

THEIMANN

ADVISORY

School of Social Work
University of North Carolina at Chapel Hill



David DeVito, MSW, LCSW-P

Kim Strom-Gottfried, PhD, LISW

Tina Souders, MSW, JD

Premela Deck, MSW, JD

November 2016

FAQ on Confidentiality and HIV+ Clients

Introduction

Theimann Advisories are periodic commentaries on the ethical, legal, and clinical implications of complex service dilemmas. They are issued with the support of the Smith P. Theimann, Jr. Distinguished Professorship in Ethics and Professional Practice and are distributed to alumni, students, and field instructors affiliated with the UNC Chapel Hill School of Social Work, as well as to the broader community of service providers.

Advisories use laws, ethics, and professional standards to craft recommendations in response to specific practice questions. They are intended to provide general guidelines for practice, but are not a substitute for legal advice or professional consultation and supervision on specific case matters. This *Advisory* utilizes North Carolina statutes in examining the issues presented. As such, some advice may not translate to other jurisdictions. Changes in laws, regulations and practice guidelines that occur after the advisory is issued may also affect the relevance of the recommendations.

This *Advisory* addresses the confidentiality challenges that arise in providing services to individuals with HIV and AIDs. It is specifically targeted to services that are ancillary to primary disease management. That is, it focuses on privacy concerns arising in residential treatment, family counseling, substance abuse services, or mental health settings, rather than in medical or health care settings. The *Advisory* is intended to apply to the array of helping professionals, including social workers, counselors, and psychologists, and any meaningful distinctions among service settings or types of professionals are noted in the document.

Relevant Definitions

HIV/AIDS – The Human Immunodeficiency Virus (HIV) is transmitted by bodily fluids such as semen, blood, or breast milk and leads to Acquired Immunodeficiency syndrome (AIDS). While these diseases may have an extended pre-symptomatic incubation period, illness and death occur from resulting failures of the immune system and the onset of opportunistic infections and/or cancers (Centers for Disease Control and Prevention [CDC], 2008). Though HIV/AIDS may resemble other sexually transmitted diseases, the conditions are unique, in that available medications cannot cure outbreaks or prevent further transmission of this chronic disease. Considerable stigma accompanies HIV/AIDS. The populations particularly

affected by the disease, such as gay men, people of color, and IV drug users, are already marginalized in much of US society. Further, some modes of HIV transmission (e.g., intravenous drug use, prostitution, anal sex) are either illegal or stigmatized or both. The revelation of HIV infection (seropositive status) can lead to self-recrimination and self-harm, the loss of employment and insurance coverage, and rejection or hostility from family, friends, and loved ones. However, detection of the disease is essential for containing the epidemic, developing services, and initiating life-extending or life-saving treatment for those afflicted.

HIV/AIDS Testing – Testing for HIV/AIDS is typically done by blood or oral fluid tests administered through health settings, specialized clinics, hospitals, county health departments, community health clinics, and mobile outreach programs. While some tests take a few days to read, rapid results tests can be read within as few as five minutes of the sample being collected (Greenwald, Burnstein, Pincus, & Branson, 2006) and thus increase the number of patients receiving test outcomes. The Centers for Disease Control and Prevention offer a web-based service to direct individuals to testing sites in their communities (National HIV and Testing Resources, n.d.). **Anonymous tests** link the test to a code number, not an individual's name, so that only that individual can access the results. Anonymous tests may be conducted by mail, home-tests, or in particular sites, but may not be available in all states. As a practical matter, anonymity can be achieved whenever individuals give false contact information at the time of testing. **Confidential tests** link the findings to an individual, but maintain limits on disclosure of that person's name and test results. However, records would indicate that the test was done and the results may be recorded in the medical file and will be known by the health professional administering the test. The health professional may be compelled to report the findings to public health authorities. Reporting is often also required for an array of other communicable diseases such as Hepatitis, tuberculosis, syphilis and Chlamydia. Any required disclosure of results should be discussed with the patient before testing, as part of informed consent.

