HUMAN IMMUNODEFICIENCY VIRUS (HIV-1)
GUIDELINES
FOR CHEMICAL DEPENDENCY
TREATMENT AND CARE PROGRAMS
IN MINNESOTA

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I. INTRODUCTION

I. INTRODUCTION

Chemical dependency (CD) treatment programs have a critical role to play in curbing the transmission of the Human Immunodeficiency Virus (HIV-1) and accessing services for those already infected. This is true not merely for programs situated in large metropolitan areas that serve a high proportion of IV drug abusers. Even CD programs in isolated rural areas throughout Minnesota have begun to confront the reality of Acquired Immunodeficiency Syndrome (AIDS) and HIV-1 infection. While at one time AIDS may have seemed confined to large cities on the east and west coasts of the United States, or to certain populations, it is now clear that AIDS knows no boundaries or borders. Everyone will be affected by the HIV-1 epidemic.

CD programs are at the forefront of the fight against HIV-1 for several compelling reasons. We know that sharing IV injection equipment is a high risk behavior for acquisition of HIV-1, but we also know that many CD clients, even those who have not injected drugs, have engaged in sexual behavior while under the influence that may also put them at risk. The correlation between a client history of drug and alcohol abuse and HIV-1 risk behavior is unacceptably high. And we also know that, for many people, chemical dependency treatment is a time that allows for intense self-examination and behavior change, in an atmosphere of trust and respect. Such an environment provides the client with a perfect opportunity to acquire new knowledge and to re-consider attitudes and behavior related to HIV-1. Many clients have already seized that opportunity by openly asking for help on HIV-1 issues while in treatment or aftercare programs. They have been instinctively aware that HIV-1 issues are not separate from CD treatment, but rather form an integral part of the whole recovery picture.

How can CD programs integrate concerns and activities related to HIV-1 without unduly burdening current treatment or unnecessarily muddying its message? The following HIV-1 Guidelines begin to answer that question and the many specific questions that follow. They were developed in direct response to program requests for help, guidance, and clarification. They have been formulated by the Chemical Dependency Program Division (CDPD) of the MN Department of Human Services (the State Alcohol and Drug Abuse Authority), under funding from the Minnesota Department of Health, and are targeted to all CD treatment programs and halfway houses licensed by the State. They represent the best current thinking available about the specific program issues related to HIV-1.

The guidelines are meant to be educational in addition to making specific recommendations. That accounts for the length of the document. It was our belief that we should not only indicate what programs might do or not do in particular matters, but why. The guidelines therefore present the array of alternatives on each subject, and make recommendations among those alternatives.

It is our expectation that program administrators will not simply review the guidelines, but act on them as well by developing and adopting appropriate policies and protocols. The CDPD can provide on-going support in that effort, and will supplement the guidelines themselves with occasional newsletter updates, training, and on-site technical assistance. Ultimately we need to ensure that all Minnesota CD programs respond in a similar manner, one that is consistent with current legal, epidemiological, clinical, and medical practice and thought.

II. CRITICAL FACTS ABOUT HIV-1 AND AIDS

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A. Introduction

There has been sufficient misinformation, and attendant confusion, about HIV-1 and AIDS that it makes sense to preface these guidelines with a simple, straightforward summary of the facts. Many individuals tend to think that "all the data aren't in yet," or that "what the experts say keeps changing," or that "even the scientists seem to disagree with each other." In reality we know a great deal and are learning more all the time. The essential information isn't changing, and public health officials are in agreement about the long-term reliability of that information. In other words, there is a solid body of data upon which to base policy, program, and clinical decisions and actions related to HIV-1.

B. The Nature and Action of HIV-1

Theories abound as to the origins of the Human Immunodeficiency Virus (HIV-1), the virus known to cause Acquired Immunodeficiency Syndrome (AIDS) and AIDS-related illness. Some of those theories are purely speculative, some rest on firmer logical premises. But the truth is that we are not able to answer with any real consensus, at least at this time, the question, "how did this thing start, where did it come from?" We do know, however, what it is and a great deal about how it works.

In 1981 doctors on the east and west coasts of the United States began reporting cases of highly unusual infection and disease among otherwise healthy young men. Two particular features of those reported cases gave a small group of doctors cause for concern. First, they were seeing kinds of infections or diseases rarely seen among that age group or population before. Second, the severity of those diseases or infections was sometimes astonishing. In fact, in the beginning, patients were sometimes dying before the physician even had a chance to engage in comprehensive study or diagnosis.

Compounding the confusion was the fact that those early cases were nearly all among gay men or intravenous drug users. Researchers struggled to determine the cause of this new cluster of diseases and understand more fully its effects.

When reported cases began to include hemophiliacs (who must use blood products to stay healthy) and transfusion recipients, the connection became increasingly obvious. It seemed that blood, and other body fluids with a high white blood cell count, were responsible for transmission of this new disease. It also became clear that somehow the immune systems of patients had been dangerously compromised; that people were getting sick and dying of secondary diseases and infections that resulted from a primary collapse of the body's natural defenses.

It appeared that all of the people who were getting sick with this disease were infected with a virus that acted directly on the body's immune system, rendering it sometimes helpless against common and uncommon diseases and infections. That virus was isolated and named. It was HIV-1. At the same time a name for the disease itself came into consistent usage. It was AIDS.

The name itself reveals a lot about the disease. It is "Acquired" because people "get it" by engaging in specific behaviors with HIV-1-infected persons; it doesn't "just happen", and is not spread through casual contact. It is "Immunodeficiency" because it depletes the strength of the body's immunity. And it is "Syndrome" because it is not just one sign or symptom; it rather manifests itself as a number of secondary symptoms, diseases and infections that result from immunosuppression.

Finally, researchers began to note that some people with AIDS had probably been carrying HIV-1 for a long time (sometimes years) before they got sick, while others got sick comparatively soon (6 months or less) after infection with HIV-1 had presumably occurred. During the time that patients had been <u>infected</u> but free of overt symptoms, they had also been <u>infectious</u> -- capable of passing HIV-1 to others through specific behaviors. This realization was disturbing and frightening, since it meant that people could otherwise look and feel healthy and still transmit the virus. It also raised the question, which has not yet been fully answered, of <u>how many</u> of those who were infected, but asymptomatic, would go on to develop AIDS or AIDS-related illnesses over the course of time.

The general public is accustomed to thinking strictly in terms of AIDS itself as the sole cause for concern, but this last fact casts a broader perspective. What actually happens is something like this: People acquire the virus, HIV-1, through very specific sexual and blood-sharing behaviors. (At that point the person is termed "HIV-1+", "HIV-1 seropositive" or "HIV-1-infected". The terms all mean the same thing.) But the body does not display external signs of that infection right away. Instead, HIV-1 "hides out", waiting, sometimes for many years, to take direct action against the immune system. At some point, probably because of the presence of one or more co-factors(1), the virus begins attacking key elements of the immune system. The fact that the body has been generating an antibody that attempts to ward off HIV-1 is insufficient by itself because that antibody is ultimately ineffective against HIV-1.

Because immunity is depleted, people may begin getting sick with a number of "opportunistic" infections ("opportunistic" indicates that they are infections that "seize the opportunity" of weakened immunity to take hold). Common opportunistic infections associated with HIV-1-related illness include Pneumocystis Carinii pneumonia (or PCP, not to be confused with the drug phencyclidine), a rare form of parasitic pneumonia that leaves the patient with a persistent fever, dry cough, and shortness of breath; and Kaposi's

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(1) The term "co-factors" indicates something else that has to take place before the virus is effectively "activated." Co-factors are not the same as behaviors that led to infection in the first place. For example, poor nutrition or high levels of chemical use may be common co-factors that explain why one person harboring a cold virus gets sick, while another doesn't. HIV-1 may act in the same way. Typical advice to people newly tested HIV-1+ is to reduce stress, decrease or eliminate chemical or alcohol use, get plenty of rest, and improve diet and exercise regimens. All of those things may be significant co-factors explaining why some HIV-1 seropositive persons get sick, and others seem to remain healthy for a very long time. The research, however, is not yet all in; scientists continue to learn more about what may "trigger" viral activity in the case of HIV-1. It is of interest to note, however, that proper attention to the aforementioned co-factors can be of benefit to <u>any</u> person in recovery.

Sarcoma (or KS), a rare form of cancer that is usually signaled by a purplish skin rash with lesions. Other infections include:

- Candidiasis (commonly known as thrush), a fungal infection in the mouth or esophagus;
- Cryptosporidiosis, an infection caused by a parasite that lodges in the intestines, causing severe diarrhea;
- Cytomegalovirus (CMV), a virus that causes mild to severe flu-like symptoms;
- herpes zoster (commonly known as shingles), which are small and painful blisters on the skin that follow nerve pathways;
- lymphadenopathy, an enlargement of the lymph nodes in the neck or groin; and
- Toxoplasmosis, a parasitic infection that generates fevers and other symptoms.

When people get one or more of the preceding symptoms, or other symptoms related to HIV-1, does that mean they have moved from being HIV-1+ to having AIDS? Not necessarily. In order to have an <u>epidemiological</u> diagnosis of AIDS itself, the individual must evidence a number of <u>particular infections or cancers</u>, according to epidemiological guidelines established by the Centers for Disease Control.

Between the point when people are first infected with HIV-1 and the point when they meet the case definition required for a diagnosis of AIDS, there is a wide range of clinical possibilities. Since there are myriad opportunistic infections -- some relatively "mild" and others comparatively severe -- and since individuals with HIV-1 infection could be experiencing any possible combination of those infections, it would be most accurate to refer to a "spectrum of infection" when talking about how people with HIV-1 do and do not get sick. In other words, if asymptomatic HIV-1 seropositivity were placed at one end of a continuum and "has AIDS, and is currently extremely ill" were placed at the other end, people with HIV-1 infection could fall anywhere along the continuum. The "spectrum of infection" reveals that AIDS is not an "either/or" disease, but rather a range of conditions related to HIV-1 infection. It is impossible in any individual case to predict to what degree, if at all, people with asymptomatic HIV-1 infection will "progress" along the spectrum of infection, or what specific opportunistic infections, if any, they will experience.

One more point about AIDS and how it works needs to be made to conclude this section. A medical diagnosis of AIDS does not necessarily tell us about the patient's present condition or physical well-being. People have been diagnosed with cancer, for example, and then experienced long periods of remission during which they felt and functioned normally. AIDS can work in the same way. A person may be diagnosed with AIDS because of a bout with Pneumocystis Carinii pneumonia, for example, and upon recovery feel otherwise fine and healthy for months or even years afterwards, but the diagnosis of AIDS still remains. When people meet people with AIDS for the first time, they may expect to see someone who appears obviously sickly. The point is, that <u>may</u> be the case, and it may <u>not</u>. The same holds true for persons who have developed symptoms related to HIV-1 infection, but who do not have a clinical diagnosis of AIDS -- we may expect that, because "they don't really have AIDS," they would not be terribly sick. In fact they may be quite ill, but simply haven't developed the particular symptoms or infections required for a clinical diagnosis of AIDS. Again, there is a range of conditions associated with HIV-1 infection.

C. <u>Transmission of HIV-1</u>

Despite public debate and disagreement, there is solid, reliable information about how HIV-1 is transmitted and how it's not. But mass media reporting on transmission hasn't always put the facts of transmission into proper perspective. In some instances it has detailed extremely rare cases as if they were commonplace. Understanding a few basic principles of transmission will help balance the picture.

1. HIV-1 is a very fragile virus. Once outside of the human body, it does not live long at all, generally no more than several minutes. While <u>inside</u> the body the virus can be very powerful; once it's exposed to the environment it is essentially deactivated in a very short period of time. This is <u>not</u> to indicate that if one should encounter spilled blood, one should estimate the amount of time it has been there before touching it. Universal Precautions should always be observed (see the section of the Guidelines on "Infection Control/Universal Precautions"). It <u>is</u> to say, however, that the fragility of the virus makes it hard to acquire.

2. HIV-1 has to effectively "get out of" one body and "get into" another body before the necessary preconditions for transmission are met. Fortunately, that is somewhat difficult to accomplish for two reasons. First, one's intact skin is a perfect barrier, and even if HIV-1-infected blood were to come into direct contact with unbroken skin, it could not pass through into the body and infect the individual. Secondly, HIV-1 is not an airborne virus. It is not, as mentioned earlier, passed by coughing, sneezing, or breathing the same air as an HIV-1-infected person.

3. Despite the fact that common advice has warned people against sharing "bodily fluids", the reality is that there are only a few specific body fluids that have been implicated in HIV-1 transmission. They are blood, semen, vaginal secretions (meaning the lubrication inside a woman's vagina, and not menstrual blood, which would be included under "blood"), and, to a much lesser degree, breast milk. The virus has been <u>detected</u> in body fluids such as saliva, but the amount of HIV-1 therein is simply not sufficient for transmission.

<u>HIV-1 is not easy to acquire</u>. Transmission requires certain specific behaviors or actions. While rare, almost "freakish" incidents of transmission could certainly occur, one need not worry about such cases.

So when some, less accurate reporting implies that one could get infected by, for example, shaking hands with an infected person or even kissing, it fails to make clear how extraordinary such events would be. Such reports are grossly misleading. Unfortunately, some people have taken this information and become worried about casual contact when they really need to pay attention to other behaviors <u>known</u> to account for HIV-1 transmission.

<u>In short, HIV-1 is not spread by casual contact of any kind</u>: touching, shaking hands, kissing (since kissing by itself is extremely unlikely to involve an exchange of blood, semen, or vaginal secretions), and other contact. Nor is it spread by coughing or sneezing, or sharing combs, eating utensils, towels, or soap. Uninfected people can safely use the same showers, bathtubs, and toilets as infected persons. And there never has been any danger from mosquitoes or other insects or animals. Even transfusions, which were responsible for a number of early cases of infection, are now safe because blood available for donation in the United States has been screened for the presence of HIV-1 since April, 1985.

What is <u>not</u> safe, and what has been implicated in nearly every single reported case of AIDS and HIV-1 infection, is a small set of specific sexual and blood-sharing behaviors. They include:

1. Anal intercourse,
2. Vaginal intercourse,
3. Oral sex(2),
4. Pregnancy(3) (from HIV-1+ mother to baby), and

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(2) The act of swallowing infected semen, blood, or vaginal secretions is not what transmits HIV-1; enzymes in the stomach kill the virus. One would have to have an opening of some kind in the mouth in order for HIV-1 to "get inside" and potentially infect.

(3) There have been several documented cases of HIV-1 transmission linked to breast milk; there have been a number of cases of HIV-1-infected mothers breast-feeding their babies <u>without</u> infection taking place. This is an area that requires more study. In the meantime, HIV-1+ mothers are advised not to breast-feed.

5. Needle-sharing and the sharing of other drug injection equipment.(4)

The degree to which the preceding behaviors have been implicated in HIV-1 transmission allows us to assert that if we could alter the sexual and injection equipment sharing behavior of everyone in the United States so that behaviors were within known risk reduction guidelines, transmission of HIV-1 in the United States would virtually stop. There would continue to be, of course, rare and exceptional cases, but they would not negate this central thesis.

D. Guidelines for Risk Reduction

The basic premise of risk reduction is that the blood, semen, and/or vaginal secretions of one person must not get inside the body of another person. Transfer of blood, semen, or vaginal secretions can be reduced or eliminated by adopting a number of possible strategies. The approach that works best is that which takes the unique needs, abilities, preferences, and beliefs of the individual into account.

1. To reduce or eliminate the risk of sexual transmission of HIV-1, one can:

a. Choose not to have anal, vaginal, and oral sex at all;

b. Establish a monogamous relationship with a partner who is HIV-1 negative (assuming that you are as well), and remain sexually monogamous in that relationship; or,

c. Engage in protected (safer) sex by the correct use of a latex condom or other barrier(5) every time one has anal, vaginal, or oral sex.

2. To reduce the risk of HIV-1 infection associated with the sharing of injection equipment, one can:

a. Stop using drug injection equipment altogether, e.g., discontinue IV drug use;

b. Acquire one's own supply of needles that do not get shared with anyone else; or,

c. Clean previously-used needles by rinsing them completely in bleach twice (which kills the virus) and then twice in water (which eliminates the bleach) before use.

3. To reduce the chance of a mother giving birth to an HIV-1-infected child, women who are pregnant or considering pregnancy, and who have a personal history of behavior that puts them at elevated risk of being HIV-1-infected, should consider getting the HIV-1 antibody test. Some women who have discovered their HIV-1 seropositivity have chosen to avoid pregnancy, or to terminate an existing pregnancy, rather than risk giving birth to an HIV-1-infected child. HIV-1 seropositivity information may be useful, in any case, to women who wish to determine the desired course of their pregnancy and childbirth.

4. To reduce the risk of the possibility of occupational infection, individuals and facilities must adopt Universal Precautions (see the section of the Guidelines on "Infection Control/Universal Precautions").

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(4) It is certainly possible, of course, that sharing needles for other purposes could transmit HIV-1. Blood-sharing rituals, such as blood brother/sister pacts, or amateur use of unsterilized needles for tattooing or ear piercing, could result in infection. No such cases have been documented to date, however.

(5) For cunnilingus (licking/kissing a woman's labia/clitoris), or analingus (licking the anus), one should use a dental dam or some other latex barrier.

E. Current State of Affairs and Future Directions

What is the current state of affairs with HIV-1 and AIDS, and what does the future hold? While difficult to summarize in just a few short paragraphs, it seems that there is cause for both optimism and pessimism.

On the negative side, the numbers are growing every day, and are likely to rise for quite some time. As of August, 1989, nearly 100,000 cases of AIDS have been reported in the United States. By the time the Guidelines have been issued, that number will be significantly higher. In addition, there are nearly 1.5 million people in the United States currently estimated to be infected with HIV-1, and as many as ten million HIV-1-infected people around the world. Reliable projections indicate 365,000 accumulated cases of clinically diagnosed AIDS in the United States by the year 1992 -- no more than a few years away.

Despite purported "breakthroughs" that are sometimes heralded in the mass media, researchers are still a long way off from a workable vaccine, much less a cure. It is unrealistic, and potentially dangerous, to expect a "miracle drug" any time in the near future. HIV-1 is simply too complex, and current technology too inadequate, to allow for an easy solution.

Part of the bad news, then, is that society really hasn't even begun to feel the full impact of AIDS. Even now it is having a profound effect on public policy, social service delivery, medical care, insurance, and even international travel -- not to mention relationships, family life, personal expectations of the future, and collective attitudes about sexuality, gay men and lesbians, drug use, and a host of other realities. In the future, change in those areas is likely to be even more dramatic.

Despite the crisis, there is good news as well. AIDS has now become a household word. Community service and education organizations have sprung up around the country, and have entered into new partnerships with state and local governments to fight the epidemic. Medical costs have been effectively contained in many areas, mainly by emphasizing home health care with the assistance of family, friends, and lovers. Education that emphasizes behavior change has, in some communities, successfully reduced the rate of infection. New medical treatments have been developed to both slow the rate at which the virus replicates and to alleviate symptoms associated with AIDS-related infections, allowing people with AIDS to live longer, and live better. They have been productively combined with alternative therapies that emphasize a positive outlook and a focus on "healing oneself" rather than a preoccupation with death and despair.

But the future will be enormously difficult. Adequate funding for research, care and education remains a continuing problem. Current partnerships need to be broadened and strengthened, so that society stands "united against HIV-1" rather than "divided against itself." Communities that have been disproportionately affected by AIDS -- gay men, people of color, and so on -- will need continuing support and encouragement, so that a "backlash" of hatred and bigotry is prevented. As much as there is to be feared in this epidemic, there is much to learn -- about how to treat people with sensitivity and dignity, about building community, about living and dying, about love and relationships.

