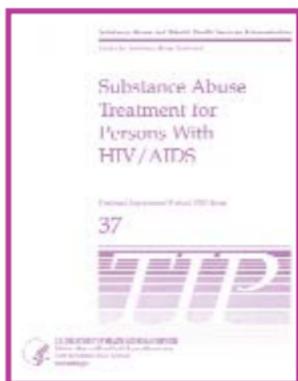


# Quick Guide

## *For Clinicians*

**Based on TIP 37**

***Substance Abuse Treatment  
For Persons With HIV/AIDS***



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Substance Abuse and Mental Health Services Administration  
Center for Substance Abuse Treatment  
[www.samhsa.gov](http://www.samhsa.gov)

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# Quick Guide

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## *For Clinicians*

### **Based on TIP 37**

### *Substance Abuse Treatment For Persons With HIV/AIDS*

This Quick Guide is based entirely on information contained in TIP 37, published in 2000. No additional research has been conducted to update this topic since publication of the original TIP.

## WHY A QUICK GUIDE?

The purpose of a *Quick Guide* is to provide succinct, easily accessible information to busy substance abuse treatment practitioners. This *Quick Guide* is based entirely on *Substance Abuse Treatment for Persons With HIV/AIDS*, number 37 in the Treatment Improvement Protocol (TIP) Series, published by the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA).

The *Quick Guide* is divided into 10 sections (see the Table of Contents) to help readers quickly locate relevant material.

Terms related to HIV/AIDS are listed at page 32 in the HIV/AIDS Glossary. Some of them are used in this *Quick Guide*, but many are included to enable clinicians to talk knowledgeably with their clients and clients' medical providers, as well as to comprehend medical reports. Using the resources in the Phone and Internet Resources section at page 30 can keep clinicians updated with current information on the most recent developments in the rapidly changing field of HIV/AIDS treatment.

For more information on the topics in this *Quick Guide*, readers are referred to TIP 37.

## WHAT IS A TIP?

The TIP series was launched in 1991. The goal of these publications is to disseminate consensus-based, field-tested guidelines on current topics to substance abuse treatment providers.

### *TIP 37, Substance Abuse Treatment for Persons With HIV/AIDS*

- Addresses concerns of a broad range of readers including administrators, clinicians, policy-makers, medical personnel, and mental health workers
- Includes extensive, up-to-date research
- Lists numerous resources for further information
- Provides a comprehensive reference on substance abuse treatment for people with HIV/AIDS

*To order a copy of TIP 37 and other TIP products, see the inside back cover of this Quick Guide.*

## **INTRODUCTION**

The Centers for Disease Control and Prevention (CDC) estimates that between 650,000 and 900,000 people in the U.S. are living with HIV. Many people who are infected don't know it.

### **HIV/AIDS and Substance Abuse**

HIV is most easily transmitted by exposure to contaminated blood. As a result, injection drug users make up the largest HIV-infected group of substance users in the U.S. However, all drug users are at high risk for HIV. Drug use can result in poor judgment, leading to unprotected sexual contact with infected partners and to sharing of infected injection equipment.

### **The Role of Substance Abuse Treatment**

Substance abuse treatment can be critical in helping to reduce the number of new HIV infections. Counseling substance-abusing, HIV-infected clients is a challenge for every clinician. Flexibility and a willingness to develop new skills are essential. Clinicians will encounter clients with a variety of ethnic and cultural backgrounds, economic statuses, ages, sexual orientations, and lifestyles. Each client's particular circumstances should be explored to avoid misunderstandings.

Clinicians are in a prime position to educate clients about HIV/AIDS. They also can assist clients who need referrals for HIV testing, treatment, and counseling.

