

# **HIV TRAINING IN CHEMICAL DEPENDENCY TREATMENT PROGRAMS, 2015 edition**

**as required in Minnesota Statute 245A.19**

**This publication is a joint venture between the  
Alcohol and Drug Abuse Division, DHS and the  
Minnesota AIDS Project.**

# Chapter 1- Introduction to HIV/AIDS Basic HIV information Available in MN

## HIV Basics

---

Many significant changes have occurred in recent years in the treatment of human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS). This impacts substance abuse treatment practices in complex ways. HIV is a community issue and one that still generates a great deal of misunderstanding and stigma. Each individual can take proper steps in knowing their own status and remaining safe to help stop the spread of HIV.

Common misconceptions and fears are huge roadblocks in the fight against this disease so prevention and education is critical. Because substance abuse and the HIV/AIDS pandemic are so interrelated, substance abuse treatment can play an important role in helping substance abusers reduce risk-taking behavior, thus helping to reduce the incidence of HIV/AIDS. (TIP 37; SAMHSA, 2008).

### What is HIV?

**Human** – because the virus can only infect human beings. Although similar diseases exist in other animals, such as monkeys and cats, those viruses cannot infect humans nor can HIV infect other animals.

**Immunodeficiency** – because the virus creates a deficiency with the body's immune system, causing it to fail to work properly.

**Virus** – because the organism is a virus which is incapable of reproducing by itself; it must use a human cell to reproduce.

**HIV (Human Immunodeficiency Virus)** is a virus that affects certain white blood cells—CD4 T cells—that manage human immune system responses. When these blood cells are damaged, it becomes difficult for people to fight off infections or diseases.

### What does AIDS stand for?

**Acquired** – because HIV is not a condition passed on genetically; a person has to become infected with it.

**Immune** – because the immune system's ability to fight off viruses and bacteria becomes much less effective.

**Deficiency** – because the immune system fails to work properly.

**Syndrome** – because there are a wide range of diseases and infections a person may experience.

When HIV disease was first recognized in the early 1980s, it was called AIDS. Today, the term "HIV disease" is a more accurate description of the condition. However, AIDS is still used, primarily for the purpose of counting infections and as a description for advanced—stages of HIV disease. AIDS refers to individuals who

have particular "AIDS–defining" conditions such as a very low CD4 white blood cell count or specific illnesses.

### How does HIV cause illnesses?

HIV reproduces continuously in the body from the first day of infection. A person may experience severe flu-like symptoms during this initial stage of infection which can last 2-4 weeks. A person's immune system attacks HIV soon after infection and at first is able to clear a large amount of virus from the body every 24 hours. However, for each virus particle cleared, at least one new one is created. The body's initial, vigorous anti–HIV response creates a temporary equilibrium between immune cells and the virus that may last for months or even years.

After the initial infection, a person typically will show no outward signs of illness for a number of years. Over time, however, the virus gains the upper hand. The amount of HIV in the body (viral load) increases and the CD4 T cell count declines. The immune system cannot work properly under constant attack from HIV. Eventually, the virus overwhelms the defenses of the immune system, which then can no longer ward off other illness–causing infections, some of which can be life threatening.

There are now many medications a person living with HIV can take to slow the progression of the disease. When taken as prescribed, these medications can keep a person's health stable for a very long time. When taken as prescribed these medications can also greatly reduce the ability to pass on the virus to others. These medical therapies will be discussed further in chapter 2.

(Re-used with permission from The Minnesota AIDS Project website).

## HIV Transmission

---

Understanding how HIV can and cannot be transmitted is at the core of preventing new infections. HIV is a rapidly changing virus but, thankfully, it is also entirely preventable. In this section, you can learn more about how HIV is transmitted and how to reduce your, or others', risk of being infected. Below are several key points to understand with HIV transmission.

### **1** HIV Must Be Present

Infection may only occur if one of the people involved in an exposure situation is infected with HIV. Some people assume that certain behaviors or exposure situations can cause HIV disease, even if the virus is not present. This is not true.

## **2 There Needs to Be Enough Virus**

The concentration of HIV determines whether infection will occur. In blood, for example, the virus is very concentrated. A small amount of blood is enough to infect someone. The concentration of virus in blood, semen vaginal fluid or breast milk can change, in the same person, over time. Persons who take HIV medications as prescribed can have very low quantities of HIV present in bodily fluids, greatly reducing the risk of transmitting HIV to their partners or their infants.

It is important to note that HIV is a very fragile virus which will die quickly when exposed to light and air. Exposure to small amounts of dried blood or other infectious fluids is not a realistic risk for HIV transmission.

## **3 HIV Must Get Into the Bloodstream**

It is not enough to be in contact with an infected fluid for HIV to be transmitted. Healthy, intact skin does not allow HIV to get into the body.

HIV can enter through an open cut or sore, or through contact with mucous membranes. Transmission risk is very high when HIV comes in contact with the more porous mucous membranes in the genitals, the anus, and the rectum which are inefficient barriers to HIV. Although very rare, transmission is also possible through oral sex because body fluids can enter the bloodstream through cuts in the mouth.

Infectious Fluids – HIV can be transmitted from an infected person to another through:

- Blood
- Semen (including pre-seminal fluid)
- Vaginal secretions
- HIV can also be transmitted through breast milk expressed through feeding, in limited circumstances, where there is exposure to large quantities.

## **HIV Transmission Routes**

HIV can enter the body through open cuts or sores and by directly infecting cells in mucous membranes. HIV cannot cross healthy, unbroken skin. Unprotected sexual intercourse (vaginal, and anal), sharing needles for injection drug use and mother to child transmission (in utero, during delivery, and breastfeeding) are the main transmission routes for the HIV virus.

### **Sexual Transmission**

Sexual activity is the most common way for HIV to be transmitted. HIV can be transmitted through sexual intercourse, both vaginal and anal. HIV can easily pass through the mucus membranes in the vagina and the anus, or may pass through cuts and sores.

Although very rare, HIV can also be transmitted through oral sex. Conditions such as bleeding gums and poor oral health increase the risk of transmission through oral sex.

### **Anal Sex**

Anal sex without a condom is the riskiest activity for HIV transmission. The receptive partner is at the greatest risk because anal tissue is easily bruised or torn during sex which then provides easy access to the bloodstream for HIV carried in semen. The insertive partner is also at some risk because the membranes inside the urethra can provide entry for HIV into the bloodstream. The presence of other sexually transmitted infections can increase the risk of HIV transmission during anal sex.

### **Vaginal Sex**

Unprotected vaginal sex is also considered risky for HIV transmission. The female is at the greatest risk because the lining of the vagina is a mucous membrane which can provide easy access to the bloodstream for HIV carried in semen. The male is also at some risk because the membranes inside the urethra can provide an entry for HIV into the bloodstream. The presence of other sexually transmitted infections can increase the risk of HIV transmission during vaginal sex.

### **Oral Sex with a Man**

The risk of HIV transmission through oral sex with a man is very low because the mouth is an unfriendly environment for HIV. Saliva contains enzymes that break down the virus and the mucous membranes in the mouth are more protective than anal or vaginal tissue. There are a few documented cases where it appears that HIV was transmitted orally and those cases are attributed to ejaculation into the mouth.

The minimal risk of transmission from oral sex with a man is only for the person performing the oral sex. Open cuts and abrasions in the mouth or bleeding gums can create an entry point for HIV and increase the risk of transmission. A person receiving oral sex is generally not at risk because that person is coming into contact only with saliva, which does not transmit HIV. The presence of other sexually transmitted infections can increase the risk of HIV transmission during oral sex.

