The risk of transmission of HIV/AIDS among injecting drug users has added a new dimension to the task of counsellors in drug treatment centres.

Many counsellors and health workers are aware of a gap in their knowledge of HIV/AIDS and of the particular techniques which may be necessary when working with clients who are at risk of HIV infection because of their injecting drug use.

This manual is intended to fill the gap and to provide an easily accessible resource for health workers in drug treatment centres and other agencies.

The author, Neil Thornton, has worked for many years in the drug treatment field and has experience of many of the problems involved in this work. The manual is his contribution to the resources necessary to ensure that counsellors have the information needed to carry out their work.

Lyn Wright
Project Manager
AIDS Taskforce.
I want to thank all the people who so willingly gave their support and advice during the planning and writing of this handbook. I am particularly indebted to the following people for their assistance:

Lorraine Kerse
Michael Baker
Richard Meech
Donna Kippax
Lee Smith
Chris Perenara
Sue Marshall, Paul Kinder and the staff, New Zealand AIDS Foundation, National Office and Burnett clinic.

Geoffrey Robinson, Mike Stones, Keith Marshall, Joanna Tennant, Pat Wilcox, Dorry Yee and the staff, Wellington Alcohol and Drug Centre.

Daryle Deering, Christchurch Alcohol and Drug Centre.

Neil Thornton
Interim Manager
Wellington Alcohol & Drug Centre
Wellington Area Health Board
# Contents

**Chapter 1: Introduction** ........................................................................................................ 1

**PART I**

**Chapter 2: Drug Use and Treatment in New Zealand** .................................................... 5

1 Injecting Drug Use in New Zealand ................................................................. 5
2 Risks of Injecting Drug Use ............................................................................. 5
3 Treatment Services ....................................................................................... 6

**Chapter 3: AIDS and Injecting Drug Use** ............................................................... 7

1 AIDS in New Zealand ..................................................................................... 7
2 Patterns of HIV Infection Amongst Injecting Drug Users in New Zealand and Overseas .............................. 8
3 Needle and Syringe Exchange Programmes and Other Measures to Control HIV Spread Amongst Injecting Drug Users ................................................................. 9

**Chapter 4: Drug Dependency, AIDS and Behaviour Change** .......................... 10

1 Modifying Personal Behaviour ...................................................................... 10
2 Factors Encouraging Behaviour Change ...................................................... 10
3 Harm Reduction Approaches ..................................................................... 11
4 Messages for Everybody ........................................................................... 11

**PART II**

**Chapter 5: Counselling Injecting Drug Users** .............................................................. 17

1 History-taking and Assessment Guidelines .................................................... 17
2 Counselling - Crisis Intervention and Supportive Counsel ............................................... 20
3 Longer-term Counselling ........................................................................... 24
4 Aftercare ................................................................................................ 25
5 Adjuncts to Counselling ........................................................................... 25

**Chapter 6: HIV Pre-test and Post-test Counselling with Injecting Drug Users** .............................. 28

1 Introduction ................................................................................................ 28
2 Confidentiality ............................................................................................. 28
3 Why Test? ................................................................................................ 28
4 Before the Test ........................................................................................... 29
5 After the Test ............................................................................................... 31
Chapter 1
Introduction

Since 1985 acquired immune deficiency syndrome (AIDS) has become a major world pandemic, with few signs that its spread is being controlled. Widespread research is under way in many countries to cure AIDS but so far to little or no avail. Injecting drug users (IDUs) constitute one of the major groups affected by human immunodeficiency virus (HIV) in Western Europe, North America and now, Australia, and there is continuing evidence of rapidly rising rates of infectivity amongst IDUs. For example, currently 60 percent of the approximately 200,000 IDUs in New York City may already be seropositive for HIV. Unless steps are taken to prevent the spread of HIV in New Zealand amongst IDUs, there is no reason to believe that the injecting drug using community here will be any less affected by AIDS than their counterparts in other countries.

Some countries are beginning to respond to the rising rates of HIV amongst their injecting drug using populations by implementing needle and syringe exchange programmes together with education and prevention messages. New Zealand is one such country.

This handbook has been developed for health professionals and others who are involved in the counselling of IDUs, and with particular reference to IDUs with HIV/AIDS. It is divided into two sections. Part I, printed on blue paper, provides the background context for HIV/AIDS and injecting drug use in New Zealand. Part II, printed on white paper, is for use by health professionals when engaged in counselling.

Appendices include background information on AIDS, a clinical questionnaire for clients undergoing HIV testing, lists of organisations assisting IDUs, and AIDS clinics and contacts.
PART 1
Chapter 2
Drug Use and Treatment in New Zealand

1 Injecting Drug Use in New Zealand

It is estimated that approximately 4,000 to 7,000 New Zealanders inject drugs on a regular basis. About 1000 of these are currently being prescribed methadone while attending outpatient drug rehabilitation programmes. Injecting drug use occurs at all socio-economic levels in our society, but IDUs are small in number compared to the large numbers of New Zealanders estimated to be dependent on alcohol or other non-narcotic drugs.

In New Zealand injecting drug use became widespread during the mid to late 1970s when heroin importation was well organised. Most of the country’s methadone programmes began then, as increasing numbers of IDUs sought help for their developing narcotic dependencies. Since then the successful interception of imported narcotics by the Police and Customs Department, and a small local demand, have contributed to a comparatively low rate of heroin use. However, IDUs have sought to fill the resulting heroin supply vacuum by manufacturing heroin and morphine and using codeine obtained in over-the-counter preparations. This locally produced "homebake" is supplied to small numbers of the "baker's" associates.

The majority of IDU clients currently listed with methadone clinics have become dependent on injectable drugs such as temgesic, MST morphine, poppy extract morphine, and to a lesser extent, on methadone tablets, homebake, pethidine and palfium. Tablets and cough syrups containing codeine phosphate are also abused. Local illegally-produced "speed", or amphetamine-type preparations ("crank") may also be injected, as is cocaine. These last two substances appear to be in short supply, though recent media reports suggest that cocaine is becoming more readily available.

2 Risks of Injecting Drug Use

While most users maintain their needle use is hygienic, high numbers (probably 60 percent of clinic attenders) will have been exposed to the hepatitis B virus. The AIDS virus has focused attention on the range of blood-borne infections IDUs are exposed to, including hepatitis B and non A, non B hepatitis (by sexual transmission and needle sharing), endophthalmitis (e.g. internal infection of the eye), endocarditis (inflammation of the inner lining membrane of the heart and valves), septicaemia, and abscesses around injection sites.

Criminal activity associated with regular dependent drug use which may involve the risk of imprisonment includes homebake manufacture, dealing and possession, and pharmacy burglaries. The consequences of chronic, severe injected drug abuse require the user to be constantly vigilant to avoid being apprehended by the police. Prostitution, the abuse of other substances, financial indebtedness (it may cost hundreds of dollars per day to support a drug habit) and a range of family, employment, emotional and relationship problems are associated with narcotic dependency.
3 Treatment Services

The first point of contact with treatment agencies for most IDUs is a doctor or counsellor at an alcohol and drug centre. Depending on location and philosophy, the user may be prescribed methadone hydrochloride.

Methadone substitution therapy is still not readily available outside the main centres, and people desiring outpatient methadone withdrawal may have to move to a city where a methadone clinic exists. Some patients elect to undergo medical detoxification in a hospital detoxification unit, followed by admission to a residential rehabilitation centre, of which there are approximately 16 throughout New Zealand.

Most outpatient drug clinics offering methadone treatment provide, and insist on, counselling or psychotherapy. This is frequently in group or family settings, using professionally trained staff such as nurse counsellors, social workers, occupational therapists, and clinical psychologists.

In most clinics, counselling will continue for as long as necessary, though, in some, because methadone availability is strictly time and dose-limited, counselling may be available for short periods only. Addiction-associated medical problems are reviewed by doctors who may also be skilled as counsellors and psychotherapists. In some units psychiatrists or psychiatric registrars are also available. As most outpatient drug treatment clinics are run by area health boards, clients can be referred to other specialist medical services in hospital departments as necessary.

In both outpatient and residential settings, attention is paid to the multi-faceted nature of the drug user's problems. Not only may clients present with chemical dependency encompassing a variety of substances, but they may also need help to develop inter-personal and assertiveness skills, or help with anger management.

Larger institutions such as Queen Mary Hospital, Hanmer Springs, and the Salvation Army Bridge Programme, may have as many as 90 beds, while most others have a 15 to 30 bed capacity. Most of these residential centres admit men and women with injecting drug use problems and expect residents to stay for a minimum of six weeks. The Odyssey House (Auckland and Christchurch) and Kahunui programmes are of longer duration. Treatment includes group therapies (perhaps focusing on family dynamics, goal setting or the use of psychodramatic techniques to explore and re-define past traumatic events), individual counselling, and education and information about drug and alcohol abuse. Some inpatient centres now offer programmes for Maori clients. The self-help groups Narcotics Anonymous and Alcoholics Anonymous also provide very important fellowship and support in a drug and alcohol free environment.
Chapter 3
AIDS and Injecting Drug Use

1 AIDS in New Zealand

The New Zealand response to AIDS began in the early 1980s with the setting up of AIDS support networks in larger cities. These support networks were the brainchild of Bruce Burnett, a New Zealander returned from San Francisco who later died of AIDS. He, and other gay men, foresaw the likelihood of an AIDS epidemic in New Zealand unless prevention and education programmes for gay men, and the general population were put in place. The networks were run by volunteers and offered practical and emotional support for people with HIV infection and AIDS.

The AIDS Support Network changed its name in 1985 to become the New Zealand AIDS Foundation. It is now contracted by the Department of Health. The foundation operates AIDS clinics in Auckland, Wellington, Christchurch and Dunedin. It is also involved in prevention, counselling, volunteer training, social support, research and the provision of information, with a substantial AIDS library and information centre in Auckland.

The Department of Health has been active in AIDS prevention and policy since 1985. Currently the AIDS Taskforce of the Department of Health develops policy advice on HIV/AIDS issues for the Minister, ensures surveillance of both AIDS and HIV is undertaken and that databases are maintained. It undertakes some behavioural and social science research and national health promotion programmes on HIV/AIDS. It contracts 11 community based groups to provide outreach services, designs and ensures the provision of the national needle and syringe exchange programme and provides test kits for the screening of all donated blood. The Department also liaises with other government departments in order to achieve co-ordinated policy implementation. In addition it services the National Council on AIDS and its Medical and Scientific Sub-committee. The health promotion campaigns undertaken have included publishing a variety of leaflets, including "An IV Drug User's Guide to AIDS", and mounting various publicity campaigns.

The National Council on AIDS advises the Department of Health and the Minister on all matters related to the legal, ethical, scientific and social aspects of HIV infection. It has recently produced a proposed national strategy on HIV/AIDS for the Minister of Health's consideration.

The Medical and Scientific Sub-committee on AIDS replaces the original AIDS Advisory Committee and is a sub-committee of the National Council on AIDS. The first national conference on AIDS was held in Wellington in November 1987 and was organised by the AIDS Advisory Committee and the Department of Health. A second conference was held at the Wellington Clinical School of Medicine during May 1989.

The IV League provided an early forum for the views of IDUs, their partners and families, due to the enthusiasm of its founder Gary McGrath. The IV League, with a membership drawn from recovering drug users, provided peer support and prevention information about HIV/AIDS to IDUs and the general public, and lobbied government departments to establish a full range of preventative services.

In Auckland recovering IDUs have set up the Auckland Drug Information and Outreach Trust (ADIO). Originally funded as a pilot programme by the Department of Health, ADIO leased premises in November 1988 and started an after-hours needle exchange programme. Wellington
Information for Drug Education (WIDE) has begun in Wellington and similar organisations exist in Palmerston North, Christchurch and Dunedin. Each of these organisations provides services under contract for the Department of Health.

