Tailoring HIV Counseling and Testing to the Unique Needs of Adolescents
Module 1:

Course Goal:

• The goal of this training is to prepare Health and Human Service Providers to effectively engage adolescents in HIV counseling, testing, partner notification and linkages to care.
Course Objectives:

As a result of this course you will be able to:

• Identify the value of understanding the developmental stages & how it impacts counseling and testing messages;

• Apply information and about how to tailor health-related discussions with adolescents;
Course Objectives:

• Understand pre and post test counseling messages for adolescents in regard to: capacity to consent, partner notification, domestic violence screening, treatment of HIV infection, and linkages to care; &

• Identify local health and human services resources that will foster collaboration and linkages among providers for youth.
First, if we are to work effectively with adolescents we need to:

- Define Adultism
- Recognize Adultism in the work that we do
What is Adultism?

- Adults hold judgments & assumptions about how youth look, what they eat, how they behave, what they do etc.
- Providers also have different philosophies as to what youth should be doing.
- Adultism is defined to mean “all those behaviors and attitudes which flow from the assumption that adults are better than young people and entitled to act upon young people in myriad ways without agreement.”
Young people are frequently:

- Not trusted to develop and make choices; therefore adults may feel as though they need to control young people. Consider how often we hear that young people are physically and sexually abused, scolded at, yelled at, intentionally or unintentionally put down.
Young people are frequently:

- Denied control, or not given control, or control is taken away. How many times have we heard adults say “You’re so smart for fifteen!” or “When are you going to grow up?” etc.
As providers it’s important to recognize that Adultism:

- Disempowers young clients.
- Most strongly impacts young people who are labeled “at-risk” and as result adults treat young people unfairly.
- Impacts the messages that are delivered during HIV Counseling Sessions.

(source: Adultism by John Bell)
Background and Rationale

- 25% of all HIV transmission occurs sexually among youth under the age of 21 (Office of AIDS Policy)
- Estimated 100,000 cases of HIV among youth 13-21 in the USA (HIV & Adolescents Guidelines, Jan. 2003)
- Estimated 1 new infection every hour (HIV & Adolescents Guidelines, Jan. 2003)
Background and Rationale

- HIV Counseling and Testing needs to be tailored to address unique concerns of youth
- Many HIV-infected youth are not diagnosed until they reach their twenties
- HIV disease has had time to advance without medical monitoring, treatment, counseling and support
- Increasing youth access to HIV testing and treatment is vital
HIV & Adolescents: Guidelines

- Summary of regulations
- Implementing regulations with special consideration for adolescents
- Consent & confidentiality
- Youth at Risk
- Risk assessment
- Risk reduction
- Tailoring testing and partner notification services to be youth sensitive
- Resources
Adolescents 13-19 Years of Age Living with HIV Infection* and AIDS, Reported through 2000

* For areas with confidential HIV infection surveillance. Includes 44 residents of areas without HIV infection surveillance but who were reported by areas with HIV infection surveillance.

**Totals include cases missing state of residence data.

***HIV cases reported by patient name

Confidential HIV Reporting**

N= 1324**  N= 1540**
**AIDS Cases in Male Adolescents and Young Adults, by Exposure Category, through 2000, United States**

<table>
<thead>
<tr>
<th>Exposure category</th>
<th>13-19 years</th>
<th>20-24 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Men who have sex with men</td>
<td>803</td>
<td>34</td>
</tr>
<tr>
<td>Injection drug use</td>
<td>148</td>
<td>6</td>
</tr>
<tr>
<td>Men who have sex with men and inject drugs</td>
<td>123</td>
<td>5</td>
</tr>
<tr>
<td>Hemophilia</td>
<td>756</td>
<td>32</td>
</tr>
<tr>
<td>Heterosexual contact</td>
<td>107</td>
<td>5</td>
</tr>
<tr>
<td>Transfusion recipient</td>
<td>95</td>
<td>4</td>
</tr>
<tr>
<td>Other/undetermined*</td>
<td>334</td>
<td>14</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2,366</td>
<td>100</td>
</tr>
</tbody>
</table>