Partner notification – Partner notification refers to a variety of compulsory or voluntary procedures to alert individuals who have had risky past or current contact with an infected individual that they may be at risk of HIV/AIDS and should be tested. **Voluntary partner notification** places responsibility with the seropositive individual to contact and inform affected individuals. At the time of testing, counselors typically address strategies for notification, overcoming apprehensions about such conversations, and even participating in such conversations with the patient. Under voluntary notification, the patient could also choose to defer notification responsibility to public health authorities.

Mandatory partner notification (“names reporting”, “coercive reporting”) compels people with HIV to notify their partners, under threat of fines or imprisonment. Such policies may also require testing sites or health providers to notify the health department about a seropositive individual's identity and the contact information for past sexual or needle-sharing partners. While this health department notification system may shield the patient from identification (contacting the person at risk without naming the person who put them at risk), critics suggest that mandatory notification discourages testing and delays treatment. Further, few individuals successfully notify their partners (American Civil Liberties Union [ACLU], 2010). Beyond mere reluctance to admit infection, this failure rate may be due to dated contact information and transient, anonymous, or indifferent partners, regardless of assiduous pursuit by health authorities.

As of 2006, 23 other states mandated that people living with HIV/AIDS must disclose their status to intimates, and subjected individuals who do not comply with these provisions to criminal penalties (Galletly & Pinkerton, 2006). An ACLU (2008) report identifies 33 states with laws that criminalize transmission of HIV/AIDS. As of 2007, North Carolina is one of only 11 states that do not allow for anonymous HIV testing (The Henry J. Kaiser Family Foundation, 2007).

Health care providers – Confidentiality regulations and notification policies make meaningful distinctions among the professionals covered in their provisions. For example, mandatory reporting rules may apply only to diagnostic laboratories, physicians and others who make medical diagnoses while specifically excluding other service providers from responsibility. While this *Advisory* endeavors to specify the responsibilities of social workers and other allied health professionals, users should be alert to differential responsibilities by discipline embedded in professional standards, policies, laws, and statutes.

Frequently Asked Questions

1. If a client I am seeing for depression, adjustment to college, or some other condition divulges that he or she is HIV+ and having unprotected sex, do I have a duty to warn or file some kind of report? I don't know who the other person is, but I could probably find out.

Health care professionals are expected to balance their commitment to upholding self-determination and maintaining confidentiality for their clients, with the responsibility of preserving the safety of others. The salient considerations in this case are what the client knows about his or her illness (and the related legal and ethical responsibilities), how the clinician came to learn of the client's HIV status, and the fact that the prospective partner(s) are not known to the worker.

The client described above is acting in violation of North Carolina's Control Measures for HIV that mandate the protective measures that people living with HIV must follow as well the reporting duties of the professionals who they work with. The code states that individuals living with HIV shall always use condoms during intercourse, inform their future sexual partners of their positive status, and notify past sexual partners of their positive status (North Carolina Administrative Code [NCAC] Title 10A, Chapter 41A, Section .0202, 2007). While it is advisable to remind the client of his or her responsibility to others and the law, it is not clear that the worker in this case has a responsibility to report the offense. A duty to warn is clearly required by the National Association of Social Workers (NASW) Code of Ethics (2008), standard 1.07, when a clinician identifies "serious, foreseeable, and imminent harm to a client or other identifiable person." Not knowing the identity of those at risk, or the extent of the risk posed, essentially absolves the conflict of disclosure.

Practicing discretion in seeking information is endorsed in the NASW Code of Ethics, which states that "Social workers should respect clients' right to privacy. Social workers should not solicit private information from clients unless it is essential to providing services or conducting social work evaluation or research. Once private information is shared, standards of confidentiality apply" (2008, 1.07a).

The distinction between necessary and extraneous information is not always clear, especially early in the helping process. However, given the sensitivity of the information about the client's condition, the worker should be cautious in seeking further disclosures, especially if they are not central to the presenting problem. While the worker may feel compelled to solve the mystery of the vulnerable partner, pursuing that information is likely tangential to his or her therapeutic role and at odds with the interests of the client. A better alternative is for the worker to educate the client about the advantages of notification, including peace of mind, facilitating testing, prevention, and treatment for the partner, and avoiding criminal and civil penalties for the client. This strategy honors the client's self-determination and autonomy and preserves the trust and openness that undergird the helping relationship (Boyd, 1992; Chenneville, 2000; Dhai and Noble, 2005; Säfken and Frewer, 2007).