Te Roopu Tautoko Trust is the only organisation in New Zealand providing a fulltime HIV/AIDS educational service to the Maori population. The Trust was established in 1986 and it is contracted by the Department of Health to provide these services. It has a national office in Wellington and a regional co-ordinator in Christchurch. Regional work is undertaken in Auckland, Taranaki, Gisborne and Dunedin. The Trust is supported by a Board of Trustees and a nationwide network of Maori community and welfare groups and has a positive working relationship with the New Zealand AIDS Foundation. Te Roopu Tautoko Trust has taken the message of AIDS prevention to Maori people in all tribal areas, at marae based hui, in schools, in factories, in homes, in prisons and on the streets.

One of Te Roopu Tautoko Trust's major barriers has been to overcome the belief held by many Maori people that AIDS only affects Pakeha or gay men. Information in the media continues to reinforce this view, in spite of overseas literature suggesting that ethnic minorities are at increased risk of acquiring HIV/AIDS.

In New Zealand it has been suggested that low self-esteem, low educational attainment and high unemployment among some sections of the Maori population may be predisposing factors which lead on to higher participation in at-risk behaviours. They may also limit access to health care and education in both rural and urban areas.

There has been no research into the incidence of IDUs in the Maori community, but estimates suggest that from 10 - 40 percent of known IDUs may be Maori. While the homosexual and transvestite subcultures of Maoridom have been very receptive to the safer sex guidelines promoted by Te Roopu Tautoko Trust, few Maori IDUs have so far sought its assistance.

Notification of AIDS cases

In 1984 only three people in New Zealand were known to have AIDS. By the beginning of March 1991, the Department of Health had been notified of 250 New Zealanders with AIDS, and HIV antibody positive results had been found in 650 tests. It is anticipated that the number of people found to be seropositive in New Zealand will continue to rise at much the same rate as in other Western countries.

When a person is diagnosed with AIDS, the District Medical Officer of Health must be notified, but no name is given. It is not necessary to notify authorities when people test positive for HIV antibodies.

2 Patterns of HIV Infection Amongst Injecting Drug Users in New Zealand and Overseas

It is thought likely that IDUs may supersede gay men as the main route of HIV infection in many western countries. In Edinburgh, and in some large urban areas in Spain and Italy for example, there are high rates of HIV seropositivity amongst IDUs. In New York City at least 60 percent of the area's estimated 200,000 IDUs are considered to be HIV seropositive. In 1988 more than 40 percent of all people with AIDS in New York were IDUs.
The higher the prevalence of HIV infection in any community of drug users, the higher the chances of contracting HIV if safe needle and syringe-sharing, and safer sexual practices are not adopted. In New Zealand most narcotic users inject, whereas in the United Kingdom for example, greater numbers of people "snort" these drugs. This places New Zealanders at greater risk of contracting HIV/AIDS. The first case of an IDU infected with HIV in New Zealand was reported in 1987. By 28 February 1991 there was a total of four IDUs with AIDS and a total of 15 had tested positive for HIV.

Because no AIDS vaccine is in sight, and few drug treatments have brought real hope to people with AIDS, it is essential that IDUs are urged to adopt behaviours that prevent virus spread, and that health workers and policy makers make prevention of HIV among IDUs a public health priority.

3 Needle and Syringe Exchange Programmes and Other Measures to Control HIV Spread Amongst Injecting Drug Users

In Amsterdam a needle and syringe exchange programme has been operating successfully since 1985. Similar schemes now operate in parts of the United Kingdom and Australia, as well as in New Zealand. In some countries, despite the well-documented spread of HIV amongst IDUs there is still substantial political, moral and legal opposition to the implementation of needle and syringe exchange schemes.

In Amsterdam (and in many other locations) support for the continued existence of needle and syringe exchange schemes is strong, and high rates of acceptability of the schemes are apparent amongst IDUs. Where schemes operate, there are no reported signs of a consequent increase in drug use generally. Higher levels of IDU contact with clinics through needle and syringe exchange programmes mean more opportunities for counselling and information exchange, and better access to medical care.

In New Zealand the Misuse of Drugs Amendment Act was passed by Parliament in December 1987, allowing the implementation of the Needle and Syringe Exchange Scheme. Medical practitioners, pharmacists and some other health professionals may sell needles and syringes if they have been approved as sellers by the Director-General of Health, local health development managers or community medicine specialists, and if the needles and syringes are of an approved type.

Needle and syringe exchange takes place at approved outlets such as community pharmacies, hospital pharmacies, general practitioners' surgeries, drug clinics and self-help organisations. Packages of ten needles and syringes are available at low cost, and condoms and a bleach sachet are included in each pack. Counselling is recommended when needle and syringe purchase and exchange takes place, and is intended to be an integral part of the prevention programme.

Needle and syringe exchange schemes are seen as one component of prevention and education programmes, which also include the dissemination of information to IDUs and their partners about safer sex and contraception, sterile needle and syringe sharing practices, the responsible safe disposal of used 'outfits' (if not exchanged) and the hygienic use of spoons, filters and associated apparatus. There is an increasing awareness that greater availability of methadone treatment, with its associated counselling and medical assistance, is an essential prevention tool in the fight against AIDS. This means drug clinic waiting lists must be reduced if IDUs are not to lose heart when they approach clinics for help.
Chapter 4
Drug Dependency, AIDS and Behaviour Change

1 Modifying Personal Behaviour

Research into AIDS prevention suggests that for everyone, personal behaviour modification needs to include a realistic assessment of personal risk of infection and transmission, a knowledge of basic information about HIV/AIDS and modes of transmission, and planning for behaviour change.

Traditionally, prevention work with IDUs has been difficult, due to:

- Poor self-regard and an accompanying lack of interest in maintaining good health.
- Low levels of trust between IDUs and health personnel.
- The failure of IDUs to build a truly supportive and caring community.
- Literacy problems.

Some counsellors in the field have brought their own negative attitudes and stereotypes to the AIDS prevention task, with many believing that IDUs will be slow to change their behaviour. These counsellors generally show little faith in the ability of non-using IDUs to become actively involved in AIDS prevention programmes, despite the fact that overseas and now in New Zealand non-using IDUs have been successfully involved in outreach programmes.

2 Factors Encouraging Behaviour Change

AIDS prevention messages must be personalised in order to be taken seriously.

Personalised change messages need ongoing reinforcement. Repetition is the key. With ongoing counselling support, there should be a sensitive examination of areas of denial and fear, and the motivations behind the continuing practice of risk-taking behaviour.

The baseline information which underpins behaviour change, needs to include the following:

- There is as yet no cure for HIV infection.
- HIV can be transmitted through vaginal, anal and oral sex; sharing needles; and contaminated blood.
- HIV infection can be prevented. To prevent sexual transmission, men should use a condom. Women should make sure their partners use condoms. Drug injectors should not share needles and syringes.
- People infected with HIV must not donate organs or body fluids such as blood, semen, and breastmilk.
• Infected people should avoid sharing toothbrushes or razors or other instruments or articles that could become contaminated with their blood.

These messages should be offered without embarrassment in a language appropriate to the level of educational attainment and culture of the client or client group. It should be remembered that risk of transmission is associated with specific exposures and not solely with membership of an "at risk group", and that people who look healthy may be infected.

Changes in personal behaviour occur when alternative behaviour is seen as still enjoyable and satisfying, and is not perceived as discriminating against so-called "at risk groups".

Behaviour change must be based on realistic objectives so that change begins in small easily achievable ways.

3 Harm Reduction Approaches

The following objectives underpin attempts to change injecting drug using behaviours:

• To persuade IDUs to stop injecting and to encourage instead the non-parenteral use of injectable drugs (i.e. oral, inhalation).

• To persuade IDUs who cannot stop injecting to use sterile needles and syringes, not to share 'outfits' and to practice safer sex.

• To encourage those who will not use new needles and syringes to clean their injection apparatus, using bleach.

Ongoing information and education programmes for IDUs need to be provided, with encouragement to seek (or remain in) drug treatment, and advice about safer sex practice, the high risk of heterosexual and homosexual virus transmission, and the very high risk, infected IDUs and their partners have, of giving birth to an HIV infected baby.

Individual and couple counselling and group work can offer continuing encouragement to all of these objectives, as can the availability of a variety of methadone treatment options including low dose, low intervention programmes.

4 Messages for Everybody

The following messages are for all IDUs:

• Find alternative "highs" to drug use.

• Don't get 'stoned' when impaired judgement might lead to risky sexual or needle-sharing behaviour.

• Tell drug using friends to get help.

• Discuss safer sex with all current or prospective partners.

• Practice safer sex.
Safer Sex Information

When discussing safer sex, counsellors should remember to tell their clients that it is the behaviour of individuals and not membership of a group which puts them at risk.

Safer Sex includes:

- masturbation;
- mutual masturbation;
- cuddling, hugging, embracing;
- thinking and reading about sex; and
- touching, rubbing, and massage.

Possible safer sex includes:

- vaginal intercourse with a condom;
- anal intercourse with a condom;
- oral intercourse (fellatio) with a condom;
- cunnilingus; and
- "wet' kissing (though scientists have not found any evidence that HIV can be transmitted through saliva).

Unsafe sex includes:

- vaginal intercourse without a condom;
- anal intercourse without a condom;
- oral intercourse (fellatio) without a condom;
- inserting fingers into the rectum;
- sharing sex toys (eg. vibrators) that have come into contact with body fluids (blood, semen, vaginal fluid) and have not been cleaned; and
- any practice or sexual activity that breaks the skin allowing infected blood into another person's bloodstream.

Clients should be advised to avoid sex with anyone who might have a sexually transmitted disease (STD). This may be indicated by sores or rashes on or near the sex organs.

Counselling should involve discussion about risk as it relates to the lifestyle and environment of each individual client. For some people, it will be important to have opportunities to talk about setting limits on sexual activity and learning to say "no".

Clients should be encouraged to avoid using intoxicating substances when sexual activity is likely to take place.

When discussing sensitive issues, counsellors will inevitably be thinking about their own attitudes and should consider the sexual activities they would be uncomfortable talking about; how they might talk about sexual activities regarded as deviant by a culture different from their own; and the language they would use to talk about sexual practices with clients of a different gender, race, culture or age group.
Condoms

Offer the following advice to clients on the use of condoms, while reminding them that condoms can never be 100 percent safe. (Clients unfamiliar with condoms or embarrassed about using them could be encouraged to practice using condoms while masturbating.)

- Store condoms in a cool place. Heat may weaken the latex.
- The expiry date should be noted. Use condoms only where the packet carries the standard code, "BS 3704".
- Water-soluble lubrication (eg KY Jelly, Sylk) should be used with the condom (outside, not inside the condom). Oil-based lubricants (eg. Vaseline) should not be used.
- Before the condom is put on, the air in the condom's tip should be squeezed out.
- The condom should be rolled onto the erect penis with the rolling edge out, and rolled to the base of the penis. (This should be done before any genital or anal contact takes place). Clients may wish to use two condoms for added safety.
- During intercourse, the condom should be checked to make sure it has not slipped off.
- The condom should not be reused.
- Soon after ejaculation the condom should be held at the base of the penis while it is withdrawn.
- Dispose of the condom hygienically. Wrap it in tissue and place it in the household waste.

 Keeping Healthy

Apart from an improved sense of well-being, the immune system will be stronger if there is behaviour change including proper sleep and rest, reasonable physical exercise, and good nutrition. Stress management and getting help to deal with emotional problems such as guilt and feelings about traumatic events also help people cope better. Relaxation and recreation are also important.
PART II
The most common complaints and presenting problems of IDUs when they approach treatment personnel for help involve:

- financial indebtedness;
- criminal charges, fear of prosecution and imprisonment, poor adaptation to life outside prison;
- history of failed relationships and poor inter-personal communication;
- accident and injury;
- health problems:
  (a) physical (related to lifestyle, overdose, infection, poor nutrition);
  (b) psychological and emotional (depression, personality disorders, bipolar disorder, obsessive/compulsive disorders, deliberate or accidental overdose, and other suicide attempts);
- other drug abuse, including alcohol, nicotine and prescribed drugs; and
- difficulties in finding work and remaining in work.

