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Chapter 6—Accessing and Obtaining Needed Services

The HIV-infected substance abuser can have multiple psychosocial and medical care needs that require extensive community resources. In areas where few or no resources exist, the treatment professional may have to be especially creative in working within existing systems. Because of the number of issues encountered in both substance abuse and HIV/AIDS, this chapter emphasizes the case management approach in dealing with this client population and encourages cooperation between mental health and HIV/AIDS service systems. Facts about general categories of resources are also provided to assist the substance abuse treatment professional with information on possible services.

The Use of Case Management To Coordinate Care

The term "case management" has been used to describe a wide range of interventions for a diverse number of populations. Mental health, aging, developmental disabilities, and primary care are just a few examples of systems that use a case management approach. For the purposes of this chapter, case management is the term used for coordinated care of the HIV-infected substance abuser and involves attempting to meet the multiple psychosocial and physical needs of individuals seeking assistance.

The purpose of case management is to ensure that all the needs of an HIV-infected substance abuser are recognized and met in a coordinated manner and that there are no gaps in, or duplication of, services provided by the many professionals who are involved in meeting the client's needs. When gaps do occur in services, this should not be because a need or resource was overlooked but because the resource was unavailable. In short, the purpose of case management is to make working with the client more efficient and more effective.

A case management approach recognizes that obtaining basic needs when an individual is actively using substances can be overwhelming and that substance-abusing behavior impairs a person's ability to gain access to a formalized system of services (Lidz et al., 1992). Drug abusers often have multiple, chronic problems beyond the need for substance abuse treatment alone, which require the coordination of services that case management provides (Bokos et al., 1992). The multiple problems often experienced by a substance abuser such as poor health, lack of housing, and a transient lifestyle can also inhibit seeking treatment (Cox et al., 1993). Not only does a case management approach provide realistic support for an individual's needs, but it has the potential to enhance the effectiveness of reatment by helping to manage the life stressors that can impede treatment progress (Graham and Timney, 1995).

Prevalence and Impact of Case Management Programs in Treatment

While there has clearly been a trend in substance abuse treatment programs toward integrating case management into the repertoire of interventions (Brindis and Theidon, 1997), there is still little information about the outcome of such interventions with substance abusers, especially those with HIV/AIDS (Brindis et al., 1995). Studies have suggested that case management may improve health care access and delivery of services to injection drug users and also may decrease a drug abuser's risks for HIV infection and thus lengthen survival time (McCoy et al., 1992). Case management also has been shown to help injection drug users gain access to treatment (Bokos et al., 1992).

A more recent study demonstrated that injection drug users receiving case management obtained substance abuse treatment more readily than injection drug users who were not and that case-managed clients remained in treatment for a longer period and showed better treatment outcomes than non-case-managed clients (Mejta et al., 1997). In a study of case management with chronic alcohol-dependent persons, case-managed clients increased their income, reduced the number of nights spent on the streets and in shelters, and increased the number of nights spent in their own housing. Certainly, more outcome data must be compiled before wide-ranging conclusions on the effectiveness of case management as an intervention can be assessed. Yet it is pertinent to note that in many situations, case management has been effective in helping substance abusers.

Case Management Models And Functions

There are various models of case management and an array of case management functions. Because case management is increasingly used within the treatment programs serving HIV-infected substance abusers, it is useful to review what case management may look like in its various configurations and what a case manager might do. TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* (CSAT, 1998B), describes case management in a substance abuse treatment context: It describes different approaches to case management, elaborates on its functions, and includes a section on the special needs of clients with HIV/AIDS. Providers should refer to the various case management models illustrated in TIP 27 to assess their treatment program's ability to use case management approaches. In addition, providers should remember that the usual functions and activities associated with case management are more difficult in dealing with HIV-infected clients because of

- Clinicians' and clients' fear of contracting HIV
- The dual stigma of being a person with both a substance abuse disorder and HIV
- The progressive and debilitating nature of the disease
- The complex array of medical and pharmacological interventions used to treat HIV/AIDS
- The onerous financial consequences of the disease and its treatment
- The hopelessness--and concomitant lack of motivation for treatment--among the terminally ill