* Includes patients whose medical record review is pending; patients who died, were lost to follow-up or declined interview; and patients with other or undetermined modes of exposure
### AIDS Cases in Female Adolescents and Young Adults, by Exposure Category, through 2000, United States

<table>
<thead>
<tr>
<th>Exposure Category</th>
<th>13-19 years</th>
<th></th>
<th>20-24 years</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Injection drug use</td>
<td>227</td>
<td>13</td>
<td>2,015</td>
<td>26</td>
</tr>
<tr>
<td>Hemophilia</td>
<td>13</td>
<td>1</td>
<td>16</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Heterosexual contact</td>
<td>877</td>
<td>52</td>
<td>4,233</td>
<td>55</td>
</tr>
<tr>
<td>Transfusion recipient</td>
<td>98</td>
<td>6</td>
<td>116</td>
<td>2</td>
</tr>
<tr>
<td>Other/undetermined*</td>
<td>480</td>
<td>28</td>
<td>1,353</td>
<td>17</td>
</tr>
<tr>
<td>Total</td>
<td>1,695</td>
<td>100</td>
<td>7,733</td>
<td>100</td>
</tr>
</tbody>
</table>

* Includes patients whose medical record review is pending; patients who died, were lost to follow-up, or declined interview; and patients with other or undetermined modes of exposure.
Module 2

Adolescent Development

Objective

• Identify the value of understanding the developmental stages & how it impacts counseling and testing messages
Tasks of Adolescence

- Physical Development
- Psychological Development
- Cognitive Development
- Sexual Orientation
Physical Development

- Girls: breast, pubic hair growth
- Boys: genitals, pubic hair growth
- Difference of timing between girls & boys
Difference between girls & boys

- Breast: 10.5 yrs
- Testicular: 11.5 yrs
- Penile: 12.5 yrs
- Public Hair: 11 yrs
Difference between girls & boys

<table>
<thead>
<tr>
<th>Event</th>
<th>Girls</th>
<th>Boys</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height spurt</td>
<td>12yrs</td>
<td>14yrs</td>
</tr>
<tr>
<td>Menarche</td>
<td>12.5 yrs</td>
<td>14yrs</td>
</tr>
<tr>
<td>Ejaculation</td>
<td>11.5yrs</td>
<td>13yrs</td>
</tr>
<tr>
<td>Acne</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Physical Development & High Risk Behavior

• Cervical ectopy & risk for STD/HIV
• Infection with STD means higher risk for HIV
• Issues for adolescent with chronic illnesses
Early Adolescence: 12-14 yrs

Psychosocial development
- Move from parents to peers
- Preoccupation with self
- Beginning of eating disorders
- Same sex friend - very important
- Greater need for privacy

Cognitive development
- Concrete
- Difficulty negotiating sexuality
## Middle Adolescence - 15-17yrs

<table>
<thead>
<tr>
<th>Psychosocial development</th>
<th>Cognitive development</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Peer group is important</td>
<td>• Abstract thought &amp; logic</td>
</tr>
<tr>
<td>• Exploration of sexuality</td>
<td>• “lives for the moment!”</td>
</tr>
<tr>
<td>• Risk-taking behaviors</td>
<td></td>
</tr>
<tr>
<td>• Clearer sense of self</td>
<td></td>
</tr>
<tr>
<td>Peer Pressure</td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td></td>
</tr>
<tr>
<td>• Greatest during middle adolescent</td>
<td></td>
</tr>
<tr>
<td>• Intense involvement with peer subculture</td>
<td></td>
</tr>
<tr>
<td>• Conform to peer values to separate</td>
<td></td>
</tr>
<tr>
<td>• Involvement in clubs, teams, gangs, groups</td>
<td></td>
</tr>
</tbody>
</table>
Late Adolescence – 18-21yrs

