

CHALLENGE AIDS NOW!



LOOK

TO

THE
AIDS
HEALTH
PROJECT
A HEALTH PROMOTIONAL EFFORT

FOR

AIDS PREVENTION

GROUPS IN STRESS MANAGEMENT, SAFE SEX, DEPRESSION PREVENTION & OTHER WAYS TO LOWER YOUR RISK



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626-6637

AIDS Risk
Reduction
Groups!



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AIDS Risk
Reduction
Groups!

To celebrate
life and living
& To honor those
who **give** so
much of **themselves**

The UCSF AIDS Health Project
Community Advisory Board presents

**Annual
Volunteer Appreciation Party**

Monday, April 3, 1995

The Golden Gate Room
San Francisco Marriott Hotel





This Evening's Program

6:00 **Informal Socializing**

7:00 **Welcome**
Kathy Bella
Chair, Community Advisory Board

Introduction
Jim Dilley
Executive Director

Volunteer Acknowledgments

Volunteer Therapist Program
Muriel Richens, MFCC
Presented by Will Werner, Intake Coordinator

Group Facilitators
Alex Martinez, Groups Facilitator
Presented by Carol Kleinmaier,
Volunteer Groups Coordinator

Publications
Stephan Follansbee, MD
Medical Advisor, FOCUS
Presented by Robert Marks, Publications Director

Administration
Glenn Ruggiero, Groups Coordinator
Presented by Dorothy Stinnett,
Assistant to the Director

ATS Volunteers
Lance McDaniel,
HIV Antibody Test Counselor
Presented by Francis Salmeri,
Roving Team Site Manager

8:00 **Closing remarks**
Kathy Bella
Jim Dilley

Celebration!
Music and dancing



AHP would like to acknowledge

Bank of America San Francisco Marriott Hotel Wells Fargo Bank
for their generous donations toward this evening's event.

The UCSF AIDS Health Project
Community Advisory Board presents

Annual Volunteer Appreciation Party

Monday, April 3, 1995

The Golden Gate Room
San Francisco Marriott Hotel



UCSF AIDS Health Project Volunteers

Our sincerest apology to any volunteer who may have been inadvertently omitted from this list.

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Dominic Ali
Lisa Allard
Randy Allgaier
Robert Anderson
Gerald Asheim
Dymond Austin
TJ Austria
Mike Bard
Wilma Bass
Alvin Baum, Jr.
Jeffrey Bell
Arnie Bellefontaine
Dan Bellm
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Frances Binnington
Chris Bishop
John Blando
John Blando
Joshua Bobrowsky
Sergei Boissier
Josh Bottfeld
Milton Bratton
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Scott Williams
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Neil Yoskowitz
Brian Young
Stephen Zollman

To celebrate
life and living

To honor those
who give so
much of themselves



The UCSF AIDS Health Project
Community Advisory Board
cordially invites you and a guest
to the



Please RSVP
by March 28
by calling
476-6430

Annual Volunteer Appreciation Party

**Monday, April 3, 1995
6:00 - 9:00 p.m.**

The Marina Room
San Francisco Marriott Hotel
Fourth and Market Streets

Complimentary hors d'oeuvres
Music, dancing and refreshments

This event is made possible through the generosity of Bank of America,
Wells Fargo Bank, and the San Francisco Marriott Hotel



UCSF AIDS Health Project

Box 0884

San Francisco, California

94103

415/476-6430

Volunteer Therapist Program

*You Can
Make A Difference!*

THE
AIDS
HEALTH
PROJECT

UCSF AIDS Health Project
Box 0884
San Francisco, CA 94143-0884
(415) 476-6430

The Volunteer Therapist Program (VTP) was established by the AIDS Health Project in 1987 to help bring professional mental health services to those affected by HIV. Adjusting to an AIDS-related diagnosis is difficult, at best, and psychotherapy can play a critical role in promoting a client's mental health. Over 100 volunteer therapists have participated in the program and are enthusiastic about their experience.

All volunteers have professional mental health training and are either licensed practitioners or registered mental health interns. They donate an hour or more per week of their private practice time to see low-income clients with HIV disease.

The VTP supports volunteer therapists with an initial orientation that includes information about AIDS, as well as optional monthly inservice trainings on topics relevant to AIDS and mental health.

One hour a week of your time can make a real difference in the fight against AIDS!

What the therapists say:

"Volunteering for the AIDS Health Project allows me to use my skills to work with a population that is increasingly underserved; I encourage therapists to become involved in this excellent and rewarding program."

Dvora Honigstein, PhD

"In the face of an overwhelming epidemic, it's comforting to know that my clinical social work skills can make a difference. The AIDS Health Project has been good for me. The trainings are invaluable, the staff extremely helpful and the volunteers warm and supportive."

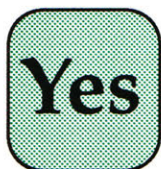
Arlene Dumas, LCSW

"Giving a portion of my time to community service is an aspect of this experience that I value highly and recommend to others. The program provides a unique and facile opportunity for psychotherapists in private practice to get involved. I can spare an hour a week. Can you?"

Paul Fishman, MD

"Working with people who face life threatening illnesses has allowed me to focus on my own quality of life issues and has offered me an opportunity to grow not only professionally, but personally as well. I've supported the program from its inception and I feel privileged to continue to do so."

Peter Bradley, MFCC



I am interested in finding out
more about the Volunteer
Therapist Program.

Please contact me regarding
the possibility of
volunteering.

(Fill in the information below and return this
postage-paid card).

*You Can
Make A Difference!*

Name _____

Address _____

City/State _____

Zip _____

Phone:

(private office) _____

(work) _____

(home) _____

BOX 0884, MCB 506



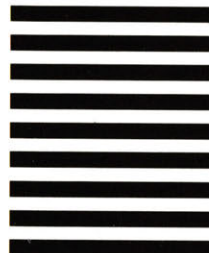
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AIDS HEALTH PROJECT
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500 PARNASSUS AVENUE
SAN FRANCISCO CA 94122-9974



UCSF
AIDS
HEALTH
PROJECT

in your honor. . .

*The UCSF AIDS Health Project
Community Advisory Board
and Pacific Bell present*

Annual Volunteer Appreciation Party

February 28, 1994

This Evening's Program

- 6:30 - Schmooze and Nosh (Visit and Eat)
- 7:15 - Welcome from Jim Dilley, *Executive Director*,
UCSF AIDS Health Project
- 7:30 - Remarks by San Francisco Supervisor, Carol Migden
- 7:45 - Volunteer Acknowledgments
- 8:15 - Remarks by San Francisco Supervisor, Kevin Shelley
- 8:30 - Remarks by Stephen Herman, *Chair*,
Community Advisory Board
- 8:35 - Entertainment by Tom Ammiano,
Comedian Extraordinaire
- 9:30 - Closing remarks

Ten Years of Serving the Community

*AHP would like to acknowledge the following
businesses for their generous donations:*

Golden Bear Winery, San Francisco
Golden Brands

Marriott Management Services—The Pacific Bell Cafe
Nestlé Beverage Company
San Francisco Wine Exchange

*AHP would also like to thank
Will Rigney and Sally Casazza
from Pacific Bell.*

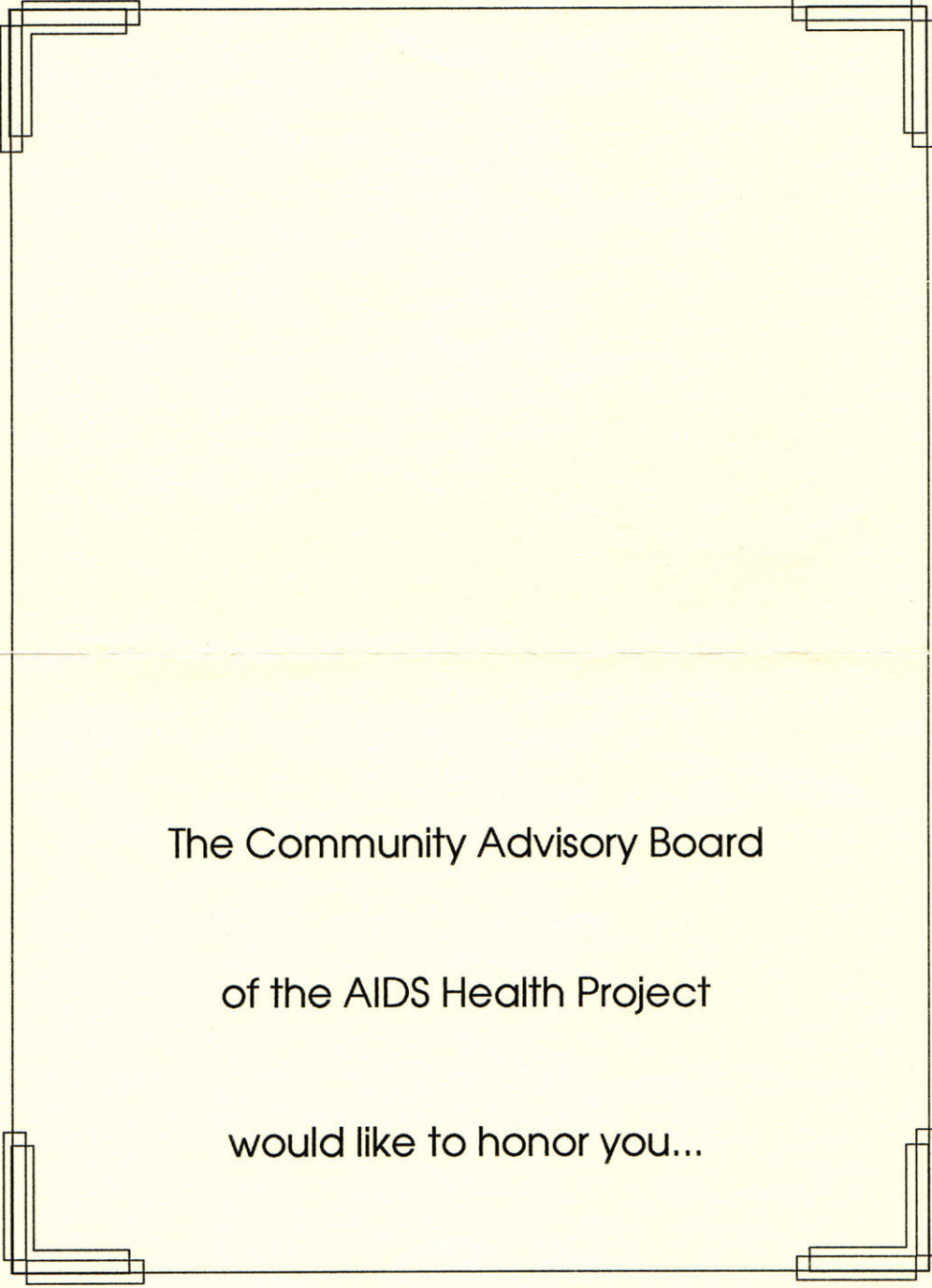
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Dominic Ali
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John Ashby
Gerald Asheim
TJ Austria
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Barry Barbour
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Nels Peterson

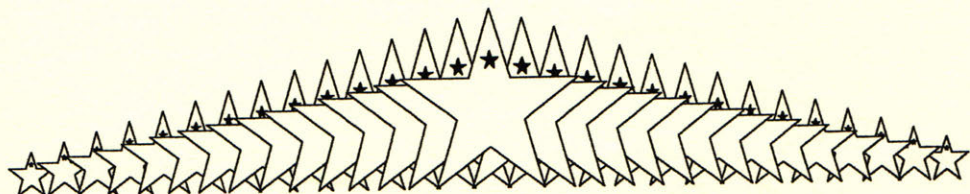
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Will Werner
Ruth K. Wetherford
Barbara Whitaker
Lou Ann Wieand
Jerry Wolfe
Jennifer Woodley
Victor Yalom
Neil Yoskowitz
Steve Zollman

Our sincerest apology to any volunteer who may have been inadvertently omitted from this list.



The Community Advisory Board
of the AIDS Health Project
would like to honor you...

at an evening of recognition
for our volunteers.



Place: Davies Firehouse
1088 Green St. (at Leavenworth)
San Francisco
Date: Friday, April 10, 1992
Time: 5:30 to 7:30 in the evening
RSVP: (415) 255-1210

Food and drinks will be provided with a
special awards presentation at 6:30 PM

We look forward to thanking you for
spending the year helping others.



first class postage here

The UCSF AIDS Health Project invites you to be our guest at

“Until There’s a Cure Day”
with the **San Francisco Giants**
in appreciation for your volunteer work in 1995-96!

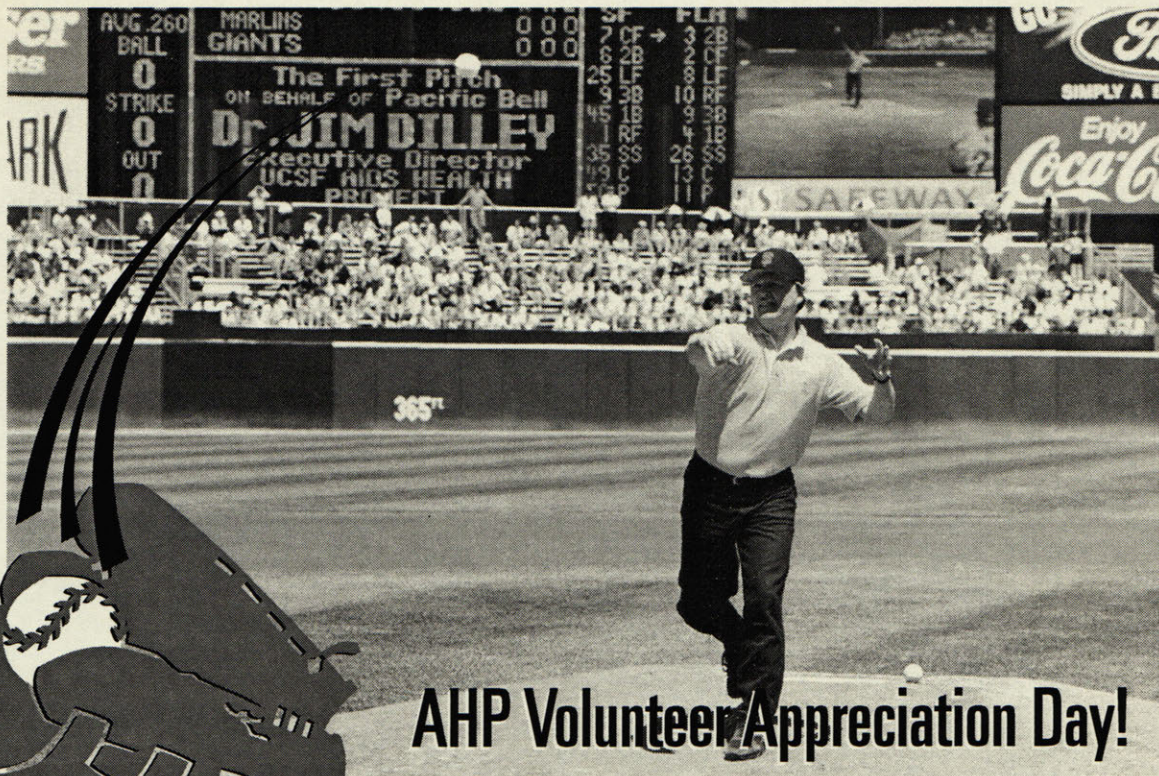
July 28, 1996

Please RSVP by July 12, 415/476-6430
to get your tickets, your fabulous “thank you” t-shirt,
and additional information!

Festivities at the ‘stick begin at noon,
game time 1:00 pm

SEE YOU THERE!!

UCSF AIDS Health Project, Box 0884, San Francisco, CA 94143-0884



AHP Volunteer Appreciation Day!



UCSF AIDS Health Project Holiday Party
Saturday, December 3, 1994



The UCSF AIDS Health Project would like to acknowledge the following businesses for their generous donations:

California Academy of Sciences

The Sonoma Wine Country Inns -

Best Western Dry Creek Inn, Healdsburg, California

Best Western Sonoma Valley Inn, Sonoma, California

The Lofthouse, Woodland Park, Colorado

San Francisco Marriott

Castro Village Wine Company

Ruth Lynch and Fabulous Catering

Chez Panisse

The Castro Cheesery



Thank you also to everyone who participated in the AIDS Health Project holiday party committee: Barbara Adler, Lisa Allard, Sean Broderick, Eileen Bulger, Steve Kolby, Sandra Kriletich, Dorothy Stinnett and Blanca Valle.

A special thank you to Steven Sams of Pacific Bell.





This Evening's Program



6:30 - Schmooze and Nosh (Visit and Eat)

7:00 - Watch for Santa



7:30 - Welcome

7:45 - Staff Awards, presented by Jim Dilley and Joanna Rinaldi



8:00 - Entertainment: Suzy Berger, comedian extraordinaire

8:30 - Grand Raffle

9:00 - Dancing the Night Away





A special thank you to our host this evening



Pacific Bell

who generously provided the space for this event
and who continues to support us year after year.



AIDS'

EFFECTS ON THE BRAIN



*Information
for
Family
and
Care Givers*

AIDS' EFFECTS ON THE BRAIN

Some people with AIDS become confused or show personality changes. These changes may be due to *direct* brain infection with the human immunodeficiency virus (HIV), the cause of AIDS. They may also result from such causes as: anxiety, depression, medication, or a treatable illness related to AIDS.

About half of those with AIDS or symptomatic HIV disease develop signs of brain involvement during their illness. Many of these signs are due to a cause other than HIV infection of the brain. Only a physician can diagnose the underlying cause of these changes. If a person with AIDS develops the problems described in this pamphlet, it is essential to seek immediate medical evaluation.

Many other medical and emotional problems can cause the changes described below and may respond to medication if correctly diagnosed.

