The issue of rational suicide has long been familiar to individuals caring for the seriously chronically ill, but it has clearly entered a new era of heightened intensity and visibility. In fact, the president of the American Association of Suicidology stated in December 1993 that assistance with rational suicide is the single most significant issue in suicidology at this time. Individuals involved with HIV-related clinical and social services encounter the professional, legal, and ethical challenges of rational suicide daily. For them, the new developments in this arena have special significance.

Background: Then and Now

Though debate on this issue dates back at least to the early Greek philosophers, the current wave of social awareness was first stimulated in the 1960s and 1970s by a progressively aging population insisting that rational suicide is a “final right.” This response appeared as a natural outcome of dramatic scientific advances that changed the medical landscape from predominantly acute and treatable disorders to increasingly chronic, progressive, essentially untreatable conditions. Though rational suicide was applied primarily in terms of terminal illness, it was not exclusively so. To clarify what was “rational” in situations short of terminal illness, practitioners were pressed to define their criteria for “rational” decision-making and to express the determination of rationality in operational terms.

In the 1980s AIDS emerged, and the experience of HIV-infected patients gave enormous impetus to the demand for the means to bring about a self-determined, dignified, and non-stigmatized death. The controversy continued to escalate to the present storm of medical, ethical, and religious debate.

The trend is apparent from articles published in this newsletter seven years apart. In the November 1986 issue, Peter Goldblum and Jeffrey Moulton recommend that when faced with an AIDS patient still contemplating suicide after carefully examining the issues, “The clinician must consider taking more active measures, such as psychotropic medication or involuntary hospitalization.”1 By contrast, in the July 1993 issue, James Jones and James Dilley suggest that “It is crucial for therapists to attempt to understand patients’ circumstances, and to consider a situation in which dying with dignity is more important than prolonged life.”2

The atmosphere has clearly changed. Two states vote on initiatives to legalize assisted rational suicide—both of which narrowly failed to pass—and Oregon prepares to vote in November. Respected physicians endorse the concept in prestigious journals. The name Jack Kevorkian becomes a household word. The National Association of Social Workers becomes the first of the counseling professions to determine that it is within its ethical standards for practitioners to attend the assisted suicides of patients. The membership of the Hemlock Society soars, and the suicide “how to” book, Final Exit, tops a best-seller list for weeks. The government of the Netherlands finally gives conditional approval for physician-assisted rational suicide.3 Organized medicine and orthodox religions remain opposed, but there is broad societal discussion of these concepts.

Paralleling these developments, numerous reports confirm what was common...
Editorial: Different Ways of Dying
Robert Marks, Editor

No discussion of rational suicide begins without a recitation of the events that have made the right to die and physician-assisted suicide political issues of the day. Both of the articles in this issue of FOCUS provide a perspective on these events. None of these events is more significant to mental health practitioners and in and of itself a better reflection of society’s changing attitudes than the recent actions by the National Association of Social Workers (NASW).

The NASW is the first of the counseling professions to consider it ethical for practitioners to attend an assisted suicide of a client. According to the guidelines, while “it is inappropriate for social workers to deliver, supply, or personally participate in the commission of an act of assisted suicide when acting in their professional role... if legally permissible [under state law], it is not inappropriate for a social worker to be present during an assisted suicide if the client requests the social worker’s presence.”

The NASW guidelines also emphasize—as co-equal to the principle of client self-determination—the responsibility of social workers to be well-informed about options to suicide including: pain management, counseling, hospice care, nursing home placement, and the range of legal documents that attest to a client’s wishes concerning health care and the removal of life support.

The Ultimate Transition

The oft-repeated danger of actions like that of the NASW is that suicide will become too easy, and people who might commit suicide will be too easily manipulated by those who would assist them. This danger is real, but it is likely overstated. In the end, bringing suicide out of the closet and into therapy, even up to the moment of death, enables mental health professionals to protect against poorly considered suicides or shadowy attempts to influence dying clients.

The most important aspect of the NASW decision is that people who choose to die should not have to do so alone. If counseling is about transitions, counselors belong with clients making the ultimate transition.

