Los Angeles County
Commission on HIV Health Services

HIV/AIDS AND SUBSTANCE USE STANDARDS OF CARE

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I. EXECUTIVE SUMMARY

As treatment providers, we know the interconnectedness of substance abuse as a factor in the transmission of HIV. Past and present drug users of both injected and non-injected substances make up at least one-third of those living with HIV in the United States. The entwined nature of both epidemics – HIV/AIDS and addiction – means that we must address both issues in order to address one.

This document offers HIV/AIDS-related standards and guidelines for providers of drug and alcohol treatment services. These standards, developed by the HIV Drug and Alcohol Task Force of the Los Angeles County Commission on HIV Health Services (HIV-DATF), are the result of the experience and efforts of people dedicated to the development of effective drug and alcohol treatment services.

The problems associated with substance use among those living with HIV/AIDS are as varied as the individuals involved. These standards strive to accommodate divergent philosophies and modalities of substance use treatment. Although treatment programs provide a wide range of services, these standards also provide a minimum level of service quality. Towards this end, the HIV-DATF hopes that the standards can be incorporated within all programs, regardless of philosophy or modality, and will contribute to program success in providing effective drug and alcohol treatment services.

II. PURPOSE

The main goal of these standards of care is to establish an acceptable level of service for individuals living with HIV/AIDS and substance abuse issues. It is essential that harm reduction education and methods be included during client's treatment experience in order to stem transmission of HIV/AIDS to those uninfected.

III. POPULATION SERVED

Substance users with HIV/AIDS seeking drug and alcohol treatment services, program services must be provided to individuals identifying as having HIV/AIDS, regardless of age, ethnic group identification, national origin, race, skin color, religion, sexual orientation, gender identification, physical or mental disability. Services can simply involve a referral to another program which is more suited to specific client issues or needs.

IV. TYPES OF PROGRAM SERVICES

In any community, it is hoped that the HIV positive (HIV+) substance using individual and their impacted support system will be able to access a full continuum of services resources. Program

philosophies and approaches will also be provided on a continuum ranging from harm reduction to abstinence-based models.

The following examples describe services within the drug and alcohol treatment setting available to individuals seeking help with their substance use and HIV/AIDS diagnosis. [Please note that these descriptions may vary between funding source (e.g., local, state, federal).]

A. Crisis Intervention

HIV/AIDS substance use crisis counseling services involve person to person contact between a qualified staff person and an identified client in crisis.

B. Information and Referral

This refers to developing and maintaining health, mental health and social service resources in order to offer the most current referrals for the substance using, HIV/AIDS affected individual. Agency staff maintains collaborative and cooperative linkages with public, private and other social, economic, health, legal, vocational and mental health service providers.

Additionally, this service is available to caregivers, family members and/or other individuals affected by the HIV+ person.

C. Educational

This service demonstrates the agency's ability to provide community or individual education on issues of substance use/abuse and HIV/AIDS, in order to improve access to health, mental health and other service for the affected individual. Educational presentations can be in the form of didactic or interactive groups with the goal of assisting individuals to make positive choices for themselves. Information is presented in an appropriate language, gender relevant and culturally sensitive format.

Agencies should provide clients access to educational presentations on a regular basis and transportation if needed.

D. Residential

1. INPATIENT HOUSING SERVICES.

Unique considerations are made for the HIV/AIDS client in a residential setting including:

- Medication availability including convenient access to refrigerator.
- Rest time
- Filtered water to remove the bacteria causing crytosporidiosis
- Nutrition and special dietary needs
- Exercise
- Time for medical management appointments

Staff training and awareness should include issues of drug interactions, such as methadone and HIV medications as well as consideration of complimentary therapy.
Drug interactions with protease inhibitors can increase risks for pancreatitis (alcohol) or increased speed of virus replication (cocaine). It must be stressed that the client be as forthcoming as possible when providing staff information about all substances used prior to admission as well as their HIV drugs take.

2. RESIDENTIAL DETOXIFICATION.

This refers to the inpatient medical services that assist a person suffering from chemical dependency and physiological removal of the intoxicating chemicals in which he or she is dependent. Only licensed facilities, approved by the appropriate local and state authorities and in accordance with current federal and state standards, can provide these services.