This advice varies, however, based on the setting, service, and professional involved. North Carolina Administrative Code mandates that physicians who receive the results of a positive HIV test must inform the local health department of the patient's status and inform the patient of required control measures (NCAC Title 10A, Chapter 41A, Section .0101 (a) (1), 2007). These control measures include abstaining "from sexual intercourse unless condoms are used" (NCAC Title 10-A, Chapter 41A, Section .0202 (1) (a), 2007) and "not sharing needles or syringes" (NCAC Title 10-A, Chapter 41A, Section .0202 (b), 2007). Furthermore, in the event that a physician "in good faith, has reasonable cause to suspect a patient infected with HIV is not following or cannot follow control measures," that physician "shall notify the local health director" [10A NCAC 41A .0202(5)]. In the same paragraph the code reads, "any other person may notify local health director" under the same circumstances. As such, the NCAC *requires* disclosure by physicians, but *permits* disclosure by other health professionals. In North Carolina an individual can be charged with a criminal offense for failing to comply with the control measures outlined in the Administrative Code (North Carolina Bar Association [NCBA], n.d.).

In the Codes of Ethics of both the American Psychological Association (APA) (2002), and the NASW (2008) clinicians are mandated to keep client information confidential in the absence of consent to release information, except in those situations in which the disclosure would likely prevent harm to the client or a third party. The NASW Code of Ethics is more specific on this point, clarifying that the confidentiality mandate is lifted to "prevent serious, foreseeable, and imminent harm to a client or other identifiable person" (2008, 1.07). This language echoes the precedent set by the *Tarasoff* decision, though

there are limits in that analogy. Some question the extent to which HIV risk constitutes imminent harm (Chenneville, 2000). “Foreseeability of harm” requires assessment of risk and level of dangerousness posed to the third party, as well as any intent to harm. In the absence of an “identifiable person,” the social worker does not have the duty to report their client to the local health director, but may do so under the provisions of North Carolina’s Control Measures for HIV.

The American Counseling Association (ACA) Code of Ethics explicitly addresses the dilemma, stating “When clients disclose that they have a disease commonly known to be both communicable and life threatening, counselors may be justified in disclosing information to identifiable third parties, if they are known to be at demonstrable and high risk of contracting the disease. Prior to making a disclosure, counselors confirm that there is such a diagnosis and assess the intent of clients to inform the third parties about their disease or to engage in any behaviors that may be harmful to an identifiable third party” (2005, B2b). It is important to note that the North Carolina Control Measures direct physicians and health professionals to disclose HIV status and potentially unsafe behaviors *to the local health director*. Direct notification of third parties is a potentially volatile and dangerous endeavor (personal communication, Sue Butler, June 25, 2010). The Division of Public Health employs specially trained Disease Intervention Specialists to work with and assist individuals living with HIV to comply with control measures (North Carolina Public Health, 2009).

The clinician in this scenario is not required to take on an investigatory role to seek out information about his/her client’s partners. And, in the absence of an identifiable partner, the worker is not mandated by the NASW Code of Ethics or the NC Control Measures for HIV to disclose the client’s status or behavior. However, clinicians have more immediate responsibilities including addressing the presenting problem or exploring the client’s understanding about his or her condition, the risk it poses to others, and the motivations for withholding information from intimates.

1a. What if I know the identity of the other person?

The worker should have been thorough from the outset in seeking the client’s informed consent for service, and specifying legal and ethical limits in confidentiality. In particular, if the worker’s jurisdiction requires mandatory public health or partner notification, that responsibility should have been discussed with the client before the disclosure of his or her HIV+ status. If the statutes permit, but do not require disclosure (similar to the ACA Code provisions, above) the worker must consider the clinical and ethical implications of various choices. As is common in ethical dilemmas, any option will involve tradeoffs among principles and standards, with compelling arguments on both sides. How should the therapist decide between breaching a client’s confidentiality and speaking out to potentially protect another individual from a life-threatening disease?

