Substance Abuse, Ethics, HIV, and Hepatitis
“John’s in charge of advising us on ethical matters, but to be honest, I’ve never had much confidence in him!”
A Little More Humor...

RUN THIS BY THE LEGAL DEPARTMENT, BUT RUN SUPER FAST SO THE ETHICS DEPARTMENT DOESN'T SEE IT.
Considering Ethics Exercise

- In a small group/pairs consider the following:
- Define “ethics” in your own words.
- How do you know you are in an ethical dilemma?
- What the main ethics you value?
Now let's consider clients with substance abuse disorders and HIV and Hepatitis...what are some of the main ethical issues when working with this population?

Any personal examples that you are willing to share?
CSAC Ethics

Non-Discrimination
The substance abuse counselor shall not discriminate against clients or professionals based on race, religion, age, gender, disability, national ancestry, sexual orientation or economic condition.

a. The substance abuse counselor shall avoid bringing personal or professional issues into the counseling relationship. Through an awareness of the impact of stereotyping and discrimination, the counselor guards the individual rights and personal dignity of clients.

b. The substance abuse counselor shall be knowledgeable about disabling conditions, demonstrate empathy and personal emotional comfort in interactions with clients with disabilities, and make available physical, sensory and cognitive accommodations that allow clients with disabilities to receive services.
Non-Discrimination

- Consider the ethical principle of Non-Discrimination and working with clients that are HIV Positive and in Recovery.
- Examples??
Responsibility
The substance abuse counselor shall espouse objectivity and integrity, and maintain the highest standards in the services the counselor offers.

a. The substance abuse counselor shall maintain respect for institutional policies and management functions of the agencies and institutions within which the services are being performed, but will take initiative toward improving such policies when it will better serve the interest of the client.

b. The substance abuse counselor, as educator, has a primary obligation to help others acquire knowledge and skills in dealing with the disease of alcoholism and drug abuse.

c. The substance abuse counselor who supervises others accepts the obligation to facilitate further professional development of these individuals by providing accurate and current information, timely evaluations and constructive consultation.

d. The substance abuse counselor who is aware of unethical conduct or of unprofessional modes of practice shall report such inappropriate behavior to the appropriate authority.
Consider the ethical principle of Responsibility and working with clients that are HIV Positive and in Recovery.

Examples??
Competence

The substance abuse counselor shall recognize that the profession is founded on national standards of competency which promote the best interests of society, of the client, of the counselor and of the profession as a whole. The substance abuse counselor shall recognize the need for ongoing education as a component of professional competency.

a. The substance abuse counselor shall recognize boundaries and limitations of the counselor’s competencies and not offer services or use techniques outside of these professional competencies.

b. The substance abuse counselor shall recognize the effect of impairment on professional performance and shall be willing to seek appropriate treatment for oneself or for a colleague.

The counselor shall support peer assistance programs in this respect.
Standards of Competency
Addiction Counselor Competencies

THE FOUR TRANSDISCIPLINARY FOUNDATIONS
I. Understanding Addiction
II. Treatment Knowledge
III. Application to Practice
IV. Professional Readiness
Understanding Addiction

**Competency 1:**
Understand a variety of models and theories of addiction and other problems related to substance use.

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Attitudes</th>
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<tbody>
<tr>
<td>◆ Terms and concepts related to theory, etiology, research, and practice.</td>
<td>◆ Openness to information that may differ from personally held views.</td>
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<tr>
<td>◆ Scientific and theoretical basis of model from medicine, psychology, sociology, religious studies, and other disciplines.</td>
<td>◆ Appreciation of the complexity inherent in understanding addiction.</td>
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<tr>
<td>◆ Criteria and methods for evaluating models and theories.</td>
<td>◆ Valuing of diverse concepts, models, and theories.</td>
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<tr>
<td>◆ Appropriate applications of models.</td>
<td>◆ Willingness to form personal concepts through critical thinking.</td>
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<tr>
<td>◆ How to access addiction-related literature from multiple disciplines.</td>
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Understanding Addiction

**COMPETENCY 2:**
Recognize the social, political, economic, and cultural context within which addiction and substance abuse exist, including risk and resiliency factors that characterize individuals and groups and their living environments.

**KNOWLEDGE**
- Basic concepts of social, political, economic, and cultural systems and their impact on drug-taking activity.
- The history of licit and illicit drug use.
- Research reports and other literature identifying risk and resiliency factors for substance use.
- Statistical information regarding the incidence and prevalence of substance use disorders in the general population and major demographic groups.

**ATTITUDES**
- Recognition of the importance of contextual variables.
- Appreciation for differences between and within cultures.
Understanding Addiction

**COMPETENCY 3:**
Describe the behavioral, psychological, physical health, and social effects of psychoactive substances on the person using and significant others.

