4-2006

IDCR: Infectious Diseases in Corrections Report, Vol. 9 No. 4

Infectious Diseases in Corrections

Brown Med
BROWN MEDICAL SCHOOL

IDCR

INFECTIOUS DISEASES IN CORRECTIONS REPORT

FORMERLY HEPP Report

April 2006 Vol. 9, Issue 4

SPONSORED BY THE BROWN MEDICAL SCHOOL, OFFICE OF CONTINUING MEDICAL EDUCATION

ABOUT IDCR

IDCR, a forum for correctional problem solving, targets correctional physicians, nurses, administrators, outreach workers, and case managers. Published monthly and distributed by email and fax, IDCR provides up-to-the moment information on HIV/AIDS, hepatitis, and other infectious diseases, as well as efficient ways to administer treatment in the correctional environment. Continuing Medical Education credits are provided by the Brown University Office of Continuing Medical Education. IDCR is distributed to all members of the Society of Correctional Physicians (SCP) within the SCP publication, CorrDocs (www.corrdocs.org).

SUPPORTERS

IDCR is grateful for the support of the following companies through unrestricted educational grants:

Major Support: Abbott Laboratories and Roche Pharmaceuticals.

Sustaining: Pfizer Inc., Gilead Sciences, Inc., GlaxoSmithKline, Merck & Co., and Schering-Plough.

HIV Testing in State Prisons: Balancing Human Rights and Public Health

David L. Rosen,[1] Victor J. Schoenbach*,[2] Andrew H. Kaplan*[1]*

[1]The University of North Carolina School of Medicine
[2]The University of North Carolina School of Public Health

***DISCLOSURES:** *Nothing to disclose*

With approximately a quarter of the one million HIV-infected individuals in the United States unaware of their infection,[1] increased testing among high-risk populations has been promoted nationally.[2] The importance of providing HIV testing to prison inmates--a population that generally suffers from a lack of routine community health care[3,4] and for whom the prevalence of HIV infection is several-fold higher than among the general population[5]--has been well documented for nearly 20 years.[6-9] Although the potential individual and societal benefits of testing this high-risk population are substantial, considerable debate remains about the best practices for screening prison inmates for HIV infection. State legislators, public health officials, and prison administrators, among others, must consider whether HIV testing should be mandated for all inmates, and if not, the degree to which consent-based voluntary testing should be available, encouraged and targeted. HIV screening policies are implemented on a state-by-state basis and have implications for the protection of inmate rights and for the public health. In this review, we briefly describe current prison-based testing practices, summarize issues raised in the existing debate, and outline possible research and evaluation efforts to help guide future HIV testing practices in prison.

Why Test?

The potential benefits of HIV testing for both the inmates being tested and society at large are compelling. In contrast to non-incarcerated settings where HIV testing is typically prompted by illness and provided late in the course of infection,[10,11] screening asymptomatic inmates may allow for earlier diagnosis and consequently more timely initiation of care, fewer opportunistic infections, and extended survival.[12] Further, the confines of prison can help facilitate the receipt of HIV test results compared to community settings where failure to return for test results is common.[13-15] In addition, testing coupled with counseling provides opportunities to engage inmates in discussions about risk reduction.

For those inmates testing positive for HIV infection, access to healthcare has been affirmed by the Supreme Court[16] and highly active antiretroviral therapy (HAART) is widely available in correctional settings.[17] The effectiveness of HIV care in prisons has brought about a 75% reduction in AIDS-related mortality,[18] a decline mirror-

Continued on page 2

WHAT'S INSIDE

HIV Testing in State Prisons... *(continued from page 1)*

ing that of non-incarcerated populations.[19] Further, the structured environment and the provision of basic necessities in prison (e.g. food and shelter) may provide therapeutic support lacking in some community settings. As discussed in the March 2006 issue of IDCR, ancillary services such as substance abuse and mental health treatment may also be more readily accessed in some prisons than in community settings, further supporting care.

In addition to entering HIV-infected inmates into treatment, HIV testing programs in prison have an important role in prevention. Identification of HIV-infected inmates can prompt contact tracing, thereby promoting others to be HIV tested and potentially hindering the spread of the virus within the community. With studies indicating that non-incarcerated individuals reduce their frequency of risk behaviors following HIV diagnoses,[20-22] inmates who are diagnosed in prison may also reduce HIV transmission behaviors both in prison and upon returning to their communities. Among those inmates who test positive and initiate care, successful maintenance of HAART minimizes infectiousness by reducing viral load in genital secretions, further reducing the risk of transmission.[23,24]

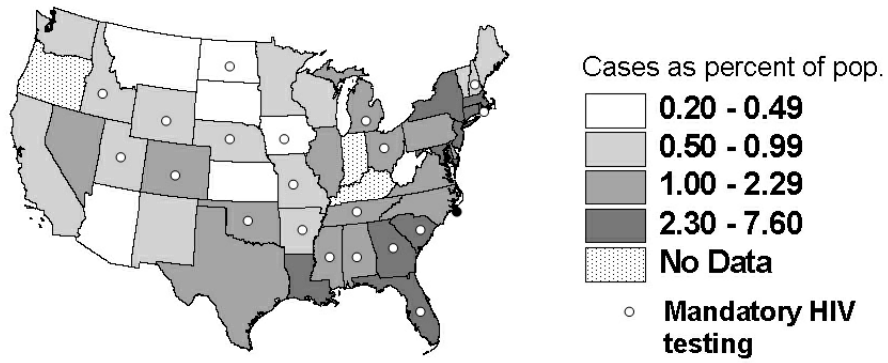
Negative Consequences of HIV Diagnosis in Prison

Despite the benefits of HIV testing, there are also disincentives for inmates to be tested. Inmates may be reluctant to be screened for HIV infection because of the fear that, if positive, information about their HIV status will disseminate throughout the prison to correctional staff and other inmates. The serostatus of HIV-infected inmates may be intentionally disclosed or, in the concentrated environment of prisons, unwittingly revealed by a number of activities associated with HIV care such as standing in a medication line, attending HIV specialty clinics, and receiving extra meals or nutritional supplements.[25] The consequences of disclosure among inmates have not been well documented, but given that social hierarchies in prison may be reinforced by coerced and consensual sexual activity, disclosure of HIV status can be stigmatizing, diminishing social support and potentially provoking violence or the threat of violence.[25] Institutional consequences of testing positive may include loss of access to activity programs, visitation, and jobs, as well as housing restrictions.[26]

In the past, some state prison systems have segregated HIV-infected prisoners from the general prison population as a means to prevent intra-prison transmission. Policies of segregation have been criticized for perpetuating stigma, forfeiting confidentiality, and restricting the opportunities (e.g. for education and work-release) of HIV-infected inmates.[25,26] Most agree that these policies have had little effect on diminishing already low rates of intra-prison transmission,[27] and segregation has now fallen out of use in all but a few state prison systems.

