Los Angeles County
Commission on HIV Health Services

And

Office of AIDS Programs and Policy

Mental Health Practice Guidelines for Treatment of People Living with HIV/AIDS

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And
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I. INTRODUCTION

Practice guidelines are a developing movement in the mental health field (Nathan, 1998). Development of practice guidelines for people with HIV/AIDS is complicated in that this is an extremely diverse group demographically. HIV/AIDS has disproportionately affected groups already disenfranchised from society: ethnic minorities (especially African-Americans and Latinos), gay men, substance abusers, the poor, and the seriously mentally ill. For many people with HIV/AIDS, HIV is only one problem among many. Therefore, the mental health needs of people with HIV/AIDS and the reaction to a diagnosis of HIV/AIDS vary considerably among individuals.

"Practice Guidelines" are a product of developments in a number of different but related and interacting fields. These fields include:

- **OUTCOME RESEARCH** From Eysenck's (1952) historic study that questioned the efficacy of psychotherapy, there has been increasing emphasis on what works and what doesn't work to assist persons with emotional problems. This has lead to increased emphasis on outcome research to prove the efficacy of treatments for various mental disorders. Examples of current practice guidelines include American Psychiatric Association (1994a), American Psychiatric Association (1994b), American Psychiatric Association (1995), American Psychiatric Association (1996), American Psychiatric Association (1997), Chambless (1996), Chambless (1998), Depression Guideline Panel (1993a), Depression Guideline Panel (1993b), Depression Guideline Panel (1993c), Depression Guideline Panel (1993d), and Task Force on Psychological Intervention Guidelines (1995).

- **MANAGED CARE** In an effort to contain costs insurers have asked practitioners to better define both the problems they propose to treat and to do provide treatment that is proven with by outcome measures. Cost curtailment does not justify exclusion of coverage for disorders that are time consuming to treat (e.g., borderline personality disorder). A limitation on treatment sessions based on outcome research done with dissimilar populations is also unjustified. This can occur when data on research participants, who were often selected for absence of co-morbid illness, is used to set treatment limits for patients in community settings, who often have co-morbid illness.

- **LEGAL** Mental health law increasingly becomes complex. This includes both explicit legislation (for example, child abuse reporting requirements) and civil law precedents (for example liability cases resulting out of ineffective intervention to prevent suicide). In California the licensure of mental health professionals and regulation of mental health care is administered by three different agencies depending on discipline: the Board of Behavioral Science Examiners[1] – Licensed Clinical Social Workers and Marriage and Family

[1] Available on the World Wide Web at http://www.bbs.ca.gov

Therapists; the Board of Psychology[2] – Psychologists; and, the Medical Board of California[3] – Psychiatrists.

- **PROFESSIONAL STANDARDS** All of the major mental health disciplines have developed ethical standards for practice. Psychologists are guided by ethical standards published by the American Psychological Association Ethics Committee (1992)[4]. Marriage and Family Therapists are guided by ethical standards published by the California Association of Marriage and Family Therapists[5]. Social workers are guided by ethical standards published by the National Association of Social Workers[6]. Such standards include practicing within one's scope of competence, maintaining confidentiality, and keeping current with new developments in one's field.

It is beyond the scope of this document to cover all areas related to practice guidelines, however, it will attempt to make recommendations for those issues related to providing mental health coverage for persons with HIV/AIDS and provide reference to other useful references. Providers should be particularly cognizant of practice guidelines for various mental disorders. See the references listed above and in the reference section of this document for other current practice guidelines. A good introduction to this subject can be found in (Nathan, 1997). Two good general references on providing mental health care to persons with HIV/AIDS are Hoffman (1996) and Acuff et al. (1999).

II. PURPOSE

Mental health treatment serves to improve and sustain the quality of life for persons impacted by HIV/AIDS. Research on persons with HIV demonstrates that counseling and psychotherapy can be helpful in alleviating or decreasing psychological symptoms that often accompany HIV disease. In many cases people with HIV may seek mental health treatment for symptoms or problems that preceded infection. Often these chronic symptoms or problems are exacerbated with HIV infection. Treatment addresses a wide variety of clinical syndromes as they relate to the adjustment to the disease.

HIV/AIDS mental health services are short-term or sustained therapeutic interventions provided by mental health professionals for patients/clients experiencing acute and/or ongoing psychological distress. Services include psychosocial assessment; development of an individualized treatment plan; individual, group, couple and/or family psychotherapy; and crisis intervention. These services are usually provided on a regularly scheduled basis with arrangements made for non-scheduled visits during times of increased stress or crisis.

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[2] Available on the World Wide Web at http://www.dca.ca.gov/psych
[3] Available on the World Wide Web at http://www.medbd.ca.gov
[4] Available on the World Wide Web at http://www.apa.org/ethics
[5] Available on the World Wide Web at http://www.camft.org/about/ethicsi.html
[6] Available on the World Wide Web at http://www.naswdc.org/PRAC/standards/standards.htm

Issues that are often the result of or exacerbated by HIV infection and are the focus of mental health treatment include, but are not limited to:

- difficulty coping with the illness or treatment
- depression and anxiety
- bereavement (for people with HIV this often complicated by multiple losses)
- end of life issues
- difficulty coping with changes with physical appearance
- isolation and lack of social support
- disclosure of HIV status to others and specific cultural group stigmas
- relationship issues (including those related to sero-discordant sexual partners, and intergenerational, i.e., grandparent-parent-child relations)
- stigma related to sexual orientation in particular communities
- substance abuse
- problems with treatment adherence
- difficulty maintaining hopefulness
- feelings of guilt, lowered self-esteem, or fear of rejection

III. DEFINITIONS OF MENTAL HEALTH PROVIDERS

Mental health providers include licensed practitioners and unlicensed practitioners who practice under the supervision of a licensed mental health professional. The information presented below is specific to the State of California. In California the provision of mental health care is regulated by the Board of Behavioral Science Examiners (Marriage and Family Therapists and Licensed Clinical Social Workers), Board of Psychology (Psychologists), and the Medical Board (Psychiatry).

Licensed Practitioners

MARRIAGE AND FAMILY THERAPISTS (MF.T.): M.F.T. have a Master's degree in counseling. In addition to their course work, M.F.T. are required to accrue 3000 hours of supervised counseling or psychotherapy experience in order to take the licensing exam. They must pass a written and an oral examination before obtaining a license to practice independently. M.F.T. typically have expertise in treating relationship and family problems.

PSYCHIATRISTS: Psychiatrists are medical doctors (M.D.) who have completed a residency in psychiatry after completing medical school. Most residency programs last for 3 years. Psychiatrists are licensed to practice independently. Psychiatrists typically have expertise and training in psychopharmacological treatment of mental disorders.