The counsellor's ability to provide adequate, up-to-date information and advice, and to make appropriate referrals requires a thorough knowledge of local and national treatment and support resources, their function, operation and philosophy.

1 History-taking and Assessment Guidelines

Using the following guidelines for history-taking and assessment will provide baseline data only. Assessment is a complex and ongoing process undertaken in the context of a growing relationship of trust between counsellor and client. Obviously not all of this information will be gathered in the first session with the client.

Presentation and Referral

- Establish referral source.
- Establish immediate presenting problems.
- Establish recent or continuing crises which precipitate referral.

General Impression

- Dress.
- Appearance.
- Mood.
- Ability to articulate concerns.
- Degree of intoxication.

History of Drug Misuse

- Age at first onset of drug use, and circumstances (source of supply, company kept, etc.).
- Drugs first used, and amounts.
- Capacity (tolerance) and reactions when drugs first abused.
- Patterns of drug-taking up to the present time.
• Current preferred drugs and daily/weekly approximate dosage.
• Duration of recent drug habit(s).
• Other drugs currently being used.
• Intervals at which client has injected over the past 10 days to two weeks (eg. drugs used daily, two to three times daily, or only occasionally?)
• Way drugs are taken (orally, inhaled, snorted, smoked, intravenous, or by intramuscular injection)
• Current drug-taking circumstances (what locales, who with, etc?)
• Present tolerance and reactions to drugs used.
• Instances of and length of periods of abstinence from drugs.
• Circumstances of drug use. (Important to establish the extent to which drugs affect stability in relationships, employment, physical health, psychological health, etc.)
• Reasons for drug use.

Previous Treatments for Drug Abuse/Dependence

• List treatments from earliest to most recent.
• Number of times client has dropped out of treatment and reasons why.
• Client's personal reactions to previous treatment and nature of relationships with treatment personnel and fellow clients.
• Length of periods of sobriety after/between treatments.
• Circumstances when drug use began again (eg. peer pressure, crisis precipitating return to drug use, etc.)

Family History

• Description of childhood, adolescence, early adulthood (parents, siblings, memories of upbringing, relationships, developmental milestones).
• Nature of present contact with parents, siblings, other relatives.
• Client's position in the birth order of siblings.
• Major illness, physical or psychological, of siblings and/or parents.
• Nature of adult relationships (including marital, family), sexual abuse history.
• Number of children client cares for, number of times client has been pregnant/fathered children.
• Drug-taking (or drinking) problems of family members.

Social History

• Network of friends and drug taking acquaintances.
• Social and leisure time activities.
• Patterns of change in social environment and lifestyle, stability of accommodation, stability of employment, present living arrangements.
• Legal involvement/criminal offending (especially related to drug use), including number of times arrested, number of times convicted, reasons for arrests, months in jail, and length of time since most recent release from penal institution.

Employment History

• Educational level (qualifications and years at secondary school).
• Major work skills.
• Jobs held from earliest to most recent.
• Patterns of job change (reasons why client left jobs - absenteeism, low productivity, relations with work colleagues and employer).
• Current financial status (drug debts, etc.)
• Current employment status (unemployed, redundant, sick leave).
• Beneficiary?
• Major source of client’s income.
• Amount the client earns?

Psychological Assessment

• Note reports available from other sources.
• Check for cognitive deficits.
• Note the client’s affect.
• Note any disoriented, aggressive, agitated behaviour and history of suicide attempts.
• Note the client’s degree of self-acceptance and self-worth.
• Note the client’s degree of insight into his/her problems.

HIV/AIDS Questions (Also see Chapter 6 HIV Pre-Test and Post-Test Counselling with Injecting Drug Users)

• Ask how many HIV tests the client has previously had.
• Explore the extent and circumstances of needle sharing.
• Ask about the number of sexual partners in the last 12 months and try to clarify the client’s sexual orientation.
• Explore the extent of the client’s knowledge, attitudes, and behaviour regarding safer sex.
• Ask if condoms are used regularly.

Questions about Physical Health

• Ask if the client has a general practitioner (or number of general practitioners).
• Ask if the client has had hepatitis with jaundice.
• Order liver function tests and check.
• Look for evidence of needle marks.

Assessment of the Extent of any Intoxication (slurred speech, gait, nystagmus)

• Record past medical complaints/problems.
• Note any hospitalisations (including psychiatric admissions).
• Note past and current prescribed medications (and drug allergies).
• Ask/note if the client is having withdrawal symptoms, eg. nausea and/or vomiting, diarrhoea, sweating profusely, muscle cramps, restlessness, insomnia, fatigue, irritability.

Counsellor’s Summary

Problems

Summarise problems under the following headings:

• Occupational and social.
• Personal and inter-personal.
• Support systems available.
• Client's perceived degree of drug dependency (extent of compulsion, withdrawal signs).
• Nature of services the client is asking for.
• Extent client is prepared to go toward abstaining from or moderating drug abuse.
• Ability of client to adhere to abstinence or moderation goals.
• Prediction the client (and counsellor) make about the client's future problems with drug use or length of time abusing drugs.
• Client's interest in inpatient rehabilitation and/or detoxification, social or medical.

Treatment Options and Strategies

• Non-residential counselling only (behavioural and/or cognitive approaches; individual and/or group therapies).
• Non-residential counselling and detoxification (methadone or other).
• Methadone maintenance and counselling, groups, etc.
• Residential detoxification (medical unit) followed by outpatient rehabilitation and support.
• Residential detoxification, followed by inpatient treatment.
• Referral to other agencies for further assessment and therapy.
• Referral to other hospital departments/health professionals/community agencies, etc.

Deciding Whether to Counsel/Treat or Refer

This decision depends on a number of factors including the ability of the agency to provide an effective service, based on adequate staff numbers, financial resources, and its attention to staff training and support; and the ability of counsellors to form therapeutic relationships with clients, based on adequate and appropriate skills and knowledge. The agency also has to consider waiting lists and their length, ease of access to psychiatric and psychological services, and to other services such as neurology, accident and emergency, and medical detoxication units.

NB: Those judged to be at high risk for contracting hepatitis B or HIV, or who have clinical evidence of either, (ie. those who are hepatitis B antigen positive and/or are HIV antibody positive, or have AIDS related illnesses) should be given special consideration for early admission to drug treatment programmes.

Record Keeping

After assessment, data collection involves recording important treatment events and changes in treatment goals. Ongoing careful record keeping enables the counsellor to scan periods of time and to summarise treatment objectives and goals more effectively and efficiently. If another counsellor is involved later with the client, then background information is readily available.

Client data should always be recorded with the client's best interests in mind and the counsellor should be able to share written records with clients if necessary.

2 Counselling - Crisis Intervention and Supportive Counselling

Crisis intervention counselling and supportive counselling will be the types of individual counselling most appropriate to the needs of the majority of clients, in conjunction with group, couple and family counselling.
At the start of counselling, clients should be given information about the agency including:

- the range of services provided by the agency;
- the extent to which information recorded by client and counsellor is confidential;
- the professional background and training of staff and of the particular counsellor involved;
- the rules and regulations of the agency’s programmes;
- written and verbal material on safer sex (and the use of the condom), safe needle and syringe use and all other relevant risk-reduction matters; and
- a list of client’s/patient’s rights.

Inpatient and outpatient centres will usually require contracts for work with clients covering the length of time in treatment, “dos” and “don’ts” of treatment, and access to relatives, partners, etc. Sometimes clients will request (and counsellors will recommend) longer-term counselling or group work in order to explore in greater depth inter- and intra-personal conflicts and the underlying reasons for drug abuse.

Counsellors will be called on to write reports (for professional colleagues, the Family Court, etc) and to summarise counselling goals and outcomes for their colleagues and clients. Progress will be assessed in part by reference to urinalysis reports, ability to find employment, work performance, and ability to adhere to therapeutic contracts.

**Crisis Intervention Techniques**

These techniques may be used with clients who have a history of appearing for support only during critical episodes in their lives. (For many counsellors their contacts with clients will primarily involve responding to crises).

The tasks for the counsellor are:

- to intervene as early as possible in the crisis situation. The counsellor should be immediately available as this is when the client, because of pain and discomfort, is most motivated to deal with the problem;
- to focus attention on current difficulties. But, because old wounds may be re-opened, there should also be opportunity to talk about past crises;
- to discourage drug misuse;
- to assist the client to clarify thinking about the nature of the problem, and help isolate salient factors so that the crisis is perceived accurately and thus better understood. Sometimes this is sufficient to enable clients to return to their former ‘steady state’;
- to assist the client to express and manage emotions;
- to accept disordered feelings, but to make cause and effect as clear as possible so that the client understands why those feelings are there;
- to take an active and directive role as people need more guidance during a crisis. Achievements should be praised;
- to encourage family and friends to help, and establish links with community resources, ie. the counsellor is part of a system of support; and
- as the crisis is resolved, the counsellor, together with the client, decides if referral is needed to other resources, whether the client will manage alone, and if counselling will continue. (Whether methadone has been prescribed or not, will influence these decisions.)
Counselling Skills

In counselling relationships (and when using the crisis intervention model) counsellors will need to practise the following skills.

Attending

This involves listening to what clients are saying, and focusing clearly on the content and meaning of what is being said.

Paraphrasing

Using this as a clarifying tool, counsellors will restate, using their own words, what the client is understood to be saying.

Reflecting Feelings

The counsellors should try to understand the feelings being experienced by the client, then respond in a way that shows an appreciation of what has been described. This skill will require the counsellors to "read between the lines," and to understand the complexity of feelings sometimes being expressed, while also taking account of verbal and non-verbal cues.

Summarising

Efforts to summarise what has been said and felt by the client should bring discussion back to its basic direction.

Goal-setting

Counsellors should help clients decide which options are realistically available, set short and longer-term goals, and then decide on a course of action.

Self-disclosure

This takes place when the counsellors reveal aspects of their own feelings and life experiences to reassure, inform and build trust with the client. To be effective, such disclosures must be relevant to the specific needs and circumstances of the client. (Self-disclosure may indicate the presence of counter-transference issues).

Interpreting

This offers an alternative and personal view of what the client has said and may assist clients (and counsellors) to expand their understandings and insights.

Defence Mechanisms

Defence mechanisms are a normal part of our everyday experience of life and include: rationalisation and intellectualisation, minimising and denial, projection, and hostile behaviour. We all use defence mechanisms to protect ourselves from aspects of life which are seen as threatening, unmanageable or uncomfortable. In working with drug dependent clients, counsellors will frequently see defence mechanisms taking on special importance. Denial, hostility and rationalisation
will be the most commonly used defence mechanisms and are essential to the client's maintenance of a drug using lifestyle.

The technique of confronting, often incorrectly understood to mean an aggressive attempt to force clients to face up to wrong doing, can be used to break through defence mechanisms. Confronting skills are used in the context of a relationship of trust and involve pointing out discrepant and incongruent behaviours (and interpretations of those behaviours) and working consistently and patiently to change them. The client's family or friends can usefully be brought into the process. When used accurately, compassionately, and firmly, these skills may help to weaken defences and therefore enable clients to begin to accept responsibility for their behaviour. Confronting is best avoided until clients can understand and deal with the feelings of anger, anxiety and depression which defence mechanisms protect them from.

Special consideration should also be given to counselling clients with the diagnosis of borderline personality disorder or anti-social personality disorder. With such diagnoses the exploration of ego defences, directly confronting denial, and close examination of past traumatic events are best avoided especially early in treatment. It is generally considered that fundamental behavioural or attitudinal change will not easily take place where such diagnoses have been made and that encouragement and support will need to be given, often over long periods of time, in the face of repeated crises.