Part of the case manager's linking function in working with an HIV-positive client is to educate the network of service providers, including substance abuse treatment staff, to recognize the competing demands of staying sober and dealing with the social and physical consequences of HIV. However, treatment professionals are not trained to know everything about HIV/AIDS, so it is helpful to ask clients questions to ensure that they are accessing medical care and that they understand their treatment. Figure 6-1 lists suggested questions that counselors can ask during the assessment process.

HIV-Specific Issues Requiring Linkages With External Systems

Living with HIV/AIDS compounds the challenges already facing the client with a substance abuse disorder. Because the disease presents a host of medical complications and potential treatments, linking a substance abuse treatment program with HIV/AIDS resources and/or case management is essential. New information about HIV/AIDS emerges daily, and it is impossible for a client to stay abreast of current knowledge on his own. In addition, there are programs for persons with HIV that are not available to other populations. HIV/ AIDS-related mental and physical health concerns are two specific areas that warrant external linkages with an HIV/AIDS system. For more information on linkages, see Chapter 2, "Medical Treatment"; Chapter 3, "Mental Health Treatment"; and Chapter 5, "Integrating Treatment Services."

Using Case Management To Increase Access to Care

The Panel recommends using case management in dealing with the multiple problems presented by HIV/AIDS in combination with a substance abuse disorder. Case management promotes teamwork among the various care providers. For example, a linkage between the client's primary care provider, AIDS case manager, mental health provider, and substance abuse treatment provider can greatly benefit the client and improve care. On the other hand, when multiple service providers do not work together, clients can play one agency off another or access duplicative resources and subsidies. The client also may receive different messages from different providers who have conflicting goals for treatment. Sometimes the messages appear different because of differences in terminology. If providers work in coordination with other providers, they will gain a more accurate picture of the client's situation.

Examples of case management programs include the Linkage Program, in Worcester, Massachusetts, and AIDS Project Los Angeles Client Services Division (McCarthy et al., 1992; Sonsel et al., 1988). Clients of such programs are likely to receive more substance abuse treatment, health care, and other services (Schlenger et al., 1992). One means of ensuring that clients receive the services they need is through a multidisciplinary team.

Forming Multidisciplinary Teams

How can a provider begin to assemble a multidisciplinary team? There are several points to consider when forming an effective team, which are outlined in Figure 6-2 .

Once a multidisciplinary team has been assembled, what are the signs that the team is not working effectively? Signs include the following: (1) the needs of the clients continue to be unmet; (2) there is uneven or unequal

participation; (3) one person dominates the discussions; (4) members do not show up for meetings; or (5) there is not enough followup by group members on discussions made in the group setting. To help avoid these situations, the group should periodically assess itself to determine if there are any concerns or frustrations about the group. There also should be a periodic formal evaluation to allow members to more thoroughly review what is, and is not, working.

Treatment Professional as Advocate

In addition to serving as a monitor for the plan implementation, the treatment professional also serves as an advocate for the client. An advocate's role is to find resources, open doors, and represent the needs of the client to other individuals and organizations. While all individuals should be empowered to help themselves, it is often difficult for clients who are overwhelmed by substance abuse and HIV/AIDS to meet their own needs by advocating for themselves.

Advocating does not mean "doing it all oneself," but rather ensuring that the work is done. As the treatment professional moves through the red tape of a State bureaucracy to obtain funding for a client, he needs to hold other people accountable. Examples of effective advocacy include asking for timelines, insisting on followthrough, and being clear about who is responsible once a request is made.

With HIV/AIDS, the advocate's role may be even more involved. The treatment professional may have to advocate for medical care for a client. This may mean obtaining funding for health care and medications and finding a medical team that understands HIV/AIDS. Advocating also means educating the treatment team about substance abuse issues, so that the client has access to a full spectrum of treatment options.