**KNOWLEDGE**
- Fundamental concepts of pharmacological properties and effects of all psychoactive substances.
- The continuum of drug use, such as initiation, intoxication, harmful use, abuse, dependence, withdrawal, craving, relapse, and recovery.
- Behavioral, psychological, social, and health effects of psychoactive substances.
- The effects of chronic substance use on clients, significant others, and communities within a social, political, cultural, and economic context.
- The varying courses of addiction.
- The relationship between infectious diseases and substance use.

**ATTITUDES**
- Sensitivity to multiple influences in the developmental course of addiction.
- Interest in scientific research findings.
Understanding Addiction

**COMPETENCY 4:**
Recognize the potential for substance use disorders to mimic a variety of medical and mental health conditions and the potential for medical and mental health conditions to coexist with addiction and substance abuse.

**KNOWLEDGE**
- Normal human growth and development.
- Symptoms of substance use disorders that are similar to those of other medical and/or mental health conditions and how these disorders interact.
- The medical and mental health conditions that most commonly exist with addiction and substance use disorders.
- Methods for differentiating substance use disorders from other medical or mental health conditions.

**ATTITUDES**
- Willingness to reserve judgment until completion of a thorough clinical evaluation.
- Willingness to work with people who might display and/or have mental health conditions.
- Willingness to refer for treating conditions outside one’s expertise.
- Appreciation of the contribution of multiple disciplines to the evaluation process.
Competency 5:
Describe the philosophies, practices, policies, and outcomes of the most generally accepted and scientifically supported models of treatment, recovery, relapse prevention, and continuing care for addiction and other substance-related problems.

Knowledge
- Generally accepted models, such as but not limited to:
  - pharmacotherapy
  - mutual help and self-help
  - behavioral self-control training
  - mental health
  - self-regulating community
  - psychotherapeutic
  - relapse prevention.
- The philosophy, practices, policies, and outcomes of the most generally accepted therapeutic models.
- Alternative therapeutic models that demonstrate potential.

Attitudes
- Acceptance of the validity of a variety of approaches and models.
- Openness to new, evidence-based treatment approaches, including pharmacological interventions.
Treatment Knowledge

**COMPETENCY 6:**
Recognize the importance of family, social networks, and community systems in the treatment and recovery process.

**KNOWLEDGE**
- The role of family, social networks, and community systems as assets or obstacles in treatment and recovery processes.
- Methods for incorporating family and social dynamics in treatment and recovery processes.

**ATTITUDES**
- Appreciation for the significance and complementary nature of various systems in facilitating treatment and recovery.

**COMPETENCY 7:**
Understand the importance of research and outcome data and their application in clinical practice.

**KNOWLEDGE**
- Research methods in the social and behavioral sciences.
- Sources of research literature relevant to the prevention and treatment of addiction.
- Specific research on epidemiology, etiology, and treatment efficacy.
- Benefits and limitations of research.

**ATTITUDES**
- Recognition of the importance of scientific research to the delivery of addiction treatment.
- Openness to new information.
| Competency 8: | Understand the value of an interdisciplinary approach to addiction treatment. |

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<tr>
<td>Roles and contributions of multiple disciplines to treatment efficacy.</td>
<td>Desire to collaborate.</td>
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<tr>
<td>Terms and concepts necessary to communicate effectively across disciplines.</td>
<td>Respect for the contribution of multiple disciplines to the recovery process.</td>
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<tr>
<td>The importance of communication with other disciplines.</td>
<td>Commitment to professionalism.</td>
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### Competency 9:
Understand the established diagnostic criteria for substance use disorders, and describe treatment modalities and placement criteria within the continuum of care.

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<td>◆ Established diagnostic criteria, including but not limited to current <em>Diagnostic and Statistical Manual of Mental Disorders (DSM)</em> standards and current <em>International Classification of Diseases (ICD)</em> standards.</td>
<td>◆ Openness to a variety of treatment services based on client need.</td>
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<tr>
<td>◆ Established placement criteria developed by various States and professional organizations.</td>
<td>◆ Recognition of the value of research findings.</td>
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<tr>
<td>◆ Strengths and limitations of various diagnostic and placement criteria.</td>
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<tr>
<td>◆ Continuum of treatment services and activities.</td>
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Application to Practice

**Competency 10:**
Describe a variety of helping strategies for reducing the negative effects of substance use, abuse, and dependence.

**Knowledge**
- A variety of helping strategies, including but not limited to:
  - evaluation methods and tools
  - stage-appropriate interventions
  - motivational interviewing
  - involvement of family and significant others
  - mutual-help and self-help programs
  - coerced and voluntary care models
  - brief and longer term interventions.

**Attitudes**
- Openness to various approaches to recovery.
- Appreciation that different approaches work for different people.
## Application to Practice

### Competency 11: Tailor helping strategies and treatment modalities to the client's stage of dependence, change, or recovery.

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<td>- Strategies appropriate to the various stages of dependence, change, and recovery.</td>
<td>- Flexibility in choice of treatment modalities.</td>
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<td>- Respect for the client's racial, cultural, economic, and sociopolitical backgrounds.</td>
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### Competency 12: Provide treatment services appropriate to the personal and cultural identity and language of the client.