In making the decision, the worker should consider the level of risk based on the reported behaviors and recent data on the transmission of HIV, determine whether it is possible that the person at risk is in fact making an informed choice by engaging in sexual or needle sharing behaviors with the seropositive client, assess the client’s resistance toward self-disclosure, the potential impact of self-disclosure on the client, the client’s motivations for engaging in high-risk behaviors, and the client’s motivations for maintaining confidentiality. This exploration may encourage the client to reconsider partner notification, initiate use of control measures, or give consent to the worker to make a referral. In the event of continued risk and resistance, the worker may conclude that a disclosure to the health department is needed in order to protect identifiable others from risk. Guidelines for this process include notifying the client of the intent to disclose the information, discussing the impact of the disclosure on the therapeutic relationship, and finally offering the client another opportunity to self-disclose or give consent for disclosure.

It is imperative that all consultations, actions, communications, and decisions made in reference to this issue be documented in the client’s case record. Entries should include the factors considered, the rationale for treatment decisions and any disclosures made.

1b. What if the other person is another client of our agency, in outpatient or residential treatment?

The fact that the person at risk is also a client of the provider indicates that their identity is known, and thus the dilemma is similar to that presented in 1a, above. The situation becomes more complex if the worker has a responsibility to both parties (as in couples therapy or residential treatment), or a differential responsibility to the identifiable person who is a client of the agency, but not a client of that worker.

If the person at risk is not able to make an informed choice about having intercourse with the seropositive client (e.g., due to lack of decisional capacity), then the provider would consider breaching confidentiality after going through the steps outlined above. In the case that the person at risk is a spouse or long-term partner of the client, North Carolina Administrative Code [Title 10A, Chapter 41A, Section .0202 (2) (b), 2007] mandates physicians who know the identity of the spouse of an HIV-infected patient who has not been notified or counseled regarding his/her spouse's HIV status, to mail a form to the Division of Public Health. The Division of Public Health shall counsel the spouse. Practically speaking, the process of spousal notification can take several weeks and it may or may not involve discussions with the professional involved who initiated the report.

If the professional is aware of the client's HIV status, he/she may encourage the seropositive client to voluntarily notify his/her spouse and address the emotional and therapeutic issues related to disclosure. Another option for the clinician is to refer one, or both, of the clients to another professional for clinical services. This decision warrants careful reflection, as the clinician must decide who to refer out, and how to inform the clients of the decision. Difficult as it is, this may be the best course of action because of the conflict of interest for the clinician that would arise should the HIV+ client decline to disclose to his/her partner.

1c. What if my client assures me he or she has done notification, but I am not so sure that's true?

Some states, like Texas, require health care providers to notify partners of all HIV+ patients regardless of whether the patient has done the notification (ACLU, 1998).⁸ Other states authorize, but do not require, physicians and/or public health officials to notify partners of individuals who have tested positive for HIV, even without the consent of the patient (ACLU, 1998).⁹ These laws authorize dramatic departures from the confidentiality that patients expect in their relationship with a health care provider. The North Carolina statute outlining control measures mandates physicians (and allows other professionals) to report a person who is believed not to be following the control measures (including notification) to the local health director (NCAC Title 10A, Chapter 41A, Section .0202 (5), 2007). In these cases, the central question is what does it mean to "believe" one's client?

What exactly makes the worker doubt the client's version of events? In new helping relationships people are often guarded and withhold or misrepresent embarrassing information. The irony is that health and social service providers must be patient with clients' initial distrust and reservations in order to build the trusting relationship in which meaningful work can commence. If the therapeutic relationship is harmed, then clients are less likely to fully or accurately disclose their behaviors, if indeed they continue seeking services at all.

However, the fact that some misrepresentations may be normative until trust is built is not a reason to ignore inconsistencies and other obvious signs that the client's reports are not true. Does the client have a history of unreliability? Do the client's statements contradict each other? Do the client's accounts of events (such as the conversation disclosing HIV+ status) lack sufficient detail or credibility under follow up questions? In these instances, the basic communication technique of confrontation may be appropriate. This skill involves presenting the client with contradictory information, such as, "You say you've told your boyfriend about your HIV+ status, but you can't seem to tell me much about that conversation..." or "You've told me you want to stop using, and you also said you're back in touch with your dealer and his friends." The observations should be delivered with a calm, caring, curious, and nonjudgmental tone. The key is to present the inconsistency and invite the client to comment upon it.