### **Oral Sex with a Woman**

The risk of transmission through oral sex with a woman is very low because the mouth is an unfriendly environment for HIV. Saliva breaks down the virus and the mucous membranes in the mouth are more protective than anal or vaginal tissue. The minimal risk of transmission from oral sex with a woman is only for the person performing the oral sex as their mouth is in contact with vaginal fluid. However, there is little data documenting HIV transmission via oral sex from an infected woman to an uninfected person.

However, performing oral sex on a woman who is menstruating increases the risk because blood has more HIV than vaginal fluid. A person receiving oral sex is generally not at risk because that person is coming into contact only with saliva, which does not

transmit HIV. The presence of other sexually transmitted infections can increase the risk of HIV transmission during oral sex.

### **Oral to Anal Sex**

Oral to anal contact (rimming) poses minimal risk for HIV transmission. However, rimming is a risk for transmission of hepatitis, parasites, and many other sexually transmitted infections.

### **Non–sexual Transmission**

HIV can be transmitted by contact between infectious fluids and bleeding cuts or open sores in the skin. However, healthy intact skin does not allow HIV to enter the body and provides an excellent barrier against the virus.

Non-sexual transmission is rare. The rare circumstances where non-sexual transmission has occurred typically involve medical settings or accident scenes where there is a very large volume of blood exposure or a needle stick.

### **Injection Drug Use**

Sharing syringes [including needles and works] poses a very high risk for HIV transmission. Sharing a syringe is the most efficient way to transmit the virus as it passes blood directly from one person's blood stream to another's. Sharing syringes is also a very efficient way to transmit other blood borne viruses such as Hepatitis B and Hepatitis C.

### **Tattoos and Piercings**

There have been no documented cases of transmission of HIV by piercing or tattooing. However, there are documented cases of Hepatitis B transmission. Since Hepatitis B and HIV are transmitted by the same activities, there is a theoretical risk of HIV transmission through tattoos and piercing.

### **Mother to Infant Transmission**

It is possible for a mother who has HIV to pass the virus to her baby by exposure to blood and vaginal fluids during birth or through breast milk during feeding. The risk of transmission from mother to child during pregnancy or birth can be greatly reduced by taking certain HIV medications as prescribed. (Re-used with permission from The Minnesota AIDS Project website).

### **HIV Incidence in Minnesota**

The current trend in the national HIV/AIDS pandemic shows that a disproportionate number of minorities who live in inner cities are affected by or at risk for contracting HIV. This population is low income, hard to reach through traditional public health methods, and in

need of a wide range of health and human services (TIP 37; SAMHSA, 2008). Although a low incidence state, Minnesota shows similar trends.

### **Minnesota HIV Summary:**

- There were 301 new HIV diagnoses reported in Minnesota in 2013, a decrease of 4% from 2012.
  - Great disparities in HIV diagnoses persist among populations of color and American Indians living in Minnesota.
  - Male-to-male sex remains the leading risk factor for acquiring HIV/AIDS in Minnesota.
  - New HIV diagnoses remain concentrated in the Twin Cities seven-county metro area (82% of new diagnoses in 2013).
  - Foreign-born (non-US born) persons made up nearly 1 in 5 of new HIV infections in 2013, and progress from HIV to AIDS more quickly than U.S. born persons living with HIV in Minnesota.
- Additional Statistical and epidemiological HIV data for the state of Minnesota and is available from the Minnesota Department of Health at (651)- 201-5414 or online at
- <https://www.health.state.mn.us/diseases/hiv/index.html>

For additional information on HIV, call the MN AIDS Project AIDSline at (612)-373-2437 or 1800-248-2437. The AIDSline will supply information on HIV/AIDS and recommend organizations to contact for more information.

## **Chapter 2- Medical Assessment and Treatment-**

### **HIV Testing**

---

Getting an HIV test is the first step in a client finding out their HIV status. It's also a vital part of preventing the spread of HIV. Regardless of the result, getting an HIV test can empower clients to make decisions that are right for them and to take the necessary steps to live a healthy life. Testing for HIV is a crucial first step in engaging the HIV-infected substance abuser.

A low threshold for testing should exist when one assesses the client's level of risk for HIV. This can be determined by the following: if the client has engaged in risky behaviors; if the client has ever had a sexually transmitted disease (STD); if the client has a history of sharing drug injection equipment; or if the client is presenting with any of a number of symptoms that might indicate recent infection with HIV or early symptomatic infection.(TIP 37; SAMHSA, 2008).

## **Rapid HIV Tests**

There are several tests currently approved by the FDA that provide results in 10 to 40 minutes. All rapid tests look for the presence of HIV antibodies. Results of rapid tests are either negative or reactive.

A negative test means that no HIV antibodies were detected by the test. If the test result is negative and the individual testing has had three or more months without an HIV risk exposure, the person is considered to be negative. If the test result is negative and the individual testing has had a risk in the last three months, the person should be tested again once a full three months has passed to get a conclusive result.

If the test result is reactive, meaning that HIV antibodies have been detected, a confirmatory test is required before a diagnosis of HIV infection can be given. A Western Blot test is generally used as the confirmatory test. This is done through a blood draw and processed at a medical lab. Results of this test are generally available in one to two weeks. (Re-used with permission from The Minnesota AIDS Project website).

## **Anonymous VS Confidential Testing**

Changes in HIV testing funding have eliminated the option for anonymous testing at most sites. In Minnesota, anonymous testing is no longer offered due to reporting requirements. However, confidential testing continues to be available. This means a testing client's information is only used if a test is reactive, and then only to facilitate the process of linking clients to care.

As noted above if a client's test result is negative, nothing further will happen with the information provided by the client. It will be kept in a secure location at the testing site. However, if a client receives a reactive test result, Minnesota's reporting law requires testing sites to pass along all identifying information about the client to the Minnesota Department of Health (MDH). This is to ensure the client receives proper medical care. Getting clients into care soon after they test HIV-positive will greatly improve their health and decrease their chance of spreading the virus.

The information released to MDH is maintained confidentially and specific information about the individual is not released for public use. MDH has established very rigid protocols to protect this data and there has never been a breach of this data. For information about out HIV testing sites, their hours and specific details about HIV testing contact the AIDSLine at 612-373-2437. (Re-used with permission from The Minnesota AIDS Project website).

## **Medical Treatment Considerations**

Treating HIV/AIDS is extremely complex. It is important that the medical care team have experience working with substance-abusing clients because the combination of substance abuse and HIV/AIDS poses special challenges. Integrated care is the best treatment option, and medical practitioners who work with substance abuse treatment centers should be experienced in treating HIV/AIDS patients.

Primary care staff serving HIV-infected patients with substance abuse disorders should understand and be responsive to patients' needs, potential for relapse, and cultural variations. Primary care models that are incorporated as part of substance abuse treatment programs should be evaluated to identify how they can be modified and expanded to address the special needs of the HIV-infected substance abuse disorder population.

Ideally, all treatment programs should be capable of conducting HIV risk assessments and providing basic HIV/AIDS education and counseling to clients. In addition, all programs should provide access to HIV testing and pre- and post-test counseling. If such services cannot be provided, linkages should be established with other agencies that can provide these services, (TIP 37; SAMHSA 2008).