Psychosocial development

- Separation but appreciation of authority/family
- Comfortable with body image
- Relationship with one person
- Full adult reasoning/identity

Cognitive development

- Able to weigh alternatives
- Conceptualize
- Verbalize thoughts
Components of Sexual Identity

- Gender Identity
- Gender/sex roles
- Sexual orientation
  - Emotional attachments
  - Sexual fantasy
  - Sexual behavior
  - Sexual identity
Challenges in LGBT development

Must develop a healthy & integrated identity in context of:

- Negative stereotypes
- Prejudice
- Often without family or peer support
Stages of Sexual Identity

Stages

- Sensitization
- Identity confusion
- Identity assumption
- Commitment

When…

- Pre-adolescence (8-12yrs)
- Early-mid adolescence
- Late adolescence
  “coming out”
- “…integration of sexual identity into all aspects of one’s life”

Troiden, 1989
Adolescent Brain Development
Adolescent Brain Development

- A snap-shot of the internal development of the brain & how it relates to adolescent behavior
Brain Anatomy...

- Prefrontal cortex
  - Judgment is formed
- Limbic system
  - Emotions are developed
Brain Anatomy...

<table>
<thead>
<tr>
<th>Adult</th>
<th>vs.</th>
<th>Adolescent</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Prefrontal cortex</td>
<td></td>
<td>• Prefrontal cortex</td>
</tr>
<tr>
<td>– Judgment</td>
<td></td>
<td>– Judgment</td>
</tr>
<tr>
<td>– Processes</td>
<td></td>
<td>– Asleep</td>
</tr>
<tr>
<td>emotions &amp; makes decisions</td>
<td></td>
<td>– Unfinished</td>
</tr>
<tr>
<td></td>
<td></td>
<td>– Trouble organizing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>multiple tasks</td>
</tr>
</tbody>
</table>
Brain Anatomy

Adult vs. Adolescent

- Limbic system
  - Raw emotions
  - Kept “in check” by the prefrontal cortex

- Limbic system
  - Raw emotions
  - Overdeveloped
  - More likely to emotionally overreact
## Effects on adolescent behavior….

<table>
<thead>
<tr>
<th>Situation</th>
<th>Emotion:</th>
<th>Behavior:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dumped by a partner</td>
<td>• Devastation “It’s the end of the world”</td>
<td>• Drink to excess</td>
</tr>
<tr>
<td>Being bullied at school</td>
<td>• Embarrassment - everyone is looking at me!</td>
<td>• Too shy to speak-up for themselves</td>
</tr>
<tr>
<td>At a party, everyone seems to be doing it</td>
<td>• Pressure - everyone is having sex!</td>
<td>• Is pressured into having sex by partner</td>
</tr>
</tbody>
</table>
Module Three: Adolescent Strengths & Communication

Objective:

Apply information about how to tailor health-related discussions with adolescents
Unique Risk Factors:

- Homeless/ runaway
- LGBT
- Sexual victims/sexual abuse
- MRDD
- Pregnant
- Minority
- STD

- Foster care
- Juvenile system
- HIV positive
- Substance use
- Limited or no parent/guardian involvement
- Older sexual partners
Youth Risk Factors

• Normal adolescent development can be hazardous
  – Physical characteristics make youth more vulnerable to STDs & sexual abuse
• STDs incidence & prevalence is highest in this age group- HIV/STD connection
Behaviors that increase risk of HIV infection

- Unprotected sex
  - Anal
  - Vaginal
  - Oral
  - Survival sex
  - Older sexual partner
  - Sexual abuse
    - Ongoing-victimization
- Steroid use
- Serial monogamy
- Body art
  - Tattooing
  - Body piercing
- Cutting/branding
- Drug use
  - IV drug use
  - Non-IV drug use
    - Ecstasy, club drugs
## Barriers to young clients’ getting tested