Resources for HIV-Infected Substance Abusers

Clients who have both a substance abuse disorder and HIV infection may require a number of specialized services as part of their overall treatment plan. Following is an overview of the primary resource needs clients may have. (See Appendix G for a list of State and Territorial health agencies and AIDS offices that can provide other resources.)

Housing

Housing for HIV-infected substance abusers is a major challenge for a number of reasons, including stigma and discrimination. HIV/AIDS seriously decreases many people's income, due to the inability to work and the cost of care. Without money, housing options are limited.

Difficulties also arise when trying to find housing for clients who are still actively using substances. Clinicians who believe in a harm-reduction model have particular difficulties finding recovery housing that is not based on an abstinence model. Most providers believe that it is nearly impossible to stabilize a client if that client cannot find adequate housing.

Counselors should be aware of a number of different housing options for people with HIV/AIDS; some of these are detailed below.

Services-enhanced, abstinence-based residential programs

Services provided to individuals in independent living residential programs--which are nearly all services-enhanced and abstinence-based--include substance abuse counseling, education regarding HIV/AIDS, mental health counseling, vocational rehabilitation, and support groups. These programs tend to be focused on helping an individual make the transition from active use to living without substances. These programs enforce rules against substance abuse, and a client's substance abuse may result in her dismissal from the program. Programs are designed to build the client's strengths so that she is able to succeed in recovery once she has left the facility.

Services-enhanced, risk-reduction residential programs

This is a vastly different approach from the abstinence-based model described above. While the services offered may be similar, they are offered to individuals who may still be using substances. The philosophy is to meet basic needs, while offering support and education to encourage the active abuser to reduce substance-abusing behaviors, or to quit entirely.

An example of this sort of housing is the Lyon Building in Seattle, Washington. This 64-unit facility serves substance abusers, the majority of whom are HIV positive, through a combination of support services. Staff at the facility know how to work with active abusers and do enforce clear rules for the residents' behavior. Although the

Lyon Building uses a risk-reduction approach, each resident is still responsible for behaving in a manner that does not jeopardize other residents or harm the facility. If the rules are broken, the resident may be asked to leave the facility. This program has been welcomed by HIV/AIDS providers in the Seattle area as a means to house active abusers who could not be housed elsewhere because of poor rental histories or concerns about behaviors associated with active substance abuse.

Independent units managed bysocial service programs

Substance abuse treatment and HIV/AIDS agencies in some communities work to make a variety of different housing options available. The advantage of these units is that the agency can take the responsibility of securing the unit and maintaining the relationship with the housing provider. Thus, individuals who may have poor rental histories or criminal records can be given a unit through the social service agency arrangement and at the same time are given an opportunity to build a rental history. Some of the agencies may offer these units at a subsidized rate or may charge fair market value, depending on the resources of the agency. Specific services are usually not offered in the facility, but residents will have access to resources as clients with a specific agency. These units tend to be available on a time-limited basis, although in the HIV/AIDS community, where clients are now living longer, the initial premise of using these units in a temporary manner is being questioned. While clients are living longer, they may still not be in a position to earn their own living and afford adequate housing.

A client must have housing in order to receive needed social services. If the client has no stable housing, it is very difficult to maintain contact and design a plan of treatment for the client to follow. This is why so many programs have incorporated housing into the range of services they offer and why some housing providers are creating a niche for themselves in serving at-risk populations. Because of the costs and complexities in creating housing, housing providers must be aware of funding opportunities, local jurisdiction building requirements, and private/public sector possibilities.

There are specific housing funds allotted to both the HIV/AIDS community (e.g., Housing Opportunities for Persons with AIDS funds), and to the drug treatment community. In addition, innovative programs are using a combination of funds from mental health, drug treatment, and HIV/AIDS sources to create housing for dually diagnosed individuals.

Home-Based Services

A variety of home-based services are of use to clients with HIV/AIDS. These include home health care, chore services, and meal delivery.