## **Quick Connect Services in Minnesota**

Quick Connect is a service of the Minnesota AIDS Project that assists HIV-positive persons in accessing such resources as transportation, insurance, emergency financial aid, and emotionally supportive services. Quick Connect can also work with individuals who are newly diagnosed, who have been out of medical care, or who are new to Minnesota to link them to on-going medical care. Quick Connect staff helps individuals by answering questions about living with HIV, assisting them in choosing an HIV clinic and making an appointment, as well as making referrals to Medical Case Management programs at both clinic and community-based Case Management programs.

For a Quick Connect appointment, contact the AIDS line at 612-373-2437.

## **Antiretroviral Therapy**

If a client is diagnosed as HIV positive, a thorough medical history is an important step to help the clinician proceed to clinical evaluation and formulate a treatment plan. Before starting antiretroviral therapy in any patient, laboratory studies should be done and may include HIV ribonucleic acid (RNA) (or viral load), CD4+ T cell counts, blood counts,

screening chemistries, syphilis, toxoplasmosis, purified protein derivative (PPD), hepatitis A, B, and C viruses, and chest x-ray. In 2015 the general medical consensus for HIV Antiretroviral treatment is to test and begin treatment as soon as possible. There are clear benefits to viral suppression. The decision to begin antiretroviral therapy in the asymptomatic patient who is also using substances is complicated. The factors that must be considered include patient willingness to begin therapy and remain adherent, the degree of immunodeficiency, the risk of disease progression as determined by plasma HIV RNA, the risks of side effects, the ongoing treatment of other medical conditions, and barriers to care, such as lack of insurance and unstable housing.

Adherence to antiretroviral treatment means that the client must follow a prescribed and Sometimes complicated treatment regimen. Adherence should be maintained because non-adherence can lead to the rapid development of drug resistance. One means to encourage adherence is to educate clients and their significant others about HIV/AIDS treatment (TIP 37; SAMHSA, 2008).

## **HIV and Hepatitis C Co-infection-**

Hepatitis C Virus (HCV) was detected in 1989 and now there is evidence of twin epidemics emerging in the U.S. including HIV/HCV co-infected individuals. About 350,000 Americans are estimated to be co-infected. The risk factors for acquiring HCV are similar to those for HIV and include:

- Transfusion prior to 1991
- Injecting drug use
- Tattooing or body piercing
- Long term hemodialysis
- High risk sexual contact
- Occupational exposures to blood or blood products
- Receiving an organ or tissue transplant from someone infected with HCV
- Transmission from HCV-infected mother to infant.

The most common route for transmission is injecting drug use. Although sexual transmission is low for HCV, it is increased when there is concurrent HIV infection. Co-infected women are three to four times more likely to transmit HCV to their unborn children than women with HCV only. Transmission of HCV from breast feeding has not been definitively demonstrated. (MDH, 2012).

About one quarter of HIV-infected persons in the United States are also infected with Hepatitis C virus (HCV). As of December 31, 2013, 7,723 persons in Minnesota are assumed to be living with HIV. Of these people, 893, (12%) are co-infected with either Hepatitis C or B.

HCV is a bloodborne virus transmitted through direct contact with the blood of an infected person. Thus, co-infection with HIV and HCV is common (50%–90%) among HIV-infected injection drug users (CDC, 2014). Progression of liver disease is accelerated among co-infected individuals, especially those with compromised immune systems from HIV infection. In co-infected persons, age at time of HCV infection, immune cell (CD4) count and level of alcohol consumption are associated with a higher rate of liver fibrosis. Without successful treatment for HCV, co-infection usually leads to an earlier death. At present, liver disease accounts for 50% of deaths among those with HIV, (MDH, 2012). The U.S. Public Health Service/Infectious Diseases Society of America guidelines recommend that all HIV-infected persons be screened for HCV infection (CDC, 2014).

## **HIV, Substance Use and Pain Management**

Managing acute and chronic pain in HIV infected patients with substance abuse disorders can be a challenging clinical problem. As with all patients in pain, the provider's primary goal is to maximize comfort while minimizing side effects. The treatment plan and the reason for using narcotics for pain control must be clear to both provider and patient. It is important not only that the patient knows that his or her pain is taken seriously but also that narcotic use will not be extended beyond a limited period required for analgesia.

Because HIV/AIDS patients often have pain problems similar to those of cancer patients, the World Health Organization's (WHO's) "cancer pain analgesic ladder," <http://www.who.int/cancer/palliative/painladder/en/>, is useful as a starting point for managing pain in HIV infected persons. Setting clear limits and devising a consistent treatment plan can help to reduce the risk of medication abuse by patients (TIP 37; SAMHSA, 2008).

## **Alternative HIV Treatment Therapies**

Care providers must be aware that HIV infected patients may be using alternative or complementary therapies; for example, acupuncture, meditation, and vitamin and herbal dietary supplements. Patients need not be discouraged from trying a therapy unless it is known to be harmful. Clinicians have a responsibility to discover, in a nonjudgmental manner, what alternative or unapproved therapies patients are using and then to obtain as much information as possible about these therapies (TIP 37; SAMHSA, 2008)

## **Chapter 3- Mental Health Treatment-**

### **Coping with an HIV Diagnosis-**

An HIV diagnosis is a life-altering event that will require a number of changes in order to maintain health. However, with the appropriate support and access to care, it is possible to continue living well. HIV is a challenge but one that can be met. Minnesota has a wide

variety of support options to assist people living with HIV and multiple AIDS Services Organizations that serve as resources to help determine the best possible options to achieve the best possible outcomes. Along with identifying a medical health care provider, clients may want to develop the social, emotional or spiritual resources that will help them deal with tough times and make the most of the good times.

MAP AIDSLine has a list of HIV support groups in Minnesota. Health care providers may also have some suggestions. Two MAP programs, Positive Link, <https://www.justushealth.mn/>, and PrideAlive, <http://www.pridealive.org/>, offer social, educational and activist opportunity to meet people who are involved in HIV advocacy and education. Contact MAP AIDSLine for additional support group suggestions and more information. (Re-used with permission from The Minnesota AIDS Project website).

## **Disclosing HIV Status-**

A person who tests HIV positive may have a responsibility to let past and current needle-sharing and/or sexual partners know that they were exposed to HIV as soon as possible so they can be tested. It is important to note, however, that disclosure of an HIV positive person's status can put him or her at risk for bodily harm. Safety considerations should always come into play when considering how and when to disclose. A person's HIV status is private medical information and there are many factors that need to be considered when a person decides when and to whom they should disclose. Some examples to be discussed are family, friends, employers, property managers etc.

For many people, telling partners, friends and family is hard. Sometimes an HIV diagnosis brings secrets about sexual partners, sexual activity or chemical dependency out into the open. In this situation, an individual might have someone a trusted friend, relative or counselor weigh the pros and cons of disclosure with them or to practice what they want to say and how to answer questions.

Isolation and loneliness can have a negative effect on overall health and well-being. Taking the risk to tell people can be helpful in the long run. The MAP AIDSLine is a resource individuals can call and ask the MAP AIDSLine health educators questions about HIV disclosure. . (Re-used with permission from the Minnesota AIDS Project website).

More information related to legal aspects of disclosure can be found in Chapter 9, Legal Issues.

