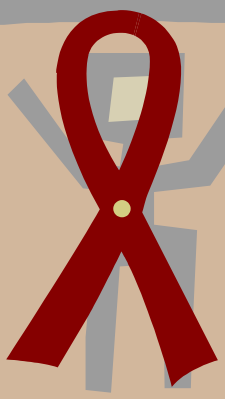
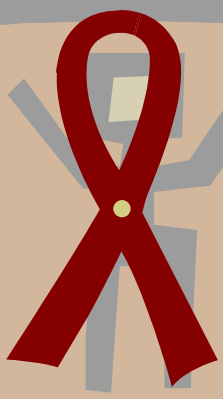
PHASE TWO:
Guidelines for Working with U2 Clients



March, 2004

Mobilizing Community Networks
to Address the Housing and Treatment Needs of
HIV Positive People who are Unwilling or Unable (U2) to Prevent the Spread of HIV

Care Guidelines for Working with U2 Clients



March, 2004

Mobilizing Community Networks
to Address the Housing and Treatment Needs of
HIV Positive People who are Unwilling or Unable (U2) to Prevent the Spread of HIV

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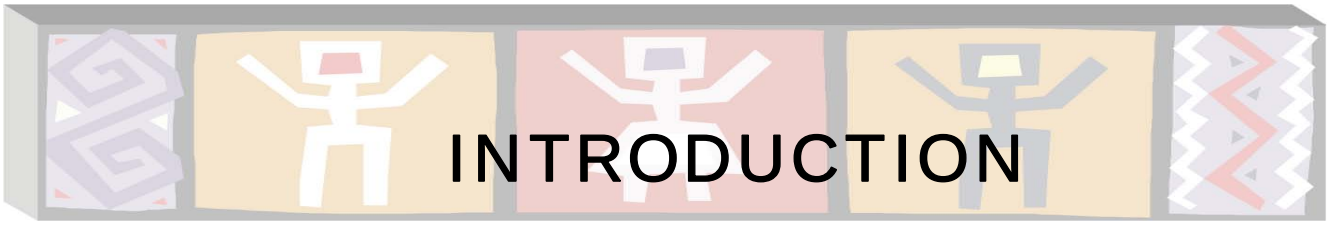


INTRODUCTION

An *HIV positive client who is unwilling or unable to prevent the spread of HIV* will be referred to in this document as a **U2 client.** The ***Alberta Public Health Act*** uses the term **"recalcitrant"** to describe a person infected with a specific communicable disease who refuses to comply with treatment or conditions prescribed by a physician to limit the spread of the disease. We prefer to use the term "unwilling and unable," which is more consistent with psycho-social support models.

U2 clients represent a relatively small proportion of people who are living with HIV. "Research indicates that U2 clients suffer a host of medical and social problems including secondary infections, homelessness, mental illness, and substance abuse. They suffer from low self-esteem and social isolation. Their behaviours are not always predictable, and their needs change over time."[1] The issues and diagnoses addressed in these guidelines are those most often associated with U2 clients.[2]

These guidelines give basic background information and practical strategies for caregivers. It is important to note that each set of information and strategies is specific to only one diagnosis or issue. U2 clients tend to have complex combinations of these diagnoses and issues. Each U2 client is unique in his or her individual needs. Therefore, the guidelines should be used with care as a source of information and ideas, and not simply applied as a Care Plan to any client.

CAUTION
These guidelines are not intended to be used by care workers to attempt a psychiatric diagnosis!
If you notice particular symptoms or indicators that are of concern, please refer the client to the doctor or psychiatrist for appropriate diagnosis and treatment.

Using The Guidelines in Care Plan Development

***Remember HIV status is confidential and should not be disclosed to other residents, staff, workplace, or school placements unless there is a significant risk of transmission (e.g., sexual relationship with another resident).** All staff should use Universal Precautions (also referred to as Standard Practice or Standard Precautions) with any and all clients, as you often may not know a client's HIV status.

[1] Howard Research and Instructional Systems Inc. (2003). Mobilizing Community Networks to Address the Housing and Treatment Needs of HIV Positive People Who Are Unwilling or Unable to Prevent the Spread of HIV. Calgary, AB. p 3
[2] Howard Research and Instructional Systems Inc. (2003). Mobilizing Community Networks to Address the Housing and Treatment Needs of HIV Positive People Who Are Unwilling or Unable to Prevent the Spread of HIV. Calgary, AB.

1) **Assess the client's situation**
   - Determine the combination of issues and problems faced by the particular U2 client by conducting an assessment interview with the client, reviewing previous file and assessment documents, and consulting with other care team members.
   - Consider social history and current social circumstances (e.g., housing, financial, social support, interests).
   - Consider how the complex combination of factors may influence the client's perceptions and behaviour around managing the HIV/AIDS. Consult with care team members, especially the HIV health nurse.
   - Look for behavioural patterns in their previous history.
   - Consult with your supervisor, psychologist and/or nurse when developing the Care Plan.

2) **Read through the guidelines** about the U2 client's specific issues to learn more about the common indicators and effects.

3) **Consider which of the strategies might be useful** in your Care Plan development.
   - For those clients with a number of issues, think about how various strategies might interact within your Care Plan design.
   - Don't assume that you can simply apply a given set of strategies! **Strategies must be tailored to the strengths, needs, interests and circumstances** of that client.
   - Talk with the client about his/her likes and dislikes, interests, hopes for the future – make the client an active part of the Care Plan development.

4) **Be sure that the client understands and agrees to the** Care Plan strategies before you start using them. Informed **consent** should be in place for all care strategies and restrictive procedures. See appendix for a sample consent form.

5) **Be prepared to monitor and change strategies** as you gain more experience with the client or as circumstances change. Review and update the Care Plan on a regular basis with the client and the team.

6) **Use a co-ordinated Care Plan approach** that includes community partners in the planning in order to facilitate treatment. Include a list of key partner contacts as part of the Care Plan. Ensure all partners are informed of the Care Plan components applicable to their service and are advised of major decisions, issues or Care Plan changes. Examples of community partners might include the residential placement agency, Southern Alberta Clinic (SAC), mental health professionals or other counsellors, Calgary Health Region, Mobile Response Team, Persons with Developmental Disabilities, or the police.

While each community agency will have their own policies and Care Plan processes, these guidelines provide supplementary information and ideas that may be integrated into your care planning.

The Appendices includes some sample forms that may help you in your Care Plan development. These include:
- AWOL Procedures Sample
- Informed consent for Treatment - Sample
- Informed consent for Information - Sample

U2 & TREATMENT ADHERENCE

People with HIV learn early in the course of the disease that there are things they can do to strengthen the immune systems and keep themselves well, including:

- getting plenty of rest
- eating well
- controlling stress
- avoiding any risky exposure to other people who may have HIV, which could introduce a new strain of HIV into their body and have a serious impact on their health
- doing what is right for them (e.g., exercise, music). [3]

It is difficult to **always** make healthy choices. Dealing with new drugs and a rigid drug schedule is demanding. People with HIV may live for years with the virus, and initial motivation and efforts to do everything right may diminish. Workers can support people by helping them to be flexible, decide what they can do, develop alternative interests and still **take pleasure in life.**

Tips To Make Treatment Schedules Easier[4]

- **Clearly explain** the importance of the HIV treatment regime (e.g., testing, appointments, check-ups) and benefits of taking medications consistently as prescribed for HIV medication to work effectively. These messages may need to be reinforced on a regular basis.
- **Teach exactly when and how to take medications** — How many pills to take each day? Do they have to be taken with food? What kind of food? Do meds need to be kept in the fridge? What if they miss a dose? Ask the doctor to write exact instructions. Some people may need simple reminders while others may need special routines, prompts/cues, or even regular supervision to help maintain the treatment regime.
- **Figure out what might prevent the client from following the treatment schedule** — maybe they don't have a fridge to store medicine in, or a place to stay. They may forget to take their meds or may not feel like eating. Talk about potential obstacles and develop strategies to make adherence easier. Talk with the doctor about any obstacles to see if there are simpler or more manageable treatment options. If side effects are a problem, talk with the doctor or pharmacist for other strategies or solutions.
- **Use reminder gadgets** (e.g., bubble pack, calendar, key chain with a beeper, digital watch with an alarm, etc.) to remind clients to take their medications. Try a special pillbox that will help organize meds for the whole day or week. Plan ahead to get medication refills so that the client's HIV medication supply does not run out.

[3] Health Canada. (1997). Comprehensive Guide for the Care of Persons with HIV Disease - Module 6 Psychosocial Care. p. 65. Canadian Public Health Association, Canadian HIV/AIDS Information Centre Ottawa, ON.

[4] Canadian AIDS Treatment Information Exchange. (date unknown). Pre*fix: harm reduction for + users: adherence & resistance. Retrieved September 14, 2003 from: www.catie.ca/prefix_e.nsf

Tips To Make Treatment Schedules Easier[4]

- **Be prepared.** Have the client carry a couple of doses with them when they go out. **Establish a consistent routine** for taking medications.
- **Be aware of, and watch for possible side-effects** If you notice side effects, refer the client to the doctor right away. Encourage them *not to stop any treatments* until they see the doctor. Help them find creative ways to manage the side-effects. Most side effects subside gradually the longer the client takes the medication.
- **Build a support network** that can encourage the client to maintain the treatment regime. Friends, family or a partner may be willing to go with the client to appointments and provide encouragement.
- **Match the client with a "buddy"[5]** – someone who is reliable, not involved in illegal activities, and is a positive role model and also has HIV. Refer to your agency safety or volunteer guidelines before finding a "buddy".
- **Don't react by blaming** the client for missed medications or appointments. **Problem solve about** the obstacles to maintaining treatment and help develop practical strategies to resolve them. **Consider increasing the level of support** to the client (e.g., go with them to appointments) until a consistent routine is re-established.

[5] Health Canada. (1997). Comprehensive Guide For The Care of Persons With HIV Disease. Module 6: Psychosocial Care. p. 52. Canadian Public Health Association Canadian HIV/AIDS Information Centre, Ottawa, ON.

U2 & SAFER SEX

Safer sex includes practices that reduce the risk of contracting sexually transmitted diseases (STDs) and blood borne diseases such as HIV. Safer sex practices reduce contact with the sex partner's body fluids, such as semen, vaginal fluids, blood, and other types of discharge from open sores.

People living with HIV are legally required to disclose their HIV status to a potential sexual partner and ensure that condoms are used for any sexual activity. U2 clients often do not use safer sex practices to prevent the spread of HIV. The majority of U2 clients are *unable* rather than unwilling. For a variety of reasons, they are unable or unwilling to disclose their HIV status to others or protect others from HIV. Some have a cognitive disability that impairs the ability to consistently use safer sex practices. Others may not have good access to condoms, or are not able to understand correct condom use. Some of the *unable* clients have a history of involvement in the sex trade and this may be their only source of income . A client may be addicted to drugs and using a condom is not important when they are high. Cognitive disabilities and psychological disorders like FAS, brain injury, addiction, and developmental disabilities such as Aspergers can interfere with good decision making. These neuro-psychosocial factors impact other health determinants such as education, employment, income and social support networks. When discussing safer sex with a U2 client, be sure to consider the range of complex issues that may be affecting their behaviour.

Some U2 clients may have a Public Health Order that does not allow them to have sexual contact at all (in order to protect community members at risk). In this case, talk to the HIV Designated Nurse about other social outlets that are appropriate for the client to participate in.

Safer sex reduces but **does not completely eliminate risk.**

Implications For U2 Clients

- Very few people living with HIV willfully put others at risk, but when this happens the issues behind the behaviour may be complex.
- The client may have trouble dealing with their HIV status, practising safer sex or safer drug use and disclosing to others. Some people may fear being rejected or face possible violence if they disclose their HIV status, or ask a partner to use a condom.
- Persons with disabilities or mental health issues that affect their understanding, their reasoning or their behaviour, may not be able to follow through on information provided about safer sex without additional hands-on teaching and practice. Safer sex information and role playing may need to be repeated on a regular basis.
- Stages of change theory[6] would suggest that although providing information (written or verbal) raises the client's awareness about the issue it is usually not sufficient to change behaviour. Changing behaviour involves not only information, but also a period of planning (increasing intent and motivation), skill development (practice practical applications, including role-playing), and ongoing support (maintenance).

[6] Prochaska, J. DiDlemente, C. Norcross, J. (1992). In Search of How People Change. *American Psychologist*. 47(9), 1102-1114.

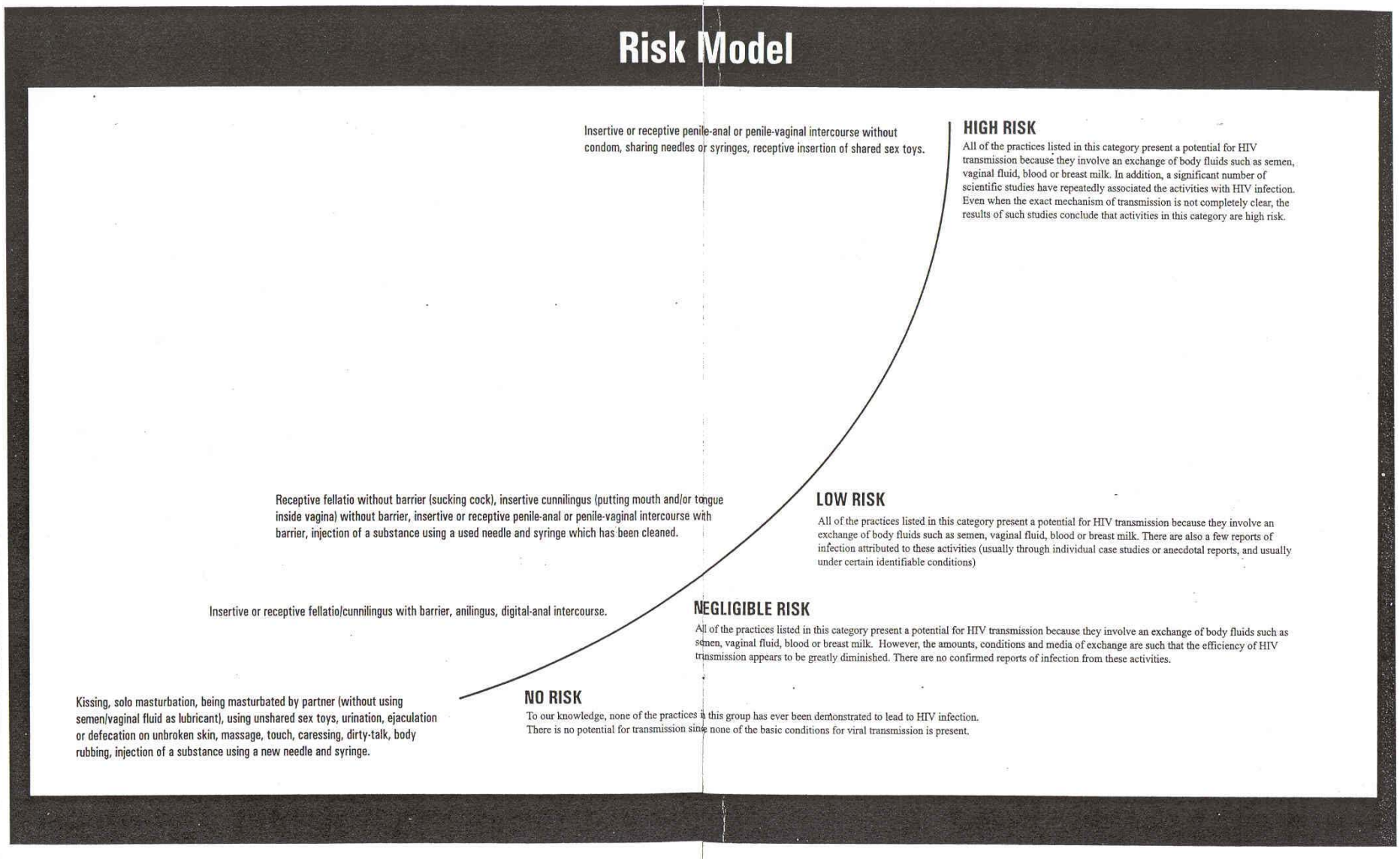
Strategies for Promoting Safer Sex with U2 clients[7]

First develop a trusting relationship with the client, then you can raise some of the following questions:

- Ask the client directly if he/she is practising safer sex.
- Ask the client some "straight forward" questions: Have you told your partner you are HIV positive? How did you tell him/her? What was his/her reaction? If you didn't tell, how did you explain that you wanted to use a condom?
- Make sure the client has a supply of condoms/dental dams.
- Work with the client to make sure that other factors, such as alcohol and drug use are not interfering with his/her ability to practice safer sex.
- Give the client's partner prevention messages/information/education on safer sex. **Due to confidentiality, this must be done with the permission of the HIV client and is usually done by the HIV public health nurse.**
- Report any unsafe sex practices to the HIV public health nurse.

The following RISK MODEL shows the different levels of risk for HIV transmission.

[7] Health Canada. (1997). Comprehensive Guide for the Care of Persons with HIV Disease. Module 6 Psychosocial Care. 84. Canadian Public Health Association Canadian HIV/AIDS Information Centre Ottawa, ON.



Used with permission from Canadian AIDS Society - Health Canada (1999). HIV Transmission guidelines for assessing risk. Canadian AIDS SocietyToronto, ON. Retrieved on December 9, 2003 from Canadian AIDS Society Website: www.cdnaids.ca/__85256B950031AAAC.nsf/(search)/3495A31A8E2C94B185256BCD004F53CF?opendocument&highlight=guidelines,transmission,hiv&language=English#Section%20III%3A%20HIV%20Transmission%3A%20

Strategies for Promoting Safer Sex with U2 Clients[8] - Refer to Risk Chart

Encourage the following strategies with clients for high, lower, and low risk sex: (refer to RISK MODEL)

HIGH-RISK SEX:

- Use a male or female latex or polyurethane condom during all sexual activity. Condom use is encouraged before sex, during foreplay and sex, not just at the point of ejaculation.
- Use high quality condoms. Avoid novelty condoms.
- Recommend the use of extra strength condoms and lots of lubricant especially during anal sex.
- Store condoms in a cool, dry place and don't use them if they are expired.
- Provide client access to a water-based lubricant, such as K-Y Jelly. Lubes that contain oil (Crisco, Vaseline, baby oil, lotion) can destroy the condom.
- Encourage the client to be prepared and not to rely on others to provide the condoms.
- Insertive or receptive anal sex are both high risk.
- Condoms with Nonoxynl 9 are not recommended as they can cause skin irritation and increase chances STD/HIV infection/re-infection. Recommend polyurethane female or male condoms to clients who have latex allergies.

LOWER-RISK OR NEGLIGIBLE RISK SEX:

- Flavoured or non-lubricated condoms are strongly recommended for oral sex (blowjobs), and dental dams or a condom cut down the middle for female oral sex (eating pussy), to lower the risk of getting other STDs.
- If a client engages in rimming (licking the anus), encourage use of a dental dam or condom cut down the middle over the anus to prevent STDs, hepatitis A and parasites.

To make a dam, cut a condom lengthwise or use a piece of non-microwavable plastic wrap. Don't reuse it.

NO-RISK SEX:

- During non contact, non-insertive/receptive sex ensure ejaculate, urine or feces does not contact broken skin or sores.
- Don't share sex toys.

Negotiating Safer Sex

To negotiate is a means to communicate with another in order to arrive at some sort of agreement or compromise. Negotiation usually occurs before any sexual activity takes place.

It can be very difficult for a woman with HIV to negotiate safer sex with partners. Because of social and economic dependency on men, women frequently have little power to refuse sex or to insist that condoms be used during intercourse. Males with HIV may also have difficulty disclosing their HIV status to a partner or asking them to use a condom.

[8] Canadian AIDS Treatment Information Exchange. (date unknown). Pre*fix: harm reduction for + users: getting it on. Retrieved October 12, 2003, from: www.catie.ca/prefix_e.nsf

Strategies for Teaching U2 Clients about Safer Sex Negotiation[9]

Develop a trusting relationship with a client before raising the following points:

- **Never assume** a client's sexual orientation, (bi-sexual / homosexual or heterosexual). Use gender neutral terms such as "partner" rather than "boyfriend/girlfriend" to encourage conversation.

- **Discuss feelings about disclosing HIV status.** Many people living with HIV are worried about disclosing HIV to a potential sex partner due to potential rejection, violence etc. The public health nurse can discuss ways to disclose HIV status in more sensitive or risky situations. For example, if a sex trade worker is uncomfortable with a partner but still has to disclose, he/she may use the term "blood borne virus" rather stating that he/she has HIV. Blood borne virus can mean Hepatitis C, B, and/or HIV.

- **Personal Limits.** Help the client to clarify his/her own reasons for not having sex or for using safer sex methods. When the client is clear about his/her own reasons for not having sex or for insisting on safer sex, it will be easier to stick to his/her limits. It will also be easier to talk with a partner about his/her decision.

- **How to start the discussion.** Help the client practice ways of raising the topic of safer sex with a partner in a non-threatening, but assertive manner (e.g., concern, sharing an article, a practised script).

- **Assertiveness.** Offer the client instruction and practice in assertive communication skills.

- **Be clear from the start.** Early discussion about safer sex can ensure that the client and his/her partner know where they stand. Talking about it at too late a stage could mean that safer sex does not happen and this may place the client at risk of criminal prosecution or result in a public health order. Encourage the client to set limits *before* sexual intimacy occurs. (e.g., "I'd like to stop now. I don't want to go any further, before we get too far.") **Encourage the client to be very clear and assertive.**

- **Role-play** negotiation scenarios to improve the client's skills. **Encourage the client to** be clear direct, and assertive. If they want a partner to stop, they need to be prepared to say "No" with confidence. Encourage the client to say it as many times as it takes.

- **Practice** possible responses that the client can use to promote safer sex while still caring about the partner (e.g., "If you loved me you wouldn't need to use a condom." – Response: "I want to use a condom BECAUSE I love you.").

- **Avoid Risky Situations.** Encourage the client to avoid situations that make it harder to say no to sex (e.g., when drinking, or alone together). Encourage the client to spend time with groups of friends or in public places. Encourage the client to avoid alcohol and drugs. Mood altering substances often affect sound decision making.

- **Discuss safer sex options** for all risk behaviours including vaginal, anal, and oral sex (fellatio and cunninglingus).

- **Discuss the option of abstinence**. Teach the client to care in other ways (e.g., notes, small gifts,

[9] Richmond, M., Barash, M. (2002). Refusal Skills – When No Means No. Journeyworks Publishing. Santa Cruz, C.A. Title #5032.

Strategies for Teaching U2 Clients about Safer Sex Negotiation[9]

doing something special). Offer alternatives to sex (e.g., go to a movie or party instead), or use "no-risk" activities (e.g., kissing, hugging). Reinforce with the client that even if they are kissing or making out, they can still say no to sex.

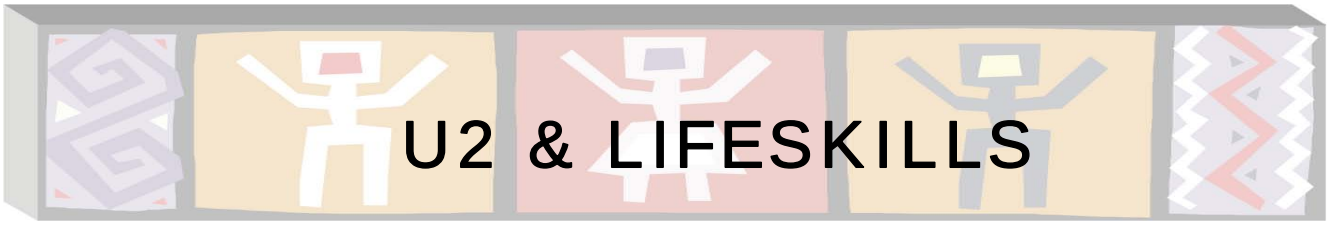
- **Encourage the client to listen to his/her partner's feelings.** The partner may support the decision re safer sex, but may also feel insecure or hurt. The client should reassure his/her partner that safer sex is about respecting needs.

Additional Resources

Bernstein, E. (2001). Sexual Abstinence – When Your Partner Wants to Have Sex (and you don't). Journeyworks Publishing. Santa Cruz, CA. Title #5248. Brochure written in plain language.

Health Canada (1999). HIV Transmission. Guidelines for Assessing Risk. Canadian AIDS Society. Ottawa, ON.

Richmond, M., Barash, M. (2002). Refusal Skills – When No Means No! Journeyworks Publishing, Santa Cruz, CA. Title #5032. Brochure written in plain language.



Life skills are the problem-solving skills individuals use to manage their lives successfully in five areas: self, family, community, career and leisure. [10] [11] Life Skills topic areas include: personal well-being, relating to others, managing (e.g., problem-solving), coping, contributing to community, and working.

Life skills are learned through experience, and must be practised over and over before they become integrated as a part of the client's regular behaviour. Many U2 clients have limited life skills to cope with the many complicated health, lifestyle and other issues they may face. Life skill limitations may include poor self-esteem, lack of assertiveness, limited problem solving ability, poor social skills. In order to help a client make positive changes in his/her behaviour and/or lifestyle, workers should support him/her in the development and integration of helpful life skills.

Life skills training is usually intensive (full days for 12 weeks) and experiential. A group format provides the opportunity for both skill development and practice in a realistic setting. The Life Skills coach uses experiential techniques such as role-playing, structured exercises and small group discussion to facilitate learning and behaviour change.[12]

The following are examples of the areas where a client may require life skills development. Specific lifeskills training is required in each area where a deficit exists and tailored programs should be found or developed considering the client's developmental and cognitive abilities.

[10] Himsl, R. (1973). Life skills: A course in applied problem solving. *In* Readings in life skills. *Edited by* V. Mullen. Department of Manpower and Immigration, Prince Albert, SK. 13-25.
[11] YWCA Toronto, (date unknown). Professional Facilitator Resources. What Are Life Skills? Retrieved December 12, 2003, from YWCA Toronto website: www.ywcator.org/lifeskills/training/index.htm
[12] YWCA Toronto. (date unknown). Professional Facilitator Resources. What Are Life Skills? Retrieved December 12, 2003, from YWCA Toronto website: www.ywcator.org/lifeskills/training/index.htm

Life Skill Areas[13]	
Personal Well Being • Self-esteem, self-image • Self-responsibility • Self-discipline • Managing feelings • Self awareness & acceptance • Confidence • Cultural identity • Spirituality	Poor self-esteem, lack of confidence and lack of self-discipline can interfere with a client's ability to maintain a safe and healthy lifestyle. Sometimes intense life experiences such as living on the street, involvement in the sex trade, substance use or incarceration can alter a client's identity.[14] A negative self-image or unhealthy lifestyle patterns can create challenges. Some people may feel disconnected from their cultural or spiritual base. The traditional Aboriginal view of health emphasizes the "whole" person (i.e., mind, body, emotions and spirit). Workers need to be sensitive to cultural views of illness, sexuality and spirituality. It is important to understand what cultural and spiritual practices a client may cherish and offer opportunities for involvement (e.g., going to church, talking to a priest, praying with sweet grass, participating in a "sweat"). [14]
Relating to Others • Social skills • Relationships – caring, sharing, empathy, trust, roles • Communication – questioning, listening, give/receive feedback, assertiveness • Expressing feelings • Anger management • Conflict resolution • Sexuality	A lack of social skills is often central to a client's difficulty in forming and maintaining positive, long-term relationships with family, friends and partners. Good social and communication skills are essential in situations where the client needs to insist on safer sex practices. It is important for the client to understand and feel comfortable with his/her own sexuality, sexual needs and issues in order to develop healthy relationships. A client living with HIV needs to be able to express his/her feelings in order to access personal support. Social skills training is highly recommended for U2 clients. [14]
Managing • Problem-solving • Decision making • Goal setting • Planning, organizing • Motivating (self and others)	A client with HIV needs strong skills to deal with the many special needs presented by his/her health and social situation. Skill areas include problem solving, decision making, goal setting, planning and organizing. A good example of a practical problem solving approach that can be applied to a wide variety of situations and problems was developed by Monti et al.[15] (1989) in their work with substance abuse. Steps include: (1) Problem recognition – determine that a problem exists; (2) Problem Identification - gather information, be as concrete as possible, check for accuracy, and define the problem; (3) Consider various approaches- generate a number of alternatives; (4) Select the best approach – consider the outcomes and feasibility of the alternatives, then choose the best approach with maximum positive and minimum negative consequences; (5) Implement the chosen alternative and evaluate its results.[14]

[13] Iowa State University. (2003). Targeting Life Skills – Model and Evaluation. Retrieved October 14, 2003, from Iowa State University website: www.extension.iastate.edu/4H/lifeskills/previewwheel.html

[14] Health Canada. (1998). A Comprehensive Guide for the Care of Persons with HIV Disease. Rehabilitation Services. Module 7. p 14. Canadian Public Health Association Canadian HIV/AIDS Information Centre. Ottawa, ON.