F. Summary

Despite fears and uncertainties to the contrary, we understand a great deal about HIV-1, how it works, how it is transmitted, and how to dramatically reduce the incidence of further infection. We know everything we need to know in order to develop policy and/or adopt guidelines about HIV-1 and HIV-1-related issues in CD treatment and care programs.

G. Resources

If you have further questions about:

The epidemiology of HIV-1 and AIDS, current case numbers, and other related questions, call the Minnesota Department of Health at 623-5414;

Psychosocial issues, personal concerns, or behavior change to reduce HIV-1 infection, call the Minnesota AIDSline at 870-0700 (Twin Cities metro) or 1-800-248-2437 (Statewide toll-free);

The CDPD HIV-1 Guidelines, implementation of policy or guidelines, or HIV-1 and AIDS training for CD providers, call the Chemical Dependency Program Division, Minnesota Department of Human Services, at (612) 296-4767.

III. EQUAL ACCESS TO SERVICES

Recommendations: Chemical Dependency treatment and care programs should adopt policy that clearly acknowledges full access to services and employment for HIV-1 antibody persons who are otherwise qualified. In addition, programs should educate all staff about non-discrimination laws related to HIV-1 infection and AIDS.

III. EQUAL ACCESS TO SERVICES

A. Introduction

Legal rulings and regulations about discrimination and access to services in relation to HIV-1 are predicated on a number of scientific facts and clinical observations. They form the basis for our thinking about working with people who are infected or who have AIDS.

First, since HIV-1 is not transmitted through casual contact, but rather through specific behaviors, there is no scientific basis for segregation, isolation, discrimination, or substandard provision of services. The rationale for discrimination or enforced isolation is fear, not fact.

Second, there is no clinical or psychosocial advantage to be achieved, either by people with HIV-1 or AIDS, or by those around them, in enforced discrimination or isolation. In fact, only psychosocial damage, in the long term, will result.

Third, there is no reason to suppose that people with HIV-1 or AIDS do not need to utilize social services available to those who are not infected. In some areas, such as chemical dependency, the need for access may be more compelling. While people with HIV-1 or AIDS may require specialized services or supports at various times, those requirements do not negate the need for mainstream services.

Finally, AIDS and HIV-1 seropositivity are disabilities, as much as blindness or mobility impairment. Our political, legal, and moral tradition asserts firmly that people with disabilities should not be mistreated or separated from the mainstream of life.

It is important to note before continuing further that, although this section addresses certain legal questions related to HIV-1 and AIDS, nothing herein should be construed as legal advice on specific questions. Program providers should always consult an attorney competent in the area of concern when faced with situations that may involve legal liability.

B. The Federal Rehabilitation Act of 1973

Section 504 of the Rehabilitation Act of 1973 (commonly referred to simply as "504") was enacted as federal law to protect the civil rights of individuals with handicaps. It is the major legal foundation, on the federal level, for non-discrimination against people with HIV-1 or AIDS. Section 504 prohibits discrimination "solely by reason of...handicap against any otherwise qualified person in any program or activity receiving Federal funds or conducted with Federal funds."(1)

In 1988 Congress amended the Act in a manner that makes it clear that the "handicaps" covered by the Act include AIDS. The U.S. Department of Health and Human Services has also formally ruled that AIDS is covered by the Act. Because the Act applies to past and perceived handicaps as well as current ones, its precautions also extend to persons who have a history or record of AIDS-related conditions, as well as people who are HIV-1 seropositive or perceived, even incorrectly, to be HIV-1 seropositive.

As stated, the Act applies to all federal agencies, as well as any "program or activity" that receives federal financial assistance. Since most social service agencies, including chemical dependency treatment programs, receive federal money directly or indirectly, the Act applies.(2)

The Act protects three groups of people broadly defined as "individuals with handicaps":

1. people who have a current "physical or mental" impairment that substantially limits one or more of their major life activities;
2. people who have a history or record of such impairment; and,
3. people who are regarded or perceived as having such an impairment.

Only those handicapped persons who are "otherwise qualified" are protected by the law. (3)

C. "Otherwise Qualified" and "Reasonable Accommodations"

What does "otherwise qualified" mean? Simply, that the person in question meets other conditions or pre-requisites for access to services or employment. If one is the director of a treatment program for women, and an HIV-1-infected man applies for admission, he may not be "otherwise qualified," and one would not be guilty of handicapped discrimination to reject his admission request.(4) If the person does not "meet the essential eligibility requirements," he or she does not have to be admitted by extenuating virtue of his or her handicap.

The Act also specifies that "reasonable accommodations" may have to be made, provided they do not cause the program undue financial hardship or change the basic nature of the program. If all the CD treatment programs in the state were housed on the third floor of buildings that had no elevators or electric stairs, CD services might be effectively barred to all persons using wheelchairs for mobility. But if a third floor CD program could use space on the first floor for outpatient groups, and the first floor were accessible otherwise, then the program may have made a "reasonable accommodation" that allows for the participation of a wheelchair-using client. On the same note, if first floor space were completely unavailable, and the only solution was the installation of an elevator, many (though not all) programs would properly experience the cost as "undue financial hardship."

What does this mean for clients who are infected with HIV-1 or who have AIDS? It means that clients must be admitted as long as they are "otherwise qualified," that is, they meet the terms and conditions for program admission. It does not mean that programs are required to take any client who is HIV-1 seropositive -- provided that the reasons for

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(1) 29 United States Code 794.

(2) Because Federal funds are included in Minnesota's Consolidated Chemical Dependency Treatment Fund (CCDTF), all CD treatment programs accepting CCDTF clients must comply with the Rehabilitation Act of 1973, as amended.

(3) Legal Action Center of the City of New York, Inc., AIDS: A Guide to Legal and Policy Issues, Legal Action Center, 1988.

(4) Of course, it is possible that the program, in this situation, could be guilty of gender-based discrimination.

refusal are not based on the client's seropositivity status. It also means that, in admitting, programs may have to make "reasonable accommodations." For example, if a client with AIDS is experiencing fatigue in a CD program that sets aside regular time for structured physical exercise, it could be a reasonable accommodation to excuse the client from active participation in that exercise.

All of the preceding apply in employment cases as well. As long as someone is "otherwise qualified" they must be considered equally for employment. If "reasonable accommodations" need to be made in order to hire the person, they must be implemented.

D. Minnesota Statutes

Several state governments have expanded federal rulings with respect to discrimination and disability. Such is the case in Minnesota. Minnesota Statutes, Chapter 363, explicitly prohibit discrimination against any person who is "materially impaired". That prohibition applies both to employment and access to services, and in Minnesota, obliges all businesses, including those that do not receive Federal funds.(5) One cannot refuse admission or employment to a disabled person who is otherwise qualified. The Minnesota Department of Human Rights clearly interprets the Minnesota Statute to prohibit discrimination against all persons infected with HIV-1, and has already acted successfully on that interpretation a number of times.

E. Minnesota Department of Health Rules for Supervised Living Facilities

Many freestanding residential treatment programs (including non-hospital programs, halfway houses, and board and care facilities) are licensed under the MDH Rules for Supervised Living Facilities (SLFs). Some of those rules have caused confusion when it comes to admitting clients who are known to be HIV-1 positive. However, the 1989 Minnesota Legislative Session amended the licensure law in a way that eliminates the confusion. The following outlines the old procedure and the new amendment.

Minnesota Rule 4665.0900 for supervised living facilities prohibits SLFs from accepting residents having or suspected of having a communicable disease. Until recently HIV-1 qualified as such, indicating that strict interpretation of the rule would prohibit SLFs from admitting clients known to be HIV-1+. That interpretation was in obvious conflict with federal and state laws that prohibit refusal of HIV-1+ clients who are otherwise qualified. Therefore CD programs had to comply with both state and federal laws prohibiting discrimination, and the conflicting SLF rule, by securing a waiver to the SLF rule. Programs were required to contact the Minnesota Department of Health in order to acquire a waiver that would allow for the admission of an HIV-1+ client.

A number of CD programs, as well as state agencies, found this process cumbersome. Therefore, the 1989 Legislature amended the law to specify that SLFs must admit, as a resident, a person infected with HIV-1, unless the facility cannot meet the care needs of the individual. The statutory language supersedes the provision in the rules.

The 1989 amendment means that the need to secure a waiver for admission of HIV-1+ clients in an SLF has been eliminated. Programs that have been operating on the basis of the need to secure an HIV-1+ waiver no longer need to do so. They can simply admit HIV-1+ clients from now on without securing a waiver from the Minnesota Department of Health and without being in violation of the rule.

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(5) Minnesota Statutes, Section 363.

F. What Would HIV-1 or AIDS-Based Discrimination Look Like?

There are a number of situations CD providers have faced which may or may not fall under the purview of Federal and State anti-discrimination laws as they relate to HIV-1. Since the application and judicial interpretation of these statutes is always based on the facts and circumstances of an individual case, the CDPD of DHS is not in a position to state with legally reliable impunity that discrimination has or has not occurred in a particular situation. Programs are always encouraged to seek the advice of private counsel, the Minnesota Human Rights Commission, or the Civil Rights Commission of the U.S. Department of Health and Human Services (listed at the end of this chapter) when they encounter dilemmas that may involve discrimination.

We can, however, outline some of the predicaments that Minnesota CD programs have experienced, and urge programs to secure competent legal advice if they find themselves faced with similar decisions.

1. A treatment center, in considering the admission of a new client, finds out upon examining the client's case file that she had been tested for HIV-1 antibody, and that the results were positive. Until that point was noted, the treatment center was leaning toward admission of the client. However, the program contemplates refusing admission on the basis that "we aren't really set up for that sort of thing [working with an HIV-1+ client] yet."

2. A supervised living facility admits a client known to be HIV-1+. Program staff are very uneasy about his admission. The particular fear that keeps emerging in staff discussions is that "he might have sex with one of the other clients, and then we'd be liable." Since clients do sometimes have sex with each other, despite a no-sex-while-in-treatment policy, it is certainly not impossible that the new client might do the same. Program staff consider handling the situation by requiring the HIV-1+ client to sign a disclaimer stating that "I will not have sex with anyone else while in treatment; if I do I understand that I will be asked to leave the program immediately."

3. A residential CD program admits an HIV-1+ client. The program accommodates 20; each client shares a room with several other clients. Worried about possible infection, program staff proposes to move one of the beds out of a room that accommodates two, so that the HIV-1+ client can be assigned a room by himself.

4. A halfway house admits a client who has some HIV-1 related infections, but does not have AIDS and is generally healthy. Clients in the halfway house are expected, as a condition of treatment, to "pull their own weight," where everybody takes rotating responsibility for chores such as cooking and cleaning. It has been suggested, however, that the new client should be excused from two areas of chore responsibility: work in the kitchen, and cleaning in the bathroom. Of course, there are many other duties to perform, and she is assigned other tasks to make up for whatever time she would have spent working in the kitchen or the bathroom.

5. An outpatient CD treatment program is interviewing candidates for a new group supervisor position. The top three candidates all appear very capable, and it seems like a difficult decision. One of the three notes on his resume that he has done a significant amount of volunteer work for a local AIDS service organization, leading support groups for people newly tested seropositive. Worried that people in the community and significant others of those in the treatment program might react negatively if they knew there was an HIV-1-infected person on staff, one of the interviewers considers asking this candidate, "Are you positive for the virus?...I mean, is that part of what motivated you to get involved in AIDS?"

6. A staff member in a CD program, upon finding out that one of the clients is seropositive, states, "Well, it's fine with me if she's here -- I just don't want her on my caseload." Concerned about alienating or perhaps losing a valuable employee, this person's supervisor would like to oblige the employee's request.

What should these programs do in order to prevent discrimination and comply with the law? The answer, of course, is that the facts of every case are different, and these Guidelines cannot make definitive judgments or recommendations. However, it deserves to be firmly asserted, beyond the intricacies of particular events, that CD treatment programs should not attempt to avoid treatment or employment of people who are HIV-1 seropositive unless there is valid cause unrelated to disability.

G. A General Disclaimer

Legal matters are inherently complex, and rarely lend themselves to absolute solutions for all conditions. This section of the Guidelines limits itself to general principles; none of the foregoing should be considered legal advice or interpretation on specific cases. When CD programs are faced with legal questions or concerns, especially those that do not "fit neatly" into standard interpretations, it is a profound mistake to attempt resolution without competent legal advice. Trying to resolve legal problems simply by reading an article, or on the basis of mass media information, can be dangerous and yield unforeseen consequences. When in doubt, contact your program lawyer or one of the resources listed below.

H. Resources

Legal Program, Minnesota AIDS Project
2025 Nicollet Avenue South
Minneapolis, MN 55404
(612/870-7773)

Minnesota Department of Human Rights
500 Bremer Tower
7th Place and Minnesota Street
St. Paul, MN 55101
(612) 296-5663 -- Voice
(612) 296-1283 -- TDD

Office for Civil Rights, Region V
U.S. Department of Health and Human Services
105 West Adams Street
16th Floor
Chicago, IL 60603
(312) 886-2359 -- Voice
(312) 353-5693 -- TDD

Your agency attorney

IV. HIV-1 EDUCATION

Recommendation: Chemical dependency treatment programs should provide for the comprehensive education of all staff and clients on HIV-1 and related issues. The fundamental focus of that education should be behavior change.

IV. HIV-1 EDUCATION

A. The Necessity of HIV-1 Education

Every chemical dependency treatment program or care facility has a minimum responsibility to provide every client, and all staff, with basic education about HIV-1, for a number of reasons.

1. Clients with a profile of alcohol or drug abuse often have a history of impaired judgment about behaviors that directly correlate with transmission of HIV-1. Regular intoxication, for example, can increase the likelihood of unsafe sexual behavior or sharing of drug injection equipment. It is essential, therefore, that CD providers provide basic education to <u>all</u> clients whose addiction and associated behaviors (whether or not those behaviors are revealed to program staff) increase the risk of contracting and transmitting HIV-1.

2. As HIV-1 continues to spread through the population, there will be increasing numbers of HIV-1-infected clients. Many programs have already served HIV-1-infected clients, sometimes without knowing it. There is every reason to believe that in the coming years most CD programs will be working with HIV-1-infected clients.

3. It is the collective mission of chemical dependency care and treatment facilities to support the physical, emotional, and spiritual well-being of addicted or affected clients. Since HIV-1 infection can be a significant barrier to that well-being, programs will want to do what they can to make sure seronegative clients stay that way, both in treatment and afterwards, while they are on the road to recovery. If programs have helped to prevent HIV-1 infection, they have acted in the best interests of clients.

4. Programs are in a similar position with staff. Program directors and managers want employees to stay healthy, both because they are valued workers and because a healthy staff will minimize program disruptions.

5. CD programs may be, for many clients and some staff, one of the few sources of comprehensive information about HIV-1 and AIDS. Other than the mass media or the often unreliable reports of peers, clients may have few other sources for accurate information and reliable advice.

6. CD program staff well understand the nature of addiction and its effects. They will be perceived by clients, therefore, as credible and dependable sources of information. Clients will <u>look</u> to staff as HIV-1 educators, even when staff fail to recognize their role as such.

7. The supportive environment of a CD treatment program provides a safe and trusting environment in which to initiate and negotiate behavior change. Clients have already demonstrated, by their presence, at least some willingness to examine and alter their behavior.

8. CD programs will want to minimize the disruptive crises that can occur when staff or clients react inappropriately to a known case of HIV-1 infection in their midst. Some facilities, having failed to undertake adequate proactive education, have found themselves in treatment disarray after receiving an HIV-1-infected client, because others, who were uninformed or misinformed, reacted hysterically or insensitively.

9. Systematic education of all clients and staff about HIV-1 minimizes potential legal liability. Educated staff and clients are less likely to behave in ways that may invite legal claims against the program.

10. CD treatment and care programs will want to make sure that staff or clients are not mistreated because others <u>perceive</u> them to be HIV-1-infected -- even when they're not. And as an earlier section of the <u>Guidelines</u> pointed out, mistreatment based simply on <u>perception</u> of HIV-1 seropositivity is illegal. The less educated people are about HIV-1 and AIDS, the more likely they are to assume incorrectly that, for example, "if you're gay, you must have AIDS."

11. And, finally, clients or staff who <u>are</u> seropositive deserve sound information about health maintenance. A program that has provided education to all staff and clients is more likely to meet those needs and goals.

B. <u>The Nature of HIV-1 Education</u>

There are two fundamental principles that guide the provision of HIV-1 education for staff and clients. The first is that <u>mere exposure to information does not equal education</u>. Another way of saying the same thing is that <u>the final goal of HIV-1 education is behavior change</u>. Simply because programs have made brochures available, or arranged screenings of videotapes, does not mean education leading to behavior change has taken place. The process of learning and changing is much more complex than that, with a host of variables.

The second guiding principle is that <u>education should include roughly the same comprehensive content for everyone</u>, though, obviously, staff education may include more detail or elaboration. Everyone needs to know what HIV-1 is, how it is transmitted, how it is <u>not</u> transmitted, and how individuals can protect themselves from infection in both their personal and professional lives. And it is unreasonable to expect that staff can provide such education for clients without having received training first.

HIV-1 education must be delivered to <u>all</u> clients. There is one compelling argument for this assertion: because of shame and guilt, because of embarrassment or fear of condemnation, it is unrealistic to expect that clients will tell CD counselors the absolute truth about their sexual or IV drug use histories. This assertion is still true even though CD treatment is founded on the importance of honesty, both with self and others. For example, a client may not reveal the affair he had with another man because he doesn't want his wife to find out. Another may be too ashamed to mention IV cocaine use. A third may be afraid to tell of multiple sexual partners, because she is afraid of being thought of as "loose". Sometimes, in CD work, it's simply that people can't <u>remember</u> everything that took place in the previous five years. For whatever reasons it cannot be assumed that what people disclose about their risk histories is the complete story. The danger, of course, is that educational strategies and content based only on what people disclose will neglect some very important factors, as well as some critical opportunities. The natural tendency is to heavily emphasize safer sex strategies with a gay client who reports multiple partners, but to gloss over that aspect with a female client who reports she has been happily -- and monogamously -- married for ten years. However, for the reasons just outlined, that tendency could have undesirable, even painful, consequences.

Does this mean, for example, that every single client should be instructed in the details of condom use for anal intercourse? Not necessarily. The CD counselor will need to use his or her best judgement about what is appropriate or inappropriate for a particular client. But it does mean that the CD counselor should be willing to question that judgment and any assumptions upon which it may be based. The central criterion for educational appropriateness is the client's needs and feelings, not the counselor's.

C. The Behavioral Focus

If the focus of education is behavioral, rather than merely cognitive, what kinds of behavior are targets for change?

The first is behavior that puts people at risk of HIV-1 infection. This includes sexual and injection equipment-sharing behaviors, pregnancy-related risks, and, to a much lesser degree, occupationally-associated risk.

The second is behaviors toward others who are already HIV-1-infected, as well as people or groups of people perceived to be HIV-1-infected -- which certainly includes gay men and lesbians, IV drug users, prostitutes, and, to an increasing degree, Blacks and Hispanics or other people of color.

In other words, the mission is to ensure that everyone who is currently seronegative stays that way, and that everyone who is seropositive, or perceived to be seropositive, is treated with respect and dignity, not hysteria or rejection.

In the long run, it won't be sufficient for clients to know the information about risk reduction but fail to act on it. Similarly, it won't be enough for staff to think to themselves, "I know intellectually I can't get infected from casual contact," but avoid people with AIDS nevertheless, "just in case."