Some prison systems, however, cluster HIV-infected inmates in particular facilities. Clustering of HIV-infected individuals can facilitate the provision of medical care and ancillary services. Policies of clustering differ from those of segregation in that they typically allow for HIV-infected inmates to live among the general prison population, which may reduce the consequences of breaches in confidentiality regarding HIV status.[27] Criticism of clustering has been less vocal than that of segregation, and several state systems that cluster HIV-infected inmates have been noted for excellence in the provision of HIV care.[17] However, like segregation, clustering can in effect breach inmates' confidentiality and result in institutional restrictions, such as those listed above.

Figure 1. Prison systems with mandatory HIV testing and known HIV/AIDS cases as a percent of total custody population, 2003



Map created using data collected by the Bureau of Justice Statistics. Please see references 31 and 34.

Current Prison-Based HIV Testing Policies

HIV testing policies in many prison systems (N=29) have been established by their respective state legislatures.[28] In other states, testing policies have been developed by state health departments or prison administrators. In both cases, financial considerations--costs of implementing a particular testing policy and providing treatment and care for identified cases--can play an important role in determining how HIV screening is conducted.[17,29]

Regardless of their policies' origins, state prison systems can be broadly dichotomized into those that mandate HIV testing for all inmates and those that provide voluntary (i.e. consent-based) testing. A Bureau of Justice Statistics (BJS) publication reported that for the year 2000, 19 state prison systems employed mandatory testing at intake; four of these states also

Continued on page 4

References:

[1]Fleming PL, Wortley PM, Karon JM, et al. Am J Public Health. 2000;90(7):1037-41.
[2]Centers for Disease Control and Prevention. Advancing HIV prevention: new strategies for a changing epidemic-- United States, 2003. 2003:52.
[3]Conklin TJ, Lincoln T, Tuthill RW. Am J Public Health. 2000;90(12):1939-41.
[4]Hammett TM, Gaiter JL, Crawford C. Health Educ Behav. 1998;25(1):99-120.
[5]The Status of Soon-to-be-Released Inmates, A Report to Congress, Volume 1. Chicago: National Commission on Correctional Health Care; March 2002.
[6]Vlahov D. AIDS & Public Policy. 1988;3(2):42-6.
[7]Vlahov D, Brewer F, Munoz A, et al. J Acquir Immune Defic Syndr. 1989;2(3):283-90.
[8]Harding TW. Lancet. 1987;2(8570):1260-63.
[9]Lewis HE. JAMA. 1987;258(17):2410-14.
[10]Wortley PM, Chu SY, Diaz T, et al. AIDS. 1995;9(5):487-92.
[11]CDC. Late versus early testing of HIV--16 sites, United States, 2000-2003. MMWR. 2003;52(25):581-86.
[12]Bozzette SA. N Engl J Med. 2005;352(6):620-21.
[13]Sabin KM, Frey RL, Jr., Horsley R, et al. J Urban Health. 2001;78(2):241-55.
[14]Hightow LB, Miller WC, Leone PA, et al. AIDS Educ Prev. 2003;15(3):282-90.
[15]Sullivan PS, Lansky A, Drake A. J Acquir Immune Defic Syndr. 2004;35(5):511-18.
[16]Estelle vs. Gamble. Vol U.S. 97: U.S. Supreme Court; 1976:429.
[17]Spaulding A, Stephenson B, Macalino G, et al. Clin Infect Dis. 2002;35(3):305-12.
[18]Maruschak LM. HIV in Prisons, 2001. Washington, DC: US Department of Justice, Bureau of Justice Statistics; January 2004. NCJ 202293.
[19]NCHS. Health, United States 2004, with chartbook on trends in the health of Americans. Hyattsville: National Center for Health Statistics; 2004.

Letter from the Editor

Dear Corrections Colleagues,

An upside of incarceration is the opportunity it affords to conduct critical health screening among individuals who may have had little prior access to or utilization of basic health care. Evaluation and testing for conditions that are prevalent among those who are incarcerated - including infections transmitted sexually or via injection drug use - is obviously wise and yields benefits not only to the individual but also to the communities to which they return. Converging data suggest that detection of HIV infection earlier rather than later improves clinical outcomes and reduces secondary transmission of the virus, leading many to advocate for broader HIV screening in the general population as well as in settings with higher prevalence of HIV infection such as jails and prisons. However, how to effectively and ethically identify inmates who are HIV-infected so that appropriate care and counseling can be implemented is a challenge states have approached differently. Unfortunately, there has been little in the way of scientific data to inform these various approaches.

In this issue, Rosen and colleagues tackle the thorny issue of screening for HIV infection in prison. They review the available data regarding current screening practices in U.S. prisons and objectively describe the debate regarding mandatory versus voluntary HIV testing. Their comprehensive and informative article will be valuable to any correctional health care provider involved in deciding how best to detect HIV in his or her prison system as well as the rest of us who must live with these decisions. With this review, readers should be able to describe the major HIV screening methods used in state prisons and their potential advantages and disadvantages.

A real-world perspective on HIV screening is provided by brief reports from Joe Bick and John May who describe their own experiences screening for HIV infection among inmates in California and Florida, respectively. These articles are complemented by a guide to HIV counseling and testing prepared by Carol Browning, a nurse at the Rhode Island Department of Health with extensive experience conducting HIV screening.

The HIV testing debate provokes passionate responses, but informed decision making is called for. As Rosen and colleagues conclude, more research is needed to identify what works and what does not and in which setting. The issue of IDCR you hold in your hands (or read on your screens) was written by experts in this field and, I hope, will provide a balanced view that will inform your own decisions on how best to effectively and ethically screen for HIV.

As always, please feel free to send letter to the editor, comments and suggestions to me at wohl@med.unc.edu.

Thanks,

David Alain Wohl, MD

Cover Artwork "Spring Fig Tree"
Woodcut print by Eric Avery. M.D. Reprinted with the artist's permission. For more information on Dr. Avery's art please see http://www.docart.com

Subscribe to IDCR

Fax to **617-770-3339** for any of the following: *(please print clearly or type)*

____ Yes, I would like to add/update/correct (circle one) my contact information for my complimentary subscription of IDCR fax/email newsletter.

____ Yes, I would like to sign up the following colleague to receive a complimentary subscription of IDCR fax/email newsletter.

____ Yes, I would like my IDCR to be delivered in the future as an attached PDF file in an email (rather than have a fax).