[15] Secondary Source - Monti, P. M., Abrams, D. B., Kadden, R. M., & Cooney, N. T. (1989), Treating alcohol dependence, New York: Guilford Press. from Government of Canada (2003). Literature Review - Substance Abuse Treatment Modalities. Correctional Services of Canada. Retrieved on December 10, 2003 from Government of Canada Website: www.csc-scc.gc.ca/text/pblct/litrev/treatmod/toce_e.shtml

Coping • Stress management • Healthy lifestyle choices • Disease prevention • Personal safety	Chronic or acute stress can effect one's health and coping ability. Under stress, a client may be more likely to refuse treatment, go AWOL, ignore medications, or seek unhealthy outlets for stress relief (e.g., sex with a stranger, alcohol or drugs). Find out what stress management techniques work best for your client (e.g., meditation, visualisation, music, relaxation techniques).[14]
Contributing to Community • Volunteering • Contribution to the group	Opportunities to demonstrate generosity and caring toward others are critical to ensuring a client's positive sense of self and self-esteem. Being able to contribute something to others empowers those who have been disempowered by being on the receiving end of services (i.e., labelled "the client", or "the problem"). Research demonstrates that contributing to others increases sense of self-worth, improves self-esteem and develops one's ability to cope with life's conflicts.[16]
Working • Marketable skills, education, training • Job search-resumes, interviews • Employment readiness – being on time, appropriate behaviour, regular attendance	Education and employment skills are a more complex skill set that typically follow development of other personal and interpersonal life skills (e.g., social skills). A client may have serious drug, behavioural, or mental health issues that need to be dealt with before education or employment are addressed. In the long run, increasing a client's employability through training or further education can have a positive effect on his/her lifestyle after treatment.[9]

Additional Resources

Adilman, A. Maxell, J. & Wilkinson, S. (1994). Core Lessons For LifeSkills. Government Publication Services, British Columbia. www.c2t2.ca/article.asp?item_id=2713&path=ecc

The Canadian Alliance of LifeSkills Coaches and Associations - Homepage. www.calsca.com Provides links to good Life Skills resources and training opportunities.

YWCA of Greater Toronto. Life Skills Training Resources Volume 2. YWCA of Greater Toronto. Toronto, ON. www.ywcator.org/lifeskills/publications/vol2.htm A collection of 35 lesson plans on a variety of Life Skills topics. Field-tested by Life Skills coaches. Features lessons on anger, goal-setting feedback, motivation, and self-esteem.

YWCA of Greater Toronto. Life Skills Training Resources Volume 3. YWCA of Greater Toronto. Toronto ON. www.ywcator.org/lifeskills/publications/vol3.htm A collection of 40 additional lessons on a variety of Life Skills topics. Lesson plans on creative problem-solving, stress, coping with limitations and fears, sexuality, communication, humour, affirming ourselves. Developed and used by YWCA Life Skills coaches in community groups.

[16] Brendto, L., Bokenleg, M. Bockern, S. (1990). Reclaiming Youth at Risk. National Educational Service. Bloomington Indiana. P. 45.

Stages of Change

Changing one's behaviour patterns is a complex and gradual process. In their work with addictions, Prochaska and DiClementi[17] identified a change process called ***Stages of Change*** (also known as the Transtheoretical Model -TTM). Stages of Change refers to the process a person goes through in order to change an established behaviour or habit. This change theory has been applied to many personal change processes in the health promotion field, such as smoking, safer sex and condom use, weight loss, exercise etc.. The actual change process does not always happen in a linear fashion. A person may be at different stages for different issues (e.g., not aware that poor nutrition is affecting their health – precontemplation; aware of the need to practise safer sex, but not yet able to do this consistently – contemplation; taking medication consistently as prescribed – action). A person can start the change process and move forward from any stage. For example, it is quite common for alcoholics or drug users to relapse (during action or maintenance) and then start the change process again beginning at the contemplation or preparation stage.

Pros and Cons of Change

A key concept within the stages of change theory is that of ***decisional balance***.[18] When considering a change in behaviour, a person weighs the pros and cons of continuing the current behaviour with those of changing to a new behaviour. When the pros outweigh the cons of a new behaviour, the person will be more likely to change.

Matching the Intervention to the Stage

To help facilitate a change in behaviour, workers must ***choose interventions that match the particular stage of change***. For example, giving information can help move a person from precontemplation to contemplation, but continuing to give more information is unlikely to result in a behaviour change (e.g., at the action phase). That is why, when encouraging safer sex practices, simply giving information about safer sex and condom use may not result in a change in behaviour. Adding other strategies such as demonstrating how to use the condom, role playing scenarios, developing assertiveness skills, and setting specific personal goals will be more likely to influence behaviour change. The stages of change and some strategies are listed below:

[17] Prochaska, J. DiDlemente, C. Norcross, J. (1992). In Search of How People Change. *American Psychologist*. 47(9), 1102-1114.
[18] Prochaska, J. Velicer, W. Rossi, J. Goldstein, M. Marcus, B. Rakowski, W. Fiore, C. Harlow, L. Redding, C. Rosenbloom, D. Rossie, S. (1994). Stages of Change and Decisional Balance for 12 Problem Behaviours. *Health Psychology.* 13 (1) 39-46.

Stages of Change[19]	Strategies
Precontemplation Person is unaware that there is a problem and therefore is not planning to make any changes.	• Provide information and feedback to increase the person's awareness and perception of a risk to his/her health. • Point out the impact of his/her behaviour on others. • Provide encouragement. A person needs to believe he/she has the ability to change in order to develop the motivation to try.
Contemplation Person is aware of the problem or issue and is seriously thinking about changing but has not yet made a commitment to act. The person is still weighing the pros and cons of making a change.	• To move out of this stage, the person needs to continue to learn, to believe in his/her ability to change and to think about decision-making. • Support the person to re-evaluate personal lifestyle, make a decision to change, and explore realistic options and choices. • Help the person explore the pros and cons of the new and old behaviour.
Preparation Person intends to take action in the near future and is taking steps to get ready for the change. The person may even report some small behaviour change, such as drinking less or purchasing condoms.	• Give positive reinforcement for the plan to act. • Acknowledge any change the person has already made. • Include an action component such as setting concrete realistic goals, role playing or skill development. • Help the person find and sign up for a treatment, training, and/or support group.
Action Person starts to change behaviour by actively practising new behaviours (e.g., attending AA, not drinking, using condoms consistently). This stage involves a lot of time and energy, and changes are most visible. Over time, the new behaviour is used more consistently and skills improve.	• Support the person to practice the new behaviour as consistently as possible; learn to accept or seek help to achieve the goals; learn coping skills and become more assertive. • Provide support, feedback, encouragement, and acknowledgement of the changes you see. • Help the person identify and avoid situations or cues that trigger the old behaviour.
Maintenance Person has practised the new behaviour consistently for at least six months. The focus is to prevent a relapse and consolidate the gains made during action. During maintenance the new behaviour must become part of the person's lifestyle. The maintenance phase can extend from six months to years to a lifetime.	• To remain in the action stage and not relapse, the person needs ongoing encouragement and support. • Build in reinforcements (self- rewards). • Develop positive substitutes for the old behaviour or activity (e.g., develop new interests and new peer group to replace drinking/drug, or risky sexual activity). • Change the environment (e.g., remove cues and/or stay away from situations that trigger old behaviours).
Relapse Relapse can occur at any stage of the change process. For some behaviours such as addictions, relapse is common. The person returns to a previous stage of behaviour, most often to the contemplation or preparation stages.	• The strategies used for relapse should be matched to the person's current stage. For example, if the person relapses to the contemplation stage, reuse the intervention strategies for that stage.

[19] Prochaska, J. DiDlemente, C. Norcross, J. (1992). In Search of How People Change. *American Psychologist*. 47(9), 1102-1114.

U2 & AGGRESSIVE BEHAVIOUR

Aggressive Behaviour may arise for a number of reasons. The behaviour may be a symptom associated with a specific disorders (e.g., bipolar disorder, schizophrenia, FAS, HIV-related dementia). The behaviour could also be a reaction to the effects of a disorder (e.g., anxiety, impulsiveness, frustration, drug/alcohol intoxication). In some cases, aggressive behaviour may be a learned way of coping that the client has developed to deal with situations he/she can not control. This may be especially true for people with limited communication and coping skills (e.g., limited assertiveness, poor problem-solving) or with limited social skills (e.g., resolving relationship issues). Other factors that can influence aggressive behaviour are psychiatric diagnosis, previous history of violence, substance abuse, alcohol or drug withdrawal, delirium, dementia, gender, beliefs, self-talk, psychological state (e.g., level of stress), and environment (including staff behaviour).

Be proactive. Challenging behaviours such as defiance, property destruction, self-injury, and aggression can be disruptive or even dangerous and can increase a client's social isolation or exclusion. When working with a client with potential for aggressive behaviour, **the best strategy is to be proactive** and develop positive supports to help the client prevent the challenging behaviours, and learn new pro-social/behavioural skills. The long-term goal should be to improve the client's overall quality of life.

Positive Behaviour Support is a client-centred approach to working with challenging behaviour that involves both behaviour analysis (i.e., functional assessment) and systems change (i.e., modifying the environment or staff approaches).[20]

The following suggestions can help to provide a positive proactive approach to supporting a client with challenging behaviours:

1. Spend time getting to know the client as an individual. What are his/her interests, abilities, likes, dislikes? Don't let the behaviour define the client or your relationship with him/her. Concentrate on the client's strengths and on providing adequate positive support rather than on deficits or diagnoses.
2. Pay attention to the client's general health by making sure he/she is getting good nutrition and adequate sleep. Challenging behaviours may arise because the client is not feeling well or because of some underlying health condition or drug side-effects. Contact the client's doctor or psychiatrist if health is a concern.
3. Think of challenging behaviour as a form of communication. Think about what the behaviour could mean or what needs are not being met. For example, the behaviour could mean that the client is lonely, bored, afraid, feeling powerless, isolated or rejected.
4. Help the client improve self-esteem and overall quality of life by focusing on the positive (e.g., abilities, successes) and developing a social network. Help the client build some fun into life.

[20] Horner, R.H. (1999). Positive behaviour supports. In M. Wehmeyer & J. Patton, (Eds.), Mental Retardation in the 21st Century. 181-196. Austin, TX: Pro-Ed.

5. Work with the client and support staff to develop a plan to prevent/decrease challenging behaviours and increase social/personal skills and choices. Ask the client what works best for them. Think about what kind of support the staff will need as well. Create an environment in which everyone feels respected and empowered.

Any client who has a history of aggressive behaviour should **have a proactive plan in place, developed with a psychologist or behavioural specialist, to guide appropriate staff responses and interventions.**

Note that there is a difference between addressing **predictable behavioural outbursts** with processes laid out in a personalized behaviour plan, and dealing with an **unexpected crisis situation**. The following crisis intervention techniques are intended to be used when dealing with an unexpected crisis.

When a Severe Behaviour Crisis Occurs

When severe problematic behaviour or aggression occurs, a quick response is necessary to ensure the safety of all involved and to quickly de-escalate the crisis situation. Safe crisis management procedures should be planned carefully in advance. Remember that the goal of crisis management is to ensure the safety of the client and those around him/her, and to de-escalate the problem as quickly as possible.

AVOID OVERREACTION!

Research into crisis management describes a number of distinct stages of crisis development. Crisis prevention/intervention training stresses the importance of matching an appropriate staff intervention to the level of the crisis. Using the wrong intervention at a particular crisis level can escalate the crisis situation (e.g., using a physical intervention to respond to verbal acting out can actually make the situation worse by causing the distressed client to respond physically).

Although described in a linear fashion, a crisis can begin at any of the following phases. If the impending crisis is identified and addressed in the Trigger Phase, a full behaviour crisis incident can often be avoided. The issue may not be fully resolved, but if the client feels listened to, they may calm down enough to prevent a potential behaviour outburst.

Any staff working with a potentially aggressive client should be trained in non-violent crisis intervention methods.

Common Stages of Crisis Development[21,22,23,24]	Strategies[25]
Trigger/Anxiety Phase An event or perceived threat may trigger the crisis. A trigger could be influenced by both internal factors (memory, perception, level of stress, self-talk) and by external factors (the environment, other people). Client shows signs of increasing **anxiety** with a general increase in **physical agitation** (e.g., rapid breathing, pacing, fidgeting, trembling, waving arms, gestures). In some cases the anxiety behaviours may include self-harm. Behaviours may be escalating but are not necessarily aggressive. The client is still rational and can be reasoned with.	Be proactive and find out what might trigger anxiety and escalate behaviours. Be flexible. Adapt environments, schedules, expectations and activities to avoid triggers. **Environment** • Create a calm environment. Think about things like noise level, temperature, lighting, use of colour, space. Arrange the environment to minimize the potential for frustration and anxiety. • Modify the environment to prevent harm (e.g., remove or replace items that the client may harm him/herself with, or that may create danger in a crisis situation). Make sure exits are easily accessible for staff. Allow enough space so the client doesn't feel boxed in. • Avoid crowded spaces or remove client from crowded area - some people with mental health disorders may be overwhelmed around a large number of people. • Some people may react to change, new expectations or rules they view as unfair or too restrictive. Be flexible. Negotiate rules, expectations, responses and consequences in advance. **Problem Solving and Communication Skills** • Challenging behaviour sends the message of needs not being met. The behaviour could mean, "I'm lonely, "I'm bored", "I have no power", "I don't feel safe", or indicate other issues (e.g., mental health symptoms are getting worse or the client is not taking his/her medication). • Help the client identify and express his/her feelings. This may involve practising assertiveness skills. • If the client has limited communication skills, develop other methods or signals to help him/her express frustration, disagreement or increasing anxiety. • Be a good listener and observer. Listen actively and with empathy. Avoid being judgmental. • Be aware of both the client's behaviours and your own. Are the client's behaviours trying to communicate something? Are your behaviours supportive? • Instead of ultimatums, give choices. If the client uses challenging behaviour to express needs, give the client choices. Say, "I know you are upset. What will help you calm down? A walk? A different activity?" **Trust** • Develop a trusting relationship with the client. Find out what strategies were effective in the past when the client was in crisis. Ask the client what has worked for him/her in the past. Be supportive.

[21] Institute of Applied Behavioural Analysis (1995). Possible Phases of Behavioural Escalation, Los Angeles, CA.
[22] Crisis Prevention Institute (1984). The Stages of Crisis Development Brookfield, WI.
[23] The Canadian Training Institute. (date unknown). The Arousal Cycle , Toronto, ON
[24] Arnett, A. (1994) Community Care- Safety First
[25] Knudson, K. (2003). Precipitating Factors Which Influence Crisis and Anger. Supported Lifestyles. Calgary, AB.

Common Stages of Crisis Development[21,22,23,24]	Strategies[25]
	Stress • As anxiety goes up, expectations and demands from staff should go down. Be helpful and supportive, not demanding. • Be aware of the possible stressors in the client's life and help him/her to reduce stress where possible. Additional stress can create a crisis or outburst. **Self-Talk** • Self-talk can help a client prepare for a situation and increase his/her chances of coping well. Teach positive and calming "self-talk" to prepare for stressful situations and encourage "self-talk" to de-escalate anxiety and crisis situations (e.g., "I'll just sit and relax a minute.").
Escalation or Defensive Phase The client begins to give cues, verbally and non-verbally that he/she is **losing control**. Staff may not know the source of the anxiety but can see that something is "different". Behaviour changes may include **verbal agitation** – (e.g., mumbling, swearing, questioning, refusing, name-calling and yelling). Behaviour may escalate to **verbal aggression** – threats or aggressive talk directed toward others (e.g., I'll hit you.), or toward self (e.g., I'm going to cut myself with this knife.").	The client may be losing control and not responding to your verbal intervention. Try to de-escalate the situation using the following strategies: • Try to diffuse the situation by diverting the client's attention to something more positive that he/she likes. Although this won't solve the problem, it gives staff more time to work out a solution with the client. Diversion works well for people with FAS, ADD or Aspergers. • Be direct. Set limits. Make sure the limits are simple and clear to the client. Setting limits may help him/her regain control. • Be sure the limits are reasonable, clear and enforceable (e.g., If you continue to yell, you must leave the area. If you calm down, you can stay.) • Don't issue ultimatums (e.g., do this or else). • Inform the client of the limits and the positive consequences of compliance. • Make the client feel they have a choice (e.g., "If you quiet down you can remain in the area"). The consequences (e.g., leaving the room) are determined by the choice the client makes. • Some people need help to calm down. They can't do it on their own. Guide them through calming activities such as deep breathing, stomping, stretching, singing loudly (as written in their behavioural plan). • Maintain the client's physical space (e.g., allow 5 times greater space than normal). Direct others out of harm's way.
Crisis Phase **Total loss of control** which often involves **physical aggression** (e.g., fist shaking, attempts to strike, hitting objects) and could include a **physical assault** on staff or others, property destruction, or **self-harm.**	Losing control is frightening and unpleasant for the client. Violence is usually not planned. It is simply an explosion of built-up energy. • Use physical control of a client's behaviour **only as a last resort** after all other efforts have been tried - when the client is no longer responding to reason and presents a danger to self, staff or others (refer to your agency's restraint protocol). • A physical hold is sometimes used as an emergency restrictive procedure. Staff restrain the client from moving his/her limbs and/or body to protect the client or others from harm (e.g., if the client is wielding a weapon, limiting movement of his/her hand may protect others from harm).

Common Stages of Crisis Development[21,22,23,24]	Strategies[25]
	• Physical control should never be used as punishment. • Physical restraint **may only be used by those trained** and competent in safe restraint techniques. • **A client should never be restrained face down or on the ground. This type of restraint is extremely dangerous and has resulted in death!** • Restrain the client only until he/she is able to regain control. • While restraining the client, reassure him/her that he/she is okay and is not going to be harmed. • Encourage the client to take a few deep breaths to help him/her relax and regain control. • Always document any type of restraint and report it to a supervisor
Recovery Phase During the crisis phase the client experiences a total release of energy. As the client "comes down" they may seem confused, emotionally withdrawn, remorseful, tired, and apologetic.	The best response at this time is communication. • Talk to the client using simple, clear phrases. • Assure the client that if he/she remains calm you can stop restraining him/her. • Allow the client to "make his/her own choices", while staff still maintain full control. • The more you encourage the client to talk the quicker he/she may regain control. • Re-establish the relationship by doing normal or routine activities. • Staff need to recognise their own feelings and realise their client's limits. If a staff is feeling too upset (e.g., insulted, physically hurt) they may need to ask another staff to take over this phase of crisis intervention. Staff must remain professional and not hold grudges.

SPECIAL HIV NOTE

HIV status may be a complicating factor when working with challenging behaviours. HIV positive people may use their HIV to threaten or intimidate others (e.g., threatening to infect someone with a used needle or a cut on a hand, intentionally not taking safer sex precautions) because they are angry or not coping well with the HIV diagnosis. One way to deal with these situations is by educating others about the real risks of transmission. If people do not react fearfully to the client, he/she will lose the ability to intimidate or threaten, and likely change his/her behaviour.[26]

Safety:[27] A client with HIV who is threatening to spit, bite, scratch, cut, or smear feces, blood, or urine, should be treated the same as any other client whose HIV status is unknown to you. Use Universal Precautions to clean up (e.g., feces, urine, blood).

Universal Precautions for Working With Clients With HIV The best way to control the spread of any infection is to use proper hygiene. People who are HIV positive can more easily get infections, colds, flu. Using Universal Precautions helps to protect the client with HIV from sources of infection or illness. Where blood is involved, it is important to use Universal Precautions, the measures

[26] Health Canada. (1997). Comprehensive Guide for the Care of Persons with HIV Disease. Module 6: Psychosocial Care. 81. **Canadian Public Health Association** Canadian HIV/AIDS Information Centre**, Ottawa, ON.**
[27] Health Canada. (1999). HIV Transmission. Guidelines for Assessing Risk. Canadian AIDS Society. Ottawa, ON.

developed to deal with blood-borne diseases like HIV and Hepatitis B. Universal Precautions should be used for every client whether you know their HIV status or not.

- Wash hands with soap and water immediately after contact with blood.
- Cover cuts.
- Use absorbent material to stop bleeding.
- Wear disposable latex gloves when cleaning blood or if you have open cuts. Wash hands immediately after removing gloves.
- Immediately clean bloodstained surfaces with soap and water and then disinfect with bleach solution: 1 part bleach to 9 parts water. Household bleach kills the HIV virus.
- Machine-wash bloodstained laundry separately in hot soapy water.
- Place bloodstained materials in sealed plastic bags and discard in a lined, covered garbage container.

Additional Resources

Beach Centre on Families and Disability. (1998). **Ten Ways to Support a Person with Challenging Behaviour**. www.pbis.org/english/Ten_Ways_to_Support_a_Person.htm An excellent resource to guide positive behaviour change.

The Crisis Prevention Institute, Inc. Homepage.
www.crisisprevention.com/store/pamphlets/hspamphlets.html This site provides excellent pamphlets and resources for front line staff. In Calgary, contact Universal Rehabilitation Services Agency (URSA) at 403-272-7722 or Supported Lifestyles at 403-207-5115 for training (Agreement to train PDD-funded services) in **CPI Non Violent Crisis Intervention** (trainers certified by the Crisis Prevention Institute Inc.).

Florida Department of Education **(1999)**. **Facilitators Guide on Positive Behaviour Support**: www.fmhi.usf.edu/cfs/cfspubs/pbsguide/facilitatorguidepbs.htm A training booklet for development of positive behaviour support plans.

Greenstone, J. L. & Leviton, S. C. (1993). **Elements of Crisis Intervention**. Brookes/Cole Publishing, Pacific Grove, California, pp. 91-101. Provides practical strategies for communicating with a person in a crisis situation.

Institute for Applied Behaviour Analysis. (2001). **IABA Professional Training Resources.** www.iaba.com Provides resources for those interested in non violent crisis intervention and supportive behaviour management techniques.

OSEP Technical Assistance Centre on **Positive Behavioural Interventions & Supports**.
www.pbis.org This site provides information on functional behaviour assessment, a step by step process for developing positive behaviour change strategies, as well as links to research, books, articles and resources on positive behaviour support.

Rehabilitation Research & Training Centre on Positive Behaviour Support. **PBS Practices**. http://rrtcpbs.fmhi.usf.edu/pbs_practices.htm This site contains brief fact sheets that describe effective practices in Positive Behaviour Support.

Rehabilitation Research & Training Centre on Positive Behaviour Support. **Research Briefs.** rrtcpbs.fmhi.usf.edu/research_briefs.htm. This site contains user-friendly summaries of key research articles in Positive Behaviour Support.

Harm Reduction

U2 & SUBSTANCE ABUSE-ALCOHOL

Substance Abuse is a common issue for the U2 client group. Substance abuse puts people at higher risk for contracting HIV and for behaviours that may contribute to the spread of HIV. Alcohol and/or drugs may be used as a way of coping with the diagnosis of HIV, mental health issues, depression, or low self esteem. The substance abuse itself often makes the underlying symptoms, issues or situational factors worse.

Substance abuse can be associated with aggressive and violent behaviours because people are less inhibited when under the influence of drugs or alcohol. People under the influence of drugs or alcohol are less likely to plan ahead and take precautions, such as safer sex or safe needles.

Alcoholism is also known as "alcohol dependence." It is a disease that includes craving alcohol and continuing drinking despite repeated alcohol-related problems, such as losing a job or getting into trouble with the law.

Alcoholism involves a physical dependence. Alcoholism is a treatable, but not a curable disease. Even if an alcoholic has been sober for a long time and has regained health, he/she may relapse and must continue to avoid all alcoholic beverages.

Studies show that a minority of alcoholics remain sober one year after treatment, while others have periods of sobriety alternating with relapses. Still others are unable to stop drinking for any length of time.

Alcoholism Indicators[28]	Description
Cognitive	**Cravings** A strong need or compulsion to drink.
Behavioural	**Lack of control** Not able to limit one's drinking on any given occasion.
Physical	**Physical dependence** • Withdrawal symptoms, such as nausea, sweating, shakiness, and anxiety, when alcohol use is stopped after a period of heavy drinking. Withdrawal may also occur after spending time in the hospital where alcohol was not available. **Tolerance** • The need for increasing amounts of alcohol in order to feel its effects.

[28] MedicineNet. (date unknown). Alcohol Abuse and Alcoholism. Retrieved October 12, 2003, from Medicine Net website: www.medicinenet.com/Alcohol_Abuse_and_Alcoholism/article.htm

Social	• Environment, peer influence, stress and how easy it is to get alcohol all influence drinking behaviours. • Social support is important for people with alcohol problems.

Implications for U2 clients
• Feeling less inhibited while drinking may lead to spontaneous sexual activities without thinking about the consequences – (e.g., not using safer sex practices/condoms when intoxicated). • Craving alcohol or wanting social contact with his/her peer group may lead to AWOL if the client does not have alternative activities and positive peer friendships. • May have aggressive or violent outbursts when under the influence of alcohol. • Alcohol use may complicate or mask medical problems and lead to increased symptoms of other disorders such as depression, schizophrenia, diabetes, etc. • General health of people who use substances may get worse because many are not working and have no steady income, so they have poor housing and inadequate nutrition. • Alcohol use may interfere with a client's ability and/or willingness to follow treatment (e.g., keep appointments, take medications, etc.).

Common Effects	Strategies[29]
Physical Cravings for Alcohol	• Remove negative influences/triggers from the home or living area and make alcohol harder to get (e.g., make an inventory of all the things in the home that reminds the client of drugs or alcohol, then remove those things). • Choose housing in an area where one must travel a long way to get alcohol (i.e., no bars or liquor stores nearby). • Encourage the client to eat nutritious meals and non-alcoholic drinks. • Encourage the client to attend an alcohol treatment program.
Social	• Help the client learn how to identify, plan and participate in positive and fulfilling sober activities that can fill in time that was formerly spent using drugs or alcohol, Encourage the client to change his/her social group and avoid situations where there are drugs or opportunities for unprotected sex. • Teach time management skills, help the client brainstorm ways to fill his/her time, and to follow through with lifestyle changes. • Give regular reminders and support to get the client to medical appointments and to consistently take medications and/or other prescribed treatments. • Encourage the client to attend addiction related support groups regularly. • Help the client find a "sponsor" or mentor to support him/her to abstain from alcohol use.
Depression, hopelessness, low self esteem	• Develop alternative strategies (other than drinking) for dealing with stress, feelings of depression, and fears related to having HIV (e.g., regular exercise, attend a self-help group, practice relaxation, talk with an HIV "buddy"). • Encourage the client to maintain self-care (e.g., regular bathing, clean clothes, tidy home).

[29] Kimberly S. Walitzer, Ph.D. and Gerard J. Connors, Ph.D.(1999). Treating Problem Drinking Update on Approaches to Alcoholism Treatment, 23(2). Retrieved October 12, 2003, from National Institute on Alcohol Abuse and Alcoholism site: www.niaaa.nih.gov/publications/arh23-2/138-143.pdf

Common Effects	Strategies[29]
Financial Issues	• Review finances to help the client meet basic needs – such as food, housing, medications. Help the client apply for any financial supports available to them.
Impulsive Behaviours & Relapses	• Set strict boundaries and explain your organization's rules clearly (e.g., for those in group living situations). • Be flexible – Set appointments at times that are appropriate and realistic for the client to achieve. • Work on prevention, focusing on strategies to reduce harm and trying to make the changes manageable and sustainable. • Role play and practice desired behaviours such as assertiveness – for example saying "no" to alcohol; negotiating safer sex. • Be prepared for relapses, they are common and do not mean the client has failed. If a relapse occurs it is important to try to stop the drinking again and get whatever help is needed to quit using alcohol. • When an alcohol-related problem and/or relapse has occurred, wait until the client is sober and then discuss the situation, issues and consequences shortly after the drinking incident. • To keep 'lapses' from becoming relapses: 1) recognize that lapses are likely to occur, 2) don't shame the client or treat the lapse as an unforgivable failure, and 3) take immediate steps to keep the lapse from happening again (e.g., remove the temptation, get away from the stress, etc.). • Stay objective – don't take it personally when the client misses appointments or has a relapse.

SPECIAL HIV NOTE

Both severe alcoholism and HIV can lead to a form of dementia that causes deterioration of a client's intellectual ability. Some people living with HIV develop neurological problems resulting from direct or indirect effects of the virus and these can lead to behaviours ***that look similar to the later stages of alcohol addiction.*** People who have had HIV for many years with no or inconsistent HIV treatment may develop dementia-type symptoms.

HIV related dementia is known as ADC - AIDS Dementia Complex. Some people experience only subtle symptoms. Some people have a gradual mental decline, whereas others get worse in a short period of time.

Symptoms may include:

- forgetfulness
- lack of concentration and attention
- decreased visual/motor skills or writing skills
- irritability
- hallucinations

Update the client's psychiatrist or doctor if you notice symptoms that are unusual.

HIV Medication Side Effects

Some HIV medications may have side effects similar to some characteristics of substance abuse. Potential medication side effects may include:

- irritability
- depression
- severe agitation
- anxiety
- confusion
- memory loss
- headaches
- insomnia
- loss of appetite

Check with doctor if medication side effects are suspected.

Additional Resources

Alberta Alcohol and Drug Abuse Commission. (2001-2003). **Information on Alcohol. Fact Sheets.** Published by AADAC. http://corp.aadac.com/alcohol/index.asp (AADAC) is a good source of information on addiction issues.

Lands, L. (2002). **A Practical Guide to HIV Drug Side Effects.** Published by the Canadian AIDS Treatment Information Exchange. Toronto, ON. www.catie.ca/pdf/SIDEEFF_EN.pdf For more detailed information on medication side effects.