PSYCHOLOGISTS: Psychologists have a doctoral degree in psychology or education (Ph.D., Psy.D., Ed.D.) . In addition to their course work, psychologists are required to

accrue 3000 hours of supervised professional experience in order to take the licensing exam and practice as a psychologist. They have to pass a written and oral examination before obtaining a license to practice independently. Psychologists typically have expertise in utilization of psychological and/or neuropsychological measures in order to assess a client's symptoms, cognitive abilities, psychological dynamics, neuropsychological functioning, adaptive abilities, and academic achievement.

LICENSED CLINICAL SOCIAL WORKERS (L.C.S.W.): Licensed Clinical Social workers have a Master's degree in social work (M.S.W.). In addition to their course work, L.C.S.W.s are required to accrue 3200 hours of post-Master's supervised therapy experience in order to take the licensing exam. They must pass a written and an oral examination before obtaining a license to practice independently. Social workers typically have expertise in understanding social systems and the impact of these systems on individuals and families.

NURSE SPECIALIST AND PRACTITIONERS: Registered nurses (R.N.) who hold a masters as a Nurse Practitioner in Mental Health or a Psychiatric Nurse Specialist are permitted to diagnose and treat mental disorders. Registered nurses who hold a bachelors degree are permitted to provide psychoeducational services but are not allowed to diagnose or treat mental disorders independently.

Unlicensed Practitioners

PSYCHOLOGICAL ASSISTANTS, MARRIAGE FAMILY THERAPIST INTERNS AND TRAINEES, SOCIAL AORK ASSOCIATES AND PSYCHIATRY RESIDENTS: These are individuals who are accumulating supervised experience as part of their preparation for their respective license/certification, and are directly supervised by a licensed mental health practitioner. They either hold a graduate degree or are graduate students in social work, counseling, medicine, or psychology. The licensed supervisor is responsible for the services provided by an unlicensed practitioner under his or her supervision and must provide the unlicensed practitioner with supervision in accordance with rules and regulations of the licensing board of their respective professions.

IV. TRAINING, SKILLS, AND EXPERIENCE

General Training, Skills and Experience

Mental health practitioners who work in the field of HIV/AIDS require a wide variety of skills in order to serve best the complex needs of their clients. In addition to skills derived from standard professional mental health training, practitioners must be able to integrate and apply information based on knowledge and familiarity with a range of other social service arenas. These arenas should include medical issues and treatments, case management, financial benefits, legal issues, housing, community AIDS organizations, and substance abuse treatment services.

The HIV mental health practitioner should possess at a minimum the following skills:

- interview and assessment skills
- ability to manage transference and countertransference
- ability to work within an interdisciplinary team approach
- risk assessment and crisis intervention skills
- ability to formulate and apply a treatment plan
- ability to identify and handle appropriately legal and ethical issues of treatment
- ability to maintain accurate documentation recorded in a timely manner
- ability to distinguish between personal and professional roles
- ability to identify resources appropriate for clients and make appropriate referrals
- ability to work in different modalities such as individual, group, and conjoint/family
- ability to identifying and implement therapeutic strategies appropriate for the client's symptoms and problems
- ability to appropriately advocate for clients
- ability to apply knowledge and concepts of human growth and development in work with clients
- awareness of mental disorders that can be induced by illicit drug use
- sensitivity towards and knowledge of diversity issues which may affect treatment. Such issues may include culture, race, ethnicity, gender, religion, sexual orientation, political beliefs and physical disability.
- ability to assess and provide treatment for substance abuse problems
- willingness to seek consultation regarding complex cases

Cultural Competence

Practitioners frequently provide care of people who differ from them in terms of cultural background, gender, class, sexual orientation, and gender identification. Basic training for mental health professionals should include examining how biases, prejudices, and assumptions related to diversity may impede assessment and treatment. Professional development should include ongoing training and education related to diversity. Two good references on developing cultural competency in mental health practice can be found in Sue and Sue (1999) and Arredondo, et al. (1996).

Practitioners should also take into consideration that a client might have multiple identifications that are each equally important in the understanding of the client's life situation. The literature on multiple identifications is limited. One good reference on the interplay between gay or lesbian identity and ethnic diversity is Greene (1997).

In terms of the HIV/AIDS epidemic Hoffman (1996) pointed out that, "this epidemic has been defined by cultural variables that are linked to private, intimate behaviors " (p. 181). HIV/AIDS has disproportionately affected groups already disenfranchised from society: communities of color (especially African-Americans, Latinos/as, and Native Americans/American Indians), gay and bisexual men, substance abusers, the poor, and the transgendered. In Los Angeles County, "of the 14,618 persons living with AIDS through February 1999, African-Americans and

Latinos/as combined accounted for: 54% of the total, 48% of the men who have sex with men, 76% of the women, 78% of the heterosexuals, and 89% of the children….Low-income persons are disproportionately represented in AIDS case data, with a cumulative AIDS rate more than double that of high-income individuals in Los Angeles County (2.2 times)" (Office of AIDS Programs and Policy, 1999, p.p. 14 & 19).

Issues related to differences in culture include:

- Specific outreach efforts are often necessary to reach people of Asian, Pacific Islander and other ethnic backgrounds who may be reluctant to seek out services for HIV testing or care. This is often due to mistrust of governmental and community based organizations and cultural beliefs and values stressing the importance of keeping personal issues within the family.
- overly informal or familiar initial behavior or dress by a therapist may offend people of some cultural backgrounds.
- non-directive counseling approaches may not make sense to persons of some cultural backgrounds. However, premature and overly directive inquires and approaches may offend people of some other cultural backgrounds.
- people of other cultural backgrounds may utilize traditional healing practices. Disrespect of these healing practices by service providers tends to drive people away from mental health and health care.
- people of other cultural backgrounds may place more emphasis on family goals and desires than individual goals and desires.
- gender and sex role expectations vary from culture to culture.
- expectations and traditions regarding illness, death, and grief vary from culture to culture.
- people of various ethnicities have undergone historic experiences of being subject to unethical practices and biases by medical and mental health providers and researchers. Distrust of health and mental health providers is reasonable given this history.

Issues related to differences in class include:

- lower income people may be accustomed to waiting for long periods of time for public services, they may not understand a professional being upset when they are late for an appointment.
- lower income people may place more priority on other life issues than health or mental health care.
- flexibility to schedule appointments during work hours is typically more limited for those in lower wage jobs.
- lower income people may have more difficulty with travel and child care arrangements, which impact their ability to access services.

Issues related to differences in gender include:

- some client's may feel uncomfortable discussing some matters with a therapist of a different sex.
- women often experience more burdens as a caretaker of children and other family members than men and may place more emphasis on these responsibilities than their own health or

mental health.
- women are more likely to be the victim of child abuse, domestic violence, and other violence.
- expected sex roles vary from culture to culture and there is dispute in many cultures about appropriate sex roles.
- women's income is often less than for men.
- transgender people's identification and issues are different from those of gay and lesbian people.
- personal and historical experiences of discrimination by men can lead to reasonable expectation of bias from men.
- individuals may have undergone historic experiences of being subject to unethical practices and biases by medical and mental health providers and researchers based on issues of gender. Distrust of health and mental health providers is reasonable given this history.