## **Substance Abuse and Mental Health- Treatment Considerations-**

Individuals with substance abuse disorders, whether or not they are HIV infected, are subject to higher rates of mental health disorders than the rest of the population. Counselors working with HIV-infected substance abusers should be aware of the variety of both HIV- and substance-induced psychiatric symptoms. It is also important to recognize that psychiatric symptoms may be caused by substance abuse, HIV/AIDS, or the medications used to treat HIV/AIDS, as well as by pre-existing

psychiatric disorders. Treatment programs that do not have the resources to adequately assess and treat mental illness should be closely linked to mental health services to which clients can be referred. Open lines of communication will enable personnel in both locations to be informed about a client's treatment program. Treatment staff should maintain contact with the client and continue treatment during and after the psychiatric referral.

Assessment and diagnosis of mental illness in HIV-infected substance-abusing clients is a challenge because of these clients' complex problems. Therefore, it is important to evaluate clients' behavior in context (e.g., acute depression is common in people who have just learned they are HIV positive).

Communication between medical and counseling staffs is important to ensure that cognitively impaired clients are not perceived as deceitful or manipulative. Care providers must keep in mind that cognitively impaired clients' non-adherence to treatment may be a result of the impairment and not caused by denial, resistance, or unwillingness to accept care. It is essential to set realistic treatment goals that correspond to the client's functional capacities.

Counseling is an important part of treatment for all substance abusers, including those with comorbid psychiatric disorders. The goal of counseling is to help the HIV-infected substance abuser maintain health, achieve recovery from the substance abuse, and attain the best possible level of psychological functioning, (TIP 37; SAMHSA, 2008).

## **Pharmacological Treatment-**

Standard pharmacologic approaches may be used to treat psychiatric disorders in HIV infected substance abusers, with some specific considerations. With highly active antiretroviral therapy, (HAART), the physician must be aware of potential drug interactions that can increase the toxicity of medications or reduce their levels in the patient's blood, resulting in decreased effectiveness and/or the development of resistance. The mental health counselor should be familiar with the symptoms that could indicate that a client is experiencing a drug interaction. When prescribing, clinicians should attempt to use the lowest effective dose to minimize side effects. With clients symptomatic with HIV/AIDS, it may be wise to begin with very low doses, of the magnitude generally associated with geriatric patients. (TIP 37; SAMHSA, 2008).

## **Suicidality-**

Substance abusers are at increased risk of suicide. HIV-infected individuals may also be at risk of suicide, especially if they are suffering from a mood disorder. Medication should be dispensed in small amounts until a client's level of responsibility can be fully assessed. Suicide risk assessments should be completed on an ongoing basis during the treatment stay. If a client is not acutely suicidal but wants to talk about suicide, the counselor should maintain interest, allow the client to discuss his feelings, assess the severity of the client's suicidality, and obtain help if needed. The counselor should not minimize the client's experiences because talking openly about suicide decreases isolation, fear, and tension. (TIP 37; SAMHSA, 2008).

## **Cultural Considerations-**

Therapeutic interventions must be sensitive to the culture and ethnicity of the client population. Whenever possible, therapists and support group leaders should share the culture of their clients and should speak the same language. Cultural compatibility between therapists and clients is important in creating an atmosphere of trust where sensitive issues, such as family support and group mores, can be addressed, (TIP 37; SAMHSA, 2008).

## **Chapter 4- Primary and Secondary HIV Prevention and HIV Risk Reduction**

HIV is like many other social and public health issues involving behavior, such as smoking, eating health foods, seatbelt use and speeding; people need to be continually reminded. HIV prevention education doesn't always reach those who need the information and for many young people they may only receive the information once while in high school. Later in life they may have many questions and that's why information about HIV prevention should be a part of on-going public health information campaigns. HIV has impacted certain communities disproportionately due to ongoing stigma and fear. Focused prevention efforts can help to engage these communities to slow the spread of HIV.

As of the end of 2013, there were 7,723 people known to be living with HIV in Minnesota. There are several thousand others who are also HIV-positive, but have not been tested and thus don't know their status. Advances in treatment have allowed people with HIV to live longer, healthier lives. That also means that there is a growing percentage of the population that is living with HIV. This trend will continue as long as there is not a viable vaccine for HIV.

HIV is a preventable disease but to achieve this everyone needs complete, accurate information in order to reduce their risk surrounding HIV. Ongoing age-appropriate education is necessary to raise awareness in the public and reduce new infections.

## **HIV Risk Reduction**

### **Sexual Transmission Risk Reduction**

Sexual activity is the most common way for HIV to be transmitted. People have varying ideas of what they think of as sexual activity. When determining risk for HIV and ways to reduce that risk, consider the range of sexual activities clients engage in.

It is important to understand that the risk of HIV transmission from various sexual activities falls along a continuum. Once understanding of where certain sexual activities are on this continuum, steps to take to lower individual risk can be determined.

The goal of traditional safer sex practices is to avoid getting the blood, semen or vaginal

fluid of sexual partners who are HIV–positive or whose HIV status is unknown in your body. It also means to avoid having your blood, semen or vaginal fluid enter your partner if an individual is HIV–positive or their HIV status is unknown.

## **Antiretroviral Advances/PrEP and HIV Risk**

Medical treatment is also now an important part of HIV risk reduction. If a person living with HIV is treated with anti-retroviral medications so that the amount of virus in their blood is undetectable it is much less likely for HIV to be transmitted. This is true even if there is contact with the blood, semen or vaginal fluid of the positive person. For an HIV-negative person, there is also an anti-viral medication that can be prescribed which is referred to as PrEP (Pre-Exposure Prophylaxis). When taken as prescribed, PrEP greatly reduces the risk of being infected when an HIV-negative person is exposed to HIV.

When the medical treatments described above are paired with condom use, the risk of HIV transmission can be nearly zero.

### **What is PrEP?**

PrEP is an acronym for Pre-Exposure Prophylaxis, which describes the taking of the HIV medication Truvada, with the purpose of not contracting HIV. Medical providers have been familiar with PEP, or post-exposure prophylaxis, for quite some time. Now, anyone who meets specific behavioral criteria can get a prescription for PrEP, and protect themselves from HIV. PrEP is a once-daily pill regimen that can reduce risk of HIV infection by 92-99% if adhered to daily by individuals who engage in high risk sexual or injection drug use behaviors. The Centers for Disease Control and Prevention endorsed the use of PrEP for HIV Prevention in May 2014.

### **Who should take PrEP?**

PrEP is approved for those individuals at high risk of contracting HIV. Individuals at high risk of contracting HIV include, but are not limited to: injection drug users, people in relationships with HIV+ folks and individuals who exclusively bareback or intermittently use condoms.

Some questions to ask when considering PrEP:

- Is your main sexual partner HIV-positive? In other words, are you part of a mixed-status couple?
- Has a man – especially an HIV-positive man, or a man whose status you’re not sure about penetrated you during anal sex (“topped” you) without a condom recently?
- Have you been treated recently for a sexually transmitted disease in your butt, such as rectal gonorrhea?
- Have you used PEP more than once in the past year?
- Have you or your partner(s) been in prison?
- Do you use alcohol and/or drugs heavily; or, does your sex partner(s)?

- Do you exchange sex for money, housing or other needs; or, does your sex partner(s)?
- Has your partner threatened you with violence or physically harmed you recently?

If you answer "yes" to any of these then you should consider discussing PrEP with your doctor. (Re-used with permission from the Minnesota AIDS Project website).

### **Where can I get PrEP in Minnesota?**

The Red Door Clinic's Health Interventions for Men (HIM) in Minneapolis accepts clients both with and without insurance, and can work with you to help with access to medication assistance. The HIM Program can be reached at 612-348-9100.

