HIV Antibody Testing

POSITION STATEMENT

Approved by the Board of Trustees, December 2004
Approved by the Assembly, November 2004

"Policy documents are approved by the APA Assembly and Board of Trustees…These are … position statements that define APA official policy on specific subjects…" -- APA Operations Manual.

The risk/benefit ratio of HIV antibody testing has radically shifted with our expanded understanding of the course of HIV infection and the development of antiretroviral treatments that delay the onset of HIV related illness, influence its course, and prolong life. The advantage of detecting HIV infection before the onset of clinical symptoms is now dramatically clear. These advantages include the prevention of HIV transmission from mother to child, the possibility of suppressing viral replication and decreasing the likelihood of mutations, and the opportunity to offer treatment to infected people before the immune system has been severely damaged. Although discrimination and stigma remain significant problems, federal and state statutes that offer protection are now in place, and the general population is better informed about the disease and the epidemic. All these factors have increased the benefits of HIV antibody testing relative to its risks. Although the APA does not endorse laws or regulations requiring the names of HIV-seropositive individuals to be reported to public health officials, it is important to know that all states require name reporting for AIDS cases, and most require name reporting for HIV positive antibody test results. In some states anonymous testing, which does not require personal identification, is available. Otherwise, HIV testing is confidential and follows usual privacy rules for medical information unless state law specifies otherwise. Some states have mandatory testing of newborns, which may be the first time a mother learns of her HIV status.

Consistent with these developments, the following recommendations can now be offered:

1. A complete psychiatric assessment needs to include a culturally competent sexual and drug use history that elucidates the patient's risk for exposure to HIV infection.
2. Patients with positive risk histories, as well as all pregnant women, should routinely be offered voluntary HIV antibody testing.
3. Psychiatrists should be competent in counseling patients about seeking HIV serologic testing.[1] Psychiatrists should be well informed about the need for pre-and post-test counseling, should be able to distinguish anonymous and confidential testing, should be aware of HIV surveillance procedures in their states, and should be aware of testing sites available to their patients. In addition, psychiatrists should always ensure that the patient is ready to be tested. Patients with high risks of untoward psychological reactions or destructive behaviors should be a special concern to anyone screening for HIV. Special consideration should also be paid to patient readiness in settings where rapid testing is used and pre- and post-test counseling are combined in the same session. The growing use of rapid testing should not weaken our efforts to provide quality counseling and education to every patient.
4. Those psychiatrists who decide to assume responsibility for conducting pre- and post-test counseling of patients should provide culturally competent counseling that includes an assessment of capacity and discussion of the risks and benefits of testing, previous experience with HIV testing, the implications of a positive or negative result, the limits of confidentiality, strategies for reducing HIV-related risk behavior and preventing the transmission or acquisition of HIV infection, the availability of and referral to appropriate resources for further counseling and assistance, and help with partner notification as appropriate with attention to the potential for domestic violence.
5. Psychiatrists have a special obligation to ensure that people who have severe and persistent mental illness, who are psychiatrically hospitalized, or who are committed to forensic settings have access to HIV testing and pre- and post-test counseling. Special counseling needs for this population may include timing the testing to optimize capacity and coping skills and developing strategies for access to medical care and for adherence.
6. HIV serological testing should not be performed solely for the purpose of staff awareness, and it cannot be used as a substitute for universal precautions. A patient's HIV status should be shared only with those staff who need to know the status in order to appropriately care for the patient.
7. All HIV antibody testing must be done with informed consent. It is not enough simply to have a consent form signed; it must also be documented that the person is informed and understands the consequences of both a positive and negative result. There are specific laws concerning confidentiality of HIV antibody testing results that define who may authorize consent for minors or adults who lack capacity. These laws vary from state to state, and they must be understood and followed prior to obtaining consent.
8. The confidentiality of information regarding HIV testing or status should be protected. Protection of confidentiality is important so that patients will not be dissuaded from testing, treatment, and behavioral counseling. Sharing of HIV status should be in compliance with applicable state and federal law. Patients should be made aware of hospital/program policy regarding documentation of HIV serologic status in the medical record (if their serologic status is known) or before initiating HIV serologic testing. Patients should be aware that when third parties pay for HIV antibody testing, both positive and negative test results may be available to the Medical Information Bureau[2] and can subsequently affect eligibility for future insurance.
9. Patients who test positive for the HIV antibody should be referred for further medical evaluation of their immune status and general health.
10. The available evidence and the current guidelines of the U.S. Centers for Disease Control and Prevention (CDC) suggest that there is no indication for mandatory HIV testing for physicians, including none for granting hospital privileges or for admission to or promotion within psychiatric residencies.
11. All counseling and testing of health care personnel and patients regarding occupational risk and actual exposure should be provided under the explicit informed consent and confidentiality protection provided for by law and should include counseling regarding the risks and benefits of HIV testing. Timely testing of source individuals should be undertaken as medical-legal limitations permit. See also the resource document, *Resource Document for Occupational HIV Exposure: Protocols and Protection*.

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[1] The main tests used for detecting HIV infection are blood tests: enzyme immunoassay (EIA), enzyme-linked immunosorbent assay (ELISA), and the Western blot test, which is used to confirm the EIA/ELISA screening tests. In addition to the standard blood tests for HIV, other tests are available including oral tests (which tests for the presence of HIV antibodies in saliva), and antigen tests (which measure the specific protein of the virus in the blood).

[2] "The Medical Information Bureau (MIB) is an association of more than 500 U.S. and Canadian insurance companies that report information to a data base. Individual insurance companies can retrieve information from the data based by request. This mechanism enables insurance companies to verify health information provided by applicants for new insurance policies."