When to Suspect Brain or Other Nervous System Involvement

Unlike most other brain infections, signs of HIV involvement may progress slowly and gradually. Forgetfulness, emotional instability, or "just behaving differently," may be early signs of HIV dementia, a progressive inability to perform normal tasks. Be alert for:



SYMPTOMS AND SIGNS:

- ♦ forgetfulness (misplacing objects, forgetting recent events and familiar names, losing track of time)
- ♦ difficulty concentrating (can't focus on conversation, is easily distracted)
- ♦ mental slowing (not as "quick" as usual)
- ♦ impaired judgement (impulsive behavior, poor decision-making)

- ♦ personality changes (apathy, withdrawal, irritability)
- ♦ mood changes (extreme "highs and lows", anxiety, emotional outbursts, rage)
- ♦ psychotic behavior (hallucinations, paranoia, grandiose thoughts)
- ♦ leg weakness or hand tremor
- ♦ impaired coordination (clumsiness, deteriorated handwriting)

As the disease progresses, affected people may become increasingly confused and develop severe memory loss. They may eventually become unable to perform simple tasks and become increasingly weak and lethargic.

Each person experiences these changes at different rates, and *not everyone* develops all of these manifestations. Many people function well for long periods of time, whereas others develop severe difficulty within a few months. Sometimes symptoms appear to improve for hours or days, producing a "good-day/bad-day" course.



ACCURATE DIAGNOSIS IS THE KEY

Many other medical and emotional problems can cause these changes and may respond to medication if correctly diagnosed. The first thing to do is to contact the person's physician. Only a complete medical evaluation can rule out the possibility of treatable illness. Some common treatable AIDS-related conditions include depression, anxiety, nutritional deficiencies, infections, recreational drug use and side effects of medication.



HOW TO HELP

People with HIV dementia are not always in control of their actions. If you become frustrated, try to remember that the sick person is not deliberately trying to make you angry. He or she is demonstrating a need for support. Here are some things you can do to help:



Orientation: Individuals may forget where they are, lose track of time, and eventually not recognize family or friends. To decrease periods of confusion, it is helpful to provide:

- ◆ familiar objects, such as photos and personal belongings.
- ◆ gentle reminders about the year, month, date, time, and place. Calendars and clocks are helpful.
- ◆ signs or pictures that highlight important considerations, such as turning off the stove or pointing the way to the bathroom.
- ◆ a low light left on at night to orient the person and light the way to the bathroom.



Structure: Changes in routine and environment further increase confusion and distress. To create structure and reduce anxiety:

- ◆ provide a consistent, predictable living situation.
- ◆ keep the person's belongings in the same place at all times.
- ◆ avoid sudden changes in daily routine.
- ◆ give the person only one task to do at a time.
- ◆ encourage self-reliance, but keep your expectations realistic.



Communication: People with HIV dementia often cannot process information or respond rapidly. Be patient, and don't confront or argue with the person. To decrease frustration:

- ♦ present information slowly, broken down into one step at a time.
- ♦ ask questions that can be answered simply, preferably with a "yes" or "no".
- ♦ don't assume that the person understands everything being said: have the individual repeat instructions, and observe to be sure that he or she understands.
- ♦ have the person keep track of things by writing them down, if possible.



Stimulation: Too much or too little stimulation can increase confusion, fearfulness, or agitation. To avoid this:

- ♦ keep social gatherings small and scheduled at regular intervals. Large groups may prove overwhelming.
- ♦ provide assistance with hobbies or pleasurable activities.
- ♦ notify the doctor if constant agitation is a problem. Medication may help decrease agitation when used properly. An AIDS-knowledgeable psychiatrist may be especially helpful if questions about medications arise.



Safety: Confused or disoriented people should not be left alone. Lock up medications and other dangerous substances. Persons who talk of suicide or who are severely depressed require immediate medical evaluation.



Future Horizons

Though there is currently no cure for HIV dementia, much can be done to help the person maintain control and cope with the disease. Furthermore, it has been observed that the drug AZT can alleviate signs of HIV dementia in some persons. Certain new antiviral drugs are currently being evaluated to determine whether they benefit people with HIV nervous system involvement. For now, you can best help those with HIV dementia by insuring proper diagnosis, setting realistic expectations, and providing a structured, caring environment.



Information Centers:

The San Francisco AIDS Foundation
25 Van Ness Avenue
San Francisco, California 94102
(415) 864-4376 or (800) 367-2437

Bay Area Physicians for Human Rights
2940 - 16th Street
San Francisco, California 94114
(415) 558-9353 or (415) 673-3189

For further Education and Training:

AIDS Health Project
Box 0884
San Francisco, California 94143-0884
(415) 476-6430

AIDS Law: A Training Manual for Mental Health Professionals

*A companion to the handbook:
AIDS Law for Mental Health Professionals*

UCSF AIDS Health Project

**AIDS Law:
A Training Manual
for
Mental
Health
Professionals**

*A Companion to the handbook:
AIDS Law for Mental Health Professionals*

UCSF AIDS Health Project

*For Information
and Comments* UCSF AIDS Health Project
Box 0884
San Francisco, California 94143-0884

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Secretary, Health and Welfare Agency; Steven P. Shon, MD, Acting
Director, California Department of Mental Health.

Linotronic plates for the production of this manual were provided by
a generous donation from *Design & Type*, San Francisco.

Disclaimers This book does not present legal advice in regard to particular situ-
ations, but is meant solely as a guide to general situations in which
the issues covered here may arise. For advice about specific circum-
stances, please consult a lawyer.
Throughout the book, the individuals named and the incidents
discussed are entirely fictitious.
This book is written for mental health professionals practicing in
California. It reflects the state of the law as of August 1990. The laws
described in this book are subject to substantial change through
judicial interpretations, statutory amendment, and voter referendum.

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Acknowledgements

This manual is based upon, and has been written by, the authors of *AIDS Law for Mental Health Professionals: A Handbook for Judicious Practice*: **Gary James Wood, JD, Robert Marks,** and **James W. Dilley, MD.**

We could not have created this manual had we not had the help of all the people who contributed to producing the handbook. We acknowledge these individuals and thank them again for their work.

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Training Text

Introduction

Introduction to Trainers

AIDS Law for Mental Health Professionals: A Handbook for Judicious Practice was published in January 1990 to educate California therapists about the range of issues they may face when treating people with concerns about HIV infection. The handbook offers guidance about ways to approach the ambiguity inherent in AIDS law and addresses the fragile distinction between ethical and legal obligations. This manual, a companion to the handbook, offers an experiential approach to training mental health practitioners about their legal and ethical rights and responsibilities.

The medical and psychological complexity of HIV infection is reflected in the breadth and depth of the public policy debate regarding the epidemic. AIDS has inspired more legislation and government regulation than any other disease in recent times, and many of these laws, particularly in California, directly affect therapists with HIV-infected clients. The result is that, while therapists may have had to deal with the law before AIDS, they did not have to deal with so *much* law. Among the most common HIV-related areas that raise legal questions for practitioners are those that relate to confidentiality and disclosure of HIV-related information, the duty to warn, suicide, and the determination of competency, areas where medical, legal, and ethical perspectives are all in flux.

Understanding AIDS law and using the handbook do not require a legal background. In approaching this area, however, it is important to keep in mind some legal concepts and ideas about the legal system in the United States. These concepts are discussed here in detail to offer trainers some background and are excerpted in the training materials.

Unsettled and Ambiguous Law

Law is mutable, and AIDS law, in particular, is unsettled. Legislatures may amend or rescind laws or pass new legislation. Courts may interpret laws in ways that change their applications or judge them unconstitutional. Voters may pass initiatives or constitutional amendments. To deal with HIV-related issues, where the scientific, social, economic and psychological ramifications of the epidemic are still evolving, the law *must* change to keep pace with the state of knowledge in these areas. The handbook and this training focus on the state of the law now, although there are instances where the book will project into the future and attempt, not to predict, but to anticipate possible legal issues that will arise.

The law is also by nature ambiguous and sometimes arbitrary. At their best, legislators fashion laws that are flexible, and, as a result, may write measures that leave many questions unanswered. At their worst, legislators write legislation incompetently or may sabotage legislation with which they do not agree by amending it in obscure ways. Since AIDS is even more mutable, complicated, and highly politicized than the subjects of most legislation, laws pertaining to the epidemic are likely to be ambiguous; and since judges and juries may have difficulty understanding the scope of these laws, their decisions may be arbitrary.

This training and the handbook attempt to clarify the uncertainty of the law by seeking analogous situations in areas where the law is more settled. For example, in interpreting the mental health professional's duty to treat people with HIV infection, the book explores the physician's broader "duty to treat," about which more has been written and litigated. In examining an institution's duty to supervise an HIV-infected patient, who, by his sexual practices might endanger other patients, the book relies on cases requiring the holds of potentially violent patients.

There are some areas where the ambiguity is not easily resolved. Many statutes cite standards that are not clearly defined. For example, statutes that refer to the psychotherapist-patient privilege, a concept that is fundamental in this area of law, rarely define who is a psychotherapist, or what must occur for a therapist and a client to establish this relationship. Statutes that require therapists to exercise "ordinary and reasonable skill" also rarely include criteria for making these determinations. Common sense is often the best arbiter of these questions, but therapists would be well-advised to exercise their common sense judiciously.

Liability

It is unclear whether there was ever a time when justice was based solely on a conception, even a faulty conception, of right and wrong. Today, in the United States, a society gone wild with litigation, the legal process is used to obtain far more, and sometimes far less, than justice. People sue one another for everything from money to publicity and revenge, and the system often responds by rewarding them. In these circumstances, everyone should be wary of situations in which they might place themselves in legal jeopardy. Health professionals, in particular, have become a focus of litigation, and mental health practitioners have every reason to follow the letter of the law to avoid lawsuits.

But in the same way that following the law may not keep you out of court, acting irresponsibly may not mean you will be sued. "Damages," or the money courts may award the prevailing parties in lawsuits, are determined using complicated formulas to gauge the extent of liability. Damages may be based on a number of criteria including pain and suffering, loss of ability to work, or loss of reputation.

For example, in the case of a practitioner who accidentally discloses to a client's insurance company that his client is HIV antibody positive, the practitioner may have to pay considerable damages if the client loses his health insurance. The client, who may then be uninsurable, can claim damages in the amount of the lost coverage. In the case of a client who commits suicide as a result of practitioner malpractice, however, the situation may change. If the client's aging mother, whom he supported while he lived, sues the practitioner for negligence, the practitioner, even if found guilty, may pay relatively little since the client's life is measured, rather callously, only in terms of earning potential. If he was dying anyway, the court might reason, his mother lost little, if any, in terms of that potential.

Law and Ethics

When considering potential legal and financial liability, the law requires practitioners to be prudent and conservative, and when legal standards are clear, they take precedence over even contradictory ethical standards. But, in the end, the letter of the law cannot be divorced from other aspects of mental health practice: professional responsibility, personal ethics, and therapeutic considerations. Are a practitioner's actions in accord with the ethical code of his or her profession, his or her own moral beliefs and the best interests of his or her patient, and, if they are, are they legal? The premise of this training and the handbook is that the

answer to this question will not always be yes. In response, the training and the book offer examinations of professional codes of ethics, which may determine the law if no prevailing legal standard exists, and of therapeutic alternatives to actions that may challenge legal and ethical standards.

This training manual, like the handbook, cannot provide easy answers to questions that pertain to issues such as suicide and the duty to treat at a time when society has reached no consensus about them. It can and does suggest ways to think about these issues, and offers some guidance from the legal and medical ethics literature.

The Handbook

The handbook is organized into sections, each reflecting the roles mental health practitioners typically play in providing services relating to HIV infection, including: as a therapist, as a witness or advisor, as a person with HIV infection, as an employer, and as an educator.

Each section is subdivided into chapters. Some chapters are further subdivided into topics and subtopics. In Sections One and Three, the bulk of the book, hypothetical cases are used to make the information covered more accessible. Throughout the book, there are marginal cross references and notes that direct readers to other parts of the book or to other sources. The book includes a comprehensive index to help readers who are uncertain about how to define their questions and several appendices to provide background information. Among these are: sample consent forms; an overview of medical information related to HIV infection; a discussion of appropriate information for pre- and post-antibody test counseling; a review of how law is created and adjudicated; and lists of California AIDS legal service providers and AIDS service organizations.

Like the training manual, while the handbook addresses specific cases, it focuses on defining *general* guidelines. It cannot offer ways to deal with every variation. In addition, it addresses California law, which, particularly in terms of HIV infection, changes as legislative bodies pass new laws and as courts issue new opinions.

Training Text

Procedures for Training about Confidentiality

The HIV-related confidentiality issues that cause the greatest concern among mental health practitioners include: the disclosure of HIV-related information in the regular course of treatment; the duty to warn, or disclosure when a client may knowingly endanger identifiable individuals; and disclosure when a mentally incompetent client may unknowingly endanger others. In addition, practitioners must know how to protect private information from unintentional disclosure.

Activity AIDS law and confidentiality for therapists.

Time 120 minutes: 15 minute overview; 30 minutes each for two case discussions; and 45 minutes for summary and closure.

Purpose To introduce AIDS and confidentiality issues, including:

- charting and disclosure of HIV-related information;
- the duty to warn in terms of both mentally capable and incapacitated people.

Materials

- *AIDS Law for Mental Health Professionals*
- Summary of Legal Criteria for Disclosure
- Confidentiality Laws
- Hypothetical Cases and Guidesheet for Trainers
- California AIDS Legal Service Providers

Rationale The confidentiality of medical information is the cornerstone of a fortress that protects people with HIV infection from the worst of society's reactions: employment and insur-

ance discrimination, familial disruption, and social ostracism. Much of the law relating to HIV infection concerns itself with confidentiality and the circumstances under which HIV-related information may be divulged.

There is broad legal support for the preservation of the privacy of people with HIV infection. *As a general rule, this privacy may be abridged only when the best interests of a patient require it or when the patient presents a clear and present danger to himself or others.* Even in these circumstances, the breach of privacy must be strictly limited to only that information that is absolutely necessary to achieve the aims of protecting those who are endangered.

For mental health practitioners, this tension between protecting their clients' privacy and the therapeutic relationship, and protecting society, is complicated by the need to protect themselves from legal liability. This training offers participants some background on how the legal system works and on HIV-related confidentiality issues in particular.

The procedures described below will assist trainers in communicating this information as clearly and as effectively as possible in a brief amount of time. The training proceeds from an overview, during which trainers introduce the topic and discuss some of the benefits and limitations of the training, to discussing hypothetical cases as a way of uncovering the legal and ethical issues and the ways in which they coincide and contradict common sense. Since some of the concepts discussed here are complex, trainers should review all materials carefully before planning a training.

Overview Procedure

1. Explain how training is organized. Tell participants that over the first 15 minutes of the training, you will offer some background on the law in general and about AIDS law in particular and that you will then discuss the privacy-related legal issues the training will explore. Encourage participants to hold questions—except requests for brief clarifications—until after a more specific discussion of the law, which will occur later.

Tell participants that after this overview, they will discuss in small groups two hypothetical cases in which these issues are illustrated. This will take about 60 minutes. Finally, for about 45 minutes, you will review the principles that apply to these situations, and focus on participants' questions.

2. Present basic disclaimers about the law and about this training. *(Some of these concepts are expanded upon in the introduction to this manual.)*

*See California
AIDS Legal Service
Providers, page 31.*

- The laws discussed in the training are specific to therapists practicing in California. Although some laws are federal laws pertinent to all states and California law is often used as a model for developing legislation throughout the country, other states may regulate these issues differently. In addition, some localities in California may have even more stringent protections. For example, San Francisco and Los Angeles Counties recently imposed HIV-related charting rules that are stricter than the state's.
- The situations discussed are fictitious, and conclusions participants reach are applicable only to these cases. It is important to remember that the law is a general template by which specific actions are judged. The guidelines the training will offer are general and should not be interpreted by participants as advice for particular situations. For specific advice, a participant should consult a lawyer.
- Laws, and the ways they are interpreted by courts, change. AIDS law, in particular, is unsettled. Also, since knowledge about AIDS itself is changeable, complicated, and highly politicized, laws pertaining to the epidemic are likely to be ambiguous; and since judges and juries may have difficulty understanding the scope of these laws, their decisions may be arbitrary. In such cases, the law is clarified by looking at similar situations in which the law is settled.
- Legal liability, that is, the therapist's responsibility according to the law, is not necessarily based on concepts of "right" and "wrong." Since lawyers weigh the potential for monetary damages when deciding to sue, and since damage formulas are complicated and based on intangible criteria such as pain and suffering and loss of reputation, following the law may not keep a person out of court, and acting irresponsibly may not mean a person will be sued.
- When considering potential legal and financial liability, the law requires practitioners to be prudent and conservative, and when legal standards are clear, these standards take precedence over even contradictory ethical standards. But the law cannot be divorced from other aspects of mental health practice: professional responsibility, personal ethics, and therapeutic considerations. When the law is unclear, these factors become especially important.

3. Present basic information about AIDS law for therapists and the issues to be discussed during the training.

- *AIDS Law for Mental Health Professionals.* There are many legal issues, in addition to privacy, that arise for therapists who are working with clients with HIV-related concerns. Among these are: the duty to treat, assisting suicide, implementing holds, the duty to supervise in institutional settings, the responsibilities of HIV-infected practitioners, and the ways in which therapists act as witnesses and advisors to the court. As stated earlier, the issue that seems to be of greatest concern to therapists, perhaps because this is the issue of greatest concern to the public, is related to privacy.
- *Privacy laws protecting HIV-related information.* In recognition of the stigma that surrounds HIV infection, the California legislature has specifically protected the confidentiality of HIV antibody test results to a greater degree than most other medical information. The confidentiality of other medical information—for example, an AIDS diagnosis, a person's sexuality, and a person's history of substance use, however, *is protected* under the California constitution's right to privacy and the Confidentiality of Medical Information Act. In light of these laws, mental health practitioners must protect their clients' confidentiality in most situations.
- *Antibody testing.* Antibody testing requires a client's informed consent, and disclosure of antibody test results is forbidden without a client's written consent. Disclosure of other HIV-related information also requires written consent. The exception to this rule is that medical doctors in California may disclose without consent their patients' antibody test results to those people who are reasonably believed to be the spouses, or sexual or needle-sharing partners of their patients, as long as they follow specific procedures.
- *Charting of HIV-related information.* HIV-related information must be carefully charted since disclosure without consent is prohibited. HIV-related information, including HIV antibody results, may be shared among the health treatment team without consent if this information is necessary for a client's diagnosis, care, or treatment.
- *Abridgment of Privacy Rights.* Privacy rights may be abridged in very specific situations when a client poses a threat to others, or to him or herself. Under these circumstances, a therapist may have a duty to warn. Such a duty

See *Professionals Who Have the Duty to Warn*, page 15.

might arise in terms of HIV infection when an HIV-infected client states that he or she will have unprotected intercourse with a specific individual at a specific time. The therapist's duty to warn can be undertaken only if all less drastic alternatives have been exhausted.