Supportive Counselling

With supportive counselling the focus will be on:

- providing clients with information about drug effects and dangers, drug treatment services, legal and other community resources, etc;
- encouraging clients to reduce drug consumption or to abstain;
- monitoring and managing withdrawal;
- monitoring and managing relapse;
- assisting clients with access to services;
- assisting clients to identify the nature and meaning of their current difficulties;
- teaching problem-solving skills;
- assisting with ventilation of emotions precipitated by more recent difficulties;
- identifying specific needs for further individual counselling, couple, family or group therapy, as necessary;
- attempting to restore the client to the former level of functioning prior to the crisis triggering referral; and
- offering encouragement and instilling hope.

This supportive counselling will tend not to be concerned with exploring underlying conflicts or intra-personal processes, but will see the counsellor appropriately confronting clients' defence mechanisms, drawing out patterns of drug misuse and their consequences, and helping clients (perhaps with the assistance of partners or other family) to identify new ways of coping.

Counselling should never ignore the importance of encouraging clients to persist in changing old ways of doing things, especially those associated with drug taking.

Leaving behind drug using friends will be extremely difficult for most clients but essential for recovery. Because such change is so difficult, counsellors should continue to assist their clients to make realistic short-term goals for sobriety. Contact with Narcotics Anonymous and other self-help groups will be important in reinforcing such goals.
Carl R Rogers (1966), famous for his client-centred psychotherapy, believed that the following characteristics made for effective counsellors.

**Accurate Empathy**

This is the capacity to "feel" the hurts, longings and sorrows expressed by clients. This empathic understanding demands that the counsellor be able to accurately reflect understandings of the client's feelings. The impact of empathy should be that the client feels understood and relieved of some of the burden of the feelings expressed.

**Non-possessive Warmth**

Rogers wanted counsellors to learn to accept people as they were. He wanted counsellors to be as non-judgemental as possible about the material clients brought to them. It was understood that counsellors should have a comprehensive understanding of their own intra-psychoic conflicts and be able to express self-respect. They would need to understand and appreciate their own and the client's sexuality. It was expected that "warmth" would be expressed more in terms of the counsellor's whole "attitude" towards clients, rather than just verbally.

**Genuineness**

This concept refers to counsellors' self-awareness and self-acceptance, and their ability to express their "true selves". Counsellors whose defence is to hide behind a "professional role" will have difficulty with this concept.

**3 Longer-term Counselling**

Sometimes clients will request longer-term counselling. At this point counsellors will need to consider the goals for therapy and how realistic they are, including the client's ability previously to sustain a longer-term (or short-term) relationship with a counsellor; the client's emotional support system and relationships with partner, family, work colleagues and other helping agencies; and current and past psychiatric illness.

There will need to be considerable emphasis on the development of a relationship of trust between client and counsellor. Before deciding to begin, client and counsellor should together consider the client's degree of insight into life's issues and their ability to further develop those insights, ie. can the client observe and interpret patterns of thought and behaviour; is there a preparedness to accept confrontation? (This will depend in part on whether drug use continues, and on consequent intellectual and emotional functioning.) Counsellors will need to help their clients explore the fear, denial and shame behind their defences. Counsellors will want to help clients understand that drug use can be a defence against strong emotions, unresolved conflicts. With understanding and acceptance, such defences may be seen as no longer useful, and will in time be left behind.

Exploration of the past, and the reconstructing of traumatic events will be required. The counsellor may use the relationship with the client to focus on transference material, discussing similarities between what occurs in the counselling relationship and what the client has experienced in other significant relationships. There may be an experiencing of regression to former developmental stages accompanied perhaps by less rational behaviour.
More in-depth and longer-term counselling will include formulating a contract to address the duration of treatment/counselling, treatment content, counselling objectives and goals, rules regarding attendance, the use of drugs, and negotiability of the contract.

There also needs to be ongoing recognition of possible and actual relapse, and its prevention and management. There could also be referral to psychodrama, assertiveness training and anger management groups. Social skills training and couple therapy should also be available in most drug treatment agencies.

4 Aftercare

Aftercare is provided for clients who have achieved sufficient of their treatment goals to be able to withdraw from regular contact with therapists. They will be interested in developing links with services outside the narrower confines of traditional outpatient or inpatient programmes, but will probably want to maintain some contact with treatment personnel. At this point the client can be offered reduced contact with the counsellor, perhaps remaining in touch by phone, or attending groups in the community. The counsellor will stress that links between counsellor and client are not necessarily being irreversibly severed. Discussion about aftercare services will probably occur in the context of talk about terminating a counselling relationship. Agreement to terminate should ideally have been built in to a contract for work together, and will usually depend on the achievement of certain stated objectives. Both counsellor and client may find it difficult to negotiate the end of a working relationship which will have involved the sharing of important personal material. Nevertheless the client can be reminded by the counsellor that managing changes in relationships is often mirrored by the way change and separation is dealt with in a therapeutic relationship. The counsellor should be alert to unconscious attempts to stall termination such as relapse or the presentation of new problems.

5 Adjuncts to Counselling

The Place of Methadone and Other Pharmaceuticals

Methadone hydrochloride is a synthetic opiate taken orally in syrup, and usually dispensed daily. Its effects are generally felt for 15 - 20 hours. Methadone is a dependency-forming drug and should never be prescribed to people who are not tolerant to narcotics. Methadone programmes follow protocols outlined by the Department of Health and recommended by the Drugs Advisory Committee. In order to treat people with controlled drugs such as methadone, all drug treatment programmes must be gazetted under Section 24 of the Misuse of Drugs Act 1975.

There has been considerable debate in New Zealand about the virtues and dangers of methadone substitution therapy, with many believing that it prolongs or intensifies narcotic dependency, while enabling drug dependent clients to continue to avoid acknowledging the real nature and extent of their dependencies. Some counsellors and ex-users advocate a "cold turkey" withdrawal (followed by inpatient treatment) as the only effective method of detoxification. Methadone substitution therapy is nevertheless accepted by most drug treatment personnel in New Zealand as a viable detoxification method. Sometimes temgesic (buprenorphine), codeine and catapres (chlonidine hydrochloride) are from time to time used in the treatment of narcotic withdrawal.
Some methadone advocates claim the following benefits:

- Regular contact with treatment personnel.
- Increased likelihood of remaining in employment.
- More financial security.
- Fewer chemist’s burglaries, less stealing (and "hoisting"), and fewer crimes of violence.
- Less involvement in prostitution.
- Less risk of hepatitis B and HIV infection. (Reduced opioid drug use probably equates with fewer episodes of serious intoxication and the consequent likelihood of unsafe sex and needle sharing).
- Less chance of infection and ill-health generally.

Some people argue against methadone substitution therapy because:

- it adds another addictive drug to an existing drug dependency;
- it may thwart a client’s readiness to get involved in other therapies;
- clients frequently come into contact with one another during drug clinic attendance and this may encourage the continuing use of illicit drugs;
- daily dispensing causes inconvenience to methadone clients and especially to those who must travel long distances to reach their drug clinic or dispensing pharmacist; and
- methadone does not prevent the misuse of other drugs.

Methadone Maintenance

Methadone maintenance is considered appropriate for clients who repeatedly fail to deal with their narcotic dependency on brief withdrawal programmes, or for whom residential rehabilitation is repeatedly unsuccessful. In recognition of the part methadone has to play in HIV prevention, methadone maintenance schemes are increasingly being offered overseas and in New Zealand. Maintenance clients are required to adhere to the conditions of a contract for treatment (eg. counselling groups, Narcotics Anonymous), with regular reviews of their progress. In New Zealand clinics, maintenance therapy does not mean indefinite prescribing, but indicates instead a willingness on the part of service providers to consider the special needs of chronically dependent people. Most methadone clinics would wish to review the progress of their maintenance clients at least every three months.

Methadone Withdrawal

Methadone withdrawal will usually be offered for a period of three to six months, though in some cases it will be shorter. Doctors and counsellors should work together closely and have a clear idea of the anticipated duration of withdrawal (in consultation with the client) and all the other components of treatment including relapse prevention, and referral to residential rehabilitation.

For many clients the fear of withdrawal symptoms, especially as methadone dosage falls to low levels can be a major stumbling block to successful completion of a withdrawal programme, and considerable time and effort will usually be expended encouraging the client through this phase of treatment. Typical withdrawal symptoms are sleeplessness, diarrhoea, muscular aches and pains, anxiety and fatigue.

For both longer-term maintenance and brief withdrawal programmes it is important to gauge the depth of a client’s motivation. Some counsellors believe that if the client does not have a strong desire to abstain from drug taking at the outset of treatment, there is little to be gained from
proceeding with methadone. Others feel that motivation to reduce drug use or abstain can be strengthened as a result of the relationship between the client and counsellor. These counsellors will not place great emphasis on motivational issues, at least until an adequate dosage of methadone, and a "settling down" of the client has been achieved.

In this new age of AIDS prevention, counsellors may need to view drug users' motivation to change, in terms of a continuum. To quote Strang (1988): "it must surely be the job of services to operate in such a way as to maximise the likelihood of beneficial change. The most appropriate interaction may alter during passage through a process of change, and will need to respond sensitively to the day-to-day and week-to-week fluctuations in the drug users' resolve to change". 
1 Introduction

The primary objective of HIV/AIDS counselling is to provide support to drug users and their friends and families as they cope with the reality of HIV infection. The counselling environment also provides opportunities to inform and educate clients about preventing HIV infection. Clients need support to deal with the stigma of HIV infection, the fear of illness and death, and changes in relationships with friends and family.

More than one counselling interview before the HIV test may be required and clients should be encouraged to bring partners or other significant people in their lives to interviews. It will be important to carefully explain the testing procedures, the antibody test itself, and what is meant by "informed consent" in terms appropriate to the client's level of educational attainment and cultural background.

2 Confidentiality

There is currently much debate amongst health professionals regarding aspects of confidentiality and anonymity in HIV antibody testing. Health personnel need to keep themselves informed about such issues and exercise great care in all their discussions or written communications with colleagues about the antibody positive or negative status of clients. If at all possible, no such discussion should take place without the client's consent. Many people have been cruelly discriminated against because information about their antibody status has passed into the wrong hands. When filling in the test form, the client's name should not appear on it, but the client should be asked to suggest a three or four letter code of his or her choosing, and to remember it. This code and the client's age is all that need appear on the test form. For research purposes (e.g. New Zealand Communicable Disease Centre and Department of Health) it is useful to include on the test form a risk category for each client, with the client's month and year of birth, and gender. This should be done with the client's consent and preferably with clients choosing their own risk category.

The antibody test should be ordered separately and anonymously, and not with other tests which identify the client by name. To further protect client confidentiality, some treatment agencies do not allow a client's antibody status (positive or negative) to be recorded on any of the client's files.

3 Why test?

The argument in favour of testing is that knowledge of HIV antibody status can enable individuals to undertake any treatments available, prophylactic or otherwise. It is also argued that for some people, real behaviour change may occur only when they know their antibody status. Knowing this can offer relief to individuals and their partners who may be anxious about possible AIDS symptoms and concerned about their future health and social circumstances.

The principal argument against testing is that people with HIV are sometimes discriminated against, and this is harmful to them, their partners and friends, and to the communities they live in. It is also
argued that behavioural change can occur without the need for a test, and that there can be no guarantees about the absolute confidentiality of test results.

4 Before the Test

Reasons for Wanting the Test

Some people will want information about the test while not wanting the test itself. Others will have considered all the risk factors and how important the test is for them, and will have made up their minds about wanting the test before coming to counselling. Some clients will be able to detail each occasion of needle and syringe sharing and unsafe sexual activity. However, it may be very difficult for some clients to speak frankly about sexual behaviour, particularly if this involves threatening discussion about sexual orientation.

People should always be given encouragement for agreeing to counselling pre-test. The first pre-test counselling interview will involve the discussion of sensitive issues (whether to begin a family, worries about AIDS-type illnesses, concern about sexual dysfunction) and sufficient time must be set aside for their thoughtful consideration.

What the Client Knows about HIV/AIDS and Modes of Transmission

The counsellor should encourage discussion and an open exchange of information about HIV/AIDS and clarify and extend the client’s knowledge wherever possible. Information should be given about the categories of HIV infection and illnesses as per appendix I, including the three stages of HIV infection. Discuss transmission routes, and treatments. This is an excellent opportunity to debunk myths about HIV infection and AIDS.

