HIV Partner Counseling and Referral Services (PCRS)

**CDPH/OA Policy Statement**

In CDPH/OA funded HIV prevention counseling and testing sites, every client receiving risk assessment counseling services should be encouraged to explore his/her feelings about and abilities to notify sex and needle-sharing partners of their possible exposure to HIV should the client test HIV-positive. These services offered to HIV-positive clients are referred to as Partner Counseling and Referral Services, and vary in their implementation between local health jurisdictions.

In San Francisco, these services are referred to as Disclosure Assistance and Partner Services (DAPS).

During the confirmatory test disclosure session, every HIV-positive client should be offered special counseling to ensure that at-risk third parties are offered HIV prevention counseling, testing and referral services. In a limited sense, this intervention may also be applicable to a disclosure session involving a client whose HIV test result is indeterminate, since there is a possibility that high-risk persons with indeterminate test results will seroconvert.

All HIV Partner Counseling and Referral Services (PCRS) will be conducted on a voluntary and confidential basis. HIV-positive clients should receive comprehensive counseling services including information regarding the spectrum of services available for them and their partner(s). Any verbal or written agreements about informing partners that are made between the HIV-positive client and the PCRS specialist are conditional and can be rescinded (canceled) or changed at any time. However, once a positive client chooses the “provider referral” option and the partner information is elicited and sent to the notification staff, the referral is initiated and cannot be rescinded.

**Background and Overview**

HIV PCRS is generally described as the process whereby the sex and needle-sharing partner(s) of an HIV-positive person is/are notified by the infected individual or by the health care provider regarding possible exposure to HIV. Partner Counseling and Referral Services include:

a. coaching a client to self disclose;

b. confidential services (the name or other identifying information of the HIV-positive client is never divulged to partner(s);

c. offering counseling to both the HIV-positive client and his/her sex and needle-sharing partner(s);

d. offering free and anonymous or confidential HIV testing to sex and needle-sharing partners;

e. Universal Access is one of the guiding principles of PCRS — making PCRS available to any positive client no matter where they are: homeless, incarcerated, in drug treatment facilities, etc.;

f. linking partner(s) to other appropriate services (treatment for HIV, STD, TB, or substance-use, social services, etc.)

**Partner Counseling and Referral Services Program Development**

HIV prevention counseling and testing programs should develop written protocols to address: exposure criteria (what constitutes a legitimate exposure risk), prioritization criteria (which exposed partners should be notified), and interview periods (partners within which time frame will be identified).

Typically the notification staff set policies on prioritizing notifications. Providers who work with infected clients are encouraged to accept a referral for any partner which the positive client feels should know of exposure — even if it’s a one time oral exposure. Notification staff will prioritize referrals according to their workload and the specifics of the referral. For example, a one time oral exposure is less of priority than a female of child bearing age who had anal or vaginal exposure. Local programs often use an interview period of one or two years, with emphasis on those partners most recently exposed, most frequently exposed, and those who may be pregnant or considering pregnancy. The PCRS state guidelines recommend a one year interview period. However, if a positive client has a partner from 2 or more years ago with high transmission potential, then local
programs may flex their policy. The federal Ryan White Care Act funding mandates require that a “good faith” effort be made to notify all marital contacts during the ten years prior to the diagnosis of the index case (the HIV-positive client). CDPH/OA encourages programs to develop a PCRS protocol that assists HIV-positive clients in notifying all sex and needle-sharing partners at greatest risk of having acquired infection.

Voluntary and Confidential Service

It is imperative that HIV prevention counselors convey to all clients that choosing to notify one’s partner(s) is voluntary and confidential. HIV-positive clients are never forced to provide marital or other partners’ names and locating information. Where partner names are provided, the name of the index client’s (HIV-positive client) is never disclosed. Neither are time, place or type of exposure. This helps protect identity of original positive client. In rare instances, partners may be notified without client consent. This is called “non-consensual notification”. It can only be ordered by a physician and it is not considered part of the PCRS program. (See section below)

All records related to the interview of index cases, the elicitation of partner names and contact information, related field activities and resulting dispositions must be retained in a confidential manner. As is true for all public health records, no PCRS documentation can ever be compelled to be presented in a criminal or civil trial.

All partners who are contacted must be offered voluntary HIV prevention counseling and testing services (and follow-up prevention counseling and testing if appropriate) and provided with referrals to other needed services as appropriate.