Issues related to sexual orientation include:
- gay and lesbian people have undergone historic experiences of being subject to unethical practices and biases by medical and mental health providers and researchers. Distrust of health and mental health providers is reasonable given this history.
- gay and lesbian people have typically received little societal support for their relationships (e.g. lack of legal ability to marry).
- not all people who engage in same sex behavior identify as gay, lesbian, or bisexual
- gay and lesbian people were, in large part, raised in environments hostile toward their sexual orientation. Therefore, it is not unusual for homophobic biases to be incorporated into the belief system of a gay or lesbian individual and these belief systems can result in significant psychological distress.
- gay and lesbian people of color may suffer homophobic discrimination from some people within their own ethnic community and suffer ethnic discrimination from some people within the gay, lesbian, and bisexual community.

HIV Training and Experience

Increasingly mental health professions are called upon to provide services to persons with HIV/AIDS. One recent study (Schmeller-Berger & Handal, 1998) found that almost half of one discipline of mental health providers nationwide had treated someone with HIV/AIDS. While this study found that this group of mental health providers had good general understanding of transmission and prevention issues, most lacked formal training in treating persons with HIV/AIDS.

Due to the increasing impact of HIV/AIDS on client populations, all mental health practitioners should have training and experience regarding HIV/AIDS related issues and concerns. State licensing boards and professions are recognizing this and increasingly are recommending or mandating continuing education for mental health professionals in HIV/AIDS. Mental health practitioners are encouraged to seek out recognized and established organizations providing continuing education in HIV mental health, including the national and regional professional

bodies. This training should include, but is not limited to:

- knowledge of HIV disease and current medical treatments
- psychosocial issues related to HIV/AIDS
- basic understanding and sensitivity to cultural issues related to communities disproportionately affected by HIV/AIDS
- awareness of mental disorders that can be induced by prescribed drug use
- awareness of mental disorders that can be related to HIV or other medical conditions
- countertransference issues related specifically to disability, end of life, and HIV/AIDS
- ability to facilitate client adherence to medical treatment plan
- diagnosis and assessment of HIV-related mental health issues
- utilizing and collaborating with adjunct services
- HIV/AIDS legal and ethical issues

Even with a good basic understanding of HIV/AIDS, mental health practitioners should actively participate in continuing education to update and enhance their knowledge and skills in these and other areas pertinent to HIV mental health as developments in the field change rapidly. The most significant recent progress in the medical treatment of HIV/AIDS has been made with the introduction of potent antiretroviral therapies in 1995, which for the first time reduced the mortality from AIDS and the rate of progression to HIV. Despite the promise of these new therapies they do not work for all people with AIDS due to viral resistance, inability to take the medications due to side effects, or limited ability to comply with a complex and demanding treatment regimen.

V. MENTAL HEALTH SERVICES AND DOCUMENTATION

The section below discusses both mental health services and documentation of these services. Mental health services must be documented and mental health records need to be maintained in a secured space. Agencies need to establish guidelines/protocol regarding appropriate staff access to the HIV mental health records. After a case is closed, records need to be archived in accordance with state law.

Progress Notes

Progress notes are the key documentation of all contacts with on the behalf of the client. Information contained in other documents (e.g., biopsychosocial assessment, treatment plan) does not need to be repeated in the progress note, but there should be a progress note indicating the date and type of contact, the time spent, and where information gathered during the contact is located.

Progress notes documenting treatment should include:

- the date and type of contact

- the time spent with or on behalf of the client
- interventions and referrals provided
- results of interventions and referral
- progress towards goals
- any newly identified issues/goals
- progress notes shall include the signature of the mental health provider. Signature shall include first name or initial, last name, and discipline. If the mental health provider is unlicensed, progress notes shall reviewed and co-signed by the licensed clinical supervisor within at least a 30 days of the service delivery date.

Intake

The purpose of the client intake is to determine if a person is eligible to register as a mental health client. Client intake shall consist of the following required documentation: date of intake; written documentation of an HIV disease or AIDS diagnosis; patient/client name, home address, mailing address, and telephone number; emergency contact name, home address, and telephone number; next of kin name, home address, and telephone number; proof of County of Los Angeles residency; a signed and dated Release of Information Form (RIF) updated annually (a new form must be initiated if there is a need for communication with an individual not listed in/on the current RIF); a signed and dated Limits of Confidentiality Form; a signed and dated Consent to Receive Mental Health Services; and a signed and dated Patient/Client Rights, Responsibilities, and Grievance Procedures Form. The Intake form must be signed and dated by staff member conducting the patient/client intake.

An appropriate release of information needs to be obtained from a mental health services client prior to releasing information about that person's mental health treatment. A release of information should specify what information is to be released, how long the release is good for, and procedures for canceling the release. If information to be communicated or released includes the client's HIV status, the release should specifically permit this disclosure.

At the minimum the therapist should request that the client authorize communication with the client's medical provider through a release of information to allow for consultation during treatment. If the client refuses or does not have a medical provider this should be documented in a progress note and followed-up with as treatment progresses.

If some of the client intake information is located in another chart, there should be a signed and dated notation in the mental health chart where this information is maintained.

Biopsychosocial Assessment

All clients with HIV should receive a baseline biopsychosocial assessment by a mental health practitioner. A biopsychosocial assessment is a cooperative and interactive face-to-face

interview process during which the client's biopsychosocial history and current presentation is evaluated to determine diagnosis and treatment needs. The assessment process may include multiple interviews with the client or significant others or gathering of information from other providers to clarify the clients problems or situation. The biopsychosocial assessment should be completed within 30 days of the first service contact with the client.

Reassessments shall be conducted when there is a significant change in the client's status or the client has left and re-entered the mental health program.

A biopsychosocial assessment can provide essential information for mental health professionals working with people living with HIV/AIDS (hereafter) referred to as "clients"). A thorough assessment includes:

PRESENTING PROBLEM/CHIEF COMPLAINT: history, including intensity and duration from the perspective of the client as well as significant others.