What the Client Knows About the Test

Find out if the client has previously been tested. Discuss briefly the enzyme linked immunosorbent assay (ELISA) and Western Blot tests and explain the difference between antibody and antigen tests, if appropriate. Explain that the antibody test may not pick up very recent exposure (less than three weeks) and that some people may have the virus without showing antibodies. The client may be advised to have a further test in four to six months time. It has been found that in some cases it takes as long as three years for antibodies to appear in the blood.

Reasons for Desiring a Test and the Client’s Risk Status

Discuss the client’s general health, history of health concerns, and ways of handling stress, any recent illnesses, any hospitalisations in recent years, use of intoxicating substances (and cigarette smoking), injecting drug use history and current injecting drug use, and history of needle and syringe sharing.

History of Sexually Transmitted Diseases (STDs)

Discuss whether the client is being treated currently for any STDs, especially cytomegalovirus, gonorrhoea, syphilis, and hepatitis B. (Medical practitioners may wish to screen for STDs.)
Procedures Involved in the Antibody Test

The procedures involved in the antibody test should be explained. These include a general medical assessment by a doctor, the anonymous coding of test request forms and blood samples, and the taking of blood for testing. Test results are never telephoned to the client. The counsellor should talk about the waiting period before the result arrives, and the availability of counselling during this stressful period.

NB: Clients should be told that in New Zealand antibody testing involves the use of two tests: the ELISA (enzyme linked immunosorbent assay) and the Western Blot. If the ELISA test (the first test) is positive, a Western Blot test is always used to confirm positivity.

Laboratory Precautions

IDUs are often already suspicious of health personnel and may be surprised at the extra precautions laboratory and other staff may take when taking blood for HIV testing. The need for extra precautions should be explained. Laboratory, medical and nursing staff will know that careful steps must be taken to avoid contamination with HIV, such as: washing hands well after procedures; disposing of needles and syringes immediately in designated safe containers; not recapping needles; using gloves; and cleaning blood spills with hypochlorite solution.

Notification

The client should be reminded that HIV antibody positive status is not notifiable to the Department of Health, but that diagnosis of an AIDS illness is followed by notification (though names are not used).

Declining HIV Testing

Some clients will choose not to have the test and will want to talk about this option. They may decide not to have the test, because they are fearful of a positive result, or because they think there is insufficient information about the test. Others will not feel sure about the accuracy of the information given to them about testing, HIV infections and AIDS. They may also be doubtful about assurances of confidentiality and worried about discrimination (in housing, at work, in hospital).

Alternatives to Having the Test

The alternatives to having the test should be discussed. These may include delaying the test (enable more discussion by giving the client further counselling appointments); referring the client to another agency or doctor; suggesting further discussion about the test with close friends; and suggesting tests of immune function (eg. absolute T4 cell count).

What a Positive Test Would Mean to the Client

Discuss what it would mean to the client if the HIV test was positive, including who and how to tell; reaction of friends, partner, family and employer; and confidentiality and consent issues. How would the client want to make changes in their life (including sexual behaviour and needle use), and how would the client react emotionally? Clients should be informed of the existence of supportive agencies, individuals and groups. Some will fear being considered a "leper" - for IDUs already stigmatised by their drug use this is an important issue. Infection control precautions at home, work etc. should be discussed.
What a Negative Test Would Mean to the Client

Discuss also what a negative test result would mean to the client including their emotional responses; lifestyle change; reduction of risk-taking techniques and practices; and safer sex, contraception, family planning issues, and, especially, condom use.

5 After the test

Negative Result

If the result is negative explain that it may be because the client is not infected with HIV. Explain that seroconversion may take up to three months (and sometimes longer) and if the client has recently been infected, antibodies will not have appeared. Explain also that sometimes antibodies may not form even though the virus is present in the person’s blood. Discuss safer sex and other risk reduction methods (these are just as important for the person with a negative result as they are for the person testing positive). Fear of HIV/AIDS will not necessarily lead to changes in behaviour. In order to encourage and monitor behaviour change, encourage the client to make further appointments.

NB: Counsellors should make sure they are aware of the work of other members of the client’s health care team and avoid any unnecessary overlapping of roles and tasks.

Positive Result

If the result is positive, explain what this means: that the client has been infected with HIV and will remain so for the rest of their life. Also that AIDS may develop after a time, although most people can expect at least seven years relatively symptom-free from the time of infection.

Contact tracing

Explain that contact tracing is not mandatory. Discuss the possibility of the client making a list of people whom they may have exposed to infection, and how or whether they could be told about their infection risk. Explain that it is not the job of counsellors to do the contact tracing but that they can certainly assist with this.

Behaviour change

Clients at risk from HIV infection, or who are HIV antibody positive, should be given advice about their future behaviour including:

• avoiding needle-sharing, unprotected sexual intercourse, giving blood, or becoming pregnant or fathering children;
• using condoms for both vaginal and anal intercourse;
• the risks of continuing to use intoxicating drugs which may seriously compromise attempts to alter sexual and needle-sharing behaviour;
• not donating blood, body organs or sperm;
• discussion about hygiene requirements (eg. no shared razors or toothbrushes), how to resist peer pressure to use drugs (eg. refer to assertiveness training), how clients might encourage their sexual partners and needle-sharing partners to practice safer sex, and attend counselling;
• and maintenance of lifestyles and reporting sickness early, to enable appropriate medical intervention.
Clients should be told that under normal circumstances there should be no risk of their transmitting the virus to other people, including members of their family, unless unsafe sex occurs. Because a woman can infect her foetus with HIV during pregnancy or at birth, antibody positive women should be advised to avoid pregnancy. Pregnant antibody positive women should be attending specialist obstetric services for ongoing assessment and care.

6 Reacting to a Positive HIV Test

Some clients may seem well prepared for a positive test result but will react with shock to it. This is a normal reaction to extremely distressing news. Feelings of acute anxiety and depression sometimes followed by suicidal ideas may quickly follow news of a positive result. Some clients will refuse to believe that they are HIV positive. Clients are best advised to be cautious at this stage about who they discuss their result with. Also evident will be feelings of despair, anger, guilt and sadness. These feelings will be jumbled until the client has had time to sort them through. For clients living alone the support of a counsellor, or other community support, will have added significance at this point. Impulsivity and irritability are often very evident.

Counsellors should tell clients how they may be contacted in an emergency. The counsellor will be faced with many questions such as whether AIDS can be passed on by kissing or whether the general practitioner will tell parents that the client has AIDS. Some clients will want to know whether their antibody status will change later.

If the client has a spouse or partner, questions about the likelihood of their being infected will be asked. For some, sharing the news with the partner or close relatives may be made much more difficult if the client’s drug dependency or sexual orientation has been a secret. Involving the partners or spouses in counselling will be an important goal.

Clients may want to know how long they might have to live, or how quickly they may expect to progress to AIDS. Because there are no definite answers to these questions the counsellor must always reply- "no one can be certain". Providing statistics in support of estimates of life expectancy is unhelpful, and may unnecessarily reinforce feelings of depression and fear.

For many clients, coming to terms with a diagnosis of AIDS or a positive test result will involve the re-emergence of old losses, resentments and guilts and other "unfinished business". Most clients will quickly see that the difference between AIDS illnesses and other "terminal" illnesses is that AIDS carries enough additional stigma to invite rejection even from those closest to the client - family, friends, or spouse.

Many of the elements of crisis counselling discussed in Chapter 6 will be used now. If the client is not too distressed, further discussion about safer sex and maintaining good health may be beneficial at this stage and should be repeated from time to time.

Summary of Psychological and Emotional Reactions of HIV-Infected People

People who have been confirmed as HIV positive have a range of psychological and emotional reactions to the news. They will have fear and anxiety about:

- physical decline and disability;
- disfigurement;
- abandonment and social or sexual rejection;
• death;
• infecting others;
• spouse's or lover's health declining; and
• inability to manage the situation.

Anger and frustration over:

• uncertainty about the illness and the ineffectiveness of treatments;
• lack of, or confusing information from health workers; and
• loss of control over personal health.

Guilt over:

• the association of the illness with sexuality and drug use;
• being identified as homosexual or a drug user;
• having possibly passed the infection on to others;
• past misdemeanours resulting in illness as "punishment".

Depression over:

• the seeming inevitability of physical decline;
• helplessness in the absence of a cure;
• physical, social, occupational and sexual limits imposed by the infection and disease; and
• social, occupational, emotional and sexual rejection.

Shock over:

• loss of hope for good news.

(Department of Health 1988)

7 Follow-Up

At later counselling sessions safer sex, healthier lifestyles, handling stress, infection control, and who and how to tell will emerge repeatedly as matters for discussion and debate. Because most clients are in a state of shock at the first post-test interview, they may have absorbed little of what was said. Partners, parents, children and close friends may all benefit from inclusion in later counselling sessions. This will facilitate better understanding of the client's need for support and continuing intimacy, better understanding of safer sex requirements and matters of hygiene generally, and clarification of information and misinformation about HIV/AIDS.

Partners and family members will be deeply affected by the diagnosis of HIV/AIDS in the client and may require just as much, if not more, support. Some couples will experience severe relationship difficulties and long-term counselling support may be required.

Until such time as AIDS symptoms and illness intervene, counsellors should encourage their clients to hold on to their jobs, stay within their families, and lead their lives as usual. Clients should be reminded that even when illness prevents the leading of a normal life, a return to normal daily routines and work is often accomplished quickly. Many clients (and not only those with AIDS diseases) will decide to make (or revise) their wills, and want to discuss next of kin and power-of-attorney issues. Some will make careful funeral arrangements.
As time passes some clients (and especially those with a history of anxiety disorders or psychiatric admissions) may find it difficult to maintain their emotional equilibrium. Appropriate referral can be made (again always with the client's consent) to psychiatric services, particularly if severe depression or persistent suicidal ideas are evident.

Later, as fear begins to subside, some clients will agree to a referral to peer support services such as those offered by the New Zealand AIDS Foundation, National People Living with AIDS Union and the Te Roopu Tautoko Trust. By this means, people with HIV and AIDS can learn how others cope, acquire the latest information about HIV/AIDS, enjoy a fellowship with people of similar experience, and have safer sex and healthier lifestyle messages reinforced.

During this period of support, counsellors should primarily be trying to assist clients to work through and understand the varied emotional responses they will experience. This will also be a time when a great deal of new information needs to be absorbed. The counsellor's goal should be to make this information as clear and straightforward as possible. The counsellor may need to gently unveil the denial a client may be using to cope with his or her new situation. Throughout the counselling process clients will need assistance in coping with feelings of anxiety and counsellors will need to help their clients identify and reduce the negative impact of stress on their lives. They may wish to share their own skills and learnings (eg. yoga, meditation, relaxation techniques) or refer their clients to more skilled practitioners. The HIV testing process is summarised in Appendix 4.
As HIV becomes more prevalent in New Zealand, alcohol and drug rehabilitation services will be considering their agency's reactions to the HIV positive clients referred to them, paying special attention to confidentiality issues and informing and educating staff and clients. Some treatment centres have already devised guidelines for an effective and humane response to their HIV infected clients. Others, still pondering the complex questions which HIV infection raises, can best focus on their concerns about HIV/AIDS by devising a policy document for their agency. This might include statements on:

- Acceptance/Non Acceptance of HIV Positive Clients for Rehabilitation.
- Access to Medical Treatment and HIV Testing.
- Counselling and Staff Education.
- Confidentiality.
- Preventing Virus Transmission in Treatment Settings.
- Methadone.

1 Acceptance/non-acceptance of HIV positive clients for rehabilitation

A statement of philosophical stance on this issue will underpin the entire policy. If it declares a willingness to treat without prejudice clients who are HIV positive it will be in line with proposed amendments to the human rights legislation under consideration by the New Zealand Parliament and by governments in other countries.