### **Substance Abuse and HIV/AIDS**

People who receive proper treatment for HIV can lead long and productive lives that include abstinence from substance use. Although it might take time before a client can discuss abstinence as a goal, the clinician should stress that alcohol and drug use can

- Interfere with HIV medications and the body's immune system
- Lead to unprotected sexual practices and sharing infected injection equipment

### **Collaborations**

To provide high-quality care for clients with HIV/AIDS, it is important for substance abuse treatment programs to develop collaborative networks with

- Medical providers
- Mental health personnel
- Public health officials

*(For more information, see TIP 37 pp. 103–116.)*

## RISK FACTORS AND PREVENTION

Clients usually express a wish to avoid getting HIV and, if they have it, to avoid infecting others.

However, as with substance abuse, denial of HIV risk-taking activities can be extreme. Clients can have unprotected sex with multiple partners (even ones whom they know are HIV positive) and still believe that they are **not** at risk. There are many myths surrounding HIV/AIDS that support denial. Clinicians who are aware of these myths can provide information to discredit them.

**Myth:** If you are HIV positive, it does not matter what behaviors you engage in because you are already infected.

**Truth:** It does matter. Different individuals can be infected with different strains of HIV. Becoming reinfected with a new strain of HIV (in addition to an earlier strain) greatly increases one's chances of becoming resistant to medications.

**Myth:** You can avoid HIV if you are careful and avoid repeated risky behaviors.

**Truth:** The use of latex condoms will greatly reduce the risk of becoming infected through sexual practices. However, even one exposure to the HIV virus can introduce it into your body where it will start replicating and spill out into the bloodstream in 3 to 5 days. HIV can infect anyone who

has unprotected sex with, shares injection drug equipment (see Glossary) with, or otherwise exchanges bodily fluids with someone who has the virus.

**Myth:** You can tell whether your sex (or injection) partners are infected.

**Truth:** Most people with HIV don't look or feel sick and don't even know they have it. A person can be infected with HIV and show no symptoms for 10 years or longer.

**Myth:** As long as you get treated for any sexually transmitted diseases, you won't get HIV.

**Truth:** No current treatment can cure or prevent HIV. Treating other infections reduces the risk of HIV infection, but the chances are still high of getting HIV through unprotected sex, sharing drug injection equipment, or otherwise exchanging bodily fluids.

**Myth:** Washing after sex will prevent HIV.

**Truth:** Douching and washing will not prevent HIV.

**Myth:** If you don't share syringes, you can't catch HIV.

**Truth:** Although it is a good idea to avoid sharing syringes, HIV can also be spread through shared cookers, filters, and prepared drugs.

### **Risk Assessment Checklist**

Use these questions to discuss risky behaviors:

- Within the past 3 to 6 months, have you had unprotected
  - Vaginal sex?
  - Anal sex?
  - Oral sex?
  - Sex for money?
  - Sex for drugs?
  - Sex with more than three people?
  - Sex with an injection drug user?
  - Sex with someone you think has HIV/AIDS?
- When you have sex, do you sometimes or never use condoms?
- Do you use drugs before sex?
- Do you use drugs after sex?
- When you use drugs, do you
  - Use syringes?
  - Share syringes?
  - Clean your works?

- Use crack or powder cocaine?
- Use several drugs at the same time?

If your client answers positively for half or more of these questions, then your client has a **high** risk of having HIV or getting HIV if he or she continues current practices.

### **Preventive Measures**

Clinicians can encourage clients to adopt these HIV prevention measures:

- Use condoms
- Don't share syringes
- Use new syringes
- Disinfect drug paraphernalia
- Get proper medical care before, during, and after pregnancy
- Elect to have cesarean delivery
- Avoid reinfection
- Observe universal precautions as directed by the CDC (see Glossary)
- If exposed, begin postexposure prophylaxis (see Glossary)

### **Risk-Reduction Counseling**

In promoting risk reduction, the clinician's goals are to

1. Help and support the client in understanding the need for behavior change
2. Assist the client in addressing cultural practices or beliefs that might contribute to resisting change
3. Assist the client in developing the appropriate skills to sustain behavior change

*(For more information, see TIP 37 pp. 93–101.)*

## **HIV TESTING**

### **Counseling and Testing**

Any client who has engaged in behavior that puts him or her at risk for contracting HIV should be encouraged to get testing. All pre- and posttest counseling should be performed by a trained HIV clinician. Counseling before and after HIV testing should

- Explain the limitations of HIV tests
- Help clients assess their risks
- Encourage and reinforce behavior change
- Refer infected clients for medical care

There are several types of HIV tests available:

- ELISA (enzyme-linked immunosorbent assay) (typically used as a first test)
- Western blot (typically a second test)
- Rapid HIV tests
- Home sample collection tests

It can take up to several weeks to obtain results from standard HIV tests (i.e., ELISA, Western blot). Rapid tests can provide results in hours.

