DSS Policy and Procedure Guide

Division 03: Child Welfare	Chapter 04: Ongoing Case Management/Practice
Item 006: **Human Immunodeficiency Virus (HIV) Testing of At-Risk Children/Youth**	
Suggested changes send to: DSS PSOA Mailbox References: Health and Safety Code sections 120775 120980, 121010 and 121020; Welfare and Institutions Code 369; Identification and Care of HIV-Exposed and HIV-Infected Infants, Children and Adolescents in foster care (RE9836); All County Information Notice I-05-14, I-16-14; Special Needs Matrix	Issued: **October 30, 2015** Revisions in Red Replaces Issues: June 26, 2003

Preamble

Child Welfare Policy and Procedure Guides are meant to be used as tools to relay best practice and staff expectations. It is understood that specific case scenarios may not always align themselves with the stated practices and that at all times what is of paramount importance is the Safety and Well-being of the children we are charged to protect.

Policy

All decisions made by Department of Social Services (DSS) employees regarding Human Immunodeficiency Virus (HIV) testing of dependents shall be based on consideration for and protection of the child/youth's rights as well as medical concerns.

Purpose

The purpose of the procedure is to provide direction to Social Workers (SW), Public Health Nurses (PHN) and other involved employees to enable them to make decisions about HIV testing which serve the best interests of at-risk children/youth.

Introduction

SWs in Child Welfare come into daily contact with adults and children who are at-risk of contracting HIV infection.

While there is wide consensus that blanket testing of all children/youth coming into care is neither legitimate nor useful, the Center for Disease Control (CDC) now encourages routine testing of all pregnant woman, as well as anyone between the ages of 13 to 64. In addition, the DeoxyriboNucleic Acid (DNA) Polymerase Chain Reaction (PCR) test is now seen as a better test for detecting HIV in children under 18 month old. In the past, risk-based rather than symptom-based screening for

referral to HIV testing was discouraged, as knowledge of serostatus would expose a child/youth to risk of stigma or discrimination with no evident benefits or subsequent changes in care.

However, medical management of the asymptomatic HIV seropositive child/youth is changing rapidly, and the availability of encouraging treatments and the need for enhanced vigilance with respect to routine pediatric medical concerns argues powerfully that early identification is indeed in the best medical interest of the child/youth.

Procedure

Confidentiality

A person's HIV status must be held in strict confidence.

- Health and Safety Code section 120980 prohibits disclosure of HIV test results to any third party in a manner that identifies or provides identifying characteristics of the test subject without written authorization of the test subject, parent(s), or the juvenile court.

- Negligent disclosure is punishable by a civil penalty of up to $2500 plus court costs payable to the test subject.

- Willful or malicious disclosure is punishable by a civil penalty of $5000 to $10,000 plus court costs payable to the test subject.

- Willful, malicious, or negligent disclosure which results in economic, bodily or psychological harm to the test subject is a misdemeanor punishable by imprisonment in the county jail for a period not to exceed one year or a fine not to exceed $25,000, or both.

According to Health and Safety Code 121010, this information cannot be shared with other individuals or agencies without a specific court order, release of information from youth if they 12 or older, or a parental release of information for minors under 12 years old. Without such a release only the following may be given test results:

- The client's private physician.

- Minors 12 and older.

- The legal parent(s) if client is a child under the age of 12.

- The designated officer of an emergency response employee.

In order to maintain confidentiality, all communications regarding testing and HIV status must be maintained separate from the main body of the physical case, as well as from CWS/CMS.

All cases will contain a 6" X 9" manila envelope stamped "Confidential". This envelope is to be filed on the right hand side of the case under the narrative section.

Information to be maintained in this envelope includes recommendations to the court, court orders, test results, any of the above referenced forms, any narrative entries pertaining to HIV testing or status, computer flash/thumb drives, and any other communications pertaining to same.

This information is NOT discoverable for any court purposes and may be released only by specific order of the court. If the SW believes it is needed for the court to make an appropriate ruling regarding the minor, the SW may indicate in the court report that the minor has a "life threatening illness."

Someone who has tested positive for HIV does not have a medical diagnosis as a result. Therefore, the HIV positive status must be very closely guarded. Once someone has "full blown" Acquired Immune Deficiency Syndrome (AIDS), that person has the medical diagnosis of AIDS. A medical diagnosis, including the one of AIDS, is legally confidential to the same extent that any medical record information would be confidential and can be shared on a need to know basis.

- HIV and AIDS are to be listed in the Health and Education Packet (HEP) under "Diagnosed Conditions" as an "Immune Deficiency Disorder". No mentions of the specific terms of "HIV" or "AIDS" are to be in the HEP.