PSYCHIATRIC HISTORY: outpatient treatment, psychiatric hospitalizations, impact of symptoms on client's level of functioning, what client feels has and hasn't worked

FAMILY AND RELATIONSHIPS: family of origin and dynamics, current relationships with family and/or support system; dependent care issues; cultural factors; domestic violence, physical or sexual abuse history; and family history of mental illness and/or substance use

CURRENT LIVING AND SUPPORT SITUATION: type of living situation and problems if any; support from community, religious, and other resources;

EDUCATION: highest grade completed, literacy, general knowledge and skills;

EMPLOYMENT HISTORY AND MEANS OF FINANCIAL SUPPORT: source of income, longest period of employment, employment history, and work related problems

LEGAL HISTORY: number and type of arrests, convictions; parole and/or probation status; divorce or child custody issues

GENERAL MEDICAL HISTORY: serious illnesses, head trauma, surgeries, accidents, chronic medical conditions other than HIV, and allergies

HIV MEDICAL HISTORY: month and year of HIV diagnosis, last T-cell count and viral load, history and current presence of any HIV related illnesses or symptoms

CURRENT MEDICATIONS (MEDICAL AND PSYCHOTROPIC) AND ADHERENCE: medication name and dosage, benefits perceived by the client, history of adherence, barriers to adherence, side effects experienced and coping skills related to adherence

CULTURAL AND IDENTITY: attitudes toward sexuality/sexual orientation, gender identity, experience with discrimination

ATTITUDES TOWARD ILLNESS, MEDICATION ADHERENCE, AND RISK/REDUCTION BEHAVIORS: attitudes toward illness, HIV, disability, death and dying, and other losses. Recent risk behaviors, precipitants of risk, benefits perceived by client of risk reduction, and risk reduction plan.

MENTAL STATUS EXAM: appearance, motor activity, attitude, mood and affect, speech and language fluency, rate, and quality, thought content, process and perception (connectedness, predominant topic, delusions, preoccupations/ obsessions, hallucinations), orientation as to time, place, person, and purpose, memory (short-term and long-term), judgement and insight, suicidal and violent ideation and history (type and frequency of ideation, past attempts, plan)

DIAGNOSIS AND FORMULATION: complete 5 Axis *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* diagnosis: including a description of symptoms and diagnostic criteria that justify the diagnosis. In all cases where the initial diagnosis on one (1) or more Axes is deferred, the mental health provider should continue to assess the client concurrent with treatment and complete the diagnosis within sixty (60) days of Biopsychosychosocial Assessment. This or any other change in diagnosis should be clearly documented in a progress note or on a Change of Diagnosis Form.

An example of a biopsychosocial assessment form for adults can be found in the Appendix and in Acuff, et al. (1999).

Treatment Plan

The treatment plan determines the course of treatment and is based on the assessment and developed in conjunction with the client. By involving the client in the formulation of the treatment plan it also becomes part of the process of gaining informed consent from the client for treatment.

The treatment plan should include:

PROBLEM: what the problems are (i.e. specific problems, symptoms, or behaviors to be ameliorated by treatment)

OBJECTIVES: is what the desired outcome of treatment.

GOALS: are measurable changes in symptoms or behaviors.

INTERVENTIONS AND MODALITIES: are specific types of interventions proposed, and what modality(ies) is/are appropriate to address the identified problem(s) (e.g.,

individual, family and/or group psychotherapy).

FREQUENCY AND EXPECTED DURATION: what frequency is appropriate (e.g., weekly, twice weekly, every-other week) and expected duration of treatment.

REFERRALS: additional service referrals to assist in resolving problem (e.g., psychiatric consult, alcohol rehabilitation, registered dietitian).

The Individual Treatment Plan shall be signed and dated by the staff member developing the treatment plan. If mental health provider is unlicensed the treatment plan shall be co-signed by the licensed clinical supervisor. The Individual Treatment Plan shall be signed and dated by the client and a copy shall be provided to the client. The initial treatment plan should be completed within 30 days of the first service contact with the client

The treatment plan should be updated as problems and symptoms change but at a minimum of every six (6) months.

An example of a treatment plan can be found in the Appendix and in Acuff, et al. (1999).

Crisis Intervention

Crisis intervention services are unplanned services provided to an individual, couple, or family experiencing a stressful event. Such services are provided in order to prevent deterioration of typical functioning or to assist in the return to a typical level of functioning. Services also include risk assessment and intervention. Examples of stressors that may provoke a crisis include, but are not limited to the following:

- potential exposure to HIV
- initial HIV diagnosis
- the onset or recurrence of a particular symptom or infection
- initiation of treatment or failure of treatment
- a sudden or profound loss of mobility or vision
- rejection by a family member or significant other
- relationship crises
- suicidal/homicidal ideation
- acute psychosis
- loss of housing or employment
- substance induced crisis or mental disorder
- having to quit a job due to physical disability

Any request to see a mental health professional immediately should be taken seriously, in many cases it may call for crisis intervention or assessment services. Because a client's first contact with a mental health professional may be during a period of crisis assisting the client with the crisis may preclude conducting a comprehensive biopsychosocial assessment and treatment plan.

At the minimum the following information should be documented in a progress note for the client:

- the date and time spent with or on behalf of the client
- time of day of contact and significant interventions (e.g., calling Child Abuse Hotline)
- summary of the crisis event
- interventions and referrals provided
- results of interventions and referrals
- follow-up plan.

Crisis services may be provided face-to-face or by phone. At these times, it is imperative to assess for client safety, when known, in light of previous functioning and coping skills. This may occur during one or more sessions that may be scheduled as often as necessary to prevent deterioration in functioning or for safety.

Some clients can not be safely maintained in an outpatient setting. In these cases psychiatric hospitalization should be considered. While it is preferable for the client to voluntarily consent to the hospitalization the practitioner should not be reticent in initiating an evaluation for involuntary hospitalization. This can be done by contacting the County Department of Mental Health[7], law enforcement, or a Psychiatric Emergency Team in order to evaluate whether the client poses serious and immediate threat to self, others, or is gravely disabled due to a mental disorder.

Once the client is stabilized and returned to pre-crisis functioning, she or he should be assessed for further needs and may be referred for short-term or long-term counseling or psychotherapy.

Individual Counseling/Psychotherapy

Individual counseling or psychotherapy, provided by a mental health professional, can be very beneficial for many clients living with HIV/AIDS. A wide range of therapies, including psychoeducational, interpersonal, supportive, insight oriented, or cognitive-behavioral approaches, have proven successful. Practitioners should be aware of outcome research and employ proven treatment methods for their client's symptoms or disorders.

Individual counseling or psychotherapy may be either short-term or long term in duration. Duration of treatment should be based upon the treatment plan. Short-term, or brief psychotherapy, usually lasts up to twenty sessions. Because it is problem-focused, short-term counseling and psychotherapy can be useful for clients dealing with specific issues, such as:

- disclosure of HIV status to friends, family, or employer

[7] Los Angeles County Department of Mental Health Access Program can be reached at (800) 854-7771.

- resolving grief in its initial stages
- deciding whether to return to work
- the onset of AIDS-related opportunistic infections
- changes in relationship status or social support
- treatment concerns

Long-term therapy provides a context to explore more deep-seated issues that may interfere with effective living. Even if the therapy may go on for an extensive period, setting short-term goals with the client to measure progress can help focus and improve the treatment.

Examples of issues that may necessitate longer treatment periods are:

- entrenched feelings of despair and helplessness
- severe mental illness
- severe internalized homophobia
- end-of-life issues
- personality disorders

Family Counseling/Psychotherapy

A family may be defined as either the family of origin or a family of choice (Bor, 1993). Interventions with the family system are often more effective in resolving problems than interventions targeted at just one member of the family system. Family therapy is especially effective in assisting children and youth with behavioral problems and symptoms.