NAME: _____ FACILITY: _____

CHECK ONE:

○ Physician ○ Physician Assistant ○ Nurse/Nurse Practitioner ○ Nurse Administrator
○ Pharmacist ○ Medical Director/Administrator ○ HIV Case Worker/Counselor ○ Other

ADDRESS: _____ CITY: _____ STATE: ___ ZIP: _____

FAX: _____ PHONE: _____

EMAIL: _____

Faculty Disclosure

In accordance with the Accreditation Council for Continuing Medical Education Standards for Commercial Support, the faculty for this activity have been asked to complete Conflict of Interest Disclosure forms. Disclosures are listed at the end of articles. All of the individual medications discussed in this newsletter are approved for treatment of HIV and hepatitis unless otherwise indicated. For the treatment of HIV and hepatitis infection, many physicians opt to use combination antiretroviral therapy which is not addressed by the FDA.

HIV Testing in State Prisons...
(continued from page 2)

mandated testing upon release.[31] The other 31 prison systems implemented voluntary HIV testing, with most of these systems providing opportunities for testing upon entry. At the time of the survey, four state systems with voluntary testing--Texas, Florida, New Yorkand California--contained about half of the nation's known HIV-infected prison population.[31]

Since the 2000 survey, the Texas[32,33] and Florida[34,35] prison systems have changed testing policies and now mandate HIV testing for all inmates preceding their release; California is considering such a policy. Other state systems to change testing policies since 2000 include Michigan, which switched from voluntary to mandatory testing,[36] and Nevada, which switched from mandatory to voluntary testing[34] (see Figure 1 which reflects data from 2003).

Voluntary testing can be offered in many different ways. In most systems inmates must request to be tested ("opt-in" testing) whereas in a few states, inmates are routinely provided testing unless they actively refuse ("opt-out" testing). Also, testing may target particular populations: 11 of the 31 systems with voluntary testing in 2000 specifically targeted "high risk" inmates[31] (e.g. injection drug users, commercial sex workers) for HIV testing. As such, prison systems with policies of voluntary HIV testing encourage testing to different degrees. Not unexpectedly, the rates of HIV testing in prisons with voluntary testing vary widely (39-71%).[37,38]

Some systems have different testing strategies depending on inmate status. For example, Rhode Island, which has a single correctional facility that serves as both the state's prison and jail, provides routine opt-out testing to arrestees. If convicted, inmates who refused testing at arrest undergo mandatory testing.[39] Texas routinely tests inmates as they enter the prison system and mandates testing of all inmates upon release.

Regardless of mandatory or voluntary policies, most prisons test inmates under the following circumstances: at an inmate's request; if clinically indicated; upon involvement in an incident, such as a fight with blood exposure; and by court order,[31] particularly for crimes of a sexual nature and sometimes for those that involve injection drug use. Testing under these circumstances, however, likely represents only a small proportion of all tests performed.

Mandatory HIV Testing

Of all the testing strategies, mandatory testing offers the greatest opportunity to diagnose HIV-infected inmates. The American Medical Association (AMA) endorsed mandatory HIV testing of prison inmates in 1987.[40] More recently, Braithwaite and Arriola endorsed mandatory testing for inmates provided such testing is conducted in a non-prejudicial manner and adequate treatment and follow-up resources are available.[41] However, guidelines from the American Public Health Association (APHA) suggest that mandatory testing of inmates is inappropriate, and the World Health Organization (WHO) deems mandatory HIV testing in prison unethical and ineffective.[42,43]

Arguing against mandatory testing, critics cite the inability to preserve confidentiality in prison[25] and the discrimination and stigmatization that HIV-infected prisoners have historically endured, particularly as a result of segregation.[26] Further, some feel that mandatory testing diminishes inmates' opportunities to engage in thoughtful counseling about risk behaviors since testing will be conducted regardless of whether an inmate deems it necessary.[44]

A study by Varghese and Peterman projected the number of HIV cases averted by providing counseling and testing (CT) in prison.[45] The results indicated that in low-prevalence settings (≤1%), the majority of averted cases (80%) resulted from seronegative inmates reducing their likelihood of acquiring HIV following CT; only 20% of cases were averted because newly diagnosed inmates reduced their potential risk of transmission following CT. Although this study was based on a number of assumptions, it implied that in prisons with a low prevalence of HIV, prisons requiring mandatory testing without (or with insufficient) counseling might be less effective at averting future cases of HIV than prisons that provide widespread counseling. It is noteworthy that in 2003, 13 of the 20 prison systems with mandatory testing had prevalence estimates of 1% or less.[34,46]

Voluntary "Opt-In" HIV Testing

Voluntary testing wherein the individual must consent (i.e. opt in) to HIV testing may preserve inmates' autonomy, but existing literature, though dated, suggests that a substantial proportion of infected inmates remain undetected in systems with voluntary testing. Rates of HIV infection determined by seroprevalence studies exceeded rates of infection determined by voluntary testing in the Maryland, California, Illinois, New Jersey[47] Wisconsin[48] and Oregon[49] state prison systems. Studies in the Maryland[50] and Wisconsin[48] state prison systems, for example, reported that rates of HIV infection among those tested in blinded studies were twice that of volunteer testers. In Wisconsin, 31% (8/26) of all HIV-infected inmates declined to be tested, and in Maryland 66% (134/204) of all HIV-infected inmates declined testing.

Unlike testing for other communicable infections, before testing for HIV infection, healthcare providers are required to counsel patients about risk behaviors and obtain written informed consent. Although these procedures were initiated to lessen potential, negative psychosocial repercussions of testing HIV-positive, some argue that they create undue obstacles for testing, including additional time spent conducting the counseling and paperwork. Further, because the written consent process is unique to HIV, it may in fact further perpetuate stigma associated with being tested.[51]

Additionally, identification of patients at risk for HIV infection who should be offered testing can be challenging. Patients are often reluctant to disclose behaviors related to transmission, and providers can be poor at eliciting information about these behaviors. Although approximately one-third of state prison systems with voluntary testing

Continued on page 5

References (Cont.):

[20]Weinhardt LS, Carey MP, Johnson BT, et al. Am J Public Health. 1999;89(9):1397-1405.
[21]Wolitski RJ, MacGowan RJ, Higgins DL, et al. AIDS Educ Prev. 1997;9(3 Suppl):52-67.
[22]Kamb ML, Fishbein M, Douglas JM, Jr., et al. JAMA. 1998;280(13):1161-67.
[23]CDC. Guidelines for Using Antiretroviral Agents Among HIV-Infected Adults and Adolescents: Recommendations of the Panel on Clinical Practice for Treatment of HIV. MMWR. 2002;51(RR07)(1).
[24]Quinn TC, Wawer MJ, Sewankambo N, et al. N Engl J Med. 2000;342(13):921-29.
[25]De Groot AS, Hammett TM. The AIDS Reader. May/June 1996:78-87.
[26]Kantor E. HIV Transmission and Prevention in Prisons. Available at: http://www.hivinsite.org/InSite?page=kb-07-04-13#S8X. Accessed Jan 4, 2006.
[27]Bartlett JG, Tripoli LC, Rappaport ES, Ruby W. HIV in Corrections. July 1, 2000. Available at: http://cm-institute.org/hivin.htm. Accessed December 22, 2005.
[28]Barron P, Staff of Journal 13. Law and Sexuality: A review of lesbian, gay, bisexual and transgender legal issues. 2004;13(1):1-604.
[29]HIV testing of state prisoners not mandatory. Indianapolis Star. Oct 24, 2001.
[30]Paltiel AD, Weinstein MC, Kimmel AD, et al. N Engl J Med. 2005;352(6):586-95.
[31]Maruschak LM. HIV in Prisons, 2000. Washington, DC: US Department of Justice, Bureau of Justice Statistics; October 2002. NCJ 196023.
[32]West M. Inmates to take HIV test before release. The Daily Texan. June 21, 2005.
[33]Stanford S. Personal Communication with HIV Program Coordinator, Texas Department of Criminal Justice; 2006.
[34]Maruschak LM. Personal communication, unpublished table, Bureau of Justice Statistics: Circumstances under which inmates were tested for the antibody to the human immunodeficiency virus, by jurisdiction, 2003; 2006.