This issue of FOCUS aims to help practitioners define their feelings about rational suicide and assisted suicide, and develop tools to help clients approach decisions and, if necessary, actions. Jerome Motto—by recounting the recent history of rational suicide and the clinical issues it raises—outlines a therapeutic process for discussing rational suicide. Susan Dunshee—by describing the philosophy and work of Compassion in Dying, a group that straddles the line separating legal from illegal assistance—offers a sense of what its like to be a frontline counselor, assisting people in dying.

knowledge anecdotally: individuals with HIV disease are at extremely high risk for suicide. Among infected gay men in San Francisco since 1984, suicide has been the leading cause of death after AIDS itself.

In New York City in 1985, men with AIDS between the ages of 20 and 59 had a suicide rate 36 times that for the same age-sex population without AIDS. In Stockholm from 1985 to 1990, 25 percent of the deaths in the HIV-infected population were suicides; most of these cases were among asymptomatic men. It is widely recognized that many deaths attributed by coroners to AIDS or to accidental narcotic overdose are actually suicides, some of which are assisted by friends, families, physicians, or all three. The reported 60 to 100 HIV-related calls received each month by the San Francisco Suicide Prevention Center confirm that the risk is ever-present. Current research is focusing on the relationship of the stage of illness to suicidal ideas, plans, and attempts, as well as to completed suicide.

Clinical Implications

Given the ethical and professional conflicts inherent in an assisted suicidal act, how can a clinician respond in a therapeutic way to a person considering suicide? While every therapist has a unique approach—especially when responding to such complex issues—there are common goals and principles that all practitioners share. What follows is one, but not the only, model for approaching this question.

First, “rational,” as used in relation to suicide, implies that the decision is based on a thorough and realistic assessment of all the available and pertinent facts. The practitioner as well as the patient must, therefore, carry out such an assessment before “rational suicide” can be considered. A clear state of mind in and of itself is not sufficient, and the presence of a cognitive deficit does not necessarily preclude it. Thus the first task of the therapist is to review with the patient all aspects of his or her life, to establish both a clear perception and a realistic interpre-
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References


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tation of the facts. By doing so in a meticulous and compassionate way, practitioners can assure themselves that they are aware of all the relevant information and assure their patients that practitioners understand and respect patient needs and limits. The term “realistic,” for want of a better criterion, is defined by what appears realistic to the clinician.

The inquiry would cover issues such as: the compatibility of suicide with the patient’s philosophy and prior approaches to problems that seemed insoluble; the possible effects of the suicide on others in their lives, especially children; the attitudes of significant individuals, for example, parents (even if these individuals are now deceased); the degree of ambivalence patients feel about the suicide; the resolution of unfulfilled obligations, projects, or goals; and conflicts with spiritual values.

In undertaking this assessment, it is also important to consider possible psychological origins of the suicidal impulse in individuals facing life-threatening diseases. For example, patients with HIV disease may consider suicide as a way to avoid pain and suffering, to spare others from financial and emotional hardship, to be remembered in a better state of health, to remain independent, to maintain control over their lives, and in response to the sense of having no one to live for and feeling socially isolated. Acknowledging these factors may help practitioners distinguish between rational and irrational suicide, and enhance their ability to provide emotional support.

Having examined all the facts, the practitioner’s criterion for determining rationality is the intuitive judgment, faulty as it may be, as to whether the patient’s awareness and interpretation of those facts is realistic. The practitioner might not agree with the decision, but it deserves respect if it is the best the patient can make while in control of his or her ability to reason.

If the patient seems to see all the facts clearly and still opts for suicide, the next step is to assure that he or she has thoroughly explored all alternatives to suicide, including simply temporizing. A suicidal person’s outlook can be shifted by time alone, and delaying the act does not require relinquishing the option. The tone of this inquiry is profound respect for the utter finality of suicide, so if other alternatives might be bearable, even temporarily, a patient might reasonably consider them first.