Home health care

Home health care can be a useful resource for short-term or intermittent use. It is paid for by private insurance, Medicare, and Medicaid, but coverage varies. Clients must qualify as homebound (i.e., unable to go to a clinic to obtain services at a lesser cost). With the HIV/AIDS population, this rule has posed some problems because an individual may feel fine one day but be unable to leave home the next. Health care providers may have misperceptions about this population. There also are concerns about safety in certain neighborhoods, perceptions about lifestyles, and attitudes about substance abuse and HIV/AIDS that influence care. Education for home health workers should be undertaken to allow for fair and unbiased health care services.

Chore services

Chore services may either be professional or volunteer. Professional chore services provide in-home services such as cooking, cleaning, medication reminders, and transportation and are funded through private funds or through public programs. The availability of such services varies from State to State, and participants must pass specific eligibility requirements to obtain service. Chore service programs may have problems stemming from feelings concerning provider safety and comfort in working with an HIV-infected substance-abusing population.

Volunteer chore programs provide the same essential in-home services. Programs vary widely in how they train volunteers and the quality of services they provide, so the provider who makes the referral should know the program's limitations. Volunteer programs may not be able to offer an immediate response, and the volunteers may change, causing disruption in a client's life. Still, these programs often can help to fill gaps for service needs.

The HIV/AIDS community has been outstanding in its development of volunteer networks of care. As the pandemic moves more into substance-abusing populations, one issue in the community is the hesitation of long-time volunteers, as well as prospective new volunteers, about working with this population. The attitudinal training that has been provided to volunteers who work with gay men must also be provided to those volunteers

working with HIV-infected clientele immersed in the drug culture.

Home-delivered meals

The "Meals on Wheels" model of in-home meal delivery, which has long been a resource for older homebound adults, has become available to the HIV/AIDS community. Meals are provided to those in need, but the service may require that participants' income not rise above a certain amount. The same safety and attitudinal concerns discussed in the in-home services sections above apply here. Another issue is ensuring that the meals reflect the tastes and nutritional needs of the clients. This requires that service providers understand current nutritional concepts while remaining flexible concerning the needs of the individual client. The case manager may have to advocate for changes in the menu to ensure that the client's needs are being met.

Homeless Shelters

Homeless shelters may be a necessary housing resource for providers who work with HIV- infected substance abusers. The strengths of shelters are the staff members, who usually possess a comfort level with disenfranchised populations, and the shelter's immediate accessibility and use as a short-term solution. HIV/AIDS service providers and substance abuse treatment workers are increasingly using homeless shelters as a place to provide education and to connect individuals to longer term, more stable resources.

The disadvantage of shelters is that the lack of available medical care exposes clients to other illnesses, especially tuberculosis (TB) and hepatitis. Shelters may also have limited hours of use. Many are open only at night and require people to leave in the morning, thus sending individuals back onto the street and making it difficult for a service provider to follow with needed services.

Adult Day Health

Adult day health is a useful resource for clients who need monitoring because of their health or mental state, or who face isolation. Adult day health is different from adult day care in that the former is treatment based, whereas the latter provides mostly socialization and support. Adult day health programs usually function with a multidisciplinary team representing physical/occupational therapy, mental health, medical, and recreational therapy. The program provides a daily schedule of activities, therapies, meals and snacks, and interaction with other individuals who are experiencing similar concerns. Adult day health programs are funded by Medicaid, if the programs meet certain standards.

Finding and Funding Services

It is sometimes difficult for the HIV-infected substance abuser both to find and pay for needed services. The case manager can play an important role in helping find specific services and navigate the maze of public and private funding options.

Substance Abuse Treatment Services

Once an individual decides that she wants treatment for substance abuse, it is crucial that she be given immediate access to such treatment. Unfortunately, the substance abuse treatment community is underfunded and unable to provide adequate treatment services for all who need them. Access to treatment is particularly difficult for the working poor, who do not qualify for public programs, and chronic recidivists, who have exhausted available treatments but who still have a host of psychosocial and psychiatric needs that require intensive treatment.