The nature of the client's response may then help the clinician decide about next steps. Comments that support the worker's suspicion that the client is lying may lead the worker to make a public health report irrespective of the client's assurances that he/she has done the partner notification. The worker might thus share the dilemma and his or her plans with the client: "I know you've told me that you notified X, but the other details you are sharing make me wonder if that's really true. That leaves me in a difficult position. Although I want to trust you in this, I'm uncomfortable just taking your word for it, if X might still be at risk. At this point, I'd like your consent for me to contact the public health department and ask them to make a notification." Clearly, if the client fails to give permission the clinician may make the report anyway, but he/ she will have at least made an effort to maximize the client's self-determination in the matter.

2. *We offer an array of residential services for teens and young adults with behavioral problems. What should foster parents, house parents, teachers and other residents be told about HIV+ clients?*

Parents are not mandated to notify schools or day care providers about their child's HIV status (NCBA, n.d.); however, if a physician believes that due to an open wound or potentially infecting behavior, the child may transmit HIV, then the physician must notify the local health department of this fact (NCBA, n.d.).

According to the North Carolina Department of Health and Human Services on-line manual 1201- Child Placement Services, children's medical needs should be reported to foster parents prior to placement. The manual explains that the provision made in the N.C. General Statute §130A-143 allows for the local Department of Social Services to disclose the diagnosis as a consenting guardian. The intent of N.C. Gen. Stat. §130A-143 is to maintain confidentiality of HIV/AIDS status in all but exceptional cases when the need to know outweighs the benefit of confidentiality. Given this stance, only those individuals designated as guardian of the child are authorized to disclose the child's diagnosis to teachers, day care providers and the like, to do so only in those cases where there is a need to know, and to inform the parties privy to the information that the child's private health information is to be kept confidential.

3. *Are needle exchange programs ethical? Don't they enable illegal behavior?*

Although the validity of existing research into needle exchange programs (NEPs) is debated (Bates, 2002), a number of national and global health organizations, including the Centers for Disease Control and World Health Organization, overwhelming support the policy (Szalavitz, 2008) as a measure to control the transmission of blood-borne diseases. Studies have shown that exchange programs neither increase the number of arrests recorded in a given area (Marx et al., 2000), nor increase the rate of intravenous drug use (Fisher, Fenaughty, Cagle, & Wells, 2003). While exchange programs facilitate harmful and illegal behavior by providing the means for intravenous drug use, greater harms and costs accrue from needle sharing. An ethical analysis of NEPs, in light of the principles of beneficence and nonmaleficence, respect for persons, justice and fairness, and utilitarianism found far more arguments in favor of NEPs than against them (Loue, Lurie, and Lloyd, 1995). Because many needle exchange programs include a counseling and referral component, they foster trust and relationships to help users consider rehabilitation services and facilitate the transition to such programs.

Needle exchange programs, while ethical, may not always be legal. For example, N. C. Gen. Stat. §90-113.20 ("North Carolina Drug Paraphernalia Act") labels syringes as drug paraphernalia and declares their distribution and possession to be punishable as a Class 1 misdemeanor. Nevertheless, two exchange programs are reported in news accounts (Duncan, 2006) as operating with little hindrance by law enforcement. Legislation under consideration in North Carolina supports harm reduction strategies, including needle exchange programs.

4. *My client engages in sex with multiple anonymous partners, sometimes in exchange for drugs or money. I have shared my concerns with him about the risk for him and others, but he's not inclined to change at this point and I don't want to alienate him by pushing it further. Is there anything else I can do to protect him or others? What about my own liability?*

This instance presents an excellent example of the importance of consultation. Specifically, the worker should consult a supervisor or trusted colleague in the same field of practice, the relevant licensure board, and an attorney or ethics committee of the worker's employer or professional organization. The worker may also want to contact law enforcement authorities to determine the significance of any related statutes and the likely actions should he/she make a report about the client's risky behavior. The worker need not and should not reveal identifying information about the client in order to seek advice. The information provided in the question may be sufficient to highlight the salient issues in the case. The worker in this circumstance should explore with the client whether he has been tested in order to determine his HIV status. If the client is indeed seropositive, then the worker should encourage proper treatment and provide the client with appropriate referrals.