- Program length can range from one to thirty days.

3. RESIDENTIAL RECOVERY.

Services provided in a 24-hour residential setting comprised of no less than six hours of planned treatment activities per day under the supervision of trained staff. The goal is to assist individuals to achieve and maintain a lifestyle free of substance use while complying with their personal treatment plan for HIV/AIDS.

- Program length can range from one to eighteen months.

4. Family Residential Recovery.

Services within a residential facility providing rehabilitative services to families, including partners, dependents and dependent children, all of whom are affected by a member of the same family unit who is HIV+ and has a substance use problem.

5. PERINATAL RESIDENTIAL RECOVERY.

This program offers pregnant and parenting women drug and alcohol treatment services within non-institutional residential facilities. These services support women in their efforts to deal with their HIV status as well as to restore, maintain and apply interpersonal and independent living skills and access community support systems.

- Program length generally does not exceed one year.

E. Day Care

Day care is a nonresidential therapeutic service providing a minimum of five hours of planned activities per day at least five days per week. These substance use recovery services provide a planned program in a setting structured to maximize the rehabilitation of clients and are design to be more intensive than an outpatient service. The target population will define the program structure, i.e., (1) substance abusing adults with HIV/AIDS, (2) substance abusing adults with HIV/AIDS and their dependent children or (3) substance abusing HIV/AIDS pregnant and parenting women and their dependent children, (4) substance abusing homeless adults with HIV/AIDS.

F. Outreach Activities

Outreach seeks to engage active substance users for a risk assessment; it generally includes referrals for HIV testing, needle exchange and other harm reduction information. Activities may take place at storefront facilities, from mobile vans or on foot in order to attract and inform individuals in a candid, unstructured manner.

G. Outpatient

Outpatient services provide individuals, pregnant and parenting women, families and the homeless who are affected by substance use and HIV/AIDS with a nonresidential setting for the reduction and prevention of substance use. Specific services may include crisis intervention, group and individual counseling and client referrals. Duration of client treatment is usually for one year. Clients receive individual and group counseling weekly.

H. Outpatient Methadone Detoxification

Methadone detoxification assists individuals who are dependent on heroin or other opiate-based drugs with the gradual withdrawal from the use of these drugs. To facilitate withdrawal, the program administers methadone (a substitute narcotic drug) in decreasing doses to reach a drug free state during a period not to exceed 21 days. Detoxification treatment helps clients to alter their lifestyles and eventually eliminate all dependency on drugs as rapidly as possible.

Adult Los Angeles residents, who are currently physiologically dependent on heroin or other opiate-based drugs, are eligible for these services.

I. Outpatient Methadone Maintenance

Ongoing methadone maintenance is available for those individuals who are currently physiologically dependent on heroin or other opiate-based drugs and have a history of two or more failures in alternative treatment programs. Methadone maintenance provides for the continued administration of methadone in conjunction with appropriate social and medical services. The program dispenses methadone at relatively stable dosage levels for a period in excess of 21 days as an oral substitute for heroin or other morphine-like drugs.

Outpatient methadone maintenance services are available to adults residing within Los Angeles County, diagnosed with HIV disease or AIDS.

J. Residential Transitional Housing

This provides interim housing for persons who are in various stages of recovery from substance abuse. The purpose of transitional housing is to facilitate continued recovery from substance abuse and movement toward more traditional and permanent housing. Although the length of stay varies, it is generally four to six months.

K. Satellite Housing

Satellite housing offers a minimum of six (6) adults and their children a safe, homelike residential facility in a drug and alcohol free environment. A House Manager oversees the day to day operations of the house, including entrance requirements and rent policies. The House Manager coordinates transportation to and from the housing unit and community services, and ensures that residents participate actively in treatment and recovery services.

L. Treatment Advocacy and Education

These HIV-specifics services provide HIV+ individuals with individuals with information about HIV disease, related illnesses, treatment options and available clinical trials. Treatment Advocacy

and Education services assure that people with HIV have appropriate access to services and are supported in their efforts to advocate on their own behalf.

M Transitional or After Care Services

Upon completion of treatment, a substance use/abuse residential program may offer clients transitional or after care services. Other clients utilizing clean and sober living homes or living on their own may also use these services.