[More about the HIM program.](#)

Red Door Clinic's HIM Program  
525 Portland Ave, 4th floor  
Minneapolis MN 55415

HCMC in Minneapolis can also start individuals on PrEP. For more inquiries and more information please contact the HCMC PrEP voicemail at 612-873-9988.

### **How Effective is PrEP?**

For full effectiveness, PrEP needs to be taken every day, and prescribed individuals need regular check-ups with a medical professional. When combined with latex, polyurethane or polyisoprene condoms, one study of gay/bisexual men and transgender women reported over 99% effectiveness in preventing HIV transmission when taken every day. The Red Door's HIM Program and HCMC's Seventh Street PrEP Clinic are dedicated to providing the supportive services necessary to make PrEP work for eligible individuals. Continue reading below to learn more about HIV risk factors and risk reduction methods for specific scenarios. (Re-used with permission from The Minnesota AIDS Project website).

### **Anal Sex**

To reduce your risk, use a latex, polyurethane or polyisoprene condom when engaging in anal sex. Some people prefer to use "bottom condoms" which can be inserted into the rectum before engaging in anal sex. No matter which type of condom you prefer, be sure to use plenty of water-based lubricant when you have anal sex. Don't use oil-based lubricants, such as petroleum jelly or hand lotion, because oil destroys the condom and causes it to break.

## **Vaginal Sex**

To reduce your risk, use a latex, polyurethane or polyisoprene condom when engaging in vaginal sex. Some people prefer to use female condoms which can be inserted into the vagina before engaging in sexual activity. Use plenty of water-based lubricant when you have vaginal sex. Don't use oil-based lubricants, such as petroleum jelly or hand lotion, because oil destroys the condom and causes it to break.

## **Oral Sex with a Man**

To reduce your risk of HIV transmission completely, use a latex, polyurethane or polyisoprene condom when performing oral sex on a man. If you do not use a condom you can also reduce your risk by not having your partner ejaculate in your mouth. Talk to your partner about their sexual health and do not perform oral sex on someone who has an active sexually transmitted infection. Do not perform oral sex if you have other oral health conditions which have significantly compromised the tissue in your mouth.

## **Oral Sex with a Woman**

There is little data documenting HIV transmission through performing oral sex on a woman. To completely eliminate HIV risk, use a barrier such as a dental dam or plastic wrap. If you do not use a barrier you can reduce your risk by not performing oral sex on a woman who is menstruating. Talk to your partner about their sexual health and do not perform oral sex on someone who has an active sexually transmitted infection. Do not perform oral sex if you have other oral health conditions which have significantly compromised the tissue in your mouth.

## **Oral to Anal Sex**

There is little data documenting HIV transmission through oral to anal sex. When engaging in oral to anal sex you can significantly reduce the HIV risk by using a barrier such as a dental dam or plastic wrap.

## **Non-Sexual Transmission Risk Reduction Injection Drug Use**

One way to reduce the risk of HIV infection is to abstain from injecting drugs. Current users or those who may be at risk for substance abuse may choose to find support from treatment programs or other sources. Another way to reduce risk is to use a new syringe each time you inject and use it only once. If a person does reuse, only their own equipment should be used. Sharing injection drug equipment is always a risk form transmission of blood borne infections like HIV and Hepatitis B and C. In Minnesota, it is legal to possess ten or fewer clean syringes. Some Minnesota pharmacies sell syringes in "ten packs" to any individual (Re-used with permission from The Minnesota AIDS Project website).

Please visit the Minnesota Department of Health website for more information and a list of participating pharmacies.

<https://www.health.state.mn.us/people/syringe/index.html>

## Syringe Exchange Programs-

Needle and syringe exchange programs are a type of harm reduction program that provide clean equipment to people who inject drugs. World Health Organization (WHO) studies report that Syringe Exchange Programs significantly and cost effectively reduce the number of HIV infections without evidence that the programs exacerbate injection drug use at either an individual or societal level. In December 2011 the United States Congress reinstated a federal ban on funding for syringe exchange programs. This has further marginalized the program participants and increased barriers for implementation and optimum management of such initiatives, (AVERT.org, 2014). You can exchange your used syringes at the following locations in Minnesota:

Minnesota AIDS Project's Mainline Syringe Exchange Program

1400 Park Avenue South

Minneapolis, MN 55404

<http://www.mnaidsproject.org/services/prevention-testing/syringe-exchange.php>

Rural AIDS Action Network Syringe Services Program-Duluth

114 1st Ave W

Duluth, MN 55802

<http://www.raan.org/>

Minnesota Transgender Health Coalition- The Shot Clinic

3405 Chicago Avenue South

Minneapolis, MN 55407

[http://www.mntranshealth.org/index.php?option=com\\_content&task=view&id=65&Itemid=68](http://www.mntranshealth.org/index.php?option=com_content&task=view&id=65&Itemid=68)

Valhalla Place- Woodbury

6043 Hudson Drive Suite 220

Woodbury, MN 55125

Phone: 651-925-8200

Valhalla Place- Brooklyn Park

2807 Brookdale Drive N.

Brooklyn Park, MN 55444

Phone: 763-237-9898

## Tattoos and Piercings

There have been no documented cases of transmission of HIV by piercing or tattooing. However, there is a theoretical risk for transmission of HIV and other blood borne viruses. To eliminate your risk only use licensed tattoo and piercing services that comply with universal precautions.

## Reducing Risk from Mother to Infant During Pregnancy, Childbirth and Breastfeeding

In the United States, reducing the risk of transmitting HIV from mother to child during pregnancy or childbirth has been a success story. With the use of antiviral therapy during pregnancy, the rate of transmission for HIV-positive women to their infants has decreased overall from 25 percent to less than two percent.

It is recommended that all pregnant women who do not know their HIV status have an HIV test as early as possible in the pregnancy. If this test does not show the woman is HIV-positive, but she is engaged in high-risk activities, the test should be repeated during the pregnancy, preferably three months after the last known high-risk activity. Knowing your status allows you to make the best decisions to protect your health and the health of your baby.

If a woman is HIV-positive, receiving antiviral treatment for HIV will reduce the risk of transmission to two percent or less. Treatment will include anti-retroviral medication during the pregnancy, labor and delivery. In some cases a physician may decide that a cesarean section will further reduce the transmission risk, but this is not always necessary. After birth, additional steps are taken to reduce the risk of HIV infection for the infant. Antiviral therapy is given to the infant for four to six weeks. Breast milk contains HIV and it is possible for an HIV-positive woman to transmit HIV to her baby through breast feeding. Talk to your physician to determine the best alternative to breast feeding to eliminate this risk.

Determining the HIV status of an infant takes time and requires repeat testing. Standard HIV tests look for the presence of HIV antibodies. Because infants of HIV-positive mothers have the mother's HIV antibodies, they will automatically test "positive" after birth. It can take up to 18 months for an infant to clear these antibodies and receive an accurate HIV antibody test. Because of this issue, physicians recommend using a testing method that looks for the presence of the actual HIV virus and can give a definitive result within a few months of birth.

## Reducing Risk in Occupational and Controlled Exposure Settings

The best way to reduce risk in occupational settings is to use universal precautions. However, accidents can occur which involve a potential exposure putting a person at risk

of infection. Post–Exposure Prophylaxis (PEP) treatment used immediately following a serious exposure that poses a demonstrated risk for HIV infection can significantly reduce the likelihood of the exposure resulting in an infection.