HIV Testing in State Prisons...
(continued from page 4)

specifically target "high risk" inmates, the definition of "high risk" has not been well defined and likely varies across, and perhaps within, state prison systems. Several studies have identified factors associated with HIV infection among inmates, but the extent that these factors have been used to screen inmates--and their ability to identify new infections--has not, to our knowledge, been documented. Without validation, targeted testing may divert prevention and testing resources away from inmates at risk for infection.

Routine or Voluntary "Opt-Out" Testing

Recommendations for routine testing, both in community and correctional populations, have been gaining support over the last several years.[51,17,52] In community settings, the proportion of those tested as a routine part of medical care is on the rise.[53] The CDC's revised HIV testing guidelines, released in 2001, and its 2003 initiative, "Advancing HIV Prevention," both recommend that routine testing be offered in settings with prevalence estimates of ≥1%, including correctional settings that fit this prevalence criterion.[2,54] A technical addendum to the 2003 initiative recommends routine testing in prisons without reference to the 1% prevalence cut-off.[55]

Unlike voluntary opt-in testing, routine opt-out testing (i.e. conducting HIV screening unless the individual refuses to be tested) does not depend on patients' self-disclosure of risky behaviors. It may help to normalize the testing process and decrease test-associated stigma, increasing acceptance of offered testing and potentially increasing new diagnoses. To further promote acceptability, some suggest that routine testing should be offered with minimal pre-test counseling; extensive counseling and services would be available for those testing positive.[51]

The provision of routine HIV testing in the Rhode Island Department of Corrections has had a substantial impact on detecting infected individuals in that state. From 1989-1999, diagnoses among prison inmates constituted 33% of all new HIV diagnoses in Rhode Island.[39] While this proportion includes convicted inmates who undergo mandatory testing, 90% of inmates accepted routine testing upon entry.[17]

Some inmate advocates suggest that opt-out testing conducted in prison, an inherently punitive environment, is coercive by nature and akin to mandatory testing.[56] Corrections-based providers in Rhode Island counter that testing is not coercive, but rather is well-accepted among inmates because it is coupled with comprehensive, prison-based treatment programs.[52] In support of this argument, a study of released Rhode Island inmates found that 77% of respondents endorsed HIV testing.[57] Despite most respondents' endorsement of testing, the high rates of acceptance raise questions about inmates' autonomy; in two community-based studies of routine HIV testing, acceptance rates were 37%[58] and 40%,[59] well below the 90% acceptance rates among Rhode Island inmates. However, in the Texas correctional system, which incarcerates more inmates than any other system in the United States,[46] refusal of routine testing at intake has been reported as less than 1%.[32]

Future Research and Evaluation of HIV Testing Policies

A variety of HIV testing policies are practiced in state prisons across the U.S. Each of these policies appears to have different implications for the protection of inmate rights (i.e. autonomy, confidentiality, and access to care) and for prevention of disease transmission in community settings. However, our understanding of these different policies is incomplete, based on anecdotal information and extrapolated from non-prison populations. The application of similar polices may vary greatly by state prison system and by prison. To truly evaluate these programs in regard to their impact on inmate rights and public health, we propose that the following areas be assessed:

- Congruity between testing policies and their applications
- Costs of testing, counseling and prevention programs
- Inmate, provider and system characteristics associated with uptake of HIV testing in systems with voluntary testing
- Efficacy of counseling on the acceptance of HIV testing and the reduction of inmate risk behaviors
- The roles of confidentiality and stigma in acceptance of testing
- Psychosocial and physical (e.g. disease-related morbidity, target of assault) consequences of testing positive in prison
- Utility of targeted testing
- Availability of and access to services following release

To our knowledge, only the last of these areas has received any attention. These evaluations could be couched as part of larger assessments of medical care in prison. Although there is certainly a disincentive for prisons to document their own lapses in care, a necessary first step to improving medical care and promoting public health through the prison system is to take a sober look at the services provided. Prison health care experts should work with governmental agencies to develop and implement these evaluations.

References (Cont.):

[35]Florida Department of Health. Florida HIV/AIDS Corrections Initiatives: Comprehensive Summary, July 2005. Available at: http://www.doh.state.fl.us/disease_ctrl/aids/corrections/Comprehensive_Corrections_Report_2005.pdf. Accessed March 2, 2006.

[36]Michigan Department of Corrections. Testing. Available at: http://www.michigan.gov/corrections/0,1607,7-119-9741_9742-23414--,00.html. Accessed March 2, 2006.

[37]Kassira EN, Bauserman RL, Tomoyasu N, et al. J Urban Health. 2001;78(2):256-63.

[38]Cotten-Oldenburg NU, Jordan BK, Martin SL, et al. AIDS Educ Prev. 1999;11(1):28-37.

[39]Desai AA, Latta ET, Spaulding A, et al. AIDS Educ Prev. 2002;14(5 Suppl B):45-52.

[40]Board of Trustees Report. Prevention and control of Acquired Immunodeficiency Syndrome. An interim report. JAMA.1987;258(15):2097-2103.

[41]Braithwaite RL, Arriola KR. Am J Public Health. 2003;93(5):759-763.

[42]Standards for Health Services in Correctional Institutions. 3rd ed. Washington, DC: American Public Health Association; 2003.

[43]UNAIDS. WHO guidelines on HIV infection and AIDS in prisons. Geneva: Joint United Nations Programme on HIV/AIDS; September 1999.

[44]de Boer B. HIV testing in the USA. Avert.org. February 1, 2006. Available at: http://www.avert.org/hiv-testing-usa.htm. Accessed March 3, 2006.

[45]Varghese B, Peterman TA. J Urban Health. 2001;78(2):304-12.

[46]Maruschak LM. HIV in Prisons, 2003. Washington, DC: US Department of Justice, Bureau of Justice Statistics; October 2005. NCJ 210344.