<table>
<thead>
<tr>
<th>Financial barriers</th>
<th>Distrust of adults/health care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of services</td>
<td>health care providers</td>
</tr>
<tr>
<td>Lack of insurance</td>
<td>Fear of judgment of health care providers</td>
</tr>
<tr>
<td>18-24 y.o. are least insured in US</td>
<td>Unfamiliar/intimidated by health system</td>
</tr>
<tr>
<td>Confidentiality issues</td>
<td>Lack of perceived risk</td>
</tr>
<tr>
<td>Parent involvement</td>
<td>Low self-esteem</td>
</tr>
<tr>
<td>Lack of social support</td>
<td>Difficulty making &amp; keeping appointments</td>
</tr>
<tr>
<td></td>
<td>One-stop shopping</td>
</tr>
</tbody>
</table>

- Financial barriers
  - Cost of services
- Lack of insurance
  - 18-24 y.o. are least insured in US
- Confidentiality issues
  - Parent involvement
  - Lack of social support
### Agency Barriers

<table>
<thead>
<tr>
<th>Agency is not centrally located &amp; operating hours are inconvenient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy/Procedures are not youth friendly</td>
</tr>
<tr>
<td>• Multiple visits “hoops”</td>
</tr>
<tr>
<td>• Does not offer a “one-stop shopping”</td>
</tr>
<tr>
<td>• bureaucracy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Agency is not “youth friendly”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency staff is not “youth friendly or culturally sensitive”</td>
</tr>
</tbody>
</table>
Provider Barriers

- Stereotypes
- Strict in guidelines
- Are not comfortable in talking about sensitive issues
- Assumes young person is not infected
- Uncomfortable assessing the capacity to consent

- Does not bring up the “risk” so the young person thinks it is not a problem
- Does not like working with youth
- Unsure of the role of the parent
Secrets to a successful youth-centered counseling session

Core Values

– Do not use shame or control
– Enjoy and like adolescents
Secrets to a successful youth-centered counseling session

- Structure your discussions around home, education and other activities
  - Open-ended questions
- Be yourself – honesty, respectful, non-judgmental
- Culturally aware and sensitive to clients
- Youth are experts on themselves
- Value and identify youth strengths
- Inquire about youth’s goals
- Language- inclusive, culturally sensitive and appropriate
- Present honest & factual information
Harm Reduction Counseling

- On-going process
- Assessing one’s sexual activity
- Decision-making skills
- Skills and knowledge related to barrier methods
- Communication with partner(s)
- Social supports (parent/guardian)
Youth are more likely to be tested…

Youth are more likely to be tested if the issue is introduced in the context of a health care visit. (Goodman et al, Samet et al.)

When the idea of HIV testing is introduced into counseling sessions –”planting the idea”
Module 4:

Objectives:

• Understand pre & post test counseling messages
  – Capacity to Consent
  – Partner notification
  – Domestic violence screening
  – Treatment of HIV infection
  – Linkages to care
Is it…… TRUE or FALSE?

Read the statement & decide if it is true or false
Youth attitudes and beliefs about HIV counseling and testing

- May not understand confidentiality protections
- Benefits of testing/treatment may not be understood
- Perception of HIV risk is not correlated with likelihood to seek testing

(Goodman, et al, Samet et al, Valdiserri et al)
Youth attitudes and beliefs about HIV counseling and testing

- Don’t always know where to go for counseling and testing
- Do not understand distinction between anonymous and confidential testing
- Do not understand what services they have the legal right to without parental consent

(Goodman, et al, Samet et al, Valdiserri et al)
1. A minor is a person under the age of 18.

TRUE
How is a minor defined in many states?

• Minor (or infant) is a person under the age of 18.
• Some exceptions to the rule:
  – Minor is married
  – Minor that is pregnant
  – Minor is a parent of a child
  – Emancipated minor
What is an Emancipated Minor?