2 Access to medical treatment and HIV testing

Individual assessment of the medical status of each HIV positive client should take place before final decisions about admission to treatment programmes. Such assessments should bear in mind the capacity of treatment centres to cater for a client's needs at various stages of HIV infection and illness. Ongoing medical appointments should be organised by the treatment centres. Medical and non-medical personnel will also want to assess the client's suitability and motivation for admission to a treatment centre.

3 Counselling and Staff Education

Counselling should be available for all clients wanting to discuss matters related to HIV infection, and especially whether they should be tested for the presence of HIV antibodies. Some antibody positive clients will want help with coming to terms with their health status and dealing with guilt, fear and confidentiality issues. Treatment centres will need to decide whether they will take on this counselling role or refer the client to other agencies. The extent to which the treatment centre should liaise with agencies in the HIV field should be addressed, especially regarding policy planning, staff education overlap, and the benefits of working with and supporting recovering users working in the fields of HIV prevention and education.

Counsellors and clients should be regularly brought up to date with information about HIV/AIDS. It should be emphasised that there are no at-risk groups, only unsafe behaviours. Some staff will
question the validity of focusing attention on the drug or alcohol dependency of HIV positive clients (and especially those with ARC or AIDS diseases) when those clients are seen to be terminally ill. There should be plenty of time set aside for the discussion of these and other matters of treatment philosophy.

4 Confidentiality

Treatment centres will understand that information about health status is confidential. In the case of HIV infection (and with hepatitis B positive antigen status) clients’ consent should, if possible, be sought before information regarding antibody status is passed on to others. Treatment centres will need to decide which staff should know about a client’s antibody status, with consideration being given to as few staff as possible knowing.

Because the antibody test is not per se diagnostic, may lead to unnecessary segregation and hysteria, may violate privacy, and will not by itself prevent unsafe sex even if the result is positive, testing should never be undertaken without the client’s consent, and clients should not be routinely screened for HIV antibodies.

All personnel involved in HIV testing must be familiar with the anonymous code required for tests (Meech 1986).

5 Preventing virus transmission in treatment settings

Precautions Against Contamination

Normal hepatitis B precautions apply when working with HIV-infected people. There should be adequate supplies of gloves, masks, disinfectant, and bags and containers for the disposal of contaminated articles. These items should be readily available to all staff and clients in case of exposure to the body fluids or secretions of an infected person. Bathrooms may be shared but it is not advisable to share toothbrushes, razors or razor blades. Hugging, kissing and normal social contact will not expose anyone to HIV. Healthcare personnel are therefore not at special risk if normal precautions are taken.

There is no vaccination for HIV. Treatment centres should, however, consider requesting hepatitis B vaccination for their at-risk employees.

Condoms

Condoms should be available, free of charge if possible, to clients in both outpatient and residential treatment settings. For residential programmes with a no-sex rule it may be difficult to justify the provision of condoms. However, a clear policy on this issue will need to be established with consultation taking place between staff and residents.

6 Methadone

There is good evidence that methadone availability at drug treatment centres will reduce sharing and thereby lessen the chances of HIV spread. A policy document may wish to address the debate as to whether treatment centres should make clean needles and syringes available directly to their clients, and whether methadone should be more easily available to clients if policies of harm minimisation and harm reduction are to be followed.
<table>
<thead>
<tr>
<th>Glossary</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
</tr>
<tr>
<td>AIDS related complex (ARC)</td>
</tr>
<tr>
<td>Antibody</td>
</tr>
<tr>
<td>Antibody tests</td>
</tr>
<tr>
<td>Antigen</td>
</tr>
<tr>
<td>AZT</td>
</tr>
<tr>
<td>B-lymphocytes</td>
</tr>
<tr>
<td>Cytomegalovirus-CMV</td>
</tr>
<tr>
<td>DNA</td>
</tr>
<tr>
<td>ELISA test</td>
</tr>
<tr>
<td>&quot;Helper&quot;T Cells</td>
</tr>
<tr>
<td>HIV</td>
</tr>
<tr>
<td>Term</td>
</tr>
<tr>
<td>----------------------------------</td>
</tr>
<tr>
<td>HIV illness</td>
</tr>
<tr>
<td>Immune system</td>
</tr>
<tr>
<td>Macrophages</td>
</tr>
<tr>
<td>MST Morphine</td>
</tr>
<tr>
<td>Opportunistic infections</td>
</tr>
<tr>
<td>Seroconversion</td>
</tr>
<tr>
<td>Seropositive</td>
</tr>
<tr>
<td>Sexually Transmitted Disease (STD)</td>
</tr>
<tr>
<td>'Suppressor' T Cells</td>
</tr>
<tr>
<td>T-lymphocytes</td>
</tr>
<tr>
<td>Virus</td>
</tr>
<tr>
<td>Western Blot Test</td>
</tr>
</tbody>
</table>


BUNNING EC, VERSTER AD, HARTGERS C. Amsterdam's policy on AIDS and drugs. Drug Department publication: Amsterdam, Netherlands, December 1987.


Appendix 1
What is AIDS?

The following has been taken from the opening chapters of the 1988 Department of Health publication, "HIV and AIDS, information for health professionals".

AIDS is the end stage of a spectrum of disease caused by a virus which attacks and weakens the immune system, the body's natural defence system. People infected with this virus become increasingly likely to develop some forms of cancer, or certain infections which the body would normally be able to easily fight off.

The Cause

The Human Immunodeficiency Virus

HIV is a member of a group of retroviruses which have caused few recognised illnesses in humans, but which have been studied in susceptible animals. They produce persistent infections for the lifetime of the host. It is characteristic of the subgroup to which HIV belongs (lentiviruses) that they have very long incubation periods, measured in years, before they produce clinical illness. There are now two groups of HIV identified: HIV1 and HIV2. HIV2 has not yet been identified in New Zealand.

Antibodies are usually produced when a person is infected by HIV, but this does not stop HIV illness developing.

The Cellular Immune System

\[
\text{WHITE BLOOD CELLS} \quad \begin{cases} \text{Neutrophils (foot soldiers)} \\ \text{Lymphocytes} \\ \text{Macrophages} \\ \text{Others} \end{cases}
\]

Immune System Attacked

HIV destroys the very system that was designed to contain it. It can also directly attack other parts of the body such as the central nervous system.

The Virus at Work

On entering the body the virus seeks out macrophages and 'helper' T cells and locks on to them before penetrating the cell. These cells then become victims instead of defenders.
The virus consists of an outer layer (or envelope) which encases a core of genetic material. Once the virus attaches itself to the cell, a special interaction takes place. The virus sheds its outer layer and injects the core containing genetic material into the cell. Once inside the cell, the virus uses an enzyme called reverse transcriptase to copy itself into DNA which can then insert itself into the cell's own genetic material and so establish a latent state.

The virus lies hidden in the cell’s nucleus for a variable period of time and the macrophages or lymphocytes continue to circulate normally. It hides there undetected until stimulated to begin to multiply, triggered perhaps by another infection or some other stress on the immune system before multiplying and exploding from the cell. From there the new-born virus make its way to other cells, hijacking them in the same way and setting in motion its devastating destruction of the immune system.

Macrophage infection is now recognised as being of special importance because:

- macrophages are infected early on, and are possibly the first cell line infected;
- they produce large amounts of HIV in an infective form;
- they form syncytia (i.e. where cells clump together enabling the HIV to spread directly from cell to cell);
- they can, with time, select strains of HIV, producing more virulent forms;
- they account for HIV infection occurring in the central nervous system; and macrophage viral replication is not inhibited by AZT.

Symptoms of HIV Illness

Within six weeks of exposure approximately 50 percent of people infected by HIV have an initial acute infection similar to glandular fever.

Symptoms of HIV illness can include the following.

- Swollen glands, especially in the neck, groin and armpits, which persist with no apparent cause.
- Persistent and unexplained tiredness.
- A succession of recurring infections such as herpes, shingles and boils.
- Recurrent fevers or night sweats, lasting for more than a few weeks.
- Unexpected weight loss of more than 4.5kg (10lb) in less than two months.
- Persistent diarrhoea.
- Persistent headache, short-term memory loss and lack of concentration.
- Shortness of breath and dry cough. This is one way that pneumocystis carinii pneumonia (PCP) may present itself.
- Skin disease is common. There can be a variety of rashes, severe acne or excessive dryness of the skin. Kaposi’s sarcoma presents as pink to purple flat or raised areas which are usually painless, involving skin or mucus membranes.
- Persistent white patches in the mouth, due to the yeast candida albicans, or on the side of the tongue (hairy leukoplakia).

People presenting symptoms or signs of HIV should be screened for other STDs. These symptoms are rather non-specific, so it is only if some of them persist over weeks to months, or there are additional appropriate features in the history, and clinical signs, that HIV should be considered as a cause.
Antibodies to HIV typically take two weeks to three months to appear after the onset of the acute illness.

Opportunistic Infections

These are infections which seize the opportunity offered by the body's impaired immune system to cause illness and are termed opportunistic. They also occur in people with artificially depressed immune systems due to drugs, such as in transplant patients. The organisms which cause the illnesses are often latent in the host, and some may be reactivated by HIV.

The opportunistic organisms most commonly found in people with AIDS are:

**Bacteria**
- mycobacterium tuberculosis.

**Parasites**
- pneumocystis carinii - causing a serious infection of the lungs, toxoplasma gondii causing encephalitis, and cryptosporidium, a cause of diarrhoea.

**Viruses**
- varicella zoster, cytomegalovirus, herpes simplex and epstein-barr virus.

**Fungi**
- candidiasis if in a severe form and in an unusual place, cryptococcus neoformans causing meningitis.
  (There are over 30 other viruses, bacteria and fungi which take advantage of the lowered immunity of people with AIDS but which do not usually pose a threat in healthy individuals.)

**Tumours**
- Several types of tumours (cancers) have been seen in people with AIDS. The most common is kaposi's sarcoma, which affects the skin or internal organs, but various types of lymphomas (cancers of the lymph system itself) are also seen.

**Dementia-neurological illness**
- HIV is a neurotropic virus, that is a virus with a marked affinity for the tissues of the nervous system. HIV infection of the brain and spinal cord is very serious and increasingly common, producing a dementing illness resembling Alzheimer's disease. Certain other infections may also affect the brain, such as cytomegalovirus, toxoplasmosis and cryptococcal infection. Even in the absence of these, HIV infection of the brain can be fatal. Neurological infection is characteristic of the lentiviruses, the group to which HIV belongs.

**Slim disease**
- Slim disease is an infection of the gut which causes diarrhoea and severe wasting.

Treatment

Currently we are dependent upon stopping the spread of HIV by persuading people to stop specific high-risk activities. Medical care can provide relief for some symptoms and often treat opportunistic infections. To date no treatment has been found which will completely restore the immune functions of a person suffering from HIV illness.
AZT (Azidothymidine)

Currently, only one drug is recognised internationally to be beneficial in the treatment of AIDS, the medicine, azidothymidine or zidovudine, marketed under the name of retrovir. AZT has reduced the mortality and morbidity in some people with AIDS and HIV illness. The treatment however does not eradicate the virus.

AZT is available on a restricted basis in New Zealand. The specialist caring for the patient applies to the Department of Health. Each case is assessed to determine whether or not this medicine should be prescribed. This is because AZT is still an experimental drug, has some serious side effects, and is very expensive.

Researchers are investigating several drugs which attack HIV at different stages of its replicative cycle. These include Al 721, ampligen, ribavin and alpha-interferon.

Information about experimental therapies may be found in the AmFAR (American Foundation for AIDS Research) Directory of Experimental Treatments for AIDS and ARC.