The therapist should refer the patient for a consultation with another experienced clinician—if such resources are available—both on the chance that the patient may benefit from another approach and for the therapist to obtain some confirmation of his or her own view of the situation. With the patient’s consent, the therapist should bring into the process appropriate family members or trusted friends, or other significant individuals in the patient’s life, for example, a minister or life partner. This will allow for further discussion of other alternatives and for psychological preparation, leave taking, and mutual support, and will avoid surreptitiousness or isolation.

If the family is resistant to a suicide plan, the therapist and patient should consider taking time to try to resolve the issue with them. If the patient does not want the family to know of suicide plans, the therapist may be under an ethical obligation to inform them nonetheless. Whether this obligation overrides the patient’s right to confidentiality can be decided only in terms of the specific circumstances, including the emotional relationship between the patient and family members, the physical proximity of family members, the potential harm to the counseling relationship, and the clinician’s personal philosophy about the issue. In any case, the therapist should inform the patient of any intended communication with family members or others.

What Would You Do?

When a patient challenges a clinician with the question “What would you do in this situation?” clinicians should candidly acknowledge that they cannot know what alternative they would choose if roles were reversed. If questioned about the lethal doses of medications or over-the-counter drugs, clinicians should respond to such questions openly and freely, including, in particular, information about the unpredictability of individual differences in drug metabolism. While there is no “standard practice” prescribed in such a situation, complete openness remains one of the most important attributes of the counseling relationship. Being open with patients ensures that they will be
open with their therapists, an especially important quality when dealing with life and death issues.

If a patient requests the clinician’s active collaboration—that is, assistance with the lethal act—it would be moral to comply if this were consistent with the clinician’s own philosophy, but is currently considered professionally unethical and a violation of the law. A clinician can base an ethical justification for passive collaboration—for example, providing a lethal amount of medication with information about the risks of overdose—on the principle of giving the patient a choice in the time, place and manner of his or her own death. Passive collaboration now occurs frequently, but it is not openly acknowledged.

How does a clinician decide to passively assist? Again, there is no standard of practice for this decision. There are points in clinical practice, and this is one of them, when clinicians have no better guidelines than their own intuition. They must base their judgments on all the circumstances of an individual’s case—ensuring, for example, that the patient is lucid, that he or she has considered all the alternatives, that he or she is not influenced by panic or depression—and applying their own clinical, ethical, and philosophical beliefs to this assessment.

The factors affecting the choice between passively assisting and actively assisting go beyond legal and ethical concerns. Last-second reversals of suicidal intent are not infrequent. For some individuals it is not until that final moment that the full implication of the act is clear. Only if suicide is under the patient’s continuous control can clinicians be completely confident of the non-coercive nature of the outcome.

The Future: When and How

The fact that passive collaboration now involves respected clinicians, loving families, and grateful patients suggests that socially sanctioned suicide in some form is an inevitable development. While there is an understandable fear that the option could be abused, for some individuals, the assurance of the choice of a quick, sure, painless, and dignified demise can dramatically reduce the suicidal impulse. A distinguished oncologist quotes one such patient: “The great thing was, once I knew I could do it, life became valuable again. I was back in charge.”

The conflicts of socially sanctioned suicide with the traditions of medicine and religion to prolong and revere life appear to be irreconcilable in the foreseeable future. Probably the only way this can be effectively addressed in the United States is to follow the steps the Dutch government took in 1990 to address the issue of physician-assisted suicide. In the Netherlands, assisting a suicide remains illegal, but if the act is reported to the coroner and prosecutor with specified details assuring non-abuse, the government will not bring charges. How long it will take for society to develop such a process can only be guessed at, but one thing can be said with confidence: the pressure to provide a non-stigmatized means for rational suicide will continue to grow.

The moral challenge to clinicians is to non-moralizing. In considering with patients the issue of rational suicide, our conduct is best determined not only by professional and legal codes, but by the dictates of a humane and caring spirit. It is part of our task as clinicians to nurture that spirit and trust its influence on our judgment.

Clearinghouse: Rational Suicide

References


Quill TE, Cassel C, Meier D. Care of the
People with HIV disease seem to come to one of three decisions in the later stages of their illness. Some fight to their last breath, trying every form of treatment. Others fight long and hard, up to a point, drawing the line around issues of independence or quality of life, choosing to succumb to the disease rather than receive institutional care. A third and smaller group chooses another option: actively ending their lives before being entirely consumed by the disease. Whether by prescription medication, illegal drugs, or violent means, whether with loved ones or alone, these people, determined to hasten their inevitable deaths, usually find a way to do so.