Family systems risk enormous disruption as they attempt to manage the impact of HIV on their lives. The overall goal of family counseling is to assist families in achieving improved functioning by addressing such issues as:

- enhancing family support
- loss and bereavement
- conflict resolution
- change in roles (e.g., children having to assume more responsibility in the family)
- homelessness or unstable living situations
- parenting skills in relation to HIV-affected families
- decreasing isolation and facilitating social support
- disclosure issues
- permanency planning for dependent children
- school-related problems
- frequent hospitalizations/separations

Couples Counseling/Psychotherapy

Couples or conjoint counseling is a type of family counseling that focuses on treating any two people who define themselves as a couple. This modality is the most appropriate where the presenting problem is dissatisfaction or conflict within the relationship except in cases where domestic violence has occurred.

In domestic violence cases the primary consideration should be ensure the safety of the victimized party. Perpetrators should be referred to programs to address this issue. Couple or conjoint counseling should not begin until both parties demonstrate progress in individual or group treatment and there has been at least six (6) months of free of violence[8].

This modality may be useful when addressing issues couples may face, including:

- dissatisfaction with the relationship
- sero-discordant HIV status
- sexual functioning or dissatisfaction issues
- poor communication skills
- conflict regarding parenting decisions
- issues related to changes in health status
- anticipated loss
- caretaking issues

Group Treatment

There are many types of group services useful for people living with HIV/AIDS and their significant others. On the whole, groups allow for the enhancement of social support vital to those isolated by HIV. Groups provide knowledge that can range from medical treatment options, coping skills, and community resources. The facilitators' jobs include ensuring that the group stays focused on matters consistent with the group's purpose.
A treatment group or drop-in psychoeducational group is led by at least one mental health professional. However, there are significant benefits to utilizing two co-facilitators to lead groups. The benefits include:

- decreased chance that a group will need to be cancelled due to facilitator illness or absence
- decreased chance that important group or individual issues will be missed
- allowing group members the benefit of the different skills and styles of each therapist
- formation and working through of different transference relationships with each therapist

[8] Local resources include the Los Angeles Commission on Assaults on Women (213) 955-9090, California Coalition on Battered Women (818) 787-0072, and the Gay and Lesbian Center Domestic Violence Program (323) 993-1600.

Groups can be subdivided based as to whether they are a planned intervention to meet a goal in a client's treatment plan (treatment groups) or whether they are an outreach activity designed to promote mental health services to persons with HIV/AIDS (drop-in groups).

Group structures and interventions should be selected to meet client need. The following describes some of the groups that fit into these two categories:

TREATMENT GROUPS: these groups may be provided in a variety of formats but require that the group be part of the treatment plan and that the client's progress is charted in his or her individual treatment record. Examples of different formats include:

- **CLOSED GROUPS:** This type of group typically meets at a regular time and location. There is typically a process for joining and terminating with the group for each client. Groups typically consist of six to ten members. Clients are encouraged to participate weekly. A particular strength of this format is the building of group cohesion and the chance for interpersonal learning. Additionally, more structured groups may want to teach specific information or skills over multiple sessions. The group may be ongoing or structured for a specific number of sessions. Groups can be oriented to provide general support, toward a specific client population, or a specific type of problem.

- **OPEN GROUPS:** This type of group tends to be a more structured group offered to clients of the mental health program of a particular agency. Clients are encouraged to attend the group but are not required to attend at any particular frequency. Participants may shift from session to session and the group leaders typically need to provide more group structure than for closed support groups. Such groups can be especially useful for persons requiring immediate support or for those whose circumstances, emotional state, or physical state may prevent them from making a commitment to an ongoing group.

Examples of psychotherapeutic groups that could be structured as open or closed include: HIV Symptomatic Group, Newly Diagnosed Group, Bereavement Group, Women's HIV Group, and HIV/Substance Abuse Group Coping with HIV Group, Sobriety Support Group, and Adherence Support Group.

Because treatment groups are a planned intervention they should be incorporated into the client's treatment plan. All modalities of intervention provided to a client can be incorporated into the same treatment plan.

Progress notes for psychotherapeutic groups can be documented satisfactorily in either of two ways:

1) a separate progress note in each client's chart; or
2) one progress note that is specially signed, identified, and placed in each client's individual mental health record. The procedure for this second method is:
   a) clients should be referred to by first name only in the body of the progress note

b) a copy is then made for each client’s chart
c) each copy is signed with the therapist’s original signature and discipline
d) the client’s full name and identification number (if any) is entered at the bottom of that client’s progress note only.

DROP-IN PSYCHOEDUCATIONAL GROUPS: These groups do no require their members to make an ongoing weekly commitment to the group. They typically allow people to attend even if they are not formally registered for services with the agency or a mental health program. Members can attend whenever they feel the need to participate in the group. This type of group is especially useful for client’s who may be fearful of establishing any record of mental health treatment or HIV services. Drop-in groups often are a client’s first contact with an HIV services agency and can often help the client feel more at ease receiving more intensive mental health or other HIV services. Drop-in groups can be focused on a particular topic or be structured in such a way that the participants decide each week what to discuss.

Drop-in groups by their nature do not have the ability to prescreen clients for group; therefore it is highly recommended that two facilitators conduct these groups in order to be better prepared to handle unexpected emergencies.

Documentation is kept for each drop-in group and not in an individual client record. Documentation should consist of the following: date, time, and length of group; record of attendance (true name or pseudonym); issues discussed and interventions provided; and signature and title of professional conducting the group or co-signature as required.

DISCUSSION GROUPS: These groups allow people to attend even if they are not formally registered for services with the agency or a mental health program. Members can attend whenever they feel the need to participate in the group. This type of group is especially useful for client’s who may be fearful of establishing any record of mental health treatment or HIV services. Discussion groups may be a client’s first contact with an HIV services agency and can often help the client feel more at ease receiving more intensive mental health or other HIV services. Discussion groups are focused on a particular topic, are educational in nature and often feature a guest speaker who is an expert in their field. Examples of discussion group topics may include: Introduction to Mental Health, Introduction to Local Resources, Medication Management, Stress Reduction, HIV Nutrition, etc. Discussion groups may be coordinated and facilitated by a paraprofessional.

Documentation is kept for each discussion group and not in an individual client record. Documentation should consist of the following: date, time, and length of group; record of attendance (true name or pseudonym); topic discussed and support services provided; and signature and title of professional or paraprofessional conducting the group with co-signature as required.

Some clients may not be appropriate for all types of group participation. This is particularly true

if it appears, in the estimation of the group facilitators that an individual would be too disruptive to the group process or unable to benefit from the proposed group. Clients who are at high risk for psychological decompensation, have severe characterological disorders, experiencing psychotic symptoms, or are actively suicidal may fall into this category and require careful assessment before introducing them into a group.

