 2006 report on the “female sex worker prevalence rate” of girls and women between ages 15 and 49 found the following:

- Sub-Saharan Africa: 0.4 percent to 4.3 percent
- Asia: 0.2 percent to 2.6 percent
- Former Russian Federation: 0.1 percent to 1.5 percent
- Eastern Europe: 0.4 percent to 1.4 percent
- Western Europe: 0.1 percent to 1.4 percent
- Latin America: 0.2 percent to 2 percent (Belize: 7.4 percent)

Despite the authors’ efforts to ensure accuracy, the numbers are probably underestimates as the population is a hidden one. Nonetheless, the number of females between 15 and 49
in some form of sex work is substantial, certainly in the millions. The estimates in major cities alone are shocking: an estimated 14,108 women in Mumbai, India; 32,448 in Jakarta, Indonesia; and 11,249 in Niamey, Niger. 15 Because sex workers have a high HIV/AIDS prevalence rate worldwide, the above numbers mean that hundreds of thousands, if not millions, of women in the sex sector are infected. The rate of infection among trafficked women and girls is certainly as high as or higher than non-trafficked sex workers given their inability to have any control over their bodies. Even though sex work, trafficking, and HIV/AIDS are inextricably linked, policies and programs aimed at combating them always operate independently despite the fact that anti-trafficking programs can have a tremendous impact upon the work being carried out by health care providers. For example, a typical concern of health care providers is the harm caused by ill conceived mass raids of brothels in which all women, not just trafficked women and minors, are taken out and detained. These raids typically result in health care workers having less or no access to sex workers in brothels. For this reason, it is important for the government and civil society to engage in greater cooperation and information sharing to ensure that they (1) ‘do no harm’ to sex workers as a result of anti-trafficking efforts, and (2) protect the rights of children and trafficked women and support people who want to exit from prostitution. It is counterproductive and ultimately harmful to the persons who are intended to benefit from these programs for governments and agencies to work at counter purposes. Only a few governments (e.g., Mali and Brazil) and NGOs (e.g., the Global Alliance Against Trafficking in Women) view sex workers as partners to combat trafficking, child prostitution, and HIV/AIDS. Most governments and NGOs do not collaborate with sex workers or sex worker collectives. In fact, most are hostile to all women in prostitution and treat them as obstacles rather than as potential partners. A challenge to such negative thinking and counterproductive practices is contained in the reports on sex worker collectives in Mali, India, and Brazil. Their impressive accomplishments demonstrate a more productive, and rights protective way forward. U.S. Law and Policy From 2000 to 2008, the U.S. government developed a set of anti-prostitution policies and Congress passed a number of anti-prostitution provisions that directly undermine U.S. efforts to prevent trafficking and HIV/AIDS and have caused harm to women and their families. The focus of these policies is directed at stopping women from selling sex to earn a living.

In 2003, Congress passed a trafficking law that states that funds may not “be used to promote, support, or advocate the legalization or practice of prostitution” and also that an organization may not use other funds to “promote, support, or advocate the legalization or practice of prostitution.” The Bush administration interpreted this to mean that all grantees were required to adopt a policy against prostitution. This was not required by the law and the Obama administration’s State Department Office to Monitor and Combat Trafficking in Persons (TIP Office) no longer requires grantees to adopt a pledge. However, grantees receiving funding for HIV/AIDS work must adopt a policy. The President’s Emergency Plan for AIDS Relief (PEPFAR) includes a somewhat similar anti-prostitution provision stating that U.S. funds may not “be used to promote, support, or advocate the legalization or practice of prostitution,” and that organizations receiving U.S. funding must adopt a policy opposing prostitution. Zoe Hudson’s paper discusses a lawsuit challenging this restriction under PEPFAR. The thinking underlying U.S. policy
during the Bush presidency is laid out in a U.S. government ‘fact’ sheet titled, The Link between Prostitution and Sex Trafficking. The sheet claims a unique link between prostitution and trafficking that does not exist between trafficking and, for example, domestic work or farm work. Academics and activists challenged the logic and evidence cited in support, pointing out that the paper does not contain any credible evidence but instead “asserts as matters of proven fact a number of statements, which, given the state of information on both trafficking and prostitution worldwide, are unsupported or unproven by valid research methods and data.” In response, the TIP Office simply stated, without evidence, that “It is obvious to us, as stated in the fact sheet, that prostitution “fuels” the increase in sex trafficking. Where prostitution thrives, so does sex trafficking!”