D. Educational Strategies

Experience and research is fairly clear in pointing out that some educational strategies and methods are more likely to support behavior change than others -- though nothing guarantees it. For example:

1. Current research indicates that the most potent motivator for change is actually knowing someone with AIDS. The implication is that if clients or staff don't know anyone, education must be personalized as much as possible, and framed in a manner individuals can understand and relate to emotionally. Mere recitation of abstract statistics is not likely to accomplish that task.

2. Information is best presented in a way that is accessible and easily understood. Many people simply do not comprehend the mechanics of retroviruses, the complexities of immunity, or the principles of epidemiology. That knowledge needs to be translated so that it fits within the layperson's worldview and understanding.

3. Education ought to acknowledge and respect the diversity of audiences and clients. Approaches that work with white men may not work with women of color, and styles effective for teenage audiences may not be successful for older adults. HIV-1 has affected a wide spectrum of communities and cultures, sometimes in very different ways. Gay men and lesbians, people of color, heterosexual women, disabled people, and other groups deserve education that is sensitive to their unique needs and realities.

4. Individual learning styles vary significantly. People will learn best when education is uniquely matched to personal learning styles. A single approach that emphasizes videotape education, for example, will not prove effective for individuals who do not learn well from visual modes of instruction. Since CD treatment programs are not always in a position to assess learning styles, a multi-faceted approach, that employs a variety of styles, is best.

5. Since the information on HIV-1 and AIDS is sometimes complex, individuals will probably require repeated exposure to facts. This does not mean viewing the same

videotape over and over again; it does mean presenting basic information in a variety of formats and settings.

6. People are more likely to change their behavior if consequences -- both positive and negative -- are immediate and tangible. Even the possibility of death in the context of AIDS is elusive, and slightly unreal to many people. To tell a teenager, for example, that "you may get infected with a virus sometime over the coming years, that may kill you sometime in the 15 years after that, unless you change your behavior," is exceedingly abstract. "I won't have sex with you unless you wear a condom" is much more immediate and tangible than "one of us could be infected, and infect the other, which could make us sick at some point in the coming years."

7. People cannot change their behavior unless they are given detailed strategies for doing so. If educators assert, for example, that "you should practice safer sex," without explaining explicitly how, they have neglected an essential ingredient in the HIV-1 and AIDS curriculum. Even advising clients to use condoms may be insufficient, since condoms are only effective if used every time, and properly -- and even then, they cannot be said to be foolproof.

Similarly, it is inadequate merely to advise clients to stop sharing drug injection equipment; the fact that they are non-prescription items available at pharmacies(1) in Minnesota needs to be conveyed, as well as detailed methods for cleaning one's "works".

What about the client who says, for example, "I don't need to know that stuff"? She or he may be uncomfortable talking explicitly about safer sex or risk reduction, but discomfort alone is insufficient grounds for dropping the educational effort. The temptation may also arise to avoid the topic because the avoidance accommodates <u>the counselor's</u> sense of discomfort. A good way to get around the discomfort, and still get important information across, is to approach the discussion obliquely. The counselor can say, "you may not need this information for yourself, but you might know someone -- a friend, perhaps -- for whom it could be helpful; so I'd like you to take the information and pass it on to them, and help them out." With such an approach, the individual can learn what she or he needs to know and "save face" at the same time.

It deserves to be noted that some of these proposals have placed the field of CD counseling in a philosophical and ethical dilemma. The suggestion that CD counselors should instruct clients in the ways and means of "safer needle use" seems to contradict the widely and deeply held belief that complete abstinence is essential to recovery from alcohol and drug abuse. "If we tell clients how to acquire and clean their 'works'," a number of professionals have asked, "aren't we tacitly approving continued drug use?" It is a difficult question to answer, because although abstinence may be the ultimate goal, a sizeable portion of clients completing CD treatment programs will relapse. And for clients who use IV drugs, this means that they may expose themselves to HIV-1 even after completing CD treatment.

CD counselors do not need to condone relapse, however, in relating critical information about risk reduction. In fact, the approach mentioned above may work best in navigating the precarious waters of the philosophical dilemma. The counselor can say, for example:

> "I fully expect that you're going to hang on to your sobriety after you get out of treatment, that you're not going to shoot up again. But my guess is that you know other folks who are still shooting up. Of course, as someone who cares about them, you would want to see them get into a treatment program. But we know that doesn't always work. Given that, I'm worried about AIDS, that you might have

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(1) It should be noted that although needles and syringes are available as non-prescription items, individuals can still be prosecuted for their possession under state drug paraphernalia laws. The charge is a petty misdemeanor, and carries a fine of up to $200.

> friends who are at risk. If they won't get into treatment, they should at least stop sharing their works, or they should clean their works. And you might be the best person to tell them about that. So I'm going to pass some of that information on to you, so that you can pass it on to them."

Such an approach allows the CD counselor to underline the long-term value of abstinence, while still providing essential details about risk reduction techniques. It may very well be that the counselor has educated the client directly, rather than the client's "friends", but at least the counselor has done so in a way that is consistent with dominant philosophy in the field of CD treatment and care.

8. HIV-1 is a topic often clouded by strong emotions and firm beliefs. It is essential that people are given, in the process of education, a chance to express those beliefs and emotions, without embarrassment or shame. Behavior change itself is usually accompanied by fear or nervousness. Education should therefore avoid simply "lecturing at" people, and adopt interactive formats instead.
9. Finally, educators and counselors need to be clear on their own values and attitudes about sexuality, sexual behavior, pregnancy and abortion, and IV drug use, being careful not to let those values sabotage the educational effort. Although counselors may not be completely comfortable with matters related to sexuality or specific behaviors, they do need to acknowledge their own discomfort or beliefs when they intrude.

E. Staff Education

Comprehensive education of staff about HIV-1 addresses several basic topic areas:

1. The fundamentals of HIV-1 and AIDS (i.e., what they are, how transmission occurs, discussion of fears related to casual contact);
2. Strategies for personal risk reduction and how to avoid transmission;
3. Strategies for occupational risk reduction, or "infection control";
4. HIV-1 antibody testing;
5. The psychosocial and clinical realities associated with HIV-1 infection or AIDS;
6. Reviews of fundamental laws and statutes regarding confidentiality and access to services;
7. An orientation to existing program policies and procedures relating to HIV-1 and AIDS; and,
8. An overview of existing resources available for HIV-1-infected persons in Minnesota.

There are several logical formats or settings in which staff HIV-1 and AIDS education can take place.

1. The information can be integrated into new employee orientation. New staff could be handed a packet that includes printed policy statements and basic background literature on AIDS. Or, they could be asked to watch an introductory video, or attend a community workshop. (The organizations listed at the end of this section can advise on selection of resources.) At the very least new staff should be expected to read and "sign off" on any existing program policies that relate to HIV-1; at best, those policies can be the basis for discussion, presentations, and hands-on training.
2. HIV-1 training can be integrated into an on-going inservice education calendar, conducted on-site for employees. Some programs are scheduling AIDS Update evenings once a year, some much more often -- every month. A three-hour inservice training for all staff can touch on the basics of HIV-1; additional training on specialized topics, e.g., "Family Issues and HIV-1," can be scheduled on an as-needed basis. Inservice training can be presented by an in-house staff person who has completed an extensive training program, or by external personnel (such as those listed at the end of this section).

3. Staff can take advantage of a wide array of external training events and workshops on all aspects of HIV-1. The Chemical Dependency Program Division, for example, makes available three-day, one-day, and shorter trainings. Many other agencies and programs offer regular education seminars at little or no cost. Every county in Minnesota has a community health service that can now provide education on the basics of HIV-1.

4. CD programs do not have to develop all educational programs -- or be able to deliver them to staff -- single-handedly. There is a growing number of resources and resource people around the state that can be easily accessed.

F. Client Education

Client education covers virtually the same topics as staff education, with slight variation. Comprehensive client education addresses:

1. The fundamentals of HIV-1 and AIDS;
2. Strategies for personal risk reduction, including not only the mechanics of risk reduction but interactive and relationship concerns;
3. Relevant treatment program policies regarding HIV-1;
4. HIV-1 antibody testing;
5. Confidentiality rules and expectations; and,
6. An overview of HIV-1 resources in Minnesota, minimally to include the telephone number of the Minnesota AIDSline (metro and state-wide toll free).

Opportunities for client education are seemingly innumerable, even in non-residential or short-term treatment programs.

1. Education can be part of the intake process. The easiest method is to hand all new clients a packet of written information. If there is time, a portion of the intake interview could be devoted to a discussion of HIV-1.
2. HIV-1 education can be integrated into one-on-one counseling with a primary counselor. When clients raise personal issues about sexuality, relationships, IV drug use, or pregnancy, the counselor is presented with a perfect opportunity to not only respond to the issues, but to disseminate HIV-1 information as well.
3. Some client therapy groups seem ideally suited for discussions about HIV-1. Sexuality groups, men's and women's groups, health classes, and even family sessions all offer appropriate occasions to provide education, either formally or informally.
4. As with staff, clients can be offered regular presentations on the basics of HIV-1 and personal risk reduction. Some programs are scheduling such lectures in a manner that guarantees each client will attend at least one during the course of treatment.
5. Staff can make written materials readily available, as well as videos that can be viewed during "non-therapy" hours (especially in residential programs).
6. Some programs are making use of special community events, allowing current clients to attend as a group. In Minnesota, for example, there are touring productions of plays that deal with the subject of AIDS. Increasingly, other special arts or community events devoted to the topic will become available.
7. Finally, HIV-1 education should be reinforced as a part of discharge or aftercare planning. Program departure is an excellent time to review personal risk reduction strategies, and to make the client aware of community-based HIV-1 resources that can be helpful in the future. Some programs have even chosen to dispense condoms to clients as they leave treatment.

It is relatively easy to integrate client AIDS education into treatment programming. Making sure that clients receive information packets during intake interviews, maintaining a library of video resources for client use, publicizing community HIV-1 and AIDS events during treatment, or imparting HIV-1 and AIDS information when appropriate during the regular course of treatment -- all of these can be accomplished without additional time or disruption of treatment continuity.

Again, programs are advised to make use of community resources and state agencies listed at the end of this section, many of which will provide client HIV-1 education at little or no cost to treatment programs.

G. "Risk Assessment"

As an HIV-1 educational tool, "Risk Assessment" refers to a variety of structured and semi-structured methods designed to determine an individual's "risk history" -- or the history of behaviors that may have involved exposure to or transmission of HIV-1. In some cases Risk Assessment may refer to a structured interview with a clinician or health care worker, during which the client is surveyed about past practices over seven years or more. In other cases Risk Assessment refers to written questionnaires about past and current behavior that can be interpreted by a clinician or health care worker and used as the basis for discussion of risk reduction. In a few cases Risk Assessment may involve a self-reporting and self-diagnostic instrument with which the individual can review past and current behaviors and assess possible exposure privately, on his or her own.

Risk Assessment presents potential benefits and liabilities that should be examined carefully before use as a part of HIV-1 education. Used correctly, as a part of an overall risk reduction education strategy, it can:

1. Help pinpoint specific behaviors that put the client at past or continuing risk of HIV-1 infection, thereby allowing for risk reduction education that focuses specifically on those behaviors;
2. Help heighten the client's sense of potential personal risk, as she or he reviews overall behavioral patterns;
3. Build client awareness of the need for critical change in order to reduce future risk;
4. Encourage self-examination that can be useful to the client in determining whether or not to take the HIV-1 antibody test (see Section VI of the Guidelines); and,
5. Eliminate at least some of the need to talk about "absolutely everything" with "absolutely everybody."

Without a proper perspective, however, an over-reliance on Risk Assessment, or its untrained use, can prove misleading or even counter-productive. For example, it can:

1. Erroneously assume the accuracy of past self-reported risk behavior. As mentioned earlier in this section, there are many understandable reasons why individual self-reporting might be unreliable as a source of information.
2. Lead the clinician to mistakenly exclude individuals from their educational efforts. One might assume, for example, that an individual who self-reports an absence of behavior that could have led to HIV-1 infection needs minimal education in risk reduction; or, conversely, provide intensive risk reduction education to another who reports high risk of exposure -- and, in all of that, the basic premise may be wrong. All clients should receive the same general educational messages -- tailored, of course, to individual needs and sensitivities -- regardless of the extent of self-reported past risk behaviors.
3. Lead individuals with self-reported low-risk histories to place too much emphasis on past behavior. Sometimes such individuals will experience intense feelings of shame, remorse, or guilt about past behaviors that, on the whole, do not indicate a high risk of HIV-1 infection. Those feelings are sometimes translated into undue worry that "I must be infected after what I did," and an unwarranted desire to "get tested right away." The real issue in such cases may be unresolved feelings about past behaviors, not potential HIV-1 infection, and such individuals should be counseled to concentrate more on future risk reduction efforts than potential past exposure. One woman, for example, thought she "had to get tested" because of an affair she had fifteen years ago "with a man who I think was

bisexual, because he wasn't real macho". On further questioning, however, the woman realized that she still felt guilty about "cheating on my husband back then", and that there was no real reason for her to get the HIV-1 antibody test.

4. Lead the counselor to disregard the sensitive nature of what is being asked and expected of clients. To inquire about the client's frequency of anal intercourse, or same-gender sex, is a delicate task for both the questioner and the respondent. Because of this, training in Risk Assessment emphasizes nonjudgmental approaches, and stresses the importance of open-ended questions. For example, the question, "Who do you have sex with -- men, women, or both?" will generate more honest and useful answers than the question, "Are you homosexual, heterosexual, or bisexual?" But even then, when such inquiry becomes too routine, the enormous sensitivity and respect that such a process demands can be too easily ignored.

In light of the above, there are two ways Risk Assessment can be productively utilized in CD treatment programs.

First, Risk Assessment can be employed as a part of the intake process. In those cases, Risk Assessment should be administered by a trained counselor, and used initially to promote one-to-one discussion about risk behaviors and risk reduction. "Trained counselor" in this context signifies someone who has undergone specific, comprehensive training in Risk Assessment theory and technique, not someone who may have merely attended a short presentation on the subject.

Second, programs might use Risk Assessment as a self-diagnostic tool by allowing individuals to fill them out and interpret the results on their own. In private, clients might be more honest in their responses. But again, some of the earlier liabilities might apply: without proper follow-up education, Risk Assessment can leave the individual "hanging", and it may lead individuals to worry unnecessarily about past, low-risk behaviors. When it is used as a personal instrument, Risk Assessment should have such warnings clearly printed in the body of the questionnaire text.

Again, Risk Assessment should not be considered as a technique or strategy separate from an overall risk reduction education process. It is not a device that provides easy solutions for educational dilemmas; it is one of a series of useful tools. As such, it requires skill and tact to successfully employ. In the absence of such demonstrable skills among current staff, CD programs should not emphasize Risk Assessment techniques too heavily. If programs wish to make such services available to clients, they can plan to provide for the Risk Assessment training of selected staff, or they can rely on the Risk Assessment services provided as part of HIV-1 Antibody Testing at the Minnesota Counseling and Testing Sites (see section VI of the Guidelines).

H. Educational "Windows of Opportunity"

As a CD treatment program administrator recently stated, "No matter how much proactive education you do, when it hits -- when you get that first client who is known to be HIV-1-infected -- there's going to be a strong reaction, there's going to be a mini-crisis." Collective experience bears out the truth of that statement.

Such events should be seen as windows of opportunity for focused education -- not as threats. They help to "make the problem real," rather than abstract. And over the course of the coming years, they are nearly inevitable for most CD treatment programs. "Windows of opportunity" can include:

1. The admission of a client who is known to be HIV-1-infected, or who has a clinical diagnosis of AIDS;
2. The awareness of a staff member similarly diagnosed;
3. The revelation that a staff member, or a client, has a family member or significant other who is HIV-1-infected or who has AIDS; or,

4. The discovery that a similar program, in a comparable location, has been working with a client or staff member who is HIV-1-infected or who has AIDS.

CD programs should not wait for such occasions before they take action. If anything, the essential message of these Guidelines is that programs should anticipate the future, and act accordingly. But when unforeseen events take place, CD programs can capitalize on the educational opportunities they provide. When emotions run high, and when beliefs and opinions rise to the surface, administrators may be able to make significant strides in changing knowledge, attitudes and behavior.

I. Resources

Minnesota AIDS Project
2025 Nicollet Avenue South
Minneapolis, MN 55404
(612) 870-7773

Minnesota AIDSline
Metro: 870-0700
State-wide toll-free: 1-800-248-AIDS

Minnesota Department of Health
AIDS/STD Prevention Services Section
717 Delaware St. S.E.
Minneapolis, MN 55440
(612) 623-5698

Chemical Dependency Program Division
Department of Human Services
444 Lafayette
St. Paul, MN 55155
(612) 296-3991

Aliveness Project
Center for Living
730 East 38th Street
Minneapolis, MN 55407
(612) 822-7946

Midwest AIDS Training & Education Center
University of Minnesota
School of Public Health
Room D322 Mayo Building, Box 197
420 Delaware Street
Minneapolis, MN 55455
(612) 625-6979

"The AIDS Educator"
A Quarterly Newsletter for AIDS Educators in Minnesota
c/o Health Services
St. Paul Red Cross
100 S. Robert St.
St. Paul, MN 55107
(612) 291-6711

U.S. Public Health Service
For updated national statistics and information, call:
1-800-342-AIDS

Asian-Pacific Task Force on AIDS
Council on Asian-Pacific Minnesotans
205 Aurora Avenue
Suite 100, Summit Bank Bldg.
St. Paul, MN 55103
(612) 296-0538

Minnesota Hispanic AIDS Partnership
Spanish Speaking Affairs Council
506 Rice Street
St. Paul, MN 55103
(612) 296-9587

Minneapolis Urban League
(Black community education)
2000 Plymouth Ave N.
Minneapolis, MN 55411
(612) 521-1099

Coalition for People of Color/AIDS
122 West Franklin, Suite 306
Minneapolis, MN 55404
(612) 870-1193

Minnesota American Indian Task Force on AIDS
Indian Affairs Council
127 University Avenue
St. Paul, MN 55155
(612) 296-3611

Deaf Services Division/Regional Service Centers for Hearing Impaired Persons
(Education for deaf clients)
MN Department of Human Services
444 Lafayette Rd.
St. Paul, MN 55155
(612) 296-3980 (Voice)
(612) 297-1506 (TDD)

Your local Community Public Health Service
(County-based throughout Minnesota)

V. INFECTION CONTROL/UNIVERSAL PRECAUTIONS

Recommendation: Chemical dependency treatment programs should adopt, as policy, an infection control plan that is appropriate to the program.

V. INFECTION CONTROL/UNIVERSAL PRECAUTIONS

A. Key Definitions: "Infection Control"

"Infection control," in the context of HIV-1, refers to the prevention of inadvertent occupational or accidental transmission of HIV-1. Protocols for infection control vary based on the setting and the consequent levels of exposure health care workers are likely to have to particular body fluids. Hospitals, obviously, will have more stringent requirements that are designed to control a wide array of contagious or infectious diseases, including those that are air-borne. Non-hospital based inpatient and outpatient CD programs and half-way houses, however, are in a much different situation. Basically the concern of these guidelines is HIV-1, hepatitis B virus (HBV), and other blood-borne pathogens, because they are the viruses about which the most concern and fear has been expressed.

There are several basic principles that guide infection control protocols in relation to HIV-1. Understanding and integrating those principles is the key to reasonable and effective infection control.