Interactions with Other Service Providers

Mental health practitioners need to make appropriate referrals based upon a thorough needs assessment of the individual client. An appropriate needs assessment takes into account the biopsychosocial aspects of the individual's circumstances. With the appropriate consent to release information from the client, the mental health practitioner should work closely with the medical providers, case managers and other members of the client's treatment team to support the integration of services for their client. This team, working with the client, sets goals and develops a comprehensive treatment plan to ensure quality of care. Mental health practitioners may need to expand their traditional role to include serving as advocates for their clients and as liaisons between medical providers and clients

At any point, other members of the client's HIV treatment team may want to refer clients for mental health assessment. In order to work with the referring provider, an appropriate consent to release information needs to have been signed by clients. Because HIV can be a devastating illness with many complications and uncertainties, it can be expected that clients may episodically utilize mental health services.

> **MEDICAL**[9]: The change in treatment options for persons with HIV/AIDS has created new issues and dilemmas for persons living with HIV/AIDS. Successful treatment is directly dependent on the ability of patient's to adhere to an often-complex medication-dosing regimen. Combination therapies require the patient to take three or more different antiretroviral medications. Total pills per day depend on the medications but typically range from 12 to 18 pills per day. Some medications should be taken on an empty stomach, some only with food. And patients often must deal with troubling side effects such as nausea, diarrhea, and changes in body fat distribution. Given the complexity of combination antiretroviral therapy it is not surprising that patients often experience difficulty in adhering to their medication regimes.
>
> The consequences of non-adherence to antiretroviral treatment can be serious. With inconsistent adherence, the viral load is much less likely to be suppressed to undetectable levels and the virus is more likely to be able to mutate and to become resistant to the medications, thus limiting further treatment options. A recent study by Patterson (as cited in Cheever, 1998) found that missing as little as 5% of scheduled dosages can result in

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[9] A version of this section was previously published in the *California Psychologist* (Fish, 1999) and was adapted for this document by the author.

decreased likelihood of a patient reaching an undetectable viral load.

The problem that we are immediately presented with is that prior research has demonstrated that typical levels of adherence to any medication regimen are typically below the levels needed for successful antiretroviral therapy (United States Department of Health and Human Services, 1998). Clearly, many patients will need the assistance of medical and mental health care providers to work out strategies to achieve the high level of compliance typically necessary for successful antiretroviral therapy. The first step in assisting your patients with HIV/AIDS adherence begins with encouraging them to be open with any problems with adherence (Chesney, 1999, January).

The second step is to explore the patient's cognitive beliefs regarding starting on medications. Cognitive beliefs such as "taking medications means I'm getting sicker" is likely to negatively effect compliance as well as depress mood. Negative beliefs regarding medications is understandable, as many people with HIV have lost many of their friends or family to the AIDS epidemic during a period when medical options were nowhere near as effective as they are today. Providing education and teaching cognitive restructuring techniques can assist the patient in forming more positive cognitive beliefs such as "I'm keeping healthy by taking my medications".

The third step is to help patients with structuring reminders to take medications. The most frequently given reason for missing a dose was simply forgetting, sleeping through a dose, or being busy with other activities (Chesney, 1999, January). Chesney recommends the following strategies to help patients with adherence:

- Daily plan – write out a daily plan linking medications to specific daily activities; use a personal log to record medication doses.
- Plan ahead for disruptions – plan in advance for weekends, holidays, vacations, and other disruptions to the regular daily routines; order special meals in advance.
- Pill planning – establish a time to count out and arrange pills for the following week; use compartmentalized pill boxes.
- Extra pill bottles – keep a supply at home, at work, and other places where one spends a lot of time; keep pills at the location where they need to be taken (e.g., by the alarm clock or the coffee maker).
- Reminders – use devices such as timers, watches with alarms, checklists, and compartmentalized pill boxes to help remember when to take medications.
- Privacy – find ways to take drugs in a way that preserves confidentiality.

In addition to Chesney's recent article, the Department of Health and Human Services guidelines on adherence is a valuable resource to practitioners (United States Department of Health and Human Services, 1998). There is also an excellent training curriculum and

workbook on adherence is available from the UCLA AIDS Mental Health Training Program[10]. Close cooperation between the mental health and medical provider is often key in helping a patient improve adherence.

In some cases it may be necessary to assist a client in obtaining medical services; this may be when clients refuse medical treatment due to fear, anxiety or denial. In this particular situation the mental health practitioner shall assist the client in accessing medical treatment. This may be in the form of exploration of fear, reduction of anxiety, and educating clients about the disease process to address denial.

CASE MANAGEMENT: Many mental health clients may benefit from case management. Case management differs from mental health services in that it addresses basic needs including but not limited to: food, shelter, transportation, and public benefits. Specialized forms of case management exist; these include medical case management and mental health case management.

PSYCHOLOGICAL EVALUATIONS: Some mental health clients may benefit from referral to a clinical psychologist for specialized assessment consisting of thorough clinical history and use of standardized psychological test instruments. Such assessment is usually to clarify diagnosis, confirm mental disability, or assist in treatment or rehabilitation planning.

NEUROPSYCHOLOGICAL/NEUROLOGICAL EVALUATIONS: Because of the potential for motor/cognitive impairment due to HIV or opportunistic infections, mental health professionals should be sensitive to cognitive changes with their clients. These can present as problems with memory, personality changes, word finding difficulty, problems with or problems with comprehension. Referral to a neurologist (M.D.) and a neuropsychologist (a psychologist with specialized training in neuropsychology) can be of assistance in clarifying the nature and the extent of the problems. Neurologists can be of assistance in diagnosing and treating the underlying disorder (if treatable). Neuropsychologists can provide assistance in establishing disability and its impact on functioning, and making recommendations for rehabilitation.

Evidence of a delirium, which is characterized as a disturbance of consciousness with changes of cognition or development of perceptual disturbances (American Psychiatric Association, 1994), should be considered a medical emergency. A delirium typically develops rapidly, often within hours or days, and can be the result of a medical illness, substance intoxication (illicit or prescribed), or substance withdrawal.

PSYCHIATRY: Clients should be referred to a psychiatrist when there is a need for evaluation of treatment with psychotropic medications. Clients with psychotic symptoms, bipolar symptoms, and melancholic depression should receive a psychiatric evaluation. In

[10] The UCLA AIDS Mental Health Training Program can be reached at (310) 794-7130.

addition, clients with obsessive compulsive disorders, other anxiety disorders, and major depression typically benefit from a combination of psychotherapy and psychotropic medications.

POPULATION SPECIFIC CONSULTANTS: Consultation with or referral to other service providers who are expert in working with clients of particular populations is recommended when the provider is unfamiliar with important cultural and community related attitudes, healing practices, beliefs, attributions, roles, or ways of relating to others.