Harms Caused by Anti-prostitution Campaigns

Many of the harms caused by anti-prostitution campaigns are evident in Sara Bradford’s piece on the crackdown on women in the sex sector in Cambodia—incarceration, rape, and other violence, and lack of health care and basic hygiene. By no means are these harms limited to the developing world. For example, in the U.S., adults in the sex sector are unable to openly collaborate and engage in actions to improve their situations and access to rights. In Sweden, the government did not consult with sex workers before adopting a law criminalizing clients, but relied instead on the views of women’s organizations that have no connections with sex worker organizations or their representatives. Many NGOs that receive U.S. government funding are also unlikely to consult with sex workers out of fear of losing funding. Many of them have purged their websites and documents of words such as “sex worker” and “harm reduction,” which were seen as conveying support for prostitution during the Bush administration. Researchers who were interested in understanding, for example, the impact of different legal regimes on the incidence and type of trafficking, health, and rights have not been funded, and so there exists practically no hard evidence today on these important questions. Some groups providing services lost funding.

According to a Bangladeshi sex worker collective, when two of their donors signed the U.S. anti-prostitution pledge in 2005, the collective lost funding and closed 17 drop in centers. Consequently, women no longer had a safe space and the collective’s condom sales dropped by more than 50 percent (from 73,000 a month to 30,000). As Gabriela Leite points out in her article, Brazil rejected US$40 million in PEPFAR funding rather than be forced to stop working with sex workers. An official explained: “Sex workers are part of implementing our AIDS policy and deciding how to promote it … they are our partners. How could we ask prostitutes to take a position against themselves?” The anti-prostitution campaign has also reduced condom use among sex workers and clients, because they know the police see condoms as evidence of prostitution. In India, sex workers fleeing raids have moved to areas where there are fewer or no support services, significantly decreasing their access to government HIV/AIDS prevention, treatment, and care programs. Crackdowns may also lead to increased trafficking. In 2004, the South Korean government closed brothels and left women with no alternative source of income. Current reports say that now sex workers cannot get out of prostitution and are migrating to work abroad, putting them at risk of being trafficked. There are also reports of prostitution increasing indoors and sex workers committing suicide.

Moving Forward:

Supporting Programs that Empower Adults in the Sex Sector

The incredible stories about sex worker programs in Mali, India, and Brazil thus serve as inspirations and guides for a way forward. They demonstrate that women in the sex sector have a tremendous capacity
to bring about change, not only in their own lives and the lives of their children, but also in their communities. The only way to bring about real, lasting change for sex workers and their families is to work with the women directly, in a non-judgmental manner. The success detailed in the stories about sex worker collectives in Mali, Brazil, and India demonstrates what is possible once moral judgments are no longer part of the equation. HIV/AIDS rates decrease, children of sex workers are educated, women start alternative income-generating programs, child prostitution is reduced, trafficked women are rescued, and fewer sex workers are subjected to violence.

To the U.S. Government

Current ideology and policy restrictions that have tainted U.S. anti-HIV/AIDS and anti-trafficking efforts do not facilitate or maximize the impact of U.S. foreign assistance. Unless the U.S. changes its policies and approach to programs that address sex workers—whether it is HIV/AIDS or human trafficking—it will fall short of achieving its own foreign policy goals, in addition to global development goals. Based on this report’s case studies from Cambodia, India, Mali, and Brazil, and policy analysis, the U.S. government should do the following:

U.S. Congress

- If it is not possible to pass legislation to remove the anti-prostitution pledge language, pass legislation to limit its impact in order to ensure that groups working on behalf of and/or with sex workers on human trafficking, health, and rights are not excluded from HIV prevention or anti-trafficking funding.
- Assert congressional oversight role by monitoring implementation of the pledge and investigating the impact of the pledge on public health, human trafficking, and human rights. Congress should consult with and engage civil society in these monitoring efforts.