Vaccines

Vaccines have been developed and are being trialled but whether they will work or not has yet to be established. There are frequent mutations as the virus replicates the part of the envelope gene that remains constant among strains. It is hoped that a vaccine may be developed against this part of the virus. Even if such a vaccine could be developed there are serious ethical problems in testing it, and it may not be marketable. The antibodies produced as a result of a vaccine may not prevent infection and disease progression. In any event, it is a long way off.
Appendix 2
Physical Complications of Injecting Drug Use

Skin
Extravascular injection
Cellulitis and Abscess
Subcutaneous injection
Thrombophlebitis
Lymphoedema
Inadvertent intra-arterial Injection
Distal gangrene and Ischaemia

Neurological
Overdose - coma
cerebral oedema
seizure -
(cocaine)

Heart
Endocarditis
Myocardial Infarction
(Cocaine)
Arrhythmia
(Cocaine)

Liver
Hepatitis B
Hepatitis non
A, non B

Lung
Pulmonary oedema
(secondary to coma or injected impurities)
Pneumonia
- septic/emboli (staph)
- inhalation

Lung abscess
Foreign body reaction
Pulmonary fibrosis

Spontaneous Abortion
Foetal Drug Dependence

Osteomyelitis
Appendix 3
New Zealand AIDS Foundation Clinical Questionnaire (adapted)

The following clinical questionnaire is adapted from the New Zealand AIDS Foundation. The original sections J, K and L have been amended.

CLINIC CODE:

CLINIC QUESTIONNAIRE

Instructions:
Complete all sections. Mark boxes with a 'X'. Provide full details for 'specify' type questions.

A  GENERAL

KNOWN NAME: ________________________________
SEX:  
Male  
Female  
Transexual  

BIRTH DATE:  
Maori  
Pakeha  
Pacific Island  - Specify  
- Specify  

YEARS IN NEW ZEALAND: ____________________________

TIME OVERSEAS SINCE 1980: ____________________________

B  REASON FOR TEST

REASON: ________________________________

DO YOU CONSIDER YOURSELF AT RISK OF BEING INFECTED WITH HIV (AIDS VIRUS)
Not at all  
Slightly  
Moderately  
Considerably  
Extremely at risk  

47
<table>
<thead>
<tr>
<th>No</th>
<th>SYMPTOM QUESTIONNAIRE</th>
<th>No</th>
<th>Yes</th>
<th>When Began</th>
<th>Duration</th>
<th>In Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>FEVER/CHILLS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>NIGHT/SWEATS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>UNEXPLAINED WEIGHT LOSS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>FATIGUE/LETHARGY</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>ALTERED BOWEL HABIT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>SWOLLEN GLANDS (LYMPH NODES)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>HEADACHE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>SKIN RASHES/LESIONS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>COLD SORES</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>SHORTNESS OF BREATH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>COUGH (PERSISTENT)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>PAINS IN JOINTS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>RECTAL/ANAL PROBLEM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>GENITAL/VAGINAL PROBLEMS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>DEPRESSION</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>ANXIETY</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>MEMORY LOSS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>OTHER - Specify</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No</th>
<th>SOCIAL STRESSES</th>
<th>No</th>
<th>Yes</th>
<th>When Began</th>
<th>Duration</th>
<th>In Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RELATIONSHIP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>OCCUPATION</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>FINANCIAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>EVER BEEN SEXUALLY ABUSED</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>OTHER PROBLEMS - Specify</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

E. SOCIAL RESOURCES

WHO COULD YOU CONFIDE IN IF YOU WERE TOLD THAT YOU WERE HIV ANTIBODY POSITIVE*:

FAMILY  
FRIENDS 
PARTNER/LOVER 
PROFESSIONAL SERVICES 
OTHER - Specify

WHO COULD SUPPORT YOU IF YOU BECAME UNWELL*:

FAMILY  
FRIENDS 
PARTNER/LOVER 
PROFESSIONAL SERVICES 
OTHER - Specify

* Actual names are not required
### F CONTACT TRACING

**WOULD YOU CONTACT FORMER SEXUAL PARTNERS**

<table>
<thead>
<tr>
<th></th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>___</td>
<td>___</td>
</tr>
</tbody>
</table>

### G PAST MEDICAL HISTORY

<table>
<thead>
<tr>
<th></th>
<th>NO</th>
<th>YES</th>
<th>WHEN BEGAN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>___</td>
<td>___</td>
<td>Month Year</td>
</tr>
</tbody>
</table>

1. **GLANDULAR FEVER (OR SIMILAR ILLNESS)**
2. **HERPES SIMPLEX (COLD SORES) - MOUTH**
3. **HERPES SIMPLEX (COLD SORES) - GENITAL**
4. **HERPES ZOSTER (SHINGLES)**
5. **THRUSH/YEAST INFECTION - MOUTH**
6. **THRUSH/YEAST INFECTION - GENITAL**
7. **VIRAL ILLNESS REQUIRING TIME OFF WORK**
8. **HEPATITIS - A**
9. **HEPATITIS - B**
10. **HEPATITIS - UNKNOWN**
11. **GENITAL/VAGINAL WARTS**
12. **ANAL WARTS**
13. **NSU (NON SPECIFIC URETHRITIS)**
14. **CHLAMYDIA**
15. **NZ PROCTITITS**
16. **GONORRHOEA (CLAP)**
17. **SYPHILLIS**
18. **PELVIC INFLAMMATORY DISEASE**
19. **INTESTINAL PARASITES (WORMS)**
20. **BLOOD TRANSFUSION**
21. **PSYCHIATRIC/PSYCHOLOGICAL PROBLEM**

### PREGNANCIES:

<table>
<thead>
<tr>
<th></th>
<th>TOP</th>
<th>MISCELLANEOUS TERMS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>___</td>
<td>___</td>
</tr>
</tbody>
</table>

### MEDICATION:

Including Contraceptive measures/Antidepressants/Tranquilizers/Sleeping Tablets.

### OTHER SIGNIFICANT ILLNESS:

*Specific Details:

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________
## DRUG USE

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>No</th>
<th>Yes</th>
<th>Time Period</th>
<th>Daily</th>
<th>Weekly</th>
<th>Monthly</th>
<th>Less Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking Tobacco - Now</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking Tobacco - Past</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marijuana</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poppers (Amyl Nitrite)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV Drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specify - (with time frame)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homebake</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specify - (with time frame)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specify - (with time frame)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shared Needle/Syringe</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shared Overseas</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shared with (HIV +ve/AIDS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

THINKING BACK OVER THE LAST FEW YEARS, WAS THERE A TIME (EVEN ONCE) WHEN YOU USED ANY DRUGS WHILE HAVING SEX, OR HAD SEX WHILE STRONGLY AFFECTED BY ALCOHOL OR DRUGS:

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

IF YES - Please specify

HOW DO/DID YOU SUPPORT YOUR DRUG HABIT:

I SEXUAL HISTORY

DO YOU IDENTIFY WITH:

<table>
<thead>
<tr>
<th>Identify With</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lesbian</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bisexual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heterosexual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transsexual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tranvestite</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prostitute</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DURATION: _______ YEARS _______ MONTHS

ARE YOU COMFORTABLE WITH YOUR SEXUALITY:

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

50
CURRENT RELATIONSHIP:  

DURATION: ____________ YEARS ____________ MONTHS

MONOGAMOUS:  

PARTNER'S RISK:

NUMBER OF SEXUAL PARTNERS:
LAST THREE MONTHS  
LAST PREVIOUS YEAR  
PREVIOUS USUAL RATE  
MAJOR CHANGES

OVERSEAS SEXUAL CONTACTS:  

HAS ANY PARTNER BEEN AN HIV CONTACT:  

J  SOURCE OF PARTNERS - INJECTING DRUG USERS

SPECIFY:  
1  FRIENDS  
2  SOCIALLY  
3  WORK  
4  PUB  
5  NIGHTCLUB  
6  ESCORT  
7  MASSAGE PARLOUR  
8  PROSTITUTE

K  CONDOM USE

HAVE YOU USED CONDOMS (SINCE 1979):

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Time Period</th>
<th>How Often(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Years</td>
<td></td>
</tr>
</tbody>
</table>

VAGINAL INTERCOURSE -  
CASUAL PARTNER  
Condom Breakages

VAGINAL INTERCOURSE  
REGULAR PARTNER  
Condom Breakages
### L  SEXUAL PRACTICE

HOW OFTEN (NUMBER OF TIMES) IN AN AVERAGE MONTH WAS THE FOLLOWING:

<table>
<thead>
<tr>
<th></th>
<th>VAGINAL INTERCOURSE</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Past 3 Months</td>
<td>Past 12 Months</td>
<td>Previous Usual Rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>ANAL - Insertive</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Condom Use (%age)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>ANAL - Receptive</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Condom Use (%age)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>FINGERING - Insertive</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Receptive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>SEX TOYS - Solo</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Dildos, etc) - Sharing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>OTHER</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specify</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### M  PHYSICAL EXAMINATION

WEIGHT kgm ________

BLOOD PRESSURE ________ / ________

SKIN - LESIONS THAT MAY BE RELATED TO HIV INFECTION

<table>
<thead>
<tr>
<th></th>
<th>BULLOUS IMPETIGO</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>CUTANEOUS STAPH LESIONS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>SEBORRHOEA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>HERPES ZOSTER (SHINGLES)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>OTHER - Specify</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

OROPHARYNX

<table>
<thead>
<tr>
<th></th>
<th>ORAL CANDIDIASIS</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>HERPES (ORAL)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>OTHER - Specify</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

GENITAL/ANAL

<table>
<thead>
<tr>
<th></th>
<th>HERPES (ANOGENITAL)</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>OTHER - Specify</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

LYMPH NODES - Mark palpable notes with X in box

<table>
<thead>
<tr>
<th></th>
<th>POST CERV</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ANT CERV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SUPRA CLEV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>AXILLA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>INGUINAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>OTHER - Detail</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
GENERAL

LIVER
SPLEEN

COMMENTS:


TESTS ORDERED

HIV
HEP B
VDRL
OTHER - Specify

DOCTOR: ______________________ Date: __________

N DETAILS OF VISIT

REFERRED BY:____________________

COUNSELLOR SEEN: ______________ DATE: __________

DOCTOR SEEN: __________________ DATE: __________

COUNSELLOR SEEN (RESULT): _________ DATE: __________

SUBSEQUENT VISITS:

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

REFERRALS:

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

53
Appendix 4
HIV Testing Process

Before the Test

Stage 1: Presentation for testing or symptom diagnosis

Symptom presentation:
- physical examination;
- biopsies;
- Screening for STDS.