NUTRITION: In assessing or treating clients, mental health practitioners should evaluate such concerns as recent weight changes, mealtime regularity, eating disorders and access to food and nutritional services. Clients should be referred to appropriate services including food banks, food voucher programs, and nutrition consultation with a registered dietitian specializing in HIV nutrition. Clients benefit from referral to a registered dietitian who can provide a nutritional assessment, education regarding the importance of nutrition in treatment of HIV, symptom management, weight management, preservation of lean body mass and discuss various nutritional services available.

COMPLEMENTARY THERAPIES: Clients may need to explore the use of complementary therapies in conjunction with traditional HIV treatment. Some clients may need a safe place to examine the option of choosing alternative therapies, instead of traditional HIV treatment. The mental health practitioner needs to remain nonjudgmental and unbiased, allowing the client to explore all his/her options. Clients should be supported in engaging in ongoing dialogue with their medical providers about their feelings and concerns that influence treatment decisions.

There are cases of exploitation of clients by alternative practitioners who utilize unfounded means to treat clients. Often unethical practitioners urge the client to reject standard medical treatments[11]. One way to address this problem is to referring clients with this issue to treatment advocates who can often help them explore all of their treatment options.

HIV COUNSELING AND TESTING: Mental health practitioners may be seeing clients who are at high risk for HIV infection and need to be educated about the HIV counseling and testing options available. Benefits of clients knowing their HIV status include early medical intervention and ability to protect sexual or drug use partners from infection. Practitioners need to be prepared to provide crisis intervention to those clients who have received a positive HIV antibody test result. In some cases individuals in mental health treatment may need to refer partners and/or family members including children for HIV counseling and testing. Practitioners need to be mindful that HIV risks are not limited to intimate sexual relationships, but may include needle sharing behaviors or casual sexual

[11] AIDS Health Fraud Task Force of California (800) 459-4503.

encounters.

SUBSTANCE ABUSE TREATMENT: Practitioners must always consider the possibility that a client's drug and/or alcohol use is exacerbating a mental health problem or interfering with treatment. Recent studies show over 50% of persons with HIV have a mental health diagnosis and/or substance abuse problem. All mental health practitioners should have completed training in substance abuse detection and treatment.

Therefore practitioners should not only work with the substance-using client, but also provide appropriate referrals to the spectrum of substance abuse recovery services, including detoxification programs, inpatient and outpatient treatment and self-help programs. A client's choice to continue using substances should not, of itself, result in termination of mental health services. Instead practitioners should familiarize themselves and their clients with one of the harm reduction models of substance use.

Discharge Summary

The purpose of a discharge inventory is to summarize the treatment history both for internal quality review and to provide a record to future providers about the present course of treatment. Documentation should include a course of treatment outline, discharge diagnosis, referrals, and reason for termination. If the client drops out of treatment without notice, the mental health provider shall document attempts to contact the client, including written correspondence and results of these attempts.

Discharge summaries shall include the date and signature of the mental health provider. If mental health provider is discharge summaries should be co-signed by the licensed clinical supervisor.

VI. LEGAL AND ETHICAL ISSUES

Excellent references on HIV/AIDS and legal issues for mental health practitioners can be found in:

- Wood, G. J. (1992). *AIDS law for mental health professionals: A handbook for judicious practice*. San Francisco: University of California, San Francisco[12]. .

- Martin, D. J. (in press). Ethics in the treatment of Human Immunodeficiency Virus infection and Acquired Immunodeficiency Syndrome. In S. F. Bucky (Ed.). *The comprehensive textbook of ethics and law in the practice of psychology*. Plenum, in press. An abstracted version of this article was recently published as Martin, D. J. (1999). Psychological treatment of HIV: Ethical and legal issues. *California Psychologist, 32* (8), pp. 12, 14-15.

All practitioners are advised to seek legal counsel if unsure of a particular issue, as laws

[12] Available from Celestial Arts, PO Box 7327, Berkeley, CA 94707, at (510) 559-1600.

regarding mental health law change frequently. Some legal and ethical issues to consider in treating a client with HIV/AIDS include the following:

Practitioners in Los Angeles County also have as a legal resource the HIV/AIDS Legal Services Alliance (HALSA) program housed at AIDS Project Los Angeles, which can be a source of information for practitioners as well as clients. This service is located at 1313 N. Vine Street, Los Angeles, CA, 90028, (323) 993-1640.

Duty to Treat

A practitioner has an ethical obligation not to refuse treatment to a person with HIV/AIDS because of fear of HIV or lack of knowledge about HIV. Licensure strictures and state laws against discrimination provide that a practitioner should not arbitrarily refuse treatment unless the client's condition is beyond their scope of competence, if treatment offers no benefit to the client, if the client does not comply with treatment recommendations, or if the provider and the client have a personality conflict that impedes appropriate treatment.

If a practitioner refuses treatment, the practitioner must give the client the reasons for this and provide referrals to other practitioners. If a practitioner is concerned about his/her own fears interfering with the professional relationship, the practitioner has an ethical duty to seek consultation and only if this fails should the provider refer the client to another practitioner.

Confidentiality

Guidelines and examples of circumstances when a client's HIV status may or may not be disclosed are included in *AIDS Law for Mental Health Professionals*. Maintenance of confidentiality is a primary legal and ethical responsibility of the therapist. An appropriate release of information needs to be obtained from a mental health services client prior to releasing information about that person's mental health treatment. A release of information should specify what information is to be released, how long the release is good for, and procedures for canceling the release. If information to be communicated or released includes the client's HIV status, the release should specifically permit this disclosure.

At times, a mental health practitioner may be a person living with HIV and find himself/herself a consumer of some of the same services that his/her own clients may use, and encounter a client in such a setting that implies the HIV status of the practitioner. In this situation, a general guideline can be used, which is to allow the client to acknowledge the practitioner first rather than to possibly embarrass or intrude upon the client by recognizing the client first with a greeting. Processing the client's feelings about the encounter at the next psychotherapy session should follow. It also provides the opportunity to consider whether the practitioner wishes to self-disclose his/her HIV status or reason for being in the setting in which the practitioner encountered the client.

Smaller communities exist even in large urban areas where practitioners and clients may be in closer proximity, the likelihood of encountering clients in public settings is increased. This may include gay or lesbian practitioners encountering clients in bars, clubs, gathering places, festivals, or other public events. While this may be awkward for both client and practitioner, close proximity may make this situation unavoidable. This situation can be made less awkward, however, when the practitioner discusses his or her general style and policy in handling public encounters beforehand with each client. Typically, this is done by assuring that the psychotherapist does not disclose the nature of the relationship or any other confidential information to any third party; by allowing the client to initiate any greeting; and, keeping any encounter brief, polite, and free of any discussion of material currently at issue in the client's therapy.

There are certain situations in which confidentiality may be breached in cases of preventing the suicide of a client, child abuse reporting requirements, elder abuse reporting requirements, and serious threat to harm another identifiable person.