National Institute on Alcohol Abuse and Alcoholism. (1996). **How To Cut Down On Your Drinking.** Published by National Institute on Alcohol Abuse and Alcoholism. www.niaaa.nih.gov/publications/handout.htm. A practical self-help brochure and workbook that can be downloaded from this site.

Harm Reduction

U2 & SUBSTANCE ABUSE-DRUGS

Substance Abuse is a common issue for many U2 clients. It is an issue that not only affects judgement, but also the ability to manage daily tasks (e.g., finances, employment, housing, nutrition). Substance abuse often places people at higher risk for contracting HIV and at higher risk for behaviours that may contribute to the spread of HIV (e.g., not using a condom). Some may use alcohol and/or drugs as a way of coping with an HIV diagnosis, mental health issues, depression, low self-esteem or abuse. The substance abuse itself often makes the underlying symptoms, issues or situational factors worse.

Substance abuse can be associated with aggressive and violent behaviours due to reduced inhibitions. People under the influence of drugs or alcohol are less likely to be able to plan ahead and practice safer sex or safer injection.

Addiction often begins with substance abuse, when a client looses control and develops a compulsion or physiological dependence to use a mind altering substance. Addiction is not just "a lot of drug use." Research indicates that drugs interfere with normal brain functioning, and have long-term effects on the brain. Changes occur in the brain that can turn drug abuse into an addiction, which is defined as a chronic illness. Drug treatment is often necessary to end this compulsive behaviour.[30]

Drug addiction is treatable. Through treatment that is tailored to a client's unique needs, one can learn to control the condition and live a relatively normal life.
The immediate goals of treatment are:[31]

- to reduce drug use,
- to improve the client's ability to function, and
- to minimize medical and social complications of drug abuse.

The long term goal of treatment is:

- to enable the client to achieve lasting abstinence.

Research shows that only two thirds of those addicted to drugs will ever stop harming themselves: 1/3 will stop using drugs; 1/3 will decrease drug use and 1/3 will never stop. People with drug addictions who stay in treatment longer than 3 months usually have better outcomes than those who stay less time.[32]

[30] National Institute on Drug Abuse. InfoFacts. (2003). Understanding Drug Abuse and Addiction. Retrieved October 12, 2003, from NIDA website: www.drugabuse.gov/infofax/understand.html
[31] National Institute on Drug Abuse, InfoFacts. (2003). Understanding Drug Abuse and Addiction. Retrieved October 12, 2003, from NIDA website: www.drugabuse.gov/infofax/understand.html
[32] National Institute on Drug Abuse. InfoFacts. (2003). Drug Addiction Treatment Methods. Retrieved October 12, 2003, from NIDA website: www.drugabuse.gov/infofax/treatmeth.html

Injection Drugs	Non Injection Drugs
Note: drugs which are injected often come in powder form or pills which can be crushed) • Amphetamines (Speed, Crystal Meth, Ice, Methamphetamine) • Cocaine • Morphine and Other Opioid Pain Killers • Heroin • PCP (Angel Dust) • Steroids • Talwin & Ritalin (T's and R's)	• Cannabis (Marijuana, Hash) • Club Drugs (e.g., Ketamine, GHB, Rohypnol) • Ecstasy (MDMA) • Inhalants • LSD • Over the Counter Drugs • Tranquilizers and Sleeping Pills • Crack (can be injected if broken down with an acidic liquid - e.g., vinegar)

The following chart is a short summary of the most popular drugs in Calgary currently.

"UPPERS"

These drugs **stimulate** the central nervous system

Proper and *Street Names*	**How is it taken?**	**How long does it take to work & last?**	**What are the effects?**	**What are the negative effects?**	**What are the effects on the unborn baby?**
Cocaine Cocaine comes in 2 forms: 1. powder 2. rock (crack) *-Blow* *-Coke* *-White* *-Up* *-Hard* *-Soft*	-Inhaled/ snorted/ Injected -Crack is usually smoked but it can also be broken down with lemon juice, vinegar, or Vitamin C to be injected	Works in: 3-5 seconds if smoked 15 seconds if inhaled/ snorted 15-30 seconds if injected intravenously Lasts: The high is intense but short -45 minutes for powdered cocaine -20 minutes for crack	-Increases alertness – especially to sensations of sight, sound, and touch -Gives a feeling of euphoria -Reduces appetite and the need for sleep -Increase in energy -People may become talkative -Some may find it helps them perform physical and intellectual tasks	-Severe crash when high is complete -Heart disruptions that can lead to heart attacks -Strokes -Seizures -Headaches -Snorting can lead to loss of smell, nosebleeds, and problems with swallowing -Injecting can lead to track marks, abscesses, blood clots, and endocarditis (heart infections)	-Moms who are using cocaine when they are expecting run the risk of having preterm delivery, separation of the placenta, low birth weight babies, and spontaneous abortions -Babies born to cocaine addicted mothers may be physically or mentally delayed -There is no significant data to support the idea that these babies are born addicted to cocaine
Ecstasy *-E -X* *-Love Drug* *-Dance Drug* *-Hug Drug* *-Blueberry, Strawberry or Banana (depending on the colour of the pill)*	-By mouth in a tablet form -The original form of the drug is a white powder which can be injected or snorted	Works in about 45 minutes Lasts: up to 6 hours but some may last up to 60 hours	-Increase in energy -Decrease in appetite -Strong feelings of well-being and increase in confidence -Feeling of closeness to others -Colours are brighter, music sounds better -Heightened sense of touch -Jaw clenching/teeth grinding	-Insomnia -Depression due to the effects the drug can have on the production, transmission, and reception of seratonin (the hormone which regulates our moods) -Brain damage -Heart damage due to high, sustained heart rates -Liver damage	-No information available
Crystal Meth *-Ice* *-Glass* *-Crystal* *-Crystal meth*	-Normally it is smoked in a pipe -Can be injected and inhaled when in powder form	Works within seconds Lasts up to 16 hours	-The effects are very similar to cocaine, however they last much longer	-Rapid heart and respiration rates -Confusion -Extreme paranoia -Withdrawal can cause severe depression -Extreme violent tendencies	-Babies born to methamphetamine users are more likely to be born prematurely, have low birth weights, and experience withdrawal symptoms like agitation and drowsiness. -They may also have an increased risk of birth defects

"DOWNERS"

These drugs **depress** the central nervous system

Proper and **Street Names**	**How is it taken?**	**How long does it work?**	**What are the effects?**	**What are the negative effects?**	**What are the effects on the unborn baby?**
Cannabis (specifically marihuana and hashish) - *Weed* - *Pot* - *Grass* - *Skunk* - *Hash*	-Smoked in a cigarette (called a blunt or joint) -May also be swallowed	Works within seconds when smoked Lasts up to 3-5 hours	-Feeling of relaxation -Feelings of euphoria -Increase in appetite -Nausea is inhibited -Some who use the drug may talk a lot, while others may be more quiet and withdrawn	-Mental confusion -Inappropriate emotional responses -Problems with short term memory, concentration, and abstract thinking -Impaired motor skills -Poor hand eye co-ordination -Stunts emotional and intellectual growth -Decreases the ability to judge speed, distance, and time -Some users may have hallucinations -Smoking cannabis damages the lungs and can lead to chronic coughing and lung infections -Long term use can lead to cancer -May cause anxiety, panic attacks and paranoia	-Moms who use cannabis during pregnancy may be more likely to have premature and underweight babies, although there is no firm evidence for this -As children grow up they may have some learning and behavioural problems
Morphine *-Grey/ Peach/ Red (depends on the colour of the pill)* *-Mo* *-Mojo* *-Peeler*	-Morphine comes in a pill form which can be taken by mouth but it is often broken down and injected	Works in several seconds to several minutes depending on the method used Lasts approx. 8 hours	-Initially produces a surge of pleasure or a "rush" -Drowsiness -Gives people a warm feeling and state of gratification -Relief from pain	-Slow, irregular heart rate -Irregular blood pressure -Decreased respirations -Those withdrawing from the drug may experience convulsions -Addiction -Injecting can lead to track marks, abscesses, blood clots, endocarditis (heart infection), and chalk lung	-Moms who use morphine while pregnant run the risk of having preterm deliveries, low birth weight babies, and miscarriages
Heroin *-Smack* *-Down* *-H*	Normally, heroin is injected, but, it can also be smoked and inhaled	Works similar to morphine -several seconds to several minutes depending on the method used Lasts approx. 8 hours	-The effects of heroin are similar to the effects of morphine, however, heroin is approx. 3 times more powerful than morphine so the effects are more intensified	-The negative effects of heroin are similar to the negatives effects of morphine, although endocarditis and chalk lung are not as common	-Moms who use heroin while pregnant run the risk of having preterm deliveries, low birth weight babies, and miscarriages -The major signs of withdrawal syndrome include irritability, restlessness, a shrill, high pitched cry, seizures, sneezing, cramps, sleep disturbance, vomiting, diarrhea, fever, rapid heart beat, rapid breathing

Used with permission from Safeworks Calgary (2002). Drugs 101 publication, Calgary Health Region. Original source - Walton, S. (2001). Get the dope on dope: first response guide to street drugs, 2nd Ed. Calgary, AB.

Some U2 clients may have a Public Health Order that does not allow them to use any type of drug (in order to protect themselves and others). **Drug use is illegal and not allowed or encouraged in any institution.** Nevertheless, it is important for staff to be aware of the basic meanings of harm reduction and the associated strategies. Drug treatment and methadone treatment options are important to raise with all U2 clients who have a history of drug use.

Harm reduction[33] The harm reduction approach serves to limit the vulnerability of people who engage in high risk behaviour, and improve their health and well being by increasing access to appropriate education, housing, mental health services, and other supports. Harm reduction is directed at reducing the negative consequences of drug use and is directed at providing a spectrum of strategies that range from **safer use** (e.g., needle exchange), to **managed use** (e.g., Methadone clinic), to **abstinence**.

Abstinence has been the traditional goal for people with addictions and most treatment and support models are based on that. However, for some people, abstinence may be so far out of reach that it becomes an ineffective strategy.[34]

People with complex problems and needs may benefit more from a harm reduction approach, which sets smaller, more achievable goals such as reducing the use of substances. The client's self-esteem may increase as he/she is able to achieve smaller goals and maintain that level of behaviour change.[35]

Even if they don't want to – or can't stop using drugs, they still have the right to get information about HIV and how to take care of themselves. Everyone has the right to understand their treatment and to make decisions about it and be treated with dignity.

Harm Reduction Strategies for Workers [36,37]

- **Accept the client** "where they are at". Be non-judgmental. Establish a trusting relationship.
- **Focus on reducing harm**. See "Strategies to Help a U2 Drug User to Reduce the Risk" on the following page. Examples of harm reduction might include: encouraging contact with Safeworks Calgary for needle exchange, switching to a less harmful drug (e.g., non-injected), encouraging the client to take care of themselves through good nutrition and adequate rest, encouraging him/her to connect with a treatment program when they are ready.
- **Affirm the client as the primary agent** of reducing the risk during drug use or with sexual partners and offer information and resources.
- **Use a case management approach** to address the psychosocial concerns. A client using drugs is often more concerned about psychosocial issues (e.g., financial, housing, legal problems, health issues,

[33] Canadian AIDS Society. (2002). Health is a human right: a brief prepared for the commission of the future of health care in Canada. Retrieved June 18, 2003, from the Canadian AIDS Society website: www.cdnaids.ca/web/backgrnd.nsf/24157c30539cee20852566360044448c/09ebf6326db72c8d85256bf1005fa435?OpenDocument

[34] Health Canada. (1997). Comprehensive Guide for the Care of Persons with HIV Disease. Module 6: Psychosocial Care. p. 92 **Canadian Public Health Association** Canadian HIV/AIDS Information Centre**.** Ottawa, ON.

[35] Health Canada. (1997). Comprehensive Guide for the Care of Persons with HIV Disease. Module 6: Psychosocial Care. p. 92. **Canadian Public Health Association** Canadian HIV/AIDS Information Centre**.** Ottawa, ON.

[36] Harm Reduction Coalition. (2001). Principles of Harm Reduction. (2003). Retrieved October 12, 2003 from Harm Reduction Coalition Website: www.harmreduction.org/prince.html

[37] Marlatt, G. Tucker, J. Donovan, D. & Vuchinich, R. (1997). Help-Seeking by Substance Abusers: The Role of Harm Reduction and Behavioural-Economic Approaches To Facilitate Treatment Entry and Retention. NIDA Monograph 165, p. 44-84. Retrieved October 12, 2003 from National Institute on Drug Abuse website: www.drugabuse.gov/pdf/monographs/monograph165/044-084_Marlatt.pdf

Harm Reduction Strategies for Workers [36,37]

depression and interpersonal problems) than their drug use. Case management could include assessing needed services, planning, linking and monitoring service delivery, reducing barriers to access, and advocacy. If using a team approach, assign a *lead* case manager to ensure frequent team communication.

- **Encourage involvement of social networks** where possible (e.g., family, friends). Research shows that informal social networks can positively influence the client to seek help.
- **Provide information** about the harmful effects of drug use and the service options.
- **Discuss the pros and cons** of continuing drug use behaviour.
- **Establish some future oriented goals** for changing their drug use habits (i.e., safer drug use, decreased drug use, treatment, abstinence). Make sure goals are broken down into specific, small, manageable steps. You may draw up a **contract** with the client and agree on particular goals and actions.
- If a client expresses interest in treatment, try to **arrange for his/her admission as soon as possible** (at least within a week, if not the same day). Many people who seek treatment are ambivalent about stopping their drug use, have unstable lives, and may interpret waiting time to mean that the program is not prepared to help them. **Be sure to provide ongoing support while the client is waiting for treatment.**

Strategies To Help A U2 Drug User Reduce The Risk [38]

The following are harm reduction pointers for injection drug users:

- Use a new, clean needle/syringe/rig every time.
- Do not share any drug use equipment: spoons, cookers, filters, ties, water, straws, pipes.
- When shooting with others, advise client to have own needles, syringes and other equipment that is marked to tell them apart.
- Learn how to prevent an overdose and how to detect overdose symptoms in others.
- Drug substitution means replacing the injection drug of choice with something that doesn't have to be injected or with something less harmful, such as methadone instead of heroin.
- Before injecting, wash hands and the injection site with soap and water to prevent germs from getting into the blood stream. Water, alcohol pads or Sani-Wipes are alternatives if soap is not available.
- A different injection site (rotate) should be used for each injection and don't go back to sites until they are healed. Avoid dangerous injection sites such as the groin, thighs, breasts, wrists, neck.
- Inject drugs in a clean place. There are germs on everything the needlepoint touches, including fingers and clothes. The less it touches, the cleaner it is.

[38] Canadian AIDS treatment Information Exchange (date unknown). Prefix: Harm reduction for positive users Retrieved October 2003, from CATIE website: www.catie.ca/pdf/ENprefixINSERT.pdf

Strategies To Help A U2 Drug User Reduce The Risk [38]

- Recap used needles right away and put it in a sealed puncture-proof container like a pop bottle, tobacco tin, or bleach bottle so nobody can use it again.
- Needles can be taken to a needle exchange. If there is no needle exchange nearby, put the needle in a sealed container and throw it in the garbage where no one will find it or get hurt. Needles can also be placed in the Yellow Community Bins in Calgary.
- Practise safer sex — use condoms for oral, vaginal and anal sex.
- Stay healthy and prevent disease: get tested for HIV, TB (tuberculosis) and hepatitis A, B and C - get vaccinated for hepatitis A and B - get a flu shot every year in early October/November.

How to Increase Motivation for Drug Treatment[39]

- You can increase the probability of getting a client who abuses drugs to enter and continue treatment by using the following strategies:
- Provide feedback about the impact substance use has on physical, social and psychological functioning.
- Provide advice about the need for change and how it may be accomplished.
- Attempt to remove significant barriers to change.
- Provide alternative choices to achieve the change.
- Decrease the attractiveness of substance use by discussing the negative consequences and risks .
- Develop attractive alternatives to substance use by helping the client to become involved with new peer groups and activities.
- Develop a clear set of personal goals for change.
- Encourage regular involvement with a support group such as Narcotics Anonymous for those who are trying to maintain a change in their drug use.

A return to alcohol or drug use does not just happen. Some signals that may indicate a client may be relapsing may include:[40]

- isolates self from others and feels bored and lonely much of the time.
- easily irritated and relationships become strained.
- doubts ability to stay abstinent.
- acts impulsively under stress, which causes even more stress.
- thinks will never use alcohol, drugs again, so doesn't need a recovery program - stops attending support groups or counselling, and rejects offers of help.
- tries to impose abstinence on others.
- eating and sleeping patterns are disturbed and cannot get things done.
- covers up feelings of unhappiness and helplessness.
- feels sorry for self.
- begins to think that he/she can handle alcohol or drugs again.

[39] Miller, W. R. (1985). Motivation for treatment. *Psychological Bulletin* 98: 84-107. Retrieved October 12, 2003, from National Institute on Drug Abuse website: www.nida.nih.gov/pdf/monographs/monograph165/000_TOC165.pdf

[40] Alberta Alcohol and Drug Abuse Commission (AADAC). (2001-2003). Relapse Prevention: Planning for Success. Retrieved January 20, 2004, from AADAC website: http://corp.aadac.com/drugs/brochures/RelapsePrevention.asp

Help the client to avoid relapse by suggesting the following:[41]

- Handle day-to-day feelings and problems as they happen –don't let stress build up.
- Keep a balance in life - reduce stress, eat healthy and exercise.
- Gain support and trust from family and friends.
- Identify and plan for high-risk situations (e.g., going out with friends to a bar).
- Plan and work for success!

Additional Resources

Alberta Alcohol and Drug Abuse Commission. (2001-2003). **Information on Drugs. Fact Sheets.** Published by AADAC. http://corp.aadac.com/drugs/index.asp - good source of information on addiction issues. This site provides user-friendly fact sheets with detailed information on each of the drugs mentioned in this document.

Lands, L. (2002). **A Practical Guide to HIV Drug Side Effects.** Canadian AIDS Treatment Information Exchange. www.catie.ca/pdf/SIDEEFF_EN.pdf For more detailed information on medication side effects.

[41] Alberta Alcohol and Drug Abuse Commission (AADAC). (2001-2003). Relapse Prevention: Planning for Success. Retrieved January 20, 2004, from AADAC website: http://corp.aadac.com/drugs/brochures/RelapsePrevention.asp

Specific Disorders

ASPERGERS SYNDROME

Aspergers Syndrome [42] is a disorder that falls within the Autistic Spectrum, and is sometimes referred to as High-Functioning Autism. Symptoms can range from mild to severe. People with Aspergers Syndrome and related disorders often show a serious lack of social and communication skills. They may have obsessive repetitive routines and preoccupations with a particular subject. People with Aspergers Syndrome frequently have no significant delay in cognitive development and sometimes have average to above average IQ. Some people with Aspergers Syndrome are gifted in the scientific, technical or artistic fields. Because their cognitive abilities are combined with extreme social naivete, people with Aspergers Syndrome are often viewed by their peers as "odd," and are frequently a target for discrimination.

Aspergers Indicators[43]	Description
Cognitive	• Inattention.
Communication	• Literal in speech and understanding (i.e., narrow and concrete understanding, difficulty with conceptual ideas). • Inappropriate body language or facial expression. • Unusual speech patterns (repetitive and/or irrelevant remarks). • Stilted formal manner of speaking, unusually loud, high or monotone voice.
Social / Emotional	• Often are inappropriate and disruptive in social settings, which may be due to a narrow and concrete understanding of social interactions.[44] • Unable to carry on a two-way ("give and take") conversation. • Easily upset by changes in routines and transitions. • Socially awkward and clumsy in relations with others. • Naive and gullible. • Often unaware of others' feelings or unable to understand social cues.
Behavioural	• Fixated on one subject, object, hobby or interest. • May show signs of attention deficit, hyperactivity, irritability, aggressive, impulsive, ritualistic, or obsessive compulsive behaviours. • Unusual body movements, gestures, tics.

[42] (ASPEN) Asperger Syndrome Education Network. (date unknown). What is Asperger Syndrome? Retrieved October 12, 2003, from ASPEN website: www.aspennj.org
[43] (ASPEN) Asperger Syndrome Education Network. (date unknown). What is Asperger Syndrome? Retrieved October 12, 2003, from ASPEN website: www.aspennj.org
[44] Kirby, B. (2001). What Is Asperger Syndrome? Retrieved October 12, 2003, from Asperger Syndrome Information & Support website: www.udel.edu/bkirby/Asperger

Physical	• Sleeping or eating problems. • Overly sensitive to loud sounds, lights or odours. • Physically awkward in sports. • Tendency to rock, fidget or pace while concentrating. • Overly active.

Implications for U2 Clients

- Pre existing problems with social relationships and interactions may negatively impact social support.
- Naïve and gullible qualities place self and others at risk for harm (e.g., could be taken advantage of by a person asking for unprotected sex).
- Changes in routine may be especially difficult.
- Tendencies to be concrete in speech and understanding make it difficult to understand HIV prevention strategies, and HIV treatment, unless directions are explicit.
- Poor appetite may result in poor nutrition.
- Poor self esteem.
- At risk for depression.

Common Effects[45]	Strategies[46]
Lack of Energy or Ability to Initiate Action (Inertia) [47]	• Discourage negative thinking. Present the positive side of things to provide a balanced view. • Help the client find ways to reduce the stress. • Lead from behind. To reduce inertia, try following behind the client. Go at the client's speed. If the client stops, you stop and give encouragement. " You're doing great work getting out the door. Are you looking for something right now?"
Difficulty with Social Interactions	• Give clear instructions on how to interpret other people's social cues direct way (e.g., the meaning of eye contact, gaze, various inflections as well as tone of voice, facial and hand gestures, non-literal communications such as humour, figurative language, irony, sarcasm and metaphor). Include repeated practise, role play and social cue interpretations.[48] • Practice appropriate social behaviours related to specific situations and then gradually try them in actual social situations. • Rehearse meetings with unfamiliar people (e.g., making acquaintances) until the client is aware of the effect of his/her behaviour on other people's reactions. Techniques such as practising in front of a mirror, listening to the recorded speech, watching a video recorded behaviour, and so forth, should all be incorporated in this program. • Teach the client to monitor his/her own speech in terms of volume, rhythm, naturalness, adjusting depending on closeness to the speaker, the situation, number of people and background noise.

[45] Kirby, B. (2001). What Is Asperger Syndrome? Retrieved October 12, 2003, from Online Asperger Syndrome Information & Support website: www.udel.edu/bkirby/asperger

[46] Klin, A. Volkman, F. (1995). Aspergers Syndrome. Guidelines for Treatment and Intervention. Learning Disabilities Association of America. Yale Study Center, New Haven, Connecticut. Retrieved October 12, 2003, from Online Aspergers Syndrome Information & Support website: www.udel.edu/bkirby/asperger

[47] Lynne, G. (1999). Five Survival Strategies To Help Children With Asperger's Syndrome Overcome Inertia. Retrieved October 12, 2003, from Childspirit website: www.childspirit.com/5Aspergers.htm

[48] Kirby, B. (2001). What Is Asperger Syndrome? Retrieved October 12, 2003, from Online Asperger Syndrome Information & Support website: www.udel.edu/bkirby/asperger

Common Effects[45]	Strategies[46]
	• Help the client develop skills to manage social situations with peers. Teach the client how to carry on a social conversation. To develop conversation skills, choose topics typically discussed by same-age peers and then practice skills such as expanding on the topic, shifting topics and ending the conversation appropriately. Help the client to recognize and use different ways to interact, mediate, negotiate, persuade, discuss, and disagree verbally. • Try using social stories: creating a short story that describes the situation and the actions and expressions that could be used by the client[49]. • Encourage and help the client to expand his/her vocabulary and to engage in communicating with others. Help the client develop the ability to make and understand inferences, and to understand motivation and accept that individuals may react in multiple ways. • Avoid words and phases with double meanings (e.g., "draw the drapes," "catch the eye") or take the time to explain what these phrases mean and how they are used appropriately. • People with AS are usually self-described loners despite an often intense wish to make friends and have a more active social life. Help increase the client's social contact by encouraging participation in an activity-oriented group based on their interests (e.g., church communities, hobby clubs, and self-support groups).
Decision Making	• Help the client make choices. Do not assume that the client can make informed decisions based on his/her own set of elaborate likes and dislikes. Help him/her to consider alternatives choices, and the consequences (e.g., rewards and displeasure) and associated feelings. Specific guidelines help offset the client's poor intuition and knowledge of self. • Teach the client to recognize the value in evaluating what various options are available when engaged in decision making. Assist the client in learning how to reason through the consequences of each option and then deciding the best course of action based on the most positive outcome.

[49] Attwood, T. (1998). Asperger's Syndrome; A guide for parents and professionals. Jessica Kingsley Publishers, Philadelphia, PN.

Common Effects[45]	Strategies[46]
Difficult Behaviours	• Try to identify stress triggers – avoid them if possible - be ready to distract with some alternative (e.g., 'come and see this...').[50] • Try to avoid power struggles. Try to anticipate such situations and avoid the confrontation through calmness, negotiation, presentation of choices, or diversion of attention elsewhere.[51] • Teach specific problem-solving strategies for handling the most common troublesome situations. Training is necessary for recognizing situations as troublesome and applying appropriate strategies [52] • The link between frustrating or anxiety-provoking experiences and negative feelings should be taught in a concrete, cause-effect fashion, so that he/she can gradually gain insight into his/her feelings. Teach about the impact of actions on other people's feelings in the same way.[53] • Set limits. Make a list of recurring problematic behaviours such as fixations (i.e. sticking to something too long, getting stuck on one topic or thought), obsessions, interrupting. Develop specific prearranged guidelines to deal with behaviors. Discuss these guidelines with the client in an explicit fashion, setting out clear expectations. • Maintain consistency across staff, settings and situations. Explicit rules should be designed based on staff's ongoing experiences with the client. Establish specific guidelines for limit setting for all possible problematic situations/behaviours, so that each staff member does not need to improvise and possibly trigger resistance or aggression. Set priorities to help staff and the client concentrate on a small number of truly disruptive behaviours (i.e., behaviours that could result in harm, to self or others or social rejection).
Inattention, impulsivity, irritability, aggression, compulsions & anxiety	• Medication can be useful if symptoms of attention deficit, hyperactivity, anxiety, obsessive-compulsive behaviours, tics, depression, delusions and/or hallucinations, or sleep disorder become significant handicaps. See the doctor about possible medications. • Provide lots of physical activity in ways that can be successful and minimize the client's "clumsiness." Individual activities (e.g. swimming) may be more enjoyable than team sports that have complex social interactions.

OTHER RELATED ISSUES

People with Aspergers Syndrome are at risk for other psychiatric problems including depression, attention deficit disorder, schizophrenia, and obsessive-compulsive disorder.[54] For someone with two diagnoses (e.g., Aspergers, ADD, HIV, etc.) it may be difficult to determine which needs or issues are related to Aspergers Syndrome and which are related to the other diagnosis. Consult with a trained clinician, ask the client or guardian or close family members which strategies work best for him/her.

HIV Medication Side Effects:

[50] Lord, R. (2003). Asperger Syndrome. Retrieved October 12, 2003 from Asperger Syndrome Coalition of the U.S. website: www.asperger.org/asperger/asperger_as.htm
[51] Bauer, S. (2003). Asperger Syndrome. Retrieved October 12, 2003 from Asperger Syndrome Coalition of the U.S. website: www.asperger.org/asperger/asperger_bauer.htm
[52] Kirby, B. (2001). What Is Asperger Syndrome? Retrieved October 12, 2003, from Asperger Syndrome Information & Support website: www.udel.edu/bkirby/asperger
[53] Kirby, B. (2001). What Is Asperger Syndrome? Retrieved October 12, 2003, from Asperger Syndrome Information & Support website: www.udel.edu/bkirby/asperger
[54] Internet Mental Health. (date unknown). Asperger's Disorder. Retrieved October 12, 2003, from Internet Mental Health website: www.mentalhealth.com

Some HIV medications may have side effects similar to some characteristics of Aspergers. Some medication side effects may include:

- Confusion
- Hypersensitivity
- agitation, restlessness
- insomnia
- headache
- depression

Check with a doctor if medication side effects are suspected.

Additional Resources

Lands, L. (2002). **A Practical Guide to HIV Drug Side Effects.** Published by the Canadian AIDS Treatment Information Exchange. Toronto, ON. www.catie.ca/pdf/SIDEEFF_EN.pdf For more detailed information on medication side effects.

Myles, B. & Southwick, J. (2001). **Aspergers Syndrome and Difficult Moments**: Practical Solutions for Tantrums, Rage, and Meltdowns.

Ozbayrak, R. Aspergers Disorder Homepage. www.aspergers.com/index.htm. For additional information on Aspergers. www.aspergers.com/asptrt.htm for treatment information.

Segar, M. (1996). **A Survival Guide for People with Aspergers Syndrome.** Online Aspergers Syndrome Information and Support: Papers and Articles website: www.udel.edu/bkirby/asperger A booklet written by an adult with Aspergers Syndrome.

Syner, J. & Myles, B. (2000). **Making Visual Supports Work in the Home and Community**: Strategies for Individuals with Autism and Aspergers Syndrome.