B. Key Definitions: "Body Fluids"

As has been pointed out, not all body fluids are infectious for HIV-1 and HBV. The indiscriminate warnings to avoid "sharing body fluids" over the past seven years have clouded the facts needlessly. For HIV-1 and HBV, infection control generally refers to <u>three specific fluids: blood, semen, and vaginal secretions</u>.(1) Of the three, infected blood is the single most important source of HIV-1, HBV, and other blood-borne pathogens in the occupational setting. There are many other body fluids that are non-infectious for HIV-1 and HBV in occupational settings. They include feces, nasal secretions, sputum or saliva, sweat, tears, urine, and vomitus, unless they contain visible blood. Providers <u>do not</u> have to worry about HIV-1 infection from occupational exposure to those fluids. Despite fears that "one can never really be sure," or "it might all change tomorrow," these are facts about which the world's research community is in agreement. And they are facts that will not change in the coming years.

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(1) There are other body fluids, such as cerebrospinal fluid (CSF), synovial fluid, pleural fluid, and amniotic fluid, that <u>may</u> be implicated in HIV-1 transmission. They are, for the most part, irrelevant to the typical CD counselor, who would have no cause or occasion to come into contact with, say, spinal cord fluid. They <u>will</u> warrant some attention by the CD counselor <u>who is also a surgical or medical practitioner and who performs invasive or emergency procedures</u>. All others should focus their concern on blood, semen, and vaginal secretions.

C. Key Definitions: "Universal Precautions"

All CD treatment providers should assume, as a matter of course, that everyone with whom they come in contact -- personally and professionally -- is infected with HIV-1. Why? Because 1) the vast majority of people who are HIV-1 infected show no external symptoms whatsoever -- people will be unable to tell just by "looking someone over," and 2) personal stereotypes tend to cloud clear thinking, in that CD staff may tend to take infection control precautions while mopping up the blood spill of a client known to be gay, but overlook such precautions for the blood spill of a middle-aged woman who has been married for many years.

This approach -- assuming the blood (and semen and vaginal secretions) of all patients is potentially infectious for HIV-1 and HBV -- is termed "Universal Precautions."

D. Infection Control/Universal Precautions Guidelines

It is the CDPD's recommendation that Minnesota CD programs adopt as policy infection control guidelines appropriate to the setting (i.e., inpatient and outpatient programs, hospital-based facilities, and halfway houses.) Since the Centers for Disease Control have already developed extensive guidelines in this area, there is no need to "reinvent the wheel." Following this recommendation simply means identifying the guidelines most appropriate to the program and conducting the necessary staff training in infection control principles and protocols.

A review of infection control guidelines can sometimes seem intimidating or daunting to non-medical personnel. In fact, some of the details are complex, but they pertain only to specific laboratory procedures or hospital practices -- situations most CD treatment programs simply do not face. For CD treatment programs, the essentials of infection control to prevent inadvertent transmission of HIV-1, HBV, and other blood-borne pathogens can be summarized in four procedural recommendations:

1. Take care when using, handling or cleaning needles or any other instrument that can puncture the skin. One should not manipulate used needles by hand, either in attempting to recap the needle or to remove it from the syringe. Puncture-resistant containers should be employed to dispose of used needles.

2. Universal precautions should be observed (by staff and other clients) by using barriers to prevent direct contact with potentially infected blood, semen, or vaginal secretions. The most significant of these is blood. "Barriers" generally refers to disposable latex gloves. There is no need to use barriers in anticipation of contact; such a use would be extreme and unpractical. However, staff and clients should be advised to wear gloves when mopping up blood spills, bandaging another's fresh cut, or at any other time when direct contact with blood, semen, or vaginal secretions is required. For all programs this means having boxes of latex gloves readily available at all times.

3. If staff are exposed to blood, semen, or vaginal secretions through direct contact and without barriers, they should wash the exposed area afterwards. HIV-1 cannot pass through intact skin; there is a small risk, however, that the skin may have small cuts or lesions that could allow access by HIV-1. Regular hand-washing by staff is a highly advisable (and generally neglected) technique apart from specific concerns about HIV-1 transmission, since there are many other viruses that are airborne and that can be transmitted by touch.

4. Advise residential clients not to share razors or toothbrushes, since there is a small risk of possible blood-sharing through such practices.

Specifically, what set of policy guidelines about infection control should individual programs consider? The answer depends on where the program falls among three different categories of CD treatment programs.

1. Hospital-based inpatient CD programs (including medical detox programs). First of all, it is extremely unlikely that the hospital as a whole does not have current infection control guidelines relevant to HIV-1 that cover all aspects of hospital administration. CD program administrators should check with the designated Infection Control Officer of the facility to find out what policies have been adopted, and how they apply to the chemical dependency unit or section. For such facilities, the recommended document spelling out specific adoptable infection control guidelines is Recommendations for Prevention of HIV-1 Transmission in Health-Care Settings, published by the Centers for Disease Control in the August 21, 1987, Morbidity and Mortality Weekly Report: Supplement. Since this is a long document (17 pages) and contains a level of specificity not germane to the vast majority of CD treatment programs, it is not reprinted here. Providers in hospital-based programs who find it essential to consult a copy can acquire one from the Minnesota Department of Health.

2. Non-hospital based residential treatment programs and halfway houses. The difference between this set of CD treatment programs and hospital-based programs lies in the general absence of invasive medical procedure. Therefore, the guidelines are much simpler. The CDPD's recommendation is that such programs adhere to the tenets set out in "Patient/Resident Care: General Infection Control Policies for Residents," which was developed for the state operated Regional Treatment Centers. (See DHS/RPMD Residential Facilities Manual, Policy Number 6701, 10/21/88). A copy is reproduced in the appendix.

3. Outpatient Programs. Outpatient programs will be primarily concerned with the management of admittedly rare blood spills or personal accidents. Guidelines for infection control can be simple and direct, and implemented without disruption. The recommended source for policy guidelines is the "Update: Universal Precautions for Prevention of HIV-1, HBV, and other Bloodborne Pathogens in Health Care Settings," most specifically, the section on "use of protective barriers." A copy is reproduced in the appendix.

E. Section Summary

There are two main recommendations about HIV-1 infection control for CD treatment programs:

1. Program providers should be familiar with, and understand, the basic principles or foundations of infection control, as set out in the beginning of this section; and, 2. CD treatment programs should adopt specific policy outlining the way in which occupationally-associated HIV-1 infection will be controlled. Since standard infection control policies have already been developed suitable for nearly every facility, it remains only to "borrow" that policy best suited to the program and refine it, if necessary, to address program-specific characteristics.

F. Resources

Minnesota Department of Health
(612) 623-5414

AIDS Program
Center for Infectious Diseases
Centers for Disease Control
(404) 639-2891

Chemical Dependency Program Division
MN Department of Human Services
(612) 296-3991

VI. HIV-1 ANTIBODY TESTING

Recommendations: Chemical dependency treatment programs should make clear to all staff and clients their stance on HIV-1 antibody testing. "The best interests of clients" is the primary criterion for decision-making about the program's approach to testing. In addition, programs and counselors should view their role as providing reliable information that will help each client decide, for himself or herself, whether to get tested, when, and where.

VI. HIV-1 ANTIBODY TESTING

A. HIV-1 Antibody Testing and the Role of CD Programs

Chemical Dependency treatment programs are faced with a wide variety of options and considerations in relation to HIV-1 antibody testing. Some programs have been hesitant to take any action or formulate policy, others have chosen to offer on-site testing coupled with pre- and post-test counseling. Between those two ends of the spectrum there are a considerable number of alternatives.

There are four guiding principles that should inform any CD program decision-making about HIV-1 antibody testing.

1. All staff should be knowledgeable about the HIV-1 antibody test, and information about the test should be made available to clients as a part of the overall HIV-1 educational effort. The degree to which programs conduct pre- and post-test counseling is dependent upon the testing option adopted by the program.

2. No one should be required to take an HIV-1 antibody test as a prerequisite for treatment admission, access to services, or to gain or maintain employment. Not only would such a policy be clinically and programmatically inappropriate, it would be highly vulnerable to legal challenge. Mandatory HIV-1 antibody testing of employees has been successfully challenged by citing the Fourth Amendment to the U.S. Constitution, which prohibits unreasonable search and seizure by the government(1). Mandatory testing of clients may also be challenged under the Federal Rehabilitation Act <u>if</u> the results are used in a discriminatory manner.

3. Since CD clients may not possess all the necessary information about HIV-1 antibody testing, and therefore may be unable to make informed judgments about whether to get tested or where, it is up to CD providers to do whatever they can to safeguard the confidentiality, rights, and well-being of their clients. This can be accomplished by providing accurate information, skilled counseling, and appropriate referrals.

4. Since the decision to get tested or refuse testing is highly personal, with limitless individual variables, it is CDPD's recommendation that CD programs <u>support the individual's right to choose</u>. Such a policy asserts that "our primary role is to provide information or referrals that will aid the individual in deciding what is desirable and appropriate in his or her unique case."

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(1) <u>Glover v. Eastern Nebraska Community Office of Mental Retardation</u>, 3 Ind. Empl. Rts. Cas. (BNA) 135 (D. Neb. 1988).

B. The HIV-1 Antibody Test

When health officials speak of the HIV-1 antibody test, they are generally referring to two specific test procedures which determine the presence or absence of the HIV-1 antibody. The first is the EIA, or the Enzyme-linked Immunosorbent Assay (also referred to as "ELISA"). The second is the Western Blot, which is more exacting and expensive than the EIA. The Western Blot is generally used to confirm a positive EIA test result. The tests require only that a health care professional draw a small sample of blood from the patient.

The HIV-1 antibody test is often referred to as "the AIDS test," especially among the general public. However, it is not a test that tells the patient whether she or he has AIDS. Nor can it indicate at what point in the past the person may have become infected. Nor can it predict when, or to what degree, the individual may experience symptoms related to AIDS. All the test does is indicate, with considerable reliability, whether or not the person is currently producing the HIV-1 antibody.(2)

When an individual has unprotected sex, or shares drug injection equipment with someone who is infected, the HIV-1 virus may pass into his or her bloodstream. At that point the body begins manufacturing an antibody, in an attempt to counteract the infection. In the case of HIV-1, the antibody the body generates is ineffective; it is incapable of destroying the virus. That is one of the main practical ways that HIV-1 is different than other viral infections. It is also why, to a certain degree, AIDS is a life-threatening illness.

The infected person's body doesn't manufacture the HIV-1 antibody immediately after infection. The antibody is produced over time. Some individuals produce detectable levels of the antibody as soon as two weeks after infection; others may take up to six months (and in rare cases, even longer) to produce a detectable amount. Even those parameters cannot be said to be absolutely reliable. It is commonly assumed that people are either HIV-1 seropositive or HIV-1 seronegative, and that there is no middle ground between the two poles. In fact, there is. At any one time the individual may be in the process of what is termed "seroconversion". When an individual is seroconverting, he or she has been infected with HIV-1, and the body is responding. Unless seroconversion is complete -- that is, unless the individual's body has developed enough detectable HIV-1 antibody -- the HIV-1 antibody test is invalid. Seroconversion does not suggest that an individual is "somewhat infected and somewhat uninfected" at the same time, for there is no "partial infection". It only suggests that the individual's body is in the gradual process of manufacturing antibody to the infection that has already occurred.

It is because of the preceding that some difficulties arise in relation to the HIV-1 antibody test.

First, as mentioned, the EIA and Western Blot both detect the antibody to HIV-1, not the actual presence of the virus itself. They assume that the virus is present because a specific antibody that is trying to counteract HIV-1 is present at sufficient levels to be noted by the test.

Second, since infected individuals manufacture the HIV-1 antibody at a variable rate, the test results cannot be said to be reliable unless the individual has waited six months after engaging in any high-risk behavior that may have resulted in exposure to HIV-1. A client coming into a CD program who was sharing needles a month before, and who is immediately tested, may receive a negative test result and still be infected, simply because the body hasn't had sufficient time to manufacture a detectable level of the antibody. In other words, she or he could be currently seroconverting. This is one of the primary technical reasons why mandatory testing is ineffective as a means of determining

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(2) It should be noted that testing technology is constantly evolving and improving. For example, a new antigen test -- which detects the presence of the virus directly, rather than just the HIV-1 antibody -- is now available, and in limited use. New technologies may change test protocols and testing considerations in the future. It is not advisable, however, to wait for such changes before drafting appropriate policy.

universally who currently carries HIV-1. The "window period" of six months, during which time the body develops an antibody in sufficient quantity to be discovered by the EIA or Western Blot, would mean that at least some of the results of that mandatory testing would be erroneous.

C. Testing Options

In Minnesota there are two main avenues available for the individual who wants the HIV-1 antibody test.

Testing can be conducted by virtually any physician, in any clinic or hospital, at the individual's request, or testing can be conducted confidentially at any one of eight Counseling and Testing Sites (CTS's) maintained by the Minnesota Department of Health. (Counseling and Testing Sites are located in Minneapolis, St. Paul, Duluth, Rochester, St. Cloud, Moorhead, Winona, and Mankato).

In both cases a health care professional will draw blood from the patient. That sample is sent to an off-site laboratory where the EIA and/or Western Blot protocols are performed. The results are then relayed back to the site where the blood was drawn, for reporting to the individual. Turnaround time is approximately ten days to two weeks.

Minnesota law requires that the identity of all HIV-1 seropositive people be reported to the Minnesota Department of Health by the testing agent (whether a private physician or a CTS), or by physicians providing medical treatment for HIV-1-infected individuals. This reporting is done for the purposes of epidemiological surveillance and partner notification (3), and is similar to the reporting of other conditions, such as Sexually Transmitted Diseases (STD's) and tuberculosis. In addition, cases of AIDS, as defined by specific criteria set out by the U.S. Public Health Service, must be reported to the Minnesota Department of Health.

Beyond that, the differences between the two avenues for HIV-1 antibody testing are significant, and lead the CDPD to recommend that individuals who choose to get tested should be given all the available information about both options, as well as the testing strategies listed below, and helped to decide which options are best for them.

D. Program Decision-Making: Testing Strategies

Chemical Dependency treatment programs need to decide what approach they will take to HIV-1 antibody testing for clients. From a program perspective, there are four

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(3) "Partner notification" refers to the process by which sexual or IV drug partners of HIV-1-infected persons are informed of their possible exposure to HIV-1.

When an individual tests HIV-1+, his or her name is forwarded to the AIDS/STD Prevention Services Section of the Minnesota Department of Health. Names so forwarded are kept confidential by the Department; in fact, they are even exempt from a court order demanding release.

At that point a staff person in the AIDS Prevention Services Section (APSS) will contact the HIV-1+ individual and request his or her assistance in developing a plan to notify the individual's sexual or IV drug partners that they may have been exposed to HIV-1. Compliance with that request is completely voluntary, and the contact is always made in a manner that will not disclose the HIV-1-infected individual's identity to third parties.

And if the HIV-1+ person is uncomfortable, for whatever reason, informing past sexual or IV partners of their possible exposure, APSS staff can inform those partners in a manner that will not disclose the identity of the HIV-1+ person.

Partner notification is one of a series of public health interventions designed to fight the HIV-1 epidemic. It is designed to be a supportive, non-coercive approach to containment of further HIV-1 transmission, as well a method for early intervention and care.

major strategies(4) from which to choose, each of which may have positive and negative attributes.

Strategy One: Referring Clients to Off-Site Physicians or Clinics for HIV-1 Antibody Testing

Some clients may feel more comfortable going to a private physician or clinic for an HIV-1 antibody test, especially if they have already established a trusting relationship with the physician. A physician who has a long professional history with a particular client, and who is aware of the client's total health and lifestyle picture, can help the client make wise choices about disease prevention, diagnosis, and treatment.

However, clients who seek an HIV-1 antibody test from a private physician or clinic should be informed, by CD program staff, of several critical facts.

First, HIV-1 antibody test results become part of the client's medical record. While this can be helpful to the client in helping to assure continuity of medical care, it can also be problematic for some people. People who have HIV-1 seropositivity documented in their medical records, and who are currently uninsured or underinsured, may have a difficult time securing health insurance in the future, since health care plan providers may view HIV-1 seropositivity as an unacceptable insurance risk. Of course, Medical Assistance will pay for health care costs if the individual meets eligibility requirements, but there may be people who do not earn enough to afford private health care insurance, and who simultaneously earn too much, or hold too many assets, to qualify for Medical Assistance. Individuals who are insured under group policies such as HMO's through their place of work generally do not have to provide medical records or undergo examinations to secure coverage, and cannot be singled out for refusal of coverage. Individuals who do not fall under a group plan, and who seek individual coverage, may be more commonly asked to provide access to medical records or to take the HIV-1 antibody test as a precondition for coverage. This is true because an individual's policy is based on individual characteristics, whereas group coverage is based on aggregate data about the group. Individuals can be refused insurance if they refuse to take the antibody test at the carrier's request (and cost), have a "pre-existing condition" that the carrier excludes (such as HIV-1 infection or AIDS), or falsely report health data on insurance application forms. But Minnesota residents who are unable to obtain standard health care coverage can obtain comparable coverage through the Minnesota Comprehensive Health Association, provided they meet the criteria for eligibility. Persons with AIDS can apply directly for MCHA coverage.

Questions and answers related to presentation of HIV-1 seropositivity on a medical file and insurability can seem confusing. Those concerns are actually similar to concerns arising from other chronic conditions, such as cancer, and insurability. The point is that when a physician records HIV-1 seropositivity on a medical file, potential complications related to health care coverage can result for some patients.

Secondly, individuals cannot be guaranteed adequate pre- and post-test counseling when the test is performed by a private physician or clinic. The physician may not have received specific training in such counseling techniques. Or it may be that, laboring under a hectic schedule, the physician does not have the time needed to provide such services.

Prior to testing, it is critical that individuals spend time with a trained HIV-1 antibody test counselor who can review the individual's personal motives for obtaining the test, explore responses and options if the results are positive or negative, and assess future risk reduction behavior and/or medical care strategies. It is equally important that the individual receive such counseling upon receiving the test results, preferably in a face-to-face setting. Without such pre- and post-test counseling that explains the process and

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(4) Conceivably programs could also decide to "do nothing", to avoid HIV-1 antibody testing concerns altogether by inaction. That is a dangerous stance to take, because there are complex and essential issues about HIV-1 antibody testing that need to be weighed before the fact. In the absence of clear policy in this area, programs are likely to make uninformed decisions with undesirable consequences.

significance of the test, helps outline alternatives, and reinforces behavior change, the educational value of the HIV-1 antibody test is significantly reduced.

If CD programs decide to adopt this strategy in response to HIV-1 antibody testing, they should do so with the following provisions.

1. Clients should be provided with all of the information outlined above, and made aware of the other alternatives (such as the Counseling and Testing Sites) listed below.

2. Clients should be encouraged to develop a personal plan for dealing with some of the potentially problematic areas associated with this strategy.

3. If program staff do not realistically have the time to provide information and encouragement, the client should be advised to call the Minnesota AIDSline (state-wide toll-free, 1-800-248-AIDS; Twin Cities metro, 870-0700) for information and referrals <u>before</u> getting the test.

<u>Strategy Two: Provision of On-Site HIV-1 Antibody Testing (Hospital-Based Programs)</u>

Some hospital-based CD treatment programs in Minnesota have already begun to provide on-site HIV-1 antibody testing to their clients. Others are considering such a step. There may be valid reasons for such a decision. Programs may view provision of testing services as a way of offering a more comprehensive package of services to clients. Some programs have reasoned that knowing one's HIV-1 status is integral to treatment and maintenance of long-term sobriety. Still others have begun on-site testing simply because of a dearth of medical personnel in their area who are trained in HIV-1 testing protocols and counseling. Frustrated that both trained physicians and CTS's are geographically distant, they have decided to train their own staff and offer HIV-1 testing services on-site.

If CD programs consider such a strategy, they need to be aware of several important factors.