The idea behind PEP treatment is to attack the virus with HIV antiviral drugs; this prevents the virus from starting its replication process in the body. PEP treatment is routinely used in occupational settings, particularly in healthcare settings to prevent infection from work–related exposures. In some circumstances, physicians will prescribe PEP treatment for individuals who have experienced a recent non–occupational exposure such as a sexual or injecting drug use exposure.

PEP treatments typically include a combination of HIV antiretroviral drugs and will last for one month. The combination may vary depending upon the seriousness of the exposure. PEP treatments needs to start as soon as possible after an exposure and no more than 72 hours after the exposure. (Re-used with permission from The Minnesota AIDS Project website).

## **Prevention Considerations in Substance Abuse Treatment-**

For HIV-infected clients in substance abuse treatment, there must be a comprehensive approach to treatment that includes three goals: living substance free and sober, slowing or halting the progression of HIV/AIDS, and reducing HIV risk taking behavior.

Counselors should address the full range of potential risk behaviors in their history taking, including both syringe sharing and unsafe sex. They must take into account a wide range of sexual orientations, including those of homosexual, bisexual, heterosexual, and transgender clients. As outlined in previous sections, condom use and safer sex practices education must be a special focus of the assessment.

HIV sexual risk reduction programs should be integrated into substance abuse treatment programs. Sexual risk reduction programs should provide clients with basic information about safer sex practices, as well as an array of alternative strategies and choices that are client controlled. Counselors need to know what the client believes about HIV/AIDS, including any information the client received from other treatment professionals.

In promoting risk reduction, the alcohol and drug counselor should help the client understand the need for change, provide psychological support for behavior change, and assist the client in developing the appropriate skills to sustain the behavior change. Discussion of risk behaviors should take place in language that is culturally appropriate, clear, and understandable.

IDU risk reduction is best approached in a step-wise fashion; for example, abstinence is the best step, no syringe use is the second best step, not sharing syringes is the third best step, using only clean syringes is the fourth best step, and so on. (TIP 37; SAMHSA, 2008).

## **Exposure Control in Substance Abuse Treatment Settings-**

The HIV/AIDS pandemic poses a number of challenges for infection control policy and practice in substance abuse treatment programs. Treatment programs should apply the same universal precautions that exist in hospitals and other health care facilities.

The most important approach to reducing the risk of occupational HIV transmission is to prevent exposure. However, in the event of occupational exposure, substance abuse treatment programs should follow the CDC's recommendations for post-exposure prophylaxis. (See the previous section: Reducing Risk in Occupational and Controlled Exposure Settings). (TIP 37; SAMHSA, 2008).

## **Chapter 5- Integrating Treatment Services-**

Treatment for substance abuse and HIV/AIDS should reflect the interconnected relationship they share and be coordinated as much as possible to maximize care for persons with both HIV/AIDS and substance abuse disorders. Substance abuse treatment counselors and HIV/AIDS service providers should continue to develop their skills in establishing and maintaining treatment plans that support the "total" person.

In any effort to develop integrated treatment for substance abuse and HIV/AIDS treatment, either within a single agency or through individual care plans, the following are essential: having a strong case management model, including social services as a core part of the treatment plan, crosstraining all providers in the requirements of the other treatment centers, and facilitating eligibility determinations.

Many HIV-infected substance abusers are unable to maintain total discontinuation of substance use. In dealing with clients' ongoing substance abuse, treatment programs must find a balance between abstinence-oriented approaches, where clients must immediately stop substance use, or public health-oriented approaches, where clients who cannot abruptly abstain are encouraged to reduce substance use gradually.

Counselors who work with HIV-positive substance abusers should familiarize themselves with the local AIDS Service Organizations (ASOs) and substance abuse treatment services. When establishing a network of care coordination, the provider must consider the issue of confidentiality. Providers must be aware of State and Federal laws and professional ethical codes, along with agency and community policies and agreements. The provider should understand the difference between "consent" and "informed consent." (TIP 37; SAMHSA, 2008).

# Minnesota Chemical Dependency Rules and Statutes-

Statutes related to chemical dependency treatment in Minnesota can be found on the Minnesota Department of Human Services Chemical Health webpage:

[http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id\\_054366](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_054366)

Minnesota statutes specifically related to HIV and Chemical Dependency can be found on the Office of the Revisor of Statutes webpage: <https://www.revisor.mn.gov/statutes/?id=245A.19>

## AIDS Service Organizations in Minnesota-

### African American AIDS Task Force-

Provides culturally specific prevention, education and case management services for people of African descent that are living with or at risk for HIV/AIDS.

<http://www.aaatf.org/>

### The Aliveness Project-

A community center located in South Minneapolis that provides nutrition, complementary therapies and case management services to the HIV/AIDS community.

<http://www.aliveness.org/>

### Clare Housing-

Clare Housing provides a continuum of affordable and supportive housing options that create healing communities and optimize the health of people living with HIV/AIDS.

<http://www.clarehousing.org/>

### Delaware Street Clinic -

Research, education and family services at the HIV primary care clinic for the University of Minnesota in Minneapolis.

<http://www.uofmmedicalcenter.org/Clinics/InfectiousDiseaseHIVClinicDelawareStClinic>

### Hennepin County Public Health/ Red Door Clinic-

Minnesota's largest HIV and STD testing site.

<http://www.reddoorclinic.org/>

### Hope House-

Provides housing and assisted care to individuals living with HIV who can no longer live independently.

<http://www.hopehousescv.org/>

### Indigenous People's Task Force-

HIV/AIDS education, prevention, case management and support services to the Native American community.

<http://indigenouspeoplestf.org/>

### Minnesota AIDS Project-

Harm reduction services, legal services, benefit counseling, case management, transportation, chemical health and peer support services with other persons living with HIV and advocacy for the gay and lesbian community.

<http://www.mnaidsproject.org/>

One Heartland-

Camping and support for kids and teens with HIV/AIDS.

<http://www.oneheartland.org/>

Open Arms of Minnesota-

Prepares and delivers meals to people living with HIV/AIDS and other chronic illnesses.\

<http://www.openarmsmn.org/>

Positive Care Center at Hennepin County Medical Center-

Provides education, Case Management and serves as a community and family resource, and contributes extensively to the advancement of HIV-related knowledge.

[http://www.hcmc.org/clinics/HCMC\\_CONDITIONS\\_80](http://www.hcmc.org/clinics/HCMC_CONDITIONS_80)

Rural AIDS Action Network -

Locates rural primary health care providers, HIV testing, outreach and case management.

<http://www.raan.org/>

Sub-Saharan African Youth and Family Services in Minnesota-

Provides HIV education and materials appropriate to African-born persons throughout Minnesota, with focus on the Ethiopian and Oromo communities.

<http://www.sayfsm.org/>

Tubman/Chrysalis-

Provides health and human service programs to women, children and families.

<http://tubman.org/>

Turning Point, Inc.-

Provides social services and public health programs to the African-American community in the Twin Cities metro area, including housing and HIV/AIDS case management.

<http://www.ourturningpoint.org/>

Westside Community Support Services, La Clinic

Provides HIV support and counseling for Spanish speaking clients.

<http://www.westsidechs.org/programs.php?clinic=4>

Youth and AIDS Projects-

Prevention programs, counseling and testing services, financial assistance, case management, mental health services and advocacy services.

<http://www.yapmn.com/>

See chapter 6 for additional resources for people living with HIV available in Minnesota.