For services or consultation related to Aspergers contact: **Society for Treatment of Autism** (403)-252-2291

Specific Disorders

ATTENTION DEFICIT DISORDER

Adult Attention-Deficit Disorder (Adult ADD). Although A.D.D. begins in childhood the symptoms often carry over into adulthood. Restless, impulsive, or inattentive behaviour may be a sign of Adult ADD and if it has existed since childhood, may result in problems affecting social interaction, family dynamics and vocational achievement. They may have problems with education, social relationships, family functioning, independence, and work, self-sufficiency, and adherence to social rules, norms, and laws. Each client may present with different symptoms, so it is important to address each area.[43, 55] [35]

ADD should be diagnosed by a qualified clinician.

ADD Indicators[56]	Description
Cognitive	• Inattention. • Lack of focus (e.g., difficulty concentrating or focusing attention on one thing; procrastinate on projects that need a lot of attention to detail, careless mistakes). • Disorganization (e.g., problems remembering appointments or obligations, may seem that their mind is "elsewhere"). • Forgetfulness (e.g., losing things). • Occasional depression and mood swings.
Behavioural	• Impulsive behaviour. • Difficulty finishing projects (e.g., start many projects at the same time, but never finish them). • Interrupting conversations. • Substance abuse.
Physical	• Restlessness or fidgetiness (e.g., persistent pencil tapping /or foot tapping). • Have trouble taking part in quiet activities (e.g., staying seated during meetings or other activities).
Social	• Difficulty maintaining relationships.

[55] Attention Deficit Disorder Ontario Foundation (A.D.D.O.) Foundation. (2002). International Consensus Statement on ADHD - January 2002. . Retrieved on December 12, 2003 from ADDO website: www.addofoundation.org/consensus.htm

[56] Eli Lilly and Company (2003). What is Adult ADD? Retrieved October 12, 2003, from AdultADD.com website: www.adultadd.com/2_1_what_is/2_1_what_is.jsp

Implications for U2 clients
• May have trouble remembering and/or following through on appointments, medications and/or safe personal care routines. • May be easily distracted, frustrated or bored, which could lead to AWOL behaviours. • Impulsive behaviours may lead to AWOL, spontaneous sexual activities, sexual risk-taking, or spontaneous use of drugs or alcohol without thinking about the consequences. • Behaviours may interfere with development of social relationships – may need help with their social skills and development of a strong social support network. • Client may have verbal or physical outbursts if frustrated or bored.

Common Effects[57] [58]	Strategies
Inattention	• Simplify complex tasks (e.g., use pillboxes or bubble pack for HIV drugs). Break large chores into small tasks to be done one at a time. • Be sure that you have the client's attention before making requests or giving information. • Give brief directions that are repeated often. • Visual cues may facilitate learning and better recall. • Help the client learn how to schedule, organize and manage his/her time. Try lists, day planners, labelling things, writing down instructions, diaries, timetables to organize activities. • Give constant reminders for appointments and other routines (e.g., handwashing and packaging items with blood before throwing away – razor, tampons, etc.; use calendar, phone call, or personal reminder for appointments).
Impulsive Behaviours	• Teach the client to use "self-talk" to help stay focused (i.e., the first thing I have to do is …). • Set up regular schedules and routines with rewards for acceptable behaviour. • Develop clear and consistent rules that staff apply to all people in the same service. • Be available for support when needed before impulsive behaviours occur. • Teach safer sex behaviours – practice safer sex negotiation through role play.
Restlessness	• Teach the client how to structure his/her time and set up a schedule and routines. • Allow for many breaks. • Know the signs that suggest the client may be about to lose control (e.g., increasing verbal agitation, verbal aggression, physical agitation). • Have a quiet area where the client can take a break from overly-stimulating environments. • Develop a range of interests and activities that help the client to keep busy and burn off energy. Schedule regular physical exercise.

[57] Attention Deficit Disorder Ontario Foundation (A.D.D.O.) (2002). ADDO - information package. Retrieved on December 12, 2003 from ADDO website: www.addofoundation.org/info.htm#inadults

[58] Attention Deficit Disorder Ontario Foundation (A.D.D.O.) (2002). International Consensus Statement on ADHD - January 2002. . Retrieved on December 12, 2003 from ADDO website: www.addofoundation.org/consensus.htm

Social	• Help the client learn to take time to think before talking or acting. • Help clients increase awareness of social interactions by having them describe what they have just done, how they might have acted differently, and why others react as they do. • Make sure staff and group leaders allow the client to take breaks as often as needed (e.g., when taking part in AA; life skills group). • Address issues of anger management, listening skills, problem solving and decision making. Teach conflict resolution strategies. • Role play and practice socially acceptable behaviours *(may benefit from a life skills course).* • Help client to avoid negative self talk. • Address any alcohol or drug abuse issues through a referral to a drug treatment program • Career counselling and assessment may help identify employment options.

OTHER RELATED ISSUES:

When a client has more than one diagnosis, it is difficult to decide which symptoms or behaviours are related to the attention deficit, and which are related to another issue (e.g., mental health, HIV). A holistic model of support eliminates the need to find the source of an adaptive skill deficit and gives support for a range of needs as required (on intermittent, limited or extensive basis).[59] Ask the client or guardian or close family members which strategies work best for him/her.

SPECIAL HIV NOTE:

Some people living with HIV develop neurological problems that are direct or indirect effects of the virus, and may result in behaviours ***that look similar to attention deficit disorder***. People who have had HIV for many years with no HIV treatment may begin to show dementia type symptoms. Some people have only subtle symptoms. Some people have a gradual mental decline. Others get worse quickly over a short period of time. Symptoms could include:

- forgetfulness
- slowness
- lack of concentration and attention, poor problem solving
- apathy
- irritability
- social withdrawal
- decreased visual/motor skills or writing skills

Update the client's psychiatrist or doctor if you notice a change in the client's typical behaviour or abilities.

HIV Medication Side Effects:

Some HIV medications may have side-effects similar to some characteristics of Adult ADD. Some medication side-effects may include:

- nervousness
- agitation
- confusion
- irritability

[59] Biersdorff, K. (1999). Duelling Definitions: Developmental disabilities, mental retardation and their measurement. *Rehabilitation Review*. 10 (7).

Check with the doctor if medication side-effects are suspected.

Additional Resources

Lands, L. (2002). **A Practical Guide to HIV Drug Side Effects.** Canadian AIDS Treatment Information Exchange. Toronto, ON. www.catie.ca/pdf/SIDEEFF_EN.pdf For more detailed information on medication side effects.

Adult ADD Homepage. (2003). Adult ADD.com www.adultadd.com/index.jsp For more information and resources on Adult ADD.

Specific Disorders

BIPOLAR DISORDER

Bipolar Disorder[60]**,** also known as **Manic-Depressive Illness**, is a brain disorder that causes extreme shifts in a client's mood, energy, and ability to function. The symptoms of bipolar disorder are severe and much different from the normal ups and downs that everyone goes through. It is often not recognized as an illness, and people may suffer for years before it is properly diagnosed and treated. Bipolar disorder is a long-term illness that must be carefully managed throughout a client's life.

Bipolar disorder can cause dramatic mood swings—from overly "high" and/or irritable to sad and hopeless, and then back again, often with periods of normal mood in between. Severe changes in energy and behaviour go along with these changes in mood. The periods of highs and lows are called episodes of mania and depression. Some individuals may have one of the extremes in behaviour and consistently demonstrate those behaviours, which are depressed or manic.

A **mixed episode** occurs when both the manic and depressive indicators occur nearly every day for at least a week. The client experiences rapidly alternating moods (sadness, irritability, euphoria). Symptoms include both the manic and depressive symptoms as well as others such as agitation, insomnia, appetite problems, psychotic features and suicidal thinking.

Manic Indicators[61][62]	Description
Emotional	• Excessively "high," overly good or euphoric mood. • Denial that anything is wrong. • Extreme irritability.
Cognitive	• Racing thoughts, talking very fast, jumping from one idea to another. • Distractibility. Can't concentrate well. • Unrealistic beliefs in one's abilities and powers.
Behavioural	• Provocative, intrusive, or aggressive behaviour. • Poor judgement – spending sprees. • Risk taking. • Abuse of drugs, particularly cocaine, alcohol, and sleeping medications.
Physical	• Increased energy, activity, and restlessness. • Little sleep needed. • Increased sexual drive.

[60] MedicineNet, Inc. (2003). Bipolar Disorder. Retrieved Oct. 12, 2003, from MedicineNet Website: www.medicinenet.com/Bipolar_Disorder/article.htm
[61] MedicineNet, Inc. (2003). Bipolar Disorder. Retrieved Oct. 12, 2003, from MedicineNet Website: www.medicinenet.com/Bipolar_Disorder/article.htm
[62] Medicinenet Inc (2003). Bipolar Disease. Retrieved October 12, 2003 from Medicinenet website: www.medicinenet.com/Bipolar_Disorder/page1.htm

Depression Indicators[63]	Description
Emotional	• Persistent sad, anxious, or "empty" mood. • Feelings of hopelessness, pessimism. • Feelings of guilt, worthlessness, helplessness. • Irritable.
Cognitive	• Difficulty concentrating, remembering, making decisions. • Thoughts of death or suicide.
Behavioural *(these indicators increase for individuals with developmental disabilities)*	• Loss of interest or pleasure in hobbies and activities that were once enjoyed, including sex. • Withdrawn, passive. • Suicide attempts.
Physical *(these indicators increase for individuals with developmental disabilities)*	• Restlessness, irritability. • Insomnia, early-morning awakening, or oversleeping. • Appetite and/or weight loss or overeating and weight gain. • Decreased energy, fatigue, being "slowed down". • Persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders, and chronic pain.

Implications for U2 clients

Mania Implications

- Increased energy and sex drive, poor judgement, unrealistic belief in one's own power may result in AWOL behaviours with potential for unsafe sex, use of drugs or alcohol, not taking medication regularly, etc.
- Spending sprees may negatively impact finances.

Depression Implications

- Feelings of hopelessness and/or suicidal thoughts may lead to not caring about the consequences of unsafe sex, not taking medication regularly, not going to appointments, poor self care.
- May turn to alcohol or drugs as a way to feel better.
- Loss of interest in life may interfere with development of social relationships and maintenance of social support network.
- If client is unable to keep a job this may result in not having enough money.
- Poor appetite may result in poor nutrition.
- Some physical symptoms may look similar to symptoms associated with HIV/AIDS.
- Increased potential for self-harm/suicide.

[63] Panzarino, PJ. (2003). Medical Information on Depression – What are the Symptoms of Depression and Mania. Retrieved October 12, 2003, from Medicine Net Inc. website: www.medicinenet.com/Depression/page2.htm

Common Effects Mania[64]	Strategies
Extreme Mood Swings	• Long-term preventive treatment is strongly recommended. . Encourage client to take medications consistently to reduce the chance of relapse. • Keep a chart of daily mood symptoms, treatments, sleep patterns, and life events to help the client better understand and track the illness. • Report extreme mood changes immediately to the doctor.
Social	• Encourage activities that provide an alternative to drinking or drug use. Help the client plan to avoid social settings that are a temptation for alcohol or drug use. • For those previously involved with peers who use drugs or alcohol, it is important to help the client develop a new, more positive peer group (e.g., help the client connect with activities and/or groups such as support groups, church community, hobby clubs, recreation activities, self-help groups).
Physical	• Establish regular daily routines and sleep schedules to help prevent manic episodes. • Monitor diet, and encourage the client to eat nutritious meals. • Changes to medications may be needed at various times during the course of bipolar disorder to manage the illness most effectively. A psychiatrist should guide any changes in type or dose of medication.

Common Effects Depression [64]	Strategies
Negative Thoughts	• Present the positive side of things to help provide a more balanced view. • Encourage the client not to expect too much too soon, as this will only increase feelings of failure. • Avoid blaming the client for a depressed mood or expecting them to "get over it". Clinical depression requires treatment, and improvement takes time.
Sense of Hopelessness or Helplessness	• Break large tasks into small ones, set some priorities, and encourage the client to do what they can when they can, a bit at a time. • Build in small successes or achievements every day. • Provide lots of encouragement, including having someone accompany the client to appointments or social activities. • Create a bright and cheerful environment. • Encourage attention to self care (e.g., cleanliness, appearance, tidy living space, treat oneself to something he/she likes).
Lack of Motivation	• Constantly encourage and remind the client to take appropriate safe sex measures (if he/she is sexually active).
Difficulty With Planning, Memory, Making Decisions	• Provide reminders for appointments and for taking medication. • Help client to schedule and organize routines, appointments, etc.
Social	• Encourage regular social contacts. For example, encourage the client to be with

[64] Medicinenet.com (2003). Bipolar Disease. Retrieved October 12, 2003 from Medicinenet website: www.medicinenet.com/Bipolar_Disorder/page1.htm

Common Effects Depression [64]	Strategies
	other people; make arrangements for friends or friendly visitor volunteers to visit on a regular basis. • Encourage client to get out and participate in social activities they used to enjoy (e.g., going to a movie, going to church, taking part in a self-help or support group, etc.). Staff may need to go beyond "encouragement" and support the client by doing the activities with them. • Encourage activities that provide an alternative to drinking or drug use. Help the client plan to avoid social settings that may tempt him/her to use alcohol/drugs. • Help the client build a strong social support network. This might include arranging personal visits, group outings or activities, phone support from a friend, volunteer or worker. Avoid phone sex lines. • For those previously involved with peers who use drugs or alcohol it is important to help the client develop a new, more positive peer group (e.g., help him/her connect with activities and/or groups such as AA group, church community, hobby clubs, recreation activities, or self-help support groups).
Physical	• Monitor diet, and encourage the client to eat nutritious meals. • Set up regular physical exercise routines and activities. • Teach relaxation methods. • Establish regular sleep patterns and make sure the client gets enough sleep. • If symptoms of depression appear, have doctor screen for clinical depression on a regular basis (annually or as symptoms suggest). Treatment may include medication and mental health counselling.
Suicidal Tendencies	• Refer to your agency suicide assessment protocol. • Ask the client, "Are you thinking about hurting yourself or other people? Do you have a plan?" It is especially important to ask about "hurting others" if the client appears irritable. • Listen without making value judgements. A depressed client often needs a supportive ear more than being told what is wrong or what to do. • Believe what the client says and take all threats seriously. • Never keep someone's suicidal feelings a secret. Report suicidal ideas immediately to a clinician or have the client transported to the closest medical/psychiatric support. (This may include calling an ambulance/police). • Act immediately if you feel someone is at immediate risk for suicide. Tell the client you must contact someone trained to deal with suicide. Take steps to safeguard the client (e.g., remove items that could be used for suicide, or remove the client from dangerous situation). • Encourage the client to seek help. Ask them to agree to access support when feeling overwhelmed (e.g., contact their worker, call Suicide Services, Distress Centre, hospital or police). • Develop a contract with the client, listing people/services to contact in an emergency and specific steps to take to prevent self-harm. (See HIV/AIDS & Suicide section for sample contract).

OTHER RELATED ISSUES

The symptoms associated with Bipolar Disorder are also common in other mental health problems. For example, while irritability and aggressiveness can be present in bipolar disorder, they also can be symptoms consistent with attention deficit hyperactivity disorder, conduct disorder, major depression or other types of mental disorders. Drug abuse also may lead to such symptoms.

Sometimes, severe episodes of mania or depression include psychotic symptoms such as hallucinations or delusions. People with these symptoms are sometimes incorrectly diagnosed as having schizophrenia.

SPECIAL HIV NOTE

It is common for people living with HIV to have symptoms ***that look similar to Bipolar Disorder.*** For example, symptoms such as weight loss, irritability, restlessness, disturbed sleep, fatigue, anorexia, lethargy, or diminished interest in sex are all commonly seen in clients with HIV. These same symptoms may be associated with bipolar disorder. It is recommended that HIV clients be screened for mental disorders by the physician on a yearly basis or as needed .

Other HIV Related Issues

Some people living with HIV develop neurological problems that may result from direct or indirect effects of the virus and may result in symptoms ***that look similar to Bipolar Disorder***. These might include:

- personality changes
- irritability
- hallucinations
- delusions

People who have had HIV for many years with no HIV treatment may begin to show dementia type symptoms. Some people experience only subtle symptoms. Others experience a gradual mental decline. Others get worse rapidly over a relatively short period of time.

Update the client's psychiatrist or doctor if you are noticing the above symptoms.

HIV Medication Side Effects

Some HIV medications may have side-effects similar to some characteristics of **Bipolar Disorder.** Be aware of potential side-effects of all medications prescribed to the client. Especially, *efavirenz* for HIV/AIDS and *interferon-a* for HCV may cause episodes of varying in intensities of depression. Consult with the specialist or physician when these medications are used with antidepressant therapy. If these medications are continued, the primary care doctor should work closely with a psychiatrist to minimize side effects.

Potential medication side effects may include:

Depression	**Mania**
• tearfulness	• irritability
• loss of appetite	• insomnia
• apathy	• excitability
• confusion	• hallucinations
• impaired memory	• severe agitation
• headache	• anxiety

Check with doctor if medication side effects are suspected.

Additional Resources

AIDS Institute. (2001). **Mental Health Care Guidelines for People with HIV Infection**. New York State Department of Health. New York. HIV Clinical Resource website: www.hivguidelines.org/public_html/center/clinical-guidelines/mental_health_guidelines/mental_health_intro.htm For more information on HIV and mental health medication side-effects.

Canadian Mental Health Association. (2001). **Bipolar Disorder. Where's The Balance?** Canadian Mental Health Association Alberta. www.cmha.ab.ca/help/publications/bipolar.htm This information booklet on Bipolar can be downloaded from the website.

Medicine Net Inc. **Bipolar Disorder.** www.medicinenet.com/Bipolar For additional information and research on Bipolar Disorder.

Mental Help Net. **Bipolar.** www.mentalhelp.net/poc/view_index.php For additional information and research on Bipolar Disorder.

Lands, L. (2002). **A Practical Guide to HIV Drug Side Effects.** Canadian AIDS Treatment Information Exchange. Toronto, ON. www.catie.ca/pdf/SIDEEFF_EN.pdf For more detailed information on medication side effects.

Specific Disorders

BORDERLINE PERSONALITY DISORDER

Borderline Personality Disorder is experienced in people in many different ways. Often, people with this disorder have trouble distinguishing between reality and their own misperceptions of the world and their surrounding environment. Their emotions often overwhelm normal reasoning and learning. They may develop an unhealthy attachment to people, places and things, lack social skills, exhibit manipulative self-destructive habits and impulsive behaviours, and lack control over aggressive behaviours. Many people with borderline personality disorder report childhood sexual abuse.

Borderline Personality Disorder Indicators[65]	Description
Cognitive	• May demonstrate suspicious or paranoid behaviour or may seem detached, out of touch with reality, "not themselves," and may not remember things they have said (severe dissociative symptoms).
Emotional	• May demonstrate unstable and quickly changing/reactive moods (e.g., intense episodes of irritability, anxiety or feelings of general discontent or illness, usually lasting a few hours and only rarely more than a few days).
Behavioural	• May be impulsive in at least two areas that are potentially self-damaging (e.g., spending money, sex, substance abuse, reckless driving, binge eating). • May have repeated suicidal behaviour, gestures, or threats, or self-mutilating behaviour. • Often demonstrates inappropriate, intense anger or trouble controlling anger.
Interpersonal	• May have a preoccupation with avoiding real or imagined abandonment issues. • May have a history of chaotic, unstable and intense interpersonal relationships – may describe feelings toward another client that alternate between extremes (i.e., love them or hate them). • May idealize relationships (e.g., believe a casual friendship is a love relationship).
Self	• May describe chronic feelings of emptiness. • May demonstrate problems with identity, and present an unstable self-image or sense of self.

[65] Internet Mental Health. (date unknown). Borderline Personality Disorder – Diagnostic Criteria. Retrieved September 20, 2003, from Internet Mental Health website at: www.mentalhealth.com/dis1/p21-pe05.html

Implications for U2 clients
• May have few friends and a limited social support network because of their history of unstable relationships. • May be unable to get or keep a job, so he/she is short of money. • May use alcohol or drugs or use non-prescription as mood altering agents or as a means to escape reality. • May describe chronic feelings of emptiness (boredom) – which may precipitate depression, insomnia, loss of appetite, unplanned AWOLs, and sexual affairs. • May often demonstrate a lack of impulse control, resulting in the client not taking significant risk precautions and may place self and others at risk of harm (e.g., unsafe sex).

Common Effects[66]	Strategies[67]
Fear of abandonment – being alone.	• Give regular feedback and reassurance. • Offer interpretations to help the client develop insight. • At other times it may be more effective to give "validation, empathy and advice". To do this, try to interact with the client in a way that is: • -accepting of the client as he/she is but which encourages change • -consistent and firm yet flexible • -nurturing and kind but insistent
Unstable and intense interpersonal relationships	• Be direct. Set clear limits for what is acceptable behaviour. • Consistently let the client know when limits have been overstepped and then teach the skills to deal with the situation more effectively and acceptably. • Encourage the client to get more social support through peer support or peer activities. • Help the client to improve his/her self-esteem.
Impulsiveness – in areas such as sex, substance abuse, crime, etc.	• Support the client to decrease behaviours that interfere with the quality of life (such as drug or alcohol abuse, sexual promiscuity, high-risk behaviour) – as defined and negotiated with the client. • Watch for cues that the client is having the feelings that usually lead up to inappropriate behaviour – signs of nervousness or agitation related to stress or unexpected situations.[68] • Set up a highly structured environment. Maintain routines. • Work on developing coping skills that will help the client gradually become more independent. • Promote self-observation to increase understanding of how behaviours come from internal motivations and feelings. • Encourage thinking through the consequences of actions.
Recurrent suicidal thoughts, gestures,	• Watch for self-destructive and suicidal behaviours. • Minimize self-blame for past abuse.

[66] Mental Help Net (date unknown). Symptoms – Borderline Personality Disorder. Retrieved October 12, 2003, from Mental Help Net website: www.mentalhelp.net/poc/view_doc.php?type=doc&id=517&cn=8&clnt%3Dclnt00001&

[67] Kiehn, B. & Swales, M.(1995) An Overview of Dialectical Behaviour Therapy in the Treatment of Borderline Personality Disorder. Retrieved October 12, 2003, from Mental Help Net website: www.mentalhelp.net/poc/view_doc.php?type=doc&id=1020&cn=8&clnt%3Dclnt00001&

[68] Internet Mental Health. (date unknown). Retrieved September 2003 from Internet Mental Health website: www.mentalhealth.com/dis1/p21-pe05.html

Common Effects[66]	Strategies[67]
or behaviours (depression, loneliness)	• Encourage the client to take responsibility for avoiding self-destructive patterns. • Focus interventions more on the here-and-now rather than on the past. • Set limits on the client's self-destructive behaviours. • Help the client develop interests and activities. • See HIV and suicide. • See HIV and depression.
Emotional instability and or mood swings	• Most anxiety and depression is directly related to short-term, situational factors or attention-seeking and will quickly come and go. • The client with BPD typically views him/herself, other people and experiences in extremes of "all good" or "all bad". • The worker should offer his/her stability as a contrast to the client's unstable emotions and thinking processes.[69] • Encourage the client to develop and practice new coping skills and ways to regulate his/her emotions.
Inappropriate displays of intense anger (outburst, upset)	• Develop an aggression protocol with the client (see HIV and Aggressive Behaviour). • Introduce behaviour modification strategies such as practising alternative ways to show anger or re-focusing attention on a less frustrating activity ("diversion").
Contradictory behaviour	• Behaviours may be seen as "manipulative", but this term is not used in Dialectic Behaviour Therapy (DBT) – see Additional Resources at end of this section. • The core strategies in DBT are 'validation' and 'problem- solving' – accept/validate the client's viewpoint or response, then problem-solve to find a more helpful approach to the situation – build skills. • Emphasize consistency. Use a firm consistent approach that is non-judgmental and not punishing. • Ensure consistency among staff. Develop specific procedures and/or verbal responses to be used consistently by all staff. • Identify behaviours that need to be changed, set limits on these behaviours and decide on consequences for inappropriate behaviour.. • Offer reinforcement for appropriate behaviour. • Avoid the following: • acceptance of favours or flattery, • arguing with the client. • lengthy or complex discussions. • Help the client understand the difference between indirect (manipulative) and direct (assertive) communication. • Encourage the client to practice direct communication and praise positive efforts.[70] • Set specific targets/goals negotiated with the client. [14]

[69] Mental Help Net Staff. (date unknown).Treatment of Borderline Personality Disorder. Retrieved October 12, 2003, from: www.mentalhelp.net/poc/view_doc.php?type=doc&id=476&cn=8&clnt%3Dclnt00001&

[70] Hanna, B. Nicholson, L. Simpson, M. (1989). Psychosocial Nursing Interventions. 1989. BLM Publications. Vancouver, BC. p. 262.

Common Effects[66]	Strategies[67]
Non psychotic – transient experiences: • Identity disturbance • Transient, stress-related paranoia, dissociation, or psychotic episodes	• Help the client integrate positive and negative aspects of self and others. • Help the client understand that perceptions are only representations of how things really are, not actually how they are. • Encourage clients to respect boundaries surrounding their relationship with care provider and friends. • Help the client build self-esteem. Be supportive and reinforce positive aspects of the client's identity • Consult with treatment specialist about proper medication for brief psychotic episodes.

Other Related Issues

Borderline Personality Disorder can sometimes be misinterpreted as bipolar disorder.

HIV Medication Side-Effects

Some HIV medications have side-effects similar to some characteristics *of Borderline Personality Disorder.* In particular, an ongoing sense of not feeling well, extreme mood swings, and distortions of reality (e.g., paranoia, hallucinations) are symptoms of both BPD and of HIV medication side-effects.

Medication side-effects may include:

- agitation, restlessness
- depression, tearfulness
- excitability, mania
- loss of appetite
- insomnia
- confusion
- headache
- paranoia
- hallucinations
- general discontent

Check with the doctor if you suspect medication side-effects.

Additional Resources

AIDS Institute. (2001). **Mental Health Care Guidelines for People with HIV Infection**. New York State Department of Health. New York. www.hivguidelines.org/public_html/center/clinical-guidelines/mental_health_guidelines/mental_health_intro.htm For more information on HIV and mental health medication side-effects.

BPD Central Homepage. (2001). Milwaukee, WI www.bpdcentral.com/ This site includes a list of resources for people who care about someone with borderline personality disorder (BPD), including self-help information, facts on BPD, and other resources.

Dialectical Behaviour Therapy is based on a bio-social theory of borderline personality disorder and has been shown to be more effective than most other psychotherapeutic and medical approaches to helping people better cope with this disorder. It teaches people how to take control of their lives, their

emotions, and themselves through self-knowledge, regulating emotions, and cognitive restructuring. It is a comprehensive approach that is most often conducted in a group setting. Because the skills learned are new and complex, it is not an appropriate therapy for those who have trouble learning new concepts. For more information, or training in **Dialectical Behaviour Therapy** contact **Hull Child and Family Services,** 403-251-8000**.**

Lands, L. (2002). **A Practical Guide to HIV Drug Side Effects.** Canadian AIDS Treatment Information Exchange. Toronto, ON. www.catie.ca/pdf/SIDEEFF_EN.pdf For more detailed information on medication side effects.

Linehan, M. Understanding Borderline Personality Disorder: The Dialectic Approach. (1995). Video by Guilford Publications Inc. New York. Available through Calgary Region Persons With Developmental Disabilities.

Specific Disorders

BRAIN INJURY

Brain Injury: The results of brain injury can be manifested in a variety of physical and emotional challenges, some of which may not be immediately obvious to the survivor or their families. It is difficult to predict just how much a client will be affected by brain injury due to the complexity of the brain… no two injuries are the same and recovery for each client with a brain injury is very individualized. [71]

Remember both the type of injury and the area of the brain to which the injury happened, determine the effects of a specific brain injury. Each client has a unique background of life experiences, emotional makeup, personality, psychological strengths and weaknesses, and history of dealing with life's difficulties. This is the background to which a brain injury occurs and upon which recovery is dependent.

Damage to the brain may result in changes in functioning in these areas:
- physical,
- cognitive,
- behavioural & personality,
- emotional & psychological,
- social.

Common Effects[72]	Strategies
Impaired memory (visual memory, auditory memory, and prospective memory)	• Encourage the client to carry a note book to record daily activities. • Encourage the use of bulletin boards, calendars. • Write down instructions for tasks and keep them handy. • Identify important items and create lists to ensure the client can locate the items that are stored away. • Use frequent prompts and cues. • Review and rehearse new information. • Try to cue the client by using associations to trigger memories. • Take pictures and use recordings to remind the client of different situations and events.
Lack of attention and concentration	• Be sure that you have the client's attention before beginning a task. • Use tasks and activities that are familiar and interesting for the client. • Reduce distractions (turn off radio). • When talking use gestures and demonstrate what needs to be done. • Encourage short periods of activities with regular breaks. • Incorporate activities that require less concentration such as physical activities (walking). • When a client is persisting on one topic gently redirect to a new topic.

[71] Brain Injury and Our Family. (2002). Southern Alberta Brain Injury Society..
[72] Used with permission from Universal Rehabilitation Services Agency (2003). URSA U2 Handbook. Calgary, AB.