**Hypothetical
Cases
Procedure**

*See Hypothetical
Cases and Guidesheet
for Trainers, page 23.*

1. Introduce hypothetical cases. Tell participants they will now have an opportunity to see how much of the law they understand by exploring hypothetical cases. The two hypothetical cases here illustrate a range of legal issues therapists are likely to encounter. By approaching legal issues through hypothetical cases, practitioners are quickly able to see the relevance of laws in their practices. Participants should be cautioned again that these cases do not represent the range of possibilities but only a specific example in which laws apply. Encourage participants to think about their own practices and to compare the cases to previous experiences.

2. Describe activity. Participants will break into small groups, review a hypothetical case, and discuss some questions related to the case.

3. Distribute copies of the case to participants.

4. Break into groups of four or five participants each. Ask that one person in each group read the case aloud to the group. After reading the case, participants should discuss their reactions to the issues raised using the questions listed to focus their discussion.

5. Observe small group discussions. Record any issues that you will want to raise in the large-group discussion.

6. After 20 minutes, facilitate large-group discussion. Ask participants from each group to briefly share some of their conclusions and to state unresolved questions. Record these questions for later discussion. Refer to the Discussion Guide for Trainers for critical issues in order to facilitate discussion. (The Guidesheet is included here with training materials that should be reproduced for distribution to participants. The Guidesheet itself, however, is intended for the use of trainers alone.)

*See Hypothetical
Cases and Guidesheet
for Trainers, page 23.*

7. Repeat procedure for the second hypothetical case.

**Summary
Discussion
Procedure**

1. Introduce exercise. Tell participants that the last part of the training will focus on summarizing some general principles they can apply when dealing with issues of confiden-

See Summary of
Legal Criteria for
Disclosure, page 11.

tiality. They will do this by referring to copies of the Summary of Legal Criteria for Disclosure in the materials. As the summary review and discussion proceeds, the questions participants generated earlier when analyzing the hypothetical cases should be answered.

2. Review some of the most common questions that came up regarding the hypothetical cases.

3. Review the summary sheet. Read through with participants each section of the summary, directing discussion in areas that seem to be unclear, and paying particular attention to the questions that were generated by the hypothetical cases.

4. Review remaining questions. At the end of the review, note the questions that still remain. Suggest further reading in the handbook, *AIDS Law for Mental Health Professionals*, and remind participants that for specific questions they should consult lawyers on the lawyer referral handout.

5. Close training. Close the training by reminding participants that there will always be questions regarding the law. There are no easy answers to these questions: the ambiguities of the law itself, its evolving nature, and the stigma associated with AIDS all conspire to deny practitioners clear guidance. Participants may be comforted, however, by the knowledge that many of the toughest legal problems in this area occur rarely, and that while the law is obscure now, it is changing and defining clearer standards.

Some general recommendations are reliable in a variety of routine situations. In most cases, practitioners who err on the side of protecting their clients, rather than themselves or society, may obtain the best legal protection. For example, creating a separate charting system may seem burdensome and unnecessary, but it will help to ensure that practitioners are safe from charges of unlawful disclosure of HIV-related information. Even the practitioner's duty to warn, perhaps the thorniest issue, may be resolved most often by protecting clients from disclosure.

Remind participants who buy *AIDS Law for Mental Health Professionals* that they are entitled to receive three free issues (the first costing \$1.00 for postage and handling) of an update newsletter, which will keep them current with changes in the law. Information about the newsletter is included in the final pages of the handbook.

Training Materials

Summary of Legal Criteria for Disclosure

This is a summary of the key legal issues discussed in this training. It is divided into the following topics: consent for testing, routine disclosure of HIV-related information, charting and disclosure, the duty to warn, and mental incapacity and endangerment.

Consent for Testing

Overview

1. Patients themselves must consent before being tested for HIV antibody, unless they are deemed incompetent, in which case a guardian, attorney-in-fact, or surrogate may make the decision.

2. Any California resident 12 years of age or older is considered legally competent to refuse or consent to HIV antibody testing, unless that person is legally judged to be mentally incapacitated. The consent of a parent, guardian, or conservator is necessary to test a mentally incapacitated person or a child under the age of 12.

3. Consent must be informed: before soliciting consent, practitioners are required by law to explain the implications of test results and the potential emotional effect on the patient of the disclosure of results to others.

Informed Consent

In the context of HIV antibody testing, informed consent requires practitioners to explain at least the following points:

1. Drawing of blood for the test is an invasive procedure with some minimal risks of infection.

2. Early knowledge of HIV antibody status will allow the client to be referred promptly to appropriate health care and social service providers.

3. Early knowledge of HIV antibody status will effectively increase the client's chances of obtaining both counseling and early medical intervention that should contribute to his or her survival.

4. Taking the HIV antibody test is a stressful event, regardless of the results, because of fears about antibody status.

5. Disclosure of an antibody test result, or sometimes the disclosure that a person even took the test, may lead to discrimination, denial of health coverage, stigmatization, and violence, so test results should be carefully guarded.

6. A client's pre-existing physical or emotional conditions, for example, a fainting response to the drawing of blood, combined with the antibody test procedure or potential test results might cause a client harm.

7. Pre- and post-test counseling should be a part of any testing program.

Routine Disclosure of HIV-Related Information

Overview

See Professionals Who Have the Duty to Warn, page 15.

1. In general, except for medical doctors in the narrowly defined circumstances discussed below, a practitioner may not disclose information in medical records to anyone, including a patient's parents, without prior written authorization of the patient.

2. This authorization must specify the party(s) to whom the disclosure is to be made, the purpose of the disclosure, and the effective dates of the authorization.

See Duty to Warn Overview, page 14.

3. In specific circumstances when a patient poses a danger to others, a practitioner may disclose medical information without the patient's consent.

Exceptions

1. The 1988 amendments to the antibody testing confidentiality act do permit an exception to the rule: practitioners may disclose antibody test results to other practitioners, without a patient's consent, but *only* when these results are relevant to the diagnosis, care, or treatment of the patient.

Under the amendments, a “provider of health care” is defined to include only a limited number of categories of licensed health care workers: psychiatrists, licensed psychologists, licensed clinical social workers, credentialed school psychologists, and licensed marriage, family, and child counselors. The term “diagnosis, care, and treatment” is not defined anywhere in the statute. It must, therefore, be examined in light of state constitutional privacy constraints and common sense, and be interpreted to strictly limit the release of HIV information from one provider to another.

2. Personnel of health care service plans (like health maintenance organizations) are not covered by the disclosure exception in the 1988 amendments, because of the danger that the plans will cancel patient coverage on the basis of antibody test results. In addition, disclosures beyond the health care team to personnel who are not involved in the diagnosis and treatment of patients—a provider's receptionist, billing clerk, or janitor, for example—remain unlawful without the prior written authorization of the patient.

3. A practitioner would be well-advised to require a client's signature on a specific antibody test result release form before sending to another practitioner records that discuss the patient's antibody status.

Charting and Disclosure

Overview

1. Although disclosure of HIV antibody status to others may require patient authorization, the results may be placed in the medical record without authorization. In order to avoid unnecessary disclosure, practitioners might develop a system that keeps antibody status separate from other medical information. For example, they may enclose antibody status records in envelopes kept in the back of each patient's chart, or develop coding systems that allow providers alone to deduce which patients have been tested and the results of those tests. Practitioners employed by some California cities and counties, for example, San Francisco and Los Angeles, are required by local ordinance to segregate HIV antibody test results.

2. Under certain circumstances, a practitioner may take measures to edit the information disclosed to others. These circumstances include: if a patient does not give permission

for the disclosure of his or her antibody test results; if these results are indicated throughout a medical record; *and* if the results themselves are not necessary for the diagnosis, care, or treatment of the patient. Among the measures available to the practitioner are obscuring the text in the chart that refers to antibody status (using correction fluid or tape, for instance) or writing a summary of the chart omitting mention of antibody status.

3. A practitioner may release to an insurance company general medical records concerning issues unrelated to antibody test results if the insurer submits a general medical release. For non-medical information, such as records regarding drug and alcohol treatment or psychological treatment, insurance companies must submit a release specifically requesting this information. It is unlawful to disclose an entire medical record to an insurance company on receipt of the company's general medical release if the record includes antibody test results.

4. Practitioners should check all medical releases to ensure that they are valid, in terms of date, condition, and disclosing party.

Duty to Warn

Overview

1. The duty to warn was first embodied in the decision *Tarasoff v. Regents of the University of California* in 1976. It was later codified by the California legislature.

2. In order to conclude that they have a duty to warn, practitioners must determine that a patient *poses an imminent danger to a specific or reasonably identifiable person(s)*. When deciding whether to warn, a practitioner must also consider the clarity of the patient's threat, the actuality of danger to another, and the suitability of the patient to other psychosocial interventions to prevent the threatened harm.

3. Only if alternative interventions are, or predictably will be, ineffective should a therapist take the more drastic step of warning a third party.

4. Short of warning, practitioners do have other ethical and legal duties. These may include: referring clients to professionals who can accurately assess danger, educating clients about the dangers of HIV transmission, and informing clients

Medical practitioners, not therapists, may be necessary to assess danger in some cases.

about the clients' legal obligations to warn sexual and drug-using partners that they are HIV-infected. Please note that while no particular mental health speciality has been shown to be able to reliably predict dangerousness, when such questions arise, therapists would be well-advised to seek consultation and to note this in patients' charts. This prudent step should protect the therapists legally by demonstrating that their decisions were appropriate and carefully considered.

Professionals Who Have the Duty to Warn

The duty to warn is required only when there is a genuine psychotherapist-patient relationship. The psychotherapist-patient relationship is defined by the statute only as: "that relationship which would be protected by the psychotherapist-patient privilege." Therapists are defined as: psychiatrists, licensed psychologists, licensed clinical social workers, credentialed school psychologists, and licensed marriage, family, and child counselors.

In 1989, the California legislature amended the antibody testing confidentiality act to allow medical doctors, but not other health professionals, to disclose their patients' antibody test results to those who are reasonably believed to be the spouses, or sexual or needle-sharing partners of their patients. As long as doctors counsel patients about HIV transmission, inform patients that they are going to make the disclosures, make such disclosures in good faith, and do not include any identifying information about individual patients, they cannot be held civilly or criminally liable for violation of the HIV antibody testing statute.

Defining "Imminent Danger"

1. In the case of HIV infection, imminent danger is extremely difficult to define. The question here concerns the nature of "unsafe sex" and "unsafe intravenous needle use," and such issues as whether all such activities comprise a clear and imminent danger, whether one exposure comprises imminent danger, and whether the "threatened" person was previously exposed.

Imminent danger cannot include past exposures to HIV. The standard refers only to those *future* dangers that the practitioner can prevent; a therapist cannot be held liable for failing to prevent infection in those cases in which a patient has exposed a partner to HIV prior to the therapist's knowledge of the possible danger to the partner. Even if a couple continues to have unsafe sexual relations after a therapist becomes aware of this situation, the therapist will probably

not be held liable for the HIV infection of the partner, since the partner cannot prove that HIV transmission occurred *after* the therapist became aware of the couple's sexual practices.

2. At present, it appears that before a therapist could be held liable for failing to warn another party of the "imminent danger," the therapist would have to know the following facts: the patient is HIV infected; the parties engage in unsafe behavior on a regular basis; such behavior is actually unsafe; the patient intends to continue such behavior even after being counseled to desist by the therapist; HIV transmission will likely occur in the future; and the endangered party was uninfected.

Defining "Identifiable Persons"

If a patient names only one or a few sexual or needle-sharing partners, a practitioner can easily identify those people who may be warned about a possible exposure to HIV. But when a patient engages in frequent anonymous contacts with large numbers of people, the practitioner probably cannot be held liable for failure to warn these unknown individuals.

Therapists do have a duty to treat behavior that may endanger the world at large, and, if this therapy fails, they have a duty to take whatever legal steps are available in their communities. These steps may include civil commitment, hospitalization, or quarantine of the patient, using a court order obtained through the local health department. These steps will be necessary only in very rare circumstances and represent a last resort. The improper use of these powers could result in liability to both practitioners and public officials for the wrongful imprisonment of the patient.

Patient's Duty to Warn

Discussions of *Tarasoff*, in light of HIV disease, often overlook the duty of patients themselves. Cases from California and other states suggest that people have a duty to warn their sexual partners that they are infected with a sexually transmitted disease before engaging in activities by which that disease might be transmitted. A patient may be relieved of this duty if the patient is mentally incompetent to understand the duty to warn or is actually unable to warn his or her partner. In this case, and this may be particularly true in an institution such as a hospital or a mental health facility, practitioners face an increased duty to supervise, and perhaps to warn.

Improper Warning

Improper warning can subject the therapist to lawsuits for breach of privacy or for the negligent infliction of emotional distress. To avoid liability, a therapist should be certain of the HIV diagnosis, of the party to be warned, and that the patient poses a real threat to that party.

Mental Incapacity and Endangerment

Overview

1. As part of their legal duties, therapists should monitor their patients' cognitive abilities and assess whether patients may endanger others as a result of mental incapacity.

2. In cases where the danger is general and those who are endangered are not a discreet, identifiable group, there is no "duty to warn." There may, however, be a duty to institute an involuntary hold.

3. Qualified therapists may institute involuntary hold proceedings if their patients suffer from mental disorders that may cause danger to themselves or to others, or if these patients are unable to provide food, clothing, or shelter for themselves as a consequence of their mental disorders. Before instituting a hold, however, practitioners would be well advised to explore less restrictive measures, such as increasing the frequency of therapeutic sessions, discussing in more detail the issue of the danger the patient may cause, prescribing appropriate medication, and making a contract with the patient to not engage in dangerous activities.

4. The conservator of an incompetent patient may have the appropriate legal authority to restrain the patient's conduct.

Duty of Sex Partners to Avoid Danger

A client's sex partners also have a duty to avoid dangerous activities. Unless a client lies about his or her HIV infection, partners who engage in what they know to be dangerous activities assume part of the risk and contribute to the client's negligence. This may diminish the practitioner's liability should a sex partner sue the practitioner.

Activities Compromised by Limited Capacity

1. Psychiatrists, who may prescribe medications that could interfere with their patients' capacities to perform dangerous functions, must at least warn them to avoid activities like driving a car, operating an airplane, operating heavy machinery or performing surgery.

2. If HIV-related cognitive impairments or other psychological conditions begin to interfere with their patients' abilities to concentrate, manipulate information, reason quickly, or render rational judgments, mental health practitioners should counsel their patients about these problems and inform them that they pose a danger to others.

3. When patients ignore such warnings, therapists have a duty to report their concerns to employers or licensing agencies, such as the state Department of Motor Vehicles or the Federal Aviation Administration. A practitioner should not report such potential dangers to the police: law enforcement agencies do not become involved until a crime is committed.

Training Materials

Confidentiality Laws

Constitutional Protections

In 1972, California voters amended the state constitution to include a specific protection for the right to privacy. But, even before that time, California courts had recognized that a psychiatrist could be sued for revealing details of a person's mental illness unless the psychiatrist had probable cause to believe that reporting the illness to an appropriate authority was in the best interests of the patient.

According to the text of the voter's pamphlet on which the privacy law is based, the constitutional amendment was proposed to respond to "the encroachment on personal freedom and security caused by increased surveillance and data collection activity in contemporary society." The amendment's authors believed that the ability of individuals to control the circulation of medical information was essential to the protection of privacy.

This right goes so far as to prohibit the disclosure of personal medical information to relatives of a patient, unless they prove a more fundamental countervailing interest. Such an interest may exist in the case of a mentally incapacitated patient who is hospitalized for emergency surgery: the patient's parents may be required to make the decision to consent to the surgery and will need to know confidential medical information to ensure that their consent is informed. The patient, even in this case, may assert the right to privacy against disclosure to family members before *or* after a physician has disclosed information. Thus, a physician may be liable if the patient, after regaining capacity, decides that this information was private and was disclosed without permission.

The right to privacy extends even to information less sacrosanct than medical records. Among those facts that

have been protected are: that a person was prosecuted for the murder of his wife, that a woman had once been a prostitute acquitted of murder, and that a man had been a convicted felon. A person who unlawfully discloses such information, regardless of whether it is true, can be sued for any damages to the reputation or well-being of the person to whom the information applies.

Under this standard, an HIV antibody test result, or even an AIDS diagnosis, is constitutionally protected information, subject to disclosure only when there is a compelling interest to override privacy, when the disclosure does not identify the person to whom the information refers, or when that person consents to the disclosure. Thus, the anonymous disclosure of AIDS diagnoses to the state Department of Public Health is legal under the amendment because patients are not identified.

Medical Records Confidentiality

While the constitution does not include a specific right to medical privacy, the Confidentiality of Medical Information Act generally prohibits the disclosure of medical information without the written authorization of the patient. In this statute, "medical information" is defined as, "any individually identifiable information in possession of or derived from a provider of health care regarding a patient's medical history, mental or physical condition, or treatment."