## **Chapter 6- Accessing and Obtaining Services-**

A case management approach recognizes that satisfying such basic needs as general health and adequate housing and food when an individual is actively abusing substances can be overwhelming and that substance abusing behavior will impair a person's ability to gain access to a formalized system of services. For best outcomes, case management should be utilized in dealing with the multiple problems presented by HIV/AIDS in combination with substance abuse. Case management promotes teamwork among the various care providers. For example, linkages among the client's primary care provider, Medical/HIV case manager, mental health provider, and substance abuse treatment provider can greatly benefit the client and improve care.

It is sometimes difficult for the HIV-infected substance abuser to find and fund needed services. The case manager can play an important role in helping find specific services and navigate the plethora of public and private funding options. The counselor should be familiar with funding options for services such as substance abuse treatment, mental health treatment, medical and dental care, and HIV/AIDS drug therapy.

Counselors should be knowledgeable about the eligibility criteria, duration of service, and amount of assistance for basic financial assistance programs, including welfare, unemployment insurance, disability income, food stamps, and vocational rehabilitation. For specific information on economic assistance available in Minnesota visit the Department of Human Services website:

<http://mn.gov/dhs/>.

In response to implementation of the Affordable Care Act, Minnesota's health care exchange, MNSURE has partnered with six health insurance agencies across the state to offer free, in-person enrollment assistance. Certified agents and navigators will be available to answer questions, recommend plan selection and work to help you complete your enrollment. Whether you seek a competitively priced private health insurance plan, or qualify for a public program like Medical Assistance or MinnesotaCare, you can contact a lead agency listed below to schedule an appointment or request walk-in hours. For more information please visit the MNSURE webpage at <https://www.mnsure.org/>, or contact MNSURE by phone at 1-855-366-7873.

The Ryan White Care Act provides additional coverage for those living with HIV that may be uninsured or under-insured. More information regarding Ryan White programs can be found in Chapter 10., Funding and Policy Considerations. For information about Ryan White Programs in Minnesota please visit the Minnesota Department of Human Services webpage:

[http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=HA\\_01](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=HA_01)

For a comprehensive guide to HIV related resources in Minnesota please visit the Minnesota AIDS Projects AIDSline resource guide webpage. Or contact the AIDSline at 612-373-2437

<http://www.mnaidsproject.org/resource-guide/>

## **Chapter 7- Counseling Clients-**

Before conducting any screening, assessment, or treatment planning, counselors should reassess their personal attitudes and experiences toward working with HIV infected substance-abusing

clients. It is important for a provider to reassess comfort level with each client because clients vary in demographic and cultural background.

Providers should identify other programs and agencies with which to network in order to provide care for their clients. At a minimum, client services should include the following in order of priority: substance abuse treatment, medical care, housing, mental health care, nutritional care, dental care, ancillary services, and support systems.

Providers must take precautions when notifying clients of HIV test results, complying with regulations to ensure that their confidentiality is preserved. Treatment providers and counselors must examine two essential factors when working with linguistically, culturally, racially, or ethnically different populations: the socioeconomic status of the client or group and the client's degree of acculturation. A distinction may need to be made between a population as a whole and a particular segment of that population.

Providers must work to develop culturally competent systems of care. One component of this involves making services accessible to and highly usable by the target risk populations. Effective systems also recognize the importance of culture, cross-cultural relationships, cultural differences, and the ability to meet culturally unique needs.

Clients facing progressive illness and disability need a variety of supportive services. The counseling of ill and dying clients should be supportive and non-confrontational, addressing issues relevant to the client's illness at a pace determined by the client. Providers should increase their proficiency at counseling clients who are at the end stages of AIDS by examining their own beliefs about death and dying. Providers should discuss end-of-life health care options with clients, such as making a living will, appointing a health care proxy, and so on, and they should do this before clients become ill. In preparing their children for the loss of parents, clients should be practically assisted in the following areas: legal guardianship, standby guardianship, leaving a legacy of living memories, and dealing with survivor guilt. (SAMHSA, 2008).

## **At Risk Clients and Substance Abuse Treatment-**

As previously discussed, in Minnesota HIV is disproportionately represented in specific populations. Some of these include but are not limited to men who have sex with men and transgender individuals, people who live in the Twin Cities Metro, people of African American, Latino and American Indian descent, and foreign born individuals. It is vital that treatment staff complete training to be competent in working with diverse populations and the unique issues that are relevant to at risk populations.

## **Chapter 8- Ethical Issues**

Because providers routinely encounter emotionally charged issues when treating substance abusers, they should possess the tools to explore ethical dilemmas objectively. By doing so, and by

examining their own reactions to the situation, providers can proceed with the most ethical course of action. All programs should have a consistent process for dealing with ethical concerns. While ethical issues are usually complex enough to require a case-by-case evaluation, agency practices should include a routine process for approaching an ethical issue, (TIP 37; SAMHSA, 2008).

## **The Need for Staff Training-**

Issues relating to ethics rarely are covered in orientation sessions or continuing education activities within agencies. Perhaps this is because these issues can be so personal and there are no clear right or wrong answers in many of the case examples. Yet, the intense nature of the job and the problem solving required in the daily work of a substance abuse treatment professional require that further training about ethics be provided. This section can be a starting point for ongoing discussions among those treating persons with HIV in substance abuse treatment programs (TIP 37; SAMHSA, 2008).

## **The Ethics of HIV/AIDS-**

Taking the most ethical course of action becomes even more complex when HIV/AIDS is thrown into the mix of concerns that the client may present. HIV/AIDS has its own unique ethical issues. Because HIV can be transmitted through sexual activity and by sharing drug equipment, it evokes significant personal feelings and judgments in the general public, as well as in health and social service providers.

Advocates for persons with HIV have fought for years to maintain confidentiality, avoid mandatory reporting, and ensure access to care for those with the disease. Because of the labels “drug abuser” or “homosexual” and the fear of a backlash toward people with HIV, advocates have been working to eliminate stigma and discrimination. This has led to creating safeguards to protect these individuals from discrimination in health care, employment, housing, and other services.

Minnesota AIDS Project launched its “HIV Stigma Stops with Me” initiative in June of 2013 with a splash of community awareness activities at the Twin Cities Pride festival. The campaign raised awareness through education and by encouraging people to sign a personal and/or organizational pledge to fight stigma. More than 700 people signed the pledge, either online or at events in 2013 and 2014. For more information on this Campaign and other Minnesota initiatives please visit the Minnesota AIDS Project web page: <http://www.mnaidsproject.org/community/hiv-stigma.php>

The duty to treat, from an ethical perspective, is especially relevant when working with disenfranchised populations. A clinician involved with homeless, chronic alcohol dependent individuals may find it difficult to access services for a client with HIV. Substance abuse treatment professionals may have to take on an advocacy role within their community to educate and campaign for care. At the same time, it is important that the counselor and the counselor’s agency appear accessible to all and that there are no restrictions that could impede the care of one client just because the client is different in some way. Adding restrictions to a population that is already disenfranchised will require more creativity, patience, and determination on the part of the clinician who is trying to advocate for a client, (TIP 37; SAMHSA, 2008).

## Reporting HIV-

Ethical and legal HIV reporting obligations for individuals and clinicians vary from state to state. For specific information related to disclosure, reporting and legal implications visit the MN Department of Health's webpage on Reporting Human Immunodeficiency Virus (HIV), Including Acquired Immunodeficiency Syndrome (AIDS) (lab-confirmed cases).

<http://www.health.state.mn.us/divs/idepc/dtopics/reportable/hiv.html#who>

See chapter 9 for additional legal information related to HIV/AIDS.