Mental Health Treatment

The mental health system is also underfunded relative to the significant needs of HIV-infected substance abusers. Clients with serious mental health disorders do not always have access to the same avenues of support that are available to other substance abusers. The treatment provider should acknowledge the specific mental health issues that HIV-infected individuals often experience, so that identification of mental health concerns becomes part of the assessment process. Available mental health treatment options include support groups, volunteer peer counseling, and outpatient and inpatient therapy. (See Chapter 3 for assessment and pharmacological treatment of mental illness.)

Support groups

There are a number of different types of support groups available that operate on a community level--among them

are Alcoholics Anonymous, Narcotics Anonymous, Women for Sobriety, Rational Recovery, and other self-help organizations. Chapter 4 provides a more thorough discussion of support groups.

Volunteer one-on-one emotional support

One-on-one emotional support, sometimes called peer counseling, involves the use of a trained volunteer to talk with the client and provide emotional support on an ongoing basis. This sort of counseling is not recommended for individuals with diagnosed mental health disorders. For some individuals who do not respond well to group interaction, or who cannot physically access a group, one-on-one support can be extremely useful. This peer counseling can complement support groups and therapy. The treatment provider should assess the quality of such programs and monitor for any inappropriate behavior on the part of the volunteer.

Outpatient mental health treatment

Many clients need more than volunteer, nonprofessional support, but their options can be rather limited. Managed care agencies, for example, may require clients to undergo more intense screening for admission to and continuation of services. Individuals who can pay privately have more options, although substance abusers with HIV/AIDS are not likely to have resources for these services. Both Medicare and Medicaid cover mental health treatment but require ongoing information regarding the intensity of need.

Some communities have created programs to address the need for outpatient mental health treatment. These programs maintain a list of counselors and therapists who have agreed to work with HIV-infected people at low or no cost. An AIDS case management program can provide information on the availability of such services.

Inpatient mental health treatment

If an individual is experiencing a severe mental health crisis, it may be necessary to find inpatient treatment. For example, if a client is suicidal or homicidal, or if his functioning is severely impaired, the situation is considered sufficiently *intensive* and *acute* to warrant an evaluation within an inpatient setting. In some cases, the client may have to be hospitalized involuntarily. Referrals for these services should use the words "intensive" and "acute." It is important that referring agencies be familiar with terminology from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), 4th ed. (American Psychiatric Association, 1994) because managed care case managers need a diagnosis to begin assessing mental health service eligibility. Besides understanding the terminology, the provider should be able to articulate examples of the client's behavior, the duration and severity of the episode, and the impact on the client's daily functioning.

In addition, it is essential for the treatment provider to understand the intricacies of the local mental health system. The provider should know how to reach mental health professionals, understand the process for obtaining crisis services in the event of a mental health emergency, and learn what will qualify a client for different levels of service. For clients who are active substance abusers, providers may have some difficulty deciding whether behaviors are due to a mental health disorder, to substance abuse, to HIV/AIDS, or to side effects of medications. Good coordination between the substance abuse treatment specialist and the mental health provider can help with this determination.

Medical and Dental Care

In the HIV-infected population, clients can be divided into three categories: (1) those with no financial means who are considered disabled and can qualify for government assistance, (2) those with financial resources who have private disability or health insurance, and (3) those in the middle who cannot afford insurance but are not impoverished enough to qualify for government aid.

To help the working poor who cannot afford insurance, several States have created State-sponsored health plans or a Medicaid Expansion Program, which provides basic health care services to those who may not qualify for traditional Medicaid benefits. This program requires the payment of premiums and/or copayments but at rates lower than commercial plans; it also counters the increasing difficulty of obtaining individual health insurance. Most insurers favor group plans over individual plans, and while some States require insurers to provide individual plans, the cost often is prohibitive.