[47]Hammett TM, Harmon P, Maruschak LM. 1996-1997 Update: HIV/AIDS, STDS, and TB in Correctional Facilities. Washington, DC: US Department of Justice, Office of Justice Programs; July 1999. NCJ 176344.

[48]Hoxie NJ, Chen MH, Prieve A, et al. WMJ. 1998;97(5):28-31.

[49]Andrus JK, Fleming DW, Knox C, et al. Am J Public Health. 1989;79(7):840-42.

[50]Behrendt C, Kendig N, Dambita C, et al. Am J Epidemiol. 1994;139(9):918-26.

[51]Beckwith CG, Flanigan TP, del Rio C, et al. Clin Infect Dis. 2005;40(7):1037-40.

[52]Boutwell A, Rich JD. Clin Infect Dis. 2004;38(12):1761-63.

[53]Inungu JN, Quist-Adade C, Beach EM, et al. AIDS Read. 2005;15(1):35-8, 42.

[54]CDC. Revised Guidelines for HIV Counseling, Testing, and Referral, and Revised Recommendations for HIV Screening of Pregnant Women. 2001;50(RR-19).

[55]CDC. Advancing HIV prevention: Interim Technical Guidance for Selected Interventions. 2003.

[56]Walker J, Sanchez R, Davids J, et al. Clin Infect Dis. 2004;40:319.

[57]Ramratnam B, Rich JD, Parkh A, et al. Journal of Correctional Health Care. 1997;4(2):155-64.

[58]Walensky RP, Losina E, Malatesta L, et al. Am J Public Health. 2005;95(1):71-3.

[59]CDC. Routinely recommended HIV testing at an urban urgent-care clinic-- Atlanta, Georgia, 2000. MMWR. 2001;50(25):538-41.

Spotlight: HIV Testing in Correctional Settings: A Tale of Two States

HIV Testing within the California Department of Corrections: Challenges, Successes, and Lessons Learned

Joseph Bick, MD
Chief Medical Officer, California Medical Facility, California Department of Corrections

The California Department of Corrections and Rehabilitation (CDCR) is the largest criminal justice system in this country, with more than 168,000 inmates and another 140,000 on parole.[1] The CDCR currently does not routinely mandate HIV testing of all inmates. Specific situations in which HIV testing is required include when the commitment offense involves certain sex crimes and/or the inmate has been responsible for causing the transmission of blood or other body fluids on, upon, or through the skin or mucous membranes of another person. A bill currently under debate in the California State Assembly would require the CDCR to test all paroling inmates for HIV at some point in the 60 days before their release.[2]

Blinded serostudies of blood collected from incoming CDCR prisoners were performed by the California Department of Health Services in 1996 and 1999, yielding HIV seroprevalence rates of 1.5 and 2.5%, respectively.[3] Applying these prevalence data to today's population would yield between 2,500-4,300 HIV-infected persons among the 168,000 individuals who are currently incarcerated. By contrast, the CDCR is aware of only approximately 1,300 HIV-infected prisoners. It is not clear how many of these patients do not know their HIV status as opposed to those who are aware but do not disclose this information to prison medical staff. Numerous serious disincentives to divulging HIV status exist within the CDCR including:

- Restrictions on job assignments
- Limitations on potential housing sites
- Decreased educational opportunities
- Prolonged sentences if restricted from work-release programs
- A prohibition against conjugal visiting
- Different punishments for in-custody infractions (those who are known to be HIV-infected are subject to harsher punishments if they are found guilty of being involved in the willful exchange of body fluids.)

Furthermore, there are a plethora of laws in California that may serve to dissuade individuals from disclosing their HIV status.[4] Among these are:

Health and Safety Code (HSC) 121015: Permits a treating physician to disclose a person's HIV status to a spouse and any person reasonably believed to be the sexual or needle-sharing partner of the individual.

HSC 120291: States that if an individual is known to know that he/she is HIV-infected and engages in unprotected sex, he/she can be charged with a felony.

HSC 121070: Requires medical personnel to disclose the HIV status of all inmates to the "officer in charge" of the detention facility who is then required to notify all employees and volunteers who may have direct contact with the inmate.

Penal code (PC) 12022.85: Increases by three years the sentence of those convicted of rape, unlawful sodomy or oral copulation if the defendant knew he was HIV-infected at the time of the offense.

PC 1202.6: Requires those convicted of prostitution to be tested for HIV.

PC 647: Elevates any subsequent prostitution conviction among those known to be HIV-infected from a misdemeanor to a felony.

PC 7520: Directs correctional officials that they must notify parole and probation officers when an HIV-infected inmate is released.

PC 7521: Allows parole and probation officers to inform the spouse of paroling inmates of their HIV status.

Currently the CDCR encourages voluntary HIV testing of all at-risk inmates. However, it is clear that many inmates do not request or accept this testing and others do not have it offered to them. As a result, many of those who are HIV-infected do not benefit from earlier diagnosis and treatment - well-described to improve outcomes.[5,6] In California, pre-test counseling and informed consent are required by HSC 120990. One recent study within the CDCR demonstrated that offering routine, one-to-one HIV counseling to all incoming inmates doubled the acceptance of voluntary HIV testing.[7] This study also concluded that a significant percentage of high-risk individuals had never previously been tested for HIV, and that offering multiple testing modalities (blood, urine, oral fluid) can increase the number of individuals who choose to test. A follow-up study is being undertaken to further evaluate those who elect to not test to identify information that may be useful in improving the number of inmates who elect to learn their HIV serostatus.

Clearly, there is a need to minimize the disincentives that currently exist for HIV testing and disclosure of HIV seropositivity within the correctional setting. Those diagnosed earlier in the course of infection may be more likely to prevent the development of opportunistic infections and malignancies, and less likely to transmit infection to others. Improving the number of inmates who voluntarily test for HIV has the potential to benefit both inmates and the communities to which most of them will one day return.

Rapid HIV Testing at the Broward County Jail, Florida

John P. May, MD
Armor Correctional Health Services

Mark Welch, Medical Student
NOVA Southeastern College of Osteopathic Medicine

Rosemary Jackson, MD, MPH
Medical Director, Broward County Jail, Armor Correctional Health Services

The Broward County Jail in South Florida is one of four nationwide sites participating in a Centers for Disease Control and Prevention (CDC) demonstration project, Rapid HIV Testing of Inmates in Short Stay Correctional Facilities. The RAPID (Reducing AIDS Prevalence in Detention) Project is a collaborative effort between the Broward County Health Department, the Florida Department of Health, the Broward Sheriff's Office, and Armor Correctional Health Services. The RAPID team, a staff of four, provides voluntary rapid HIV testing utilizing the OraQuick HIV-1/2 test kit, prevention counseling, and referrals to post-release care and services to Broward County jail inmates. The opportunity for voluntary HIV testing and counseling is provided at no charge to inmates during the initial health assessment or by request through sick call. Individuals who test positive for HIV infection receive post-test counseling, medical treatment, preventive health care, transmission prevention counseling, and

Continued on page 7

SPOTLIGHT...
(continued from page 6)

are linked to case management and discharge planning through the health department's on-site Jail Release Linkage Project.

