CHAPTER

4

This is

STUDY GUIDE 3

Examples of Effective Programs and Strategies

The chapter describes how practitioners have implemented three prevention and treatment programs as part of a comprehensive strategy to prevent and treat HIV among people living with mental illness and/or substance use disorders (SUD):

- Faster Paths to Treatment: a SUD bridge clinic program implementing practices to Increase Uptake and Improve Adherence to ***Pre-Exposure Prophylaxis (PrEP)***
- Louisville Metro ***Syringe Exchange Program*** (**SEP**): a ***Syringe Services Program (SSP)***
- The Alexis Project: a HIV linkage and retention program implementing both **Contingency Management (CM) and Patient Navigation.**

The three examples highlighted in this chapter were identified through an environmental scan and in consultation with experts. While there are additional programs that could have been featured in this chapter, those highlighted below were included to provide diverse examples of settings in which HIV and mental illness and/ or SUD can be addressed.

To be included, the interventions had to:

Include one or more of the practices identified in Chapter 2:

- Be replicable (well-defined with guidance materials or a manual)
- Have research to support their impact on HIV and mental illness and/or SUD, or
- be identified as a promising practice

- Provide appropriate and effective interventions for varied geographic areas, practice settings, and diverse populations

Programs should implement practices with fidelity to evaluated models. Fidelity is the degree to which a program delivers a practice as intended and must be maintained for desired therapy outcomes. However, many programs adapt chosen practices to better serve their clients. As practitioners modify practices to address the needs and constraints of their population, budget, setting, and other local factors, they should strive to adhere to the practice's foundational principles.

Faster Paths to Treatment

Boston Medical Center (Boston, MA)

Faster Paths to Treatment is a low-barrier SUD bridge clinic that opened in 2016 to address the opioid *use disorder (OUD)* epidemic and overdose crisis. It is part of a network of SUD treatment programs at Boston Medical Center, and it uses a *flexible, client-centered, harm-reduction model* to provide rapid access to medications for OUD, outpatient medically-managed withdrawal, overdose and HIV prevention services, sexually transmitted infection testing and treatment, and linkage to long-term SUD treatment and primary/ psychiatric care after stabilization. *Faster Paths serves a population with high rates of prior drug overdose, polysubstance use, and homelessness.* It is funded by the Massachusetts Department of Public Health Bureau of Substance Addiction Services.

Model Features and Elements

Recognizing the need for *on-demand services,* Faster Paths offers both scheduled and walk-in appointments and aims to provide same day access to buprenorphine (a form of medication for opioid use disorder) and HIV prevention services including testing, ***PrEP, and post-exposure prophylaxis (PEP).*** Same day services mitigate the chance of loss to follow-up and support client engagement.

Evidence-Based Practice Implemented by the Program

Practices to increase uptake of and improve adherence to PrEP

Population of Focus

People who use substances; 66 percent of clinic clients report injection drug behavior. Many clients have co-occurring psychiatric disorders and face significant psychosocial barriers to care, including housing instability.

Approximate Time Period (Duration)

Clients are typically followed in Faster Paths for weeks to months

Related Resources

Program Website

Taylor, J. L., Walley, A. Y., & Bazzi, A. R. (2019). Stuck in the window with you: HIV exposure prophylaxis in the highest risk people who inject drugs. Substance Abuse, 40(4), 441-443. https://pubmed.ncbi.nlm.nih.gov/31644387/

eReview of PrEP in PWID

Findings and Outcomes

Because Faster Paths clients often report recent potential HIV exposures, "PEP-to-PrEP" (starting on PEP and transitioning to PrEP) has been the safest, most efficient, and effective way to start PrEP for this population.[1] If a client reports being exposed to HIV within the last 72 hours, Faster Paths emphasizes PEP as a bridge to PrEP, which can be started immediately at the end of a 28-day PEP course in clients who remain HIV negative. In April 2020, 22 percent of provider visit notes (including initial visits and follow up visits) addressed PEP or PrEP.

- To support practitioners in consistently evaluating HIV prevention needs, Faster Paths has a standardized intake laboratory panel and electronic medical record note templates to assess risk of getting HIV and PrEP eligibility.