In some cases, social services agencies can assist patients in obtaining financial coverage for acute or emergency care. Individuals with AIDS who have a significant work history may be eligible for Social Security Disability Insurance (SSDI), which will provide Medicare benefits after 2 years. Individuals with AIDS may be eligible for Supplemental Security Income (SSI), which will also provide Medicaid coverage. Providers can also access Ryan White funds in some medical and dental cases. See TIP 29, *Substance Use Disorder Treatment for*

People With Physical and Cognitive Disabilities (CSAT, 1998c), for more information on funding options for people with disabilities (such as HIV/AIDS).

Community clinics are another option for care; they receive subsidies through Federal, State, and/or local agencies and can thus take uninsured or underinsured individuals. In addition, these clinics are staffed by individuals who know about the specific needs and concerns of low-income individuals and also may know of other community resources that could complement care.

Dental care is also important for clients and involves similar access issues. Some public funding can be obtained to help subsidize dental clinics and providers. Unfortunately, some dentists have demonstrated concern about treating HIV-infected persons because of the fear of infection. Stories of transmission occurring in dental offices have been misrepresented and have contributed to the unwillingness of providers to treat people with HIV/AIDS. However, in 1998 the U.S. Supreme Court held that under the terms of the Americans With Disabilities Act, HIV is considered a disability, making it therefore illegal for a dentist to refuse to provide care to an HIV-infected individual (Bragdon v. Abbott, 524 U.S. 624 [1998]).

As a provider of services, the substance abuse treatment specialist should know of medical and dental providers who will accept HIV-infected individuals, as well as the financial criteria required for obtaining care. Partnering and advocating with the public health department and community clinics may be required on a larger scale to obtain needed services.

HIV Drug Therapy

After a client has managed to obtain medical care, the next challenge is to find the means to pay for drug therapy. Persons with HIV can have multiple prescriptions, and drug costs may exceed $1,000 per month. Even individuals who have private insurance may have prohibitive copayments or restrictions on the drugs covered by the plan. Persons who rely on public insurance programs may also face such restrictions, and some public programs are moving toward a copayment system to reduce costs.

AIDS Drug Assistance Programs (ADAPs) have helped many persons with AIDS. These federally funded programs, administered by the States, have allowed persons with AIDS who are underinsured or have no insurance to obtain funding for AIDS-related drugs, including some prophylactic treatments. Unfortunately, the huge cost of combination therapy has significantly impacted the budgets of the ADAPs, and the number of clients relying on such services has increased. Several States have run out of funds before the end of their fiscal years, or have had restricted access to the funds. ADAPs have been curtailed in 23 States, and there are waiting lists for entry into the program in 9 States and specific waiting lists for protease inhibitors in 7 States. In 36 States, additional money has been added to the Federal amounts to meet the rising demand (U.S. Department of Health and Human Services [DHHS] and the Henry J. Kaiser Family Foundation, 1997). In addition, some States are expanding the program to benefit persons who are HIV positive but not yet diagnosed with AIDS in the hope that early intervention will lessen total cost.

Income and Other Financial Concerns

Financial assistance is a basic need, and obtaining resources for a client can be a challenging task. There are complex and constantly changing options for financial assistance available. Following is an overview of basic financial assistance programs. Eligibility criteria, duration of service, and amount of assistance available vary from State to State. Providers should be familiar with funding sources and should be aware of changes in these social programs.

Welfare

Welfare agencies are enforcing stricter eligibility criteria and imposing limits on the amount of time during which benefits are available. Welfare reform aims to provide enough assistance so that the individual can obtain training and move into employment. However, in reality this is not always possible. For example, States may now limit the amount of time allowed on welfare but not yet provide effective training programs to help welfare recipients become employable. Or, the training programs may not provide needed guidance in finding and maintaining a job. Or, the jobs available may not pay enough to cover child care or transportation expenses.

Welfare is available on a time-limited basis to single parents who are unemployed and to individuals whose disabilities render them unemployable. The treatment provider should help the client understand and navigate through the system of benefits, assist with the application process, explain what the limitations of the program are, and educate the client about how to maintain benefits for the period allowed. These programs usually include Medicaid coverage. For a fuller explanation of welfare reform, refer to the forthcoming TIP 38, *Integrating*

Substance Abuse Treatment and Vocational Services (CSAT, in press [a]).