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<td>- Various cultural norms, values, beliefs, and behaviors.</td>
<td>- Respect for individual differences within cultures.</td>
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<tr>
<td>- Cultural differences in verbal and nonverbal communication.</td>
<td>- Respect for differences between cultures.</td>
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<td>- Resources to develop individualized treatment plans.</td>
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### Competency 13: Adapt practice to the range of treatment settings and modalities.

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<tr>
<td>- The strengths and limitations of available treatment settings and modalities.</td>
<td>- Flexibility and creativity in practice application.</td>
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<tr>
<td>- How to access and make referrals to available treatment settings and modalities.</td>
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</table>
Application to Practice

**COMPETENCY 14:**
Be familiar with medical and pharmacological resources in the treatment of substance use disorders.

**KNOWLEDGE**
- Current literature regarding medical and pharmacological interventions.
- Assets and liabilities of medical and pharmacological interventions.
- Health practitioners in the community who are knowledgeable about addiction and addiction treatment.
- The role that medical problems and complications can play in the intervention and treatment of addiction.

**ATTITUDES**
- Open and flexible with respect to the potential risks and benefits of pharmacotherapies to the treatment and recovery process.

**COMPETENCY 15:**
Understand the variety of insurance and health maintenance options available and the importance of helping clients access those benefits.

**KNOWLEDGE**
- Existing public and private payment plans including treatment orientation and coverage options.
- Methods for gaining access to available payment plans.
- Policies and procedures used by available payment plans.
- Key personnel, roles, and positions within plans used by the client population.

**ATTITUDES**
- Willingness to cooperate with payment providers.
- Willingness to explore treatment alternatives.
- Interest in promoting the most cost-effective, high-quality care.
Application to Practice

Competency 16:
Recognize that crisis may indicate an underlying substance use disorder and may be a window of opportunity for change.

Knowledge
- The features of crisis, which may include but are not limited to:
  - family disruption
  - social and legal consequences
  - physical and psychological
  - panic states
  - physical dysfunction.
- Substance use screening and assessment methods.
- Prevention and intervention principles and methods.
- Principles of crisis case management.
- Posttraumatic stress characteristics.
- Critical incident debriefing methods.
- Available resources for assistance in the management of crisis situations.

Attitudes
- Willingness to respond and follow through in crisis situations.
- Willingness to consult when necessary.
Common Crises In Substance Abuse and HIV

- Relapse
- Detox
- Homelessness
- Physical Illness
- Recent Diagnosis
- Non-compliance with medications
- Any others?
Case 1

- Jackie is a 30 year old Latina female with a history of intravenous cocaine addiction and abusive relationships. She has been sober for 2 months. She has recently (in the last 2 weeks) tested positive for HIV.
- She is a resident at the battered women shelter you currently volunteer at as a “crisis worker”.
- She reports she has been getting calls from her ex-boyfriend (even though it is against the shelter’s rules), he has been telling her how much he misses her and that if she comes home to him he will never hit her again. He is currently using cocaine and tells her that he has some waiting for her when she comes back to him. He is unaware of her HIV positive diagnosis and has not been tested himself.
Case 1 (continued)

- The last time they were together he threatened to kill her with a gun. He broke her arm and three of her ribs. Her 10 year old witnessed this incident and called 911. She has three children, ages 5-12, all have been removed by DSS due to her drug use and abusive relationship.
- She states that she knows that he will hurt her again but “I need my independence- I feel like a caged animal here” and “I am lonely and I don’t know if I could survive financially on my own right now, especially with this disease”. She also states “I love my children and I want them back”. She currently has no plan to tell her boyfriend or children of her positive diagnosis.
- What ethical issues are involved? How would you respond to her?
Professional Readiness

**Competency 18:**
Understand diverse cultures, and incorporate the relevant needs of culturally diverse groups, as well as people with disabilities, into clinical practice.

**Knowledge**
- Information and resources regarding racial and ethnic cultures, lifestyles, gender, and age as well as relevant needs of people with disabilities.
- The unique influence the client’s culture, lifestyle, gender, and other relevant factors may have on behavior.
- The relationship between substance use and diverse cultures, values, and lifestyles.
- Assessment and intervention methods that are appropriate to culture and gender.
- Counseling methods relevant to the needs of culturally diverse groups and people with disabilities.
- The Americans with Disabilities Act and other legislation related to human, civil, and clients’ rights.

**Attitudes**
- Willingness to explore and identify one’s own cultural values.
- Acceptance of other cultural values as valid for other individuals.
Competency 19:
Understand the importance of self-awareness in one’s personal, professional, and cultural life.

Knowledge
- Personal and professional strengths and limitations.
- Cultural, ethnic, or gender biases.

Attitudes
- Openness to constructive supervision.
- Willingness to grow and change personally and professionally.
Professional Readiness

**Competency 20:**
Understand the addiction professional's obligations to adhere to ethical and behavioral standards of conduct in the helping relationship.