In the absence of written authorization from the patient, this information may be disclosed to government entities pursuant only to a court order or the ruling of a government agency, to other health care providers only for purposes of diagnosis and treatment of the patient, to insurers and employers only to the extent necessary to obtain payment for services rendered, and to licensing or investigating agencies examining the quality of care rendered by the professional. Any authorization (or "medical release") signed by the patient must include information defining use of the disclosure, the name of the specific health care provider to whom it applies, and the specific time limits of the authorization. Practitioners should not release information that a patient might not consider to be medical, such as drug and alcohol use or psychological treatment, unless it is identified specifically in the release.

Disclosure to additional parties requires another medical release. In the absence of a patient's written request to the contrary, however, the statute *allows* a provider to release to family members, and others who may be as close to the

patient, general information about a patient hospitalized in an emergency situation, including: the patient's name, address, age, and sex, a general description of the reason for treatment, the general condition of the patient, and some non-medical information.

Any violation of this statute can subject the disclosing party to a claim by the patient for general damages for economic loss or personal injury, for punitive damages not to exceed \$3,000, for attorneys' fees not to exceed \$1,000, and the costs of the resulting lawsuit. Additionally, local prosecuting attorneys, at their discretion, can file criminal misdemeanor charges against the offending provider.

HIV Antibody Test Confidentiality

In 1985, when the first HIV antibody tests were licensed for distribution in the United States and were made available to alternative test sites in California, the California legislature enacted the "Mandated Blood Testing and Confidentiality to Protect Public Health Act" (the antibody testing confidentiality act). This law was aimed at preventing anyone or any institution from disclosing an individual's identifiable HIV antibody test results and was meant to encourage testing at both alternative test sites and in private medical offices. The act requires a special release for disclosure of information regarding HIV antibody test results and strengthens the privacy rights of the state constitution and the Confidentiality of Medical Information Act.

A negligent disclosure, made without the written authorization of the test subject, could result in a civil lawsuit for damages for economic, bodily, or psychological harm, an additional civil penalty not to exceed \$1,000 plus court costs, and a possible misdemeanor criminal charge, punishable by a county jail term not to exceed one year or a criminal fine not to exceed \$10,000. A willful disclosure could raise the civil penalty to \$5,000, and each additional disclosure is considered a separate offense.

Although the antibody test confidentiality act still prohibits most HIV antibody disclosures by any individual, it has been amended several times since 1985, and is subject to further amendment during future legislative sessions. As of 1989, the following changes have been made:

- Medical records. It is now legal to include an HIV antibody result in a patient's medical record. However, any disclosure of the record showing the test result or of the test result itself, outside the office in which this information is kept, still requires an HIV-specific authorization.

- Disclosure to other health care providers. A health care provider may disclose HIV antibody test information to another health care provider treating the same patient, for purposes of diagnosis, care, and treatment of the patient's HIV-related health care concerns or conditions.
- Disclosure to legal representatives. Practitioners may disclose antibody test results to a patient's legally appointed representative, conservator, guardian, or, if the patient is a child under the age of 12, his or her parent.
- Disclosure to designated public health agencies. It is legal to report AIDS diagnoses, as required, to the California Department of Public Health or the federal Centers for Disease Control.
- Disclosure to other third parties. Medical doctors, including psychiatrists but not other mental health professionals, may disclose their patients' antibody test results to those people who are reasonably believed to be the spouses, or sexual or needle-sharing partners of their patients. As long as doctors counsel patients about HIV transmission, inform patients that they are going to make the disclosures, make such disclosures in good faith, and do not include any identifying information about individual patients, they cannot be held civilly or criminally liable for violation of the HIV antibody testing statute.

Training Materials

Hypothetical Cases and Guidesheet for Trainers

Hypothetical Case #1: Guidesheet for Trainers

*See Hypothetical
Case #1 handout,
page 24, for the text
of the scenario
discussed here.*

Must Mr. Stephens obtain a specific release for information regarding HIV antibody status before he sends Stan's chart to Sarah Fields? May Mr. Stephens omit the antibody test discussions from the chart he releases?

Mr. Stephens may disclose Stan's antibody test results to other practitioners without Stan's permission if this information is relevant to the diagnosis, care, or treatment of Stan. In this case, however, Mr. Stephens would have to omit any mention of Stan's antibody test results from the chart he sends to Ms. Fields, since it appears that this information is not relevant to the particular problems Ms. Fields is treating. If Stan wanted to include this information in the chart sent to Ms. Fields, he would have to sign a specific release.

How should Ms. Fields respond to Stan's impending marriage to Karen?

Ms. Fields is probably unaware that Stan has not signed an HIV-specific release that would allow mention of his antibody status to be included in the chart Mr. Stephens sent her. Even if she were aware that he had not released the information, it is Mr. Stephens, and not Ms. Fields, who is liable for the disclosure. Therefore, she should have no hesitation discussing with Stan the potentially dire consequences of his having unprotected sex with Karen.

Must Ms. Fields warn Karen of the potential danger of infection if she has unprotected sex with Stan? Does the duty to warn in these circumstances increase because the couple intends to have children?

Hypothetical Case #1

For several years, Stan, a 34-year-old accountant and former intravenous (I.V.) drug user, has been in therapy with Frank Stephens, LCSW, and has dealt with an emotional crisis stemming from a positive HIV antibody test result. Following an adjustment period, Stan, who is asymptomatic, has adapted to his antibody status and made significant changes in his life, and, for the past two years, has not discussed HIV infection in therapy.

Stan accepts a job with a big accounting firm in New York and Mr. Stephens refers Stan to Sarah Fields, LCSW for continuing therapy. To expedite this referral, Stan signs a general medical release granting permission to send his chart to Ms. Fields. Mr. Stephens sends the complete chart, including information regarding Stan's antibody status.

At one point in his therapy with Ms. Fields, Stan says that he is going to marry Karen and that the couple plans to have children. Ms. Fields knows from Stan's chart that Stan is antibody positive, but Stan has not discussed this issue with her. When she confronts Stan about the danger of his having unprotected sex, Stan says that Karen is also a former I.V. drug user, is not HIV infected, and therefore must be immune to the virus since she must have been exposed to it when she was using drugs. Stan also says that he does not want to tell Karen about his infection because he is afraid she will leave him.

Consider these questions as you discuss the case:

- Examine each therapist's actions. What legal considerations govern Mr. Stephens's actions to release information to Ms. Fields? Does he handle this situation appropriately?
- Is it legally appropriate for Ms. Fields to take any action in response to Stan's decision to keep his antibody status secret from Karen?
- How should these legal issues be addressed? How should the therapists respond to these situations?
- What therapeutic issues are involved here? How might legal options affect therapeutic approaches?
- Are there ethical concerns that should be considered in light of the legal and therapeutic needs?

The duty to warn obligates Ms. Fields to act if she concludes that Stan poses an imminent danger to a specific or reasonably identifiable person or persons. The terms "imminent danger" and "identifiable person," however, are standards not easily attained.

For example, in order to fulfill the imminent danger criterion, Ms. Fields must know that Stan is HIV infected, that he is going to have unprotected sex with Karen in the near future, and that there is probably little chance that Karen was infected during sexual or drug-using activity prior to the imminent danger. In order to fulfill the "identifiable person" criterion, Stan must clearly identify, in ways that are understandable to the therapist, a specific person or persons. The law does not define beyond this description what information would comprise such an identification.

In addition, Ms. Fields's duty to warn is diminished by the duty of the parties involved to take responsibility for their actions. For example, if Karen knows or should know about the danger of sexually transmitted diseases, she should take steps to protect herself, and Stan, himself, has a duty to warn Karen that outweighs Ms. Fields's legal duty to intercede. So, in this case, it seems unlikely that Ms. Fields has a duty to warn.

While Ms. Fields may not have a duty to warn, she may have a duty to implement less drastic alternatives. For example, she should educate Stan to the best of her abilities about the danger he poses to Karen. This may include stating that if he is infected he could infect Karen through vaginal intercourse, that the fact that Karen has remained uninfected up to now does not mean that she is immune to HIV, that any children born to Karen and Stan have at least a 30 percent chance of being born with HIV infection, and that Stan has a legal obligation to inform Karen about his infection. If Ms. Fields believes that she is any way unqualified to talk to Stan about his risk, she should refer him to an AIDS-knowledgeable medical or mental health practitioner.

If she is qualified to counsel Stan about his risk, and after informing him of the danger he poses to Karen, he states that he does not care, Ms. Fields may have a duty to take more drastic therapeutic or legal action. For example, she may suggest more frequent or in-depth therapy, or, if Stan were so mentally ill as to be incapable of understanding the consequences of his actions, initiate hospitalization or civil commitment.

Can Stan sue Mr. Stephens for disclosing his antibody status without permission?

Yes. To defend himself, Mr. Stephens would have to prove that the information was relevant to Stan's diagnosis, care, and treatment. This might be difficult since Stan had not discussed the issue for two years prior to the transfer of the records.

What are some of the issues raised for the therapist in this situation?

Without more specific information about Stan's presenting concerns, all that can be clearly deduced about his therapeutic situation is that he is denying the implications of his HIV infection. Among the possible reasons for this denial are Stan's: fear of rejection and loss; inability to confront the seriousness of his condition; fear about the seriousness of his condition; sadness about the limitations his illness imposes on his relationship with Karen; or sadness about the possibility of not having children. Alternatively, Stan may simply misunderstand the risk unsafe sex poses to Karen and their future children.

Therapeutically, Ms. Fields gains nothing by attempting to warn Karen and losing Stan's trust when he may most need her help. She should confront Stan's denial by continuing to raise the issues of HIV infection, safe sex, and the potential effects of unsafe sex. She should also be aware of counter-transference issues, that is, her own frustration in counseling a client who appears to be unconcerned about spreading HIV.

What are some of the ethical issues involved here?

The duty to warn always raises the ethical conflict between the right of the client to privacy versus the right of endangered person(s) to freedom from danger. If this case were one where the duty to warn was clear, there would be an ethical as well as a legal obligation to exhaust all other alternatives before sacrificing Stan's privacy.

In addition, Ms. Fields probably has an ethical right to refer Stan to another therapist if she becomes so uncomfortable with his behavior that she can no longer offer him appropriate care. She might say to Stan: "Under the circumstances, I no longer feel I can be helpful to you because I believe what you are doing is wrong."

**Hypothetical
Case #2:
Guidesheet for
Trainers**

*See Hypothetical
Case #2 handout,
page 28, for the text
of the scenario
discussed here.*

What are Dr. Portnoy's obligations if Peter is incompetent and is practicing unsafe sex?

Dr. Portnoy has an obligation to monitor Peter's mental status, and to protect potential partners by exploring such measures as: prescribing medication, increasing the frequency of therapy, and further educating Peter about the danger he may cause. If Peter is unresponsive, Dr. Portnoy may consider initiating hold proceedings, and may counsel Ruth to petition to become Peter's guardian so she can exercise more control over his behavior.

Dr. Portnoy does not have a duty to warn since there are no identifiable sex partners involved, and since it is difficult to predict the imminence of the danger. Since Dr. Portnoy is a medical doctor, she has greater discretion regarding the duty to warn than other mental health practitioners, according to California's HIV antibody testing confidentiality act. She may disclose her patient's antibody test results to those people she reasonably believes are the spouses, or sexual or needle-sharing partners of her patients, but only after attempting to convince Peter that he himself should inform his partner and advising him that if he refuses she will inform his partner. (This provision was written into the law primarily to resolve the situation of HIV-infected people who refuse to alert their regular sexual partners or to change their sexual behaviors.)

What are Dr. Portnoy's obligations if Peter is practicing unsafe sex, out of anger and impulse, as a result of his borderline personality disorder?

Dr. Portnoy has an obligation to counsel Peter about behavior that may endanger others. Again, if counseling fails, she may consider prescribing appropriate medications, increasing the frequency of therapy, and initiating hold proceedings.

Again, Dr. Portnoy does not have a duty to warn since there are no identifiable sex partners involved, and since it is difficult to predict the imminence of the danger.

What rules govern the institution of holds?

Under Section 5150 of the California Welfare and Institutions Code, a person may be involuntarily detained for observation in a designated mental health evaluation facility if the person is found to be mentally disordered. This finding may be determined only by an evaluation facility or a mental health professional who has been trained and credentialed

Hypothetical Case #2

Peter, a 21-year-old man with a diagnosis of borderline personality disorder, has just returned from the hospital to his mother's home after his second bout of *Pneumocystis carinii* pneumonia. Peter has been in and out of therapy for several years, and is prone toward angry outbursts and impulsive sexuality.

A month after his return, Peter begins to show signs of increasing forgetfulness. Peter's mother, Ruth, knows from the statements of Peter's friends that Peter is still sexually active and has engaged in anonymous sex in the past. She is not sure that he understands safe sex in his present mental state, and she does not believe he can be trusted not to be sexually active.

Ruth talks Peter into seeing his therapist, Lisa Portnoy, MD, who believes that Peter is suffering from AIDS dementia. She also determines that because of his cognitive deficiencies he does not always understand the importance of safe sex and what it entails and consequently does not practice it. In addition, she believes that Peter's anger about his illness may induce him to use his sexuality to try to hurt others. Finally, Dr. Portnoy is concerned that because Peter sometimes has trouble concentrating and reacting quickly he may endanger others when he drives a car.

Consider these questions as you discuss the case:

- What legal considerations govern Dr. Portnoy's actions in response to her concerns about Peter's mental capacity to protect himself and others?
- Will Dr. Portnoy's legal obligations vary depending on Peter's diagnosis: borderline personality disorder versus AIDS dementia complex?
- What therapeutic issues are involved here? How might legal options affect therapeutic approaches?
- Are there ethical concerns that should be considered in light of the legal and therapeutic needs?
- What are her obligations if she believes Peter may endanger other drivers because of his impairment?

for this purpose by an authorized local mental health agency. Further, the person must be found to pose a serious threat to his or her own life, the life or safety of others, or must be unable to provide for his or her food, clothing, or shelter.

Danger, in this case, must be imminent, specific, and clearly defined. A hold may be instituted only when there is actual evidence of threat. If the disturbed person's behavior poses a real but general threat to the community at large, he or she may be detained upon court order pursuant to police and health department powers to quarantine infection or to restrain criminal behavior. People detained in this way are held in mental health facilities.

What are Dr. Portnoy's obligations if she believes Peter may endanger other drivers because of his impairment?

If Dr. Portnoy is concerned about Peter's ability to drive safely, she must inform Peter about this concern and counsel him to consider not driving. If Peter continues to drive, Dr. Portnoy has a duty to report this to the Department of Motor Vehicles.

What are some of the issues raised for the therapist in this situation?

Because of the sometimes elusive nature of AIDS dementia, it is often difficult for a therapist to be certain of such a diagnosis. It is helpful in these situations to refer a patient to an AIDS-knowledgeable psychiatrist or neurologist for diagnosis and possibly for care. This practitioner would have to consider whether Peter's endangering actions are a result of his incapacity and whether medication could control Peter's incapacity. Further, the practitioner would have to evaluate other alternatives that might be effective in enabling Peter to regain capacity or to control his actions.

Under the second scenario, Peter's actions are the result of his personality disorder. Dr. Portnoy would continue to monitor Peter's emotional state and focus on his anger, denial, and impulsive behavior, suggesting medication where appropriate. Finally, Dr. Portnoy should offer Peter's mother a referral to a professional who can offer her instruction on caring for Peter. Such instruction might focus on the practical management of dementia and HIV disease, and supportive care to help Peter's mother deal with her own emotional reactions to her son's situation and the demands placed on her as his caretaker.

What are the ethical issues involved here?

Drastic actions, such as holds, go beyond warning because, in addition to abrogating the right to privacy, they deny people the right to make decisions about personal courses of action. Again, these rights must be balanced with the rights of endangered people to freedom from danger.

There are few ethical issues regarding the denial of a driver's license for reasons of mental incapacity. The state regularly denies this privilege to people with poor vision, mental disability, and incomplete knowledge of the rules of the road.

Training Materials

California AIDS Legal Service Providers

The following are free or low-cost legal referral sources for people with HIV infection, listed by county. All are members of the California State AIDS Legal Services Association.

Please do not travel to these offices; referrals to attorneys will be made over the telephone.

Fresno and Central Valley

Central Valley AIDS Team
606 East Belmont
Fresno, CA 93701
(209) 264-2437

Los Angeles County

Hospice/AIDS Project
Los Angeles County Bar Association
PO Box 55020
Los Angeles, CA 90055
(213) 627-2727 extension 272

Los Angeles Gay and Lesbian
Community Services Center
1213 North Highland Avenue
Los Angeles, CA 90038
(213) 464-7400

Orange County

Orange County AIDS Legal Panel
c/o Duran and Loquvam
709 South Anaheim Boulevard
Anaheim, CA 92805
(714) 533-9399

Riverside and San Bernardino Counties	Desert AIDS Project/Legal Services 68487 Paseo Real Cathedral City, CA 92234 (619) 324-8388
Sacramento and Northeast California	AIDS Legal Referral Panel, Legal Services of Northern California 515 12th Street Sacramento, CA 95814 (916) 455-6118
San Diego	Legal Aid Society of San Diego 110 South Euclid San Diego, CA 92114 (619) 546-0400
San Francisco Bay Area and North Coast	AIDS Legal Referral Panel 25 Hickory Street San Francisco, CA 94102 (415) 864-8186
San Joaquin County	San Joaquin AIDS Foundation 4410 North Pershing Avenue, Suite 65 Stockton, CA 95207 (209) 476-8533
Santa Clara and San Benito Counties	AIDS Legal Services 480 North First Street, Suite 214 San Jose, CA 95112 (408) 293-3135
Santa Cruz County	Santa Cruz AIDS Legal Panel 2103 North Pacific Avenue Santa Cruz, CA 95060 (408) 457-9735
All other counties (on a limited basis)	National Lawyers Guild AIDS Network 558 Capp Street San Francisco, CA 94110 (415) 824-8884

THE AIDS LAW SERIES

The UCSF AIDS Health Project explores in a series of publications AIDS law for mental health professionals: the legal and ethical issues confronting therapists when they treat people who have concerns about HIV infection. Focusing on California law, these materials cover issues relevant to practitioners everywhere: the duty to treat, confidentiality, the duty to warn, suicide, and the responsibilities of the HIV-infected therapist. Although California law is not necessarily applicable in other states, the decisions of its courts and the laws passed by its legislature serve as models for the development of laws elsewhere. The ethical issues discussed in the book are universal. Finally, while these materials concentrate on the special legal circumstances surrounding AIDS, their examination of the legal aspects of mental health practice may be useful to therapists dealing with other situations in which challenges like these arise.