The project began testing in January 2004. As of March 2006, the RAPID team had provided testing and counseling to more than 10,000 inmates. Most of those approached agreed to the HIV screening and many inmates reported that they would not have gotten tested if they had not been offered the test in jail or if they would have had to return for the results.

A medical and correctional record review was conducted of persons newly identified as HIV-infected through the RAPID Project from March 2004 through April 2005. During the 13 month period, 62 (0.8%) previously unknown HIV infections were found among 7,403 tested. The average age of those infected was 35.8 years (range 20-64). Those newly identified had an average of 6.7 prior incarcerations, with a range of 1-24 prior admissions to the jail. The criminal charges of inmates newly identified with HIV were drug offenses (41%); violations of probation (25%); many related to illicit substance use; theft or burglary (14%); assault (9%); or other (11%). Most (72%) were released from the jail on a bond, probation, or time-served sentence. Some (23%) were transferred to a state prison or another jail facility. Five percent were admitted to a court-ordered drug-treatment program.

The average length of stay for those newly identified was 81 days, although most (53%) were released in less than 30 days after their test result. Latent tuberculosis infection was present in 20% of the patients. Because of the limited length of stay for most inmates, many were released from the jail before completing their comprehensive health assessment and laboratory testing. Of those remaining in the jail long enough to complete the laboratory testing, one third (33%) had CD4+ T-cell counts less than 200 cells/mm3. Of these, and others eligible for antiretroviral treatment based on clinical criteria, few (6 patients) remained in the jail long enough to initiate a program of antiretroviral treatment. None of the newly identified patients required hospitalization during the review period. On the other hand, one inmate who chose not to have HIV testing and with no known history of HIV was hospitalized for an extended period and found to have HIV infection and disseminated tuberculosis.

The RAPID HIV testing project is enormously successful at the Broward County Jail. The dedication and skill of the health department and on-site staff, the support of the jail leadership, and the funding and collaboration from public and private agencies facilitates its success. The project identifies many who would otherwise not be aware of their HIV infection, including some with advanced HIV disease, and connects these individuals to medical treatment, transmission prevention counseling, and case management. While many are arrested on drug-related offenses and the criminal court directs few to drug treatment, health department linkage to post-release medical care provides an opportunity for further intervention and treatment. Collateral costs of the project, such as on-site medical evaluations, laboratory tests, and antiretroviral treatments are not prohibitive, in part because of the limited length of stay, but also because early intervention and treatment is cost-effective particularly if hospitalizations are avoided. Because of the high rate of turnover in a jail population, rapid testing is an effective method to reach many at-risk individuals, bring care and treatment to those in need, and deliver prevention messages.

References:
[1]http://www.cdc.state.ca.us/ReportsResearch/OffenderInfoServices/WeeklyWed/TPOP1A/TPOP1Ad060322.pdf
[2]http://www.leginfo.ca.gov/cgi-bin/usweb/postquery?bill_number=ab_2383&sess=CUR&house=A&template=California
[3]http://www.dhs.ca.gov/ps/ooa/Reports/
[4]http://www.dhs.ca.gov/ps/ooa/Reports/aidslaws/pdf/2616HIVAIDSLaws2005.pdf
[5]Beckwith CG, Flanigan TP, del Rio C, et al. It is time to implement routine, not risk-based, HIV testing. Clin Infect Dis. Apr 1 2005; 40(7):1037-40.
[6]Boutwell A, Rich JD. HIV infection behind bars. Clin Infect Dis. Jun 152004;38(12):1761-63.
[7]http://www.retroconference.org/2004/cd/Abstract/90.htm

HIV 101: PREVENTION COUNSELING, TESTING AND REFERRAL

Carol A. Browning, MS, RN, BC*
Rhode Island Department of Health's Office of HIV and AIDS

**Nothing to Disclose*

HIV Prevention Counseling and Testing is routinely recommended for all clients in settings where the population is at increased behavioral or clinical risk for acquiring or transmitting HIV infection,

Continued on page 8

Stepwise Approach to HIV Counseling, Testing and Referral[3]

PRESTEST SESSION	
1. Introduce yourself to the client. Hello my name is Mary and I will be talking with you today about your risks and concerns regarding HIV. **2. Explain the role of the counselor.** I will be working with you to help determine your risk of HIV infection from any previous risky behavior as well as your risk of getting infected with HIV in the future. **3. Indicate the duration and content of the session.** You will probably be here about 20-40 minutes. We will talk about the HIV test itself and what it means. We will see whether you will need to have another test because of any recent risky exposure you may have had that would not be picked up by the test today. Counseling regarding the nature of the HIV antibody test and the so called 'window period' between exposure and detection of HIV antibodies may be appropriate to discuss. Discuss procedure for notification of the inmate of the test result and who else will be notified of the result. Describe whether information discussed will be confidential and any limits of that confidentiality.	**4. Explore HIV and STD risks.** If you were infected, how do you think you may have gotten infected? **5. Identify challenges to risk reduction.** What do you think may have kept you from protecting yourself at the time you had unsafe sex/shot drugs? **6. Discuss strategies to risk reduction.** How would you most like to reduce your risk for HIV? Tell me how you feel you could go about making the change? **7. Provide referrals.** Who in your life do you feel is supportive of you? Would you feel comfortable talking to someone about your risks and how to change your risks? **8. Address immediate questions and concerns.** What other concerns do you have before you leave today? Provide information regarding who the inmate should contact if he/she has any other questions after the session.

IDCR 101...

(continued from page 7)

regardless of setting prevalence.[1] HIV Prevention Counseling seeks to reduce HIV acquisition and transmission. Field specialists have identified skills and counselor characteristics that are important for effective HIV Prevention Counseling.[2] These skills and characteristics include some of the following:

- Belief that counseling can make a difference
- Active listening skills
- Ability to use open-ended rather than closed-ended questions
- Ability to provide a supportive atmosphere to allow trust to be built
- Comfort in discussing specific HIV risk behaviors (i.e. explicit sex or drug behaviors)

Additionally, providers must be willing to stay current on new counseling techniques and testing technology. Below is an abridged guide for assisting providers in providing a client-centered counseling session. An example of a statement/technique is provided for each step. For more thorough guidelines, please refer to the CDC Recommendations issued in 2001.[1]

Although it is unlikely that a single episode of HIV Prevention Counseling will result in the immediate and permanent adoption of safer behaviors,[4] client-centered HIV counseling and attendant prevention services (i.e. referral and partner notification) do contribute to the initiation and maintenance of safer behaviors. By utilizing the above steps, high-risk behaviors (and the potential for transmission) are more likely to decline when a patient undergoes personalized, interactive counseling rather than a didactic, information approach.[5]

PROVIDING NEGATIVE RESULTS

1. Welcome the client back.
My name is Mary, you may remember from last time. Come in and have a seat.

2. State results clearly and simply.
Your test result is negative, which means that the test did not detect evidence of HIV infection in your blood.