Common Effects[72]	Strategies
Reduced motivation	• Help the client to structure the day to avoid periods of inactivity. • Daily activities recorded on a schedule or in a day timer. • Use an alarm or a watch as a reminder to refer to the schedule. • Encourage the client to get plenty of rest and be aware of when they are tired.
Difficulty expressing or understanding language	• Reduce distractions. • Encourage the client to consider alternative terms when they cannot think of a word. • Provide opportunities to practice communication. • Speak slowly and naturally, do not over enunciate words. • Include the client in conversations. • Use short simple sentences. • Use gestures, pointing, pictures and other cues to aid in understanding. • Be patient and do not supply answers for the client. • Don't ask questions if you do not have time to wait for an answer. • Remember honesty is important so if you don't understand say so.
Reduced ability to plan, learn new tasks, organize, make good judgements, and set goals	• Break the task down into small steps. • Define the steps clearly and write them down. • Use checklists to ensure that each step is performed in the correct sequence. • Help the client to identify several possible solutions to a problem. • Decision making may be easier if the client chooses from two or three options. • Provide consistent training on a new task and repetition of the task.
Slower speed of information processing & mental processing	• Allow ample time for a response and to complete tasks. • Avoid asking multiple questions. • Arrange conversation so one topic and/or one question is addressed at a time.
Decreased reasoning, insight or denial of disability	• Maintain routines and structure as much as possible and try to avoid sudden changes. • Give advance notice and explanation to prepare client for change. • Provide clear simple explanations. • Educate the client about his/her brain injury.
Mood changes and Agitation	• Redirect the client's attention away from the frustration. • Have a familiar environment and clients around. • Model calm behaviour. • Limit abrupt changes or surprises. • Structure the client's time and provide a schedule of events. • Provide feedback so the client knows alternative ways of dealing with the situation. • Provide the client with choices and control. • Discuss difficulties privately with the client in an open and direct manner. • When the client is successful at controlling emotions, acknowledge and support them.

Common Effects[72]	Strategies
Egocentrism	• Give clear guidelines on appropriate conversation, provide feedback. • Help the client to identify topics of conversation. • Reassure the client that you understood.
Impulsiveness	• Encourage the client to slow down and think before speaking or acting. • Have the client talk through an activity before carrying it out. • Develop a system to cue the client to slow down. • Help the client to monitor their behaviour and develop their own cues. • Give positive feedback to emphasize the importance of controlled behaviour. • Role model appropriate behaviour.
Anger control	• Do not take anger personally, but also reinforce that angry outbursts are not acceptable forms of behaviour. • Attempt to identify the kinds of things that irritate the client and try to avoid theses situations. • Remove the client form the situation that provoked the outburst. • Change the subject and maintain a calm approach. • When the client has calmed down discuss better ways of dealing with the situation next time. • Model calm, consistent behaviours.
Depression	• Be supportive. • Refer client to a trained counsellor in the community. • Medication may be required. • Spend time with the client. • Encourage the client to take time out and relax and enjoy themselves.
Social Dependency and Isolation	• Encourage the client to: • remain active, and independent, • maintain and build new friendships, • attend brain injury support groups, • build confidence and self esteem.

Brain injuries are complex and different for each client. The support requirements of the brain-injured client may be influenced by a combination of disabilities and symptoms. A holistic model of support directs and provides support toward a range of client needs (intermittent, limited, or extensive)[73] often eliminating the need to determine the source of an adaptive skill deficit. Ask the client or people in the client's network which strategies work best for him/her.

[73] Biersdorff, K. (1999). Duelling Definitions: Developmental disabilities, mental retardation and their measurement. Rehabilitation Review, 10 (7).

HIV Medication Side Effects:

Some HIV medications may have side effects, which result in an impaired ability to carry out many life activities. Potential medication side effects may include:

- depression, tearfulness
- irritability
- loss of appetite
- insomnia
- apathy
- confusion
- impaired memory
- headache
- severe agitation
- anxiety

Check with doctor if medication side effects are suspected.

Additional Resources

Head Injured Relearning Society. (2003). **Welcome to Brain Resource**. http://brainresource.ca/index.asp Provides information on services for brain injured and training opportunities in Alberta.

Brain Injury Network (Alberta). www.cd.gov.ab.ca/helping_albertans/bii/index.asp. Information on brain injury.

Brain Injury Rehabilitation Centre. www.brainrehab.ca/ Information on brain injury.

Southern Alberta Brain Injury Society www.sabis.ab.ca/index.htm Information on brain injury.

British Columbia Rehabilitation Society. G.F. Strong Centre. (1989). **Brain Injury Rehabilitation Manual**. ISBN 0-9213608-02-0

Lands, L. (2002). **A Practical Guide to HIV Drug Side Effects.** Canadian AIDS Treatment Information Exchange. Toronto, ON. www.catie.ca/pdf/SIDEEFF_EN.pdf For more detailed information on medication side effects.

Northern Alberta Brain Injury Society. (2003). **Insight into Brain Injury**. 20(1).

Keyser-Marcus, L. Briel, L. Sherron-Targett, P. Yusuda, S. Johnson, S. Wehman, P. (2002). **Enhancing the Schooling of Students with Traumatic Brain Injury**. *Teaching Exceptional Children.* P 62-67.

Clinical depression is a syndrome (group of symptoms) that reflects a sad mood greater than normal sadness or grief. The sadness of depression is more intense and lasts longer, with more severe symptoms and more serious impact on a client's ability to cope with day-to-day activities.

Clinical depression[74] is the most common psychiatric disorder among people with HIV. Up to 20% of people with HIV have clinical depression. People with HIV have many risk factors for depression. The diagnosis of HIV itself may lead to sadness, fear of rejection, and negative self-image. HIV may result in declining health, weakness, pain, and confusion, which often adds to a client's negative feelings. Although **sadness and grief are normal responses** to these factors, **clinical depression is a more debilitating condition that requires specific interventions and support**.

Depression Indicators[75][76]	Description
Emotional	• Persistent sad, anxious, or "empty" mood. • Feeling hopeless, pessimistic. • Feeling guilty, worthless, helpless. • Irritable.
Cognitive	• Trouble concentrating, remembering, making decisions. • Thoughts of death or suicide.
Behavioural	• Losing interest or pleasure in hobbies and activities that were once enjoyed, including sex. • Suicide attempts.
Physical	• Restless, irritable. • Insomnia, early-morning awakening, or oversleeping. • Appetite and/or weight loss or overeating and weight gain. • Decreased energy, fatigue, being "slowed down". • Physical symptoms that do not respond to treatment, such as headaches, digestive disorders, and chronic pain.

[74] AIDS Institute New York State Department of Health. (2001). Mental Health Care for People with HIV Infection: HIV Clinical Guidelines for the Primary Care Practitioner. Retrieved August 12, 2003, from New York State Department of Health AIDS Institute website: www.hivguidelines.org/public_html/center/clinical-guidelines/mental_health_guidelines/mental_health/supp_html_files/mental_health_page6.htm

[75] MedicineNet Inc. (1995-2004). Medical Information on Depression. Retrieved October 12, 2003, from MedicineNet website: www.medicinenet.com/depression/focus.htm

[76] Canadian Mental Health Association. (2003). Depression. What is it? What to do? Retrieved December 15, 2003 from CMHA Alberta website: www.cmha.ab.ca/download/depression/ch3.pdf

Implications for U2 clients
• Feeling hopeless and/or suicidal may lead to not caring about the consequences of unsafe sex, use of drugs or alcohol, not taking medication, or not going to appointments. Not motivated to take special precautions. Poor self-care. • May turn to alcohol or drugs as a way to feel better. • Losing interest in life may interfere with making friends and maintaining a social support network. • Not being able to keep a job may mean the client is short of money. • Poor appetite may lead to poor nutrition. • Some physical symptoms may be the same as symptoms associated with HIV/AIDS. • Increased potential for self-harm/suicide. • Not being motivated to take special precautions may place self and others at risk of harm (e.g., unsafe sex). • Not motivated to take part in daily tasks and activities. • Decreased self care resulting in poor hygiene, poor housekeeping etc.

Common Effects	Strategies[77,78]
Negative Thoughts	• Present the positive side of things to give a more balanced perspective. • Split large tasks into small ones, set some priorities, and encourage the client to do what he/she can when he/she can, a bit at a time. • Encourage the client not to expect too much too soon, as this will only increase feelings of failure. • Don't blame the client for his/her depressed mood or expect him/her to "get over it". Clinical depression needs treatment and improvement takes time.
Sense of Hopelessness or Helplessness	• Give lots of encouragement including having someone go with the client to appointments or social activities. • Create a bright and cheerful environment. • Encourage self-care (e.g., cleanliness, appearance, tidy home or living area, doing something he/she likes or that brings pleasure – as long as it's safe). • Build in successes each day, no matter how small.
Difficulty With Planning, Memory, Making Decisions	• Remind the client about appointments and taking medication. Help the client schedule and organize his/her routines, appointments, etc. • Constantly encourage and remind the client to take appropriate safer sex measures (if he/she is sexually active).
Social	• Make sure regular social contacts occur. Encourage the client to be with other people. Arrange for friends or friendly visitor volunteers to visit regularly. • Encourage the client to get out and participate in social activities he/she enjoys (e.g., going to a movie, going to church, taking part in a self-help or support group, etc.).

[77] Medicinenet.com (2003). Depression. Retrieved October 12, 2003 from Medicinenet website: www.medicinenet.com/Depression

[78] Canadian Mental Health Association. (2003). Depression. What is it? What to do? Retrieved December 15, 2003 from CMHA Alberta website: www.cmha.ab.ca/download/depression/ch3.pdf

Common Effects	Strategies[77,78]
	• Encourage activities that are an alternative to drinking or drug use. Help the client plan to avoid social settings that tempt him/her to use alcohol or drugs. • Help the client build a strong social support network. This might include personal visits, group outings or activities, phone support from a friend, volunteer or worker (avoid phone-sex lines). • For those who have used drugs or alcohol, help the client develop a new, more positive peer group.
Physical	• Watch the client's diet and encourage him/her to eat nutritious meals. • Set up regular physical exercise routines and activities. • Teach relaxation methods. • Help the client establish regular sleep patterns and get enough sleep. • If symptoms of depression appear, have physician screen for clinical depression regularly (annually or as symptoms suggest). Recommended treatment is a combination of medication and mental health counselling.
Suicidal Tendencies	• Refer to your agency suicide assessment protocol. • Ask the client, "Are you thinking about hurting yourself or other people? Do you have a plan?" • Listen without making value judgements. A depressed client often needs a supportive ear more than being told what is wrong or what to do. • Believe what the client says and take all threats seriously. • Never keep someone's suicidal feelings a secret. Contact someone who is trained to deal with suicide. • Act immediately if you feel someone is at immediate risk for suicide. • Encourage the client to seek help. Ask the client to agree to get support when he/she feels overwhelmed (e.g., contact his/her worker, call suicide services, the distress centre, hospital or police). • Develop a contract with the client that includes a list of people/services to contact in an emergency and specific steps to take to prevent self-harm. (See HIV/AIDS & Suicide section for sample contract).

SPECIAL HIV NOTE

It is common for people living with HIV to have many symptoms ***that look similar to clinical depression.*** For example, symptoms such as weight loss, irritability, restlessness, disturbed sleep, fatigue, anorexia, lethargy, or diminished interest in sex are all commonly seen in HIV-infected clients. These same symptoms are associated with depression. HIV-infected clients should be screened for clinical depression, by the physician, annually or as needed.

What to Watch For[79]:

The following behavioural changes may indicate that the HIV infected client is falling into a clinical depression:

- not following treatment (i.e., missing appointments or medications, etc.),
- not being able to make life choices including those related to medical care,
- being preoccupied with a particular problem, usually something minor,
- a change in functioning, including not being able to do day-to-day activities,
- a return to substance use,
- self-imposed isolation.

Other HIV Related Issues

Some people living with HIV develop neurological problems from direct or indirect effects of the virus that may result in symptoms ***that look similar to clinical depression***. People who suffer years of untreated HIV may begin to show dementia-type symptoms. Some people have only subtle symptoms. Some people have a gradual mental decline. Others get worse over a short period of time. Watch for the following signs:

- forgetfulness,
- lack of concentration and attention,
- irritability.

Update the client's psychiatrist or doctor if you are noticing the above symptoms.

HIV Medication Side Effects

Some HIV medications may have side-effects similar to some characteristics of clinical depression. Be aware of potential side-effects of all medications the client is taking. Especially, efavirenz for HIV/AIDS and interferon-a for HCV may cause episodes of depression varying in intensity. Consult with the specialist or physician when these medications are used with antidepressant therapy. If these medications are continued, the primary care practitioner should work closely with a psychiatrist.

- depression
- tearfulness
- loss of appetite
- insomnia
- apathy
- confusion
- impaired memory
- headache

Check with doctor if medication side-effects are suspected.

Additional Resources

AIDS Institute. (2001). **Mental Health Care Guidelines for People with HIV Infection**. New York Department of Health. New York. www.hivguidelines.org/public_html/center/clinical-guidelines/mental_health_guidelines/mental_health_intro.htm For more information on HIV medication side-effects.

[79] MedicineNet Inc. (1995-2004). Medical Information on Depression. Retrieved October 12, 2003, from Medicine Net website: www.medicinenet.com/depression/focus.htm

Canadian Mental Health Association. (2001). **Depression. What Is It?** www.cmha.ab.ca/help/publications/depression.htm A self-help booklet explaining depression and strategies for dealing with it. Can be downloaded from the site.

Depression & Suicide from Health Touch Online website: www.healthtouch.com/bin/EContent_HT/hdSubIndex.asp?goto_type=1x5-Grid&index=117464&title=Depression+%26+Suicide&cid=HTHLTH

Lands, L. (2002). **A Practical Guide to HIV Drug Side Effects.** Canadian AIDS Treatment Information Exchange. Toronto, ON. www.catie.ca/pdf/SIDEEFF_EN.pdf For more detailed information on medication side effects.

Suicide and Suicide Prevention. www.psycom.net/depression.central.suicide.html - good articles on specific aspects of suicide prevention, including information on suicide and HIV.

For services related to Depression contact:
Canadian Mental Health Association 403-297-1700.

Specific Disorders

DEVELOPMENTAL DISABIILITY

Developmental Disability[80] is a label most commonly applied to people who meet the criteria of Mental Retardation set by the American Association of Mental Retardation (AAMR). The AAMR says that Mental Retardation is a disability characterized by significant limitations both in intellectual functioning and in adaptive behaviour as shown in conceptual, social and practical adaptive skills and that this disability originates before age 18.[81]

In Alberta, eligibility for Persons with Developmental Disabilities (PDD) funded services is determined by the following three criteria: 1) significantly below average intellectual capacity 2) onset prior to the age of 18, and 3) related limitations in two or more adaptive skill areas.

Developmental Disability Indicators[82]	Description
Cognitive	• Below average intellectual functioning. An IQ of approximately 70 or below on an individually administered formal test of intelligence.
Adaptive Behaviour	Deficits or impaired functioning in at least two of the following skill areas: **Conceptual Skills:** • Language - understanding and expressing information through words, symbols or gestures. • Reading and writing – well enough to function in the community. • Money concepts. • Self-direction – making choices, self-advocacy, problem-solving and getting help when needed. **Social Skills** • Interpersonal - managing social interactions and relationships. • Responsibility. • Self-esteem. • Gullibility - likelihood of being tricked or manipulated. • Naivete. • Following rules. • Obeying laws. • Avoiding victimization and safety issues through good habits.

[80] Biersdorff, K. (1999). Duelling Definitions: Developmental Disabilities, Mental Retardation and Their Measurement. Rehabilitation Review. 10 (7).
[81] American Association of Mental Retardation. (2002). Definition of Mental Retardation. Retrieved September 29, 2003 from: www.aamr.org/Policies/faq_mental_retardation.shtml
[82] American Association of Mental Retardation. (2002). Mental Retardation Workbook: Definition, Classification, and Systems of Supports. AAMR. Washington, DC

Developmental Disability Indicators[83]	Description
Adaptive Behaviour (continued)	**Practical Skills** • Activities of daily living: eating, transfer/mobility, toileting, dressing, hygiene. • Instrumental activities of daily living: preparing meals, housekeeping, transportation, taking medication, managing money, using the telephone. • Occupational skills: specific job finding and job skills, good work habits and taking direction well. • Maintaining safe environments: preventing, recognizing, and addressing health issues.

Implications for U2 clients
• Client may have trouble understanding what HIV status means, following treatment and preventing the spread of HIV (because of lack of understanding or lack of ability to take precautions). • Relationships and social support networks may be smaller due to limited life experiences associated with being labelled developmentally disabled. • Client may be naïve and therefore vulnerable to being taken advantage of. • Relationships and dating may need to be supervised as the client may not be able to negotiate safer sex or understand the risk involved in an intimate relationship • Limited job options may mean he/she is short of money. • Current level of home living skills may interfere with good self-care. • May inappropriately disclose HIV status to strangers.

[83] American Association of Mental Retardation. (2002). Mental Retardation Workbook: Definition, Classification, and Systems of Supports. AAMR. Washington, DC

Common Effects[84]	Strategies
Communication	• Use plain simple language when explaining instructions or concepts – slow down, watch language you use. • Use a variety of ways to communicate in order to make messages more clear (e.g., talking, demonstrating, pictures, role play, practice, repetition). • Have the client repeat back information or instructions in his/her own words to check for understanding. • Use step-by-step instructions – ask for one step at a time. Try to keep instructions specific and concrete rather than broad or abstract. • Do not pretend you understand the client when you don't. Let the client know and ask for their patience. • Provide options for communication (e.g., PIC symbols, personalized picture and photo books).
Self-care	• Break down tasks into simplified steps. • Use simple routines, repetition, and visual supports to teach skills. • Be prepared to use reminders and/or support – create a range of prompts from words to gestures. • Encourage age appropriate clothing and accessory choices. • Use calendars and agenda books. • Create structure in daily routines. • Use dosettes or bubble packs for medication. • Match level of support to the client's abilities - don't over or under support.
Home-Living	• Check what level of home-living skills the client already has (e.g., cleaning, basic cooking, shopping). • Create a personalized support plan to teach and/or support home-living skills (targeted to areas of need).
Social	• Facilitate positive interactions with friends, co-workers, community contacts. • Explore interests and community connections and help the client develop a plan for social activities. • Remind the client of social activity plans or schedules. • Some people may need help arranging transportation to and from social activities/engagements. Contact *Access Calgary* to book Calgary Handi-Bus or Access Calgary taxi service.
Self-direction	• Encourage the client to talk about his/her ideas and preferences by asking what he/she likes, or what he/she wants. • Clearly explain options/choices and support decision-making. One way to teach decision-making is to break the decision into two options. The client makes one of those decisions or choices. Then break down the next part of the issue into two more decisions, and the client makes one of these decisions until the job is done. • Provide advocacy as necessary.
Health and Safety	• Give support to facilitate positive health choices. Try role modelling,

[84] American Psychiatric Association. (2000). DSM-IV-TR . American Psychiatric Association, Washington D.C.

Common Effects[84]	Strategies
	prompting, and simplifying tasks as much as possible. • May need repeated instruction, practice and monitoring to fully integrate learning. • Teaching safer sex must include not only specific and simple instructions, but also demonstrating with the use of models, visual supports that the client is comfortable with. • Practice safer sex negotiation skills until the client is able to show he/she has the skills needed to negotiate safer sex. • Follow-up periodically to make sure the client remembers important information, instructions and skills.
Functional Academics	• Build on academic support strategies that already work for the client. • Access community-based resources for additional upgrading and skill development.
Leisure	• Get to know the client's interests, abilities, likes and dislikes. Don't make assumptions about someone's interests based on his/her disability (e.g., don't assume all people with developmental disabilities like bowling). • Develop a plan for leisure activities and help the client incorporate physical activity, hobbies and interests into their routine. Leisure activities provide a good opportunity for community integration and socialization.
Work	• Explore work/career interests. Support the client's choice of work activity and ensure the job is realistic and achievable given the client's disability. Help the employer identify tasks or modify jobs (i.e., job carving) suitable for the client. • Encourage positive interactions at work and give support when necessary. • Make sure the client knows how to use Universal Precautions to prevent the spread of HIV. • **HIV is a confidential issue and does not need to be shared with other institutions, work placements, schools, etc. unless there is a distinct risk of the spread of HIV.**

SPECIAL HIV NOTE

It is common for people with developmental disabilities and people living with HIV to have many symptoms ***that result in a reduced ability to carry out many life activities.*** Cognitive impairments may be a result of HIV dementia, metabolic or neurological diagnosis, psychological disorders or substance abuse related disorders[85].

When a client has two diagnoses, it may be difficult to decide which needs are related to a developmental disability and which are related to another issue (e.g., mental health, HIV). The support requirements of the untreated HIV positive client may be influenced by a combination of disabilities and symptoms. A holistic model of support directs support toward the clients needs and provides support for a range of needs as required (intermittent, limited, or extensive)[86] often eliminating the need to determine the source of an adaptive skill deficit. Ask the client or people in network which strategies work best for him/her.

[85] Health Canada. (1998). A comprehensive guide for the care of persons with HIV disease, module 7. **Canadian Public Health Association** Canadian HIV/AIDS Information Centre, Ottawa, ON.
[86] Biersdorff, K. (1999). Duelling Definitions: Developmental disabilities, mental retardation and their measurement. Rehabilitation Review, 10 (7).

Some people living with HIV develop neurological problems, which may result from direct or indirect effects of the virus and may lead to cognitive impairments. People who have had HIV for many years with no treatment may begin to show dementia-type symptoms.

Some people have cognitive, behavioural or motor problems as a result of the HIV-related dementia. Some people have a gradual mental decline. Others get worse rapidly over a short period of time. Symptoms might include:

- forgetfulness
- slowness
- irritability
- lack of concentration and attention, poor problem-solving
- decreased visual/motor skills or writing skills
- apathy

Update the doctor if you are concerned about changes in the client's typical behaviour or abilities.

HIV Medication Side Effects

Some HIV medications may have side-effects that result in a reduced ability to carry out many life activities. Possible medication side-effects include:

- impaired memory
- confusion
- loss of appetite
- apathy
- insomnia
- irritability
- excitability

Check with the doctor if you suspect medication side-effects.

Additional Resources

American Association for Mental Retardation (AAMR). (2002). **Mental Retardation Workbook. 10th Edition.** For proposed approaches to community inclusion planning.

Progressive Alternatives Society of Calgary. **Building Community Solutions Guide Book**. www.pasc-calgary.org/sections/bcs/bcs_guidebook.asp Learn how to further welcome people with disabilities into your group, community or organization. For information on disability-related concepts, issues, myths and stereotypes commonly associated with people with disabilities and accommodation strategies and creative options that can be used in any environment or situation.

Community Services for Adults with Developmental Disabilities - Calgary. www3.gov.ab.ca/pdd/docs/calg/calgary_service_providers.pdf A list of Calgary-based agencies that can provide residential support, job preparation and placement, community access programs and respite support for adults with developmental disabilities.

Lands, L. (2002). **A Practical Guide to HIV Drug Side Effects.** Canadian AIDS Treatment Information Exchange. Toronto, ON. www.catie.ca/pdf/SIDEEFF_EN.pdf For more detailed information on medication side effects.

Persons with Developmental Disabilities (PDD). www.pdd.org For information regarding services for adults with developmental disabilities.

Specific Disorders

FETAL ALCOHOL SYNDROME

Fetal Alcohol Spectrum Disorder[87](FASD), Fetal Alcohol Syndrome (FAS), Alcohol-Related Birth Defects (ARBD), Fetal Alcohol Effects (FAE), and Alcohol-Related Neurological Disorders (ARND) are the most commonly used terms to refer to the range of issues resulting from **prenatal exposure to alcohol**. Each client with FAS is unique with distinctive strengths, weaknesses and issues.

FAS commonly results in abnormal cognition (i.e., ability to learn and reason), language, and behaviour. These abnormalities may lead to health, speech and language problems, learning disabilities and behavioural problems. However, each client suffering from FAS is affected differently. Some may have greater learning disabilities while others may be challenged by behavioural issues. FAS is a lifelong condition that presents different challenges at different stages in a client's life.

FASD Indicators[88]	Description
Emotional	• Poor understanding of social expectations. • May be depressed.
Cognitive	• Impulsive, attention deficits. • Significant learning disabilities. • Cognitive delay (normal development related to learning and reasoning may be delayed). • Not able to appreciate cause and effect. • Memory problems.
Behavioural	• Delayed developmental milestones. • Trouble adapting to change. • Problems with independent living. • Trouble keeping a job. • Possible addictions (alcohol, drugs) and possible inappropriate sexual behaviour. • Involvement with the legal system.
Physical	• Low weight compared to height. • Unique facial features such as short eye slits, thin lips, flattened facial bone structure. • Sleeping problems. • Other physical abnormalities such as heart or kidney defects.

[87] Alberta Children's Services. (2003). About Fetal Alcohol Spectrum Disorder. Retrieved September 20, 2003, from Government of Alberta website:: www.child.gov.ab.ca/whatwedo/fas/page.cfm?pg=index

[88] Alberta Children's Services. (2003). FASD Tip Sheets. Retrieved September 20, 2003, from Government of Alberta website: www.child.gov.ab.ca/whatwedo/fas/pdf/profestips.pdf

Implications for U2 Clients
• Not being able to appreciate cause and effect plus impulsive behaviours may lead to AWOL, spontaneous sexual activities, or spontaneous use of drugs or alcohol without thinking about consequences. • Consequences such as public health orders or criminal charges may not prevent unacceptable or risky behaviours. • May have trouble remembering and/or following through on instructions (e.g., safer sex), appointments, medications and/or safe personal care routines. • May lack motivation to take special precautions. Poor self-care. • May turn to alcohol or drugs as a way to feel better. • Poor understanding of social relationships means the client may have trouble making friends and keeping a social support network. • May be easily/negatively influenced by peers (e.g., taking part in illegal activities, use of alcohol or drugs, unsafe sex activity). • Not being able to get or keep a job may mean he/she is short of money.

Common Effects	Strategies[89]
Attention Difficulties	• Reduce visual distractions (e.g., materials not in use should be stored in boxes or cupboards - not on counter tops, avoid spinning mobiles, dim the lights). • Simplify tasks. The more difficult the task, the more distractible the client will be. • Ensure a quiet living / working environment. Have as little competing noise as possible. Use non-verbal cues to reduce the amount of talking and stimulation in a group. • Over time, the client may learn to know when there are too many distractions and go to a quieter working area. This should never be seen as punishment.
Hyperactivity	• Allow for some movement without disrupting others. • Periods of physical activity followed by quiet activities may help some people. Try planning the day around the times that work best for the client. Use input from the client as a guide and fit activities to the natural flow of the day.
Cause and Effect Thinking	• FASD clients are often unable to understand the cause or consequence of their actions. • Take time to talk to the client, as they may have ideas on how to come up with a strategy. • Decide on what is most important and what is within the control of the client. Pick your battles wisely. • Be as consistent as possible in routines and consequences. • Help the client problem-solve (i.e., What did I do? What else could I have done?). • Help the client take another client's point of view. • Consider the client's verbal and memory limitations in working through an incident and deciding on consequences.

[89] Used with permission fromUniversal Rehabilitation Service Agency. (2003). URSA U2 Handbook, Calgary, AB.