**Knowledge**
- The features of crisis, which may include but are not limited to:
  - family disruption
  - social and legal consequences
  - physical and psychological panic states
  - physical dysfunction.
- Substance use screening and assessment methods.
- Intervention principles and methods.
- Principles of crisis case management.
- Posttraumatic stress characteristics.
- Critical incident debriefing methods.
- Available resources for assistance in the management of crisis situations.

**Attitudes**
- Willingness to conduct oneself in accordance with the highest ethical standards.
- Willingness to comply with regulatory and professional expectations.
Professional Readiness

**Competency 21:** Understand the importance of ongoing supervision and continuing education in the delivery of client services.

**Knowledge**
- Benefits of self-assessment and clinical supervision to professional growth and development.
- The value of consultation to enhance personal and professional growth.
- Resources available for continuing education.
- Supervision principles and methods.

**Attitudes**
- Commitment to continuing professional education.
- Willingness to engage in a supervisory relationship.
Professional and Ethical Responsibilities

**Competency 115:**
Adhere to established professional codes of ethics that define the professional context within which the counselor works to maintain professional standards and safeguard the client.

**Knowledge**
- Federal, State, agency, and professional codes of ethics.
- Clients’ rights and responsibilities.
- Professional standards and scope of practice.
- Boundary issues between client and counselor.
- Difference between the role of the professional counselor and that of a peer counselor or sponsor.
- Consequences of violating codes of ethics.
- Means for addressing alleged ethical violations.
- Nondiscriminatory practices.
- Mandatory reporting requirements.

**Skills**
- Demonstrating ethical and professional behavior.

**Attitudes**
- Openness to changing personal behaviors and attitudes that may conflict with ethical guidelines.
- Willingness to participate in self, peer, and supervisory assessment of clinical skills and practice.
- Respect for professional standards.
Competency 116: Adhere to Federal and State laws and agency regulations regarding the treatment of substance use disorders.

Knowledge
- Federal, State, and agency regulations that apply to addiction counseling.
- Confidentiality rules and regulations.
- Clients’ rights and responsibilities.
- Legal ramifications of noncompliance with confidentiality rules and regulations.
- Legal ramifications of violating clients’ rights.
- Grievance processes.

Skills
- Interpreting and applying appropriate Federal, State, and agency regulations regarding addiction counseling.
- Making ethical decisions that reflect unique needs and situations.
- Providing treatment services that conform to Federal, State, and local regulations.

Attitudes
- Appreciation of the importance of complying with Federal, State, and agency regulations.
- Willingness to learn the appropriate application of Federal, State, and agency guidelines.
Professional and Ethical Responsibilities

**Competency 117:** Interpret and apply information from current counseling and psychoactive substance use research literature to improve client care and enhance professional growth.

**Knowledge**
- Professional literature on substance use disorders.
- Information on current trends in addiction and related fields.
- Professional associations.
- Resources to promote professional growth and competency.

**Skills**
- Reading and interpreting current professional and research-based literature.
- Applying professional knowledge to client-specific situations.
- Applying research findings to clinical practice.
- Applying new skills in clinically appropriate ways.

**Attitudes**
- Commitment to lifelong learning and professional growth and development.
- Willingness to adjust clinical practice to reflect advances in the field.
**Professional and Ethical Responsibilities**

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**Competency 118:**
Recognize the importance of individual differences that influence client behavior, and apply this understanding to clinical practice.

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**Knowledge**
- Differences found in diverse populations.
- Personality, culture, lifestyle, and other factors influencing client behavior.
- Culturally sensitive counseling methods.
- Dynamics of family systems in diverse cultures and lifestyles.
- Client advocacy needs specific to diverse cultures and lifestyles.
- Signs, symptoms, and patterns of violence against persons.
- Risk factors that relate to potential harm to self or others.
- Hierarchy of needs and motivation.

**Skills**
- Assessing and interpreting culturally specific client behaviors and lifestyles.
- Conveying respect for cultural and lifestyle diversity in the therapeutic process.
- Adapting therapeutic strategies to client needs.

**Attitudes**
- Willingness to appreciate the life experiences of individuals.
- Appreciation for diverse populations and lifestyles.
- Recognition of one’s biases toward other cultures and lifestyles.
Professional and Ethical Responsibilities

**COMPETENCY 119:**
Use a range of supervisory options to process personal feelings and concerns about clients.

**KNOWLEDGE**
- The role of supervision.
- Models of supervision.
- Potential barriers in the counselor–client relationship.
- Transference and countertransference.
- Resources for exploration of professional concerns.
- Problem-solving methods.
- Conflict resolution.
- The process and effect of client reassignment.
- The process and effect of termination of the counseling relationship.
- Phases of treatment and client responses.

**SKILLS**
- Recognizing situations in which supervision is appropriate.
- Developing a plan for resolution or improvement of feelings and concerns that may interfere with the counselor–client relationship.
- Seeking supervisory feedback.
- Resolving conflicts.
- Identifying overt and covert feelings and their effect on the counseling relationship.
- Communicating feelings and concerns openly and respectfully.