AIDS Law for Mental Health Professionals: A Handbook for Judicious Practice

The handbook is the centerpiece of the AIDS law series. In 250 pages, it provides a comprehensive examination of the legal implications of HIV disease. It builds a foundation, an approach to specific issues, and answers questions most likely to concern therapists: who is affected, under what conditions, and what are their legal and ethical obligations and options?

Bernard L. Diamond, MD, Professor of Law, Emeritus, at the University of California Berkeley, and Clinical Professor of Psychiatry at University of California San Francisco, applauded the book: "In clear, understandable, jargon-free language, the authors discuss each clinical situation apt to be encountered. Mental health professionals who treat AIDS patients will sleep better at night with this book on their bedside tables."

AIDS Law: A Training Manual for Mental Health Professionals

The training manual, a companion to the handbook, offers an experiential approach to training mental health practitioners about the most important legal issue they may face: the confidentiality of HIV-related information. By using hypothetical cases relating to charting and the duty to warn, the manual explores these principles. Written by the authors of the handbook, with the help of the AIDS Health Project's respected training staff, the manual promises to contribute to thought-provoking and rich training sessions.

Judicious Practice:

An Update to AIDS Law for Mental Health Professionals

As time passes, legislatures and courts create and reinterpret law. Up to now, there has been no easy way for therapists, or lawyers for that matter, to easily obtain current information about AIDS law. The eight-page update newsletter, the third component of the AIDS law series, will be published every six months beginning in August 1990. As a result of a California Department of Mental Health grant, the project will distribute the first three issues of the update free to those purchasers of the handbook who notify the project of their desire to receive it.

\$9.95
ISBN 1-879168-00-6

THE
AIDS
HEALTH
PROJECT

Since 1984, the UCSF AIDS Health Project has been a leader in developing mental health programs for people with HIV infection and those at risk of infection, and has championed the cause of educating the professional community about the implications of the epidemic.



PUBLICATION AND TRAINING INFORMATION

In this packet:

Ordering Information for AHP
Educational Materials

UCSFAIDS Health Project
Box 0884
San Francisco, CA
94143-0884

A Guide to AHP Training Services

These days, it's
just good
practice.

*The latest trainings on
AIDS/HIV and mental health
for health and mental health
providers.*

THE
AIDS
HEALTH
PROJECT

Why trainings on HIV and mental health?

Over 25,000 Californians have been diagnosed with AIDS. Perhaps 100,000 California residents are currently infected with HIV.

You have probably already worked with someone who has concerns about HIV. If not, your chance of having clients or patients with HIV related concerns is growing every day.

HIV is different. HIV presents special issues and concerns, even for the experienced clinician. New information is reported about HIV every day. Special laws apply to HIV-related practice. Political issues influence the emotional state of people with HIV. How much do you need to know, and how can you integrate this information into the care you offer? Our trainings can give you answers.

Staying updated on the psychological and emotional concerns of people affected by HIV is just good practice.

Who does the AIDS Health Project train?

- Mental health providers
- Health care providers
- Alcohol and substance abuse specialists
- Alternative health care providers
- Clergy
- Employee assistance program staff
- HIV specialists in any of the helping professions
- Graduate and undergraduate students in the helping professions
- Work groups affected by HIV/AIDS in the workplace

What kind of training is available?

Our trainings are designed to be interactive and interesting, and focus on practical clinical skills

- Inservices and presentations to agency staff
- HIV antibody counselor trainings
- Care for caregivers workshops
- HIV updates
- Coping with HIV-related diagnoses among colleagues
- Training and education techniques

What topics are offered?

We can tailor our trainings to your staff's needs and interests because we are able to cover a broad range of topics related to HIV issues. We have offered trainings ranging in length from one hour to three days. Some typical topics of our trainings include:

- Care for the Caregiver workshops
- General psychosocial issues of people living with HIV
- Neuropsychiatric issues in HIV disease
- Current legal concerns for providers working in HIV
- HIV prevention in mental health settings
- Countertransference with the HIV-related client
- Counseling about death, dying, grief and loss
- HIV and alcohol/HIV and substance abuse
- Case consultation

How do I arrange a training?

Call the AIDS Health Project at:

(415) 476-6430

Ask for the Training Unit.
Weekdays, 8:30 - 5:00.

Are there fees?

Our fees are based on the type of agency requesting training, the location, and the nature of services provided.

What is the AIDS Health Project?

Since 1984, the AIDS Health Project has provided direct service to over 81,000 individuals concerned about HIV. Over 45,000 providers have participated in our trainings. AHP is internationally recognized for its expertise in the development and provision of trainings for mental health and health providers on psychosocial aspects of HIV.

Our trainers are mental health professionals with considerable HIV-related experience.

Funding for the AIDS Health Project is provided through a variety of sources, including San Francisco Department of Public Health AIDS Office and Community Substance Abuse Services, and the California Department of Health Services Office of AIDS.

AIDS Health Project
Box 0884
San Francisco, CA 94143-0884
Attn: Training Unit

*"Masterful...dynamic...invaluable to the work
I do."*

*"The best AIDS training I've had so far, and
I've been to many."*

*"Got me in touch with some problem areas,
and gave me ways to resolve them."*

"This day has been a boost of energy for me."

THE EFFECTS OF AIDS ON THE BRAIN

Information for Families and Caregivers



About half of those with AIDS or symptomatic HIV disease may develop signs of brain involvement sometime during their illness. Some people with AIDS become confused or develop personality changes. These changes may be due to direct infection of the brain by the human immunodeficiency virus (HIV), or to causes such as: anxiety, depression, the side effects of medication, or a treatable illness related to AIDS. This pamphlet focuses on the symptoms and HIV-related signs of brain disease and suggests ways to help when these problems arise.

Only a physician can diagnose the underlying cause of these changes. If a person with AIDS develops the problems described in this pamphlet, it is important for him or her to seek immediate medical evaluation, since many of these problems may respond to medication if correctly diagnosed.



hen to Suspect Nervous System Involvement

Unlike the signs of most other brain infections, the signs of HIV infection may progress slowly and gradually. Forgetfulness, emotional instability, or “just behaving differently” may be early signs of HIV-associated dementia (HAD). Be alert for the following signs and symptoms:

- Forgetfulness: misplacing objects, forgetting recent events and familiar names, losing track of time, getting lost.
- Difficulty concentrating: trouble focusing on conversation, easily distracted.
- Mental slowing: not as “quick” as usual.
- Impaired judgment: impulsive behavior, poor decision-making.

- Personality changes: apathy, withdrawal, irritability.
- Mood changes: extreme “highs and lows,” anxiety, restlessness, emotional outbursts, rage.
- Psychotic behavior: hallucinations, paranoia, grandiose thoughts.
- Muscular weakness: most often leg weakness, but sometimes hand tremor.
- Impaired coordination: clumsiness, deteriorated handwriting.

If these signs and symptoms are severe enough to interfere with the ability to conduct usual social or occupational activities, a person is diagnosed as having HIV-associated dementia. As the disease progresses, a person may become confused and forgetful. Eventually, he or she may be unable to perform simple tasks and may become increasingly weak and lethargic.

Each person experiences these changes at different rates, and not everyone develops all of these manifestations. Many people function well for long periods of time, whereas others develop difficulty within a few months. Sometimes symptoms appear to improve for hours or days, producing a “good-day/bad-day” pattern.

Accurate Diagnosis Is the Key

If you are HIV infected and notice these symptoms, contact your primary care provider. If you are caring for a person with HIV disease and notice these symptoms, contact his or her primary care provider. Only a complete medical evaluation can diagnose the cause of these symptoms and determine whether they are

treatable. Some common treatable AIDS-related conditions include depression, anxiety, nutritional deficiencies, infections, recreational drug use, and the side effects of medication. It is also important to note that while there is no treatment for the underlying causes of HAD, some of its symptoms can be helped through the appropriate use of medication.

How to Help

People with dementia are not always in control of their actions. If you become frustrated in response to what seem to be deliberately annoying actions, try to remember that the person with dementia is not trying to make you angry. He or she is demonstrating a need for support. You can help in five areas: orientation, structure, communication, stimulation, and safety.

Orientation. People with dementia may forget where they are, lose track of time, and eventually fail to recognize family or friends. To decrease periods of confusion, it is helpful to:

- Ensure that there are familiar objects, such as photos and personal belongings, in the environment.
- Provide gentle reminders about the year, month, date, time, and place, and make sure calendars and clocks are clearly displayed.
- Post signs or pictures to highlight important instructions, such as turning off the stove or pointing the way to the bathroom.
- Leave on low light at night to orient the person and light the way to the bathroom.

Structure. Changes in routine and environment further increase confusion and distress. To create structure and reduce anxiety:

- Provide a consistent, predictable living situation.
- Keep the person's belongings in the same place.
- Avoid sudden changes in daily routine.
- Give the person only one task at a time.
- Encourage self-reliance, but keep your expectations realistic, and offer help when it appears to be needed.

Communication. People with HIV-associated dementia often cannot process information or respond rapidly. Be patient, and don't confront or argue with the person when he or she seems slow to respond. To decrease his or her frustration:

- Present information slowly, broken down one step at a time.
- Ask questions that can be answered simply, preferably with a "Yes" or "No."
- Don't assume that the person understands everything being said. Have him or her repeat instructions, and then observe to be sure that he or she understands.
- Have the person keep track of things by writing them down.

Stimulation. Too much or too little stimulation can increase confusion, fearfulness, or agitation. To avoid this:

- Keep social gatherings small and scheduled at regular intervals. Large groups may prove overwhelming.
- Provide assistance with hobbies or pleasurable activities that engage the person.
- Notify the physician if constant agitation is a problem. Medication may help decrease agitation when used properly. To

decide about prescribing these medications, the physician may want to consult an AIDS-knowledgeable psychiatrist.

Safety. Do not leave disoriented people alone. To protect safety:

- Lock up medications and other dangerous substances.
- Ensure that people who talk about suicide or who are severely depressed receive immediate medical evaluation.

Future Horizons

Though there is currently no cure for HIV-associated dementia, much can be done to help people maintain control and cope with the disease. Furthermore, high doses of antiviral drugs can sometimes improve the symptoms of HAD. New antiviral drugs are currently being evaluated to determine whether they provide even greater benefit to people with HIV nervous system involvement. For now, you can best help those with HIV-associated dementia by insuring proper diagnosis, setting realistic expectations, and providing a structured, caring environment.

Information Centers

For education and training about caring for people whose brain functioning is affected by HIV disease, call or write the UCSF AIDS Health Project, Box 0884, San Francisco, CA 94143-0884, 415-476-6430.

For further information about AIDS, call the national AIDS Hotline at 800-342-AIDS, or call or write the federal Centers for

Disease Control and Prevention, 1600 Clifton Road, NE, Atlanta, GA 30333, 404-639-3311.

For a referral to an AIDS-knowledgeable physician or psychiatrist in your area, call or write the American Association of Physicians for Human Rights, 273 Church Street, San Francisco, CA 94114, 415-255-4547.

Further Reading

The following materials provide more in-depth information about this topic:

Face to Face: A Guide to AIDS Counseling, edited by James W. Dilley, Cheri Pies, and Michael Helquist, was published by the UCSF AIDS Health Project in 1989 and updated in 1992. This 402-page book is available at libraries, bookstores, or from the project at the address noted above.

Facing the Future: AIDS Counseling in the Second Decade, edited by James W. Dilley and Robert Marks, also published by the UCSF AIDS Health Project and due out in the spring of 1995.

Living with Dementia, a 16-page booklet, was published in 1992 by Impact AIDS and is available by writing or calling Impact AIDS, 3692 18th Street, San Francisco, CA 94110, 415-861-3397.

The 36-Hour Day, by Nancy L. Mace and Peter V. Rabins, MD was published by the Johns Hopkins University Press in 1981. The book, for families caring for people with Alzheimer's disease and memory loss in later life, offers insights into dealing with people with impaired brain functioning.

The Effects of AIDS on the Brain is a production of the UCSF AIDS Health Project. Written by Alicia Boccellari, PhD and James W. Dilley, MD. Edited by Robert Marks. Designed by Leslie Samuels. Proofread by Dorothy Stinnett and John Tighe. Original edition produced by Joanna Rinaldi, 1987.





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FOCUS

A Guide to AIDS Research and Counseling
Volume 11 Number 5 April 1996

Negotiating Sex: Skills From the World of the Sexually Different

Guy Baldwin, MS

Almost any discussion of so-called "perverse" sexual behaviors, or "kinky" communities, as they are often called, usually runs the risk of activating people's defenses because we are socialized to be judgmental about non-normative sexual behaviors. Unfortunately, professional training in health care and mental health does not create immunity to these cultural biases. The result for professionals is that we run the risk of overlooking potentially useful teaching resources merely because they emerge from among the ranks of the sexually unpopular.

Except among a few researchers, clinicians, and journalists, it is a little known fact that many practitioners of the leather, sadomasochistic, and fetish styles of erotic expression have raised the skills of sexual negotiation to the level of high art. Also surprising to many outside the kinky world is the fact that in large cities, it has been possible for at least 20 years for people interested in these sexualities to attend a vast array of workshops designed to facilitate and refine these negotiation skills. Put simply, kinky people as a group, both gay and non-gay, have developed a powerful and effective means of achieving erotic satisfaction while minimizing the physical and emotional risks that are inherent to the pursuit of these erotic interests. With the advent of kinky news groups, chat rooms, and cyber forums on the internet, information about these skills has spread to every corner of the globe. The result is that no kinky person anywhere in the world is without this information and support if he or she seeks it.

Traditional models for encouraging "safer sex" have not been uniformly successful, particularly in terms of negotiation between sexual partners. This article shares some of the ideas that have successfully informed the way kinky people negotiate their sexual encounters to achieve satisfaction while minimizing risk of injury during sex. The hope in so doing is that these techniques can be successfully adapted by sex educators to augment the tools available to help seronegative people protect themselves against infection and seropositive people minimize viral re-exposure and "transmission guilt."

Some epidemiological studies have demonstrated that high-risk sexual behaviors are likely to occur in the context of casual sexual encounters, that is to say, outside the context of an existing relationship. Similarly, most kinky encounters occur between people who are essentially strangers, especially in the gay male world. This suggests that the techniques of negotiation in the kinky world are likely to be particularly well-suited to most risky sexual situations in the non-kinky world. The successful translation of the negotiation skills from the kinky world should result in effective prevention and, at the same time, improve the quality of sexual experience in general.

Kinky Culture and Communication

The range of possible erotic activities available to kinky people represents a mind-numbing smorgasbord of behaviors. It is widely accepted among kinky people that nobody likes everything on the smorgasbord table, but that everybody wants to have a good time. Because we want to ensure the pleasure of an encounter and because we acknowledge that mind-reading does not work—an understanding that is notably absent in many non-kinky sexual encounters—sexual partners communi-

Editorial: Kinky Sex

Robert Marks, Editor

When I suggested to Guy Baldwin, the author of the lead article in this issue of *FOCUS*, that he might have to offer more of a definition of "the kinky community" than he had, he became annoyed. After thinking about it, I found I couldn't blame him: in fact, I realized that explaining our sexuality can border on apology and fly in the face of the affirmation that all of us who are "sexual minorities" desire.

As Baldwin and I negotiated language for the article, I was struck by this investment in sexual identity and how societal attitudes about sexuality are transported from the larger world into the intimacy of the bedroom. At the moment of desire a person may be faced not only with a gap in knowledge—between personal expectations of the encounter and the expectations of his or her partner—but also with a social bias toward sexual silence, and often toward

embarrassment, fear of judgment, and fear of rejection. The only defense to this onslaught of emotion is a biological drive that seems to master, at least for a moment, any psychological interference. But in overcoming this response, instinct also banishes any thought and any inclination toward talking about sex and negotiating safer sex.

Baldwin offers an alternative that harnesses biological desire. By looking at the practice of the kinky community, he provides a view of negotiation as high art—highly evolved not because people are committed to safer sex (although I'm certain many are), but because they are conscious of their commitment to pleasure. To ensure pleasure, instinct must relent while intellect negotiates.

Likewise, in this issue, Dan Bigg challenges our assumptions about the role of substance use in foiling safer sex. Contrary to

the prevailing advice, he suggests that while using substances might lead to greater risk-taking among some, it may also facilitate negotiation among others, helping them to get beyond their inhibitions so they can talk about what they want and what they fear.

Much research has demonstrated that moments of intimacy are pregnant with presumption—about pleasure and about disease. One common finding seems to be that if you do not talk about HIV, your partner assumes that he or she is the same serostatus as you and that no discussion of safer sex is necessary. Talking about sex will not by definition lead to safer sex (or, for that matter, to pleasure); it is only a starting point. Not talking about sex, on the other hand, leads to safer sex (and, for that matter, pleasure) only by accident. To combine pleasure and safety, counselors must help their clients define what they find pleasurable and safe and understand how they can attain it through negotiation.

cate with each other prior to the kinky experience itself. It is clear in the kinky world that the odds are poor that there will be a workable erotic fit, especially with strangers, if there is no prior communication. Also, just as in conventional sex, negotiations are often difficult or impossible to conduct once kinky play has commenced. Interruptions in the flow of the encounter to manage safety issues or technical problems can destroy the mood that is essential to most kinds of erotic satisfaction.

The objectives of communication are essentially selfish for both players in kinky scenarios. A kinky person's inner conversation might go: "I want an encounter that is ecstatically wondrous and deeply fulfilling. To increase the chances of achieving this, we must both be as spontaneous as possible, and do our best to minimize safety-related interruptions during the encounter. The only way of doing this is to get the negotiations out of the way before we begin." Worrying about safety during sex is mood-killing. In short, a person is unlikely to get what he

or she wants unless there is honest talk first. The formula is a simple one: Good communication = Good sex; Great communication = Great sex.