Compassion in Dying, a Seattle organization founded in 1993, seeks to support and honor the choices of people in this third group. So far, the majority of inquiries to Compassion have come from people with HIV disease, who, being knowledgeable health care consumers, have given serious thought to rational suicide even if they decide not to proceed. The experience of Compassion staff and volunteers provides a glimpse into the world of counseling people considering rational suicide.

Compassion in Dying
Compassion in Dying was formed to validate the concept of rational suicide for the terminally ill and to provide support for people requesting assistance. Operating within a framework of strict guidelines, Compassion accepts only terminally ill people of sound mind whose private physicians confirm that death is expected within a “reasonable” period of time, usually six months. This prognosis must be confirmed by at least one other physician who is affiliated with Compassion. Medical conditions must cause severe, unrelenting suffering that patients find unacceptable and intolerable. Patients must have explored alternatives to suicide, including better pain management, hospice services, and spiritual counseling if requested.

Patients must make requests to Compassion—in writing or on videotape, by themselves and not via health care directives or any other person—on three separate occasions with an interval of at least 48 hours between the second and third requests. Finally, to minimize legal complications at a time when assisting suicide represents a gray area of the law, Compassion will not assist if any close, involved family member, partner, or friend of the patient expresses disapproval about this choice.

Throughout the process, a case review team meets regularly with the patient and his or her family to explore alternatives, to further evaluate the level of family support for the decision, and to guarantee that the Compassion protocol is followed to the letter. Currently, Compassion’s work—including case review—is carried out only by the group’s executive director and the 10 founding members of its board of directors, with consultation from Compassion’s executive director.

Observing the enormous relief of the patient gently escaping from further suffering makes the experience of participating in an assisted death rewarding as well as moving.


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See also references cited in articles in this issue.
Advisory Committee of physicians and, if there is any doubt about a patient’s mental competence or state of mind, referral to a mental health professional.

The team informs the patient of the medications to be obtained from his or her doctor, and provides careful instructions about the proper and effective use of these medications. The patient must be able to self-administer the drugs. The patient decides when to take the medications, who will be present at the suicide, and whether to request the attendance of two members of Compassion In Dying.

The Compassion protocol ensures that patients and their loved ones have reviewed alternatives to suicide and have consciously and rationally accepted suicide as the preferred choice. It ensures that in preparation, patients take care of unfinished life business, and plan carefully and creatively as they approach their final hours. It deters violent suicides by offering a method that results in a deep sleep within a few minutes and a quiet death within a few hours. It facilitates the presence of a patient’s loved ones, and if desired, of Compassion members, so that patients need not die alone. It relieves the pressure on loved ones to actively assist and eliminates the potential of guilt feelings should they assist alone and the suicide fail or lead to a difficult death. Compassion has found that all of this facilitates the grieving process of loved ones.

Supporting Rational Suicide

The process of rational suicide raises many challenges for counselors facilitating or observing it, three of which are particularly important. First is determining that a suicide is indeed rational. “Irrational” suicide may be the result of severe depression or overwhelming life situations. While Compassion does not presume that everyone requesting assistance should be subjected to intensive psychological testing, members watch for “red flags” that may indicate irrational motivation: for example, an obsessive focus on suicide with no willingness to discuss options, a history of non-medically related suicide attempts, a history of clinical depression, and signs of mental incompetence. In such cases, Compassion members refer patients for psychiatric evaluation and do not proceed unless all doubts about mental state are satisfied. Compassion disqualified one patient—a 60-year-old man with emphysema—because he was obsessed with suicide, refusing to discuss or consider any alternative course of action.