After care services provide a safety net for clients who are new to recovery while rebuilding their lives and living with HIV. Services are in the form of individual or group counseling and range from three to twelve months depending on clients needs.

Individual sessions address issues such as:

- Relapse prevention
- Personal budgeting
- Program sponsor work
- Reconnecting or reestablishing support groups
- Redefining sexual identification and behavior
- Maintaining clean and sober status and medication adherence
- Crisis intervention

Pending court dates, getting kids back, dental problems, resumes, etc.

Group sessions can deal with the expression of feeling in a familiar setting known to the clients from their residential status at the program. Ideally transitional or after care services should be provided by a program counselor who is involved with the discharge planning and is familiar with the clients issues at the time of program completion.

V. Harm Reduction

Harm reduction is a non-judgmental approach which views substance use as a social behavior which involves a continuum from experimental use to occasional use to regular use to compulsive use. The belief is that after a period of time, compulsive substance users mature and desire to either discontinue drugs or reduce drug usage. The model does not view substance use as “bad” in and of itself, but believes that people can and do misuse drugs in such a way as to cause bio-psychosocial harm to themselves and/or others. The harm reduction strategy tries to reduce the harmful consequences of substance use from the experimenters to the compulsive users, in a series of objectives that lead to abstinence for those who wish it.

The goal of harm reduction is twofold. One is to reduce the risk of harm that involves substance use. The other is to reduce the risk of HIV infection or reinfection through substance use. The service providers’ goal is to engage substance users in a relationship that can build toward readiness of treatment while educating them on the associated risk, transmission, and danger of infection.

VI. Program Models, Structure and Staffing

A. Program Models

Drug and alcohol services generally are provided in one of three models.

1. Social model which is peer based or paraprofessional
2. Therapeutic community
3. Medical or professional model

Within these models, various levels of education support each model of treatment. All staff directly involved in treatment for people with HIV must have a critical, progressive and demonstrated level of knowledge and training relative to HIV-specific needs and sensitivity issues. Training topics, which can be far ranging and evolving, may include:

- The role of drugs, including non-injection drugs in HIV disease prevention and progression;
- Sensitivity around sexual orientation and gender fluidity;
- Relationships between drug use and sexual expression;
- Current medical treatment, including updates within the last six months;
- Mental health issues specific to people living with HIV;
- Religious and spiritual beliefs which may impact an individual response to HIV;
- Perceived discrimination;
- Cultural issues relative to HIV;
- Housing and homelessness;
- Confidentiality and disclosure
- Knowledge of community resources;
- Benefits, including financial and housing benefits;
- Dealing with various forms of loss; and
- Disposition and aftercare plans

Most important is the ability to integrate these concepts within drug/alcohol treatment services.

B. Structure

Regardless of the type of program model, all staff providing services to the substance abuser who may be HIV+, should receive a minimum of twelve to sixteen hours of HIV training annually.

As drug and alcohol treatment organizations incorporate HIV services in response to clients' needs, a diverse range of structures have emerged to integrate these two areas of care. The focus of a few are described here:

1. **Specialized**: - Providers employ specific HIV/AIDS counselor/s trained to address HIV/AIDS issues within the context of drug/alcohol treatment.

2. **Caseload**: - Within some programs, dual or multiply-diagnosed persons are assigned to specific caseloads, the care for which is correspondingly tailored. Confidentiality sometimes emerges as an issue with this model, and must be strategically addressed to protect client safety.

3. **Staffing:** - In this structure, providers match staff expertise in a given area with client need. Programs address client needs by linking them with corresponding experts within the staff structure or outside community experts and resources through referrals.

Of course, other models have, and will continue to emerge to address the progressively changing needs of substance users with HIV. The harm reduction model would be an example of a developing modality which addresses the needs of an HIV/AIDS client unable or unwilling to achieve abstinence.

C. Staffing

Employment non-discrimination must ensure that employees are treated in accordance with Federal and State affirmative action laws.

The utilization of three critical resources must be evident to achieve responsive, dual-focused care for substance users with HIV: they are peer, paraprofessional and professional. Although not all organizations will include each of these elements in their staffing patterns, agencies must incorporate the value of each, and bring such resources to the treatment environment/setting.