First, physicians in hospital-based CD treatment programs are no different than private physicians or clinics with respect to their obligation to chart HIV-1 seropositivity on medical records. This means that clients who test HIV-1 seropositive within a hospital-based program will encounter the same potential problems outlined in the first strategy detailed above.

Secondly, <u>if</u> there is a trained physician or a Counseling and Testing Site nearby, provision of on-site HIV-1 testing constitutes an unnecessary duplication of services. The Counseling and Testing Sites, especially, employ highly skilled staff, and have developed solid testing and counseling protocols. It is unlikely that a CD program in the same general area could match that same quality of service, at least at the present time.

And finally, CD programs that initiate on-site HIV-1 testing for clients as a way of expanding general services may discover that testing services do not necessarily enhance the goal of CD treatment. There is no available evidence that would allow anyone to conclude that on-site testing services either enable recovery from addiction, or inhibit it.

<u>If</u> a program is currently offering on-site HIV-1 antibody testing to clients, or is contemplating such a service, it should be prepared to meet the following conditions:

1. All clients who are tested on-site should be presented with the same information detailed above, under "Strategy One".

2. Staff who administer the HIV-1 antibody test should be thoroughly trained, preferably through the Minnesota Department of Health, in both test protocols and pre-/post-test counseling. Such counseling ought to be required for each client who requests the test.

3. The program should draft specific consent forms for the HIV-1 antibody test. Those forms should explain in simple language how the test works, what it does, and potential liabilities or consequences.

4. The program administrator should make it explicitly clear, to staff and clients, that refusing a test in no way jeopardizes the client's access to treatment or standing within treatment. Completion of HIV-1 testing, participation with Partner Notification Services of

the Minnesota Department of Health, or any other testing requirement that is not related to CD treatment should not be employed as a way to measure successful completion of treatment.

Strategy Three: Provision of On-Site HIV-1 Antibody Testing (Non-Hospital Programs)

It seems unlikely that any but the largest non-hospital CD programs would seriously consider provision of on-site HIV-1 antibody testing, simply because few such programs have the necessary resources or medical personnel. Those that do, or that are considering expansion to include comprehensive testing services, should note that all of the factors and suggestions mentioned under "Strategy Two" will apply to non-hospital programs as well.

Strategy Four: Referring Clients to a Minnesota CTS for the HIV-1 Antibody Test

Minnesota currently maintains eight Counseling and Testing Sites to "help uninfected persons initiate and sustain behavioral changes that reduce their risk of becoming infected and to assist infected individuals in avoiding infecting others." For at least two reasons, clients may find them a preferable setting in which to obtain the HIV-1 antibody test.

First, the CTS's are strictly required, by contract, to provide comprehensive pre-/post-test counseling for every client. During pre-test counseling the site technician will pose a number of critical questions, such as the following:

1. "What is it that leads you to seek testing?"(6)
2. "Do you clearly understand the nature of the test, what it does and does not do?"
3. "What have you been doing to reduce your risk of HIV-1 infection? How will getting tested help you in that process of behavior change?"
4. "What will you do if your test results are positive? If they are negative?"

While the client is not required to answer questions, they serve, merely in the asking, to make the testing process educational.

In addition, the client is required to report in person to receive his or her test results. At that time he or she is offered post-test counseling. If the results are negative, the technician can reinforce the importance of continued behavior change. If the results are positive, the technician can provide initial support and make referrals to agencies and programs that will address the client's psychosocial and medical needs.

The second reason clients may choose a Counseling and Testing Site has to do with confidentiality of records. When a client obtains an HIV-1 test at a CTS, a client-identifying health record will be initiated. The results of the client's HIV-1 test will be entered into that record when they are received. However, unlike other medical records, health records established for epidemiological purposes are barred to any party but the Minnesota Department of Health (MDH), with only a few, specific exceptions. First, individuals have the right to access data when they are the subject of that data, or to authorize disclosure to other parties the individual may designate (such as a personal physician). Second, the MDH commissioner or a local board of health may disclose health data to the data subject's physician "as necessary to locate or identify a case, carrier, or suspect case, to establish a diagnosis, to provide treatment, to identify persons at risk of illness, or to conduct an epidemiologic investigation."(7) And third, with the commissioner's approval, health data may be disclosed "to the extent necessary to assist the commissioner to locate or identify a case, carrier, or suspect case, to alert persons who may be threatened by illness as evidenced by epidemiologic data, to control or prevent the spread of serious disease, or to diminish an imminent threat to the public health."(8) Even

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(6) By probing in a number of areas that derive from this question, the technician is conducting Risk Assessment, as mentioned in Section IV of these guidelines.

(7) Minnesota Statutes, 1988, 13.38 Subd. 2 (b).

(8) Minnesota Statutes, 1988, 13.38 Subd. 2 (c).

a subpoena cannot supersede these provisions. What all of this means is that health records established at a CTS, and which may identify an individual as HIV-1 seropositive, are protected by stringent rules that protect individual confidentiality. Health records maintained at the CTS's or at MDH cannot be accessed, therefore, by insurance carriers, unless the data subject authorizes disclosure by MDH or the CTS. This confidentiality of records helps eliminate some of the problems associated with the first three strategies detailed above.

Finally, the CTS's can provide post-test referrals based on the client's test results or needs. CTS staff are well acquainted with available programs and agencies, and can make appropriate recommendations for support groups, medical evaluations, or other services.

Which Strategy is Best?

There is no single correct approach. Programs will need to review their needs and goals, consider the advantages and disadvantages of each strategy, and choose the one that seems most logical. The deciding criterion is always, in the end, the best interests of clients. And no matter which strategy programs adopt, clients should always be informed of all the facts and all the options. It is not the job of CD staff to decide for clients critical questions such as whether to get tested, when, or where. CD staff are only required to offer a balanced view of facts and alternatives so that clients can make informed and uniquely appropriate decisions.

The previous section addressed possible strategies for getting the HIV-1 antibody test. But how should CD counselors respond when the client asks whether she or he should get tested in the first place? The following section details the relevant factors that may influence individual decision-making about whether to get the HIV-1 antibody test.

E. Individual Decision-Making: Potential Benefits of HIV-1 Antibody Testing

There are a number of reasons an individual might benefit from an HIV-1 antibody test. They include the following:

1. New medical advances allow health care professionals to provide better proactive, preventative treatment for people who test positive but don't show symptoms. In the beginning, there wasn't much that clinicians could do; individuals were told to "wait and see", and often ended up feeling helpless. That is much less true as the 1990's begin. While there is yet no cure in sight, early determination of seropositivity can lead to medical interventions that seem to effectively stem replication of the virus. Clinical trials of AZT (Retrovir) have yielded promising results among asymptomatic infected persons, as has the use of aerosilized pentamidine. In addition, HIV-1+ persons can be immunized against other diseases that might otherwise "seize the opportunity" of potentially weakened immunity. In short, there are now effective therapies available that can help maintain the health and well-being of persons who are asymptomatic HIV-1-infected.

2. Early detection of HIV-1 seropositivity can lead to lifestyle and behavior changes that will additionally support the maintenance of long-term health and well-being. People who are HIV-1 seropositive can be aided in developing a health maintenance plan that emphasizes good nutrition, adequate rest, regular exercise, and other lifestyle changes that are believed to bolster or maintain the immune system.

3. For some, experiencing the testing process may help raise awareness about the importance of behavior change that will reduce the risk of infecting others or getting infected. This is true whether the test results are positive or negative. If getting the HIV-1 antibody test helps underscore risk behavior change, it can be said to be a beneficial process.

4. For others, there is considerable anxiety surrounding the possibility of HIV-1 infection, and the only way that anxiety is relieved is by getting tested. There have been individuals whose possibility of infection, based on past behavior, is almost nil, yet they

have been literally unable to sleep at night because of fears of infection. Such individuals may want to get tested in order to put the panic behind them. In any case, individuals who are gripped by anxiety about possible seropositivity should receive adequate pre-test counseling.

5. The results of the HIV-1 antibody test can assist individuals in their personal decision-making about childbearing, family planning, organ donation, relationships, and other matters. For example, some women who are pregnant or considering pregnancy, and who may have been exposed to HIV-1, are choosing to get tested so they can decide on the course of pregnancy. Since there is a high possibility that babies born to infected mothers will also be infected, some women choose, on the basis of seropositive test results, to avoid pregnancy or to terminate an existing pregnancy. Women who test positive and who have decided to carry a pregnancy to term regardless of their HIV-1 antibody status can use test information in planning for effective pre-natal care.

6. Finally, early detection of HIV-1 seropositivity can enable early notification of the person's sexual or IV drug partners, who may be at risk of HIV-1 infection. From a public health perspective, early partner notification increases the possibility that widespread transmission can be curtailed.

F. Individual Decision-Making: Potentially Questionable Motives for HIV-1 Antibody Testing

All other things being equal, there may also be questionable motives for getting tested, personal reasons that should be explored in more depth as the CD counselor talks to the client. They include the following.

1. Some people have heard a lot about the test, but actually know very little about it. Some have come to believe that the test "does something" that will protect them from infection. In fact, the only thing the test "does" is to indicate the presence of antibody to HIV-1. It is not predictive in individual cases; it cannot indicate whether someone will get infected. Only behavior will determine that.

2. Some have used the test as a way to give themselves a "clean bill of health," so that they can return to previous behaviors without concern. Such a strategy renders the test functionally useless. If the test is not part of larger progress toward reduction of risk behaviors, it cannot have much value.

3. Some people may not be emotionally ready to hear that their test results indicate seropositivity. Unprepared, individuals are vulnerable to a wide variety of emotional responses, ranging from denial to despair. Unless someone has seriously considered the possibility of a positive test result, and outlined personal coping strategies in advance, it might not be advisable for them to take the test at that time. The CD provider, for his or her part, should be well-versed in available referrals, for medical or psychosocial services, which can assist the client who is emotionally prepared to take the test and who subsequently tests HIV-1 seropositive.

4. Some people might choose the test because they have heard repeated recommendations from others to do so. Especially when persons in authority recommend testing, the advice carries considerable weight. But unless getting tested is <u>personally and uniquely appropriate</u>, such blanket recommendations are not germane to the individual and his or her situation. That is not to say that advice from authorities should not be taken into account as part of the decision-making process. It is rather to suggest that broad recommendations appropriate for the majority of people may not be relevant in each individual case. The care provider can help the client assess whether the HIV-1 antibody test is individually appropriate.

5. Some new couples are getting tested simultaneously so that they don't have to use condoms or other barriers when having intercourse or oral sex. But to be truly effective, such a strategy has to take into account the six-month window period, and place

considerable trust in on-going sexual and needle-sharing monogamy. Few couples are willing to wait that long, and it is clear from long years of research that intended monogamy is not always matched by practice.

G. Individual Decision-Making: Timing of the Test

It is also important to consider the timing of an individual client's test. Most clients enter CD treatment after years of accumulated chemical or alcohol abuse, and their lives -- internally or externally -- are in disarray. They are fragile, groping, trying to build a new way of thinking and living. Relationships are often in serious disrepair and demand attention; family life is fractured and requires care. In short, the average CD client, while in primary treatment, may not be in a very good psychological state or position to hear that, on top of everything else, she or he is positive for the HIV-1 antibody. On the other hand, if the client is ready, and the treatment program provides a supportive setting in which to deal with issues related to HIV-1 seropositivity, there might be just cause for getting tested during CD treatment. In addition, the client may be manifesting physical symptoms associated with HIV-1 infection, such as enlargement of the lymph nodes or chronic diarrhea, that might indicate the advisability of HIV-1 antibody testing in order to determine medical treatments and interventions. Only the individual's particular needs, concerns, and goals will determine which choice is best.

H. Guidelines for Individual Decision-Making

Beyond general guidelines that compare on-site and off-site testing and the difference between the use of CTS's and private physicians or clinics, counselors need guidelines that will aid them when the client asks, "Should I get tested?"

The first guideline, stated at the beginning of this section, is fundamental: It is not the task of the counselor to decide for the client, or to push the client toward a decision that reflects the counselor's personal bias; it is the counselor's job to provide accurate, balanced information that can help the client determine what is uniquely best for him or her.(9)

With that in mind, the counselor can, if time and training permit, provide the kind of information and questioning that will help the client decide what to do, and how. The counselor may want to explore some of the following:

1. Is the client clear on what the test is and does, and what it does not do?
2. Are the client's motives for getting tested logical and well-reasoned?
3. Has the client considered what she or he will do if the test turns up positive? If it turns up negative?
4. Is the client aware that, no matter how the test turns out, the real focus is behavior change?
5. Is the client aware of the difference between being tested privately and at one of the Counseling and Testing Sites?
6. Is it important that she or he get the test immediately, as opposed to waiting until completion of primary treatment?

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(9) The CD counselor who notes in a client the symptoms of any illness should, of course, refer the client for medical diagnosis and treatment. The physician who receives that referral, and who notes in that client symptoms associated with HIV-1 infection (such as swelling of the lymph glands, chronic fatigue, night sweats, extended diarrhea, or others) will very probably order the HIV-1 antibody test. The presence of any symptom by itself does not prove HIV-1 infection, since the symptoms just listed can have multiple causes. Only the results of the antibody test will allow the physician to determine with finality that HIV-1 infection is the likely cause of observed illness.

7. <u>If the client is getting tested, does she or he have a "support person" to accompany her or him for the test</u>? Some people find the testing process anxiety-producing and frightening; it may help to bring a friend along who can be trusted and who can offer support after receiving test results.

I. Additional Concerns

Testing also raises a host of difficult questions for CD providers that have not been addressed directly in this section. "If a client tells me he or she is positive, am I required to report that information to the Department of Health?" "How should I respond, and what should I do with the information, when a client tells me she or he is positive?" "If I know a client is positive, and is having sex with someone who doesn't know, am I obliged to act under Duty To Warn?" "Should test information be entered in a client's treatment file?" There is a transparent link between these questions, in that they all have to do with some aspect of confidentiality; HIV-1 antibody testing, and related policy, is fraught with such issues. These particular concerns will be addressed in the next section of the <u>Guidelines</u>, "Confidentiality and HIV-1 Information Management."

J. Resources

Counseling and Testing Sites:

Minneapolis:
Red Door Clinic
527 Park Avenue South
Minneapolis, MN 55415
(612) 347-2437

The Red Door Clinic has five satellite offices. Call the
Red Door clinic to make appointments at the following sites:
Brooklyn Center
Bloomington
North Minneapolis
South Minneapolis (two locations)

St. Paul:
St. Paul Division of Public Health ("Room One-Eleven")
Room #111
555 Cedar St.
St. Paul, MN 55415
(612) 292-7752

St. Cloud:
Quiet Care Clinic
Stearns County Community Health Services
510 25th Avenue North
St. Cloud, MN 56302
(612) 255-6155

Duluth:
Duluth Community Health Center
2 East 15th Street
Duluth, MN 55805
(218) 722-1497

Rochester:
Olmsted County Health Department
415 Fourth Street
Rochester, MN 55901
(507) 285-8370

Moorhead:
Clay County Health Department
123 1/2 South 21st Street
Moorhead, MN 56560
(218) 299-5222

Winona:
SEMCAC Clinic
64 1/2 West 5th St.
Winona, MN 55987
(507) 452-4307

Mankato:
121 Clinic
310 Bell Avenue
Mankato, MN 56001
(507) 388-9950

Minnesota AIDSline:
Twin Cities Metro: 870-0700
State-wide Toll-free 1-800-248-AIDS (2437)

For information on health care coverage and the HIV-1 antibody test, contact:

Insurance Division
Minnesota Department of Commerce
(612) 296-2488

or:

HMO Section
Minnesota Department of Health
(612) 623-5365

VII. CONFIDENTIALITY AND HIV-1 INFORMATION MANAGEMENT

Recommendation: Chemical dependency treatment programs should develop and adopt policy that addresses the range of specific concerns about confidentiality of HIV-1 information.

VII. CONFIDENTIALITY AND HIV-1 INFORMATION MANAGEMENT

A. Introduction

Data privacy laws have their basis in legally established rights to privacy and freedom from undue governmental intrusion into personal affairs. But as with most legal rights, there are limits to absolute freedom. The courts have recognized that when compelling public health and safety are involved (among other reasons) the public good may prevail over private liberties. It is the awareness of those two polarities of "need" and "good" that has preceded many of the discussions about confidentiality and HIV-1 status.

Data privacy law intends to protect individuals from the potential harm that can occur when confidentiality is violated. If no unwarranted harm ever came to individuals because of public revelation of private information, the need for such protection would not exist. But harm has resulted from loss of privacy, in many areas of life. In the past individuals suffered loss of employment, alienation within the community, occupational ostracism, and personal torment because it became known that they were recovering from alcohol or drug addiction, or that they were being treated for some form of mental illness. Since 1981, similar reactions have occurred because of known or suspected seropositivity. In this country HIV-1-infected persons, or those believed to be infected, have been:

1) refused employment, and terminated from current employment, despite qualifications;
2) refused mental health services, and expelled from programs they were already in;
3) denied medical care, including emergency services;
4) evicted from their apartments and homes;
5) placed in unnecessary isolation or segregation in care settings, schools, and even court rooms;
6) denied entrance to schools and other public institutions;
7) refused entry into the country, even for the purposes of research and study;
8) victimized by taunting, threats, and verbal harassment; and
9) the targets of violence.

Countless acts of discrimination and abuse against people who are HIV-1-infected have been documented, and doubtless there are many more that go unreported. Clearly there is a need to protect individuals from involuntary disclosure of HIV-1 status.

As in the earlier section addressing discrimination issues, nothing in this section should be construed as legal advice on specific matters. As always, one should consult competent legal authorities on questions relating to the law and its application.

B. Federal Laws Addressing Confidentiality

While there is as yet no federal statute that specifically protects the confidentiality of individuals who are HIV-1 seropositive, there are a number of statutes and regulations that apply to data, including HIV-1 antibody status, on clients receiving drug or alcohol abuse treatment.

The federal government enacted legislation in the early 1970's to guarantee strict confidentiality of persons receiving alcohol or drug abuse treatment.(1) The Department of Health and Human Services issued revised regulations implementing these laws in June of 1987; they are published in 42 Code of Federal Regulations, Part 2.

In enacting regulations, Congress reasoned that because of the stigma attached to alcohol and drug abuse, a firm assurance of confidentiality would be required, so that substance abusers would continue to seek treatment.

The law and regulations govern when and how drug and alcohol programs may make any disclosures about clients -- including HIV-1/AIDS-related information. In general, such information cannot be revealed in a manner that would, directly or indirectly, identify the client as a substance abuser. There are a few very limited and specific exceptions:

- Programs can disclose information if the client so consents on a written form, but the form must meet certain criteria.
- Disclosures can be made without client consent to other staff within the program or to an "entity having direct administrative control over that program" if the disclosure is needed in order to provide drug or alcohol services.
- Disclosures can also be made without client consent:

1. if the disclosure will not identify the individual as an alcohol or drug abuser;
2. to "qualified service organizations" when the information is needed by that organization to provide services to that program;
3. to qualified medical personnel in a medical emergency;
4. for scientific research, audits or evaluations, if certain safeguards against redisclosure are followed;
5. by a court order obtained through procedures outlined in the federal regulations;
6. to law enforcement authorities when a client commits or threatens to commit a crime on program premises or against program personnel; or,
7. to comply with state laws mandating reporting of suspected child abuse and neglect.

HIV-1 and AIDS data must adhere to the same rule and exceptions; that is, agencies covered by the federal confidentiality laws and regulations may disclose information relating to AIDS or HIV-1 infection only if that disclosure would be permitted -- according to the guidelines above -- by federal rules. This is true even if a state law were to require a disclosure that federal law prohibits: in those cases, federal law overrides state regulations.