HIV Testing of Children in Placement (Post-Detention)

Criteria which places children at risk of becoming HIV positive:

- A parent is known to be HIV positive, or has previously had prenatally HIV infected children.
- A parent or child/youth admits to present or past intravenous (IV) drug use.
- A parent or child/youth has physical evidence of IV drug use, including needle marks or positive screen for drugs commonly abused by IV route, for example, opiates, cocaine, or amphetamines.
- A mother or child/youth admits to prostitution, having sex without a condom, or multiple sexual contacts.
- A mother or child/youth admits to having had sexual contact with an individual with HIV positivity, or sexual contact with an IV drug user, hemophiliac, or bisexual man since January 1, 1978.
- A mother received blood products (transfusions and/or clotting factor), or tissue or organ transplant from an unscreened donor prior to June 1, 1985, and has not been tested for HIV or HIV results are not known.
- A child born to a mother suspected of having been infected with HIV who has been tested and refuses to reveal the results.

- An abandoned new-born infant.
- A child born to a mother with positive syphilis, Hepatitis B and/or Hepatitis C screen.
- A mother or child/youth involved in practices that are potentially unsafe involving the exchange of blood or blood products with a person in a high risk category, such as: tattooing/ear piercing with shared needles, rituals involving blood to blood contact, and/or self mutilation.
- A mother or child/youth with chronic infections, sexually transmitted diseases, poor health, and/or opportunistic infections most frequently associated with the HIV virus.
- Child/youth has been raped or sexually abused. Any perpetrator must be viewed as "high risk" for having the HIV virus.
- Child was born to mother who did not receive HIV testing during her pregnancy and who refuses to be tested.
- Other medical evidence, reviewed by medical consultants that indicate the mother or child/youth is at risk.

Decision to Test

In the case of perinatal risk factors the SW will ask the child's mother if they were tested while pregnant, and if so, what the results were. If they were not tested, request that the mother be tested and have them sign a release of information in order for the doctor to release the test results to DSS.

- If the mother tests negative, there is no need to test the child.

If the parent(s) test positive or refuse to test, parental consent to test a child between the ages of one and 11 years must be requested by the DSS SW. Youth 12 years and older must legally consent for testing (form 6230).

Effective January 1, 2014, AB 506 amended Health and Safety Code section 121020, allowing a SW to provide written consent for an HIV test to be performed on an infant who is less than 12 months of age when:

- The infant has been taken into temporary custody; or the infant has been adjudged a dependent of the juvenile court; or a petition has been filed with the court to adjudge the infant a dependent,
- The infant is receiving medical care pursuant to Welfare and Institutions Code section 369,
- The attending physician and surgeon determine that HIV testing is necessary to provide appropriate care,

- The SW provides known information about the infant's possible risk factors (form 6223, *Referral for Medical Evaluation to Determine Need for HIV Testing*) regarding exposure to HIV to the attending physician and surgeon, and

- The SW has made reasonable efforts to contact the parent but was unable to do so.

    - The SW will ask all involved family and friends if they know the whereabouts of the parent.

    - The SW shall complete a Parent Search for the parent.

If the child is under 18 months old, the SW will request a DNA PCR test instead of an HIV test.

During this contact with the parent(s)/youth, the SW must counsel the parent(s)/youth and provide information which is adequate to enable the parent(s)/youth to give informed consent. To assist in this process, *Human Immunodeficiency Virus (HIV) Antibody Test Implications and Limitations* (6225) is to be shared with the parent(s)/youth. Topics to be discussed are: reasons to test, possible negative consequences and the meaning of the test. A DSS PHN can be asked to help with this discussion.

If the parent(s)/youth consent to the testing, the SW should request that they sign consent (form 6224 or 6230) for testing and disclosure of test results to the DSS, Department of Public Health (DPH) and the child/youth's care provider(s).

If the parent(s)/youth refuse or are unavailable to give consent for testing, or if the mother is unavailable for testing, the SW will complete the *Referral for Medical Evaluation to Determine Need for HIV Testing* (6223) and be prepared to discuss reasons for requesting the HIV test/DNA PCR test with the medical provider.

If the decision is made to test the child/youth, the SW will request a written recommendation from the doctor. The SW will then obtain the recommendation directly from the medical provider and submit the doctor's recommendation to the juvenile court with an ex-parte application requesting a court order authorizing an HIV antibody test/DNA PCR test of the child/youth. The court will also be asked to authorize the SW to sign necessary consent forms and to authorize the disclosure of test results to the parent(s), the DSS, DPH, the child's physician and the child's care provider(s). The SW must make every effort to inform the parent(s), when authorized, of the court ordered test.

- If the doctor disagrees that testing is needed, the SW may still file an ex-parte application with the juvenile court as specified above, making sure to explain why DSS believes testing is needed.

The SW will consult with the child/youth's doctor about where the HIV test should be completed. If the doctor does not know, the SW will consult with one of the DSS PHNs.

The SW will accompany the child/youth to the test site with the parent(s) (unless deemed inappropriate or impossible). A copy of the parent/youth's consent or court order will be provided to the tester and a copy will be in the confidential envelope of the physical case.