Second is helping patients deal with the ambivalence their decision may raise. This occurs more often when suffering is not yet acute and when patients have time to weigh again and again the pros and cons of their choice. The process of repeatedly putting the wish to die into writing or on tape helps patients clarify their feelings and may move them to consider anew how they might cope if they were not to choose suicide. Over the course of several meetings with a patient, Compassion staff cover the patient’s spiritual and philosophical beliefs, family traditions, views about suicide, and alternatives to suicide, such as hospice care and allowing the disease to run its course without further treatment.

Third is helping families, partners, and close friends come to terms with the client’s decision and supporting them through the process. Compassion staff facilitate discussions to air everyone’s concerns and to gauge the probability that loved ones will fully support the patient’s wishes. To prepare family and friends who plan to be present at the suicide, staff describe the suicide process and the physical symptoms that can accompany dying. Compassion staff also seek to support others who decide not to attend the death.

Conclusion

For Compassion staff, observing the enormous relief of the patient gently escaping from further suffering makes the experience of participating in an assisted death rewarding as well as moving. The gratitude of loved ones for ending the patient’s agony, without violence and not in isolation, bolsters this feeling. This sort of death is not frightening, certainly not as frightening as it would be if the disease proceeded. For those for whom this is an issue of individual choice, these deaths are celebrated as victories, not mourned as defeats.

Authors

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Comments and Submissions

We invite readers to send letters responding to articles published in FOCUS or dealing with current AIDS research and counseling issues. We also encourage readers to submit article proposals, including a summary of the idea and a detailed outline of the article. Send correspondence to:

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FOCUS April 1994
Suicidal ideation in clients with a debilitating illness may not represent a wish to die, but rather, a blocked wish to live.

Counseling about Rational Suicide


Rogers JR, Britton PJ. AIDS and rational suicide: A counseling psychology perspective or a slide on the slippery slope. Counseling Psychologist. 1994; 22(1): 171-178. (Youngstown State University, Ohio, and John Carroll University, Ohio.)

Two review articles examine the appropriate role of therapists in counseling about rational suicide. The first outlines the legitimate and rational reasons HIV-infected clients may have for committing suicide and advocates for their rights to proceed. It states that the process of life review, often used by therapists to covertly convince clients to choose life, may, in the face of HIV-related issues, favor suicide, especially if the therapist is prepared to accept this choice.

If asked, practitioners should help clients explore suicide as a viable option. It then outlines the defining characteristics of rational suicide: First, individuals must possess a realistic assessment of their situation. To confirm this, therapists must determine whether or not clients understand their prognosis (both physical and psychosocial) and whether clients are aware of potential resources and alternatives. Realistic assessment requires the passage of a period of time during which clients consider and reconsider suicide. Second, the mental processes leading to a decision to commit suicide must be unimpaired by psychological illness or severe emotional distress, a factor that is particularly relevant to people with AIDS, 20 percent to 70 percent of whom may have some degree of clinically evident cognitive impairment. Finally, the motivation for the person’s decision should fit the conceptions of a “reasonable person.”

In response to this approach, the second article suggests that with the large number of HIV-infected people presenting with dementia, it is difficult to accurately identify psychological, emotional, or cognitive impairment and rule out irrational suicide. Research addressing the prevalence of central nervous system disturbances suggests that as many as 80 percent of people with AIDS have neuropsychological changes at autopsy. Moreover, as many as 25 percent of HIV-infected people experience neurological changes before the development of opportunistic infections, and mental status exams lack sensitivity to detect the mild neurocognitive impairment that might occur early in the course of HIV infection.

Suicidal ideation in clients with a debilitating illness may not represent a wish to die, but rather, a blocked wish to live. AIDS clearly represents a substantial deviation from the expected developmental process of many people 20 to 49 years old. It is more appropriate to work through these developmental issues than to collude with suicidal clients.

Finally, while a client’s decision may make sense to the client, that very rationality may cloud the client’s ability to express or be aware of ambivalence. In response, therapists must explore the proportion of ambivalence to certainty of a client’s decision. Therapists must also consider whether or not a decision to commit suicide can be rational yet transient in light of the rollercoaster effects of HIV disease.

Epidemiology of AIDS and Suicide


A large national study of death certificates confirmed that people with AIDS have elevated rates of suicide, although this rate may be decreasing. Suicide occurred among people with AIDS of all ages, throughout most regions of the United States, and the rate of suicide for men with AIDS was 7.4 times higher than for men in the general population.