Unemployment Insurance

Unemployment insurance is useful for clients who have enough credits (quarters worked) to qualify. Unfortunately, many HIV-infected substance abusers do not have enough work credits to qualify. If unemployment insurance is an option, it is important that the provider discuss realistic next steps with the client. Is it the intention of the client to find another job? Is her HIV status such that applying for disability benefits might be necessary? Does the individual need vocational training to find a position that meets the needs of her situation? Because unemployment insurance is available for a limited time only, assisting the client in planning ahead can be helpful.

Disability Income

There are two types of disability income--private and public. Private disability insurance (which may be available through employers or paid privately) pays a percentage of one's salary as long as the individual remains disabled, or until the individual can find a position that may be physically possible to perform. It is important that the case manager realize that every individual disability policy is unique. The provider should encourage the client to review the policy and talk with the insurance provider about any questions.

Public disability insurance is available through Social Security (SSI and Medicare). Providers may become frustrated in working with clients whose perceived degree of disability is not enough to qualify for SSI or Medicaid. Many AIDS service organizations have financial or legal advocates who are experienced in the complexities of applying for benefits and who know how to appeal disability decisions. The treatment provider can work with these experts to strategize the appropriate next steps for the client who has been unsuccessful in obtaining disability benefits. It is important, when possible, to work with the client *before* she is rejected because it is easier to present the original case for disability than to try to overturn a negative decision. Providers should also note that although persons with HIV qualify as disabled, depending on their health, individuals whose primary "disability" is a substance abuse disorder do not qualify.

The concept of disability may also be changing for persons with AIDS. There have been some accounts of individuals whose cases have been reviewed and who have had their disability awards discontinued because of improved health. There also are accounts of more stringent screening of disability applications from persons with AIDS. As people with AIDS show improved health with new treatments, a presumption of disability may be more difficult to obtain or maintain.

Food Stamps

Food stamp programs have also been significantly revamped in some States with the advent of welfare reform and cost cutting. To qualify for food stamps, an individual must be in a low-income bracket; the amount of aid received will vary from State to State.

Vocational Rehabilitation

Longer term survival for persons with HIV has, in some cases, created a need for vocational rehabilitation. No longer facing a death sentence, persons with HIV who were unable to work are now looking to return to the work force. Organizations such as IAM CARES (International Association of Machinists Center for Administering Rehabilitation and Employment Services), which has provided traditional vocational rehabilitation services, are now targeting the HIV population with programs designed to promote reentry into the work force. For more information about vocational services for people with substance abuse disorders, see the forthcoming TIP, *Integrating Substance Abuse Treatment and Vocational Services* (CSAT, in press [a]).

Hospice Programs

Hospice programs try to provide a compassionate environment for those who are nearing death. Hospice programs are multidisciplinary, usually including a physician, nurse, social worker, and pastoral care provider to assist with the dying process. Hospice programs can be offered either in-home or in a facility setting. Many acute-care hospitals now have affiliations with hospice programs. Hospice programs are funded through Medicare, Medicaid, and private insurance, although there may be variability in the amount of care allowed or in how the hospice program allocates the funds allowed for hospice services.

Hospice services have not always been compatible with the needs of persons with HIV/AIDS because AIDS can be so erratic in its progression. There is not a predictable physical progression with AIDS, so it is difficult to know if a person will need hospice care. The advent of combination therapies has also made hospice services less

necessary, as the disease becomes more chronic than terminal. Still, hospice care can be a positive experience for those in need and can be extremely supportive for family and other caregivers who are caring for a person with AIDS.