Lessons Learned

Many clients seen in Faster Paths have limited awareness about PrEP and its potential benefits as a result of not having had the opportunity to discuss PrEP with a provider in the past, limited information about PrEP within their social network, and marketing that has not been inclusive of ***people who inject drugs (PWID).***

- The way a provider discusses PrEP can be crucial for uptake. For example, it can be important to *emphasize that PrEP is recommended for preventing HIV for a wide range of populations* (e.g., PWID, men who have sex with men, and heterosexual people) to reduce stigma related to PrEP.

- Faster Paths aims to educate clients about PrEP in a manner that is *not overwhelming* (e.g., at initial or follow-up visits, depending on client preference), highlighting the ways PrEP can *benefit both the client and their* ***networks (i.e., sexual and injection drug use equipment–sharing partners),*** and emphasizing that PrEP will not necessarily be a life-long medication.

Faster Paths clients have an increased likelihood of acute HIV disease due to a current outbreak among PWID in Boston, MA. In April, 2020, 13 percent of HIV screening tests in Faster Paths resulted in a new diagnosis of HIV transmission associated with injection drug use.

Providers have expressed concern about starting same-day PrEP while awaiting HIV test results due to potential barriers to reaching the client to stop PrEP if the test returns positive.

However, providers realized when they asked the client to return to the clinic to begin PrEP at a later date, opportunities were missed due to loss to follow-up. *Therefore, if a client has a reliable method of contact, providers consider starting PrEP while HIV test results are pending.*

- Many SUD providers were not educated about PEP/PrEP during their clinical training, and the PEP/PrEP cases seen in Faster Paths are complex. To increase provider confidence prescribing PEP/PrEP in PWID, Faster Paths conducts didactic sessions with faculty, nurses, fellows, licensed drug and alcohol counselors, and administrative staff and provides real-time clinical support when PEP/PrEP questions arise.

Louisville Metro Syringe Exchange Program (LMSEP)

Louisville Metro Department of Public Health and Wellness (Louisville, KY)

The Louisville Metro Syringe Exchange Program (LMSEP) is a SSP that started in 2015. Established through the Louisville Department of Public Health and Wellness, LMSEP has two main goals:

- Prevent the spread of blood-borne infectious diseases transmitted through syringe sharing
- Link PWID to treatment

As a harm reduction program, LMSEP works with numerous community organizations and stakeholders to provide the following to PWID in the Louisville Metro area:

- Access to free and sterile syringes
- Safe syringe disposal (on site and at two mailbox disposals in the community)
- Fentanyl test strips
- Safe injection supplies
- HIV and ***hepatitis C virus (HCV)*** testing and referrals
- Referrals for mental illness and/or SUD treatment
- Counseling
- Harm reduction education on HCV, HIV, sexually transmitted infections, wound care, and overdose prevention (including providing naloxone)

LMSEP offers syringe exchange services at their main site inside the Louisville Metro Department of Public Health and Wellness. In addition, they offer mobile van exchange services at seven satellite locations during the week.

Model Features and Elements

The primary pillar of LMSEP is trust. Through its outreach work, LMSEP emphasizes accepting participants where they are and not judging them or stigmatizing them further. Staff and volunteers also tell participants that pursuing SUD treatment is voluntary and not a requirement of the program.

- Underscoring the importance of mutual respect between participants and staff, LMSEP created a Participant Bill of Rights and Responsibilities to ensure the rights and expectations of participants, staff, and volunteers are clear to all individuals involved with the program.

- During their first visit, participants are asked to complete a voluntary intake form. Using the Program Staff Check List and this intake form, staff discuss LMSEP's numerous harm reduction and treatment services with participants.

- Within LMSEP's harm reduction model, certified alcohol and SUD counselors and HIV prevention specialists provide onsite support, testing, and linkage. LMSEP staff link participants who test positive for HIV to a Kentucky Care Coordination program case manager at the University of Louisville to facilitate HIV-specific care and treatment.

Evidence-based Practice Implemented by the Program

Syringe Services Program (SSP)

LMSEP is an outpatient SSP organized by the Louisville Department of Public Health and Wellness. LMSEP offers social and health services to PWID through fixed-site and mobile van settings.

Population of Focus

PWID, specifically adults aged 18 to 25.