1. **Professional**

The substance abuse professional should possess recognized medical or clinical expertise, usually defined by a Masters degree or higher.

2. **Paraprofessional**

Individuals who have a personal substance abuse history or who have worked in a substance abuse setting and have received some specialized relevant substance use/abuse training. Paraprofessional should be certified as a drug and alcohol counselor and/or HIV counselor.

3. **Peer**

Utilizes common histories and current status as a foundation for cross-support and assistance; which can be provided by a current or former client and is HIV+. This person may have their certification as a drug and alcohol counselor.

a) **Peer Counselors** (PCs) can play a critical role in engaging and sustaining client involvement in their own development and growth. PCs provide encouragement and involvement in the agency's diverse groups, provide information and guidance, and more importantly, provide peers with a creative and constructive method of expressing/advocating for themselves. Agency training must include the following topics:

- Outreach
- New client orientation/assessment
- Buddy system
- Peer to peer support groups
- Knowledge of HIV/AIDS resources
- HIV treatment/education/medical updates
- HIV prevention

PCs are more likely to effectively participate if appropriate training is provided and responsibilities are defined, substantive, and appropriately supervised.

b) **Peer Counselors** (PC) should:

- Demonstrate qualities/behavior of a role model figure (Clients who have completed treatment or in "upper" house of Program)
- Have earned the respect/admiration of the agency
- Possess constructive communication skills
- Be problem solvers
- Be team players with peers, paraprofessionals and professionals.
- Seek professional guidance/assistance when necessary
- Have working knowledge or utilized HIV/AIDS services in the community
- Possess leadership skills

- Self-identify as substance misuser with HIV/AIDS; actively participate in 12-step related fellowships

- Possess networking skills
- Altruism
- Possess knowledge of client confidentiality policy and procedures.
- Possess basic knowledge of HIV disease including prevention and transmission methods of HIV.

VII. Service Responsibilities

A. Initial Screening

The usual contact would be by telephone but could be a walk in with the individual requesting service information, such as the agency location, type of services, hours and so forth. If the caller s in crisis, see Crisis Intervention under Treatment Modalities

At this time, staff determine the status of the substance use and the length of time since the last use. This is done to determine which type of service, i.e., detoxication, residential, etc. and to determine the caller's motivation for treatment or a referral to other, more appropriate services. If the individual offers their HIV/AIDS status and it is positive, and it is determined the person would be appropriate for services, a priority admission status would be assigned to the individual.

Provide the individual with an agency fact sheet describing the funding for their services if they're unable to pay, or if able to pay, the fee for service procedures. Also include information about their rights as a client, the types of forms needing their signature, length of program and other information to review when they are more able to assimilate the many things happening at admission.

Finally, let the individual know a peer advocate or another type of new client helper can be accessed when requested.

Priority Admission For any individual identifying as having HIV/AIDS. This person would be placed on a high priority status for services at the agency.

Assess English language skills and determine the preferred language for services or a need for access to telephonic devices for the deaf (TDD's) and interpreters.

Staff assess transportation needs and facilitate transportation if necessary.

If a child, or children are present, assess the children's needs. Determine if there is a responsible adult, family or friend able to provide supervision r does the agency need to facilitate or provide childcare.

Inquire of the individual if they are aware of any urgent medical care needing attention such as opportunistic infections, TB or any recent surgery needing special attention.

B. Client Assessment

Determine current status and historical information on client's physical and emotional health, alcohol and/or drug use, vocational history, education, legal issues both past and present,

housing, family interpersonal, recreational, support systems, independent living skills and self advocacy skills.

Clients should be referred to a psychiatrist when there is a need for evaluation of treatment with psychotropic medications. Clients with psychotropic symptoms, bipolar symptoms, and
The Client record is the usual form in which client information is maintained. The following is a listing of the basic data necessary for documentation of client services to incorporate into the client record. This listing can be modified based on agency needs or funding source requirements.

INTAKE DOCUMENTATION

1. Demographics

- Name
- Address
- Phone number/emergency contact
- Date of Birth
- Gender/sexual orientation
- Ethnicity
- Primary language
- Special needs, e.g., mobility, hearing impaired, etc.