There are other federal confidentiality laws that provide limited protection to HIV-1-related medical records and information that is collected or maintained by federal agencies and certain other federally-funded programs.

The Privacy Act (1974) forbids federal agencies from disclosing protected records without the consent of the person concerned except: 1) to other federal agencies for civil or criminal law enforcement purposes; 2) to a specific party upon a showing of "compelling circumstances affecting the health or safety of an individual"; or 3) to a designated party if a court order authorizing disclosure is obtained.(2)

A second law, the U.S. Public Health Services Act, has confidentiality provisions that apply to certain federal agencies conducting health-related research. While this does not pertain directly to chemical dependency treatment programs, it is important to note

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(1) U.S.C. 42 && 240dd-3.

(2) 5 U.S.C. 552a.

that it replicates, once again, in the form of federal law the basic philosophical foundations for data confidentiality, and that it also covers HIV-1 data.(3)

Finally, under a provision of the Public Health Service Act, public and private entities receiving federal funds and grants to establish AIDS education and surveillance programs must keep confidential all individually identifying information they obtain unless: 1) the subject of the information consents; or 2) state or local law requires the disclosure.(4)

All of the preceding point to several key summary facts about federal law governing data disclosure:

1. Privacy of data is held as the first principle, the foundation from which all other exceptions diverge.
2. Disclosure of private data cannot be made arbitrarily or without compelling cause. The law provides very specific exceptions, and only those exclusions, to the inviolability of data privacy.
3. Some existing laws addressing a range of data privacy concerns also cover HIV-1 data.

C. Minnesota State Laws Addressing Confidentiality

There is at present no single statute in Minnesota that specifically governs confidentiality protections to be accorded HIV-1 carrier information. There are, however, a number of statutory sources that may have a direct or indirect bearing on HIV-1 data confidentiality.

The Minnesota Government Data Practices Act (5) classifies government health data on individuals as "private data" -- that is, it can be accessed by the subject of the data but not by the public. This act would apply to agencies receiving state funds. The statute does allow the government to disclose data to the subject's physician for certain purposes, or, with the approval of the Commissioner of Health, for a variety of public health purposes, such as location of a carrier or prevention of the spread of disease. But health data on an individual "collected by public health officials conducting an epidemiological investigation to reduce morbidity or mortality is not subject to discovery in a legal action".

Another section of the Act defines medical data as "private" with a very few, specific exceptions. Medical data is defined as "data collected because an individual is or was a patient or client of a hospital, nursing home, medical center, clinic, health or nursing agency operated by a state agency" (or receiving state funds for operation). Again, this means that only the subject has the right to access that information. Violation of the Act by an agency is subject to civil action and potential damages of $10,000; violation by an individual is a misdemeanor and subjects him or her to job suspension or termination.

Another statute (6) addresses confidentiality of medical records under the "Patients and Residents of Health Care Facilities Bill of Rights." The statute covers persons in acute care inpatient facilities for longer than 24 hours, persons in long-term care, and persons receiving mental health treatment on an outpatient basis. It states, in part, that patients and residents "shall be assured confidential treatment of their personal and medical records," and may approve or refuse the release of those records to any individual outside the agency.

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(3) 5 U.S.C. 242 et seq.

(4) 42 U.S.C. 247c(e)(5).

(5) Minnesota Statutes Chapter 13.

(6) Minnesota Statutes 144.651,subd.16:1986.

D. Is This Anything New?

Anyone familiar with the management of substance abuse treatment programs already has more than a passing acquaintance with federal and state laws governing confidentiality of records. The question is, does HIV-1 data qualify as an exception to current law? The answer, clearly, is "no." HIV-1 does not present a new series of exceptions, qualifications, or disclaimers that radically alter application of existing law. Whatever obligations substance abuse programs have in protecting client information apply to HIV-1 identifying data. In significant ways, it is not something "new."

What is different about HIV-1 data is that:

1. the need for data confidentiality is heightened, not in a legal sense, but because public fear about HIV-1 is still very high;
2. there are sometimes strong feelings among staff and clients about "right to know" versus "privacy rights";
3. measures to assure the confidentiality of HIV-1 information are still evolving.

E. Specific HIV-1 Data Confidentiality Concerns

Numerous issues concerning HIV-1 data confidentiality have already arisen and CD treatment programs have begun grappling with possible answers. Crucial decisions need to be made on such questions as:

1. Intake: Does the program request information on client HIV-1 status during intake?
2. Internal Disclosure: How should test results be handled internally? Who "needs to know" test results, and on what basis is that determination made?
3. In-treatment Client Disclosure: Does the program expect, implicitly or explicitly, clients who are tested during the course of treatment to reveal test results to program staff? To other clients with whom they are in treatment?
4. Disclosure Liability: What program responsibilities and/or liabilities emerge if a client voluntarily reveals positive test results? What if those results are revealed without the client's permission, either by another client or a staff member?
5. Charting: Should the results of an HIV-1 antibody test be charted? What about the fact that they took the test, or requested it, apart from the results? If information is charted, where, by whom, and how does that take place?
6. Client Transfer: If the agency maintains files that identify client HIV-1 status, and the client is transferred to another agency, does the HIV-1 status data get transferred as well?
7. Test Confirmation: If a client self-reports a positive HIV-1 status, should the program seek confirmation, either through the M.D. who ordered the test or through a confirmatory test?
8. Duty to Warn: What third party disclosure might be and might not be warranted according to "Duty To Warn"?

F. General Principles

There are a few general principles which precede a discussion of specific issues and inform possible resolutions of confidentiality problems.

1. Programs should actively safeguard and protect the HIV-1 status confidentiality of all clients and staff. There will be rare exceptions, of course, but they do not negate this primary position.

2. When the HIV-1 seropositivity of a client needs to be shared with specific staff, either through charts or verbally, incontestable "need to know" should be the criterion for disclosure.

What constitutes such need should be determined through clear agency standards and rules. The National Association of State Alcohol and Drug Abuse Directors (NASADAD) recommends that CD treatment programs take the following factors into account when determining who among staff (both on-site and adjunct) "needs to know":

a. the potential for discrimination against the client both within and outside the program;
b. the continuity of care, especially medical care;
c. the client's right to privacy;
d. the extent to which program staff is trained and knowledgeable about HIV-1 issues; and,
e. program liability.(7)

While the NASADAD guidelines do not state definitively who needs to know, they do delineate decision-making parameters. The question of "who needs to know" should be resolved by program staff <u>before</u> a demand for the answer arises.

3. Programs ought not pressure any client to reveal his or her HIV-1 status.

The rationale is simple: pressure may encourage clients to lie, as a form of self-protection, and at the very least places the client in a clinical double-bind. This is not to say that staff knowledge of a client's HIV-1 status wouldn't be helpful. If program staff are well-educated and skilled on HIV-1 issues, such information may lead to better client service or care. But in the end, it is not necessary to know a client's HIV-1 status in order to provide effective CD treatment or counseling services. It is the primary purpose of CD treatment to facilitate recovery from chemical addiction or abuse, <u>not</u> to determine the prevalence of HIV-1 infection among clientele.

4. Even as CD program staff adhere to strict rules about confidentiality of HIV-1 data, they should take care to plan in advance for crises that may result if a client self-discloses his or her seropositivity to another client.

For example, "Jane", a client, may tell "John", another client, that she is HIV-1 seropositive -- because Jane believes John's promise of confidentiality. But John may tell another client, who tells another, and then another. In this case <u>staff</u> has not disclosed private data, but other clients have found out anyway. If they end up rejecting, persecuting, ostracizing, or otherwise hurting Jane, staff will nevertheless be faced with a "crisis of confidentiality" for which they are not directly responsible. Since such "rumor mills" are not uncommon in CD treatment, it is wise to proactively plan for their management. At the very least, program staff can play a critical role in helping an HIV-1 seropositive client decide who she or he does, and does not, want to tell.

5. There is no reason that CD program staff <u>must know</u>, for the purposes of infection control, risk management, or provision of CD treatment services, the HIV-1 antibody status of all clients.

It cannot even be claimed that knowledge of client HIV-1 antibody status will reduce risk of accidental infection on the job; there is no basis for such a contention when Universal Precautions are followed.

6. CD treatment and care programs should assume, as mentioned in the section on "Infection Control," that all staff and all clients are already and currently HIV-1 seropositive.

There is a danger in any action, such as pre-admission testing or requesting disclosure of HIV-1 status at intake, that gives unreliable information about whether particular clients are HIV-1-infected. Not only do people naturally tend to be more "careful" around people known to be infected, and less careful around people not known as

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(7) "AIDS and IV Drug Abuse: Critical Issues, Policy Options, and Recommendations for Drug Abuse Treatment Programs". (AIDS Policy Project Monograph, September, 1988).

such, but the reliability of test results (because of the seroconversion period) or self-reports themselves are questionable. There may be HIV-1 positive clients who are unaware of their status themselves.

Program staff can take this point an additional step by encouraging health promotion activities for all clients. The reasoning that asserts "we should know so we can encourage the HIV-1 client to improve his or her general health" neglects the fact that most CD clients, whether or not they are HIV-1-infected, are in poor health when they enter treatment, and could benefit from proper attention to nutrition, stress reduction, smoking cessation, and other matters.

7. Program administrators should provide for the education of all staff and clients about basic issues and policy relating to confidentiality, so that inadvertent violation of data privacy is minimized.

G. Specific Issues: When A Client Tells a Counselor

If a client voluntarily reveals his or her seropositive status, the program is legally bound to keep confidential, within the rules and provisions of law, that self-report. The program is also obligated (as is discussed further in the section on "Access to Services") to provide the same level of effective care after the client self-disclosure that would be provided any other client, provided the client in question remains otherwise qualified. To ensure quality treatment and attention to unique needs, program staff to whom the revelation was made should provide the client, if such services are not available within the agency, with appropriate referral resources that can assist him or her with seropositivity-related needs or concerns.

There is no law or statute that compels the non-medical CD counselor to report a client self-disclosure of HIV-1 seropositivity to the Minnesota Department of Health or any other agency. The only person so obligated in the CD context would be the in-house medical worker who orders the HIV-1 antibody test that turns up positive.

There may be circumstances in which a client claims to be HIV-1+ but there is good reason to believe that she or he is not. Should the clinician then request that the client receive HIV-1 antibody testing, or order to confirm or rule out the client's claim?

It seems that in such cases there is a deeper clinical issue that is not necessarily associated with HIV-1 at all. It is this: How does an effective clinician respond at any time she or he thinks a client is lying, about whatever matter, or for whatever motive? For the most part, the clinician will confront the client with that perception; if the client continues to lie, or if the perception of lying persists, the behavior is treated as a therapeutic issue, to be addressed through therapeutic means.

H. Specific Issues: Charting Client HIV-1 Data

Under what circumstances, if any, should the HIV-1 status of a seropositive client be entered into the client's treatment file? If entered, where should such data be charted? What forms or phrasings should such charted information take?

In response to these questions, CD treatment programs have taken a variety of approaches to charting HIV-1 client data. Some programs chart information about client HIV-1 status in only the most general, euphemistic terms, e.g., "client talked about sexuality concerns," "we talked about client health issues," and so on. Some programs keep a client medical file that is separate from the client's "treatment progress" file. The medical file is accessed only by a program nurse or physician, and is not available to general counseling staff. HIV-1 seropositivity data is then recorded in the medical file, which is typically not requested or released in a standard Request for Release. By maintaining a separate file, health care professionals who need to know will know and others will be barred from such data. Still other programs have recorded client seropositivity in a general file, but have maintained scrupulous control over file access by both internal and external parties who have no need to know client HIV-1 status.

The dilemmas related to charting of HIV-1 status may not be fully resolvable at this time. There are unanswered and volatile questions about what is appropriate, legal, and clinically sound in terms of charting policy and practice. Therefore, the CDPD cannot make any specific recommendation in these Guidelines, but will be laboring, in the coming months, to come up with clearer information and guidance.

I. Specific Issues: Tarasoff and "Duty to Warn"

Tarasoff v. Regents of the University of California(7) and related decisions impose a common law duty upon mental health professionals to take reasonable steps to protect identifiable third party victims of patients believed to pose a serious threat of violence. Such "duty to warn" is seen as superseding obligations of confidentiality.

The question is, does Duty to Warn apply in some HIV-1 cases? Perhaps. The law in this area is so potentially unstable that no volume could give absolute advice. Again, programs are urged to consult competent legal counsel as specific cases arise. It does appear that in cases where a specific threat can be identified against a specific individual that a duty to warn is implied. If a client, for example, tests HIV-1 seropositive, and refuses to disclose that fact to his sexual partner and the client continues to engage in unprotected sexual intercourse with his partner, then a duty to warn that partner may prevail. It should be noted, however, that the intent of such common law is not to circumvent necessary therapeutic intervention. When faced with a client as resistant as the one just mentioned, the clinician should attempt every available therapeutic strategy before resorting to the duty to warn.

J. Specific Issues: Minnesota's Health Threat Procedures Act(8)

1987 Minnesota law established a civil judicial procedure by which Minnesota health authorities can force education, counseling, medical testing, treatment and confinement upon individuals who are, or who are suspected of being, carriers of serious infectious disease (including HIV-1) and who behave in a manner which subjects other people to a risk of contracting the disease. The law is most decidedly not intended to apply to the overwhelming majority of HIV-1-infected persons, but rather intended to provide intervention measures in those extreme cases where HIV-1-infected clients continue to willfully and knowingly place others at risk, or in those cases where an incapacity to function at a reasonable level renders the person functionally unable to practice risk reduction measures. If CD treatment and care programs do encounter such clients, and if all therapeutic avenues have been exhausted to no avail the Minnesota Department of Health should be contacted for legal and procedural clarification.(9)

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(7) 17 Cal. 3rd 425, 551 P.2d 334 (Cal. 1976).

(8) Minnesota Statutes, 144.4171 to 144.4186.

(9) A copy of DHS Informational Bulletin No. 89-53A, which explains the act in more detail, is included in the appendices to the Guidelines. It also outlines the specific steps that must be taken in order to have an individual deemed a "non-compliant carrier" and subject to the legal provisions of the Act.

K. Specific Issues: Confidentiality and "Employee Right to Know"

The Minnesota Employee Right to Know Act(10) requires employers to provide basic training and information on hazardous substances and harmful physical agents to which employees are routinely exposed at work. Some employee groups have brought legal actions claiming that the Act compels their employers to notify them of the known presence of HIV-1-infected co-workers or service users. The judicial response to date has indicated that the Act, because it requires the condition of "repeated exposure," generally applies only to hospitals, clinics, and blood banks.

L. A Final Disclaimer

The importance of securing specific legal counsel on specific program situations involving confidentiality and the laws and regulations by which it is governed cannot be overstated. While there is much about which programs can be fairly certain, and many areas around which policy and protocol can be confidently designed, confidentiality issues surrounding HIV-1 can precipitate new and complicated program dilemmas and represent an area about which program administrators often feel most uneasy. It is essential, however (as indicated by the basic intent of the guidelines as a whole) that CD treatment and care programs respond to such dilemmas proactively, rather than wait for a crisis to occur.

M. Resources

Legal Program, Minnesota AIDS Project
2025 Nicollet Avenue South
Minneapolis, MN 55404
(612) 870-7773

Chemical Dependency Program Division
Minnesota Department of Human Services
444 Lafayette
St. Paul, MN 55155
(612) 296-3991

Minnesota Department of Human Rights
500 Bremer Tower
7th and Minnesota St.
St. Paul, MN 55101
(612) 296-5663 (Voice)
(612) 296-1283 (TDD)

Your agency attorney

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(10) Minnesota Statutes 182.653.

VIII. SUMMARY CHECKLIST

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A. Equal Access to Services

Basic Principle
No one should be denied services, or offered sub-standard services, because of real or perceived HIV-1 antibody status. There is no valid ethical, clinical, epidemiological, or legal reason for CD programs to refuse admission for an HIV-1 antibody person who is otherwise qualified for that service.

Recommendation(s)
That CD treatment and care programs adopt a policy statement that explicitly acknowledges full access to services and employment for HIV-1+ persons who are otherwise qualified. In addition, programs should endeavor to educate all staff about non-discrimination law as it relates to HIV-1 and AIDS.

B. HIV-1 Education

Basic Principle
Education that emphasizes behavioral change is one of the only tools presently available in the fight against transmission of HIV-1. Though difficult, education can be effective in changing knowledge, attitudes, and behaviors. All clients in CD treatment and care programs and the staff who work in them, deserve the best education that can be provided.

Recommendation(s)
That CD treatment and care programs provide education on HIV-1 for all staff and all clients. Education should be integrated smoothly into existing program format and philosophy, and include at the very least, an explanation of the nature and action of HIV-1, the facts about transmission, and personal and occupational risk reduction strategies.

C. Infection Control/Universal Precautions

Basic Principle
There is a minute risk of HIV-1 exposure through occupational exposure to blood, semen, and vaginal secretions. Despite the fact that it is extremely unlikely that such exposure would take place in CD treatment and care programs, it is sensible, for general hygienic reasons and to control infection of other blood-borne pathogens such as Hepatitis B Virus, to adopt simple, accessible infection control procedures and protocols in treatment programs and other client service settings.

Recommendation(s)
That CD treatment and care programs ought to adopt, as a matter of policy, an infection control plan appropriate to the program. Outpatient programs will have different infection control guidelines than inpatient programs; the policies reproduced in this volume should be consulted.

D. HIV-1 Antibody Testing

Basic Principle
The current HIV-1 antibody test has both potential advantages and limitations. The HIV-1 antibody test should not be required as a precondition for employment or services. Persons thinking of getting the test should carefully weigh a number of critical factors before getting the test. Clinicians working with clients have a role to play in helping the client: 1) to decide whether or not to be tested, 2) to learn about resources for testing and their respective advantages and disadvantages, and 3) to provide adequate and appropriate follow-up counseling, or referral for counseling, after testing.

Recommendation(s)
That CD treatment programs ought to make clear to all staff and clients their stance on HIV-1 antibody testing. Staff should help clients reach uniquely appropriate decisions on the question of being tested, rather than forcing one recommendation over another. Treatment programs should endeavor to protect client confidentiality in the entire process of test decision-making and actual testing, and should endeavor to make sure that no client comes to harm because of a positive test result. On-site testing is generally problematic for CD treatment programs. Substantial consideration should be given to the timing of the test, and whether or not a test is performed during the client's stay in a CD program should be based on the individual circumstances and vulnerability of each client.

E. Confidentiality and HIV-1 Information Management

Basic Principle
Since a great deal of potential harm can come to clients whose HIV-1 positive antibody status is inappropriately or illegally disclosed to third parties, CD programs should scrupulously guard the confidentiality of client and staff HIV-1 status.

Recommendation(s)

That CD programs develop and adopt policy that addresses specific questions about HIV-1 antibody status and confidentiality. Policy should address issues such as who needs to know when a client self-reports HIV-1 seropositivity, program responsibilities and liabilities in relation to HIV-1 status information, third party disclosure, charting protocols of HIV-1 status, and other matters. Specific recommendations on confidentiality questions are contained in the body of these Guidelines.

IX. APPENDICES

IX. APPENDICES

A. Notes on Terminology

B. Hospital-Based Programs

C. DHS Instructional Bulletin No. 89-53A.

D. "DHS Residential Facilities Manual, Policy No. 6701. Patient/Resident Care: General Infection Control Policies for Residents."