Approximate Time Period (Duration)

Indefinite

Related Resources

- Program Website
- LMSEP Overview (slides)
- LMSEP Brochure of Services
- LMSEP Guidelines
- LMSEP Research Brief

Findings and Outcomes

Since its establishment in 2015, LMSEP has served more than 20,000 unique participants, has had about 115,000 visits, and has distributed more than five million sterile syringes. LMSEP has also:

- Tested more than 35,000 people for HIV and referred 29 for treatment
- Tested more than 4,800 people for HCV and referred approximately 700 for treatment
- Referred 719 people for SUD treatment
- Connected more than 300 people to other community services

Since LMSEP staff began distributing naloxone, 890 participants have reported almost 2,000 overdose reversals.

- Louisville has prevented a substantial rise in new HIV diagnoses, reporting a stable transmission rate while neighboring states have experienced increases. Before LMSEP opened, the rate of new HIV diagnoses in the Louisville metropolitan region was 15.3 per 100,000 in 2014. In 2017, the rate of new HIV diagnoses was 13.9 per 100,000.[2]

Lessons Learned

Less restrictive dispensation policies (e.g., providing the number of supplies a client reports needing instead of offering one set of sterile supplies for every one set of used supplies) reduce syringe re-use and may benefit people who use injection drugs and may not directly attend a SSP.

Build community collaboration and support to counter the stigma attached to the SSP practice.

Engage partners from the start of program development throughout implementation. When assessing community readiness to start an SSP, LMSEP worked to build support with various partners and stakeholders, including political and social leaders, healthcare and social services providers, law enforcement, neighborhood associations, business owners, fire and rescue departments, the local media, and district and county attorneys.

Building trust with program participants is often difficult but especially important. In LMSEP, this trust facilitated an increase of immunizations and treatment during a hepatitis A outbreak and the ability to educate participants on COVID-19 health and safety issues.

The Alexis Project

Friends Community Center, a Division of Friends Research Institute (Los Angeles County, CA)

The Alexis Project was developed under the Enhancing Engagement and Retention in Quality HIV Care for Transgender Women of Color Initiative funded by the Health Resources and Services Administration's (HRSA) Special Programs of National Significance (SPNS). The project utilizes a multi-tiered approach to identify, engage, and retain in care transgender women of color with HIV.

The Alexis Project is named after Alexis Rivera who died on March 28, 2012, at the age of 34, from complications related to HIV. She was a proud Latina transgender woman, community activist, and peer advocate.

Model Features and Elements

The Alexis Project incorporates social network recruitment and engagement, peer health navigation, and contingency management to promote achievement of health outcomes along the HIV care continuum. Through social network recruitment, the Alexis Project recruits transgender women of color, who know they have HIV but are not in care, to the combined peer health navigation and contingency management intervention.

Peer Health Navigation (PHN):

Peer health navigators work with participants to develop a client-centered treatment plan and link them to HIV care and/or other needed services (e.g., hormone therapy, mental health counseling, substance use treatment, legal services, transportation assistance). Participants receive unlimited PHN sessions and can contact peer health navigators any time.
Participants complete a needs and barriers assessment at each session.
The goals of sessions are to:

- Identify barriers to care,
- Identify and link participants to needed services, and
- Increase participants' self-efficacy in work-ing with HIV care providers and other treat-ment facilities.

Evidence-based Practice Implemented by the Program

Contingency Management (CM), Peer Health Navigation (PHN)

Friends Community Center is a non-clinical community research center that collaborates with two medical clinics that provide HIV primary care.

Population of Focus

Transgender women of color with HIV

Approximate Time Period (Duration)

18 months

Resources on the Program

- Program Website
- Alexis Project Implementation Manual
- SPNS Initiative: Enhancing Engagement and Retention in Quality HIV Care for Transgender Women of Color, 2012-2017 background
- Reback, C.J., Kisler, K.A., & Fletcher, J.B. (2019). A novel adaptation of peer health navigation and contingency management for advancement along the HIV care continuum among transgender women of color. AIDS and Behavior. https://doi.org/10.1007/s10461-019-02554-0

Participants receive increasingly valuable reinforcers in the form of CM reward points, which are redeemable for goods or services that promote a healthy, prosocial lifestyle (e.g., gift cards, bus tickets, payment of a utility bill, clothing). Increasingly valuable reinforcers serve as motivators for HIV care-seeking behavior and are specifically awarded to participants for attending HIV care visits and reaching and maintaining HIV milestones.