**ATTITUDES**
- Willingness to accept feedback.
- Acceptance of responsibility for personal and professional growth.
- Awareness that one’s personal recovery issues have an effect on job performance and interactions with clients.
Professional and Ethical Responsibilities

**Competency 120:**
Conduct self-evaluations of professional performance applying ethical, legal, and professional standards to enhance self-awareness and performance.

**Knowledge**
- Personal and professional strengths and limitations.
- Legal, ethical, and professional standards affecting addiction counseling.
- Consequences of failure to comply with professional standards.
- Self-evaluation methods.
- Regulatory guidelines and restrictions.

**Skills**
- Developing professional goals and objectives.
- Interpreting and applying ethical, legal, and professional standards.
- Using self-assessment tools for personal and professional growth.
- Eliciting and applying feedback from colleagues and supervisors.

**Attitudes**
- Appreciation of the importance of self-evaluation.
- Recognition of personal strengths, weaknesses, and limitations.
- Willingness to change behaviors as necessary.
Competency 121: Obtain appropriate continuing professional education.

Knowledge
- Education and training methods that promote professional growth.
- Recredentialing requirements.

Skills
- Assessing personal training needs.
- Selecting and participating in appropriate training programs.
- Using consultation and supervision as enhancements to professional growth.

Attitudes
- Recognition that professional growth continues throughout one’s professional career.
- Willingness to expose oneself to information that may conflict with personal or professional beliefs.
- Recognition that professional development is an individual responsibility.
Competency 122: Participate in ongoing supervision and consultation.

Knowledge
- The rationale for regular assessment of professional skills and development.
- Models of clinical and administrative supervision.
- The rationale for using consultation.
- Agency policy and protocols.
- Case presentation methods.
- How to identify needs for clinical or technical assistance.
- Interpersonal dynamics in a supervisory relationship.

Skills
- Identifying professional progress and limitations.
- Communicating the need for assistance.
- Preparing and making case presentations.
- Eliciting feedback from others.

Attitudes
- Willingness to accept both constructive criticism and positive feedback.
- Respect for the value of clinical and administrative supervision.
Competency 123:
Develop and use strategies to maintain one’s physical and mental health.

Knowledge
◆ Rationale for periodic self-assessment regarding physical health, mental health, and recovery from substance use disorders.
◆ Available resources for maintaining physical health, mental health, and recovery from substance use disorders.
◆ Consequences of failing to maintain physical health, mental health, and recovery from substance use disorders.
◆ Relationship between physical health and mental health.
◆ Health promotion strategies.

Skills
◆ Carrying out regular self-assessment with regard to physical health, mental health, and recovery from substance use disorders.
◆ Using prevention measures to guard against burnout.
◆ Employing stress-reduction strategies.
◆ Locating and accessing resources to achieve physical health, mental health, and recovery from substance use disorders.
◆ Modeling self-care as an effective treatment tool.

Attitudes
◆ Recognition that counselors serve as role models.
◆ Appreciation that maintaining a healthy lifestyle enhances the counselor’s effectiveness.
Considering Competence

- How can we ensure we are competent when working with this population?
- Examples??
Just a Reminder to Wake Up!
Legal and Moral Standards
The substance abuse counselor shall uphold the legal and accepted moral codes which pertain to professional conduct.
a. The substance abuse counselor shall be fully cognizant of all federal laws and laws of the counselor’s respective state governing the practice of alcoholism and drug abuse counseling.
b. The substance abuse counselor shall not claim either directly or by implication, professional qualifications/affiliations that the counselor does not possess.
c. The substance abuse counselor shall ensure that products or services associated with or provided by the counselor by means of teaching, demonstration, publications or other types of media meet the ethical standards of this code.
Legal and Moral Standards

- What are some legal considerations when working with this population?
- Consider your morals and values. How do these interact when working with this population?
HIV and NC LAW

HIV TESTING

- Can I Get An Anonymous HIV Test? • No. North Carolina does not allow anonymous HIV testing. All testing is confidential, but name-based. All positive HIV test results must be reported to the State.

- Does My Doctor Have To Report My HIV Infection?
  - Yes. If a doctor or medical facility has a positive test result or has reason to suspect that a patient is infected with HIV, the patient’s name and address must be reported to the local health director. After any positive HIV test result, a trained specialist from the Health Department may contact you to provide counseling.