E. "Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and Other Bloodborne Pathogens in Health Care Settings."

Appendix A: Notes on Terminology

The fight against AIDS and HIV-1 infection has resulted in a new vocabulary of words and phrases that have entered common usage. Many are epidemiological or medical terms. Others, like "bodily fluids" have been employed as a way of explaining how HIV-1 is transmitted, or how one can reduce the potential for infection.

It is not essential that the CD practitioner be conversant in the wide array of medical or epidemiological terms used to define various aspects of HIV-1 infection. It is vital, however, that practitioners be aware of, and guard against, some of the imprecise or value-laden terms often used to talk about HIV-1. A listing of such terms, and proposed alternative terminology, follows.

Terms: "HIV-1" vs. "AIDS".

Many people use "HIV-1" and "AIDS" interchangeably. It is important to note that all people with AIDS are HIV-1-infected, but that most people who are HIV-1-infected do not have AIDS. An over-reliance on the use of "AIDS" has also tended to minimize the severity of the public health crisis, since it ignores the 1.5 million Americans who are HIV-1-infected but who do not currently evidence the symptoms of AIDS. "HIV-1" is the preferred term when referring to the public health crisis, transmission, infection, and personal risk reduction. "AIDS" is most accurate when referring to the specific disease that can ultimately result from HIV-1 infection.

Term: "bodily fluids".

When educators warn people against "sharing bodily fluids", it is not unlike saying "don't drink the water". Does that include bottled water? Water in every city, throughout the world? Water used as an ingredient in foods? Tap water that has been boiled? Clearly, some water, in some locations, may contain an unacceptable quantity of parasites. But there is no reason to avoid all water. Not only is such a recommendation impossible to follow, it introduces an unnecessary amount of fear into daily affairs.

So when the general public hears "bodily fluids", they tend to think of many things: saliva, tears, blood, sweat, semen, and others. And they may become afraid that all bodily fluids can transmit HIV-1 -- the saliva contained in a sneeze, the residue sweat on exercise equipment. The reality is that bodily fluids, as a group, do not transmit HIV-1. For all practical purposes, non-medical personnel need concern themselves only with blood, semen, and vaginal secretions.

"Bodily fluids" therefore, is unnecessarily confusing, rather than clarifying. The term should be used only when its meaning can be precisely clarified. Otherwise, it is better not to use it at all, referring instead to "blood, semen, and vaginal secretions".

Term: "vaginal secretions".

While the vast majority of people understand what semen is, some are confused about what constitutes "vaginal secretions", believing that it may refer only to menstrual blood. In fact, it does not (though the menstrual blood of an HIV-1-infected woman is infectious, simply because it is blood). Vaginal secretions refers to the natural lubrication of the vaginal walls.

Educators who employ the term should take special care to explain it in lay terminology, by using phrases such as "vaginal secretions, or the wetness that's always inside a woman's vagina."

Term: "high risk groups/persons".

Referring to gay men, IV drug users, prostitutes, prisoners, or others as "high risk groups" or "high risk persons" is not only inaccurate, it tends to fuel existing biases and discrimination. Gay men who have been celibate or who have been in a long-standing monogamous relationship, IV drug users who never share injection equipment, and prostitutes who never take semen into their bodies are not at real risk for HIV-1 infection. It is not who someone is that determines the possibility of HIV-1 infection, but rather what someone does. Therefore, "high risk groups/persons" should be rejected entirely in favor of "high risk behavior".

Term: "AIDS victims".

Many people with AIDS, struggling to live their lives as fully as possible in the face of a life-threatening disease, have rightfully objected to the use of "victims". It is a word that reinforces the negative, helpless, and hopeless aspects of an individual's experience. The preferred term, in widespread use, is "people with AIDS", sometimes seen abbreviated as PWA.

Term: "innocent victims".

This term is sometimes applied to children with AIDS, or those who acquired HIV-1 through transfusions or blood products. It implies that there is another group of people who are "guilty" of something, and who, by implication, "deserve the consequences." In reality no one chooses to become HIV-1-infected, and no one deserves it. The misnomer "innocent victims" should be avoided altogether.

Term: "general population".

This term is sometimes used as a euphemism for the heterosexual, non-infected segment of the population -- as though gay men and people with AIDS did not form a part of the whole. "As HIV-1 begins to affect the general population", for example, suggests that it hasn't already -- and what is really being said is "as HIV-1 begins infecting large numbers of non-IV drug using heterosexuals." It is a term that should be used only when it is clear that it is inclusive of all members of society.

Terms: "intimate contact/sex".

Like "bodily fluids", these terms are vague and may generate unnecessary fear. Many people regard kissing as intimate, or fondling a part of sex, but in terms of HIV-1 transmission, kissing is not risky, while unprotected anal intercourse is. Sexual behaviors should not be lumped together under one large heading that includes behaviors that may transmit HIV-1, and those that do not. When speaking of risks associated with HIV-1 transmission, it is best to refer directly to the sexual behaviors (e.g., unprotected vaginal intercourse) that could pass the virus from an HIV-1 infected person to someone who is not infected.

Term: "promiscuity".

This is a value-laden term with too many variable meanings. For some, "promiscuity" is heterosexual intercourse before marriage, others may have intercourse or oral sex with many partners and not consider themselves "promiscuous". People labeled as "promiscuous" during the course of HIV-1 education, either by design or by implication, are likely to react with shame or anger. "Promiscuity" is another term that should be eschewed entirely, in favor of "multiple sexual partners." The later is more descriptive and less condemning.

There are a variety of other terms and expressions that have been inappropriately, offensively, or inaccurately utilized when talking about HIV-1 and AIDS. The preceding are but a few of the more common examples. They point to the need for precision and sensitivity in language, so that meaning is clear and blame is avoided. CD counselors would be wise to carefully consider the terms they use to talk about HIV-1, both in conversations and in education of clients or other staff.

Appendix B: Hospital-Based Programs

Hospital-based inpatient CD treatment programs and the Minnesota Regional Treatment Centers may encounter HIV-1-related problems or dilemmas that differ slightly from the experience of freestanding CD treatment programs. While the HIV-1 Guidelines are equally appropriate for hospital and non-hospital programs, several additional considerations should be addressed in the process of implementing these guidelines in the hospital-based setting.

Considerations

1. Hospital-based programs, the Regional Treatment Centers, and methadone clinics are generally bound not only by Minnesota State CD licensing requirements, but by the rules of other regulatory or accreditation agencies as well, such as the Food and Drug Administration or the Joint Commission on Accreditation of Health Care Organizations (JCAHCO). While there is no essential contradiction between the recommendations in the HIV-1 Guidelines, and the policies of other bodies, there may be differences in emphasis or protocol.
2. It may be easier to implement HIV-1 guidelines and policies in freestanding, CD-only programs. Ideally, hospital-based programs or the Regional Treatment Centers would implement institution-wide guidelines simultaneously, so that divisions or sections can work together toward the achievement of common goals and objectives. In practice, that may not always be possible, because of varying priorities. Chemical dependency programs housed in larger agencies may, in the process of guidelines implementation, find themselves somewhat isolated in the degree to which they have chosen to emphasize the importance of HIV-1-related issues.
3. Hospital-based programs and the Regional Treatment Centers (as well as some larger freestanding programs) may embrace a larger variety of staff with diverse perspectives. Physicians and nurses play a much larger role, working hand-in-hand with counseling staff. Hospital-based programs may have teachers, vocational counselors, chaplains, or even art/music therapists on staff. Each additional discipline represents, by virtue of training and occupational goals, a new outlook that will need to be integrated into the process of guidelines implementation.
4. Aside from varying perspectives, the mere size of staff will have an impact on the process of guidelines implementation. Hospital-based programs and the Regional Treatment Centers tend, for the most part, to have larger staffs than freestanding facilities (though there are notable exceptions). All other things being equal, a CD treatment program with five counselors on staff will find guidelines implementation simpler and less cumbersome than a CD program with 50 counselors.

Recommendations

1. Hospital-based programs or others who are regulated or accredited by agencies not addressed in the body of these guidelines (such as the JCAHCO) should consult with those bodies as an essential ingredient in guidelines implementation.

2. CD programs in hospitals or multi-service agencies should make every effort to inform and involve other divisions or sections in the process of guidelines implementation. It is not necessary to ensure that all sections or divisions are in perfect agreement before CD programs proceed in the task of implementation, but it will prove ultimately beneficial if those sections or divisions are kept informed and involved.

3. Larger CD programs (including freestanding agencies) would be wise to begin the guidelines implementation process by assembling an HIV-1 Project Team that will map out specific strategy and monitor progress. That team should be charged with a clear mission and objectives and operate with focus on action as opposed to research or discovery. Team members should be selected for their basic knowledge of HIV-1 issues and their personal commitment to guidelines implementation. Team membership should include representation from all significant staff constituencies. The HIV-1 Project Team can begin with a thorough review of the HIV-1 Guidelines, and thereafter construct strategies, resource allocations, and timelines that will ensure smooth implementation and monitoring over time.

The preceding does not intend, by any means, to suggest that there are sharp distinctions between hospital-based programs and freestanding facilities. There are, to be sure, freestanding programs with large and diverse staffs, and hospital-based programs that are small and relatively unencumbered by the dynamics of large institutions. It is to suggest, however, that hospital-based programs may need to take a few additional factors into account while implementing guidelines. Freestanding facilities that find value in the preceding recommendations are welcome to incorporate them as well.

Appendix C: DHS Instructional Bulletin No. 89-53A

INFORMATIONAL BULLETIN NO. 89-53A **January 17, 1989**

TO:

Chairperson, Board of County Commissioners
Attention: Director

Chairperson, Human Services Board
Attention: Director

Chairperson: Community Health Board
Attention: Director

Chairperson, Mental Health Centers
Attention: Director

Attention: Directors, Rule 12/36 Providers

Attention: Directors, Rule 14 Providers

Attention: Directors, Rule 5 Providers

SUBJECT:

1) Procedures for notifying the Commissioner of Health of persons with communicable diseases who pose a health threat to others; and
2) Authorized actions the Commissioner of Health may take to alleviate health threats posed by others.

I. PURPOSE

The purpose of this bulletin is to provide information to mental health providers to facilitate serving persons infected with a communicable disease, including human immunodeficiency virus (HIV-1, the causative agent of AIDS), hepatitis B virus (HBV), or Mycobacterium tuberculosis (M. tuberculosis). As additional information, a recent article from Minnesota Medicine on the confidentiality of medical records is attached.

II. BACKGROUND

The Health Threat Procedures Act (Minnesota Statutes, sections 144.4171 to 144.4186) grants authority to the Commissioner of Health, or a local board of health with delegated authority from the Commissioner, to deal with communicable disease carriers who pose a health threat to others. The Act outlines the procedures the Commissioner of Health and the courts must follow when intervening against such a carrier and takes into account the full due process rights of the individual.

Under the Act, communicable disease means:

"a disease or condition that causes serious illness, serious disability, or death, the infectious agent of which may pass or be carried, directly or indirectly, from the body of one person to the body of another" (Minnesota Statutes, section 144.4172, subdivision 2).

Directly transmitted means predominantly:

"1) sexually transmitted;
2) blood-borne; or
3) transmitted through direct or intimate skin contact"
(Minnesota Statutes, section 144.4172, subdivision 5).
(e.g., HIV-1, HBV)

Indirectly transmitted means:

"any transmission not defined by" the above (Minnesota Statutes, section 144.4172, subdivision 9)
(e.g., M. Tuberculosis)

Carrier means:

"a person who serves as a potential source of infection and who harbors or who the commissioner reasonably believes to be harboring a specific infectious agent whether or not there is present discernible clinical disease. In the absence of a medically accepted test, the commissioner may reasonably believe an individual to be a carrier only when a determination based upon specific facts justifies an inference that the individual harbors a specific infectious agent" (Minnesota Statutes, section 144.4172, subdivision 1).

Health threat to others means that:

"a carrier demonstrates an inability or unwillingness to act in such a manner as to not place others at risk of exposure to infection that causes serious illness, serious disability, or death. It includes one or more of the following:

(1) With respect to an indirectly transmitted communicable disease:

  (a) behavior by a carrier which has been demonstrated epidemiologically to transmit or which evidences a careless disregard for the transmission of the disease to others; or
  (b) a substantial likelihood that a carrier will transmit a communicable disease to others as is evidenced by a carrier's past behavior, or by

statements of a carrier that are credible indicators of a carrier's intention.

(2) With respect to a directly transmitted communicable disease:

  (a) repeated behavior by a carrier which has been demonstrated epidemiologically to transmit or which evidences a careless disregard for the transmission of the disease to others;
  (b) a substantial likelihood that a carrier will repeatedly transmit a communicable disease to others as evidenced by a carrier's past behavior, or by statements of a carrier that are credible indicators of a carrier's intention;
  (c) affirmative misrepresentation by a carrier of the carrier's status prior to engaging in any behavior which has been demonstrated epidemiologically to transmit the disease; or
  (d) the activities referenced in clause (1) if the person whom the carrier places at risk is: (i) a minor, (ii) of diminished capacity by reason of mood altering chemicals, including alcohol, (iii) has been diagnosed as having significantly subaverage intellectual functioning, (iv) has an organic disorder of the brain or a psychiatric disorder of thought, mood, perception, orientation, or memory which substantially impairs judgment, behavior, reasoning, or understanding, (v) adjudicated incompetent, or (vi) a vulnerable adult as defined in Minnesota Statutes, section 626.557.

(3) "Violation by a carrier of any part of a court order issued pursuant to this chapter" (Minnesota Statutes, section 144.4172, subdivision 8).

III. COMMUNICATING TO THE COMMISSIONER OF HEALTH REGARDING PERSONS BELIEVED TO POSE A HEALTH THREAT TO OTHERS

Minnesota Statutes, section 144.4175, subdivision 1 states that "any licensed health professional or other human services professional regulated by the state who has knowledge or reasonable cause to believe that a person is a health threat to others or has engaged in noncompliant behavior...may report that information to the commissioner."

The statute also states that a professional "who has knowledge or reasonable cause to believe that a person is a health threat to others or has engaged in noncompliant behavior, and who makes a report in good faith under subdivision 1, is not subject to liability for reporting in any civil, administrative, disciplinary, or criminal action" (Minnesota Statutes, section 144.4175, subdivision 2).

To facilitate effective and efficient reporting of carriers who are health threats to others or noncompliant, the Act provides for a waiver of privilege which may otherwise prohibit certain health and human services professionals from disclosing pertinent information and opinions about patients and clients. These professionals include licensed physicians or surgeons, dentists, chiropractors, public health officers, registered nurses, psychologists, consulting psychologists, and sexual assault counselors. Minnesota Statutes, section 144.4175 states that "any privilege otherwise created in (Minnesota Statutes) section 595.02, clauses (d), (e), (g), and (j), with respect to persons who make a report under subdivision 1, is waived regarding any information about a carrier as a health threat to others or about a carrier's non-compliant behavior in any investigation or action."

Mental health providers should note that Minnesota Statutes, section 144.4186 classifies all data on individuals contained in a health directive as private. Such data is thus not available to the public but is accessible to the individual subject of the data.

"AIDS and the Law: Confidentiality and Duty to Inform" (attached) also discusses privacy rights and reporting obligations of providers when serving persons with a communicable disease. It contains information which mental health providers may find helpful in fashioning workable policies to facilitate serving persons infected with a communicable disease, including human immunodeficiency virus (HIV-1), hepatitis B virus (HBV), or M. tuberculosis.

IV. AUTHORIZED ACTION BY THE COMMISSIONER OF HEALTH

When a report of a suspected carrier who poses a health threat is received at the Minnesota Department of Health, an investigation is conducted to confirm the person is, in fact, both a carrier and a health threat to others, as defined by the Act. Efforts are then made to alleviate the carrier's health threat behavior through education and counseling. If the carrier continues to demonstrate an inability or unwillingness to conduct himself or herself in such a manner as to not place others at risk despite education and counseling, then the Commissioner of Health may issue a directive to the carrier. The directive, a written statement, or, in urgent circumstances, an oral statement, may require a carrier to cooperate with health authorities in efforts to prevent or control transmission of communicable disease and must be individual, specific, and cannot be issued to a class of persons (Minnesota Statutes, section 4172, subdivision 6).

If a carrier fails or refuses to comply with the commissioner's directive, then the carrier is considered "noncompliant and the commissioner may petition the court for relief. Upon a finding by the court that the commissioner has proven the allegations set forth in the petition, the court may order one of several remedies available, with the least restrictive alternative used.

For procedural and informational questions, and to make a report of a person who may be a health threat to others, contact:

Steve Schletty
AIDS Prevention Services Section
Minnesota Department of Health
717 Delaware St. S.E.
Minneapolis, MN 55440
(612) 623-5698

For questions on the content of this bulletin, contact:

AIDS Policy Coordinator
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3828
(612) 296-6046

Appendix D: Infection Control Policy

RESIDENTIAL FACILITIES MANUAL
Policy Number: 6701
21 October 1988

PATIENT/RESIDENT CARE
General - Infection Control Policies for Residents

1. POLICY

Universal precautions shall be consistently used for all clients as recommended by the Centers for Disease Control because medical history and examination cannot reliably identify all persons infected with Human Immunodeficiency Virus (HIV-1), Hepatitis B Virus (HBV), or other blood-borne pathogens.

2. AUTHORITY:

A. Minnesota Statutes Sections 144.12 (1986) (Department of Health Authority to Control Infectious Diseases); 144.651 (1986) (Patients and Residents Bill of Rights); 144.68 and 144.69 (Suppl. 1987) (Records, Reports and Privacy Rights); 145.36 (1986) (Willful Exposure to Disease); Chapter 182 (1986 and Suppl. 1987) (Occupational Safety and Health Act); 246.01 (1986) (Powers of the Department of Human Services' Commissioners); Chapter 253B (1986 and Suppl. 1987) (Civil Commitment Act); 626.557 (1986 and Suppl. 1987) (Vulnerable Adult Abuse Reporting Act); 246.017 (1986) (Duties of Department of Human Services' Medical Director).

B. Minnesota Department of Human Services Rules 9515.1000 to 9515.2600 (Cost of Care for Residents in a State Hospital); 9525.0210 to 9525.0430 (Residential Facilities for Persons with Mental Retardation); 9530.2500 to 9530.4000 (Residential Facilities for Inebriate and Drug Dependent Persons); 9520.0500 to 9520.0690 (Residential Facilities for Adult Mentally Ill Persons); 9545.0900 to 9545.1090 (Child Care Institutions); 9555.8000 to 9555.8500 (Vulnerable Adult Abuse Reporting).

C. Minnesota Department of Health Rules for Health Care and Residential Facilities 4655.0090 to 4655.9900 (nursing and boarding care homes); 4640.0100 to 4640.6400 (hospitals); 4665.0100 to 4655.9900 (supervised living facilities).

D. Centers for Disease Control, Recommendations for Prevention of HIV-1 Transmission in Health Care Settings, MMWR 1987, 36 (Supplement No. 2S); Centers for Disease Control, Update: Universal Precautions for Prevention of

Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and other Bloodborne Pathogens in Health Care Settings, MMWR 1988, 37 (Supplement No. 24).

3. PURPOSE

A. To prevent the spread of HIV-1, HBV, and other blood-borne pathogens through contact with blood and certain body fluids at the Department's residential facilities.

B. To protect HIV-infected persons from the acquisition of other infections.

4. DEFINITIONS

A. Universal Precautions: Procedures intended to prevent parenteral, mucous membrane, and non-intact skin exposure of health-care workers to blood-borne pathogens.

1) Body Fluids to Which Universal Precautions Do Apply:

a) Blood is the single most important source of HIV-1, HBV, and other blood-borne pathogens in the occupational setting.

b) Semen and vaginal secretions.

c) Other body fluids containing visible blood.

d) Tissues and the following body fluids: cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, amniotic fluid.