A minor who ...

- is married
  - has established a home & is economically independent
- is in the armed services
- has a parent that has failed to fulfill parental support obligations & the minor seeks emancipation
Rights of a Minor who is married, pregnant, a parent or emancipated

- Can consent to an HIV test & disclosure of HIV information
  - If they decide not to be tested, a parent/guardian cannot override their decision.
- Can consent to treatment- no other consent is necessary
2. The HIV test counselor is responsible for assessing whether a young person has the capacity to consent.

TRUE
Determining Capacity to Consent to Testing with Minors

- Group Brainstorm

  - What questions might a provider ask a young person to determine the capacity to consent?
Definition of Capacity to Consent

- Ability, determined without regard to the individual’s age, to understand and appreciate the nature and consequences of a proposed health care service, treatment, or procedure, or of a proposed disclosure of confidential HIV related information, as the case may be, and to make an informed decision concerning the service, treatment of disclosure
How is Capacity to Consent Determined?

• Youth-centered counseling sessions
• Assessing if the patient understands & appreciates the nature/consequences of undergoing an HIV test?
• Is the youth able to make an informed decision about whether to be tested?
• Capacity is based on developmental capacity … not on age!
Strategies for determining capacity

- Thought processes (concrete vs. abstract)
- Future orientation
- Ability to plan
- Capacity to weigh options
- Ability to assess risk realistically
- Ability to assess skills for implementing behavior change
What are some reasons to defer testing based on lack of capacity to consent?

- Psychosocial situation of youth
- Doesn’t understand basic information about HIV/AIDS
- Can’t comprehend the consequences of test results
- Is not able to make an informed decision
If the minor lacks capacity to consent what are provider’s options?

- Determine if someone else may legally consent for them
- Be aware of safety issues: regarding reaching out to parent/guardian

- Conduct pre-test counseling & defer the test until a later date
- Don’t perform the test
- Work to “bring them up” to a level where they can consent
Pregnant Minor’s: HIV Testing

• If the minor lacks capacity to consent a test may not automatically be done

• The provider should work:
  – with the minor to determine if there is a parent/guardian who may be able to consent on their behalf
  – with client to bring them to a level of consent
Role parents/legal guardians in regard to HIV testing?

- Minors with the capacity to consent
  - Parents/legal guardians do not have the right or legal authority to decide or consent to HIV tests or disclosures about the minor
Role of parents/legal guardians in regard to a young client’s health care

• Minors **without the capacity to consent**
  – Cannot authorize their own HIV test
  – The person authorized by law to consent to health care for minor
    • Parent/legal guardian
3. A minor that has the capacity to consent to an HIV test also has the capacity to give legal permission to disclose his/her HIV-related information.

TRUE
Where do minors fit into the legal framework?

- Minors who have the capacity to consent have the authority to make decisions about HIV testing and to control disclosures about their HIV status.
4. Young people cannot consent to their own reproductive health care without a parent/legal guardian being present.

false
5. If a minor seeks out reproductive health care or an HIV test, parents/legal guardians are immediately informed.

false
Types of Care Minors Can Generally Consent To…

- Reproductive health services
  - Birth control
  - Prenatal care, labor, and delivery services
  - Abortion
- STDs
- Outpatient Mental health services for minors under 15*
- Substance abuse treatment
- Inpatient Mental Health Treatment for minor 16 or older
- Emergency Care

*Certain conditions must be met
Minors are authorized to...