U.S. Administration

- Instruct the Department of Justice (a) to issue a tentative letter ruling, along the lines of the Bush administration’s initial determination, that applying the anti-prostitution pledge to U.S.-based NGOs violates the Constitution and (b) to cease enforcement of the prostitution pledge to U.S.-based NGOs.
- Instruct the Department of Justice to cease its appeal of the litigation brought by OSI and others challenging the anti-prostitution pledge under PEPFAR.
- Issue clear guidance that public health and anti-trafficking best practices such as collaborations with sex worker groups to implement empowerment programs and drop-in centers, and other support services like banking and legal assistance, are not excluded from U.S. funding, and are in fact encouraged as proven models of effective outreach with sex workers.
Notify recipients of U.S. foreign assistance and their affiliates that sex workers are able to claim the benefits to which all citizens are entitled, such as identification or voter cards, national health insurance, and housing and banking rights.

Ensure transparency in policy making, consistency with U.S. and international human rights law, and the promotion of best practices in public health, by routine consultations with a broad range of experts in the HIV/AIDS field before any agency or office issues program directives interpreting global U.S. HIV/AIDS laws.

Promote the inclusion of sex worker groups in the design, implementation, and evaluation of national HIV prevention programs to ensure such programs fully and effectively address the prevention needs of sex workers and their clients, partners, and children.

Ensure that all scientific and program evidence is regularly reviewed by experienced researchers and program managers, and is shared with U.S. missions and embassies overseas.

To Governments

To ensure that laws and law enforcement officials are part of the solution and not an impediment to the protection of human rights and effective responses, governments should ensure the following:

Abolish or revise laws that seek to eliminate human trafficking by criminalizing the sex industry as a whole. Most anti-trafficking legislation takes a criminal-based approach to combating human trafficking, yet all prostitutes are labeled trafficking victims and are criminalized for their work in the sex industry.

Focus law enforcement efforts less on emptying the streets of sex workers, through often violent and abusive police campaigns, and more on prosecuting actual traffickers.

Focus efforts on identifying actual trafficked persons instead of trying to rescue all sex workers from prostitution.

Train law enforcement to identify trafficking victims. Often raids are made in a sweeping manner, resulting in the detention of non-trafficked sex workers who, as a result, are taken away from their only source of income.

Monitor for and strictly condemn corruption. Governments should create systematic complaint procedures and investigate alleged police corruption and human rights violations. A zero-tolerance policy, including prosecution, should be implemented when abuse or corruption is discovered.

Create and implement non-discrimination laws for sex workers and their children so that they are not denied essential health care and other services. The health care of sex workers is a public health matter that should not be politicized.
To Donors

Donor choices have a tremendous impact on the lives of people. Donors also have a responsibility to ensure that their grants are being used in a manner that promotes rights and the agency of the target population. So, in addition to the funding-related recommendations contained in the recommendations to the U.S. government, donors should:

- Focus funding on filling gaps left by the U.S. anti-prostitution pledge requirement. Programs that support sex workers need the support of private funding so that sex workers are not further marginalized by U.S. funded organizations, who often limit the services they provide to sex workers in order to continue to receive U.S. funding.
- Increase funding to support sex worker collectives and NGOs that advocate rights-based approaches to protecting trafficking victims and HIV/AIDS.
- Treat sex workers as partners to combat trafficking, child prostitution, and HIV/AIDS. Most governments do not collaborate with sex worker collectives and instead view them as obstacles, rather than as potential partners. Sex workers engaged in the industry are, very likely, in the best position to identify sex trafficking victims.
- Support and allow street outreach to sex workers. In some countries, it has become difficult for NGOs to do street outreach because of police harassment. Street outreach is crucial to ensure that sex workers have access to condoms and are educated on how to prevent the spread of HIV/AIDS and other sexually transmitted diseases or infections.
- Make regular contact with organizations and health clinics that serve potential trafficking victims, such as NGOs serving domestic violence and sexual assault victims. Governments should provide training to these groups so that actual trafficking victims are identified and assured that their rights are protected and their traffickers prosecuted.