Reviewing National Center for Health Statistics records from 1987 through 1989, researchers identified 165 reports of AIDS and suicide on the same death certificate. Of these, 99 percent were men; 87 percent were White, 12 percent were Black, and 1 percent were other races. Drug poisoning, firearms, and suffocation were the most common methods of suicide.

The rate of suicide among people with AIDS declined from 10.5 times the general population to 7.4 times in 1988, and 6.0 times in 1989. This may have been the result of renewed hope in the wake of advances in medical care, diminished social stigma toward people with AIDS, and increased availability of psychiatric support for people with AIDS.
Suicidal Ideation in Long-Term Survivors


A small New York study found a surprisingly low level of psychiatric distress among long-term survivors. In particular, wishes to die were context-specific, occurring almost exclusively during serious illness, often accompanied by severe pain or at times of bereavement. One out of four men spontaneously referred to rational suicide, saying that they considered suicide an option if circumstances became intolerable.

Participants were Gay Men's Health Crisis (GMHC) clients who had had an AIDS-defining illness for at least three years prior to the 1990 study. Researchers administered a 25-page, 90-minute interview, including several self-rating scales. Assessment covered physical functioning, psychological functioning, thoughts about living and dying, and past and current suicidal ideation and behavior.

Of the 54 participants: all were self-identified gay men; 24 percent were African American or Latino; 56 percent had been raised as Catholics, 29 percent as Protestants, and 10 percent as Jews; and 90 percent had attended college. Their average age was 39. Eighty-eight percent had insurance and benefits.

When feeling rested, alert, and energetic, no man reported thoughts about wanting to die. Of those who had thought about ending their lives, most said that these thoughts had occurred during specific instances of either personal illness or bereavement rather than as recurrent ruminations. Only two participants had attempted suicide after knowing they had AIDS and both had a prior history of suicide attempts. Furthermore, neither suicide attempt was related to AIDS.

The rate of depressive disorders among participants was 6 percent, not significantly different from the general population rate of 5 percent. Measures of positive mental health for the group were largely equivalent to non-psychiatric samples.

Physician-Assisted Suicide


In a small study of physicians, 24 percent of participants said they would likely prescribe a lethal dose of medication to an HIV-infected patient who requested it. More than 50 percent said they would refer the requesting patient to a mental health professional, and 41 percent said they would refer him to the Hemlock Society.

Two groups of San Francisco physicians responded to a self-administered questionnaire, including a hypothetical case study, about their beliefs and intentions concerning physician-assisted suicide: specifically, providing medications to a patient who requested them in order to commit suicide. Sixty-nine worked primarily with people with HIV disease, and 86 were randomly selected from the mailing list of the California Medical Association (CMA).

Variables that predicted the intention to assist included: believing that assisted suicide is ethical; favoring pain control and reduction of suffering over other treatments; identifying with patients in terms of age and background. Variables that did not predict the intention to assist included: personal or professional experience with HIV disease or other life-threatening illnesses; and feelings of helplessness about AIDS treatment.

Next Month

The controversy surrounding services for seronegative people in high-incidence communities has been fueled by a general scarcity of AIDS funding and an historical belief that psychosocial support is unnecessary. Over the past three years, however, with data showing a relationship between psychosocial support and HIV prevention, policy planners have accepted these services as a responsible use of resources. In the May issue of FOCUS, James W. Dilley, MD, Associate Clinical Professor of Psychiatry at the University of California San Francisco and Executive Director of the UCSF AIDS Health Project, and Thomas Moon, MS, a therapist doing doctoral research on seronegative gay men, report on a survey of seronegative gay and bisexual and their attitudes towards relationships and safer sex practices.

Also in this issue, Shirley Hansell, EdD, RN, Wendy C. Budin, MSN, RN, and Phyllis Russo, EdD, RN, all at Seton Hall University in New Jersey, examine the psychosocial and developmental challenges faced by the youngest seronegatives: uninfected siblings and children of HIV-infected people.
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