- give consent to certain kinds of treatment (without parental involvement)
  - STDs
  - Drug or alcohol problems (with limits)
  - Family planning
  - Prenatal care
  - Pregnancy termination
Treatment for Minor

• Parent or guardian’s consent is generally required before a minor may be given medical, dental or hospital services
6. If a young person can consent to an HIV test, they can also consent to HIV treatment.

false
Testing vs. HIV Treatment

• The law* gives minors who have capacity to consent the right to decide whether to be tested for HIV
• The law does not govern who can authorize a minor’s treatment for HIV/AIDS

*Article 27-F
Adults Who Can Generally Authorize Treatment for Minors

- Parents
- Guardians (court-appointed)
- Commissioner of Social Services (When parents have delegated the authority or when a child has been abused/neglected and taken into court custody)
What about youth seeking treatment for HIV/AIDS?

- Encourage disclosure to parent/guardian or other supportive and safe adult
- Assess the reasons behind the minor’s refusal or reluctance to disclose
- Assessment should include mental health provider
- Assessment must determine if disclosure will result in any harm (i.e. violence, abandonment)
7. A physician can disclose a minor’s HIV status to his/her parents under any circumstances.

false
Physicians’ Discretionary Disclosure Rule:

- Applies to only physicians
- The rule does not permit persons other than physicians to make disclosures to parents without the minor's consent
Physician may disclose about a minor without minor’s consent

• Physician reasonably believes…
  – the disclosure is medically necessary
  – After appropriate counseling about the need for the disclosure, the minor will not inform the parent
Physician **may not** disclose about a minor without minor’s consent

- Physician reasonably believes…
  - The disclosure “would not be in the best interest” of the minor
  - The minor “is authorized pursuant to law to consent to the care and treatment” the doctor believes medically necessary
Health Providers working with youth

- Play a vital role in adolescent’s health care
  - Counseling youth on risky behaviors
  - Respect a client’s right to privacy

- Health Providers- are bound by HIV Confidentiality Laws
If client defers parent involvement

- Provider has an obligation to assess a minor’s overall safety in continuing to live under the supervision of parent/guardian
- Provider **must** report any suspicions of child abuse or maltreatment
- If no neglect exists, provider can continue providing routine care
- Provider should work with youth towards goal of disclosure to parent or other adult
8. Domestic violence risk assessment is a required component of post-test counseling for all HIV-infected individuals. 

TRUE
DV Screening Protocol-7 Easy Steps

1. Discuss DV in post-test counseling before partner names are elicited
2. Screen for risk of DV separately for each partner
3. Provider referral(s) for DV services and discuss release forms
4. Make determination(s) regarding HIV partner notification
5. Discuss & implement partner notification option(s)

6. Collaborate with public health partner notification staff

7. Revisit partner notification & DV risk throughout the continuum of care
DV screening for a young client is encouraged during…

• Pre-test session
• During risk assessment
• During sexual history taking
• During discussion of how youth might react to testing HIV positive
• Whenever partners are discussed
• During safer sex discussion
Tailoring Domestic Violence Screening for Youth

- Regulations require DV discussions
- Discuss DV during pre-test counseling session
- Regulations require DV screening with HIV+ clients for each known/named partner prior to partner notification
- Use concrete examples and familiar terms
Tailoring Domestic Violence Screening for Youth

- Be familiar with how youth refer to their sexual or romantic partners
- Be familiar with terms used by youth so you do not miss cues and signals about violence
- Keep in mind that some young people may think DV refers only to adults or “married” adults
- Ask if you do not understand a term being used
If DV screening reveals the possibility of harm

- Disclosure should be deferred
- Consider another adult with whom the youth has a trusting relationship
Coping with a test result

- Providers should assess how youth copes with stress and how they would cope with HIV test results.
- Based on prior history and/or direct questioning on mental status by a mental health professional, suicidality may be ruled out.
- A mental health professional should carefully assess youth with mood disorders as they are associated with suicidal ideation and attempts.
Coping with a test result

- Guidelines contain questions that may be used to assess suicidality
  - Have you ever felt so sad that you considered hurting yourself?
  - Have you ever thought about suicide?
  - How often, and how many times a day, do you think about suicide?
- See guidelines for additional screening questions
What do I do if I think my client is suicidal?