If a client tests *positive*, a second test is needed to confirm the result. If a client tests *negative*, a second test is needed in about 6 months to make sure the first test was not a false-negative.

Clinicians should find out about HIV testing in their States and the options available to clients. All States and most Territories have a toll-free AIDS hotline and an office of AIDS in the public health agency.

### **State Reporting Requirements**

Clinicians should be familiar with the HIV/AIDS reporting requirements for the State in which they work. All States require AIDS cases to be reported to public health authorities. Some States also require that new cases of HIV infection be reported. The reports are forwarded to the CDC. State

laws vary regarding whether reports must include client-identifying information.

### **If the Client Is HIV Infected**

If a client tests positive, more testing is needed to determine the disease progression. Physicians use two measurements to determine this:

- The CD4+ T cell count (see Glossary)
- The viral load count (see Glossary)

### **If the Client Is Not HIV Infected**

If the client tests negative, the clinician should inform the client how he or she can best remain uninfected.

*(For more information, see TIP 37 pp. 5–7; 3–35; Appendix F.)*

## **MEDICAL ISSUES**

### **Adherence to HIV Medication Regimens**

Medication adherence is critical because it is likely that the first combination of medications prescribed for the patient will be the most effective. A client who adheres to medications will

- Likely have a more healthy, longer life
- Help prevent the development of drug-resistant strain(s) of HIV

Factors that might contribute to a client's failure to take medications include

- Relapse into substance use
- Living in an institution (e.g., halfway house, homeless shelter, prison)
- Psychiatric disorders
- Side effects

The key to encouraging adherence is education for both clients and their families or significant others. Clinicians should help clients become familiar with the generic and brand names of all the medications they take. If clients experience unpleasant side effects, they should be encouraged **not** to stop taking medications without talking to their doctors.

### **Techniques To Help Clients Adhere to Medication Schedules**

- Repeat instructions for taking medications.
- Put the medication schedule in writing.
- Use a timer to make sure medications are taken at the proper time.
- Use lists that clients can post on a mirror.
- Give positive feedback to the client.

- Ask support people (e.g., case managers, family members) to reinforce the importance of taking medications on time.
- Use visual tools (e.g., pictures of pills) to help illiterate or non-English-speaking clients.

In addition, support groups to connect clients with other clients facing similar problems can be effective for maintaining adherence.

It is also important for substance abuse clinicians to work with their clients' physicians. If they obtain appropriate consents to disclosure of confidential information, clinicians can inform physicians of clients' relapses. Physicians should know when clients relapse into substance use because it can affect clients' adherence to drug treatment. Clinicians also can help physicians determine clients' living patterns so that medications are chosen that fit clients' lifestyles.

### **Drug Resistance**

If a client stops taking HIV drugs, HIV can become resistant to those drugs, limiting medication options. This means that the discontinued drug is no longer effective for that client. These drug-resistant viruses can then be given to others. HIV can also become resistant to a family of drugs (i.e., cross-resistant).

Clinicians can help their clients avoid drug resistance by discouraging them from

- Taking only some of their pills
- Taking “drug holidays”
- Skipping doses
- Stopping medication without consulting a doctor

### **Drug Interactions**

The most common drugs used to treat substance abuse are methadone, disulfiram, buprenorphine, and naltrexone. Clients with HIV can use these drugs the same as other clients. However, they should be observed for potential interactions between these drugs and their HIV medications. The most documented interactions are between HIV drugs and methadone. See below for a list of HIV drugs and how they may interact with methadone.