Common Effects	Strategies[89]
	• Anticipate and prevent problems through close supervision. • Set up the environment for success.
Motor Skills	• Encourage physical activities. • Allow for practice of fine motor skill activities.
Impulsivity	• Teach the client to use "self-talk" to help stay focused (i.e., the first thing I have to do is…). • Use concrete reinforcements or reminders (i.e., use of the stop hand signal). • Consequences for inappropriate behaviour need to be immediate. • A client who needs the stimulation of movement could do some activities such as reading in a rocking chair. • Try meeting the need for physical stimulation by providing a stress ball to squeeze. • Some people are calmed by quiet relaxing background music. • Arrange a quiet area to use when distractions are too great. • Rhythmic activities such as swinging, rocking, or walking may hold attention. • Encourage the client to use a signal to indicate frustration. • Teaching or completing tasks through music can be effective. • Make each activity brief. • Ask the client what helps him/her learn (i.e., What can we do to make this work?).
Social Skills	• Model appropriate behaviour. • Give immediate and consistent feedback about inappropriate behaviour. • Practice the behaviour with guidance. • Reinforce appropriate behaviours. • Be aware that negative behaviour may be a symptom of unmet needs. • Provide direction in social settings. • Let the client make mistakes and help him/her learn better responses. Work with the client to find solutions to problems as often as possible. • Take turns during an activity (i.e., I set one place setting at the table and you set one.). • Set limits and consistently follow them. • Encourage the use of positive self-talk (i.e., I can do this. I can figure this out.) • Assist the client to develop and plan routines. • Use teachable moments including: how to negotiate what you want, how to accept criticism, how to show someone you like them, how to get someone's attention in a positive way, how to handle frustration, fear and disappointment, how to ignore someone who is bothering you and how to use a variety of ways to communicate.
Adapting to Change	• Have a regular and predictable schedule of activities. • Help the client to look at a schedule and look forward to what will be happening that day. At the end of the day, look over the day's activities and talk about what went well. • Prepare the client in advance for changes to come. • Have consistent sequences of activities. • Have a few simple rules, starting with language which is very concrete. (e.g.,

Common Effects	Strategies[89]
	"if you hit you sit" is more concrete than "respect others"). • When moving from one activity to the next, prepare the client for the change by letting him/her know how much time is left. • Make expectations and goals reasonable, attainable and realistic. • Define, organize and respect a space that belongs to the client. • Make a quiet working area.
Memory Skills	• Give one instruction at a time. • Give opportunities for the client to practice saying directions (i.e., write the directions down for the day). • When the client seems to have learned a repetitive skill, continue practising and aim for over-learning (i.e., the skill becomes a habit). • Help the client generalize skills (e.g., practice the same skills in a number of different places). • Ideas presented concretely (i.e., with examples) will be easier to learn and remember than abstract ideas. • Skills practised in their usual <u>context</u> make the most sense (e.g., buying something <u>at the store</u> vs. pretending to buy something in a classroom setting). • Learning through art and music activities may use the client's strengths. • When giving verbal instruction, try to give written instructions at the same time. • The parts of memory that involve paying attention can be enhanced through memory games and teaching memory strategies. • Practice putting events in the order they occur (i.e., sequencing). For example, create a story out of pictures. Use language that is familiar to the client. • Use prompting to help the client recall details. • Teach the client strategies for remembering (i.e., making a list, notes on a calendar). • Note that memory retention varies from day to day – what the client could remember yesterday, may not be present today. Don't mistake this for stubbornness or defiance.
Language Development	• Choose simple materials with illustrations. • Tape record stories so the client can listen and read along. • Use a picture dictionary to help the client learn new words. • Do not use figures of speech and sarcasm. Be concrete. • Give instructions one step at a time. Use rhythm techniques such as slow rhythmic clapping to focus attention. • Match your communication level to the client. • Use strategies that involve more than one of the senses (i.e., visual – seeing, auditory – hearing, tactile - touch, and kinesthetic – physical movement). • When unsure how to respond to direct questions, individuals with FAS often make up answers they think you want to hear or that are logical for the circumstances. Constantly reassure them that it is okay to say "I don't know" or "I don't remember." Staff should use these phrases themselves then demonstrate how to find the information (notes, schedules, other people). This will reduce accusations of "lying" for people with FAS.

Common Effects	Strategies[89]
Reading and Writing	• Check the client's literacy level and ensure all written materials are at an appropriate level. • Speak face to face. • Use the client's name. • Don't give too many instructions at one time. • Ask the client to explain the instructions to you in their own words. • Give instructions with pictures and with words. • Use checklists, calendars and schedules. • Slow the speed and give the client time to understand. • Be concrete and specific. Not following instructions may mean that the message was too complex or unclear. • Use sequential, repetitive strategies, which build on what the client knows.

SPECIAL HIV NOTE

It is common for people living with HIV to have many symptoms ***that result in a reduced ability to carry out many life activities.*** Strategies to allow for reduced learning and reasoning abilities must be individualized and based on the client's strengths. A holistic model of support eliminates the need to find the source of an adaptive skill deficit and gives support as required for a range of needs.[90]

Some people living with HIV develop neurological problems from direct or indirect effects of the virus that may result in symptoms that ***look similar to FAS***.

People who have had HIV for many years with no HIV treatment may begin to show dementia type symptoms. Some people have only subtle symptoms. Some people have a gradual mental decline. Others get worse over a short period of time. Symptoms may include:

- forgetfulness,
- lack of concentration and attention,
- irritability,
- unsteady gait, loss of balance,
- trouble performing previously learned complex tasks,
- poor judgement.

Update the client's doctor if you are concerned about changes in the client's typical behaviour or abilities.

[90] Biersdorff, K. (1999). Duelling Definitions: Developmental Disabilities, Mental Retardation and Their Measurement. Rehabilitation Review. 10 (7).

HIV Medication Side Effects:

Some HIV medications may have side-effects which result in a reduced ability to carry out many life activities. Side-effects may include:

- impaired memory
- confusion
- loss of appetite
- insomnia
- apathy
- restlessness
- irritability
- headache
- depression

Check with a doctor if you suspect medication side-effects.

Additional Resources

Calgary Fetal Alcohol Network Homepage. www.calgaryfasd.com/what.html

Alberta Children's Services. (2003). **FASD Tip Sheets for Health And Human Service Professionals**. Government of Alberta www.child.gov.ab.ca/whatwedo/fas/pdf/profestips.pdf

Fetal Alcohol Syndrome Information Support and Communication Link. www.acbr.com/fas/

Swan, A. Hollander, E. (2002). **Impulsivity and Aggression Diagnostic Challenges for the Clinician**. ACCESS Medical Group. Illinois. Council for Excellence in Neuroscience Education: http://cene.com/PDFs/D11-1_Impulsivity.pdf for information and treatment strategies.

Lands, L. (2002). **A Practical Guide to HIV Drug Side Effects.** Canadian AIDS Treatment Information Exchange. Toronto, ON. www.catie.ca/pdf/SIDEEFF_EN.pdf For more detailed information on medication side effects.

Specific Disorders

POST TRAUMATIC STRESS DISORDER

Post Traumatic Stress Disorder (PTSD) is an anxiety disorder that develops in some people who have had major traumatic experiences (such as sexual abuse, rape, victims of torture and war). The client is typically numb at first but later has symptoms including depression, excessive irritability, guilt, recurrent nightmares, flashbacks to the traumatic scene, and overreactions to sudden noises. Some people will have a history of previous severe trauma in childhood, such as sexual or physical abuse. Most women who were victims of physical assault have Post Traumatic Stress Disorder.

PTSD Indicators	Description[91]
Cognitive	• A client may relive the experience as terrible dreams or nightmares or as daytime flashbacks. • Internal thoughts, memories, fantasies or everyday experiences may reactivate the traumatic experience. • Loss of memory (emotionally caused) for the traumatic event. • Difficulty concentrating. • Mistrust of people.
Emotional	• Detachment from other people, difficulty maintaining relationships, overwhelming fear of people. • Lack of self-esteem. • Feeling numb (restricted range of feelings). • Unpredictably weepy; sudden crying. • Generalized anxiety, helplessness, hopelessness. • Sad affect with sense of impending doom, restricted range of affect.
Behavioural	• Ongoing avoidance of trauma related thoughts, feelings, activities or situations. • Loss of interest in previously enjoyable activities, roles and relations. • Increased state of arousal that can include: - sleep disturbances and/or eating disturbances, - irritability, - outbursts of anger, - increased vigilance, - exaggerated startle response when shocked.
Physical	• Physical reactions to stress (e.g., headaches, muscle tension, rise in blood pressure, rapid heart rate, sweating - fight or flight response). • Physiological reaction to cues (or events) similar to an aspect of the traumatic event.

[91] Mental Help Net. (1995-2004). Posttraumatic Stress Disorder – Symptoms. Retrieved September 20, 2003, from Mental Help Net: http://mentalhelp.net/poc/view_doc.php?type=doc&id=575&cn=109&clnt%3Dclnt00001&

Implications for U2 clients
• Stress of dealing with HIV may compound the stressors associated with PTSD and reactivate the sense of trauma. • Coping skills may decrease. • Stress/anxiety reactions may interfere with treatment (e.g., ability to keep appointments or maintain treatment regime). • At risk for depression and possible self harm behaviours, including lack of care regarding safer sex. • At increased risk for substance abuse. • Sense of detachment from others may interfere with development of social relationships and social support network. • Potential for angry outbursts when under stress. • May be at increased risk for suicide.

Common Effects	Strategies[92]
Intrusive (unwelcome) thoughts, flashbacks)	• Carefully monitor the client's thoughts that follow from thinking about the traumatic event. Then use a prepared script (self talk) to change the unwelcome thoughts that occur whenever the client has been thinking about the trauma. • Use role playing to practice new ways of thinking and reacting to stressful situations. • Have the client keep a journal to help change the sequence of thought patterns, and separate the intrusive thoughts from the associated anxiety/stress.
Panic and Avoidance Behaviours	• Help the client learn to manage stress/anxiety with relaxation, breathing retraining (such as breath counting and deep breathing exercises). • Try repeated exposure to the past trauma in small doses, gradually increasing exposure until the issue can be remembered without a panic reaction. Do this only as part a treatment plan under the guidance of a therapist. Dealing with too much at one time can be overwhelming and create a crisis. • Encourage the use of self-help books to help the client increase his/her sense of self-control and learn how not to feel victimized again. • The client needs to gradually build trust in him/her self and others.
Social	• Help the client get involved in activities that provide a healthy alternative to substance use. • Help the client build social support networks (e.g., facilitate social contacts through activities of interest to the client – AA group, church communities, hobby clubs, volunteer work, recreational activities, and self-help support groups).

[92] Panzarino, P. (2002). Posttraumatic Stress Disorder. Retrieved September 20, 2003, from Medicine Net website: www.medicinenet.com/posttraumatic_stress_disorder/article.htm

OTHER RELATED ISSUES

People with Post Traumatic Stress Disorder (PTSD) have an increased number of suicides and hospitalizations, and are more likely to have alcohol abuse or drug dependency problems. Up to one third of people experiencing PTSD will have other psychiatric, marital, occupational, financial, and health problems.

HIV Medication Side Effects

Some HIV medications may have side effects similar to some characteristics of PTSD. Possible medication side effects may include:

- anxiety
- nervousness
- agitation
- confusion
- irritability
- appetite loss
- sleeping difficulties
- tearfulness, depression
- nightmares
- memory loss

Check with doctor if medication side effects are suspected.

Additional Resources

Lands, L. (2002). **A Practical Guide to HIV Drug Side Effects.** Canadian AIDS Treatment Information Exchange. Toronto, ON. www.catie.ca/pdf/SIDEEFF_EN.pdf For more detailed information on medication side effects.

AIDS Institute. (2001). **Mental Health Care Guidelines for People with HIV Infection**. New York State Department of Health. New York. www.hivguidelines.org/public_html/center/clinical-guidelines/mental_health_guidelines/mental_health_intro.htm For more information on HIV medication side-effects.

National Centre for PTSD. (2003). **Treatment of PTSD**. www.ncptsd.org/facts/treatment/fs_treatment.html. Provides information on PTSD including practical suggestions for treatment.

Specific Disorders

SCHIZOPHRENIA

Schizophrenia[93] is a mental disorder that impairs a client's ability to think clearly, manage his or her emotions and relate to others. The exact cause of this disease is unknown, but it appears to be genetic and is the result of problems with brain chemistry and structure, perhaps including brain abnormalities early in life as well. Viral infections may also be responsible. Schizophrenia affects one in 100 persons or 1 percent of the global population. There is no known cure, but schizophrenia is treatable. Medications are the cornerstone of treating this illness. Treatment includes: medications, regular medical follow-ups, psychosocial rehabilitation, community support, and hospitalization.

There are several schizophrenia subtypes, defined by the predominant symptoms present. Subtypes include: Paranoid Type, Disorganized Type, Catatonic Type and Undifferentiated Type.

Schizophrenia Indicators	Description
Cognitive	• Hallucinations –see or hear something that is not real or present. • Delusions – a false idea or belief held in spite of all evidence from one's own senses and others that the belief is false (e.g., delusions of grandeur, delusions of persecution). • Paranoia – extreme mistrust and suspicion. • Disorganized thinking and speech. • Difficulty with abstract thinking. • Obsessive thinking or compulsive rituals. • Poor concentration, attention, memory or learning ability.
Emotional	• Emotional withdrawal. • Prolonged anxiety, tension or worry. • Flat affect (mood) or inappropriate affect ranging from fear to laughter. • Irritability or hostility. • Reduced interest in previously enjoyed activities.
Behavioural	• Reckless or impulsive behaviour. • Overly dependent behaviour. • Disorganized behaviour. • Physical violence. • Risk of harming self. • Distrust or suspiciousness. • Lack of motivation. • Decreased daily living skills (e.g., poor grooming and hygiene, poor money management).

[93] Schizophrenia Society of Alberta. (2003). What is Schizophrenia? Retrieved September 20, 2003, from Schizophrenia Society of Alberta website: www.schizophrenia.ab.ca/007-info/007-01.info.htm

Schizophrenia Indicators	Description
Physical	• Fidgeting, pacing, or hyperactivity. • Fatigue (physically tired all day) or sleeping problem. • Appetite or eating problem.

Implications for U2 clients
• Anxiety, feelings of hopelessness, depression and generally poor self care may lead to not caring about the consequences of unsafe sex, use of drugs or alcohol, not taking medications, or not following through on appointments. • May turn to alcohol or drugs as a way to feel better or as an attempt to self-medicate. • May have difficulty developing social relationships and maintaining a social support network – vulnerable to being taken advantage of. • Inability to maintain employment may negatively impact finances. • Lack of appetite may result in poor nutrition/health. • Deterioration in physical well being may mimic symptoms associated with HIV/AIDS. • Poor judgement, grandiosity may place self and others at risk of harm (e.g., unsafe sex). • Increased potential for self-harm/suicide.

Common Effects	Strategies[94] [95]
Anxiety *Note: Anxiety may be directly related to medication, hallucination or delusions.*	• Establish a predictable daily routine. • Prepare the client in advance for upcoming changes that may be occurring. • Encourage self-talk to maintain focus in a difficult situation. • Keep lines of communication open through regular chats about problems or fears that the client may be having (i.e., progress checks). Identify stressors and strategies for coping with these. • Encourage the client to participate in stress management activities such as: • regular exercise, • deep breathing exercises, • meditation. • Ensure the client gets enough rest and relaxation.

[94] Used with permission fromUniversal Rehabilitation Service Agency. (2003). URSA U2 Handbook. Calgary AB.
[95] Schizophrenia Society of Alberta. (2003). Relating to People Seriously Ill with Schizophrenia. Retrieved December 12, 2003, from Schizophrenia Society of Alberta website: : www.schizophrenia.ab.ca/007-info/007-01.info.htm

Common Effects	Strategies[96] [97]
Depression	• Present the positive side of things to help provide a more balanced perspective. • Break large tasks into small ones, set some priorities and encourage the client to do what they can when they can, a bit at a time. • Create a bright cheerful environment.
Motivation	• Provide reminders for appointments and medication regimes. • Provide lots of encouragement, including having someone accompany the client to appointments or social activities. • Help the client to schedule and organize routines and appointments. • Provide ongoing encouragement and reminders about appropriate safe sex measures (if he/she is sexually active).
Social Skills	• Act as a positive role. • Give immediate feedback about the client's behaviour (both positive and negative behaviours). • Provide private direction in social settings. • Remember the dignity of risk taking. Allow the client to learn through mistakes and provide time to debrief and strategize on how to handle similar situations the next time. • Teach social skills in functional moments such as: - turn taking, - sharing, - win-win approaches, - agreeing to disagree, - boundary teaching. • Encourage participation in a support group for people with schizophrenia. • Provide conflict management training in areas of: - negotiation, - accepting feedback, - appropriate interaction techniques, - how to manage the situation when you dislike someone/something.
Daily Living Skills	Teach independence in daily living skills such as: • cooking, housecleaning and laundry, • budgeting, • recreation and leisure planning.
Coping and Problem Solving Skills	Teach appropriate coping strategies such as: • journaling, • developing a support network of people who the client can talk to, • crisis debriefing, • self-management – encourage client to recognize when they need to take a break, • appropriate healthy distractions that assist a client to 'get away' from the problem for a short time.

[96] Used with permission from Universal Rehabilitation Service Agency. (2003). URSA U2 Handbook. Calgary AB.
[97] Schizophrenia Society of Alberta. (2003). Relating to People Seriously Ill with Schizophrenia. Retrieved December 12, 2003, from Schizophrenia Society of Alberta website: : www.schizophrenia.ab.ca/007-info/007-01.info.htm

Common Effects	Strategies[96 97]
	• Ask the client to identify possible solutions. • Break the problem or crisis down into more manageable parts, then address one part at a time. • Identify triggers and stressors with the client and help them plan to avoid these where possible. • Focus on concrete issues at hand and address them in order. • Reduce distractions. • Encourage stress management techniques. - Sit down to talk if possible, in a private space – this creates equality, and indicates that the talk/discussion is important to both parties. - Avoid patronizing (talking down to the client as if they were a child) or authoritative statements (ordering the client around). - Allow the client to express him/her self in order to get the feelings out. - Help the client learn to identify his/her own signs of relapse, and establish a plan of action that both parties agree to. - Encourage the use of positive self-talk to self-manage emotions and behaviour.
Communication Skills	• Use appropriate role modeling to show positive communication skills. • Teach using all methods of learning (kinesthetic, auditory, and visual). • Keep communication simple and concrete. • Identify and avoid triggers, or hot words, that the client may be sensitive to. • Ensure that staff use calm, patient verbal and non-verbal language.
Employability	• Help the client develop interests and activities that help to create meaningful activity in the day. • Encourage the client to choose low stress work options and reduce time spent in work activities (e.g., look for part time or occasional hours). • Look for work options with a lot of flexibility to accommodate the client when health issues interfere with the ability to work. • Encourage volunteer work.
Possible Suicidal Tendencies	• Ask the client "Are you thinking about harming yourself or others? Do you have a plan?" • Act immediately if you feel someone is at immediate risk for suicide. Encourage the client to seek help from his/her worker, Suicide Services, the Distress Centre, hospital or police. • If you must take action yourself, tell the client what action you will be taking (e.g., call the hospital or police).

SPECIAL HIV NOTE

Some people living with HIV develop neurological problems from direct or indirect effects of the virus that may result in symptoms ***that look similar to schizophrenia***. People who have had untreated HIV for many years may start to show dementia type symptoms. Some people experience only subtle symptoms. Some people experience a gradual mental decline. Others get worse rapidly over a relatively short period of time. Some symptoms to watch for include:

- forgetfulness
- lack of concentration and attention
- irritability
- personality changes
- hallucinations
- delusions

Update the client's psychiatrist or doctor if you are noticing the above symptoms.

HIV Medication Side Effects

Some HIV medications may have side effects similar to some characteristics of schizophrenia. Possible medication side effects may include:

- agitation, restlessness
- depression, tearfulness
- excitability, mania
- loss of appetite
- insomnia
- confusion
- headache
- paranoia
- hallucinations
- apathy
- impaired memory

Anti Psychotic Medication Side Effects:

Anti psychotic medications may produce side effects such as:

- tremors
- stiffness

Check with doctor if there are concerns about medication side effects.

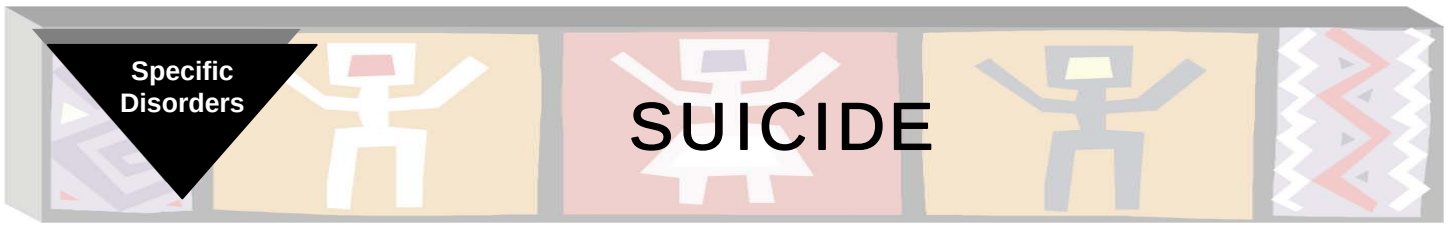
Additional Resources

AIDS Institute. (2001). **Mental Health Care Guidelines for People with HIV Infection**. New York State Department of Health. New York. www.hivguidelines.org/public_html/center/clinical-guidelines/mental_health_guidelines/mental_health_intro.htm For more information on HIV medication side-effects.

Lands, L. (2002). **A Practical Guide to HIV Drug Side Effects.** Canadian AIDS Treatment Information Exchange. Toronto, ON. www.catie.ca/pdf/SIDEEFF_EN.pdf For more detailed information on medication side effects.

Schizophrenia Society of Alberta. **www.schizophrenia.ab.ca/007-info/007-01.info.htm** Provides practical information on Schizophrenia.

Howell, G. (1999). **Rays of Hope: A Reference Manual for Families & Caregivers.** Schizophrenia Society of Canada**.**www.schizophrenia.ca/szreference.html Good information and practical strategies for families and caregivers including contact information for Canadian chapters of the society, and additional references and resources for further reading.



Suicide refers to an intentional self-inflicted death. Suicide is not a distinct disorder. Rather, it is a symptom of underlying problems such as depression, low self-esteem, and sense of helplessness or hopelessness.

A suicidal client may be feeling so much pain that they can see no other option. They may feel that they are a burden to others and see death as a way to escape the overwhelming pain and anguish. The suicidal person may feel self-hatred, rejection, and hopelessness.[98]

Some people who are diagnosed with HIV may become suicidal due to overwhelming anxiety, the potential stigma of being diagnosed with HIV, lack of information about HIV and resources, and lack of hope. They may be concerned about practical realities, such as the high cost of treatment or becoming a burden to family or friends.

A suicide threat or attempt should always be taken seriously. A suicide attempt is a major risk factor for future suicide. Those who have attempted suicide are at greater risk of eventually dying by suicide, and a history of repeat attempts further increases a client's risk of death by suicide.

Being aware of choices and the available resources can have a positive effect on people's perception of their circumstances. It's a practical way to help people in despair to envision a time when they will have more support and more control.

Many people who feel suicidal also benefit from peer support through reassurance from someone who has been through the same thing and survived. Other people with HIV (sometimes referred to as "buddies") can be a strong source of support and help portray how people with HIV can live and cope with the illness.[99]

[98] Centre for Suicide Prevention. (date unknown). Questions About Suicide. Why Do People Kill Themselves? Retrieved December 12, 2003, from Centre for Suicide Prevention website: www.suicideinfo.ca/csp/go.aspx?tabid=15

[99] Health Canada. (1997). Comprehensive Guide for the Care of Persons With HIV Disease. Module 6. Psychosocial Care. p. 52. **Canadian Public Health Association** Canadian HIV/AIDS Information Centre, Ottawa, ON.

Suicide Indicators[100, 101]	Description
Cognitive	**Preoccupation with Death or Dying.** • The client who talks about death, others who have died, or the afterlife most of the time and/or makes preparations for death (such as making out a will, or writing letters to be opened after they are dead). ***This client needs to be immediately hospitalized for suicide risk. Call 911, police and ambulance to get the client the care they require.** **Suicidal Thoughts (Ideation).** • Some clients may be thinking about suicide even though they're not talking about it. Look at the behaviours to determine this. Don't rely merely on self disclosure.
Emotional	**Signs of Depression** The client exhibits signs of depression such as: Sense of hopelessness, helplessness, or futility. Feelings of guilt or failure. • Feelings of worthlessness or of being a burden. • Depressed or agitated mood, despair, grief, guilt, shame, hopelessness and/or helplessness. • Unable to concentrate. • Loss of interest in activities that were formerly pleasurable. • Moodiness (shifting moods, fast changes from deep depression to calmness). • Sudden shift in mood from depressed to elated or happy may indicate that the client has made a decision to die. • Changes in personality: from outgoing to withdrawn, from polite to rude, from compliant to rebellious, from well-behaved to "acting-out". • Poor eye contact. • Sudden shift in mood to "happy" – do not assume the client feels better. Rather this may reflect relief in coming to a decision to commit suicide and having a plan.
Social	• Social withdrawal from family and former friends. Sometimes acting in a manner which pushes others away. • Recent life crisis or trauma such as illness (e.g., HIV positive status), depression, divorce, grief over the loss of a loved one or job, or an accident.

[100] Medicinenet.com (2003). Suicide. Retrieved October 12, 2003 from Medicinenet website: www.medicinenet.com/Suicide/article.htm

[101] Centre for Suicide Prevention. (2002). Suicide. Common Warning Signs. Retrieved December 15, 2003 from Centre for Suicide Prevention website: www.suicideinfo.ca/csp/go.aspx?tabid=30

Behavioural	**Suicidal Talk.** • All suicidal threats should be taken seriously. • The client talks about committing suicide and/or makes suicidal threats or statements such as, "The world would be a better place without me in it", or "Everyone will be better off when I'm gone". **Previous Suicide Attempts**. • If a client has made suicide attempts in the past there is a 40% chance they will try again. **Gives away possessions or disposes of cherished belongings.** • Quietly putting affairs in order ("taking care of business). • Makes a will. Writing poetry or stories about suicide or death. • Threatens suicide. • Hoards pills, hides weapons, describes methods for committing suicide. • Decreased activity. Isolation. • Changes in behaviour, eating and/or sleeping habits. • Accident proneness and increase in risk-taking behaviour such as careless driving, unsafe sex, gambling, financial irresponsibility. • Sexual promiscuity. • Heavy use of alcohol and drugs. • Preoccupation with thoughts of death.
Physical	• Neglect of personal appearance. • Sudden changes in manner of dress, especially when the new style is completely out of character. • Chronic or unexplained illness, aches and pains. • Sudden weight gain/loss. • Sudden change in appetite.

Implications for U2 clients

- Feelings of hopelessness and/or suicidal thoughts may lead to not caring about the consequences of unsafe sex, use of drugs or alcohol, not taking medications, not going to appointments, poor hygiene and appearance. Not motivated to take special precautions such as using condoms.
- Younger people may be less aware of their choices, have less support and be less comfortable asking for help.
- May turn to alcohol or drugs as a way to feel better.
- Loss of interest in life may interfere with development of social relationships and maintenance of social support network.
- Be aware of potential for manipulation – some people will threaten suicide as a way to get other things they want, such as money, housing or attention.[102]

[102] Health Canada. (1997). Comprehensive Guide for the Care of Persons With HIV Disease. Module 6. Psychosocial Care. **Canadian Public Health Association** Canadian HIV/AIDS Information Centre, Ottawa, ON.p.47.

Assessing Suicide Risk

Who Is At Risk?[103] People most likely to commit suicide include those who:

- Have made previous suicide threats
- Are having a serious physical or mental illness
- Are abusing alcohol or drugs
- Are experiencing a major loss, such as death of a loved one, unemployment, divorce
- Are experiencing major changes in their life (such as teenagers, seniors)

To Assess Suicide Risk Consider The Following[104]

- Current suicidal thoughts, intent, and plan (when, where, how and access to "how")
- Perception of available support from others (e.g., low support may increase risk of suicide)
- Previous suicide attempts * * *this is the **single best predictor** of possible suicide*
- Family history of suicide
- History of violence (e.g., weapon use, circumstances)
- Intensity of current depressive symptoms
- Alcohol and drug use patterns * *50 times more likely than non-drinker, drug user*
- Psychotic symptoms
- Current treatment plan and response
- Recent life stressors (e.g., marital separation, job loss)
- Current living situation (e.g., social supports)

Highest Risk:

Clients with suicidal thoughts, plan and intent.

A depressed client with suicidal thoughts, plan and intent should be hospitalized, especially if they have current psychosocial stressors and access to lethal means (i.e., something to harm themselves with). There are a number of resources available:

- Suicide Services, Intervention - Canadian Mental Health #400, 1202 - Centre St SE Calgary, AB 403-297-1744;
- Distress Centre (DC, Distress Centre/Drug Centre, The, Drug Information Centre) #300, 1010 - 8th Ave SW Calgary, AB 403-266-1601;
- Main Crisis Line - Distress Centre (Distress Line) #300, 1010 - 8th Ave SW Calgary, AB 403-266-1605;
- Telecare Calgary 403-266-0700

High Risk:

Clients with suicidal thoughts and plan but without intent.

A depressed client with suicidal thoughts and a plan but without intent may be treated on an outpatient basis, especially when they have good social support and no access to lethal means. However, some of these clients may need hospitalization, especially if their environment does not offer adequate safety measures, such as responsible supervision. Outpatient treatment may consist of antidepressant therapy, referral to a drug and alcohol treatment program, psychotherapy or all of these.

At Risk:

Clients with suicidal thoughts but no plan or intent.

A client who expresses suicidal thoughts but denies having a plan or intent should be evaluated carefully for psychosocial stressors. Staff should ensure removal of any weapons and other potentially lethal means from the client's environment. In general people in this category may be safely treated with antidepressant medication on an outpatient basis, but they should be seen by their physician often, as long as suicidal thoughts persist. If depression does not improve within 4 to 6 weeks of treatment, consult a psychiatrist.

[103] Canadian Mental Health Association. (1993). Preventing Suicide. Retrieved December 12, 2003, from CMHA Alberta website: www.cmha.ca/english/info_centre/mh_pamphlets/mh_pamphlet_12.pdf

[104] Frierson, R. Melikian, M. Wadman, P. (2002). Principles of Suicide Risk Assessment. 112(3). Postgraduate Medicine. Retrieved October 12, 2003 from The McGraw-Hill Companies Website: www.postgradmed.com/issues/2002/09_02/frierson4.htm

Strategies[105,106]

What to do to help someone who is considering suicide:

- Get formal suicide prevention/intervention training
- Talk openly and matter-of-factly about the possibility of the client hurting him/herself. Be direct (e.g., "Are you thinking about hurting yourself?").
- Be nonjudgmental.
- Be willing to listen and allow expressions of feelings.
- Be available. Show interest and support. Become involved.
- Seek support. Don't be sworn to secrecy.
- Don't dare the client to do it.
- Don't act shocked. This will put distance between you.
- Offer hope that alternatives are available but do not offer glib reassurance.
- Take action and try to remove items that could be used for suicide.
- **Get help from clients or agencies specializing in crisis intervention and suicide prevention**. Tell someone who can help (a mental health specialist) about what is happening and ask him or her to help you manage the situation.
- Develop a "contract" that includes a list of people/services to contact in an emergency and specific steps to take to prevent self-harm. The contract might be between the client and staff, or between the client and their closest supports (e.g., friends, family).
- Call the Mobile Response Team (CHR) or the Distress Centre.
- **Take the actively suicidal client to the nearest hospital emergency room** (see assessment of suicide risk).
- **Call the police and report the location of actively suicidal clients who will not go to the hospital**. The police can intercept a suicidal client and, if in their judgement a client is in danger of harming themselves, can take the client to the hospital for care.