3. Review the meaning of the results.
This negative result means that you did not get infected with HIV from anything that happened to you within the past 3 to 6 months.

4. Assess the client's reaction to the result.
What are you feeling about your negative test result?

5. Note the need to retest for any recent risk behavior.

1) For the inmate who has had a recent risk (< 3 to 6 months):
You mentioned last time you had a recent exposure. You may want to consider another test 3 months from that high-risk exposure; or,

2) For the inmate who has had a risk greater than 3 to 6 months ago:
From your last session, I recall that your exposure was more than 3 to 6 months ago, therefore, you do not need to be tested again for that exposure.

In addition to the above points consider the following where applicable:

1. Assess the client's readiness to make efforts toward safer behavior.
- Let's talk about the plan that you made last week.
- Do you plan to use condoms/clean needles, talk to your partner about being safe, etc?
- How do you continue to remain negative for HIV?

2. Provide encouragement and support for efforts.
- It's great you were able to consider talking to your partner about being safe.
- Sounds like you made a healthy change for you.

3. Identify benefits/barriers to the risk-reduction plan.
- What will work best for you?
- What would make it easier for you?
- What is challenging to do?

PROVIDING POSITIVE RESULTS

1. Welcome the client back.
My name is Mary, you may remember from last time. Come in and have a seat.

2. State results clearly and simply.
Your test result is positive, which means that at some point in your past you have been infected with HIV.

3. Allow the client time to absorb the tests results.
Counselor may want to sit quietly with the client at this time.

4. Review the meaning of the results.
This positive result means you have HIV, not necessarily that you have AIDS. Other tests can help you and your doctors understand more about the infection.

5. Assess the client's reaction to the result.
How had you thought the results would come back?
Is the result surprising to you?

6. Recognize the challenges of dealing with a positive result.
What is the most difficult thing for you to deal with right now?

In addition to the above points consider the following where applicable:

1. Assess whom the client plans to tell of the results.
- Do you want to tell those who care about you?
- Who you can trust?
- How do you think they will respond?
- I will write down some support agencies that you may find helpful (if applicable).

2. Review medical care available and identify medical care in community if inmate about to be released.
- Where do you go for medical care? (if applicable)
- What do you think about going to see a specialist (provide name)?

3. Identify need for referrals.
- What is the most important thing for you to deal with first?
- What other things do you need help with?
- Do you have concerns about housing, medical issues or insurance after you are released (if applicable)?

References:
[1]CDC. Revised guidelines for HIV counseling, testing, and referral. MMWR 2001;50(RR-19).
[2]Technical Expert Panel Review of CDC HIV Counseling, Testing and Referral Guidelines. February 18-19, 1999; Atlanta, Georgia.
[3]CDC. 2-Session RESPECT HIV Counseling Intervention. May 16, 2003.
[4]Higgins DL, Galavotti C, O'Reilly KR, et al. Evidence for the effects of HIV antibody counseling and testing on risk behaviors. JAMA. 1991;266:2419-29.
[5]Ram Stead, C. HIV Counseling, Testing and Referral: Putting revised guidelines to use. Clinician Reviews. 2003;13(11):58-64.

Save the Dates

Satellite Videoconference "Hepatitis B & C with HIV Co-infection"
April 19, 2006
12:30-2:30 EST
CME-accredited webstream of last conference available online
Visit: www.amc.edu/patirnt/hiv/hivconf/index.htm

17th International Conference on the Reduction of Drug Related Harm
April 30-May 4, 2006
Vancouver, British Columbia, Canada
Visit: http://www.harmreduction2006.ca/

American Correctional Health Services Association Conference
May 11-13, 2006
Durham, NC
Visit:http://www.achsa.org/displaycommon.cfm?an=4

Society of Correctional Physicians Semiannual Meeting
May 13, 2006
Durham, NC
Visit:http://www.corrdocs.org/events/events.html

Understanding Our Patients: HIV and Women in Corrections
June 16, 2006
Moody Gardens Resort and Conference Center
Galveston, Texas

International Prisoner Health: Achieving International Standards in Prison Health Care
June 19-20, 2006
Tallinn, Estonia
Visit:http://www.tandfevents.com/prisonerhealth

News and Literature Reviews

Prior, unprotected sex with multiple partners among young, incarcerated men

Margolis et al. surveyed 550 men (mean age 23 years, range 18-29) in California, Mississippi, Rhode Island and Wisconsin state prisons about their HIV/STD risk behaviors prior to incarceration to identify factors associated with the men's engaging in unprotected vaginal or anal sex with two or more partners ("multiple partners") in the three months prior to incarceration. Men were asked about their sexual activity, condom use and perception of risk during the three months prior to incarceration, with two types of partners: "main" (defined as having a special emotional commitment) and "casual" (defined as lacking a feeling of commitment). They were also asked about their history of alcohol and drug use, housing status (with stable housing defined as living in a house or apartment that the participant or his friend rented), employment, access to healthcare services, and involvement in organized religion.

Seventy-one percent of the men reported multiple sex partners and 45% (n=249) reported having unprotected sex with multiple partners. These 249 men constituted 53% of the cohort with a prior STD diagnosis and 57% who reported having a "risky" sexual partner (defined as someone they believed to have used crack, injected drugs, traded sex for drugs or money, had multiple sex partners or been infected with HIV or an STD). Participants had engaged in vaginal (98%) and anal (46%) sex.

Multivariate analyses indicated that men who reported having a high-risk sexual partner or having drunk five or more alcoholic beverages at least once per week were more likely to have engaged in unprotected sex with two or more partners. By contrast, men who reported having stable housing or having participated in organized religion were less likely to have engaged in unprotected sex with multiple partners. The authors laud prisons that have opened their doors to community-based organizations, creating linkages to preventive health programs as well as a continuity of care that extends from the period of incarceration through the men's transitions back to their communities.

Margolis AD, MacGowan RJ, Grinstead O, Sosman J, Kashif I, Flanigan TP, and the Project Start Study Group. Unprotected Sex With Multiple Partners: Implications for HIV Prevention Among Young Men With a History of Incarceration. Sexually Transmitted Diseases 2006;33(3):175-80.