### **Methadone Interactions With HIV and Other Medications**

*Significantly reduces methadone levels*

- Rifampin
- Dilantin
- Phenobarbital

*Reduces methadone levels*

- Carbamazepine
- Ritonavir
- Rifampin
- Nevirpine
- Efavirenz

*May raise methadone levels*

- Alcohol
- Delavirdine
- Fluconazole

*May affect methadone levels*

- Nelfinavir

*No significant effect on methadone levels*

- Clarithromycin/Azithromycin
- Didanosine
- Lamivudine
- Saquinavir
- Stavudine
- Trimethoprim/Sulfamethoxazole
- Zalcitabine
- AZT

## **CULTURE/GENDER/SEXUALITY**

To provide the most effective treatment, a clinician should develop sensitivity to each client's culture, gender, sexual orientation, age, race, and ethnicity. Clinicians should work to ensure that clients are not excluded from, or do not prematurely withdraw from, treatment because of culture, gender, sexual orientation, age, racial, or ethnic issues.

### **Considerations When Counseling Clients From Different Cultural Groups**

- The socioeconomic status of the client; that is, whether poverty is a relevant issue and whether it affects the client's illness.
- The client's degree of acculturation; that is, how many generations of the client's family have lived in the United States.
- The heterogeneity of cultural, racial, and ethnic groups. Hispanos/Latinos, African Americans, and Asian/Pacific Islanders originate from many countries. There are 557 federally recognized tribes of Native Americans.

Each client is unique, not a stereotypical representative of a culture, gender, sexual orientation, age group, ethnicity, or race.

### **Cultural Beliefs and Values That May Influence Health Practices**

- Role of the family in treatment
- Importance of spirituality in treatment
- Degree of trust in the health care system
- Views toward injection drug use and unprotected sex, two major means of HIV transmission
- Reliance on verbal communication in medical treatment
- Ways in which safer sex practices are negotiated

Knowledge and attitudes about HIV/AIDS can also influence clients' health practices.

### **Gender Issues**

- A woman's identity as caregiver to others is a powerful factor in her reluctance to seek testing and counseling for HIV.
- Women have special issues regarding HIV/AIDS and reproductive decisionmaking.
- Gay, lesbian, bisexual, and transgender clients deal with the social stigma of their sexual orientation and/or gender roles.

### **Homophobia Questionnaire**

Homophobia is an irrational aversion to gay men and lesbians and to their lifestyles. The following

questions can be used by clinicians as a self-assessment or with clients. The goal of the questions is to increase sensitivity to, or knowledge of, lesbian and gay issues.

- Do you think that people can influence others to change their sexual orientations? (Answer: No one can cause another to change sexual orientation.)
- Do you think someone could influence you to change your sexual orientation?
- If you are a parent, how would you (or do you) feel about having a lesbian daughter or gay son?
- How do you think you would feel if you discovered that one of your parents, a parent figure, or a sibling were gay or lesbian?
- Would you go to a physician whom you knew or believed to be gay or lesbian if the physician were a different gender from you? If the physician were the same gender as you? If not, why not?
- Can you think of three positive aspects of a lesbian or gay lifestyle? Can you think of three negative aspects of a heterosexual lifestyle?

For both clients and clinicians, being aware of homophobic reactions is the first step in confronting these feelings and working to understand them.

### **LEARN Sensitivity**

The LEARN model is a helpful communication tool to develop sensitivity to cultures and genders.

- **L**isten with empathy and understanding.
- **E**licit cultural information from the client.
- **A**cknowledge and discuss differences and similarities between cultures.
- **R**ecommend action, treatment, and intervention that incorporate cultural knowledge.
- **N**egotiate agreements and differences in partnership with the client.

### **The Facts**

HIV/AIDS affects people of all ethnicities, cultures, sexual orientations, genders, and ages. Providing counseling to women, MSMs (men who have sex with men), and people from minority cultural groups is becoming more important as HIV/AIDS increasingly affects these groups.