2) Body Fluids to Which Universal Precautions Do Not Apply:

a) Saliva: General infection control practices already in existence, including using gloves for digital examination of mucous membranes, suctioning, oral hygiene, and handwashing after exposure to saliva should further minimize the minute risk, if any, for salivary transmission. Gloves need not be worn when feeding clients or when wiping saliva from skin.

b) Feces.

c) Nasal secretions.

d) Sweat.

e) Tears.

f) Urine.

g) Vomitus, unless it contains visible blood.

The risk of transmission of HIV-1 and HBV from these fluids and materials is extremely low or non-existent.

3) Universal precautions are intended to supplement rather than replace recommendations for routine infection control, such as handwashing and using

gloves to prevent gross microbial contamination of hands. Because specifying the types of barriers needed for every possible clinical situation is impractical, sound judgment must be exercised. Implementation does not eliminate the need for other category or disease-specific isolation precautions, such as enteric precautions for infectious diarrhea or isolation for pulmonary tuberculosis.

5. RESPONSIBILITIES:

A. Chief Executive Officers:

Develop and implement facility policies and procedures in consultation with the Medical Director and Infection Control Nurse.

6. PROCEDURES:

A. Room Assignments: Isolation is not necessary for known HBV and HIV-infected clients. They may use common waiting areas and bathroom facilities, unless the presence of other communicable infections requires special precautions. Clients with known HIV-1 infection shall receive protective isolation only to prevent their exposure to potentially infectious agents. However, it may be prudent to provide HIV-infected clients with private rooms if they are coughing, non-compliant with hygiene and treatment instructions, or cannot be adequately instructed in blood, secretion, and enteric precautions. When a double or larger room is used, the additional client(s) will not be an impaired host(s) (e.g., another client with a known HIV-1 infection who might be susceptible to potential infections).

B. Protective Garments: The following protective garments are to be used as specified:

1) Gloves: Personnel in direct contact with blood, semen and vaginal secretions, and other body fluids containing visible blood, shall wear vinyl or latex gloves. Gloves must be changed between client contacts. Hands shall be washed after removing gloves.

General purpose utility gloves (e.g., rubber household gloves) shall be used for housekeeping chores involving potential blood contact, for instrument cleaning, and for decontamination procedures. Utility gloves may be decontaminated and reused, but must be discarded if they are peeling, cracked, discolored, or have punctures, tears, or other evidence of deterioration.

2) Gowns: Personnel in direct contact with blood, semen and vaginal secretions, and other body fluids containing visible blood, must wear gowns. Water-protective barrier gowns or plastic aprons are recommended when exposure to large volumes of body fluid is expected.

3) Handwashing: Hands and other skin surfaces contaminated with blood, body fluids containing visible blood, or other body fluids to which universal precautions apply must be thoroughly washed immediately after contact.

4) Eye Protection and Masks: In certain rare instances, such as when a splash of body fluids is likely, eye protection and masks should be used.

C. Specimens: Blood and body fluids to which universal precautions apply shall be placed in an impervious bag or container for transport. A 1:10 dilution of bleach or hospital-approved disinfectant shall be used to clean the outside of visibly soiled containers.

D. Equipment:

1) Precautions must be taken by all personnel to prevent injuries caused by needles, scalpels and other sharp instruments or devices. All needles and syringes are to be disposed of in rigid wall, puncture-resistant containers. Needles are not to be resheathed or clipped after use before being discarded in the container. The container must be handled carefully to prevent accidental injury to either staff or clients.

2) The following procedures must be implemented for equipment used commonly by all clients: a) lensed instruments should be sterilized with ethylene oxide; b) respiratory therapy tubing should be disposable or sterilized before reuse; c) instruments which come in contact with blood or secretions must be sterilized before reuse, including anesthesia instruments, i.e., laryngoscopes and tracheal tubes.

All reusable items should be transported in impervious bags or containers. Scheduling procedures, as appropriate, for the end of the day to allow for overnight sterilization (e.g., endoscope) should be considered.

3) All disposable contaminated items (visibly soiled with blood or body fluids) are considered infectious wastes and must be bagged before disposal, in accordance with facility procedures for infectious waste. Non-disposable contaminated items are to be bagged and labeled prior to decontamination.

E. Linen: Soiled linen shall be handled as little as possible, and with minimum agitation to prevent contamination to persons bagging it. All soiled linen should be bagged at the location where it is used; it should not be sorted or rinsed in client areas. Linen soiled with blood or body fluids must be transported in bags that prevent leakage. If hot water is used, linen should be washed with detergent in water, at least 160 degrees F, for 25 minutes. If low-temperature water (less than 158 degrees f) laundry cycles are used, chemicals suitable for low-temperature washing at proper use concentrations must be used.

F. Dishes: Standard dishwashing procedures shall be maintained for all residents.

G. Cardiopulmonary Resuscitation: An AMBU-BAG and oral airway shall be available for CPR even though current knowledge suggests passage of HBV or HIV-1 by this means has not occurred.

H. Housekeeping: Environmental surfaces contaminated with blood or other body fluids shall be immediately cleaned with chemical germicides approved for use as "hospital disinfectants".

I. Dental Care:

1) Personnel shall wear latex gloves, masks, and protective eyewear (i.e., glasses, goggles, face shields) when performing dental procedures on all clients because contamination of saliva with blood is predictable; trauma to health-care workers' hands is common; and blood spattering may occur.

2) Instruments used in the mouths of all residents (e.g., mirrors, drills, etc.) shall be disinfected after use according to the manufacturer's instructions.

J. Laboratories:

1) Use of gloves is recommended for performing phlebotomy and is mandatory when health-care workers have cuts, scratches, or other breaks in their skin.

2) Gloves shall be used in situations in which the health-care worker judges that hand contamination with blood may occur; for example, when performing phlebotomy on an uncooperative client.

3) Gloves shall be used when performing finger-sticks.

4) Gloves shall be used when persons are receiving training in phlebotomy.

5) Mechanical pipetting devices are to be used for the manipulation of all liquids in the laboratory. Mouth pipetting is not permitted.

6) Needles and syringes are to be handled as required in 6-D-(1), above.

7) Laboratory coats, gowns, or uniforms shall be worn while working with potentially infectious materials and appropriately discarded before leaving the laboratory.

8) All employees processing blood and body-fluids shall wear gloves and aprons. Gloves and aprons shall be changed and hands washed after completing specimen processing.

7. <u>CANCELLATIONS</u>:

Residential Facilities Manual Policy Number 6701B, dated 4 January 1988.

<u>Reviewer</u>: Residential Program Management Division Director, Medical Director, Department of Human Services; and the State Epidemiologist, AIDS Epidemiology Unit Supervisor, Acute Disease Epidemiology Section, Minnesota Department of Health.

Please direct any questions/comments regarding this policy to the Policy Coordinator, at 296-7014, DHS Residential Program Management Division.

MINNESOTA DEPARTMENT OF HEALTH
DISEASE CONTROL
NEWSLETTER

Volume 14, Number 4 (pages 33-40) June/July 1988

Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and Other Bloodborne Pathogens in Health-Care Settings *

Introduction

The purpose of this report is to clarify and supplement the CDC publication entitled "Recommendations for Prevention of HIV Transmission in Health-Care Settings" (1). (The August 1987 publication should be consulted for general information and specific recommendations not addressed in this update.)

In 1983, CDC published a document entitled "Guideline for Isolation Precautions in Hospitals" (2) that contained a section entitled "Blood and Body Fluid Precautions." The recommendations in this section called for blood and body fluid precautions when a patient was known or suspected to be infected with bloodborne pathogens. In August 1987, CDC published a document entitled "Recommendations for Prevention of HIV Transmission in Health-Care Settings" (1). In contrast to the 1983 document, the 1987 document recommended that blood and body fluid precautions be consistently used for all patients regardless of their bloodborne infection status. This extension of blood and body fluid precautions to **all** patients is referred to as "Universal Blood and Body Fluid Precautions" or "Universal Precautions." Under universal precautions, blood and certain body fluids of all patients are considered potentially infectious for human immunodeficiency virus (HIV), hepatitis B virus (HBV), and other bloodborne pathogens.

Universal precautions are intended to prevent parenteral, mucous membrane, and nonintact skin exposures of health-care workers to bloodborne pathogens. In addition, immunization with HBV vaccine is recommended as an important adjunct to universal precautions for health-care workers who have exposures to blood (3,4).

Since the recommendations for universal precautions were published in August 1987, CDC and the Food and Drug Administration (FDA) have received requests for clarification of the following issues: 1) body fluids to which universal precautions apply, 2) use of protective barriers, 3) use of gloves for phlebotomy, 4) selection of gloves for use while observing universal precautions, and 5) need for making changes in waste management programs as a result of adopting universal precautions.

Body Fluids to Which Universal Precautions Apply

Universal precautions apply to blood and to other body fluids containing visible blood. Occupational transmission of HIV and HBV to health-care workers by blood is documented (4,5). **Blood is the single most important source of HIV, HBV, and other bloodborne pathogens in the occupational setting. Infection control efforts for HIV, HBV, and other**

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bloodborne pathogens must focus on preventing exposures to blood as well as on delivery of HBV immunization.

Universal precautions also apply to semen and vaginal secretions. Although both of these fluids have been implicated in the sexual transmission of HIV and HBV, they have not been implicated in occupational transmission from patient to health-care worker. This observation is not unexpected, since exposure to semen in the usual health-care setting is limited, and the routine practice of wearing gloves for performing vaginal examinations protects health-care workers from exposure to potentially infectious vaginal secretions.

Universal precautions also apply to tissues and to the following fluids: cerebrospinal fluid (CSF), synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, and amniotic fluid. The risk of transmission of HIV and HBV from these fluids is unknown; epidemiologic studies in the health-care and community setting are currently inadequate to assess the potential risk to health-care workers from occupational exposures to them. However, HIV has been isolated from CSF, synovial, and amniotic fluid (6-8), and HBsAg has been detected in synovial fluid, amniotic fluid, and peritoneal fluid (9-11). One case of HIV transmission was reported after a percutaneous exposure to bloody pleural fluid obtained by needle aspiration (12). Whereas aseptic procedures used to obtain these fluids for diagnostic or therapeutic purposes protect health-care workers from skin exposures, they cannot prevent penetrating injuries due to contaminated needles or other sharp instruments.

Body Fluids to Which Universal Precautions Do Not Apply

Universal precautions do not apply to feces, nasal secretions, sputum, sweat, tears, urine, and vomitus unless they contain visible blood. The risk of transmission of HIV and HBV from these fluids and materials is extremely low or nonexistent. HIV has been isolated and HBsAg has been demonstrated in some of these fluids; however, epidemiologic studies in the health-care and community setting have not implicated these fluids or materials in the transmission of HIV and HBV infections (13,14). Some of the above fluids and excretions represent a potential source for nosocomial and community-acquired infections with other pathogens, and recommendations for preventing the transmission of nonbloodborne pathogens have been published (2).

Precautions for Other Body Fluids in Special Settings

Human breast milk has been implicated in perinatal transmission of HIV, and HBsAg has been found in the milk of mothers infected with HBV (10,13). However, occupational exposure to human breast milk has not been implicated in the transmission of HIV nor HBV infection to health-care workers. Moreover, the health-care worker will not have the same type of intensive exposure to breast milk as the nursing neonate. Whereas universal precautions do not apply to human breast milk, gloves may be worn by health-care workers in situations where exposures to breast milk might be frequent, for example, in breast milk banking.

Saliva of some persons infected with HBV has been shown to contain HBV-DNA at concentrations 1/1,000 to 1/10,000 of that found in the infected person's serum (15). HBsAg-positive saliva has been shown to be infectious when injected into experimental animals and in human bite exposures (16-18). However, HBsAg- positive saliva has not been shown to be infectious when applied to oral mucous membranes in experimental primate studies (18) or through contamination of musical instruments or cardiopulmonary resuscitation dummies used by HBV carriers (19,20). Epidemiologic studies of nonsexual household contacts of HIV-infected patients, including several small series in which HIV transmission failed to occur after bites or after percutaneous inoculation or contamination of cuts and open wounds with saliva from HIV-infected patients, suggest that the potential for salivary transmission of HIV is remote (5,13,14,21,22). One case report from Germany has suggested the possibility of transmission of HIV in a household setting from an infected child to a sibling through a human bite (23). The bite did not break the skin or result in bleeding. Since the date of seroconversion to HIV was not known for either child in this case, evidence for the role of saliva in the transmission of virus is unclear (23). Another case report suggested the possibility of transmission of HIV from husband to wife by contact with saliva during kissing (24). However, follow-up studies did not confirm HIV infection in the wife (21).

Universal precautions do not apply to saliva. General infection control practices already in existence - including the use of gloves for digital examination of mucous membranes and endotracheal suctioning, and handwashing after exposure to saliva - should further minimize the minute risk, if any, for salivary transmission of HIV and HBV (1,25). Gloves need not be worn when feeding patients and when wiping saliva from skin.

Special precautions, however, are recommended for dentistry (1). Occupationally acquired infection with HBV in dental workers has been documented (4), and two possible cases of occupationally acquired HIV infection involving dentists have been reported (5,26). During dental procedures, contamination of saliva with blood is predictable, trauma to health-care workers' hands is common, and blood spattering may occur. Infection control precautions for dentistry minimize the potential for nonintact skin and mucous membrane contact of dental health-care workers to blood-contaminated saliva of patients. In addition, the use of gloves for oral examinations and treatment in the dental setting may also protect the patient's oral mucous membranes from exposures to blood, which may occur from breaks in the skin of dental workers' hands.

Use of Protective Barriers

Protective barriers reduce the risk of exposure of the health-care worker's skin or mucous membranes to potentially infective materials. For universal precautions, protective barriers reduce the risk of exposure to blood, body fluids containing visible blood, and other fluids to which universal precautions apply. Examples of protective barriers include gloves, gowns, masks, and protective eyewear. Gloves should reduce the incidence of contamination of hands, but they cannot prevent penetrating injuries due to needles or other sharp instruments. Masks and protective eyewear or face shields should reduce the incidence of contamination of mucous membranes of the mouth, nose, and eyes.

Universal precautions are intended to supplement rather than replace recommendations for routine infection control, such as handwashing and using gloves to prevent gross microbial contamination of hands (27). Because specifying the types of barriers needed for every possible clinical situation is impractical, some judgment must be exercised.

The risk of nosocomial transmission of HIV, HBV, and other bloodborne pathogens can be minimized if health-care workers use the following general guidelines: (The August 1987 publication should be consulted for general information and specific recommendations not addressed in this update.)

1. Take care to prevent injuries when using needles, scalpels, and other sharp instruments or devices; when handling sharp instruments after procedures; when cleaning used instruments; and when disposing of used needles. Do not recap used needles by hand; do not remove used needles from disposable syringes by hand; and do not bend, break, or otherwise manipulate used needles by hand. Place used disposable syringes and needles, scalpel blades, and other sharp items in puncture-resistant containers for disposal. Locate the puncture-resistant containers as close to the use area as is practical.
2. Use protective barriers to prevent exposure to blood, body fluids containing visible blood, and other fluids to which universal precautions apply. The type of protective barrier(s) should be appropriate for the procedure being performed and the type of exposure anticipated.
3. Immediately and thoroughly wash hands and other skin surfaces that are contaminated with blood, body fluids containing visible blood, or other body fluids to which universal precautions apply.

Glove Use for Phlebotomy

Gloves should reduce the incidence of blood contamination of hands during phlebotomy (drawing blood samples), but they cannot prevent penetrating injuries caused by needles or other sharp instruments. The likelihood of hand contamination with blood containing HIV, HBV, or other bloodborne pathogens during phlebotomy depends on several factors: 1) the skill and technique of the health-care worker, 2) the frequency with which the health-care worker performs the procedure (other factors being equal, the cumulative risk of blood exposure is higher for a health-care worker who performs more procedures), 3) whether the procedure occurs in a routine or emergency situation (where blood contact may be more likely), and 4) the prevalence of infection with bloodborne pathogens in the patient population. The likelihood of infection after skin exposure to blood containing HIV or HBV will depend on the concentration of virus (viral concentration is much higher for hepatitis B than for HIV), the duration of contact, the presence of skin lesions on the hands of the health-care worker, and - for HBV - the immune status of the health-care worker. Although not accurately quantified, the risk of HIV infection following intact skin contact with infective blood is certainly much less than the 0.5% risk following percutaneous needlestick exposures (5). In universal precautions, **all** blood is assumed to be potentially infective for bloodborne pathogens, but in certain settings (e.g., volunteer blood-donation centers) the prevalence of infection with some bloodborne pathogens (e.g., HIV, HBV) is known to be very low. Some institutions have relaxed recommendations for using gloves for phlebotomy procedures by skilled phlebotomists in settings where the prevalence of bloodborne pathogens is known to be very low.

Institutions that judge that routine gloving for **all** phlebotomies is not necessary should periodically reevaluate their policy. Gloves should always be available to health-care workers who wish to use them for phlebotomy. In addition, the following general guidelines apply:

1. Use gloves for performing phlebotomy when the health-care worker has cuts, scratches, or other breaks in his/her skin.
2. Use gloves in situations where the health-care worker judges that hand contamination with blood may occur, for example, when performing phlebotomy on an uncooperative patient.
3. Use gloves for performing finger and/or heel sticks on infants and children.
4. Use gloves when persons are receiving training in phlebotomy.

Selection of Gloves

The Center for Devices and Radiological Health, FDA, has responsibility for regulating the medical glove industry. Medical gloves include those marketed as sterile surgical or nonsterile examination gloves made of vinyl or latex. General purpose utility ("rubber") gloves are also used in the health-care setting, but they are not regulated by FDA since they are not promoted for medical use. There are not reported differences in barrier effectiveness between intact latex and intact vinyl used to manufacture gloves. Thus, the type of gloves selected should be appropriate for the task being performed.

The following general guidelines are recommended:

1. Use sterile gloves for procedures involving contact with normally sterile areas of the body.
2. Use examination gloves for procedures involving contact with mucous membranes, unless otherwise indicated, and for other patient care or diagnostic procedures that do not require the use of sterile gloves.
3. Change gloves between patient contacts.
4. Do not wash or disinfect surgical or examination gloves for reuse. Washing with surfactants may cause "wicking," i.e., the enhanced penetration of liquids through undetected holes in the glove. Disinfecting agents may cause deterioration.
5. Use general-purpose utility gloves (e.g., rubber household gloves) for housekeeping chores involving potential blood contact and for instrument cleaning and decontamination procedures. Utility gloves may be decontaminated and reused but should be discarded if they are peeling, cracked, or discolored, or if they have punctures, tears, or other evidence of deterioration.

Waste Management

Universal precautions are not intended to change waste management programs previously recommended by CDC for health-care settings (1). Policies for defining, collecting, storing, decontaminating, and disposing of infective waste are generally determined by institutions in accordance with state and local regulations. Information regarding waste management regulations in health-care settings may be obtained from state or local health departments or agencies responsible for waste management.

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Editorial Note: Implementation of universal precautions does not eliminate the need for other category- or disease-specific isolation precautions, such as enteric precautions for infectious diarrhea or isolation for pulmonary tuberculosis (1,2). In addition to universal precautions, detailed precautions have been developed for the following procedures and/or settings in which prolonged or intensive exposures to blood occur: invasive procedures, dentistry, autopsies or morticians' services, dialysis, and the clinical laboratory. These detailed precautions are found in the August 21, 1987, "Recommendations for Preventation of HIV Transmission in Health-Care Settings" (1). In addition, specific precautions have been developed for research laboratories (28).

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