Suggestions on Finding Resources

Although some locations have all the resources discussed in this chapter, others have very few. Here are some ideas on what a provider can do if he is the only formal resource for the client with HIV:

- Mobilize friends, family, and the community for support. Church groups, for example, can help with day-to-day caregiving needs and respite. The provider may have to function as an educator within the community, especially concerning HIV/AIDS and substance abuse issues. Because of the degree of prejudice and the stigmas attached to both issues, the provider should take advantage of existing relationships within the community and build new relationships to manage community needs in these areas.
- Ask for support from other areas of the State. There may be professionals who represent more progressive services elsewhere who might be willing to come into a community and consult on ways to fund or create new resources. Public agencies that coordinate statewide HIV/AIDS care have a responsibility to ensure that all residents with HIV receive an equal level of services, and officials within such agencies may be able to assist with funds or resources. Where long distances are involved, it may be possible to establish relationships with experts who can be consulted by phone or e-mail.
- Counselors may need to suggest that the client relocate. To take advantage of options and receive the best care, a client may have to move closer to services. Clients will certainly find it difficult to leave family and friends behind, but if their health care is not adequate, relocation is a worthwhile option to consider.

Boxes

Figure 6-1: Helpful Questions To Ask When Assessing a Client's Needs

- Do you have a doctor?
- How often do you see your doctor?
- What do you see your doctor for?
- Are there other physical concerns bothering you that you don't discuss with your doctor? If so, what are they?
- Has your doctor prescribed medications of any kind for you to take?
- Could you give me the names of the medications? Or may I see the medications?
- Could 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 with your doctor?

Figure 6-2: Forming a Multidisciplinary Team

1. Determine who the significant providers are in the client's network of care. Depending on the setting and area, there may be several candidates for the multidisciplinary team. When considering a biopsychosocial model, it is useful to have a representative from the client's medical, psychological, and social treatment providers. This could include a social worker, a physician, an alcohol and drug counselor, an HIV/AIDS case manager, and perhaps a representative from an agency (e.g., day health program) with whom the client has frequent contact. Additionally, consideration should be given to the cultural and linguistic makeup of the group.
2. The group can be a fixed one, in which members review the needs of several clients on an ongoing basis, or the group can form as needed for a specific client. Within fixed groups, members tend to be the same core set of providers, perhaps adding specific providers for a particular client's situation. The group that forms on an as-needed basis can be made up of different members each time.
3. When the group is brought together, members should first discuss the expectations of group members, the rules for how the group will interact, and how the group will structure the time. Time should be built in so that adaptations can be made as needed.
    - **Expectations.** Group members should discuss what it is that they want to achieve. Does the group exist to provide brief information about the clients to ensure a basic level of communication, or does it exist to solve problems and provide consultation about each others' clients?
    - **Rules.** Ground rules should be determined by the group members. Rules can include arrival and start times for meetings, keeping whatever is discussed in the group confidential, not interrupting when other group members are speaking, and not allowing one group member to dominate the discussion. Rules will vary depending on the purpose and structure of the group.
    - **Structure.** Group structure should be discussed so that meetings can be the most productive and efficient for all the busy professionals involved. Questions should be asked, such as "How much time will be spent on each client?," "How will the group document its work?," "Will there be a facilitator and/or a timekeeper?," and "Who puts together the agenda?"
4. Establishing formalized linkages with other agencies is one means of building a team. Affiliation agreements, for example, between a public health department and a hospital that serves low-income pregnant women can allow for formalized sharing of client information as well as a partnership approach to serving the client. It is important to discuss issues such as identifying the roles and responsibilities of each party, the mode of collaboration, and who the participants will be. An

affiliation agreement should be drawn up that includes a renewal date for the agreement, so that both parties have the opportunity to periodically reconsider the reason for affiliating.

5. In multisystem work, there can be several case managers. If possible, one "lead" case manager should be identified who has the responsibility to ensure that services are coordinated. This lead person can also bring together the various providers for ad hoc multidisciplinary meetings.
6. Confidentiality should be kept in mind when forming multidisciplinary teams. It is imperative that the group keep client information confidential, and it is necessary that the client agree to allow the treatment professional to share information with the other members of the group.