- NC Substance Abuse Counselors/Mental Health Professionals are NOT mandatory reporters
RESPONSIBILITIES FOR PEOPLE WITH HIV
The law requires you to take certain precautions to stop the spread of HIV. The required “control measures” are:
• You must not have sexual intercourse without a condom;
• You must not share needles or other drug-related equipment;
• You must not donate or sell blood products, semen, organs, or breast milk;
• You must tell all future sexual intercourse partners that you have HIV;
• If you know when you became infected, you must tell any sex or needle partners since that time about your infection. Otherwise, you must notify partners from the previous year.
If you violate any of these control measures you can be placed under an “isolation order” which sets up an individual plan to reduce the risk of. You can also be criminally prosecuted for violating control measures.
Is HIV Status Confidential?
• Yes. North Carolina law makes it a misdemeanor to disclose information about HIV infection. However, there are a few exceptions. First, information about your HIV status can be disclosed with your consent. Also, as discussed above, your doctor has to report your HIV infection to the State. The State can inform your spouse. There are several situations when your HIV status can be disclosed for medical, research or public health reasons: (1) for medical or epidemiological purposes provided no identifying information is given; (2) to provide proper medical care; (3) when necessary to protect public health, if disclosure is made according to law; (4) by the Department of Health Services for bona fide research purposes; (5) when required by a court order or subpoena; (6) when someone is exposed to your blood or body fluids.
HIV and NC Law

- Can I Be Discriminated Against Based On HIV?
- Federal law prohibits discrimination against people with disabilities in employment, housing, public services, and public accommodations. HIV infection qualifies as a federal disability. Disability is defined as a physical or mental impairment that substantially limits a person in one or more major life activities.

http://www.ncblpc.org/forms/13_Exam_Briefs/Confidentiality_HIV_AIDS.pdf
Hepatitis and the LAW

- Communicable Disease Law Handout
CSAC Ethics

Client Welfare

The substance abuse counselor shall promote the protection of the public health, safety and welfare and the best interest of the client as a primary guide in determining the conduct of all substance abuse counselors.

a. The substance abuse counselor shall disclose the counselor’s code of ethics, professional loyalties and responsibilities to all clients.
b. The substance abuse counselor shall terminate a counseling or consulting relationship when it is reasonably clear to the counselor that the client is not benefiting from the relationship.
c. The substance abuse counselor shall hold the welfare of the client paramount when making any decisions or recommendations concerning referral, treatment procedures or termination of treatment.
d. The substance abuse counselor shall not use or encourage a client's participation in any demonstration, research or other non-treatment activities when such participation would have potential harmful consequences for the client or when the client is not fully informed. (See Principle 9)
e. The substance abuse counselor shall take care to provide services in an environment that will ensure the privacy and safety of the client at all times and ensure the appropriateness of service delivery.
Client Welfare

- Consider the ethical principle of Client Welfare and working with clients that are HIV Positive and in Recovery.
- Examples??
Confidentiality
The substance abuse counselor working in the best interest of the client shall embrace, as a primary obligation, the duty of protecting client's rights under confidentiality and shall not disclose confidential information acquired in teaching, practice or investigation without appropriately executed consent.

a. The substance abuse counselor shall provide the client his/her rights regarding confidentiality, in writing, as part of informing the client in any areas likely to affect the client's confidentiality. This includes the recording of the clinical interview, the use of material for insurance purposes, the use of material for training or observation by another party.

b. The substance abuse counselor shall make appropriate provisions for the maintenance of confidentiality and the ultimate disposition of confidential records. The counselor shall ensure that data obtained, including any form of electronic communication, are secured by the available security methodology. Data shall be limited to information that is necessary and appropriate to the services being provided and be accessible only to appropriate personnel.
c. The substance abuse counselor shall adhere to all federal and state laws regarding confidentiality and the counselor’s responsibility to report clinical information in specific circumstances to the appropriate authorities.

d. The substance abuse counselor shall discuss the information obtained in clinical, consulting, or observational relationships only in the appropriate settings for professional purposes that are in the client's best interest. Written and oral reports must present only data germane and pursuant to the purpose of evaluation, diagnosis, progress, and compliance. Every effort shall be made to avoid undue invasion of privacy.

e. The substance abuse counselor shall use clinical and other material in teaching and/or writing only when there is no identifying information used about the parties involved.
Confidentiality

- Consider confidentiality and the disclosure of HIV status
- HIPAA
- Exceptions
- Duty to Warn
CSAC Ethics

- **Societal Obligations**
- The substance abuse counselor shall to the best of his or her ability actively engage the legislative processes, educational institutions, and the general public to change public policy and legislation to make possible opportunities and choice of service for all human beings of any ethnic or social background whose lives are impaired by alcoholism and drug abuse.
HIV and Ethics

Confidentiality Vs the Duty to Warn

- Social Workers HIV LAW Sheet
- NCBLPC Professional Brief
- HIV/AIDS LAW pamphlet
Additional Ethical Issues

- Duty to Treat
- Duty to Warn
- End of Life Issues
- Confidentiality
- Dual Relationships
- Scarce Resources

Complex of STD’s, HIV, Hepatitis and Drug Use

- Sexually active males and females
  - Average age of initiation (males 15-20)
  - (females 15-20)
  - Usually no knowledge of STD’s including HIV
  - Sexually active without protective measures
  - High risk for multiple partners & STD
  - High risk for abuse & turning to drug use
  - Exchanging sex for drugs
  - Homeless adolescents & psychiatric illness
Complex of STD’s, HIV, Hepatitis and Drug Use

**Onset of Drug Use**
- Initial exposure either alcohol or tobacco
- US- 57% adolescents tried tobacco by 12\textsuperscript{th} gr
- US- 78% adolescents tried alcohol by 12\textsuperscript{th} gr
- 47% by the 8\textsuperscript{th} grade
- 55% adolescents used illicit drug by 12\textsuperscript{th} gr
- 1\% heroin; 10\% amphetamines; 40\% marijuana
Drug Use and STD’s

- Crack cocaine and STD’s
  - Crack house: 13% syphilis; 61% HSV-2; 12% HIV ; 52% HBV
  - 41% HCV (40% injectors)
  - Heightened sexual arousal with crack
  - Heightened exchange sex for money/drug
  - Increased number of sex partners
  - Syphilis & HSV predictors for HIV
How does drug treatment prevent viral transmission?