Duty to Warn

Confidentiality is a primary obligation to clients and must be balanced with other legal considerations such as duty to warn. California law makes a specific exemption to confidentiality when a client, regardless of HIV status, makes a serious threat to a psychotherapist of physical violence against a reasonably identifiable victim or victims. California law protects a psychotherapist from liability from failure to protect a third party from harm once the therapist has taken reasonable steps to report the threat to the potential victim and law enforcement (California Civil Code 43.92).

This exemption to confidentiality does not apply to consensual needle-sharing or sexual behavior in most cases. Patients that disclose to their therapist that they are engaging in behaviors that place others at risk of infection typically are distressed by this behavior and seeking assistance in changing their behavior. A poorly thought out response to notify third parties or public health authorities is not only unlikely to help clients change their behavior, it is likely to drive them away and result in further risk (Martin, in press).

Duty to warn is a complex issue and practitioners who have questions are advised to seek legal counsel. Generally, practitioners may not legally disclose the HIV status of a client to the client's sexual or needle-sharing partner. An HIV infected client engaging in behaviors that may put others at risk for HIV infection is **not** a circumstance, in and of itself, that warrants breaking confidentiality. For a fuller, more detailed discussion of this topic please consult Martin (in press).

California law does allows physicians, to warn presumed sex and needle-sharing partners of HIV-infected patients under certain parameters. Martin (in press) points out that typically partner notification programs notify the person at risk without revealing the identity of the potential source of infection. Confidential partner notification maximizes the chances that the infected

person will provide accurate information on others possibly exposed to HIV and allow others at risk to be contacted and provided with counseling regarding reducing risk behavior and the advisability of testing for HIV.

Dual Relationships

Dual relationships occur when a psychotherapist relates to a client in more than one manner, professionally, socially, or business (National Association of Social Workers). Ethical principles discourage psychotherapists from having dual relationships with clients, interns, and students due to the potential for abuse and exploitation. The ethical codes do recognize that in smaller communities an absolute prohibition on dual relationships may be impractical and deny important services to members of the community. The community of providers especially skilled in dealing with issues such as HIV, gay and lesbian issues, ethnic minority issues, and transgender issues is, even in a large metropolitan area, limited. Therefore, practitioners may have to weigh competing ethical concerns of duty to treat and avoidance of dual relationships. In all cases the decision should solely be based on the best interests of the client.

Issues to consider in making a decision regarding initiating a dual relationship include:

- the nature, intensity, and currency of the other relationship
- avoiding any exploitation or appearance of exploitation of the client
- are there other providers who could offer comparable services
- fully informing the client, prior to initiating assessment or treatment, of potential problems (this discussion should be documented)
- bartering for services, due to the potential for exploitation, is specifically forbidden by the ethics code of National Association of Social Workers and the American Psychological Association

Ethical and legal standards are absolute in forbidding sexual relationships with providing mental health services to anyone once a sexual partner or a current client. Ethical standards also discourage becoming sexually involved with someone who is a family member or in a close relationship with a client or taking on a client where that relationship already exists. Beginning a sexual relationship with a former client is ethically suspect and discouraged by the ethics code of National Association of Social Workers and the American Psychological Association.

VII. PARAPROFESSIONAL SUPPORTIVE SERVICES GUIDELINES

Paraprofessional Supportive Services: are services provided by a lay person with specialized training and demonstrate knowledge regarding psychosocial issues, services, and treatment options affecting and available to persons with HIV disease under the supervision of a mental health professional. Paraprofessionals preferably have life experience and/or prior knowledge and understanding of the multifaceted impact of HIV/AIDS. The paraprofessional shall not be permitted to operate independently and it is the licensed mental health professional that is responsible for direction, supervision, and quality of care provided by the paraprofessional.

Scope of Service

Paraprofessional counselors understand the limits of their service and provide referrals to mental health professionals in crisis situations and for deep-seated issues which require psychotherapy. These circumstances for referral may be present upon intake or may occur during the course of supportive counseling. Paraprofessionals shall recognize indicators that are beyond the scope of supportive counseling techniques, such as:

- Unusual behaviors or evidence of thought disorders, such as hallucinations or delusions
- Cognitive deficits such as dementia due to HIV disease
- Substance abuse
- Depression and suicidal ideation
- Anxiety and feelings of panic
- Homicidal ideation
- Child or elder/dependent adult abuse and/or neglect
- Domestic violence

Paraprofessionals may:

- conduct intakes
- identify crisis situations for immediate mental health professional intervention
- assist a mental health professional with a therapeutic group or drop-in group
- lead a discussion group
- provide individual paraprofessional support to supplement professional services as directed by the mental health professional
- provide emotional support to assigned clients

Documentation

Paraprofessional supportive services required documentation should consist of the following:

- intake, treatment plan (completed by a mental health professional specifying type and frequency of paraprofessional services)
- progress notes documenting date, time spent with or on behalf of the client, issues discussed, supportive services provided, and signature and title of paraprofessional providing the service. Progress notes shall be co-signed by the paraprofessionals supervisor within one month of the date of service.
- discussion group documentation includes date, time, and length of group; record of attendance; issues discussed; support services provided; and, signature and title of paraprofessional conducting the discussion group. Progress notes shall be co-signed by the paraprofessionals supervisor within one month of the date of service.

Supervision

Paraprofessional counselor shall at a minimum, be supervised monthly by a Master's level or

doctoral candidate therapist or clinician in social work, counseling, nursing, psychology, or psychiatry with specialized mental health training. If supervision is delegated to a non-licensed mental health professional it is the licensed supervisor and the agency that is accountable for services provided by the paraprofessional. Reasonable provision needs to be made for the paraprofessional to have access to a supervising therapist/clinician between regularly scheduled supervision sessions, should the need arise.

Supervision shall be conducted individually or in a group setting of a maximum of five (5) paraprofessionals based on the hours of service provided per week by the paraprofessional. Paraprofessionals working ten (10) hours or less per week shall receive a minimum of two (2) hours of supervision monthly; paraprofessionals working eleven (11) or more hours per week shall receive supervision a minimum of one (1) hour per week.

Training

Training shall include, but not be limited to, the following:

- basic information about HIV
- orientation to paraprofessional support including role of the paraprofessionals; services provided by paraprofessionals; limitations of paraprofessional activity; how and when to access supervision; and how to utilize and refer to case management and other available services
- paraprofessional skills including facilitation of discussion groups; non-judgmental responding; communication skills; and documentation
- common issues faced by persons living with HIV/AIDS including: emotional reactions to being newly HIV diagnosed; emotional reactions to beginning HIV medication; emotional reactions to HIV related illness; emotional reactions surrounding receiving an AIDS diagnosis; and family issues related to HIV/AIDS
- crisis and red flags including recognizing situations requiring immediate assessment by a professional mental health professional
- cultural diversity sensitivity including finding common ground; respecting differences; and how HIV interacts with race, class, gender, and sexual orientation
- legal/ethical issues including confidentiality of HIV status, mental health records and services; and limitations and boundaries of the paraprofessional role

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IX. APPENDIX