- Inform supervisor and be familiar with agency policy! Do not perform an HIV Test at the moment.
- Place youth in safe environment immediately
- Immediate assessment by trained mental health provider
- If the youth is a threat to his/her safety you may involve the parent/guardian over possible objection of the minor (English, A.)
Providers should also assess for other types of violence

- Peers
- Siblings
- Family members
- Parents
- others

- Being thrown out of their home
  - Strangers
  - so-called “trusted adults”
  - Partners- older partners
9. In order to access services of PNAP or CNAP a young person’s parents must be present.

false
Tailoring PN services for youth

- Voluntary nature of PN
- Review PN options
- Stabilize and support your client first
- Use judgment on when to talk about PN
- Consult PNAP/CNAP for guidance
- Work with PNAP/CNAP to ensure programs are accessible/sensitive to youth
10. All clients who test HIV positive are required to report their sexual and needle sharing partners.

false
Partner Notification

• **Self-notification**- client informs partner

• **Assisted notification** – in which a provider and the adolescent informs the partner together

• **Notification by public health staff (PNAP/CNAP)**- in which the name & identifying information about the index patient is not shared
11. Partner notification should be deferred any time risk of domestic violence may have severe negative impact on the physical health and safety of a person with HIV or someone close to him/her.

TRUE
When to defer Partner notification...

• Notification should be deferred
  – Anytime risk of DV may have a severe negative impact on the physical health and safety of a person with HIV or someone close to him/her contacts
  – Referral should be offered and recommended if the risk of DV is identified
  – PNAP/CNAP will follow-up with the provider in 30-120 days & will consult the provider to determine whether and when notification would proceed.
What is the provider’s role?

• Assess the client’s willingness to participate in partner notification services
• Report all known contacts
• Stabilize & support client
• Help anticipate the threat of domestic violence
• Provider resources and linkages to care
Working Together

- Benefits of the provider & PCAP/CNAP staff working together to ensure a young person’s confidentiality during the partner notification process…
  - Learn the process
  - Learn who the key people are
  - Develop ways to ensure a young person’s confidentiality
  - Encourage face to face meetings with the young client; so young people understand the process & steps
Supporting youth in acquiring HIV testing and other health care

- Supportive parent/guardian or other adult
- Health care team
- Mental health provider
- Peer support
- Community support—schools, agencies, youth-centered programs
12. Young people in foster care are mandated to get an HIV test

false
Requirements for Foster Care

• All young clients are assessed for the capacity to consent
• If the client has the capacity to consent; testing can/cannot occur depending on youth wishes
• If the client does not have the capacity to consent- a person must be identified to make this decision
Module 5: Collaboration & linkages to Care

Objective:
Identify local health and human resources that will foster collaboration and linkages among providers who serve youth
Collaboration & linkages to Care

• Write/Create protocols for HIV counseling and testing in various settings where youth may access services
• Create youth-friendly environment for care
Where, when & how youth are tested for HIV

- Offer during routine primary care in youth-friendly environment
- Have youth magazines & posters with health messages
- Create/be familiar with HIV testing protocols at agency
- So-locate HIV testing with other services such as school health centers & community agencies
The benefit of linkages….  

• If an adult is not identified as a source of support for the young client…
  
  – Establish connections in advance between health providers & community agencies identified with trained
    • peer counselors,
    • educators,
    • Mentors, &
    • youth program staff
Accreditation Information

This continuing education activity is approved for 2.0 contact hours by the Association of Nurses in AIDS Care (ANAC). ANAC is approved as a provider of continuing education by the Virginia Nurses Association which is accredited as an approver of continuing education in nursing by the American Nurses Center’s Commission on Accreditation.

To receive your CE certificate, you must complete and submit a test that accompanies this module. Please return to ANAC’s website at ***** to download the test.

If you have any questions about accreditation, please contact ANAC at 330-670-0101.