- HIV prevalence is higher among African Americans and Hispanos/Latinos than in other ethnic groups.
- Minority MSMs are disproportionately affected by HIV/AIDS.
- HIV diagnoses among women, youth, and children of all ethnicities are increasing.

*(For more information, see TIP 37 pp. 131–158.)*

## **COUNSELING CONSIDERATIONS**

### **Relapse Prevention**

Certain HIV/AIDS milestones may initiate client relapse. With assistance from clinicians, these milestones can be used to provide an impetus for developing new coping skills and strategies:

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

Clinicians can suggest the following strategies to clients who are at risk of relapse because of HIV/AIDS-related fears and concerns:

- Participation in a peer support group
- Medical attention for serious discomfort
- Relaxation and stress management
- Recreational activities, if physically able

### **Group Therapy**

To assist clients in examining their HIV risk-taking behavior and its impact on others, consider asking the following questions to promote group discussion:

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

- Do people close to you ever talk about HIV/AIDS? What do they say?

Consider organizing separate groups for

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

### **Death and Dying**

Death and dying are very hard topics for everyone. Counselors should ask for help from supervisors and other staff about how to talk with clients about death and dying issues:

- Loss
- Unfinished business
- Pain management
- Religious and cultural traditions

Clinicians should inform clients what to expect about the process of dying, if and when they want to know about it. More information is available from local AIDS resource groups.

Hospice staff are skilled in caring for those in the last stages of terminal illness. Clinicians can

arrange hospice services for clients if needed. They should also explore the advisability of providing ongoing counseling services while clients are in hospice.

Clients can be encouraged to:

- Make a will
- Arrange for child custody
- Decide about health care directives (e.g., DNR [Do Not Resuscitate] orders)

Healthy people also often make plans for unexpected illness or death.

### **Grief and Bereavement**

It may take a client time (a year or two) to cope with the death of another (bereavement) or with finding out that he or she is terminally ill.

People often go through five stages when coping with death or loss: (1) denial, (2) anger, (3) bargaining, (4) depression, and (5) acceptance.

**Remember:** Clinicians are often most helpful by simply being with clients and reassuring them that

their reactions are acceptable and understandable. Clinicians can also

- Acknowledge deaths (e.g., by attendance at memorial services, if appropriate)
- Encourage the expression of grief both verbally and nonverbally (e.g., in art therapy)
- Provide group support for clients and significant others experiencing grief/bereavement
- Help clients leave a legacy of living memories (e.g., video or cassette recordings for others)

The National Hospice Organization has an excellent library of grief and bereavement materials, including age-appropriate materials for children.

*(For more information, see TIP 37 pp. 160–171.)*

## **COLLABORATION AND CASE MANAGEMENT**

Clients with both substance abuse disorders and HIV/AIDS may need a number of services.

Essential participants in an effective care network include

- Medical doctors and other health care workers
- Hospice services

- HIV organizations and support groups
- Local health departments
- Legal assistance providers
- Agencies providing housing, financial assistance, medical care funding, and/or medications
- Mental health providers
- Members of the criminal justice community
- Spiritual caregivers

### **Case Managers**

The case manager is an indispensable part of a smooth and efficient network of care providers. Clinicians should develop case management skills of their own or learn to assist someone from their own or another agency who is performing the role of the case manager.

### **Role of Clinicians**

Part of the clinician's function in a collaborative network is to educate other service providers. Team members may need help to recognize the competing demands involved in assisting a client to meet substance abuse recovery goals while also treating his or her HIV infection.

In counseling sessions with clients, clinicians should ask questions to make sure clients are getting the medical care they need and that they understand their treatment. Use the questions below to find out whether clients are receiving adequate medical care.

- Do you have a doctor?
- How often do you see your doctor?
- What do you see your doctor for?
- Are there any physical problems that you don't discuss with your doctor? What?
- Has your doctor prescribed medications for you? What medications? Or, may I see them?
- Can you tell me what each medication is for and when you take it?
- Are you having any problems taking your medications?
- Are you satisfied with your medical care and your doctor?