To Non-governmental Organizations

In order to develop effective programs and practices that do no harm, non-governmental organizations (NGOs) working with issues affecting the lives of people in the sex sector must do more to understand and work in partnership with sex workers. As a starting point, they should:

- Learn about and draw lessons from sex worker-run programs that are highly effective and promote rights.
- Develop methods to collaborate with sex worker collectives, which are part of the solution to addressing HIV/AIDS, trafficking, and child prostitution.
- Cease categorizing all sex workers as victims and refuse to assist governments that pick up adult sex workers who are not trafficked.
- Conduct systematic research, with replicable methodology, to collect accurate data on trafficking victims in the sex industry.
✓ Tailor vocational training to meet the articulated needs of specific communities and cultures so that skills learned will actually provide a living. Long-term support for fundamental skills-building and education are important to ensure self-sufficiency and avoid trafficking.

To the Media

Given the ability of all forms of media to mold public reactions to important, but little understood issues, such as sex work, it is incumbent on the media to ensure that they are not responsible for spreading myths and misinformation. Journalists should endeavor to: Report accurately on trafficking issues and educate the public on the realities of trafficking in the sex industry, so that the public understands that although human trafficking is a major human rights and criminal abuse, not all sex workers are trafficking victims and not all trafficking victims are in the sex sector. Frame coverage of human trafficking objectively without using inflammatory language that distorts the issue. Information should not be conflated, so that distinct terms such as slavery, prostitution, and trafficking are not used interchangeably.

10. Resources

- AIDS.org: Mental Health
  Articles and publications on depression and coping, stress and anxiety, and death and grief.

- AIDS.org: Telling Others You Are HIV Positive
  Issues and guidelines about telling family members, friends, and others that you are HIV positive.

- American Academy of Family Physicians: HIV: Coping With the Diagnosis
  Q and A about coping with fear, legal issues, and other information.

- American Psychiatric Association's Coping with AIDS and HIV: An Overview
  Information on psychiatric reactions, treatment, and getting help.

- The Body: Mental Health
  Articles and links on depression, anxiety, stress, relationships, and other mental health issues.
The Body: AIDS Hotlines and Organizations
A comprehensive listing of HIV/AIDS hotlines and organizations, including a state-by-state breakout of HIV/AIDS organizations and support groups.

Centers for Disease Control and Prevention's Caring for Someone with AIDS at Home: Providing Emotional Support
Information for caregivers and loved ones on providing emotional support.

HIV InSite Links: Hotlines

HIV InSite Links: Mental Health
Links to organizations and other resources dealing with depression, anxiety, stress and other mental health issues.

Pets Are Wonderful Support (PAWS)
A non-profit organization that focuses on pets as a way to improve the mental health and well-being of people with HIV/AIDS. Includes information on health issues and international list of organizations.

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About the Course Presenter:
Nicole Hiltibran, MA, LMFT, is a graduate from Pepperdine University, where she earned her Masters Degree in Clinical Psychology with an emphasis in Marriage and Family Counseling, and is a Licensed Psychotherapist. Nicole has 25 years of experience serving adults, children, couples and families both in the public sector and private practice. Nicole has written state licensing exams for the California State Board of Behavioral Sciences for 10 years as well as offering continuing education courses to licensed mental health and social work professionals including LMFT’s, LCSW’s, LPCCs, RN’s, and PhD’s.