2. Status and Resources

- Relationship status and dependents
- Insurance status/medical provider and whether private or public benefits, disability status and reason.
- Sources of income, including financial from family and friends
- Fee determination
- Urinalysis testing, when required for drug court, parolee, etc.
- Education completed profession, trade or skill
- Required documentation and/or Client acknowledgement for Client Record
- Proof of self identification
- Medi/Cal
- Driver's License
- Social Security
- Documentation of HIV disease or AIDS diagnosis or an initial, brief overview of how HIV is contracted and transmitted along with an educational brochure.
- TB status

3. Acknowledgements

- Nondiscrimination in Services
- Confidentiality of Client Records
- Child Abuse Reporting Acknowledgement
- Elder Abuse Reporting Acknowledgement
- Dependent Adult Abuse Reporting Acknowledge
- Consent for release of information
- Sexual conduct policy
- Admission/Discharge follow up agreement policy
- HIV/AIDS risk reduction education policy

C. Client Contact/Progress Note

All encounters with the client are documented

- Progress notes should correspond to the treatment plan.
- Enter date, time, and length of contact.
- Type of contact, i.e., group, crisis, phone call
- Relevant information from contact
- Necessary action requested or needed.
- Name and title of staff making the entry, in ink.
- Indicate whether the contact is in person, phone, or letter.
- Frequency weekly.
- Assessment Elements
- Presenting problems
- Medical history and status, includingTB, dental, and vision.
- History of significant hospitalizations. HIV medical history,
- Status, name and phone number of medical provider.
- Current medications and adherence issues, if any.
- Substance use history
- Type of substance
- Duration of use
- Route of administration. Which substance is the major problem?
- Voluntary abstinence history. Over dose history. Detoxification treatment history.
- Employment history and status
- Support system and status
- Relationship status and satisfaction
- Usual living arrangements
  - Do you live with someone who uses drugs and/or alcohol?
  - Number of close friends
- History of emotional, physical, and/or sexual abuse
- Legal history and status
  - Was this program admission a requirement of the criminal justice system?
  - Are you on probation or parole?
  - Have you ever been arrested while under the influence of drugs and alcohol?
- Psychiatric history. Include hospitalizations, previous psychotherapy and
- Any psychiatric medications
  - Do you currently, or have you ever had a significant period (that was not a direct result of substance use) in which you experienced psychological distress?
- Danger to others (Duty to warn)
- Danger to self (Right to warn)
- Danger to property (Right to warn)
- Mental health history and status
  - Suicide ideation
  - Homicide ideation
  - Affect
  - Mood
  - Judgement

Insight
- Orientation times 4: person, place, time and purpose
- Memory: normal or impaired. Test for immediate, recent and remote
- Intellectual functioning/cognition
- Thought process/thought content
- Housing status
- Literacy
  - Reading level
  - Writing level
- Religious/spiritual beliefs
- Experiences with discrimination
- Issues relating to death and dying
- Risk category
- Injection drug user
- Male to male sex
- Non injection substance user
- Heterosexual contact
- Bisexual contact
- Tuberculosis clearance from physician
- Recommended treatment modality(ies)

CLIENT RIGHTS
- Allowed to review own client file
- Program rules and regulations
- Grievance procedures
- Appeal process

D. Treatment Plan

After assessing the individual, a treatment plan is initiated within 30 days. The purpose of a treatment plan is to develop individualized service goals in conjunction with the client and may include a review by a supervisor and/or other program staff.

The treatment plan shall identify client goals and specific steps required to meet the client's needs.

In the event a client has not disclosed or is not aware of their HIV status, assessment of their testing readiness should take place. The client can then receive more intensive education and discussions about HIV and provided the opportunity for HIV testing and counseling.

The treatment plan must be updated with the client and shall include target dates for client and program goal completion. The treatment plan may be updated to include new goals, action steps and target dates based on client needs. Updates should occur on a regular basis, but at least every 90 days.

Included in the treatment plan are referrals to community based organizations such as peer support groups, on-going out-patient counseling, for non substance use issues, vocational services and medical services.