There is often a hierarchy to the topics kinky people discuss during negotiations prior to an initial encounter. The use of drugs and alcohol during an encounter usually enters the conversation earlier rather than later. Many kinky people have discovered that they have a better time when under less chemical influence rather than more. Since many kinky activities involve specialized technical skills (for example, from the correct use of a condom to complex bondage setups), there is concern that these skills may be compromised by "recreational" substances. Drugs and alcohol can undermine prior negotiations and render them useless.

Once the drug issue is settled one way or the other, conversation usually turns to specific genital practices and concerns about disease transmission. Regardless of a partner's disclosure to the contrary, kinky people playing with strangers usually presume their partner is seropositive

and negotiate accordingly. When penetration is an issue (with anything including penis, tongue, finger(s), hands, dildos or other sex toys), the receiving partner either solicits information from the inserting partner about how penetration will be managed or the receiving partner flatly states how penetration must be managed as a condition of the encounter.

Once partners have gotten past these issues, they generally go on to discuss their respective erotic interests until they both determine there are enough shared interests to proceed with the encounter. If they agree to play, there is usually one last element that will be important for non-kinky populations, and this is the discussion of something we call a "safe word."

About "Safe Words"

Since about 1986, the credo of the kinky community has been "Safe, Sane, and Consensual." One of the chief tools used to ensure that encounters are safe and consensual has been the "safe word." A safe word is a chosen word or phrase that is not likely to come up normally during a sexual

encounter, the utterance of which is understood as a signal that all action stops immediately at least temporarily. Either partner may invoke the safe word. In kinky sex, safe words make several things possible: first, they enable so-called "rape" scenarios to proceed despite the "protestations" that are part of the scenario; second, they afford players a concrete method of ensuring that the intensity of play is within the limitations of the recipient; and third, since they enforce limitations, they offer players a way to give free rein to their spontaneity.

Refinements and elaborations of the safe word concept also exist. For example, following the traffic light model, "Green" means all is well, full speed ahead; "Yellow" can mean that the receiver requires his or her partner to become conscious of what is happening—that a possible area of danger is being approached and that some change is needed for the encounter to continue; and

"Red" means an absolute and immediate stop is necessary. The utterance of "Yellow" or "Red" requires both partners to "come up for air"—to break out of the spontaneous flow of action, leave the sexual haze behind for a moment, and make adjustments in their interaction.

Once partners agree to the concept of the safe word and have had a chance to apply it, it takes very little consciousness to keep an eye out for impending safety breaches. With some practice, a safe word functions as an unobtrusive safety net, of which the high flyers above take no notice unless mental alarm bells begin to ring. A single breath—a single word—is enough to suspend erotic spontaneity if sex has been preceded by clear negotiations conducted without the interference of drugs or hormones.

A Community Ethos

In general, kinky communities have accepted responsibility for the development and proliferation of our own morality. Many of us recognize a bond with each other and therefore a shared responsibility for each other's welfare. Rather than take the approach of "Every man for him-

self," we tend to prefer something like, "Have as much fun as you want, but do no unwanted harm to anyone." It is this perspective that informs our sexual negotiations and increases the probability that we will meet our erotic needs for as long as possible. Because the kinky communities are relatively small, there is the opportunity to brand as pariahs those who cannot or will not respect the limits of those with whom they play. The best defense against renegades who

cannot or will not abide by this moral code is to identify them during pre-sex conversations and steer oneself and others away from them.

Two things are necessary to identify those who are either unable or unwilling to negotiate sex in good faith. First, a person must be willing to pay close attention to his or her potential partner during their pre-sex discussion. This means maintaining good eye contact during negotiation in order to observe body

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The "right" partner is sufficiently attractive, responsive to negotiation, checks out in the drug and alcohol department, has matching opinions about safety, and shares erotic interests.

language, for example, looking away, changing the subject, and fidgeting. Such subtle cues indicate the prospective partner is not fully engaged in the negotiations. Second, negotiation is facilitated when individuals commit to themselves to stay in touch with their feelings during the interview process. This allows them to detect any internal or intuitive signs of their reluctance to play with a candidate. These two approaches can screen out all but the best "actors" who might successfully hide their bad faith intentions.

The sense of community among kinky people is a great boon to sexual negotiation. The source of this bond is an acknowledged sense of "insiderness." The silence in sexual negotiations that is the norm outside the kinky community can be replaced by one that validates staying healthy through negotiation if we come to see "insiders" as those individuals who are willing to protect health even at the expense of forfeiting a particular sexual conquest or activity. Insiders are those of us who love life, believe there is value in extending and savoring it, and are willing to work together with other like-minded people to enjoy sex.

To do this, a person must be aware of feelings and attitudes towards sexual activities during pre-sex conversations

and be guided by those feelings no matter how physically attractive a prospective partner may be. This stance is more powerful when we are able to respond to the desperate quality that characterizes so many sexual decisions: the extent to which a person believes that there is always someone else to whom he or she will be attracted and who will seek to do no harm will determine his or her willingness to walk away from a potential partner who is unwilling to negotiate.

For many kinky people, a potential sex partner must qualify on several counts before they agree to the encounter. The "right" partner is one who is sufficiently attractive, responsive to the negotiation process, checks out in the drug and alcohol department, has matching opinions about safety both from disease transmission and safe word standpoints, and has enough shared erotic interests. Only when all these lights are green is sex a possibility. If any of these five areas are a mismatch, there is a high probability of a "wrong choice" at best or outright trouble at worst. Solo masturbation is and must always be preferable to playing in unsafe waters.

Conclusion

For the partner qualification process to work, conversation is an absolute necessity. Kinky people who have developed proficiency at such conversation can conclude such negotiations successfully in as little as 10 minutes. For others, negotiations can go on for weeks. But regardless of the time investment, the process will bear fruit even if the results are not to have sex, because sometimes getting practice at these skills is its own reward.

Authors

Guy Baldwin, MS is a private practice psychotherapist in Los Angeles who works primarily with those on the sexual frontier. His book, *Ties that Bind*, has become part of the standard literature in the world of SM/leather/fetish sexuality.

Clearinghouse: Negotiating Sex

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Harm Reduction, Drug Use, and Sexual Negotiation

Dan Bigg

Over the years, a "common sense" has developed about the issue of drug use and sexual behavior: separate them in order to reduce the chances of risky sex. While the logic for this conclusion is clear, the realities of drug use and sex are much more complicated. In fact, separating drug use and sexual behavior may increase HIV-related risk. Without drugs, for example, an anxiety-ridden person may be socially disabled and unable to discuss risk reduction options, but with some drug use this same person may be disinhibited enough to negotiate and engage in lower risk sex.

This may be an uncomfortable conclusion for those who have adopted a zero-tolerance stance toward drug use, but for those whose primary goal is to diminish HIV-related risk, there is no question that, in this circumstance, such a "harm reduction" approach is appropriate and effective. This article will briefly address the positive and negative impact of alcohol and other drug use on sexual behavior and then discuss harm reduction approaches designed to help people become aware of and change their sexual and drug use behaviors to reduce HIV-related risk.

While many studies have associated risky sex with alcohol or other drug use, this relationship is likely to be far more complicated than such correlations suggest. Recently, researchers have uncovered other connections that may more completely and realistically explain the associa-

tion between drug use and risky sex. For instance, an unpublished study from the Medical College of Wisconsin found a strong association between "sexual adventurism"—which is described as an "underlying dispositional factor"—and high-risk sexual behavior, to the point where there was little direct relationship between high-risk behavior and substance use.¹ In addition, for many of us, using chemicals or not, the primary and most powerful "drug" associated with sexual behavior is passion or the "intoxication of love." While research continues on this topic, this article attempts to focus on the practical struggle to reduce risks and keep pleasure alive.

Drug...Set...Setting

Contrary to popular belief, the impact of a drug is complicated by factors other than the drug itself. For example, in some people, opiates generate energy and endurance, in others they produce sleepiness. Similarly, alcohol causes drowsiness in some and releases a torrent of emotion in others. Why does the same drug have different effects?

The answer is that the drug itself comprises only one-third of the factors that determine its true impact. The other major elements are often referred to as "set" and "setting." Norman Zinberg makes a compelling argument that drug use affects people differently at different times and in different places.² For most of us, the impact of drug use varies in terms of three factors:

- type, amount, route of administration, and purity of drug used;
- mind set and expectations before and during use;

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See also references cited in articles in this issue.

- the environment in which use occurs, for example, who else is around, physical features of the environment, and comforts and threats in the environment.

In order to appreciate the true impact of drug use on sexual interactions, it is

Instead of rigidly separating drug use and sex, harm reduction seeks to focus on an individual's unique personal experience.

important to understand an individual's relationship with a particular drug and with his or her sexual partners. What is the drug experience when the person is alone?; when he or she is with each partner? What is the impact of drug use on the relationship? Are there indirect effects of drug use that increase risk by decreasing choices or increasing demands? For instance, maintaining an addiction may mean a person has to use sex to pay for drugs. Similarly, increasing reliance on a drug can impede communication and intimacy in a relationship.

Harm Reduction and Collaboration in Action

The basic premise of harm reduction is that the clinical response should recognize, respect, and assist with "any positive change" as an individual defines "change" for him or herself. Instead of rigidly separating drug use and sex, harm reduction seeks to form a respectful and collaborative relationship between clinician and client, focusing on an individual's personal experiences. In working with each person to clarify experiences of combining drug use and sexual behavior, there emerges a unique mosaic of risks and pleasures.

Harm reduction approaches are based on a deliberate humility about the ways in which people are able to achieve change. Years of study tell us that people change when they are ready and that there is little a clinician can do but be there to provide assistance when someone is ready to change. For example, for some people, developing skills in having sex without drug use may greatly expand sexual repertoire and allow them greater control and desired safety. Alternatively, attempting sober sex may sabotage a person's scripted safer sexual practices and increase risk. Some drug use may make a person uninterested in sex, thus, completely protecting someone from sexually transmitted diseases. Alternatively, someone might conclude that the only time they have high-risk sex is when using drugs. In any case, harm reduction-based assistance centers on identifying an individual's

unique experience and developing a personalized plan for greater satisfaction.

Harm reduction requires an appreciation for and assistance with a host of incremental changes. This willingness to address small but constructive changes makes success more likely and allows individuals to build on these achievements and facilitate further change.

Harm reduction functions most effectively within the context of an alliance between clinician and client. If either sexual behavior or drug use obstructs the clinician's ability to respectfully collaborate with the client, then the clinician should refer the client to another provider. This collaboration will be sabotaged by applying universal assumptions about the effects of drug use on sexual behavior. Real collaboration is possible only if a clinician can approach each client as an individual. Clinicians should seek to develop a unique profile of each client by respectfully gathering information on drugs used, expectations while using, and environment of use. The patterns of drug use that most correspond to risky and safer sex should become clear as the collaboration proceeds. The goal of the collaboration should be to alter those behaviors that the individual identifies as most problematic.

It is crucial to keep in mind that the client's desired outcome may or may not include decreasing drug use, the goal being to reduce harm, not to eliminate it. This goal and the absence of immutable patterns of response to drug use and sexual behavior makes the priority of counseling the development of a clear understanding of each individual's experience. Such a fundamental tenet of mental health practice may seem obvious, but it is an approach that is often overlooked when working with people who use drugs.

AIDS Conference Reminder

Registration for the International Conference on AIDS (June 7–June 12 in Vancouver) closes on May 1. Delegates may register by writing to XI International Conference on AIDS, Registration Bureau, c/o 1304 Hornby Street, Vancouver, British Columbia, Canada V6Z 1W6; or faxing: 604-684-0905. For general conference information, call: 800-780-AIDS (Canada/US) or 604-878-9995; or email: aids96@hivnet.ubc.ca.

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Recent Reports

Tailoring Safer Sex for Adolescents

Sanderson CA, Cantor N. Social dating goals in late adolescence: Implications for safer sexual activity. 1995; 68(6): 1121-1134. (Princeton University.)

The effectiveness of safer sex education for adolescents depends upon its relevance to dating goals. According to two studies, adolescents who have established identities independent of their families and friends date in order to achieve intimacy and learn more from education that emphasizes interpersonal communication skills. Those who are still struggling to assert independence from family date in order to experiment with different identities and are more likely to learn from education that emphasizes technical skills.

The first study consisted of 905 male and female students: six independent groups of undergraduates and one group of high school students from Virginia and Pennsylvania. Researchers created a Social Dating Goals Scale by surveying participants about their interpersonal and ideological identity, styles of

attachment to others, willingness to engage in sexual relations in the absence of an exclusive relationship, and dating patterns.

Social dating goals were classified in two ways: identity and intimacy goals. Identity goals reflected dating as part of the process of exploring different beliefs and values, and forming identities separate from friends and family members. Intimacy goals were marked by the disclosure of intimate thoughts and feelings, mutual dependence, and emotional attachment to another person. Identity goals correlated with more casual dating and more sexual partners; intimacy goals correlated with longer dating relationships

and less willingness to engage in sexual relations in the absence of a committed relationship.

The second study comprised 136 undergraduates, including 87 women and 49 men. Participants completed a set of questionnaires assessing attitudes and beliefs about HIV disease, perceived vulnerability to HIV infection, attitudes toward condoms, intentions to use condoms in the

future, sexual behavior, and social dating goals. Subjects were randomly assigned to one of three educational sessions. In the technical skills session, participants rated condoms, put condoms on practice models, and discussed eroticizing condom use. In the communication skills session, the students did role plays and discussed how to increase their negotiation skills with partners. The third session was a control group that received no education until after the three-month follow-up.

After three months, participants with intimacy dating goals who were enrolled in the communication skills session had more positive attitudes and beliefs about condoms and more realistic attitudes and beliefs about HIV disease than those enrolled in the technical skills or no education sessions. On the other hand, it was the technical skills session that evoked these attitudes and beliefs in participants with identity dating goals.

The Effectiveness of Appeals for Condom Use

Sheer VC. Sensation seeking predispositions and susceptibility to a sexual partner's appeals for condom use. *Journal of Applied Communication Research*. 1995; 23(3): 212-229. (University of Florida.)

Expressing care for a sexual partner, appealing to a sense of responsibility, and describing condom use as pleasurable were the most effective ways to initiate condom use in a relationship, according to a study of college students. The effectiveness of specific appeals were determined by a partner's level of "sensation seeking"—a predisposition toward behavior based on a combination of thrill and adventure seeking, experience seeking, disinhibition, and "boredom susceptibility."

Researchers recruited 205 undergraduates—100 men and 102 women—from introductory communication courses. The students filled out questionnaires measuring their sensation seeking level and how they rated the effectiveness of various requests for condom use in terms of the request's appealingness, the respondent's attitude toward condom use, and his or her intentions to use condoms.

High sensation seekers—or those influenced by high levels of adventurousness, impulsiveness, and disinhibition to take on risk behaviors—were most responsive to requests regarding the pleasure of condom use. But they were also more likely than low sensation seekers to respond to negative appeals (threats to withhold sex or fears of AIDS), presumably because high sensation seekers regard sex

Responses to requests to use condoms are related to whether a person is a "high sensation seeker" or a "low sensation seeker."

FOCUS

A Guide to AIDS Research and Counseling

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with a condom better than no sex at all. High sensation seekers found appeals that were longer and situation-specific to be more persuasive than shorter, slogan-like appeals, suggesting that interpersonal persuasion may be a source of arousal.

In general, women viewed condoms more positively than men and found all of the requests to use condoms more appealing than did male respondents. They were most persuaded by expressions of caring and invocations of a sense of responsibility, while men preferred appeals to the pleasure of condom use. Despite some correlations in how certain appeals were viewed, gender and sensation-seeking were independent variables; sensation-seeking correlated with intentions to use condoms, while gender was linked to appealingness and condom attitudes.

Negotiating Sex after Testing Positive

Adam BD, Sears A. Negotiating sexual relationships after testing HIV-positive. *Medical Anthropology*. 1994; 16(1): 63-77. (University of Windsor, Ontario.)

Relationship status at the time of testing antibody positive affects the issues a seropositive person confronts when resuming a sex life, according to a small study of people with HIV disease and their caregivers. However, concerns about diminished sexuality and negotiating safer sex appear to be universal among people who take the test, regardless of their relationship status.

The sample was comprised of 60 people with HIV disease and 40 caregivers drawn from support groups and personal referrals networks of others who had been interviewed. There were 48 men and 12 women in the seropositive sample; 38 self-identified as ethnically European, 20 as Black, and two as aboriginal. Thirty-seven identified as gay or homosexual, seven as bisexual, and 16 as heterosexual.

For those not currently in couple relationships, the initial response to a positive test result was withdrawal and loss of interest in sex. Some withdrew because they associated sex with their infection. Others reported that they no longer felt desirable or that they were overwhelmed by the complexity of initiating a sexual relationship. The fears of infecting somebody and of disclosing serostatus and being rejected were the two main obstacles to starting a new relationship. Some respondents expressed interest in finding another seropositive person for a relationship. Others said they would rather adhere to safer sex guidelines than limit themselves by serostatus.

While disclosing seropositivity was a universal worry for the respondents, nearly all had had a positive experience doing so. Some found it easier to disclose their serostatus by revealing affiliation with an AIDS organization or by discussing AIDS work, in this way "feeling out" the attitudes of a prospective partner. Others allowed themselves to be seen taking HIV-related medication in public. Some were surprised to find that their revelation attracted people to them, often because it involved an appeal for trust and compassion.

Seropositives in existing relationships had different issues to deal with depending upon whether their partners were positive or negative. Even in serodiscordant couples, few post-test breakups occurred, and for those that did, HIV disease was not the primary divisive issue. But, relationships were disrupted by the positive partners' feelings of desexualization, by the introduction of condom use into the relationship, and by the sense that the partners no longer shared the same fate. Seropositive respondents often found that it fell to them to implement safer sex, since negative partners considered themselves immune to HIV infection or saw condoms as restrictive.