When a child/youth's test result is positive, the SW will consult with the DSS PHN about making arrangements for post test counseling for the parent(s), care provider(s) and child/youth (when fitting). The SW also should be present at that counseling session, if possible. Youth 12 and older shall be asked if they would like to have anyone accompany them to the counseling session, and help make those arrangements.

When the test results are negative, the SW shall assess for any needed post test counseling and/or education about high-risk behaviors.

If the Test is Positive

The primary reason to test is so that a health care plan can be developed for the child/youth. Knowing whether a child/youth has HIV can be the key to potentially lifesaving and life enhancing treatment. The SW will consult with a DSS PHN about where the child/youth's ongoing health care needs should be met.

Children/youth with HIV have special care needs, even before they are symptomatic, which can only be attended to if they are identified.

Knowing whether an individual has HIV disease may be crucial to prevent the possible spread of HIV infection to others.

Possible negative consequences:

- A positive test result can have a significant emotional impact on the entire family, including fear, grief, stigmatization and rejection by others.
- The stress of having a positive test may cause adolescents to run away or act out their fear in other ways.

Outcomes of the test:

- There is no AIDS test! A positive HIV test shows if one has been infected with the virus and has produced antibodies. It does not tell if one has AIDS or will develop AIDS.
- When the HIV antibody test is positive in infants over 18 months of age, that person is probably infected with HIV.
- A positive HIV test in an infant under 18 months of age may mean either that:
    - The child is infected or,

- The child is not infected but the child is still carrying the mother's antibodies. The test should be repeated after 18 months of age.

- The DNA PCR test is able to distinguish between the child's and the mother's antibodies when the child is under 18 months old.

A positive test may indicate any of the following:

- The person may get sick and develop early symptoms.
- The person may remain healthy.
- The person may become infected with an opportunistic disease, get very sick with AIDS and eventually die.

Placement in Out-of-Home Care

When a child/youth who has tested positive to HIV antibodies, is being placed in out-of-home care, the placing SW can only advise the care provider(s) or prospective risk-adopt parent(s) of the child/youth's HIV status if there is a court order, the parent has consented for children under the age of 12, or the youth 12 or older has consented. This is the same if the meaning of the test results is discussed and the form 6225 provided to the care provider(s).

If there is no court order or consent, care providers and prospective risk-adopt parents may be advised that the child/youth has an "immune deficiency disorder."

A copy of form 6252 (located in CWS/CMS), indicating that the child/youth has an immune deficiency disorder shall be provided to the care provider(s) who sign two (2) copies. One copy remains with the care provider(s) and one goes in the confidential envelope.

Blood and Body Fluid Precautions (6227) shall be discussed with and a copy provided to the care provider(s). It is strongly recommended that care provider(s) exercise these precautions universally with every child in their care. Such precautions are primarily good hygiene and prevent identification of an HIV positive child/youth.

The care provider(s) must be advised to maintain absolute confidentiality in regards to the child/youth's medical status. Copies of the above documents and any written communication regarding the child/youth must be maintained in a place where it will not be inadvertently seen by anyone other than persons directly responsible for the child/youth's care.

Care provider(s) must be advised of the legal requirement for obtaining authorization from the parent(s), youth, or court prior to disclosure of the child/youth's medical status to anyone. Unauthorized disclosure of HIV information may result in civil liability and/or criminal penalties of $2500 to $25,000 in fines and one year in jail. An important exception is that care provider(s) may and should tell licensed health care providers of the child/youth's HIV status if it is for the purpose of diagnosis, care, or treatment.

Parents of other children in a setting where there is a child with HIV disease do not need to know the infected child's health status except under extraordinary circumstances, e.g., when there has been an exposure. When there is exposure, the parent(s) of the child placed at risk should be informed, but do not need to know the identity of the infected child.

It is preferable to have a minimal number of other infants and toddlers in the foster home in order to protect the HIV positive child from exposure to common childhood illnesses.

Foster care rates for children with HIV infection should be based on the difficulty of care criteria used for other children with special needs. In the case of HIV disease, the difficulty of care is magnified and enhanced financial and service support may be necessary.

The eligibility forms documenting level of care for specialized care rates are distributed to staff who do not need to know a child/youth's HIV status. In order to preserve confidentiality the diagnosis of AIDS or HIV status should not appear on these forms, and is generally not required in order to specify level of care. For example, explaining that the child/youth has many medications, has an above average amount of doctor appointments, etc.

HIV Testing of Non-Dependent, at Risk Minors, in Placement

For all non-dependent infants the SW may be concerned about, if the concern is that the infant may have contracted HIV in utero, the SW will first encourage the mother to test.

- If the mother tests negative, there is no reason to continue.
- If the mother tests positive or refuses to test, the SW will encourage the parent(s) to have the infant tested and release the results to DSS.

For all other non-dependents who the SW may be concerned about having contracted HIV, the SW shall encourage the parent or youth to test and release the results to DSS.

- For children under the age of 12 years, the parent must consent.
- For youth 12 and older, the youth must consent.