*(For more information, see TIP 37 pp. 117–120.)*

## HIV/AIDS LEGAL ISSUES

### Counselors and Clients Need To Know

- Equal access to health care and substance abuse treatment is guaranteed to HIV/AIDS patients by Federal law.
- All cases of AIDS must be reported to public health officials. The details of reporting (such as using codes rather than identifying information) vary by State.
- Some States also require that new cases of HIV be reported to public health officials. Like AIDS reporting, the reporting requirements for HIV vary by State.
- Confidential HIV/AIDS information may be disclosed to specified persons **if** the client has given written consent. (See *TIP 37 pp. 194–198.*)
- States have additional laws mandating reporting of other behaviors related to HIV/AIDS such as threats and alleged exposures.

### Disclosure and Consent

- State laws regulate the disclosure of patient information related to HIV/AIDS.
- These laws differ from Federal laws that govern consent to disclose substance abuse-related information.

**Alert to Counselors**

- Laws vary among States. Clinicians should be aware of the laws that affect their work with substance-abusing HIV/AIDS clients.
- Clinicians should not give legal advice to clients.
- Neither TIP 37 nor this Quick Guide is a substitute for competent legal advice from a qualified attorney. If legal issues arise, consult counsel. Insist that clients seek their own legal counsel.

**Legal Resources**

- State Department of Health
- Single State Authority for Substance Abuse and/or Mental Health Services
- State Attorney General
- Local bar associations
- Agency board members who are attorneys
- Local advocacy groups for people living with HIV/AIDS
- Local law schools

*(For more information, see TIP 37 pp. 185–212.)*

## PHONE AND INTERNET RESOURCES

The Body

<http://www.thebody.com>

Centers for Disease Control and Prevention

(800) 311-3435; <http://www.cdc.gov>

Gay Men's Health Crisis (800) 243-7692;

<http://www.gmhc.org>

Harvard AIDS Institute (617) 432-4400;

<http://www.hsph.harvard.edu/Organizations/hai>

JAMA HIV/AIDS Resource Center

<http://www.ama-assn.org/special/hiv/>

National AIDS Treatment Advocacy Project

(212) 219-0106; <http://www.natap.org>

National Association of People With AIDS

<http://www.napwa.org>

Office of Minority Health Resource Center

<http://www.omhrc.gov>

### **National Hotlines for Persons With HIV/AIDS**

National AIDS Hotline (800) 342-2437

National AIDS Hotline (Spanish) (800) 344-7432

National Immunization Hotline (800) 232-2522

National Immunization Hotline (Spanish)  
(800) 232-0233

National STD Hotline (800) 227-8922

### **Funding Information**

AIDS Education and Training Centers  
<http://www.hab.hrsa.gov/educating.htm>

CSAT, Division of State and Community Assistance  
(301) 443-3820

The Foundation Center (800) 424-9836;  
<http://fdncenter.org>

Funders Concerned About AIDS (FCAA)  
(212) 573-5533

### **Housing**

AIDS Housing of Washington  
[info@aidshousing.org](mailto:info@aidshousing.org)

HUD's National Homeless Assistance Hotline  
(800) HUD-1010 or (800) 483-1010

HUD's Super Notice of Funding Availability  
(800) 483-8929 or (800) 483-8209 (TDD)

### **The Ryan White CARE Act**

HRSA Grant Application Center (877) 477-2123;  
<http://www.hrsa.gov>

Title I Information (301) 443-9086

Title II Information (301) 443-6745

Title III Information (301) 443-0735

Title IV Information (301) 443-9051

*(See TIP 37 Appendix F for further information.)*

## **HIV/AIDS GLOSSARY**

### **AIDS (acquired immunodeficiency syndrome):**

AIDS is the end stage of HIV disease and is characterized by a severe reduction in CD4+ T cells. At this point, an infected person has a very weak immune system and is vulnerable to contracting life-threatening infections. AIDS is inevitably fatal.