Next Month

As more and more people with HIV disease live longer, the term "long-term survivor" is becoming non-descript. Over the past 15 years, many HIV-related terms have undergone similar transformations; as our knowledge of HIV disease has expanded faster than the normal evolution of language, the terms we've chosen to describe the stages of HIV progression have one after another become obsolete. In the May issue of *FOCUS*, Founding Editor **Michael Helquist** provides a personal perspective of "AIDS identities": what it's like to traverse a landscape littered with terms like "asymptomatic" and "long-term survivor."

Also in the May issue, **Jonathan Grimshaw**, co-founder of the Body Positive in London, focuses on the experience of "long-term non-progressors." Grimshaw talks in a compelling way about the angst and uncertainty that accompanies living symptom-free with HIV disease when every moment promises progression.

THE EFFECTS OF AIDS ON THE BRAIN

Information for Families and Caregivers



About half of those with AIDS or symptomatic HIV disease may develop signs of brain involvement sometime during their illness. Some people with AIDS become confused or develop personality changes. These changes may be due to direct infection of the brain by the human immunodeficiency virus (HIV), or to causes such as: anxiety, depression, the side effects of medication, or a treatable illness related to AIDS. This pamphlet focuses on the symptoms and HIV-related signs of brain disease and suggests ways to help when these problems arise.

Only a physician can diagnose the underlying cause of these changes. If a person with AIDS develops the problems described in this pamphlet, it is important for him or her to seek immediate medical evaluation, since many of these problems may respond to medication if correctly diagnosed.



hen to Suspect Nervous System Involvement

Unlike the signs of most other brain infections, the signs of HIV infection may progress slowly and gradually. Forgetfulness, emotional instability, or “just behaving differently” may be early signs of HIV-associated dementia (HAD). Be alert for the following signs and symptoms:

- Forgetfulness: misplacing objects, forgetting recent events and familiar names, losing track of time, getting lost.
- Difficulty concentrating: trouble focusing on conversation, easily distracted.
- Mental slowing: not as “quick” as usual.
- Impaired judgment: impulsive behavior, poor decision-making.

- Personality changes: apathy, withdrawal, irritability.
- Mood changes: extreme “highs and lows,” anxiety, restlessness, emotional outbursts, rage.
- Psychotic behavior: hallucinations, paranoia, grandiose thoughts.
- Muscular weakness: most often leg weakness, but sometimes hand tremor.
- Impaired coordination: clumsiness, deteriorated handwriting.

If these signs and symptoms are severe enough to interfere with the ability to conduct usual social or occupational activities, a person is diagnosed as having HIV-associated dementia. As the disease progresses, a person may become confused and forgetful. Eventually, he or she may be unable to perform simple tasks and may become increasingly weak and lethargic.

Each person experiences these changes at different rates, and not everyone develops all of these manifestations. Many people function well for long periods of time, whereas others develop difficulty within a few months. Sometimes symptoms appear to improve for hours or days, producing a “good-day/bad-day” pattern.

Accurate Diagnosis Is the Key

If you are HIV infected and notice these symptoms, contact your primary care provider. If you are caring for a person with HIV disease and notice these symptoms, contact his or her primary care provider. Only a complete medical evaluation can diagnose the cause of these symptoms and determine whether they are

treatable. Some common treatable AIDS-related conditions include depression, anxiety, nutritional deficiencies, infections, recreational drug use, and the side effects of medication. It is also important to note that while there is no treatment for the underlying causes of HAD, some of its symptoms can be helped through the appropriate use of medication.

How to Help

People with dementia are not always in control of their actions. If you become frustrated in response to what seem to be deliberately annoying actions, try to remember that the person with dementia is not trying to make you angry. He or she is demonstrating a need for support. You can help in five areas: orientation, structure, communication, stimulation, and safety.

Orientation. People with dementia may forget where they are, lose track of time, and eventually fail to recognize family or friends. To decrease periods of confusion, it is helpful to:

- Ensure that there are familiar objects, such as photos and personal belongings, in the environment.
- Provide gentle reminders about the year, month, date, time, and place, and make sure calendars and clocks are clearly displayed.
- Post signs or pictures to highlight important instructions, such as turning off the stove or pointing the way to the bathroom.
- Leave on low light at night to orient the person and light the way to the bathroom.

Structure. Changes in routine and environment further increase confusion and distress. To create structure and reduce anxiety:

- Provide a consistent, predictable living situation.
- Keep the person's belongings in the same place.
- Avoid sudden changes in daily routine.
- Give the person only one task at a time.
- Encourage self-reliance, but keep your expectations realistic, and offer help when it appears to be needed.

Communication. People with HIV-associated dementia often cannot process information or respond rapidly. Be patient, and don't confront or argue with the person when he or she seems slow to respond. To decrease his or her frustration:

- Present information slowly, broken down one step at a time.
- Ask questions that can be answered simply, preferably with a "Yes" or "No."
- Don't assume that the person understands everything being said. Have him or her repeat instructions, and then observe to be sure that he or she understands.
- Have the person keep track of things by writing them down.

Stimulation. Too much or too little stimulation can increase confusion, fearfulness, or agitation. To avoid this:

- Keep social gatherings small and scheduled at regular intervals. Large groups may prove overwhelming.
- Provide assistance with hobbies or pleasurable activities that engage the person.
- Notify the physician if constant agitation is a problem. Medication may help decrease agitation when used properly. To

decide about prescribing these medications, the physician may want to consult an AIDS-knowledgeable psychiatrist.

Safety. Do not leave disoriented people alone. To protect safety:

- Lock up medications and other dangerous substances.
- Ensure that people who talk about suicide or who are severely depressed receive immediate medical evaluation.

Future Horizons

Though there is currently no cure for HIV-associated dementia, much can be done to help people maintain control and cope with the disease. Furthermore, high doses of antiviral drugs can sometimes improve the symptoms of HAD. New antiviral drugs are currently being evaluated to determine whether they provide even greater benefit to people with HIV nervous system involvement. For now, you can best help those with HIV-associated dementia by insuring proper diagnosis, setting realistic expectations, and providing a structured, caring environment.

Information Centers

For education and training about caring for people whose brain functioning is affected by HIV disease, call or write the UCSF AIDS Health Project, Box 0884, San Francisco, CA 94143-0884, 415-476-6430.

For further information about AIDS, call the national AIDS Hotline at 800-342-AIDS, or call or write the federal Centers for

Disease Control and Prevention, 1600 Clifton Road, NE, Atlanta, GA 30333, 404-639-3311.

For a referral to an AIDS-knowledgeable physician or psychiatrist in your area, call or write the American Association of Physicians for Human Rights, 273 Church Street, San Francisco, CA 94114, 415-255-4547.

Further Reading

The following materials provide more in-depth information about this topic:

Face to Face: A Guide to AIDS Counseling, edited by James W. Dilley, Cheri Pies, and Michael Helquist, was published by the UCSF AIDS Health Project in 1989 and updated in 1992. This 402-page book is available at libraries, bookstores, or from the project at the address noted above.

Facing the Future: AIDS Counseling in the Second Decade, edited by James W. Dilley and Robert Marks, also published by the UCSF AIDS Health Project and due out in the spring of 1995.

Living with Dementia, a 16-page booklet, was published in 1992 by Impact AIDS and is available by writing or calling Impact AIDS, 3692 18th Street, San Francisco, CA 94110, 415-861-3397.

The 36-Hour Day, by Nancy L. Mace and Peter V. Rabins, MD was published by the Johns Hopkins University Press in 1981. The book, for families caring for people with Alzheimer's disease and memory loss in later life, offers insights into dealing with people with impaired brain functioning.

The Effects of AIDS on the Brain is a production of the UCSF AIDS Health Project. Written by Alicia Boccellari, PhD and James W. Dilley, MD. Edited by Robert Marks. Designed by Leslie Samuels. Proofread by Dorothy Stinnett and John Tighe. Original edition produced by Joanna Rinaldi, 1987.



WOMEN CONCERNED ABOUT AIDS

Drop-In Group

Especially for women

Get support.

Find out more about your risk for AIDS.

Call if you...

- are feeling scared, angry or confused
- want to learn safe sex practices
- have had sex with gay or bisexual men
- have had sex with an IV drug user
- have taken drugs intravenously
- are sexually active with more than one person
- wondering about taking the antibody test
- are having medical symptoms related to AIDS or have AIDS

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- are having medical symptoms related to AIDS or have AIDS

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HEALTH AWARENESS

Drop-in Group

For all populations concerned
about AIDS & HEALTH

Emphasis will be on the following:

- TRANSITIONS—Understanding & Dealing with Changes
- HEALING—What are the Alternatives?
- SEX—Sexual Issues in a Health Crisis
- COUPLES—Communication, Problem Solving and other Relationship Issues
- AND MORE...

No Appointment Necessary

MONDAYS · 6:30-8:30 PM

HEALTH CENTER NUMBER ONE

3850 17th Street
(Noe and Sanchez)
LOBBY

Call for topic of the week

THE
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Donations Appreciated

Drop-in Group

FOR INDIVIDUALS TESTING POSITIVE
FOR THE HIV ANTIBODY

THURSDAYS · 6:00-8:00 PM

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1853 MARKET STREET AT GUERRERO

NO ADVANCE REGISTRATION NECESSARY

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For support and information

HEALTH AWARENESS

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WOMEN CONCERNED ABOUT AIDS

Drop-in Group

For women at risk for AIDS, or women
wanting more information about their risk.

**Tuesdays through February
6:00-7:30 PM**

**Langley Porter Institute (UCSF)
401 Parnassus
Room A109**

**THE
AIDS
HEALTH
PROJECT**

626-6637

Donations Requested

PEOPLE WITH AIDS-RELATED CONDITIONS (ARC)

Drop-in Group

For support and information

THURSDAYS • 6:00-8:00 PM

HEALTH CENTER NUMBER ONE

WOMEN CONCERNED ABOUT AIDS

Support Group

The AIDS Health Project offers educational support groups for women at risk for AIDS. If you are a woman at risk, or would like more information, call the AIDS Health Project.

**THE
AIDS
HEALTH
PROJECT**

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401 Parnassus
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Donations Requested

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Evaluation of Post Test Education
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- 292 Positive Awareness: Moving Beyond
the Test Drop-In Group.

PEOPLE WITH AIDS-RELATED CONDITIONS (ARC)

Drop-in Group

For support and information

THURSDAYS · 6:00-8:00 PM

**HEALTH CENTER NUMBER ONE
3850 17th Street
(Noe and Sanchez)
ROOM 206, UPSTAIRS**

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STRESS MANAGEMENT

Drop-In Group

For persons with AIDS or ARC

Emphasizing how to apply the following to daily living:

- meditation techniques
- letting go of pain
- nutrition
- time management
- thought-stopping
- dealing with depression
- and more...

Thursdays, 9:00-10:30 AM
San Francisco General Hospital
Room 5K8 – Main Bldg.

THE
AIDS
HEALTH
PROJECT

For more information, call Ann West: 821-8830

Name: AIDS Health Project
Disk: 105 / File: 338
Date: 2/13/86



STRESS MANAGEMENT

Drop-In Group

For persons with AIDS or ARC

HEALTH AWARENESS

Drop-in Group

For all populations concerned
about AIDS & HEALTH

Emphasis will be on the following:

- TRANSITIONS—Understanding & Dealing with Changes
- HEALING—What are the Alternatives?
- SEX—Sexual Issues in a Health Crisis
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- AND MORE...

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3850 17th Street
(Noe and Sanchez)
LOBBY

Call for topic of the week

THE
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WHO GETS AIDS?

"I HEAR ONLY
WHITE PEOPLE
GET AIDS"

Why
should I
KNOW ABOUT
AIDS
?

SEPARATE THE FACTS
FROM THE FICTION
ABOUT AIDS!

put your knowledge
and understanding to work by
**DISPELLING THE MYTHS
AND FEARS ABOUT AIDS TODAY!**

Third World and AIDS What's the Connection?

**THE
AIDS
HEALTH
PROJECT**

- 40% of all AIDS cases are people of color
- Are you worried about AIDS? Would you like to talk to someone about your concerns?

The **AIDS Health Project** of UCSF offers educational support groups for people of color. For more information call 626-6637.

AIDS
IS
EVERYONE'S
PROBLEM

Now

is

the

time



COUPLES GROUP

For persons with AIDS and their partners, dealing with improving communication, problem solving, and other relationship issues. Six week groups begin every other month; for the next starting date and further information, call the AIDS Health Project.

626-6637

THE
**AIDS
HEALTH
PROJECT**

*A project concerned
with AIDS Prevention
and Health Promotion
University of California,
S.F. and Department of
Public Health*



**WOMEN
MAKE YOUR MOVE
LET'S TALK ABOUT AIDS**

IF YOU WANT TO TALK MORE ABOUT:

- **ANTIBODY TESTING**
- **SAFER SEX**
- **RISK REDUCTION**
- **RELATIONSHIPS & DATING**

JOIN US at any of the following meetings:

TUESDAY, September 1, 6:30 - 8:30 PM

TUESDAY, October 6, 6:30 - 8:30 PM

TUESDAY, November 3, 6:30 - 8:30 PM

Sponsored by:

**THE
AIDS
HEALTH
PROJECT**

**1855 Folsom St., Suite 506
(Folsom at 15th Street)
For More Information Call
476-6430**

Free of Charge

SUPPORT GROUP FOR PEOPLE OF COLOR

Drop-in Group

An educational support group
for people of color experiencing anxiety
about Health, Sex & AIDS

TUESDAYS 6:00-8:00 PM
513 Valencia Street at 16th

GOALS:

- To provide a supportive atmosphere for people of color interested in discussing personal issues regarding their risk for AIDS
- To provide an environment in which representatives from AIDS organizations can introduce and share their services with people of color
- To address issues regarding the range of services needed by people of color
- Open to people of color who are homosexual and heterosexual; drug users and non-drug-users; male and female; with and without children (call 681-7887 in advance for childcare)

FREE OF CHARGE

Sponsored by:

**THE
AIDS
HEALTH
PROJECT**
626-6637

Facilitated by:

Julius M. Johnson, PhD
Licensed Clinical
Psychologist

GROUPS CURRENTLY OFFERED BY THE AIDS HEALTH PROJECT

Administrative Offices:

333 Valencia St., 4th Floor
San Francisco, CA 94103
(415) 626-6637

- AIDS Mental Health Program
- AIDS Prevention Program
- Youth & AIDS Prevention Program
- AIDS Health Professional Training Program
- AIDS & Substance Abuse Program
- HTLV-III Counseling Program

1. STRESS MANAGEMENT - closed 8 week group
Open to: Gay and Bisexual men; "worried well"
Offered: Ongoing
2. HOT & HEALTHY SEX - closed 8 week group
Open to: Gay and Bisexual men; "worried well"
Offered: Ongoing
3. ANTIBODY POSITIVE DROP-IN GROUP
Open to: Individuals testing positive to the HIV antibody
Offered: Thursday evenings, 6-8 pm, at Operation Concern, 1853 Market Street
4. ARC GROUP - closed 8 week group
Open to: People diagnosed with ARC or meeting our criteria for ARC (determined at intake)
Offered: Ongoing
5. ARC DROP-IN GROUP
Open to: People with ARC; no intake necessary
Offered: Thursday evenings 6-8 pm, Health Center #1 3850 17th Street, Room 206
6. STRESS MANAGEMENT DROP-IN GROUP
Open to: Persons with AIDS or ARC
Offered: Thursday mornings 9:00-10:30 am, SFGH, Main Building, Room 5K8
7. COUPLES GROUP
Open to: Persons with AIDS and their partners
Offered: Ongoing
8. TRANSITIONS
Open to: Gay and Bisexual men; "worried well" and persons with AIDS or ARC
Offered: Ongoing
9. SUPPORT GROUP FOR PEOPLE OF COLOR - DROP-IN
Open to: All people of color who are experiencing anxiety about Health, Sex & AIDS
Offered: Tuesday evenings 6-8 PM, 513 Valencia St. at 16th, call 681-7887 in advance for childcare

Note: All closed 8 week groups require an initial consultation

1/27/87 rd





UCSF AIDS Health Project

*Ten
Years
of
Facing
the
Future
Together*

F E A T U R E D P E R F O R M E R S

(In alphabetical order—talent subject to change)

Members of the cast of *Angels in America*

Suzy Berger • Brian Boitano • Clairdee & Scotty Wright
Peter Coyote • Henrietta Davis-Blackmon • Val Diamond
Renée Lubin • Meg Mackay & Billy Philadelphia

Members of the Ethel Merman Memorial Choir • Ney Fonseca Dance Group

Members of the cast of *The Phantom of the Opera*, including

Franc D'Ambrosio, Lisa Vroman, Ray Saar & Cristin Mortenson
Romanovsky & Phillips • Members of the San Francisco Gay Men's Chorus
Tony Stroh • Alan Temple Baptist Choir
Robin Williams

V I D E O A P P E A R A N C E S B Y

Michael Feinstein • Whoopi Goldberg • Lily Tomlin

The UCSF AIDS Health Project (AHP)
cordially invites you to

Ten Years of Facing the Future Together

A V A R I E T Y S H O W B E N E F I T F O R A I D S R E L I E F

Monday, September 26, 1994 — 8:00 pm
The Castro Theatre

Ticket Prices: \$25, \$100 & \$250

Tickets are available through BASS Tickets and can be purchased at all BASS centers,
including Tower Records/Video and The Warehouse or by calling (510) 762-BASS.

All proceeds from ticket sales go directly to support AHP programs.

The full ticket price is tax deductible to the extent allowable by law—please consult your tax advisor.

Free parking and cable car shuttle to the theatre are available at the UCSF Mission Center, 1855 Folsom Street at 15th.

For additional event information, call AHP at (415) 476-6430.