The ethical obligation to protect others (as required by NASW Code section 1.07(c) and other standards) is complicated in this case by the anonymity of the people being put at risk and the perils already created by IV drug use and promiscuous sex. Clearly the worker cannot broadcast messages or advertise the client's status in order to protect the public, particularly individuals who are already engaging in illegal or life-endangering acts. Ideally, the worker's efforts to forge a constructive

relationship with the client and help him/her to get healthy will reduce the possibility of harm to the client and to others. Treatment goals should be aimed at harm reduction and educating the client about AIDS and control measures. These efforts and the client's responses should be documented.

Another perspective to consider is whether the client is knowingly engaging in a crime and whether that is sufficient to breach confidentiality. For example, N.C. Gen. Stat. Article 27, §14-203 defines prostitution as including "the offering or receiving of the body for sexual intercourse for hire, and shall also be construed to include the offering or receiving of the body for indiscriminate sexual intercourse without hire." Consultation about this case should help the worker assess the impact of reporting the client's illegal activity to the police and the implications for the helping relationship, for actually mitigating the client's dangerous activity, and for the effect on other clients who may distrust the worker and/or the agency for such a breach of confidentiality. Instead of reporting the client to the police, a frank discussion with the client regarding his risky behavior and alleged violation of criminal law may be sufficient to protect others and the client from potential or future harm. Again, documentation of the consultation, decision and discussion with the client is essential.

Another ethical obligation that is relevant to this case involves terminating care when services are no longer required or no longer meet the client's needs or interests. Terminating services should occur only after careful, thoughtful, and deliberate evaluation and assessment. Are meaningful goals being addressed in the helping process? Is the client appropriately participating in the services? For individuals who live on the margins of society, even a tenuous connection to services may be an appropriate and laudable objective. On the other hand, the referral, suspension, or termination of service may be appropriate if the worker and client are not able to achieve their objectives. This is not to suggest terminating the client in this case because of resistance to change or the creation of liability or distress for the worker. However, the worker must seek supervision or consultation to determine if his/her targets and interventions are appropriate for the client and the agency, or if he or she is simply abiding the status quo.

5. A client reports that she has been physically hurt by her partner in the past, and is afraid that disclosing her newly-discovered HIV positive status will put her in danger of abuse. She believes the infection may have even come from her partner. Must she disclose? Does this affect the clinician's duty to report?

The intersection of intimate partner violence and HIV/AIDS is an important area of concern in women's health. A literature review by Gielen and colleagues (2007) includes several studies indicating that a diagnosis of HIV is a risk factor for interpersonal violence. Many domestic violence advocates and health professionals recognize that "an assessment of domestic violence and a more nuanced approach that would account for the risk of disclosure-related abuse" should be included in partner notification laws (Stoeber, 2009, pg. 1171).

In the absence of notification laws that take the risk of violence into account, clinicians must assess whether clients have experienced intimate partner violence or fear that disclosure of HIV status might result in abusive behaviors such as bodily injury, intimidation, emotional abuse, or threats of social harm. These considerations must then be weighed with compulsory partner notification and the legal and statutorily defined protective measures available to the client. Partner notification by the state will result in the partner finding out about the possibility of infection, even if he/she is not told the source of exposure. The client should be informed about the heightened risk of injury and measures should be taken to develop a safety plan for the client.

While further research into prevention and treatment measures on the confluence of HIV and interpersonal violence is sorely needed (Gielen et al., 2007), the most current recommendations are that practitioners remain aware of the intersection of these concerns, conduct abuse and violence assessments with their clients with HIV/AIDS, and maintain a working knowledge of the available resources in the community for this population (Willard & Angelino, 2008; Gielen et al., 2007).

Acknowledgements

Many thanks to Scott Rutledge, Natasha Bowditch, Tashuna Albritton, and Sue Butler for sharing their wisdom and knowledge in reviewing and refining this document.

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