SPECIAL HIV NOTE

It is common for people living with HIV to have many symptoms ***that look similar to clinical depression.*** For example, symptoms such as weight loss, irritability, restlessness, disturbed sleep, fatigue, anorexia, lethargy, or diminished interest in sex are all commonly seen in HIV-infected clients. These same symptoms are associated with depression. The HIV infected client should be screened for clinical depression (by their physician) on a yearly basis or as needed.

HIV Medication Side Effects

Some HIV medications may have side effects similar to some characteristics of clinical depression. Be aware of potential side effects of all medications the client is taking. Especially, efavirenz for HIV/AIDS and interferon-a for HCV are associated with episodes of depression varying in intensity. These medications may need to be discontinued or used with antidepressant therapy. If these medications are continued, the primary care practitioner should work closely with a psychiatrist.

- Depression
- apathy
- Tearfulness
- confusion

[105] Suicide Awareness Voices of Education. (2003). Someone You Know Is Suicidal. Retrieved December 15, 2003 from SAVE website: www.save.org/prevention/someone_you_know.html

[106] Canadian Mental Health Association. (2003). Preventing Suicide. Retrieved December 15, 2003 from CMHA website: www.cmha.ca/english/info_centre/mh_pamphlets/mh_pamphlet_12.pdf

- loss of appetite
- impaired memory
- insomnia
- headache

Check with the doctor if medication side effects are suspected.

Additional Resources

CMHA website - www.cmha.ab.ca/ provides an excellent overview of Depression, Suicide, and Positive Prevention and Intervention strategies and can be downloaded in pdf format.

Centre for Suicide Prevention. www.suicideinfo.ca A good source of information on suicide and suicide prevention.

Centre for Suicide Prevention. (2002). **Suicide. Common Warning Signs**. Suicide Information & Education Collection. www.suicideinfo.ca/csp/assets/feature3.pdf One page information handout on suicide warning signs. This is one of a series of information leaflets in the Suicide Information & Education Collection.

Centre for Suicide Prevention. (2003). **Suicide Prevention Training Programs (SPTP).** www.suicideinfo.ca/csp/go.aspx?tabid=2 To arrange for Suicide Intervention Skills Training.

Lands, L. (2002). **A Practical Guide to HIV Drug Side Effects.** Canadian AIDS Treatment Information Exchange. Toronto, ON. www.catie.ca/pdf/SIDEEFF_EN.pdf For more detailed information on medication side effects.

Medicine Net Inc. (2002). **Suicide: Common Warning Signs**. www.medicinenet.com/Suicide/page1.htm

Mental Health Care Guidelines for People with HIV Infection. HIV Clinical Resource website: www.hivguidelines.org/public_html/center/clinical-guidelines/mental_health_guidelines/mental_health_intro.htm For more information on HIV and mental health medication side-effects.

Suicide Awareness Voices of Education. (2003). **Suicide Prevention.** www.save.org/prevention Additional information on Suicide Prevention strategies.

For services related to Suicide in Calgary contact:

- Canadian Mental Health Association, 403-297-1700
- Calgary Distress Centre, 403-266-1601
- Calgary Health Region – Mobile Response Team

SAMPLE CONTRACT[107]

Name: _____

If I start to think about suicide, I will contact these friends and family members (in order of priority):

	Name	**Number**
1.	_____	_____
2.	_____	_____
3.	_____	_____

Or I will call my Doctor or therapist:

Doctor's Name	**Number**
_____	_____
Therapist Name	**Number**
_____	_____

If the doctor or therapist is not available, I will call the following professional or services:
(e.g., Distress Centre, Canadian Mental Health Association)

Name	**Number**
_____	_____
_____	_____

I know that I am becoming depressed when I experience the following warning signs:

_____

If someone I cared about was considering suicide, this is what I would say to him/her:

_____

Preferred hospital _____ Health care # _____
Diagnosis _____

[107] Canadian Mental Health Association. (2003). Depression. What is it? What to do? Chapter 3. Strategies for Living – Make A Plan For Living. Retrieved December 15, 2003 from CMHA Alberta website: www.cmha.ab.ca/download/depression/ch3.pdf

Appendix A

HIV RESOURCES

Community AIDS Treatment Information Exchange. (1997). Managing Your Health, A Guide for People Living With HIV or AIDS.
A practical self-help guidebook for people living with HIV or AIDS.

Cournos, F. & Bakalar, N. AIDS & People with Severe Mental Illness. (1996). Yale University Press London.
A very comprehensive guide book for mental health practitioners aimed at containing the spread of HIV among people with severe mental illness and providing services to those with mental illness and HIV. While this resource includes treatment strategies it reflects an academic tone.

Cournos, F. & Forstein, M. (eds.). (2000). What Mental Heath Practitioners Need to Now About HIV and AIDS. New Directions for Mental Health Services. 87. Jossey-Bass.
This resource covers topics, such as adherence, substance abuse, mood and anxiety disorders and prevention and much more. This book reflects an academic tone.

Health Canada. (1997). Comprehensive Guide for the Care of Persons with HIV Disease – Module 6. Psychosocial Care.
A Canadian plain language resource for social workers working with someone who has HIV/AIDS. Topics include how to support clients and families re deciding to be tested for HIV, disclosure of HIV status, living with HIV, managing symptoms and illness, support for dying, grief and bereavement, and preventing the spread of HIV. Addresses the needs of special populations such as women, adolescents, aboriginal and ethnic communities, incarcerated individuals, those with addictions or mental health issues. Includes practical strategies and discussion of ethical dilemmas.

Health Canada. (1998). A Comprehensive Care Guide for the Care of Persons with HIV Disease - Module 7. Rehabilitation Services.
A Canadian plain language resource for rehabilitation practitioners working with someone who has HIV/AIDS. Topics include, men, women, adolescents, children and youth, nursing care, palliative care, managing health, psychosocial care, rehabilitation services and psychiatric care, substance abuse. Includes many practical strategies for example: dealing with communities and families affected by HIV disease, pain management and returning to work.

Health Canada. (1998). A Comprehensive Care Guide for the Care of Persons with HIV Disease – Module 8. A Manual for Home Support Workers.
A Canadian plain language resource which explains HIV and disease, fears around HIV/AIDS, how HIV affects certain groups (e.g., Aboriginal), legal and ethical decisions, mental health, spiritual and financial issues, caring for caregivers. It also includes numerous practical strategies on the deliverance of care to a person with HIV/AIDS.

Health Canada. (1997). HIV and Psychiatry: A Training and Resource Manual. Published by the Canadian Psychiatric Association.
Topics in this Canadian resource include: cognitive disorders, mood disorders, suicide, anxiety, psychotherapy, chronic mental illness, substance abuse, women, gay men, aboriginal communities, prison populations and more. It provides case studies, issues commonly associated with particular conditions and HIV disease and intervention strategies.

Herman, R. (1999). HIV Prevention for People with Mental with Mental Illness, A training manual for mental health professionals. HIV Mental Health Training Project. New York State Psychiatric Institute N.Y.
This manual includes numerous topics related to HIV/AIDS, techniques for group leaders, exercises and role plays, as well as handouts and overheads. Very practical and written in plain language.

Health Canada. (1999). HIV Transmission: Guidelines for Assessing Risk. Canadian AIDS Society.
This manual offers a framework for assessing levels of risk of HIV transmission through various activities and discusses risk reduction strategies and psychosocial factors which may affect a client's ability to adopt them.

Nugent, J. (1997). Handbook on Dual Diagnosis: Supporting People with a Developmental Disability and a Mental Health Problem. Nugent Training & Consulting Services.
This handbook provides concrete information on providing holistic treatment and support with an emphasis on quality of life for people with a dual diagnosis. It includes a chapter on Post Traumatic Stress Disorder.

Appendix B

SAMPLE AWOL PROCEDURE

What To Do If Your U2 Client Is Missing[108]

1) Call the client's name loudly to see if he/she responds
2) Ask other staff and other clients if they know of the missing client's whereabouts
3) Search the site from room to room starting upstairs and moving downstairs.
4) Search immediate surrounding area outside and likely whereabouts (i.e., where client tends to go)
5) *If client is not found notify relevant contacts. For example:
   - Agency on-call contact client
   - Key partners involved in the co-ordinated Care Plan
   - Next of kin (maybe client has called, or is visiting them)
   - Guardian if applicable
   - Police – Fax Dependent Adult Act to them if needed.
   - Calgary Transit
6) Maintain contact with the above clients. *Consider calling hospital emergency departments, as directed.
7) *Contact emergency shelter locations and leave a message for the AWOL client to contact your agency. Examples of shelter you may wish to contact:
   - Drop In Centre
   - Mustard Seed
   - Salvation Army
8) Questions to keep in mind:
   - What was the client's state of mind prior to AWOL?
   - What was the client wearing?
   - Does the client have any striking features? Refer to photo of the client.
   - Approximate height and weight?
   - Did he/she have any money with them?

When The Client Is Found

1) Check for any obvious injury (i.e., bleeding, difficulty breathing) and act accordingly.
2) Notify those individuals previously contacted that the client has returned.
3) Document the incident.

Debriefing Instructions

After the client is located and safe, the CHR designate nurse and the care staff should debrief together with the client wherever possible. Questions you might ask include:

- What happened?
- Where did you go?
- Who were you with?
- Where did you sleep?
- Were you harmed in any way?
- Did you take your medications?
- Did you use any illegal drugs?
- Did you drink alcohol?
- Did you eat regularly?
- Did you have sex?
- Did you disclose your HIV status?
- Was it protected or unprotected sex?

***When calling other agencies, police, family members, friends etc., it is very important <u>not</u> to breach confidentially by disclosing the HIV status of the client.**

[108] Universal Rehabilitation Service Agency. (2003). Calgary Unwilling Unable Project URSA Manual. <u>Upon Discovery of Missing Client;</u> Calgary AB.

Appendix C

SAMPLE CONSENT FOR TREATMENT

Community Residential Service Agreement[109]

I/We, _____ have received a copy of the Service Agreement outlining the responsibilities and obligations of client/parent(s)/guardian(s) and am/are in possession of a copy of the Client Grievance Procedures.

I/We, _____ have read and fully understand my/our responsibilities as client/parent(s)/guardian(s).

I/We do hereby agree to fulfill these responsibilities/obligations as explained and outlined to me/us by Service Provider.

Date:_____ Signature(s):_____

_____

Witness: _____

(Please note that this consent may not work well with clients who have cognitive impairments. To have "true" informed consent" more detail and explanation would have to be provided).

[109] Universal Rehabilitation Service Agency. (2003). Calgary Unwilling Unable Project URSA Manual. Community Residential Service Agreement; Calgary AB.

Appendix D

SAMPLE CONSENT TO RELEASE OF INFORMATION

Consent to Release and to Obtain Confidential Information[110]

I, We _____ the

undersigned, of the city of Calgary, Alberta, do hereby grant permission:

❑ to obtain

❑ for the release of

necessary information on _____
(client name)

to/from _____
(staff, agency)

_____
(staff, agency)

_____
(staff, agency)

It is understood that this information shall be treated as confidential by the recipient and by the *Service Agency*.

Dated at Calgary, Alberta, this _____day of _____, 20_____.

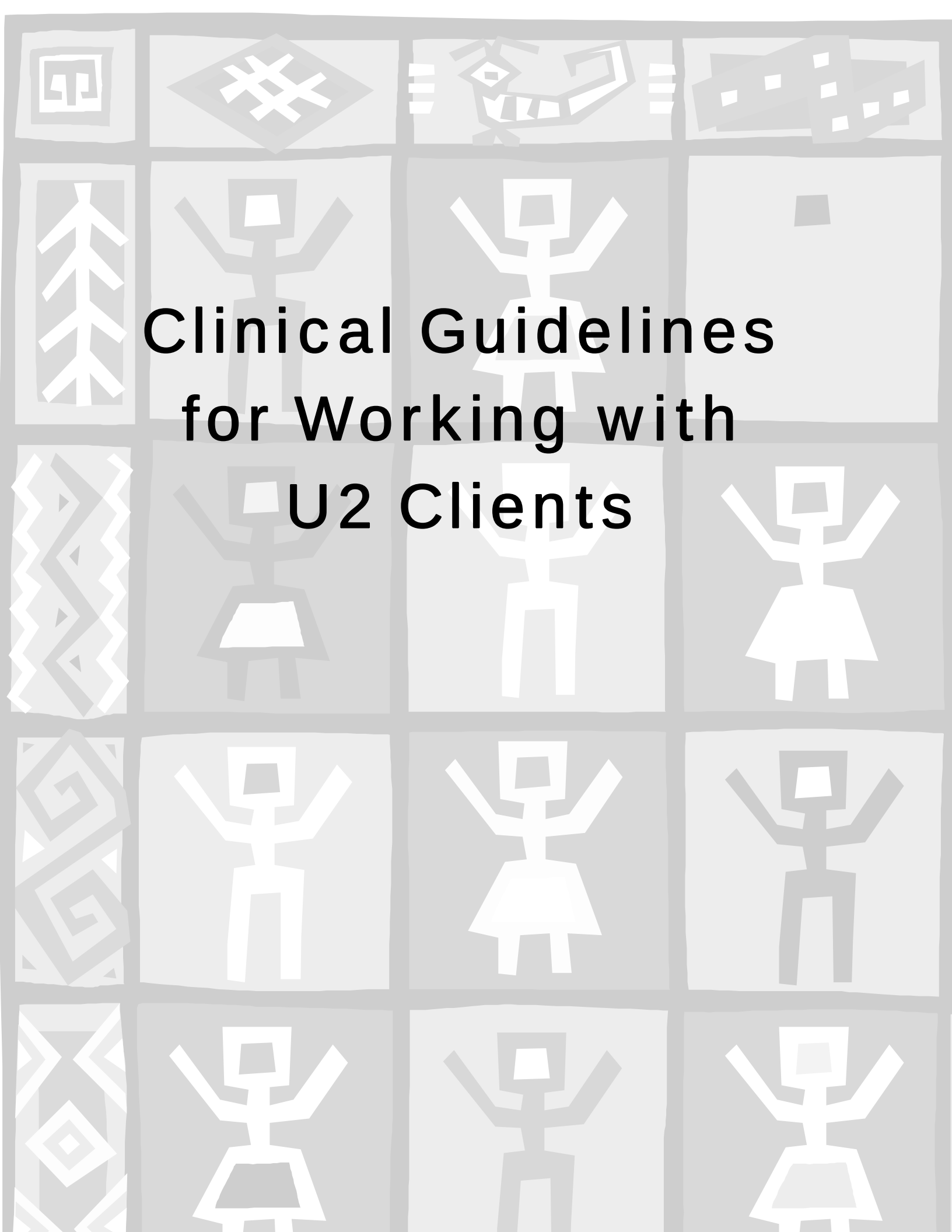
Signature(s) _____

Witness _____

This consent is given for a period of **one year** from the above date.

Note: This consent is not to be used for sharing or requesting HIV documentation on a client. HIV is a confidential issue and does not need to be shared with other institutions, work placements, schools, etc. unless there is a distinct risk of the spread of HIV.

[110] Universal Rehabilitation Service Agency. (2003). Calgary Unwilling Unable Project URSA Manual. Consent to Release Confidential Information; Calgary AB.



Clinical Guidelines for Working with U2 Clients

INTRODUCTION

An HIV positive client who is unwilling or unable to prevent the spread of HIV is referred to as a **U2 client**. The **Alberta Public Health Act** uses the term **"recalcitrant"** to describe clients infected with specific communicable diseases who refuse to comply with treatment or conditions prescribed by a physician to limit the spread of the disease. In keeping with a psycho-social model, we prefer to use the term U2 client.

U2 clients represent a relatively small proportion of people who are living with HIV. "Research indicates that U2 clients suffer a host of medical and social problems including secondary infections, homelessness, mental illness, and substance abuse. They suffer from low self-esteem and social isolation. Their behaviours are not always predictable, and their needs change over time."[111]

The **U2 Clinical Guidelines** are intended to support a clinical team to assess the needs of a client demonstrating U2 behaviour and facilitate service planning, placement and individual Care Plan development.

SCREENING INTERVIEW

The client is generally the first best source of information about personal strengths, challenges, motivations, needs, and previous successes. Family members and/or service providers who are involved with the client are also a good source of information as long as the client gives consent to speak with them. Information from the client can often be obtained through a brief interview ("rapid functional assessment") that asks specific targeted questions (e.g., Are you currently using drugs? What type? How often?).

Screening provides baseline information that can help a consulting psychologist or psychiatrist determine needs for medications, interventions and Care Plan recommendations.

What to Include in a Screening Interview

The purpose of the screening interview is to collect baseline information about the client and to clearly identify U2 behavioural characteristics.

[111] Howard Research and Instructional Systems Inc. (2003). Mobilizing Community Networks to Address the Housing and Treatment Needs of HIV Positive People Who Are Unwilling or Unable to Prevent the Spread of HIV. p3

Information collected through the screening interview might include:
- Issues with HIV status (e.g., coping)
- A profile of the risk behaviour (i.e., frequency and nature)
- Physical impairments
- Mental health – possible family history
- Addictions
- Neuro-cognitive issues (should be assessed annually)
- Functional ability
- Residential situation, history and needs
- Social health: income, occupation, ability to live independently, social supports (friends, family, peer group)

Steps in the Screening Interview Process

- Use a "Rapid Functional Assessment" approach.
- Develop a simple statement of need based on the screening interview information.
- Identify any specific areas where additional information is needed.
- Get permission from the client/guardian for a file/document search for additional information.
- Refer the client for assessment in targeted areas as needed.

Previously completed assessments may provide good information from the client's previous service providers and/or service situations. Again, informed consent from the client is required.

A file review or document search can often provide more in-depth information about the client such as previous diagnosis, medications and assessments. It is best to begin the document search early in the admission process in order to have information available for service planning.

FORMAL ASSESSMENTS

After you have collected as much information as possible from existing sources, you may feel that some client behaviours or issues are still unclear or unexplained. At this point you may wish to request additional formal assessments in those areas where you are still lacking information crucial to service planning.

There are many possible clinical assessments available and each clinician has their favourites. Keep your request for assessments specific and targeted to only those areas where you feel additional information is required.

Recommended Assessment List

There are hundreds of possible assessments. Following are a few examples of commonly used assessments that may be useful in assessing the needs of a client with U2 behaviours. Training requirements, time and costs for these assessments vary depending on the specific instrument.

Safety & Support Assessments	Summary
Supervision Rating Scale (SRS)	Functionally oriented outcome scale measures the level of supervision a client requires as an indicator of the impact that a brain injury has had on a client's life.
Judgement and Safety Screening (JASSI)	Caregivers of clients with brain injury, stroke, Alzheimer's and other neurological disorders often worry about safety and danger inside and outside the home. The JASSI was developed to identify, describe and communicate concerns, which may not be apparent to professionals or others. Designed to be comprehensive, the JASSI items are organized into nine content areas – Travel, Financial, Appliances and Tools, Interpersonal, Medication and Alcohol, Food and Kitchen, Household, Fire Safety and Firearms.
Supports Intensity Scale	For age 16 to 70+. Measures the level of practical supports needed. Assesses frequency, time and type of supports needed in 49 life activity areas (home and community living, learning, employment, health/safety and social) as well as specific behavioural and medical supports. Allows re-testing to assess change in support needs. (Normed on clients with developmental disabilities. With modifications, may be useful for assessing clients with a broad range of support needs in order to plan their services.)

Behavioural Assessments	Summary
Behaviour Assessment Guide – Problem Behaviour Inventory[112]	Assessment and functional analysis of behaviour problems and development of non-aversive behavioural intervention plans.
Functional Assessment Interview Tool (FAI)[113]	A shorter behaviour assessment guide adapted from Functional Assessment and Program Development for Problem Behaviour.
Motivational Assessment Scale (MAS)	The MAS is a tool used to assess why an client's problem behaviours persist by assessing the influence of social attention, tangibles, escape and sensory consequence. It is a 16 item questionnaire that is organized into the above four categories of reinforcement.
Satisfaction with Life Scale[114]	A measure of life satisfaction from the client's point of view.

[112] Available for download - Institute for Applied Behaviour Analysis website: http://www.iaba.com
[113] Available for download - LRE for Life Project website: http://web.utk.edu/~lre4life/ftp/faitcomp.doc
[114] Diener, E.,. Larsen J., & Griffin, S. (1985). The Satisfaction with Life Scale. Journal of Personality Assessment, 49 (1), p. 71-75.

Daily Living Skills Assessments	Summary
Community Living Assessment Scale (CLAS)	Assesses ability to function independently within the living environment.
Scale of Independent Behaviour Revised (SIB-R)	Infancy to age 80+. Adaptive and problem behaviour. Assesses 14 areas of adaptive behaviour (in motor skills, social and communication skills, personal living skills and community living skills) and 8 areas of risk behaviour (harm to self, others and property, disruptive, unusual, and socially offensive behaviour, withdrawal and uncooperative behaviour). Allows re-testing to track progress or regression. Is scored according to level of independence demonstrated in each area.
Disability Rating Scale	Scores functional level from coma to community including eye opening, communication ability, motor response, cognitive ability (for feeding, toileting, grooming), and overall level of functioning and employability.

Leisure Assessments	Summary
Leisure Interest Checklist	Measures knowledge of leisure activities and amount of participation in leisure activities.

Substance Abuse Assessments	Summary
Substance Abuse Assessment[115]	Substance Abuse Assessment & Education Kit, 2nd Edition -The kit begins with two checklists that screen for risk factors and common indicators of substance abuse. It screens for drugs and/or alcohol.

FAS Assessments	Summary
Assessment for Organic Brain Damage	For those with suspected FAS who are not yet diagnosed. By referral only in Calgary. Pre-screen takes 15 hours – but only .5 to 1 hour with the client.

Neurocognitive[116] Assessments	Summary
Trail Making Test A & B	These tests measure attention, visual searching, mental processing speed, and the ability to mentally control simultaneous stimulus patterns. These tests are sensitive to global brain status but are not too sensitive to minor brain injuries.
Digit Span (WAIS-III)	Measures attention and immediate auditory-verbal recall. Particularly sensitive to left-hemisphere damage.
Rey Auditory Verbal Learning	Assesses new learning, recognition, immediate and delayed

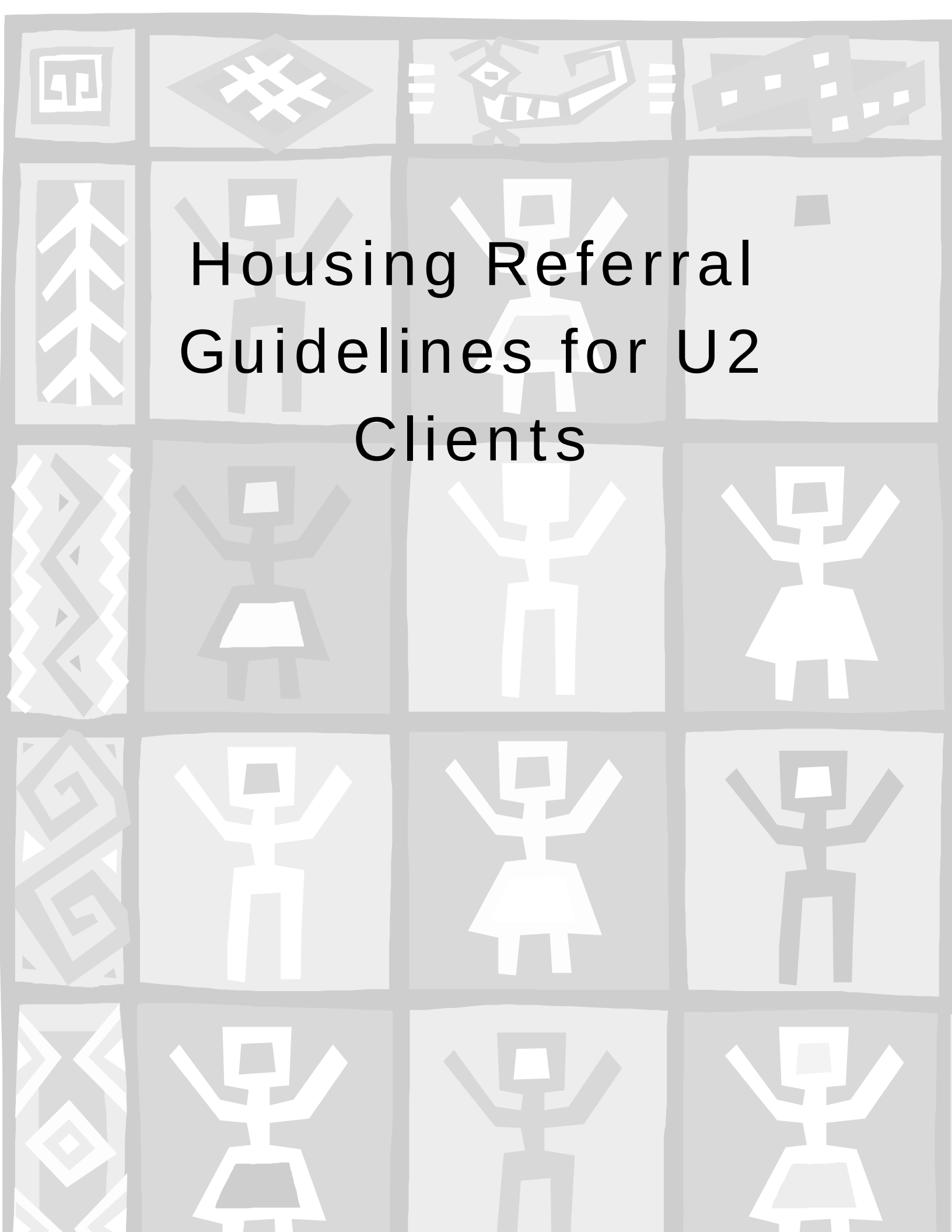
[115] Kreutzer, J. West, D. (1998). The Substance Abuse Assessment and Education Kit, 2nd Edition. National Resource Center for Traumatic Brain Injury. Virginia Commonwealth University Medical College.
[116] Selnes, O. Jacobson, L. Machado, A Becker, J. Wesch, J. Miller, E. Visscher, B. McArthur, J. (1991). Normative Data for a Brief Neuropsychological Screening Battery. Multicenter AIDS Cohort Study. Perceptual and Motor Skills. 73, p. 539-550.

Test (Rey AVLT)	recall of verbal material.
Symbol Digit Modalities	Tests for brain injury. A brief test where the client matches numbers to symbols.
Controlled Oral Word Association Test (Verbal Fluency)	Sensitive to frontal-lobe impairments.
Grooved Pegboard (Lafayette Instrument Model 32025)	A test for psychomotor speed and fine motor control.

Mental Status Exam Assessments	Summary
Mini Mental Status Exam	Good screen for memory loss and dementia related to HIV.
Dementia Scale for Down's Syndrome (and Developmental Disabilities)	Suitable for adults. Diagnosis of cognitive deterioration (stage and progression) or to rule out dementia. Assesses presence of early, middle and late stage dementia indicators and flags for further exploration concerns that mimic dementia symptoms (differential diagnosis of vision/hearing change, pain, thyroid disorder, depression, medication effects and sleep apnea). Allows for tracking changes over several years.

Depression Assessments	Summary
Beck Depression Scale (BDI)	Assessing depression
Depression Screen for Developmental Disability	To assess depression. For Developmentally Disabled or those up to 85 IQ. Request assessment from Resource Team at Persons with Developmental Disabilities – Calgary Region.

Post Traumatic Stress Assessments	Summary
Davidson Trauma Scale	PTSD. Not easy to use. Assumes only 1 traumatic event. Geared to clients with higher education level.



Housing Referral Guidelines for U2 Clients

INTRODUCTION

U2 clients often face difficulty in finding appropriate housing and support. A stable residential placement is important to managing their health and maintaining healthier behaviours.

Finding an appropriate residential placement or environment for a U2 client requires a great deal of work, advocacy and collaboration among community service providers. The client with U2 behaviours often requires ongoing support. Case management and collaboration among partners are important aspects in ensuring stable placements and continuing support.