Ten
Years
of
Facing
the
Future
Together

This event is made possible through the generosity of AHP's community partners, including:
(partial list as of August 9)

M A J O R S P O N S O R S

Bank of America • Gannett Outdoor • Hennessy Martini
New West Pictures • Pacific Bell • vaughndesign
Wells Fargo Bank • Zink Communications

E V E N T S P O N S O R S

Andersen Consulting • Browne Zukow & Associates • Castro Lions Club
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Metagraphics • The Midnight Sun Video Bar • Brian Monahan Designs
Multimedia Public Relations • NAMES Project Foundation • PG&E • Prince/SF Productions
Jallen Rix-Tri-am Music • Steven Sams • San Francisco AIDS Foundation
Shanti Project • Telephone Pioneers of America-SF Council • You Name It Promotions

AHP EXECUTIVE DIRECTOR
James W. Dilley, MD

E V E N T C O M M I T T E E

E V E N T C H A I R
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E N T E R T A I N M E N T
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Stephen J. Herman

F U N D R A I S I N G
Steven Sams

P R O M O T I O N S
Richard Vaughn

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Edward Patterson

AHP STAFF COORDINATOR
Jim McBride



UCSF AIDS Health Project

*Ten
Years
of
Facing
the
Future
Together*

Dear Friends of AHP,

On behalf of the clients, volunteers, staff and Community Advisory Board of the UCSF AIDS Health Project (AHP), I am pleased to welcome you to *Ten Years of Facing the Future Together*, AHP's variety show benefit for AIDS relief.

We chose to commemorate our tenth anniversary with a celebration of life – to reflect on those we've lost to AIDS over the years, and to acknowledge all of us who are affected by HIV in our daily lives.

The Castro Theatre was selected for the event because it is in the heart of the community hardest hit by the AIDS epidemic. And, later this year AHP is opening a new HIV intake center at 400 Castro Street, right across the street.

We also wanted to create a way to thank all of the people who have supported our efforts over the years. Without you, our programs would not have reached the thousands of men, women and youth we have served over the last decade.

We hope you enjoy this very special evening, and we thank you for your continued support as we all join in facing the future together.

With warm regards,

A handwritten signature in dark ink, appearing to read "James W. Dilley, MD". The signature is fluid and cursive, with a large initial "J" and a stylized "Dilley".

James W. Dilley, MD
Executive Director



The
UCSF AIDS Health Project
welcomes you to

Ten Years of Facing the Future Together

A VARIETY SHOW BENEFIT FOR AIDS RELIEF

September 26, 1994
Castro Theatre

*Ten
Years
of
Facing
the
Future
Together*

Prologue/Welcome
James W. Dilley, MD

•
“Celebrate”

(Music by Janet Hood. Lyrics by Bill Russell. Arranged by Don Haas.)

Val Diamond, Lisa Vroman, Henrietta Davis-Blackmon, and the Allen Temple Cantateers

•
MC’s Welcome

Brian Boitano and Renée Lubin

•
“If There Is A God (He’s A Queen)” and “No False Hope”

(Music and Lyrics by Ron Romanovsky and Paul Phillips.)

Romanovsky and Phillips

•
Comedian—Diane Amos

•
“Somewhere, Out There”

(Written by James Horner, Barry Mann, and Cynthia Weil. Arranged by Annbriitt Gemmer.)

Cristin Mortenson and Ray Saar—Dancers: Linda Montaner, David Scamardo

•
Scene from “Angels In America”/“Perestroika”

(Written by Tony Kushner. Directed by Mark Wing-Davey. Presented by the American Conservatory Theatre.)

Actors—Prior: Garret Dillahunt, Belize: Gregory Wallace, Henry: Christine McMurdo-Willis

•
“What Would I Do?”

(From “Falsettoland.” Music and Lyrics by William Finn.)

Franc D’Ambrosio

•
Video Appearance—Michael Feinstein

•
Duke Ellington Medley and “When I Fall In Love”

(Arranged by Scotty Wright.)

Clairdee and Scotty Wright

•
Comedian—Suzy Berger

•
“Solitude”

(Music and Lyrics by Thomas Megan.)

Lisa Vroman (Mary Fettig, Alto Sax)

Video Appearance—Lily Tomlin

•
“Someone Else’s Story”

(From “Chess”: Music by Benny Andersson and Bjorn Ulvaeus. Lyrics by Tim Rice. Arranged by Billy Philadelphia.)

Meg Mackay and Billy Philadelphia

•
“Bud’s Story”

(From “Elegies for Angels, Punks and Raging Queens” by Bill Russell.)

Tony Stroh

•
“My Brother Lived In San Francisco”

(Music by Janet Hood. Lyrics by Bill Russell.)

Meg Mackay and Billy Philadelphia (Terry Adams, Cello)

•
Forever Tango—“Libertango” (Astor Piazzola)

(Hugo J. Brani, Exec. Producer. Luis Bravo, Artistic Producer and Director.)

Choreographed and Performed by Norma and Luis Pereyra

•
Video Appearance—Whoopi Goldberg and Peter Coyote

•
Special Guest—Peter Coyote

•
Special Guest—Robin Williams

•
“Hero”

(By Walter Afanasieff and Mariah Carey.)

Renée Lubin

•
AHP Music Video *“The Face of Love”*

•
Finale: “Love Lives On”

(Music by Bruce Broughton, Barry Mann, Cynthia Weil, and Will Jennings—from the film “Harry and the Hendersons.” Arranged by John David Scott.)

Franc D’Ambrosio, Lisa Vroman, Brian Boitano, Renée Lubin, and The Entire Company

A D D I T I O N A L E N T E R T A I N M E N T

•
Phillip Greenleaf Quartet

•
Ethel Merman Memorial Choir

•
‘Nota Bene’—San Francisco Gay Men’s Chorus

E V E N T P A T R O N S

Bank of America



Gannett Outdoor



Hennessy Martini



New West Pictures



Pacific Bell



vaughndesign



Wells Fargo Bank



The Zink Group

E V E N T B E N E F A C T O R S

Andersen Consulting
IBM

E V E N T S P O N S O R S

Brunetti Productions
Castro Lions Club
Castro Village Pharmacy
Chuck Gould
Graham & James
HealthNet
Stephen J. Herman & Michael Lipp
George W. McCauslen
NAMES Project Foundation
Northern Telecom
PG&E
Steven Sams
San Francisco AIDS Foundation
Shanti Project
Telephone Pioneers of America-SF Council

E V E N T S U P P O R T E R S

Continental Airlines
Steve Coulter & Greg McIntyre
Craig R. Miller
Honorable Kevin Shelley

S H O W P R O D U C T I O N

Producer—*Steven Rivellino*

Director—*Ray Gin*

Musical Director—*John David Scott*

Lighting Designer—*Brian Monahan*

Choreographer—*Irene Cho*

Copy—*Stephen Witkin*

Sound Designer—*Margot McFedries*

Sound—*James Morris, Bill Woody*

Technical Coordinator—*Axis Debruyn*

Production Stage Manager—*John David*

Stage Managers—*Neil Twitchell, Kate Stewart*

Announcer—*Michael Lackey*

Associate Producer—*Steven Lee*

Assistant to the Producer—*Gina Plante*

Assistant Choreographer—*Chris Johnson*

Hair and Makeup—*Liz Spetnagel, Robert Bouvard, Enrique Vega, and Robin Atlas*

Wardrobe—*Debbie Burkman, Dale Foster, Jean Fredrickson, and Frank Morales*

Public Relations—*Browne Zukow & Associates*

Graphic Design—*vaughndesign*

O R C H E S T R A

Keyboards—Annbritt Gemmer, Don Haas, Jon Olson, and John David Scott

Percussion—Arthur Storch

Cello—Terry Adams

Electric Bass—David Schoenbrun

Electric Guitar—Glen Swarts

Alto Sax—Mary Fetting

S T A G I N G A N D E Q U I P M E N T

Lighting and Staging Equipment—LiveLight

Audio Equipment—McCune Audio-Visual Video

Production Van—Ed Souza Studio Rentals

Tent—Special Events

Musical Instrument Rentals—ProPiano

Hotel Accommodations—JOIE DE VIVRE HOTELS

S P E C I A L T H A N K S T O :

Alonso King Contemporary Ballet Theatre

Benny Ambush, James Haire, Carey Perloff, and Dianne Pritchard/American Conservatory Theatre

Carol Blumenfeld, Bob Blumenfeld, and The Blumenfeld Theatres

Castro Theatre • Chip Conley/JOIE DE VIVRE HOTELS

Peter Coyote • Jeff Davis/The Lumen Production Company • Nancy DeSoto • Ney Fonseca

Betty Gadling, Allen Temple Cantateers/Allen Temple Baptist Church, Oakland CA

Amy Glin/On Target Entertainment

Phillip Greenlief, Adam Levy, Bobby Lurie, and Richard Saunders/Phillip Greenlief Quartet

Pat LaGrave/McCune Audio-Visual Video • Linda Lever • Ken Malicelli/Prince Productions

Carolyn Morton and Stan Hill/San Francisco Gay Men's Chorus • Reg/LiveLight

Jonathan Reinus and Joe Watson/Theatre on the Square

Michael Sanfilippo/THE PHANTOM OF THE OPERA Company

San Francisco Police Department/Traffic Division • The Zink Group, New York and San Francisco

A D D I T I O N A L C R E D I T S

Graphics—Leslie Samuels

Film output—Metagraphics

Printing—interface-Printing Services

Banners—Doublet

Public Relations—Charles Zukow & Theresa Burton/Browne Zukow & Associates,
Doug Mealy/Multimedia Public Relations

Photography—Steve Hathaway Photography,
Ray “Scotty” Morris, Marcia Quackenbush

Videotaping—Alison Glazier, AD Oppenheim/Winsome Productions,
Mike Pierce/New West Pictures, David Richardson/DR Associates,
Sims Video Production Ltd./Toronto

Additional Footage—Mentor Media



Alpha Phi Omega Fraternity

Kathy Barr

San Francisco Giants

Walden House

I N - K I N D D O N O R S

Air Canada	<i>inter</i> face Printing Services
Backstage Restaurant	IXIA
Badman Jose's	Lou Levin, Key Magazine
Bass Tickets	Mason's Restaurant in the Fairmont Hotel
Brian Monahan Designs	Pamela May, Mayhem Productions
Browne Zukow & Associates	Metagraphics
Betsy Davidson	Metro Bar and Restaurant
D.R. & Associates	The Midnight Sun
Evian	Multimedia Public Relations
Fairmont Hotel	Opts Cafe
Flower Works, Inc.	Pacific Marine Yacht Charters
Four Seasons Hotel, Toronto	Palio D'Asti
Frontiers Magazine	Dennis Perry, Key Magazine
Golden Brands	Prince/SF Productions
Great Brands of Europe, Inc.	Jallen Rix, Tri-am Music
Greeff Fabrics/Imperial Wallcoverings	Walgreens
Hyatt Fisherman's Wharf	You Name It Promotions

Our sincerest apologies to anyone whose name may have been inadvertently omitted.

" T H E F A C E O F L O V E "

AHP would like to thank the actors and AHP staff and volunteers who portrayed people with HIV.

AHP would also like to thank the people and companies whose tireless dedication and generous support made this film a reality:

Producers—Kristine Jensen and Jim McBride

Director—Mike Pierce

Actors—Curt Branom, Colman Domingo, and Sylvia Gonzales

Extras: Domenic Ali, Mae Araujo, Katherine Bella, JD Benson, Suzy Berger, Joshua Bobrowsky, Jackie Brookman, Grace Chu, Joao DeSales, Ed Diaz, James W. Dilley, Alison Glazier, Carol Kleinmaier, Robert Marks, Anh Nguyen, Yvette Phillips, Willie Simpson, Ameera Snell, John Tighe, Carl Yoshimoto, Bernie Wagner, Dan Warfield, and Sean Willet.

Cinematographer—Matthew Uhry

Editor—John Maguire

Art Director—Betsy Davidson

Gaffer—Ken Butler and Chris Pavey

Key Grip—David "Skippy" Shippy

Grips—Jon James and Roger Kopsell

Graphic Artist—Tim Archer

Makeup—Sylvia Gonzales

Additional Camera—Dario San Miguel

Production Assistants—Edgar Cayago, Alison Glazier and Dan Warfield

Negative Cutter—Angela Chou

Film processing, transfers—Monaco Film Labs & Video Services, Kodak, and FilmCraft Lab

Equipment—Art Freyer, Adolph Gasser Inc., Starlite Studios

Avid Editing—David Hoggan/Bottomline Studios

Expendables—Expendables

Music written and composed by—Jallen Rix/Tri-am Music

Music performed by—Clairdee and Scotty Wright

Additional recording—Pamela May

Arrangers—Michael Hatfield and Scotty Wright

Audio Recording—Russell Bond/Digital Audio Productions, Tom Carr/Music Annex,
and David Richardson/DR Associates

Special Thanks—Katherine Bella, J.B. Molaghan/SFGH, Miriam Garfinkel, Bill Lorton, AD Oppenheim,
Steven Sams, Richard Vaughn, Breene Kerr Productions, and Winsome Productions

V O L U N T E E R S

Special thanks to AHP intern Willie Simpson, who contributed significantly in coordinating the volunteers for this event.

AHP also wishes to thank the following volunteers for donating their time and energy:

Michael Adams	Carol Dawson	Laura Lloyd	Bonnie Schwartz
Lisa Allard	Ellen Dayton	Emanuel M.	Jenifer Sey
Tracy Allyn	Joao DeSales	Joe MacNeil	Lizetta Shadler
Ronald Aragon	Gennarro Devis	Candice Maher	Nanci Sircus
Mae Araujo	Jerry Diverdo	Sonya Martinez	Craig Siulinski
Dymond Austin	Richard Elwart	Bruce Mc.	Andre Soifa
Keith B.	Paul Enriquez	Lance McDaniels	Lisa Soloway
Mike Bard	Judy Fazackerley	Marilyn McKechnern	Jan Speller
Phillip Bauer	Florette	Chip McNeil	Sandy Starky
Meridith Belmens	Elizabeth Furlow	Meryl Mertz	Dorothy Stinnett
Bill Benet	Easton Glynn	Bill Meyer	Nancy Stowski
Michael Benning	Angelo Guerreo	Steve Miller	Susan Sunshine
JD Benson	Diane "DK" Haas	Jon Minagro	Steven Sutton
Mindy Benson	Khalil Habeeb	Michael Moncriz	Mike Trevino
David Blautovich	Christopher Hammer	Alfred Morales	Laura Tudor
Kelly Bolcavage	Nikki Hampton	John Naughton	Blanca Valle
Rachel Brewer	Heidi Heidelberg	Ken Neal	Dana W.
Joshua Bobrowsky	John Heinzel	Robin Ortiz	Jim Weber
Sean Broderick	Valerie Helmond	Maryanna Otsea	Don Welchert
Jackie Brookman	Sue Inac	Yvette Phillips	Lisa Weisenfeld
Jon Malcolm Brownson	Sheila Jones	Baxter Posey	Will Werner
Jon Cadealleau	Patty Kanaoh	Bob Pritchard	Todd Wilcox
Kenny Campbell	Debra Kent	Marcia Quackenbush	Sean Willett
Ricci Catella	Andrea Kissack	Brad Reiss	Michael Williams
Doreen Chin	Thomas Knoble	Robin Rhearst	Oliver Williams
Grace Chu	Sandra Krietich	Jon Richet	Shadrick Williams
Ric Clay	Bruce Lake	Toni Lee Roberts	Joseph Wilson
Jennifer Cohen	Sara Lan Sang	Angie Robles	Randy Wyatt
John Cole	Seison Leaufenberg	Kvia Rogenberger	Cedric Yarbrough
Peter Campos	Emily Leavitt	Roxanne Romero	Trisha Yoglencang
Aaronette Connors	Jane Levikow	Ozzie Santiago	Neil Yoskowitz

Our sincerest apologies to anyone whose name may have been inadvertently omitted.

C O M M U N I T Y A D V I S O R Y B O A R D

Stephen J. Herman—*Board Chair*

Katherine Bella—*Vice-Chair*

Larry Fuller—*Secretary/Treasurer*

Arnold Bellefontaine

Peter Bradley, PhD

Louis Dunn, MS

Kris Getz

Daniel Hernandez

William Lorton

Elizabeth Mitchum

Victor Murphy

Edward Patterson

Jerry Polon, MFCC

Steven Sams

Brandy Sebron-Kelley

Virginia Yee, RN

M I S S I O N S T A T E M E N T

The mission of the UCSF AIDS Health Project (AHP) is to provide culturally sensitive counseling and education to stop the spread of HIV infection, and to help people face the emotional, psychological and social challenges of living with HIV disease.

We accomplish this mission by providing
HIV education and health promotion services, including:

Support groups for people with HIV and those at risk

HIV counseling and antibody testing

Individual psychotherapy

Psychiatric evaluation and consultation

Substance abuse assessment

HIV counselor training

Publications for providers about the psychological and social aspects of HIV disease

D E D I C A T I O N S

AHP would like to thank all of the people who, over the last ten years,
have shared their precious time and donated generously to help support the work of AHP:

Our wonderful staff members, past and present, who have helped shape AHP along the way

The members of our Community Advisory Board, who provide valuable guidance even in our darkest hours

Our donors, without whom many of AHP's programs would not be possible

The hundreds of AHP volunteers whose spirit and energy continues to inspire us all

And our clients, who so deeply enrich our lives and touch our hearts

We also wish to acknowledge, and remember, our many friends whom we have lost to HIV disease
—most recently, our Community Advisory Board member and dear friend—

Andrew Foxwell

E V E N T C O M M I T T E E

Katherine Bella—*Event Chair*

Arnold Bellefontaine—*Entertainment*

Stephen J. Herman—*Finance*

Steven Sams—*Fund Raising*

Richard Vaughn—*Promotions*

Doug Mealy/Gail Browne & Charles Zukow—*Public Relations*

Steven Rivellino—*Show Production*

Lisa Weisenfeld—*Sponsor Reception*

Victor Murphy/Leandro Balido—*Volunteer Coordination*

Peter Bradley, William Lorton, Edward Patterson—*Event Consultants*

Jim McBride—*AHP Event Coordinator*