Findings and Outcomes

- Combined PHN and CM intervention was found to be effective in linking and retaining transgender women of color in HIV care.
- Average time from enrollment to linkage with HIV care was 67 days.
- 88 percent of participants attended at least two PHN sessions.
- 85 percent of participants attended a first HIV care visit, and 57 percent returned for a second HIV care visit.
- 14 percent of participants escalated through the entire CM schedule to achieve undetectable status.
- At intervention completion, 85 percent of participants were linked to care, and 44 percent had achieved and/or maintained viral load suppression.
- Increased attendance at PHN sessions was associated with increased probability of achieving behavioral and biomedical CM targets.

Lessons Learned

- Program administrators should support patient health navigators in setting boundaries to prevent burnout and vicarious trauma. Patient health navigators should receive ongoing training and support.
- Implementation teams will need to train HIV clinics on providing culturally competent health care to transgender women of color.
- Programs can promote retention in HIV care by providing unlimited PHN sessions, linking participants to other needed services, and providing an increasingly valuable reward schedule based on advancement through the HIV care continuum.
- PHN can be time consuming; for some participants, it may take multiple PHN sessions to feel ready to make a behavioral change. PHN should adopt a client-centered approach and build relationships first to develop a trusting partnership that facilitates lasting change for the client.

Coordination of Mental Health and HIV Care in a Mental Health Setting

Each of the case examples in this chapter illustrates how organizations have implemented one or more evidence-based practices in a clinical or community setting. While none of these examples highlights a program that is primarily focused on mental health, it is critical that programs primarily serving people with mental illness assess their clients for HIV risk, conduct HIV testing, and provide appropriate and integrated HIV prevention and treatment services and mental health treatment to address their client's complex needs.[3x]

When first working with a potential client, mental health providers can conduct an intake and/or mental health assessment using screening tools such as the brief measure for assessing generalized anxiety disorder (GAD-7)[4] or the major depressive disorder module of the Patient Health Questionnaire (PHQ-9).[5] During this intake and screening, a mental health provider has an opportunity to discuss a client's overall health and wellbeing, including co-occurring medical conditions such as HIV.

If a client has not had a recent HIV test, mental health providers can supply a self-administered oral fluids test which can provide results within 20 minutes.

- If a client does not have HIV, a mental health provider can provide PrEP education, and support PrEP uptake and adherence (as described in Chapter 2); PrEP is highly effective in preventing HIV transmission from condomless sex and injection drug use.
- If a client has HIV, a mental health provider can link a client to HIV primary care treatment, and provide the counseling necessary to support client mental health and ART uptake and adherence (including Cognitive Behavioral Therapy, as described in Chapter 2).

For clients at risk for or with HIV, mental health providers can also connect the client to case management to address a client's unmet ancillary needs (e.g., housing, employment, transportation), which will help reduce barriers to PrEP and ART adherence.

Integrated behavioral health and infectious disease care can facilitate rapid screening, testing, and treatment, and improve health outcomes for people experiencing mental disorders and HIV. **One example of effective mental health and HIV service integration is an infectious disease psychiatric consultation service embedded within the infectious disease outpatient department in a Boston hospital. Participants were offered a comprehensive approach to depression care that included pharmacologic and ancillary psychological therapies.** When psychiatric consultation services were offered and linked to primary care, participants experienced benefits to both their mental health and HIV-related health outcomes. Participants had a statistically significant reduction in depression and viral load, and statistically significant increase in CD4 count. Additionally, a greater number of participants were prescribed anti-depressants and stimulants to treat their depression.[6]

Continue next page . . .

Photos are for illustrative purposes only.
Any person depicted in a photo is a model.

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Substance Abuse and Mental Health Services Administration

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As is clear in the description of the programs highlighted in this SAMHSA publication, untreated Opioid Use and Mental Disorders including PTSD and Depression increase the likelihood of behaviors associated with contracting HIV. Therefore, concurrent treatment of HIV and behavioral health disorders is important to effectively prevent and treat HIV. Further, pharmacotherapies and psychosocial therapies (e.g., relapse prevention, contingency management, coping skills, etc.) are essential for effective treatment of both HIV and behavioral health disorders.

The need for concurrent treatment of all disorders is further addressed in SAMHSA's *May 2021 Update of 'Pharmacologic Guidelines for Treating Individuals with Post-Traumatic Stress Disorder and Co-Occurring Opioid Use Disorders.'* HHS Publication No. SMA-12-4688, Rockville, MD, as follows:

"*Untreated PTSD in opioid dependent individuals* receiving opioid dependence therapies (methadone or buprenorphine treatment and drug-free residential treatment) *has been associated with ongoing mental, physical, and occupational disability,* despite improvements in substance abuse (Mills et al., 2007).