Methods of Notification

HIV-positive clients should be informed that either of two methods can be utilized to notify or refer partners: 1) client-referral or 2) provider-assisted referral. Provider-assisted referrals can be implemented with the direct assistance of the counselor, in a dual motif, or by the provider only, generally through a field intervention. HIV prevention counselors must be competent in describing the PCRS program protocols in their local health jurisdictions and facilitating a referral for clients who request provider assistance.

Client Referral (Or Self Referral)

Clients who choose to notify their partners themselves can be “coached” by the HIV prevention counselor (through role playing, prioritization, scheduling, follow-up consultations) to help prepare for this process. The coaching process can enhance or build new skills and/or confidence for the client and enhances the likelihood that the referral will actually take place. While counselors can assist clients during the disclosure session, it may be more appropriate to schedule a separate visit for special PCRS discussions. At a minimum, we want to check in with the client to see when they will be seeing the person they intend to disclose to. Since all HIV-positive persons should be routinely receiving referrals to an early intervention program (EIP) or other follow up medical service, PCRS counseling may be deferred until the client meets his/her EIP case worker. This referral should only be made when the HIV prevention counseling and testing program is certain that PCRS services are available through the EIP and that the HIV-positive client understands that the issue will be fully addressed at that visit.

Dual Referral (Provider-Assisted Referral)

HIV prevention counselors may offer direct assistance to their clients, by offering “dual counseling” services (services whereby partners are notified of their exposure by the index client in front of the HIV prevention counselor and the counselor takes on the role of facilitator). Although potentially challenging to the counselor, this method may be a desirable option for the client and, hence, the best option. This is particularly true if the client’s partner is in waiting room; the coaching process (as in the Self referral above) needs to occur. It is recommended that only trained mental health professionals and/or veteran HIV prevention counselors with PCRS expertise deliver “dual” notification services.

Provider-Referral

HIV-positive clients who wish to have public health representatives notify their partners must provide identifying and locating information for their partners. The elicited partner information is collected by the test counselor on plain paper and then the field notification /DIS staff transfer this information to the correct form. Standard forms have been developed by CDC for this purpose.

Counselors who have not attended the State-sponsored PCRS training (with the recommendation of their HIV testing coordinator/program) should not be delivering PCRS services. Only disease intervention specialists (DIS) or HIV prevention counselors who have experience in obtaining identification and location information for partners should be authorized to counsel HIV-positive persons for PCRS purposes.
PCRS can also occur effectively in an anonymous test site. There is no need to know the name of the original client. All that is needed is their confirmed positive status. If the client wishes for a partner(s) to be notified, counselors can still collect the partner(s) identifying and locating information without ever compromising the anonymity of the original positive client.

**Referrals to PCRS**

Since not all California health departments have established HIV PCRS programs, HIV prevention counseling and testing programs should identify a PCRS contact or point person with their local health department’s EIP, HIV/AIDS, and/or other appropriate communicable disease control program. HIV prevention counselors should become familiar with how PCRS activities are conducted in their jurisdictions, especially how confidentiality is ensured, so that they are able to adequately describe the process and convey a sense of confidence when referring a client elsewhere for PCRS counseling.

**Obtaining Written Authorization**

Written authorization is not necessary (nor is it recommended) to allow PCRS programs to inform sex/needle-sharing partners. However some local health jurisdictions are requiring it. The client is using “INFORMED CONSENT” when they accept PCRS in whichever manner/option they choose. This will serve to protect client anonymity in anonymous test sites and provide appropriate documentation of the index client’s diagnosis. (NOTE: The CDPH/OA is currently in the process of updating HIV Counseling and Referral Services Standards/Guidelines which will include suggested protocols for anonymous and confidential HIV prevention counseling and testing services).

**Benefits and Risks**

Several states, as well as many local health jurisdictions in California, carry out voluntary partner counseling and referral services as part of their primary HIV prevention efforts. Since there are potential benefits as well as risks associated with partner notification, these services have supporters as well as detractors.

**POTENTIAL BENEFITS OF VOLUNTARY PCRS MAY INCLUDE**

a. Identifying previously unidentified HIV-positive persons who can be counseled regarding risk-reduction methods and referred to early care;

b. Preventing HIV infection by providing risk-reduction counseling to exposed, uninfected persons previously unaware of, or in denial about, their risk;

c. Preventing HIV transmission to unborn babies of HIV exposed women who are pregnant or couples who are planning pregnancy, who might not have otherwise known about their risk/status;

d. Referring high risk and HIV-positive individuals to other needed services (e.g., drug treatment, STD screening/treatment, tuberculosis testing/treatment, contraceptive counseling, teen clinics, job training, psychosocial support);

e. Preventing human suffering; and,

f. Providing cost-effective intervention services.