- Effective treatments reduce the frequency of drug use
- Fewer drug-related risk behaviors/sexual partner
- Fewer infections
Acceptability of STD Screening in Drug Abuse Treatment

- Study of STD screening for women in drug treatment center
  - 86% of 209 accepted screening for chlamydia, gonorrhea & trichomona infection
  - Urine test and self collected swab
  - 23% with STD
  - 90% trichomona
  - Hard to reach population; 76% uninsured; 45% previous medical care in last year
  - Lally et al STD 29:752,2002
HIV and Substance Abuse

Substance users have poor HIV-related health outcomes
- Less access to health care
- Less access to antiretroviral therapy (ART)
- Worse adherence to ART
- Slower decline in morbidity and mortality

Turner, Kalichmand, Shapiro, Celentano, Strathdee, Arnsten, Tucker, Golin, Chesney, Lucas, Bouhnik Knowleton, Chitwood 1999 & 2001, Cronquist
# Illicit Drug Interactions With ART

<table>
<thead>
<tr>
<th>Drug</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amphetamines</td>
<td>may ↑ level 2-3 fold with <em>ritonavir</em></td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>↑ HIV replication, fatal OD with <em>ritonavir</em>/saquinavir</td>
</tr>
<tr>
<td>Cocaine</td>
<td>↑ HIV replication, ↓ immune system function</td>
</tr>
<tr>
<td>Ecstasy (MDMA)</td>
<td>overdose or death with <em>ritonavir</em></td>
</tr>
<tr>
<td>GHB (liquid X)</td>
<td>↑ levels with <em>ritonavir</em> or saquinavir</td>
</tr>
<tr>
<td>Heroin</td>
<td>levels may ↓ or ↑ with <em>ritonavir</em></td>
</tr>
</tbody>
</table>

Antoniou, Henry, Harrington, Roth, Bagasra, Peterson 1991 & 1992, Ellis, Gavrilin, Urbina, Hales
DVD Clips

Life Support
Scene 1: We Have Felt it
Scene 2: Make the Virus Go Away
(up to 17:00)
Scene 3: Worried About Amare
Scene 4: Selling His Meds (up to 57:00)
Scene 5: In Honor of Those We Have Lost
Overview of Hepatitis A, B, and C

- http://www.youtube.com/watch?v=CRr_cilgfEk

- Questions/Comments/Discussion
<table>
<thead>
<tr>
<th>Virus</th>
<th>Transmission</th>
<th>Incubation Period*</th>
<th>Chronic Infection</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>fecal-oral</td>
<td>4 (2-6)</td>
<td>No</td>
</tr>
<tr>
<td>B</td>
<td>parenteral</td>
<td>8-12 (6-24)</td>
<td>Yes</td>
</tr>
<tr>
<td>C</td>
<td>Parenteral</td>
<td>6-9 (2-24)</td>
<td>Yes</td>
</tr>
<tr>
<td>D</td>
<td>Parenteral (any route</td>
<td>? (2-10)</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>other than mouth/anus/injection)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>fecal-oral</td>
<td>4-5 (2-9)</td>
<td>No</td>
</tr>
</tbody>
</table>

* Weeks
Hepatitis B Virus (HBV)
# Clinical Features of Hepatitis B

<table>
<thead>
<tr>
<th>Feature</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Incubation period**         | Average: 60-90 days  
                                  Range: 45-180 days |
| **Clinical illness (jaundice)** | < 5 years: <10%  
                                  >5 years: 30-50% |
| **Case-fatality rate**        | 0.5-1.0%    |
| **Chronic infection**         | YES         |
|                              | <5 years: 30-90%  
                                  5 years: 6-10% |
Infection

- Asymptomatic acute hepatitis B
  - Chronic infection
    - Asymptomatic carrier
    - Liver cancer and cirrhosis
  - Resolved & immune

- Symptomatic acute hepatitis B
  - Chronic infection
    - Asymptomatic carrier
    - Liver cancer and cirrhosis
  - Resolved & immune
Chronic HBV Infection, Vietnam
HBsAg Prevalence

- >=8% - High
- 2-7% - Intermediate
- <2% - Low
# Concentration of HBV in Body Fluids