Discharge planning will include: (1) client identification information and date of admission, (2) reason client entered treatment, (3) treatment progress related to problems and goals in the treatment plan, (4) key services provided to address the problems, (5) problems remaining at discharge, (6) type of discharge, examples: treatment complete, AWOP (away without

permission), (7) is aftercare to be provided? Yes/No? (8) discharge date, and (9) disposition and aftercare plans.

If the agency does not have a specific discharge form, the above discharge planning information should be included on the Client contact/progress note format. Samples of treatment plans are included in Section IX.

E. Treatment Services

CRISIS INTERVENTION Determine potential danger to the individual or others or if their substance use is enough to have their current environment threatened, i.e., eviction, physical harm or job loss. At this time, appropriate staff would assess lethality risk.

- Assessment of precipitating factor(s)
- Assessment of lethality risk
- Take control of the situation based on risk assessment

1. If low risk (does individual have thoughts of hurting self or others;) develop a no suicide contract and conduct a daily check in

2. If medium risk (does individual have the means to hurt self or other, i.e., more drugs and/or a weapon) refer to voluntary residential or in-patient. :

3. If high risk (imminent danger to self or others and/or has a plan and the means). This category always requires involvement with the Psychiatric Emergency Team (PET) or the police/paramedics via 911

INDIVIDUAL COUNSELING Also referred to as psychotherapy. May be either short term at one to ten sessions or long term which is usually twenty sessions or more and can address such issues as:

- Client's desire to reduce substance use or work towards a substance free life style;
- The impact of HIV/AIDS and how it interacts with substance use and the clients desire for a more meaningful lifestyle;
- Co-existing mental health concerns, such as depression, incest and issues of grief;
- Loss, all of which can affect the individual's desire to more effectively deal with their substance use; and
- Cross addictions. sobriety in one area does not always equal sobriety in every area of one's life. (Examples are substance use and sexual addiction or compulsive gambling.)
- Relapse: can be a normal part of the recovery process. The client should be prepared for the possibility of relapse and with the counselor develop coping strategies in event of such a possibility.

COUPLES COUNSELING Sessions take place between a counselor or therapist and any two people who define themselves as a couple. Couples counseling can address such issues as: Interaction between substance use and domestic violence.

- Sero different couples
- HIV and substance use
- Substance use and sexual issues
- Substance use and parenting
- Grief and loss between the couple
- Domestic violence

FAMILY COUNSELING Sessions take place between a counselor or therapist and consist of a minimum of one adult and one child infected or affected with HIV/AIDS and dealing with substance use in the family system. Family counseling can address such issues as:

- Parenting
- Co-dependency
- Family roles
- Conflict resolution
- Housing and access to food.
- Community support services for various family members such as Alateen, Alanon, Big Brothers/Sisters.

GROUP COUNSELING Sessions which are facilitated by one to two counselors and typically four to ten participants. Group are process oriented and may be didactic or psychoeducational.

These groups often begin with the facilitator presenting prepared materials to the group members in order to educate and assist the participants in making better life decisions and more informed choices. Participants then have a more meaningful understanding of such topics as:

- HIV/AIDS and substance use
- Risk behaviors and substance use
- Interactions between HIV medications and substance use
- Sexual identify and substance use
- Identifying triggers for relapse
- Unique aspects of women's recovery issues

F. Support Groups

May either be peer facilitated or professionally led and provide individuals an opportunity to discuss such issues as:

- Gender specific groups
- Family support groups
- Bereavement groups
- 12-step meetings: referrals to Alcoholics Anonymous, Cocaine Anonymous, Narcotics Anonymous, Marijuana Anonymous, Crystal-Meth Anonymous, Sexual Compulsion Anonymous

G. Treatment Linkages

While many referrals are provided in house, many substance use providers make appropriate referrals based upon an assessment and needs of the individual client. Valuable linkages can be made with the following services providers

TREATMENT ADVOCATE/EDUCATOR On behalf of client, works with health care professionals to address the client needs for proper treatment information, to understand medications, treatment modalities, and interpret laboratory reports. This service helps to empower people living with HIV/AIDS to make conscious, well informed decisions regarding their treatment and care. The Treatment Advocate also informs and educates the client on all available clinical trials which may benefit the client.