Symptoms of PTSD *do not improve* with opioid therapy in those with co-occurring PTSD and opioid dependence (Trafton et al., 2006). Therefore, it is important to screen those presenting for treatment with opioid dependence for co-occurring PTSD. Likewise, it is important to screen those with trauma symptoms for concurrent opioid abuse. *It is essential to develop a treatment plan that will appropriately address both disorders.*

Effective treatments for PTSD in individuals with opioid disorders include both psychosocial interventions (e.g., relapse prevention, contingency management, prolonged exposure, and teaching coping skills) and pharmacotherapies. The types and sequencing of these modalities will vary between individuals and be influenced by individual choice. Prescribers should discuss risks and benefits of medications so every individual can make an informed choice regarding different treatment options.

Psychosocial interventions are key to effective treatment of both conditions. They serve to educate individuals about both disorders, improve awareness on how these problems interact to contribute to poor outcomes, and assist in the development of coping skills to manage PTSD and opioid use disorder (OUD) symptoms (both in the early and later phases of treatment). A review of effective psychosocial interventions is beyond the scope of these guidelines, but the SAMHSA and NIDA websites provide extensive current research." -- May 2021 Update, HHS Publication No. SMA-12-4688, Rockville, MD,

The link to this Depression Rating Scale is provided by SAMHSA in its complete published document from which this course material has been extracted. You may use this and any other material found in this course document in your practice, for free.

The Montgomery-Åsberg Depression Rating Scale (MADRS)

1. Apparent sadness Representing despondency, gloom and despair (more than just ordinary transient low spirits), reflected in speech, facial expression, and posture. Rate by depth and inability to brighten up.	
0 = No sadness.	☐
2 = Looks dispirited but does brighten up without difficulty.	☐
4 = Appears sad and unhappy most of the time.	☐
6 = Looks miserable all the time. Extremely despondent	☐

2. Reported sadness Representing reports of depressed mood, regardless of whether it is reflected in appearance or not. Includes low spirits, despondency or the feeling of being beyond help and without hope.	
0 = Occasional sadness in keeping with the circumstances.	☐
2 = Sad or low but brightens up without difficulty.	☐
4 = Pervasive feelings of sadness or gloominess. The mood is still influenced by external circumstances.	☐
6 = Continuous or unvarying sadness, misery or despondency.	☐

Notes:

3. Inner tension Representing feelings of ill-defined discomfort, edginess, inner turmoil, mental tension mounting to either panic, dread or anguish. Rate according to intensity, frequency, duration and the extent of reassurance called for.	
0 = Placid. Only fleeting inner tension.	☐
2 = Occasional feelings of edginess and ill-defined discomfort.	☐
4 = Continuous feelings of inner tension or intermittent panic which the patient can only master with some difficulty.	☐
6 = Unrelenting dread or anguish. Overwhelming panic.	☐

4. Reduced sleep Representing the experience of reduced duration or depth of sleep compared to the subject's own normal pattern when well.	
0 = Sleeps as normal.	☐
2 = Slight difficulty dropping off to sleep or slightly reduced, light or fitful sleep.	☐
4 = Moderate stiffness and resistance	☐
6 = Sleep reduced or broken by at least 2 hours.	☐

Notes:

5. Reduced appetite Representing the feeling of a loss of appetite compared with when-well. Rate by loss of desire for food or the need to force oneself to eat.	
0 = Normal or increased appetite.	☐
2 = Slightly reduced appetite.	☐
4 = No appetite. Food is tasteless.	☐
6 = Needs persuasion to eat at all.	☐

6. Concentration difficulties Representing difficulties in collecting one's thoughts mounting to an incapacitating lack of concentration. Rate according to intensity, frequency, and degree of incapacity produced.	
0 = No difficulties in concentrating.	☐
2 = Occasional difficulties in collecting one's thoughts.	☐
4 = Difficulties in concentrating and sustaining thought which reduced ability to read or hold a conversation.	☐
6 = Unable to read or converse without great difficulty.	☐

Notes:

7. Lassitude Representing difficulty in getting started or slowness in initiating and performing everyday activities.	
0 = Hardly any difficulty in getting started. No sluggishness.	☐
2 = Difficulties in starting activities.	☐
4 = Difficulties in starting simple routine activities which are carried out with effort.	☐
6 = Complete lassitude. Unable to do anything without help.	☐

8. Inability to feel Representing the subjective experience of reduced interest in the surroundings, or activities that normally give pleasure. The ability to react with adequate emotion to circumstances or people is reduced.	
0 = Normal interest in the surroundings and in other people.	☐
2 = Reduced ability to enjoy usual interests.	☐
4 = Loss of interest in the surroundings. Loss of feelings for friends and acquaintances.	☐
6 = The experience of being emotionally paralysed, inability to feel anger, grief or pleasure and a complete or even painful failure to feel for close relatives and friends.	☐

Notes:

9. Pessimistic thoughts Representing thoughts of guilt, inferiority, self-reproach, sinfulness, remorse and ruin.	
0 = No pessimistic thoughts.	☐
2 = Fluctuating ideas of failure, self-reproach or self- depreciation.	☐
4 = Persistent self-accusations, or definite but still rational ideas of guilt or sin. Increasingly pessimistic about the future.	☐
6 = Delusions of ruin, remorse or irredeemable sin. Self- accusations which are absurd and unshakable.	☐

10. Suicidal thoughts Representing the feeling that life is not worth living, that a natural death would be welcome, suicidal thoughts, and preparations for suicide. Suicide attempts should not in themselves influence the rating.	
0 = Enjoys life or takes it as it comes.	☐
2 = Weary of life. Only fleeting suicidal thoughts.	☐
4 = Probably better off dead. Suicidal thoughts are common, and suicide is considered as a possible solution, but without specific plans or intenstion.	☐
6 = Explicit plans for suicide when there is an opportunity. Active preparations for suicide.	☐

Notes:

This is the end of Course 8K - Strategies & Challenges in HIV Programming for People Living with Co-Occurring SUD and/or Serious Mental Disorders.

We recommend that you take a look at the following page for an explanation about how to use ATTACHMENTS 1, 2, 3, and 4 to locate additional material (online) about program features that are mentioned in this course, now or at any time in the future.

To earn your certificate, you must pass Quizzes 1, 2, and 3, and fill out and submit the short Feedback Form. To find the quizzes, return to your My Home Page and click the name of this course on that page. You can attempt the three quizzes as many times as necessary to pass them.

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About Attachments 1, 2, 3, and 4

The following pages [Attachments 1, 2, 3, and 4] contain the list of references which have been cited by SAMHSA within Chapters 1 through 4. We have moved the reference lists from the end of each of the four chapters to the end of this course to facilitate smooth reading from chapter to chapter.

You can access these references at any time on the Internet, to further explore the treatment strategies that are cited in this course. Many of these references contain examples of downloadable assessment forms, program design options, assessment and program checklists, and other materials that you may find to be useful in your program practice.

How to find what you would like to explore further in these Attachments, now or in the future: When you find a **numbered reference** in the text of chapter 1, 2, 3, or 4 that you want to know more about, you can find an Internet link to that reference in Attachment 1, 2, 3, or 4 that takes you to that information. **FOR EXAMPLE:** Reference #46 in Chapter 1 (seen as [46]) refers to an article published by the DEA that contains many **slang terms** for each of the major drugs encountered on the street. To view that referenced document on line, go to Attachment 1 (following page) and look for reference #46. There you will find an active link to the Slang Terms document that looks like this:

https://www.dea.gov/sites/default/files/2018-07/DIR-020-17%20Drug%20Slang%20Code%20Words.pdf

Click the link and it will take you to an on-line publication authored by the DEA that contains a thorough listing of slang terms for most drugs currently found on the street. You can search that 'slang terms' document for the 'street name' or 'code name' of a drug you have heard or seen.

Most links found in these four Attachments are clickable when you are viewing the text on line. However, some URL links have been changed by the authors and publishers and are not clickable - but you can 'google' for the title of the document or the name of the author, if you wish to further explore the information mentioned in that publication.

You may now return to your My Home Page to locate Quiz 3 and any other quizzes you still need to take for this Course 8K. Click the NAME OF THIS COURSE on your My Home Page, and we will take you to the Study Guides and Quizzes download page.

Attachment 1 - Reference List for Chapter 1 of Course 8K

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