**POTENTIAL RISKS OF VOLUNTARY PCRS MAY INCLUDE**

a. The potential for confidentiality breaches (spouses or other steady sex/needle-sharing partners). That is why all the “options” must be fully explored by the PCRS counselor. The goal is to assist the client in making the right decision.

b. HIV’s long incubation period could require the notification of partners from months or years earlier. Programs should be flexible and willing to serve client’s individual needs on a case by case basis.

c. Possible personal safety risks associated with the notification of injection drug using partners and/or other partners involved in illegal activities and abusive relationships;

If a PCRS notification would or could put an HIV positive person or his/her partner(s) at risk of violence, the safety of the affected person(s) must be reasonably secured before the PCRS intervention can take place. Furthermore, if the original client (OC) requests that notification not be conducted because of a partner’s possible violent reaction, PCRS activities must be deferred indefinitely or until the OC gives written or verbal consent. The PCRS provider must adequately document the threat of domestic and other partner violence in the OC’s medical chart or other appropriate encounter form.
d. Possible extreme reaction of the client being notified (some persons may go on a sex and drug/alcohol-using binge or become depressed or even suicidal);

e. Limited resources to which to refer exposed/infected clients;

f. The difficulty of evaluating such programs; and,

g. The program may be time and labor intensive, as well as costly.

**Non-Consensual Notification**

In some local health jurisdictions, exposed third parties are notified without client authorization. CDPH/OA has traditionally been conservative in promoting this practice because of its limited scope (physicians/surgeons only or local health officers upon report), specific conditions (described below in steps 1-4), and concerns regarding HIV prevention counseling and testing program integrity.

California Health and Safety Code Section 121015 exempts a physician or surgeon from civil or criminal liability in the confidential notification of specified third parties and describes the following conditions which must be met in advance of a disclosure:

a. The initial HIV positive test result (ELISA) or preliminary positive result (OraQuick) must be followed up by an FDA approved confirmatory test (IFA or Western blot);

b. The notification must be made only for the purpose of diagnosis, care and treatment of the person(s) notified or to interrupt the chain of transmission;

c. The exposed partner is “reasonably believed” to be the spouse, sexual partner, and needle-sharing partner;

d. Before a non-consensual notification can be attempted, the physician must:

   1. discuss the positive test result with the index case,
   2. offer appropriate education and psychological counseling,
   3. attempt to obtain voluntary consent to notify from the index case,
   4. inform the index case of his/her intent to notify the third party(ies).

In addition to meeting all of the above conditions, the code requires that physicians refer all notified third parties for appropriate care, counseling and follow up. The law also permits physicians/surgeons to disclose pertinent information to a county health officer so that the health officer, not the physician, conducts the notification. (In most counties, the health officer delegates this duty to DIS on staff with the STD control program and/or the HIV/AIDS program.)

It is significant that California law is permissive in that physician/surgeons are not required to notify persons at-risk; however, they may choose to do so and they may not be held criminally or civilly liable for any potential damages incurred as a result of a notification they may initiate.

The PCRS program will make an effort to intervene when a non-consensual notification has been ordered so that the client is supported as much as possible around the physician’s decision to notify the partner. The client may often have valid reasons for not previously notifying their partner(s) and communication with the trained PCRS provider can help to identify specific client barriers. In some instances, this type of client-centered intervention can also help to avoid a non-consensual notification from occurring.

**Conclusion**

The current possibilities for managing HIV disease are very encouraging. Nucleoside analogue and protease inhibitor therapy, combined with medically managing HIV associated opportunistic infections and employing viral load testing, has recently brought about significant improvement in the health status of many patients with advanced HIV disease. Available data suggest that the earlier such interventions are started, the greater the chances of a beneficial outcome. PCRS services have the potential to identify exposed and infected persons early in the course of HIV disease. The possibility that sex and needle-sharing individuals could be prophylactically treated and counseled to prevent further spread of the virus may serve as a basis for more widespread acceptance of and commitment to the development of carefully targeted and properly managed HIV PCRS programs throughout California. Efforts to increase the availability and use of PCRS may well prove worthwhile given the ability of PCRS to deliver HIV prevention services to individuals at maximum risk, while other HIV prevention efforts continue to target individuals and groups at high risk.