MEDICAL PROVIDER This referral requires the appropriate consent to release information from the client. The substance use counselor works closely with the medical providers, case managers and other members of the client's treatment team to support the integration of services for the client. It is important for the treatment team to make certain that clients are referred to medical providers who have an extensive knowledge of HIV/AIDS and substance use and understand the significance of interactions between the diseases of HIV/AIDS and substance use.

CASE MANAGEMENT Many individuals with HIV/AIDS and substance use may benefit from case management. Case management addresses such basic needs, but it not limited to, food, shelter, transportation, public benefits and other appropriate HIV/AIDS services. The case manager can be instrumental in locating suitable services, as noted above, based on the unique need of the individual client.

NUTRITION In assessing or treating clients with HIV and substance use health care professionals should evaluate such concerns as appetite, recent weight changes, eating disorders, hypertension, dehydration, constipation, mealtime regularity, amount of sugar, caffeine and nicotine consumed, 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 who specializes in HIV nutrition. Nutrition intervention, education and counseling are essential from the start of treatment. Clients benefit from a referral to a registered dietitian who can provide a nutritional assessment, education regarding the importance of nutrition in the treatment of HIV and substance use, symptom management, weight management, preservation of lean body mass, behavior modification counseling, discuss various nutritional services available and provide follow up services.

Clients shall only be referred to agencies known for their demonstrated knowledge and expertise in resources for people living with HIV/AIDS.

VIII. ETHICAL AND LEGAL ISSUES

A. Confidentiality

All HIV/AIDS substance abuse providers shall hold in confidence all information obtained in the course of professional service. Separate and specific releases that include to whom the disclosure is to be made, the purpose of the disclosure and the beginning and ending dates of the client authorization shall be signed by the client and all outside parties, going both ways, involved in the receipt and sharing of the information.

Exceptions to confidentiality are when clients divulge to professional staff any known cases of suspected child/dependent adult/elder abuse. Furthermore, the professional may break confidentiality if it is determined that the client is a potential danger to self or others. This would involve the client's disclosure of a specific homicidal or suicidal plan directed at themselves or an identified, intended victim along with the weapon, plan and means.

Any references to the client's HIV/AIDS status should be kept in the clients file when it is required by the funding source. Should the client file be subpoenaed, a copy should be made and any references made to the client's HIV status must be blacked out with a marker and the file must then be hand carried to the legal venue by an agency representative. The client's HIV status and medical data should be maintained in the medical section of the client file or in a separate medical file altogether.

Issues regarding the confidentiality of the clients HIV+ status must be dealt with by agency staff on a regular basis. In residential settings, having individual bottles of filtered waters, being

excused from chores or program activities make it almost impossible to maintain the clients desire for individual confidentiality.

It may be more helpful to examine or question with the client their need for confidentiality and/or secrecy. Further, having group and/or individual discussions with other clients regarding judgmental attitudes may be beneficial.

B. Dual Relationships

This situation can occur in settings where clients are counseled by either professional or peer counselors. Special attention should be paid to a situation where one peer is elevated to a responsibility to communicate privileged information to the agency.
Examples:

- keeping secrets
- withholding information which could jeopardize the client or the program
- special relationships such as secret or sexual relationships
- relationships with clients that involve money or business deals
- to acknowledge a client in public as being somebody in treatment
- receiving gifts

C. Competency and Professional Development

All providers involved in the treatment of substance users should strive to become, and remain, proficient in professional practice and the performance of professional functions. This would include regular agency and individual training on appropriate substance use and HIV/AIDS subjects and updates.

D. Primary of Client's Interest

The provider's primary responsibility is to provide comprehensive and responsive HIV substance use care to the client.

It is the ethical responsibility of the provider to make certain the client has been informed of the availability of a treatment advocate/educator and how this service will assist the client in fostering maximum self determination in the treatment of their HIV/AIDS medical care.

E. Self Determination

The provider should make every effort to foster self determination on the part of the client.

F. Maintaining Appropriate Boundaries

It is the counselor's responsibility to be aware of their personal feelings toward the client and the client's personal feelings towards the counselor, which may impact the therapeutic relationship.

IX. Sample Forms

A. See Attached Sample Forms