**Antiretroviral:** A medication that weakens or halts the reproduction of retroviruses such as HIV.

**CD4+ T cell count:** The number of CD4+ T cells in a milliliter of blood. These cells (white blood cells within the immune system) are continually measured in HIV-infected clients because their number reflects the overall health of the immune system.

**Combination therapy:** The treatment of HIV disease with multiple medications. Combinations of three or more different medicines are used to treat a client, with each medicine working in a different way to completely stop the virus. This is the most effective treatment for HIV. However, once combination therapy is begun, it must not be stopped because the virus can then develop resistance to these medications.

**Cross-resistance:** Resistance that can develop in the HIV virus once a medication from a certain class is used (e.g., protease inhibitors) to treat it. The virus not only becomes resistant to one particular drug but also becomes resistant to some or all of the other drugs from that class. For this reason, it is widely believed that the best chance for success in HIV treatment is with the first treatment regimen.

**HAART (highly active antiretroviral therapy):** Aggressive combination therapy that usually includes a powerful protease inhibitor medication.

**HIV (human immunodeficiency virus):** The retrovirus that causes AIDS in humans. HIV is transmitted through direct contact with human bodily fluids. Roughly 10 years after infection, AIDS-defining conditions begin to occur. New medicines can control HIV and extend the life of the patient.

**Injection drug equipment:** Includes all drug paraphernalia (such as syringes, cookers, and filters) as well as prepared drugs.

**Opportunistic infection:** An infection that usually does not harm a healthy person but can cause a life-threatening illness in someone with a compromised immune system.

**Postexposure prophylaxis (PEP):** Antiretroviral therapy that is administered within 72 hours after exposure to HIV in an attempt to eradicate the virus from the body. PEP treatment may continue for up to 1 month.

**Protease inhibitor:** A group of powerful drugs used in combination therapy that slows or halts the replication of HIV.

**Universal precautions:** Guidelines provided by the CDC and other organizations establishing the necessary standard of practice for all settings in which exposure to bodily fluids is a potential hazard (see TIP 37 p. 100 for a list of precautions).

**Viral load:** The level of HIV circulating in the bloodstream. This level becomes very high soon after initial infection, then drops to normal levels. It again becomes very high with the onset of AIDS. Drug therapy can keep viral load low or undetectable, but the client can still infect others

because the virus still exists—it is simply not visible. Even when testing reveals a low viral load, HIV continues to live inside certain cells in the body and can begin reproducing at any time if the infected person is not on effective treatment.

*(For more terms, see TIP 37 Appendix B.)*



# Ordering Information

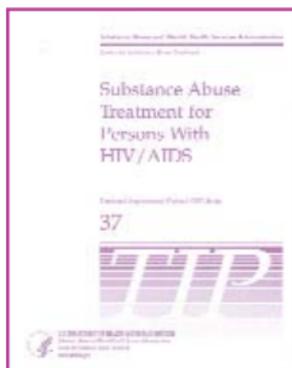
## **TIP 37** *Substance Abuse Treatment for Persons With HIV/AIDS*

### **TIP 37-Related Products**

**Fact Sheet (MS676)**

**TIP Preview (MS677)**

**Quick Guide (MS678)**



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### **Easy Ways to Obtain Free Copies of All TIP Products**

1. Call SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at **800-729-6686**, TDD (hearing impaired) **800-487-4889**
2. Visit CSAT's Web site at **[www.csat.samhsa.gov](http://www.csat.samhsa.gov)**



## **Other Treatment Improvement Protocols (TIPs) that are relevant to this Quick Guide:**

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**TIP 6**, *Screening for Infectious Diseases Among Substance Abusers* (1993) **BKD131**

**TIP 11**, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases* (1994) **BKD143**

**TIP 27**, *Comprehensive Case Management for Substance Abuse Treatment* (1998) **BKD251**

**TIP 35**, *Enhancing Motivation for Change in Substance Abuse Treatment* (1999) **BKD342**

**TIP 42**, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (2005) **BKD515**

**See the inside back cover for ordering information for all TIPs and related products.**