Sexual Activity of HIV-Infected Persons Recently Released from Prison

To investigate sexual HIV transmission risk behaviors among HIV-infected state prison inmates prior to and after incarceration, Stephenson and colleagues interviewed soon-to-be-released, HIV-infected North Carolina State prison inmates both before and after their release. Researchers administered qualitative and quantitative questionnaires to the inmates both pre-release (face-to-face) and an average of 45 days post-release (via telephone). The questionnaires addressed sexual activity, number and types of sexual partners, condom use, HIV disclosure to sexual partners, beliefs about HIV transmission, and substance use during sexual relations.

Prior to release, 86 participants (57% women, 74% African-American, 83% heterosexual, 77% unmarried, 76% diagnosed with HIV infection prior to this incarceration, mean sentence duration of 416 days) were interviewed. In the year prior to their incarceration, all had been sexually active and the mean number of partners was eight. Condom use varied by sex act; 22% of those engaging in penile-vaginal sex and 42% and 14%, respectively, of the seven men and seven women who had receptive anal intercourse reported not using condoms during this period.

Following release, 64 (75%) of the participants were re-interviewed a mean of 45 days after release. The remaining participants were lost to follow-up, re-incarcerated, dead or had dropped out of the study. Following their release from prison, almost half (47%) of the participants were sexually active within an average of 11 days (range 1 hour to 60 days post release). Ninety percent of these sexually active participants had a "regular" (i.e. main) partner and 86% had sex exclusively with their regular partners. Of those with a regular partner, 81% returned to the same partner they had prior to incarceration. Only one releasee had both a regular and non-regular partner, and only two participants (3%) reported having a new sexual partner after their release. Condom use was less likely during sex with a regular partner than with a more casual partner; 26% of those with a regular partner had sex with that partner without using a condom while all of those with non-regular partners used condoms during sex with these individuals. More than half of sexually active participants believed their partners to be HIV-uninfected, and of those who were sexually active, 31% believed it was "somewhat" or "very" likely they would eventually infect their HIV-uninfected partner. Post-release, 79% of sexually active participants reported an increase in condom use following release and 97% of releasees reported disclosure of their HIV status to their current sexual partners.

These results suggest that a significant proportion of HIV-infected individuals engage in unsafe sex while non-incarcerated, particularly with their main or regular partners. However, self-reported disclosure of HIV status to partners was high and condom use reportedly increased following incarceration, suggesting that in-prison counseling may have been at least partially effective. The authors recommend enhancement of testing and counseling, including the development of prevention interventions that can span the period between incarceration and release.

Stephenson BL, Wohl DA, McKaig R, Golin CE, Shain L, Adamian M, Emrick C, Strauss RP, Fogel C, Kaplan AH. Sexual behaviours of HIV-seropositive men and women following release from prison. Int J STD AIDS. 2006;17(2):103-8.

Resources

CDC Guidelines Related to HIV
http://www.cdc.gov/hiv/resources/guidelines/index.htm
CDC Guidelines for Rapid HIV Testing
http://www.cdc.gov/hiv/rapid_testing/index.htm
CDC Routine HIV Testing of Inmates in Correctional Facilities
http://www.cdc.gov/hiv/topics/prev_prog/AHP/resources/guidelines/Interim_RoutineTest.htm
CDC Demonstration Projects for State and Local Health Departments: Routine Rapid HIV Testing of Inmates in Short-Stay Correctional Facilities. October 2004.
http://www.cdc.gov/hiv/topics/prev_prog/AHP/resources/factsheets/Correctional_Facilities.htm
HIV Care in Corrections. Dr. Douglas Fish, Head of Division of HIV Medicine, Albany Medical College
http://www.nynjaetc.org/curriculum/Corrections.ppt
Videos Pertaining to HIV Testing in Correctional Settings
Available at:http://www.aids-ed.org/aidsetc?page=et-30-36
HIV Transmission and Prevention in Prisons
Dr. Elizabeth Kantor, University of California-San Francisco
http://hivinsite.ucsf.edu/InSite?page=kb-07-04-13
International AIDS Society-USA: Webcasts and Podcasts
http://www.iasusa.org/webcast/index.html

Self-Assessment Test for Continuing Medical Education Credit

Brown Medical School designates this educational activity for one hour in category one credit toward the AMA Physician's Recognition Award. To be eligible for CME credit, answer the questions below by circling the letter next to the correct answer to each of the questions. A minimum of 70% of the questions must be answered correctly. This activity is eligible for CME credit through February 28, 2006. The estimated time for completion of this activity is one hour and there is no fee for participation.

1. The potential benefits that follow the diagnosis of HIV infec tion among the incarcerated include each of the following EXCEPT:
   A. Opportunity to initiate medical care to prevent opportunistic infections and HIV disease progression
   B. Prevention counseling
   C. Referral to community based services prior to release
   D. Permits correctional staff to identify which patients to examine only while wearing gloves

2. Each of the following organizations opposes mandatory HIV testing of inmates EXCEPT:
   A. American Medical Association (AMA)
   B. World Health Organization (WHO)
   C. American Public Health Association (APHA)
   D. None of the above

3. Which of the following statements regarding voluntary HIV testing are TRUE:
   A. Opt-in testing entails the individual providing informed consent to be tested
   B. With opt-out testing the individual will be tested unless he or she requests that the test not be performed
   C. The majority of state prisons in the US provide voluntary HIV testing to entering inmates
   D. A and B
   E. A, B and C

4. As described by Rosen et al., criticism of voluntary HIV testing for inmates includes:
   A. In some state prisons, HIV prevalence rates detected through voluntary testing programs were lower than prevalence rates found in blinded seroprevalence studies.
   B. The required pre-test counseling and consent process create an undue obstacle to testing and may perpetuate stigma associated with HIV.
   C. Voluntary HIV testing affords inmates less confidentiality as compared to mandatory testing.
   D. A and B
   E. A, B and C

5. In most prisons, inmates diagnosed with HIV infection are segregated in specialized facilities (TRUE or FALSE)?
   A. True
   B. False

IDCR Evaluation

5 Excellent 4 Very Good 3 Fair 2 Poor 1 Very Poor

1. Please evaluate the following sections with respect to:

	educational value	clarity
Main Article	5 4 3 2 1	5 4 3 2 1
In the News	5 4 3 2 1	5 4 3 2 1
Save the Dates	5 4 3 2 1	5 4 3 2 1

2. Do you feel that IDCR helps you in your work?
   Why or why not?

3. What future topics should IDCR address?

4. How can IDCR be made more useful to you?

5. Do you have specific comments on this issue?

Brown Medical School • Office of Continuing Medical Education • Box G-A2 • Providence, RI 02912
The Brown Medical School is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education activities for physicians.

For Continuing Medical Education credit please complete the following and mail or fax to 401.863.2202 or register online at www.IDCRonline.org. Be sure to print clearly so that we have the correct information for you.

Name _____ Degree _____

Address _____

_____

City _____ State _____ Zip _____

Telephone _____ Fax _____