<table>
<thead>
<tr>
<th>High</th>
<th>Moderate</th>
<th>Low/not Detectable</th>
</tr>
</thead>
<tbody>
<tr>
<td>blood</td>
<td>semen</td>
<td>urine</td>
</tr>
<tr>
<td>serum</td>
<td>vaginal fluid</td>
<td>feces</td>
</tr>
<tr>
<td>wound exudate</td>
<td>saliva</td>
<td>sweat</td>
</tr>
<tr>
<td></td>
<td></td>
<td>tears</td>
</tr>
<tr>
<td></td>
<td></td>
<td>breast milk</td>
</tr>
</tbody>
</table>
Modes of Transmission of HBV

- Percutaneous and permucosal – e.g., IDU, needle stick injuries
- Sexual – homosexual and heterosexual
- Perinatal – From mother to child during labor and delivery (*in utero* transmission rare)

- Heterosexual (43%)
- IDU (20%)
- MSM (12%)
- Other¹ (5%)
- Unrecognized (14%)

¹ Other: Household contact, institutionalization, hemodialysis, blood transfusion, occupational exposure

Source: Sentinel Counties Study of Acute Viral Hepatitis, CDC
Who is at Risk for HBV Infection?

- High-risk heterosexual men and women
- Sexually active homosexual men
- Injection drug users
- Health care workers
- Household and sex partners of persons with chronic infection
- Hemodialysis patients
- Recipients of blood products
- Clients and employees of institution for developmentally disabled
- Families of adoptees from HBV endemic countries
- Inmates of correctional facilities
HBV Prevalence Among Various Risk Groups

- General population: 4.9%
- >10 sex partners: 6%
- >50 sex partners: 12%
- MSM: 20-40%
- IDU: 60-80%
Current Strategy

- Routine vaccination of infants
- Routine vaccination of adolescents not vaccinated in infancy
- Vaccination of high-risk children, adolescents, and adults
Faces of Hepatitis B

http://www.youtube.com/user/ViralHepatitisCDC
HEP C Video Clip

- [YouTube Video](http://www.youtube.com/watch?v=Zl_kw8qHGTI)
Features of HCV Infection

- **Incubation period**: Average, 6–7 wk; Range, 2–26 wk
- **Acute illness (jaundice)**: Mild (20%–30%)
- **Persistent infection**: 75%–85%
- **Chronic hepatitis**: 70%
- **Immunity**: No protective antibody response identified
Risk of Fatal Outcome in Persons Who Develop Hepatitis C Infection

- 100 persons start
- 15% resolve
- 85% remain chronic
- 20% progress to cirrhosis
- 75% of cirrhosis patients die
- 25% of cirrhosis patients die

15 resolve
68 stable
13 stable
17 cirrhosis
4 mortality

Courtesy of Seeff, LB and Alter, HJ.
Future HCV-related mortality may double over the next 10 to 20 years

- $10.7 billion in direct medical care expenditures
- $75.5 billion in societal (indirect) costs

National Hepatitis C Prevention Strategy

• Prevent HCV infection
• Detect and control chronic liver disease
• Evaluate effectiveness of activities
• Conduct surveillance and research
Reasons to Identify Persons with Chronic HCV Infection

• **Medical management**
  – evaluate for chronic liver disease
  – treatment if indicated
  – substance abuse treatment (alcohol, drugs) if appropriate
  – immunization (HB, HA, influenza, pneumo)

• **Counsel to prevent disease transmission**
  – household contacts
  – sexual contacts
  – drug use contacts
HCV Testing Routinely Recommended

Based on increased risk for infection

- Ever injected illegal drugs
- Received clotting factors made before 1987
- Received blood/organs before July 1992
- Ever on chronic hemodialysis
- Evidence of liver disease

Recommendations for Prevention and Control of Hepatitis C Virus (HCV) Infection and HCV-Related Chronic Disease. MMWR 1998; 47: RR-19
## Viral Hepatitis - Overview

<table>
<thead>
<tr>
<th>Source of virus</th>
<th>Route of transmission</th>
<th>Chronic infection</th>
<th>Vaccine</th>
<th>Pre/Post prophylaxis</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Feces</td>
<td>fecal-oral</td>
<td>no</td>
<td>yes</td>
<td>pre/post (IG)</td>
</tr>
<tr>
<td>B Blood*</td>
<td>Percutaneous</td>
<td>yes</td>
<td>yes</td>
<td>post (HBIG)</td>
</tr>
<tr>
<td>C Blood*</td>
<td>Percutaneous</td>
<td>yes</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>D Blood*</td>
<td>Percutaneous</td>
<td>yes</td>
<td>yes**</td>
<td>no</td>
</tr>
<tr>
<td>E Feces</td>
<td>fecal-oral</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
</tbody>
</table>

* Blood and blood-derived body fluids  **Prevention of Hep B with vaccine

http://www.aidslaw.org/confidentiality.pdf
http://www.ncblpc.org/forms/13_Exam_Briefs/Confidentiality_HIV_AIDS.pdf
http://www.cdc.gov/hepatitis
Hepatitis Fact Sheet/Info NC

We Are Done!!

- Questions, Comments...

- Nah...just the end of this training