In the past, U2 clients at varying stages of diagnosis, substance abuse, recovery etc. were placed in agencies that would take them rather than first considering the agencies that would best suit the client's current needs. We have found that there is a continuum of housing/treatment available from least intensive to very intensive. The following charts list some (this is not an exhaustive list) examples of the different housing and treatment options available for U2 clients in this continuum. These are brief summaries and examples of programs available in Calgary and surrounding areas. *Please contact the actual program for more complete information on their services and referral possibilities.* You may also find more information on the Inform Calgary Website – www.informalberta.ca or the Calgary Street Survival Guide- www.calgary.ca/docgallery/BU/community/ssg_04.pdf. Be sure to assess the comprehensiveness of services that your client currently needs, then please use the charts as a guide to ensure more appropriate referrals for U2 clients.

HOUSING/TREATMENT CONTINUUM

Outreach Support and Referral

Outreach Support and Referral service providers may provide referral to affordable housing and/or various types of outreach support for individuals living in his/her own apartment or home environment. In some cases, outreach is provided to individuals on the street or in homeless shelters. Some examples include:

Outreach Support and Referral			
Service Provider	**Special Expertise**	**Staff**	**Service Description**
Addiction Centre (Calgary Health Region) #944-2025	Addictions	Nurses Psychiatrist	- Comprehensive assessment diagnosis and treatment of concurrent disorders - Specializes in the assessment and treatment of adults and adolescents experiencing substance abuse disorders, along with chronic physical and/or mental health concerns. - Outpatient clinics to assess the severity of substance abuse/dependence and provide psychiatric and physical evaluation; - 3 adult and 1 adolescent beds to voluntary patients for treatment; - Interdisciplinary and evidence-based intervention philosophy is practiced with active participation in a wide variety of research and education initiatives. - Multidisciplinary approach which may involve psycho-therapy, family therapy, group therapy and psychometric evaluation and treatment; liaison and referral to the most appropriate community resources; consultation to in-hospital patients; teaching and research; - **Physician referral required**
AIDS Calgary Awareness Association #508-2500	HIV/AIDS	Diverse and varied backgrounds such as Social Work, Psychology, Sociology, Communications	- Provide education, support, advocacy, referral and case management to various target populations: first nations people , men, women, youth, gay, lesbian, and transgender and intravenous drug users.
Alexandra Health Bus #266-2622	Medical treatment	Staffed by 2 nurses 1 crisis/resource worker	- Provides mobile medical services to hard to reach and disadvantaged populations at various locations in Calgary. - The bus operates 1pm-9pm Mon-Wed, 9am-5pm Thurs & Fri. - No AHC required. Provides full nursing assessments and advice, with medical and resource referrals as needed. Monitoring of blood pressure, blood glucose, follow up for blood work, wound management, harm reduction teaching, and general support. - Offer crisis and resource support. - **Blood work is limited to HIV, Hepatitis and syphilis testing.**

Outreach Support and Referral

Service Provider	Special Expertise	Staff	Service Description
Canadian Mental Health Association, Independent Living Support (ILS) #297-1709	Mental Health Schizophrenia, Bipolar Disorder, Severe Chronic Depression	Nurses, Social Worker, Human Services Workers	- ILS available on an outreach basis when there is no support worker available within the housing situation/complex. - ILS includes support with goals towards independence such as: cooking, budgeting, transportation etc, referrals. - Leisure and recreation program available which provides free indoor and outdoor activities. - Screen for active addictions, self harming, aggressive and violent behaviour - **Once a week for 2-3 hours is the highest level of support available.**
HIV Designated Nurse (Calgary Health Region) #944-7075	HIV/AIDS Housing Resources Mental Health Issues Street and Sex Trade Issues Comprehensive assessment and support Advocacy Criminal and Public Health Legislation	Registered Nurse	- Advocate for housing; arrange meetings between clients and agencies. - Refer clients to detox as necessary - Co-ordinate care with SAC - Refer clients to psychiatric and psychological services as needed. - Refer clients with addictions issues to appropriate resources. - Refer clients with developmental disability to appropriate resources. - Investigate and follow-up of clients with communicable diseases as mandated under the Public Health Act - Communicable Disease and Criminal code Regulations. - Provide case management. - Assess U2 clients and address the determinants of health.
CUPS – Calgary Urban Project Society #221-8788	Street Life Homeless Physicians, nurses, dentist, mental health worker, social worker	Social Sciences	- Referral, advocacy, medication, home visits, emergency transportation, dental care, obstetrics and gynaecology care, crisis counselling, short and long-term housing assistance and assist in providing support for basic needs. - CUPS offers primary health care services to both aboriginal and nonaboriginal clients. Offsite health Services are also offered to the Calgary Dropin Centre and Native Addiction Services once a week. - Drop in Medial services at site. - **Outreach primarily deals with crisis situations.**
EXIT Community Outreach Mobile Van (Woods Homes) #262-9953	Street life Sex trade workers	Diploma/Degree in human services or social sciences	- **24 and younger** - Mobile outreach to people on the street. Provide supportive counselling, condoms, referrals to medical, legal, dental, and educational programs. - Van hours are 8pm to midnight, Monday through Saturday. - Have storefront (117-7th Ave SW, Inn from the Cold) which provides outreach on a drop in basis.

Outreach Support and Referral

Service Provider	Special Expertise	Staff	Service Description
Mobile Response Team – (Calgary Health Region) #297-7432	Mental Health Suicide Crisis prevention, intervention & follow-up.	Multidisciplinary – Nurses, Psychiatrist, Social workers	- Respond to psychiatric and psychological emergencies within Calgary. Crisis can include: mental health problems; anxiety/panic reactions; critical incident stress, depression; post-traumatic stress, stress; suicidal thoughts. Provide crisis prevention by providing support in periods of transition between services, urgent psychiatric assessment in a community setting, crisis intervention by mental health professionals, crisis follow-up. - 7 days a week 9 am to 11 pm - Access through Distress Centre 24 hour Line at 266-1605. Professional agencies may contact directly at 299-2940 - **Do not provide case management**
Native Addiction Services Society #261-7921	Addictions	Social Work Addictions certificate/diploma	- Inpatient 4-week program and Outpatient drop-in program available. - **Must be drug free for three days, must be open to Aboriginal beliefs, values and practices.**
Resourceful Futures Community Support Ltd #531-8631	Developmental Disability, Dual Diagnosis, FASD, Brain Injury, Autism, Aspergers * Some experience in supporting clients with HIV	Comm. Rehabilitation Social Sciences, dependent upon client's needs	- Residential support- comprehensive 24/7support provided, if required - Outreach support also provided to people living independently, - Hours vary depending upon client's needs - Day Program- community access, recreation and leisure, employment, staffing offered as per client requirements - **Vast majority of people served must be eligible for PDD funding, if not, sometimes private contracts can be arranged**
Safe Works (Calgary Health Region) #232-3838	HIV/AIDS Addictions Needle Exchange	Registered nurses Social workers	- Harm reduction model - Mobile and drop-in education and prevention program for HIV/AIDS - Provide clients with needles and sharps containers, condoms - Provide vaccinations - Conduct presentations about HIV and hepatitis prevention, harm reduction and sharps awareness - Provide referrals for addictions services, detox, housing, post-prison help, and medical services (HIV and non-HIV) - Provide HIV, hepatitis B, hepatitis C and syphilis blood testing, Chlamydia and pregnancy urine testing - Provide vaccinations (tetanus, hepatitis B, flu, pneumonia)

Outreach Support and Referral

Service Provider	Special Expertise	Staff	Service Description
Southern Alberta Clinic (SAC) (Calgary Health Region) #234-2378	HIV medical care and treatment for southern Alberta (Red Deer and south)	Social Workers Psychiatrists Nurses Physicians Pharmacy services GI, neurology and LIPID specialists Dietician (2 days /week)	- Everyone receives HIV/AIDS related treatment based on medical needs assessment and readiness to participate in care - Social workers available for multiple needs - 3 pharmacists are available for consultation and support - Nursing triage and support available - All HIV drugs dispensed by SAC pharmacy - Clinical drug trials and ongoing research - **Must be HIV positive**
Supported Lifestyles #207-5115	Developmental Disability or Dual Diagnosed (DD/MH) with difficult behaviours FAS Autism/Aspergers Adults with Acquired Brain Injury	Rehab workers Psychologist available	- Provide outreach support to clients who require community and residential support. - Psychiatric/Developmental Disability /Brain Injury support offered in both drop-in and residential settings - **Client must have a developmental disability or an acquired brain injury**
URSA (Universal Rehabilitation Services) #272-7722	Developmentally Disability Brain Injured	Rehab workers Personal care attendants	- Clients may receive service in the community or in their home. - Support may vary from 1-2 hours per week to more intensive.
VRRI (The Vocational and Rehabilitation Research Institute) #284-1121	Developmental Disability *Extensive library available to the public	Must have a degree or diploma in Community Rehabilitation or a related field. Resource Team (Psychologist, Nurse and 3 Social Workers).	- provides service within a holistic support model. - Clients may receive service in any or all of the following: Community Employment, Community Access, Community Living or Education Services. - Support to clients may vary from 1-2 hours a week to 24 hours a day. - All services are planned with the client and are unique to his/her particular needs, abilities and preferences. - **Client must have a developmental disability.**

Emergency Shelter & Respite Services

Emergency Shelter and Respite Services provide short term housing alternatives, and are not considered a long term solution to address the housing needs of an individual. Although these services typically provide some type of 24 hour staff supervision, individual support is limited. Emergency Shelters are available to those who are homeless. Respite services are used by individuals who are either temporarily between residential placements, or those who have a permanent residential placement but need temporary shelter while caregivers take a break. Some examples include:

Emergency Shelter & Respites Services:

Service Provider	Special Expertise	Staff	Service Description
Alpha House #234-7388	Homeless with substance abuse issues	Variety of social science backgrounds, in house training, not medical background	- **Short stay** - 51 beds, Overnight shelter for clients who are intoxicated or high, providing a safe place for people. - 24 hour supervision, people are monitored every half an hour. - Crisis management provided. - Daytime drop in and rest centre with coffee, doughnuts, shower, crisis needs and connects people with medical services.
Aventa Addiction Treatment for Women #245-9050	Addictions	Social Work Nursing Addictions cert/dip Interdisciplinary	- **Women only** - 6 crisis stabilization beds
Calgary Drop-In Centre #263-5707	Homeless Many clients have addictions or mental health issues	Care workers Social workers Social Sciences background	- **Short stay** - **Beds available from 9 pm to 6 am only.** - Emergency beds, 570, basic living services provided: beds, meals, showers, long distance call for emergency, laundry, mail receiving, casual labour - Crisis counselling, referrals to services - Outreach medical services provided through CHR Communicable Disease, Safe Works, CUPS
Mental Health Short Stay Unit (Peter Lougheed Psychiatric Unit 16)	Mental Health	Psychiatrists, Social workers, Registered Nurses, Registered Psychiatric Nurses.	- **Short term, 3 days, 15 beds.** - Access through hospital emergency departments. If you are assessing this patient as appropriate for the Short Stay Unit a telephone call to the psychiatric assessment team at the hospital to advise them of your assessment is helpful. - The Short Stay Unit provides crisis intervention and stabilization. - They connect or reconnect with appropriate community resources. - If there are supports in place in the community the team may invite these people to attend one of the patient care conferences. - Work closely with SAC and HIV Designated nurse (e.g. referral source).

Emergency Shelter & Respites Services:			
Service Provider	**Special Expertise**	**Staff**	**Service Description**
Mustard Seed #269-1319	Homeless	Human Services field	- 80 places for homeless to find respite from the cold - Step Up Housing: 2 ½ week average stay - 14 stabilization beds - Transitional Housing: average 6 month stay, residents chosen from Step up housing. - Support Services: counselling, advocacy, discipleship training anger management, life skills training, employment training opportunities - Substances abuse support groups available to all guests at no charge.
Salvation Army - Centre of Hope #410-1111	Homeless Many clients have addictions or mental health issues	Social workers, psychologists, doctors/nurses in training	- 159 beds with meals and short-term transitional rooms (78 beds) for males ages 18 - 59; - 20 beds and short-term transitional rooms (4) for women ages 18 - 59; - 2 units for families in crisis; - All residents receive intervention counselling, referral and case management as required. - Maximum length of stay is 6 months. - Residential services open 24 hours, 7 days each week. - Free meals are for street people at 4:00 pm daily; - **Nursing services on site are limited to those provided through Safeworks**
Supported Lifestyles - Respite #207-5115	Developmental Disability with behaviour issues and/or mental health issues	Rehab workers Psychologist available	- 5 beds - length of stay: 2 –30 day periods with possible 30 days extensions per year. - **Crisis/relief short-term for adults unable to access other respite/placements**
YWCA Mary Dover House #232-1599	Women in need	Social Work Counsellors	- **Women and women with children. Male children up to 16 years of age only.** - Dorm beds: 5 beds for emergency housing. No charge. Two week stay, after which support is provided to obtain funding for transitional housing. Common sleeping area shared with other residents. - Family Violence Turn Away: 10 beds for women and children fleeing violence and unable to be accommodated in one of the emergency shelters.

Supported Living Programs (with limited or intermittent support)

Supported Living Programs often provide independent living with outreach support, or semi-independent or shared living situations with intermittent support. In some cases a roommate provides support. People who use this type of service need to be quite independent in their daily living skills. Some examples include:

Supported Living Programs with limited or intermittent support (e.g., outreach, live in roommate)

Service Provider	Special Expertise	Staff	Service Description
Calgary Drop-In Centre Centre 110 #263-5707	Homeless Many clients have addictions or mental health issues	Care workers Social workers Social Sciences background	- Offers day and night shelter, food, recreation, counselling, computer training, wood workshop training program, job placements and referrals to support services in the community. - help reintegrate clients back into the mainstream of society. - Outreach medical services provided through CHR Communicable Disease, Safe Works, CUPS.
Calgary Housing Company #221-9100	Low Income *bachelor units in the downtown core have a short wait list (i.e. York Hotel, and Baker House).	Tenant Assistance Officers (Social Workers) work with tenants to identify the concerns and make referrals to appropriate supports.	- Over 7,500 housing and rent supplement units, for low and moderate income households. Housing types include duplexes, townhouses, walk-up and high-rise apartments and shared living accommodations. - Subsidized rent is available to low income clients and families, based on 30% of total combined family income. - Application forms are available at the CHC Office at 1701 Centre Street NW or call 221-9100 and a form will be mailed out. - Calgary Housing Company works with tenants and community based service providers to assist tenants to maintain their housing.
Canadian Mental Health Association, Independent Living Support, (ILS) Transitional Housing (Horizon Housing) #297-1709	Mental Health Schizophrenia, Bipolar Disorder, Severe Chronic Depression	Nurses, Social Workers, Human Services Workers	- **Once a week for 2-3 hours is the highest level of support available.** - Housing provided as long as ILS support is needed. - ILS includes support with goals towards independence such as: cooking, budgeting, transportation etc, referrals. - Leisure and recreation program available which provides free indoor and outdoor activities. - Client must have a case manager. - Screen for active addictions, self harming, aggressive and violent behavior

Supported Living Programs with limited or intermittent support (e.g., outreach, live in roommate)

Service Provider	Special Expertise	Staff	Service Description
Canadian Mental Health Association Supported Housing, Intake #297-1724	Mental Health	Nursing, Social Work, Human Services	- **Must be over 18 years of age** - provides a number of individual and group living situations. - Access to housing is through a central intake. - Must meet following criteria: Diagnosed with a severe and persistent mental illness, which is primary source of difficulty with independent living; (Axis I disorder), demonstrates a need for supports re: achieving greater independence; has psychiatric/medical care in place, with case management; is compliant with treatment plan; is not experiencing active addictions, active suicidal and/or self-harming behaviors, and/or violent and/or aggressive behavior or anger management concerns.
Dream Centre #243-5598	Transitional Housing	Program Director & Assistant Education Coord Life Skills Coach Intake Coord 4 Floor Monitors	- **Men only - No one with violent histories** - **Do not provide hospice care.** - Max 180 beds, average length of stay 6 months to a year. - Provide life skills, employment training to help people become employed or better employed and a spiritual component. - Streams of admission (a) attend day program (b) come from addictions treatment program (c) pay $300/month room and board, attend programs during evening. - Partner with community agencies to offer education and support to the men e.g. AADAC and smoking cessation classes. - A Christian organization so clients should be willing to be exposed to Christian values.
Oxford House #214-2046	Transition housing for persons recovering from addictions	Staff who ensure homes are operating properly	- Self-managed homes with peer supported living for persons recovering from addictions - must be employed or seeking employment - 20 homes for men and 2 for women-only, in shared living environments - 1 home for women with children, in shared living environments
Resourceful Futures Community Support Ltd #531-8631	Developmental Disability, Dual Diagnosis, FASD, Brain Injury, Autism, Aspergers * Some experience in supporting individuals with HIV	Comm. Rehabilitation Social Sciences, dependent upon clients needs	- Community based supported living - live-in support provided, hours depend on needs - Outreach support to people living independently, hours vary depending upon needs - Day Program - community access, recreation and leisure, employment, staffed depending upon client's needs - Home care support for individuals with brain injuries wishing to remain in own home. - **Most clients must be eligible for PDD funding. Sometimes private contracts can be arranged**
Langin Place (Calgary Housing Company, Calgary Alternative Support Services) #237-5433	Mental Health	Social work or safety background	- **Men only** - 53 residents - Bachelor suites with shared bathrooms - On site Independent Living Support weekdays 8:00 to midnight. Security midnight to 8Am weekdays and weekends - ILS support includes, advocacy, help with filling out funding forms, outreach, harm reduction model, teach cooking, laundry budgeting etc. - AISH 335 month, SFI 30% gross, all residents pay monthly $100 for ILS - **Building is not wheelchair accessible**

Supported Living Programs with limited or intermittent support (e.g., outreach, live in roommate)			
Service Provider	**Special Expertise**	**Staff**	**Service Description**
Lethbridge Family Services #327-5724	Developmental Disability Brain Injured FASD		- Residential support to people in their own homes, ranging from 8-20 hours per week. - offer approved homes in which a client lives in the home of a family or individual. - operate a small number of roommate/companion options.
Mustard Seed #269-1319	Homeless	Care Workers Social Workers	- Transitional Housing: 30 bed semi-independent residence program for those dealing with longer term life issues. - Assist with needs for education life skills training, anger management and/or addictions counseling. Up to 2 year stay (or more).
Scott House #272-2912	Transitional housing for HIV+ clients	No staff in house May access Beswick House for support	- House with 3 residents - **Very independent living situation**
Servants Anonymous #237-8477	Sex trade workers	Live in volunteers act supervisory role	- **Women only** - provide semi-independent, shared accommodation - Provide housing, support and job training allowing for long-term integration back into society and an independent life - Voluntary program and need to be self motivated - First Stage Housing: short term beds, for 6 to 12 month stay - Transitional Housing: apartments for 9 women and 2 additional women with special health needs. Stay up to 18 months. - Second Stage Housing: 7 apartments for up to seven women and their children. Independent subsidized living for 3 to 5 years. - Must attend day program to access First Stage housing. Transitional as well as Second Stage Housing require involvement in SAS Follow-up care Program.
Supported Lifestyles #207-5115	Developmental Disability Behaviour Challenges Dual Diagnosis (DD/MH) FAS Autism/Aspergers	Rehab workers Psychologist. Staff training for individual needs	- Provides an array of housing options from 24-hour support to outreach support conditional upon funding availability - **Client must have a developmental disability**
URSA (Universal Rehabilitation Services) #272-7722	Developmentally Disability Brain Injured	Rehab workers Personal care attendants	- Operates a variety of residential settings (group and 1:1).

Supported Living Programs with limited or intermittent support (e.g., outreach, live in roommate)			
Service Provider	**Special Expertise**	**Staff**	**Service Description**
VRRI (The Vocational and Rehabilitation Research Institute) #284-1121	Developmental Disability *Extensive library available to the public	Degree/diploma in Community Rehab or related field. Resource Team- Psychologist, Nurse & Social Workers.	- provides service within a holistic support model. - Clients may receive service in any or all of the following: Community Employment, Community Access, Community Living or Education Services. - Support may vary from 1-2 hours a week to 24 hours a day. - All services are planned with the client and are unique to his/her needs and abilities. - **Client must have a developmental disability.**
Youville #242-0244	Addictions Mental Health Abuse Issues	Social Work	- **Women only** - Independent second stage apartments with outreach support for women graduating from the Youville Women's Residence treatment program

Supported Living Programs with 24 hour support

Supported living programs tend to offer a more intensive service often provided in a group living situation. Some service providers use a live-in roommate to provide the support required. Some examples include:

Supported Living Programs: with 24 hour support

Service Provider	Special Expertise	Staff	Service Description
Fresh Start Society #387-6266	Persons recovering from addictions	Exec director 2 counsellors careworker cook	- 22 spaces for men who have been through detox. Second stage treatment with a maximum one year stay.
Resourceful Futures Community Support Ltd #531-8631	Developmental Disability, Dual Diagnosis, FASD, Brain Injury, Autism, Aspergers * Some experience in supporting individuals with HIV	Comm. Rehabilitation Social Sciences, dependent upon clients needs	- Community based supported living - live-in support provided, hours depend on client's needs - Day Program- community access, recreation and leisure, employment, staffed depending upon client's needs - **Majority of people served must be eligible for PDD funding. Sometimes private contracts can be arranged**
Sharp Foundation Beswick House #272-2912	Transitional, long term and palliative care for HIV+ clients	Personal Care Aides Home Care available on outreach basis through CHR	- Subsidized residential housing and care service for up to 9 HIV/AIDS clients who having trouble coping in the community - 24/7 supported living, provided through support of home care/palliative care and care aide assistance. - Rapid referral available
Supported Lifestyles #207-5115	Adults with Developmentally Disabled and Behaviour Issues Dual Diagnosis (DD/MH) FAS Autism/Aspergers	Rehab workers Psychologist available	- current capacity - 80 - residential support for adults and children with developmental disabilities; - **Must be eligible for PDD funding**
URSA (Universal Rehabilitation Services) #272-7722	Developmentally Disability Brain Injured	Rehab workers Personal care attendants	- provide Personal Care Homes funded through CHR - provide residential services and day services - 24 hour residential program with care support and some rehabilitation services - group living situations accommodate 1 to 6 individuals - may include facilities with locked doors and windows to discourage AWOL

Supported Living Programs: with 24 hour support			
Service Provider	**Special Expertise**	**Staff**	**Service Description**
VRRI (The Vocational and Rehabilitation Research Institute) #284-1121	Developmental Disability *Extensive library available to the public	degree or diploma in Community Rehabilitation or a related field. Resource Team (Psychologist, Nurse and 3 Social Workers).	- provides service within a holistic support model. - Clients may receive service in any or all of the following: Community Employment, Community Access, Community Living or Education Services. - Support may vary from 1-2 hours a week to 24 hours a day. - All services are planned with the client and are unique to his/her needs, abilities and preferences. - **Client must have a developmental disability.**

Residential Treatment Program with 24 hour supervision

Residential treatment programs provide an intensive and targeted intervention. Treatment programs tend to be specialized (e.g., addictions) non-permanent placements that typically would last a few weeks to a few months. Some examples include:

Residential Treatment Programs: with 24 hour supervision

Service Provider	Special Expertise	Staff	Service Description
Alpha House #234-7388	Non-medical detox	Staff: Variety of social sciences, Service Description:	- **Must be over the age of 18, minimum 3 day commitment** - 20 beds, length of stay depends on individual, provide referrals for counselling, assessment, housing and treatment after detox . - 85% of people who use the detox service are homeless. - Support for chronic substance abusers - Work with Safeworks and AIDS Calgary.
AVENTA Addictions Treatment for Women #245-9050	Addictions	Social Work Nursing Addictions cert/dip Interdisciplinary	- **Women only** - Assist to understand the impact of alcohol, drug or gambling addiction on self, family and community; to develop a healthier, addiction free lifestyle and provide education and treatment services to reduce the negative consequences of addiction. - 20 - 4-week Treatment beds and 10 - Long-term 3-month beds - The residential facility will house 10 Long-term Support beds (1 year Transitional Beds) - 4 beds are wheelchair accessible
Claresholm Care Centre #625-8500	Mental Health Services Rehabilitation Focus	Psychiatrist Psychologist Social Worker Registered Nurse Mental Health Aid Pharmacist Rehabilitation Practitioner Group Therapist	- **No emergency care, acute care or long-term placements.** - **Need referral by physician or psychiatrist.** - Psychiatric rehabilitation facility. - Average length of stay is 3 to 6 months. - 100 beds for men and women ages 18 to 64. - Open to referrals from anywhere in Alberta. - Can take patients who are certified under the Alberta Mental Health Act, but they need to be stable enough to benefit from rehabilitation services. - Accept individuals with psychiatric AXIS I diagnosis. Consideration is given to those with addiction issues, although other specialised agencies may be more suitable.
Fresh Start Society #387-6266	Addictions	Executive director 2 counsellors Care worker	- **Must have gone through detox** - **Up to one year residency in the 32 spaces available**
Native Addiction Services Society #261-7921	Addictions Aboriginal Culture	Social Workers Addictions Cert./Dip.	- **Must be drug free for three days** - **must be open to Aboriginal beliefs, values and practices.** - 4 week co-ed residential treatment program; 30 beds Long Term Residential Treatment Program. 3 months, 6 beds - Residential services are for men and women who are 18 and older

Residential Treatment Programs: with 24 hour supervision

Service Provider	Special Expertise	Staff	Service Description
Renfrew Recovery Centre (Part of AADAC's services) #297-2018	Substance Abuse Medical detoxification	Nurses Contract physician Addictions counsellors	- **Short stay (5 to 10 days).** - 40 bed residential facility offering medical detox services - **24 hour nursing care** - No appointments necessary, Admissions are 9-4PM daily - Assessment and referrals via counseling services to ongoing treatment - No charge to attend detox program
ReDi (Recovery Discovery) Calgary Drop-In Centre #263-5707	Homeless Many individuals have addictions or mental health issues	Social Sciences	- Staffed 24/7, non locked facility - 10 beds, 1 year stay, intensive addiction treatment - Intake is through counsellors - **Individuals must be committed to attend meetings etc.**
Salvation Army - Centre of Hope Addictions Treatment Program #410-1111	Homeless Many individuals have addictions or mental health issues	Social workers, psychology, medical/nursing training who have additional training in Addictions Counselling.	- **Males - ages 18 - 59, detoxed and stabilized,** - Full time residential addictions treatment, aiming to provide counseling for alcohol, drug and gambling addictions; Based on Christian teachings and the 12 steps of AA; - required to attend classes in the AA steps, anger management, emotions, understanding addictions, Christianity and personal life management; - Clients may come from anywhere as long as they are accepted for Alberta Health coverage - Minimum of 3 months; pre and after care available; length of stay is individualised; clients <u>may</u> be transferred to residential Services following treatment if they have no place to stay.. - **limited ability to provide services for medically dependant clients.** - **abstinent-based service.**
Simon House (Recovery Home) #247-2050	Addictions	Social Workers and/or addictions expertise, all staff are first aid certified	- **Men only. Must be detoxed for 3 to 5 days before you can be admitted.** - Provide an alcohol and drug addiction recovery home using the guidelines of Alcoholics Anonymous, can examine and rebuild their lives. - All residents will be examined by the doctor, within the first three weeks of admission. - Phase I (19 beds), 7 week relapse prevention group with the average residential stay of 3 to 4 months, staffed 24 hours. - Phase II (12 beds) up to 18 month in combination of Phase I and II, long term aftercare and more independent living. - clients may stay for a period of up to eighteen months; Phase III housing: indefinite stay (27 beds) - consists of low-cost residency in safe and sober shared accommodation in Bowness; - residents work together to create a home environment.
Youville Women's Residence 242-0244	Addictions Mental Health	Social workers	- **Women only, women must demonstrate motivation in recovery from addiction, mental health issues and history of violence** - 8 beds - Residential addiction care and treatment. They provide a caring, family style environment to promote healing and personal growth for women who have experienced family violence, addictions, and mental health distress.

Secure Treatment Programs: locked

Comprehensive services are provided within facilities that are locked in order to ensure client and community safety. Secure treatment is often non-voluntary compulsory care that usually requires a psychiatric referral and/or a court order. Some examples include:

Secure Treatment Programs: locked

Service Provider	Special Expertise	Staff	Service Description
Alberta Hospital Ponoka and Edmonton	Mental Health	RN and aides.	- 24/7 secure and non secure compulsory care and treatment for individuals with active mental health disorder - **require psychiatrist or physician referral.**
Alberta Hospital Brain Injury Rehabilitation Program	Acquired brain injury rehabilitation	OT's PT's, RN's, speech, psychologist, neuropsychologist, dietician	- 16-65, 48 beds, staffed 24/7, secure, - severe to moderate brain injury, must have exhausted short term rehab options medically stable, have a discharge strategy non progressive brain injury average length of stay is 9-10 months voluntary admission - **client must be able to communicate in some ways**
Forensic Services (inpatient) (Calgary Health Region)	Forensic psychiatric issues May include substance abuse issues or developmental disability	Forensic Psychiatrists, Psychologists, Psychology Assistant, Recreation Therapist, Social Workers, 24 hour Security Guard on the unit, Registered Nurses, Registered Psychiatric Nurses.	- complete a court ordered 30 day psychiatric assessment - may also see certified psychiatric - provide referrals for mental health, addictions issues, developmental disability, and housing - assist with AISH applications - doesn't 'provide' outpatient follow-up - only refer to FAOS (Forensic Assessment and Outpatient Services). - **Court ordered** - **Short term assessment only**