- Pre-counselling;
- Significance and possible consequences of testing

- Time to consider and possibly decline testing

- Blood sample taken

After the Test

Stage 2: Informing of results

- Results given face to face;
- Giving vent to feelings;
- Counselling on safer sex infection-control;
- Health boosting;
- Inform partner(s) only;
- Providing support

Follow-up

Stage 3: Follow-up

Regular STD screening

- Repeat counselling (with partner/family);
- Questions answered;
- Who and how to tell;
- Problem-solving;
- Psychiatric/ psychological screening and referral

Stage 4: Linking with other services

Hospital
- Alcohol and drug dependency service;
- Gynaecologist;
- Psychologist/ psychiatrist;
- Chaplain;
- STD Clinic;
- Social worker;
- Surgeon;
- Dentist

Community
- Alcohol and drug dependency centres;
- Alcoholics Anonymous;
- Narcotics Anonymous;
- Dentist;
- Gay community welfare agencies;
- Haemophilia Society;
- Self-help groups (ADIO, WIDE, etc);
- Legal advice service;
- NZ AIDS Foundation;
- Te Roopu Tautoko

- Further counselling as required

(Department of Health 1988)
Appendix 5
Organisations AssistingInjecting Drug Users

Drug Treatment Agencies

Psychiatric Unit
Northland Area Base Hospital
Hospital Road
WHANGAREI (089) 482-079

Drug Dependency Clinic
393 Great North Road
Grey Lynn
AUCKLAND (09) 765-816

Odyssey House
323 Queen Street
AUCKLAND (09) 396-714

Salvation Army Bridge Programme
15 Ewington Avenue
Mt Eden
AUCKLAND (09) 608-389

Dr D Seddon, Dr B Foggo
Otumoetai Health Centre
506 Otumoetai Road
TAURANGA (075) 62321

Waikato Area Health Board
Contact Community Alcohol Services
for Assessment and Referral
19 Ruakiwi Road
HAMILTON (071) 394-352

Kahanui Village Trust
RD 2
OPOTIKI (076) 54750

Taranaki Opiate Treatment Programme
C/- Taranaki Addiction Service
Taranaki Base Hospital
Ground Floor, Staff Hospital
Tukapa Street
NEW PLYMOUTH (067) 36139
Hawkes Bay Addiction Services
(Hawkes Bay Area Health Board)
C/- Springhill Centre
42 Morris Street
NAPIER (06) 835-2119

Alcohol and Drug Assessment Unit
Wanganui Hospital
Heads Road
WANGANUI (06) 345-3909

Alcohol and Drug Centre
159 Queen Street
PALMERSTON NORTH (063) 72066

Wairarapa Outpatients Addiction Service
(WOPAS)
Assessment and Referral
C/- Sedgley Family Centre
25 Intermediate Street
MASTERTON (059) 85716

Salvation Army Bridge Programme
1 Tasman Street
WELLINGTON 1 (04) 850-395

Narcotic Dependency Clinic
Wellington Alcohol & Drug Centre
265 Adelaide Road
Newtown
WELLINGTON (04) 898-653

Alcohol Clinic
(Nelson Area Health Board)
115 Kawai Street
NELSON (054) 61800

Queen Mary Hospital
Hanmer Springs
HANMER (03) 315-7016

Alcohol & Drug Centre
258 Armagh Street
CHRISTCHURCH (03) 650-983

Odyssey House
98 Greers Road
Burnside
CHRISTCHURCH (03) 358-7791
Salvation Army Bridge Programme
35 Collins Street
Addington
CHRISTCHURCH 2 (03) 338-4436

Substance Abuse Services
Psychiatric Services Centre
Dunedin Hospital
Private Bag
DUNEDIN (03) 474-0999

New Zealand AIDS Foundation Clinics

Burnett Clinic
Wallace Block
Auckland Hospital Ph (09) 395-560
AUCKLAND Fax (09) 793-279

Awhina Clinic
35 Mein Street
Newtown Ph (04) 893-169
WELLINGTON Fax (04) 894-207

Ettie Rout Clinic
453 Montreal St Ph (03) 791-953
CHRISTCHURCH Fax (03) 652-477

Dunedin Clinic
Dunedin Public Hospital
Outpatients Clinic
Cumberland Street Ph (03) 479-2874
DUNEDIN Fax (03) 477-9400

New Zealand AIDS Foundation Offices and Affiliate Groups

Head Office
PO Box 6663 Ph (09) 303-3124
Wellesley Street Fax (09) 393-149
AUCKLAND AIDS Hotline Ph 0800 802 437

Auckland
PO Box 8875 Ph (09) 302-1542 (Rex Halliday/Joe Kelleher)
Symonds Street AUCKLAND Fax (09) 302-2338

Hamilton
PO Box 41 Ph (071) 383-557 (Imelda Quilty)
HAMILTON Fax (071) 383-514
Rotorua
Bay Area Support Services  Ph (073) 23113 (Michael Hay)
P O Box 439  Fax (073) 480-217 (C/- NZPO, ask for Michael to be contacted when transmitting a fax)
ROTORUA

Gisborne
AIDS Awareness Committee  Ph (06) 867-9099 (Adrian Toki)
Tairawhiti Area Health Board  Fax (06) 867-8527
Private Bag  GISBORNE
GISBORNE

Hawkes Bay
P O Box 679  Ph (06) 835-5554 (Tony Ewing)
NAPIER

Taranaki
P O Box 6041  Ph (067) 46627 - Private (Brian Avison)
Moturoa  NEW PLYMOUTH
NEW PLYMOUTH

Manawatu (Affiliate)
I V Union  Ph (063) 71059 Sherrin English)
P O Box 1942  WELLINGTON NORTH
PALMERSTON NORTH

Wellington
PO Box 7287  Ph (04) 893-169 (Michael Cody)
WELLINGTON SOUTH  Fax (04) 894-207

Nelson
P O Box 4022  Ph (054) 61989 (Diane Thurston)
NELSON SOUTH  Fax (054) 61542 (C/- Jean Simpson, Nelson/Marlborough AHB)

Christchurch
PO Box 21285  Ph (03) 793-353 (Marie Glenys)
Edgeware  CHRISTCHURCH
CHRISTCHURCH  Fax (03) 652-2477

Christchurch IVDU Resource Group (Affiliate)
PO Box 13026  Ph (03) 652-293
CHRISTCHURCH

Timaru
South Canterbury AIDS Network  Ph (03) 688-8871 (Brian Walker)
PO Box 452  TIMARU
TIMARU
Otago
C/- Otago Area Health Board
Community Health Services
304 Castle Street
DUNEDIN
Ph (03) 479-2874 (Dave Verrall)
Fax (03) 477-9400

Southland
PO Box 7068
INVERCARGILL
Ph (03) 218-1949 (Donna McEntyre)
Branch No (03) 218-9916 (Answerphone)
Fax (03) 218-2680 (Nurse Mngt, Southland Hospital)

STD Clinics

HIV testing is carried out at STD clinics attached to the following hospitals:

Whangarei
Hamilton
Rotorua
Gisborne
Napier
Hastings
New Plymouth
Wanganui
Palmerston North
Wellington
Blenheim: Primary Health Nursing Care Clinic
Invercargill

Further Useful Organisations

Al-Anon and Alateen (contact through Alcoholics Anonymous or treatment agencies).

Alcoholic Liquor Advisory Council, PO Box 5023, Wellington, Ph (04) 720-997, Fax (04) 730-890.

Alcoholics Anonymous (see phone book or contact through Citizens Advice Bureau).

Auckland Drug Information Outreach Trust, PO Box 68134, Newton, 227A Symonds St, Auckland,
Ph (09) 398-519, Fax (09) 398-519.

Auckland Gay Lesbian Welfare Group, PO Box 3132, Auckland, Ph (09) 393-268, Fax (09) 393-268.

Cancer Society of NZ, 101-105 Molesworth St, Wellington, Ph (04) 736-409, Fax (04) 499-8049.

Counselling Services (then) Dunedin Intravenous.
Family Planning Association Clinics.

Counselling Services - see the back of the yellow pages in the telephone book.

Dunedin Intravenous Organisation, 30 Moray Place, Dunedin, Ph (03) 479-2300.
General Practitioners.

Hospice New Zealand, PO Box 7181, Wellington South, Ph (04) 733-159, Fax (04) 733-159.

Lesbian and Gay Rights Resource Centre, PO Box 11695, Wellington.

Narcotics Anonymous (contact through treatment centres).

National People Living with AIDS Union, PO Box 2558, Wellington, Ph (04) 828-791, Fax (04) 801-5690.

National Society on Alcoholism and Drug Dependence, 124 Dixon Street, Wellington, Ph (04) 851-517.

NZ Dental Association, 3 St Mark's Road, Remuera, PO Box 28-084, Auckland South, Ph (09) 524-2778, Fax (09) 520-5256.

NZ Haemophilia Society, PO Box 122, Auckland, Ph (09) 302-2522.

NZ Medical Association, PO Box 156, Wellington, Ph (04) 724-741, Fax (04) 710-838.

NZ Nurses Association, PO Box 2128, Wellington, Ph (04) 850-847, Fax (04) 829-993.

New Zealand Prostitutes Collective, PO Box 11-412, Manners Street, Wellington, Ph (04) 828-791, Fax (04) 801-5690.

NZ Society of Physiotherapists, PO Box 27386, Wellington, Ph (04) 801-6500 Fax (04) 801-5571.

Pacific Island AIDS Trust, PO Box 12453, Wellington, Ph (04) 735-544 (Eti Laufiso).

Pharmaceutical Society of New Zealand, PO Box 11640, Pharmacy House, 124 Dixon Street, Wellington, Ph (04) 859-604, Fax (04) 829-297.

Pharmacy Guild of NZ (Inc), PO Box 27139, Pharmacy House, 124 Dixon Street, Wellington, Ph (04) 859-708, Fax (04) 848-085.

Te Roopu Tautoko Trust, PO Box 16050, 8 Hall Street, Newtown, Wellington, Ph (04) 899-679, Fax (04) 899-750.

Wellington Information for Drug Education, (WIDE), PO Box 11-412, Manners Street, Wellington, Ph (04) 828-404, Fax (04) 801-5690.
AIDS
- cause 42
- conferences 7
- global perspective 1,8
- history 1,7-9
- in New Zealand 7
- modes of transmission 10,29
- opportunistic infections 38,44
- notification of cases 8,30
- Taskforce 7
- vaccine 9,36,45
AIDS Related Complex (ARC) 36,37,45
Alcohol dependency 5
Alcoholics Anonymous 6
AmFAR 45
Anger management 6,25
Antibody and antigen tests 29
Assertiveness training 6,25
At risk behaviour 8
Auckland Drug Information and Outreach Trust (ADIO) 7,59
AZT 37,43,45
Bleach, use of 9,11
Behaviour modification 10,11,13,31
Blood donation 10,31
Blood screening 7
Breastmilk 10
Burnett, Bruce 7
Condoms, use of 9,10,19,21,31,36
Contraception 9
Counselling injecting drug users 6,9,10,11,17
- after care 25
- characteristics of effective counsellors 24
- crisis intervention techniques 20-21
- defence mechanisms 22
- history taking and assessment guidelines 17-20
- longer term counselling 24
- skills 22
- supportive counselling 23
- treatment options and strategies
Criminal activity 5,17,18,26
Detoxification 6,20,25
Department of Health 7,25,28
Drugs Advisory Committee 25
Education for injecting drug users 1,6,9,11
Ethnic minorities 8
Enzyme linked immunosorbent assay (ELISA) test 29,30,37
Gay community 8
Hepatitis B virus 5, 20, 26, 29, 36

HIV infection
- global perspective 8
- modes of transmission 10, 29
- notification of tests 30
- precautions when treating 36
- prevention of spread 10-11

HIV testing 54
- alternatives to testing 30
- confidentiality 28, 35-36
- contact tracing 31
- declining testing 29
- emotional reactions 32-33
- follow-up 33
- precautions to be taken 30
- pre-test counselling 29-31
- post-test counselling 31-34
- reacting to a positive test 32

HIV virus
- at work 42
- symptoms 43
- treatment 44

Injecting drug users 5
- risks of 5

Injectable drugs 5, 9, 11
IV League, the 7
Inform ed consent 28, 36
Maori perspective 6, 8
McGrath, Gary 7

Medical and Scientific Sub-Committee on AIDS 7

Methadone treatment 5, 6, 9, 11, 25-27, 36

Misuse of Drugs Act 1975 25

Misuse of Drugs Amendment Act 9

Narcotics Anonymous 6, 23, 26, 60

National Council on AIDS 7

National People Living with AIDS 34, 60

Needle and syringe exchange programme 1, 7, 9

Needle and syringe sharing 9, 10, 19, 26, 29, 31

New Zealand AIDS Foundation 7, 34, 57

New Zealand Communicable Disease Centre 28

Non A and non B hepatitis 5

Odyssey House programmes 6, 55

Organ donation 10, 31

Outpatient drug clinics 6

Policy making 35

Pregnancy 31, 32

Prostitution 5, 26

Psychodrama 25

Psychotherapy 6

Queen Mary Hospital 6, 56

Rehabilitation/treatment centres 6, 35, 55-60
Rogers, Carl R 24
Safer sexual practices 9,11,12,31
Salvation Army Bridge Programme 6
Semen donation 10, 31
Sexual orientation 19, 29,32
Sexually transmitted diseases (STDs) 12, 29, 38, 43
Te Roopu Tautoko Trust 8, 34, 60
Unsafe sexual practices 12,26,29
Wellington Information for Drug Education (WIDE) 8, 60
Western Blot test 29, 30, 38