## Chapter 9- Legal Issues

Substance abuse treatment providers may encounter discrimination against their clients as they try to connect them with services. Counselors should be familiar with Federal and State laws that protect people with disabilities and how these laws apply to HIV-infected substance abusers. Although the Federal law protecting information about clients in substance abuse treatment and State laws protecting HIV/AIDS-related information both permit a client to consent to a disclosure, the consent requirements are likely to differ. Therefore, when a provider contemplates making a disclosure of information about a client in substance abuse treatment who is living with HIV/AIDS, he or she must consider both Federal and State laws.

The rules regarding confidentiality in the provision of substance abuse treatment to persons with HIV/AIDS are very specific. Generally, no more than two sets of laws will apply in any given situation. If only substance abuse treatment information will be disclosed, a program is generally safe following the Federal rules. If HIV/AIDS– treatment-related information will be disclosed, and the disclosure will reveal that the client is in substance abuse treatment, the program must comply with both sets of laws (Federal and State). When in doubt, the best practice is to follow the more restrictive rules.

Any counselor or program considering informing someone of a client's HIV/AIDS status without the client's consent should carefully analyze whether there is, in fact, a duty to warn. It may be possible to persuade the client to communicate this information him or herself or consent to the program staff doing so. For information about criminal charges that may result after HIV transmission, as well as criminal charges that can result in a person being required to take an HIV test, please visit the Minnesota AIDS Project HIV Statutes page:

<http://www.mn aidsproject.org/public-policy/minnesota-hiv-statutes/criminal.php>

As noted in Chapter 8, Ethical Issues, providers in Minnesota should refer to reporting and disclosure guidelines specific to the Minnesota Department of Health.

<http://www.health.state.mn.us/divs/idepc/dtopics/reportable/hiv.html#who>

For additional legal inquiries clients and providers in Minnesota can also contact the AIDSline at 612-373-2437, or consult with the Minnesota AIDS project's legal department. Legal staff are available to assist with a variety of legal services related to HIV including confidentiality, estate planning, debt counseling, discrimination and accessibility, and benefits assistance. Please use the link below for additional information.

# Chapter 10- Funding and Policy Considerations

## State and Federal Policy Shifts-

Dramatic changes in clinical management of HIV/AIDS have resulted in a shift from regarding AIDS as a fatal disease to a chronic one, and as a result funding urgency and need has diminished in the eyes of both policymakers and some segments of the public. Questions have been raised about why AIDS support has been so great given that other disease conditions such as cancer and heart disease kill many more people. Organizations advocating for these conditions have begun to lobby intensively for increased funding, thereby increasing competition for dollars that were allocated to HIV/AIDS.

## National HIV Strategy-

In 2010, President Barack Obama committed to developing a National HIV/AIDS Strategy with three primary goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities.

This strategy focuses on effective treatment as prevention. More must be done to ensure that new prevention methods are identified and that prevention resources are more strategically concentrated in specific communities at high risk for HIV infection. People who are aware of their HIV status and who are effectively engaged in antiretroviral treatment are much less likely to transmit the virus to others. For more information related to The National HIV Strategy please visit the White House's Office of National AIDS Policy: <http://www.whitehouse.gov/administration/eop/onap/nhas>

## Mainstreaming HIV Services-

AIDS-related comprehensive treatment planning groups are increasingly recommending the mainstreaming of some services to help address fragmentation of services and funding. In some instances, this takes the form of awarding services under competitive bid processes to private or public organizations that historically have not been identified as HIV/AIDS service organizations.

Examples of mainstreaming include:

- Awarding Housing Opportunities for Persons With AIDS (HOPWA) contracts to private housing brokers who maintain lists and links of available housing units, manage vendor payments, and provide home management skills training to residents.
- Awarding home-based meal services to meal delivery organizations such as Meals on Wheels.

- Providing transportation by private bus companies and taxi-jitney services.
- Providing contracts to private providers for mental health services and spiritual counseling.
- Awarding dollars for return-to-work initiatives to work placement companies such as Goodwill Industries and Manpower Development Services.

There are several advantages to mainstreaming:

- Increased familiarity with scopes of work for specific services.
- Less time and effort spent in program startup Industry-wide standards of care, service, and quality are often already in place

Those considering mainstreaming services may have to address the following challenges:

- Refragmentation of services
- Increase in the size and complexity of multidisciplinary teams.
- Reluctance of private sector providers to attend multidisciplinary team meetings without identifying meeting attendance as billable services.
- Difficulties in establishing linked entries in Uniform Reporting System from private providers.
- Possible harm to people with HIV/AIDS from providers not trained in cultural competency, HIV/AIDS, or substance abuse treatment

## **Ryan White HIV/AIDS Program-**

The Ryan White HIV/AIDS Program works with cities, states, and local community-based organizations to provide services to an estimated 536,000 people each year who do not have sufficient health care coverage or financial resources to cope with HIV disease. The majority of Ryan White HIV/AIDS Program funds support primary medical care and essential support services. A smaller but equally critical portion is used to fund technical assistance, clinical training, and the development of innovative models of care.

The Ryan White HIV/AIDS Program, first authorized in 1990, is funded at \$2.32 billion in fiscal year 2014. The Program is administered by the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB). (HRSA, 2014).

Program and enrollment information on Minnesota's Ryan White assistance program, Program HH, can be found on the Minnesota Department of Human Services website:

[http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=HA\\_01](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=HA_01)

For more information on current initiatives and recent information on HIV related funding and services can be located on the Health Services and Resources Administration HIV/AIDS programs webpage <http://hab.hrsa.gov/>.

## **HIV/AIDS Policy Recommendations for Minnesota-**

## **Investments in HIV Prevention and Services is Smart Public Policy-**

In 2012, Minnesota experienced an 8 percent overall increase in new HIV infections, followed by a 4% reduction in 2013. Government has a responsibility to the state's public health, and HIV is a public health issue. Investment in HIV prevention and services is smart public policy and saves taxpayers in the long run ensuring that people living with HIV receive necessary medical treatment and support, assisting them with living their lives to the fullest potential, and help prevent new HIV infections.

### **HIV Prevention Programs Can Save Taxpayer Dollars**

Minnesota currently provides approximately \$1.4 million for HIV prevention programming to targeted communities. In a cost-benefit analysis of HIV prevention programs, researchers found that the lifetime costs of caring for a person living with HIV are far greater than the funding needed to reach that same individual with prevention messages. The study found that even a greatly expanded HIV prevention program in the U.S. could pay for itself through savings in averted medical care costs.

### **Treatment and Services for People Living with HIV are Essential**

Minnesota currently provides approximately \$1.2 million per fiscal year for insurance premiums and case management program support. While HIV prevention programs are a public health priority, we must also commit to ensuring that people living with HIV receive the medical care and services they need. State resources currently fund important services for people living with HIV. This includes subsidized insurance premiums for low income, or uninsured individuals. Case management programs rely on state funds to help people living with HIV manage the disease and access services necessary for their health and well being. When HIV positive individuals learn their status, receive education about HIV and how it is transmitted, and begin to receive necessary medical care and support services, they are less likely to transmit the virus to others.

### **Take Action**

Minnesota funds targeted HIV prevention programming and services for people living with HIV with state resources from the General Fund. These resources are vital to preventing new HIV infections and helping people living with HIV to do so with respect and dignity. In these difficult financial times, it is all the more important to invest in these vital programs. Please protect state resources for HIV prevention and services. (Reprinted with permission from the Minnesota AIDS Project webpage).